NOW and COMP Waiver Rate Study

Public Comments and Responses

– PREPARED FOR –

Georgia Department of Behavioral Health and Developmental Disabilities

– PREPARED BY –

Burns & Associates

A Division of Health Management Associates

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PROJECT BACKGROUND

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) is in the process of reviewing payment rates and policies for services provided through the New Options Waiver and the Comprehensive Waiver. Burns & Associates, a division of Health Management Associates (HMA-Burns), was contracted to assist with the rate study.

The rate review encompassed several tasks, including:

- A thorough review of service requirements and payment policies for all covered services
- Meetings with DBHDD personnel to identify rate study goals
- Meetings with a rate study advisory group that included service providers, family members who help self-direct services, and system advocates
- Development and administration of a provider survey that was emailed to all providers to collect information regarding service designs and costs
- Identification of other data sources to inform the development of the rate models, including cross-industry wage and benefit standards and rates paid for comparable services in other Georgia Medicaid programs and in other states
- Analyses of claims data as well as related data such as assessment data used to assign individuals to a rate tier

Based on this work, detailed rate models were developed. These rate models include the specific assumptions regarding the costs that providers incur in the delivery of each service, such as direct support workers' wages, benefits, and billable time; staffing ratios; travel; and agency overhead.

The proposed rate models were presented to providers on December 12, 2022, and a webinar explaining the proposals was recorded and published. DBHDD issued a special bulletin announcing the release of the draft recommendations and worked with system partners to help inform interested stakeholders. This began the public comment period, which lasted through January 20, 2023 (although any comments submitted after the deadline were also accepted). During the comment period, DBHDD and HMA-Burns met with a number of groups, including providers, participant-direction groups, and other advocates, to explain the recommendations and solicit feedback.

Interested stakeholders were asked to submit written comments. In total, comments were received from approximately 385 providers, provider organizations, participants and their family members, and system advocates. DBHDD and HMA-Burns reviewed all comments. This document summarizes those comments and responds to each.

Several changes to the proposed rates and related policies have been made in response to these comments, including:

- All wage assumptions tied to a median wage value from Bureau of Labor Statistics data were increased by ten percent.
- A productivity factor for recordkeeping was added to the rate model for Respite billed in 15-minute increments.
- The 344-day billing limit for Group Home and Host Home services will be reset when an individual changes providers during their plan year.

- The proposal to increase the minimum payment that Host Home agencies must make to their subcontracted homes from 60 percent to 65 percent was withdrawn and the requirement will remain at 60 percent.
- The existing daily and monthly limits for the combination of Community Access-Group and Prevocational Services would be eliminated. No changes have been made to the initial recommendation to increase the annual limit from 1,440 hours to 1,500.
- The proposed rate models for facility-based Community Access-Group services have been withdrawn. These services would continue to be reimbursed at the current permanently authorized rate. The rate study continues to recommend implementation of the higher tiered rates for community-based supports.
- The program support assumption in the Community Access-Group rate models for community-based services was increased from $10.00 per individual per day to $12.50.
- The mileage assumption in the Community Access-Group rate models for community-based services was increased from 200 miles per week per group to 250 miles.
- The proposed rate models for Prevocational Services have been withdrawn. Services would continue to be reimbursed at the current permanently authorized rate.
- The proposed interim reimbursement structure for job maintenance services has been withdrawn. DBHDD will work with providers to develop the envisioned long-term model with a goal of implementation in 2025.
- The existing narrow service codes for Adult Therapies would be consolidated into fewer, broader codes that cover more activities within therapists’ scopes of practice; the rate would be standardized at the current highest 15-minute rate of $30.23.
- The lifetime limit on Assistive Technology would be eliminated.
- The proposed wage caps for workers employed through a participant-direction model have been modified to be equal to the full agency rates (less the cost of mandatory payroll taxes) and to exclude certain qualified staff and vendors from the wage caps.
- The proposal to eliminate the personal assistance retainer for both agency-provided and participant-directed Community Living Services has been withdrawn.

The remainder of this document provides DBHDD’s response to each specific comment.

MULTIPLE SERVICES/ GENERAL

1. ***Several commenters expressed support for the proposed rate increases. Other commenters expressed support for lifting lifetime limits on vehicle and environmental modifications.***

   DBHDD appreciates the support for many of the proposed rate models. Overall, the rates represent an increase of nearly 45 percent compared to current, non-temporary rates and the cost to implement the rates would be substantial – a net increase of $315 million compared to fiscal year 2021 expenditures, with $107 million coming from State funds. DBHDD believes that these rates are necessary to address existing workforce challenges and to invest in the necessary infrastructure to support high-quality services.

2. ***Several commenters stated that the rate study should incorporate automatic cost of living adjustments.***

   By detailing individual cost components and data sources, the rate models are structured to accommodate future changes to select assumptions without the need for a full rate study. For example, the rate models use the Internal Revenue Service's standard mileage rate to reflect vehicle-related costs. Since the IRS generally publishes the mileage rate once per year, the rate model could be adjusted when the new amount is released. However, DBHDD's ability to increase rates will be dependent on additional appropriations through the state budget process.

3. ***Several commenters stated that the rate study did not factor in regional cost variations or cost of living differences in different parts of the state.***

   Consistent with current NOW and Comp rates as well as those in other waiver programs in Georgia, the rate study did not establish regionally differentiated rates. Potential cost differences were considered, however. For example, wages are generally higher in the Atlanta area than in other regions of the state, but because Atlanta is the single largest employment base by a large measure, average statewide wages are close to the Atlanta figures. Thus, if regional rates were established, rates in Atlanta would be marginally higher than those proposed by the rate study, but rates for other regions would be substantially lower. Conversely, it is likely that travel-related costs are greater in rural parts of the state. Given these offsetting factors, rates that apply statewide continue to be reasonable.

4. ***One commenter stated that individuals who are capable of living in their own home with supports cannot afford to do so due to the lack of housing assistance.***

   It is understood that many individuals struggle to access housing without assistance. However federal law prevents using Medicaid funds for housing-related expenses and the rate study therefore did not consider these issues.

Rate Study Process

5. ***One commenter expressed appreciation for the rate study process, including efforts to communicate with providers, service recipients, and family members. One commenter noted the need for a transparent and comprehensive implementation plan developed in collaboration with stakeholders.***

   DBHDD appreciates the support for the rate study process. Key elements of the rate study include:

   - Establishment of a rate study advisory group that was convened several times during the rate study to provide feedback.
   - A detailed review of service requirements.
   - The development and administration of a provider cost survey to collect information related to current service delivery models and providers' costs.
   - Identification of benchmark data to inform individual cost components (such as staff wage assumptions) and to serve as a point of comparison for overall rates.
   - Development of detailed and transparent rate models that outline the assumptions made for individual cost drivers to establish the total rates.

- Facilitation of a public comment process to solicit feedback on the draft rate models. During the comment period, DBHDD held several meetings with individuals and families who self-direct services, providers, and other groups.

Should the rate models be approved, DBHDD intends to continue involving stakeholders throughout the next stages of rate model implementation.

6. ***One commenter objected to the use of provider survey data since fewer than half of all providers participated in the survey.***

A key element of the rate study was the development and administration of a survey to collect information regarding providers' program designs and costs. Participation in the survey was voluntary and 61 of 400 providers submitted a survey. Although only 15 percent of all providers, these respondents accounted for 40 percent of total waiver payments.

Although the rate study considered survey results when developing rate models, most key assumptions rely on other independent sources of information so that the rates reflect market-based costs. In these cases, the survey data served as a reference point. For example, wage assumptions for direct care staff considered Georgia-specific data from the Bureau of Labor Statistics while health insurance cost assumptions relied on Georgia-specific data from the U.S. Department of Health and Human Services' Medical Expenditure Panel Survey. In both of these examples, the independent data sources result in higher cost assumptions than reported through the provider survey.

7. ***Several commenters stated that individuals and families that self-direct services were not engaged as part of the rate study.***

The rate study endeavored to incorporate input from individuals and families who self-direct services at key points during the project. The rate study advisory group noted in the response to comment 5 included family representatives. Further, once draft recommendations were released for comment, DBHDD worked with various advocacy groups to help inform individuals and families of the recommendations and the process to submit comments. DBHDD and HMA-Burns also hosted a webinar specifically for those who self-direct services during the public comment period. Additionally, before any recommendations are formally adopted, the Department of Community Health will conduct a public hearing during which all stakeholders are invited to offer comments.

8. ***Several commenters expressed objections to the public comment process. A number of these commenters stated that the process should have included opportunities for comments to be submitted other than in writing. Other commenters stated they did not have enough time to submit comments.***

As highlighted in the response to comment 5, the rate study included a public comment process to offer an opportunity for stakeholders to offer feedback regarding the draft recommendations. This comment period is not required by federal or state regulations, but was included to ensure that final recommendations included consideration of stakeholder feedback. As noted in the response to comment 7, before any recommendations are formally adopted, the Department of Community Health will conduct a public hearing during which all stakeholders are invited to offer comments.

The draft recommendations were published on December 12, 2022 and stakeholders were asked to submit their comments by January 13, 2023. In response to stakeholder requests, the comment period was extended to January 20, 2023, allowing nearly six weeks for stakeholders to participate in the public comment process. Additionally, late submissions were still accepted, reviewed, and addressed within this document.

DBHDD and HMA-Burns participated in a number of presentations during the comment period to explain the recommendations and accept feedback, including:

- December 7: Rate Study Advisory Group
- January 3: Service Providers Associations for Developmental Disabilities (SPADD)
- January 5: Developmental Disabilities Advisory Council
- January 5: Participant-Direction Advisory Group
- January 5: Supported Employment providers
- January 6: All providers
- January 10: Georgia Council on Developmental Disabilities

Stakeholders were asked to submit comments in writing to ensure an accurate accounting of all feedback, but input offered during the various presentations held during the comment period were also considered. Overall, nearly 400 comments were received with approximately 220 comments from individuals who receive services and family members, 157 comments from providers and staff, and 10 comments from provider associations and advocacy organizations.

Direct Support Staff Wages, Benefits, and Productivity

9. One commenter suggested that Georgia make permanent a temporary flexibility authorized under Appendix K to allow family members to be paid to care for their loved ones.

As part of its response to the Covid-19 pandemic, DBHDD requested and received authorization to allow agency providers to hire family caregivers or legally responsible individuals to provide certain services. That flexibility will cease with the end of the Appendix K authority under which it is authorized (in November 2023). Consideration of this issue is outside of the scope of the rate study.

10. Several commenters stated that the direct support professional wage assumptions were too low. Some commenters objected to the Bureau of Labor Statistics' occupational classifications used to benchmark DSP wage assumptions. One commenter asked whether the BLS wage data represented wages pre or post-pandemic, noting there has been a dramatic increase in wages following the pandemic Alternatively, some commenters suggested using a higher benchmark than the 50th percentile wages. DSP wage assumptions suggested by the commenters ranged from $18.00 to nearly $40.00 per hour.

As observed by the commenters, the rate model wage assumptions are based on Georgia-specific data from the Bureau of Labor Statistics (BLS).

The BLS reports wage data for more than 800 occupations. For many services, there is a direct relationship between the qualifications for staff delivering direct care and one of the BLS' occupational classifications. For example, there is a BLS classification for first-line supervisors of personal service workers, which the rate study uses for the direct support professional (DSP) supervisor position in a number of rate models. For several other services, the rate study uses a weighted average of multiple BLS classifications.

The BLS classifies DSPs as home health and personal care aides. However, using that occupation alone may not fully account for the varied responsibilities of DSPs and will produce low wage assumptions because DSPs and other staff in the home health and personal care aides classification

tend to earn relatively low wages. The rate study therefore creates a composite of multiple BLS classifications to establish wage assumptions for DSPs. Since DSPs are categorized as home health and personal care aides in the BLS data and the description of the occupation describes many of the responsibilities of DSPs, the heaviest weighting – 50 percent – is applied to this occupation. Additionally, the rate study applies a 20 percent weight for social and human service assistants and a 10 percent weight to three other BLS classifications: community health workers (to reflect supports associated with helping individuals adopt healthy behaviors), psychiatric aides (to reflect assistance in managing behaviors), and recreation workers (to reflect assistance in accessing the community).

The BLS reports wage values at several different levels (the 10th percentile, 25th percentile, 50th percentile, 75th percentile, and 90th percentile). In general, the rate study relies on the median (50th percentile) reported wages to reflect a reasonable market-based estimate since these are the wages at which half of staff are expected to earn more and half are expected to earn less.

Since the BLS' most recent available data reflects May 2021, the rate study applied an inflationary factor to develop wage estimates for January 2024 (the midpoint of the first full fiscal year during which the rate recommendations could potentially be implemented). 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 October 2022, net earnings in Georgia increased 9.1 percent between 2020 and 2021 while the ten-year compound annual growth rate was 4.7 percent. The rate study increased BLS wage estimates by 9.1 percent for twelve months and then applied an annual growth rate of 4.7 percent for 20 months – a total of 17.78 percent over 32 months – to project wages for January 2024.

For DSPs, this methodology produces a composite wage of $15.18 per hour, which is about 7 - 15 percent higher than the DSP wages reported in the provider survey and consistent with a review of current DSP job postings in Georgia that found advertised wages of $14 to $15 per hour.

However, recognizing ongoing challenges with staff recruitment and retention and the importance of staff on the quality of services, the rate study has added a ten percent increase on all wage assumptions that are based on the BLS median wage assumptions, including DSPs, standard support coordinators, and job coaches.

For DSPs, the result is a wage assumption of $16.70 per hour. To ensure that a significant share of the rate increases benefit DSPs through higher wages, the rate study also recommends that a wage floor be established. For any service with a rate model based on the $16.70 wage, providers would be required to pay at least $14.00 per hour (excluding Community Access-Group since the rates for facility-based services are not changing). The floor is less than the wage assumption to support providers' ability to offer a career ladder (that is, starting DSPs at a wage less than assumed in the rate model while paying more experience staff a higher wage than assumed).

11. ***One commenter expressed appreciation for the proposal to implement rates for individuals who are deaf or hard of hearing, but stated that the proposed rates are not sufficient to hire DSPs who can communicate with participants who are deaf or hard of hearing.***

DBHDD appreciates the support for the development of rates to better accommodate participants who are deaf or hard of hearing. Higher rates to support those who are deaf or hard of hearing were established for Community Living Service, Respite, Community Residential Alternative-Group Home, Supported Employment-Individual, Supported Employment-Group, Community Access (group and individual), and Prevocational services.

The rate models for supports for individuals who are deaf or hard of hearing include a wage premium of $3.00 per hour over the standard direct support professional (DSP) wage to account for the added skill needed for DSPs who are proficient in American Sign Language (ASL). This funding enhancement was based on research of premiums included in other states' rates as well as job postings across the country for DSPs who can communicate ASL.

DBHDD is continuing to develop guidelines for these rates, but DSPs will not need to be certified in ASL, but will need to be conversant.

12. ***One commenter stated that the rate study failed to include actual benefit costs.***

The benefit cost assumptions are detailed in Appendix B of the rate model packet. In general, these assumptions exceed the costs reported by providers participating in the provider survey. In particular, the benefit cost assumptions include:

- 7.65 percent of wages for Social Security and Medicare payroll taxes
- 0.60 percent of the first $7,000 in wages for federal unemployment insurance and 2.70 percent in wages on the first $9,500 in wages for state unemployment insurance
- 3.59 percent of wages for workers' compensation (compared to 1.42 percent reported in the provider survey)
- 25 days of paid leave, including holidays, vacation, and sick leave (compared to 16 days reported in the provider survey)
- $582.58 per month for employer-paid health insurance (compared to $376 reported in the survey)
- $100 per month for other benefits such as dental insurance, retirement contributions, etc. (compared to $128 reported in the survey)

The provider survey figures noted above are for full-time staff; benefits levels for part-time staff – who represent one-third of the reported workforce – are substantially less. The rate study, however, assumes that all staff work full-time and does not discount costs for part-time staff.

The benefit cost assumptions are translated to a benefit rate as a percentage of wages, which is reflected in the rate models. Since some benefit cost assumptions are fixed (for example, the health insurance cost is the same for all staff), there is an inverse relationship between the wage and the benefit rate (that is, the higher the wage, the lower the benefit rate as a percentage of those wages).

13. ***One commenter stated that the health insurance premium cost assumptions in the rate models do not cover recent cost increases.***

The health insurance assumptions were derived from Georgia-specific data for private sector employers published as part of the U.S. Department of Health and Human Services' Medical Expenditure Panel Survey (MEPS). This information is from 2021 so the reported costs for the employer share of premium were increased to account for cost growth. For example, the employer's share of cost for an employee-only plan was increased from the reported $466 per month to $525, an increase of 13 percent. The cost assumptions for employee-plus-one and family plans were similarly increased.

Overall, the rate models include about $583 per employee per month for health insurance, which is the weighted average of nonparticipating staff and the assumed mix of plan types for participating employees. In comparison, the weighted average cost reported in the provider survey for full-time

staff was $376 per employee per month. Further, participants in the survey reported that one-third of the workforce works part-time with a cost of only $34 per employee per month (since so few part-time workers have access to or participate in employer-sponsored health insurance). When considering the overall workforce, the rate models provide a substantial premium over reported current costs.

14. ***Several commenters stated that the benefit assumptions are not sufficient for Community Service Boards, noting that CSBs pay 29.454 percent of payroll for health insurance costs regardless of whether an employee participates and that CSBs provide a minimum of 30 days of paid leave.***

Community Service Boards (CSBs) participate in the State Health Benefit Plan (SHBP) and are required to pay 29.454 percent of total wage expenses regardless of whether a given employee participates in the plan. As observed by the commenter, the health insurance cost assumptions in the rate models translate to less than the CSBs are required to pay. If the health insurance cost assumption in the rate models was set at 29.454 percent of wages, the rates for services provided by direct support professionals would be around 6.5 percent higher than the recommended rates.

However, DBHDD makes separate contractual payments to the CSBs to account for SHBP requirements and other costs. An analysis of these payments suggest that they exceed the additional costs of benefits compared to the assumptions in the rate models. DBHDD may decide in the future to establish separate payment rates for CSBs (and to reduced or eliminate the contract payments), but at this time, the contracts will be maintained, eliminating the need for higher waiver rates.

There is no similar requirement that CSBs offer a minimum of 30 days of paid leave.

15. ***One commenter asked why the rate models include different driving speed assumptions, stating for example, that the Community Access-Individual rate assumes that staff are driving 50 miles per hour.***

The commenter is comparing the mileage assumption in the rate models to the productivity assumption for travel between participants. However, for a number of services, the mileage assumption includes both travel between members and miles associated with transporting members. Since providers can bill when transporting members as part of the program, this time is not included as a productivity adjustment. For Community Access-Individual, for example, the mileage assumption covers both the non-billable time driving between service encounters (which is addressed through a productivity factor) and billable time transporting members. The productivity factor only covers the non-billable time and thus cannot be compared to the total number of miles. The rate models do not assume that staff drive an average of 50 miles per hour.

16. ***Several commenters stated that the rate study did not adequately incorporate funding for developmental disability professionals (DDPs).***

The cost of developmental disability professionals (DDPs) is incorporated in the administration and program support allowances. The rate study includes higher funding levels for both factors than the costs reported through the provider survey. Since those reported expenses included costs associated with DDPs, the assumptions remain reasonable.

Program support is generally funded at $10 per day, which, when combined with the separate supervisor-related factor in the rate models, equates to about 15.0 percent of providers' costs. In comparison, the weighted average program support rate reported through the provider survey was 11.5 percent.

The rate models also include 10 percent of the total rate for administration. Given the overall proposed rate increases, this allowance translates to about 14.5 percent of current expenses compared to the 12.5 percent weighted average administrative cost rate reported through the provider survey.

17. ***Several commenters stated that the administrative rate should be increased to 12.7 percent to align with the average reported through the provider survey. One commenter recommended an administrative rate of 15 percent.***

    As with the 2015 rate study, the rate models include 10 percent of the total rate for administrative costs. While the administrative *rate* is less than the 12.5 percent rate reported through the provider survey (when excluding respondents that reported an administrative rate greater than 50 percent), the administrative *funding* is greater because the rate is applied to a higher cost base. Specifically, since rates are increasing by about 45 percent overall, the 10 percent allowance translates to 14.5 percent of current costs, a significant increase compared to the 12.5 percent that was reported through the provider survey.

SUPPORT COORDINATION

18. ***Several commenters stated that the rate for standard Support Coordination should be no lower than $230 per month based on rates in neighboring states as well as a 2019 rate study in Georgia that recommended a rate of $268 per month. One commenter objected to increasing Support Coordination rates, stating that they have found limited value in working with a support coordinator.***

    After increasing the wage assumption in the standard Support Coordination rate model as discussed in the response to comment 10, the overall rate increases to $209.97 per member per month. This is an increase of 37 percent compared to the rate in effect prior to the increases authorized through Appendix K authorities and 28 percent compared to the current permanent rate.

    To review the reasonableness of these rates, HMA-Burns considered the rates paid by states that cover support coordination as a service in their 1915(c) waiver programs for individuals with intellectual and developmental disabilities. This review found that the recommended rates are in the middle of the rates paid by other states. Of 19 identified states, the recommended rate for standard Support Coordination would rank a few spots below the median, 12th out of 19 states. However, after accounting for Intensive Support Coordination (since few states pay higher rates for individuals receiving more intensive supports), the average rate paid to support coordination agencies would be about $259 per member per month, which is slightly above the median at 9th out of the 19 states.

    The rate study does not believe that the 2019 study referenced by the commenter is a reasonable benchmark. In particular, those rates were based on unreasonably low caseload assumptions (21 cases per case manager for standard Support Coordination and 12 cases for Intensive Support Coordination). If the rate models were set based on caseload assumptions that low, it is likely that the standards would be revised to require lower caseloads, requiring providers to hire many more support coordinators.

19. ***Several commenters objected to the wage assumptions for support coordinators. These commenters suggested that different Bureau of Labor Statistics occupational classifications should be used as the benchmark for support coordinator wages or that the 75th percentile wage level should be used rather than the 50th percentile.***

    As discussed in the response to comment 10, the rate model wage assumptions are based on Georgia-specific wage data published by the Bureau of Labor Statistics (BLS). This approach requires an assumption regarding the best fitting BLS occupational classification(s) to represent the staff providing a given service. To make this determination, the rate study considers the BLS' description for each occupational classification as well as the typical educational and experience requirements for each.

    For standard Support Coordination, the rate study used the BLS' child classification child, family, and school social workers. The high-level description focuses on children, but many of the typical tasks are aligned with Support Coordination such as assessing situations and capabilities, developing service plans, assessing service quality, making referrals to community resources, and maintaining case histories. Further, the typical job requirements are consistent with Support Coordination standards.

    Commenters suggested the BLS' classification for healthcare social worker as an alternative. Although many elements of the service description and tasks are consistent with Support Coordination functions, but these social workers typically have a master's degree and an internship or residency, which are not requirements for Support Coordination. Another suggestion was the all other social workers classification (that is, social workers who are not classified in one of the other categories). The BLS does not have a meaningful description for this classification (as it is defined by what it is not), but the median wage for this occupation is more than $80,000, which is not typical of support coordinators.

    As discussed in the response to comment 10, in response to public comments, all wage assumptions based on BLS median wage values (after adjusting for inflation) have been increased by 10 percent. The result is an assumed wage of $24.75 per hour, or about $51,500 annually. This assumption is 29 percent higher than wages reported by providers participating in the provider survey.

20. ***One commenter stated that the rate models assume support coordinators have only standard or intensive cases, but many support coordinators carry a mixed caseload and that DBHDD's policies specify a maximum mixed caseload of 20 when at least 10 of the cases are intensive.***

    Rather than creating a single, blended rate, there are separate models for Standard and Intensive Support Coordination to ensure appropriate reimbursement based on differing service requirements. As noted by the commenter, the rate models reflect scenarios in which a support coordinator has a uniform caseload. In particular, the rate models reflect the maximum allowable caseload with a ten percent reduction (resulting in caseload assumptions of 36 cases for standard Support Coordination and 18 for Intensive Support Coordination) to allow for agency flexibility.

    However, the rate study acknowledges that in practice many support coordinators will have a mixed caseload. This rate modeling approach is consistent with other models in this this rate study. For example, the Group Home rate models reflect staffing levels as if everyone in the home is assigned to the same rate category although most homes will have residents with a range of needs. Like the Group Home rates, the result is that an agency will be billing different rates for individuals served by a given support coordinator reflecting the assumed greater amount of support for those receiving Intensive Support Coordination. The resulting size of the caseload for a given support coordinator and the average payment per case for that support coordinator will reflect the mix of individuals served.

21. ***One commenter stated that supervisors oversee 13-15 support coordinators and that clinical supervisors oversee five intensive support coordinators. The commenter also listed a number of other program support positions that are necessary for quality services.***

    The rate model assumptions related to supervision are consistent with the figures cited by the commenter. Specifically, the rate model for standard support coordination funds one supervisor for every 10 support coordinators (compared to the ratio of one supervisor for 13 to 15 support coordinators noted in the comment) and one clinical supervisor for every 100 cases (which translates to one supervisor for every five or six intensive support coordinators, compared to one clinical supervisor for every five support coordinators noted in the comment).

    The rate study acknowledges the importance of various other positions. As with the rate models for other services, these support and administrative staff are intended to be captured in the program support and administrative cost components of the Support Coordination rate models.

COMMUNITY LIVING SERVICES

22. ***One commenter stated that there should be tiered rates for Community Living Services because some participants require more training and oversight.***

    In general, there are 'tiered' rates for group services to reflect the more intensive staffing required for members with more significant needs. That is, individuals with greater needs should be served in smaller groups. Because requirements do not otherwise vary based on an individual's level of need (for example, there are not higher standards for staff providing support to individuals with greater needs), the rate model assumptions for services with tiered rates do not otherwise differ. Since individuals generally receive one-to-one Community Living Support regardless of their level of need, there are not tiered rates for this service (though there are group rates for individuals who share services). Individuals who require more support receive more hours of support, but the per-hour rates are the same.

23. ***Two commenters stated there should be a one-to-four rate Community Living Service rate to accommodate individuals in a shared living environment.***

    Community Living Services are primarily delivered on a one-to-one basis. There are currently rates for one-to-two and one-to-three services to account for instances in which individual may share supports (for example, siblings or two individuals who have chosen to share an apartment). The service is not intended to reflect more congregate programs implied by a one-to-four ratio. As a result, a one-to-four rate has not been established.

24. ***One commenter stated that the rate model should be increased to accommodate additional costs associated with electronic visit verification.***

    As discussed in the response to comment 16, the rate models include an administrative cost factor of ten percent of total costs. In dollar terms, this assumption is greater than the amounts reported by respondents in the provider survey. For Community Living Services in particular, the rate model assumes approximately 50 percent more administrative funding than the rate model established in 2015. DBHDD believes that this is adequate to cover costs associated with electronic visit verification.

RESPITE

25. *One commenter stated that the 15-minute Respite rate model should include a productivity adjustment for recordkeeping and reporting.*

There were only a few providers that reported information in the provider survey related to the productivity of Respite workers, but none of these reported time spent on recordkeeping responsibilities. The proposed rate model therefore assumed that recordkeeping could be completed during the course of service delivery. In response to this comment, however, a productivity adjustment for recordkeeping time – a half-hour per week, the same amount included in the extended rate model for Community Living Support – has been added to the Respite rate model.

COMMUNITY RESIDENTIAL ALTERNATIVE

26. *Several commenters objected to the 344-day billing limit, arguing that providers are unpaid for up to 21 days per year. Commenters also stated that the billing limit results in losses when an individual changes providers during their plan year, but has already used much of their 344 billing days.*

When an individual is away from their home for a short period (to spend time with their natural family, due to hospitalization, or for any other reason), most of the providers' costs do not change. Staffing is shared across residents so there is often little ability to reduce staff hours. To some extent, agency administration and program support costs are similarly fixed. Thus, if there is no absence factor built into the rate model, providers lose money that they can never recoup every day that an individual is absent and they cannot bill. Additionally, providing for an absence factor removes a financial incentive for providers to discourage members from participating in activities that may result in an absence (for example, spending a weekend with their natural family) because the provider does not wish to lose any billing days.

The rates for Group Home and Host Home services are calculated based on a 344-day billing year to protect providers against lost revenue due to members' occasional absences. Specifically, the rate models for these services estimate the annual cost of providing services and divide this total by 344 days rather than 365. This produces a rate that is 6.1 percent higher than a rate based on a 365-day billing year. The result is that providers are fully compensated for a full year (365 days) of care once they have billed 344 days. Providers are therefore limited to billing 344 days even if an individual is in the home every day.

The 344-day assumption was intentionally chosen to exceed the typical number of absences that an individual has in order to minimize the number of individuals for whom a provider does not receive the maximum amount of funding. Group Home providers participating in the provider survey reported an average of 11 days absent from the program while Host Home providers reported an average of 7 days absent from the program.

Although infrequent, commenters are correct that current policies do not include any provision for instances when an individual changes providers during their plan year. If an individual switches providers late in their plan year and the first provider has already billed most of the 344-day limit, the second provider will be limited in their billing for the duration of the plan year. To address this issue, DBHDD intends to update policies so that the billing limit is reset when an individual changes providers during their plan year (this will only apply to a change in providers not a change from one home to another managed by the same provider).

With this change, it is impossible for a provider to be worse off under the 344-day billing rate than with a rate based on a 365-day billing year. For an individual in the home for 365 days, a provider's revenue would be the same under either approach, but for any individual with one or more absences, a provider's revenue will be higher with the 344-day billing rates.

Group Homes

27. ***Several commenters objected to the Group Home staffing assumptions that assume that individuals participate in activities outside of the group home, stating that this will force individuals to participate in activities or will require providers to absorb the cost of unfunded hours.***

    As noted by the commenters, the Group Home rate models do assume individuals participate in activities outside of the home, reducing the need for residential staff during these times. However, the models also include 'floating staff', which are intended to recognize that staffing needs will vary by home. For example, if a home has one or more residents who do not leave the home during the day, the floating hours can be used to staff a shift to provide coverage during these times. Overall, the staffing assumptions are not meant to be prescriptive and providers are expected to staff their homes based on the needs of the residents.

    Overall, the Group Home rate models fund enough staff hours to provide 24-hour coverage in every circumstance except a three-person home where all residents have been assessed to have low support needs. The staffing levels included in the rate models are somewhat greater than reported by participants in the provider survey.

    Finally, if a provider requires more staffing to operate a home than funded in the rate models, they may request Additional Staffing Services.

28. ***One commenter indicated it was their understanding that the State's settlement agreement with the U.S. Department of Justice stipulated that only homes with four or fewer residents would be allowed, and asked why a rate was being published for five-bed homes.***

    New group homes must have a licensed capacity of four or fewer residents. However, homes with five or more residents before this restriction took effect were grandfathered, although they cannot accept new placements. In fiscal year 2021, fewer than two percent of individuals in group homes resided in a home with five or more residents. The rate study did not recommend any changes to the rate for these larger homes.

Host Homes

29. ***Several commenters objected to the proposed increase in the minimum payment to the Host Home provider from 60 percent to 65 percent of the total rate.***

    As noted by the commenters, the rate study recommended increasing the amount of the total rate that agencies must pass through to their subcontracted home providers from 60 percent to 65 percent of the total rate. This recommendation sought to more closely align the requirement with the rate models – which assume that 72 percent or 75 percent of the total rate is associated with the home payment – while maintaining flexibility for agencies (since the requirement would still be less than the amount funded in the rate models). Nevertheless, in response to these comments, the recommendation was withdrawn and the 60 percent requirement will remain in place. Agencies remain able to pay their subcontracted homes higher amounts as assumed and funded in the rate models.

30. ***One commenter stated that the Host Home rate models should account for nursing expenses.***

    As with individuals living in other settings, individuals in host homes who require direct nursing services or nursing oversight may be authorized to receive Nursing Services. As with other rate models, indirect costs – such as a registered nurse who provides general medical training to staff or develops clinical care guidelines – are included in the administrative and program support components of the Host Home rate models.

ADDITIONAL STAFFING SERVICES

31. ***Several commenters objected to the lower administrative and program support rates included in the Additional Staffing rate models, stating the service requires a greater degree of training, oversight, and management to serve individuals with higher levels of need.***

    As noted by the commenters, the administration and program support assumptions in the rate models for Additional Staffing Services equal one-half of the assumptions for other services. That is, the rate model includes $5 per day for program support (which is in addition to first-line supervision that is funded at the same level as other services) and five percent for administration. This approach maintains the approach in the rate model established as part of the previous rate study in 2015.

    The rate models for Additional Staffing Services include lower program support and administration funding levels because the service is only intended to add staff hours to an existing program. Further, the service is used most frequently by individuals with significant needs who would be receiving the highest Group Home and CAG rates, which already include the greatest amount of administrative funding.

COMMUNITY ACCESS-INDIVIDUAL

32. ***One commenter stated that the increase in the Community Access-Individual rate is inadequate.***

    The commenter did not offer any specific feedback on the rate model assumptions so it is unclear what aspect of the model they believe is inadequate. After increasing the assumed wage for direct support professionals as discussed in the response to comment 10, the recommended rate for Community Access-Individual services provides for a 32 percent increase compared to the current permanent rate.

COMMUNITY ACCESS-GROUP

33. ***Several commenters objected to any reductions in Community Access-Group (CAG) rates, noting that rates have seen few changes over the past ten years. Several commenters suggested that overall CAG payments would decrease because 90 percent of individuals would be assigned to Categories 1 and 2, which would experience rate reductions. One commenter asked whether the reduced rates would be implemented after the American Rescue Plan Act maintenance of effort restrictions expire.***

    There is currently a single rate for Community Access-Group services. As the commenters note, the current permanent rate of $3.33 per individual per 15 minutes is only about 10 percent higher than the rate in effect almost 15 years ago. Recognizing that delivering services in the community generally requires more intensive staffing to manage in less-controlled environments, the rate study recommended the establishment of separate rates for center-based and community-based services.

Additionally, because individuals have a range of needs and those with more significant needs generally require more intensive staffing, the rate study also recommended the establishment of tiered rates with higher rates for those with more significant needs.

In total, the rate study recommended eight separate rates based on four rate categories and two service settings. Of those eight rates, three would have been less than the current permanently funded rate while five of the rates would have been higher. Some of the rates would have been reduced despite the minimal increases in recent years because Georgia's waiver standards allow large group sizes. Current standards allow for a one-to-ten staffing ratio. A provider operating at a one-to-ten ratio (which provider survey responses suggest is rare), would generate more than $133 per staff hour for an employee being paid around $15 per hour. Since the wages paid to direct support professionals generally represent programs' largest expense, the rate study could not justify the current rate at ratios as high as one-to-ten or one-to-eight.

It is not accurate that the majority of individuals would be assigned to the lower rate category. Based on HMA-Burns' analysis, the proposed rates would have been higher for more than 70 percent of billed CAG units compared to the current permanent rates.

In response to these comments, however, the proposed changes to facility-based rates have been withdrawn. Consistent with existing practices, the current permanent rate will be maintained for all facility-based services without any differentiation based on level of need. The rate study does recommend implementing tiered rates for community-based services. With the changes to the rates discussed in response to comments 38 and 39, all four rate categories exceed the current permanent CAG rate. These rate increases are intended to facilitate more community-based services, consistent with the 2014 federal rule on community integration as well as the wishes of many individuals receiving services.

34. ***Several commenters expressed support for separate facility and community rates. One commenter stated that the rate study does not recognize the value of facility-based services, which will result in limiting individuals' access to activities provided in a facility setting (such as yoga classes, art classes, concerts, etc.). Several commenters stated that not all communities have a robust infrastructure to offer a consistently meaningful community-based experience. Several commenters stated that DBHDD should offer providers financial assistance to transition to more community-based supports.***

As discussed in the response to comment 33, the rate study recommended the establishment of separate rates for facility-based and community-based services. As further discussed in that response, the original recommendation was modified to maintain the current rate for facility-based services and to adopt the higher tiered rates for community-based services.

Neither the original nor modified recommendation is intended to devalue facility-based services. Rather, the proposed rates aim to recognize the additional costs associated with delivering community-based services, including more staffing and vehicle-related costs. There is no intention to eliminate facility-based services; rather, the goal is to ensure that community-based supports are financially viable.

35. ***Several commenters highlighted challenges associated with providing services in the community such as the lack of adult changing rooms in the community to accommodate adults who are incontinent, and the additional staffing required to assist individuals in the bathroom while other individuals wait outside.***

    The rate study recognizes the additional complexity of delivering Community Access-Group (CAG) services in the community, which is why higher rates are recommended for community-based supports. The increased rates for community-based services, which are tiered to provide higher reimbursement for supporting those who require more intensive needs, are intended to allow for more intensive staffing to address the types of challenges cited by the commenters. The rate models are based on staffing ratios ranging from one-to-two to one-to-five, but the rate study does not dictate how providers structure their programs. For example, providers could establish groups of six or seven individuals that are served by two staff. Additionally, an individual can request Additional Staffing Services to supplement their CAG staffing.

36. ***Several commenters asked how billing procedures will be updated to accommodate separate community-based and facility-based rates, and recommended that DBHDD implement separate billing codes or modifiers.***

    DBHDD intends to establish new modifiers to accommodate the creation of tiered rates for supports delivered in the community. That is, consistent with current practices for waiver services, there will be a separate procedure code and modifier combination for each individual rate.

37. ***Several commenters stated that implementing separate rates for facility-based and community-based services will increase recordkeeping time, stating, for example, that if an individual begins their day in the facility, spends time in the community, and then returns to the facility, the provider would have to record three daily notes.***

    As discussed in the response to comment 33, the rate study recommends maintaining the current permanent Community Access-Group rate for facility-based services and establishing higher tiered rates for community-based services. The rate models for community-based services include a productivity adjustment for direct support professionals to perform recordkeeping activities. The assumed time is somewhat less than reported through the provider survey because the rate study recommends lower staffing ratios for community-based services so each staff person will have fewer individuals for whom they are responsible for recording notes. As a result, no adjustment has been made.

38. ***Several commenters stated that the rate models for community-based Community Access-Group services did not account for additional costs such as purchasing food or admission to events.***

    As discussed in the response to comment 16, the rate models include $10 per day for program support related costs, which would include the types of expenses cited by the commenters. Across all services, the total amount of funding assumed in the rate models for program support (including first-line supervision) is substantially greater than the amounts reported through the provider survey. However, in response to these comments and to encourage the development of more community-based programs, the program support assumption in the rate models for community-based Community Access-Group services has been increased to $12.50 per individual per day.

39. ***Several commenters stated that the rate models for community-based Community Access-Group services did not provide enough funding for vehicle-related costs. One commenter stated that smaller group sizes in the community would result in the need for additional vehicles.***

    The originally proposed rate models for Community Access-Group services provided in the community included 200 miles per week per group. This assumption was greater than the approximately 160 miles per week reported through the provider survey. However, it is noted that the mileage reported through the survey covered both facility-based and community-based activities. Thus, in response to these comments and to encourage the development of more community-based programs, the assumption in the recommended rate models has been increased to 250 miles.

    In terms of vehicle expenses, the rate models rely on the Internal Revenue Service's 2023 standard mileage rate, which includes the amortized cost of vehicle acquisition as well as the cost of fuel and other maintenance.

40. ***Several commenters asked how Supports Intensity Scale (SIS) assessment results would be used to assign participants to a rate category. One commenter noted that SIS and Health Risk Screening Tool results can fluctuate.***

    The framework for assigning individuals to one of four rate categories for community-based Community Access-Group services will mirror the structure already in place for Group Home services. Individuals are assigned to one of seven levels based on the results of their Supports Intensity Scale (SIS) and Health Risk Screening Tool (HRST) assessments.

    These seven levels are then consolidated into four rate categories. The criteria for each of the seven levels is available on DBHDD's website and is not changing at this time. DBHDD notes, however, that the American Association on Intellectual and Developmental Disabilities (AAIDD), the publishers of the SIS, has recently released a revised version of the assessment. It is anticipated that this revision will require some adjustments to the criteria used to assign individuals to a category.

    As the commenters note, an individual's level assignment can change when their assessment results change. When this occurs, an individual's authorization will be updated to reflect the appropriate rate category.

41. ***Several commenters stated that the proposal requires individuals to participate in groups where everyone is assigned to the same rate category, which limits individual choice.***

    There is nothing in the rate study recommendations that suggests or requires Community Access-Group (CAG) programs or groups to include only individuals assigned to the same level of need.

    As discussed in the response to comment 33, the rate study recommends the establishment of tiered rates for community-based supports based on individuals' assessed needs (the proposal to establish tiered rates for facility-based supports has been withdrawn and those services would continue to be reimbursed at the current rate). This is consistent with current practices for Group Home services. As with most group homes, it is expected that most CAG programs will support individuals with a range of needs. Providers operating programs that tend to serve more individuals with higher needs will receive higher total payments than providers operating programs that tend to serve more individuals with lesser needs. The additional funding for the programs serving those with greater needs is intended to allow providers to employ more staff.

    Although it is assumed that programs serving more people with greater needs will require more staffing – and will be paid more to employ these staff – to promote flexibility, the staffing

requirements are the same across programs regardless of who is served, as discussed in the response to comment 35.

42. ***Several commenters noted that the proposed lower staffing ratios would require providers to hire additional staff, particularly for community-based services. Multiple commenters stated that differing staffing requirements for facility-based services and community-based services will make it difficult to staff a program.***

As discussed in the response to comment 33, the rate study recommends the maintenance of the current permanent rate for facility-based Community Access-Group (CAG) services and the establishment of tiered rates for community-based services. The rate study additionally recommends that the maximum allowable ratio be reduced from one-to-ten to one-to-eight for facility-based services and to one-to-five for community-based services.

More than 90 percent of CAG programs reported the provider survey indicated they already operate at a ratio of one-to-eight or less. Thus, few programs would need to hire additional staff to meet the recommended maximum facility-based ratio of one-to-eight. Slightly fewer than half of reported CAG programs reported delivering community-based services at a one-to-five ratio of less. Thus, about half of CAG programs would need to hire additional staff to meet the proposed requirement for community-based services. HMA-Burns estimates that reimbursement for community-based CAG services will increase by about 60 percent, allowing providers to meet the new staffing standards.

Additionally, the majority of programs reported through the provider survey already vary staffing ratios based on setting, with smaller ratios reported for community-based services. DBHDD acknowledges the complexity of staffing a program and does not dictate staffing practices. That said, like those programs that already vary staffing based on setting, providers likely have a variety of approaches they could employ to address the differing staffing ratio requirements. For example:

- A provider could staff their overall programs at the lower required ratios for community-based services. At the current permanent rate of $3.33 per 15 minutes (which the rate study recommends maintaining for facility-based services), a provider would generate about $67 per staff hour, which is comparable to the assumptions in the rate models for community-based services.
- A provider could use part-time staff to support the greater staffing requirements for community-based activities.
- A provider could stagger the groups within their program so that some groups spend one part of the day in the community and other groups spend a different part of the day in the community, allowing the provider to balance their staff throughout the day.

43. ***One commenter suggested that programs that offer support for individuals who have personal care needs such as assistance with toileting should receive a higher payment rate.***

Providing assistance with personal care needs is already part of the covered activities described in current policies for Community Access-Group services. Additionally, individuals may be approved for Additional Staffing Services.

Recognizing that individuals with more significant needs, which could include personal care needs, the rate study recommended the establishment of tiered rates that assume more intensive staffing for those with greater needs. As discussed in the response to comment 33, the tiered rates proposed for facility-based services have been withdrawn, but the rate study continues to recommend tiered rates

for community-based services. The establishment of tiered rates is intended to encourage more providers to serve individuals with greater needs.

44. ***One commenter stated that individuals' absences negatively impact Community Access-Group programs because they have fixed staffing costs regardless of attendance, and suggested that providers be paid a monthly rate.***

The rate study recognizes that the cost of delivering shared services such as Community Access-Group is largely fixed regardless of attendance. For example, if a provider staffs their program at a one-to-six ratio, the provider's staff are paid the same even if only five individuals attend the program (the cost of vehicles, utilities, etc. are similarly the same if that one individual is absent).

However, the rate study does not recommend a monthly rate since this approach reduces the incentive to encourage participation in these programs and can result in unrealistic payment amounts (e.g., a provider being paid more than a $1,000 for a month in which someone may have only attended for one day). Additionally, a monthly rate will generally pay the provider the same regardless of the mix of center-based and community-based supports, which does not incentivize the delivery of more community-based services.

Instead, the CAG rate models for community-based services continue to be based on a 15-minute billing unit that include a 15 percent absence factor to inflate the rate to cover billing revenue that is lost when an individual is absent (as discussed in the response to comment 33, the rate for facility-based services is not changing). This assumption is slightly greater than the 14 percent absent rate reported through the provider survey.

45. ***One commenter suggested that the daily cap of six hours (24 units) should be removed to accommodate events that are longer or activities that may take place into the evening.***

The rate study recommended increasing the number of hours of Community Access-Group and Prevocational Services that an individual may receive from 1,440 hours per year to 1,500 hours so that individuals receiving these services have access to support over the course of the entire year (the recommended limit is based on six hours per day for 250 non-holiday weekdays per year). As the commenter notes, current policies also place limits of six hours per day and 26 hours per month. These limits were established to ensure that individuals did not reach their annual limit significantly prior to the end of their plan year. However, as service expectations continue to evolve – for example, not everyone wishes to participate in a traditional 9:00 AM to 3:00 PM day program – DBHDD agrees with the suggestion to eliminate the daily and monthly limits (while maintaining the annual limit at the recommended 1,500 hours). It is hoped that this new flexibility will encourage the development of innovative programs to meet the needs and wishes of individuals receiving these services.

PREVOCATIONAL SERVICES

46. ***One commenter recommended eliminating Prevocational Services, stating that the service promotes sheltered workshop environments and runs counter to the objectives of Employment First. Another commenter questioned the increase in the annual limit on hours of Prevocational Services, also suggesting this does not support competitive integrated employment.***

Consideration of the potential elimination of services was not within the scope of the rate study. Further, the federal American Rescue Plan Act that has provided hundreds of millions of dollars to expand, enhance, and strengthen home and community-based services includes maintenance of effort

requirements that prevents the elimination of any services until these one-time funds have been fully spent (which will likely not be complete until 2025).

As discussed in the response to comment 45, the increase in the annual limit of 1,440 hours to 1,500 hours was recommended so that individuals receiving day program-type services had access to these supports over the course of the entire year. This increase was not specifically targeted to Prevocational Services. Rather, the limit applies to the combination of Prevocational Services and Community Access-Group since individuals may choose to receive both services. As a result, the overall increase also affects the amount of Prevocational Services that an individual may receive.

47. ***Several commenters expressed support for a rate reduction for Prevocational Services, stating, for example, that services are not typically provided in a manner that respects the abilities of people with developmental disabilities and that there is not currently accountability for the outcomes of these services. One commenter objected to rate reductions for Prevocational Services and stated that existing rates should be maintained to avoid disrupting the provider community or the participants who rely on this service.***

There is currently a single rate for Prevocational Services. As with the current approach to paying for Group Home services, the rate study recommended the establishment of tiered rates for Prevocational Services based on the presumption that individuals with more significant needs will required more intensive staffing. Rates would further vary based on setting with higher rates paid for services delivered in the community. The result would have been that three of the eight rates (based on four rate categories and two service settings) would have been less than the current permanently funded rate while five of the rates would have been higher.

In response to comments and based on DBHDD's goal to promote competitive integrated employment, the proposed rate models for Prevocational Services have been withdrawn. Services will continue to be reimbursed at the current permanent rate without any differentiation between level of need or setting.

48. ***One commenter asked whether DBHDD will enforce the time limit for individuals receiving Prevocational Services.***

Current policies do not place any time limit on Prevocational Services. There is a requirement that an individual's continued participation in Prevocational Services be reviewed at least once every 12 months, but this does not require that services be discontinued after 12 months. No changes have been recommended for this policy.

49. ***Two commenters objected to the presumption that program income would cover operating costs such as rent and utilities.***

Many Prevocational Services programs generate business income. Waiver-funded Prevocational Services are intended to pay for the cost of providing habilitative training to individuals rather than the costs of business operations.

For example, current standards list cleaning and landscaping as types of programs. The rate study therefore assumed that business-related expenses such as equipment and supplies should be covered by the fees charged to customers as would be true for any business providing, for example, cleaning or landscaping services.

As discussed in the response to comment 47, however, the draft rate models for Prevocational Services have been withdrawn and no changes to program standards or payments are proposed at this time.

SUPPORTED EMPLOYMENT-GROUP

50. ***One commenter asked why DBHDD continues to support Supported Employment-Group services that support segregated enclave work environments.***

    Supported Employment-Group (SEG) services cover situations when multiple individuals at the same job site may be supported by a single staff. These scenarios are not necessarily limited to segregated environments (and current SEG standards prohibit sheltered work and services in specialized facilities).

    Historically there has been a single payment rate for SEG services regardless of the staffing ratio, which has resulted in substantially higher reimbursement for larger groups than for smaller groups. To encourage the development of smaller, more integrated employment programs, the rate study has recommended rates that vary based on group size, with higher per-person rates for smaller groups than for larger groups.

51. ***One commenter objected to the proposal to establish Supported Employment-Group (SEG) rates that vary based on staffing ratio, stating that this would complicate billing and authorizations as every individual receiving SEG services would need an authorization for every ratio since they move between groups.***

    As noted in the response to comment 50, the rate study recommends Supported Employment-Group (SEG) rates that vary based on a given program's staffing ratio. This recommendation is intended to encourage the development of smaller, more integrated programs. At the current permanent rate of $2.16 per quarter-hour, a provider earns $86.40 per staff hour when providing services at a one-to-ten ratio compared to only $17.28 per staff hour when providing services at a one-to-two ratio (although staff is not the only relevant cost, it is the most significant expense). The establishment of rates based on staffing ratio is intended to make smaller programs more viable.

    Billing for SEG will work similarly to the current process for Community Living Services in which an individual has an authorization for the service and the provider bills for either the standard or extended rate based on the amount of service provided. That is, an individual will be authorized for SEG and the provider will bill the appropriate rate based on the staffing ratio delivered.

52. ***One commenter stated that all individuals working in a job paying more than minimum wage should be billed at the Supported Employment-Individual rate.***

    Supported Employment services are intended to support individuals in their jobs, ideally earning a competitive wage. A key distinction between Individual and Group services is the staffing ratio. That is, providers should be paid more on a per-person basis for one-to-one services than for group services to ensure that reimbursement reflects their expenses. Thus, when multiple individuals are supported by a single staff, the appropriate Group rate should be billed regardless of the wages earned by the individuals.

SUPPORTED EMPLOYMENT-INDIVIDUAL

53. ***Several commenters objected to the proposed reimbursement structure and stated that providers should continue to be able to bill the Supported Employment-Group rate for job maintenance. Several other commenters expressed support for the proposed reimbursement structure.***

    Current policies allow for the billing of the Supported Employment-Group (SEG) rate as 'job maintenance' for individuals working in individual employment for at least 60 hours per month. However, there is no specific relationship between the SEG rate and providing follow-along support. For example, a provider may earn nearly $700 per month for providing only an hour or two of service. Further, there is no incentive to support individuals with higher needs; rather, the incentive is to support those with minimal needs since reimbursement is not linked to needs or the amount of support provided. To address these issues, the rate study originally recommended a two-phase approach to revising the reimbursement structure for job maintenance.

    Long-term, the goal is to formalize a framework wherein providers are reimbursed based on the number of hours that an individual works. These rates would be tiered based on an individual's assessed needs and, potentially, based on the length of time in the job. The goals include incentivizing providers to work with individuals to increase their work hours, to serve individuals across the continuum of need, and to fade supports over time.

    Acknowledging that the development of this model will require more data collection and stakeholder engagement, the rate study proposed an interim reimbursement structure.

    This interim model included a very high rate for the first hour of service that a provider delivers in a month. Subsequent hours of support would be billed at a more traditional fee-for-service rate. This approach sought to balance the need to pay for infrastructure with the need to pay more when more supports are provided (that is, the first hour rate pays for infrastructure and the hourly rate pays for additional support).

    HMA-Burns' analysis suggested that this approach would increase revenues for most providers. However, there would likely be some instances where billing for a participant would decrease (that is, when a provider is billing for 60 to 80 hours of job maintenance, but delivering only a few hours of direct support). This reduction may have conflicted with the maintenance of effort requirements established by the federal American Rescue Plan Act (ARPA), which prevents any rate reductions until Georgia spends all of the home and community-based funds made available through ARPA (which will likely not be fully spent until 2025).

    Due to these considerations and the public comments, the recommended interim approach has been withdrawn. DBHDD remains committed to working with providers on the long-term model with the goals of establishing an approach that comports with CMS requirements, is aligned with the number of hours that an individual works, and accounts for differences in level of need. DBHDD's goal is to implement these changes in 2025.

54. ***Several commenters stated that the requirement for a participant to work at least 40 hours per month in order for providers to bill the 'first hour' rate will be a barrier for providers that support participants who do not work that many hours.***

    As discussed in the response to comment 53, the rate study originally proposed an interim reimbursement model that included a substantial rate billed for the first hour of support to cover infrastructure costs and a more traditional fee-for-service rate billed for subsequent hours of support. As part of this proposal, the threshold for billing these job maintenance type activities was to be

reduced to allow for billing for individuals working 40 hours per month from the 60-hour threshold required for the current job maintenance billing. With the withdrawal of the proposed interim solution, the current job maintenance requirements will remain in place, including the 60-hour threshold.

As DBHDD works with providers to develop a new reimbursement model for employment supports to be implemented in 2025, the threshold for billing will be reevaluated.

55. ***One commenter suggested a new reimbursement approach. Initially, an individual is served through the Georgia Vocational Rehabilitation Agency (GVRA) or DBHDD using the same steps and payment levels as GVRA. Then, after the individual is placed in a job, the provider would be paid a standard monthly rate for six months regardless of how much an individual works or how much support the provider delivers. Further, the provider would be eligible for an incentive payment if the individual increases their work time by five hours per month or secures a significant company benefit such as paid leave or health insurance. Finally, if after 12 months, an individual has not increased their work hours or achieved a significant company benefit, the provider would no longer support the individual.***

    DBHDD appreciates the suggestion. As noted in the response to comment 53, DBHDD intends to work with providers on a new reimbursement model for employment supports to be implemented in 2025 and will consider this and other potential approaches

56. ***One commenter stated that the proposed rates were not aligned with services available through the Georgia Vocational Rehabilitation Agency. Another commenter expressed confusion regarding the relationship between the monthly competitive integrated employment (CIE) rate of $616.90 and the draft waiver rate and noted concerns about a future reduction to the CIE rate.***

    The rate study has not proposed any changes to the relationship between services available through the Georgia Vocational Rehabilitation Agency (GVRA) and DBHDD's waiver programs. The creation of a Job Development rate in the waiver is intended to account for instances when job development services are not available through GVRA for whatever reason (for example, if an order of selection is in place preventing waiver enrollees from receiving services).

57. ***One commenter stated there was no provision in the rate study to promote or create self-employment opportunities.***

    Consistent with current policies, Supported Employment-Individual services can be used to "assist individuals in achieving self-employment through the operation of a business, including helping the individual identify potential business opportunities, assisting in the development of a business plan, identifying the supports that are necessary for the individual to operate a business, and ongoing assistance, counseling and guidance once the business has been launched."

58. ***One commenter stated that productivity assumptions for Job Development and Job Coaching services are too high and do not reflect provider survey results.***

    The productivity assumptions in the Job Coaching rate model are consistent with reporting through the provider survey. The rate model assumes 31.75 billable hours per typical workweek (and about 28 hours per week after accounting for annual training and paid time off). Respondents to the provider survey reported that job coaches spend an average of 30.5 hours per week on billable activities, but also reported another hour on job development activities that are not intended to be part of the Job Coaching service.

The productivity assumptions for the Job Development rate model are somewhat less than reported through the provider survey. The rate model assumes 31.25 billable hours per typical workweek (and a little less than 28 hours per week after accounting for annual training and paid time off). In comparison, the provider survey suggested between 26.5 and 28.5 billable hours per 40-hour workweek. However, these figures appear to have been skewed by the fact that nearly half of responding providers reported that job developers work half-time or less. Overall, the rate study continues to believe that the assumptions are reasonable.

59. ***One commenter stated that the Supported Employment-Individual rate model does not include adequate funding for transportation, which the commenter stated is a significant barrier for some participants to access employment.***

    The travel-related assumptions in the Supported Employment-Individual (SEI) rate model are consistent with the results of the provider survey. Further, the rate model is only intended to reflect travel associated with traveling to and between service encounters. It does not include assumptions related to transporting individuals to the job site as that is not an expectation of SEI services. Instead, individuals can request Transportation services to provide transportation to and from the workplace.

60. ***One commenter stated there was no provision to provide additional support to individuals who require customized accommodations or who have more challenging behaviors or complex medical needs. Another commenter agreed with basing the criteria for intensive support on those receiving Intensive Support Coordination. One commenter stated there should be a two-to-one Supported Employment rate for individuals who need that level of support.***

    With the withdrawal of the proposed interim reimbursement model as discussed in the response to comment 53, the current framework, which does not include a differentiated rate for individuals with more significant needs or a two-to-one rate, will remain in place (with the Supported Employment-Individual rate increasing 60 percent). As part of the process to create a new reimbursement model to replace the current job maintenance framework, DBHDD will seek to develop options to encourage supports for individuals with more significant needs.

NURSING SERVICES

61. ***One commenter recommended that private duty nursing rates across all home and community-based services programs in Georgia should be studied in order to establish standard rates across programs.***

    The rate study proposes to align payment rates for services provided by licensed professionals with those paid by other Medicaid programs in Georgia due to a high degree of similarity across services in terms of staff qualifications, scopes of practice, etc. For Nursing Services, the proposed rates are aligned with those paid for Community Behavioral Health and Rehabilitation Services, which are assumed to be a reasonable benchmark. The rates paid by other home and community-based programs in Georgia are outside of the scope of the rate study.

Behavior Support Services

62. One commenter stated that the proposed rates for Behavior Support Services did not recognize the level of training and expertise required.

The rate study proposes to align payment rates for services provided by licensed professionals with those paid by other Medicaid programs in Georgia due to a high degree of similarity across services in terms of staff qualifications, scopes of practice, etc.. For Behavior Support Services, the proposed rates are aligned with rates paid for services delivered to children with an autism spectrum disorder under early period screening, diagnostic, and treatment (EPSDT) standards. The Level 1 rate is tied to the rates for board certified assistant behavior analysts (BCaBAs) while the Level 2 is tied to the rate for out-of-clinic board certified behavior analysts (BCBA). The rate study continues to assume these are reasonable benchmarks in terms of staff qualifications and ability to serve populations with special needs. Compared to the current permanent rates, the recommended rates represent a 45 percent increase for Level 2 services and a 21 percent increase for Level 1 services.

Therapy Services

63. One commenter stated that current rates make it difficult to hire and retain therapists. One commenter objected to tying therapy rates to rates paid by other Georgia Medicaid programs and instead suggested that rates should be aligned with local Medicare rates. One commenter stated that a rate premium should be paid for services through the NOW and Comp programs as this population requires specialized knowledge and training.

The rate study proposes to align payment rates for services provided by licensed professionals with those paid by other Medicaid programs in Georgia due to a high degree of similarity across services in terms of staff qualifications, scopes of practice, etc. HMA-Burns' review of therapy rates paid by other programs found that DBHDD's current rates are already similar so no changes have been proposed. Other recommendations discussed in the responses to comments below – including consolidation of procedure codes with broader coverage of billable activities, adopting a single rate across disciplines based on the highest current rates, and billing for assessments in 15-minute increments – are intended to reduce administrative time and increase providers' revenues.

64. Several commenters recommended either adding service codes for Therapy services or creating fewer service codes with broader scopes to ensure coverage for more therapeutic activities such as wheelchair management.

There are presently 21 different procedure codes for agency-provided Adult Therapies, many of which cover a narrow activity. As a result, some therapeutic activities, such as examples noted by the commenters, are not covered. To address these limitations, the rate study recommends the adoption of broader procedure codes (either a separate code for each discipline or a single code with a modifier for each discipline) that will cover the breadth of activities within each discipline's scope of practice. As part of this change and to increase consistency across disciplines, the rate study also recommends the adoption of the highest 15-minute rate current permanent rate – $30.23 for occupational therapy services billed under 97530-GO – for all therapy services.

65. ***One commenter suggested creating a tiered rate structure to account for the added costs of serving individuals with more complex needs as has been proposed for other waiver services.***

    The rate study has only proposed acuity-based payment rates for services where there are defined differences in service requirements (for example, Intensive Support Coordination) or for group services where there is a presumption that individuals with more significant needs will require more intensive staffing (for example, Group Homes). Since there are no additional requirements for therapists providing care to individuals with more significant needs and services are provided on a one-to-one basis, the rate study has not proposed tiered rates for Adult Therapies. Individuals with more significant needs may require more support, which will be facilitated by the recommended increase in the aggregate cap for Adult Therapy services from $5,400 per year to $10,000.

66. ***Several commenters expressed concern that therapists spend a lot of time training paid caregivers, which is not a billable activity. Additionally, several commenters stated that evaluation costs for individuals with intellectual and developmental disabilities are higher than for other Medicaid populations as therapists need to rely on multiple forms of input when a participant is unable to communicate their needs directly, such as input from caregivers.***

    As part of the streamlining of procedure codes discussed in response to comment 64, the rate study recommends that the list of covered activities be updated to include certain 'on behalf of' activities such as providing training to paid caregivers. Evaluation work will also be billed through these 15-minute codes, ensuring that providers are paid based on the amount of time required to complete the assessment.

67. ***One commenter stated that administrative time in tracking down documentation such as consents, prescriptions, signed plans of care, and service authorizations represents a significant burden for Therapy providers.***

    The rate study acknowledges that compliance with these tasks require administrative effort, but these requirements are consistent with other Medicaid programs and the rate study does not recommend any changes to these standards.

ASSISTIVE TECHNOLOGY

68. ***One commenter suggested increasing the annual cap on Assistive Technology above what was recommended to support individuals' independence and reduce the need for paid supports.***

    The rate study recommendation to increase the annual cap on Assistive Technology from $1,195 to $2,000 is unchanged. As with the recommendations for services used to purchases items (that is, environment modifications and vehicle modifications), this proposal was based on a review of typical limits in other states' programs for individuals with intellectual and developmental disabilities.

    The rate study additionally recommends the elimination of a lifetime limit as proposed for environment modifications and vehicle modifications.

PARTICIPANT DIRECTED SERVICES

69. ***Many commenters objected to the proposed wage caps on participant-directed Community Living Services, Respite, and Community Access-Individual services, stating that the caps would limit their ability to hire and retain qualified staff, especially in rural areas and higher-wage areas. Specific comments included:***

    - ***Individuals may hire staff with specific qualifications such as a special education teacher or a nurse who demand a higher wage than a direct support professional.***
    - ***Individuals may access vendor-based services such as music therapy, swim lessons, or yoga classes that are more costly than direct supports.***
    - ***Wages for Respite should be higher than those for other services because Respite is on-call rather than scheduled.***
    - ***Any wage caps should be periodically increased.***

    The rate study originally recommended the establishment of caps on the wages that individuals can pay self-directed staff that are based on the full employee costs assumed in the rate models for agency-provided services (wages, benefits, and productivity). This recommendation was intended to ensure compliance with federal requirements that rates be consistent with economy and efficiency and to promote some level of parity across direct support professionals regardless of their employer.

    In response to comments, there were several modifications to the recommended wage caps:

    - Rather than setting the wage cap based on the staff components of the agency rate models, the wage cap will be equal to the full agency rate less the cost of mandatory payroll taxes applied to the individual's wage. The rate study continues to recommend a wage cap to ensure compliance with the federal requirement for efficient and economical rates (that is, since the agency rate is intended to reflect the total cost of service delivery including agency infrastructure, it would be difficult to argue that the cost of participant-directed services are higher). The total wage caps (inclusive of payroll taxes) would therefore be $39.57 for Community Living Services, $32.98 for Respite, and $41.82 for Community Access-Individual. An analysis of payment data shows that more than 98 percent of self-directed employees are already below these caps.
    - The wage caps will not apply to 'specialized' staff who meet one of the requirements for a developmental disability professional as detailed in DBHDD's Provider Manual for Community Developmental Disability Providers.
    - The wage caps will not apply to vendors delivering services through Community Access-Individual.

    To allow time for any necessary transitions, DBHDD does not intend to institute the wage caps until 2025. Additionally, since the caps are tied to the agency rates, the rate study recommends that the caps be adjusted whenever the corresponding agency rate is updated.

70. ***One commenter stated that the recommendation related to a wage cap for participant-directed services relied on a comparison of rates set in other states, but that this approach ignores the unique labor markets in each state.***

    Both the original and revised wage cap proposals for participant-directed services discussed in response to comment 69 are tied to the Georgia-specific rate models for the corresponding agency-

provided services. The rate study considered polices related to whether and how other states establish limits on rates or wages for participant-directed services. However, other states' rates or wage cap amounts were not a consideration in the rate study recommendations; the actual recommendations for the caps are based only on the rate models developed for agency services as part of this rate study.

71. ***One commenter expressed appreciation for including benefit costs within the participant-directed wage caps. Several commenters said that participant-directed employees should have paid time off. One of these commenters stated that paying employees a higher wage to allow them to access benefits is not reasonable because staff in "entry level positions simply do not think that way."***

As noted in the response to comment 69, the rate study recommends that the wage caps be tied to the full agency rates, which include employee costs related to wages, benefits, and productivity (as well as other agency program and administrative costs). In general, there is no mechanism to directly pay for benefits such as health insurance and paid time off for participant-directed employees. Instead, allowing individuals who self-direct their services to pay wages as high as the agency rates indirectly allows for benefits. For example, an individual could pay their staff $25 per hour (which is substantially higher than the $16.70 wage assumed for direct support professionals in the rate models for agency-provided services) and the employee could use a portion of their pay to, for example, purchase their own health insurance in the individual marketplace or to take an unpaid vacation (or course, the employee is not obligated to use their wages in this way).

72. ***One commenter suggested that participant-directed employees be paid for attending training.***

Neither agency-provided services nor participant-directed services may bill for time that staff spend in training. Since individuals who self-direct services do not have a mechanism to bill for training time, they can take this time into account when setting hourly wages by paying a higher wage for the hours spent delivering services to recognize that staff may spend time in unpaid training.

73. ***One commenter suggested that there should be tiered rates for participant-directed services.***

The rate study has only proposed acuity-based payment rates for services where there are defined differences in service requirements (for example, Intensive Support Coordination) or for group services where there is a presumption that individuals with more significant needs will require more intensive staffing (for example, Group Homes). Since there are no additional requirements for participant-directed employees based on an individual's level of need and services are provided on a one-to-one basis, the rate study has not proposed tiered rates for participant-directed services. The services to be subject to the wage caps described in the response to comment 69 – Community Access-Individual, Community Living Service, and Respite – are not tiered for agency providers so there are not tiered wage caps for participant-directed services. However, individuals who self-direct services already have the ability to establish their own rates, which could take into account an individual's level of need.

74. ***One commenter asked whether the $3.00 wage premium assumed in rate models for services delivered to participants who are deaf or hard of hearing would be extended to participant-directed services.***

Consistent with the alignment of the wage caps (inclusive of mandatory payroll taxes) to the full agency rates, the rate study recommends that individuals who are deaf or hard of hearing be able to pay wages equal to the higher agency rates.

75. ***One commenter stated that individuals who self-direct must perform administrative tasks for which they are not paid.***

    It is acknowledged that individuals who self-direct services or their representative must perform administrative tasks. As is true for self-direction in Medicaid programs broadly, there is no mechanism to pay individuals or their representatives. These requirements are explained to those exploring participant direction and should be part of the decision-making process regarding whether self-direction is the best option for the individual. Both Support Coordination and Financial Support Services assist with many, though not all, administrative requirements.

76. ***Several commenters stated that eliminating the personal assistance retainer (PAR) would make it more difficult to retain staff as individuals and families use the PAR to provide vacations for staff or to pay staff when the individual is not available to receive services.***

    The rate study originally recommended that the personal assistance retainer (PAR) for Community Living Services be eliminated (this recommendation also included the PAR for agency-provided services, but retainers are primarily billed for staff in self-directed models). The rate study suggested that the retention of staff when an individual is unable to receive services could be achieved through other means, such as setting a higher wage to allow staff to afford to have unpaid time off whether to take a vacation or because the individual is unavailable to receive services. In response to comments, the proposal to eliminate the PAR has been withdrawn.

    In reviewing some comments, it was noted that some individuals reported billing the PAR in circumstances that are inconsistent with the standards. For example, some individuals reported using the PAR to provide a paid vacation to their staff; however, the PAR is limited to instances when the individual is not available to receive services. In response, DBHDD intends to provide refresher training reiterating the allowable uses of the PAR.

77. ***One commenter stated that Additional Staffing Services should be available to individuals who self-direct services.***

    No changes are being made to the service model for Additional Staffing Services at this time. Individuals who self-direct other services may still access agency-provided Additional Staffing when they meet the service criteria.

78. ***One commenter stated that participant-directed Supported Employment should have minimum quality standards and a requirement to first access vocational rehabilitation for initial employment funding.***

    DBHDD appreciates this input. At this time, no changes are proposed related to the service requirements for participant-directed Supported Employment. However, as discussed in the response to comment 53, DBHDD will be conducting a comprehensive review of the reimbursement model for agency-provided Supported Employment and may also consider participant-directed requirements at the same time.

79. ***One commenter suggested that Georgia make permanent a temporary flexibility authorized under Appendix K to allow family members to be paid to care for their loved ones.***

    As part of its response to the Covid-19 pandemic, DBHDD requested and received authorization to allow agency providers to hire family caregivers or legally responsible individuals to provide certain services. That flexibility will cease with the end of the Appendix K authority under which it is authorized (in November 2023). Consideration of this issue is outside of the scope of the rate study.

80. One commenter asked if DBHDD is considering increasing the cap for Individual Goods and Services.

The rate study does not include a recommendation to increase the annual limit of $1,500 for Individual Goods and Services.

FINANCIAL SUPPORT SERVICES

81. One commenter asked if the rates for fiscal intermediaries were being reviewed as part of the rate study. The commenter also asked if the number of annual background checks covered within the fiscal intermediary rate could be increased to ensure individuals who self-direct can maintain qualified staffing.

Financial Support Services (FSS) are part of this rate study though the data collection and rate development occurred after the publication of the draft rate models for other services. A similar approach was employed for the review of FSS as for other services. HMA-Burns met with the two FSS providers, developed a provider survey, conducted ancillary research, and shared the resulting recommendation with the service providers.

82. One commenter objected to the proposal to maintain the current payment rates. The commenter noted that rates had not increased prior to recent increases granted under Appendix K authority and that the number of services available through participant-direction have increased over the years. The commenter suggested a rate of $132 per member per month based on the rate in effect in 2006 and a measure of inflation.

The analysis of the provider survey results yielded markedly different financial pictures for the current providers and a rate model could not be developed to reflect the current rate without the inclusion of a very high administrative rate.

The rate study therefore also evaluated benchmark data, including rates that various FSS providers have proposed in response to competitive procurements in other states as well as a listing of current rates researched and summarized by Applied Self-Direction's 2022 report, Costs of Providing Financial Management Services in a Medicaid 1915(c) Waiver Context. The median rates across all identified programs (calculated as the minimum and maximum FSS rates within a program) found in that report were $96 and $104, respectively.

Since the $101.75 rate currently being paid for the NOW and Comp programs (inclusive of both temporary and permanent rate increases authorized under Appendix K authority) is in the range of the rates paid by other programs across the country, the rate study recommended and continues to recommend maintaining the rate.