

# **State of New Mexico**

## **Developmental Disabilities Supports Division**

### **Rate-Setting Project**

### **Public Comments and Responses**

prepared by:

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## INTRODUCTION

The New Mexico Developmental Disabilities Supports Division (DDS) is in the process of implementing the provisions of the reauthorized Developmental Disabilities Waiver (DDW), including a review of provider reimbursement rates. Burns & Associates, Inc. (B&A) is providing assistance with this project.

The provider reimbursement rate review has been in progress since the summer of 2011. The project has included an examination of the current and proposed service standards; the establishment of a Rate Study Steering Committee of providers to offer input into the project; the development, administration, and summarization of a provider survey; special studies and additional research; and the development of proposed rate models.

The proposed rate models were posted on DDS's website for public comment on February 22, 2012. Providers were notified via email. Interested stakeholders were given approximately five weeks, through March 30, 2012, to submit comments in response to the proposed rate models. An email was sent to all providers on March 26 reminding them of the comment deadline.

In addition to the proposed rate models, DDS simultaneously sought comments on proposed service packages and individual budgets. Comments in regards to these topics are being separately addressed and are not included in this document.

In total, comments related to the proposed rate models were received from representatives of approximately 60 providers as well as a few family members and associations. The comments were summarized and organized into topical areas and responses were prepared. This document presents the 98 summarized comments and responses in the following order:

- General (beginning with comment 1)
- Case Management (beginning with comment 21)
- Living Supports – Supported Living and Family Living (beginning with comment 32)
- Customized Community Supports-Group (beginning with comment 46)
- Community Integrated Employment (beginning with comment 49)
- Therapies and Behavioral Support Consultation (beginning with comment 64)
- Nutrition Counseling (beginning with comment 83)
- Socialization and Sexuality Services (beginning with comment 90)
- Preliminary Risk Screening and Consultation (beginning with comment 93)
- Respite (beginning with comment 94)
- Customized In-Home Supports (beginning with comment 96)

Most of the comments objected to various provisions of the proposed rate models. A significant number of comments were directed to the rate models for Behavioral Support Consultation, Case Management, Family Living and Substitute Care, and Therapies. There were few comments received regarding Customized Community Supports, Customized In-Home Supports, Crisis Support, Intensive Medical Living Supports, Adult Nursing, or Respite. Overall, the greatest number of responses was received from therapists.

In the case of Case Management, commenters objected to a 'cut' to the rate for this service. It is noted, however, that although the proposed rate model produced a reduced rate, it was stated that the current rate would be maintained at least through fiscal year 2013. Revisions have been made to the Case Management rate model that increase the rate, although it is still less than the current rate. It is still recommended that the current rate remain unchanged for at least one year.

In terms of the components of the proposed rate models, most comments were directed to productivity factors, several were directed to the administrative and program support percentages, and few were received on wages or employment related expense factors.

As discussed in the response to comment 11, the wages assumed in the rate models rely on data from the federal Bureau of Labor Statistics from May 2010 and inflated to December 2012. It is noted that on March 27, 2012, the BLS released May 2011 wage data. B&A compared the wage data (inflating both to December 2012). The results are in the table below.

|  | <b>5/10 BLS<br/>(rate<br/>model)</b> | <b>Using<br/>5/11<br/>BLS</b> | <b>Difference</b> | <b>Notes</b>     |
|--|--------------------------------------|-------------------------------|-------------------|------------------|
| Case Management                            | \$19.13                              | \$18.43                       | (\$0.70)          |                  |
| Supported Living                           | \$11.46                              | \$10.90                       | (\$0.57)          |                  |
| Intensive Medical Home                     | \$15.81                              | \$14.26                       | (\$1.55)          |                  |
| Crisis Support                             | \$16.82                              | \$15.48                       | (\$1.34)          |                  |
| Family Living (Trainer)                    | \$17.97                              | \$17.54                       | (\$0.43)          |                  |
| Family Living (Supervision)                | \$19.13                              | \$18.43                       | (\$0.70)          |                  |
| Customized In-Home Support                 | \$11.46                              | \$10.90                       | (\$0.57)          |                  |
| Custom. Community Supp.-Indiv. and Grp.    | \$12.75                              | \$12.27                       | (\$0.48)          |                  |
| Custom. Community Supp.-Intense Behav.     | \$15.57                              | \$14.59                       | (\$0.98)          |                  |
| Community Integrated Employ.-Indv./ Grp.   | \$13.85                              | \$13.14                       | (\$0.71)          |                  |
| Personal Care                              | \$9.15                               | \$9.34                        | \$0.19            |                  |
| Respite                                    | \$10.39                              | \$10.20                       | (\$0.19)          |                  |
| RN Services                                | \$32.51                              | \$32.78                       | \$0.27            |                  |
| LPN Services                               | \$23.06                              | \$23.05                       | (\$0.00)          |                  |
| Nutrition Counseling                       | \$28.94                              | \$24.43                       | (\$4.51)          |                  |
| Behav. Supp. Consult. (Ind. Prac. Lic.)    | \$26.78                              | \$27.74                       | \$0.96            |                  |
| Behav. Supp. Consult. (Sup. Prac. Lic.)    | \$22.03                              | \$21.96                       | (\$0.06)          |                  |
| Occupational Therapy (OT)                  | \$35.26                              | \$34.10                       | (\$1.16)          | \$35.00 in model |
| Occupational Therapy (COTA)                | \$25.96                              | \$17.37                       | (\$8.59)          |                  |
| Physical Therapy (PT)                      | \$35.29                              | \$38.80                       | \$3.51            | \$35.00 in model |
| Physical Therapy (PT Asst.)                | \$18.24                              | \$17.97                       | (\$0.27)          | \$25.96 in model |
| Speech Therapy (SLP)                       | \$32.77                              | \$32.98                       | \$0.21            | \$35.00 in model |
| Screen./ Consult.- Inapprop. Sexual Behav. | \$26.78                              | \$27.74                       | \$0.96            | \$30.79 in model |

As the table shows, in most instances wages based on 2011 data are less than those based on 2010 data. DDS is not proposing to change the wages assumed in the rate models based on this data.

The large majority of comments were thoughtfully written and constructive, and DDS appreciates all those who took time to provide feedback. Based upon the comments received, DDS has made a number of revisions to the proposed rate models:

- Changes have been made to the case management rate model, including an increase in funding for administration, greater detail about the split of administrative costs between the agency and case manager as well as the specific assumptions regarding case managers' administrative costs, and an increase in the mileage assumption
- The administration rate assumed in the Supported Living and Customized Community Supports-Group rate models has been increased from 10 percent to 12 percent
- For rate models that include van acquisition costs (Supported Living, Customized Community Supports-Group, and Community Integrated Employment-Group), the purchase price has been increased from \$30,000 to \$35,000; for Intensive Medical Living Supports, the cost was increased to \$40,000
- The Supported Living, Non-Ambulatory Stipend, Intensive Medical Living Supports, and Family Living rate models have been revised to continue the existing 340-days per year billing policy rather than the proposed 28-days per month billing policy
- The Supported Living rate models have been revised to add 60 hours of additional annual staffing (about 1.2 hours per week) to account for holidays on which day programs close and individuals remain at their residences
- The Family Living rate model has been revised by restructuring the assumptions related to provider supervisors (monitors) and their mileage, by adding funding for on-call nursing support, by increasing the nutritional counseling assumption from two to three hours, and by increasing the administration rate to 11 percent
- The Family Living rate models has been further amended by increasing the annual substitute care hours built-in from 500 to 750 and funding these hours at the current substitute care rate of \$3.33 per 15-minute unit; additionally, substitute care can continue to be provided by others living in the household
- In the Intensive Medical Living Supports rate model, the annual nutrition counseling assumption has been increased to 12 hours from five hours
- The Respite rate model was revised by reducing the assuming direct support staff wage and the assumed mileage; the new rate remains 35 percent greater than the current rate
- For Respite, the proposed rate models for two- and three-person groups have been replaced with a single group rate for groups of two-to-five individuals per staff person
- For Customized Community Supports-Group, a new 'Community-Only' rate has been established; this higher rate reflects the greater costs of providing a service wholly in the community
- For Community Integrated Employment-Individual, the productivity adjustment for weekly travel time has been increased to five hours from two hours

- The Supported Employment Job Development 'milestone' rate has been replaced with a 15-minute rate that will be limited to 80 hours per individual per ISP year
- A Personal Care rate model has been developed to complement Customized Community Support and Community Integrated Employment by allowing for an additional staffing resource for individuals who require assistance with personal care
- For Therapies, Behavioral Support Consultation, and Preliminary Risk Screening and Consultation, the mileage and travel time factors were revised; additionally, the 'urban' and 'rural' labels were replaced with 'standard' and 'underserved' to better reflect the purpose of the rate variations (the counties within each group are unchanged)
- The Physical Therapist Assistant rate model has been eliminated and will be reimbursed at the same rate as Certified Occupational Therapist Assistants
- The Speech Pathology Clinical Fellow rate has been eliminated; clinical fellows will be reimbursed at the Therapist rate
- The supervisory-level practice rate for Behavioral Support Consultation has been eliminated and all services will be reimbursed according to the rate model originally proposed only for independent practice licensees; a policy change will eliminate the ability of supervisory-level practice licensees to bill directly and require that all BSC billing be done by a specified agency-type or an independent practice licensee
- A 'block' rate has been established for completing an initial Positive Behavior Supports Assessment and briefing the individual's interdisciplinary team
- An underserved rate has been added for Preliminary Risk Screening and Consultation

The summarized comments and responses follow.

## GENERAL

- 1. One provider objected to the characterization of New Mexico as a high waiver cost State, noting that these costs may be a result of the use of small settings coupled with deinstitutionalization and of allowing family members to be paid to provide Family Living services.***

In the DD Waiver Renewal Slide Presentation<sup>1</sup> that the commenter referenced, it was noted that New Mexico had the sixth highest per-recipient home and community based service cost in the country in fiscal year 2009 (\$72,525, 60 percent higher than the national average of \$45,463). The presentation also noted several reasons for this high cost, including:

- The high usage of paid residential supports (71 percent of enrollees received 12 months of paid residential supports – including 45 percent that received paid Family Living – and another nine percent received at least one month of paid residential support);
- The fact that, over time, the system has allowed about 54 percent of enrollees to be assigned to the highest levels of need (Level 1 and outliers), which allow providers to bill the highest rates; and
- The very high utilization of therapy services (64 percent of DDW enrollees utilized one or more therapies in fiscal year 2011 and they received an average of 65.5 hours).

These conclusions are consistent with the points made by the commenter. There are also other influences that impact costs in each state, including the utilization of ICF/ MRs (which impacts the profile of individuals receiving home and community based services), the type(s) of waivers operated in each state (i.e., ‘supports’ or ‘comprehensive’ waivers), and provider reimbursement rates. Regardless of the causes, though, New Mexico has one of the highest per-person home and community based services costs of any state in the country.

- 2. One commenter suggested that the State review previous rate studies to determine whether the proposed models are lacking any elements. Several commenters noted that rates have not kept pace with inflation since 1999 as measured by the Consumer Price Index (CPI).***

Three previous rate studies were reviewed as part of this project: the Deloitte and Touche 1991 and 1996 studies as well as the Myers and Stauffer 2000 study. The Developmental Disabilities Supports Division believes that all applicable costs contained in those studies have been considered in the current rate study.

Given the length of time that passed since the most recent study, it is not reasonable to use the results from that study as the starting point for the current review. It is a best practice to study and rebase rates every five years, and the current project is a rebasing of the current rates.

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<sup>1</sup>The presentation is available at:  
<http://nmhealth.org/ddsd/resourcesupportbureaupublications/DDW/CommitmentToCommunityDDW.htm>

Additionally, the current project differs in its approach from the most recent past study, which produced rates based upon the weighted median value of providers' unit costs. That approach contained no specificity as to the elements of costs that produced the rates, and had a significant 'black box' component to deriving the recommended rates. The current study uses an independent cost model approach which explicitly indicates the cost elements, factors, and policy decisions incorporated into each rate.

DDS recognizes that the proposed rate models contain reductions in some rates (as well as increases in other rates). However, DDS believes that the proposed rate models should be evaluated based on the criteria and methodology used to derive the rates and not on the basis of inflation adjusted historical rates.

- 3. Several commenters expressed various objections to the provider survey, including concerns related to the time given to complete it, the lack of follow-up or outreach to providers in need of assistance, their difficulty in completing it, and its applicability to small providers.***

The Developmental Disabilities Supports Division took a number of steps to maximize the usefulness of the provider survey. A Rate Study Steering Committee of providers representing the major services covered by the Developmental Disabilities Waiver was established. This Committee was given an opportunity to review drafts of both the provider survey and instructions as well as an outline of the proposed independent rate models. These reviews were used to verify that the survey captured the costs associated with delivering DDW services. The survey materials were revised based on the Committee's feedback before distribution to all contracted providers.

The original deadline for completion of the survey was three weeks. Based upon requests from providers, DDS extended the deadline by approximately ten days to September 19, 2011. Additionally, every request from a provider for further individual extensions was granted and all surveys submitted after the deadline were accepted. DDS sent multiple reminders and requests to providers to encourage them to participate in the survey and again encouraged providers attending the October 13 Association of Developmental Disabilities Community Providers meeting to submit a survey if they had not already done so. Given this flexibility in deadlines, DDS believes that it is unlikely that any lengthier timeframes would have improved the response rate.

Technical assistance in the completion of the survey was made available throughout the time that the survey was in the field. A dial-in conference call was scheduled in order to provide group training, and the survey instructions and each page of the survey itself included a contact name, number, and email for Burns & Associates. Individual assistance was given to every provider that requested it.

Not every question on the survey was applicable to every provider. For example, a one-person provider would not have separate administrative staff and might be unable to report an hourly wage. However, most providers should have been able to include most of the other questions on the survey (e.g., whether or not they have/ offer benefits, the number of hours spent on various tasks within a given workweek, miles traveled, etc.). Providers that felt that

certain questions were inapplicable to their organization were encouraged to complete those sections that they could and partially completed surveys were accepted and included in the analysis.

4. *Several commenters asked questions or made comments regarding the use of the data gathered through the provider survey. Commenters observed that participation (particularly amongst ‘professional services’ providers) was poor; asked how incorrect or non-responses were addressed; stated that median, rather than average (mean), responses were used; and asked how the survey was validated.*

As Burns & Associates has previously reported, approximately 18 percent of contracted providers participated in the provider survey. These respondents accounted for about 45 percent of total Developmental Disabilities Waiver spending, illustrating that larger providers (that serve the most individuals) were more likely to complete the survey. The overall response rate was diminished by the very low participation by therapists and behavior support consultants (participation across these disciplines ranged from 10 to 16 percent, accounting for between 20 and 36 percent of spending on these services).

As noted throughout the rate-setting project, the provider survey was intended to provide one source of data for the development of rate models, but was never intended to be the sole determinant of the rates. Other sources of data include independent third-party data (e.g., federal Bureau of Labor Statistics wage data), special studies, and a public comment period. In instances in which participation in the survey was low, the reported data was weighed less heavily.

In the analysis of the survey data, a couple of quality control strategies were employed. First, B&A reviewed every survey that was submitted and followed-up with providers regarding responses that appeared erroneous. Second, in the summarization of data, B&A performed calculations of weighted averages using all data and of weighted averages that excluded ‘outlier’ responses (defined as greater than two standard deviations from the mean). In addition, B&A also presented median responses for most questions since medians are less impacted by extreme values. All of these calculations were considered when developing the rate models, but as noted above, the provider survey was only one of several data sources considered. Blank values were excluded from the analysis (i.e., they were not treated as a zero value).

No field reviews – i.e., visits to providers to compare survey responses to financial and other provider records – were performed on the survey responses.

5. *One commenter stated that “the survey led providers to include non-Waiver revenues in its total, but tended to direct us only for Waiver Administration and Program overhead expenses, thereby artificially reducing its “finding” of those percentages”.*

The Developmental Disabilities Supports Division disagrees with this comment. The provider survey did ask respondents to report revenues earned from the Developmental Disabilities Waiver, other developmental disability (DD) program sources, and non-DD program sources, but the survey provided respondents the option to report administrative and

program support costs either for DDW services only or for their entire DD programs. B&A's original draft of the survey asked providers to report these costs across their entire DD programs – which is apparently the methodology that the commenter prefers – without providing an option to report costs limited to DDW services. However, the providers on the Rate Study Steering Committee asked that the survey be revised to provide a Waiver-only reporting option and B&A did so before distribution of the survey.

The instructions accompanying the provider survey did not state a preference as to which methodology to use and specifically noted that the question was asked in part to avoid understating administrative rates. The specific language included in the instructions is below (*emphasis added*):

The final question on this sheet asks whether your agency will be reporting administrative and program support costs at the DD waiver level or for all DD programs. *This question is included to ensure the appropriate funding base against which to compare administrative and program support expenses (because, for example, if waiver-related expenses are compared to total DD program revenues, the administrative rate would be understated and vice versa).* If your organization is able to identify administrative and program support costs at the waiver level, select “Waiver Only” from the drop down list. Oftentimes, providers do not allocate their expenses at the fund source level, but do so at the program level (e.g., they are unable to allocate a portion of the executive director's salary to a specific funding source like the DD Waiver, but can allocate the appropriate portion to the overall DD program); in these instances, select “Total DD Program” from the list.

Further, if the commenter was correct in that the survey “tended to direct” survey participants to reporting only DDW-related costs, it would be expected that the majority of respondents chose this option. However, the surveys were fairly evenly split, with 26 selecting the DDW-only option and 20 selecting the total program option.

Lastly, if the commenter's statement was true, it would be expected that those who chose the total program option would have lower administrative and program support rates. However, an analysis of the responses of these two groups demonstrates just the opposite; those providers that reported total program costs had an average combined administrative and program support rate of 23.9 percent, compared to 17.9 percent for providers that reported only DDW costs.

- 6. Several commenters stated that they have federally-approved administration or indirect rates that exceed the 10 percent included in the proposed rate models. One commenter concluded that the combined administration and program support rate should be 30 to 35 percent. Another commenter suggested that the administration rate should be at least 12 percent.***

The proposed rate models include a combined 20 percent for administration and program support (with 10 percent assumed for each). This allowance is nearly equal to the 20.7 percent average total reported by respondents to the provider survey, although providers

reported a higher amount for administration (12.2 percent) than for program support (8.5 percent).

Without supporting materials related to any federally approved rates, it is unknown how such rates compare to the proposed rate models. For instance, the costs included within each administrative rate would have to be compared to determine whether any costs included in a federally-approved administrative rate are separately funded in the proposed rate models (e.g., mileage, nursing supports, or program facility space). Finally, it is unknown whether these federal rates relate to the type of home and community based services provided through the Developmental Disabilities Waiver or to other services that may have different overhead costs (e.g., services with greater equipment or facility requirements).

As a reasonableness check for the administrative rate, B&A examined the IRS Form 990 returns (Return of Organization Exempt from Income Tax) for the ten largest non-profit community providers in New Mexico that were available on GuideStar<sup>2</sup> and found the weighted average management and general expense for these providers to be 11.95 percent of total revenue, with a range of 6.36 to 17.91 percent. This weighted average percentage of management and general expenses compared favorably to the 12.2 percent reported through the provider survey.

Overall, the Developmental Disabilities Supports Division believes the administration and program support rates in the rate models are sufficient, but has made two minor adjustments. First, DDS recognizes that the settlement agreement in the Jackson v. Ft. Stanton lawsuit places significant administrative burdens on Supported Living and Customized Community Supports-Group providers. For this reason, the administrative rate for these services has been increased to 12 percent. Second, DDS has increased the administration rate for Family Living from 10 to 11 percent in order to allow for additional time to complete Therap-related requirements.

**7. *One commenter stated that they did not understand how nursing costs are included in the rate models. The commenter further suggested that 120 hours of nursing supports for individual in Supported Living Category 3 was inadequate.***

The Developmental Disabilities Supports Division is working to ‘unbundle’ nursing supports from other services. In the proposed service standards and rate models, nursing is no longer bundled into Family Living or Independent Living. Nursing services authorized and provided to individuals in these living situations will be separately billable. However, Family Living providers must maintain on-call nurses to respond to individuals’ needs. If these nurses are called upon, their time is billable, but DDS also recognizes that there is sometimes a cost associated with on-call time. In response, the Family Living rate model has been revised to include \$36.00 per day (which assumes on-call pay of \$1.50 per hour) allocated across 100 individuals, or \$0.36 per day per individual for nurse on-call time.

At this time, nursing services remain bundled into Supported Living and Customized Community Support-Group. The proposed rate models for Supported Living includes 18

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<sup>2</sup><http://www.guidestar.org/Home.aspx>

hours per year for Category 1, 60 hours annually for Category 2, and 120 hours per year for Category 3. The proposed Customized Community Support-Group rate models include 12 hours of annual nursing support for Category 1 and 36 hours per year for Category 2. These numbers are intended to represent the average amount of nursing that individuals in the various Categories will receive. Some individuals will require less nursing than assumed in the rate models and, as the commenter notes, some individuals will require more.

- 8. *One commenter stated that the inclusion of revenues reported by Family Living providers results in lower administrative costs because Family Living providers are “pass through programs incurring significantly less cost to administer than Supported Living programs.”***

Family Living providers do generally have lower administration and program support rates (as a percentage of total revenues) than other provider types, but this has only minimal impact on the calculated averages. If the providers that derive more than 50 percent of their revenue from Family Living were excluded from the analysis of provider surveys, the average (mean) administration and program support rate would increase from 20.7 percent to 22.6 percent.

As noted in the response to comment 6, the Developmental Disabilities Supports Division believes that the combined 20 percent administration and program support rate included in the rate models is sufficient. DDS has, however, increased the administration rate for Supported Living and Customized Community Supports-Group providers to 12 percent (for a combined administration and program support rate of 22 percent) and increased the administration rate for Family Living to 11 percent (for a combined administration and program support rate of 21 percent).

- 9. *One commenter inquired as to the administrative assumptions used in DDS’s submission to CMS.***

Presuming that the commenter is referring to the rates depicted in Appendix J of the Developmental Disabilities Waiver application, the rates used in the Developmental Disabilities Supports Division’s submission to the federal Centers for Medicare and Medicaid Services (CMS) were estimated total rates based on the changes in the services included in the waiver reauthorization. The estimates were submitted in anticipation of the current rate study and did not include specific assumptions regarding individual rate components.

- 10. *One commenter asked whether the proposed rates accommodate Santa Fe’s local minimum wage requirement of \$10.29 per hour.***

B&A notes that the Santa Fe ordinance exempts “non-profit organizations whose primary source of funds is from Medicaid waivers” (Ordinance 2007-43). That said, however, each of the proposed rate models assumes an hourly wage that exceeds the local minimum wage in Santa Fe with the exception of Respite and the Personal Care rate discussed in response to comment 53. However, the Ordinance allows the value of health benefits to be considered as

an element of wages and the proposed rate models (including the Personal Care model) include funding for health insurance for all direct support staff.

**11. *Several commenters stated that the wages assumed in the proposed rate models are not graduated to reflect tenure.***

The wage assumption used in each of the rate models is based upon the median wage for employees working in comparable job classification(s) in New Mexico according to the federal Bureau of Labor Statistics. The median wage is used to recognize that there will be a range of experience amongst staff delivering services. It is therefore recognized and expected that some staff with less experience will earn less than the assumed wage and others with more experience will earn more. Rather than establishing multiple experience-based rates for every service, an 'average' rate (and wage) is used and providers are given the flexibility to operate their programs within the rate.

**12. *One commenter stated that the wages assumed in the proposed rate models do not account for providers' overtime costs.***

The wage assumptions in the proposed rate models are inclusive of overtime costs. As noted in the response to the previous comment, it is not expected that every staff person will be earning exactly the assumed wage. Inexperienced staff may earn less while more experienced staff may earn more. Similarly, a direct support staff's base wage may be less than the wage assumption while any overtime wage would obviously be more.

In the provider survey, providers were asked to report total hours worked (including overtime hours) and total wages paid (including overtime costs). Using these reported figures, a weighted average wage was calculated for each service. As noted in the presentation accompanying the proposed rate models, the wage assumptions included in the models are generally significantly greater than the weighted averages (inclusive of overtime costs) reported by providers.

**13. *One commenter asked how the proposed rate models account for turnover.***

The commenter did not detail how they believe turnover should affect the rate models, but there are at least a couple of areas that may be impacted. First, turnover may result in higher overtime costs as agencies must cover for vacant positions. Second, there are greater training requirements for new staff compared to more experienced staff. Both of these impacts are considered.

As noted in the response to the preceding comment, the wage assumptions included in the proposed rate models are inclusive of overtime. In terms of training, weighted averages of first year and after-first year requirements reported in the provider survey were calculated and these values informed the productivity adjustments included in the proposed rate models. It is also hoped that the more generous wages and benefits included in the proposed rate models (compared to the amounts reported by providers) will have the effect of reducing turnover.

**14. One commenter asked how paid time off was addressed in the proposed rate models.**

The proposed rate models assume that direct support staff receive 25 days of paid time off annually, including holidays, vacation, and sick time. After adjusting for offer rates and eligibility, the median amount of paid time off reported by respondents to the provider survey was 11.3 days.

Paid time off is included as part of the employee-related expense rate, which in total is 40 percent for staff with an hourly wage of less than \$13.00 per hour, 35 percent for staff with wages between \$13.00 and \$20.00 per hour, and 30 percent for staff with wages greater than \$20.00 per hour. The assumptions related to benefit costs have been publicly reported in various places, but for clarity, the documentation has been added to Appendix A of the proposed rate model packet.

**15. Several commenters suggested that the proposed rate models include a mileage reimbursement rate of \$0.50 or \$0.555 cents per mile since that is the allowable Internal Revenue Service rate with one commenter suggesting that State employees receive \$0.555 per mile.**

The per-mile reimbursement rate included in the rate models – \$0.444 – is the rate at which New Mexico State employees are reimbursed. Commenters stating that State employees receive the standard business mileage rate established by the federal Internal Revenue Service to calculate deductible costs are mistaken. New Mexico Administrative Code sets the reimbursement rate at “80% of the internal revenue service standard mileage rate set for January 1 of the previous year...” (see 2.42.2.11 NMAC). Federal employees are reimbursed at a rate determined by the General Services Administration, currently \$0.51 per mile.

**16. One commenter suggested that there should be ‘rural’ rates for all services rather than only for professional services.**

The proposed rate models for therapies and behavioral support consultation include a ‘standard’ rate (formerly referred to as ‘urban’) and an underserved rate (formerly referred to as ‘rural’). The higher rates for underserved areas have been proposed to address apparent barriers to access to these services. It is not believed that there are comparable barriers to other services.

A number of commentators mentioned transportation specifically as a cost that is higher in rural areas of the State. Inasmuch as providers in rural areas travel greater distances, costs would be higher. However, other costs are frequently lower in rural areas. Wages are an example. Using federal Bureau of Labor Statistics data from May 2011, wages were evaluated for one professional job classification (21-1021: child, family, and school social workers) and one paraprofessional position (39-9021: personal and home care aide):

- For social workers, the median wage in the Albuquerque metropolitan area (\$17.55) was between three and 20 percent higher than every nonmetropolitan area (the median wage in Santa Fe was even higher at \$18.78).

- For home care aides, the median wage in Albuquerque (\$9.10) was between five and 15 percent higher than the nonmetropolitan areas (the median in Santa Fe was \$9.97).

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

***17. One commenter stated that facility costs should be included in all services.***

Facility costs are included in all of the proposed rate models. In broad terms, facility costs relate to either program space (in which services are delivered) or overhead- or support-type activities (such as a central office).

Overhead-type facility costs were requested in the administration and program support section of the provider survey (and were reported as the second largest cost, after staff). In the rate models, these costs are included in the 20 percent allowance for administration and program support.

Additionally, the rate models for facility-based services (e.g., Customized Community Supports-Group) include a specific allowance for program space. Mortgage/ rent and maintenance costs for a Supported Living or Family Living home are not included in the proposed rate models for these services because federal law prohibits waiver coverage of ‘room and board’ costs [see 42 U.S.C. § 1396n(c)(1)].

***18. One commenter stated that the rates should include a profit margin.***

As the commenter correctly observes, the proposed rate models do not include a specific allowance for profits. The assumptions built into the rate models (e.g., agency’s administrative costs or the wages paid to direct support staff) are not prescriptive so profit (or excess earnings) can be generated by operating at a lower cost than assumed in the rate model.

***19. Several commenters suggested that the productivity adjustment related to missed appointments in several rate models was inadequate and should be increased to two-to-five hours per week.***

When an individual cancels or misses an appointment, it is assumed that the staff person engages in some other productive activity (e.g., catching up on paperwork or other administrative tasks) rather than ‘doing nothing’ during the time when that visit was supposed to occur. Thus, the proposed rate model is not intended to account for the length of the cancelled visit, but only for the time that is truly lost as the staff person shifts to another productive task.

- 20. One commenter stated that including several Supports Intensity Scale (SIS) Groups within a single rate category will encourage providers to serve only lower-needs individuals within a rate category.**

The proposed rate models seek to simplify the current level-based rates (for Supported Living, Customized Community Support-Group, and Community Integrated Employment-Group) by collapsing these levels into fewer rate 'categories'. As noted by the commenter, the proposed rate categories each include multiple SIS Groups (for example, for Customized Community Supports-Group, the Category 1 rate includes SIS Groups A through D and the Category 2 rate applies to Groups E through G). The staffing assumptions associated with each rate category are intended to be adequate to meet the needs of individuals in these SIS Groups and therefore the rates should not discourage providers from serving higher-need individuals.

The Developmental Disabilities Supports Division believes that establishing a different rate (and, by extension, different staffing ratios) for each of the seven SIS Groups would be only marginally more beneficial than the proposed approach, and any benefit gained would be offset by the added administrative and programmatic complexity that would be imposed on providers.

#### CASE MANAGEMENT

- 21. Several commenters objected to 'cuts' to the Case Management rate. One commenter objected to maintaining, rather than reducing, case management rates.**

No cuts to case management were proposed. The case management rate model does yield a rate lower than the current reimbursement level, but the Developmental Disabilities Supports Division stated that it did not intend to reduce the rate in fiscal year 2013. As discussed in the responses to the other comments in this section, a number of changes have been made to the rate model, although it still produces a lower rate. DDS continues to note that the existing rate will be maintained in fiscal year 2013.

The proposed rate is being maintained in fiscal year 2013 because it will be a transitional year for the Developmental Disabilities Waiver program as the Support Intensity Scale is administered to all adults, needs-based individual budgets are implemented, and new service standards are instituted. Given these significant changes, DDS believes it is appropriate to maintain case management rates in fiscal year 2013 and reconsider these rates for fiscal year 2014.

- 22. One commenter stated that the survey was sent to all DDS providers except the case managers. The commenter also stated that the information regarding workspace and computers reported in the survey results is inaccurate because they do not provide computers.**

The provider survey was sent to all providers on the Developmental Disabilities Supports Division's distribution list. The survey was not sent to subcontracted individuals or entities

because they do not have a direct contractual relationship with DDS. Contracting agencies were responsible for gathering any data they needed from their subcontractors.

The commenter noted that they do not provide workspace or computers to their subcontractors, but other agencies reported that they did. The fact that other agencies operate differently than the commenter and do provide workspace and/ or computers for their case managers (whether subcontractors or employees) does not invalidate the survey.

***23. Two commenters made several objections to the proposed rate model because they do not feel that it is appropriate for subcontractors (e.g., hourly wages and benefits are not applicable, a 40-hour workweek is not applicable, etc.).***

The proposed rate model is valid regardless of whether a firm employs case managers or treats them as independent contractors. In either case, the same factors must be considered: the wages that the case manager will earn, benefit costs (which are not necessarily provided through the agency), the hours required to do the job, and program support and/ or administrative overhead (which includes costs at both the agency and subcontractor levels).

In the case of a subcontractor model, case managers generally receive a single monthly rate for each individual on their caseload. This single payment is implicitly inclusive of all of the costs noted (wages, benefits, and mileage and other overhead costs). Rather than presenting these various factors as a single amount, the proposed rate model was designed to provide transparency regarding the specific assumptions included in the model. Thus, the model assumes that a case manager should earn \$19.13 per hour (about \$39,800 annually) and should have benefits equal to 35 percent of their earnings, and that administration and program support (across both the agency and the subcontractors) should be equal to 20 percent of total costs, etc. As with all of the proposed rate models, these assumptions are not prescriptive; for example, a subcontractor may not purchase the exact benefits assumed in the model.

In response to these comments, however, the proposed rate model has been revised to be more intuitive for agencies utilizing subcontractors. The rate model retains the assumptions regarding wages and benefits (because the wages and benefits of the staff delivering services to individuals is an issue of importance to the State and are applicable regardless of the service models), but now details the case managers' component of the administrative allowance. Specifically, the rate model includes expenses of \$9,800 annually for office space, phone and internet, office equipment and supplies, and other expenses, in addition to \$4,800 for mileage (discussed in more detail in response to comment 31).

Since a portion of administrative expenses are borne by the case manager, the administrative rate retained by the agency is reduced from 10 percent to 5 percent. In total, it is assumed that agencies retain 15 percent of the total payment.

Based on these assumptions, the proposed rate model assumes that a case manager with a full caseload of 30 individuals should earn \$68,300 annually to cover their wages, benefits, and expenses.

**24. *One commenter stated that the hourly wage assumption used in the proposed rate model is invalid because the Bureau of Labor Statistics (BLS) data upon which it is based does not include self-employed individuals.***

The commenter is correct in that BLS data does not include self-employed individuals. This is because the compensation earned by self-employed individuals must also include the value of their benefits and any ancillary costs. Simply put, as a rule, subcontractors will earn more than employees performing the same function because subcontractors are responsible for their own benefits (e.g., FICA, any health or dental insurance they purchase, etc.) and any other business costs. As noted in the response to the previous comment, the revised rate model assumes that a case manager with a caseload of 30 will earn \$68,300 annually to provide for their wages, benefits, and other expenses.

**25. *One commenter noted that contracted case managers do not receive benefits. Another commenter stated that state government employees receive more generous salaries and benefits.***

As noted in response to the two previous comments, it is recognized that subcontractors do not receive benefits through the agency with whom they are contracting. That does not mean, however, that they do not have benefit costs. Some of these costs are unavoidable, such as FICA, while others are at the subcontractors' discretion (e.g., whether or not to purchase health insurance). The models include the assumption that subcontractors will use an amount equal to 35 percent of the assumed wages for benefits, but the assumptions are not mandatory so an individual case manager may decide to spend more or less than this amount for benefits.

The commenter is correct that the assumptions related to benefits, while generally more generous than what providers reported as currently being offered, are not as extensive as benefits available to State employees. The State's health insurance and retirement program costs exceed the assumptions included in the proposed rate model. However, the State's benefit package is uncommon in the private sector, with which the proposed rate model is competitive.

**26. *One commenter stated that the gross receipts tax is deducted from payments to case managers.***

All of the proposed rate models are before the addition of the gross receipts tax (since that tax varies by area of the State and contractors' for-profit or non-profit status). As with current rates, an amount equal to the appropriate gross receipts tax will be added to the claim and payment.

- 27. One commenter suggested that contracted case managers should receive 35 percent of wages for benefits and 41.1 percent for “business expenses”. These costs include the use of home office space, etc. Another commenter stated that subcontractors’ business expenses such as automobile and home office costs have been omitted and should be 40 percent of wages.**

The commenter did not provide any detail to support the claim that 41.1 percent of costs should be directed to subcontracting case managers’ ‘business expenses’. For example, the base against which this cost is compared is unknown, but it is unlikely that this 41.1 percent is based upon the same wage and benefit costs assumed in the proposed rate model. Further, it is unknown what costs are included in this total, but it is likely that some of the costs are already incorporated in the proposed rate model (e.g., mileage and, potentially, benefit costs).

As noted in the response to comment 23, the rate model has been revised to make the business expenses assumptions clearer and total payments to case managers are expected to total \$68,300 annually. It is noted that this amount assumes a caseload of 30 and case managers with fewer cases will earn less.

- 28. Several commenters noted that their case managers have fewer than the 30 cases assumed in the proposed rate models. Reported numbers included 20, 23, 25, or 29.**

Based on the proposed service standards, a case manager should be able to carry a caseload of 30 individuals, as long as they have a mix of needs within their caseload (e.g., they do not have a caseload composed exclusively of Jackson Class members). Agencies, however, are free to assign smaller caseloads, although smaller caseloads will reduce case managers’ potential earnings below the \$68,300 assumed in the revised rate model.

- 29. Several commenters objected to the productivity assumptions included in the proposed rate model, generally stating that case managers have significant non-billable time. Two commenters questioned the assumption that case managers provide 4.59 hours of service to individuals per month, but another commenter stated that they provided 4.66 hours of billable time per individual. One commenter stated that case managers work nine hours per day. One commenter stated that travel time should be 28 hours per month and another stated that supervision should be 3.9 hours per month.**

Since the payment for case management is (and is proposed to remain) a monthly rate, the rate is a function of case managers’ costs and caseloads, rather than of productivity. Productivity was included for informational purposes to illustrate assumptions related to case managers’ workweeks. To eliminate the confusion associated with the productivity section of this rate model, it has been removed.

- 30. Several commenters stated that too many requirements are placed upon case managers. One commenter made several references to a 2009 time study.**

Both the existing and the proposed service standards place significant responsibilities on case managers. For this reason, caseloads are capped at 30, which is significantly less than the caseload allowed in many other states. To identify opportunities to reduce requirements, the

Developmental Disabilities Supports Division continues to seek specific suggestions from case managers. DDS released a third iteration of draft service standards for public comment at the same time that the proposed rate models were released. Comments related to these standards, including potential easing of requirements, are being addressed separately from this document. Analysis of the 2009 time study is incomplete, but as previously noted, DDS believes that a caseload of 30 is appropriate for a full-time case manager.

- 31. Several commenters stated that mileage should be between 800 and 1,300 miles per month. However, one of the commenters then noted that mileage costs should not be included in the model because “Case Managers are not employees therefore their mileage costs are already included.”**

The mileage assumption has been increased to 900 miles per month from 450. It is recognized that subcontracting case managers will not be specifically reimbursed by their agency for miles traveled. Rather, this cost is part of the total monthly payment that case managers receive. However, as noted in previous responses, the assumptions are separately delineated in order to provide transparency into how the rate was developed.

## LIVING SUPPORTS

### Common Comments

- 32. Several commenters objected to the proposal to change the billing rule allowing providers to bill up to 340 days per year to permitting them to bill up to 28 days per month.**

The proposed rates have been revised to permit 340 days to be billed per year. Further details regarding related billing policies can be found in the revised service standard for Living Supports.

### Supported Living

- 33. One commenter stated that the hours included in the proposed Supported Living rate models are too low based on “industry standard staffing formulas”. Another commenter stated that the proposed Category 3 rate model does not include adequate staffing hours because “clients will have only one staff a significant amount of time.” That commenter also noted that the rate model does not account for holidays on which day programs are closed and individuals remain at their residences.**

The commenter did not specify what they consider to be industry standard staffing formulae so it is unclear what staffing level the commenter believes is appropriate. The proposed rate models include between 159 and 278 staff-hours (when including the overnight hours included in the non-ambulatory stipend) per residence per week. These staff-hours figures exclude nursing support and do not include the Intensive Medical Living Supports model. On the provider survey, respondents reported that the typical three-person Supported Living residence has 220 staff-hours per week.

The proposed Category 3 rate model without the non-ambulatory stipend is developed such that it provides for two staff during all awake hours for a three-person home. Specifically, there are 82 awake hours in a 168-hour week after subtracting 30 hours for meaningful day activities and 56 hours for sleep time. Of the 222 hours in the Category 3 rate model, 56 are presumed to be for a single, awake, overnight staff person. The remaining 166 hours allow for two staff at all times during the 82 weekly awake hours. The staff hours included in the proposed rate model are virtually identical to the worksheet submitted by the commenter. Further, if an individual is non-ambulatory, the non-ambulatory stipend provides for an asleep staff person in the home in addition to the primary awake staff person.

Upon review, DDS concurs that the proposed rate models should be adjusted to provide for additional staffing hours to account for holidays on which day programs close and individuals remain at their residences. The model has been revised to include an additional 60 hours per year (10 holidays multiplied by six hours of typical day program attendance). On a weekly basis, this adds approximately 1.2 hours to the staffing hours (60 hours divided by 52 weeks).

***34. One commenter objected to the productivity adjustments, reporting that “Employer and One-on-One Supervision Time” should be two hours per week rather than one hour, and training should be more than 128 hours per year.***

The productivity adjustment for Employer and One-on-One Supervision time is intended to account for time for which the staff person is participating in employer-required activities that require another staff person to ‘cover’ for them. If the staff person is participating in employer activities or receiving one-on-one supervision, but still providing service within the home (without the need for that time to be covered by a staff person not included in the staffing hours assumed in the proposed rate models), that would not be considered a productivity adjustment. On this basis, it is believed that one hour per week is adequate. This is slightly greater than 0.91 hours per week reported in the provider survey.

As with employer time, the productivity adjustment for training is intended to account for time for which a direct support staff is receiving training that requires their time to be covered by another staff person. Training received outside of the home certainly meets this criterion. Client-specific training that is delivered in the residence would not require a productivity adjustment unless additional staffing hours (not included in the proposed rate models) are brought into the home. It is recognized that some trainings require staff to attend during their off-hours, which would require a productivity adjustment. Overall, the proposed rate model includes 1.25 hours per week (65 hours) of training per year for each direct support staff in the home to cover both training that occurs outside the residence as well as off-hours client specific training.

## Family Living

- 35. A commenter stated that the Family Living providers that completed the survey may not be representative of all Family Living providers and concludes that the results may not reflect actual program costs.**

Of the 46 providers that delivered Family Living services in fiscal year 2011, 16 completed the provider survey (35 percent). These providers represented 47 percent of total Family Living billing, demonstrating that larger providers were more likely to participate in the survey. Overall, ten of the respondents were in the top half of providers by revenue with the balance in the bottom half.

The commenter states that those submitting the survey are not representative of all providers, presumably because of the greater participation by the larger providers. Without information from those who chose not to complete the survey, it is unknown to what, if any, extent their business models differ from those that did participate. For example, the commenter alludes to the fact that larger providers may have lower administration rates because they are able to achieve economies of scale, and this may be true. That said, even if more smaller providers completed the survey, the proposed rate models would still be more weighted towards larger providers. These larger providers are responsible for serving the majority of individuals and it would be unreasonable to weight the responses of a provider serving 200 individuals equally to those of a provider serving two individuals.

- 36. One commenter noted that the proposed service standard and rate model includes \$2,051 per month for the Family Living provider, which is less than the \$2,150 that the provider is currently receiving.**

The proposed service standard establishes a minimum payment to Family Living providers of \$2,051 per month and this is the amount assumed in the proposed rate model. Agencies are permitted to pay an amount greater than the minimum, although it is acknowledged that doing so would require that the agency identify savings elsewhere in the rate model.

- 37. One commenter asked why there is not a non-ambulatory stipend for individuals in Family Living as there is for individuals in Supported Living.**

The proposed rate models include a Supported Living non-ambulatory stipend for individuals meeting certain criteria. This stipend would be to bring another direct support staff into the Supported Living residence overnight. This direct support staff would be sleeping, but available to help in the event of an emergency because the single overnight awake staff person may not be able to evacuate three individuals if one is non-ambulatory. In the case of Family Living, most residences have only a single waiver enrollee so the Family Living provider would only need to evacuate this one individual.

**38. *Several commenters objected to the proposed reduction of substitute care to 500 hours (20.8 days annually).***

In response to the comments received on this issue, the Developmental Disabilities Supports Division has increased the proposed cap to 750 hours (31.3 days per year). In the rate model, these hours are funded at the existing Substitute Care rate of \$3.33 per unit (\$13.32 per hour).

**39. *Several commenters expressed concern that family members will no longer be able to support the Family Living provider in caring for the individual receiving services.***

There was no proposal to prohibit other persons in the Family Living household from providing support to an individual. It was proposed that other household members (who are often the individual's parent or sibling) would no longer be paid for providing this support. However, in response to comments on this issue, the Developmental Disability Supports Division has eliminated this proposal.

**40. *One commenter stated that they heard that "we will also not be paid for the days our loved one is in substitute care and community care."***

The proposed rate model assumes that Family Living caregivers will receive a monthly payment. This payment should not be reduced when the Family Living caregiver utilizes substitute care, up to the maximum allowable amount. With respect to "community care" it is unclear as to what setting or service the commenter is referring.

**41. *One commenter noted that the proposed rate model includes two hours of nutrition counseling, but the proposed service standards requires that "an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT."***

The proposed rate model has been revised to include three hours of nutritional counseling for each individual. It is noted that it is expected that some individuals will receive more than three hours of nutrition services while others will receive less, or none, but the average will be three hours.

**42. *Several commenters suggested that the productivity assumptions for Family Living supervisors do not include enough non-billable time. Additionally, one commenter stated that the rate model does not include the cost associated with an annual updated home study.***

After further evaluation, the Developmental Disabilities Supports Division has revised the assumptions related to Family Living provider supervisors (monitors). The revised rate model calculates supervisors' annual wage and benefit costs (using the same assumptions included in the proposed rate model), assumes that supervisors carry a caseload of 20 Family Living providers, and then calculates the per-client cost of supervisors' wages and benefits. This methodology allocates both 'billable' and 'non-billable' time on a per-client basis (similar to the structure of the revised case management model).

Specifically, the model allocates about 8.67 hours (both direct and indirect) per month per Family Living provider. This revision to the rate model acknowledges the other supports provided by the supervisors, including the annual home study update.

Finally, it is noted that several providers reported that their supervisors have caseloads of 25; using that assumption would translate to 6.93 hours per individual per month and reduce the rate by approximately \$2 per day.

***43. One commenter suggested that the rate model should include 571.25 miles of travel per individual per year.***

The proposed rate model assumed that the average supervision visit entails 30 miles of driving and that each Family Living home receives a monthly visit, for a total of 360 miles per home per year. This amount approximates the per visit mileage reported by providers participating in the provider survey. Respondents reported a weighted average of 29 miles per visit (excluding one provider that reported an average of 300 miles per visit) and a median distance of 20 miles.

However, consistent with the change to the rate model discussed in the response to the previous comment, the rate model now includes an estimate of the mileage traveled by a supervisor in a year. Specifically, it is assumed that supervisors travel 10,800 miles per year (900 miles per month). With a caseload of 20, that translates to 540 miles per consumer per year.

***44. One commenter stated that funding for program support and administration is too low.***

Based on the revisions to the rate model outlined in the responses to comments 6, 42, and 43, the administration and program funding included in the rate model increases from \$385.08 per Family Living provider per year to \$1,021.40. This funding is in addition to the supervision and training allowances separately delineated in the rate model that would be considered program support in the proposed rate models for other services, as well as the administration and program support components of the nutrition and substitute care supports built into the rate model.

***45. Several commenters suggested that the Family Living should be held-harmless.***

Between the information gathered during the provider survey and the revisions made based upon public comments, the Developmental Disabilities Supports Division believes that the rate model adequately accounts for Family Living providers' costs and does not see any reason to disregard this information by maintaining existing rates.

#### **CUSTOMIZED COMMUNITY SUPPORT-GROUP**

***46. Several commenters stated that the productivity adjustments are too low, particularly for IDTs, progress notes and training.***

The Developmental Disabilities Supports Division believes that the productivity adjustments contained in the proposed model are adequate.

With respect to training, suggestions were made to increase the productivity adjustment from .75 hours per week (38 hours per year) to levels of 1 hour per week (52 hours annually) and even 2 hours per week (104 hours annually). It is assumed that the reasoning for suggesting higher training factors is to accommodate client specific training. As discussed in the response to comment 34, productivity adjustments for training are intended to account for time in which the direct service staff is receiving training and not providing billable services. In the case of client specific training for Customized Community Supports – Group, the Developmental Disabilities Supports Division assumes that most, if not all client specific training would occur during the time the client is receiving this service. Therefore, no productivity adjustment is included for client specific training and the adjustment factor is intended to only address the more generic training the DSP receives each year.

With respect to the productivity adjustment for progress notes, different commenters suggested increases to the proposed model's 1.5 hours per week to either 3.5 or 5 hours per week. After considering these suggestions and reviewing the progress note adjustments for other services, no revisions were made to this factor.

Finally, commenters offered suggestions to increase the productivity adjustment for attending IDT meetings from the proposed model's .5 hours per week to 1 hour per week. Assuming that direct support staff attend IDT meetings (i.e. that these meetings are not routinely attended by support staff such as internal support coordinators), the proposed model factor provides for 26 hours of IDT attendance per year. Assuming that a DSP provides services to an average of either 4.5 or 2.75 individuals in this service, the 26 hours per year translates to either 5.8 or 9.5 hours per individual served per year. This level of IDT participation by the DSPs is considered sufficient and no revision has been made to this factor.

***47. Several commenters suggested that the assumed vehicle price be increased from \$30,000 to \$40,000 (or more) in order to allow for a wheelchair accessible van.***

The majority of respondents to the provider survey reported an average vehicle purchase cost of less than \$30,000. However, after further evaluation, the vehicle cost assumption for this service (as well as for Community Integrated Employment-Group and Supported Living) was increased from \$30,000 to \$35,000. This adjustment was made in order to provide an adequate vehicle acquisition amount to provide for a mix of vehicles, including vans with and without wheelchair lifts. Given that individuals in Intensive Medical Living Supports are more likely to have conditions requiring specialized vehicles, the vehicle acquisition cost was increased to \$40,000 for this model.

**48. *One commenter stated that 50 percent of individuals' time in the community is not in their clients' best interests.***

The rate model assumes that individuals will be in the community for one-half of their time in their Customized Community Supports-Group program. The rate model itself is not prescriptive; the service standard outlines requirement on providers so this comment is not fully addressed in this document, but will be addressed as part of the responses to service standard comments Developmental Disabilities Supports Division. However, it is noted that inclusion of the community time in the proposed rate model (with a higher staff-to-consumer ratio) has resulted in a proposed rate that is greater than would be the case if the service was assumed to be completely facility-based.

Additionally, Developmental Disabilities Supports Division has established a higher 'Community-Only' rate for programs that do not have a facility-based component in order to recognize the greater costs associated with delivering a service that is delivered wholly in the community.

#### COMMUNITY INTEGRATED EMPLOYMENT

**49. *Several commenters objected to billing on a 15-minute unit basis for Community Integrated Employment-Individual. Commenters suggested that such a rate will lead to more dependence because the current "monthly" rate promotes "fading away" and encourages providers to deliver less support. Conversely, another commenter raised several objections to the currently monthly rate, stating that "[c]hanges are needed under this service" because "one phone call to one potential employer ought not be billed to the budget for all 20 clients served" and "during my 10 years of DD Waiver CM duties not one of my clients have found work because of an employment agency."***

The Developmental Disabilities Supports Division does not believe that shifting from a 'monthly' rate to a rate billed in 15-minute increments (as is the case with most home and community based services, other than case management and residential supports) will result in diminished outcomes for individuals, for several reasons:

- Billing for employment supports actually delivered instead of (what is essentially) a monthly maintenance rate is already commonplace in New Mexico. Currently, there are two Supported Employment-Individual rates: the 'regular' monthly rate alluded to in the comments and an Intensive rate that is billed in 15-minute increments. In fiscal year 2011, 43 percent of all total Supported Employment-Individual billing was for the Intensive rate. The majority of supported employment providers billed the Intensive rate for at least some of the individuals who they served. Further, reviewing providers' wage and hour reports, 92 percent of individuals receiving Intensive services were reported as employed compared to 90 percent of those receiving 'regular' individual services. Given the frequency with which providers are already tracking and billing employment supports in 15-minute increments, and the fact that outcomes for individuals appear comparable, it is unclear why providers would be

unable to bill for actual supports provided or why outcomes would be expected to deteriorate.

- The extent to which ‘fading’ is currently occurring is questionable. Comparing the wage and hour reports to claims data, billing actually increases the longer that an individual is employed. In fiscal year 2011, providers billed an average of 23 units of Supported Employment-Individual for individuals who were unemployed, 25 units for those employed less than one year, 35 units for those employed for one to three years, and 38 units for those employed for more than three years (a provider may bill up to 48 units per year). Since DDS is unable to determine how much support is actually provided for individuals receiving Supported Employment-Individual, it is possible that providers are fading their support over time. However, there does not appear to be evidence that providers are reducing their billing. In fact, if supports are fading, the evidence would suggest that providers are actually billing more for less support.
- Similarly, there does not appear to be any evidence that the current monthly rate is tailored to meeting individuals’ needs. Evaluating the months in which Supported Employment-Individual was billed for an individual in fiscal year 2011, providers billed the maximum allowable amount (four units) 83 percent of the time (3,863 of 4,667 member months). This suggests that fading is minimal and that the service is treated as an ongoing stipend.
- A significant portion of individuals reported as employed are actually employed by the agency being paid to provide supported employment services (and the individuals are usually paid far less than the providers bill the State for the service). Of those reported as employed and for whom the provider is billing Supported Employment-Individual services, at least 29 percent are actually employed by that provider. In these instances, providers should have no difficulty in determining the amount of support that an individual needs to maintain that job (separate and apart from ‘standard’ supervision, which is not billable).

Tying payment to services actually delivered will increase accountability within the system by allowing for the monitoring and evaluation of the actual services that individuals receive, whether fading is occurring, etc. Based on these facts, DDS believes that providers will be able to administer a program that makes payment for supports actually delivered.

***50. Several commenters stated that the proposed rates are inconsistent with an employment-first philosophy.***

The Developmental Disabilities Supports Division disagrees with this statement. Employment remains a priority service over other day service options (and the Community Integrated Employment-Individual rate is 4.5 percent greater than for Customized Community Supports-Individual) and individuals are to receive informed choice on employment. The proposed rate model has not changed this philosophy, but intends only to more closely align payment with services provided.

**51. *One commenter reported that, in some cases, they will receive only \$30 in a month for someone for whom they currently receive \$200.***

The Developmental Disabilities Supports Division believes that this comment underscores the need to transition to a rate model that ties payment to services provided. If a provider is delivering only one hour of direct service (the implicit assumption for \$30 in billings) to an individual, the State should not be paying \$200 for that hour.

**52. *One commenter stated that some individuals require multiple services during an ISP year (e.g., job coaching, service coordination, and job development), but the proposed rates do not permit such flexibility.***

Neither the proposed rates nor the service standards prohibit an individual from receiving these various services within a year. In fact, it should not be uncommon that a provider bills the job development rate while assisting an individual to obtain a job, provides extensive job coaching (through the Community Integrated Employment-Individual rate) while the individual becomes acclimated to the job, and gradually decreases job coaching with a goal of moving the individual to needing only periodic assistance.

**53. *One commenter reported that some individuals require two staff-persons to be on site, with one of the two assisting with the individual's personal care needs.***

Community Integrated Employment-Individual assumes a one staff to one individual staffing model and is not intended to address situations that require two staff for a single individual. To address these types of situations, the Developmental Disabilities Supports Division has established a rate model for Personal Care supports, which would support a staff person to accompany individuals receiving Customized Community Supports or Community Integrated Employment services in order to assist with their personal care needs.

**54. *Several commenters proposed alternative productivity adjustments in the Community Integrated Employment-Individual rate model. The most significant changes related to travel time, progress notes, and training time.***

The commenters' suggestions with respect to the proposed model's productivity adjustments for training time and progress notes are similar to the suggestions that were offered with respect to Customized Community Supports – Group. In this case, the proposed model's training time factor is suggested to be increased from .75 hours per week to either 1 hour or 4 hours per week, and the proposed progress notes factor is suggested to be increased to either 2 hours or 3 hours per week.

The Developmental Disabilities Supports Division considered these suggestions in a similar manner as the suggestions for Customized Community Supports – Group: assuming that the adjustments to training time were motivated by the amount of client specific training that is required and comparing the progress notes factor to the factor used for other services. As with Customized Community Supports – Group, no change in either of these factors was made. In the case of training, the model assumes client specific training will be provided

while the client is receiving services. In the case of progress notes, the current factor is considered appropriate based on the factors contained in other service models.

However, with respect to the suggestions related to travel time, the Developmental Disabilities Supports Division increased the amount of travel time included in the rate model from two hours per week to five hours per week (one commenter had suggested 4.25 hours and another had proposed eight hours).

**55. *One commenter suggested a higher rate for self-employment services, based on a higher direct support staff salary, 5 hours per week for progress notes and record-keeping, and a higher mileage allowance.***

The Developmental Disabilities Supports Division proposes to pay the same rate for the Self-Employment service as for Community Integrated Employment-Individual. The proposed rate model uses:

- A wage rate \$13.85, which is considerably higher than the \$10.00 median and the \$10.07 weighted average wage rate reported in the provider survey
- A factor of .75 hours per week for progress notes and record-keeping, which is below the provider survey reported amount of 1.7 hours per week
- A mileage allowance of 120 miles (with 2 hours per week of travel time) compared to the provider survey reported 65 miles (and 1.38 hours per week of travel time)

Given the factors that were used in the proposed rate model to develop the rate for the Self-Employment service, the lack of frequency with which the Self-Employment Service is utilized, and the 8.4 percent increase in the Self-Employment proposed rate over the current rate, DDSD does not believe a separate, higher rate for Self-Employment is justified.

**56. *One commenter noted that the proposed service standards call for a QI committee that must convene at least quarterly, but the proposed rate model does not address this issue.***

The proposed service standard requires that agencies institute a Quality Assurance/ Quality Improvement (QA/ QI) Committee that meets quarterly to review a variety of measures. The QA/ QI Committees are considered a program support function and so are included in the 10 percent allowance for program support. Further, the QA/ QI Committees do not necessarily have to include direct support staff so a productivity adjustment for these staff is not warranted.

**57. *One commenter suggested that facility and supply costs should be included in the Community Integrated Employment-Group rate model.***

As noted in the response to comment 17, program-related facility costs are only included for those services which are, at least partially, facility-based (e.g., Customized Community Supports-Group). Community Integrated Employment-Group services are primarily intended to support individuals in the community rather than in facilities. Consequently, facility costs are not included in the rate model. Inasmuch as some providers may be

operating center-based programs, facility-related costs should be paid from the business' revenues (as with any other business).

Supply costs are not included in the rate model for a similar reason. The Community Integrated Employment-Group rate is intended to provide support to individuals to assist them in employment, but is not intended to cover the cost of normal business-related expenses such as supplies (or facilities).

***58. Several commenters stated that the proposed service standards 'bundle' nursing into Community Integrated Employment, but the rate models do not include an allowance for nursing support.***

The proposed service standard for Community Integrated Employment does not include a requirement that the employment provider deliver nursing services. For individuals that require nursing support that is not the responsibility of another provider (e.g., their Supported Living provider), nursing services would be billable in addition to the Community Integrated Employment rate.

It is possible that the commenters confused the service standard for Community Integrated Employment-Group with the service standard for Customized Community Support-Group. The proposed rate model for Customized Community Support-Group does include an allowance for nursing support. However, in reviewing the Customized Community Support service standard it was observed that the requirement for nursing support was not limited to the Group service. This oversight will be addressed in the revision to the service standard.

***59. One commenter proposed alternative productivity adjustments, with the largest changes being increases in the time associated with progress notes and training time. Overall, the commenter suggested that a staff person has 29.25 billable hours in a 40-hour workweek rather than 35 billable hours.***

This comment, as well as the response, is similar to the suggested productivity adjustments contained in comment 46 for Customized Community Supports-Group and comment 54 for Community Integrated Employment-Individual. The Developmental Disabilities Supports Division believes that the current productivity adjustments for progress notes and training time are adequate.

***60. One commenter stated that the proposed group rates will require providers to shift to institutional services.***

The proposed rate models were developed assuming a community focus. The proposed rate models are built on small groups (one staff for four individuals in Category 1 and one staff for 2.5 individuals in Category 2), which are reflective of the more intensive staffing required in community settings and includes funding for a vehicle in order to provide transportation for individuals. Without greater detail regarding the specific assumptions in the rate models that the commenter believes do not facilitate community employment, this comment cannot be more specifically addressed.

- 61. One commenter stated that the different staffing ratios associated with Community Integrated Employment-Group will result in segregation. The commenter additionally stated that a group of 5 individuals with two staff (at the ratio of 1 staff person per 2.5 individuals) would not be “community inclusion”, but would be an “outing” (the commenter noted that their current community ratio is 1:3).**

It is not DDS's intent that individuals be segregated based on their SIS Group and the proposed rate models do not require such a result. The proposed rate models do make assumptions regarding staffing levels for individuals with different levels of need, but these assumptions intentionally overlap. Specifically, the Category 1 rate model establishes a maximum staffing ratio of one staff person for every 5.5 individuals, but is actually funded at a 1:4 ratio, which is the maximum ratio allowed for Category 2. Conceptually, this does not differ from the current rates for Supported Employment, which vary based upon level of need (and implicitly assume different staffing levels), but neither the current nor proposed service standard require or encourage segregation of individuals.

In regards to staffing levels in the community, as noted above the proposed Category 2 rate model allows for a maximum staffing ratio of one staff person per four individuals, but is funded at a smaller ratio (1:2.5) in order to provide flexibility to providers. However, there is no requirement that services be delivered at a 1:2.5 ratio (or a 2:5 ratio) and the commenter could continue to provide services at a 1:3 ratio.

- 62. One commenter objected to milestone payments for job development because there will be no payment if job developers are unsuccessful. Another commenter suggested that this rate be billed in 15-minute increments.**

After further evaluation, the Developmental Disabilities Supports Division agrees with the suggestion to develop a 15-minute rate for job development rather than the existing milestone payments and has created a 15-minute rate. The primary differences in the job development rate compared to the job maintenance rate are a wage that is 10 percent higher and an assumption that five hours per week is spent on non-client specific program development activities (e.g., establishing relationships with potential employers). The resulting rate is \$9.13 per 15 minutes. Individuals should not be in job development status on a permanent basis so individuals will be limited to 80 hours of job development services per ISP year.

- 63. One commenter stated that the administrative requirements associated with Community Integrated Employment exceeds other day services because they must provide benefit counseling, task analysis, workplace environmental modifications, ADA compliance, WOTC support, and write VAPs and fade plans. Another commenter referred to VAPs as “unfunded mandates”.**

These activities are not administrative, but are job development activities. As noted in the previous response a 15-minute job development rate has been created. Services such as those noted in the comment that are for the benefit of a specific client will be billable.

## THERAPIES AND BEHAVIOR SUPPORT CONSULTATION

### Common Comments

**64. Several commenters objected to the establishment of 'rural' and 'urban' rates and/ or the methodology employed to determine when each would apply. Several commenters noted that there could be significant travel within an urban area. One provider said that therapists may or may not cluster individuals together for more efficient access and scheduling while another said that this is customary. Most commonly, providers suggested that rates be based on the distance that a provider travels to deliver a service. Other commenters expressed support for the proposed rural rates.**

As noted in Burns & Associates' report, entitled "Special Studies and Additional Analysis to Support the Development of Therapy Rates", an analysis of therapy utilization by county indicates that individuals outside of the counties in the Metro Region (Bernalillo, Sandoval, Torrance, Valencia) and Santa Fe County are less likely to receive therapy services and, when they do, they receive fewer hours of support. These results suggest unequal access across the State.

A review of the location of individuals and their therapists suggests a likely contributing factor to this inequity. In the Metro Region and Santa Fe County, individuals are usually within ten miles of their provider, but in the other 'underserved' areas individuals are usually more than 25 miles away from their provider and, in several instances, much further (although it is believed that all of these numbers overestimate travel distances for the reasons outlined in the Methodology and Limitations section of the report). A similar review of behavioral support consultation services yielded similar results.

Given the differences in individuals' access and the additional travel required to serve individuals in underserved areas, differentiated rate models have been developed. The most appropriate method to differentiate these rates is on the basis of individuals' residences.

As noted, several commenters suggested that different rates be established based upon the distance that the provider travels. However, this methodology could result in undesirable outcomes. For example, a therapist could receive a higher rate for traveling from Santa Fe to Albuquerque when there is already adequate access to services for individuals there. It could also produce inefficiencies because rather than incentivizing therapists to schedule appointments that are close together, a mileage-based rate encourages providers to maximize driving time.

One commenter noted that a therapist could locate in an underserved area and bill the higher rate even if they do not have to travel far. The Developmental Disabilities Supports Division does not believe that this issue argues against the proposed methodology. First, DDS believes it would be a desirable outcome if therapists opt to live in the communities that they serve. Second, given the much lower population densities in the underserved areas, it is still likely that more travel will be necessary for providers residing in those areas.

**65. Several commenters objected to the mileage assumptions included in the proposed rate models. Alternative suggestions ranged from 195 to 520 miles per week.**

After further evaluation, the mileage assumption in the proposed standard (formerly 'urban') rate model was increased from 150 to 270 miles per week and from 300 miles per week in the underserved (formerly 'rural') model to 440. Further, weekly travel time assumptions (based on a 40-hour workweek) were increased from 5 to 9 hours for the standard model and from 10 to 14 hours for the underserved model.

Effectively, the standard model now provides 10 miles for every billable hour and the underserved model now provides 20 miles per billable hour. Assuming that a billable hour is equivalent to a visit to an individual, the assumptions now included in the rate models are still less than the Special Study calculated distances between individuals and their providers. However, as previously noted, the Special Study figures likely overstate true travel distances (because the claims data includes only 'corporate' addresses, which may differ from the rendering providers' addresses, and because it makes no assumptions that providers schedule their visits efficiently by serving individuals in the same area on the same day).

Additionally, it is noted that some of the billable hours will not relate to visits (e.g., the billable time spent writing up assessments and evaluations), and some travel is not considered part of the workday (i.e., commute time from home to the first appointment and from the last appointment back to home is not considered work time any more than it is for an employee traveling to and from an office everyday).

**66. Several commenters objected to the productivity assumptions included in the proposed rate model. In general, commenters stated that only 19 to 25 hours are spent delivering services in a 40-hour workweek. In particular, commenters suggested that the allowances for travel, missed appointments, and report-writing were inadequate.**

As discussed in the response to comment 19, the adjustment for missed appointments (0.5 hours per week) is not intended to represent the length of cancelled visits; rather, it is the amount of time that is lost while a provider shifts to another productive activity such as catching up on paperwork or other administrative tasks. The 0.5 hour assumption is consistent with what the (few) occupational therapists and physical therapists reported in the provider survey, and less than reported by speech therapists.

Finally, the proposed rate models do not include an adjustment for report-writing time because these activities will be billable (see the response to comment 68 for additional discussion of billable Therapy assessments and plans, and the response to comment 77 for Behavioral Support Consultation). The models do include two hours per week for updating progress notes and medical records, which is not a billable activity.

With the increase in travel time discussed in the response to the preceding comment, the billable hours in the proposed standard (formerly 'urban') rate model has been reduced to 27 hours within a 40-hour week and to 22 hours in the underserved (formerly 'rural') rate model. These numbers are somewhat greater than those proposed by commenters, but are believed to be reasonable because the development of assessment and treatment plans are

billable activities that several commenters appear to have excluded from their calculation of billable time.

## Therapies

**67. Several commenters objected to the wage assumption included in the proposed rate models. Specific comments included:**

- a. The wage at the 90th percentile for Certified Occupation Therapist Assistants is greater than the wage at the 25th percentile for Occupational Therapists.**
- b. Commenters offered a variety of alternative wages, including figures reported by the American Physical Therapy Association (\$80,000 in the Mountain West, which includes New Mexico and seven other states) and Advance for Occupational Therapy Practitioners (\$72,592). One commenter noted that contracted therapists are currently receiving \$82.50 per hour. Another proposed a wage of \$50 per hour, the amount they identified as the current hourly rate.**
- c. One commenter objected to comparing the proposed wage to those paid by public schools while another commenter suggested using Albuquerque Public School's salary schedule as a point of comparison.**

The proposed rate model assumes an average hourly wage of \$35.00 per hour, equivalent to \$72,800 annually. As with the wages included in each of the proposed rate models, this assumption is derived from federal Bureau of Labor Statistics (BLS) data. Specifically, the wage is approximately the median wage for therapists in New Mexico.

In addition to median wages, the BLS reports wages at the 10th, 25th, 75th, and 90th percentiles. Comparing wages at one percentile for one job class to a different percentile for another job class, as one commenter suggests, misunderstands the data. It is not surprising that one of the highest-paid certified occupation therapist assistants earns more than one of the lowest-paid occupational therapists. At the national level, the 90th wage percentile for COTAs is also greater than the 25th percentile for OTs (similarly, the 90th wage percentile for licensed practical nurses exceeds the 25th percentile for registered nurses). There would be cause for concern if the median wage for COTAs was higher than the median wage for OTs, but the comparison that the commenter makes is invalid and in no way undermines the data.

The reasonableness of the data appears to be generally confirmed by the other data sources suggested by commenters. The proposed wage is in-line with the salary found by Advance for Occupational Therapy Practitioners, although somewhat less than the APTA estimate for the region. Additionally, as commenters noted, Burns & Associates compared the assumed wage to the salaries earned by therapists in public schools (which were used due to the availability of data). After adjusting for the length of the school year, the wages earned by therapists in public schools were approximately the same as the wage assumed in the rate model. It is emphasized, however, that the public school wage data was not used in the

development of the proposed rate model; rather, the study was undertaken only to provide some validation of the BLS data that was used to develop the model.

It is likely that the other wages suggested by commenters – \$50.00 (equivalent to \$104,000 annually) and \$82.50 (\$171,600 per year) – reflect rates paid to subcontractors and, therefore, include the value of benefits that subcontractors do not receive through their agency and non-billable time. These factors are separately addressed in the proposed rate model.

**68. *Several commenters expressed concern that time spent on “6 mo. Reports, and direct therapy to develop plans” will no longer be billable.***

The Developmental Disabilities Supports Division acknowledges that the proposed service standard was unclear regarding what assessments and reports would be billable. In one section of the proposed service standard, the development of therapy plans and written direct support instructions are specifically listed as billable. However, another section erroneously states that “writing or updating assessments, reports, progress notes and logs” is not billable.

The service standard has been revised to clarify the assessment and reports for which therapists will be able to bill and those for which they will not be able to bill. Billable assessments and reports are Initial Therapy Evaluation Reports (as part of the ‘block’ payment for an initial assessment), Therapy Interventions, Annual Re-Evaluation Reports (to be billed in 15-minute increments rather than as a block payment as originally proposed), Written Direct Support Instructions, Comprehensive Aspiration Risk Management Plans, and Discontinuation of Services Reports. Progress notes, logs, and Six-Month Therapy Reports are not billable and the rate models include a productivity adjustment for time spent on these activities.

**69. *One commenter stated that the physical therapist assistant rate should be equal to the certified occupational therapist assistance rate.***

The only difference between the assumptions in the proposed rate models for certified occupational therapist assistance and physical therapy assistants relates to wages. According to federal Bureau of Labor Statistics data for New Mexico, the wages earned by these two occupations differ significantly. However, when reviewing BLS wage data for COTAs and PTAs nationally, the wages for the two disciplines are nearly identical. For this reason, the COTA and PTA models have been combined in the proposed rate model originally proposed only for COTAs.

**70. *Several commenters stated that the speech-language pathology clinical fellows should receive the same payment rate as a speech-language pathologist because clinical fellows have completed their education, passed the national certification exam, and provide the full range of services.***

After further evaluation, the Developmental Disabilities Supports Division has decided not to adopt separate rates for speech-language pathology clinical fellows and will allow clinical fellows to bill the same payment rate as the speech-language pathologists.

**71. Several commenters objected to the proposed rates. Some commenters proposed comparing the proposals to rates paid by other programs such as Medicare (reported by a commenter as \$150 for a visit) or private insurers. Alternative proposals ranged from \$27.58 to \$43.33.**

As noted in Burns & Associates' Special Studies and Additional Analysis to Support the Development of Therapy Rates report, the proposed rates compared to the rates paid for therapy services by other Medicaid programs. These services differ in terms of the types of activities covered and the duration of services, but the comparison found that the proposed rate were within the range paid by the other Medicaid programs in the State. With the revisions related to travel time and mileage discussed in the response to comment 65 the standard rate (formerly labeled 'urban') is almost equal to the current rates paid through the Developmental Disabilities Waiver and the underserved rate is significantly more than the current DDW rates.

**72. One commenter stated that the proposed rates assume that providers will recoup losses by taking on more clients which will result in "mandating overtime, which is currently illegal."**

The proposed rate model was developed assuming a 40-hour workweek. It is recognized that some therapists will work fewer hours and others will work more, but the proposed rates make no assumptions regarding the earnings of any individual therapist or how many hours they will need to work in order to earn a desired income.

The commenter may be referring to limits to therapy hours included in the proposed service packages, which could result in fewer hours being delivered to an individual, but more individuals receiving services if the State is able to move more individuals from the waiting list into services. Again, however, no assumptions are made regarding the numbers of hours that a therapist will work.

Lastly, it is noted that the commenter is mistaken in regards to labor laws. Therapists are contractors of the State (and sometimes subcontractors to agencies contracting with the State), not employees, so the State has no ability to mandate that a contractor work any number of hours.

**73. One commenter objected to comparing therapy utilization in New Mexico to utilization in Arizona because the states operate their program under different Medicaid waiver provisions and because Arizona "has multiple ICF/ MRs."**

Burns & Associates reviewed individuals' access to therapy services in its report, Special Studies and Additional Analysis to Support the Development of Therapy Rates. To provide a point of context, B&A compared the utilization of therapy services within the Developmental Disabilities Waiver to therapy utilization in Arizona, a neighboring state for which B&A had available data. The commenter is mistaken in asserting that Arizona has a large ICF/ MR population (less than one percent of its Medicaid population with a developmental disability is in an ICF/ MR) and that therapy utilization is significantly impacted because Arizona operates under a system-wide Section 1115 demonstration waiver.

However, to provide additional points of comparison, the waiver applications for the other states in the same federal Medicaid region as New Mexico (Region 6, which includes Arkansas, Louisiana, Oklahoma, and Texas) were reviewed. Each of these states provides services to individuals with developmental disabilities through a Section 1915(c) waiver, the same authority through which the DDW operates. The results of this comparison are noted in the table below.

|                                | New Mexico | Arkansas <sup>3</sup> | Louisiana <sup>4</sup> | Oklahoma <sup>5</sup> | Texas <sup>6</sup> |
|--------------------------------|------------|-----------------------|------------------------|-----------------------|--------------------|
| Total Enrollees <sup>1</sup>   | 3,464      | 4,203                 |                        | 2,900                 | 34,729             |
| Receiving OT <sup>2</sup>      | 1,134      | NC                    | NC                     | 289                   | 38                 |
| % Receiving OT                 | 33%        | -                     | -                      | 10%                   | 0.1%               |
| Avg. Hrs./ Yr. of OT per User  | 35.6       | -                     | -                      | 20.7                  | 5.3                |
| Receiving PT                   | 1,081      | NC                    | NC                     | 413                   | 118                |
| % Receiving PT                 | 31%        | -                     | -                      | 14%                   | 0.3%               |
| Avg. Hrs./ Yr. of PT per User  | 36.7       | -                     | -                      | 15.0                  | 7.3                |
| Receiving SLP                  | 1,795      | NC                    | NC                     | 420                   | 28                 |
| % Receiving SLP                | 52%        | -                     | -                      | 14%                   | 0.1%               |
| Avg. Hrs./ Yr. of SLP per User | 36.1       | -                     | -                      | 14.9                  | 8.0                |
| Receiving BSC                  | 1,983      | NC                    | NC                     | 784                   | NC                 |
| % Receiving BSC                | 57%        | -                     | -                      | 27%                   | -                  |
| Avg. Hrs./ Yr. of BSC per User | 57.6       | -                     | -                      | 28.0                  | -                  |

<sup>1</sup>Enrollee and utilization figures for New Mexico are based on analysis of fiscal year 2011 claims data for individuals that received a full year of services; since such data was not available for the other states, the figures are taken from the estimates included in the waiver applications submitted to the federal Centers for Medicare and Medicaid Services (CMS).

<sup>2</sup>NC means that a service is not covered.

<sup>3</sup>Alternative Community Services waiver. Accessed at [http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html?filterBy=1915\(c\)#waivers](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html?filterBy=1915(c)#waivers). Arkansas does not cover therapies or behavior support services. Numbers are Year 1 (fiscal year 2011) estimates.

<sup>4</sup>Louisiana provides services through three waivers: a New Opportunities Waiver, a Supports Waiver, and a Residential Options waiver. Therapies are not covered by either the New Opportunities or Supports waiver. The relatively new Residential Options waiver does cover these services, but a copy of the waiver was not available on the CMS website.

<sup>5</sup>Oklahoma provides services through two waivers. The figures in the table reflect the larger Community Waiver (estimates are for Year 1, fiscal year 2012). Utilization in the In-Home Supports Waiver for Adults is much lower (no higher than 4 percent for any of the therapies). The numbers in the BSC section of the table reflects Psychological Services. The waivers were accessed at [http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html?filterBy=1915\(c\)#waivers](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html?filterBy=1915(c)#waivers).

<sup>6</sup>Texas provides services through several waivers. The figures in the table reflect the largest of these, the Community Based Alternatives waiver. Numbers reflect Year 1 (calendar year 2012) estimates. The waiver was accessed at <http://www.dads.state.tx.us/providers/cba/CBAWaiver.pdf>.

As the table shows, the percentage of clients that use therapies and behavioral support consultation in New Mexico is at least twice as high as any other state in the region. Further, among the users of the services, individuals in New Mexico always receive a greater number of hours of service. Two of the states – Arkansas and Louisiana – do not even provide coverage for these services. Based on its experience, B&A believes that New Mexico has one of the highest utilization rates of therapy and behavior support consultation in the country, regardless of what states or regions are used as a basis of comparison.

## Behavior Support Consultation

**74. Several commenters objected to varying rates according to whether staff has an independent practice license or a supervisory practice license. Several commenters acknowledged that there is often a pay differential between the classes of licensure, but “[t]he fact that the provider agency has to do more to ensure quality with a lower level licensure person is made up for in the standard rate that they receive.” One commenter stated that there should be a higher rate for psychologists.**

The qualifications of practitioners with independent practice licenses differ from those with supervisory-level practice licenses and, as confirmed by several commenters, these classes of practitioners generally receive different compensation (e.g., a psychologist does not receive the same payment as a psychologist associate). Additionally, there are oversight requirements associated with supervisory-level practice licenses. The cost structures associated with these classes of staff are clearly different and these differences were the basis for the establishment of different rates.

In response to the comments on this issue, the Developmental Disabilities Supports Division reviewed the standards for behavioral therapy-type services covered by other Medicaid programs in the State (although it is noted that these services are not identical to BSC). Based on this review, DDS has made two changes to the rate models and service standards to better align with other Medicaid programs in the State.

First, the review revealed that Medicaid generally has only a single rate for most behavioral therapy-type services regardless of licensure status. In response, DDS has eliminated the proposal for a separate supervisory-level practice licensee rate. There will be a single rate, using the assumptions for the independent practice licensee rate model, with the changes to the travel time and mileage assumptions discussed in the response to comment 65.

Second, DDS will revise the service standard to require that all billing for BSC services be submitted by independent practice licensees; supervisory-level practice licensee will not be permitted to bill directly.

Medicaid only permits the services of supervisory licensed providers to be billed by the following agencies: community mental health centers, federally qualified health centers, the Indian Health Service and EPSDT school-based service providers (8.310.8 NMAC). Medicaid also requires that the services of these practitioners be “furnished under the direction and supervision” of an independent licensed practitioner. DDS is not limiting billing to the agency-types noted above, but will take advantage of the latitude afforded by the Developmental Disabilities Waiver and permit the services performed by supervisory licensed practitioners to be billed by both the Medicaid designated agencies as well as by independent licensed practitioners.

It is expected that these billing and rate changes will assist DDS’s quality assurance efforts and better ensure that appropriate services are delivered to the DDW clients.

**75. *Several commenters noted that the rate model includes one hour of clinical supervision per week, but the service standards require up to one hour of supervision for every ten hours of individual contact time.***

The proposed service standards include varying degrees of supervisions depending upon the staff's license type. As noted by the commenter, mental health counselors (LMCH) and professional mental health counselors (LPC) require one hour of supervision per ten individual contact hours (two to three hours per week), master social workers (LMSW) require one hour of supervision per 40 hours of work (one hour per week) and some of this supervision may be conducted in groups, and psychologist associates (PA) require two hours of supervision per month (one half-hour per week). Given this variability, the proposed rate model included one hour of supervision per week, which recognized that some behavior support consultants require more supervision and some require less. However, with the elimination of the separate rate for supervisory-level practice licensees as discussed in the response to the preceding comment, this comment is no longer pertinent.

**76. *Several commenters objected to the hourly wages assumed in the proposed rate models and opined that the job classifications chosen to develop the wages are not representative.***

It is acknowledged that the Bureau of Labor Statistics job classifications used to develop the wage assumption for this service do not precisely mirror the responsibilities of behavior support consultants. In instances in which there was not a specific job classification for a service (as there is for a registered nurse or occupational therapist, for example), Burns & Associates had to approximate the job responsibilities with the available job classifications. This was true for the majority of services.

For independent practice licensees, B&A chose the following classifications and descriptions:

- 19-3031 Clinical, Counseling and School Psychologists: Diagnose and treat mental disorders; learning disabilities; and cognitive, behavioral, and emotional problems, using individual, child, family, and group therapies. May design and implement behavior modification programs (the BLS also notes that the education necessary to gain entry to this job classification is a doctoral or professional degree)
- 21-1012 Educational, Guidance, School, and Vocational Counselors: Counsel individuals and provide group educational and vocational guidance services (master's degree)

Although not an exact match for the responsibilities of a BSC, these classifications appear to provide a reasonable approximation.

**77. *Several commenters noted that the proposed rate models do not include an allowance for writing assessments, treatment plans, crisis plans, and quarterly reports, which the service standard states are not billable activities.***

The rate model does not include a productivity adjustment for many of these activities because most will be billable. Specifically, behavior support consultants will be able to bill

for developing Positive Behavior Supports Assessments, Positive Behavior Supports Plans, Behavioral Crisis Intervention Plans, PRN Psychotropic Medication Plans, Comprehensive Aspiration Risk Management Plans, and Risk Management Plans.

Additionally, a new 'block' rate has been established for completing an initial Positive Behavior Supports Assessment and briefing the individual's interdisciplinary team.

Providers will not be permitted to bill for writing progress notes or semi-annual progress reports. The rate model includes a productivity adjustment to account for this non-billable time, providing two hours per week.

The service standard has also been revised consistent with these billing policies.

**78. *One commenter stated that the productivity adjustment for training is not sufficient to fulfill the requirements delineated in the proposed service standard.***

The rate model includes an allowance of 0.5 hours per week (26 hours per year) for behavior support consultants to receive training (note that this is not associated with providing training to direct service staff, which is a billable activity for BSCs). It is expected that a BSC's training hours will vary from year-to-year (e.g., a first-year BSC will need more training than a more experienced BSC), but, overall, the Developmental Disabilities Supports Division believes that this allowance is adequate to meet the training requirements included in the service standard. Additionally, DDSD intends to ensure that the majority of the instruction that it requires and delivers will provide continuing education units.

**79. *One commenter noted that most BSCs work more than 40 hours per week.***

The proposed rate models for behavior support consultants are intended to represent a 'typical' 40-hour workweek, but they are not dependent on a 40-hour week because it is assumed that the values in the model will move proportionally to the number of hours actually worked. For example, if an individual works 20 hours per week, it would be assumed that all of the factors in the model would decrease by 50 percent and the resulting rate would remain unchanged. Similarly, if an individual works 50 hours in a week, it would be assumed that all of the factors in the model would increase by 25 percent and, again, the unit rate would not change.

**80. *Several commenters stated that the rates do not account for rounding down when the next 15 minute mark is not met.***

The proposed rate models for behavior support consultation utilize a 15 minute unit, as do most other services (excluding residential supports and case management). As the commenter notes, billing rules (see Subsection F of 8.302.2.10 NMAC) require that units be rounded down when a specified threshold is not met. However, providers are able to round up when that threshold is met. It is assumed that providers will manage their time to avoid the need to round down an excessive amount of time, and that time that is rounded down will be roughly offset by time that is rounded up.

It is noted that these commenters indicated that the threshold for rounding up or rounding down was 12 minutes. Unless these commenters know of a different authority, we believe the Subsection F provisions cited above control with respect to rounding conventions. That Subsection uses an eight minute threshold.

**81. Several commenters objected to the proposed rates. Some commenters proposed comparing the proposals to rates paid by other programs, particularly Medicaid state plan services. Alternative proposals ranged from \$80 to \$120 per hour.**

The Developmental Disabilities Supports Division reviewed the Medicaid services cited by the commenters. Based on this review, DDSD does not believe that these Medicaid services are comparable to behavior support consultation as defined within the Developmental Disabilities Waiver. Additionally, without information regarding how these other rates were derived, it is difficult to compare them to the assumptions included in the proposed rate models. One service commonly referenced by commenters is CPT code 90806, which is defined as “individual psychotherapy... in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient.” The rate for this service is \$66.93. Comparing this rate to the BSC rate is imprecise because it is not billed in 15-minute increments, but the standard BSC rate after accounting for the changes in the rate model discussed in this section, provides for \$70.00 per hour. The underserved rate provides for \$90.20 per hour. The rates are comparable to Medicaid’s 90806 rate, although it is again emphasized that BSC and psychotherapy are not the same service.

**82. One commenter proposed a flat monthly rate to eliminate overbilling, increase demand for professional competency, and reduce the billing burden. The commenter specifically proposed a standard \$400 per month rate, which assumes 5 hours at \$80 per hour, with the ability to vary the rate across a range of \$285 to \$525 based on individual need.**

The Developmental Disabilities Supports Division does not believe that a monthly rate for behavior support consultation is appropriate. A monthly rate would be administratively simpler for both providers and the State, but would not provide adequate accountability. Billing services in 15-minute increments ensures that the State pays for the services that individuals actually receive and allows for more effective monitoring of utilization.

## NUTRITION COUNSELING

**83. Several commenters stated that the five hours of annual nutrition counseling ‘bundled’ into the Supported Living rate was inadequate and proposed that every individual receive 20 to 50 hours of nutritional counseling annually. The commenters further compared the amount of nutritional counseling assumed in the proposed rate models to the amount of nursing included and to assumptions regarding therapy hours in the proposed individual service packages.**

The commenters correctly note that the proposed rate models for Supported Living provide for five hours of nutritional counseling annually. This assumption is the estimate of the

average number of hours that an individual will require, but it is assumed that some individuals will use more and some will utilize none. In the provider survey, respondents reported that individuals receive an average of 12.4 hours per year. This figure, however, was skewed by two providers that reported that every individual receives more than 20 hours annually. Amongst the other 15 providers, average utilization was less than 2 hours per year. DDS believes that five hours per year on average (with some individuals receiving more and others receiving less) is adequate.

DDS does expect that all individuals in Intensive Medical Living Supports will require nutrition counseling so the assumption in that rate model has been increased from five hours to twelve hours annually.

- 84. Several commenters objected to the ‘unbundling’ of nutrition counseling from the Customized In-Home Supports service (formerly independent living). These commenters suggested that this service should include 10 or 20 hours per year. One commenter provided a variety of examples of the types of support they offer to individuals in independent living.**

The Developmental Disabilities Supports Division is working to unbundle nursing and nutrition counseling from other services. This shift is intended to ensure that individuals receive the services that they need while increasing accountability within the system. In the first part of the shift, these services have been unbundled from Customized In-Home Supports. Individuals will still be able to receive prior authorization for these services, if needed, and these services will be separately billable. It is noted, however, that several of the services that commenters reported providing, such as assistance with money management or accompanying individuals to the grocery store, are outside of the scope of services for nutrition counseling.

- 85. Several commenters suggested that Interdisciplinary Teams should not have the responsibility for determining whether an individual requires nutrition counseling and that every individual should receive an annual nutrition assessment.**

The Developmental Disabilities Supports Division does not believe that every individual requires nutrition counseling and that IDTs are best able to determine when these services are necessary. As noted, individuals who need this assistance will be able to receive prior authorization for these services.

- 86. Several commenters noted that “screening, assessment, and monitoring nutrition status and risk and providing nutrition information and recommendations can only be conducted legally by a licensed nutrition professional.”**

Although certain activities, such as the development of a formal nutrition plan, are the responsibility of a nutrition counselor when required by an individual, other non-nutrition staff supporting individuals can assist by modeling good dietary habits, assisting in making healthy choices, etc.

- 87. Commenters compared Nutrition Counseling to other therapies that “are nice, but not necessary”, stating that “Nutrition is the only therapy that demonstrates direct medical and therapeutic effects and saves thousands”. Commenters stated that every dollar invested in Nutrition Counseling will produce savings of four to 27 dollars.**

The Developmental Disabilities Supports Division agrees that Nutrition Counseling can be very beneficial to many individuals but also believes that other therapies provide significant benefits as well. The proposed Nutrition Counseling rates are intended to continue to allow individuals to receive this valuable service.

- 88. One commenter stated that the “proposed 4.5 hours of nutrition services for those teams that request nutrition services is not enough”**

The commenter’s reference to 4.5 hours of nutrition services is unclear. Nutrition services are bundled into both Supported Living and the Intensive Medical Living Supports.

There is no specific amount of service specified in the Intensive Medical Living service standard and the Living Supports service standard specifies: “That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT”.

However, the rate models provide for five hours of nutrition services for Supported Living, 12 hours for Intensive Medical Living Supports (after the adjustment noted in response to comment 83), and three hours of nutrition services for Family Living services (after the adjustment noted in the response to comment 41). As the Division does not expect all recipients in these service settings to require nutritional counseling (except in the case of recipients of Intensive Medical Living Supports), the amount of nutritional counseling is considered to be sufficient.

- 89. Several commenters questioned the proposed rate, particularly related to wages. One commenter stated that the assumed wage is based on the pay scale for WIC nutrition counselors “who have little or no education in the field.” A commenter suggested that the Academy of Nutrition and Dietetics recommends a \$40.69 hourly wage. Finally, commenters made reference to a specific nutrition consultant in another state that charges \$175 per hour.**

The proposed rate model assumes an hourly wage of \$28.94 (about \$60,200 per year), which is taken from the median wage for dietitians and nutritionists in New Mexico, according to the federal Bureau of Labor Statistics. A reference to a recommendation from the Academy of Nutrition and Dietetics of an hourly wage of \$40.69 (about \$84,600 annually) was not provided; a fact sheet produced by the Academy notes that their 2009 compensation survey found that “half of all RDs [Registered Dietitians] in the U.S. who have been working in the field for four years or less earn between \$43,400 and \$62,200 per year” (and reported that Dietetic technicians, registered, earn between \$30,800 and \$43,100). The wage assumed in the proposed rate model fits within this range. The Developmental Disabilities Supports Division does not believe that an hourly rate of \$175 is warranted.

## SOCIALIZATION AND SEXUALITY SERVICES

- 90. One commenter asked whether the series rate applies to each attendee and, if so, whether there a limit to the class size. The commenter also asked how the proposal addresses those who do not attend all classes. Lastly, the commenter recommended an hourly rate.**

The series rate does apply to each attendee. As noted in the proposed service standard, one-half of the rate is billable upon an individual's registration and the second half is billable upon completion of the entire series. No maximum class size is specified, but the proposed rates were constructed with the assumption that classes in urban areas will have 18 students on average and classes in underserved areas will have an average of nine students.

The Division considered and rejected an hourly rate for this service largely because each claim for a Medicaid service must be billed for services rendered to a Medicaid eligible client. It would be unwieldy to have an hourly rate that would have to be apportioned among as many as 18 clients.

- 91. One commenter stated that the variation between urban and rural rates is too large since the instructor does not have to travel and noted that the proposed difference will encourage providers to conduct the classes in rural areas (even for individuals residing in urban areas).**

As noted in the response to the previous comment, the variation in the rate is due to the assumed differences in class sizes. The rate that may be billed is based upon the individual's county of residence, rather than the area where the class is delivered, eliminating providers' ability to require individuals from urban areas to travel to underserved areas in order to bill for the higher rate.

- 92. One commenter asked whether individuals approved for one-one-one support would be attending the class series, allowing the provider to bill for both the series rate and the one-on-one rate for a staff person to accompany the individual to the courses. The commenter recommended the elimination of the one-on-one rate.**

The one-on-one rate was intended for those individuals who are unable to participate in a classroom setting (e.g., due to behavioral issues). In these cases, individuals would receive services one-on-one and the staff person would provide the content, rather than accompanying the individual to the class. Since the rate had been set equal to the Behavior Support Consultant rate, the Developmental Disabilities Supports Division has eliminated the separate one-on-one rate. For those individuals unable to attend a class, they can receive the instruction from a qualified BSC who will be reimbursed according to the BSC rate schedule. The series and BSC rates may not be simultaneously billed.

## PRELIMINARY RISK SCREENING AND CONSULTATION

- 93. *One commenter stated that the proposed rate is too low, particularly due to the requirements for certification to provide this service and because there is no rural rate. The commenter also requested that current rates be reported for comparison.***

Consistent with the changes made to the Therapy and Behavior Support Consultant rate, the travel time and mileage assumptions have been revised. Additionally, an underserved (rural) rate has been established. These changes have resulted in a significant increase to the proposed \$17.67 unit rate (\$70.68 hour). The revised standard rate is \$19.92 per unit (\$79.68 per hour) and the newly established underserved rate is \$25.52 per unit (\$102.08 per hour).

The Developmental Disabilities Supports Division currently contracts for a similar service, although it is not funded with Developmental Disabilities Waiver dollars. The current rate for that service is about \$80 per hour, which is approximately equal to the revised standard rate (the new underserved rate is a significant increase over the current rate).

## RESPITE

- 94. *Two commenters expressed concerns relating to the use of group rates when a single staff person provides services to multiple individuals simultaneously due to the administrative complications such a system would entail.***

The cost of delivering group services is less than the cost of providing one-on-one services because staffing expenses account for the majority of cost for these services, and this expense does not change (or does not change much) when delivering services to a group. The proposed rate models reflect that fact.

In response to these comments, however, the Developmental Disabilities Supports Division has eliminated the proposed two- and three-person rates and established a single group rate for the delivery of services to between two and five individuals. This group rate is intended to address concerns expressed by providers relating to the complications associated with tracking billable time for different group sizes as individuals come and go throughout the day.

The group rate is less than the individual rate, but includes a 'premium' that results in greater hourly earnings for a provider in order to recognize the additional complication associated with providing services to multiple individuals, for both the direct support staff and the agency. Specifically, when providing Respite services to an individual, an agency may bill \$4.58 per 15-minute unit (\$18.32 per staff hour). Under the group rate of \$2.62 per 15-minute, an agency may bill \$20.96 per staff hour, and for five individuals an agency may bill \$52.40 per staff hour.

Establishing these group premiums is intended to balance the efficiencies generated with serving groups and the additional effort required to serve individuals in groups, and to

provide individuals an option to 'stretch' their budgets by taking advantage of the savings associated with group services.

**95. *One commenter noted that they currently provide respite services to several groups of four individuals, but the proposed rate model only accommodates groups of up to three.***

A group rate model for Respite services has been established that may be billed for groups of two to five individuals. See the response to the previous comment for additional discussion of the development of these group rates.

**CUSTOMIZED IN-HOME SUPPORT**

**96. *One commenter stated that the proposed rate for Customized In-Home Support is \$6.34 per 15 minutes so providers will earn \$38.04 for six hours of service which is less than the \$85.93 staffing cost that they would incur for that period of time.***

The provider correctly notes that the proposed rate for Customized In-Home Supports is \$6.34 per 15 minutes (which equates to \$25.36 per hour, significantly greater than the existing \$13.87 Personal Support Services hourly rate), but incorrectly calculates the amount that would be billed for six hours. The correct amount is \$152.16 [ $\$6.34 \times 4$  (15 minute periods in one hour)  $\times 6$  (hours)], which is greater than the \$85.93 staffing cost reported by the commenter.

**97. *One commenter stated that the productivity adjustment for travel time included in the rate model is not sufficient to transport individuals to and from work and other activities.***

The travel time productivity adjustment is only attended to account for non-billable travel, such as driving from one individual to another. Transporting individuals is a billable activity so there is no productivity adjustment for this time.

**98. *One commenter suggested that the proposed rate for Customized In-Home Support be compared to the current Independent Living rate.***

The current Independent Living rates are monthly rates: \$1,773.30 for 'regular' Independent Living and \$2,535.17 for 'Intensive' Independent Living. Since these are monthly rates, the Developmental Disabilities Supports Division does not know how much support individuals actually receive so these rates cannot be accurately compared to the proposed Customized In-Home Supports, which is to be billed in 15-minute increments for services actually provided.

To provide some context for comparison to the proposed \$6.34 Customized In-Home Supports rate, previous standards for Independent Living stated that the 'regular' monthly rate requires 20 to 100 hours of actual support, which would translate to a 15-minute rate ranging from \$4.43 to \$22.17. The Intensive Independent Living rate required at least 100 hours of actual support so the equivalent 15-minute rate would be \$6.34 or less. Based on these estimates, it appears that the proposed rate is in-line with current Independent Living rates.