Attachment 7: Responses to Public Comments

RATE AND PAYMENT OPTIONS STUDY

RESPONSES TO PUBLIC COMMENTS

– PREPARED FOR –

RHODE ISLAND DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS

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BACKGROUND AND SUMMARY

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

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

BHDDH contracted with Burns & Associates, a division of Health Management Associates (HMA-Burns) to provide technical assistance and support throughout this project.

Work related to assessments and individual budgets has been delayed due to changes to the adult version of the Supports Intensity Scale (SIS-A) announced by the assessment's author, the American Association on Intellectual and Developmental Disabilities (AAIDD) after this project began. Rhode Island uses the SIS-A to assess individual needs and expects to continue to use it as one part of the assessment process so the changes in the assessment instrument must be evaluated before additional changes to assessments and individual budgets can be considered. The revised version of the SIS-A should be available in early 2023.

Despite the pause in the evaluation of assessments and budgets, the reviews of the service array and provider payment rates have continued. HMA-Burns released its initial proposals during two online meetings held on September 28th and 29th. These presentations were recorded and posted online along with supporting materials, including draft rate models that detail the specific assumptions regarding the costs providers face in the delivery of each service, such as direct support workers' wages, benefits, and billable time; travel; agency overhead; and program operations costs. In the subsequent weeks, HMA-Burns noted a formula error primarily affecting rate models for new services. Revisions to the draft rate models and related materials were published on October 14, 2022.

Interested parties were invited to submit written comments on the draft recommendations. The comment period ran until October 24, 2022, but comments submitted after the deadline were also considered.

HMA-Burns received comments from caregivers, advocates, providers, and other stakeholders. These comments have been summarized and categorized, and written responses to each comment were developed.

A number of changes to the rate models have been made in response to the public comments, including:

- Increasing assumed health insurance costs.
- Withdrawing the recommendation to establish Group Homes rates that vary based on the size of the home.
- Withdrawing the recommendation to 'unbundle' Professional Services from the rate models for residential services.
- Increasing the assumed payment to home providers in the Enhanced Shared Living Arrangement rate models.

- Unbundling Respite services from the Enhanced Shared Living Arrangement rate models.
- Withdrawing the rate model for Daily Respite and instead tying the rate to the Tier E rate for Enhanced Shared Living Arrangement.
- Withdrawing the proposal to establish maximum staffing ratios for Community-Based Supports and Center-Based Supports.
- Developing a one-to-one rate for Center-Based Supports.
- Increasing the annual limit on Discovery services.
- Revising the productivity assumptions to add more recordkeeping time for Job Coaching services.
- Establishing a single rate model for Transportation services.
- Adding rates for Professional Services provided by licensed practical nurses and board certified assistant behavior analysts
- Withdrawing proposed rates changes for Fiscal Intermediary (Support Facilitation) services.

The remainder of this document provides responses to each comment.

ASSESSMENTS AND INDIVIDUAL BUDGETS

1. ***Several commenters asked questions or offered feedback regarding how individual needs are assessed, including:***

    - ***Several commenters asked questions regarding how the adult version of the Supports Intensity Scale (SIS-A) is used to assess individuals' needs, with one suggesting that the criteria should include additional sections of the SIS-A.***
    - ***Several commenters emphasized the need for the assessment process to include information beyond what is collected by the SIS-A such as needs related to life transitions, aging, and communication needs.***
    - ***One commenter expressed concerns about BHDDH staff conducting the assessment.***
    - ***Several commenters stated that changes to assessment practices should include opportunities for further input.***
    - ***One commenter asked what impacts in terms of funding and time are anticipated based on the forthcoming changes to the SIS-A.***
    - ***One commenter asked about the timing of changes to the assessment framework, particularly given the current five-year assessment cycle. Another commenter suggested that the SIS-A should be administered every three years.***

    A key element of this study is an evaluation of the assessment framework for assessing individual needs and tying assessment results to individual budgets and tiered payment rates for certain services.

    Currently, BHDDH assesses individuals with the adult version of the Supports Intensity Scale (SIS-A) with supplemental questions related to extraordinary behavioral and medical needs. Assessment results are used to assign individuals to one of seven levels that are consolidated into five tiers. BHDDH intends to continue to use the nationally normed SIS-A – which remains the instrument used by more states than any other to assess the needs of individuals with intellectual and developmental disabilities – as one of the components of the overall assessment process. In early 2022 – after this

study began – the American Association on Intellectual and Developmental Disabilities (AAIDD) announced a number of forthcoming changes to the SIS-A, including:

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

These changes are not expected to increase the length of a SIS-A interview, but directly impact the scoring of several of the sections used to assign individuals to a level of need. It will therefore be necessary to change the criteria used to assign levels, but the analyses to support these changes cannot begin until BHDDH has assessment results conducted with the revised SIS-A for at least a sample of individuals. As a result, the review of assessment and budgeting frameworks has been delayed. Ultimately, this review will consider the issues raised by the commenters.

The review will include consideration of the additional information to supplement SIS-A results when determining individual need. As noted, the assessment process already includes supplemental questions related to extraordinary medical and behavioral needs, but it is expected that additional questions or individual characteristics will be added to the assessment. The review will additionally consider what information from the SIS-A (including which sections are considered) and supplemental sources will be used to categorize individual needs.

This study, coupled with the renorming of the SIS-A, provides an opportunity for a comprehensive review of all aspects of the processes and practices used to assess individuals and establish funding levels. This study will include an evaluation of existing processes, identification of alternative approaches, and testing of any potential changes. Given the significance of the potential changes to the assessment and budgeting framework and the importance to individuals' lives, the evaluation will include opportunities for broad stakeholder feedback.

This evaluation is anticipated to occur in 2023, but the timing of the implementation of any potential changes to assessment and budgeting processes is not yet known as it will depend in part on the particulars of recommended changes.

2. ***One commenter made several suggestions related to the assessment process, recommending that everyone have an independent facilitator to provide assistance, a comprehensive person-centered plan should be developed, and the assessment should include an evaluation of individual outcomes.***

   While some of this feedback may be part of conflict-free case management as discussed in the response to comment 34, BHDDH will consider these suggestions as it reviews the processes for assessing individual needs, relating budgets to these needs, and planning the use of these budget.

3. ***Several commenters asked questions or offered feedback regarding how individual budgets are established, including:***

   - ***Several commenters emphasized the need for flexibility and facilitating person-centered individual lives.***

- ***One commenter asked whether budgets will be similar to the current budget structure that includes 20 tier packages based on an individual's assessment and their residential setting.***
- ***One commenter stated that changes to individual budgets should be implemented by July 1, 2023.***

The level of supports that individuals can access are informed by their assessed needs and their residential placement. There are a total of 20 individual budgets (referred to as tier packages) based on five assessment levels and four residential settings (living with a relative, living in their own home or apartment, living in a shared living arrangement, or living in a 24-hour residential placement, such as a group home). This framework is intended to support an equitable approach to providing access to supports. That is, similarly situated individuals should have access to similar supports.

As discussed in the response to comment 1, individuals' needs are assessed using the Supports Intensity Scale for adults (SIS-A) and the instrument's author is releasing an updated version that, among other changes, revises the scoring of the SIS-A. Since individual budgets will continue to be informed by assessed needs, an evaluation of potential changes to the budgeting framework must follow changes to the assessment framework. As a result, changes to individual budgets will not be implemented by July 2023.

As with the assessment framework, BHDDH intends to conduct a comprehensive evaluation of individual budgets. This will include consideration of whether to maintain a tier-based framework, how to align service-level assumptions with assessed needs, which services should be subject to a budget limit and which should be authorized in addition to a budget limit, and other factors. These decisions have not yet been made. Comments received to this point will be considered as part of the evaluation and there will be additional opportunities for stakeholder input as options are identified and considered.

4. ***One commenter asked whether there will be any changes to the service levels assumed in the current tier packages.***

   As described in the response to comment 3, BHDDH intends to conduct a comprehensive evaluation to how individuals are assessed and how budgets are established. However, this evaluation has been delayed due to forthcoming changes to the Supports Intensity Scale. As a result, no changes to the assumptions regarding the amounts of services included in the current tier packages have been recommended at this time. As described in the response to comment 5, it has been recommended that employment supports be managed outside of the tier packages and that the existing tier packages be repriced at the recommended rates so that individuals are able to access the same level of support.

5. ***Several commenters provided suggestions related to the existing tier packages, including:***

   - ***Several commenters expressed support for the recommendation to remove employment supports from the individual budget limits. One commenter asked how the proposal will encourage greater participation in employment. Another commenter cautioned that employment supports should not become a "limitless bank of funds".***
   - ***Other commenters suggested that other services, such as Supports Brokerage, Professional Services, Vehicle Modifications, and Transportation, be similarly managed outside of individual budget limits.***
   - ***One commenter asked whether the tier packages will include a predefined mix of Center-Based Supports and Community-Based Supports. Another commenter stated that the tier packages should assume that individuals receive 30 hours of Community-Based Supports***

per week rather than the current assumptions that assume a mix of Center-Based Supports and Community-Based Supports.

- ***One commenter asked how the recommended rate increases will impact existing tier packages.***

As discussed in the response to comment 3, consideration of potential changes to individual budgets have been delayed due to forthcoming changes to the Supports Intensity Scale. However, the study has offered several recommendations for interim changes to current tier packages:

1. Move employment supports outside of the tier packages so that these higher-cost services are not in competition with other services (that is, individuals can receive employment supports without the spending on these services 'counting' against their tier package). BHDDH appreciates the support for this recommendation and acknowledges that additional strategies will be needed to improve employment outcomes. Given the limited use of employment supports currently and the fact that Job Coaching will be limited to the hours that an individual works, BHDDH does not believe a limit on these services is needed at this time.

   Although not stated in the presentation of proposed rates, the rate study recommends that approved Vehicle Modifications be in addition to the services funded through an individual's tier package. BHDDH will consider suggestions related to other services as part of the evaluation of individual budgets.

2. Bill for Community-Based Support and Center-Based Support services (currently termed Day Programs) based on an individual's assigned tier rather than the staffing ratio of the program in which they receive services. This recommendation reduces the administrative burden of continually tracking staffing ratios and increases the predictability in the amount of support that an individual can receive because they will know how much will be billed for each unit of service.

3. Combine several individual components of the tier packages for the purposes of planning. In particular, amounts assumed for Community-Based Supports, Day Programs, Transportation, Overnight Shared Supports, and Respite would be treated as a single budget.

4. Reprice the tier packages to account for the proposed changes in payment rates. This is consistent with BHDDH's current practices and ensures that individuals are able to receive the same level of support assumed in the tier packages.

6. Several commenters expressed concern about the lack "parity" among residential options because the tier packages include different levels of funding based on residential setting. One of these commenters emphasized that fewer dollars are available to individuals who living with family or in their home compared to those who live in a provider-controlled settings. Another one of these commenters stated there is no residential support for individuals who live with their family.

As noted in the response to comment 3, the current tier packages consider an individual's residential setting, with different budgets based on whether an individual lives with a relative, in their own home or apartment, in a shared living arrangement, or in a 24-hour residential placement such as a group home. Each tier package includes funding for residential support (for individuals who live with their family, the service is Community-Based Support).

As additionally described in the response to comment 3, consideration of potential changes to individual budgets have been delayed due to forthcoming changes to the Supports Intensity Scale. This input will be considered as part of the evaluation of potential changes to individual budgets, but it is noted that there are significant differences in funding requirements across settings. For example,

funding for individuals in group homes must provide for 24-hour support while this will not necessarily be true for individuals who live with family. Similarly, some services, such as Group Homes and Supportive Living programs, generally rely on employees earning an hourly wage and benefits while Shared Living Arrangement home providers are not employees, but instead receive stipends that are generally exempt from income taxes.

7. ***One commenter asked how the rate study addresses the issue of individuals who self-direct services competing with agencies for direct support professionals when individuals who self-direct receive the same tier packages but must typically pay higher wages.***

   As the commenter notes, individuals who choose to self-direct services receive the same tier package as individuals who do not. As discussed in the response to comment 3, the evaluation of how individual budgets are established and managed has been delayed due to forthcoming changes in the Supports Intensity Scale, which is used to assess individual needs and assign tier packages. This evaluation will include consideration of how to support individuals who self-direct services. It is noted, though, that individuals who self-direct services do not have the same cost structure as agencies (that is, they do not employ administrative or support staff) giving them more flexibility in the use of their tier package funding.

8. ***One commenter stated that it would reduce the administrative burden on providers if purchase orders only be amended when circumstances change rather than annually.***

   Federal regulations require that person-centered service plans must be reviewed at least every 12 months (42 CFR § 441.725). That said, BHDDH is willing to work with stakeholders to consider strategies to streamline the purchase order process in the event that there are not changes to the service plan.

RATE STUDY PROCESS

9. ***Several commenters expressed appreciation for the rate study process, including the involvement of various stakeholders and stated that the recommendations will help address longstanding structural rate issues that have reduced capacity and restricted program flexibilities while potentially strengthening the provider workforce. Other commenters were critical of the process, stating that information was not provided timely to all stakeholders, that there was not enough opportunity for comment during public presentations, that Excel-based versions of the rate model were not published, that materials were only available in English, and that the comment period was not long enough.***

   BHDDH appreciates the support for the rate study process, but recognizes that not everyone is satisfied with either the process or recommendations. HMA-Burns did provide Excel-based versions of the several rate models when requested. These examples provided adequate information to understand all of the rate calculations, but a separate file inclusive of all services was later developed and shared. Additionally, BHDDH and HMA-Burns provided extensions to the deadline for comments when requested.

   BHDDH remains committed to involving stakeholders in the implementation of the service- and rate-related recommendations and the review of assessment and individual budgeting frameworks as discussed in the responses to comments 1 and 3. BHDDH will consider this feedback when developing strategies for stakeholder engagement.

10. ***One commenter stated that all comments received should be published as received rather than being reflected only in a summarized format.***

    The actual comments that were submitted are not being published by BHDDH or HMA-Burns as commenters were not told that their comments would be released publicly. Every effort has been made to accurately summarize the spirit of comments within this document.

11. ***One commenter raised concern with the use of provider survey results in the development of rate models, particularly given the impact of the pandemic. This commenter also suggested that the statement that providers participating in the survey account for 86 percent of services provided is misleading. Another commenter expressed concern that the rate models did not rely on costs reported by providers.***

    A key element of the rate study was the development and administration of a survey to collect information regarding providers' program design and costs. The public presentation of results reported both the number of providers that submitted a survey (24 of 35, or 69 percent) and the percentage of services delivered by responding providers (86 percent).

    Although the rate study considered survey results when developing rate models, this was not the sole source of information. The rate study considered other, independent data sources so that the rates reflect market-based costs. For example, wage assumptions for direct care staff considered Rhode Island specific data from the Bureau of Labor Statistics while health insurance cost assumptions relied on Rhode Island 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.

    The results of the provider survey analysis have been published, allowing for comparison between reported costs and rate model models assumptions; additionally, the public presentation of rate models included comparisons of key costs drivers.

12. ***Several commenters expressed disappointment in the low number of responses received for the individual and family surveys and expressed concern about drawing conclusions from the surveys. One commenter requested that the specific results of the individual and family survey be released. Commenters offered recommendations to improve the response rate for future survey efforts.***

    BHDDH included a notice of the survey in two newsletters and asked several advocacy groups to share the link to the survey, but the response rate (7 individuals receiving services and 54 family members) was lower than hoped. A report summarizing the results of the individual and family survey is attached to the report summarizing rate study recommendations. In addition to the Individual and Family Survey, online meetings were held with family representatives in May 2022, June 2022, and August 2022. Additionally, like all stakeholders, individuals and family members were welcome to submit public comments.

    Individual and family input will be particularly important to the comprehensive evaluation of assessment and individual budget frameworks discussed in the responses to comments 1 and 3 so BHDDH looks forward to collaborating with interested stakeholders to improve engagement.

13. ***Several commenters expressed concerns that the rate study would increase administrative burdens associated with tracking and billing for new services. One commenter expressed disappointment that the rate study did not adequately change the system delivery and payment structure because of the continued use of fee-for-service rates.***

    The rate study sought to balance a number of considerations, including:

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

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

Thus, while administrative burden was one consideration, it was not the only concern. Several proposals are intended, in part, to reduce administrative burden, including consolidation of Home-Based Day Program costs into Group Home rate models (as discussed in the response to comment 43); requiring that billing for group Community-Based Supports and Center-Based Supports be based on an individual's assigned tier rather than a program's staffing ratio (as discussed in the response to comment 5), which will reduce the need for constant monitoring of staffing ratios; and creating a single Transportation rate (as discussed in the response to comment 81). In response to public comments, other proposals were withdrawn based, in part, on feedback that it would add to the administrative burden, including Group Home rates that vary based on home size and the unbundling of Professional Services from Group Home services.

Some remaining recommendations will admittedly add to administrative work, including billing for Professional Services based on the provider's qualifications and billing for new services that an agency chooses to offer. However, these recommendations support other goals, including aligning payments with providers' costs and covering a comprehensive array of services based on stakeholder input.

Overall, the rate study recommendations, including primarily fee-for-service rates, intend to reasonably balance the various considerations outlined above.

14. One commenter suggested that some form of bundled rates be established to replace many of the billing codes. The commenter further suggested that providers be permitted to bill for one-twelfth of the budget each month, but they would be required to track the amount of support they provide.

The federal Centers for Medicare and Medicaid Services (CMS) generally does not support such "bundled" arrangements. For example, the Instructions, Technical Guide and Review Criteria that CMS issues for Section 1915(c) waiver applications states:

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

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

Additionally, this approach can limit or complicate individuals' choice in providers. For example, an individual may choose to receive different services from different providers so there would not be a single bundled payment. Finally, BHDDH believes that payments should be tied to the level of services actually delivered rather than the services included in the individualized service plan.

15. ***Several commenters expressed concerns related to the impacts of the rate recommendations, including:***

    - ***One commenter stated that the rate study does not promote individualized community-based services and instead over-emphasized facility-based services.***
    - ***One commenter stated that the rate study does not incentivize one-to-one services rather than shared supports.***
    - ***One commenter state that the rate study does not promote or incentivize person-centeredness or community integration.***
    - ***One commenter stated that the rate study did not provide sufficient strategies to support self-direction or reduce the administrative burdens on those who self-direct.***

    The rate study aimed to establish payment rates that reflect the reasonable rates providers incur to deliver the services made available to individuals with intellectual and developmental disabilities in Rhode Island. This includes both community-based and center-based services as well as individual and shared services. Payment rates for community-based services are higher than those for center-based services and one-to-one services have higher rates than group services, but an array of services is available because different individuals have different needs.

    Rates are only one factor in promoting the types of services advocated by the commenters. Achieving these goals also includes the processes for establishing individual budgets, the quality of case management, and a network of providers willing to offer more progressive services. Work on these other elements continue. For example, BHDDH will be conducting a comprehensive review of assessment and budgeting frameworks as discussed in the responses to comments 1 and 3 and Rhode Island is in the process of transitioning to conflict-free case management as discussed in the response to comment 34.

16. ***One commenter stated that the rate study does not promote a system of value-based payment methodologies. Another commenter asked whether consideration was given to increasing payment rates for providers that have been accredited.***

    Due to the lack of agreed-upon standards, data management and reporting infrastructure, and inadequate funding value-based payment models in home and community-based services programs have historically been limited. The rate study emphasizes the development of rates that reflect market realities, which should be a prerequisite prior to decreasing or increasing payments based on quality measures. That said, although the rate study does not include recommendations that reduce or

increase provider reimbursement based on performance measures, it does include several elements that tie payment to the values of the service delivery system, including:

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

The rate study did not recommend enhanced payments for accredited providers as accreditation is not necessarily tied to individual outcomes.

17. ***One commenter noted the need for additional information related to how and when the recommendations will be implemented.***

    In general, the recommendations related to payment rates are intended to be implemented on July 1, 2023 subject to available funding. For services that involve only a change to the payment rate, the implementation is expected to be straightforward. For services with additional changes (such as the development of differentiated Professional Services rates based on staff qualifications) and new services, more effort will be required. Additionally, some recommendations involve changes to service definitions and/or changes to billing requirements. BHDDH must also evaluate the impacts of all recommendations to ensure compliance with maintenance of effort requirements established by the federal American Rescue Plan Act.

    BHDDH intends to work with providers and other stakeholders on implementation planning to determine what can be implemented as of July 1, 2023 and what may require more time.

18. ***One commenter asked whether there was anything that prevents BHDDH or the legislature from adjusting rate model assumptions, such as wages and productivity. Another commenter noted the need to regularly update the rate models to account for future cost increases.***

    The detailed rate models are designed to allow for changes over time. This could include increases to reflect rising costs or decreases to reduce costs. Regardless of the reason for (or direction of) the change, the use of detailed rate models allows for a public accounting of the changes in comparison to what was included in the original iteration.

The recommended rate models are intended to reflect estimated expenses for the first year of anticipated implementation (that is, fiscal year 2024). As noted by the commenter, costs generally increase over time so the rate models would need to be updated to account for these increases.

The rate models include detailed assumptions related to specific cost drivers – many of which rely on regularly published data sources – allowing for regular reviews of their adequacy. For example, as discussed in the response to comment 22, the rate models rely on data reported by the U.S. Department of Health and Human Services' Medical Expenditure Panel Survey to set health insurance cost assumptions for direct care staff. DHHS publishes this data every year, allowing BHDDH and stakeholders to determine how well the assumed health insurance costs reflect current market conditions. Increases to provider payment rates will generally require new funding and will therefore need to be considered as part of the overall state budget process.

19. One commenter stated that the rate study should include a review of rates for institution-based services.

Rates for institutional services are not within the scope of this project.

MULTIPLE SERVICES

20. Several commenters expressed support for the recommended new services, but noted the need for additional information about how the services could be accessed and which would be subject to individuals' budget limits (tier packages). One commenter stated that several services only relabel existing services.

The rate study recommends adding coverage for several services, including:

- Supportive Living
- Remote Supports
- Companion Room and Board
- Personal Care in the Workplace
- Peer Supports
- Family to Family Training
- Vehicle Modifications

As the commenter observes, some of these services represent updates to existing services (for example, Supportive Living is expected to replace some current Non-Congregate Residential programs), but the proposals are intended to refine and clarify service standards.

As with other services, these services will be offered to individuals as part of the person-centered planning process. At this time, it is recommended that these services would be available as part of individuals' tier packages, with the exception of Vehicle Modifications. However, as noted in the response to comment 3, the comprehensive evaluation of individuals budgets will include consideration of which services are part of any budget limit so this may change in the future.

21. One commenter asked how rate exceptions will be handled.

As is currently true, Group Home services are expected to account for the large majority of exceptions. The process for establishing rate exceptions for these services is described in the response to comment 45. There will be a similar process for Supportive Living services.

The rate study assumes that the number of rate assumptions, which are separate from budget exceptions, for other services will be reduced. For example, the establishment of a single rate for Transportation services means that there will no longer be exceptions and the formalization of Enhanced Shared Living Arrangement rates will eliminate the need for exceptions for these models.

At this time, exceptions related to budget levels will follow current procedures. These processes will be considered as part of the evaluation of individual budgets described in the response to comment 3.

Wage Assumptions

22. One commenter stated that the rate model wage assumptions rely on Bureau of Labor Statistics data from 2019 and asked how using dated information affects assumed wages.

The rate model wage assumptions are based on projected January 2024 wage levels.

As noted by the commenters, the rate model wage assumptions first consider data from the Bureau of Labor Statistics (BLS). The BLS reports wage information on an annual basis, with data published each March and reflecting the preceding May. The rate study uses the most currently available BLS data, the May 2021 dataset published in March 2022. Recognizing that wages increase over time and that recent wage growth has been greater than historic trends, 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 August 2022, net earnings in Rhode Island increased 8.0 percent between 2020 and 2021 while the ten-year compound annual growth rate was 3.5 percent. HMA-Burns increased BLS wage estimates by 8.0 percent for twelve months and then applied an annual growth rate of 3.5 percent for 20 months – a total of 14.37 percent over 32 months – to project wages for January 2024.

23. One commenter stated that the mix of Bureau of Labor Statistics occupations used to construct a composite wage for direct support professionals does not adequately reflect the responsibilities of DSPs.

The Bureau of Labor Statistics (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 registered nurses, which the rate study uses in the rate model for Professional Services delivered by a registered nurse. For several other services, the rate study uses a weighted average of multiple BLS classifications.

The BLS classifies direct support professionals (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 – 70 percent – is applied to this occupation. Additionally, the rate study applies a 10 percent weight to three other BLS classifications: nursing assistants (to reflect supports associated with medical needs), psychiatric aides (to reflect assistance in managing behaviors), and recreation workers (to reflect assistance in accessing the community).

This weighting of occupations produces a composite wage of $17.53 per hour, which is consistent with DSP wages reported in the provider survey. However, as discussed in the response to comment 24, the rate models do not use this BLS-based approach, but include a $22.14 per hour wage assumption for DSPs based on BHDDH's agreement to support rates that assume a $20 per hour starting wage.

24. One commenter expressed support for the increase in the assumed wage for direct support professionals. This commenter also asked how the wage assumption was developed and how it accounts for wage compression. Finally, the commenter offered alternative approaches to establishing the wage assumption. Two commenters suggested that wage assumptions vary based on staff qualifications, such as additional training or a credential.

In 2021, BHDDH agreed to an Action Plan to continue reform efforts. Among other provisions, the Action Plan commits to increasing provider payment rates to support a starting wage for direct support professionals of $18 per hour in fiscal year 2023 and $20 per hour in fiscal year 2024. Since the Action Plan specifies that the rates must support a *starting* wage of $20 per hour rather than an *average* wage, the rate study had to develop an assumption for an average wage given a $20 starting wage.

The rate study considered various data sources to inform this methodology. The Staff Stability Survey administered by the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI) collects data from service providers regarding DSPs, including starting and average wages. According to the 2020 survey (the most recent available publication), the minimum average hourly wage reported by Rhode Island providers was $13.23 per hour while the average wage was $13.80 and the median wage was $14.00. This data suggests the difference between the starting and average hourly wages could be less than $1.00, although only five Rhode Island providers participated in the survey. Bureau of Labor Statistics (BLS) wage data similarly suggests a modest difference between starting and average wages. According to the BLS, the 10th percentile wage for home health and personal care aides (the occupation to which the BLS assigns DSPs, as discussed in the response to comment 23) was $13.73 per hour while the median wage was $14.09.

Overall, the Staff Stability Survey and the BLS data demonstrate substantial wage compression at the lower end of the DSP wage scale. However, recognizing the importance of graduated pay to support recruitment, retention, and job satisfaction, the rate study established a methodology that would produce a larger spread of wages. Specifically, the rate study measured the difference between the 10th and 90th percentile wages ($13.73 and $18.01, respectively, the lowest and highest values reported by the BLS) for home health and personal care aides and added one-half of that amount ($2.14) to the $20.00 wage floor established by the Action Plan. Thus, the rate models include an assumed average wage of $22.14 per hour for DSPs. As noted in the response to comment 23, this result is substantially greater than the DSP wage produced based on a composite of multiple BLS occupational classifications. The result is also much higher than the state-by-state average reported in the Staff Stability Survey. Of the 27 states that participated in the 2020 survey, the highest average wage was $16.15 in Connecticut.

One commenter suggested alternative approaches to estimating an average wage based on a $20 starting wage that would produce higher wage assumptions. However, based on the data described above, the rate study adequately accounts for wage compression across DSPs and maintains the assumed DSP wage assumption. The commenter suggested that future adjustments be based on a percentage difference between the starting and average wages. For example, if the assumed starting wage were to increase to $22.00 per hour, the average wage could be calculated by adding 10.7 percent ($2.14 divided by $20.00) to the new starting wage assumption rather than again adding $2.14. This is an approach that could be considered in future adjustments to wage assumptions.

Although the rate study does not include specific assumptions related to different wage levels based on staff qualifications, the rate models do assume that some staff will earn less than the amount assumed in the rate models and others will earn more. This offers providers the flexibility to establish their own internal compensation guidelines, which could include higher wages for more highly qualified staff.

The increase in program support funding described in the response to comment 31 also provides flexibility to increase compensation for other program support staff.

Benefit Assumptions

25. Several commenters asked how the benefits rate was calculated.

The benefits rates are derived from the assumed benefits package detailed in Appendix B of the rate model packet. The rate model includes the following:

- 7.65 percent of wages for Social Security and Medicare payroll taxes (the benefit rate calculations also account for the cap on the wages subject to the Social Security tax and the additional Medicare tax on high-income earners, but these adjustments apply only to the Professional Services rate model for psychiatrists)
- 0.60 percent of the first $7,000 in wages for the federal unemployment insurance tax
- 0.98 percent of the first $24,600 in wages for the state employment security tax
- 0.21 percent of the first $24,600 in wages for the Job Development Tax Fund
- 4.09 percent of wages for workers' compensation
- $619.05 per employee per month for health insurance
- $100.00 per employee per month for other discretionary benefits

The assumed cost of health insurance reflects the increase discussed in the response to comment 26. Additionally, the benefits package includes 25 days of paid leave (the combination of holidays, vacation, and sick leave), but this benefit is incorporated as a productivity adjustment in the rate models rather than as part of the benefits rate discussed in this response.

Overall, the benefit assumptions are somewhat greater than the benefits reported in the reported survey for full-time staff. When considering that providers reported nearly one-third of their staff work part-time and received much more modest benefits, the rate model assumptions – which assume nearly all staff work full-time and have access to comprehensive benefits – represent a substantial increase over reported current benefits.

The rate models convert the benefit assumptions to a benefit rate. Since the rate models assume that all staff have access to the same benefits package, the benefit rate varies based on the assumed wage

because, for example, the assumed annual $7,429 annual cost of health insurance represent a smaller percentage of the wages of an employee earning $40 per hour than an employee earning $24 per hour. For direct support professionals earning the $22.14 assumed in the rate models, the benefits package translates to a benefits rate of 31.20 percent. If a lower wage was assumed, the benefits rate would be higher; for example, the benefits rate based on an $18 per hour wage assumption would be 35.68 percent.

26. Several commenters objected to the assumptions related to health insurance in the benefits package for direct care staff. Commenters stated that the assumptions do not reflect costs in Rhode Island and are lower than providers' costs, do not adequately account for increasing costs, and assumes that providers only offer employee-only plans. One commenter also asked whether the assumptions account for state-operated programs (Rhode Island Community Living and Supports, RICLAS).

The health insurance assumptions were derived from Rhode Island-specific data for private sector employers published as part of the U.S. Department of Health and Human Services' Medical Expenditure Panel Survey (MEPS). Health insurance costs for state employees were not considered as part of the development of the rate model assumptions.

Appendix B of the rate model packet details the assumptions related to overall employee participation rates, the mix of health insurance plan types (employee-only, employee plus-one, and family plans), and the employer cost per participating employee in each plan type. In response to comments, a larger inflationary adjustment – totaling 14.6 percent – was applied to inflate the 2021 cost data to 2024. With this change, the rate models include $619 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. Without the inflationary adjustment, the assumed monthly cost would be $540 per employee per month, slightly less than the $554 reported through the provider survey for full-time staff. However, as noted in the response to comment 25, nearly one-third of the workforce works part-time and providers reported a cost of $34 per employee per month for these staff (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.

27. Two commenters stated that dental insurance was not included in the assumed benefits package.

As noted by the commenters, the benefits package does not include a specific assumption related to dental insurance. Instead, as noted in the response to comment 25, the models include $100 per employee per month for other discretionary benefits, which could include dental or life insurance, a retirement plan, or other optional benefits. This level of funding is slightly greater than the $94 per employee per month expense reported through the provider survey for all discretionary benefits for full-time staff. However, as noted in the response to comment 25, nearly one-third of the workforce works part-time and providers reported a cost of $19 per employee per month for these staff. When considering the overall workforce, the rate models provide a substantial premium over reported current costs.

28. One commenter stated that the assumed state unemployment insurance tax rate does reflect providers' actual costs.

As discussed in the response to comment 25, the rate models assume a state unemployment insurance tax rate of 0.98 percent, which is equal to the rate assigned to new employers in 2022. This rate is the same as the weighted average reported through the provider survey.

Productivity Assumptions

29. One commenter requested more detail on the productivity calculation included in the rate models.

Productivity factors account for the time that direct care workers spend on non-billable activities. Appendix C of the rate model packet details productivity assumptions. As shown in Appendix C, the assumptions are first made about the amount of time a direct care worker spends on various activities during an average workweek. These figures are then adjusted for training and paid time off, which are activities often concentrated in a specific period (for example, employees are more likely to take several days or a week off rather than taking a few hours of paid leave every week).

These productivity assumptions are then translated to a productivity factor, which (for most services) is calculated by dividing a 40-hour workweek by the assumed number of billable hours. The productivity factor is used to inflate wage and benefit costs to spread costs associated with non-billables tasks over the direct care worker's billable time. Productivity-related assumptions primarily relied on information gathered through the provider survey, but also considered rate models developed for I/DD services in other states and input from BHDDH staff.

30. Two commenters suggested that the time staff spend receiving training be a separately billable activity. These commenters also suggested that the training assumptions are too low.

The rate models indirectly pay providers for the time that direct care staff spend in training through a productivity adjustment as described in the response to comment 29. Specifically, the rate models include a productivity factor of 40 hours of training per direct care worker per year. This reflects a weighted average across all direct care staff, recognizing employees receive more training in their first year of employment and less in subsequent years. This total is consistent with provider survey results.

Allowing separate billing for training time would allow for more transparency into the time that staff spend in training and ensure that providers that invest more time in staff training receive more funding. However, the rate study continues to recommend that training be bundled into all rate models for several reasons. First, separate billing for training would require significant effort to define training that does and does not qualify for billing (for example, training on a providers' internal procedures would likely not be billable). Second, tracking and billing for training time would add a new administrative burden for providers. Third, since a significant amount of training would likely not be participant-specific, this time would not be eligible for Medicaid service dollars, which would increase state costs.

If training were removed from the service rate models, the rates for these services would be reduced so providers' total revenues would not increase unless their staff spend more than 40 hours per year in qualifying training.

Program Support and Administration Assumptions

31. One commenter asked how the program support cost assumptions were developed and what costs were included. The commenter listed a variety of expenses that providers incur, including technology and upfront work before individuals begin receiving services.

The rate models include funding for both program support and administrative functions. Program support includes activities related to specific programs, but that are not direct care, including supervision, program development, and quality assurance.

In general, the rate models include $30 per individual per day for residential services, $30 per direct care staff per day for services usually provided on a one-to-one basis, and $60 per direct care staff per day for services usually provided to groups of individuals. Using fixed daily amounts rather than a percentage of the total rate is intended to fairly compensate both individual and group services, and high-cost and low-cost services. For comparative purposes, these amounts were translated to a percentage of provider revenues based on fiscal year 2021 payment rates. On this basis, the program support assumptions equate to about 20 percent of provider revenues. In comparison, the provider survey found that program support was equal to about 14 percent of provider revenues (also based on fiscal year 2021 payment rates).

This significant increase in program support funding is intended to account for increasing costs and to allow for investment in program infrastructure, including compensation for program staff. Additionally, as discussed in the response to comment 35, the additional funding accommodates the elimination of the Support Coordination service as part of the transition to conflict-free case management, by incorporating these costs into the program support allowance for other services.

32. One commenter objected to incorporating the cost of frontline supervision in the program support allowance in the rate models rather than as a specific set of assumptions. The commenter also asked whether the rate models provide for raises for supervisors.

As noted in the response to comment 31, the rate models include funding for program support activities, including frontline supervision. Similar to how there is a single factor for administrative costs rather than detailing assumptions for individual positions, the broader program support assumption recognizes that providers have different internal operations related to supervision in terms of qualifications, spans of control, and whether supervisors have other responsibilities. As additionally discussed in the response to comment 31, the program support assumptions represent a significant increase over providers' current costs, which include supervision. This increase provides opportunities for investment in a variety of areas, including supervisor compensation, particularly as wages for direct support professionals increase as discussed in the response to comment 24.

33. Two commenters suggested the 10 percent administrative rate was too low, and asked how it was established and how it compared to the rate models developed as part of Project Sustainability. One of these commenters listed a variety of expenses that providers incur, including staff (noting both program staff such as program directors, residential directors, house managers as well as administrative employees such as finance and human resources staff), office space, and information technology.

The rate models include funding for both program support and administrative functions. The 10 percent of the total rates included for administration is intended to account for expenses associated with general tasks associated with the overall operation of the administration such as executive leadership, finance, and human resources. It is not intended to cover program support such as the program directors and residential directors noted by the commenter.

The assumed administrative rate was derived primarily based on data reported through the provider survey. Providers reported an average administrative rate of 10.8 percent. However, because payment rates are increasing an average of 20 percent, the rate model assumption represents an increase in administrative funding. For example, assuming a current rate of $100, a 10.8 percent administrative rate translates to $10.80 in administrative funding; if this rate increases to $120, a 10.0 percent administrative rate produces $12.00 in administrative funding. The approximately 11 percent increase in administrative funding (from $10.80 to $12.00 in the example) is intended to accommodate general cost growth.

The rate models established as part of the Project Sustainability also included a 10 percent administrative rate. BHDDH has not published updated rate models as rates have been increased in recent years, but if it assumed that the current rate models continue to include 10 percent for administration, the recommended rate models represent a 60 percent increase in administrative funding since 2017 since the recommended rates for most services are about 60 percent higher than those in effect in 2017.

To ensure the reasonableness of the administrative cost assumption, the rate study considered the level of administrative funding (not administrative rates) included in other states' rate models for a few representative services (group homes, in-home services, and day programs). This comparison found that the administrative funding in the recommended rates are generally in the top half to top third of other states' rate model assumptions.

SUPPORT COORDINATION

34. Several commenters asked questions related to Rhode Island's federally mandated transition to conflict-free case management. Questions covered both programmatic issues (how to ensure that case managers have sufficient time to understand the needs of individuals) and financial issues (how the cost of case management will affect individual budgets).

As noted by the commenters, Rhode Island is in the process of instituting conflict-free case management. This process is being led by the Executive Office of Health and Human Services (EOHHS) so questions related to service requirements and payment rates for case management providers are outside of the scope of this rate study.

As discussed in the response to comment 35, recognizing that providers will retain some supports related to the existing Support Coordination, such as internal coordination activities, the program support allowances in other rate models were increased.

The current tier packages include a specific category for Support Coordination such that the cost of this service does not affect the amount of funding available for other services. As discussed in the response to comment 3, recommendations related to how funding levels are established for individuals have been delayed due to forthcoming changes in the Supports Intensity Scale, but the cost of conflict-free case management will not be a factor in the determination of the amount of other services that an individual can receive.

35. One commenter asked how the rate models accommodate costs related to supports covered by the current Support Coordination service that will not transition to new conflict-free case management providers. Another commenter stated that the rate models eliminate all funding related to Support Coordination.

The existing Support Coordination service covers traditional case management functions, including those responsibilities outlined in the BHDDH Billing Policy Manual: assisting in the development of individualized service plans (ISPs), ongoing monitoring of services, and modifying ISPs as needed. However, some providers have noted payments associated with this service all cover other functions that are not part of traditional case management, such as internal service coordination.

Only one agency may provide case management services to an individual so the rate study recommends the elimination of Support Coordination once conflict-free case management is implemented. Although a number of functions currently covered by Support Coordination will become the responsibility of the new conflict-free case management providers, current providers will retain some responsibilities such as internal coordination activities. Due to the challenge in asking

providers to detail the costs associated with each individual task funded through Support Coordination and because conflict-free case management standards have not been finalized, the rate study did not attempt to quantify the division of these expenses. Instead, the rate study included a substantial increase in the program support allowance to continue to fund these supports.

As discussed in the response to comment 31, providers reported program support expenses equal to about 14 percent of their revenues, generally covering fiscal year 2021. That year, Support Coordination equaled about 2.3 percent of provider revenues. As additionally noted in the response to comment 31, the program support assumptions equate to about 20 percent of provider revenues based on fiscal year 2021 rates. Even if current providers' responsibilities do not change with conflict-free case management (which will not be the case), the program support assumptions ensure that any loss in Support Coordination revenue can be offset by increased payments for other services.

RESIDENTIAL SERVICES GENERALLY

36. One commenter offered support for the recommended additions to the array of residential supports.

The rate study recommends the addition or refinement of several services to ensure an array of residential supports in addition to existing Group Home, Shared Living Arrangement, and Community-Based Supports (for individuals living in their own home or family home):

- *Supportive Living*, which would be a residential living option that is less intensive and offers greater independence than a group home. In this model, individuals live in their own homes and share staffing supports provided by the agency that owns or controls the housing. It is anticipated that many existing Non-Congregate Residential Support programs would transition to this service.
- *Remote Supports*, which allow individuals to receive support from staff who are at a centralized location rather than physically present with the individual. It is anticipated that many existing Overnight Shared Supports services would transition to this service.
- *Companion Room and Board* to cover the cost of room and board of a companion/ roommate living with an eligible individual.

37. Several commenters asked for clarification on the 344-day billing limitation associated with Group Home, Supportive Living, and Shared Living Arrangement services, including:

- ***Several commenters suggested that providers will not be paid for a full year of service.***
- ***Several commenters noted that most individuals are not absent from their home 21 days per year.***
- ***One commenter asked why the Shared Living rate model assumes that the daily payment to the home provider is based on a 365-day year. Additionally, clarification on the rationale for the limitation as well as why providers do not receive a full year of reimbursement were expressed.***
- ***One commenter asked whether BHDDH will provide vacancy support to group home providers referring residents to Shared Living Arrangements.***

The rate models for Group Home, Supportive Living, and Shared Living Arrangement services all account for the total annual cost of care based on 365 days of service. All assumptions, including Group Home staffing and Shared Living Arrangement home provider payments, assume 365 days of services.

However, recognizing that providers' short-term costs are fixed even when an individual is absent, the rate models divide this annual (365-day) cost over 344 billable days. The result is a payment rate that is 6.1 percent higher than it would be if the total cost were spread over 365 billing. This ensures that a provider is fully paid for a full year (365 days) of support as long as the individual is in the home for at least 344 days. In short, providers are paid for a full year of care as long as the individual is absent for 21 or fewer days per year. The large majority of residents are in their home for more than 344 days per year, but this standard was selected to minimize the number of individuals for whom the provider forgoes revenue. That is, if the standard were based on the average number of absences, providers would forgo revenue on half of the population. Since providers are paid for a full year of service once they have billed 344 days, billing for an individual will be limited to 344 days during their plan year.

The rate models for residential services do not include any separate proposal for "vacancy support."

GROUP HOMES AND IN-HOME DAY PROGRAMS

38. One commenter asked for clarification on the Group Home rates, including whether the higher rates are related to the incorporation of Support Coordination and In-Home Day Program costs. Further, the commentors stated that the proposed rates incentivize services to individuals in assigned to Tiers A, B, and C compared to individuals assigned to Tiers D and E. One commenter objected to any reduction in payment rates for individuals assigned to Tiers D and E.

The recommended rates are a function of the assumptions detailed in the rate models. Key drivers of the increased rates included higher assumed wages for direct support professionals, increases in program support funding (which is partly related to the elimination of Support Coordination when conflict-free case management is implemented), and elimination of the assumption that homes are unstaffed for 30 hours per week (which is related to the recommendation to eliminate In-Home Day Programs as discussed in the response to comment 43).

With the changes to the proposed rate models (including the increase in assumed health insurance costs discussed in the response to comment 26, bundling of Professional Services into the Group Home rates discussed in the response to comment 49, and the withdrawal of the proposal to pay different rates based on the size of the home discussed in the response to comment 39), all Group Home rates are increasing, including Tier D and E. The magnitude of the increases, however, vary across the rate tiers. The rate models are not intended to incentivize or disincentivize supports for individuals in any particular tier. As with all services, the rate models intend to reflect the reasonable costs of service delivery. The rate models for the lower tiers are increasing by higher percentages because the rate study determined that the current rates for the higher tiers are more adequate (or less inadequate) than the rates for the lower tiers. Additionally, the elimination of the assumption that homes are unstaffed for 30 hours per week has a larger impact on the lower tiers because this represents a larger percentage increase in staffed hours compared to the higher tiers.

39. Several commenters objected to the establishment of rates that vary based on the size of a group home. Specific concerns included additional complication associated with billing based on home size and a potential reduction in group home capacity. One commenter expressed support for higher rates for smaller group homes.

The rate study proposed the establishment of rates that vary according to home size with higher rates paid for individuals in smaller homes. The recommendation was intended to recognize that there are certain minimum staffing requirements for a home regardless of size so per-person costs are higher in smaller homes (because these and other baseline costs are spread over fewer individuals).

In response to comments, this proposal has been withdrawn. Consistent with the current fee schedule, rates will be the same regardless of home size, but will continue to be tiered based on individual need.

40. One commenter requested clarification on the staffing assumptions included in the rate models, asking whether these hours include only direct support professionals or also include managers providing direct support, whether the fact that providers are not required to staff to the levels assumed in the rate models could lead to understaffing or overstaffing of the homes, and why some models include "floating" staff hours and others do not. Another commenter expressed concern that the rate models assume less staffing during some periods of the day.

The staffing hours are based on the overall assumptions outlined in Appendix D, which are then translated to per-person amounts. With the withdrawal of the proposal to vary rates based on the size of the home, this staffing model has been simplified. It now includes one 'base' staff person 24 hours per day, seven days per week. Then, beginning with Tier B, one additional full-time equivalent staff person is added for each subsequent tier (that is, Tier B includes one full-time equivalent staff over the base staffing, Tier C includes two full-time equivalent staff, etc.). Overall staffing levels are consistent with reporting through the provider survey.

The rate models assume these hours are provided by direct support professionals, but it is acknowledged that some providers may choose to cover shifts with supervisory staff. More broadly, the staffing assumptions are only meant to represent one potential approach to staffing a home (particularly because most homes will serve a mix of individuals). As with all rate model assumptions, the staffing model is not meant to be prescriptive and homes should be staffed to meet the needs of residents.

41. One commenter objected to the characterization of group home staff providing "care" to individuals and was concerned that this impacted the staffing levels assumed in the rate models. This commenter also objected to the characterization of people "choosing" to live in a group home stating that individuals reside in group homes not out of choice, but because they need the level of support provided in these settings.

Any use of the term care was not intended to reflect any change to the supports that staff provide in group homes, which are defined in the Billing Policy Manual as "Adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development… [and] personal care and protective oversight and supervision." Staffing assumptions, which are consistent with reported current staffing levels, are intended to reflect the supports described in the service definition.

Additionally, the rate study referenced choice in the sense that the system of supports should cover an array of service options to allow individuals to make decisions regarding those services that best meet their needs.

42. Several commenters asked for clarification on where the cost and time related to supervisory staff and/or the group home manager.

The rate models do not make specific assumptions regarding supervisory hours. However, as with the rate models do for other services, the Group Home rate models include this expense in the program support allowance discussed in the response to comment 31 and the administrative allowance discussed in the response to comment 33. It is expected that providers have different operating models, some may have supervisors that only provide management and no direct care, others may have supervisors that are part of the direct support hours provided, and still others may have supervisors that have both programmatic and administrative responsibilities.

43. Several commenters asked for clarification regarding the elimination of Home-Based Day Programs. Specific questions included how much In-Home Day Program support has been included in the Group Home rate models, how one-to-one support needs are accommodated, and whether there will be separate billing for Community-Based Supports and Center-Based Supports.

The rate models do not include a specific assumption related to In-Home Day Programs supports delivered in a group home. Instead, recognizing that individuals in group homes should be able to access community supports on their own schedule – rather than assuming that all individuals are away from the home during the same hours – the Group Home rate models assume that homes are staffed 24 hours per day (although, as noted in the response to comment 40, these assumptions are not mandates and 24-hour staffing is not required if there are times when no residents are in the home). The specific staffing assumptions are detailed in Appendix D of the rate model packet. Since the models provide for around-the-clock staffing, including during traditional 'day program' hours, and to avoid duplicative billing for the same staff hours, the rate study recommends the elimination of the Home-Based Day Program service.

Importantly, this recommendation does not seek to eliminate existing supports, but incorporates these staff hours into the Group Home rates. Further, as discussed in the response to comment 45, there will be a process for providers to request additional funding if a home requires more staffing than assumed in the rate models.

44. Several commenters asked for clarification on the level of funding included in the Group Home rate models for support coordination, stating this information is needed to compare the current and recommended rates.

As discussed in the response to comment 35, the rate study recommends the elimination of the existing Support Coordination services when conflict-free case management is implemented. The response to comment 31 notes that the rate study substantially increases program support funding for other services to recognize that current providers will retain some responsibilities that they fund through Support Coordination revenues, but does not quantify the amount of existing Support Coordination revenues associated with case management versus other tasks.

In terms of comparing rates, each provider is in the best position to quantify the impact for their organization. The rate study clearly shows the difference between the current and recommended Group Home rates, but only the providers know the proportion of their Support Coordination revenues that are associated with the operation of their Group Homes. With this information, providers can add amounts to their existing Group Home revenues and compare the total to the amount that would be earned based on the new Group Home rates.

45. One commenter requested additional clarification regarding the established of customized rates for Group Home services. The commenter asked whether it is equivalent to the current "L9" process.

The rate study uses the term 'customized rate' to describe the approach to establishing rate exceptions for homes that require more staffing than assumed in the rate models. In short, instead of 'promoting' an individual to a higher tier as currently occurs for most exceptions, this process envisions the replacement of the staffing assumptions in the rate model with a higher staffing level proposed by the provider and approved by BHDDH.

For example, a four-person home with one person each assigned to Tiers B, C, D, and E would be funded for 268 staff hours. If the provider believes that an individual requires more support than assumed in their rate, the provider would submit a justification and staffing schedule demonstrating the need for more staff hours than assumed in the home (to avoid duplicating payment for a service).

If approved, this alternative staffing level would be input into the rate model to determine the new rate for the individual(s).

46. Two providers expressed concern that an individual would be forced to reside in a specialized group home. One commenter asked how the rates for such homes would be established.

The rate study recommends the development of a framework to establish rates for group homes specifically designed to meet a need. For example, a home could be established for individuals who are deaf or hard of hearing. Such homes are only meant to provide an additional option for individuals who choose such a home. No one would be forced to move to one of these homes.

Recognizing that there will likely be unique costs to operate these settings and each will look different, a framework would be established to build rates for these homes. This framework would primarily consider difference in staff wages and staffing levels while other factors (such as mileage or the benefits package for direct care workers) would be the same as for standard rate models. Continuing the example of a home for individuals who are deaf or hard of hearing, the provider may need to hire staff who are conversant in American Sign Language. Employees with this skill will likely require a higher salary so the direct support professional wage assumption in the rate model would be augmented with a wage premium. Or, a medically-focused home may require one full-time registered nurse and an onsite licensed practical nurse at all times. These costs would not be covered by the rates for standard group homes so the use of a customized rate ensures that these homes will be viable.

47. One commenter asked how the rate models account for vehicle-related transportation costs.

The rate models use the Internal Revenue Service's 2022 standard rate of $0.625 per mile. The standard mileage rate incorporates all vehicle-related expenses, including acquisition and depreciation, registration, maintenance and repairs, gasoline, and insurance.

48. One commenter asked whether the mileage assumptions included in the Group Home rate models are too low as providers shift to more person-centered services.

The mileage assumptions in the rate model are consistent with provider survey results. It is already expected that providers are delivering person-centered services so it is not clear that more travel will be required in the future, but providers can monitor this factor and report whether there is a significant increase.

49. Two commenters asked questions related to the proposal to unbundle professional supports from the Group Home payment rates, primarily relating to the level of Professional Services to which individuals would be entitled. Commenters also expressed concern related to the additional administrative work to separately track and bill for Professional Services.

As noted by the commenters, the rate study proposed unbundling Professional Services from the Group Home rates and allowing providers to bill for these services directly. However, after further consideration, this recommendation was withdrawn and professional supports will continue to be bundled into the Group Home rates. The rate models have been updated to allocate one hour of registered nursing support per individual per week for all tiers except for Tier D, which includes two hours. Additionally, the Tier E rate model includes an allocation of one hour per individual per week for psychologist support. These assumptions are meant to be averages and it is expected that some individuals will require more support and other will require less (or no) support.

50. One commenter asked whether Group Home providers will be able to continue to bill for Center-Based Day Programs.

The rate study did not propose any changes to who may receive Center-Based Day Programs (now titled Center-Based Supports) or which providers may deliver them. As discussed in the response to comment 43, the rate study does propose to eliminate the Home-Based Day Program service because the Group Home rate models provide funding for 24-hour supports, but individuals receiving Group Home services may continue to access Center-Based Supports and these programs can be operated by the Group Home provider.

51. One commenter asked how the rate models account for costs associated with the capital expenses of group homes.

The rate study does not include any recommendations related to changing funding for room and board expenses. In almost all circumstances, federal law prohibits the use of Medicaid funding for room and board costs, so the rate models do not include these costs. Rather, these expenses are intended to be covered by the federal benefits that individuals receive such as Social Security Income.

SHARED LIVING

52. One commenter expressed support for the increased Shared Living Arrangement rates, but noted that the rates continue to be less than those for Group Homes and Supportive Living.

BHDDH appreciates the support for the increased Shared Living Arrangement (SLA) rates, which have not received meaningful adjustments in many years. The rates for SLA are less than those of for Group Homes and Supportive Living because they are based on different service delivery models. Group Homes and Supportive Living settings are generally staffed around-the-clock by employees who do not living in the home and who earn a wage and have employee benefits. SLA services are provided by a contractor living in their own home and being paid a stiped that is typically tax free. Due to these differences, most states and systems (such as child welfare) pay different rates for foster home models and staffed models.

53. Several commenters stated that individuals in Shared Living Arrangements should have access to Respite. One commenter asked why Respite was bundled into the Enhanced SLA rates, but not the standard SLA rates.

The current tier packages for individuals in Shared Living Arrangements (SLA) includes a separate line item for Respite services and a review of claims data demonstrates that Respite services are separately billed. Consistent with these practices, the standard SLA rate models did not include respite hours. The proposed Enhanced SLA rate models, however, did include a bundled component for respite hours. To maintain consistency with current practices across both standard and enhanced services, the respite hours in the Enhanced SLA rates have been removed. Providers will be able to separately bill for Respite services pursuant to the limits in the applicable tier package for individuals in Enhanced SLAs just as they can for individuals in standard SLAs.

54. One commenter asked several questions related to other services available to individuals in Shared Living Arrangements, including Center-Based Supports, Community-Based Supports, Transportation, Professional Services,

The rate study did not recommend change the services available to individuals who reside in standard Shared Living Arrangements.

Individuals in standard SLAs will continue to be able to access both Center-Based Supports and Community-Based Supports. Consistent with the purpose of Enhanced SLAs – providing additional support to home providers when the individuals they support do not receive other paid supports – individuals receiving Enhanced SLA will not be able to access Center-Based Supports or Community-Based Supports.

No changes to Transportation and Professional Services are recommended at this time. The current tier packages for SLA include line items for both of these supports and they would also be available to individuals receiving Enhanced SLA.

The intent of the Enhanced Shared Living service is to provide for an incentivized rate for family homes that provide a 'whole life' care model. Under the 'whole life' model, the individual does not seek to avail themselves of other supports and desires to spend more time in the family environment. The service is only available to those individuals that do not intend to seek other paid supports. If the individual does intend to seek out these other supports, the standard Shared Living Arrangement service is available for their living situation.

55. Several commenters asked for clarification related to Enhanced Shared Living Arrangement services. One commenter asked whether it is the same as "whole life" SLA and asked why individuals receiving Enhanced SLA would not be able to access employment supports. Another commenter stated that there should be more rigorous monitoring of Enhanced SLA.

As part of its response to the Covid-19 pandemic, BHDDH created a process to increase payments to Shared Living Arrangement (SLA) home providers who provided additional support due to day program closures. In some documents, this was referred to "whole life" services. The rate study recommends formalizing this version of SLA through the establishment of Enhanced SLA. The service would be available to individuals who are not receiving other paid supports such as Center-Based Supports, Community-Based Supports, or employment services. The rate models for Enhanced SLA include a higher assumed payment to the home provider since they are providing more support compared to individuals who do receive other paid services. The rate study recommended an increase in SLA agencies' oversight of their home providers by requiring at least monthly home visits for all SLA placements.

56. Several commenters objected to the proposed rates for Enhanced Shared Living Arrangements, particularly the assumed payment to the home provider. Some of these commenters stated that the additional payment to the home provider should be equal to the value of the Day Program component of an individual's tier package.

Currently, when individuals do not receive external supports such as day program or employment services, BHDDH may authorize an enhanced rate that adds the value of an individual's tier package for Day Program to the payment to the home provider. However, the Day Program rate models are based on a much different service model in which employees generally provide care to a group of individuals.

As noted in the response to comment 55, the rate study proposed the establishment of specific rate models for Enhanced Shared Living Arrangement services, including a 20 percent increase in the assumed payment to the home provider. In response to public comments, the assumed payment to the home provider was further increased. Specifically, the rate model now increases the assumed payment to the home provider by 35 percent for Tiers A, B, and C to reflect the additional hours of supervision they will provide. Assuming 56 hours of sleep time per week, there are 112 hours awake hours. If an individual participates in day activities 30 hours per week, the home provider is delivering 82 hours of supervision per week. Increasing this 82 hour baseline by 30 hours for individuals who do not

receive other supports is an increase of 36.6 percent. Due to the more intensive needs of individuals in Tiers D and E, the assumed home payment for these tiers is increased by 70 percent.

57. One commenter suggested the development of payment rates for emergency Shared Living Arrangements, Noting that the service is not Respite.

The rate study does not include a recommendation for a new emergency Shared Living Arrangement service. The Daily Respite rate continues to be available for emergency placements when appropriate and this rate has been set equal to the Tier E rate Enhanced SLA, which is the highest SLA rate.

COMPANION ROOM AND BOARD

58. Several commenters offered support for the proposed creation of a Companion Room and Board service. One commenter expressed concern about "pay[ing] people for friendship" and stated the service could lead to emotional and mental abuse.

The Companion Room and Board service is intended to provide another residential option for individuals that offers a high degree of independence. BHDDH appreciates the concerns raised by the commenter, but notes that the service will be delivered through a provider agency responsible for ensuring an appropriate match between the companion and individual receiving service and providing ongoing oversight.

SUPPORTIVE LIVING (SUPERVISED LIVING)

59. Two commenters expressed concerns related to the proposed Supportive Living service. One commenter shared negative experiences with the service. The other commenter objected to the assumption that the typical site as four-and-a-half placements.

As noted in the response to comment 20, the rate study recommends the establishment of Supportive Living to provide a residential living option that is less intensive and offers greater independence than a group home. In this model, individuals live in their own homes and share staffing supports provided by the agency that owns or controls the housing. It is anticipated that many existing Non-Congregate Residential Supports programs would transition to this service.

These programs will serve varying numbers of individuals, but it is expected that most will serve four or five individuals, as is currently true for Group Homes. The staffing assumptions are therefore divided by 4.5 individuals to develop a per-person amounts (as is now true for Group Homes with the withdrawal of the proposal to differentiate rates based on home size). There will obviously not be any settings that actually serve 4.5 individuals, but the rates are on a per-person basis so funded staff hours will reflect the actual number of residents served at the site. Further, the staffing assumptions are not prescriptive and providers will be expected to staff their programs at the level appropriate to meet the needs of the individuals they serve.

REMOTE SUPPORTS

60. One commenter expressed support for the establishment of Remote Supports, but asked how the privacy of participants would be ensured in delivering such services.

BHDDH appreciates the support for the recommended addition of Remote Supports, and agrees that individuals' privacy must be respected. Individuals would have to agree to the service, which could be provided through a number of different systems, including motion sensing system, radio frequency

identification, live video feed, live audio feed, GPS tracking, web-based monitoring system, or a device that otherwise meets the requirement for two-way communication. In all cases, the system must protect the privacy of individuals and Remote Supports cannot be provided in private living areas like bathrooms or bedrooms. Finally, individual interaction with the staff person may be scheduled, on-demand, or in response to an alert from a device in the remote support equipment system.

61. One commenter asked whether Remote Supports is replacing Overnight Shared Supports. The commenter also asked how the rates for Remote Supports compared to those of Overnight Shared Supports.

The rate study anticipates that many of the current Overnight Shared Supports services will transition to Remote Supports, but a final determination will require a review of each current program.

The comparison of rates will depend on the number of hours of Remote Supports that an individual needs. While Overnight Shared Supports is reimbursed on a per diem basis (that is, according to a fixed daily rate), Remote Supports would be billed in 15-minute increments since individuals may need access to Remote Supports for different periods of time. In general, though, Overnight Shared Supports that transition to Remote Supports would likely receive a substantial increase in funding. For example, if an individual requires eight hours of Remote Supports to cover overnight hours, payment would be $84.48 compared to the current Overnight Shared Supports rate of $28.94. If an individual receives at least three hours of Remote Support per day, their provider would earn more than the current Overnight Shared Supports rate.

62. One commenter asked about the basis of the payment rate (for example, whether it is per-person, per staff, etc.).

The recommended payment rate for Remote Supports would be billed per individual per 15-minutes. The rate model assumes there is one Remote Supports worker for every four individuals supported, but providers' actual models may include more or fewer individuals per worker.

63. One commenter asked whether Rhode Island's state Medicaid plan needs to be amended to allow for the provision of Remote Supports.

At this time, it is believed that current service definitions in the state Medicaid plan are broad enough to cover Remote Supports.

RESPITE

64. One commenter asked why Respite is not covered on a 24-hour basis. Another commenter suggested that the proposed payment rate for Daily Respite was too high.

The proposed rate model for Daily Respite service assumed that services were provided by an employee and assumed that services were provided for a 24-hour period with 16 hours compensated (and the remaining 8 hours being uncompensated sleep time). In responses to comments, the proposed rate model has been withdrawn and, instead, Daily Respite will be reimbursed at the Tier E rate for Enhanced Shared Living Arrangement services. Additionally, the rate study now recommends maintaining the current threshold that requires the daily rate to be billed when more than nine consecutive hours of support are provided.

COMMUNITY-BASED SUPPORTS AND CENTER-BASED SUPPORTS

65. Several commenters objected to payment rates based on 15-minute units, arguing that it maintains the burden on providers to track and bill for the services they provide. Commenters suggested that providers bill by the hour, half-day, or day.

Although most states – including Rhode Island – use 15-minute units for their community-based and center-based day services, there are several other states that reimburse on a day or part-day basis. The rate study acknowledges that it requires more effort to bill in 15-minute increments than for a larger unit of service. However, administrative simplification is only one goal of this evaluation. The rate study recommends the continuation of 15-nminute billing for several reasons:

- BHDDH seeks to move the system away from the concept of a traditional 'day program' that is only available during daytime hours Monday through Friday. Supports should be available based on an individual's schedule, meaning that what constitutes a 'day' will vary from one individual to the next.
- Individuals should have the flexibility to mix and match services and providers. For example, an individual may want to participate in only a few hours of Community-Based Supports because they also work for a few hours. 15-minutes rates support this flexibility as individuals can choose how much or how little support to receive.
- 15-minute units are best able to provide greater funding to providers that deliver more community-based supports than center-based supports. The rate study recommends continuation of rates that vary by setting, meaning that providers who provide more community-based services earn more than those delivering more center-based services. Daily rates often result in providers being paid the same rate regardless of the amount of time spent in the community.

Although the rate study does recommend the continuation of 15-minute billing, it also recommends the elimination of billing based on staffing ratio as discussed in the response to comment 5, which will eliminate the need for providers to track ratios throughout the day.

66. Two commenters objected to any reduction in rates, noting that the recommended rates for Community-Based Supports for Tiers D and E, and Center-Based Supports for Tier E are less than current rates.

The current rate models assume that Community-Based Supports for Tiers D and E and Center-Based Supports for Tier E are always provided on a one-to-one basis. The rate models assume that there may be instances when individuals in these tiers may be appropriately served in a small group. For example, the rate model for Tier E Community-Based Supports assumes that three individuals can be supported by two staff.

The rate study originally proposed a one-to-one rate for Community-Based Supports. In response to comments, a one-to-one rate model was developed for Center-Based Supports. These services will be available to individuals in Tier E (and any other tier) who require one-to-one support and the rates are higher than the current Tier E rates.

67. One commenter noted that the amount of funding per DSP declines as the Tier increases.

The rate models assume the same wages and benefits packages for direct support professionals across all rate tiers (since most programs will likely serve a mix of individuals). All rate model cost assumptions are equal to or greater for higher tiers than for lower tiers. That is, providers are paid more for supporting individuals with greater needs.

The commenter compares the revenue per DSP staff hour and accurately notes that the revenue per staff hour declines as the tier increases. This, however, is simply a reflection that the rate models include costs other than DSP wages and benefits. For example, there is a greater total facility cost for a larger group (that is, it takes more space to serve a group of four participants than a group with three participants). The rate models assume larger groups at the lower tiers so the result is a larger facility cost on a per staff hour basis at these lower tiers.

68. Several commenters asked how the rate structure will incentivize more integrated services.

The rate study recommends higher rates for Community-Based Supports than for Center-Based Supports. The size of the premium varies by tier, but the Community-Based Supports rates are all at least 55 percent greater than the corresponding Center-Based Supports rates. This premium is intended to support the provision of more supports in the community, which are more likely to occur in integrated settings.

69. One commenter stated there are separate rates for community-based, center-based, and facility-based services and requested definitions for each.

Consistent with current payment structure for Day Program rates, the rate study recommends separate rates for Community-Based Supports and Center-Based Supports. The rate study does not include recommended changes to the definition of community-based supports and center-based supports except that programs that are entirely community-based except for the use of a central 'hub' space used to meet individual's personal care needs and/or for meals would be able to bill the time spent at the hub at the Community-Based Supports rates. There are not separate rates recommended for center-based and facility-based services, but the rate study uses those terms interchangeably.

70. Several commenters expressed concerns related to staffing ratio assumptions in the rate models for Community-Based Supports and Center-Based Supports. One commenter asked whether the rate reflect the staff ratios included in the presentation of the proposed rate models. This commenter also objected to ratios in some models that are based on groups of direct support professionals (for example, a two-to-three staffing ratio). Finally, this commenter stated that the ratios do not provide flexibility in induvial plans.

The development of rates for shared services such as Community-Based Supports and Center-Based Supports requires that assumptions be made regarding staffing levels. In other words, a rate model cannot make an assumption related to the cost of the direct support professional to support an individual without making an assumption regarding the number of individuals across whom that cost will be spread. The rates are a function of the assumed staffing ratios documented within the rate models.

However, these ratios are not intended to be prescriptive. To promote flexibility in the design of tailored programs, providers will not be required to deliver the level of staffing funded in the rate models. There will be no minimum staffing standards and providers can deliver the level of staffing deemed appropriate to meet participants' needs within each program.

Some of the rate models do assume two direct support professionals (DSPs) serve a group of individuals, but this will not be a requirement. For example, the Tier C rate model for Community-Based Supports assume a staffing ratio of two direct support professionals for five individuals (or a 1:2.5 ratio). Since these ratios will not be enforced, providers could, for example, serve one group of individuals at a one-to-three ratio and serve another group at a one-to-two ratio. Further, most programs likely serve a mix of individuals across a mix of tiers so the staffing ratios assumed for each tier are intended to provide funding to support a level of staffing appropriate for the overall program.

71. One commenter expressed both support for the recommendation that billing for group Community-Based Supports and Center-Based Supports based on an individual's assigned tier regardless of the staffing ratio in the program in which the individual is served and concern that this recommendation will be disadvantageous to providers because they will not be able to bill a more intensive tier when an individual is absent.

As discussed in the response to comment 5, the rate study recommends that billing for group Community-Based Supports and Center-Based Supports be based on an individual's assigned tier rather than the program's staffing ratio. This recommendation is intended to reduce providers' administrative work and to increase predictability for individuals in the management of their budgets.

The expected result is that there will be times when providers will be billing a rate based on more intensive staffing than they are providing and, as noted by the commenter, there will be time when providers will be billing a rate based on less intensive staffing they are providing. The rate study includes two features designed to ensure providers receive adequate funding to support their programs. First, the rate models include an absence factor that increases the rates to account for times when a provider cannot bill because an individual is absent from the program. Second, as discussed in the response to comment 70, there will be no minimum staffing requirements. This structure should provide enough flexibility to design and staff their programs based on the needs of individuals served and typical attendance levels.

72. Several commenters noted that Tier E rates for Community-Based Supports and Center-Based Supports previously assumed one-to-one supports whereas the proposed rate models assume shared services. Several commenters asked when individuals would be able to access the one-to-one Community-Based Supports rates. One commenter noted there was no one-to-one rate for Center-Based Supports

For Community-Based Supports, the rate study recommends the establishment of both shared and one-to-one rates. This includes the development of group rates for individuals assigned to Tiers D and E. The intent is to provide both individual and shared options to all individuals regardless of level of need. The rate study does not recommend limiting the one-to-one service to individuals in any specific tier(s) or to require any special approval process for one-to-one services.

In response to comments, a one-to-one rate model for Center-Based Supports was developed. Like Community-Based Supports, this gives all individuals a choice between one-to-one and group services.

As is currently true, one-to-one services have higher rates than shared services so there will be a tradeoff (fewer hours) within the existing tier packages when individuals opt to receive one-to-one services. When individual budgets are evaluated as discussed in the response to comment 3, the potential inclusion of one-to-one supports will be considered.

73. One commenter noted differences between the rate model structures for individual and group (tiered) Community-Based Supports.

The primary difference between the rate models for individual and group Community-Based Supports obviously relates to staffing assumptions (that is, whether services are provided one-to-one or to a group). Additionally, the group rates include a facility component because it is anticipated that many of these services will be part of a program that also includes center-based activities. Including the facility cost in the community rates ensures that these costs are covered even a portion of the program is delivered in the community.

74. One commenter asked for clarification regarding the mileage built into the rates for Community-Based Supports and whether providers delivering Community-Based Supports are able to bill for Transportation services.

The mileage included in the rate models for Community-Based Supports are intended to account for 'in-program' transportation, that is, transportation costs related to transporting individuals between community settings. Consistent with current practices, Community-Based Support providers will be able to bill for Transportation services associated with transporting individuals to and from their homes.

75. One commenter asked for clarification on the amount of Professional Services assumed for individuals in Community-Based Support and Center-Based Support programs.

As discussed in the response to comment 3, the evaluation of existing tier packages has been delayed due to forthcoming changes in the Supports Intensity Scale. As a result, no changes to the assumptions of the number of hours of Professional Services while in Day Programs (now Community-Based Supports and Center-Based Supports) incorporated in the current tier packages have been proposed at this time.

As discussed in the response to comment 88, the rate study recommends Professional Services rates that differ based on the qualifications of the employee delivering supports. For the purposes of pricing the hours assumed in the tier packages, it is recommended using the rates for registered nurses since this is the most common qualification of staff providing Professional Services and is one of the higher rates. Providers, however, would bill based on the actual services they deliver.

EMPLOYMENT SERVICES

76. One commenter objected to 15-minute billing rates for Discovery and Job Development rather than hourly.

Consistent with current practices for Job Coaching (through which Discovery and Job Developmental activities may currently be provided), the rate study recommends a 15-minute billing unit for these services.

77. Several commenters requested the rationale for limits on Discovery and Job Development services and how this is consistent with the recommendations to allow individuals to access employment supports outside of the tier package limits. One commenter suggested that the proposed limit on Discovery services was too low.

As discussed in the response to comment 5, the rate study recommends that employment services – including Discovery and Job Development – not be subject to the budget limits established by the tier packages. This recommendation is intended to eliminate the need for individuals to choose between employment supports and other, less costly services. However, the rate study does recommend limits on the amount of Discovery and Job Development that an individual can receive as these are intended to be short-term services with a specified goal.

In response to public comments, the recommended limit on Discovery services has been increased to 60 hours. The recommended limit for Job Development services remains 200 hours. Both limits apply to an individual's plan year, that is the period of time covered by their individualized service plan.

78. One commenter stated that the Job Coaching rate will decline over time. This commenter also asked whether providers will bill based on the hours that an individual works or the amount of support provided.

The rate study proposes to shift to a payment model wherein the provider is paid based on the number of hours that an individual works regardless of the number of hours of Job Coaching support provided. This approach incentivizes working with individuals to increase the number of hours they work while fading unnecessary supports. Ultimately, rates would be tiered based on two factors: an individual's assessment-based tier (with higher rates for individuals with greater needs) and length of time on the job (with the expectation that fewer supports are necessary as individuals gain more experience in the job).

The rates will be based on the typical ratio of individuals' work hours to the amount of support they receive. These assumptions must be based on actual data so implementation of this model will be delayed until that data is collected, which will also allow for more time to discuss outcome-based models with stakeholders. Until that transition, providers will bill based on the actual supports they provide with no differentiation in rate based on an individual's assessed tier or length of time on the job.

79. One commenter suggested that more recordkeeping time is required for employment services. This commenter also asked how the Job Development rate model accounted for time that job developers spend networking with employers.

In response to this comment, the amount of recordkeeping in the Job Coaching rate was increased to 2.50 hour in a typical week (prior to adjustments for training and paid time off), or 30 minutes per day. The Job Development rate models include 3.75 hours per typical week (prior to adjustments for training and paid time off), or 45 minutes per day based on findings from the provider survey and rate models developed in other states.

TRANSPORTATION

80. One commenter expressed support for the proposed Transportation rate. Another commenter asked whether the rate model represent a one-way or round trip.

Consistent with current policies, the Transportation rate applies to a one-way trip from the individual's residence (or the immediate vicinity thereof) to the individual's regular activity (e.g., community support, employment) or from the activity back to the individual's residence. The service may be billed when transporting an individual to their Community-Based Supports, Center-Based Supports, employment, or activity that is not connected to a paid service (such as transporting someone to their place of worship when no other services are provided).

81. Several commenters objected to the proposal to base Transportation rates based on the number of individuals transported.

The rate study proposed Transportation rates that varied by ridership to recognize that one-to-one supports are generally more expensive than shared supports on a per-person basis. In response to public comments, this proposal has been withdrawn. Instead, a single Transportation rate has been developed to cover all trips.

82. Several commenters suggested that the assumptions related to loading and unloading time as well as the typical length of a trip (10 miles) were inadequate.

The original proposal assumed an average of ten miles per trip when a single individual is transported. As part of the revision to create a single rate regardless of the number of individuals transported as discussed in the response to comment, the single recommended rate model now assumes 15 miles per trip.

The rate model assumes two minutes per individual for loading and unloading time. Commenters did not offer alternative data and this assumption remains unchanged. As with all rate model assumptions this is meant to be an average and it is likely that some individuals will require considerably less time while others will require more.

83. One commenter asked whether there is a limit on the number of one-way trips.

The current tier packages include 512 trips per year. As discussed in the response to comment 3, recommendations related to changes to the tier packages have been delayed due to the forthcoming changes to the Supports Intensity Scale. However, as discussed in the response to comment 5, the rate study does recommend that the allotment for Transportation be combined with other allotments (including Day Program and Community-Based Supports), which would provide the ability for individuals to access more transportation albeit with the tradeoff of accessing fewer other services.

84. One commenter noted the need for transportation options other than the Rhode Island Public Transit Authority.

Although the rate study does not include any recommendations related to new transportation options, it is noted that the current rules related to Transportation Billing Alternative do provide the ability to access options such as a taxi or ride share.

PEER SUPPORTS AND FAMILY-TO-FAMILY TRAINING

85. Several commenters expressed support for the new Peer Supports and Family-to-Family Training services. Commenters also noted that additional information related to service requirements is needed.

BHDDH appreciates the support for the recommended Peer Supports and Family-to-Family Training services, which are intended to allow individuals with lived experience and training to mentor others, helping individuals to navigate the service delivery system and identify community resources. Proposed service standards, including requirements for staff delivering services, will be available soon.

86. One commenter suggested that Peer Supports and Family-to-Family Training be funded outside of an individual's tier package.

At this time, the rate study assumes this service will be subject to the limits established in individuals' tier packages. However, the comprehensive evaluation of individual budgets described in the response to comment 3 will provide an opportunity to review which services will and will not be included in any changes to the individual budgeting framework.

87. One commenter objected to the assumption that peers and family members providing the service will work part-time and will therefore have a reduced benefits package.

Individuals who use this service are expected to use a modest amount of support over a limited period of time. Additionally, in other states that cover similar services, utilization is typically low. As a result, it is anticipated that the peers and family members who provide this service will typically not

work a regular, full-time schedule. However, the use of the service will be monitored and the rate models can be adjusted if it is determined that staff do typically work full-time.

PROFESSIONAL SUPPORTS

88. One commenter stated that billing based on staff qualification will result in a significant administrative burden for providers.

The rate study recommends Professional Services rates that vary based on the qualification of the staff providing services in order to recognize differences in the cost of employing different types of licensed employees. This is commonplace in Medicaid reimbursement, including in Rhode Island (e.g., Medicaid does not pay the same rates for RNs and LPNs). The psychologist rate does not differentiate between those with or without a PhD.

Since providers will know the qualification of their staff providing Professional Services, this recommendation should not represent a significant burden on providers to bill appropriately.

89. One commenter asked for clarity on the definition of "community" as it relates to these services.

The rate study recommended different rates based upon the location of the service with higher rates for services delivered in the community to account for travel expenses and related lower productivity. The clinic-based rates would apply to services provided in the clinic/ office/ facility where the service provider works. Community-based services refer to locations in the general community where services may be provided such as the person's home, parks, libraries, and other community settings.

FINANCIAL MANAGEMENT SERVICES (FISCAL INTERMEDIARY) AND SUPPORTS BROKERAGE

90. Several commenters expressed concerns related to the draft rates for Financial Management Services, noting that the proposed rate is lower than current payment rates, which have not changed in many years. Commenters stated that agencies providing Support Facilitation do not deliver the supports described in the service definition in the BHDDH Billing Policy Manual other than the fiscal intermediary function (counseling, facilitation, and assistance related to the development of the individualized service plan and assisting the individual in securing and employing their staff) so the agencies would not be able to separately bill for these supports. Commenters suggested alternative payment rates or changes to the payment model.

In response to public comments and recognizing that the implementation of conflict-free case management will likely impact the expectations of FMS providers, the proposed rate for Financial Management Services (Fiscal Intermediary) has been withdrawn. The rate study instead recommends that payment rates be reevaluated once the conflict-free case management requirements have been finalized. The rate study does recommend changing the title of the current Support Facilitation service to Financial Management Services and limiting the service definition to fiscal intermediary functions.

91. One commenter asked whether there would be a limit on the amount of Support Facilitation that could be provided.

The rate study proposed the development of a rate model and service definition for Support Facilitation that consolidated the Supports Brokerage service and the portions of the current Support Facilitation that do not relate to fiscal intermediary functions such as assisting in the development of the individualized service plan and in securing staff. However, as discussed in the response to comment 90, commenters stated that existing Support Facilitation providers are

not delivering supports other than the fiscal intermediary functions. In response, the proposed changes to payment rates and billing policies for the current Support Facilitation function have been withdrawn. As a result, the rate model that was developed for Support Facilitation will apply only to the Supports Brokerage service, which will be continued under that same title. No changes are proposed to current policies related to how individuals choose how much Supports Brokerage services to access.

VEHICLE MODIFICATIONS

92. One commenter asked whether the vehicle modification benefit can be accessed by Shared Living Agency home providers.

The vehicle modification benefit will only be available for vehicles owned by the individual or a family member with whom the individual lives or has consistent and ongoing contact. Vehicles owned by providers, including Shared Living Arrangement home providers, will not be eligible.

SELF-DIRECTED GOODS AND SERVICES

93. One commenter asked whether any changes have been proposed for Self-Directed Goods and Services and emphasized the value of these funds to individuals who self-direct services.

The rate study has not offered any recommendations related to Self-Directed Goods and Services at this time, but intends to consider the role of this service as part of the larger review of individual budgets as discussed in the response to comment 3.