HEALTH MANAGEMENT ASSOCIATES

Rate and Payment Options Study

Final Report on Rate Study Recommendations

PRESENTED TO

RHODE ISLAND DEPARTMENT OF BEHAVIORAL HEALTHCARE,
DEVELOPMENTAL DISABILITIES AND HOSPITALS

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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Attachments:

Executive Summary

The Rhode Island Department of Behavior Healthcare, Developmental Disabilities and Hospitals (BHDDH) oversees the system of supports for approximately 4,000 Rhode Islanders with intellectual and developmental disabilities (I/DD). This system includes home and community-based services (HCBS) delivered by a network of 35 private providers. These services include residential supports (including services provided in individuals' own homes and family homes, shared living arrangements, and group homes), community-based and center-based supports that offer meaningful day activities, and employment supports.

BHDDH is leading a significant systems-change initiative focused on strengthening the service delivery system for individuals with I/DD. Broadly, this work includes three key elements:

- A review of the array of available services and the definitions and standards for each service
- A study of provider payment rates as well as billing policies
- An evaluation of the tools and processes used to assess individual needs and how these assessments translate to individual funding allocations ('tier packages')

Building on system reforms stretching back over a decade as well as Rhode Island's consent decree with the United Stated Department of Justice, this project seeks to support the shift toward a robust community-based support system that promotes individual self-determination, choice, and control; to promote flexibility and innovation in services; and to ensure that payment rates adequately cover the cost of high-quality services.

BHDDH contracted with Burns & Associates, a division of Health Management Associates (HMA-Burns) to provide technical assistance and support throughout this project. Since its founding in 2006, Burns & Associates has consulted with I/DD agencies in 22 states, including leading comprehensive rate studies for home and community-based services in 12 of these states.

Assessments and Individual Budgets

After BHDDH began the project and contracted with HMA-Burns, the American Association on Intellectual and Developmental Disabilities (AAIDD) announced that it was revising the adult version of its Supports Intensity Scale (SIS-A), including renorming the scoring of the instrument. Rhode Island uses the SIS-A in concert with supplemental questions to assign individuals to one of five 'tiers'. These tiers, in turn, are used to determine the rates providers are paid for certain services as well as the amount of funding that individuals receive to access services. AAIDD has stated that the revised SIS-A would be released in early 2023. Given that the revision makes substantial changes to the scoring of the SIS-A, it became necessary to delay the evaluation of the assessment framework and tier packages. This evaluation will require a reasonably sized sample of assessments conducted with the revised SIS-A; it is anticipated that the analysis can be conducted in mid-2023.

In the interim, HMA-Burns has offered several recommendations to respond to stakeholder concerns and increase flexibility and self-determination for individuals:

- *Removing employment services from the tier packages.* This change supports Rhode Island's employment first goals by eliminating the need for individuals to choose between employment supports and other services.
- *Requiring providers to bill for Community-Based Support and Center-Based Support services (currently termed Day Programs) based on an individual's assigned tier rather than a program's staffing ratio.* This change will ensure greater predictability in the level of service that an individual will be able to access, eliminating instances in which individuals receive fewer services than planned because their provider bills a higher rate than assumed in their tier package. Additionally, this change would simplify providers' monitoring and billing processes.
- *Combining several individual components of the tier package for the purposes of planning.* The study recommends that the amounts assumed for Community-Based Supports, Day Program, Transportation, Overnight Shared Supports, and Respite be treated as a single budget to increase the flexibility in the use of the tier packages.
- *Repricing the tier packages to account for the proposed changes in payment rates.* This is consistent with BHDDH's current practices and ensures that individuals are able to receive the same level of support assumed in the tier packages.

Service Array

This study found that Rhode Island has an expansive service array with broad service definitions that support flexibility in program design and delivery. The study does recommend the establishment of several new services. Some of these changes would establish a clearer framework for existing supports while others would constitute new services. Recommendations include:

- *Supportive Living*, which would be a residential living option that is less intensive and offers greater independence than a group home. In this model, individuals live in their own homes and share staffing supports provided by the agency that owns or controls the housing.
- *Remote Supports*, which allow individuals to receive support from staff who are at a centralized location rather than physically present with the individual.
- *Companion Room and Board* to cover the cost of room and board of a companion/ roommate living with an eligible individual.
- *Discovery* to help individuals identify the type of job they want to do.
- *Personal Care in the Workplace* for individuals who require assistance with personal care needs while at work, but who do not need employment-related supports.
- *Vehicle Modifications* to pay for adaptations or alterations to a privately-owned vehicle that serves as the individual's primary means of transportation.
- *Peer Supports and Family-to-Family Training* to allow individuals with lived experience help others navigate the service delivery system and identify other community resources.

In addition to the establishment of these services, the study recommends several changes to existing services, including:

- *Consolidating Home-Based Day Programs into Group Home rates.* The rate study establishes Group Home funding levels that provide for 24-hour staffing, eliminating the need for a separate service for individuals who do not receive services away from the home.
- *Establishing a framework for 'specialized' group homes.* To support the development of homes customized to serve residents with specialized needs, the rate study proposes to create a structure to establish rates for these homes based on staff qualifications and staffing levels.
- *Establishing outcome-based rates for Job Coaching.* The rate study proposes to pay Job Coaching providers based on the hours that the individual they support works rather than the number of hours of support provided. This approach incentivizes both working individuals to increase the hours that they work, consistent with their goals, and fading unnecessary supports.
- *Renaming Day Programs and eliminating ratio requirements.* The rate study proposes to replace Day Programs with Community-Based Supports and Center-Based Supports to emphasize that programs should be designed around the needs of individuals rather than a specific, limited time of day. For similar reasons, the rate study recommends the elimination of staffing ratio requirements for these services.

Provider Payment Rates

Drawing on its experience conducting more than a dozen similar rate studies across the country, HMA-Burns facilitated a rate study comprised with three broad phases:

- *Phase 1: Background Research and Kick-Off Meetings* covered a review of background materials (such as the terms and conditions of Rhode Island's Medicaid Section 1115 Waiver, BHDDH's billing manual, and previously issued reports) as well as initial meetings with BHDDH staff and service providers. This phase aimed to document current service requirements and to begin to identify the existing strengths and needs of the system.
- *Phase 2: Data Collection* included both primary data collection (the design and administration of a survey for providers and a survey for individuals and families as well as additional stakeholder meetings) and secondary data collection (benchmarks for individual cost drivers such as staff wages as well as rates paid by other programs for comparable services).
- *Phase 3: Rate Model Development* included the design of rate models for each service and a public comment process to solicit stakeholder feedback before finalizing recommendations.

In total, the recommended rate changes would increase total payments by an estimated 22 percent based on fiscal year 2021 utilization. Rate increases are driven primarily by higher assumed costs for direct support professional compensation and program support. These adjustments build on a number of increases granted over the past three years that have totaled approximately 40 percent for most services. Although the rate study recommends increases for most services, some rates would be reduced. However, the federal American Rescue Plan Act (ARPA) prevents full implementation of some of these reductions until early 2025.

If funded, implementation of the proposed rate changes could begin in July 2023, but would need to be accompanied by updates to existing policies and billing systems.

Section 1: Background

The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) administers the system of supports for Rhode Islanders with intellectual and developmental disabilities (I/DD), including Medicaid-funded home and community-based services (HCBS) authorized through the state's Section 1115 waiver. The program has an annual budget of more than $300 million, more than half of which is funded with federal Medicaid funds, and provides services to approximately 4,000 individuals.

Individuals with I/DD have access to a variety of services, including residential supports (including services provided in individuals' own homes and family homes, shared living arrangements, and group homes), community-based and center-based supports that offer meaningful day activities, and employment supports. These services are delivered through a network of 33 private I/DD providers. Additionally, approximately 800 individuals self-direct some or all of their services.

BHDDH is leading a significant systems-change initiative focused on strengthening the system of supports for individuals with I/DD. This work includes comprehensive reviews of service requirements, provider payment rates, and methods to assess individual needs and establish individual funding allocations.

Through a competitive procurement process, BHDDH contracted with Burns & Associates, a division of Health Management Associates (HMA-Burns), to assist with this effort. Since its founding in 2006, Burns & Associates has consulted with I/DD agencies in 22 states, including leading comprehensive rate studies for home and community-based services in 12 of these states. Health Management Associates acquired Burns & Associates in September 2020.

Founded in 1985, HMA is a leading independent, national research and consulting firm employing more than 250 consultants, excluding its subsidiaries, with experience that spans the health and human services environment and stretches across the nation. Since its inception, HMA's mission has been to provide meaningful support grounded in real-world experience to policymakers, providers, health plans, foundations, community-based organizations, and communities that serve populations who depend on publicly funded services.

BHDDH's current initiative builds on a number of previous system reforms over more than a decade.

In 2010, Burns & Associates and the Human Services Research Institute (HSRI) were contracted to support the Project Sustainability initiative, which had several goals, including transitioning from bundled payments to standard fee-for-service rates and aligning provider payments with individuals' objectively assessed needs.

Prior to that initiative, funding for services was negotiated at the provider level and bundled into one overall payment for multiple services. While this approach simplified provider administration and produced predictable revenues for providers, it limited individual choice in providers and did not align payment with the actual level of service provided. Further, the federal Centers for Medicare and Medicaid Services (CMS) generally does not support such "bundled" arrangements. For example, the Instructions, Technical Guide and Review Criteria that CMS issues for Section 1915(c) waiver applications states:

> 42 CFR §441.301(b)(4) also provides that "multiple services that are generally considered to be separate services may not be consolidated under a single definition." The chief reasons why

> services may not be "bundled" are to: (a) ensure that waiver participants can exercise free choice of provider for each service and (b) ensure that participants have access to the full range of waiver services. Bundling means the combining of disparate services with distinct purposes (e.g., personal care and environmental modifications) under a single definition and providing that the combined services will be furnished by a single provider entity (e.g., one provider would furnish both personal care and environmental modifications) that is paid one rate for the provision of the combined services.[1]

In addition, the negotiated rate process did not ensure that funding was allocated in a manner that aligned with the needs of individuals served. To increase equity by ensuring that individuals with similar needs have access to similar levels of support, Rhode Island adopted the Supports Intensity Scale for Adults (SIS-A) to assess the needs of individuals. The American Association on Intellectual and Developmental Disabilities (AAIDD) launched the SIS in 2004 after five years of development that included an extensive norming process. SIS-A assessments, which include the individual with I/DD and people who know the individual well, evaluate the supports the individual needs to live independently, rather than focusing on deficits. Rhode Island uses the results of the SIS-A to assign an individual to one of five 'tiers'.

Proposed rates for discrete, defined services were published in May 2011. For shared services such as group homes and day programs, the proposed payment rates varied based on an individual's assigned tier, recognizing that individuals with more significant support needs generally require more intensive supports.

Before these rates could be implemented, the legislature, reacting to a severe downturn in state revenues, cut the program's budget by $16 million. In response, BHDDH directed Burns & Associates to scale back the rates to conform to the reduced budget. This resulted in reductions to the originally proposed rates of about 18 percent. For several years, only modest adjustments were made to the fee schedule and many payment rates remained below what Burns & Associates proposed in 2011 until a round of rate increases implemented in July 2021. The state has made substantial investment in provider payments in more recent years with notable rate increases in October 2019, July 2021, and July 2022. Overall, payment rates for most services (as measured by billing volume) have been increased by approximately 40 percent over the past three years. There are notable exceptions, with effectively no changes in payment rates for Shared Living Arrangements, Professional Services, and Support Facilitation.

As part of the transition away from bundled payment rates, Project Sustainability also sought to align the total level of support that individuals may receive with their assessed needs. Based on the tier assignment and an individual's living situation, tier packages (individual budgets) were established for various categories of service. The result is a more consistent approach to authorizing services in which individuals with relatively fewer needs receive a lower cost tier package than those with greater needs. A series of quantitative analysis memos written by the New England States Consortium Systems Organization (NESCO) in January 2020 affirmed that funding for individuals with I/DD in Rhode Island is being allocated as intended.

BHDDH is also working to achieve the outcomes identified in the Consent Decree entered into with the United States Department of Justice (DOJ) in 2013. The Consent Decree resolves findings by the DOJ that Rhode Island violated the Americans with Disabilities Act (ADA) by failing to serve individuals with I/DD in

integrated settings and by putting youth with I/DD at risk of segregation. While the Consent Decree relates to access to employment and day services, the resulting systems changes are impacting many aspects of the I/DD service system.

BHDDH formed five Consent Decree workgroups to address specific barriers. A summary of the work done by these workgroups was shared by BHDDH leadership earlier in 2022. Highlights include moving to annual service authorizations, adding questions to the assessment process to better capture funding needs upfront, and creating more detailed SIS-A result letters for individuals and families.

In 2021, BHDDH agreed to an Action Plan to continue reform efforts. The Action Plan commits to increasing provider payment rates to support a starting wage for direct support professionals of $18 per hour in fiscal year 2023 and $20 per hour in fiscal year 2024; creating a statewide workforce initiative focused on recruiting, creating pipelines, and credentialing; allocating new funds for integrated day activities and supported employment services as well as technology acquisition for individuals; and working with the Rhode Island Public Transit Authority (RIPTA) to become a service provider.

Enhancing opportunities for people with I/DD to access and engage in the community supports the outcomes envisioned by the Consent Decree as well as Rhode Island's compliance with the home and community-based services settings rule issued by CMS in 2014. A key focus of the rule is the expectation that people with disabilities are able to access and participate in their communities to a degree similar to those without disabilities. The rule also requires that case management be 'conflict-free', meaning that the agency responsible for service planning must not be the agency that provides the service. Additionally, planning for services must be individually focused and reflect personal goals and support needs. Recognizing the significance of many of the requirements in the rule, CMS originally provided a five-year implementation timeline. Due to the pandemic, the timeline was extended to March 17, 2023.

BHDDH expects the rate and payment options study to support these ongoing efforts. In particular, the project seeks to support the shift toward a robust community-based support system that promotes individual self-determination, choice, and control; to promote flexibility and innovation in services; and to ensure that payment rates adequately cover the cost of high-quality services.

This report summarizes the results of HMA-Burns' findings and recommendations to date, organized as follows:

- *Section 2: Assessments and Individual Budgets* describes BHDDH's current approach to assessing individuals' levels of need. Due to forthcoming changes to the SIS-A, the intended comprehensive review of the approach and methodology to assessing individuals, using assessment results to measure individual needs, and establishing individual budget amounts has been delayed to allow time for the collection and analysis of assessments conducted using the revised SIS-A.
- *Section 3: Rate Study Process* summarizes the objectives of the rate study (for example, fairly accounting for providers' costs while supporting programmatic goals and ensuring compliance with applicable payment requirements) and describes the process employed to develop rate models for each service.
- *Section 4: Rate Model Development* describes the factors, calculations, and assumptions included in the rate models, such as the wage levels paid to direct care workers, the benefit package for

direct care workers, productivity assumptions, service-specific factors, and agency overhead costs.

- *Section 5: Recommended Rates and Associated Changes* reports the final recommended rates for each service included in the rate study as well as proposed changes to service requirements and billing policies.
- *Section 6: Implementation Considerations* discusses issues to be considered as Rhode Island looks to implement the recommendations resulting from this study.

Section 2: Assessments and Individual Budgets

As discussed above, BHDDH adopted the Support Intensity Scale more than a decade ago to assess individual needs. BHDDH uses assessment results coupled with supplemental questions to group together individuals with similar support needs into one of five tiers. These tier assignments are used both to determine provider payment rates for a number of services and to establish the level of funding that individuals receive for certain services.

This study intends to conduct a comprehensive evaluation of current processes to assess individuals and establish funding levels, but forthcoming changes to the adult version of the Supports Intensity Scale (SIS-A) have prompted a delay in this work. However, several recommendations have been developed to make interim changes to individual budgets in order to improve individuals' access to services.

Overview of Current Assessment and Individual Budgeting Frameworks

Like more than 20 other states[2], Rhode Island uses the SIS-A to assess the needs of individuals with I/DD. Assessments are completed by state staff who have been trained by the American Association on Intellectual and Developmental Disabilities (AAIDD), the developer and publisher of the SIS-A. Individuals receive an assessment every five years or more frequently if they experience a change in condition.

BHDDH uses results from select sections of the SIS, coupled with supplemental questions added to identify extraordinary medical or behavioral needs, to assign individuals to one of seven levels that are further consolidated into five tiers. In particular, the level assignments rely on the following:

- The sum of the normed (or "standard") scores in three of the six subsections within the Support Needs Index (SNI, which is Section 2 of the instrument): subsection 2A for home living activities, subsection 2B for community living activities, and subsection 2E for health and safety. These subsections, which are collectively labeled 'ABE', were used to assign levels of need because analysis found that they were most correlated with the utilization of paid supports.
- Section 1A, which measures exceptional medical support needs.
- Section 1B, which measures exceptional behavioral support needs.
- Supplemental questions related to medical and behavioral support needs. These questions were adopted to identify individuals who *may* have extraordinary needs related to medical or behavioral conditions. Because these questions were designed to identify needs that would otherwise be missed, they were intentionally designed to be broad and flag individuals who will not meet the criteria for the highest levels. As a result, there is a verification process to determine whether individuals identified through the supplemental questions should be assigned to the extraordinary medical or extraordinary behavioral levels.

Figure 2-1 details the criteria for the levels and tiers.

Figure 2-1: Criteria for Assigning Rate Tiers

Tier	Level	ABE Score	Medical (1A OR Supp. Questions)	Behavioral (1B OR Supp. Questions)
A	1	24 or less	6 or less	6 or less
B	2	25 to 30	6 or less	6 or less
C	3	30 or less	6 or less	7 to 10
	4	31 to 36	6 or less	10 or less
D	5	37 or more	6 or less	10 or less
	6	any	7 or more OR verified supp. questions	10 or less
E	7	any	any	11 or more OR verified suppl. questions

Recognizing that individuals with greater needs generally require more intensive supports, particularly for shared services, provider payment rates vary based on an individual's assigned tier for several services:

- Group Homes
- Non-Congregant Residential Supports
- Shared Living Arrangements
- Day Activity Transportation
- Job Retention

There are also tiered rates for Day Program and Support Facilitation services, but these rate tiers are based on factors other than an individual's assessed needs.

In addition to provider payment rates, individuals' tier assignments are used to determine the amount of support they can receive for a variety of services. These "tier packages" also consider individuals' living arrangements with four classifications:

- Living with a relative
- Living in own home or apartment
- Living in a shared living arrangement (SLA)
- Living in a 24-hour residential placement (such as a group home)

The result is 20 different tier packages (four living arrangements each with five tier assignments) comprised of funding associated with the following services:

- Case Management
- Community-Based Supports (living with relative and living in own home or apartment only)
- Overnight Shared Support (living in own home or apartment only)

- Residential (24-hour residential and SLA only)
- Professional Services in SLA (SLA only)
- Respite (SLA only)
- Day Program
- Professional Services in Day Program
- Transportation

The assumptions related to the amount of support associated with each service are intended to meet the needs of the large majority of individuals in each group. Figure 2-2 offers an example, listing the tier packages for individual who live with relatives.

Figure 2-2: Current Tier Packages for Individuals Living with Relatives (Annual Amounts)

Service	Tier A	Tier B	Tier C	Tier D	Tier E
Case Management	12 months	12 months	12 months	12 months	12 months
Community-Based Support	260 hours	520 hours	1,040 hours	1,560 hours	1,560 hours
Center-Based Day Program	614 hours	614 hours	614 hours	614 hours	614 hours
Community-Based Day Program	922 hours	922 hours	922 hours	922 hours	922 hours
Day Activity Transportation	512 trips	512 trips	512 trips	512 trips	512 trips
Professional Hours in Day Program	48 hours	48 hours	48 hours	260 hours	260 hours

The services assumed in the tier packages are priced based on the fee schedule to establish funding amounts for each category of services (the funding for Center-Based Day Programs and Community-Based Day Programs is reported and managed as a single budget amount, but is listed separately in Figure 2-2 for clarity).

Both individuals receiving services and providers have suggested the need for changes to the assessment framework and tier packages that were first established a decade ago. These issues are interconnected such that a comprehensive evaluation must consider the process in its entirety. For example, a budget framework or budget amounts cannot be established without knowing the needs of the individuals for whom the budget is being established. As a result of forthcoming changes to the SIS-A, this element of the study and any resulting recommendations have been delayed until late 2023.

Changes to the SIS-A and Impacts to Rhode Islands' Current Tier Packages

In early 2022 – after this study began – AAIDD announced a number of changes to the SIS-A, including:

- Re-norming the subsections of the Support Needs Index as well as the overall SNI (which has been renamed the Support Needs for Life Activities, SNLA)
- Adding the protection and advocacy scale to the SNLA (this section had not previously been normed)
- Adding six items to the medical support needs section and one item to the behavior support needs section
- Rewording some items and changing the order of items within some sections to improve the clarity and flow of the assessment
- Making changes to the demographic section

The second edition of the SIS-A incorporating these updates will be released in early 2023. AAIDD also announced that the current edition of the SIS-A will be retired in mid-2024, but that a modified timeline for states currently using the SIS-A may be considered on a case-by-case basis.

These changes have direct implications for the assignment of tiers in Rhode Island. As summarized earlier, the current assessment framework uses the normed scores for three subsections of the SNI. The re-norming of these subsections means that the same responses may yield different normed scores in the second edition of the SIS-A. The assessment framework also incorporates the medical and behavioral support needs sections that are being expanded.

The changes to the SIS-A require that BHDDH update the assessment framework used to assign individuals to a tier. However, that process cannot be completed until individuals begin receiving assessments using version 2 of the SIS-A. Additionally, given the significance of the changes being made, significant stakeholder involvement will be required.

Although the revisions to the SIS-A require a delay in potential changes to tier packages, they also present an opportunity to conduct a comprehensive evaluation of all related practices and policies, including:

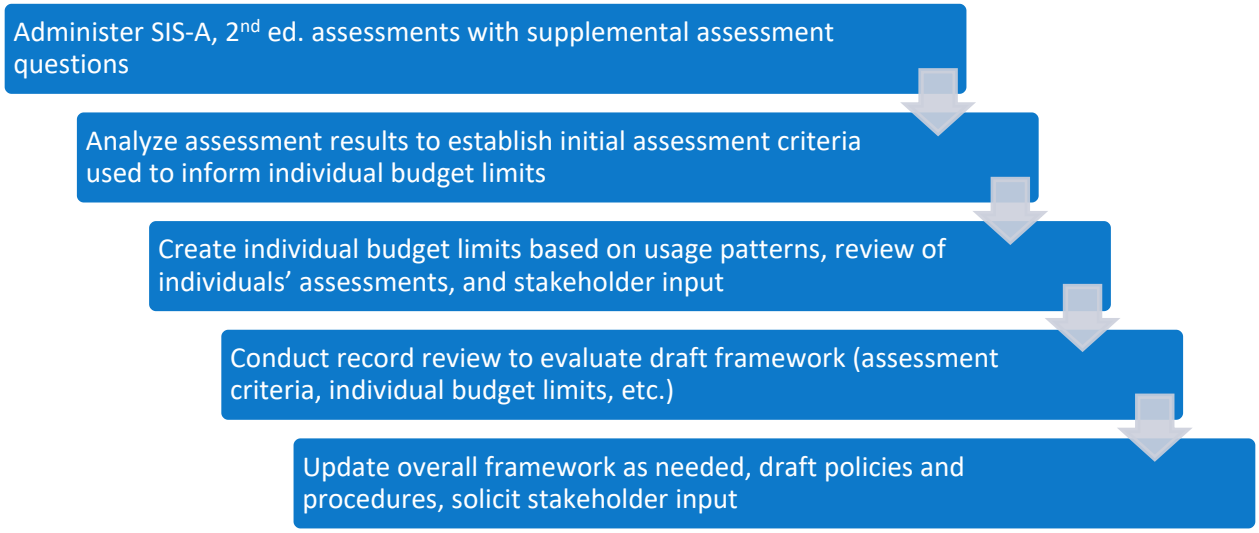
- *How individuals are assessed.* The SIS-A provides a comprehensive assessment of the support needs of individuals with I/DD and remains the tool used by the largest number of state I/DD authorities. BHDDH intends to continue to use the SIS-A as part of the assessment process. However, there may be other factors or individual characteristics that affect an individual's needs or the types or amounts of support they require. As noted above, Rhode Island's initial implementation of the SIS included the adoption of supplemental questions to identify potential extraordinary medical or behavioral needs. This study will explore whether other information should be incorporated in the assessment process.
- *How assessment results are used to measure individual needs.* As detailed in Figure 2-1, the assessment framework considers three of the six subsections of the Support Needs Index as well as the exceptional behavioral and medical sections of the SIS-A. Responses to these sections of the assessment, coupled with the supplemental questions, are used to assign individuals to one of

seven levels that are consolidated into five tiers. This study will analyze whether the assessment of needs should consider other sections of the SIS-A. As described above, Rhode Island assigns individuals to tiers for the purposes of determining budget amounts. A comprehensive review of states' HCBS programs conducted by HSRI in 2018 found that three-quarters of programs that assign prospective budgets to individuals use 'level methodologies' such as that employed in Rhode Island.[3] However, this study will also consider alternative approaches and, if BHDDH maintains a level-based framework, the number of levels and criteria associated with each.

- *How tier packages are structured.* As noted above, Rhode Island currently has 20 tier packages based on an individuals' assessed needs and living arrangements. A number of other states use similar models, but other structures could be considered, too. For example, there could be additional funding added to the tier packages to address a specific identified need such as support for individuals who are parents. The study will also consider the services subject to the tier package limits rather than being managed outside of the tier packages. For example, many states do not include 24-hour residential services in their individual budgets because individuals do not have any discretion in how to plan these dollars. That is, once an individual chooses to live in a 24-hour setting, that provider must be paid for the service; the individual cannot, for example, choose to receive 300 days of support in order to direct the balance of funding to other services.
- *How budget amounts are established.* The study will evaluate the amount of services assumed in the tier packages or alternative budgeting framework. For example, all tier packages include 512 one-way transportation trips per year, but some stakeholders have suggested increasing this assumption.
- *How budgets are managed.* The study will consider the rules associated with managing budget amounts once assigned, including the flexibility to move funds across service categories, how individuals who self-direct services are impacted, and the process for requesting and approving exceptions.

Figure 2-3 summarizes the process for evaluating assessments and budgets.

Figure 2-3: Major Tasks for Review of Assessment and Budget Frameworks



As the figure illustrates, the first steps in this process involves consideration of the assessment framework because decisions related to budgets or funding necessarily require data about for whom funding is being allocated. Although preliminary analyses can be performed using existing SIS-A assessments scored with the new re-normed criteria, it will be important that any changes to the assessment framework reflect assessments conducted with the second version of the SIS-A, coupled with supplemental data collection.

Once an assessment framework is established, a budgeting framework can be developed. As noted above, this could reflect several different approaches: a level-based model similar to Rhode Island's current structure; a level-based model with funding add-ons to account for other, specified factors; an individual budgeting formula; or some other structure.

After a draft assessment and budgeting framework has been developed, it will be tested through a record review process. In this process, case files for a sample of individuals are compiled and reviewed by small teams asked to consider several questions:

- Does the tier (or other categorization of need) for each individual reasonably reflect their needs based on the information in their case file?
- Do individuals who have been assigned to the same tier (or other categorization of need) generally appear to have similar needs based on a review of their case files?
- Is the budget that the individual would receive adequate to meet their needs?

The small teams will be multidisciplinary, including both BHDDH staff and external stakeholders such as individuals receiving services, family members, providers, and system advocates. After the record review process, the draft assessment and budgeting framework will be updated and there will be opportunities for broad stakeholder feedback such as facilitated meetings to present the framework and a public comment process.

It will likely be no earlier than mid-2023 that there will be an adequate number of completed assessments to conduct the needed analyses. The record review process and opportunities for stakeholder feedback will likely require several months to ensure that this input is considered before recommendations are finalized. However, the rate study includes several recommendations for changes to the existing tier packages while the broader redesign progresses.

Recommendations for Changes to Current Tier Packages

Although the comprehensive review of Rhode Island's current assessment framework and tier packages must be delayed due to the changes to the SIS-A, HMA-Burns has recommended four changes to the existing design and administration of tier packages to address concerns raised by stakeholders.

First, the rate study recommends that employment supports be managed outside of the tier packages. Currently, employment-related services 'count' against the same portion of the tier package that funds day program services. Since the rates for employment supports are substantially higher than the rates for day programs, individuals using employment supports exhaust their budgets more quickly and cannot access as many hours of support as those using day program services. Individual budgets seek to empower individuals to make decisions regarding how best to use their allocated funding and these types of tradeoffs are a feature of this approach. However, the current structure does present a barrier to

employment supports. Allowing individuals to receive employment support in addition to their tier packages removes this disincentive and supports Rhode Island's Employment First goals.

Second, the rate study recommends a change to how Community-Based Support and Center-Based Support services (currently termed Day Programs) are billed. Individuals' current tier packages are priced based on their assigned tier. However, providers bill based on the staffing of their program. For example, the service package for an individual assigned to Tier B includes Community-Based Day Program services based on a one-to-five staffing ratio, but if they receive services in a program operating at a one-to-two ratio, their provider bills the Tier D rate. The result is that individuals will not be able to receive the number of hours of support assumed in their tier package. Further, because individuals do not have control over the ratios of the programs in which they receive services and because these ratios may change over time, they have limited ability to predict the number of hours of support they will be able to receive.

The rate study recommends that providers bill for services based on an individual's assigned tier, regardless of the program's staffing ratio. This will promote greater predictability in individuals' budgets, providing greater self-determination in planning. As described later in this report, this approach is aligned with the recommendation that there be no staffing ratio requirements for Community-Based Support and Center-Based Support. Additionally, this recommendation is consistent with billing requirements for several other services with tiered rates. For example, providers bill for Group Home services based on an individual's assigned tier regardless of the staffing level in the home.

Third, the rate study recommends that several individual components of the tier packages be combined for the purposes of planning. In particular, amounts assumed for Community-Based Supports, Day Program, Transportation, Overnight Shared Supports, and Respite would be treated as a single budget. For example, an individual could choose to receive fewer hours of Day Program services in order to access a greater number of trips. Remaining services would continue to be managed separately. For example, an individual who chooses to live in a group home or shared living arrangement cannot choose to receive fewer days of support to move funds to a different service category so these services would remain separate.

Fourth, the rate study recommends that the tier packages be repriced to account for the proposed changes in payment rates. This is consistent with BHDDH's current practices and ensures that individuals are able to receive the same level of support assumed in the tier packages.

Overall, these recommendations are intended to increase flexibility and self-determination for individuals until the comprehensive review of the assessment and budget framework can be completed.

Section 3: Rate Study Process

Provider payment rates should support the objectives of the service delivery system so the rate study process began with identifying these goals. Based on discussions with BHDDH and system stakeholders as well as a review of previous reports and findings, several objectives were specified, including:

- *Fairly account for providers' costs*. Rates aim to reflect the direct and indirect costs providers incur to deliver services consistent with the state's requirements and individuals' service plans.
- *Support programmatic goals*. Rates should further the program's goals such as supporting individuals' independence and community engagement.
- *Provide flexibility*. Rates should be consistent with flexible service delivery.
- *Comply with applicable payment requirements*. Federal Medicaid funds pay for the majority of service costs so payment rates must comply with federal law that states that payment rates must be "consistent with efficiency, economy, and quality of care".[4]
- *Reduce administrative burden*. When practical, rates should minimize administrative requirements while maintaining accountability.
- *Allow for regular updates*. Payment rates should be designed to permit regular consideration of whether they continue to reflect providers' costs.

These objectives can, at times, be in conflict so the development of payment rates and procedures sought a balance. For example, a single bundled payment to providers might be the most administratively simple, but may not reflect differences in costs (such as more intensive supports for individuals with more significant needs) or comply with federal requirements that generally discourage bundled payments.

HMA-Burns employs an 'independent rate-setting' approach when developing payment rates for home and community-based services. Rather than depending on any single source of information, HMA-Burns draws on data and insights from a variety of sources. This approach recognizes two important features of HCBS programs, particularly for individuals with I/DD.

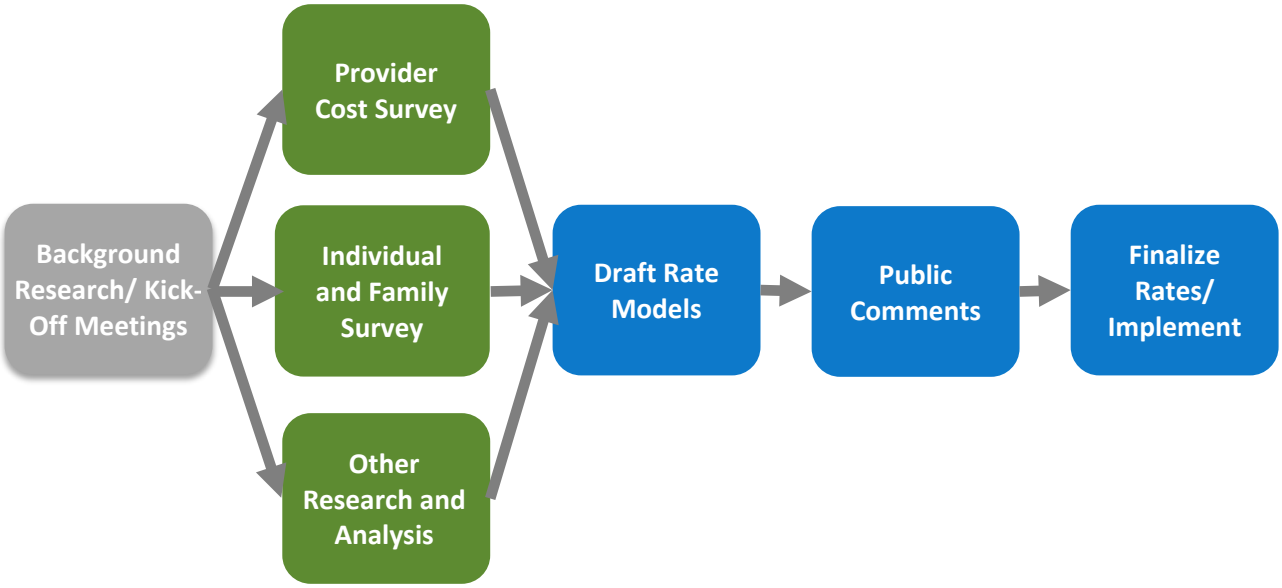
First, whereas most medical procedures follow the same guidelines in every state, most home and community-based services lack a typical standard of care. Thus, although state HCBS programs generally cover similar arrays of services, the requirements of these services can vary significantly across different states. For example, every state provides coverage for day habilitation services (though such services may be titled day program, day treatment adult day health, community support, or something else), but each state establishes its own standards in terms of staffing ratios, transportation, ancillary supports, and other factors. Setting rates for these services therefore requires consideration of state-specific requirements.

Second, in every state the large majority of payments for home and community-based services comes from a single source: the state I/DD department. In contrast, providers of medical services may receive payments from a variety of sources in addition to state Medicaid programs, including Medicare, commercial insurance, and self-pay. Due to the near complete reliance on a single payer, HCBS providers' costs will largely be a function of the rates paid by the state I/DD department. Thus, if payment rates are too low, costs will be artificially depressed. Conversely, if rates are too high, services may not be delivered

in an efficient manner. The use of external data sources to supplement provider cost data aims to ensure that payment rates reflect actual market costs.

HMA-Burns' independent rate-setting process for reviewing HCBS provider payment rates encompasses three phases with seven discrete tasks as illustrated by Figure 3-1.

Figure 3-1: Independent Rate-Setting Process



Phase 1: Background Research and Kick-Off Meetings

As noted above, state programs for individuals with I/DD typically cover similar arrays of services – particularly those services that constitute the majority of spending, including residential, in-home, and day programs – but service requirements, billing rules, and limits can vary significantly across programs. HMA-Burns' HCBS rate-setting process therefore always begins with a review and documentation of the current service environment.

HMA-Burns began this study by reviewing materials governing the operation of the program as well as previous reports and findings; the Section 1115 waiver that authorizes all Medicaid services in Rhode Island, including home and community-based services for individuals with I/DD; the Division of Developmental Disabilities' Billing Policy Manual, which provides service definitions and billing requirements; the state's Consent Decree with the Department of Justice and the related Action Plan; the series of quantitative analysis memoranda written by NESCO; and the rate study performed as part of Project Sustainability.

To supplement insights gained from the review of program materials, HMA-Burns held several stakeholder meetings to hear directly from system participants. This included meetings to provide an overview of the project, answer questions, and receive preliminary input on issues of concern; to present the draft provider survey; and to hear directly from individuals who use services and their family members about their opinions regarding the current service array and potential changes they wish to see.

This system review yielded several initial observations, including:

- *Many stakeholders believe services should be more flexible despite very broad service definitions.* Many individuals and families reported the need for flexible services that can be tailored to individual needs while others reported the need for more narrowly tailored services such as programs specifically designed for older individuals, people with autism, and other populations. A review of Rhode Island's service definitions suggests, however, that substantial flexibility already exists. That is, the existing service definitions are already very broad so providers have the flexibility needed to develop more customized programs.
- *Both individuals and providers believe that the direct support workforce is one of the most critical elements of the service delivery system.* Stakeholders additionally noted substantial challenges with recruiting and retaining staff and emphasized the importance of adequate compensation and supports to make them successful in their jobs.
- *There is a perception that some provider costs are not covered in the rate model.* A number of providers stated that existing payment rates do not cover certain costs. Specific examples included time that staff spend in training, program absences, and transition costs (for example, the time to onboard a participant into services). Many of these costs are actually included in the rate models even if they are not specifically billable. For example, the existing rate models include productivity adjustments to account for the time staff spend in training.
- *Many providers prefer monthly or daily billing for day program services.* These providers believe that tracking individual attendance in 15-minute increments is administratively burdensome, particularly because providers must also track staffing ratios that are tied to billing. Providers also noted that many of the costs of shared programs are fixed regardless of whether someone attends a full or partial day of service.
- *Many stakeholders believe that changes should be made to assessment processes and tier packages.* Specific concerns related to individuals receiving fewer hours of day program support than assumed in their tier package when providers bill a higher (more costly) rate tier based on the program's staffing ratio, inadequate funding for employment and community-based supports, a lack of flexibility in moving funds across service categories, and some individuals' needs not being reflected in the assessment process.
- *Many individuals and families want more support in service planning.* A number of individuals and families reported current service planning does not consider the full range of available supports and could be improved with conflict-free case management. Many individuals and families who self-direct services reported a desire for more support in understanding and managing their responsibilities.

Observations from this initial system review informed both the data collection efforts and the development of rate models and related recommendations described below.

Phase 2: Data Collection

In the second phase of its HCBS rate-setting methodology, HMA-Burns collects data and input to inform cost assumptions. This phase includes three tasks:

- Development, administration, and analysis of a provider cost survey
- Development, administration, and analysis of a survey of individuals receiving services and their family members
- Identification and analysis of other data sources to inform rate model assumptions

***Provider survey*.** HMA-Burns developed a survey to collect data directly from service providers regarding their programs' operations and expenses such as:

- Wage and benefit costs for direct care, program support, and administrative staff
- Non-staff expenses, such as costs associated with facilities, vehicles, office equipment and supplies, insurance, professional services, etc.
- Direct care staff productivity, which measures the amount of time staff spend providing direct services and engaging in non-billable activities such as training, travel between service encounters, and recordkeeping
- Caseloads as well as staffing levels and ratios in shared services
- Typical length of service encounters
- Miles driven transporting recipients or traveling between encounters

A draft of the Microsoft Excel-based survey was shared and reviewed with service providers. The HMA-Burns team incorporated a number of changes based upon feedback obtained and finalized the instrument. To assist with completion of the survey, guidance was embedded into the survey instrument itself, instructions were written to provide background and definitions, a webinar walking through each survey form was recorded and posted online, and a dedicated contact for questions was assigned.

HMA-Burns emailed the finalized survey to service providers in April 2022. Providers were given five weeks to respond to the survey, but all late submission were accepted and incorporated in the analyses. Of the 35 providers serving the I/DD population, 24 provided a response. The responding providers represented 86 percent of the total claims volume for services included in the rate study during the fiscal year 2021.

The survey instrument, instructions, and analysis are included as Attachments 1, 2, and 3 to this report.

***Individual and family survey*.** HSRI developed a survey to collect opinions from individuals who receive services and their families regarding their current services and changes they would like to see. The online survey was made available beginning June 30, 2022. The survey was distributed through email listservs and through announcements in two DD News notices. Surveys were received from seven service recipients and 54 family members.

Key findings from the survey include:

- Finding, recruiting, and retaining well-trained direct support staff is challenging
- Day programs should offer a wider variety of recreational activities and events, and social activities should be available on nights and weekends
- Job development and volunteering opportunities are needed
- Self-directed funds should be available to hire parents as caregivers; purchase gym memberships; and purchase phone, computer, and internet services
- The service array should cover broader transportation options and vehicle modifications, online courses and supports, increased respite limits, mental health supports, and person-centered planning facilitation

The summary of results is included as Attachment 4.

***Independent data sources*.** HMA-Burns identified data from independent sources to supplement information gathered through the provider survey. By using data that is not limited to the I/DD system, the rates aim to reflect reasonable, market-based costs. For these independent sources, HMA-Burns endeavored to gather information that was current, credible, and directly applicable to the rate study. Data sources include:

- Wage data from the Bureau of Labor Statistics and wage growth data from the Bureau of Economic Analysis
- Data regarding the cost of health insurance from the federal Department of Health and Human Services' Medical Expenditure Panel Survey
- The Internal Revenue Service's mileage rate, which is used to estimate the non-staff cost of travel

Section 4 includes additional discussion of the use of independent data sources in the development of rate models.

In addition to data to inform individual cost assumptions, HMA-Burns benchmarked the recommended Rhode Island rates to the rates paid for similar services in other New England states. The results of this benchmarking are presented as part of the service-specific recommendations in Section 5.

Phase 3: Rate Model Development

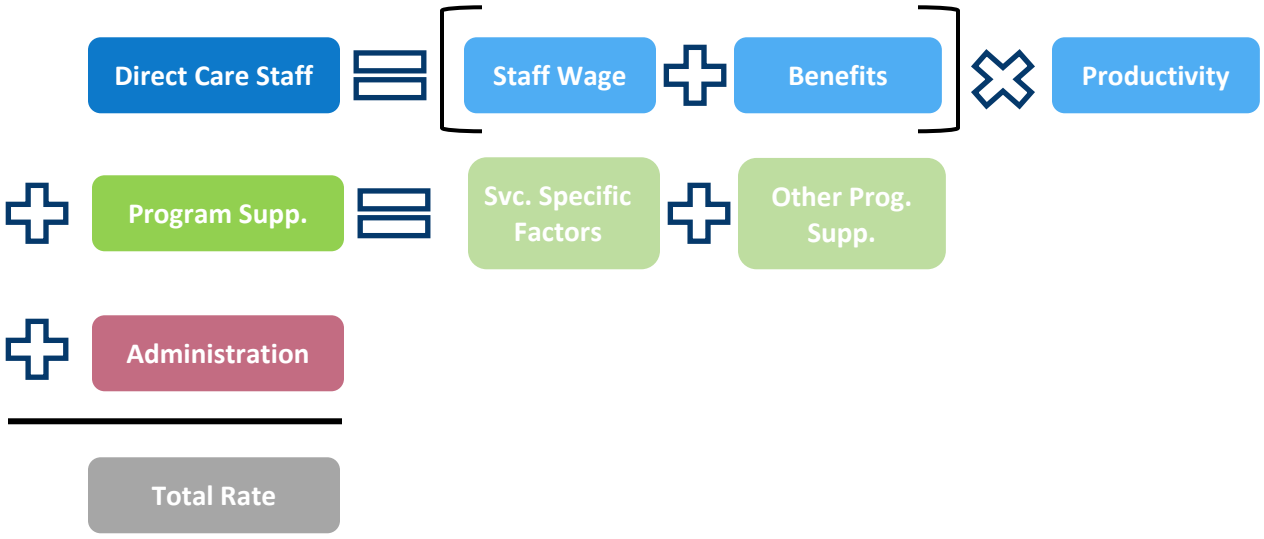
The third and final phase of the rate-setting process involves the development of the fee schedule and any recommended changes to existing policies and procedures, such as service requirements or billing rules. Three tasks comprise this phase:

- Development of draft rate models and associated recommendations
- Facilitation of a public comment process
- Finalization of rate models and other recommendations

Draft rate models and associated recommendations. To support transparency in the development of provider payment rates, HMA-Burns creates detailed rate models that include the assumptions related to

individual cost drivers used to establish the overall rates. Figure 3-2 presents a pictorial representation of the rate models.

Figure 3-2: Rate Model Structure



As depicted in the graphic, the major cost drivers fall into three categories:

- Wage and benefits costs for the direct care worker providing the billable service, including adjustments for 'productivity', which accounts for their non-billable responsibilities.
- Program support expenses, which include non-staff costs associated with service provision such as miles driven by direct care staff and the cost of the physical space in which services are delivered, as well as other program infrastructure such as costs related to supervision, program design, and quality assurance.
- Staff and other expenses associated with organizational administration such as executive leadership, finance, and information technology.

The individual cost assumptions incorporated in the rate models do not intend to prescribe an individual provider's costs. That is, providers are not expected to align their costs with rate model assumptions and, for any given provider, it is expected that some costs will be lower than assumed and other costs will be higher. Instead, the rate model assumptions aim to reflect the reasonable costs of delivering services.

The development of rate models draws on findings from the first phase of the project where preliminary decisions are made related to the structure of rate models (such as the basis of billing), key cost drivers to be included in the model, and whether multiple rates are needed for a given service to account for differences based on individual need, staff qualifications, or other factors. The rate model structures are then populated based on data collected during the second phase of the project.

Section 4 provides an overview of the process for establishing cost assumptions within the rate models.

Public comment process. HMA-Burns' HCBS rate studies always include the solicitation of public comments on the draft proposals before recommendations are finalized. This public comment process is

specific to the rate study and does not replace other opportunities for comment, such as state rulemaking, federal requirements for comment when amending Medicaid waiver programs, and legislative deliberations.

Draft rate models were released and posted online on September 28, 2022. After publication of the draft rate models, HMA-Burns noted a formula error primarily affecting rate models for new services and reposted materials on October 14. Stakeholders were asked to submit comments by October 24 although all comments submitted after that date were accepted.

Twelve individuals and organizations submitted comments. Many commenters offered feedback on multiple issues so there is a much larger number of topics addressed. Broadly, comments can be organized into three categories:

- *Comments relating to assessments and individual budgets.* As discussed in Section 2, most of the work relating to these issues has been delayed due to the renorming of the SIS. However, the comments received regarding these issues will be considered as this work is undertaken.
- *Requests for clarifications.* Many comments did not specifically offer feedback on the recommendations, but instead asked questions about the proposals.
- *Suggested changes.* A number of comments suggested changes to the draft recommendations.

Several changes to the draft recommendations were made in response to public comments:

- Assumed costs for the employer share of health insurance premiums were increased.
- The proposal to vary Group Home rates based on the size of the home (with higher rates for smaller homes) was withdrawn.
- The proposal to unbundle professional services from the Group Home rates was withdrawn and funding for these supports was built into the group home rate models based on data from the provider survey.
- The assumed payments to home providers of 'enhanced' Shared Living Arrangements were increased.
- The Respite hours that were bundled into the enhanced SLA rate models were removed consistent with what was proposed for standard SLA services.
- The rate model for Daily Respite was withdrawn; instead the rate is tied to the Tier E for Enhanced Shared Living Arrangements
- A one-to-one rate for Center-Based Supports was developed.
- The annual limit on Discovery services was increased.
- Additional recordkeeping time was included in the Job Coaching rate model.
- The proposal to establish different Transportation rates based on the number of individuals transported was withdrawn and replaced with a single per-trip rate.

- Rates for Professional Services provided by licensed practical nurses and board certified assistant behavior analysts were established.
- The proposed rate model for Financial Management Services was withdrawn.

Responses to all public comments are included as Attachment 7.

Final recommendations. HMA-Burns updated the rate models to reflect changes made in response to public comments. Section 5 reports the final service-specific recommendations resulting from the rate study. Similar information was included in the presentation used to present the draft rate models and related recommendations as well as an addendum that discusses changes made in response to public comments, which have been included as Attachments 5 and 6.

Section 4: Rate Model Development

As discussed above, HMA-Burns developed rate models for the services included in the rate study. These models make specific assumptions around individual cost drivers that combine to establish an overall rate for a unit of service. In general, there are five common factors in each rate model:

- Wage paid to the direct care worker
- Benefits package for the direct care worker
- Productivity of the direct care worker
- Provider-level program support expenses
- Provider-level administrative expenses

Each of these major cost drivers are discussed below. Additionally, a number of rate models include other factors based on the nature of a given service. For example:

- Rate models for shared services (that is, services where a direct care worker delivers support to multiple individuals at the same time) include assumptions related to staffing intensity.
- Rate models for services that include driving between service encounters or transporting individuals include assumptions related to travel costs.
- Rate models for center-based or office-based services include assumptions related to the cost of the physical space wherein services are provided.

Cost assumptions are informed by both information gathered through the provider survey and from other published sources. Key assumptions were compared to fee schedules and rate models established in other programs, particularly programs providing services to individuals with I/DD in other states. These comparisons did not guide the establishment of rates for services for individuals with I/DD in Rhode Island because every program is unique in terms of service requirements, historic practices, economic characteristics, and provider networks. Instead, these comparisons offered benchmarks to ensure the reasonableness of the Rhode Island rate models.

Direct Care Worker Wages

Payroll and benefits costs for direct care workers represent the single largest category of expenses for HCBS providers; in HMA-Burns' experience, these costs often account for between 65 and 80 percent of total expenses. As a result, spending in these areas tends to be subject to the greatest constraints when payment rates do not reflect market costs. Thus, although current wage and benefit levels are informative, HMA-Burns primarily relies on independent, published sources of market wage data for comparable positions to ensure cost assumptions reflect current economic realities.

HMA-Burns' typical approach to establishing wage assumptions for direct care staff includes the following:

- Use of state-specific wage data from the United States Department of Labor's Bureau of Labor Statistics (BLS) and identification of the most representative occupation or occupations for each individual service.

- Application of an inflationary adjustment to the BLS wage data so that values represent the period when rates will be implemented.
- Identification of any scheduled minimum wage increases that may impact relatively lower-wage occupations, including direct support professionals.

Although HMA-Burns followed its typical approach to establishing rate model wage assumptions, the Consent Decree Action Plan agreed to by BHDDH dictated the assumed wage for the DSPs who deliver most services.[5] According to the Action Plan, "For [fiscal year 2024], the Medicaid reimbursable rate will be increased to support the starting wage of DSPs to $20.00/hour." Since the plan specifies that the rates must support a *starting* wage of $20 per hour rather than an *average* wage, HMA-Burns had to develop an assumption for an average wage given a $20 starting wage.

The Staff Stability Survey administered by the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and HSRI collects data from service providers regarding DSPs, including starting and average wages. According to the 2020 survey, the minimum average hourly wage reported by Rhode Island providers was $13.23 per hour while the average wage was $13.80 and the median wage was $14.00.[6] This data suggests the difference between the starting and average hourly wages could be less than $1.00, but it is noted that only five Rhode Island providers participated in the survey.

BLS wage data similarly suggests a modest difference between starting and average wages. According to the BLS, the 10th percentile wage for home health and personal care aides (the occupation to which the BLS assigns DSPs, as discussed below) was $13.73 per hour while the median wage was $14.09.[7]

Overall, the Staff Stability Survey and the BLS data demonstrate substantial wage compression at the lower end of the DSP wage scale. However, recognizing the importance of graduated pay to support recruitment, retention, and job satisfaction, HMA-Burns sought to establish a methodology that would produce a larger spread of wages. Specifically, HMA-Burns measured the difference between the 10th and 90th percentile wages ($13.73 and $18.01, respectively, the lowest and highest values reported by the BLS) for home health and personal care aides and added one-half of that amount ($2.14) to the $20.00 wage floor established by the Action Plan. Thus, the rate models include an assumed average wage of $22.14 per hour for DSPs. As detailed below, this result is substantially greater than the DSP wage produced by HMA-Burns standard methodology. The result is also much higher than the state-by-state average reported in the Staff Stability Survey. Of the 27 states that participated in the 2020 survey, the highest average wage was $16.15 in Connecticut.

Although the Action Plan results in higher DSP wage values than HMA-Burns' rate-setting methodology would otherwise produce, it was important to document the standard methodology for two reasons. First, since the Action Plan does not include any higher wage floors in future years, HMA-Burns' typical methodology will result in a higher wage assumption at some future date. Documentation of this methodology allows for an annual review of the wage that would be produced and the point at which it exceeds the $22.14 assumed in the rate models. Second, other services are delivered by staff with higher wages so the typical methodology must be used to establish these wage assumptions.

HMA-Burns' standard approach to establishing rate model wage assumptions relies on state-specific BLS wage data for more than 800 standard occupational classifications. As the BLS states, it is the "only

comprehensive source of regularly produced occupational employment and wage rate information for the U.S. economy, as well as States, the District of Columbia, Guam, Puerto Rico, the U.S. Virgin Island, and all metropolitan and nonmetropolitan areas in each State."[8] This statement highlights several of the features of the BLS data that makes it particularly useful for setting wage assumptions, including:

- *It is comprehensive.* BLS wage data is representative of 1.2 million establishments and about 57 percent of the employment in the United States.
- *It is regularly produced.* BLS wage data is published on an annual basis, allowing rate model assumptions to be regularly reviewed and updated.
- *It is cross-industry.* BLS wage data is not limited to a single industry so estimates for a given occupation are representative of the overall labor market for that occupation; this is particularly important when considering wage levels for underfunded programs.
- *It is state- (and local-) specific.* BLS wage data is reported for individual states and sub-state areas so that assumptions are tailored to the state in which rates are being developed.

HMA-Burns relies on state-specific wage data when developing payment rates to ensure that assumptions reflect the market conditions within the state. However, given a degree of workforce mobility within New England (that is, some individuals work in a state other than the state in which they reside)[9], wages across the region were reviewed. Figure 4-1 presents the median wages reported by the BLS for home health and personal care aides across New England. As the table shows, with the exception of a notably higher wage in Massachusetts, there is minimal variation across the region. The rate models therefore rely on Rhode Island wage data.

Figure 4-1: Median Wages for Home Health and Personal Care Aides in New England States

State	Median Wage
Rhode Island	$14.09
Connecticut	$14.30
Maine	$14.28
Massachusetts	$17.45
New Hampshire	$14.12
Vermont	$14.44

Although the BLS wage data is published annually, it is always backwards looking. The BLS typically releases data in late March of each year, with the dataset representing May of the previous year. Thus, the rate models use the May 2021 dataset, which was published in March 2022. In addition to typical wage inflation, Rhode Island's minimum wage in 2021 was $11.50 per hour whereas the minimum wage is scheduled to increase to $14.00 on January 1, 2024.[10] The rate models take steps to account for both wage inflation and the rising minimum wage.

Data from the United States Department of Commerce's Bureau of Economic Analysis (BEA) was used to estimate wage inflation. According to the BEA as of August 2022, net earnings in Rhode Island increased 8.0 percent between 2020 and 2021 while the ten-year compound annual growth rate was 3.5 percent.[11] HMA-Burns increased BLS wage estimates by 8.0 percent for twelve months and then an annual growth rate of 3.5 percent for 20 months – a total of 14.37 percent over 32 months – to project wages for January 2024, the midpoint of the first full fiscal year in which the rates could potentially be implemented. Other

sources on national wage growth estimates suggest that year-over-year wage growth between 2021 and 2022 was not as high as the one-year estimate from the BEA:

- The BLS employment cost index summary reports wage and salary growth of 5.3 percent for the 12-month period ending in June 2022[12]
- The Economic Policy Institute estimated year-over-year growth of 6.43 percent in May 2022[13]
- The Federal Reserve Bank of Atlanta estimated year-over-year growth of 6.1 percent in May 2022[14]

However, employer surveys suggest that wage growth in 2023 may be higher than the ten-year average used in the rate model, with estimates ranging from 4.0 to 4.6 percent.[15] If the averages from these sources are substituted (assuming 5.9 percent into mid-2022 and 4.3 percent annually thereafter), the total inflationary adjustment would be 13.60 percent, which is somewhat less than has been assumed.

In addition to typical wage inflation, Rhode Island, like many states, is in the process of increasing its minimum wage. Although HMA-Burns does not consider direct support to be a minimum wage job, DSPs tend to earn relatively low wages and tend to benefit as wages in other lower-paid industries increase. Given the number of states with increasing minimum wages, in recent years HMA-Burns has researched the effects of an increased minimum wage and developed a formula to quantify these impacts. This formula accounts for two widely accepted features of an increasing minimum wage.

First, an increasing minimum wage will have 'spillover' effects, meaning that some individuals who already earn above the minimum wage will receive a pay raise when the minimum wage increases.[16] Two examples illustrate this phenomenon:

- Assuming a $11.50 per hour minimum wage that will increase to $14.00, consider a supervisor earning $14.50 to supervise staff earning $11.50. The employer must increase the pay of the subordinate staff by $2.50 per hour to comply with the new minimum wage. There is no legal requirement for the supervisor to receive a pay raise as their current wage exceeds the new minimum wage, but if they receive nothing while their subordinates receive a substantial raise, there would be nearly no financial benefit associated with the additional responsibility of supervision.
- Again assuming a $11.50 per hour minimum wage that will increase to $14.00, consider two direct care workers. The first has been with their shared employer for three years and is earning $13.50 per hour while the second is new to the job and is earning $11.50. In order to comply with the higher minimum wage, the employer only needs to move both workers to $14.00. This would result in both employees receiving a raise, but the tenured employee would receive a much smaller raise and would no longer be receiving any wage differential for their experience.

The second feature of a minimum wage increase is 'compression', meaning that there will be some narrowing of the difference in pay between employees as the minimum wage rises.[17] That is, pay raises associated with a rising minimum wage will decrease as an employee's current wage increases. To assume otherwise would require that everyone in a state, regardless of how much they currently earn, would receive a pay raise every time the minimum wage increases. Using the same examples as above:

- The supervisor currently earning $14.50 per hour is expected to receive a pay raise even though they already earn more than the new minimum wage, but they are not expected to receive the full $2.50 value of the increase in the minimum wage from $11.50 per hour to $14.00.
- Similarly, the experienced worker is expected to receive a pay raise so that they continue to earn more than a new employee. Again, however, their raise is not expected to be $2.50 so they will still be earning more than their less-tenured coworker, but it will no longer be the existing $2.00 gap.

Figure 4-2 illustrates the formula employed to adjust BLS wage data to recognize the rising minimum wage while accounting for both spillover and compression effects.

Figure 4-2: Assumptions to Account for Minimum Wage Rising from $11.50 per Hour to $14.00

Current Wage in $1.00 Increments	% of Marginal Dollar 'Captured' as Part of Wage Increase	Marginal Dollar Amount 'Captured' as Part of Wage Increase	Cumulative Wage Increase (in Relation to $14.00)	Revised Wage
$11.50	100%			$14.00
$11.51 - $12.50	90%	$0.90	$0.90	$14.01 - $14.90
$12.51 - $13.50	80%	$0.80	$1.70	$14.91 - $15.70
$13.51 - $14.50	70%	$0.70	$2.40	$15.71 - $16.40
$14.51 - $15.50	60%	$0.60	$3.00	$16.41 - $17.00
$15.51 - $16.50	50%	$0.50	$3.50	$17.01 - $17.50
$16.51 - $17.50	40%	$0.40	$3.90	$17.51 - $17.90
$17.51 - $18.06	30%	$0.30	$4.20	$17.91 - $18.07

In the first column, the table lists wage ranges in $1.00 increments. The next two columns provide an assumption of the amount of that $1.00 increment that will be 'captured' and added to the $14.00 minimum wage. For example, for a worker earning $12.50, there is a single $1.00 increment above the current $11.50 minimum. According to the table, 90 percent of this first $1.00 is captured, translating to $0.90 ($1.00 multiplied by 90 percent). This total is added to the new $14.00 minimum wage such that this worker will be assumed to be earning $14.90 per hour after the minimum wage increase. The fact that this worker will receive a raise beyond the $14.00 minimum wage illustrates the spillover effect, while the fact that they will now be earning $0.90 more than the new minimum wage compared to the $1.00 more than the existing minimum that they are currently earning illustrates the impact of compression.

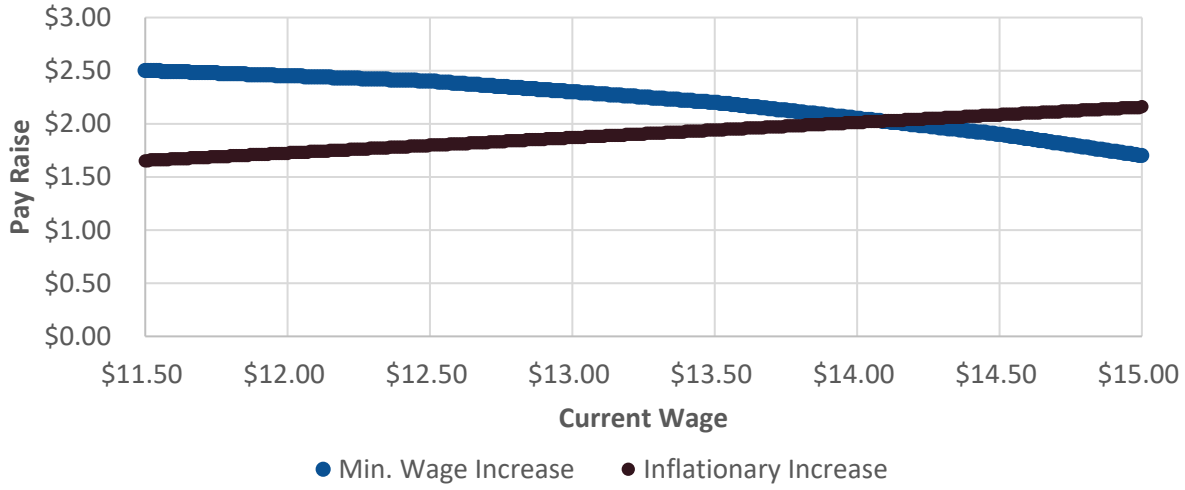
The fourth column is a running total of the aggregate captured dollar amounts in relation to the $14.00 per hour minimum wage. For example, for a worker currently earning $13.50 per hour, they will capture 90 percent of the first $1.00 above the minimum wage (as discussed in the previous example) and 80 percent of the second $1.00 above the minimum, for a total of $1.70 ($0.90 plus $0.80). Thus, their new wage will be $15.70 per hour. The final column lists the new wage ranges after the application of the values in the preceding columns.

Based on these assumptions, every worker currently earning up to $18.06 per hour would receive a pay raise when the minimum wage increases from $11.50 to $14.00 per hour although the raise for someone at $18.06 would be $0.01.

In 2021, the American Network of Community Options and Resources (ANCOR, the national provider trade association) commissioned a report by HMA-Burns to model the state-by-state impact of a potential $15 per hour minimum wage.[18] This report offers additional information related to this formula as well as HMA-Burns' testing of how effectively it predicts actual results.

Both the wage inflation and the rising minimum wage adjustments were calculated independently for every BLS wage value and the larger of the two was applied to each reported wage. Figure 4-3 illustrates the estimate associated with each of these adjustments across a range of current wages.

Figure 4-3: Impact of Inflationary and Minimum Wage Adjustments, by Wage



As demonstrated in the chart, the adjustments intersect at approximately $14.10 per hour. Thus, BLS wage values of $14.10 per hour or less were updated based on the minimum wage adjustment while those greater than $14.10 were revised using the inflationary adjustment.

After adjusting the BLS wage data to account for inflation and a rising minimum wage, the most appropriate BLS occupation had to be selected for each service code. At times, there is a precise match. For example, when setting rates for nursing, there are specific occupational classifications for registered nurses and for licensed practical nurses.

For other services, however, there may not be an exact match. DSPs provide one such example. Although DSPs are covered by the BLS survey and a review of the national industry-level estimates makes clear that they are classified as home health and personal care aides (SOC 31-1120) as this occupation accounts for more than three-quarters of all direct care, administrative, and support positions in I/DD-related industries, they have been combined with similar workers in other industries.[19] The BLS provides the following description for home health and personal care aides:

> This occupation includes the 2018 SOC occupations 31-1121 Home Health Aides [*Monitor the health status of an individual with disabilities or illness, and address their health-related needs, such as changing bandages, dressing wounds, or administering medication. Work is performed*

under the direction of offsite or intermittent onsite licensed nursing staff. Provide assistance with routine healthcare tasks or activities of daily living, such as feeding, bathing, toileting, or ambulation. May also help with tasks such as preparing meals, doing light housekeeping, and doing laundry depending on the patient's abilities.] and 31-1122 Personal Care Aides [*Provide personalized assistance to individuals with disabilities or illness who require help with personal care and activities of daily living support (e.g., feeding, bathing, dressing, grooming, toileting, and ambulation). May also provide help with tasks such as preparing meals, doing light housekeeping, and doing laundry. Work is performed in various settings depending on the needs of the care recipient and may include locations such as their home, place of work, out in the community, or at a daytime nonresidential facility.*].[20]

This description, especially the personal care aides portion, describes aspects of the work that DSPs perform, but it arguably does not fully represent the responsibilities of DSPs who work with individuals with I/DD and who are expected to provide training and support to increase individuals' independence and to manage often challenging behaviors. The rate models therefore create a composite of multiple BLS occupations in order to construct the rate model wage assumption for DSPs. As Figure 4-4 shows, the rate models use four BLS occupations to represent a DSP. The largest weighting – 70 percent – is applied to the home health and personal care aide classification, which is the occupation to which DSPs are currently assigned. The remaining 30 percent is evenly allocated to three other occupations that are representative of the work performed by DSPs based on a review of BLS occupational descriptions and service requirements.

Figure 4-4: Rate Model Wage Assumption for DSPs Prior to Application of $20 Wage Floor

BLS Standard Occupational Classification	Weighting	Median Wage (Adjusted)
31-1120 Home Health and Personal Care Aide	70%	$16.12
31-1131 Nursing Assistant	10%	$20.40
31-1133 Psychiatric Aide	10%	$25.41
39-9032 Recreation Worker	10%	$16.64
Weighted Avg.		**$17.53**

As the table demonstrates, HMA-Burns' typical methodology produces a wage of $17.53 for DSPs. As discussed earlier, however, the Action Plan commits BHDDH to establishing rates that allow for a starting DSP wage of $20.00 per hour, which HMA-Burns has assumed will yield an average wage of $22.14.

HMA-Burns compared this wage assumption to the values reported in rate models and rate studies in other states. For this comparison, HMA-Burns relied on documentation it compiled earlier in 2022 as part of a report it authored for ANCOR regarding states' approaches to establishing DSP wage assumptions.[21] For this project, HMA-Burns identified DSP wage assumptions in rates or rate studies in 26 jurisdictions (25 states and the District of Columbia). In reviewing the wage assumptions for three core services – in-home habilitation, group homes, and day programs – no state had an hourly wage assumption of $20 or more. It is noted, however, that many of these rate studies are several years old with about half predating

the Covid-19 pandemic, which worsened already existing workforce challenges. Overall, the DSP wage assumptions included in the Rhode Island rate models are amongst the highest in the country.

The development of wage assumptions for services provided by staff other than DSPs, such as job coaches and nurses, followed the same BLS-based approach described above. The BLS wage data before and after wage growth adjustments as well as the job mix assumptions are included in Appendix A of the rate model packet.

Direct Care Worker Benefits

In addition to market-based wages, the rate models include a comprehensive benefits package intended to support providers in the attraction and retention of a qualified and stable workforce. The rate models assume that all employees providing direct care receive the same benefits.

The rate models include the following standard employer-paid payroll taxes[22]:

- Social Security – 6.20 percent of total wages[23]
- Medicare – 1.45 percent of total wages[24]
- Federal unemployment insurance – 0.60 percent on the first $7,000 in wages paid[25]
- Employment security insurance – 0.98 percent on the first $24,600 wages paid[26]
- Job development tax fund – 0.21 percent on the first $24,600 wages paid[27]
- Workers' Compensation – 4.09 percent of total wages[28]

The rate models also include assumptions related to paid time off, health insurance, and other benefits.

The rate models aim to fund the employer share of the cost of various health insurance coverage plans (employee-only, employee-plus-one, and family plans). Assumptions related to take-up rates, distribution across plan types, and employer contributions to premium expenses are derived from Rhode Island specific data from the United States Department of Health and Human Services' Medical Expenditure Panel Survey (MEPS).29 The employer costs were increased by approximately 14.6 percent to account for cost increases. Figure 4-5 presents the assumed distribution across plan types and the assumed provider cost for each.

Figure 4-5: Rate Model Health Insurance Assumptions for Direct Care Workers

Coverage Type	Participation Rate	Employer Cost
Employee Only	39.5%	$582.20
Employee + One	10.9%	$1,091.06
Family	17.5%	$1,543.76
All Coverages	67.9%	

Overall, these assumptions translate to an assumed employer cost of $619.05 per employee per month. This is the assumed average cost for all employees, including those who do not participate in their employer's health insurance plan. In comparison, the average cost reported by provider survey respondents was $554 per month for full-time employees. For part-time staff, the reported average monthly cost was only $34 per employee because most part-time staff are not offered health insurance. Since providers reported that nearly 32 percent of direct care workers are part-time, the overall reported

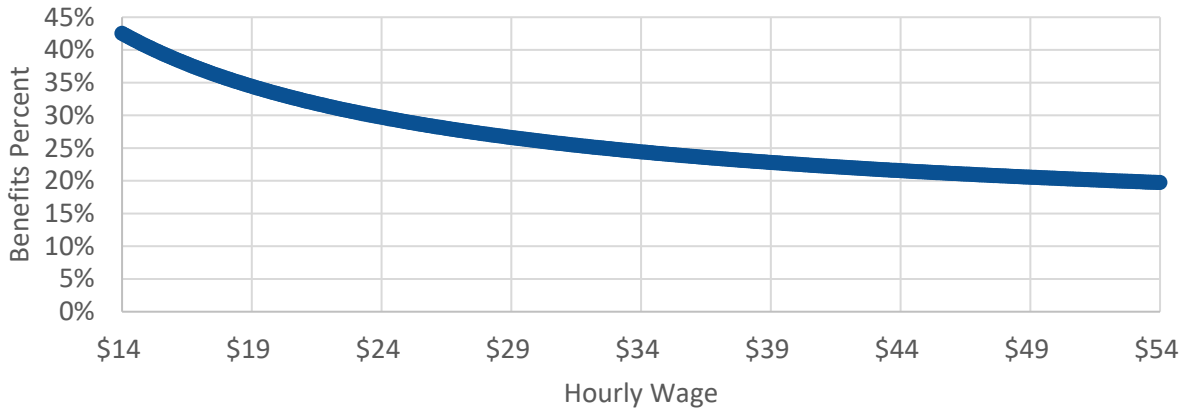
cost was about $389 per employee per month. As noted in the discussion below related to direct care worker productivity, the rate models assume all staff work full-time so there is no discount applied to health insurance costs to account for part-time workers.

In addition to health insurance, the rate models assume that direct care workers receive 25 days of paid time off, inclusive of paid holidays, vacation, and sick leave. This assumption is consistent with provider survey results for full-time staff. As with health insurance, part-time staff are reported to receive less paid time off, but the rate model assumes all staff are full-time.

Lastly, the rate models include $100 per direct care worker per month for all other benefits such as dental or life insurance, a contribution to a retirement plan, tuition reimbursement, etc. In comparison, the provider survey found an average cost of about $94 per full-time employee per month, but only $19 per employee per month for part-time staff.

The benefits package for direct care workers is detailed in Appendix B of the rate model packet. In the rate models themselves, the benefits package is translated to a benefit rate expressed as a percentage of the direct care worker's wage. Since certain benefit costs are assumed to be fixed (for example, the rate models provide the same $619.05 per month for health insurance for all direct care workers), there is an inverse relationship between the wage of the direct care worker and the benefit rate. That is, as the direct care wage increases, the benefit rate declines as illustrated in Figure 4-6.

Figure 4-6: Benefit Rate Assumed in Rate Models, by Wage Level (excludes paid time off)



For a direct care worker earning $14 per hour, the benefits package translates to a 42.5 percent benefit rate; for a worker earning $50 per hour, that same benefits package yields a 20.4 percent rate. For the $22.14 per hour wage assumption for DSPs described above, the benefit rate is 31.2 percent. These rates exclude paid time off, which is recognized in the rate models as an adjustment to worker productivity as discussed below.

HMA-Burns compared the per-hour cost of employee benefits built into a number of other states' rate models for key services. For mid-tier rate models for group home services in 15 states, the Rhode Island rate models include the largest per-hour cost for employee benefits; for small group community-based day programs in 18 states, the Rhode Island rate model has the third highest per hour benefit amount; and Rhode Island also has the third-highest employee benefit cost for one-to-one in-home and

community-based supports in 18 states. This result was expected due to the high wage assumptions built into the Rhode Island rate models. That is, since some benefits are based on a percentage of wages (Social Security, Medicare, and workers' compensation, for example), the cost of these benefits will increase as wages increase.

Direct Care Worker Productivity

In general, direct care workers are not providing direct care all of the time due to other responsibilities that relate to service delivery or their employment. Employees are still working, however, and must be paid for this time. To ensure that providers recover these costs, the time associated with these activities must be distributed across workers' billable hours.

For example, if an employee earns $20.00 per hour with a benefit rate of 30 percent, the cost of that employee to their employer is $26.00 per work hour, or $1,040.00 per 40-hour workweek. However, if the employer is only able to bill for 32 hours of direct service per week because the other 8 hours are devoted to non-billable activities, the billable rate must be inflated to cover the cost of those non-billable activities. The rate models achieve this by applying a 'productivity factor' that is calculated as the ratio of total work hours to billable hours. In this example, that would be 40 work hours divided by 32 billable hours, yielding a productivity factor of 1.25. Applying the productivity factor to the $26.00 cost per work hour produces $32.50, which is the cost per billable hour that would be included in the rate model to fully compensate the employer for the $1,040.00 weekly cost of the employee.

To account for non-billable activities, the rate model for each service first establishes a typical 40-hour workweek for a direct care worker. These workweeks incorporate activities that are likely to occur during any given week. These activities – and the time spent on each – vary from service to service and include:

- *Travel time between individuals* applies to services typically delivered in individuals' homes and the community to account for the time when staff travel from one service encounter to the next.
- *Program set-up and clean-up* applies to center-based supports and community-based supports to reflect staff time before and after program hours to prepare for and clean-up after service time. The models include 1.25 hours per week (15 minutes per day) for all direct care workers in these programs.
- *Networking/general developmental activities* is included only in the job development rate model to account for time that job developers spend developing their general network of providers rather than working on behalf of a specific individual. The model assumes 3.75 hours per week (45 minutes per day) for this purpose.
- *Recordkeeping and reporting* is included for most services to accommodate documentation requirements. The time assumptions vary across services, but are generally higher for 'professional' services that usually have more extensive reporting requirements and for group services since a worker will have to complete documentation for each service recipient. This productivity assumption does not cover documentation time that occurs during the course of service delivery, which is a billable activity.

- *Supervision and other employer time* reflects workers' employment-related activities such as attending staffing meetings or periodic meetings with their supervisors. Most services include one hour per week for these activities.
- *Missed appointments* are included to reflect the time lost when a recipient has an unscheduled absence. This adjustment is intended only to accommodate the time that is not redirected to some other activity. For example, if a two-hour encounter is scheduled in someone's home and the worker drives to that home to find that individual is not there, it is assumed that the staff person will move onto another task. This may not be a billable activity, but could be catching up on training or recordkeeping. In other words, some portion of that two-hour appointment would be allocated to the missed appointment adjustment, but another portion would be associated with the activity to which their time was redirected.
- *Individual Planning Meetings* is time associated with participation in individual planning meetings.

The typical workweeks are then adjusted for training and paid time off, activities that are likely to be concentrated during specific weeks rather than occurring during a typical week.

As described above, the benefits package for direct care workers assumes they receive 25 days of paid time off, which translates to 3.85 hours per week (25 days multiplied by 8 hours, divided by 52 weeks). Paid time off is included in all rate models.

For all services, the rate models assume that staff receive 40 hours of training annually. Consideration was given to creating a framework to allow training time to be billed directly, but was not recommended for a couple of reasons. First, this framework would require additional administrative effort to create rules to define what would and would not qualify for billing. For example, this framework could require the development of criteria to distinguish between training related to service delivery versus training associated with an agency's administrative operations. There would also be an added administrative burden to track and bill training time. Second, because a substantial portion of training is likely general in nature rather than related to a specific service recipient, the cost would not qualify for Medicaid matching funds based on the federal medical assistance percentage (FMAP), resulting in an increase in the state's share of expenses. Although providers cannot bill for staff training time directly, including this time in the rate models as a productivity adjustment ensures that providers are paid – albeit indirectly – for time that staff spend in training.

Productivity assumptions were informed by data collected through the provider survey and discussion with BHDDH program staff regarding the amount of time that would be needed to perform the non-billable activities associated with various services. Productivity assumptions are detailed in each individual rate model and in Appendix C of the rate model packet.

Program Support Expenses

Program support includes supervision, internal coordination activities, quality oversight, training, curriculum development, and other program-specific activities – functions that are crucial to the delivery of quality services.

Given differences in providers' organizational structures, the rate models do not include assumptions related to individual program support positions. Instead, program support is funded within the rate models as a fixed daily amount to account for differences in individual and group services and in high-cost and low-cost services:

- Services generally provided on a one-to-one basis are funded at $30 per day
- Services generally provided to groups are funded at $60 per day
- Residential services are generally funded at $30 per day

According to the provider survey, program support costs account for about 14.0 percent of provider revenues. Overall, the rate models represent an estimated funding level of about 20.0 percent of provider revenues based on rates in effect during the cost reporting period. This translates to an increase of almost 43 percent in funding for program support. The increase is intended to account for:

- The elimination of the Support Coordination service as part of the transition to conflict-free case management as providers will retain some responsibilities such as coordination of services with other providers. Support Coordination equaled about 2.3 percent of provider revenues in fiscal year 2021.
- Increases in wages and other expenses.
- Investment in program infrastructure.

Comparing program support cost assumptions across other states' rate models is complicated because of differences in what costs are included and how costs are categorized. Nonetheless, the program support funding levels included in the Rhode Island rate models generally fall within the top half to top third of costs built into other states' rate models for group home, day program, and one-to-one in-home services.

Administrative Expenses

Providers require administrative infrastructure – general management, finance and accounting, information technology, human resources, etc. – in order to effectively deliver services. The rate models include funding to support the costs associated with these functions, such as administrative staff salaries and benefits, facility-related expenses, equipment and supplies, insurance, professional services (for example, lawyers and accountants), and licensing and accreditation fees.

Specifically, the rate models generally include 10 percent of the total overall rate for administrative expenses. This is less than the average administrative rate of 10.8 percent reported by participants in the provider survey.

However, although the administrative *rate* in the rate models is lower than currently reported, the administrative funding *amount* is greater because the administrative rate is being applied to a higher cost base. For example, assuming a current rate of $100, the 10.8 percent administrative rate would produce $10.80 in administrative funding. Since rates are increasing by an average of 20 percent, the $100 rate would become $120. With a 10 percent administrative rate, the administrative funding amount would be $12.00, an increase of 11 percent over current funding levels.

Comparing administrative funding allowances in other states' rate models includes the same complications as in comparing program support allowances. Like program support, though, the administrative funding amounts in the Rhode Island rate models are consistent with the amounts included in other states, generally falling within the top half to top third of the states in which rate models have been identified.

Linking Payments to Values

As noted above, payment models should reflect programmatic goals and values. Value-based payment (VBP) models link funding to performance measures to improve quality in outcomes and reduce cost.[30] When defining VBP, CMS notes a three-part aim:[31]

- Better care for individuals
- Better health for populations
- Lower cost

Most often associated with hospital and clinical payment structures, VBP models are more challenging to implement for HCBS. CMS' stated goal of lowering costs is particularly problematic in an HCBS environment. For many healthcare services, reduced utilization represents a desirable goal. For example, supporting access to preventative care and effectively managing chronic conditions can result in reductions in the use of other undesirable services such as avoidable hospitalizations. Although there may be some opportunity to reduce unnecessary utilization of HCBS, the large majority of these services relate to assisting with personal care tasks; helping individuals to access the community, which often would not be possible without support; and providing general supervision. Reducing these supports does not necessarily translate to improved outcomes and may instead run counter to the values of I/DD service systems.

A number of reports have summarized the challenges associated with linking HCBS payments to quality, including:

- The National Quality Forum identified barriers including a lack of standardized measures, a lack of access to timely data, varied reporting requirements, and the administrative burden placed on a state.[32]
- According to the Center for Evidence Based Policy's Medicaid Evidence-Based Decisions project, challenges include the diversity of HCBS programs, beneficiary and provider heterogeneity, provider and system capacity, and varied stakeholder viewpoints.[33]
- The National Association on States United for Aging and Disability listed challenges that include the unique needs of the I/DD population that make it difficult to adopt quality measures used with other Medicaid populations, existing measures that do not emphasize individual outcomes and experiences, the difficult in quantifying quality-of-life measures, and a lack of agreement on how to define quality.[34]
- The American Network of Community Options and Resources (ANCOR), a national nonprofit trade association of HCBS providers, found quality and outcome measures are not widely agreed upon

and that the field is still evolving to measure and incentivize aspects of community services that go beyond medical care to measure goals like independence and individual choice, but that these measures are not easily defined.[35]

Recognizing the longstanding lack of consistent quality measures for HCBS, CMS issued a State Medicaid Director Letter in July 2022 to establish nationally standardized quality measures.[36] The measures cover three areas:

- *Access:* the level to which individuals are aware of and able to access resources.
- *Rebalancing:* achieving a more equitable balance between spending on HCBS in relation to spending on institutional care.
- *Community Integration:* ensuing the self-determination, independence, empowerment, and inclusion of individuals with disabilities in all parts of society.

This marks the first time CMS has issued guidance to states on a standard set of quality measures that can be used across HCBS systems to assess quality. However, most measures do not immediately lend themselves to provider-level VBP models for several reasons:

- *Measures require more robust data collection infrastructure.* Many of the measures are based on participant surveys such as the National Core Indicators (NCI), in which Rhode Island already participates. However, currently only a sample of individuals is surveyed. If payments were tied to these surveys, it is likely that a much larger population would need to be surveyed to ensure sufficient representation for every provider and to minimize sampling error. Further, many questions are subjective (for example, whether individuals feel that their service plan includes things that are important to them), so significant care would be required to ensure consistency in surveying. Other measures would be based on review of "paper records", which are often of varying quality.
- *Many measures are systems-level.* Many of the measures are designed to evaluate state performance (for example, many measures related to the content of service plans) rather than the performance of individual providers.
- *Many measures cannot be related to a specific service.* A number of measures address broad outcomes for an individual that cannot be associated with a specific service preventing a link to payment for a service (for example, whether or not individuals feel lonely or are as active in the community as they would like to be).
- *Many measures reflect compliance and/or the absence of negative outcomes.* Attainment of minimum standards should not serve as the basis for value-based payments. Many of the measures are not indicative of high quality, but represent standards that should be expected (for example, staff do not yell or curse at an individual or individuals take part in deciding how to spend their time).

Despite the barriers to VBP models for HCBS and the inability to reasonably link most of CMS' HCBS quality measure set to provider reimbursement, many elements of Rhode Island's current reimbursement

framework and the rate study already tie payment to the values of the state's system of supports for individuals with I/DD. For example:

- The rate study recommends significant investment in direct support professionals, incorporating wage assumptions that would make DSPs in Rhode Island amongst the best-paid in the country. As demonstrated by the number of CMS measures that relate to the support provided by staff, DSP are a primary determinant of service quality.
- The rate study proposes the establishment of new services, including Supported Living, Remote Monitoring, and Companion Room and Board, to support individuals in the least restrictive environment, a key value expressed by stakeholders.
- The rate study continues the current practice of paying higher rates for services provided in the community rather than in a center-based environment, reflecting the goal of delivering integrated services. These rates affirm the state's commitment to supporting individuals as they build and maintain relationships and gain independence in their communities.
- The rate study proposes the creation of Peer Supports and Family-to-Family Supports, which are designed to create additional pathways to accessing the community.
- The rate study proposes an outcome-based model for supported employment services wherein the provider is paid based on the number of hours that the individual works regardless of the number of hours of direct support provided. Through this model, the provider is incentivized both to maximize the number of hours that an individual works and to fade direct support over time.

Additionally, before providers are held financially accountable for achieving outcomes, they should be adequately funded to deliver services consistent with state requirements. This is particularly true because many VBP models incorporate downside financial risk; that is, providers' payments are reduced when they do not achieve required outcomes. The rate study seeks to establish fair rates for services, which can provide a foundation for future VBP models with upside and downside financial impacts.

Section 5: Recommended Rates and Associated Changes

The rate study included a review of the service requirements, payment rates, and billing policies for each service. The resulting recommendations are described below. Additionally, the presentation of the draft rate models with the addendum to reflect changes based on public comments also summarize these recommendations and are included as Attachments 5 and 6. The rate models are included as Attachment 8.

Group Homes and Home-Based Day Programs

The Billing Policy Manual provides the following definition for Group Home services:

> Individually tailored supports provided in a group home setting, that is subject to licensure, to assist with the acquisition, retention, or improvement in skills related to living in the community. [Responsibilities include] Adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist an individual in the most integrated setting appropriate to his/her needs. [Group Homes] also includes personal care and protective oversight and supervision.

No changes are proposed to the service definition.

Key elements of the proposed rates include:

- *Tiered rates based on individual needs.* Provider payment rates would continue to vary based on the assessed needs of the individual. In particular, the rate models assume more intensive staffing to support individuals with more significant needs. Consistent with current practices, assessment levels are based on the individual rather than based on the home overall, and individuals with different assigned tiers can reside in the same home. The specific staffing assumptions are detailed in Appendix D of the rate model packet and, overall, represent a modest increase compared to staffing levels reported in the provider survey. Providers are not required to deliver the level of staffing in the rate models. Instead, providers are expected to staff the home to meet the needs of residents. However, if an exceptional rate is requested, the provider will be required to demonstrate that it is already providing the level of staffing in the home for which it is funded.
- *Elimination of Home-Based Day Program service.* Recognizing that individuals in group homes should be able to access community supports on their own schedule – rather than assuming that all individuals are away from the home during the same hours – the Group Home rate models assume that homes are staffed 24 hours per day (although, as noted in the previous bullet, these assumptions are not mandates and 24-hour staffing is not required if there are times when no residents are in the home). Since the models provide for around-the-clock staffing, including during traditional 'day program' hours, the rate study proposes the elimination of the Home-Based Day Program service. A provider may request an exception if total staffing needs in the home exceed the amount of staffing funded within the home.
- *344-day billing year*. Because group homes generally rely on shared staffing, the cost of operating a home is fixed regardless of whether or not a given resident is away from the home, particularly in the short-term. To minimize lost revenue when these absences occur, the rate models assume

a 344-day billing year. That is, the rate models distribute the assumed annual cost of the home over 344 days rather than 365 days. Rates based on a 344-day billing year are 6.1 percent higher than rates calculated on a 365-day basis. The large majority of residents are in their home for more than 344 days per year, but this standard was selected to minimize the number of individuals for whom the provider misses out on revenue. That is, if the standard were based on the average number of absences, providers would forgo revenue on half of the population. Since providers are paid for a full year of service once they have billed 344 days, billing for an individual will be limited to 344 days during their plan year. However, if an individual changes providers, the 344-day billing limit will reset.

- *Changes to the exceptions process.* Like individual budgets or service caps, rate models are based on assumptions related to the intensity of support individuals need. These assumptions are not intended to reflect the greatest intensity of support that an individual in a given group will potentially need (that is, rates are not intended to reflect the highest possible need within a group). As a result, an exceptions process will continue to be necessary. Rather than the current process in which an individual receives additional funding to move them to a higher rate tier, requests for exceptions will be based on the providers' proposed staffing level in comparison to the total number of hours funded across all residents in the home. If BHDDH approves the proposed staffing level, an additional per diem rate will be established for the additionally approved hours based on the same wage, benefit, and productivity assumptions included in the standard rate model.
- *Rate framework for specialized group homes.* There are some instances when individuals' needs can best be best met in a group home developed for individuals with specialized needs. For example, individuals with significant medical needs who require continuous support from staff with medical training could potentially be served in homes staffed by certified nursing assistants (CNAs) with regular onsite nursing. Since it is not feasible to identify every potential type of specialized home, a 'customizable' rate model has been developed to allow for the identification of the specific types and amounts of staffing to be provided. For a medically-focused home, for example, there could be 300 hours per week of CNA staffing and 40 hours of a licensed practical nurse. These values would be input into the rate model and priced at wages appropriate to those positions. The remaining components of the rate would follow the same conventions of the standard Group Home rate models (for example, the benefit rate assumptions would be the same). These specialized homes would be an option for individuals, not a mandate. For example, an individual with significant medical needs would still be able to choose a standard group home if that home were able to meet their needs.

Figure 5-1 compares the current and proposed rates. The rates continue to be based on a daily unit of service.

Figure 5-1: Proposed Group Home Rates Compared to Current and Recent Rates*

Service	Sep. 30, 2019	Oct. 1, 2019	Jul. 1, 2021	Jul. 1, 2022	Proposed Rate	Change to Current	Change Since 2019
Tier A	$130.14	$137.76	$161.30	$181.91	$293.79	62%	126%
Tier B	$130.14	$137.76	$161.30	$181.91	$350.56	93%	169%
Tier C	$181.25	$192.65	$226.90	$256.89	$407.31	59%	125%
Tier D	$290.69	$309.70	$365.47	$414.29	$472.96	14%	63%
Tier E	$326.92	$348.14	$410.09	$464.32	$529.78	14%	62%
*Current and recent rates are converted to a 344-day equivalent for comparative purposes.							

As the table demonstrates, the proposed rates represent significant increases compared to current rates. The largest increases relate to the lower tiers as analysis of current staffing patterns suggest that these models required the largest increases to assumed staffing levels.

Supportive Living

The rate study proposes to establish a new Supportive Living service to encourage the development of a residential living option that is less intensive and offers greater independence than a group home. In this model, individuals live in their own homes and share staffing supports provided by the agency that owns or controls the housing. For example, the service may be provided in a four-plex, with each individual having their own living unit but receiving support from the same agency, often by staff who move between the units. Services may also be provided in scattered sites or mixed-tenancy locations. Like a group home, the housing is part of the service.

This model is envisioned to be beneficial in various cases, including the following.

1. Individuals who need access to regular support but who do not do well in a congregate setting.
2. Individuals who do not need group home level of care but need more supports than independent living.
3. Individuals who are learning to live independently but need more practice and support before they are ready to move to their own apartment.
4. Individuals who have lived independently but who are beginning to require more supports due to aging or illness.

It is expected that some programs currently reimbursed through Non-Congregate Residential as well as some supports delivered through Overnight Shared Supports will transition to Supportive Living.

Tentatively, the service will be defined as:

> Supportive Living is a combination of housing and supports to help people with I/DD live as independently as possible in the community. Providers deliver adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, personal care, and protective oversight and

supervision as needed. Staff must be onsite during typical awake hours when residents are present. Overnight staff may be onsite and awake, or may be offsite in on-call status as long as they have the ability to provide an onsite response within 15 minutes.

Key elements of the proposed rates include:

- *Tiered rates based on individual needs.* Provider payment rates would be based on the assessed needs of the individual. In particular, the rate models assume more staffing to support individuals with more significant needs. Assessment levels are based on the individual rather than based on the program overall, and individuals with different assigned tiers can participate in the same program. The specific staffing assumptions are detailed in Appendix E of the rate model packet. Providers are not required to deliver the level of staffing in the rate models. Instead, providers are expected to staff the home to meet the needs of residents. However, if an exceptional rate is requested, the provider will be required to demonstrate that it is already providing the level of staffing in the home for which it is funded.
- *Separate rates for models with overnight asleep or on-call staff.* Because it is more costly to pay staff who are awake in an active employment status compared to those in on-call status, the rate study proposes higher rates for programs with onsite awake staff during overnight hours.
- *344-day billing year*. As discussed above for Group Home services, the Supportive Living rates are based on a 344-day billing year.

Figure 5-2 details the proposed rates, which are based on a daily unit of service.

Figure 5-2: Proposed Supportive Living Rates Compared to Current and Recent Rates*

Service	Sep. 30, 2019	Oct. 1, 2019	Jul. 1, 2021	Jul. 1, 2022	Proposed Rate	Change to Current	Change Since 2019
Tier A, Awake	$130.14	$137.76	$161.30	$181.91	$266.03	46%	104%
Tier A, Asleep					$208.52	15%	60%
Tier B, Awake	$130.14	$137.76	$161.30	$181.91	$316.49	74%	143%
Tier B, Asleep					$258.98	42%	99%
Tier C, Awake	$181.25	$192.65	$226.90	$256.89	$369.50	44%	104%
Tier C, Asleep					$311.94	21%	72%
Tier D, Awake	$290.69	$309.70	$365.47	$414.29	$428.79	3%	48%
Tier D, Asleep					$371.28	(10%)	28%
Tier E, Awake	$326.92	$348.14	$410.09	$464.32	$466.71	1%	43%
Tier E, Asleep					$409.20	(12%)	25%

*Current and recent rates reflect Non-Congregate Residential services, though each program will need to be evaluated to determine whether they meet the requirements for Supportive Living. Non-Congregate Residential rates are converted to a 344-day equivalent for comparative purposes.

As shown in the table, the proposed rates are substantially greater than the current Non-Congregate Residential rates for Tiers A, B, and C. The proposed rates for programs with overnight awake staff for Tiers D and E are effectively equal to the current Non-Congregate Residential rates while the proposed rates for programs with overnight asleep staff are about 10 percent lower, though still significantly greater than the rates in effect in 2019.

Shared Living Arrangement

The Billing Policy Manual provides the following definition for Shared Living Arrangement (SLA) services:

> Individually tailored support option for an individual to reside with and receive supports from someone who has contracted with a shared living placement agency. Agencies will recruit, train, monitor and oversee qualified SLA contractors (host home families).

No changes are proposed to the service definition.

Key elements of the proposed rates include:

- *Tiered rates based on individual needs.* Payment rates to SLA agencies would continue to vary based upon the assessed needs of the individual. In particular, the rate models assume lower caseloads for agency monitors and higher payments to the home provider for individuals with more significant needs. Figure 5-3 compares the current minimum amounts that SLA agencies must pay to their contracted home providers to the minimum amounts included in the proposed rate models.

Figure 5-3: Comparison of Minimum Payments to SLA Agencies' Contracted Home Providers

Service	Current Min.	Proposed Min.
Tier A	$48.00	$75.00
Tier B	$58.00	$90.00
Tier C	$75.00	$105.00
Tier D	$90.00	$120.00
Tier E	$90.00	$135.00

- *Standardized monitoring requirements*. Current standards require an annual number of visits or monitoring calls that varies based on an individual's assigned tier. The rate study proposes to standardize this expectation by requiring a monthly home visit regardless of tier.
- *Unbundling of Respite*. Consistent with current practices, Respite is directly billable so these costs are not bundled into the SLA rate models.
- *344-day billing year*. As discussed above for Group Home services, the SLA rates are based on a 344-day billing year.

Figure 5-4 compares the current and proposed rates for SLA agencies, which include the minimum payment amounts for their contracted home providers listed in Figure 5-3. The rates continue to be based on a daily unit of service.

Figure 5-4: Proposed Shared Living Arrangement Rates Compared to Current and Recent Rates*

Service	Sep. 30, 2019	Oct. 1, 2019	Jul. 1, 2021	Jul. 1, 2022	Proposed Rate	Change to Current	Change Since 2019
Tier A	$75.64	$75.73	$76.00	$76.24	$147.26	93%	95%
Tier B	$92.44	$92.53	$92.80	$93.04	$164.95	77%	78%
Tier C	$117.22	$117.36	$117.77	$118.13	$187.49	59%	60%
Tier D	$140.62	$140.76	$141.16	$141.51	$210.02	48%	49%
Tier E	$140.62	$140.76	$141.16	$141.51	$227.71	61%	62%

*Current and recent rates are converted to a 344-day equivalent for comparative purposes.

As the table demonstrates, the proposed rates represent significant increases compared to current rates, partly because these rates have generally not been increased in recent years.

The rate study also proposes to formalize of enhanced SLA rates. Currently, when individuals do not receive external supports such as day program or employment services, BHDDH may authorize an enhanced rate that adds the value of an individual's tier package for day supports to the payment to the home provider. However, the Day Support rate models are based on a much different service model in which employees generally provide care to a group of individuals. The rate study proposes to establish specific rate models for enhanced services. To do so, the rate model increases the assumed payment to the home provider by 35 percent for Tiers A, B, and C to reflect the additional hours of supervision they will provide. Assuming 56 hours of sleep time per week, there are 112 hours awake hours. If an individual participates in day activities 30 hours per week, the home provider is delivering 82 hours of supervision per week. Increasing this baseline by 30 hours is an increase of 36.6 percent. Due to the more intensive needs of individuals in Tiers D and E, the assumed home payment for these tiers is increased by 70 percent. Figure 5-5 lists the proposed rates for Enhanced SLA.

Figure 5-5: Proposed Enhanced SLA Rates

Service	Proposed Rate
Tier A	$178.21
Tier B	$202.09
Tier C	$230.81
Tier D	$309.06
Tier E	$339.12

Remote Supports

The rate study proposes to add Remote Supports to provide another option to assist individuals to live independently in their own homes. Individuals receive support from staff who are at a centralized location. The service is intended to support individuals who require access to support, but who do not require staff to be physically present during the time that Remote Supports are available. It is expected that some services currently delivered throughout Overnight Shared Supports will transition to Remote Supports.

Tentatively, the service will be defined as:

> Remote Supports is the provision of supports by staff at a remote location who are engaged with the individual through technology/devices with the capability for live two-way communication. Equipment used to meet this requirement must include one or more of the following systems:

motion sensing system, radio frequency identification, live video feed, live audio feed, GPS tracking, web-based monitoring system, or a device that otherwise meets the requirement for two-way communication. The system must protect the privacy of individuals. Backup systems are required to ensure support is not interrupted due to inclement weather, power outages or other unforeseen circumstances. Remote supports cannot be provided in private living areas like bathrooms or bedrooms. Individual interaction with the staff person may be scheduled, on-demand, or in response to an alert from a device in the remote support equipment system.

The Remote Supports provider must have the capability to provide an onsite, in-person response within 15 minutes when required either through the use of its own staff or contractual relationships with an in-state developmental disabilities organization.

Remote Supports are comprised of three components, the rates for which are listed in Figure 5-6:

- *Equipment*, to cover the costs of devices and technology necessary to provide the service.
- *Monitoring*, which reflects the time that the provider is monitoring the individual. Monitoring supports cannot be billed at the same time as another paid service. Because the amount of monitoring that an individual needs will vary (for example, some people may require Remote Supports during overnight hours while others may have other support systems in place that can assist during these hours), the service will be authorized and reimbursed in 15-minute increments.

Figure 5-6: Proposed Remote Supports Rates

Service	Jul. 1, 2022	Proposed Rate
Equipment	N/A (new)	Cost
Monitoring	N/A (new)	$2.64
In-Person	N/A (new)	$12.36

- *In-Person Supports*, to compensate for time when an in-person response is delivered. This support will be billed in 15-minute units at the same rate as one-to-one Community-Based Supports.

Companion Room and Board

The rate study proposes to add a new service to cover the cost of room and board of a companion/ roommate living with an eligible individual. The service intends to provide another residential option for individuals that offers a high degree of independence.

Tentatively, the service will be defined as:

> Companion room and board covers defined living expenses of an unrelated individual who does not receive I/DD services. The individual being supported is matched with a roommate by a developmental disabilities organization. The matching process considers shared values, hobbies, and interests, and is driven by the choice of the individual receiving services. The roommate is provided with a stipend and has an occupancy agreement. The roommate may provide supports to the individual through Community-Based Supports. The service is available in a home owned or rented by the individuals receiving services and may not be provided in a home owned by a provider organization or the roommate.

As described in Figure 5-7, a monthly rate would be established for each program based on the actual cost of the living arrangement.

Figure 5-7: Proposed Companion Room and Board Rates

Jul. 1, 2022	Proposed Rate
N/A (new)	Varies*

*Rate will be equal to half of the cost of the home's rental and utility expense plus 10 percent for the agency's administrative fee.

Community-Based Supports and Center-Based Supports

Day programs provide meaningful and important supports for many individuals. However, to some, the term 'day program' represents a rigid program offering services at a prescribed time based on providers' programming rather than tailored to the needs of individuals. To emphasize that these services are meant to be flexible and available according to individuals' schedules rather than providers' operations, the rate study proposes to relabel these services Community-Based Supports and Center-Based Supports.

Additionally, the rate study proposes to consolidate the existing Community-Based Supports and Community-Based Day Program definitions:

> Direct support and assistance in or out of the individual's residence intended to achieve and/or maintain the outcomes of increased independence, productivity, enhanced family functioning, and inclusion in the community, as outlined in the individual's individualized service plan (ISP). This service includes activities to support individuals with building problem solving skills, social skills, adaptive skills, daily living skills, and leisure skills. Services are scheduled based on the needs of the individual receiving services. For programs that operate exclusively in the community except for incidental time at a provider-operated "hub" (for example, to serve lunch), the time spent at the hub may be billed as Community-Based Supports. This service cannot be provided at a home owned or controlled by the service provider, including group homes, supportive living programs, or shared living arrangements.

Based on the current Day Program definition, the rate study proposes the following for Center-Based Supports:

> The provision of education, training, and opportunities to acquire the skills and experience needed to participate in the community. This service includes activities to support individuals with building problem solving skills, social skills, adaptive skills, daily living skills, and leisure skills. Services are scheduled based on the needs of the individual receiving services. Services are provided at a nonresidential location controlled by the provider. This service cannot be provided at a home owned or controlled by the service provider, including group homes, supportive living programs, or shared living arrangements.

Key elements of the proposed rates include:

- *Incorporation of Prevocational Services.* The rate study proposes to fold existing Prevocational Services into Community-Based Supports and Center-Based Supports. This consolidation is not

intended to result in the elimination of existing supports as the service definitions are sufficiently broad to cover these programs.

- *Tiered rates for group services billed based on an individual's assigned rate tier rather than the program's staffing ratio.* Currently, providers bill based on the staff ratio they are providing regardless of the assessment-based tier to which an individual is assigned. For most other services (for example, Group Home and Shared Living Arrangement), billing is based on an individual's assigned tier. Like these other services, the rate study proposes that provider payment rates for group-based Community-Based Supports and Center-Based Supports would be based on the individual's assessment-based tier. Since rates will be tied to an individual's assessment level, a provider may bill different rate tiers for different individuals in the same group.
- *Elimination of staffing ratio requirements.* As noted in the previous bullet, providers' billing is currently based on the staffing ratio for their program. The proposed rate models include assumed staffing ratios in order to establish group rates. However, there will be no minimum staffing requirements for group services. Instead, providers will be expected to design their programs and staffing plans to meet the needs of the individuals receiving services.
- *Individual and group rates for all tiers both Community-Based Supports and Center-Based Supports.* In addition to the group rates that vary based on an individual's assessment-based tier, the rate study proposes the continuation of one-to-one rates for both Community-Based Supports and Center-Based Supports. All individuals would be able access the one-to-one rates based on their individualized service plan.
- *Inclusion of an absence factor for group services.* Recognizing that providers' costs do not change when an individual is absent, arrives late, or leaves early, the rate models for group services include an absence factor that has the effect of increasing rates to cover the cost of absences.

Figures 5-8 and 5-9 compare the current and proposed rates. The rates continue to be based on a 15-minute unit of service.

Figure 5-8: Proposed Community-Based Supports Rates Compared to Current and Recent Rates*

Service	Sep. 30, 2019	Oct. 1, 2019	Jul. 1, 2021	Jul. 1, 2022	Proposed Rate	Change to Current	Change Since 2019
Tier A, Grp.	$1.44	$1.53	$1.79	$2.01	$5.61	179%	290%
Tier B, Grp.	$1.44	$1.53	$1.79	$2.01	$5.61	179%	290%
Tier C, Grp.	$3.26	$3.47	$4.11	$4.67	$6.63	42%	103%
Tier D, Grp.	$6.63	$7.07	$8.40	$9.56	$8.12	(15%)	22%
Tier E, Grp.	$6.63	$7.07	$8.40	$9.56	$10.72	12%	62%
Individual	$6.67	$7.10	$8.37	$9.47	$12.36	31%	85%

*Current and recent rates for group services represent the Community-Based Day Program rates; there are also shared Community-Based Supports rates that are not listed. Current tier billing is based on the program's staffing ratio while the proposed rates would be billed based on an individual's assessment-based tier.

Figure 5-9: Proposed Center-Based Supports Rates Compared to Current and Recent Rates*

Service	Sep. 30, 2019	Oct. 1, 2019	Jul. 1, 2021	Jul. 1, 2022	Proposed Rate	Change to Current	Change Since 2019
Tier A, Grp.	$1.08	$1.13	$1.26	$1.38	$3.33	141%	208%
Tier B, Grp.	$1.23	$1.28	$1.45	$1.59	$3.33	109%	171%
Tier C, Grp.	$1.68	$1.77	$2.03	$2.26	$4.04	79%	140%
Tier D, Grp.	$2.50	$2.64	$3.07	$3.45	$5.25	52%	110%
Tier E, Grp.	$6.63	$7.06	$8.35	$9.47	$6.20	(35%)	(6%)
Individual	-	-	-	-	$11.78	-	-

*Current tier billing is based on the program's staffing ratio while the proposed rates would be billed based on an individual's assessment-based tier.

As illustrated in the tables, two rates are declining. The recommended rate for Tier D Community-Based Supports represents a 15 percent reduction compared to the current rate, but is nearly equal to the rate in place prior to the most recent rate increase adopted on July 1, 2022. The recommended rate for Tier E Center-Based Supports represents a more significant reduction. The lower rates are lower because the current rates reflect a one-to-one staffing ratio whereas the proposed group rates all assume shared services. However, as noted above, the one-to-one rates listed in the table would be available to all individuals regardless of tier.

Respite

The rate study proposes updating the definition included in the Billing Policy Manual to eliminate the use of the term "outings":

> Direct support to individuals furnished on a short-term basis due to the absence of a caregiver or the need for relief of those persons who normally provide care for the individual. Respite can be delivered in an individual's home, a private place of residence or at the location of a respite care provider or in the community. The provider must ensure that the individual's routine is maintained to attend school, work, or other community activities. Community activities shall be included in the supports provided and the provider is responsible for providing transportation for community activities.

No changes are proposed to the service definition.

Key elements of the proposed rates include:

- *Continuation of 15-minute and daily rates.* Consistent with current standards, the daily rate will be billed when more than nine consecutive hours of support are delivered. The Daily rate has been set equal to the Enhanced Shared Living Arrangement rate for Tier E.
- *Establishment of multi-person rates*. The rate study proposes the establishment of rates for intermittent (hourly) services provided to groups of individuals such as when a single worker supports two siblings.

- *Standardization of daytime and overnight rates*. The rate study proposes the establishment of a single 15-minute rate regardless of when the service is provided.

Figure 5-10 compares the current and proposed rates.

Figure 5-10: Proposed Respite Rates Compared to Current and Recent Rates*

Service	Sep. 30, 2019	Oct. 1, 2019	Jul. 1, 2021	Jul. 1, 2022	Proposed Rate	Change to Current	Change Since 2019
15 Min., 1:1	$5.73	$5.73	$6.78	$7.71	$11.28	46%	97%
15 Min., 1:2	-	-	-	-	$6.37	-	-
15 Min., 1:3	-	-	-	-	$4.32	-	-
Per Diem	$206.28	$206.28	$244.08	$277.56	$339.12	22%	64%

*The current 15-minute rates reflect the daytime rates; overnight rates are lower (currently $5.43)

As the table demonstrates, the proposed rates for 15-minute services are nearly double the rates in place three years ago while the per diem rate represents an increase of more than 60 percent over the same period.

Discovery

Recognizing that everyone has skills and abilities to offer regardless of disability or complexities of life, Discovery provides supports to help individuals identify the type of job they want to do. Discovery is the first step in customized employment and may also be used as a first step for traditional supported employment, and typically yields information useful for community inclusion as well.

Discovery starts with understanding who the person is, highlighting what they can do. It translates information learned from the individual's daily life through spending time with the person in different settings, interviewing people who know them well, visiting their home, and focusing on their strengths rather than testing and evaluating. The individual controls the process, and the facilitator seeks permission and direction from the individual.

The tentative definition is:

> A qualitative process aimed to better understand individuals by understanding their strengths (potential contributions to employers), their needs (the features that need to be in place for success), and their interests (providing a direction to the type of work that the individual wants to do). Discovery is meant to be an intensive, focused process, so it is limited to 60 hours in one 120-day period during a plan year.

Figure 5-11 lists the proposed rate based on a 15-minute billing unit.

Figure 5-11: Proposed Discovery Rate

Jul. 1, 2022	Proposed Rate
N/A (new)	$17.61

Job Development

Job Development services (currently titled Job Assessment and Development) assist individuals in getting a job. The tentative definition is:

> Activities to assist individuals in securing employment consistent with their career plan (as applicable), including job search and matching, helping with resumes, and planning for interviews. Job Development is limited to 200 hours per plan year.

Figure 5-12 compares the current and proposed rates.

Figure 5-12: Job Development Rates Compared to Current and Recent Rates*

Sep. 30, 2019	Oct. 1, 2019	Jul. 1, 2021	Jul. 1, 2022	Proposed Rate	Change to Current	Change Since 2019
$15.05	$15.05	$15.05	$15.05	$19.73	31%	31%
*The current hourly rate is presented as a 15-minute equivalent for comparative purposes.						

As the table demonstrates, the proposed rates for Job Development are greater than the current rate, although the increases are more modest than for several other services given the relatively high existing rate.

Job Coaching

The Billing Policy Manual provides the following definition for Job Coaching services:

> Training for individuals by a job coach, who uses structured intervention techniques to help the individual learn to perform job tasks to the employer's specifications and to learn the interpersonal skills necessary to be successful as an employee at the job site and in related community contacts.

No changes are proposed to the service definition.

Key elements of the proposed rates include:

- *Payment based on the number of hours an individual works.* The rate study proposes to shift to a payment model wherein the provider is paid based on the number of hours that an individual works regardless of the number of hours of Job Coaching support provided. This approach incentivizes working with individuals to increase the number of hours they work while fading unnecessary supports. Ultimately, rates would be tiered based on two factors: an individual's assessment-based tier (with higher rates for individuals with greater needs) and length of time on the job (with the expectation that fewer supports are necessary as individuals gain more experience in the job). The rates will be based on the typical ratio of individuals' work hours to the amount of support they receive. These assumptions must be based on actual data so implementation of this model will be delayed until that data is collected.
- *Elimination of Job Retention.* With the shift to payment based on individual work hours, the Job Retention service will no longer be needed.

Figure 5-13 compares the current and proposed rates per 15-minute unit.

Figure 5-13: Job Coaching Rates Compared to Current and Recent Rates*

Sep. 30, 2019	Oct. 1, 2019	Jul. 1, 2021	Jul. 1, 2022	Proposed Rate	Change to Current	Change Since 2019
$6.94	$7.36	$8.60	$9.69	$18.06	86%	160%

*The proposed rate represents the payment amount prior to applying the ratio of worked hours to supported hours. The intent is that, on average, providers will earn this amount per hour of support provided.

As the table demonstrates, the proposed rates represent significant increases compared to current rates. As noted, the proposed rate is the target revenue per hour of support provided, but providers who are able to operate more efficiently than the outcome-based rates (to be based on assumed ratios of worked hours to supported hours) will earn more than this amount.

Personal Care in the Workplace

To expand the array of services to support individuals in the workforce, the rate study proposes to establish a new service for individuals who require assistance with personal care needs while at work, but who do not need employment-related supports. This proposal intends to allow for targeted supports aligned with the needs of the individual and the skillsets of staff by allowing job coaches to focus on employment related skills and tasks while having other staff support the person with ADLs.

The tentative definition for this service is:

> A range of personal care supports during paid competitive community employment hours to enable individuals to be successful in a work environment. The service is available for individuals who do not need job related support, but do need assistance with activities of daily living (ADLs) (eating, personal hygiene, etc.) at the job site.

Figure 5-14 lists the proposed rate based on a 15-minute billing unit. The proposed rate is equal to the Community Supports rate but will be billed under a separate code to allow tracking and monitoring of utilization.

Figure 5-14: Proposed Personal Care in the Workplace Rate

Jul. 1, 2022	Proposed Rate
N/A (new)	$12.36

Group Supported Employment

Group Supported Employment is currently covered by the Job Coaching service definition in the Billing Policy Manual. To distinguish between individual and shared supports, the rate study proposes to establish separate (but very similar) service definitions. Group Supported Employment would be defined as:

> Employment supports for a group of individuals who work at the same location and who are supported by a job coach who uses structured intervention techniques to help these individuals learn to perform job tasks to the employer's specifications and to learn the interpersonal skills necessary to be successful as an employee at the job site and in related community contacts.

The rate proposes to maintain rates based on the number of individuals per job coach. Individuals in each assessment-based tier will be able to access any of the ratio-based rates to avoid barriers to individuals working in the job most appropriate to them. For example, an individual with relatively low assessed support needs may have a job where they are supported with a job coach working with one other individual so their provider would bill the one-to-two rate.

Although the rate study proposes to maintain rates tied to staffing ratios, it also recommends reducing the administrative burden associated with billing for different ratios throughout the day if individuals arrive or leave the worksite at different times. Specifically, the provider would bill one ratio for the job coach's shift for all individuals served during that shift. For example, if three individuals start and end at the same time and work a total of four hours while a fourth individual leaves after three hours, the provider would bill the one-to-three rate for all hours of support delivered to each of the four individuals (four hours or 16 units for the three individuals, and three hours or 12 units for the remaining individual) because that is the ratio for the majority of the day.

Figure 5-15 compares the current and proposed rates, which are billed per person in 15-minute units.

Figure 5-15: Proposed Group Supported Employment Rates Compared to Current and Recent Rates

Service	Sep. 30, 2019	Oct. 1, 2019	Jul. 1, 2021	Jul. 1, 2022	Proposed Rate	Change to Current	Change Since 2019
1:2	$3.99	$4.23	$4.95	$5.57	$8.53	53%	114%
1:3	$2.77	$2.94	$3.44	$3.88	$5.79	49%	109%
1:4	$2.17	$2.30	$2.69	$3.03	$4.41	46%	103%
1:5	$1.80	$1.91	$2.24	$2.52	$3.58	42%	99%
1:6	$1.56	$1.66	$1.94	$2.18	$3.01	38%	93%

As the table demonstrates, the proposed rates represent significant increases compared to current rates, with rates approximately double those in place three years ago.

Transportation

The Billing Policy Manual provides the following definition for Transportation services:

> A program providing transportation for an individual from his/her residence, or the immediate vicinity thereof, to and from the individual's program in order to participate in employment/day activities. In providing these services, the DDO is requested to utilize the most clinically appropriate, least restrictive method of transporting the individual. DDOs shall make every effort to support individuals with accessing the Paratransit Program RIDE or any other statewide initiative that is available to transport individuals.

The rate study recommends that "day activities" be replaced with "community activities" to make clear that the support does not need to be attached to a traditional day program, but may be used to transport individuals to a variety of community engagements (including traditional day programs). Recognizing the need for expanding transportation options, the rate study proposes that existing policies make clearer that Transportation may be provided by agencies other than those that provide residential or day

program services to the individual. The determination of which agency or agencies would be authorized to provide Transportation services would be determined as part of the person-centered planning process. No provider will be expected to provide Transportation services without receiving payment.

Since the length of a trip and the number of individuals transported is not necessarily related to an individual's assessment-based tier, the rate study proposes the establishment of a single Transportation rate.

Figure 5-16 compares the current and proposed rates. The rates continue to be based on a one-way trip.

Figure 5-16: Proposed Transportation Rates Compared to Current and Recent Rates*

Service	Sep. 30, 2019	Oct. 1, 2019	Jul. 1, 2021	Jul. 1, 2022	Proposed Rate	Change to Current	Change Since 2019
Tiers A-C	$8.92	$9.19	$9.95	$10.62	$21.20	100%	138%
Tiers D-E	$14.38	$15.06	$16.97	$18.64	$21.20	14%	47%
*The current 15-minute rates reflect the daytime rates; overnight rates are lower (currently $5.43)							

As the table demonstrates, the establishment of a single rate represents an increase over both current rates, although the increase is obviously greater for the lower tier. The increase for the higher tier is still significant, representing an increase of almost 50 percent compared to the rate in effect three years ago.

Vehicle Modifications

In order to facilitate access to the community, the rate study proposes to provide coverage of vehicle modifications to pay for adaptations or alterations to a privately-owned vehicle that serves as the individual's primary means of transportation.

The tentative definition for this service is:

> Adaptations or alterations made to a vehicle that is the individual's primary means of transportation, when such modifications are necessary to improve the individual's independence and inclusion in the community. The vehicle may be owned by the individual, or a family member with whom the individual lives or has consistent and on-going contact.
>
> The service requires prior approval from BHDDH. The service may not be used to purchase a vehicle or for general repairs or maintenance. The service may not be used for vehicles owned or leased by a provider. Vehicle modifications are limited to $15,000 every five years.

Peer Supports and Family-to-Family Training

In response to feedback that many individuals have challenges navigating the service delivery system and identifying community resources, the rate study proposes the creation of two services that allow individuals with lived experience and training to mentor others.

The tentative definitions for these services are:

> Peer Supports provide individuals with a support system to develop and learn healthy living skills, to encourage independence and self-determination, to link individuals with the tools and

education needed to promote their health and wellness, and to teach the skills that are necessary to engage and communicate with providers and systems of care. Supports are provided by individuals with I/DD who have received training on serving as a peer.

Family-to-Family Training is training provided to the family member(s) of an individual by a primary caregiver(s) of someone with an intellectual or developmental disability. This service is intended to provide families with a system to develop and learn to link families with the tools and education needed to promote the health and wellness of the individual they care for, and to teach the skills that are necessary to engage and communicate with providers and systems of care.

These services are not intended to replace the informal relationships and sharing that regularly occurs between families. Instead, the services would be designed to assist individuals and families to achieve a specific goal. The development of these services will require collaboration between BHDDH, providers, families, individuals with I/DD, and advocates to establish requirements and identify individuals and families interested in providing these services.

Figure 5-17 lists the proposed rates based on 15-minute billing units.

Figure 5-17: Proposed Peer Supports and Family-to-Family Training Rates

Service	Jul. 1, 2022	Proposed Rate
Peer Supports	N/A (new)	$11.65
Family-to-Family Training	N/A (new)	$12.36

Professional Services

The rate study proposes to consolidate the currently separate service definitions and rates for Professional Services while at Day Program, Community-Based Supports by Professional Staff, and Natural Supports Training by Professional Staff into the existing Professional Services definition included in the Billing Policy Manual:

> Services and supports include, but are not limited to: psychologist, psychiatrist, physical therapist, occupational therapist, speech therapist, registered nurses, interpreters, licensed social workers, licensed mental health counselors (“LMHCs”), and licensed marriage and family therapists (“LMFTs”).

The rate study recommends the following changes to this definition:

- Adding licensed practical nurses and board certified assistant behavior analysts (BCaBAs) to the list of qualified providers.
- Clearly specifying billable activities. In addition to direct supports, staff are able to bill for certain ‘on-behalf of’ activities, including participating in planning meetings and assessments, training paid and unpaid caregivers on an individual’s service plan, and collateral contacts.

Additionally, key elements of the proposed rates include:

- *Differentiated rates based on staff qualification.* Recognizing that wage costs vary across different staff (for example, wages for psychiatrists are different than wages for licensed practical nurses), the rate study establishes separate rates for each qualified provider.
- *Differentiated rates based on service setting*. The rate study proposes higher rates for services delivered in the home and community in comparison to rates delivered in the office or clinic or through a telehealth model to account for travel-related costs and lower productivity when working with individuals in the community.

Figure 5-18 compares the current and proposed rates.

Figure 5-18: Proposed Professional Services Rates Compared to Current and Recent Rates*

Service	Sep. 30, 2019	Jul. 1, 2022	Proposed Rate	Change to Current	Change Since 2019
Psychiatrist, Community	$13.13	$13.13	$72.44	452%	452%
Psychiatrist, Office/ Telehealth	$13.13	$13.13	$60.90	364%	364%
Psychologist/ BCBA, Community	$13.13	$13.13	$24.36	86%	86%
Psych./ BCBA, Office/ Telehealth	$13.13	$13.13	$20.01	52%	52%
BCaBA, Community	$13.13	$13.13	$20.77	58%	58%
BcaBA, Office/ Telehealth	$13.13	$13.13	$16.77	28%	28%
Therapist, Community	$13.13	$13.13	$28.48	117%	117%
Therapist, Office/ Telehealth	$13.13	$13.13	$23.51	79%	79%
Registered Nurse, Community	$13.13	$13.13	$24.20	84%	84%
Registered Nurse, Office/ Telehealth	$13.13	$13.13	$19.88	51%	51%
Licensed Practical Nurse, Community	$13.13	$13.13	$20.75	58%	58%
Lic. Prac. Nurse, Office/ Telehealth	$13.13	$13.13	$16.76	28%	28%
Licensed Social Worker, Community	$13.13	$13.13	$24.20	84%	84%
Lic. Social Worker, Office/ Telehealth	$13.13	$13.13	$19.87	51%	51%
LMHC/ LMFT, Community	$13.13	$13.13	$19.54	49%	49%
LMHC/ LMFT, Office/ Telehealth	$13.13	$13.13	$15.91	21%	21%
Interpreter, Community	$13.13	$13.13	$16.73	27%	27%
Interpreter, Office/ Telehealth	$13.13	$13.13	$13.53	3%	3%

*Current rates reflect Professional Staff providing Community-Based Supports and Day Programs, the rates for Natural Supports Training provided by Professional Staff equate to $11.93 per 15 minutes

As the table demonstrates, the rates for Professional Services have not been adjusted in recent years. Partly as a result, the proposed rates represent significant increases compared to current rates for most practitioners and settings. Given that currents rates do not vary based on practitioner or setting, the largest increases apply to the most highly paid practitioners and to services delivered in the community.

Supports Brokerage and Financial Management Services

The Centers for Medicare and Medicaid Services broadly defines two types of supports for individuals who self-direct services:

- *Information and Assistance.* Broadly, this service assists an individual or their representative in understanding the responsibilities involved with directing their services, and in arranging, directing, and managing services. The service assists in identifying immediate and long-term needs, developing options to meet those needs, and accessing identified supports and services. The provider offers skills training such as providing information on recruiting and hiring personal care workers, managing workers, and providing information on effective communication and problem-solving.
- *Financial Management Services.* This service assists an individual or their representative with employer authority and/or budget authority. Employer authority includes verifying worker citizenship status, processing payroll, withholding employment taxes and making payments to appropriate taxing authorities, and distributing payroll checks. Budget authority includes performing fiscal accounting, tracking individuals' funds; and making expenditure reports to the individual and state authorities.

The Billing Policy Manual effectively combines both types of supports into a single definition for Support Facilitation. In practice, Support Facilitation providers are performing the financial management services function, but not the information and assistance function. Additionally, the current Supports Brokerage service definition includes some elements of the information and assistance function.

Because these are two separate functions requiring different skillsets that may be delivered by different providers, the rate study recommends more clearly distinguishing between these two separate services by changing the title of Support Facilitation to Financial Management Services (FMS) and removing elements of the service definition that relate more to information and assistance functions.

Financial Management Services would be tentatively defined as:

> Service and supports that assists the individual and/or their representative with the financial management of self-directed services. The fiscal intermediary is responsible for verifying employees' eligibility to work, processing payroll, withholding employment taxes and making payments to appropriate taxing authorities, distributing payroll checks, tracking and monitoring expenditures in comparison to individuals' budgets, and making expenditure reports to the individual and state authorities. All individuals who choose to self-direct services must have a fiscal intermediary.

Consistent with practices in the large majority of states, the rate study recommended a single monthly rate for Financial Management Services (which are currently titled Support Facilitation). According to research compiled by Applied Self-Direction, the rate currently paid by Rhode Island for most individuals would be the fifth-highest of 49 programs identified (several states have multiple programs).[37] The recommended rate represented a significant reduction compared to the current Support Facilitation rate billed in most instances. In response to public comments and recognizing that the implementation of

conflict-free case management will likely impact the expectations of FMS providers, this proposal was withdrawn so the current rates for fiscal intermediaries would be retained, as illustrated in Figure 5-19.

Figure 5-19: Proposed Financial Management Services (Support Facilitation) Rates Compared to Current and Recent Rates*

Service	Sep. 30, 2019	Oct. 1, 2019	Jul. 1, 2021	Jul. 1, 2022	Proposed Rate	Change to Current	Change Since 2019
Tiers A-B	$49.20	$49.20	$49.20	$49.20	$49.20	0%	0%
Tier C	$98.41	$98.41	$98.41	$98.41	$98.41	0%	0%
Tiers D-E	$197.88	$197.88	$197.88	$197.88	$197.88	0%	0%

As shown in the table, the rates for Financial Management Services have not changed in several years. The rate study recommends that payment rates be evaluated once the conflict-free case management requirements have been finalized.

Supports Brokerage services – which represent the information and assistance function – would be tentatively defined as:

> The service assists the individual or their representative in understanding the responsibilities involved with self-direction, and in arranging for, directing, and managing self-directed services. The support broker assists in identifying immediate and long-term needs, developing options to meet those needs, and accessing identified supports and services. The service broker may provide practical skills training related to recruiting and hiring direct care workers, managing workers, and effective communication and problem-solving. This service is optional for individuals who choose to self-direct services.

Since individuals will require different amounts of engagement with a Supports Brokerage, the rate study recommends maintaining 15-minute billing units. The comparison of proposed rates to current and recent rates are listed in Figure 20.

Figure 5-20: Proposed Supports Brokerage Rates Compared to Current and Recent Rates

Sep. 30, 2019	Oct. 1, 2019	Jul. 1, 2021	Jul. 1, 2022	Proposed Rate	Change to Current	Change Since 2019
$12.50	$12.50	$12.50	$12.50	$15.99	28%	28%

Section 6: Implementation Considerations

Building on the current service and rate framework, the rate study intends to reduce the administrative burden on BHDDH and service providers associated with implementing systems changes and to facilitate a timely implementation. Rate study recommendations have generally been designed for implementation to begin July 1, 2023. As discussed in Section 2, recommendations related to assessments and individual budgets have mostly been delayed due to the forthcoming changes to the SIS so implementation of any changes – which may require more significant updates to policies and procedures – likely will not occur prior to mid-2024. This section offers an overview of considerations for implementing the recommendations outlined in this report in several key areas.

Fiscal Impact Analysis

Implementation of the rate study recommendations depends on additional state investment in the program. Broadly, spending may increase based on recommendations related to:

- Increases in provider payment rates
- Changes to polices related to management of tier packages
- Addition of new services

Provider rate increases represent the largest component of the fiscal impact. Compared to the rates in effect as of July 1, 2022, the recommended rates would increase total payments by an estimated 22 percent when fully implemented. Based on fiscal year 2021 utilization levels, the additional cost is about $57 million annually on a total funds basis. Costs in future years will be based on overall forecasted utilization (that is, utilization estimates for future fiscal years should be increased by 22 percent to account for the effects of the rate study), which is beyond the scope of this rate study.

This estimate does not include the impact of any rates that are held harmless as a result of the federal American Rescue Plan Act (ARPA). Part of the federal government's response to the Covid-19 pandemic, ARPA included a provision that provided a temporary 10 percentage point increase in the federal matching rate for home and community-based services. States were required to use the state dollars that were freed-up when the federal contribution rate increased to enhance, expand, or strengthen HCBS. These dollars must be spent by March 31, 2025. Until the funds are expended, state cannot impose stricter eligibility requirements; reduce the amount, duration, or scope of services; or reduce payment rates below those in effect as of April 1, 2021 (except that temporary increases that were already to expire are permitted to end). Although the rate study provides significant increases overall, some rates would decline and such reductions cannot be implemented until the ARPA maintenance of effort period ends (March 31, 2025 or earlier if the state fully expends the HCBS funds prior to that date).

Although instances when a rate would decline without any related changes to billing requirements are easy to identify, changes involving changes to billing guidelines are harder to characterize. Given that CMS has not issued comprehensive guidance for all scenarios, these issues will require legal review and, likely discussion with CMS. Examples include:

- *Enhanced SLA.* There are not published rates for instances when the Shared Living provider delivers all of an individual's support (that is, the individual does not receive other paid services

such as day program or employment supports). However, BHDDH's practice has been to increase the standard SLA rate by the value of the Day Program component of an individual's tier package. The rate study proposes to establish formal rates for enhanced SLA. These rates may not be greater than the current combined standard SLA rate and Day Program budget amounts.

- *Implementation of tiered billing for Community-Based Supports and Center-Based Supports.* As described in Section 2, the rate study proposes to align payment for Community-Based Supports and Center-Based Supports with an individual's assigned tier rather than the staffing of their day program. This change reflects feedback from both individuals and providers; however, this will result in a lower payment in some instances. For example, if an individual assigned to Tier A receives center-based supports at a 1:3 ratio, the provider would bill the Tier D rate. Under the proposal, the provider would bill the Tier A rate, which is less than the current Tier D rate, regardless of ratio.
- *Replacement of Job Retention.* The rate study proposes to replace Job Retention with an outcome-based model wherein the provider is reimbursed based on the number of hours of support provided. Since this will require additional data collection, services would initially be reimbursed on a fee-for-service basis. Although the fee-for-service rate represents a significant increase compared to the current Job Coaching rate, total payments may be reduced in instances in which providers are delivering minimal supports. For example, it is possible that a provider delivers one hour of support to an individual assigned to Tier E. The Job Retention rate in this example would be $727 whereas the fee-for-service billing would be $72.
- *Changes to Non-Congregate Services.* Similar to Job Retention, the rate study proposes changes to Non-Congregate Residential services. Some programs will transition to Supportive Living where the comparison of rates is straightforward, but others will transition to hourly billing for Community-Based Supports. For providers delivering relatively few supports, the transition to hourly billing would reduce total payments.

If it is determined that any of these proposals would violate the ARPA maintenance of effort requirements, Rhode Island may consider suspending any changes to the rate for the service. For example, if the proposal around Job Retention and Job Coaching is determined to be in conflict, BHDDH may want to maintain current rates. The impact on the fiscal impact will depend on these decisions. The cost could be higher in the initial years until the maintenance of effort period ends if BHDDH simply holds-harmless any potential reductions. Or, the cost may be lower if certain proposals are suspended until after the end of the maintenance of effort period.

In comparison to the cost of the rate increases, the fiscal impact associated with changes to tier packages and the addition of new services is expected to be modest, particularly initially. For example, the rate study proposes to move employment supports outside of the tier packages, but the utilization of employment supports is so low (representing less than five percent of the spending for Day Program services despite having higher rates) that the cost will likely be small. Similarly, a review of other states' reported utilization of the services that the rate proposes to add finds limited use. Overall, it is expected that these changes will increase overall system costs by less than two percent initially. The impacts of these changes should be monitored to determine if costs increase over time.

Updating Regulations and Policies

As noted earlier, Rhode Island's 1115 waiver includes broad service definitions. A joint review of these definitions conducted by BHDDH and the Executive Office of Health and Human Services (EOHHS) concluded that new services recommended by the rate study could be delivered under the current terms and conditions, with one exception. Although the service is currently being delivered, there is not clear authorization for Financial Management Services so this support should be added to the waiver.

BHDDH's billing manual will require numerous changes to reflect the changes proposed by the rate study related to service definitions, billing rules, and billing limits. Service-by-service changes are summarized in Section 5 of this report.

Rhode Island may additionally consider adopting procedures to regularly review and update payment rates. This is particularly relevant because, as observed earlier, the payment rates first established as part of Project Sustainability did not undergo substantial adjustments for several years. Rate stagnation places a burden on providers, inhibiting investment in their workforces and the development of innovative programs.

HMA-Burns generally defines two approaches to updating payment rates.

- A ***rebase*** involves a comprehensive rate study, including reviewing service requirements and billing policies and collecting data from providers. Given the time and expense of a rebase, HMA-Burns recommends that, in the absence of significant systems changes, states undertake this process only every four or five years.
- Although annual rebases are not recommended, a ***refresh*** cannot be regularly undertaken to ensure the adequacy of payment rates. A refresh does not seek to update underlying payment structures or to collect new data from providers, but seeks to update cost assumptions in the rate models. As discussed in Section 4, the proposed rates are based on rate models with detailed assumptions. Many of these assumptions are derived from published cost data from a number of sources. When new data is released, the new values can be input into the rate models to update the overall rate. For example, the Internal Revenue Service generally publishes its standard business mileage rate in December for the following calendar year. Since the rate models rely on this value for vehicle-related expenses, the models can be updated with the new mileage rate when it is released.

There may be instances when targeted adjustments are required. For example, if a new administrative requirement is placed on providers, BHDDH may want to consider the cost impact. In these circumstances, BHDDH may request data from providers to demonstrate increased costs, such as hiring new positions or incurring new fees. In these scenarios, the data request should be limited to the additional costs. Otherwise, the rate study does not propose provider cost reporting. The rate model assumptions are not meant to be prescriptive so providers may choose to use funding differently than assumed in the models. Instead, monitoring should focus on compliance with service requirements and individuals' service plans.

Increases to provider payment rates will generally require new funding and will therefore be part of the overall state budget process. As a result, very few states automatically update payment rates for home

and community-based services for individuals with intellectual and developmental disabilities. However, even if the rates are not increased, updating the rate models to reflect current costs is a best practice to ensure a transparent accounting of the difference between the rate model values and the rates actually being paid.

System Requirements

The rate study recommendations will likely require some updates to information technology systems such as claim edits. Many of these changes will be related to changes to billing policies that also impact the billing manual and that are outlined in Section 5. Examples include:

- Implementing 344-day billing limits for residential services
- Accommodating customized rates for Group Homes and Companion Room and Board
- Limiting billing for Community-Based Supports and Center-Based Supports to the tier to which an individual is assigned
- Establishing billing codes for new services as well as new codes or modifiers for services with more variants (such as Professional Services).
- Developing a mechanism to track both hours that an individual works and hours of direct support provided for individuals receiving Job Coaching services

In addition to the rate-related changes, the recommendations for tier packages outlined in Section 2 may require changes to systems processes.

End Notes

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