Georgia Department of
Behavioral Health and Developmental Disabilities
DBHDD

Developmental Disabilities Rate Setting Project

Public Comments and Responses

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INTRODUCTION

Since the Fall of 2010, the Georgia Department of Behavioral Health and Developmental Disabilities' (DBHDD) Division of Developmental Disabilities (Division) has been evaluating provider reimbursement rates for its major services with the assistance of Burns & Associates, Inc. Proposed rate models were released during a February 23, 2011 presentation to providers that participated in a provider cost survey. The models and additional supporting materials were subsequently sent to all providers in a February 28 email.

Interested parties were given one month, through April 1, 2011 to submit comments in response to the proposed rate models. On March 28, 2011 a reminder email was sent to all providers reminding them of the comment deadline.

In total, comments were received from representatives of 92 providers, 46 parents, and other associations, advocacy groups, and stakeholders. The comments were summarized and organized into topical areas and responses were prepared. This document presents the 134 summarized comments and responses in the following order:

- General
  - Provider Cost Survey
  - Other Comments
- Assessing Individual Needs Using the Supports Intensity Scale
- Wages
- Employee Related Expenses (ERE)
- Productivity
- Administration and Program Support
- Transportation
- Support Coordination
- Community Residential Alternative
  - Group Homes – Service Design
  - Group Homes – Rate Model Assumptions
  - Host Homes – Service Design
  - Host Homes – Home Functions
  - Host Homes – Agency Functions
- Community Living Supports and Respite
- Community Access and Prevocational Services
  - Annual Expenditure Cap
  - Group Sizes
  - Billing
  - Rate Model Assumptions
  - Community Access-Individual
- Supported Employment
  - Service Design
  - Rate Model Assumptions
- Behavioral Supports Consultation

The summarized comments and responses follow.

GENERAL

1. One provider stated that the waiver application sets out that there will be a cost-based rate-setting methodology collected from providers annually and that "While this hasn't been done until now… the cost study is being used to justify a new rate setting methodology based on levels of care and tiers, not to determine if the current rates for services are adequate."

In the waivers approved beginning October 1, 2007, Appendix I-2 states:

> Finally, DHR's goal is to transition to a cost-based rate setting methodology, by January 1, 2009 in order to develop future NOW rates. This methodology entails the collection of provider cost reports from providers to develop and justify rates. Cost information will be submitted annually using a uniform cost report form prescribed by DHR with approval from DCH.

Although the January 1, 2009 timeline was not achieved, the ongoing rate-setting process is in substantial compliance with this provision. A cost report was developed and administered to the providers (the provider cost survey) and the information gleaned from the reports was used to inform and justify the rates. The Appendix does not require cost reports from all providers.

Inasmuch as the information contained in the report was the most recent completed fiscal year (2010) it is not yet timely for the Division to request a new report.

With respect to the recent renewal of the Comprehensive waiver, Appendix I-2 states:

> At the time of waiver renewal submission, DBHDD is engaging in collection and analysis of provider cost reports in order to transition to a cost based rate setting methodology. Cost information will be analyzed by both DCH and DBHDD and new service rates, if indicated, will be recommended through the established process and submitted to CMS through waiver amendment.

The current rate setting process complies with this statement.

2. One commentator noted that the proposed rate models provide a "logical, orderly approach".

The Division appreciates the commentator's observation.

The independent cost model used to develop the proposed rates is intended to reflect the costs that providers face in delivering services based on several sources of information, including a provider cost survey.

These costs are detailed in the proposed rate models so that providers and other stakeholders can see exactly the assumptions that were made for every component of the rate (direct care staff wages, benefits, and productivity; administration and program support; and other service-specific factors). This level of detail is intended to provide transparency, the ability to adjust the rates for policy objectives (e.g., if the State wished to increase training requirements, the productivity factor could be adjusted to reflect this change), and efficiency in maintaining rates by allowing the models to be scaled and adjusted.

3. One provider stated that the rate-setting process lacks transparency.

The Division disagrees with this comment. Providers have been involved throughout the rate-setting project. Efforts to include providers in the process include:

- Meeting with provider representatives (drawn largely from the membership of SPADD, the Service Providers Association for Developmental Disabilities) on August 8, 2010 to present the format and questions to be asked in the survey.

- Conducting conference calls on August 17 and August 24 to accept input from the representatives.
- Using the Division's provider contact list to email on August 30 an invitation to all providers to participate in the provider cost survey
- Meeting with the provider representatives on October 22 to discuss the summary of cost survey results.
- Working with SPADD to resurvey providers on administrative and program support costs in November.
- Inviting all providers that participated in the cost survey to attend a February 23 presentation of the proposed rate models.
- Emailing the proposed rate models and related materials to all providers on February 28
- Allowing a 30-day public comment period and, via this document, distributing the comments, responses, and consequent revisions to the proposed rate models

Before the proposed rates are finalized, the Division is planning to organize a forum to which all providers will be invited. This forum will cover the proposed rate models and any revisions that are being made as well as areas for which additional provider input will be requested. This meeting is anticipated to take place in May or June. Once details are finalized, invitations will be emailed to providers. Overall, the Division believes this rate setting process has been open and transparent.

4. Several commentators stated that the process was not open to providers and family members.

The response to comment 3 outlines the efforts undertaken to involve providers in this rate-setting project. As noted, Burns & Associates invited all providers to participate in the provider cost survey using DBHDD's provider contact list. No providers were excluded, though some email addresses proved to be incorrect.

Consumers' family members were not surveyed and have not been directly involved in the rate setting process to date. However, several family members did provide input during the open comment period and those comments are incorporated in this document.

The rate setting process to this point has primarily focused on the development of proposed rates based on the providers' costs and the service requirements. The Division appreciates that families may want to have the opportunity to comment on the proposed rates and, now that rate models have been proposed, intends to conduct a consumer and family forum in each of the Division's six regions. These forums are expected to occur in June. Information regarding the times and locations of the forums will be announced once plans have been finalized.

With respect to self-directed services and the rate setting process, the Division notes that service guidelines are the same whether or not a service is self-directed. The rate-setting project includes most of the services eligible for participant direction. It has been the policy of the Division to maintain rate parity between agency and self-directed delivered services. The Division believed that the agencies rather than the families could provide more meaningful information with respect to costs, and therefore the families were not included in the provider cost survey process. As indicated above, however, the Division is planning to hold consumer and family forums to allow families to comment on the proposed rates.

Provider Cost Study

5. One commentator asked whether Burns & Associates visited any providers.

No site visits were conducted as part of the provider cost study, but, as detailed in the response to comment 3, provider representatives have been involved throughout the process.

6. Several providers stated that they were not invited to participate in the provider cost survey and one stated that the initial survey was sent only to SPADD membership. Additionally, several commentators stated that providers were given insufficient time to complete the cost survey and one commentator stated that providers were never briefed on how to complete the survey.

The provider cost survey and instructions were emailed to providers on August 30, 2010 using a list of email addresses on file with DBHDD. All providers for whom the Division had a valid email address, whether SPADD members or not, received the survey at the same time.

Burns & Associates provided several avenues for providers to receive assistance in completing the cost survey. B&A hosted a conference call to explain the survey and answer questions. Subsequently, a question-and-answer document was produced and emailed to all providers. Additionally, the survey and instructions included contact information for B&A staff who could provide assistance and respond to questions.

The original due date for the submittal of the cost survey was September 17, allowing three business weeks for completing the survey. Prior to releasing the cost survey, the quick turnaround was discussed with provider representatives during the meetings and conference calls described in the response to comment 3 and these representatives were asked to alert their fellow providers to the nature of the survey and the tight time frame. Ultimately, based on provider requests, the due date was extended an additional week, to September 24. Additionally, B&A provided extra time to every provider that requested it, and continued to accept surveys for two more weeks, through the first week of October.

7. Several commentators noted that only 29 percent of the Division's providers participated in the provider cost survey and asked whether the study was therefore invalid. One provider stated that Burns & Associates reported that the responding providers represented 80% of total funding, but since they are one of the largest providers and did not participate based on the advice of their attorney, the 80% figure "might be a little high."

As Burns & Associates has reported, approximately 29 percent of Division providers opted to complete the provider cost survey. This figure, however, requires context.

The overall percentage is depressed due to the number of small Community Residential Alternative providers that did not complete the survey. Looking at each of the other major services included in the rate-setting project (those on which DBHDD expended at least $1 million in fiscal year 2010 –), at least 40 percent of the providers submitted a survey. For CRA, 27 percent of providers completed the survey. Provider participation by service is included in the table below.

Figure 1: Provider Cost Survey Participation Rate by Service

Service	Total Providers[1]	Survey Respondents	Percent	As a Percent of Total Spending[2]
Community Residential Alternative	204	54	26.5%	60.5%
Community Access-Group	136	56	41.2%	60.0%
Community Access-Individual	139	60	43.2%	44.5%
Community Living Support (15 min.)	87	46	52.9%	46.2%
Community Living Support (daily)	87	41	47.1%	59.2%
Prevocational Services	95	45	47.4%	70.7%
Support Coordination	4	4	100%	100%
Supported Employment-Group	78	42	53.8%	65.5%
Supported Employment-Individual	80	39	48.8%	35.4%

[1]For each service, total number of providers that submitted at least one claim in FY 2010, through April 2010.
[2]The percentage of total Division spending in FY 2010, through April 2010, paid to cost survey respondents.

As demonstrated by the table, the relatively larger providers, those that provide care to the majority of waiver enrollees and that most influence the market, responded to the survey at much higher rates than smaller providers. Participating providers represented 61 percent of all waiver expenditures. Even in CRA, the 27 percent of providers that completed the survey represented 61 percent of CRA spending, underscoring that the major CRA providers participated in the survey. Of the 10 largest providers (as measured by revenue), 7 completed the survey; of the 25 largest, 19 participated. Of the 50 largest CRA providers, 27 completed the survey.

This information is included in both the Provider Survey Results (see page 4) and Overview Presentation of Proposed DDD Rates (see slide 14) documents that were shared with providers. B&A does not believe that it ever stated that responding providers represented 80 percent of waiver expenditures; such a comment would have been in error. All documents correctly note that respondents accounted for 61 percent of waiver expenditures.

While the relatively low response rate in terms of the number of providers is unfortunate, the amount of payments these responding providers represent (61 percent) produces a picture of the provider community that is more than adequate to inform the rate setting process. The fact that a number of small providers chose not to respond to the survey does not compromise the information gleaned from the responding providers.

8. Several commentators stated that provider cost survey data submitted by Community Service Boards was excluded from the survey analysis and rate-setting process. One provider suggested that Community Service Boards are overrepresented in the data and that small providers should be weighted more heavily.

Responses from Community Service Boards (CSBs) were not excluded from the analysis of the provider cost survey and Burns & Associates is uncertain why several commentators believe otherwise. All submitted surveys were included in the survey analysis and, since CSBs participated at a greater rate than other providers, their responses had an outsized impact on the results (though B&A does not believe this influence is so large as to require an adjustment to reduce their impact).

In terms of developing the factors for the proposed rate models, B&A did state that the proposed employee benefits package is more representative of what is offered by non-CSBs than by CSBs (see slide 18 of the Overview Presentation of Proposed DDD Rates). This issue is discussed in greater detail in the response to comment 40.

With respect to the suggestion of "overweighting" small providers, the Division presumes that the suggestion is made because the commentator believes small providers have higher costs than larger providers, and as a result, such overweighting would result in higher rates. While the Division appreciates the role that small providers play in delivering services to its service population, it does not believe that overweighting the small provider responses is in the best interests of the service delivery system as a whole.

9. One provider stated that it was "reported in several meetings, that very few data from providers was used in the final proposal" and suggested that another survey be conducted.

The purpose of the provider cost survey was to inform the rate-setting process. All of the information submitted by providers was reviewed and considered as part of the rate-setting process.

The results of the provider cost survey were never intended to be the sole determinant of the proposed rates, though the survey results do have a significant influence. The proposed rate models consider information from a number of sources as well as State policy decisions. In some instances, the assumptions built into the proposed rate models exceed the costs reported by providers (e.g., salaries and benefits for non-CSBs) and in other instances the assumptions are less

than the costs included in the proposed rate models (e.g., benefits for CSBs, administrative and program support costs).

10. One provider stated that "Removing two standard deviations of responses lowers the statistical accuracy of the 'sample' since it wasn't taken randomly. In fact a statistically correct sample would require confidence level which is not apparent" in the report.

The provider cost survey was not designed to be a random sample of provider costs; indeed, if all providers that were supplied with the survey submitted responses, all of the results would have been used in the rate setting process. If the cost survey had been designed as a random sample, given the stratification that would have been necessary and the 29 percent response rate discussed in response comment 7, it is likely that either there would have been the necessity to continually reselect sample candidates or the overall results would have been far less representative than the results achieved through the approach employed in the process.

The objective of the provider cost survey was to develop information on costs that would inform the rate setting process, and it is believed that the survey provided sufficient information (again, as described in the response to comment 7) to meet this objective.

As to the commentator's objection to removing responses that were greater than two standard deviations from the mean, failure to remove such outlier responses would have produced unreasonable information. As noted, the survey aimed to establish representative values for the factors in the rate models. The 'extreme' values that were excluded from the analyses were not representative of overall market costs and/ or were not credible responses. Examples of values that were removed included a provider's response that each Community Living Support worker receives 49 hours of one-on-one supervision per week and another provider's Community Access staff traveling 400 miles in an average day.

It is believed that the cost survey provided a sufficiently accurate representation of provider costs to inform the rate setting process.

11. One provider stated that "CMS has three general standards for determining levels within populations, 100% review, a stratified review or a representative sample with an associated confidence level" and that the provider cost survey meets none of these.

The commentator appears to be referring to a section of the Medicaid Section 1915(c) waiver related to performance measures. Various quality sections of the waiver application require performance measures and states must specify the sampling approach that will be employed as part of the measurement. These performance measures, and the associated sampling approaches, are not related to provider rates. The rate-setting approach employed to develop the proposed rates is consistent with federal requirements and has been used to set provider rates in waiver programs in numerous jurisdictions across the country.

Other Comments

12. Several commentators noted that individual budget allocations must be amended to accommodate changes to provider rates.

The commentator is correct. Changes to the provider rate schedule will necessitate revisions to individual budget allocations. Once rates are finalized but prior to implementation, budgets will be revised to reflect the amount necessary to access appropriate services.

13. One provider noted that DBHDD has stated that "no person would receive a cut of more than 20% [of their budget] in any one year", but estimates that individuals at SIS levels 1 through 4 would lose between one-quarter and one-half of their funding "or at least the ability of providers to bill, which is the purpose of the funding in the first place".

The proposed rate models are not intended to result in reductions to services for individuals. As noted in the response to comment 12, implementation of new rates would be preceded by recalculations of individual budget allocations. This will result in increased budgets for some individuals and decreased budgets for others. These changes, however, will reflect changes in reimbursement rates rather than service levels.

14. One provider stated that "if cuts need to be made, make them a percentage across the board."

The purpose of the rate-setting project is not to reduce spending, but to establish appropriate reimbursement rates for the major services covered by the Comprehensive Supports Waiver and the New Options Waiver. Analyses were conducted for each service and the proposed rate models attempt to account for the wages and benefits of direct care staffs, administrative and program support expenses, and other costs. For some services, the proposed rates would be increases; for others, rates would be reduced.

Once the rates are finalized, an analysis will be performed to determine the impact of the rates on the Division's budget. Once that impact is determined, a strategy will be developed on the best approach to implement the new rates.

15. One provider stated their belief that the proposed rates "restrict community inclusion, individual choice in their living situation, and unfairly biased toward more restrictive settings such as group homes and facility-based prevocational programs."

Each of the proposed rate models was developed to reflect the costs of the services without regard to whether the service was community-based or facility-based.

As such, the proposed rate models do not include any value judgments regarding the services, but try to reflect the cost of providing the services. The commentator did not make clear how the proposed rates would restrict community inclusion or individual choice, which are values that the Division shares.

16. Several commentators noted the difference in providing services in rural areas compared to urban areas.

The Division's current rates do not vary between urban and rural areas. The decision was made to continue this practice in the current rate setting project based on the assumption that there are, in general, off-setting differences between the costs faced by providers in rural areas and those in urban areas.

A number of commentators mentioned transportation specifically as a cost that is higher in rural areas of the State. Inasmuch as providers in rural areas travel greater distances, costs would be higher. However, other costs are frequently lower in rural areas. Wages are an example. Using federal Bureau of Labor Statistics data from May 2009, wages were evaluated for one professional job classification (21-1021: child, family, and school social workers) and one paraprofessional position (39-9021: personal and home care aide). For social workers, the median wage in the Atlanta metropolitan area ($16.80) was two to ten percent higher than every other metropolitan area except for Chattanooga (part of this metropolitan area crosses into Georgia) and Savannah. For home care aides, the median wage in Atlanta ($9.10) was two to 17 percent higher than every area except for Savannah.

The proposed rate models aim to reflect the 'typical' cost of providing a given service. It is expected that individual cost components within each model (e.g., wages, benefits, etc.) will vary across providers and across regions. Since some costs are higher in rural areas and some are lower, it is assumed that the cost variances across regions offset overall. The individual cost components are not prescriptive (e.g., providers do not have to pay the wages assumed in the proposed rate models, see the response to comment 35), so providers have the flexibility to utilize their revenues in the manner best suited to their unique cost structures.

17. One provider stated that certain services ("Specialized Medical Supplies, Specialized Medical Equipment, Environmental Modification, FSS etc.") and self-directed services were not measured in any capacity and that this "exclusion… represents a selective process that indicates a preferred status. This is not allowable under CMS Medicaid rules."

The current rate setting process includes all of the major waiver services, accounting for approximately 99 percent of total waiver expenditures, but it does not include all waiver services. For most of the services mentioned by the commentator – specialized medical supplies, specialized medical equipment, and environment modifications – there is not a set rate because of the wide variety of goods and services that are included in these categories. For these services, the existing method/ level of compensation to providers will be maintained; for example specialized medical equipment and environmental modifications are based on the lower of three price quotes or the annual cap for each service while specialized medical supplies are participant-specific.

Similarly, many, but not all, of the services eligible for participant direction were included in the rate-setting process. For the services that were included, because the service guidelines are the same whether or not a service is self-directed, the same rate will apply to self-directed services and those that are not self-directed. For the services that are eligible for participant direction but not included (therapies and transportation), the current rates will continue to be utilized.

18. One provider stated that submitting comments to Burns & Associates "is so fraught with conflict of interest issues [that] to be even contemplated as orthodox is insensible" and suggested that comments be collected by the Department of Community Health or the Department of Behavioral Health and Developmental Disabilities.

The process of submitting comments to Burns & Associates' was decided upon in order to facilitate the summarization of the comments and to allow B&A to review the comments to identify potential revisions to the proposed models. Commentators were free to provide copies of their comments to the Division and to DCH, and indeed many did. Further, this summarization of comments will be made available to the public so that individual summaries that are misinterpreted or omitted can be identified to the Division and DCH.

Finally, since the Division, and not Burns & Associates, is making final decisions on the proposed rates, it is not apparent how a conflict of interest could occur as a result of the process adopted for the submission and summarization of comments.

19. One commentator noted that "…critical oversight in assuring that the organizations were distributing their allocations effectively and that the individuals being served were receiving everything they needed…" is not occurring.

The scope of this rate-setting project is limited to the development of provider reimbursement rates based on the costs that providers face in delivering services. The project does not address monitoring issues.

ASSESSING INDIVIDUAL NEEDS USING THE SUPPORTS INTENSITY SCALE

20. Many commentators voiced support for varying rates based on individual need as determined by the Supports Intensity Scale (SIS), while many others objected to the concept.

The rates that vary according to individual needs as measured by the SIS are referred to as 'tiered' rates. The primary purpose of establishing tiered rates is to ensure fairness in the rate structure for both providers and service recipients.

Individuals should receive the services that they need in order to lead meaningful lives. These needs vary across individuals with some individuals requiring more intensive staffing and others requiring less staffing. In either case, providers should receive compensation that reflects the staffing required to meet the varying support needs. The tiered rates are intended to ensure that individuals can be provided the appropriate intensity of services (e.g. staffing requirements) associated with their support needs and that providers are appropriately compensated.

As summarized in the comments included in this section, commentators expressed a number of valid concerns related to the linkage of individuals' SIS assessments and provider reimbursement rates. Independent of the rate-setting project, the Division has been looking at many of the issues related to the training on and administration of the SIS. During this review, the Division has suspended the phase-in of individual budgets and continued to receive technical assistance from the American Association on Intellectual and Developmental Disabilities (AAIDD).

The Division is considering potential strategies to improve the administration of the tool. Areas of review will include, but not be limited to, training, inter-rater reliability, and information systems. The Division will also consider potential changes to the criteria used to assign individuals to SIS levels.

21. Several providers argued that tiered rates are contrary to person-centered principles and result in "labels" for individuals.

It is unclear why these commentators believe the tiered rates are contrary to person centered principles.

In fact, as noted in the response to comment 20, the proposed rate models seek to ensure that individuals receive the level of care that they need and, therefore, contribute to the person centered principles. Since the degree of support (e.g. staffing requirements) vary according to a person's needs, 'tiered' rates for Community Residential Alternative, Community Access-Group, Prevocational, and Supported Employment-Group services are proposed to recognize the differences in costs that providers face in providing the degree of support necessary. To not tier the rates for different levels of support needs will result in either some providers not receiving adequate compensation for individuals with higher support needs or providers declining to provide services to individuals with higher support needs. In either case, the outcome is undesirable.

With respect to the "labeling" comments, this is a valid concern. The Division discourages the labeling of individuals but feels that the merits of the tiered rates outweigh this concern.

22. One provider suggested a model based on the Department of Labor's Vocational Rehabilitation Program in which rates are negotiated between the vocational rehabilitation counselor and the provider based on a four-level system.

The current system operates on a published rate schedule, rather than negotiated rates, and the Division intends to continue this approach to provider reimbursement rates.

The tiered rates proposed for Community Residential Alternative, Community Access-Group, Prevocational, and Supported Employment-Group services are similar in concept to those in the Vocational Rehabilitation Program. Both systems seek to account for the fact that individuals require variable levels of support according to their individual needs. The difference relates to the determination of the appropriate tier for individuals.

The proposed rate models assign individuals to a tier based upon the Supports Intensity Scale. The SIS is a norm-referenced tool, providing more objective assessments. Additionally, using the SIS makes the system less reliant on providers' negotiation abilities. Overall, the use of SIS assessments is intended to produce a system designed to ensure fairness by providing similar services to individuals with similar needs.

23. Objections to the SIS included:

- ***It is too subjective.***
- ***It is conducted too infrequently to measure individuals' current needs.***
- ***It was designed for service provision and not financial allocation.***
- ***It is an incomplete tool that "does not create a true picture of an individual's life" and should be used along with the HRST, Nursing, Psychological, Behavioral, Social Work Assessments, and ISPs.***
- ***It does not account for services currently being received to maintain their current level of functioning, thereby understating that individual's needs.***

As has been readily acknowledged, the Support Intensity Scale (and all assessment tools) is not infallible. However, the SIS has gained wide acceptance and is used in numerous jurisdictions in this country and internationally due to its accuracy in gauging individuals' needs and its reliability.

No tool is absolutely complete as no instrument can capture a complete picture of a person's life. The SIS is used to determine the level of individual need and to help guide the service planning process. SIS results are currently used to influence individuals' budget allocations and are proposed to determine staffing requirements for the services noted in response to comment 22. However, the SIS is not intended as a replacement for other assessments; these tools will also be necessary to develop Individual Service Plans.

Assessment of an individual's capabilities very often requires judgment. What's key is to settle on a series of decision rules to govern how observers make their judgments. By doing so, observers can be trained to use the same decision rules and come to see pretty much the same thing and reach the same conclusions about what they see. In other words, observer judgments become reliable. Properly administered SIS's are highly reliable. As a result, the judgments made, because they are consistent with governing decision rules and reliable across observers, provide an "objective", not subjective measure of support needs.

Finally, in regards to timing, the SIS is meant to measure an individual's support needs in order to complete various tasks in relation to the support a typical adult would require. Assessed support needs do not vary considerably from week to week as developmental disabilities are not episodic. In fact, the SIS is shown to have ample "test/ retest reliability."

24. Commentators stated that the SIS does not assess certain specific needs, including:

- ***Mental health issues***
- ***Physical issues***
- ***Specific issues associated with autism (the commentator also noted that assessors do not have an adequate understanding of autism)***

While the SIS does gather information related to each of the issues noted by various commentators, it is true that no assessment tool is perfect for every issue for every individual.

The SIS was developed to assist in support planning for individuals with intellectual and developmental disabilities (IDD). IDD in Georgia covers a number of conditions, including autism spectrum disorders (ASD) and other IDD diagnoses. The needs that the SIS assesses – home living, community living, lifelong learning, employment, health and safety, and social – are all germane to individuals with IDD. The SIS also includes specific sections to identify individuals' exceptional medical support needs (Section 3A) and exceptional behavioral support needs (Section 3B).

In a process that was separate and apart from the rate setting process, the Division adopted the SIS to use in service planning and as a factor in determining individual budget allocations. As discussed in the responses to comments 20 and 21, a tiered rate was developed to better reflect staffing requirements and costs associated with individuals with higher support needs. While the SIS may not be a perfect tool for this purpose, it is widely recognized as among the best, if not the best tool to assess individuals that have IDD support needs. Given this recognition and the availability of SIS scores for all individuals receiving services in the system, the SIS results were used as a basis for the tiered rates.

Certainly some areas of the SIS will be less relevant to individuals with ASD (e.g., using the toilet) while others will be more relevant (e.g., interacting with others); this is true for persons with other IDD. In addition to the proposed rates, the exceptional rate process addresses the enhanced service delivery needs of individuals with exceptional behavioral and/or medical needs.

25. Several providers objected to SIS results for specific individuals.

The reasons for SIS level assignments that differ from provider expectations vary on a case-by-case basis. However, one explanation for several cases is that, in a number of instances, the SIS scores used to develop the provider rosters with consumer IDs and SIS levels were not based on individuals' most current assessments. The file that was used contained SIS assessments from 2008 and 2009. Although a total population's needs should not change much from year-to-year, an individual could see changes over the course of a couple of years. Updated SIS level assignments have not been completed because, as noted in response to comment 20, the Division is evaluating potential changes to the criteria for SIS levels. Prior to implementation of the proposed rate models, providers will receive notice of the SIS tier levels of individuals served.

26. Several providers also offered criticism of the administration of the SIS, stating that:

- ***There is wide scoring discrepancies in SIS scoring due to support coordinator turnover, insufficient training, inconsistencies across the State, etc.***
- ***SIS's were often completed by the support coordinator prior to the assessment meeting.***
- ***Providers are not always included during the administration of the SIS assessment.***
- ***Parents may provide unrealistic responses during the administration of the SIS so that their child does not hear negative comments.***

The Division believes that the substantial majority of SIS assessments are appropriately administered. However, as the commentators noted, there are instances in which the administration of the tool could be improved. As noted in the response to comment 20, the Division intends to review the administration of the SIS and opportunities for improvement. These efforts will include

an emphasis on the training that support coordinators receive, the number of individuals permitted to administer the tool, an evaluation of interviewer reliability, and other related issues.

27. One provider asked how the SIS assessment process will be safeguarded to ensure that scores are not unnecessarily inflated or deflated due to funding constraints.

The Division acknowledges the importance of ensuring that SIS assessments are not driven by funding or rate considerations. Some safeguards do exist. For example, the inclusiveness nature of the assessment provides perspectives from multiple observers. Responsibility for completing the SIS is assigned to support coordinators who are independent of the Division and of service providers. Further, as discussed in the response to comment 30, the criteria for assigning individuals to SIS levels is undisclosed so that no one "targets" particular scores in order to be assigned to a specific level. As part of its review of the administration of the assessment noted in response to comment 20, the Division will consider strategies to further safeguard SIS scores.

28. One provider stated that the SIS should be evaluated by a qualified neutral party rather than by the support coordinator.

The Division believes that support coordinators, who are independent of the Division and service providers, are well-positioned to administer the SIS and is not changing this practice. However, as noted in the response to comment 20, the Division will review the administration of the tool and identify potential improvements.

29. One provider stated that, since there are four rate tiers, there is no reason for seven levels; there should be only four.

The SIS assignments are expressed as seven levels rather than four (corresponding to rate tiers) in order to provide greater insight into the reasons that individuals are assigned to a given rate tier (e.g., Tier 4 includes SIS levels 5, 6, and 7 which correspond to serious intellectual or developmental disabilities, extraordinary medical needs, or extraordinary behavioral needs, respectively). However, as part of the review of the criteria used to assign SIS levels noted in response to comment 20, the Division will consider this suggestion.

30. Several providers requested the formulae for determining SIS levels.

The SIS levels are determined based upon individuals' scores on various sections of the SIS. The scoring of the SIS is open and transparent and the SIS levels (and corresponding rate 'tiers') are derived from these scores. It is at the assessment scoring level that involved stakeholders should confirm the appropriateness of the scores. The criteria for assigning SIS levels are not necessary in order to ensure that individuals are appropriately assessed. Further, as noted in the response to comment 20, the Division continues to evaluate these criteria and some adjustments may be made prior to implementation of the proposed rates.

31. One provider asked how rates would be determined for children under the age of 16 who do not have a SIS.

As the commentator notes, the adult version of the SIS in use in Georgia is not designed for administration to children under 16 years of age so they cannot be assigned to a tier in the same manner as adults. However, children are much less likely to be receiving the services with proposed tiered rates because they are generally not in a group home or host home, should not be receiving Prevocational or Supported Employment services, and are likely to be in school rather than a Community Access-Group program. Assignment of children who are receiving one of these services to a rate tier will be determined on a case-by-case basis.

32. One provider asked about how SIS levels would be affected by individuals moving to a different agency.

Individuals' SIS scores and levels should not be affected based on a change in provider.

33. One provider noted the need for an appeals process.

The Division has a process for the request of a review of the administration of the SIS by the individual or his/her representative.

34. One provider stated that it is their hope that the "individualized rate system" will decrease the need for the exceptional rate process.

It is expected that tiered rates for several services based on individuals' needs as determined by the SIS will substantially reduce, though not eliminate, the number of requests for exceptional rates. DBHDD is currently considering what, if any, revisions may be necessary to the exceptional rate process when the new rates are finalized and implemented.

WAGES

35. Several providers asked whether the salary and benefit assumptions included in the rate models will be mandatory.

No, providers are not required to offer the salary and benefit levels that are assumed in the proposed rate models.

The proposed rate models are intended to model the costs for the average provider of a given service. There are numerous variations that individual providers have from the rate models and, as such, within the total rates, providers are free to spend more or less on wages and benefits than what is included in the models.

With respect to wages specifically, the wages included in the proposed rate models generally exceed the wages providers reported in the cost survey. The wage levels included in the proposed rate models are based on the median wages for comparable positions (or combinations of positions) in Georgia as reported by the federal Bureau of Labor Statistics. The following table compares the wages assumed in the proposed rate models and those reported by providers. In general, the wages in the models are about 20 percent greater than the wages reported in the cost survey.

Figure 2: Comparison of Wages in Proposed Rate Models and Provider Cost Survey

	Wage in Proposed Rate Model	Provider Survey	% Diff
CRA - Group Home	$11.11	$9.11	22.0%
Community Living Support	$11.11	$8.94	24.3%
Respite -15 Minutes	$11.11	$10.28	8.1%
Respite Daily	$11.11	$11.50	(3.4%)
Community Access - Individual	$12.48	$10.40	20.0%
Community Access - Group	$12.48	$10.32	20.9%
Prevocational - Facility	$12.48	$10.66	17.0%
Prevocational - Crew	$12.48	$9.94	25.5%
Supported Employment - Group	$13.59	$10.49	29 6%
Support Coordination	$17.10	$17.30	(1.2%)

The use of median wages is intended to allow providers to offer competitive wages. However, the models are not intended to be prescriptive.

36. One provider stated that the rates show no distinction between providers who hire staff with minimum requirements, pay low wages, experience high turnover, etc. and those that pay better, offer more training, etc. Another provider stated that the proposed wages would not allow for promotions. A third provider stated that their wages for an experienced employee are 25 percent higher than the proposed rate models.

As discussed in the previous question, the proposed rate models use median market wages, which are, on average, significantly higher than those currently being paid, but are not prescriptive. Providers have the flexibility to pay more or less than the wages assumed in the models.

Based on the assumption that providers have employees of varying tenure and experience, the use of a median wage is consistent with providing a salary progression for staff. It is likely that providers will have a mix of wage levels, with less experienced staff earning less than the assumed wage and more experienced staff earning the same as or more than the assumed wage. Given the degree to which the assumed wages exceed providers' reported wages as illustrated in Figure 2, there appears to be significant flexibility to reward experienced staff.

EMPLOYEE RELATED EXPENSES

37. Several commentators expressed concern that the rates do not reflect the more generous benefits packages offered by Community Service Boards, referencing slide 18 in the February 23, 2011 presentation entitled "Proposed Service Rates". Several providers suggested that Burns & Associates staff did not understand the required benefits structure.

The commentators are correct that the employee related expenses (ERE) rate does not fully reflect the benefit levels provided by Community Service Boards (CSB). However, from a total compensation perspective (wages and benefits), the rate models do generally reflect CSBs' costs.

Both currently and under the proposed rates, CSBs receive the same payment rates as non-CSBs. As indicated on the same slide referenced by the commentators, analysis of providers' cost surveys suggest a tradeoff between wages and benefits with CSBs offering more generous benefits but paying lower wages compared to non-CSBs. This appears to be particularly true for days services (Community Access, Prevocational, and Supported Employment), where CSBs are paying between 4 and 14 percent less than non-CSBs (with the exception of Community Access – Individual, for which they are paying about four percent more).

The ERE rate included in the proposed rate models (40 percent for services with direct staff wages less than $15 per hour and 35 percent for services with higher direct staff wages) allows for a more generous benefits package than offered by most non-CSB providers, but does not reflect the scope of the benefit package offered by CSBs. In particular, CSBs currently pay 25.586 percent of salaries for health insurance and 7.50 percent of salaries for retirement contributions, and offer, on average, 38 days of paid time off per year. The CSB benefit package translates to approximately 67 percent. However, when considering total compensation – both wages and benefits – for all major services, the totals in the proposed rates equal or exceed the amounts reported by the CSBs, as illustrated in the following table.

Figure 3: Comparison of Wages and Benefits Reported by CSBs and Amounts in Proposed Rates

Service	CRA-GH	CLS	CAI	CAG	PV	SEI/ SEG
Wages and Benefits Reported by CSBs						
Weighted Average Hourly Wage	$9.36	$8.96	$10.26	$10.06	$9.77	$9.78
Benefits	$6.23	$5.97	$6.82	$6.69	$6.50	$6.51
FICA (Social Security/ Medicare) at 7.65%	$0.72	$0.69	$0.78	$0.77	$0.75	$0.75
Unemployment Insurance (fed. at 0.8% on first $7,000; state at avg of 2.738% on first $8,500)	$0.14	$0.14	$0.14	$0.14	$0.14	$0.14
Workers' Compensation (avg $3.138 per $100)	$0.29	$0.28	$0.32	$0.32	$0.31	$0.31
Health Insurance at 25.586%	$2.39	$2.29	$2.63	$2.57	$2.50	$2.50
Retirement at 7.5%	$0.70	$0.67	$0.77	$0.75	$0.73	$0.73
Paid Time Off (avg of 38 days/ year)	$1.99	$1.90	$2.18	$2.14	$2.07	$2.08
Total Wages and Benefits Reported by CSBs	**$15.59**	**$14.93**	**$17.08**	**$16.75**	**$16.27**	**$16.29**
Benefits as a Percent of Salary	66.6%	66.7%	66.5%	66.5%	66.5%	66.5%
Wages and Benefits in Rate Models						
Hourly Wage	$11.11	$11.11	$12.48	$12.48	$12.48	$13.59
Benefits	$4.44	$4.44	$4.99	$4.99	$4.99	$5.44
Total Wages and Benefits in Rate Models	**$15.55**	**$15.55**	**$17.47**	**$17.47**	**$17.47**	**$19.03**
Model in Excess of Current CSB Total (Dollar)	($0.04)	$0.62	$0.39	$0.72	$1.20	$2.74
Model in Excess of Current CSB Total (Perc.)	(0.3%)	4.1%	2.3%	4.3%	7.4%	16.8%

The individual components of the rates are not prescriptive; e.g., though the proposed rate for Community Living Supports assumes that direct support staff receive $11.11 in hourly wages, there is no requirement that any employee be paid this amount. Providers have the flexibility to pay a greater or lesser amount or to offer more or fewer benefits. It is acknowledged that the statutory requirements placed upon CSBs result in less flexibility for these organizations, but the proposed rates permit them to continue offering total compensation packages at least equal to their current practices.

38. One provider noted that the ERE rates do not take into account changes mandated by federal health care reform.

At this time, there is not adequate information to determine the impact that federal health insurance reform will have on provider costs.

Several provisions impacting private insurance that have already taken effect (e.g., prohibition on declining coverage due to preexisting conditions, mandating coverage of certain dependents to the age of 26, etc.) will increase the cost of insurance, but it is unknown whether these increased costs will be absorbed by employers or passed on to employees. It is likely that this answer will differ across employers. Other significant changes do not become effective until 2014.

PRODUCTIVITY

39. ***One provider stated that 26 hours of annual training is inadequate to meet the expectations of DBHDD related to documentation and person-centered service provision. Another provider commented that the productivity adjustment for training should be "adequate for daily training of the staff" and that there should also be "an allotment made for annual training requirements." The commentator concludes that since annual training "requires large blocks of time, the allocated time should not be created using a productivity adjustment based upon daily hours as this time cannot be accumulated like comp time and then used for training."***

The proposed rate models include 26 hours of annual paid training, which is consistent with the totals reported in the provider cost survey.

The table below includes the average number annual training hours reported by providers (see the response to comment 56 for discussion of training for support coordinators).

Figure 4: Annual Training Hours Reported by Providers

Service		Provider Survey
Community Residential Alternative	Group Home	30.0
	Host Home – Agency Staff	30.0
Community Living Support	15 Minutes	25.3
	Day	26.1
Community Access	Individual	25.9
	Group	26.6
Prevocational Services	Facility	22.8
	Crew	22.8
Supported Employment	Individual	21.0
	Group	22.3

The proposed rate models include an allowance for training based on an eight-hour workday although staff are likely not participating in paid training every day (or for 30 minutes per week), but rather participate in blocks of formal training throughout the year. By providing the allowance in a typical day, the total training allowance (26 hours) is accounted for over the course of the year.

In addition to the allowance for paid training, each proposed rate model includes allowances for Employer and One-on-One Supervision Time for, among other activities, the daily training of staff, such as meetings in which information is disseminated, on-the-job-type training, mentoring, and similar activities.

40. One provider stated that the productivity factors do not include plan development time, which should be 13 hours per client per year (three staff for two hours for the ISP, two staff for two hours for the SIS, and one staff for three hours for the HRST).

The proposed rate models do include time for non-billable plan development such as the ISP, SIS, and HRST.

The allowances included in the proposed rate models, however, cannot be compared to the commentator's assumptions because the comment 1) did not specify the service(s) to which it applied and 2) did not indicate staff persons' caseloads, which is necessary to determine the number of total hours per year that a direct care staff is participating in planning activities.

The table below notes the annual number of Client/ Assessment Planning hours reported in the provider survey for several services as well as the number of hours included in the proposed rate

models. It should be noted that these hours are separate and apart from the program preparation and program development allowance in the proposed rate models for Community Access, Prevocational, and Supported Employment-Group services.

Figure 5: Planning Hours
Comparison of Total Reported by Providers and Proposed Rate Model

Service		Provider Survey	Proposed Rate Model
Community Residential Alternative	Group Home	6.5	5.2
	Host Home – Agency Staff	26.6	20.8
Community Living Support	15 Minutes	14.0	10.4
	Day	24.9	10.4
Community Access	Individual	20.7	20.8
	Group	32.4	10.4
Prevocational Services	Facility	25.4	10.4
	Crew	16.2	10.4
Supported Employment	Individual	18.6	20.8
	Group	14.2	10.4

The proposed rate models assume that the number of planning hours varies by service type. Considerations in developing the number of planning hours included:

- The recognition that not every direct care staff (particularly in group situations) will be involved in the planning process, but by necessity, the allowance for planning in the rate models is applied to every direct care staff.
- The variance in caseload per direct care staff; e.g., a direct care staff in a group home will have fewer planning hours (than, for example, a direct care staff providing individual Community Access) because they have a smaller caseload.
- The recognition that not every direct care staff providing service to a consumer participates in all aspects of the planning process. Restated, not all direct staff participate in the SIS, the ISP, and the HRST.

The Division considers the amount of time allocated to plan development to be sufficient.

41. One commentator stated that the productivity "adjustments for attendance days versus program operation days" for Prevocational Services should be applied to all services to account for "staff having vacation and sick days."

The attendance adjustment included in the proposed rate models for Community Access-Group and Prevocational Services relates to individual, rather than staff, attendance. Paid time off is addressed as part of the employee related expense allowance in the models.

The Community Access-Group and Prevocational Services models include the attendance adjustment to reflect the fact that individuals occasionally do not attend their day program, but providers still incur costs (e.g., for staff). The attendance adjustment assumes that a consumer attends their day program 230 days per year, but is designed to allow providers to recover the annual cost of operating their program for 250 days.

In regards to for employees' paid time off, the proposed rate models assume that staff take 30 paid days off per year, including holidays, vacation, and sick days (see slide 19 of the Overview Presentation of Proposed DDD Rates).

ADMINISTRATION AND PROGRAM SUPPORT

42. Several commentators stated that a 15 percent allowance for administration and program support is inadequate and was chosen arbitrarily because Burns & Associates did not use provider survey responses. Alternative proposals ranged from 20 percent to 75 percent.

B&A attempted to gather information regarding administration and program support costs as part of the provider cost survey. However, responses to the survey indicated that these costs totaled nearly 72 percent of revenues, with 18 providers (22 percent) reporting administration and program support expenses in excess of their reported revenue. As discussed in the response to comment 43, B&A attempted to resurvey providers on this issue, but received a total of only 18 responses (not necessarily the providers reporting expenses in excess of revenues).

Without credible information from the cost survey, several other benchmarks were utilized when considering the administrative and program support allowance (as a percent of revenue) included in the proposed rate models. These include:

- When the federal Centers for Medicare and Medicaid Services (CMS) approves capitation rates for Medicaid managed care organizations (MCOs), it typically allow 8 to 14 percent for administration, profit, etc.
- The Affordable Care Act (federal health care reform) will require insurers to have a medical loss ratio of 80 percent (85 percent for large group insurance plans), which means that insurers must spend at least 80 (or 58) percent of their funding on services with only 20 (or 15) percent expended on administration, profit, etc.
- In its experiences reviewing and setting home and community based service rates in other jurisdictions, B&A has typically found that administration and program support accounts for 10 to 20 percent of providers' costs.

While none of these benchmarks directly relate to services in Georgia for individuals with developmental disabilities, they do provide some ranges that were considered when adopting the 15 percent allowance for administration and program support.

In general, providers commenting on this issue did not provide quantifiable data and documentation that supported any particular level of funding for administration and program support. However, in response to the volume of comments submitted on this particular issue, the Division has instructed B&A to again survey providers regarding their administration and program support costs. This second resurvey will be emailed to all providers later this year.

43. Several providers suggested that they were not invited to participate in the resurvey of administrative and program support costs.

Burns & Associates believes that all providers that originally submitted the survey were invited to participate in the resurvey of administrative and program support costs.

In consultation with SPADD, the resurvey was organized in a manner that had SPADD send the resurvey form to its membership and B&A send it to non-SPADD members. It is possible that a provider may have been overlooked and, if so, B&A regrets the error. However, in compiling these comments B&A checked its records with respect to each provider that indicated that they did not receive a request to review their administrative and program supports. The result of that check was that all providers indicating they were not contacted were either SPADD members or were on the B&A list of non-SPADD providers to whom the resurvey was sent on November 8, 2010.

44. One provider asked whether Burns & Associates determined which survey participants had Directors of Accounting or Finance that understand the difference between administrative and program support costs.

Burns & Associates did consider who in an organization completed the cost survey and did not discount any responses on the basis that they were not completed by a financial professional. All submitted surveys were tallied and included in the analysis of the cost survey.

45. Several providers stated that administrative requirements mandated by the Division have greatly increased over the years and proposed that relief from various administrative requirements be considered.

The Division is willing to review administrative requirements to determine whether there are opportunities to reduce or streamline these regulations. It is important to note, however, that many requirements are not at the discretion of the Division, but are federal mandates or regulations required by other state agencies (e.g., the Department of Community Health and the Department of Human Services). As part of the second resurvey on administration and program support costs, B&A will be asking providers for specific suggestions on administrative requirements that should be reviewed.

46. One commentator stated that the proposed rates "failed to take into account… program supervision, case management, transportation, meals, and other program supports made available by providers… that are not billable services."

Some of the activities (program supervision and other program supports) noted by the commentator are intended to be included in the administrative and program support component of the proposed rate models. Other activities (transportation) are either separately delineated in the proposed rate models or are separate services (case management) with their own rate model. Finally, one service mentioned (meals) is not a covered service under the waivers.

47. One provider suggested that administration and program support costs are higher for Community Service Boards than for "small providers".

The administrative and program requirements are the same for both CSBs and non-CSBs so there are not different rates proposed for CSBs than for non-CSBs.

Given that CSBs are, on average, larger than non-CSBs, their absolute costs are likely higher, but that does not necessarily mean that their percentage of revenue for administration and program support costs is higher. Since CSBs provide, on average, more services, they receive greater revenue, and therefore a larger absolute amount for administration and program support.

It is also possible that being larger providers, CSBs enjoy an economy of scale with respect to administration and program support costs. For example, it may be that as a percentage of revenue, their costs for items such as an executive director, outside audit, and legal fees may represent a smaller percentage of revenue compared to smaller providers.

Given these factors, the decision was made not to adjust administration and program support costs for CSBs.

48. One commentator stated that the proposed administrative and program support allowance "violated" federal cost principles and referenced OMB Circular A-122 stating that the term "admin" is not used and urging the design "of a system in compliance" with federal guidelines.

OMB Circular A-122, titled "Cost Principles for Non-Profit Organizations" is not a direct authority with respect to Medicaid service rate setting. The Circular provides guidance to non-profits

receiving awards or contracts directly from the federal government or through subawards. The Circular provides definitions of allowable costs (e.g. categories of direct costs) and allowable cost allocation methodologies for non-profits with multiple awards or functions, but it does not provide guidance on the development of provider rates under the Medicaid program.

It is noted, however, that the cost components included in the proposed rate models are all allowable costs as defined by the Circular (noting that the Circular is applicable only to non-profits). Additionally, the Circular does specifically note that "administration" is an allowable category of costs.

49. One provider asked whether there would be an impact if a provider had a federally approved indirect cost rate that differs from the administration and program support rate included in the rate models.

The administration and program support rate included in the rate models has no impact to a provider's federally approved indirect cost rate.

The provider's federally approved indirect cost rate is applicable to any grants or awards that an agency receives from a federal department. The administration and program support rate is used by the Division in the development of the proposed rate models to determine the rate that will be paid to the provider for services rendered. Just as the wage and benefit levels included in the proposed rate models will not impact the costs reported by the provider for wages and benefits (actual expenses will impact the amount), the administration and program support rates in the rate models will not impact the allocation of the provider's indirect costs across programs.

50. One commentator suggested that a "federal standard" of 20 to 30 percent be used.

There is no federal standard regarding administrative or indirect costs. Such costs vary significantly across grants, programs, and grantees. If the commentator believes such a "federal standard" exists, it is requested that documentation of the standard be provided.

51. One commentator stated that administrative and programmatic costs should not be combined.

The proposed rate models include a single category for administrative and program support costs; it is unclear what impact the commentator believes the separation of the costs would have on the overall rate.

The line between administration and program support is not always clear, which was noted by many providers during the cost survey and the comment period. Largely in response to this fact, the proposed rate model combines administration and program support to reflect all costs that are not specifically related to the staff and materials actually involved in the direct provision of services to consumers.

As noted in the response to comment 35, the models are not prescriptive in that providers are not required to match their spending to the assumptions for each component in the rate models; they may spend less or more on administration and program support (or wages, etc.) than assumed in the model. Thus, a separate delineation of these costs would not impact either the total proposed rates or providers' ability to structure their programs within the overall rate.

52. One commentator stated that agencies' management staff are "grossly overpaid".

The provider cost survey did not collect or review compensation levels for individual management staff, therefore no particular response is offered to this comment.

TRANSPORTATION

53. One provider asked why $0.50 per mile is used rather than the newly implemented federal rate.

The proposed rate models intend to maintain a per-mile reimbursement rate equal to the State's rate. According to State statute (O.C.G.A. § 50-19-7), the rate is set according to the United States General Services Administration (GSA) rate. Effective January 1, 2011, the GSA rate was increased to $0.51 per mile. Accordingly, the proposed rate models will be updated with a rate of $0.51 per mile.

54. Several providers expressed concerns that a mileage rate of $0.50 per mile does not take rising gasoline, insurance, and other costs into account.

As discussed in the response to comment 53, the proposed rate models use the same reimbursement rate as used by the State, which, in turn, is set at the federal business standard mileage rate, which is intended to include the costs noted by the commentator (the proposed rate models will be updated to reflect the recent increase in the federal and state rates to $0.51 per mile).

Per the Internal Revenue Services' Revenue Procedure 2010-51, the business standard mileage rate includes "Items such as depreciation or lease payments, maintenance and repairs, tires, gasoline (including all taxes thereon), oil, insurance, and license and registration fees." The 2011 reimbursement rate was announced in December 2010. According to federal Energy Information Administration data, gas prices have increased by $0.39 per gallon comparing the final quarter of 2010 to the first quarter of 2011. Depending on fuel efficiency, this increase is equivalent to $0.02 to $0.03 per mile. If the federal and state mileage reimbursement rates are adjusted to reflect these rising costs prior to finalization of the proposed rate models, the models will be updated accordingly.

55. Several providers noted that transportation costs will be greater in rural areas and suggested a transportation stipend for certain geographic areas.

If providers are required to travel greater distances, as is often true in rural regions, transportation costs will be higher. However, these expenses are assumed to be offset by lower costs in other areas (e.g., wages, rents, etc.) so the proposed rate models do not include additional transportation funding or stipends for rural providers (see also the response to comment 16).

SUPPORT COORDINATION

56. Two support coordination agencies reported that mandatory annual Division-sponsored training per Medicaid waiver policy totals 20 hours and internal training is about 25 hours per year for a total of 45 hours, which exceed the 26 hours assumed in the proposed rate model.

The Division reviewed the detailed documentation provided by the support coordination agency and agrees with their analysis. Accordingly, the proposed rate model for support coordination will be updated to reflect 45 hours of annual training.

57. Two providers stated that they require staff to attend monthly six-hour meetings, which are not addressed in the proposed rate model.

The proposed rate model does include a productivity adjustment for staff meetings and other types of employer-required non-billable activities, though the adjustment is less than six hours per month. Specifically, the proposed rate model includes 4.33 hours per month for employer and one-on-one supervision time.

58. The support coordination agencies detailed the additional responsibilities that have been placed upon the agencies between 2003 and 2010. One provider reported that, as a result, administrative and program support costs approximately tripled between 2005 and 2010 while caseload increased only about 30 percent.

The Division appreciates the detail provided by the support coordination agencies. As discussed in the responses to comments 42 and 45, B&A will be resurveying all providers regarding their administration and program support costs as well as soliciting provider input for suggestions on administrative requirements relief. Administration and program support costs for all services, including support coordination, will then be reevaluated as appropriate.

59. One commentator expressed support for capping the number of individuals assigned to a support coordinator.

As noted on slide 47 of the Overview Presentation of Proposed DDD Rates, the Division is evaluating a limit of 35 individuals per support coordinator. No decision has been made.

60. Several commentators objected to holding support coordination rates harmless. One provider further noted that support coordination providers have received more recent rate increases.

Rather than reduce the reimbursement rate for support coordination, the Division is considering the establishment of a caseload limit of no more than 35 individuals per support coordinator. As mentioned in the response to comment 59, a final decision has not been made. Reducing caseloads from the current reported average of 37.2 to 35 would have the impact of increasing the proposed rate to an amount nearly equal to the current rate (because smaller caseloads or groups are more costly).

COMMUNITY RESIDENTIAL ALTERNATIVE

61. A number of commentators stated that the limit of 27 billing days per month will result in a financial loss because they are providing services for 31 days per month.

As is current practice, Community Residential Alternative providers would be permitted to bill for only 27 days per month. However, the proposed group home rates are designed to provide revenue equivalent to the amount that would be received if the provider was able to bill 30 or 31 days. Providers would not lose any revenue as a result of the 27-day billing limit.

To illustrate, the proposed Tier 4 rate for an ambulatory individual in a group home was calculated to be $168.42 per day. For an average month with 30.42 days (365 / 12), that would translate to $5,122.78.

However, providers are only able to bill for 27 days per month. The proposed rate, therefore, was converted to ensure equivalent monthly funding. Specifically, the proposed rate is $189.73, which was calculated as follows: $168.42 x (365 days per year / 324 billing days). Billing the proposed $189.73 rate for 27 days equals $5,122.71, equivalent to the $5,122.78 discussed in the previous paragraph.

Upon reflection, the commentators may find that this approach is more advantageous from a provider perspective than the 31 day a month approach that they propose. Under Medicaid rules, payment will not be made for two placements for a single individual on the same day. Therefore, if a client were to be hospitalized, payment will not be made for the Community Residential Alternative. Under the 31 day a month methodology, the provider would lose revenue; under the 27 day approach, the provider

would receive compensation (assuming that the inpatient stay does not extend beyond 4 days). Similarly, other absences of an individual from a Community Residential Alternative (such as home visits) would cause the same kind of revenue losses under the 31 day approach. The table below provides an example of the total revenue that providers would receive for a Tier 4 individual who is in their group home for 29 days in a month.

Figure 6: Example of CRA Revenue Comparison Based on Annual Billing Days

Maximum Annual Billing Days	365	324
Proposed Rate	$168.42	$189.73
Hypothetical Attendance Days	29	29
Allowable Billing Days	29	27
Revenue	$4,884.18	$5,122.71

Group Homes – Service Design

62. Two providers noted that the proposed rates assume four-person group homes, but some homes have only three individuals with the same costs (and, therefore, a higher per-person cost).

The proposed rate models, like the existing rates, do not provide for rate variances based on the occupancy of a group home, and as the commentators correctly note, the proposed group home rate models assume that four individuals share a home. Providers will continue to be permitted to serve fewer people in a home, but if they do so, they will not be maximizing their revenue, and as the commentators also indicated, they will be experiencing relatively higher per-person costs.

63. One provider noted that some providers reported having more than four individuals in a group home and asked whether this is contrary to state policy. Another commentator stated that the proposed rate models do not take this into account.

DBHDD policy does limit group to four individuals unless granted a waiver by the Division (see page XX-6 of the Policies and Procedures manual for the Comprehensive Support Waiver). Accordingly, the proposed rate model is based on a four-person group home.

64. One provider suggested that group homes be permitted to have more than four residents if they are all Tier 1 individuals.

Consistent with existing policy and the State's settlement agreement with the United States Department of Justice, group homes will be limited to no more than four individuals in all newly established homes and new individual placements.

65. One commentator asked, for those individuals receiving a higher rate, whether budgets will be increased or if the higher CRA reimbursements will come at the expense of other services.

As noted in the response to comment 12, individuals' budgets will be redetermined to account for changes to provider reimbursement rates. It is not intended that an increase in the rate for one service will cause a decrease in any other service needed by an individual.

66. One provider asked whether the State is " 'getting out' of the business of operating group homes…because it is losing too much money".

For a number of reasons, the Division is moving to no longer having state-operated group homes. This shift is unrelated to the provider rate-setting initiative.

Group Homes – Rate Model Assumptions

67. Two providers commented that the proposed group home rates were inadequate and provided examples.

- ***If an individual has significant needs and requires a second staff person during waking hours in addition to the first staff person in the home, the staffing cost at $9.00 per hour is $288 per day (two staff multiplied by two 8-hour shifts multiplied by $9.00 per hour), but the provider is reimbursed only $116 per day per individual.***

  This example is erroneously framed for several reasons but it is important to note that the proposed rate models do provide for additional staffing (and higher rates) for individuals with more significant needs.

  The example is erroneously framed for several reasons:

  - The example implies that there is only one resident of the home and as a consequence, the provider only receives compensation for one resident. As indicated in response to comment 62 above, the models assume the occupancy of a home to be four. As a result, the cost for the first awake staff would not be borne solely by the rate paid for one individual; rather it would come from the rates paid for each of the residents in the home.
  - The example does not recognize – as the proposed rate models do – that individuals are expected to be attending meaningful day activities for 25 hours a week for which there will be separate compensation (if necessary) to providers of these activities.
  - Depending on the results from the SIS, an individual that requires a second staff person during waking hours would be assigned into a rate tier that would pay a higher rate. The example above cites the lowest group home rate of $116.30 per day. However, based on individuals' needs, basic rates of $137.49, $165.25 and $189.73 are also included in the proposed rate schedule. Based on the information supplied in the commentator's example, the subject individual would likely be placed at the highest rate tier.

  The commentator is correct in indicating that the proposed rates do not provide one-to-one staffing for all awake hours for an individual in a group home (see page 6 of the Proposed Rate Model package for staffing assumptions) and it is believed that such a requirement for one-to-one staffing is unusual. If such a situation does exist due to exceptional behavioral and/or medical support needs, the exceptional rate process would be used.

- ***"If you minus 6 hours out of 24 it leaves 18 hours per day that we provide residential service to our clients. I came up with a rate of $4.63 per hour that… we are paid to provide 18 hours of service, per client."***

  The assumptions underlying this comment were not specified and appear to contain some of the same erroneous assumptions as above. While the proposed rate models for group homes do not include hourly rates, it is possible to calculate the hourly equivalent in order to make a comparison to the comment.

  The proposed rate models assume that group homes will be staffed for a minimum of 19 hours per day on weekdays and 24 hours per day on weekends with the higher tiers having additional hours provided for one-to-one staffing (see page 6 of the Proposed Rate Model package for staffing assumptions). The rate that a provider receives would vary according to individuals' needs. Additionally, the proposed rate models assume that each group home will have four residents so it is also important to look at the assumed total per-hour revenue. The table below

illustrates the hourly rate that a group home would receive per individual according to their rate tier.

Figure 7: Calculation of 'Hourly' Group Home Rates

	Tier 1		Tier 2		Tier 3		Tier 4	
	Wkdy	Wkend	Wkdy	Wkend	Wkdy	Wkend	Wkdy	Wkend
Day Rate/Person	$116.30		$137.49		$165.25		$189.73	
Total Daily/ @ 4	$465.20		$549.96		$661.00		$758.92	
Base Staff Hrs	19	24	19	24	19	24	19	24
1:1 Staff Hrs	0	0	4	4	8	8	12	12
Total Staff Hrs	19	24	23	28	27	32	31	36
Hr. Equiv.	$24.48	$19.38	$23.91	$19.64	$24.48	$20.66	$24.48	$21.08

As the table demonstrates, the total per hour revenue assumed in the proposed rate models would range from $23.91 to $24.48 per weekday hour and $19.38 to $21.08 per weekend hour.

68. Two providers stated that they have awake staff at their homes at all times.

The proposed rate models provide funding for 24-hour awake staff.

The supplemental materials for the proposed rate models (see page 6 of the Proposed Rate Model package for staffing assumptions) show the number of staff hours per week per home. The basic assumption is that there are 143 hours per week that residents are in the home (168 total hours less an average of 25 hours per week that residents are out of the home for a day program). The materials indicate that these 143 hours are broken down into 87 awake hours and 56 sleeping hours. This division between awake and sleep hours refers to clients, not staff. The staffing hours for sleep time are assumed to be for staff that is awake. The models provide funding for overnight staff at the same rate as day time staff.

69. One provider stated that they continue to staff their homes during the hours that were deducted for day programs in order to take clients to appointments and because not all clients go to day services or employment five days per week.

The proposed rate models are structured in a manner that generally provide hours to accommodate appointments and individual absences from their day programs, though as a rule, do assume that all individuals engage in meaningful day activities and do not remain in their group home 24 hours per day.

Hours are provided to accommodate appointments and individual absences from their day programs in the following manner:

- Twenty-five hours a week are allowed for day programs and other meaningful day activities even though the Division aspires to having individuals participate in these activities for 30 or more hours per week rather than 25 hours.
- All tiers except for Tier 1 provide for a number of one-to-one staffing hours that can be used to accommodate the situation presented. Tier 2 provides for 7 hours per week, Tier 3 provides for 14 hours per week, and Tier 4 provides for 21 hours per week.

To the extent that there is a situation that cannot be accommodated through the above examples due to the exceptional behavior and/or medical support needs of individuals, the exceptional rate process is available.

70. One provider stated the rates for Tiers 1 and 2 should have hours for nursing services as do Tiers 3 and 4.

Consideration was given to adding nursing service units for Tiers 1 and 2. However, based on the available information as to the expected utilization of nursing services for these clients, no nursing service units were included in the proposed rate models for Tiers 1 and 2.

71. One provider stated that there should be non-ambulatory rates for individuals at Tiers 1 and 2 as there are for Tiers 3 and 4.

It is assumed that the necessity for non-ambulatory rates for Tiers 1 and 2 is very infrequent. However, should there be a perceived need for a non-ambulatory rate for individuals in Tiers 1 and 2, requests for such a rate will be considered on a case-by-case basis with approval by the Division.

72. One provider stated that the proposed rate does not include office space, office supplies, utilities, accreditation, database, financial audit, liability insurance, and behavioral and nursing supports.

Most of the expense examples cited in the comment are included in the administration and program support costs in the proposed rate models.

As to the behavioral and nursing supports, the proposed rate for Tier 3 includes 1 hour per week per individual of nursing and other services while the proposed Tier 4 rate includes 1.5 hours per week per individual.

Host Homes – Service Design

73. Several commentators objected to the proposed host home rates. Several commentators disagreed with the linkage of host home rates to foster care rates because, for example, "Many of the individuals served in host homes have multiple needs including medical and behavioral" and several stated that they should be equal to group home rates as host homes provide "24/7" care and the host home payment is frequently the provider's sole source of income.

Host homes operate on a model that is, in many respects, more similar to child foster homes rather than group homes; in fact, in other states, the service is often referred to as "adult foster care".

A group home utilizes various paid employees to staff the home throughout the day. These staff receive an hourly wage on which they pay payroll and income taxes and may quit or be fired from their job. These employees generally do not live at the group home. In a host home arrangement, the individual moves into a family home to, according to DBHDD's Host/ Life-Sharing Home Guidelines, "liv[e] with and shar[e] life experiences with supportive persons who form a caring household." In other words, the individuals join the host home family.

The payments to host homes are not income in the strictest sense, as evidenced by the fact that host home families do not pay income or payroll taxes, but are intended to reimburse the family for the costs associated with the individual's living expenses. This is the same treatment that foster care payments receive.

In terms of the amount of payment to host homes, the proposed Tier 2 rate model uses the highest foster care payment, which is reserved for children with the most significant medical and behavioral issues, rather than the "standard" foster care rate.

The proposed rate models would provide $66 dollars per day ($2,007.50 per month) for Tier 1 and $88 per day ($2,676.67 per month) for Tier 2. Additionally, host homes receive a portion of individuals' social security payments – 90 percent of the federal benefit rate ($674 per month in 2010) for room and board. Adding $606.60 for room and board to the payments translates to a total

of $31,369.20 annually paid to host homes for Tier 1 individuals and $39,399.20 annually for Tier 2 individuals. If a host home cares for two individuals, payments could total as much as $78,798.40 annually. None of these payments are subject to payroll or federal or state income taxes.

The agencies supervising host homes reported that, on average, host homes currently receive $93 per day or $41,224.20 per year for one individual (including the SSI offset) or $82,448,40 for two individuals. The benefit of not paying taxes on these payments adds about 25 to 30 percent to the value of the payment (i.e., the $41,000 in host home payments is equivalent to more than $50,000 in "income" earned by a worker who must pay income and payroll taxes). According to the Georgia Department of Labor, the average worker in Georgia earned about $824 per week in 2009, or $42,848 annually (http://explorer.dol.state.ga.us/mis/Current/ewcurrent.pdf).

Due to the volume of comments on this topic, the Division has instructed B&A to collect additional data in order to gain a deeper understanding of current payment practices. Later this year, B&A will survey all providers that deliver host home service regarding the payment amounts made to each individual host home as well as host home contact information.

74. One commentator expressed surprise that the study dictates what an agency can pay a subcontractor, stating this is "not consistent with acceptable business practice".

The proposed rate is not prescriptive and there is no requirement that agencies pay host home providers the amounts assumed in the model.

75. Two commentators expressed surprise that acuity and support need levels were not assigned to individuals in host homes because such support can and should vary based on individual need.

The proposed rates do include two tiers of rates to reflect levels of support need. The proposed rates are $96.78 for Tier 1 and $121.56 for Tier 2.

76. One provider stated that costs are the same regardless of whether the individual is Tier 1 or Tier 2; e.g., food and utility costs are the same.

The difference in rates between Tier 1 and Tier 2 reflect the differences in support needs for the groups of individuals that will be assigned to each group. In recognition of the difference in support needs and the likely difference in incidental expenses to the host family, different rates were developed for each Tier.

77. One host home asked who would be responsible for funding behavioral, nursing, and other supports.

The proposed rate model includes 208 hours of support annually (with a value of $4,867.20) in addition to the amounts included for payments to the host homes and the provider agency staff that train and monitor the host home. The behavioral, nursing, and other supports provided by the provider agency will be paid from this support allowance.

78. One provider suggested eliminating duplicative services such as both support coordinator and the host home agency providing monthly visits.

Although there is some overlap between the responsibilities of the support coordinator and host home agency monitor, they do have distinct functions. Agency monitors ensure that the host home is meeting service standards while the support coordinator is responsible for the individual's overall service plan.

Host Homes – Home Functions

79. One provider stated that host home staff must have the same screening and training, and meet the same standards, as group home staff. Another agency stated that it reimburses host home providers for transportation and such reimbursement should be included in the rate. A third commentator offered examples of the services that are provided, in addition to room and board paid for through consumers' Supplemental Security Income payments, including prescription copayments, vision and dental services, increased car insurance premiums, professional liability insurance, transportation to and from the family of origin, activity fees, gym memberships, furniture, and clothing.

The costs highlighted by the commentators are assumed to be included in the total payments that are made to the host home families.

80. Several providers mentioned that they provide services that are "not covered under Medicaid such as dental care, community activities."

The rate-setting project is limited to the services included in the New Options Waiver and Comprehensive Supports Waiver and, since dental care is not a covered service under the waivers, factors for dental care are not included in the rate models. With respect to "community activities", depending on the nature of the activities, reimbursement for these activities is included in the total payments that are made to the host home families.

Host Homes – Agency Functions

81. Commentators provided various examples of the services that agencies provide, including training, monthly quality assurance visits, nursing visits, monitoring and maintaining progress notes and paperwork, ensuring that all State rules and regulations are kept, and interfacing with DBHDD.

The proposed rate model considers each of these factors, though since the commentators for the most part did not provide specific estimates for each of these services, it is unclear how the rate model assumptions compare.

The proposed rate model assumes that host homes receive 30 hours of training annually (providers responding to the provider cost survey estimated that host homes receive 19 hours of training per year) and 16 two-hour monitor visits per year (providers reported an average of 15.5 visits per year lasting 1.7 hours). The rate model also provides for recordkeeping time for both training and monitoring staff. Also, as discussed in response to comment 77, the model assumes that each home receives an additional 208 hours of supports (e.g., behavioral or nursing services).

82. One provider stated that the annual salary for monitoring staff should be at least $40,000.

The proposed rate model assumes an average wage of $31,117, which is generally consistent with the $32,490 average ($29,702 if only non-supervisors are considered) reported by respondents to the provider cost survey. Additionally, the annual salary for training staff assumed in the proposed rate models is $35,568, which exceeds the $33,737 average reported by providers ($32,198 for non-supervisors only).

83. One provider stated that transportation for monitoring staff should be tripled.

The transportation factors assumed in the proposed rate model are consistent with the figures reported by providers.

The proposed rate model provides for 16 monitoring visits per host home per year and travel of 30 miles per visit. Providers responding to the cost survey reported an average of 15.5 visits per host home per year and an average travel distance of 30.8 miles. The number of visits is consistent with Division expectations and 30 miles per trip is consistent with estimates provided for other services.

84. Two providers stated that spreading the recruitment cost over seven years ignores the fact that virtually all costs occur before a home is approved.

Although recruitment costs are incurred "up front" the benefit is spread over the life of the agency's relationship with the host home provider, necessitating an amortization of the cost.

The proposed rate models assumes a recruitment cost of $1,400 and an average relationship of seven years (slightly less than the length reported in the provider survey) for an amortized cost of $200. If the full $1,400 was added to the annual cost, providers would be overpaid in years two through seven by this amount. As an alternative to the amortization of the recruitment costs two rates could be adopted: one for host homes in their first year of operation and one for host homes after their first year. This alternative was considered, but was rejected.

85. One provider stated that recruitment costs are inadequate, that direct expenses total $1,200 and there are other indirect expenses (personnel who facilitate orientation, pre-service training, assembling an application package). Further the commentator reported that for every ten inquiries, there are three approvals, and only one placement. Another provider suggested that recruitment costs are $2,000.

The proposed rate models assume a recruitment cost of $1,400 per host home, an amount between the two figures mentioned by these commentators. Neither commentator provided detail for these estimates.

86. One provider said that the supports (behavioral support plans, supportive medical equipment and supplies, etc.) that they provide total $1,000 to $3,000 annually. One provider noted that the proposed rate does not include nursing oversight (which would be $350 per year), development of behavior support plans ($2,500), intake for new consumers conducted by program managers ($1,500 - $2,000), and training for DDPs.

As noted in response to comment 77, the proposed rate model includes 208 hours totaling $4,867.20 of additional supports, an amount that should cover the development of behavioral support plans (if necessary) and nursing oversight. Specialized medical equipment and specialized medical supplies that are not covered under the Medicaid State Plan are separate services under the waivers and can be separately reimbursed. The intake and training costs mentioned by the second commentator are intended to be part of the administrative and program support component of the proposed rate.

87. One provider noted that administration should be based on the total service rate (including payments to host homes) rather than only to the provider costs, further noting that the $360 provided per home per year for administration barely covers liability insurance.

The commentator raises a valid issue. The agency-portion of the host home rate will be revised to reflect the cost of liability insurance. This may be accomplished by applying the administration and program support rate to all host home costs, including the payment made to the homes, or by adding a specific factor to the rate for this issue. This issue will be considered in concert with the resurveying of administrative and program support costs noted in response to comment 42 and of host home payment rates noted in response to comment 73.

COMMUNITY LIVING SUPPORTS AND RESPITE

88. Several commentators expressed appreciation for the increases in the proposed rate models. One provider stated that the proposed rates are too high (stating that the administration and program support percentage is too low, but benefits are too generous) and suggested a reduction to be directed to host homes.

The proposed rate model for this service (and all others) is intended to reflect the costs that providers face in delivering services. Rates were considered independently and there were no predetermined limits for rates that are "too high" or "too low". In the case of Community Living Supports and Respite, the one-on-one nature of these services (for the most part), results in higher costs, which are reflected in the increases included in the proposed rates.

89. One commentator stated that, for individuals receiving CLS services and unable to administer their own medication, the provider must contract with an LPN to administer medications. The commentator stated that the proposed daily rate should be adjusted to compensate for LPN services.

The proposed rate models include separate rates for RN and LPN services (see page 11 of the Draft Rate Models packet).

90. Several providers objected to the "incremental decrease" in the daily CLS rate when more than one individual is served and further commented that the proposed rate "would pay even less… in a group setting than it currently does."

CLS is intended to be a one-on-one service. The proposed rate model reflects the need for CLS to be provided in groups in some situations, creating two- and three-person rates. The CLS service would be redefined in the waiver application and policies to reflect the provision of CLS to two or three individuals. These per-person rates are less than the one-on-one rate because the largest component of the rate – the staff person's salary and benefits – does not change when more than one individual is being served.

However, from the providers' perspective, the revenue per staff hour of service with the two and three individual rates does increase as illustrated in the table below. With costs fixed, the provider does realize a gain with the two and three person rate, though not to the same extent as if the individual rate was paid for each individual in the group receiving services.

Figure 8: CLS Revenue per Staff Hour, by Group Size

# of Individuals	Rate per 15 Minute Unit	Revenue per Staff Hour
1	$5.85	$23.40
2	$3.66	$29.28
3	$2.93	$35.16

91. One provider asked how the rate would be calculated for individuals residing with non-Medicaid clients.

The proposed rates should be applied based on the total number of individuals receiving services. Thus, if a provider is delivering CLS services to one Medicaid client and one non-Medicaid client, they would bill the Division for the Medicaid client at the two-person group rate.

COMMUNITY ACCESS AND PREVOCATIONAL SERVICES

Annual Expenditure Cap

92. Several providers noted that the annual $10,454 cap is at least as consequential to provider revenues as the proposed rates.

The proposed rate models assume that the annual $10,454 cap would be eliminated and that individual caps would be determined based on individual budget allocations, individual service plans, and service authorizations and the provider rate that corresponds to individuals' SIS level.

As stated in the response to comment 12, individual budget allocations will be redetermined after the proposed rates are finalized.

The existence of the annual cap is a significant consideration in comparing existing rates to the proposed rates. Although providers may currently bill $3.04 per 15-minute unit of service, the effective rate, assuming the provision of 6 hours per day for 230 days a year, is much lower due to the annual cap. For example, for a typical six-hour day program, providers deliver 115 hours of service per month (230 attendance days per year divided by 12 months multiplied by 6 hours per day). If providers could bill $3.04 per 15 minutes, they would earn $1,398.40 per month. However, the $10,454 cap limits their billing to $871.17 per month. Thus, providers are effectively earning $1.89 per unit ($871.17 monthly billing divided by 115 hours divided by four 15-minute units). Numerous providers confirmed the fact that they provide many more units of service than they can bill at $3.04.

The current effective rate of $1.89 is, therefore, the more appropriate comparison to the proposed rates, which range from $1.53 to $3.26 for Community Access-Group with an estimated average of $2.13 (and an estimated average of $1.91 for Prevocational Services-Facility). The elimination of the cap, therefore, is estimated to result in most providers earning higher revenue rather than the 30 or 40 percent losses mentioned by many commentators.

93. One provider stated that the rate-setting process for Community Access-Group appears to be "an attempt to justify a lower rate for CAG and similar services" due to the implementation of the annual cap because "The proposed rate setting for CAG is based on support level established by SIS and other data. The proposed rates setting for CAG is based upon staff to member ratios and is not based on any level of care. There is a lack of consistency in the rate setting methodology which is unexplained."

The commentator has reached some unfounded conclusions. As stated in comment 92, the rates set for Community Access-Group anticipate the annual cap will be eliminated. As stated elsewhere in this summary of comments, the rates for all services, including Community Access-Group, were considered independently and there were no predetermined limits for rates that are "too high" or "too low". The proposed rate models are intended to reflect the costs that providers face; there was no attempt to justify lower rates. In fact, as discussed in the response to comment 92, provider revenues are expected to increase due to the combination of the elimination of the annual cap and the proposed rate models.

Finally, as to the assertion that "rates setting for CAG is based upon staff to member ratios and is not based on any level of care", the proposed rate tiers are based on measures of support needs as reflected by the SIS. In order to provide supports commensurate to support needs, the proposed rates vary the staff to consumer ratios according to the determined SIS levels. Individuals with greater needs would be served in smaller groups and those with comparatively lesser needs would be served in larger groups.

Group Sizes

94. One provider asked whether the staffing ratios assumed in the model would be mandatory.

Staffing ratios assumed in the model are not mandatory. However, the Division is considering (and requesting comments on) potential billing rules that will limit payment to the lesser of an individual's authorized or actual staffing ratio. For a more expansive discussion of this topic, see comment 98.

95. Several providers stated that it is beneficial to have groups with individuals of varying functional levels and expressed concern that the proposed rate models would prevent this 'mixing' (i.e., Tier 1 individuals could only be in a group with Tier 1 individuals, Tier 2 individuals could only be with Tier 2 individuals, etc.).

The intent of the proposed rate models is not to result in individuals being served only with individuals in the same Tier. Individuals may be mixed in a number of ways. For example, a Tier 1 group with 10 individuals and one staff person and a Tier 2 group with seven individuals and one staff person could be combined with the two staff persons coordinating the activities of the 17 total individuals. Or, an individual may be served in a group size that differs from that assumed in the proposed rate models if that is the preference of the individual or family; however, as detailed in the response to comment 98, the Division is considering a policy in which providers will only be permitted to bill the lesser of the group size for which the individual is authorized or the group size in which the individual is actually served.

96. A number of providers commented on the group size assumptions:

- ***Several providers noted that they currently have higher ratios than assumed in the proposed rate models (e.g., individuals at SIS levels 5 through 7 are in groups with more than three individuals per direct care staff as assumed in the proposed rate model) and reducing these ratios will increase costs to hire additional staff.***
- ***One provider stated that agencies do not utilize groups with ratios of 10 individuals for one staff person although such groups are permitted.***
- ***One provider reported that none of their groups have more than three individuals.***
- ***One provider stated that a one-to-three ratio is inadequate for individuals requiring total care.***
- ***One provider expressed concern that larger groups will harm individuals who could benefit from smaller group activities (i.e., relatively high-functioning individuals).***

Providers comments related to group size make it clear that there is significant variation in the programs that providers have created to deliver these services, with some providers apparently placing most individuals in large groups and others utilizing mostly smaller groups. In order to ensure that the group sizes that are assumed in the proposed rate models are appropriate, the Division has instructed B&A to request additional information from providers regarding their programs. Later this year, B&A will resurvey Community Access-Group, Prevocational and Supported Employment-Group services providers regarding group sizes.

97. Two providers noted that community-based groups in particular should be smaller, and that such groups rarely exceed a one-to-four ratio.

As discussed in the response to comment 96, the Division intends to seek additional input regarding group programs and group sizes, including those issues identified by these commentators.

Billing

98. A number of commentators provided examples of the administrative difficulties of managing different rates according to group size. Examples include staff absences and day-to-day differences in scheduled attendance (e.g., some clients only attend three days per week).

The Division is considering rules for billing that will minimize administrative difficulties. The procedures under consideration are outlined below. The Division would appreciate comments from providers on the possible procedures including suggestions as to how these possible procedures should be modified:

- Providers will bill the lesser of the rate associated with: a) the authorized staff to consumer ratio for each individual, or b) the staff to consumer ratio actually delivered for each individual.
- The provider may calculate the staff to consumer ratio actually delivered for each consumer either daily, weekly, or monthly. However, once a provider has elected a methodology (daily, weekly or monthly), the methodology can only be changed with the approval of the Division.
- To determine the staff to consumer ratio the provider shall, for each group of consumers:
  - Divide (the total billable hours for consumers in the group) by (the total direct care staff hours provided to the group); and
  - Use the resulting quotient, which is the number of consumer billable hours per direct care staff hours and can be stated as "1: (the resulting quotient from the step above)" staff to consumer ratio
- Compare the actual staff to consumer ratio to the authorized staff to consumer ratio for each individual, select the lesser ratio, and invoice for the units delivered to the individual at the rate associated with the lesser ratio
  - For example, if the number of hours attended by all consumers in a group totaled 55 hours for a day (1,100 for the month), and the number of hours worked by direct care staff when consumers were present at the program totaled 14 for that day (280 for the month), then the calculation would be:
    - Total billable consumer hours divided by total direct care staff hours = 55 / 14 (or 1,100 / 280) = 3.928. This group's ratio for this day is 1:3.928, or 1:4
    - For consumers in the group authorized at 1:3 (with a proposed unit rate of $3.26), the appropriate rate to bill is $2.27 – the proposed rate associated with the 1:3 – 1.5 staffing ratio
    - For consumers in the group authorized at the 1:3 – 1.5 staffing ratio (with a proposed unit rate of $2.27), the appropriate rate to bill is $2.27
    - For consumers in the group authorized at the 1:5 – 1.7 staffing ratio (with a proposed unit rate of $1.84), the appropriate rate to bill is $1.84, the authorized rate

99. One provider stated that within their Prevocational-Crew program, individuals spend some days at a facility (e.g., to participate in workshops) and asked whether services would be billed at the Prevocational-Facility rate on those days.

The time spent at the facility should be billed at the Prevocational – Facility rate, assuming the individuals are authorized to receive this service in their ISPs.

100. One provider stated that there should be flexibility in group sizes in terms of billing; e.g., if an individual should be in a three-person group, but is in a six-person group due to a staff illness on a day that a support coordinator visits, the provider should still be able to bill the three-person group rate that day.

The "flexibility" suggested in this comment is contrary to the intent of the proposed Tiered rates. As outlined in response to comment 98, the Division is considering billing rules that will provide some flexibility as to the calculation of the staff to consumer ratio (in terms of time periods included in the calculation) but is also considering requiring that the rate billed should be the lesser of the authorized or actual staff to consumer ratio.

101. One provider suggested maintaining tiered rates, but allowing providers to bill by day similar to the group home rate, with support coordinators providing oversight of the appropriateness of services (e.g., group sizes).

The service specifications for Community Access and Prevocational services require billing in 15 minute units. The Division does not intend to change this requirement.

102. One provider noted that the proposed rates were less than rates for comparable services in the behavioral health system, providing the following information:

DD Service	*Current Rate*	*Proposed Rate*	*BH Service*	*Rate*
Prevocational (7-10)	***$3.04***	***$1.47***	***Group Skills Training***	***$3.30***
Community Access Grp. (7-10)	***$3.04***	***$1.53***		
Supported Employ. Grp. (3-5)	***$1.80***	***$1.91***		
Community Access Individual	***$7.26***	***$6.97***	***Community Support Indiv.***	***$15.13***
Supported Employ. Indiv.	***$7.26***	***$7.01***		
Community Living Supports	***$4.93***	***$5.85***		

The Group Skills Training service referenced by the commentator is similar in many ways to the existing Community Access-Group and Prevocational services rates, and shares the same primary drawback. Specifically, the Group Skills Training rate is the same regardless of the size of the group being served. Like Community Access-Group and Prevocational services, this service allows group sizes of up to 10 individuals. So, a provider earns greater revenue by placing as many individuals into large groups as possible; a group size of three will generate $39.60 per staff hour while a group size of ten will generate $132.00 per staff hour. The Division's proposal to move to tiered rates eliminates much of this incentive and ensures that service decisions are based on individual need. It is important to note that the comparison in the table may be misleading because Group Skills Training may be delivered to groups smaller than seven individuals, but the table includes only the lowest proposed rates for Community Access-Group and Prevocational services though there are higher rates for smaller groups (based on individual need).

In regards to Community Support-Individual service, the rate translates to more than $60 per hour. According to the service description, the staff permitted to provide this service may be various social work professionals, which would explain a higher cost, but there are other staff permitted to deliver this service who require only a high school diploma or equivalent and 40 to 46 hours of training. All of these staff must work under the supervision of a medical or social work professional (e.g., physician, psychologist, licensed master's social worker, etc.), which will increase costs. However, even with these requirements, it is unknown whether the behavioral health $60-plus per hour rate is justified.

Rate Model Assumptions

103. One provider stated that the proposed rate models do not account for provider losses due to unavoidable absences.

The proposed rate models do account for consumer absences.

The proposed rate models assume that consumers will attend their day program 230 days per year. This translates to about 20 absences per consumer per year, which is somewhat more than the number derived from the provider cost survey. The proposed rate models then adjusts the various factors to account for these absences. For example, the assumed hourly cost for direct care staff salary and benefits after productivity adjustments is $23.30. However, the model recognizes that consumers will occasionally be absent, but that providers still must pay the salaries of its staff. The model therefore adjusts the hourly cost to $25.32 ($23.30 x 250 / 230), allowing providers to cover the full staffing cost despite consumer absences. Other costs are similarly amortized over 230 days rather than 250 days per year.

104. Two providers stated that the Community Access-Individual rate should include capital costs for the purchase of vehicles.

The proposed rate model provides transportation-related funding based on estimated mileage and a per-mile expense of $0.50, which includes capital costs.

Per the Internal Revenue Services' Revenue Procedure 2010-51, the business standard mileage rate includes "Items such as *depreciation or lease payments*, maintenance and repairs, tires, gasoline (including all taxes thereon), oil, insurance, and license and registration fees" (*emphasis added*). The proposed rate models for group homes, Community Access-Group, Prevocational Services, and Supported Employment-Group do include vehicle capital costs in addition to mileage reimbursement because these services are using larger, more costly vehicles (due to both to higher purchase costs and operating costs) that may not be wholly captured in the business standard mileage rate. For individual services, it is assumed that standard vehicles are utilized (either staff's personal vehicles or company-owned vehicles), the purchase costs of which are included in mileage rate.

105. One provider asked whether insurance costs for provider-owned and/ or privately owned vehicles are included in the proposed rates.

Insurance costs are included in the business standard mileage rate. See the definition in the response to comment 104.

106. Two providers said that the use of 15-passenger vans assumed in the Community Access-Group and Prevocational rate models have been discouraged due to safety and accessibility issues, and that the models should assume a 15-passenger, wheelchair accessible shuttle.

The Division is reconsidering the vehicle assumptions for these services.

107. One provider stated that survey responses regarding route distances are understated because providers are only transporting consumers who live in close enough proximity to one another to make a route feasible. For others, providers sometimes purchase transportation at $12.50 per trip.

The proposed rate models assume that routes (picking up consumers and taking them to the program or taking consumers home) average 30 miles, which is consistent with provider cost survey responses regarding Community Access-Group services and somewhat less than responses

for Prevocational services (responses averaged 34 miles per route). The proposed rate models reflect current practices so, as the commentator notes, the models do not directly account for longer routes.

As noted in the response to comment 35, however, the proposed rate models are not prescriptive so inasmuch as some other costs in the models are greater than a provider's existing practices (e.g., wages), providers have the flexibility to direct additional funding to transportation. Further, the proposed rate models include transportation funding for every consumer although day programs do not provide transportation to each consumer (according to the provider cost survey, transportation is provided for 63 to 74 percent of consumers). The funding for individuals who have other means of transportation (e.g., from their group home) allows for additional investment in transportation services for those who do require it.

108. One provider noted that transportation distances and times (and, consequently, costs) vary across areas of the State. This provider stated that their vans travel an average of 110 miles per day (routes plus outings) with 8 consumers per vehicle, which translates to a per client per hour cost of $1.79 compared to the $1.17 assumed in the proposed rate model.

The proposed rate models aim to reflect the 'typical' cost of providing a given service. It is expected that individual cost components within each model (e.g., wages, benefits, etc.) will vary across providers and across regions.

The commentator appears to have pointed out a situation where the proposed rate model(s) may not have addressed a particular situation. However, this possible deficiency must be evaluated in consideration of other aspects of the proposed rate model in comparison with the particular provider's situation. For example:

- The proposed rate model provides for transportation for all attendees of the program. It is unknown what percentage of the commentator's program participants receives transportation. If less than all program participants receive transportation, the cost to the provider may not be that much greater than the amount included in the proposed rate model.
- As indicated in the response to comment 35 (and others), the factors included in the proposed rate model(s) are not prescriptive. That is, providers are free to assign costs however they deem appropriate; savings can be realized from one factor and applied to higher expenses in another factor. While the commentator has identified a particular cost that is higher than the allowance in the proposed rate model, there may be other areas in the commentator's costs structure where costs are lower than the proposed rate model allowance.
- As indicated in the response to comment 16, the Division is not considering the adoption of two rate schedules – one for urban areas and one for rural areas. As pointed out above, the rate models are not prescriptive, and as pointed out in comment 16, while some areas of the State may have cost factors that are higher than in other areas, these same areas are likely to have other costs that are lower than in other areas of the State.

109. One provider noted that, because the rate differs across group size based on SIS levels, the amount of funding for administrative and program support varies across individuals although documentation standards are the same.

The Division is reconsidering the productivity adjustments for this service.

110. Two commentators stated that larger groups (1:7 or larger) should receive additional productivity allowances for documentation, transportation, and transition (onto/ off of a van, in/ out of a building).

The Division is reconsidering the productivity adjustments for this service.

111. One provider stated that the $2.40 per consumer per day supplies allowance is underestimated and reported that their cost is $2.98 per day.

The $2.40 per consumer per day supplies allowance is the average cost reported by providers. Individual responses ranged from $0.16 per consumer per day to $5.00.

It is expected that there will be differences in providers' program designs and, consequently, their costs may not be identical to the assumption in the proposed rate models. Providers may pay their staff more or less than assumed in the model, may have different supply costs, etc., which is why the individual components of the models are not prescriptive.

112. One provider stated that facility costs are not accurately calculated because the proposed rate model is based on 230 service days rather than 365 days.

The proposed rate model takes into account the fact that consumers are in services for only 230 days per year, allowing providers to recoup the total estimated facility cost over these service days.

The proposed rate model assumes that there are 120 square feet of space per client and a cost of $12.43 per square foot. This translates to an annual cost of $1,491.60. The model then allocates this annual cost over 230 service days, yielding a daily cost of $6.49. If 365 days were used, the daily cost would be lower and provider would not recoup the full cost because they can, on average, bill only 230 days.

113. One provider stated that facility costs should be included in the Prevocational-Crew rate because programs sometimes begin the day at the office.

The proposed rate model for Prevocational-Crew services does not include funding for facility costs because it is assumed that maintaining standalone program space for a crew would not be economical for providers (because the space would go unused most of the time). A crew may meet at a provider's administrative offices, which would be included in the administration and program support costs or at a program facility that is utilized by a facility-based group so that the costs are incorporated in the rates billed for the facility-based services. In either example, facility costs are accounted for.

114. One provider noted that the proposed rates do not take into account the cost of tickets to sporting events and other such activities.

The proposed rate models are not intended to support activities such as sporting events or other special functions. In the Policies and Procedures manual for the Comprehensive Support Waiver, "Admission fees, memberships, subscriptions, donations, or related items" are specifically listed as non-covered services (see page XVII-15).

Community Access-Individual

115. Two providers stated that the Community Access-Individual rate does not support the transportation and planning needs associated with community inclusion activities.

Both factors are included in the proposed rate models.

The proposed rate model includes the equivalent of 1 hour per week for program development and 1.2 hours per week for program preparation. This amount of time is deemed sufficient for planning needs associated with community inclusion activities.

With respect to transportation, the proposed rate model includes 30 miles of travel per day. This amount includes both travel between and with individuals. The time transporting individuals is billable time under the service.

116. Several commentators objected to any reduction to the Community Access-Individual rate. One provider stated that it is very reasonable.

The Division acknowledges the commentators' objections, and appreciates the comment that the rate is reasonable. Rates for each service were considered independently and there were no predetermined targets. In the case of Community Access-Individual, the proposed rate is about four percent less than the current rate. In general, the commentators did not identify specific areas of the proposed rate models that do not reflect the cost structure faced by providers of the service, e.g. wages too low, productivity adjustments are insufficient, etc.

SUPPORTED EMPLOYMENT

117. Several commentators objected to the proposed reduction in the Supported Employment-Individual rate (for job coaching the rate is proposed to decrease from $7.26 to $7.01 per 15-minute, while a rate of $7.86 per 15-minute unit is proposed for job development).

The Division acknowledges the commentators' objections, and appreciates the comment that the rate is reasonable. Rates for each service were considered independently and there were no predetermined targets. In the case of Supported Employment-Individual, the proposed rate for job coaching is about three percent less than the current rate while the proposed job development rate is eight percent higher than the current rate. Responses to specific comments related to the assumptions underpinning the proposed rate models begin with comment 127.

Service Design

118. One commentator stated that supported employment should not be billed in 15-minute increments. Another provider stated that payments should be "outcome-based" rather than unit-based.

The service specifications for Supported Employment require billing in 15 minute units. The Division does not intend to change this requirement.

As to the suggestion that payments for Supported Employment be "outcome-based" the Division is willing to consider suggestions for the outcomes upon which payments should be based. These comments should be forwarded to Byron Sartin at bssartin@dhbdd.ga.gov.

119. One provider stated that the proposed rate funds face-to-face time rather than results and does not allow for discovery and profile development with each individual, design of training, etc.

The purpose of developing proposed rate models for both job development and job coaching is to allow for, and measure the delivery of and payment for both direct supports and the types of development activities outlined by the commentator.

Job development allows the providers to identify job opportunities that are tailored to the individual consumer, design a training program for the consumer, etc. Job development should not continue indefinitely; these activities are intended to lead to employment and, if that is not presently possible for a consumer, that individual may need to be enrolled in a Community Access or Prevocational program in order to work on necessary job skills. A limit on the duration of job development services will be established by the Division.

Job coaching is the face-to-face time with consumers, including training and on-the-job assistance. This ongoing support is intended to assist consumers to maintain their employment and, ideally, will decrease over time.

120. Two commentators objected to the delineation between job development and job coaching. One provided the example of " 'teaching' an individual how to join in on a co-worker lunch… The job is already 'developed', but has the person 'developed' the skills to retain a new job?"

The response to comment 119 describes the difference between job development and job coaching activities. Job development is the upfront work done to establish a person-centered employment plan and identify employment opportunities consistent with that plan. Ongoing supports to provide training and then support a consumer in their job, including those described by the commentator, are job coaching activities.

121. Several commentators stated that limits on job development are unrealistic in this economy. One suggested that any limit should be based on the length of time that individuals may claim unemployment insurance benefits (including federal extensions) increased by 40 percent.

The poor economy will undoubtedly impact consumers' ability to obtain employment (as is this case for individuals without developmental disabilities) and job development is important in helping consumers to overcome these barriers. As noted in the response to comment 119, however, job development should not continue indefinitely. In circumstances in which employment is not currently likely for a consumer, due to the economy or other reasons, that individual should receive other services, such as Community Access or Prevocational Services, that will provide a meaningful day.

122. Several commentators stated that "maintenance" payments should not be eliminated as that would eliminate incentives to improve hours and wages for consumers and eliminate the flexibility to visit consumers when needed.

The Division is not proposing to eliminate job maintenance payments at this time.

123. One provider stated that residential providers "receive 'maintenance-like' payments even when a person they serve is working in the community" so supported employment providers should receive similar payments.

The proposed rate model for group homes does not include any "maintenance-like" payment. The proposed group home rate model assumes that individuals participate in day programs for 25 hours per week and deducts these hours from the staffing requirement (see the response to comment 69).

124. One commentator stated that the proposed rate models include only group settings, with no option for one-on-one services.

Rate models are proposed for job development and job coaching under Supported Employment-Individual as well as for Supported Employment-Group. There is no proposal to eliminate individual services.

125. One provider stated that supported employment should be for individuals only and that they are unaware of group supported employment in Georgia that meets their definition of supported employment: "a community-based job that pays at least minimum wage and is a job performed in an integrated setting".

The waiver programs currently cover both Supported Employment-Individual and Supported Employment-Group services and rate models are proposed for both; there is no proposal to

eliminate group services. The waiver and related materials do not include separate definitions for services delivered to individuals and to groups. The Policies and Procedures manual states such services "consist of activities needed to obtain and sustain paid work by participants, including job location, job development, supervision, training, and services and supports that assist participants in achieving self-employment…"

126. One commentator noted that larger groups (e.g., for SIS level 1) will hinder individuals' ability to maintain employment.

As noted in the response to comment 96 the Division intends to further consider group sizes and has instructed B&A to solicit additional information from providers.

Rate Model Assumptions

127. One provider noted that the beginning salary for its supported employment staff is $33,000 annually and that it provides medical benefits that cost the company $350 per person "when opted".

The salary and benefit assumptions in the proposed rate models for Supported Employment exceed the amounts reported by providers in the cost survey.

The proposed rate models assume annual salaries of $33,238 for job development and $28,267 for job coaching and Supported Employment-Group activities. On average, providers reported that supported employment staff are paid $10.09 per hour ($20,987 annually) or $10.97 per hour ($22,818 annually) when supervisory staff are included.

The proposed rate models include $300 per month for health insurance for every direct care staff (see slide 19 of the Overview Presentation of Proposed DDD Rates). That amount is equal to the average reported by providers other than CSBs for those employees that participate in providers' health insurance plan (see page 32 of the Provider Survey Results and see the response to comment 37 for discussion of CSB's employee related expenses). However, as inferred by the provider's comment, not all employees typically receive health insurance; non-CSBs reported that only about one-third of their staff participate in providers' health insurance plans so their monthly per-employee cost is only about $100.

128. One provider noted that employees receive paid time off and holidays, which are "un-billable within the calculations provided."

The proposed rate models account for employees' paid time off as part of the employee related expense (ERE) allowance. Specifically, the proposed rate models assume 30 paid days off per year, including holidays, vacation, and sick days (see slide 19 of the Overview Presentation of Proposed DDD Rates).

129. One provider stated that supported employment staff travel more than 30 miles per day.

The proposed rate model for Supported Employment-Individual assumes that direct care staffs travel 30 miles per day, which is close to, but somewhat less than, the totals reported through the provider cost survey.

Providers reported that Supported Employment staff travel about 37 miles per day (7 miles between clients and 29 miles transporting clients) for cases that are not billed as job maintenance and 26 miles per day (8 miles between clients and 18 miles transporting clients) for job maintenance cases. The split between non-maintenance and maintenance cases is uncertain, but based on the provider survey would be about 87 percent non-maintenance cases. Using this distribution, providers

reported that Supported Employment staff travel 35 miles per day on average. Of the 23 providers that reported travel distances, 11 reported more than 30 miles per day and 12 reported fewer.

130. One provider offered an estimate that supported employment staff are only billable for 5.09 hours per day (compared to the 7.01 hours assumed in the proposed rate model). The biggest components of the non-billable hours reported by the provider were 2.00 for travel and 0.75 for documentation and required paperwork.

The proposed rate model for Supported Employment-Individual assumes that direct care staffs spend 0.5 hours per day traveling between client visits and assumes that documentation is completed as part of the billed direct service time.

The productivity allowance for travel time includes only time traveling between clients because time spent transporting clients would be billable. As noted in the response to comment 129, providers reported that client visits are, apparently, arranged such that the distance between clients is 7 miles. Allowing a half-hour for this travel should be more than adequate. In the provider cost survey, respondents stated that staff travel between client visits averages 0.86 hours per day, but given the relatively short distances reported this did not appear reasonable. Similarly, two hours of travel between client visits every day of the week appears too high, particularly given that providers reported that staff see, on average, fewer than two clients per day.

In general, the proposed rate models do not include a productivity adjustment for recordkeeping as it is assumed that this documentation occurs in the presence of the consumer and the provider agency already bills for this time.

131. One provider reported that it provides cell phones and laptops to staff.

These materials are not specifically contemplated in the proposed rate model as they are not required by the State. However, the proposed rates are not prescriptive so providers are permitted to provide these tools to their staff within the overall rate.

BEHAVIORAL SUPPORTS CONSULTATION

132. Several commentators stated that the proposed rates for Behavioral Supports Consultation are too low and will perpetuate a shortage of Board Certified Behavior Analysts (BCBAs) and Board Certified Assistant Behavior Analysts, prevent implementation of successful applied behavioral analysis interventions, and understate the importance of the service as consumers are deinstitutionalized. One of the commentators stated that BCBAs charge $75 per hour.

There is a shortage of BCBAs nationally, including in Georgia. The proposed rate models allow for BCBA billing of $83.04 per hour and assume that BCBAs earn $93,600 annually. Only one provider completed the provider cost survey so it is uncertain how this salary compares to current wages, but according to PayScale.com, the average salary for applied behavior analysts ranges from $42,393 to $61,976. The proposed rate appears to be sufficient to adequately compensate BCBAs.

133. One commentator stated that the limited availability of BSC is a result of a requirement that such service be provided by sole proprietors and not agencies.

The Division has previously convened a Behavioral Services Workgroup comprised of various stakeholders, including providers. One of the charges of this Workgroup is to evaluate how to permit agencies to provide this service while ensuring that the professionals actually delivering the service meet minimum qualifications.

134. One provider stated that the existing $2,450.24 annual cap on services needs to be eliminated.

With the establishment of proposed rate models for two levels of professionals, the Division is interested in evaluating appropriate service allowances for each type of provider. The Behavioral Services Workgroup mentioned in response to comment 133 will be tasked with providing recommendations.