PROJECT BACKGROUND

The State of Georgia is preparing to submit an application to the federal Centers for Medicare and Medicaid Services (CMS) requesting the reauthorization of the Comprehensive Waiver program. Among other requirements, the State must demonstrate the appropriateness of reimbursement rates for service providers. Consistent with this requirement, are the Department of Behavioral Health and Developmental Disabilities (DBHDD) has undertaken a review of the payment rates. In the first phase of this review, DBHDD is considering the rates for Community Residential Alternative Group Home and Host Home services, Community Living Supports, and Respite. DBHDD intends to review the rates for most other waiver services in the second phase of this project, scheduled to commence later this year. The consulting firm Burns & Associates, Inc. (B&A) is assisting in this review.

The rate review has encompassed several tasks, including:

- Multiple meetings with service providers and other stakeholders
- A detailed review of service requirements and DBHDD's policy objectives
- Development of a provider cost survey and analysis of submitted data
- Identification and research of other available benchmark data

Based on this work, detailed rate models were developed for the services included in this first phase of the rate review. These models include assumptions regarding the specific costs that providers incur in the delivery of each service, such as direct support professionals' wages, benefits, and billable time; staffing requirements; travel-related costs; and agency overhead.

DBHDD presented the proposed rate models, related documentation, and associated policy changes to providers and other stakeholders on July 9. Interested parties were asked to submit their comments in writing to a dedicated email account. The comment period lasted until July 27, but comments submitted after the deadline were accepted.

Comments were received from approximately 35 providers and other interested parties. All comments have been reviewed and summarized, and responses to each have been prepared. Several changes to the proposed rates and policy changes have been made in response to these comments.

Additionally, DBHDD established a separate email account dedicated to families' questions and comments. DBHDD responded directly to families who emailed. Those comments and responses are being published in a separate document.

Comments were thoughtfully written and constructive, and DBHDD appreciates all those who took time to provide feedback.

DOCUMENT SUMMARY

In total, 89 unique comments related to the proposed rate models and changes to service requirements were received. The comments were summarized and organized into topical areas as follows:

- Cost Study Process (beginning with comment 1)
- Issues Affecting Multiple Services (beginning with comment 7)
    - Implementation (beginning with comment 7)
    - Direct Support Staff Wages, Benefits, and Productivity (beginning with comment 15)
    - Agency Overhead (beginning with comment 22)

  - Rate Categories Based on the Supports Intensity Scale (SIS) and the Health Risk Screening Tool (HRST) (beginning with comment 27)
  - Certification to Serve Members with Significant Needs (beginning with comment 41)
- Community Residential Alternative (CRA) (beginning with comment 45)
  - Community Residential Alternative (CRA) – Group Home (beginning with comment 48)
  - Community Residential Alternative (CRA) – Host Home (beginning with comment 54)
- Additional Residential Staffing (beginning with comment 58)
- Community Living Support (CLS) (beginning with comment 67)
- Respite (beginning with comment 80)

In response to the comments received, DBHDD has made a number of revisions to the proposed rate models and related policies:

- The proposed establishment of monthly billing limits on Community Living Supports has been withdrawn. There will continue to be an annual limit for CLS, but members will have flexibility in regards to how they use their budgets over the course of their plan years.
- The proposed elimination of the personal assistance retainer for Community Living Supports has been withdrawn. The CLS rate model was revised to exclude a productivity adjustment for missed appointments.
- The minimum share of the Host Home rate that agencies must pass-through to the home providers has been reduced from 65 percent to 60 percent.
- The workers' compensation cost assumed in the rate models has been increased from 3.0 percent of wages to 3.2 percent.
- Overhead funding has been added to the Additional Residential Staffing rate model at one-half of the amounts included in other rate models (producing an overhead rate of about 10 percent).

The remainder of this document provides DBHDD's responses to each specific comment.

COST STUDY PROCESS

1. Several commenters offered support for the proposed rate increases and expressed optimism that service quality will also increase.

DBHDD appreciates the support for the proposed rate increases that, when fully implemented, will increase spending on the Comprehensive Waiver by $XX million. Like the commenters, DBHDD expects this investment to result in a number of positive changes, including:

- Improved pay and benefits for direct support professionals
- Better alignment between members' needs and the intensity of support that they receive
- Strengthening of the service infrastructure to facilitate the transition of members into community-based homes
- More individualized supports for members
- Fewer exceptions to the published rates

2. ***Several commenters stated that the cost study does not do enough to support a variety of housing options for members and does not align with recent federal requirements relating to home and community based services. One of these commenters suggested that the study emphasized group homes rather than members' choice of where to live. Another commenter suggested that DBHDD offer housing vouchers or other housing supports.***

   DBHDD believes that members should have access to a variety of residential options, including in-home supports for members living independently or with family, host homes, and group homes. DBHDD further believes that the changes to the rates will strengthen each of these options. Members will continue to have choices in terms of their residential service, all of which must comply with federal home and community based services regulations and person-centeredness guidelines.

   The cost study did not emphasize any single residential option and the new rates represent improvements to each service. Group Home rates are increased and 'tiered' so that the rates are higher for individuals with more significant needs and allow all members to receive more individualized attention. Higher rates are established for the three-person group homes to support smaller residences. A higher Category 2 Host Home rate is created in order to make host homes a more viable option for members with the greatest needs. The Community Living Support rate is increased and 'multi-person' rates are created to allow members to effectively pool supports and 'stretch' their budgets.

   The issue of housing vouchers is outside the scope of this rate review, but DBHDD does note that it has a memorandum of understanding with the Department of Community Affairs to identify vouchers available to individuals with intellectual and developmental disabilities.

3. ***Several commenters expressed objections that the rates for Supported Employment, Prevocational, and Community Access services were not reviewed.***

   In order to allow for thorough, thoughtful, and timely consideration of the rates for Comprehensive Waiver services, DBHDD decided not to try to review all rates simultaneously. Rather, the process was divided into two phases. This first phase of the rate review included residential supports and respite. These services were reviewed first for several reasons: they comprise XX percent of total Comprehensive Waiver expenditures, account for almost all exceptional rates, and are most integral to transitioning members into the community as required by the State's settlement agreement with the Department of Justice.

   Reviewing the rates for Supported Employment, Prevocational, and Community Access services is also a priority for DBHDD. The second phase of this initiative will cover these services, as well as Support Coordination and possibly other services. DBHDD plans to begin the second phase in the fall of 2015 with the review completed in early 2016.

4. ***Several commenters suggested that they did not have sufficient information regarding changes to policies, service definitions, and other requirements to evaluate the proposed rates and to offer informed comments.***

   DBHDD has endeavored to be as thorough and transparent as possible throughout this process. The rate models themselves outline detailed assumptions regarding the various costs associated with delivering each service, including the wages, benefit rates, and 'productivity' of direct support professionals (with supporting materials that illustrate how these assumptions were constructed); expected staffing ratios; transportation-related costs; and agency overhead. At the same time, DBHDD outlined proposed changes to service requirements. In some instances, these proposals were in 'concept' form, but the intent was to share information regarding DBHDD's intended direction.

This was done, in part, to give stakeholders an opportunity to offer suggestions on how to make these proposals workable.

Overall, DBHDD believes that the information shared has been sufficient to provide an understanding of the general requirements that will be associated with the rates for the services included in this review. Further, the proposed 'concepts' will be detailed to a greater degree, based partly on feedback collected as part of this process, in the forthcoming application to reauthorize the Comprehensive Waiver. This application must go through the Department of Community Health's public comment process, providing stakeholders another opportunity to offer feedback.

5. Several commenters expressed concern that families were not included in the review of provider rates to a greater extent. Some of these commenters stated that materials were too complicated and asked for simplified explanations of the proposals.

This rate review is, fundamentally, an analysis of the cost of providing a given service. Service providers possess information about the manner in which they deliver services and their associated costs so this project has necessarily sought to engage providers to a significant extent.

However, DBHDD also offered opportunities for families to be involved in this process, particularly once the data collection stage of the project was completed and proposals were developed:

- There was a family member representative on the project advisory committee that was convened periodically to provide feedback at various stages of the project.
- A webinar was conducted specifically for families to explain the rates and related proposals. DBHDD worked with various organizations to inform families of the webinar and posted a recording of the webinar on its website.
- An email account dedicated to questions from families was created. Emails were routed to DBHDD leadership and each email received a direct response from the Department.

Families have had and will continue to have opportunities to offer suggestions regarding the Comprehensive Waiver program. Forums across the State were held earlier this year to discuss the coming reauthorization of the program. The Department is continuing to facilitate a series of forums called *Conversations that Matter* through the fall of 2015 to allow families to provide feedback directly to DBHDD leadership. Additionally, the changes resulting from this project must be incorporated into the State's application to reauthorize the program. The complete application must go through the Department of Community Health's public comment process, offering families and all stakeholders another opportunity to provide input.

6. Two commenters asked several questions regarding current enrollment and utilization figures. One of these commenters also asked how many members receive both CRA and CLS services.

The fiscal impact analysis that was part of the materials released for public comment included much of the requested information. The analysis has been updated to include all waiver services, rather than only those included in phase 1 of the rate review, and accompanies this document.

Members cannot simultaneously receive Community Residential Alternative and Community Living Support services.

ISSUES AFFECTING MULTIPLE SERVICES

Implementation

7. One commenter asked whether the proposed rate increases will make it difficult to move individuals off of the waiting list and into the Comprehensive Waiver.

DBHDD recognizes the importance of balancing increased provider rates with continued admission of individuals to the Comprehensive Waiver. An appropriate rate-setting methodology is a requirement in the renewal of the Comprehensive Waiver. This rate review suggests that most rates should be increased in order to ensure high quality services to current waiver participants. At the same time, DBHDD remains committed to identifying opportunities to admit wait listed individuals into services.

8. One commenter stated that the proposed rates are more complex than the existing system, which will complicate the annual planning process with support coordinators. The commenter suggested that training and technical support should be made available to all providers, including support coordinators.

DBHDD recognizes that the new rates are more complex than the existing fee schedule. For example, there is currently a single rate for Group Home services, but under the new fee schedule, rates will vary based on the size of the home and the member's assessed level of need. Further, the manner in which exceptions to the published rates will be supported is also being revised. DBHDD intends to educate members, families, and providers on these changes and is in the process of developing the necessary training.

9. One commenter suggested that the rates for Group Home services should be implemented for every resident within a given home at the same time rather than person-by-person based on their individual service plan date. The commenter expressed concern due to differences in staffing assumptions in the current rates compared to the proposed rate models.

To avoid disrupting members' existing plans and to accommodate the time that it will take to re-administer the Supports Intensity Scale to all members, members will be transitioned to the new service definitions and fee schedule based on their individual service plan dates. DBHDD expects to begin transitioning members on April 1, 2016.

Members' planning dates will not be shortened or extended in order to align the plans of every individual in the home. As a result, there will be periods of time when a provider is billing the existing rate for some members in a given group home and billing the new rates for other members in the same home. As the commenter notes, there are different staffing assumptions in the new rates compared to the existing rate. However, these staffing assumptions are not mandates and providers may deliver more or fewer hours of support than assumed in the rate models. Thus, it is not necessary to transition every member in a home at the same time.

DBHDD acknowledges that this will add complication to the billing process during the transition year, but believes this approach is the best alternative. DBHDD also considered an approach whereby each home would first be evaluated to identify the latest transition date amongst the members. Then, each member with a plan date prior to that last transition date would receive two authorizations in their plan year for Group Home services. The first authorization would be at the current rate and would cover the period between that member's planning date and the planning date for the member with the latest transition date. The second authorization would reflect the appropriate rate on the new

fee schedule and would cover the remainder of that member's plan year. In this manner, everyone in the home would transition to the new fee schedule at the same time (that is, the planning date for the member with the last transition date). DBHDD rejected this option because it would delay implementation of the rate increases.

Note that there is an exception to this approach for homes in which one or more residents has an exceptional rate. This exception is discussed in the response to comment 10.

10. One commenter suggested that individuals with current exceptional rates be transitioned to the new fee schedule first.

As noted in the response to comment 9, implementation of the new fee schedule is expected to begin April 1, 2016 and members will be transitioned based on their individual service planning dates. Thus, providers will be billing based on both the current and new fee schedule for members in the same group home until the last member in the home is transitioned. This approach must be altered, however, for homes in which one or more members have an exceptional rate.

As discussed in the response to comment 58, the current exceptional rate process is being eliminated and replaced with the Additional Residential Staffing service. Since this service is based on the total staffing within the home, it cannot be approved until everyone in the home has been transitioned to the new fee schedule and the associated staffing assumptions. Thus, if a member in a group home has an exceptional rate that continues to be necessary, that rate will be reauthorized until the planning date of the member in the group home who will be the last to transition to the new fee schedule.

For example, consider a three-person group home in which the members have planning dates in August, October, and December. Assume the member with the October planning date has an exceptional rate. The first member would transition to the new fee schedule in August. The second member has an exceptional rate and may therefore need to access the Additional Residential Staff service. However, that service is authorized for staffing that is required over and above the staffing that is paid for in the rates for all members in the home (since members are sharing staff). Since the third member has not transitioned to the new fee schedule, DBHDD cannot expect the staffing associated with that member's new rate. Thus, the exceptional rate for the second member will be reauthorized for October through December. If Additional Residential Staffing is requested and approved, the authorization for that service for the second member would begin in December when the third member is transitioned.

11. One commenter asked how providers would "recoup their additional expended funds" for January and February 2016 if the proposed increase will occur later in the year.

As discussed in the responses to comments 9 and 10, implementation of the new rates will begin for members with planning years beginning on and after April 1, 2016. Members will be authorized for services at the new rates as they receive their annual individual service plans so full implementation will occur over a 12-month period with the final members transitioning in March 2017. Until members are authorized for services at the new rates, their existing authorizations – at the current rates and with the current service requirements – will remain in place. There is no expectation for providers to expend additional funds and, therefore, no need for 'recoupments'.

12. One commenter suggested that the proposed rates apply to state contracted (non-waiver) services.

With the exception of Respite services – for which billing policies and rates will be aligned between the Comprehensive Waiver and state-only contracts – DBHDD is not currently intending to change the rates for state-only contracts.

13. One commenter asked whether there is a plan for adults with autism entering the system, asking whether they will be "forced to be with clients with physical disabilities or housed with [similar] clients".

DBHDD appreciates the concern related to the transitioning of young adults with autism. All members should have a choice in where they live and with whom. There is nothing in any of the proposals that seeks to dictate the housing decisions of individuals with autism or any other members. The larger issue of individuals with autism reaching adulthood is outside of the scope of this rate review.

14. One commenter suggested that annual caps on services be eliminated or, at least, that members be permitted to "move" funds from one category to another.

DBHDD appreciates this suggestion and intends to consider issues related to service caps as part of the second phase of the rate review.

Direct Support Staff Wages, Benefits, and Productivity

15. Several commenters objected to the wage assumption for direct support staff providing Group Home and Community Living Support services.

- ***One commenter stated that the use of the median wage reported by the Bureau of Labor Statistics is not sufficient; that the $10.63 per hour wage assumed in the rate model only provides for a "starting/base pay" of $8.50. The commenter further stated that the wages are not competitive with other industries such as fast food and retail, that the proposed rates will only permit providers to "get essentially the same level of staff as we have now". This commenter suggested a wage assumption of $11.85 per hour.***
- ***The same commenter disagreed with the manner in which the wage assumptions were constructed and asked for "empirical data" to support these decisions. The commenter then suggested alternative assumptions that deemphasize personal care responsibilities, suggesting job classifications related to training and nursing and psychiatric support.***
- ***The same commenter also suggested that the rate models should assume the same wage for group home staff as for host home oversight staff because "the role of a direct support professional is essentially the same".***
- ***Other commenters generally stated that the wage assumption in the proposed rate model is too low and not a "livable wage".***

The rate models include assumptions relating to the wages paid to direct support professionals. These assumptions are derived from Bureau of Labor Statistics (BLS) data for Georgia. The BLS publishes wage levels for a variety of occupations across industries. The BLS job descriptions were compared to service requirements to determine which occupations best reflect the responsibilities of DSPs. In most cases, Comprehensive Waiver services include aspects of several BLS-defined occupations. Thus, multiple BLS occupations were selected and weighted in order to account for the varied functions associated with each service. DBHDD believes that the original assumptions are reasonable and has not made any changes.

The responsibilities of staff providing Group Home, Community Living Support, and Respite, are most closely associated with the BLS classification for personal care aides (standard occupational classification 39-9021) who have the responsibility to:

> Assist the elderly, convalescents, or persons with disabilities with daily living activities at the person's home or in a care facility. Duties performed at a place of residence may include keeping house (making beds, doing laundry, washing dishes) and preparing meals. May provide assistance at non-residential care facilities. May advise families, the elderly, convalescents, and persons with disabilities regarding such things as nutrition, cleanliness, and household activities.

The policies and procedures manual for the Comprehensive Waiver lists 'covered' Group Home services, which are:

A. Assistance with, and/or training in, activities of daily living, such as bathing, dressing, grooming, other personal hygiene, feeding, toileting, transferring and other similar tasks.

B. Accompanying participants and facilitating their participation in visits for medical care, therapies, personal shopping, recreation and other community activities. This category includes staff to serve as interpreters and communicators and transportation costs to provide the service.

C. Training or assistance in household care, such as meal preparation, clothes laundering, bed-making, housecleaning, shopping, simple home repair, yard care and other similar tasks.

D. Assisting with therapeutic exercises, supervising self-administration of medication, basic first aid, arranging and transporting participants to medical appointments, documenting a participant's food and/or liquid intake or output, reminding participants to take medication, assisting with therapeutic exercises, supervising self-administration of medication and performing other medically related services including health maintenance activities.

E. Training and support in the areas of social, emotional, physical and special intellectual development. This category includes mobility training and programming to reduce inappropriate or maladaptive behaviors.

F. Transportation is required to and from all waiver services specified in the Individual Service Plan.

G. Implementation of behavioral support plans to reduce inappropriate behavior and to acquire alternative skills and behaviors.

A comparison of the BLS job description to the Group Home requirements suggests significant overlap. Paragraphs A through C fit well within the BLS description. However, DSPs have other 'higher-level' responsibilities, such as training responsibilities, specialized training, and some minimal healthcare support. The rate models therefore assume that 60 percent of staff's responsibilities are associated with personal and home care (70 percent for Respite staff), but uses other BLS classifications – including social and human service assistant, home health aide, and recreation worker – to account for other responsibilities.

A similar process was followed for other services. In the case of agency staff supporting host homes, the wage assumptions reflect responsibilities associated with recruiting, training, and supervising host homes, not providing direct supports. All wage assumptions are documented in Appendix A of the rate model document.

The resulting wage assumption for Group Home and CLS services is $10.63 per hour. This figure is more than 10 percent greater than the average wages reported by participants in the provider survey. The rate model assumptions are not mandatory and providers may choose to pay

more or less than assumed. In fact, it is likely that agencies will pay new staff a lesser wage and more experienced staff a higher wage, but DBHDD is uncertain how one commenter concluded that the rate model assumption translates to an $8.50 per hour starting wage.

Overall, the rate models represent a significant increase in total compensation for DSPs. As noted, the wage assumptions exceed current reported levels by 10 percent. The rate models also provide for a comprehensive benefits package, including paid time off and health insurance. DBHDD believes that these improvements will assist providers in attracting and retaining a dedicated, quality, and stable workforce.

16. One commenter asked what contingencies are in place to cover a potential increase in the minimum wage to $10.10.

There is no specific contingency in place to address a potential increase in the minimum wage, which is not a certainty. That said, the rate models are designed in such a way that they can be easily updated to reflect changes such as an increase in the wage assumptions for direct support professionals. In particular, the wage assumption for each service is clearly detailed, allowing that specific assumption to be changed, which will update the bottom-line rate. It is additionally noted that only one service is predicated on a wage of less than $10.10 per hour – the Respite rate model assumes a wage of $9.69 per hour – so an increase in the minimum wage to $10.10 will not necessarily require changes to the associated rate models.

17. One commenter stated that the assumed benefit rates are too high because they exceed the cost of payroll taxes and workers' compensation.

One of DBHDD's goals in the rate-setting process is to improve compensation for direct support professionals. As discussed in the response to comment 15, the wage assumptions included in the rate models are about 10 greater than current wage levels reported by providers that participated in the provider survey. In addition to increased wages, the rate models include a comprehensive benefits package for DSPs that is not limited to the mandatory costs cited by the commenter. The rate models include 25 days of paid time off, $375 per month for health insurance, and $50 per month for other benefits (such as short-term or long-term disability, a retirement contribution, dental or life insurance, etc.). It is hoped that providers will invest a substantial portion of the rate increases in their DSPs, including enhanced benefits, in order to attract high-caliber staff and reduce turnover.

18. Several commenters objected to the benefits assumptions for direct support staff because they are less than Community Service Boards' benefit costs, particularly in terms of health insurance and retirement plans.

The Comprehensive Waiver currently has a single fee schedule for both Community Service Boards and private providers. The new rates maintain this rate equite. As the commenters note, the rate model assumptions are intended to reflect a comprehensive private-sector benefits package. In some cases, these assumptions are less than CSBs' costs.

The rate model assumptions are intended to be reasonable assumptions and are not prescriptive. It is expected that, for a given provider, some assumptions will be less than actual costs and other assumptions will be greater. In circumstance where a provider's costs are higher – whether due to a CSB's mandated benefit costs or due to the mileage incurred by a provider in a rural area as discussed in the response to comment 72 – they will have to identify other areas in which their costs are less. In this case, a CSB may choose to pay direct support professionals less than assumed in the rate model (given that DSPs are receiving generous benefits) or they may direct less funding to agency overhead.

19. Several comments were received in regards to the health insurance assumption for direct support staff. One commenter asked which staff qualify for health insurance. A second commenter stated that health insurance rates are projected to rise substantially in 2016 and asked whether the rate models incorporate this increase. Another commenter stated their belief that an increase in wages will result in increased health insurance participation, but that the rate models are built on current participation.

The rate models assume that every direct support professional receives employer-sponsored health insurance at a cost to the provider of $375 per DSP per month.

The rate model assumes that all staff qualify for – and participate in – health insurance plans offered by their employer. The rate models are not based on current participation levels. Among provider survey participants, private providers report that 31 percent of their full-time staff and 1 percent of their part-time staff receive health insurance from their agency; participating Community Service Boards reported 54 percent and less than one percent, respectively. Since the models assume 100 percent participation, it is not possible for the assumed participation rate to increase further.

The rate model assumption for health insurance is intended to account for the employer's share of cost for an individual health insurance plan. The estimated monthly cost was derived from several data sources.[1] The U.S. Department of Health and Human Services' Medical Expenditure Panel reported the average Georgia employer cost for health insurance in 2014 was $4,367 per year ($5,570 total cost less an average employee share of $1,203), or $363 per month. The federal Bureau of Labor Statistics reported an average employer cost of $363 per month for private employers in the South Atlantic region, which includes Georgia. Data from the Kaiser Family Foundation and the Urban Institute found that the average cost of a 'benchmark silver' plan offered through the federal health insurance exchange in Georgia in 2015 was about $260 per month. Based on these figures and the fact that the models assume 100 percent employee participation that is generally unlikely (because some employees are likely to decline coverage), DBHDD believes that the assumed $375 per month cost is reasonable.

20. One commenter asked why the workers' compensation assumption was set at 3.00 percent of wages rather than the weighted averages reported by participants in the provider survey, which were 3.17 percent (private providers) and 3.46 percent (Community Service Boards).

The numbers cited by the commenter were the averages (means, weighted by provider revenues) reported by respondents to the provider survey. The median reported values were 3.05 percent amongst providers other than Community Service Boards and 2.95 percent amongst the CSBs. DBHDD reconsidered this assumption and increase it to 3.20 percent.

[1] http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2014/tiic1.htm and http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2014/tiic2.htm, http://www.bls.gov/ncs/ebs/benefits/2014/ownership/private/table11a.htm, http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/, http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000149-Marketplace-Premium-Changes-Throughout-the-United-States-2014-2015.pdf

21. One commenter suggested that the rate model assumption of an average of 39 hours of training per year is insufficient because, currently, "40 hours of training is required plus Proxy Caregiver Training, training on all Behavior and Crisis Support Plans and newly implemented initial and annual fire safety training".

As noted by the commenter, the rate models assume that direct support professionals receive, on average, 39 hours of training per year. This training is intended to account for training that occurs outside of service delivery (that is, it is not intended to include training received while a service is being billed). The assumed hours are consistent with figures reported by participants reported in the provider survey and DBHDD believes the assumptions are sufficient.

DSPs will receive a greater amount of training in their first year of employment than in subsequent years due to training required before they can begin delivering services, orientations, etc. The rate model assumption therefore is intended to be a weighted average based on staff with varying years of experience. The provider survey included questions regarding training requirements in the first year of employment and subsequent years of employment as well as turnover. Based on this information, the weighted averages varied from 26 to 49 hours per year for the services included in this rate review.

In terms of the specific trainings noted by the commenter, DBHDD notes that not all of these trainings are required for all DSPs and that some may be imparted during the course of service delivery.

Agency Overhead

22. Two commenters objected to the rate model assumption for overhead costs. One of these commenters stated that the rate models should include 27 percent of total costs for overhead, the average reported by participants in the provider survey. This commenter noted the intent to maintain existing overhead funding amounts, but stated that agencies may not be currently covering their full overhead costs and that changes to service requirements may increase administrative burdens. The other commenter stated that 10 percent for overhead is not sufficient.

The rate models include an average of 20 percent of total costs for agency overhead. The resulting dollar amounts generally correspond to the current spending levels reported by participants in the provider survey. DBHDD continues to believe that this assumption is reasonable and has not made any changes.

Participants in the provider survey reported an average overhead rate of about 27 percent. This figure cannot be directly compared to the rate model assumption for two reasons. First, some of the costs reported by providers appear to be incorporated elsewhere in the rate models (such as direct service costs including facilities and transportation) or are not appropriate for inclusion in the rate models (specifically, recoupments and fines). More importantly, the 27 percent total corresponds to a lower cost base.

On average, the rates for services included in this rate study are increasing by an average of XX percent. When considering the increases in the rates, the 20 percent overhead rate generates funding that is roughly equivalent to providers current reported costs. Consider Group Home services, the single largest category of spending in the Comprehensive Waiver. The average daily rate in fiscal year 2014 was $181.64; 27 percent of that amount is $49.04. Under the new rates, the average comparable rate is estimated to be $252.90. An overhead rate of 20 percent of this amount produces $50.58. Thus, administrative *funding* is consistent with the amounts reported by provider survey participants although the administrative *rate* is less.

In brief, the rates are increasing primarily due to assumed increases in wages and benefits for direct support professionals. Using the Group Home example above, fixing the administrative rate at 27 percent would produce an increase in administrative funding of more than 50 percent [calculated as $252.90 x 80 percent to produce the typical cost base of $202.32. At a 27 percent overhead rate, the total rate would be $277.15 ($202.32 / 73 percent - $202.32 = $277.15). Backing out the cost base leaves $74.83]. DBHDD does not believe that such an increase is warranted.

As the commenter notes, the rate models aim to maintain current overhead funding levels. That said, the rate model assumptions are not mandatory and providers have the ability to direct a greater portion of the $XX aggregate increase to their overhead.

23. One commenter asked what costs are included in program support.

The rate models divide agency overhead costs into two categories: administration and program support. Conceptually, administration is intended to account for agency-level functions such as executive leadership, accounting/finance, human resources, and information technology. Program support is intended to account for program-level functions such as quality assurance, supervision, and staff training. In practice, agencies are all organized differently and some functions will overlap, but the rate models report these functions separately to illustrate that overhead costs are not limited to administrative functions.

The program support functions mentioned above are not specifically billable so these costs are incorporated into the rate models. The models include $14 per day for program support, which provides for an average of 10 percent of costs across all services.

24. One commenter asked how bowel tracking activities are built into the proposed rate models noting that this requires DDP oversight. This commenter also asked how the time that registered nurses spend on Health Risk Screening Tool (HRST) assessments were incorporated in the rates.

Developmental disability professionals and registered nurses are considered to be program support staff. The costs associated with these staff are therefore assumed to be incorporated in the program support component of the rate models.

25. One commenter asked what contingency is in place in order to address federal rules that would increase the income threshold for salaried employees, thereby potentially increasing overtime costs.

The rate models do not include a specific contingency to address the federal Department of Labor's proposal to increase the salary threshold at which employees are automatically non-exempt from certain provision of the Fair Labor Standards Act (such that these employees must would be subject to overtime requirements). The proposed rule would increase the threshold from $23,660 annually to an estimated $50,440 and would take effect January 1, 2016.

DBHDD does not have information regarding how frequently agencies are using the 'white collar' exemption to avoid paying overtime. It is unlikely that many direct support professionals could be classified as white collar workers for the purposes of the FLSA, but some agencies may be using this exemption for supervisory-type staff. Regardless, DBHDD does not intend to adjust the rates if the rule is implemented.

26. One commenter asked whether DBHDD is considering any changes to reporting requirements to reduce administrative costs.

As part of the reauthorization of the Comprehensive Waiver, DBHDD is interesting in working with providers on any suggestions they have to streamline administrative responsibilities.

Rate Categories Based on the Supports Intensity Scale (SIS) and the Health Risk Screening Tool (HRST)

27. One commenter expressed support for tiered rates as well as using the SIS and the HRST for this purpose. Another commenter agreed with the decision to reassess all members prior to being authorized for a rate based on the level to which they are assigned.

DBHDD appreciates the support for the establishment of 'tiered' rates. The new rates take into account the reality that individuals with more significant needs generally require more intensive supports and there is a higher cost associated with providing these supports.

The creation of tiered rates (labeled rate 'categories' in the new fee schedule) requires a process through which members are assigned to a rate. DBHDD has decided to rely on two nationally recognized tools that have already been adopted in the State: the Supports Intensity Scale (SIS) and the Health Risk Screening Tool (HRST). Using both of these tools – the SIS that measures support needs across a number of home and community based activities, and the HRST that measures health risk – is intended to provide a comprehensive assessment of individuals and ensure that they receive the level of support that they need.

To further ensure that assessments reflect members' current needs, DBHDD has decided that members will receive a new SIS, conducted by regional staff who have been trained and certified by the tool's creator, the American Association on Intellectual and Developmental Disabilities (AAIDD), before they are assigned to a rate category for Group Home or Host Home services. These reassessments are scheduled to begin in October.

28. One commenter expressed concern that members will be grouped together by their support needs rather than their preferences.

Members' services should be determined by a person-centered planning process. The new rates neither require nor expect that members will be served only with members with similar needs.

Evaluating existing group homes, for example, it is common for members with varying levels of need to be living together. There is no reason for this to change. With 'tiered' rates, a provider may be paid different rates for each of the members in a home. This already occurs; in many homes, a member with an exceptional rate frequently lives with members without exceptional rates. The new rates offer enough flexibility for such situations to continue. DBHDD is not mandating the specific staffing ratios assumed in the rate model, allowing providers to tailor a home's staffing plan to the needs of the members there.

29. One commenter stated that there must be transparency in the assessments.

DBHDD agrees with the importance of transparency in the assessment process and has historically taken steps to ensure that this occurs. Providers already have access to assessment results. Additionally, DBHDD has published the assessment criteria that will be used to assign individuals to a level of need, which will determine the rate category that providers will bill for certain services.

30. One commenter requested information regarding the supplemental questions that may be asked during a SIS assessment, the related training for assessors, and the process for verifying the results of the questions and asked whether the questions have been nationally normed or validated.

DBHDD added certain supplemental questions to the Supports Intensity Scale in order to identify individuals with significant behavioral needs. These questions are intended to identify individuals who *may* have behavioral issues that require more support than indicated in the SIS instrument itself.

The supplemental questions can only result in a member being promoted to the highest level of need – Level 7 – it never results in members being placed in a level lower than indicated by the SIS.

In order to identify members who would otherwise have been missed, the questions by design will 'flag' many members who do not have the support needs indicated by Level 7. Thus, there is a verification process that will be instituted to review cases in which the supplemental questions indicate that a member should *potentially* be assigned to Level 7. DBHDD is in the process of developing the verification protocols, but expects to establish criteria that will then be implemented by the regional office.

The supplemental questions have not been formally normed or validated. However, they were created in response to real world observation that there was a small number of high-need individuals who did not score highly on the behavioral section of the SIS. The questions have since been adopted in several states.

The Human Services Research Institute, which has helped numerous states adopt these supplemental questions, will provide training on the administration of the questions.

31. One commenter objected to support coordinators administering the SIS.

Support coordinators will no longer be responsible for administering the Supports Intensity Scale. Rather, assessments will be conducted by regional staff for whom administering the SIS will be their primary responsibility. As discussed further in the response to comment 33, these staff will be trained and certified by the creator of the SIS, the American Association on Intellectual and Developmental Disabilities (AAIDD).

32. One commenter asked whether there will be quotas regarding the number of members assigned to each level.

No. Members will be assigned to a level of need based on their scores on the Supports Intensity Scale and the Health Risk Screening Tool. In the interests of transparency, the criteria for each of the seven levels have been posted online. The results of the assessments – and not any predetermined quotas – will determine each member's level assignment.

33. One commenter asked what kind of training SIS assessors will receive.

SIS assessors will be trained and certified by the instrument's creator, the American Association on Intellectual and Developmental Disabilities (AAIDD). Information regarding the training can be found on AAIDD's website at http://aaidd.org/sis/training. In brief, the training includes three phases: orientation, individual guided practice, and interviewer reliability review (IRR).

The orientation phase includes three-to-four days of classroom training as well as group administration of an assessment. Individual guided practices prepare trainees for conducting assessments through practice interviews. At least four practice interviews are conducted. In the interviewer reliability review phase, an AAIDD trainer observes the trainee completing an interview and independently scores the assessment. The trainee's scores are compared to the trainer's to ensure a high level of agreement. Assessors who pass the IRR phase are certified by AAIDD. This certification must be renewed approximately every 12 to 15 months.

As discussed in the response to comment 30, the Human Services Research Institute will provide training on the supplemental questions that DBHDD has added to the SIS.

34. Several commenters asked whether provider staff and host home providers will be included in the SIS assessments.

The Supports Intensity Scale User Manual outlines respondent qualifications:

> Respondents must have known the person being rated for at least 3 months and have had recent opportunities to observe the person in one or more environments for substantial periods of time… A respondent can be a parent, relative, guardian, direct support staff, work supervisor, teacher or any other individual who works or lives with the person…

DBHDD does not intend to dictate who participates in the assessment and expects these decisions to be made by the member and his or her selected representative, but as the User Manual excerpt notes, provider staff (particularly direct support professionals) and host home providers may certainly be respondents.

35. Two commenters discussed training for the SIS and HRST assessments. One commenter stated that training on the HRST has been reduced and provider staff do not receive any training on the SIS. Another commenter suggested that providing specialized training to support coordinators and not to other providers "seems to put providers at a disadvantage to debate scores on the SIS."

Respondents participating in Supports Intensity Scale assessments do not need any training. Trained and certified assessors will guide respondents through the interview. The assessments are not "debates". As noted in the SIS User Manual, the assessor is responsible for rating each assessment item by "integrat[ing] the information from the multiple respondents…"

Training on the Health Risk Screening Tool continues to be offered to staff performing the assessment through web-based modules.

36. One commenter expressed concern that providers might encourage certain responses during the assessments in order to access a higher rate.

It is recognized that linking rates to assessment results has the potential to result in some respondents having 'an agenda' during the assessments. DBHDD is relying on trained and certified assessors to produce accurate results. One of the four assessor qualities that the American Association on Intellectual and Developmental Disabilities encourages states to consider is "strong group facilitation skills" so that assessors are "very transparent about the process of selecting ratings…[to] integrate information from a variety of perspectives, while also keeping the group 'on board' with the final decision."

37. One commenter asked how the SIS will account for the risk of a behavior rather than only the current frequency of episodes, noting that an individual's current stability may be the result of existing enhanced staffing.

According to the Supports Intensity Scale User Manual, the assessment is to be completed "without regard to the services or supports currently provided or available." Additionally, "[s]cores should reflect supports that would be necessary for this person to be successful in the activity." In other words, the assessment is intended to consider an individual's level of need in the absence of supports. Similarly, the behavioral support needs section seeks to ascertain the level of support needed to manage a given behavior rather than the current frequency of that behavior. Assessments will be conducted by trained and certified assessors so that interviews are conducted in accordance with these guidelines.

38. One commenter expressed concerns about inaccurate assessment results.

No assessment instrument is infallible, but the proposed framework has built in several safeguards, including:

- The framework uses two separate nationally recognized assessments: the Supports Intensity Scale and the Health Risk Screening Tool.
- Individuals administering either tool must receive training from the developer of that instrument so that assessments should be standardized and objective.
- SIS assessments must include at least two respondents (and will often include more) so that multiple perspectives are available.
- Higher Health Care Level assignments must be reviewed and approved by a registered nurse.
- If an individual or their guardian believes that the assessment was improperly administered, they may request a reassessment.

Members who believe they need a greater level of support than their assigned rate category provides will be able to request additional support.

39. Two commenters asked how the process for requesting a new assessment will operate. One of these commenters asked how providers can appeal if they disagree with the assessment. The commenters also asked how members would be moved to a new rate category and how providers would be notified of the change.

DBHDD is in the process of developing the protocols for requesting a new Supports Intensity Scale assessment and for communicating any resulting change in a level assignment. Requests will be granted when the SIS was not properly administered and when there is clear evidence of a change in a member's condition. Dissatisfaction with an assigned level will not be a valid justification for approving a reassessment. Providers will not be able to request a new assessment; only members and guardians will be permitted to do so.

40. One commenter stated that the SIS cannot be completed for individuals under 16 years of age or over 70 years of age and asked how individuals in these age groups will be assessed.

The Supports Intensity Scale was standardized based on assessments of 1,306 individuals with intellectual and developmental disabilities across the United States and Canada. The age of individuals in this population ranged from 16 to 72 years-old. Although the population used to standardize the instrument did not include anyone over the age of 72, it is not true that the assessment "cannot" be administered to older individuals. DBHDD believes that the criteria from the SIS used to assign individuals to levels of need remains appropriate for older members. The SIS will therefore be administered to individuals older than 72 years of age.

The 'adult' SIS (SIS-A) is not intended to be administered to children under than 16 years of age. There is a separate 'child' SIS (SIS-C) for younger persons. DBHDD is considering whether to adopt the SIS-C or a different mechanism for assigning these younger members to a level of need. DBHDD does note that very few children live in group homes or host homes, which are the primary services with tiered needs-based rates included in this phase of the rate review. In fiscal year 2014, no more than 14 children under 16 years of age received Group Home or Host Home services.

Certification to Serve Members with Significant Needs

41. Two commenters expressed support for a higher level of certification for providers billing Category 4 Group Home services or Category 2 Host Home or Respite services (that is, serving individuals assigned to Levels 5, 6, and 7).

DBHDD appreciates the support for this proposal. Members assigned to Levels 5, 6, and 7 have the most significant needs, including members with severe disability, medical, or behavioral issues. Requiring certification of providers serving these members is intended to ensure that the agency is capable of meeting the needs of these individuals.

42. Two commenters asked about the certification criteria as well as the timeframe for certification. One commenter asked who will provide technical assistance for host homes serving high-needs members and who will monitor the host homes for compliance.

DBHDD continues to develop the guidelines in regards to the certification process. Initially, DBHDD intends to require each site at which Category 4 Group Home or Category 2 Host Home or Respite service are being delivered to receive certification from the Department based on the same Standards Quality Review that is currently required of providers with less than $250,000 in annual revenue. Over time, these standards may be adjusted. Provider agencies will be responsible for ensuring the ongoing compliance of their host homes.

The timeframes for achieving this certification has not been decided, but there will be a transitional period to allow time for both providers and DBHDD to prepare for the reviews. DBHDD is developing guidance to assist providers in this process.

43. One commenter suggested that providers accredited through the State's process or independently through a rating agency should be deemed as certified.

Accreditation from a national accrediting body will not substitute for DBHDD certification because DBHDD will consider issues that may not be available to the national bodies, such as past incident reports and outcomes.

44. One commenter asked what will happen to members who require Category 4 Group Home services, but who are served by a provider that does not achieve certification. The commenter suggested that transitioning a member in this circumstance to another provider would be contrary to person-centered principles.

It is DBHDD's hope that all providers serving individuals with significant needs will achieve certification. If a member with significant needs is served by a provider that does not or will not become certified, DBHDD will assist that member to transition to another provider just as it does when members are affected by providers that cease operations. DBHDD disagrees with the statement that this would violate person-centered principles as the Department has an obligation to ensure that members' needs can be met.

COMMUNITY RESIDENTIAL ALTERNATIVE (CRA)

45. One commenter expressed general support for the proposed CRA rates, particularly DBHDD's decisions to not increase rates for group homes with more than four residents and to not reduce any rates for host homes.

DBHDD appreciates the support. The changes to the rates are intended to increase options for waiver enrollees and to allow for more personalized supports. For example:

- Group Home rates are 'tiered', providing higher rates to account for more intensive staffing for individuals with more significant needs.
- There are higher rates for three-person homes to make these smaller residences more viable. As noted in the response to comment 49, rates for group homes with five or more residents will not change, but the number of billable days will increase from 324 days per year to 344 days.
- All three- and four-person rates exceed the current rate, allowing for more individualized care.
- A higher Category 2 Host Home rate is established for members assigned to the highest levels of need with the intention of opening the service to a greater number of individuals.
- Although the Category 1 Host Home rate model suggests that a reduction would be appropriate, DBHDD is not implementing the rate so that the service does not become less attractive to providers.

46. Several commenters expressed support for the shift from a 27-day per month billing limit to a 344-day per year limit. One commenter asked whether there would be a limit on the number of days that could be billed in a month. One commenter asked whether there are any federal problems with a billing limit. Two other commenters objected to this change. In particular, these commenters noted that the policy complicates their internal management because they pay their host homes for every day the member is in the home.

DBHDD appreciates the support for the replacement of a 27-day per month billing limit with a 344-day per year limit. Both approaches are intended to protect providers against lost revenue due to members' occasional absences. In brief, the rates are 'inflated' so that providers are fully compensated for 365 days of service over 324 or 344 billing days.

When the Community Residential Alternative rates in the Comprehensive Waiver were originally established, the appropriate daily rate was determined to be $138.09, which is equivalent to $50,402.85 per year. However, concern was expressed that providers would not earn that annual amount if a member was absent for even one day although many of their costs are fixed, particularly in the short-term. Further, DBHDD wanted to remove financial incentives for providers to discourage members from participating in activities that may result in an absence (for example, spending a weekend with their natural family) because the provider does not wish to lose any billing days. In response, DBHDD decided to build an absence factor into the rate. Specifically, the annual cost was divided by 324 days, which yielded $155.56.[2] Since providers are fully compensated for 365 days of support once they bill this rate for 324 days – that is, they have earned approximately $50,402.85 – they are not permitted to bill additional days. This limit has been managed on a monthly basis with providers permitted to bill up to 27 days each month.

[2] Effective July 1, 2015, the daily rate was increased to $158.67.

The shift to an annual limit is intended to increase flexibility for members and agencies so that providers do not lose revenue if a member is in the home for fewer than 27 days in a month. Under the new policy, there is no monthly limit and providers are effectively compensated for up to 21 absences during a member's plan year.

It will be providers' responsibility to manage their revenues. For example, they will need to budget appropriately to accommodate the end of members' plan years when they do not have billable days remaining. Agencies are also responsible for managing their agreements with host homes.

The federal Centers for Medicare and Medicaid Services (CMS) has historically approved this approach to managing absences in residential services in Georgia's Comprehensive Waiver as well as numerous other states' waiver programs. DBHDD foresees no federal concerns regarding this methodology.

47. One commenter asked whether group homes or host homes would be required to demonstrate client engagement in social outings, activities, or work, and if so, how many hours would be required. This commenter also asked whether there is "any plan for having [members] go to a work site each day if they are capable even if they are not paid?"

DBHDD has not completed drafting revisions to service definitions, but does not expect to dictate specific levels of client engagement other than to ensure that the opportunity for community engagement is available consistent with the recent federal rules relating to community integration. That said, it is important that members have opportunities to participate in paid and unpaid supports outside of their home. As is currently true, the types and duration of these engagements will vary by individual and will be considered as part of the annual individual service planning process.

Community Residential Alternative (CRA) – Group Home

48. One commenter expressed support for the establishment of rate models specifically for three-person group homes. Another commenter stated that the proposed rates are not sufficient to support three-person homes because, 1) the cost of operating a three-person home is approximately the same as the cost of a four-person home and the rate differential does not offset the revenue from a fourth resident and, 2) the rate does not address room and board costs. A third commenter stated that four-person residences will remain the norm.

DBHDD appreciates the support. The establishment of higher rates for three-person homes is intended to encourage the development of such homes in order to expand member choice.

As inferred by the commenter, although the *per-person* rates are higher for members in a three-person residence, the *per-home* revenue will be lower for three-person homes. This is due to the reduced staffing expectations for a three-person home, which translates to a lower operating cost for smaller homes. As the commenter notes, the rate models do not address room and board costs because federal Medicaid statutes prohibit the use of Medicaid funds for room and board expenses.

Providers will need to examine the staffing and other costs associated with operating a three-person home as well as the revenue that would be generated based on the three-person rates and members' room and board payments in order to make their own determination as to whether to establish three-person homes.

49. One commenter asked whether a group home licensed for four beds would be able to bill the three-bed rates until a fourth member moves into the home. Another commenter suggested that homes with more than five bedrooms should be able to bill the three- and four-person rates if there are only three or four residents in the home.

The Group Home rates will be based on the licensed capacity of home rather than occupancy. Providers will determine whether to have their group homes licensed for three or four members. The allowable rate will be based on the licensed number of beds even if a bed is vacant. Providers will always be able to seek a change to their licensed capacity if they do not expect to fill a vacancy.

The second comment was not entirely clear. New group homes with more than five beds have not been permitted for several years, but existing homes have been permitted to continue operating. This policy is not changing. The rate for members in homes with more than four residents remains $158.67 per day (although providers will be able to bill for up to 344 days per year rather than the current limit of 324 days, producing a de facto rate increase of 6.2 percent). If one or more vacancies occur such that there are three or four members in the home, the provider may seek to limit the home's licensed capacity to three or four members. However, the provider will not be able to later seek to place more than four members in that home.

50. One commenter stated that "It appears from the material provided that individuals that fall into Category 1 would not be allowed to reside in a group home setting" and asked whether this is accurate.

DBHDD is unsure what materials are being referenced by the commenter and has not proposed any restrictions on members assigned to Level 1 receiving Group Home services. Rather, the Category 1 rate was specifically developed for those in Level 1. It is true that members assigned to Level 1 generally do not require the level of support offered in a group home and it is hoped that these individuals and their families and guardians, as appropriate, will consider less restrictive options, but group homes will remain an option for everyone.

51. Several commenters asked how the staffing assumptions incorporated in the rate models will be defined and communicated to support coordination agencies. Specifically:

- ***One commenter stated that staffing should be considered across the entire home rather than the amount of support that each individual needs being "stacked one on top of the other".***
- ***One commenter noted that the rate model for individuals assigned to Category 4 assumes that there will be two overnight staff, but if not everyone in the home is assigned to Category 4, that second staff person is not fully funded. The commenter concluded by asking 1) whether support coordination agencies will mandate that providers maintain a second overnight staff person and 2) whether the Additional Residential Staffing service could be used to support a second overnight staff person if necessary. More generally, this commenter objected to the Category 4 rates, stating that their calculations suggested the cost of supporting the member would exceed the proposed rates, but did not provide details on these calculations.***
- ***Another commenter suggested that the Category 4 rates are inadequate because the difference between the Category 3 and Category 4 rates are less than the cost of a 'requirement' for a second overnight staff person.***

The Group Home rate models are based upon staffing assumptions with more intensive staffing assumed for members with more significant needs. The rates do assume that members are sharing staff support and the assumptions do not, as the comment suggests, 'stack' supports for each member. The staffing assumptions are not mandates upon providers; that is, they are not required to provide the

amount of staffing incorporated in the rates (except in cases where Additional Residential Staffing is requested – this service will not be authorized unless and until the amount of support paid for in the Group Home rate models is delivered). More generally, the amount of support that members need will be part of members' annual individual service planning meetings and should not be dictated by rate model assumptions.

The Category 4 rate model does assume that there will be two staff on the overnight shift in a home in which everyone is assigned to Category 4, but as with the staffing assumptions overall, this is not a mandate. The other rate Categories do not assume that there are two staff on the overnight shift. Thus, the commenter is correct in that a home in which members assigned to Category 4 reside with members assigned to other Categories will not be funded for two overnight staff. However, two overnight staff will not necessarily be expected in these homes.

DBHDD believes that the Category 4 rates are reasonable. If the rate does not meet the needs of a given individual, they have the ability to request the Additional Residential Staffing service for additional support.

52. One commenter stated that the vehicle acquisition cost for Categories 3 and 4 should be revised to accommodate a higher proportion of vehicles with wheelchair lifts.

The Group Home rate models include assumptions for member-related transportation. Among these assumptions is a vehicle acquisition cost of $35,000. This assumption, which is intended to represent a reasonable average, is the same across all rate categories.

As the commenter suggests, $35,000 is likely insufficient to purchase a vehicle with a wheelchair lift. Further, it is likely that members assigned to Category 3 or 4 are more likely to have conditions requiring wheelchairs. However, the rate model assumptions have not been revised. First, although members in Categories 3 and 4 are more likely to require wheelchairs, it is still expected that most of these members are not in wheelchairs. Second, most members reside in homes with members of varying levels of need. That is, a member in Category 4 is as likely to reside with a member assigned to Category 1 or 2 as with a member assigned to Category 3 or 4. It therefore makes sense to use the same assumption across all levels of need.

DBHDD believes the $35,000 vehicle acquisition assumption is a reasonable average. It is less than the cost of a wheelchair-equipped vehicle, but higher than the cost of other vehicles. Providers that participated in the provider survey reported an average vehicle cost of less than $25,000.

53. One commenter noted that exceptional rates will be phased out, but the proposed rates do not appear to be as high as some current exceptional rates and asked how additional funds would be acquired for individuals with Group Home authorizations in excess of $100,000 per year.

The commenter is correct that none of the Group Home rates are as high as some members' current exceptional rates as the rate models are not intended to reflect 'exceptional' circumstances. Other mechanisms are being established to provide supports needed by members that exceed those built into the rate models.

First, many exceptional rates are due to the need for nursing and behavioral supports. These services will become separately billable and, therefore, will no longer be incorporated in exceptional Group Home rates. Second, members who require staffing support that is greater than assumed in the rate models will have the ability to request the Additional Residential Staffing service to meet these needs.

Community Residential Alternative (CRA) – Host Home

54. One commenter suggested that host homes should have the same number of rate categories as group homes.

The Group Home rate models include four 'tiers' based on members' levels of need. The rate Categories vary based on assumed staffing differences; members with more significant needs are presumed to receive more intensive staffing supports. In the case of Host Home services, however, there is no additional staffing. That said, a higher Category 2 rate has been established for members with the greatest needs, those assigned to Level 5, 6, or 7. Although no additional 'staffing' is provided, the higher rate is intended to incentivize providers and qualified host homes to serve individuals with significant needs.

55. Two commenters asked whether DBHDD intends to implement a lower Category 1 rate.

No. The Category 1 Host Home rate model suggests that the rate should be reduced. However, DBHDD does not intend to implement the lower rate because it does not wish to disincentivize the service. Rather, the Host Home rate will be 'held-harmless' such that providers' annual revenue will not decrease. The current rate is $158.67 per day. At the current maximum of 324 billing days (27 days per month for 12 months), providers can bill up to $51,409.08 per year. As discussed in the response to comment 46, the new billing policy will permit billing up to 344 days per year. Thus, the new Category 1 daily rate will be $149.45, which will allow them to earn the same annual revenue.

56. Several commenters expressed support for the proposed requirement that agencies must pass through at least 65 percent of the waiver payment to the host home. Two commenters objected to a minimum percentage. One of these commenters suggested that the floor be set at 50 percent. The other commenter stated that a minimum percentage will create more transparency, but stated that such a policy favors large providers because they will generate more overhead funding.

DBHDD appreciates the support for the establishment of a minimum payment standard for host homes. This standard is intended to address significant reported differences in how much host homes are paid by their parent agencies, with some homes receiving less than half of the waiver payment. DBHDD believes that the majority of the payment should be received by the home providers who are responsible for caring for the member. In response to the dissenting comments, the minimum required payment has been reduced from 65 percent of the total payment to 60 percent.

The 60 percent payment threshold will require that a host home caring for a member receiving a Category 1 rate will be paid at least $30,846 annually while a home caring for a member receiving a Category 2 rate will be paid at least $38,231 (both cases assume that the member is in the home for at least 344 days as discussed in the response to comment 46). The payments from the Comprehensive Waiver rates are *in addition to* room and board payments to the host home provider.

Providers may choose to exceed the 60 percent minimum requirement. In fact, the rate models assume that 64 percent of the Category 1 rate and 74 percent of the Category 2 rate is paid to the host home. The minimum requirement has been established at the lesser 60 percent amount to provide flexibility to agencies. The comment that large agencies will generate more billings and, thus more funding for overhead costs, is true regardless of the service. Establishing the minimum payment requirement at 60 percent of the payment, rather than the 64 or 74 percent assumed in the rate model, should help support smaller agencies.

This policy better aligns the Comprehensive Waiver with requirements for comparable services in other State waiver programs. In the Community Care Services Program, at least 50 percent of the

Alternative Living Services – Family Model daily rate must be paid to the family provider ($18.69 of $37.38). In the Independent Care Waiver Program, at least 60 percent of the Alternative Living Services – Family Model daily rate must be paid to the family provider ($42.00 of $70.00).[3]

57. Two commenters asked whether provider agencies who serve as the representative payee for a member must use a portion of these funds to pay the host home provider for room and board or if this will be at the agencies' discretion.

A member's Social Security benefits must be used to meet their daily living needs. It is appropriate and consistent with federal requirements to use these benefits to cover their room and board expenses. Other than a modest personal allowance for the individual's use, it is unclear for what other purposes the commenters would use members' benefits. Information regarding the use of benefits and the responsibilities of representative payees can be found at http://www.socialsecurity.gov/payee/faqrep. Further, the Centers for Medicare and Medicaid Services makes a clear distinction between room and board costs that should be reimbursed through an individual's personal benefits and service costs that are reimbursed using Medicaid funds.

Due to these comments, DBHDD intends to consider developing more specific guidance regarding the appropriate use of members' federal benefits.

ADDITIONAL RESIDENTIAL STAFFING

58. Two commenters expressed support for replacing the current exceptional rate process with this new service.

DBHDD appreciates the support for the changes to the exception process. Changes to the rates, such as the development of 'tiered' rates for Group Home and Host Home services, should significantly reduce the number of exceptions that will be necessary. However, no rate schedule will cover the needs of every member so there will continue to be a need for an exception process. DBHDD believes that the new approach is a significant improvement from the existing process.

First, the tiered rate categories provide higher rates for members with more significant needs, compensating providers for delivering more intensive supports without having to request an exceptional rate. Second, certain 'add-on' services are being 'unbundled' from residential services. Specifically, providers will be able to separately bill for nursing and behavioral support services that are provided. Finally, the Additional Residential Staffing service is being created for instances in which members require more supports than assumed in the rate models.

Additional Residential Staffing is intended to be used in three instances:

- In group homes, when more staff hours than funded in that home are required for the support of a member,
- In host homes, when the home requires some external staffing for the support of a member, and
- When a member needs more support than their Community Living Support budget will permit.

[3] Note that materials accompanying the proposed rates stated that other State waiver programs required 50 to 75 percent of the payment for services comparable to Host Home. This was an error; the other programs have standards of 50 percent and 60 percent.

In each instance, the Additional Residential Staffing service is authorized for services that are clearly in excess of what is funded through the Group Home or Host Home rate or CLS budget. The new service is billed in addition to Group Home, Host Home, or CLS services. Overall, DBHDD believes that this process will effectively align payments with the supports that members need and that providers deliver.

59. One commenter suggested that exceptional rates be kept in place for medically fragile members because of their concern that the rates for these members will be reduced.

The existing exceptional rates will be phased out for all members, including those who are medically fragile. These individuals are expected to be assigned to the highest Category 4 Group Home rate or Category 2 Host Home rate. As the commenter notes, even these highest rates are less than some currently approved exceptional rates. DBHDD notes that some of these exceptional rates are driven by behavioral supports and nursing services that are being 'unbundled' from other services and will be separately billable. However, there will be situations in which a member simply needs more support than incorporated in the rate for their residential service. In these cases, the member will be able to request the Additional Residential Staffing service.

60. Two commenters requested additional information regarding the process for requesting and approving Additional Residential Staffing. One commenter stated that the approval process for Additional Residential Staffing must be prompt. Another commenter noted that this service must be implemented in conjunction with the other rates.

Additional Residential Staffing can be requested based on a member's needs in comparison to the level of support that their other services would provide. DBHDD is in the process of developing the protocols for approvals, which will be managed by the regional offices. The process will include consideration of a member's clinical needs based on their Supports Intensity Scale and Health Risk Screening Tool assessments as well as the staffing schedule for the member's group home or host home (as applicable). It is anticipated that guidelines will be established to relate certain SIS and HRST results with a range of hours that may be approved so that there is consistency across regions.

61. One commenter suggested a number of scenarios for which Additional Residential Staffing should be used, including temporary absences from a day program, "retirement" from participating in day activities, or unexpected medical or behavioral issues. The commenter does not believe that the 'floating FTE hours' included in the Group Home rate models should be used for these purposes.

Each of scenarios mentioned by the commenter *may* constitute the basis for approval of Additional Residential Staffing. At the same time, these situations, particularly short-term issues, may also be appropriately managed through the 'floating' staff hours built into the Group Home rate models.

The Group Home rate models include assumptions regarding the typical staffing pattern of a home, in particular the number of staff on site during daytime hours and during overnight hours. The models also recognize that group homes require additional staffing at certain times. The models therefore including 'floating' staff hours to accommodate busy times of the day (for example, at meal time), to cover instances when someone stays home during the day due to illness or another reason, and to provide individualized supports to members.

The Additional Residential Staffing service may be authorized in cases when a member needs more support than funded for their group home, considering both shift and floating staff. Providers have discretion in how they staff their group homes and do not have to follow the rate model assumptions. However, since members in group homes are, by definition, sharing staff support, the Additional Residential Staffing service will not be approved unless all of the hours assumed in the rates for all

members in the home are being delivered. That is, the need for *additional* staff hours must be demonstrated. If the rates for members in a certain home translate to 250 hours of staff support (based on the rate model assumptions), Additional Residential Staffing will only be approved for hours in excess of the 250 that are already paid for.

Thus, approval of Additional Residential Staffing requires demonstration of both an individual's need for the service (which may include the examples cited by the commenter) and delivery of the staff hours that are already funded through the rates for the members in the home.

DBHDD does note that Additional Residential Staffing is unlikely to be approved for very short-term circumstances such as a member's temporary absence from a day program. As noted, the rate model staffing assumptions are not mandated and providers are not required to deliver the level of staffing that is assumed. As a result, it is expected that there may be weeks during which fewer staff hours than assumed in the rate models are delivered and other weeks during which more hours are provided (such as a week when a member stays home from their day program).

62. One commenter stated that authorization for this service should consider not only the needs of the member, but also the ability of the agency to deliver the staffing. For example, the commenter noted that they cannot reasonably find a staff person to provide only 30 minutes of support in the morning to help someone prepare for the day; the commenter stated that additional supports should be authorized in no less than four-hour increments.

Medicaid waiver programs require that services must be ordered in type, frequency, and duration identified through assessed needs and individual goals. Medicaid waiver programs do not allow the 'over-reimbursement' of services to meet agency needs.

That said, it is not expected that there will be instances in which a member requires 30 minutes of Additional Residential Staffing. In the example cited, DBHDD believes that the rate models provide sufficient flexibility to address the member's needs. As noted in the response to comment 51, the staffing assumptions in the rate models are not mandates and providers have discretion in how they staff their group homes. In the example, providers could potentially overlap shifts to provide more coverage in the morning, rely on the 'floating' staff hours built into the rate model, or schedule supervisory visits for this time of day.

63. One commenter asked how approval for additional funding in 2015 would apply to the rate increase that will be enacted in 2016.

An authorization for additional services or for an exceptional rate will remain in place for the duration of each member's plan year. As discussed in the responses to comments 9 and 10, transition to the new rates is expected to begin for members with individual service planning years beginning in April 2016. Members' authorizations for services, including exceptional rates, will not change until their planning meeting occurring after April 1, 2016. At that time, their exceptional rate will have expired, but they will be able to request Additional Residential Staffing.

64. Several commenters objected to the exclusion of overhead costs in the rate model.

The Additional Residential Staffing service is only intended to add staff hours to an existing service delivery model. Further, it is anticipated that this service will be used most frequently by individuals with significant needs who would be receiving the highest Group Home and Host Home rates. Since the rate models fund administrative costs as a percentage of the total rate, providers are already receiving greater amounts of administrative funding for these members. For these reasons, the proposed rate model did not include any funding for agency overhead costs.

However, commenters raised legitimate issues regarding additional overhead costs associated with the delivery of this service. In response, DBHDD has added overhead costs to this rate model, funded at half of the rate used in other rate models. Specifically, the rate model now includes 5 percent for administrative costs and $7 per day for program support, for a total effective overhead rate of about 10 percent.

65. Two commenters asked how the proposed changes to exceptional rates would impact the process for providers to access funds for specialized medical supplies, nursing services, and behavioral support services. One of these commenters asked if site-specific Medicaid provider numbers will be required for nursing and behavioral support services.

Specialized medical supplies, nursing services, and behavioral supports services are all being 'unbundled' from other rates and will be billable in addition to any residential support that a member receives. As with any service, these services would be requested as part of a member's individual service plan. Providers will need to be licensed to provide nursing or behavioral supports services, but will not need site-specific provider numbers.

DBHDD intends to consider the annual cap on specialized medical supplies as part of the second phase of the rate review.

66. One commenter asked whether members using consumer-directed services would be able to access this service.

There is not a consumer-directed option for Additional Residential Support.

This service augments staffing in Group Homes and Host Homes, neither of which can be consumer-directed. Additional Residential Service can also be accessed by members who need more than 9,000 units of Extended Community Living Support per year. However, consumer-directed CLS does not have a limit on the number of hours of support that they may receive. Rather, they receive the same annual budget limit as members receiving agency-directed services. Members utilizing consumer-direction have the flexibility to negotiate with their care provider, allowing them to, for example, negotiate a lower hourly rate (given that there are not the same agency-related infrastructure costs) so that they can receive more hours of support within their budget.

COMMUNITY LIVING SUPPORT (CLS)

67. Several commenters expressed concern that the proposed rates are not adequate to support members in their homes. Two commenters suggested that the rates for members sharing supports in a residence not owned or controlled by an agency should be equivalent to the Group Home rates.

DBHDD believes that the CLS rates, which are more than 15 percent greater than the existing rates, are reasonable and sufficient. As discussed in the response to comment 68, however, the service is not intended to be provided on a one-to-one basis 24 hours per day, 365 days per year. CLS is also not intended to be equivalent to a group home. The CLS rates reflect the requirements of this service while the Group Home rates reflect the different requirements and staffing expectations of that service.

68. Two commenters asked whether CLS can be delivered on a 24-hour-a-day, seven-day-a-week basis. One commenter expressed support for allowing members to receive 24-hour one-to-one support 365 days per year. One of these commenters asked whether it is DBHDD's intent that groups of two-to-four members would be served in an unlicensed setting.

Community Living Support can be delivered on a 24-hour basis. There will be an annual cap on CLS services such that individuals will not be able to receive more than 9,000 units (2,250 hours) per year, which means that they could not access 365 days of 24-hour one-to-one support. Members who need more than 2,250 hours could request Additional Residential Staffing. Only in very rare circumstances, however, would any member be expected to receive any combination of one-to-one services for 24 hours per day, 365 days per year.

Members who choose to share supports with up to two other individuals will be able to 'stretch' their CLS budget. On a per-person basis, the two- and three-person group rates are lower. As a result, the annual CLS limit would allow a member to receive 16,348 units annually at the two-person rate and 22,460 units at the three-person rate. CLS services, whether delivered one-to-one or to a group, are provided in homes controlled by members or their families and these homes do not require licensure.

69. Two commenters expressed support for the elimination of the Daily rate. Two other commenters expressed concern that the annual budget limit will not be sufficient for members currently approved for an exceptional Daily rate. One of these commenters suggested that these individuals continue to have access to exceptional rates.

DBHDD appreciates the support for the elimination of the Daily CLS rate. This proposal is intended to better align payments to providers with the amount of support they provide. With the existing Daily CLS rate, providers receive the same payment regardless of whether they deliver eight hours or 24 hours of support.

With the elimination of the Daily CLS rates, there will no longer be exceptional Daily CLS rates. There will continue to be processes in place to ensure that members receive the services that they need.

Many existing exceptional rates are related to nursing or behavioral support services. As discussed in the response to comment 53, those services will no longer be 'bundled' into Community Residential Alternative and CLS services. Rather, these services will be separately billable.

Members who require support in excess of the annual CLS limit will be able to request Additional Residential Support services. Or, members can choose to share supports. As noted in the response to comment 68, the lower group rates allow members to 'stretch' their budgets.

70. One commenter objected to the CLS rate because "the DSP [is] paid $10.63 per hour and the provider [gets] another $15.00 for the effort and work the DSP does." The commenter further asked how many agencies actually provide paid time off and health insurance or reimburse direct support staff for mileage.

The commenter misunderstands the rate model. It is accurate that the rate model assumes the direct support professional (DSP) receives a wage of $10.63 per hour and the total cost for the Basic rate is $25.40 per hour, but the nearly $15 difference is not intended for the agency. Of the total cost, $10.63 per hour is assumed for the DSP's wage, $3.84 for the DSP's benefits, $4.26 for 'productivity adjustments' that cover the DSP's wage and benefit costs when they are performing non-billable tasks (such as attending training or attending an individual service plan meeting), and $1.86 for the DSP's mileage-related costs. That leaves $4.81 per hour for support agency operations and overhead.

The commenter asked to what extent agencies are currently providing paid time off and health insurance to staff. DBHDD does not have that information for all providers, but did report the results for those agencies that participated in the provider survey. These providers reported that 92 percent of their full-time DSPs (across all services; the survey did not ask providers to report this information separately for each individual service) received paid-time off and 38 percent receive health insurance. The survey did not ask whether agencies reimburse staff for the use of their personal vehicles or if they provide fleet vehicles.

As discussed in the response to comment 18, the rate model assumptions are not mandates (that is, there is no requirement that providers pay the wages and benefits assumed in the rate models), but DBHDD hopes that the increased rates will allow providers to increase DSPs' total compensation.

71. One commenter stated that the proposal "assume[s] that most visits are less than 3 hours and the DSP must travel between consumers." The commenter also suggested that there are instances in which DSPs do not travel for some members who receive four-to-six hours of support.

DBHDD has not assumed that most visits are less than three hours. In fact, an analysis of claims data suggests that more than 80 percent of CLS units will be billed at the Extended rate, that is, for visits lasting more than three hours.

Two rates have been developed for CLS, a Basic rate for visits of fewer than three hours and an Extended rate for longer visits. The rate models are intended to reflect the cost of providing a given service. For CLS, the Basic rate is higher to reflect higher costs associated with shorter-term services, including a greater likelihood of travel between members and, due to the fact that a staff person providing short-term services will see more members, spend more time on recordkeeping, and attend more individual service plan meetings.

As the commenter notes, there may be instances in which staff travel fewer miles than assumed in the rate model. It is equally true, however, that some staff will travel more miles than assumed. Overall, DBHDD believes that the rates are reasonable.

72. One commenter stated that the mileage assumption in the rate model is inadequate for rural parts of the State and asked what contingency is in place for circumstances in which a staff person travels more than 100 miles. Another commenter suggested that the mileage assumptions are not person-centered.

The Basic CLS rate model assumes that DSPs travel 100 miles per week. This assumption is consistent with figures reported by agencies that participated in the provider survey. These providers reported that staff providing CLS services travel about 100 miles per week (median response was 74 miles, weighted average was 124 miles).

As with all rate model assumptions, the mileage included in the CLS rate model is intended to represent a reasonable average. In practice, it is expected that, for a given provider, some costs will be greater than assumed in the rate models and that other costs will be less than assumed. It is true that there will be instances in which staff drive more than 100 miles per week and this is probably more likely in rural areas. However, there may be offsetting savings compared to the assumptions. For example, wages are often lower in more rural areas or the cost of office space may be less.

There is no provision to adjust rates when travel requirements exceed the rate model assumption. DBHDD believes that the overall CLS rates are reasonable and that there is sufficient flexibility in the rates to allow providers to manage such instances.

73. One commenter suggested that CLS be billed in hourly increments rather than in 15-minute units. Another commenter asked how 15-minute units will be tracked and what type of documentation will be required.

CLS services will continue to be billed in 15-minute increments. Quarter-hour units – which are how most other waiver services are billed (the primary exception is 'full-time' residential services that are billed on a per diem basis) – better align payment with the amount of service actually provided. In comparison, hourly units require that significant amounts of time be 'rounded'. For example, 29 minutes of service would be rounded down to zero (so the provider would not be paid for 29 minutes of service that were provided) while 30 minutes would be rounded up to one hour (resulting in the provider being paid for 30 minutes of service that were not provided).

Tracking and documentation requirements are similarly unchanged. Providers are expected to track and document the amount of time that staff delivers CLS services in order to bill appropriately. Providers are not required to separately document supports in 15-minute increments. Rather, providers are required to document activities and the associated time (for example, meal preparation instruction for one hour).

74. One commenter asked how the Basic and Extended CLS services will be authorized, given that the amount of service may vary from day-to-day.

The Basis and Extended CLS services will be authorized in the same manner as other services. During members' annual individual service plan (ISP) meetings, the team will determine the amounts of services that members need based on specific circumstances. The team will consider a member's routine and determine the amount of Basic and Extended services that the member is likely to use (which could be one or the other or both). If a member's actual use of services varies from what is presumed in the service plan, their authorization can be amended later in their plan year to incorporate these changes.

75. One commenter asked whether there will be multiple billing codes for services delivered to more than one individual concurrently. This commenter further asked what type of documentation will be required in these instances.

There will be billing modifiers for services delivered to two- and three-person groups so that the service is reimbursed at the appropriate rate. DBHDD is in the process of developing documentation requirements, which will build on existing expectations while recognizing the shared nature of these group services.

76. One commenter asked why there are not rate categories for CLS when there are rate categories for Host Home services, which are also typically delivered on a one-to-one basis.

In general, there are 'tiered' rates for group services to reflect the more intensive staffing required for members with more significant needs. That is, individuals with greater needs should be served in smaller groups. There are not tiered rates for Community Living Support because the service is not a group service. Members receive one-to-one support regardless of their level of need. There are no differences in staffing ratios so there are not rate categories.

The commenter notes that Host Home services are also typically one-to-one, but there are two rate categories for that service. The analogy, however, is imperfect. Host Home services are reimbursed on a daily basis. There is a higher rate (Category 2) for members with the most significant needs because it is presumed that the host home provides a greater amount of support over the course of a day. The higher rate is intended to accommodate this greater support. In the case of CLS, providers

are paid on a quarter-hour basis based on the amount of service actually provided. Thus, CLS providers do receive greater payment when they deliver a greater amount of service.

77. One commenter asked who would qualify for two-to-one staffing.

CLS does not provide for two staff persons for one member and the service cannot be billed for two staff persons providing services simultaneously. If a member needs support from two staff, they would need to request the Additional Residential Staff service. As discussed in the response to comment 60, DBHDD's regional offices will be responsible for reviewing these requests. If approved, the service could be provided when a member requires support from two staff – one staff person would bill CLS and the second staff would bill Additional Residential Staff.

78. Several commenters objected to a monthly limit on CLS services, stating that such a limit does not take into account variations in the amount of support a member needs over the course of a year.

DBHDD has eliminated the proposed monthly limits for agency-directed and consumer-directed CLS.

The proposal was intended to ensure that the annual limit on services was not fully utilized early in a member's plan year such that they would be left without support at the end of the year. In response to the requests for flexibility in allowing members to decide when to use their services, the proposal for monthly limits has been retracted. There will continue to be an annual limit, so monitoring a member's use of their budget and ensuring that sufficient services will be available throughout their plan year will be a responsibility shared amongst the member, their guardian (as applicable), their provider, and their case manager.

79. Several commenters objected to the proposed elimination of the personal assistance retainer, expressing concern that members would lose access to their caregiver.

The Community Living Supports rate models included two assumptions to address members' occasional short-absences. The rate models provide for 25 days of paid time off for direct support professionals that could be used in instances when a member is absent and a productivity adjustment for missed appointments that incorporates absences into the billable rate. In response to the dissenting comments, particularly from those using consumer-directed services, DBHDD has withdrawn the proposal and will keep the personal assistance retainer. The paid time off for DSPs assumed in the rate models has not been changed, but the missed appointment productivity factor has been eliminated.

DBHDD also intends to establish a separate modifier to track the use of the personal assistance retainer. Protocols for authorizing the services are in the process of development.

RESPITE

80. Two commenters expressed support for the proposed changes to Respite, stating that the proposed rate increases will expand the number of providers. One of these commenters stated that they support one rate for shorter periods of respite and a higher rate for overnight respite.

DBHDD appreciates the support. Respite can be critical to supporting families caring for individuals with disabilities. The rate increases are intended to make Respite more attractive to providers so that the service is more available to those who could benefit from it.

81. One commenter objected to the proposed rates, stating that they are not sufficient to maintain and support a pool of providers.

DBHDD believes that the rates are appropriate. Compared to the existing 15-minute and Daily Respite rates in the Comprehensive Waiver, the new rates represent increases of XX percent and XX percent, respectively. A review of payments under state-only contracts and the corresponding amount of services that providers report delivering demonstrate that the new rates exceed the current contract rates. On average, the new rates are XX percent and XX percent greater than 15-minute and Daily Respite rates, respectively.

Further, the Respite rates exceed those in other State waiver programs. The new 15-minute Respite rate in the Comprehensive Waiver is $XX per 15-minutes and the new Daily Respite rate is $XX. Respite rates in other waiver programs are lower: $3.00 per 15-minutes and $42.57 per day in the Community Care Services Program, $4.00 per 15-minutes and $128.00 per day in the Community Based Alternative for Youth program, and $2.20 to $3.00 per 15-minutes and $70.55 per day in the Independent Care Waiver Program.

82. Two commenters expressed concern regarding the potential loss of Respite services. One of these commenters stated that they were told if services are not used "you lose your respite waiver". The other commenter objected to "removing emergency respite and flexibility from state funded contracts".

DBHDD does not intend to limit access to Respite services. Rather, the rate increases are intended to attract more providers to the service, thereby increasing availability. As noted in the response to comment 81, the new rates are higher than both the current Comprehensive Waiver and state-only contract rates.

Emergency Respite will continue to be funded through state-only contracts, but these contracts are intended to provide services to individuals who are not enrolled in a waiver program. Respite services for individuals on the Comprehensive Waiver should be funded through the Waiver.

Finally, DBHDD is uncertain what the commenter may have been told about losing a "respite waiver" as there are no such waivers. The limits for Respite services covered through the Comprehensive Waiver are defined in the program's service definitions.

83. One commenter stated that rates should be tiered in order to support individuals with more significant needs.

As discussed in the response to comment 76, 'tiered' rates are generally established to provide more intensive staffing for group-based services. Since Respite is primarily a one-to-one service, like Community Living Support, there are not tiered rates for the 15-minute rate.

The Daily Respite rate, however, is tiered. The Daily Respite rates are linked to the Host Home rates (specifically, the Daily Respite rates are set at 120 percent of the Host Home rates). There is a higher Category 2 Host Home rate for individuals with the most significant needs, that is, those assigned to Levels 5, 6, or 7. Since the Daily Respite rates are linked, there are two rate categories for this service, as well. Any member assigned to Levels 5, 6, or 7 will therefore be supported at the Category 2 Daily Respite rate (members assigned to Levels 1 through 4 or without a level assignment will be supported at the Category 1 rate).

84. One commenter stated that the Respite rate should be higher than the rate for Community Living Support.

The rate models for each service were developed independently based on the requirements for each service. The Respite rates were constructed based on the requirements for that service, not for Community Living Support. DBHDD believes that the Respite rates are appropriate for the service.

85. One commenter stated that the rate model does not account for the expense associated with a registered nurse developing a plan of care, supervising the care every 92 days, and being on-call 24-hours per day.

As with all services, clinical oversight is assumed to be incorporated in the overhead component of the rate model. The rate models include an average of 20 percent for overhead costs, split between administrative functions and program support such as nursing oversight.

86. One commenter stated that DBHDD should "purchase capacity for respite… whether it is being used or not."

The Comprehensive Waiver has always paid for services solely on a fee-for-service basis; that is, payments are only made for services that are delivered. State-only contracts have historically made payments for activities other than service delivery, such as transportation, staff training, and agency overhead. As noted in the response to comment 12, Respite payment policies will be aligned between the Waiver and state-only contracts. Thus, payments under the state-only contracts will be limited to fee-for-service.

DBHDD recognizes the need for service capacity – across all Waiver services. Thus, the costs that the state-only contracts separately reimburse are intended to be 'wrapped into' the fee-for-service rates. As noted in the response to comment 81, the new rates are XX percent higher than the total payments made under the state-only contracts based on reported service levels. The new rates should therefore support existing capacity and, ideally, result in an expansion of services.

87. One commenter objected to the "restriction on using state funded family support funding to assist in the care and support of individuals", stating that persons in emergency situations need the flexibility to access other family support funds.

DBHDD intends to align Respite policies and rates across the Comprehensive Waiver and state-funded contracts. Respite services will continue to be available to the families of individuals on the Comprehensive Waiver. However, the services will be paid for through the Waiver – with the accompanying federal matching dollars – rather than using state-only dollars.

88. One commenter asked whether a provider can deliver Respite services in a group home, using a vacant bed.

No. As is the current policy, Respite cannot be provided in an occupied group home. Bringing members into a group home for Respite services would be disruptive for the individuals living in that home.

89. Two commenters stated that the fiscal agent does not permit them to bill a single Overnight unit when services cross midnight. Rather, the commenter stated that they are required to separately enter hours on both days, which results in the use of two units of service. The commenters noted the fiscal agent then told them to bill the service using the 15-minute rate, but will not permit that service to be billed for more than eight hours in a day.

The situation described by the commenters – a period of Respite services beginning on one day and ending the following day – should be billed as a single Overnight unit. It would not be appropriate to bill two Overnight units or to bill 15-minute units for more than eight hours. DBHDD contacted the commenters directly and provided the following guidance:

> When entering respite services for overnight/daily (RSO) into web time entry, you will want to stop the shift at 1159pm as you usually do. However, you do not want to enter the continuing shift onto the next day, because as you said, it will cause Acumen to pay 2 RSOs and quickly exhaust your supply. While this is not the true time your employee works, it is the best method for submitting the time and I would also suggest always keeping a record of your employee's true hours worked, you can do this on the web time entry by entering a note for the shift and it will not change how we pay.