DDS Vendor Rate Study
Responses to Public Comments

– submitted to –

California Department of Developmental Services

– prepared by –

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January 2020

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SUMMARY

The California Department of Developmental Services (DDS) contracted with Burns & Associates, Inc. (B&A) to conduct the vendor rate study required by § 4519.8 of the Welfare and Institutions Code as added by ABX2-1 during the Second Extraordinary Session of the 2015-16 Legislature. The rate study incorporated several tasks, including:

- A series of meetings with the Developmental Services Task Force's Rates Workgroup
- A detailed review of service requirements
- Development of a provider survey that all agencies were given the opportunity to complete in order to collect information regarding service delivery and costs
- Identification and research of independent published sources data to inform the development of rate models such as wage data from the Bureau of Labor Statistics
- Analysis of regional cost differences related to wages, travel, and real estate

Based on this work, detailed draft rate models were developed for each service included in the scope of the rate study. The rate models include the specific assumptions regarding the costs vendors face in the delivery of each service, such as direct support workers' wages, benefits, and billable time; staffing ratios; travel; agency overhead; and program operations costs.

The draft rate models and related materials were published on February 25, 2019. B&A presented the results at two-day meetings held in Northern California and Southern California. The first meeting was live-streamed, recorded, and posted online. The rate study report was submitted to the Legislature on March 15, 2019. All project materials are available at www.burnshealthpolicy.com/DDSVendorRates/.

Interested parties were invited to comment on the draft rate models and were asked to submit their feedback in writing to a dedicated email account. The comment period ran until April 5, 2019, but comments submitted after the deadline were also considered.

In total, comments were received from hundreds of individuals, caregivers, advocates, vendors, and other stakeholders. The comments have been summarized and categorized, and written responses to each comment were developed.

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

For issues affecting services in multiple categories:

- The newest wage data from the Bureau of Labor Statistics released after publication of the draft rate models was incorporated into the updated models
- An assumption that 30 percent of the direct care workforce works part-time, with a larger productivity adjustment but lower benefit costs, was added to all rate models except for those for staff who typically have at least a bachelor's degree and who provide services the rate study included in the 'professional' category
- The rate models for Enhanced Behavioral Supports Homes, Community Crisis Homes, and Supported Living Services were revised to assume five percent of staff hours are paid at an overtime rate

- The rate models for Supported Living Services and residential services were revised to assume five percent of supervisors' work hours are paid at an overtime rate
- The wage assumption for registered behavior technicians was increased and their training assumption was increased to 50 hours per year
- The newest workers' compensation rate estimates for January 2020 released after publication of the draft rate models were incorporated into the updated models; additionally, the assumed overhead rate for insurers was increased to 18 percent
- The Internal Revenue Service's standard mileage rate for 2020 released after publication of the draft rate models was incorporated into the updated rate models

For services included in the Personal Support and Training category:

- The proposal to establish separate rates for short-term and long-term encounters was withdrawn
- The wage assumption for direct support professionals providing Independent Living services was increased and their assumed productivity was reduced
- Rate models for staff working overtime hours were established for parent/ participant-directed services
- Rate models for Respite services provided through an employer of record model were developed and the recommendation that providers become vendored as financial management services providers was withdrawn
- The productivity assumptions for training was reduced from 35 hours per year to 6 hours for parent/ participant-directed services and Respite services provided through an employer of record model
- The supervisory span of control for Respite and Personal Assistance services was increased from one supervisor for every ten direct care workers to one supervisor for every fifteen workers

For services included in the Residential category:

- The assumed hourly cost of consultants was increased
- The wage assumption for overnight staff in level 3 and 4 Community Care Facilities were increased to match the wage assumption for daytime staff
- The wage assumptions for line and lead staff in level 5, 6, and 7 Community Care Facilities were increased by 10 percent
- The administrator staff hour offset was reduced to 20 hours for level 3 and 4 Community Care Facilities
- Assumed line staff hours in Community Care Facilities for children were increased by 6.4 percent
- The wage assumptions for line and lead staff in Enhanced Behavioral Supports Homes and Community Crisis Homes were increased
- The assumed payments to family homes in the Family Home Agency rate models were increased

- The administrative rate in the Family Home Agency rate models was set at 12 percent rather than being tied to administrative costs in Community Care Facilities
- The rate models for Family Home Agencies were updated to include 5,200 miles annually for recruiters and direct support professionals
- The assumed productivity of direct support professionals in the Family Home Agency rate models was reduced

For services included in the Day, Employment, and Transportation category:

- The assumed attendance rate was reduced from 90 percent to 88 percent for Community-Based Day Programs, Supported Employment-Group, and Work Activity Programs
- Rate models were developed for non-medical/ non-behavioral day programs delivered in the community at a one-to-four ratio and day programs with a behavioral or medical focus delivered in the community at a one-to-three ratio
- The training assumption for certified nursing assistants providing medically-focused day program services was increased to 50 hours per year
- The oversight and supervision of staff in medically and behaviorally focused day programs was revised to assume a registered nurse or board certified behavior analyst provides two hours of oversight per week, and day-to-day supervision is otherwise provided by a qualified direct support professional (DSP) supervisor
- The square footage assumption for non-medical/ non-behavioral day programs was increased from 50 square feet per individual to 75 square feet.
- The wage assumption for Supported Employment services was increased
- Productivity assumptions were reduced in the Supported Employment-Individual Job Coaching rate models
- Funding was added to the Supported Employment rate models to account for accreditation expenses
- Funding for facility space was added to the Work Activity Program rate models to support the provision of work adjustment and supportive habilitation services
- Separate rate models were established for Transportation Company and Transportation-Additional Component services, with differing assumptions related to driver wages, the number of passengers transported, and the cost of the vehicles used
- The proposal to create a Transportation Coordination service to reflect the program operations and administrative expenses associated with transportation was withdrawn; these costs were incorporated in the rate models for Transportation Company and Transportation-Additional Component and a rate model was developed to reflect the existing Transportation Broker service
- The rate models for Socialization Training and Creative Arts programs as well as certain specific programs currently authorized under service code 055, such as Project SEARCH and College to Career, were withdrawn until such time as service regulations are developed

For services included in the Professional category:

- The proposal to tie the rates for therapists and certain other services to Medi-Cal rates was withdrawn and rate models for various specialists providing Infant Development Program services, Specialized Therapeutic Services, and Adaptive Skills Trainer were developed
- The Infant Development Program rate models were reworked to reflect two categories of staff: Early Intervention Specialists and Early Intervention Assistants; rate models were additionally developed for other specialists who provide early intervention services
- The assumed productivity in the rate models for Infant Development Programs was reduced
- The assumed productivity in the rate models for behavioral services was reduced
- The assumed cost of supervision was increased for paraprofessional and specialist services
- The rate models for Crisis Team services were withdrawn until such time as service regulations are developed

The remainder of this document provides responses to each comment.

RATE STUDY PROCESS

This section covers comments related to the scope of work of the rate study and potential implementation of the resultant recommendations, the provider survey, the consumer and family survey, and the public comment process.

Scope of Work and Implementation

1. ***Commenters expressed appreciation for B&A's approach to the rate study and voiced support for various aspects of the study including the transparency of the process and resulting rate models.***

   The support for the rate study process is appreciated. If implemented, the rate models and related recommendations are intended to further several goals for the systems of supports for Californians with intellectual and developmental disabilities, including:

   - Enhancing fairness and consistency across regions, vendors, and individuals using services,
   - Establishing a framework that can estimate the current costs of providing services, including accounting for regional variability, and that can be efficiently maintained over time,
   - Recognizing differences in individual needs, with rates that vary based upon staff qualifications, staffing ratios, and other factors,
   - Professionalizing the direct care workforce through additional training, funding for market-based wages and benefits, and 'tiered' rates whereby staff with demonstrated skill in the field can bill at higher rates, and
   - Offering a variety of living options and supporting greater community integration.

2. ***Commenters offered feedback on issues outside of the scope of the rate study, including:***

   - ***Concern that services not included in the scope of work would eventually be eliminated,***
   - ***Questions about whether DDS plans to institute a standardized individual assessment tool given references to 'acuity-based' rates, and***
   - ***Disappointment that the rate study did not include a proposal to eliminate the Family Cost Participation Program.***

   The rate study covered more than 90 percent of Regional Center services as measured by spending. Generally, excluded services have rates set according to vendors' usual and customary charges (rates charged to the general public) or tied to Medi-Cal rates (the schedule of maximum allowances). The omission of these services was based solely on the fact these rates are set by external sources and should not be interpreted as an intent to eliminate these services.

   As noted by the commenters, several rate models are designed to better align payments with individual support needs. For example, the rate study recommends enhanced rates for Community-Based Day Programs serving individuals with exceptional medical or behavioral needs. Rates for other services, such as Community Care Facilities, vary based upon the staffing needs of those receiving services. The rate study did not recommend the adoption of an assessment instrument or offer any other suggestions on how the appropriate service level would be determined, instead assuming existing processes already employed by the Regional Centers to assess needs would continue to be used.

The Family Cost Participation Program was not considered as part of the rate study and no recommendations were proffered.

3. ***Commenters stated the rate study does not address the requirement to assess whether current rate-setting methods provide an adequate supply of providers.***

As discussed in Sections 1.3 and 4.1 of the March 15, 2019 rate study report, the rate study does not attempt to offer a quantifiable standard for "an adequate supply of providers". There is no national standard and the federal requirement that rates be "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area"[1] is difficult to apply to home and community-based services for persons with intellectual and developmental disabilities as there is no substantial private market for comparative purposes. Further, it is not the rate-setting *methodologies* that are likely to impact the supply of providers, but the *actual rates*.

Thus, the rate models developed through the rate study are built upon market data intended to compensate vendors for the estimated cost of delivering services. The rate study recognizes costs can differ dramatically across California. To account for differences in costs associated with wages, travel, and real estate, a separate rate model has been constructed for each of the 21 Regional Centers for nearly every service in the rate study. The development of these regional rate models is intended to help support the supply of providers across the State, although it is recognized barriers unrelated to rates may remain.

4. ***Commenters provided suggestions related to the potential implementation of the rate models, including:***

- ***The financial, legal, and policy changes associated with the rate models should be fully articulated before the rates are implemented, there should be a process to remediate issues identified by providers, and the Legislature should play an oversight role,***
- ***Potential impacts to service recipients, individual vendors and programs, and other Departments should be considered,***
- ***Implementation should be phased-in over a period of time to give providers sufficient opportunity to restructure services to adapt to new service definitions and service codes, and***
- ***Negotiated rates should be grandfathered and no vendor's rates should be reduced.***

Implementation of the rate study would require changes to statutes and regulations, Regional Center and vendor operations, and authorization and billing policies. It is therefore recognized that implementation must be thoughtful and incorporate input from self-advocates, vendors, and other stakeholders.

Although implementation of the rate models would require significant additional funding overall, the rates for some vendors would be reduced. There are a small number of service codes that would experience a reduction in total funding. Even within service codes that would receive an increase in total funding, there may be individual vendors that would experience a rate reduction since there are often wide variations in what vendors are paid for providing the same service in the same area. The estimated cost of the rate study assumes those vendors with rates in excess of the applicable rate

[1] 42 U.S.C. § 1396a(a)(30)(A)

model would see a rate reduction. It is acknowledged that these decreases would require careful planning, including sufficient time for vendors to make adjustments to their operations to be able to operate within the rate.

5. ***Commenters asked how the rate models will take into account cost increases in the future, referencing scheduled increases in the statewide minimum wage and rising costs for health insurance and other benefits, rent, utilities, vehicles, and other operating expenses. Similarly, commenters noted the need for the rate study arose because rates were frozen for a long period of time and suggested the Legislature should codify a regular adjustment of rates.***

   The rate models are structured in a manner that enables DDS and policymakers to update specific cost assumptions in future years. In particular, the rate models use data from a variety of published sources that are updated on annual basis, including wage data from the Bureau of Labor Statistics (BLS), health insurance data from the BLS and the United States Department of Health and Human Services' Medical Expenditure Panel Survey, and the mileage rate from the Internal Revenue Service. As updated data is published, the rate models can be updated – although funding any increased rates would be subject to the budgetary process.

6. ***Commenters stated the rate study made no meaningful progress toward creating more inclusive and compliant service models consistent with the January 2014 federal rule on home and community based services.***

   Payment rates are not the only, or even the primary, factor in achieving compliance with the federal Home and Community Based Services (HCBS) rules published in 2014 and currently set to take effect in March 2022. That said, the rate study does include a number of features intended to support compliance, including, for example:

   - Generally higher rates for services such as Personal Assistance and Respite that support individuals in their own homes,
   - Higher rates for Supported Employment services for individuals working in integrated settings and earning at least the minimum wage,
   - Creation of separate, higher rates for day program services delivered in the community compared to services provided in a facility, and
   - Creation of non-English rates to better support individuals who do not speak English.

   Efforts to implement the statewide transition plan remain a priority to move toward system-wide compliance with the HCBS rules. DDS is committed to working with vendors and stakeholders to achieve compliance.

7. ***Commenters noted the rate study proposes removing the prohibition against for-profit vendors providing several services, but stated the impact of removing this prohibition should be evaluated before it is implemented to ensure it will improve the system or lead to better quality.***

   In general, for-profit vendors are able to provide the same services as nonprofit organizations. There are limited exceptions, however. For example, statute requires vendors of Supported Employment services to be nonprofit agencies.[2] The rate study recommends repealing this requirement, noting

[2] WIC § 4857.1

several expected benefits including expanded access to employment supports. The recommendation further recognizes for-profit vendors are already delivering similar services, but are doing so through miscellaneous service codes. Integrating these services into the Supported Employment service codes would result in greater transparency into individuals' participation in employment activities.

8. ***Commenters questioned whether vendors will have to structure their spending to match rate model assumptions or if they will have the flexibility to manage within the overall rate as they deem appropriate. Commenters stated vendors will not be able to afford the direct care worker wages and benefits assumed in the rate models. Additionally, commenters sought confirmation that DDS will not audit providers for compliance with the rate model assumptions.***

   The rate models seek to account for the estimated costs of delivering services consistent with the State's requirements and individuals' supports plans. To do so, the rate models include detailed assumptions related to the wages, benefits, and productivity of direct care workers; agency administrative and program operations functions; and other program-specific costs such as mileage or staffing ratios.

   These assumptions are necessary in order to establish the overall rates, but for any given vendor it is expected that actual costs may be greater than assumed in some areas and less than assumed in others. In general, the rate models assumptions are not prescriptive so DDS would not audit vendors to compare their actual costs to these assumptions.

   Although the cost assumptions are not prescriptive, vendors would need to comply with underlying standards that would be auditable. For example, vendors would need to adhere to specified staffing ratios or levels in day and residential programs. Or, if a given rate is based upon staff having certain qualifications, the vendor would only be able to bill that rate if the standards are met.

9. ***Commenters expressed support for standardizing service codes and service definitions across the State. Conversely, commenters objected to proposed consolidations of service codes, noting different Regional Centers use a given service code to cover different activities and expressing concern that the consolidations may limit options for individuals.***

   One of the statutory requirements of the rate study was to evaluate the number and type of service codes and to make recommendations for simplifying and making service codes more reflective of the level and types of services provided. Currently, there are numerous service codes that lack meaningful service standards defining the intent of the service. Further, there are a number of redundant service codes allowing the same activity to be claimed under multiple service codes. The rate study therefore included a number of proposals to consolidate service codes based on the premises that similar supports should be available statewide and a given support should be associated with a single service code. The intent is to provide for a consistent array of statewide services, as required by federal law, while permitting flexibility in how these services are delivered to meet the needs of individuals.

   Implementing the consolidations and other changes to service requirements would require regulations to be established or revised for most service codes. Consistent with State requirements, the regulatory process would include an opportunity for public input.

10. ***Commenters stated the fiscal impact analysis is based on erroneous assumptions, including the assumption that individuals will continue using the same services after rate models are implemented.***

To estimate the potential cost of the rate models, the fiscal impact analysis attempted to 'reprice' fiscal year 2016-17 claims for in-scope services as if the recommended rates had been in effect. Due to a lack of transparency into how many service codes are currently used, a number of assumptions were employed to attempt to develop the fiscal estimates. B&A has continued to refine these assumptions.

The broad nature of many service codes and the various ways in which these codes can be used made it necessary to rely on ancillary data, such as information reported in the provider survey, to generate estimates. For example, a number of service codes can be used for several different staffing ratios for which different rates have been recommended. However, the staffing ratio associated with a given claim is usually not evident. Thus, the provider survey was used to estimate the distribution of staffing ratios within a given service.

In other instances, the rate models assumed changed service requirements or the consolidation of service codes. Similar to the estimates for staffing ratios discussed above, data from the provider survey was used to estimate the amount of a given service code that would transition to a new service code.

The analysis did not attempt to estimate costs associated with shifts in utilization from one service code to another although this will likely occur over time. To the extent the rate models are implemented, it is expected that any shifts would be gradual such that any resulting costs or savings would have to be incorporated in future budgets.

Provider Survey

11. Commenters expressed various concerns regarding the provider survey. Issues cited included the length and complexity of the survey and the approach to making providers aware of it. Other commenters expressed satisfaction with the design and ease of use of the provider survey.

A provider survey was conducted as part of the rate study to gather data regarding vendors' costs and service delivery (for example, staffing ratios, direct support professionals' non-billable responsibilities, etc.). As discussed further in the response to comment 13, the provider survey was only one consideration in the development of proposed rates.

The provider survey instrument was produced in collaboration with the DS Task Force's Rates Workgroup. Over the course of three meetings, B&A presented an initial draft of the survey to the Workgroup and made refinements based on feedback from the group, which generally suggested more detailed reporting was needed to understand differences in costs across regions and services.

The survey was released in May 2018. Several strategies were employed to make agencies aware of the survey, including:

- The survey was emailed to vendors based on the email addresses they had on file with the Regional Centers,
- All undeliverable emails were compiled and shared with the Regional Centers for research and follow-up,
- The survey instrument and accompanying instructions were posted on DDS' website; many Regional Centers similarly posted the materials and/or links on their websites, and

- B&A sent several reminder emails to vendors during the survey period; many Regional Centers similarly sent reminders.

Recognizing the complexity of the survey, B&A employed multiple strategies to provide technical assistance throughout the survey period, including:

- A worksheet within the survey to alert the user to common errors,
- A comprehensive written instruction manual,
- A series of recorded webinars that walked-through each schedule in the survey, and
- A 'help desk' phone number and email address vendors could contact for assistance; in most cases, vendors were provided with same or next day assistance, including end-to-end walk-throughs of the entire survey if requested.

In addition to assistance provided by B&A, many Regional Centers, provider groups, and individual providers offered help and advice through webinars and workshops. B&A supported several of these efforts.

Efforts were made to ensure vendors had sufficient time to complete the survey. The survey originally included a six-week deadline for submittals. In response to requests from vendors, DDS agreed to extend the due date by four weeks, giving vendors a total of ten weeks to complete the survey. Further, extensions beyond the ten-week timeframe were granted to vendors when requested.

12. ***Commenters cited various objections to the analysis of data from the provider survey, including:***
    - ***A low response rate undermined the value of the survey,***
    - ***Allowing providers to submit partially completed surveys skewed the results, and***
    - ***Some responses were inappropriately 'thrown out', including respondents reporting operating losses.***

As discussed in the response to comment 13, information collected through the provider survey was not the only consideration in the development of rate models. That said, the provider survey was an important part of the rate study and B&A and DDS employed several strategies – described in the response to comment 11 – to encourage participation in the survey and to ensure quality responses.

The procurement for the rate study envisioned only inviting a sampling of vendors to complete the survey, but in the interest of being as inclusive as possible, B&A and DDS agreed to invite all agency vendors to participate. Ultimately, 1,138 agencies submitted surveys. This group represented 20 percent of all agencies and, importantly, 52 percent of total spending on in-scope services in fiscal year 2016-17. In other words, the responding agencies accounted for the majority of the 'market' for developmental services.

One of the strategies to achieve this level of participation was expressly informing vendors they could submit a partially completed survey as it was recognized that even with the technical assistance described in the response to comment 11, some vendors would not be able to complete the entire survey. This approach was appropriate due to the independent nature of most sections of the survey. For example, the survey included separate forms for reporting administrative salaries and direct care wages. A vendor may have chosen to only report direct care wages while omitting a response for administrative salaries. The reported direct care wage data is usable even in the absence of data regarding administrative salaries.

Care was taken to ensure partially completed surveys did not skew the results. For example, questions that were left blank were not included in the analysis of the results for that particular question (that is, blanks were not counted as zeroes). Further, if any sections of the survey were connected for the purposes of the analysis, responses were excluded if only one part was completed. For example, the determination of administrative rates requires both revenue and expense figures; if either was not completed, that vendor was not included in the analysis of administrative rates. Similarly, the calculation of average direct care wages required both total wages paid and total hours worked to be reported; if either was not completed, the vendor was not included in the analysis of direct care wages. However, responses to other questions in partially completed surveys were incorporated in the analysis, which facilitated greater survey participation without skewing the results.

The survey analysis did not exclude survey responses based on operating losses or any other reason. Other than the omission of incomplete data as described above, even obviously erroneous data, such as administrative costs exceeding reported revenues or wages less than the legal minimum wage, was included in the analysis to avoid the perception that the survey intended to 'tip the scales'. The analyses did, however, present a number of different calculations to most completely and accurately present the data. Specifically, for most sections of the survey, several calculations were reported: the unweighted average in which all vendors were considered equally despite differences in the amounts of services they provide, the weighted average based on each vendors' revenue for a given service in fiscal years 2016-17 (for most schedules), and the median or the middle reported value (that is, half of the responses are greater than the median and half are less). Further, the unweighted and weighted averages were also presented with and without outliers, defined as greater than two standard deviations from the mean value. The median value as well as the averages without outliers are generally intended to screen out the responses that are likely erroneous, but all calculations were reported – including those with outlier responses – so stakeholders would have access to complete information.

13. ***Commenters expressed concerns related to the use of data from the provider survey, stating:***
    - ***It was not clear how the data would be used,***
    - ***Reported costs were artificially depressed due to current low reimbursement rates, and***
    - ***Values reported through the provider survey were not always incorporated in the rate models.***

The provider survey was intended to gather current information about the costs vendors incur in the provision of developmental services. The insights gained from the survey were informative but did not necessarily dictate rate model assumptions. Rather, the data from the provider survey was one of the data sources used in the development of rate models and served as a basis of comparison to data collected from other sources.

Information collected through the provider survey was not the only consideration in the development of rate models for a number of reasons. Most significantly, B&A recognizes vendors' expenses are largely a reflection of current reimbursement rates rather than a reflection of what costs 'should' be. Additionally, despite the substantial participation in the survey described in the response to comment 12, the voluntary nature of the survey introduces the possibility of self-selection bias making it unknown whether participating vendors are representative of all vendors.

Thus, data collected through the survey was generally just one of several sources of information used to develop the rate models. Other sources included DDS staff's regulatory and programmatic knowledge, the individual and family survey, and input from stakeholders through the public process

as well as published independent cost data from federal agencies including the Bureau of Labor Statistics, the Bureau of Economic Analysis, the Census Bureau, the Department of Health and Human Services, and the Internal Revenue Service; the California Workers' Compensation Insurance Rating Bureau; and commercial firms such LoopNet, Colliers International, and Bing's API mapping services.

In addition to informing the development of the rate models, data from the provider survey was used to support assumptions applied in the fiscal impact analysis when claims data lacked sufficient detail. For example, since a number of rates vary based on staffing ratios and claims do not usually identify the applicable ratio, data from the provider survey was used to estimate the proportion of services within a given service code provided at each allowable ratio.

Individual and Family Survey

14. Commenters expressed appreciation for the individual and family survey, including the fact that the survey was made available in multiple languages.

The support for the individual and family survey is appreciated.

This survey was not part of the original work plan for the rate study, but was added in response to requests from members of the DS Task Force's Rates Workgroup and other stakeholders. This element of the rate study was led by the Human Services Research Institute (HSRI), through a subcontract with Burns & Associates, Inc. To make the survey accessible to as many individuals and families as practicable, it was made available online in 17 languages.

The results of the individual and family survey were useful in understanding individuals' experiences with services. These insights helped to inform various recommendations in the rate study, including creating broader training requirements for direct care staff and the establishment of higher rates for serving non-English speakers in their native language.

15. Commenters objected to various aspects of the content of the individual and family survey, including:

- ***It was not clear how the data would be used,***
- ***It may have been confusing to some users, and***
- ***It did not include explicit questions regarding rate sufficiency.***

The survey was intended to solicit feedback from individuals receiving services and their families regarding their perceptions regarding services and potential opportunities for improvement. These insights were considered in the development of the rate models.

To make the survey accessible and relatable, it was developed in consultation with an advisory group of individuals with disabilities and family members who provided input on the topics to be covered and reviewed the survey instrument before it was finalized and distributed. The survey also included a dedicated email account to which respondents could submit questions.

Specific topics covered by the survey included individuals' opinions about the types of supports they need, the quality of their direct care workers, their priorities, and their experiences accessing and receiving services. The survey was not designed to collect information regarding the costs associated

with delivering services as that data was collected through the provider survey since only vendors possess detailed information related to the costs of providing services.

16. ***Commenters objected to the distribution of the individual and family survey as well as the timeframes for completing the survey and evaluating results.***

    DDS generally does not have access to email addresses for individuals receiving services or their family members. Consequently, the Human Services Research Institute relied on stakeholders groups to inform individuals of the survey. In particular, the survey was shared with the advisory group described in response to comment 15 and they were asked to share it with their membership. For instance, the California Disability Community Action Network (CDCAN), the Autism Society of California, and other groups helped to distribute the survey. DDS posted the survey on its website and asked Regional Centers to distribute the survey to people in their networks, as well.

    The survey was made available online from October 4 through October 28, 2018. Ultimately, more than 1,700 individuals, family members, and stakeholders across California participated in the survey.

    The analysis of survey results was presented to the advisory group. Further, HSRI facilitated ten public comment meetings at seven different locations across the state in March 2019. These meetings covered both the results of the individual and family survey and a high-level overview of the results of the overall rate study to gather in-person feedback and to encourage participation in the public comment process.

17. ***Commenters objected to the conclusion that most families and consumers are satisfied with their current provider.***

    The rate study report included a section describing the individual and family survey and providing a general summary of the results. The report indicated that "for the most part, respondents are pleased with the support they receive," but that "the survey also found that there is room for system improvement, particularly where areas with 'good' ratings lower than 50 percent were identified." This conclusion reflects the fact that about 75 percent of respondents rated their direct care provider as "good," while acknowledging there were questions where fewer than half of respondents rated their experience as "good," including knowing about the system; finding services and quality staff; getting specialized services; and choosing or changing staff.

Public Comment Process

18. ***Commenters stated the public comment process was ineffectively communicated, and the forum and format for submitting public comments were confusing.***

    The public comment process was designed for members of the DS Task Forces' Rates Workgroup as specified in the statute that authorized the rate study. To allow for broader participation, B&A and DDS expanded the comment process to include provider associations and other stakeholder groups as well as each Regional Center's vendor advisory committee. These representatives were invited to one of two, two-day meetings in late February 2019 in which B&A walked through the results of the rate study and the rate models.

    This presentation – which was streamed live and then the recording was posted online – included discussion of how the comment process would be administered. In particular, B&A and DDS encouraged representatives to consult with their members and colleagues, but sought to channel

comments through the representatives who were asked to consolidate and summarize feedback from their members and colleagues. To assist in this process, a public comment collection form was developed and made available to all prospective commenters to more efficiently organize comments by service and topic. As indicated in the instructions for the form, its use was optional, however, and representatives were welcome to submit comments in any format they found suitable.

19. Commenters stated the public comment period was too short to synthesize the large volume of complex published materials.

It is acknowledged the rate study was lengthy and detailed. Although the written report was released on March 15, the detailed rate models and a PowerPoint presentation that served as an outline for the report were released and presented the week of February 25, 2019. As noted in the response to comment 18, B&A facilitated two, two-day meetings (one in Northern California and one in Southern California) to present the results and recommendations. The first meeting was streamed online and a recording of the meeting was posted on DDS' website.

Thus, although the comment period officially ran from March 15 through April 5, 2019, the materials on which comments were sought were actually available three weeks prior to the opening of the comment period. Further, B&A continued to accept comments beyond the official closing date, with comments submitted as late as April 16. That said, there was a considerable volume of documentation to review, which likely required vendors and others to spend a significant amount of time evaluating the materials relevant to them.

If the rate study is implemented, there would be further opportunities to comment. In particular, the rate study includes recommendations that would require additional funding, changes to state regulations or statutes, and/or changes to the State's Medicaid State Plan or waiver programs. Since each of these processes includes public comment opportunities, stakeholders would be able to provide input before the rate study could be implemented.

ACROSS SERVICES

This section summarizes comments that apply across service categories. Topics include rate models; regional adjustment factors; direct care worker wages, benefits, and productivity; and program operations and administrative expenses.

Rate Models

20. ***Commenters expressed support for standardized rates whereby vendors are paid the same rate for providing the same service in the same area. Conversely, other commenters objected to the development of standardized rates, stating they are not fair and equitable or consumer-driven. One or more of these commenters stated vendors who have been providing services for many years should be paid higher rates than those that have been operating for a shorter period. Additionally, one or more of these commenters suggested rates should instead be based on the cost statement procedure used in the 1980s and 1990s.***

    Historic rate-setting practices – including rates based on cost statements, negotiated rates, and median rate limitations – have resulted in significant inequities in payment rates across and within Regional Centers. Vendors providing the same service in the same area are often paid very different rates. In order to increase the fairness of payment rates, the rate study produced standardized rate models. Instead of rates that vary based on vendors' historical costs, negotiating prowess, or date when they began delivering services, the rate models intend to account for the estimated costs of providing services consistent with DDS' requirements and individuals' service plans.

    Service payment does not determine person-centeredness; service planning and service delivery do. Consistent with State and federal requirements, individuals' service plans must still reflect a person-centered process. The rate models would only ensure vendors providing the same service in the same area would be paid the same rate.

21. ***Commenters stated the rate models assume each vendor will receive a specific number of referrals from their Regional Center in order to adequately cover the vendor's overhead costs through hourly billing. One or more of these commenters stated vendors will lose money until a critical mass of referrals is achieved so DDS should consider a startup rate for new providers. Finally, commenters stated Regional Centers' referral processes lack accountability.***

    Regional Centers' referral processes are beyond the scope of the rate study and the rate models do not include any specific assumptions related to the number of referrals a vendor will receive. It is acknowledged, though, that a vendor will need to achieve some level of service delivery in order to be viable over time. As with most businesses, it may take some time before these service levels are achieved during which time the vendor will likely need to minimize administrative spending and control other costs. As noted in the response to comment 20, the rate models do not vary based on the tenure of the vendors; the rate for a given service in a given area is the same for both new and established vendors.

22. ***Commenters stated the bases of the rate models were unclear and asked whether they were based on actual costs, which some vendors argue are understated.***

The rate study report and accompanying materials provide extensive documentation regarding the data sources and methodologies employed in the rate models. In particular, the following documents are available online:

- The rate study report outlines existing rate-setting methodologies in California, provides an overview of the rate study including the data sources used to inform the rate models, discusses the major components of the rate models, and summarizes the rate study results,
- The rate models themselves, which detail the specific assumptions included in each individual rate with the appendices that provide additional information about how wage, benefit, and productivity assumptions were developed,
- A report explaining how the rate study accounts for regional cost differences,
- The analysis and presentation of provider survey results,
- The presentation of consumer and family survey results,
- The fiscal impact analysis, and
- A presentation summarizing the rate study.

The provider survey was designed to capture vendors' current actual costs, which were considered in the development of the rate models. However, recognizing vendors' costs are largely a function of current rates, the rate study also relied on data and benchmarks from a variety of other sources. Examples include wage data from the Bureau of Labor Statistics and the Internal Revenue Services' standard mileage rate. The various data sources employed in the rate study are outlined in section 2.3 of the rate study report.

23. ***Commenters objected to the recommendation that all services be converted to hourly billing, stating that while this is the simplest form of billing and is most appropriate for certain services, it impairs the ability of vendors to meet the needs of individuals. Commenters asked whether various services would still have session rates.***

The rate study recommends most, but not all, services be reimbursed on an hourly basis. In general, the rate models for residential services assume a monthly billing unit and the models for transportation services assume billing for trips while the rate models for personal support and training services, day and employment programs, and professional services assume an hourly billing unit.

The standardization of hourly billing and the elimination of other billing units (such as days, weeks, months, and sessions) for these services is intended to increase consistency, accountability, and transparency. When an intermittent service is billed on a daily, weekly, or monthly basis, a vendors' payment is not directly tied to the amount of service they provide. For example, a weekly rate may be established based on the expectation that an individual will receive 20 hours of service, but the vendor's rate is the same regardless of whether they actually provide 15 hours or 30 hours. Further, there is no way to ascertain how much support an individual actually received during the week so DDS and Regional Centers cannot monitor utilization or the amount of authorized services provided.

For every service code included in the personal support and training category and nearly every service code included in the professional services category, the majority of services are already reimbursed on an hourly basis, demonstrating that this approach is manageable. Most day services are currently reimbursed on a daily basis so the adoption of hourly billing, which is further discussed in the response to comment 149, would require changes to these vendors' monitoring and billing practices.

24. ***Commenters stated the rate study assumes specific qualifications for staff for a number of service codes, but it was not clear whether staff would be required to actually meet these qualifications. Commenters indicated that if specific staffing requirements will be defined in regulation, there should be a stakeholder engagement process to ensure the requirements are appropriate for the service. Additionally, commenters stated the recommended rate models are not sufficient to cover the cost of the required staff.***

    Developing rate models requires clear service requirements, a key element of which is the qualifications of the worker providing the service.

    Most services included in the rate study are provided by direct support professionals and similar paraprofessionals. The only qualification assumed to be changing for these staff is the requirement they receive 70 hours of training in their first two years of employment (there would be additional qualifications for DSPs certified as part of the tiered DSP framework discussed in the response to comment 41, but participation in the certification process would not be required).

    For certain other services, the rate study does assume new qualifications for staff. For example, individuals providing Tutor services (service code 680) are assumed to have a bachelor's degree in a relevant field. For the rate models for Specialized Therapeutic Service (service codes 115, 116, and 117), there are separate rate models for therapists and for therapy assistants. For all service codes, the wage assumptions in the rate models are intended to reflect the assumed qualifications of the staff providing the service.

    If the rate study is implemented, it is assumed these requirements would be defined in regulation. The development of these regulations would include opportunities for stakeholder input.

25. ***Commenters suggested rates should be tied to quality and outcomes for individuals. Additionally, commenters suggested the ultimate measure of the success of the rate study is consumer satisfaction, which DDS should track through the National Core Indicators as the rate models are implemented. Commenters suggested there should be incentives for vendors that transition individuals to less restrictive environments such as a lower level home or from group employment to individual employment.***

    The rate study report includes a brief overview of the extent to which outcome-based rates are – or are not – utilized in home and community-based services programs across the country (see page 14). It is difficult to tie HCBS payments to quality and outcomes system-wide due to a lack of consensus on what should be measured, how to conduct the measurement, and how to verify measurements. The Department is committed towards working with stakeholders to explore how services can be incentivized to improve quality and outcomes where appropriate.

    The rate study seeks to support high-quality services. Key elements of the rate study include the creation of consistent service standards – a prerequisite to measuring outcomes – and the establishment of rate models reflective of the estimated cost of providing services. Participant satisfaction is also an important consideration and California currently participates in National Core Indicators (annual results can be found at https://www.nationalcoreindicators.org/states/CA/), but this is a complex issue affected by many factors unrelated to payment rates.

    The rate study emphasized indirect determinants of the quality of services and positive outcomes for individuals. As discussed in the rate study report (see pages 57 and 58), direct care workers are identified as one of the primary determinants of the quality of services as well as individuals'

satisfaction with services. For this reason, the rate models include a number of assumptions intended to support a quality workforce, including:

- Market-based wages and a comprehensive benefits package as discussed in the responses to comments 32 and 43,
- A requirement that most staff receive 70 hours of training over their first two years of employment as discussed in the response to comment 54,
- Funding for productivity assumptions reflecting non-billable responsibilities necessary to be effective in the job, such as receiving feedback from their supervisor and attending training, and
- The establishment of DSP 'levels' whereby staff who receive more training and demonstrate greater competency can be billed at higher payment rates to reflect the higher wages such staff would command as discussed in the response to comment 41.

26. ***Commenters stated that, while rates may be sufficient for most individuals, they may be insufficient for individuals with the highest support needs.***

In general, there are not enhanced rates for services because there are no defined requirements for what enhanced services would entail. For example, there are no additional requirements for staff serving individuals with more extensive needs. However, the rate models accommodate individuals with more significant needs in a number of ways:

- The rate models for residential and day programs include a variety of staffing levels and staffing ratios,
- Existing service codes exist for staff with specified credentials, such as registered behavior technicians and nursing assistants,
- There are customizable rate models for Community Care Facilities, Enhanced Behavioral Supports Homes, Community Crisis Homes, and Shared Supported Living services that are tailored to the individuals receiving services in these settings,
- Supplemental Program Support services (service codes 109, 110, and 111) can be used to augment staffing levels for individuals who require more extensive supports, and
- The tiered DSP framework discussed in the response to comment 41 would produce a credentialed workforce with demonstrated competency that vendors could assign to individuals with greater needs.

27. ***Commenters recommended the establishment of an exceptions process through which Regional Centers or DDS can augment rates for various reasons, such as to address unique situations where the recommended rates are not sufficient to serve a particular individual, to support positions that are difficult to fill, to fund new and innovative services, to account for attendance rates impacted by a heavy snow season, to ensure services in rural areas, and to respond to local laws that increase costs. Further, commenters stated Regional Centers must have the ability to contract for services that are not covered by the consolidated service codes and to deviate from the applicable rate if necessary to meet the needs set forth in an individual program plan.***

If the rate study is implemented, the creation of an exceptions process – perhaps modeled on the existing health and safety waivers – would be considered.

28. ***Commenters noted the rate models contained technical or computational errors.***

    The detailed review by the commenter is appreciated. In response to this comment and additional review of the rate models, calculations have been updated for several rate models.

29. ***Commenters objected to the use of national data in the development of the rate models, stating this understates costs in California. Commenters stated the cost of living in Los Angeles and other areas of California is higher compared to other states in which Burns & Associates, Inc. has conducted rate studies.***

    The rate study is intended to reflect the estimated costs of providing services in California and is not based on rates developed by Burns &Associates, Inc. in other states in which it has worked. As discussed throughout the rate study report, the rate models are informed by cost data collected from vendors of services in California and from various published sources of California-based cost information.

Regional Adjustment Factors

30. ***Commenters expressed support for efforts made to differentiate rates by geography to acknowledge variable costs of wages, real estate, and travel. Commenters also objected to various aspects of the regional adjustment factors, including:***

    - ***There should be five regional adjustment factors rather than three,***
    - ***The adjustments put lower-cost areas at a disadvantage and suggested the regional adjustment factors be set no lower than 100 percent of the applicable base rate model assumption,***
    - ***The regional adjustment factors are insufficient for the most expensive parts of the State,***
    - ***The regional adjustment factors for travel do not account for traffic congestion or long distances in rural areas,***
    - ***The rates should incentivize services in underserved communities, but the rate models will cause vendors to leave these area,***
    - ***Facility costs cannot be based on average real estate data because building must meet licensing and accessibility requirements (such as sprinkler systems, additional restrooms, etc.), and***
    - ***The rate study should consider the property value matrix used by public schools to address regional differences.***

    As discussed in the rate study report (see pages 44 through 52), the rate study endeavored to account for differences in costs related to direct care worker wages, travel distances and time, and real estate for center-based programs across different parts of California. For each of these cost factors, three regional adjustment factors are established based on a given region's cost in relation to a statewide average. The table to the right reports the regional adjustment factors (labeled as Category A, B, and C) for the three cost factors. Since these regional adjustment factors compare regional costs to a statewide average, some factors are less than 100 percent (that is, not all factors can be above

	Wages	Travel	Real Estate
Category A	95%	90%	80%
Category B	100%	105%	115%
Category C	115%	125%	130%

average). Each Regional Center is assigned to a regional adjustment factor for each cost factor. A Regional Center may be assigned to a different category for a different cost factor; for example, a Regional Center may be assigned to Category A for wages and Category C for travel.

For each service code or service code variant, a base rate model is established with baseline assumptions for these (and other) cost factors. Then, a rate model for each Regional Center is established by applying the appropriate regional adjustment factors to the applicable cost factor. For example, if the base rate model assumes an hourly wage of $14.00, the rate model for a Regional Center assigned to Category A would include a wage assumption of $13.30 ($14.00 multiplied by 95 percent), rate models for Category B would include a $14.00 wage, and models for Category C would include $16.10.

A report published with the rate study report and titled *Accounting for Regional Cost Differences Related to Wages, Travel, and Real Estate* detailed the methodologies employed to develop the regional adjustment factors and the process for assigning a regional adjustment factor to each Regional Center for each cost factor. In brief:

- The regional adjustment factors for wages were based on an analysis of wages reported by the Bureau of Labor Statistics for the State's metropolitan statistical areas compared to statewide average wages,
- The regional adjustment factors for travel considered both an analysis of purchase of service data to evaluate differences in travel time and distance between vendors and the individuals they serve in each Regional Center and an analysis of population density, and
- Since the regional adjustment factors for real estate applies to center-based programs and does not apply to residential real estate, it was based on analyses of commercial real estate costs published by commercial real estate firms.

While data from the BLS was directly used to set the wage assumptions in the rate models, the same is not true for travel and real estate costs. That is, the travel and real estate analyses described above were used to measure relative differences across the State (and to produce the regional adjustment factors), but *not* to set the cost assumptions in the base rate models. Rather, the base rate model assumptions related to these cost factors primarily considered data reported by respondents to the provider survey. The regional adjustment factors were then applied to the base rate model assumptions.

When setting the values for the geographic adjustment factors, Regional Centers were grouped based on the similarity of their costs. The geographic adjustment factor was generally set towards the high-end of the range of values within that grouping. For example, the Regional Centers assigned to Category B for the purposes of wages had average wages between 95 and 98 percent of the statewide average so the regional adjustment factor was set at 100 percent. Thus, creating a greater number of categories would result in a greater number of Regional Centers being assigned a lower regional adjustment factor than a higher one.

31. ***Commenters stated treating Los Angeles County as a single region – as is done by the Bureau of Labor Statistics – for the purposes of establishing regional adjustment factors fails to recognize significant cost variations within the County. Commenters similarly stated there is significant variability within certain Regional Centers and suggested rates should be established by county.***

In the development of the regional adjustment factors, the rate study sought to balance several goals, including accounting for differences in costs across the State, minimizing administrative complexity to the extent practicable, and relying on credible data sources that could be revised over time. The latter goal is a practical one: the rate study sought a data-based justification for accounting for regional cost variations.

As acknowledged by the commenters, the Bureau of Labor Statistics data used to establish both wage assumptions and regional adjustment factors treats Los Angeles County as a single metropolitan statistical area for the purposes of reporting wage data. This data cannot be broken down to a finer level that would allow analysis of differences across the Regional Centers within the County. The same is true for the real estate data described in the response to comment 30. As a result, the regional adjustment factors for wages and real estate are the same for each of the Regional Centers in Los Angeles County. However, since one of the data sources for travel differences was purchase of service data, this analysis could differentiate between the Regional Centers in the County and resulted in different category assignments for this cost factor.

These limitations also applied to other Regional Centers in that the published data is sometimes published for a grouping of counties or is otherwise unavailable for a single county. Further, county-based rates would add additional complication in terms of establishing billing rules to determine whether the rate is determined based on where the vendor is located, the service recipient lives, or where the service is delivered – which may change during the course of service delivery. The rate study therefore recommended rates tied to the Regional Center rather than to a county.

Direct Care Worker and Supervisor Wages

32. Commenters objected to the use of Bureau of Labor Statistics data to set the wage assumptions in the rate models. For example, commenters stated the rate study relies on national data and the BLS data reflects wages for staff with no experience. Commenters also suggested the rate models use the 75th percentile wage levels rather than medians.

As noted by the commenters, the wage assumptions in the rate models are derived from information published by the federal Department of Labor's Bureau of Labor Statistics. According to the BLS, it is the "only comprehensive source of regularly produced occupational employment and wage rate information for the U.S. economy, as well as States, the District of Columbia, Guam, Puerto Rico, the U.S. Virgin Islands, and all metropolitan and nonmetropolitan areas in each State." The rate study report outlined the benefits of using data from the BLS, including:

- *It is comprehensive*. The BLS publishes wage levels grouped into more than 800 occupations based on data collected from 1.2 million establishments, representing about 57 percent of the employment in the United States.
- *It is regularly produced*. BLS wage data is published on an annual basis, allowing rate model assumptions to be regularly reviewed and updated.
- *It is cross-industry*. BLS wage data is not limited to a single industry so estimates for a given occupation are representative of the overall labor market for that occupation; this is particularly important when considering wage levels for traditionally underfunded programs such as Medicaid.

- *It is state- (and local-) specific*. BLS wage data is reported for individual states and sub-state areas, permitting the evaluation of wage variance across states and within a given state.

For each occupation, the BLS publishes a variety of data, including various wage levels that range from the 10th percentile to the 90th percentile. This range of wages reflect differences in the labor market, including a mix of experience levels.

The rate models use the wage data for workers in California; national wage estimates are *not* used. In most instances, the rate models utilize the median wage levels – in California – for the selected standard occupational classifications used to represent the direct care worker for each service. The median wage, also known as the 50th percentile, is the wage at which half the individuals in the occupation earn more and half earn less. Thus, the wage assumptions reflect a range of experience levels. As with all rate model assumptions, the assumed wage is intended to represent a reasonable average. Thus, it is expected that some staff would earn more than the assumed wage (for example, those with more experience) and others would earn less (for example, new hires).

33. ***Commenters stated the Bureau of Labor Statistics wage estimates were too low because they were outdated and reflected a period during which the State's minimum wage was $10.00 per hour. Commenters expressed appreciation for the steps taken in the rate study to account for wage inflation and increases in the statewide minimum wage. Commenters objected to the approaches employed to update the BLS wage estimates, questioning why the reported 3.6 percent wage inflation was not used, questioning whether the calculated effects of the increasing minimum wage are accurate, and stating the 'spillover' effect of the minimum wage increase should be expected to affect those earning more than $17.00 per hour. Additionally, commenters stated the rate models should be updated with the more recent BLS wage data that became available after the release of the rate study.***

As mentioned in the response to comment 32, the BLS data is published annually. Results are released each March for the previous May. The draft rate models relied upon the BLS wage data released in March 2018, which reflects wage estimates for May 2017 and was the most recent dataset available when the rate study was published.

The State's minimum wage in May 2017 was $10.50 per hour. Recognizing this, the rate study adjusted the BLS wage data to inflate the wages to January 2020. These adjustments are detailed in the rate study report (see pages 29 through 33). In brief, the rate study estimated the effects of wage inflation – projected to be 3.6 percent annually based on the ten-year average in California according to the federal Bureau of Economic Analysis (BEA) – and the increase in the statewide minimum wage to $13.00 per hour in January 2020.

The minimum wage adjustment was designed to account for both spillover effects and wage compression. Spillover refers to the fact that the impacts of a minimum wage increase will extend to some wages that already exceed the new minimum wage. For example, an individual earning $13.25 per hour is likely to receive a raise as the minimum wage increases from $10.50 to $13.00 even though their employer is not obligated to provide a raise as they already earn more than the new minimum wage. Compression refers to the fact that the size of pay raises will diminish as the beginning wage increases. For example, the worker earning $13.25 per hour will likely receive a raise, but that raise will be less than the $2.50 per hour raise the worker earning $10.50 per hour will receive as the minimum wage increases to $13.00 (to assume otherwise requires the belief that every worker in the State – regardless of how much they already earn – will receive a pay raise when the minimum wage increases). Both phenomena are widely accepted in the economic literature, but a

review of this research did not identify specific formulae for quantifying the effects. The rate study therefore designed its own methodology to estimate the effects, which is detailed in the rate study report.

The wage inflation and minimum wage adjustments were separately calculated for every wage value, with the larger result applied. This resulted in wages greater than $15.00 per hour increased by 9.89 percent (32 months at 3.6 percent) and wages less than $15.00 increased by larger percentages based on the projected impacts of the increasing minimum wage.

Subsequent to the publication of the rate models, new data has become available and has been incorporated into the updated rate models.

The newest BLS dataset reflecting wage estimates for May 2018 was released after the rate study report was published in March 2019. Additionally, the BEA released a newer estimate for the compound annual growth rate in net earnings in California – an increase to 4.3 percent – reflecting 2008 through 2018. This more current data has been incorporated into the updated rate models. For most rate models, this update produced wages *less* than had been assumed. This was true for both relatively high and relatively low wages, as demonstrated in the table below.

Service	Base Wage Using May 2017 BLS Data + Minimum Wage/ Inflation	Base Wage Using May 2018 BLS Data + Minimum Wage/ Inflation	Percent Difference
Respite/ Personal Assistance	$14.44	$13.98	(3.2%)
DSPs (Independent Living/ Day Programs)	$15.34	$15.00	(2.2%)
Behavior Technician – Paraprofessional	$19.11	$18.48	(3.3%)
DSP Supervisor	$21.04	$20.30	(3.5%)
Infant Development Specialist	$32.47	$29.01	(10.7%)

Thus, both the wage inflation and minimum wage adjustments incorporated in the rate study appear to have overstated actual wage growth between 2017 and 2018.

However, as noted in the response to comment 34, these assumptions continue to reflect wages as of January 1, 2020 when the statewide minimum wage is $13.00 per hour. If the rate models are implemented, the wage assumptions will need to be revised again to account for further inflation and the statewide minimum wage to be in effect at that time (the statewide minimum wage is scheduled to increase to $14.00 per hour on January 1, 2021).

34. Commenters stated the rate models tie direct support professional wages to the State's minimum wage. Commenters expressed concern that the rate study accounts for the State's minimum wage increasing to $13.00 per hour in 2020, but does not address future changes to the minimum wage.

The rate models do not assume direct support professionals are paid at the minimum wage. Rather, the rate study recognizes DSP wages should be increased as the minimum wage increases so they do not become minimum wage positions. The rate study produced rate models for fiscal year 2020 when the statewide minimum wage would be $13.00 per hour. As noted by the commenters, the rate models do not account for a $15.00 statewide minimum wage because it will not be effective until January 2022 (in fiscal year 2021-22). However, as discussed in the response to comment 5, the rate models

are designed so they can be updated over time in order to account for changes in costs, including the effects of further increases in the statewide minimum wage. The table below illustrates what the wage assumptions would be for select services, incorporating the May 2018 BLS data released after publication of the draft rate models adjusted for the next two scheduled statewide minimum wage increases employing the methodology discussed in the response to comment 33.

Service	$13 Min. Wage	$14 Min. Wage	$15 Min. Wage
Personal Assistance/ Respite	$13.98	$14.88	$15.79
Supported Living/ CCF (line staff)	$14.49	$15.28	$16.12
Independent Living/ Day Services	$15.00	$15.69	$16.44

The table illustrates that updating the rate models to account for the increase in the statewide minimum wage to $15.00 per hour would, for example, increase the wage assumption for DSPs in Supported Living and Community Care Facilities from $14.49 per hour to $16.12. As discussed in the response to comment 33, the increase is less than the $2.00 increase in the statewide minimum wage due to the effects of wage compression.

35. ***Commenters stated the rate models should account for regional variation in wages, including local minimum wage ordinances. Commenters expressed specific concern that the rate models for the Los Angeles County-area Regional Centers do not account for that area's local minimum wage.***

The rate study does account for regional variability in wages. This process was detailed in the *Accounting for Regional Cost Differences Related to Wages, Travel, and Real Estate* report that accompanied the rate study (see pages 3 through 8). In brief, the rate study compared BLS wage estimates for 'metropolitan statistical areas' comprised of one or more counties to statewide wage estimates in order to measure wage differences across California. This analysis was used to group Regional Centers into one of three wage categories with a regional adjustment factor to modify the wage assumption in the base rate model. For example, the regional adjustment factor for the Regional Centers assigned to the highest category (wage category C) is 115 percent. Thus, a base rate model wage assumption of $14.49 per hour would be increased to $16.66 for the Regional Centers in category C.

As discussed in the response to comment 33, the rate study did seek to account for increases in the statewide minimum wage. There is no specific provision for local minimum wages. However, the regional adjustment factors do indirectly account for local minimum wages – to a degree – since areas with higher minimum wages tend to be high wage areas.

Los Angeles area Regional Centers were assigned to wage category B based on the regional wage analysis. The regional adjustment factor for wage category B is 100 percent, meaning the wage assumption in these Regional Centers is set equal to the base rate model assumption. The city and county of Los Angeles, though, reach a $15 minimum wage before the statewide minimum wage reaches this level. That said, if the rate models are adjusted to account for the increase in the statewide minimum wage as discussed in the response to comment 34, the wage assumptions in the rate models for the Los Angeles area Regional Centers would mostly remain ahead of the local minimum wage as shown in the table below.

Fiscal Year	Statewide Min. Wage (end of FY)	Personal Assistance/ Respite/ Transportation Assistant/ Supplemental Program Support Wage Assumption	City of Los Angeles Min. Wage (end of FY)
2020	$13.00	$13.98	$14.25
2021	$14.00	$14.88	$15.00
2022	$15.00	$15.79	$15.00

The table shows the wage assumption for the services with the lowest assumed wage: Personal Assistance, Respite, Transportation Assistant, and Supplemental Program Support. As the table illustrates, the wage assumption for these services in fiscal years 2019-20 and 2020-21 would be slightly less than the minimum wage in the city of Los Angeles before the statewide minimum wage (and the rate model assumption) 'catches up' in fiscal year 2021-22. As discussed in the rate study report, however, total compensation – wages, payroll taxes, paid leave, and other benefits – built into the rate models exceeds all applicable state and federal requirements. Thus, in the short-term, vendors in the Los Angeles area can potentially offer less generous benefits than assumed in the rate model in order to cover the cost of the minimum wage. The wage assumption in all other rate models exceeds the minimum wage in Los Angeles.

36. ***Commenters objected to the specific Bureau of Labor Statistics occupations used to establish the wage assumption for direct support professionals. Commenters stated the rate study should reflect greater variability between services (for example, wage assumptions for more personal care driven services such as Personal Assistance and Respite should be less than wage assumptions for more habilitative services such as Independent Living). Conversely, other commenters stated there should be less differentiation (for example, the wage assumptions for community-based day programs and supported employment services should not differ). Commenters stated wage assumptions in the rate models for various personal care and habilitative services are too low while other commenters suggested the wage assumptions for some of these services are too high.***

As discussed in the rate study report, the Bureau of Labor Statistics does not have a specific occupational classification for every occupation (see pages 33 through 35). For example, there is not a specific occupation for direct support professionals. That is not to say DSPs are not included in the BLS survey – they are – but they are grouped into a larger classification for personal care aides. In these instances, and to account for the varied responsibilities of many staff, the rate study created a composite occupation drawing on multiple BLS classifications. The table to the right illustrates the mix of occupations used to establish the wage assumption for DSPs.

BLS Standard Occupational Classification	Weighting	Median Wage (Adjusted)
39-9021 Personal Care Aide	55%	$13.72
31-1011 Home Health Aide	15%	$15.47
31-1013 Psychiatric Aide	15%	$15.70
39-9032 Recreation Worker	15%	$15.12
Weighted Average (Base Rate Model Wage Assumption)		$14.49

This wage assumption – which was reduced to $14.49 once the May 2018 BLS data was incorporated into the rate models as discussed in the response to comment 33 – was used in the rate models for a number of services that employ DSPs, including Independent Living, Supported Living, Community-Based Day Programs, and Community Care Facilities (CCF). The wage assumption in the base rate models for services with a greater emphasis on personal care, such as Personal Assistance (service code 062) and Respite (service code 862) was somewhat less at $14.44 per hour (revised to $13.98 based on the newest BLS data). In response to comments, a number of changes were made to DSP wage assumptions:

- The mix of occupations for Independent Living (service code 520) and Independent Living Specialist (service code 635) was revised to reduce the use of the personal care aide occupation, producing a base rate model wage assumption of $15.00 per hour.
- The mix of occupations for Community-Based Day Programs was revised to reduce the use of the personal care aide occupation, producing a base rate model wage assumption of $15.00 per hour.
- The wage level for line staff in CCFs at level 5 and above was increased by 10 percent.

The assumed mix of occupations for services with a substantial personal care focus – Personal Assistance, Respite, Supported Living (service code 896), Supplemental Program Support (service codes 109, 110, and 11), and Transportation Assistant (service code 882) – are unchanged.

Additional discussion of comments relating to other service-specific wage assumptions are included in the service-specific subsections of this document (for example, comments related to wage assumptions for staff providing Supported Employment services are addressed in the Supported Employment subsection).

37. ***Commenters stated differential pay should be factored in to rate models for 'split shifts', overnight and weekend shifts, and shifts on normally-recognized holidays. Commenters stated the rate models should include staff bonuses.***

Although the rate models do not include specific assumptions related to pay differentials, the wage assumptions in the rate models are intended to reflect a typical hourly cost. Vendors have the flexibility to establish their own wage policies as it is expected that some staff would earn more than assumed in the rate model and others would earn less. For example, a vendor can choose to pay a higher wage than assumed for staff working a less desirable shift, for staff with more experience or training, etc., and a lower wage to staff working a more desirable shift, with less experience or training, etc.

38. ***Commenters stated the wage assumptions in rate models for various services provided by direct support professionals do not accommodate higher-skilled DSPs who work with individuals with greater needs.***

In general, existing regulations do not specify additional qualifications for staff who work with individuals with more significant needs. As a result, the rate study does not include differentiated wage assumptions based on individual need. There are, however, already service codes for staff with specialized skills, such as behavior technicians and nurse's assistants. Additionally, the tiered DSP framework discussed in the response to comment 41, if adopted, could be used to assign higher-skilled staff to individuals deemed to have greater needs.

39. ***Commenters stated the assumption that five percent of work hours in residential programs are paid at an overtime rate is too low. Further, commenters stated overtime should be built into all programs. Commenters suggested separate rate models should exist for straight time and overtime, particularly for parent-coordinated services.***

    The rate models for CCFs and ARFPSHNs include an assumption that five percent of front-line staff's work hours are paid at an overtime rate because these services have continuous responsibility for individuals. In response to this comment, a similar five percent overtime assumption was added for Supported Living services, CCF staff-operated models (for the home administrator), and line staff in Enhanced Behavioral Supports Homes (EBSH) and Community Crisis Homes (CCH). This is less than overtime rates reported through the provider survey (for example, eight percent of Supported Living direct care hours and 14 percent of CCF direct care hours were reported to be paid at an overtime rate), but it is presumed the use of overtime hours can be reduced as the overall increases in payment rates would allow for investment in staff that would improve recruitment and retention, decreasing the need for overtime.

    Services not provided on a continuous basis (such as day programs and most services in the personal support and training category) do not include an assumption of overtime hours.

    Additionally, since 'average' wages are not feasible for self-directed/ parent-coordinated services, separate rate models have been established for work hours paid on an overtime basis.

40. ***Commenters expressed appreciation for the non-English rates provided for in many of the service rate models. Conversely, commenters indicated vendors should not be required to pay a non-English stipend in situations such as Respite when the member and family speaks Spanish, for example, since they would never send a non-Spanish speaking worker to provide the service. Commenters also offered a number of suggestions, including:***

    - ***The non-English rates should be extended to more services, including Community Care Facilities, Supported Employment, Work Activity Programs, and licensed professionals,***
    - ***The non-English rates should apply to individuals who are deaf and individuals with limited receptive and/or expressive language skills who communicate through non-verbal communication techniques as well as augmentative or alternative communication devices,***
    - ***There should be a regional adjustment factor for the wage stipend and a premium for rare languages, and***
    - ***Clarification should be provided so vendors understand when they can or cannot bill the non-English rates, including for group-based services such as residential and day programs.***

    Finally, commenters requested clarification on the calculation for non-English rate premiums.

    The rate study recommended enhanced rates for services delivered to non-English speakers in their language. The recommendation covers American Sign Language but not other non-verbal communication techniques or augmentative or alternative communication devices. Non-English rates were recommended for most services, including Community Care Facilities, Supported Employment, and Work Activity Programs. There were exceptions related to certain highly-compensated professional services as well as services with a lower-level of provider and individual interaction including transportation services and housekeeping. In response to comments, non-English rates were added for crisis evaluation and behavioral interventions, Behavior Analyst, Associate Behavior Analyst, Behavior Management Assistant, Behavior Technician – Paraprofessional, Behavior

Management Consultant, and all Infant Development disciplines. Additionally, Specialized Therapeutic Services rate models were constructed in the revised rate model package and there would be non-English rates for these services.

The non-English rates are based on the addition of $100 per month per worker plus the marginal cost of benefits. This is consistent with a stipend offered to California State employees who qualify. This stipend does not vary by region, but is in addition to the base rate model assumption that already accounts for regional variability. The stipend is also fixed across non-English languages, including American Sign Language.

If the rate models are implemented, policies would need to be developed to specify the requirements for accessing the non-English rates, including when an individual qualifies for the rate and how staff would be determined to be fluent in the applicable non-English language. For residential and day programs in particular, the vendor would need to ensure the individual has access at all times to an onsite staff person who speaks their language in order to bill the non-English rate for that individual.

It is not anticipated there would be a requirement that vendors bill the non-English rates or pay higher wages to staff providing services in a language other than English, but it is hoped these rates would expand access to services and reduce disparities.

41. ***Commenters expressed support for the proposed tiered DSP structure, noting it has the potential to provide a strong workforce while providing DSPs with a career ladder. Commenters raised questions or concerns relating to the implementation strategy and billing requirements, noting:***
    - ***The assumed wage levels for tiered DSPs were higher, but there was no accounting for the added training costs affiliated with implementing and certifying DSPs,***
    - ***Additional clarification or guidance will be needed for vendors to understand when they can bill the higher DSP tiered rates and vendors should be involved with the development of the DSP billing criteria,***
    - ***The tiered DSP rate structure will complicate billing, especially when coupled with other rate variants, such as group size or setting, and implementation should not be imposed on vendors, and***
    - ***A DSP credentialing structure be established for supervisors.***

To support high-quality services, the rate study recommended the development of a direct support professional credentialing system that would allow vendors to bill higher rates for services delivered by staff who have demonstrated competency in the field.

Although the rate study does not presuppose the adoption of any particular credentialing model, the framework established by the National Alliance for Direct Support Professionals is an illustrative example.[3] This framework is comprised of three DSP levels, each with specified training and professional requirements.

The rate models support this system by increasing the wage assumption by $1.00 per hour for each achieved level (such that the wage assumption for a DSP III is $3.00 per hour higher than the base

[3] National Alliance of Direct Support Professionals. (April 2019). Direct Support Professional Certification Program Guidebook. Retrieved from https://www.nadsp.org/wp-content/uploads/2019/07/NADSP-2019-Certification-Guidebook-Final-2019.pdf.

DSP wage assumptions) *and* recognizing the additional non-billable time associated with acquiring the required training. The rate models do not include additional funding for vendors' administrative costs.

The development of this credentialing system would require the establishment of infrastructure both within DDS and within the vendor community to adopt or create the criteria for the levels, to track who achieves each credential, to develop billing guidelines, to consider whether there should be a similar system for supervisors, and to address other issues raised by commenters. This would be a significant and important undertaking that should involve vendors, DSPs, and participants.

If a credentialing system is established, vendors would not be required to participate, although that could affect their ability to attract staff and participants.

42. ***Commenters stated the wage assumption for first-line supervisors of paraprofessional staff should be set at twice the minimum wage to allow vendors to classify these positions as exempt and avoid paying overtime. Other commenters stated DSP supervisor wages should be twice the assumed wage for direct support professionals. Further, commenters stated that if supervisors are not classified as exempt, overtime for these positions should be included in the rate models.***

Most rate models for services delivered by direct support professionals and other paraprofessionals include a factor for supervisor costs. There is no requirement that these positions be classified as exempt so the rate models do not set the wage level at twice the minimum wage, which is required to classify a position as exempt in California. Rather, the base rate model assumes a wage of $20.30 per hour, or approximately $42,200 annually.

In response to this comment and recognizing certain programs are responsible for individuals on a continuous basis, a five percent overtime factor has been added to the rate models for Supported Living (supervisors), CCF staff operated models (home administrator), and ARFPSHN, EBSH, and CCH (lead staff).

Direct Care Worker and Supervisor Benefits

43. ***Commenters stated a robust benefits package recognizes the value of staff, contributes to the health and wellbeing of employees, and aids in retention. Commenters stated the overall benefits rate was too low and government agencies and Regional Centers offer more generous benefits. Separately, commenters stated the rate models inaccurately assume all direct care staff receive the same benefits. For example, commenters stated the rate models do not take tenure into account, but longer-tenured staff receive more generous benefits. Finally, commenters suggested the rate models do not detail or do not include the cost of payroll taxes, unemployment insurance, health insurance and other benefits for staff.***

As detailed in the rate study report (see pages 35 through 39), the rate models include a comprehensive benefits package for direct care staff, including:

- 25 days of paid time off for holidays, vacation leave, and sick leave,
- $360 per employee per month for health insurance based on an 80 percent participation rate and an employer contribution of $450 per participating employee, and
- $100 per employee per month for other benefits offered at the discretion of the employer.

As discussed in the response to comment 51, the rate models have been revised to incorporate an assumption that 30 percent of direct care workers are part-time. The rate models include 7.5 days of paid time off and $100 per employee per month for benefits for part-time staff. The rate models do not include health insurance for part-time staff.

These benefits assumptions, which exceed the benefits reported by provider survey respondents, are designed to provide a competitive benefits package for direct care workers reflective of the private sector that employs the majority of employees in the field. Further, for both full-time and part-time staff, the rate models also account for the costs of Social Security and Medicare payroll taxes, state and federal unemployment insurance, and workers' compensation.

As with all rate model assumptions, the assumed benefits package is intended to represent a reasonable average. Thus, it is expected that some staff would have more generous benefits (for example, those with more experience) and others would have less generous benefits (for example, new hires).

44. ***Commenters suggested the benefit rate should be the same for all staff, including supervisors. Commenters suggested the rate models do not account for the increased cost of benefits associated with the rising minimum wage.***

    The rate models assume all full-time direct care workers receive the same benefits package as described in the response to comment 43. The same benefits package is also assumed for supervisors identified in the rate models.

    The rate models translate this benefits package to a benefit rate expressed as a percentage of the wage assumption for the worker. As observed by the commenters, the cost of some components of the benefits package does increase as the wage rises; specifically, this is true for Social Security and Medicare payroll taxes (the cost of paid time off also increases, but this is handled as a productivity factor rather than included in the benefit rate). However, the cost of other benefits is assumed to be fixed so they translate to a lower percentage as the wage increases. Thus, there is an inverse relationship between wages and the benefit rate: as the wage increases, the benefit rate declines. For example, although the *benefit rate* for supervisors is less than for direct care workers, the *benefits package* is the same.

45. ***Commenters stated the 25 days of paid time off assumed in the rate model is too low and is based on employees with one-to-five years of experience. Conversely, commenters stated the assumption is excessive and will be an added burden to vendors. Additionally, commenters stated the paid time off assumption is not adequate to comply with the State's sick leave requirements. Further, commenters stated the rate models should account for local jurisdictions that require more sick time – noting, for example, San Diego requires employers to provide five days – so vendors in these areas are not put at a disadvantage.***

    As discussed in the response to comment 43, the benefits package assumed in the rate models for full-time staff includes 25 days of paid time off to account for 10 holidays and 15 days of vacation and sick leave. This assumption – and the more limited assumption of 7.5 days for part-time staff – is more than sufficient to comply both with California law requiring employers to provide at least 24 annual hours of paid sick leave to staff and with local ordinances.

    As referenced by the commenters, the rate models reported that data from the Bureau of Labor Statistics showed employees with one-to-five years of experience receive an average of 15 days of

vacation and sick leave and employees with six-to-ten years of experience receive an average of 22 days. Although the provider survey did not include a question regarding staff tenure, it did ask respondents to report turnover rates. Reported turnover varied by service code, but the overall average was approximately 30 percent. Given that the turnover rate suggests 30 percent of direct care staff will be within their first year of employment, it appears reasonable to assume the majority of staff will have fewer than five years of service with their employer.

These assumptions are somewhat greater than reported by respondents to the provider survey. Participants reported full-time staff receive nine holidays and 10 or 14 days (median and weighted average) of vacation and sick leave. Part-time staff were reported to receive less.

The rate model assumptions are not prescriptive; that is, vendors are not required to offer the level of paid time off (or other benefits) assumed in the rate models so this assumption is not creating a burden for vendors. As noted by the commenters, however, vendors must comply with State laws and local ordinances so those operating in areas with sick leave policies that exceed the State's minimum requirements will have less flexibility than those operating in areas without these requirements.

46. ***Commenters stated Regional Centers have different holiday schedules, with some Regional Centers mandating 12 holidays. Additionally, commenters stated the 25 days of paid time off assumed in the rate models should be increased to 29 days due to the uniform holiday schedule.***

As noted by the commenters, the assumed benefits package in the rate models includes 25 days of paid time off to account for 10 holidays and 15 days of vacation and sick leave. The uniform holiday schedule defined at WIC § 4692 establishes 14 holidays on which Community Based-Day Programs and Transportation services cannot be paid. The uniform holiday schedule was created as a cost-savings measure. Vendors are not required to pay staff for the four additional holidays, but may choose to do so.

The fiscal year 2019-20 budget suspended the uniform holiday schedule; however, the rate models will not include the four additional days if and when the uniform holiday schedule takes effect as doing so would eliminate most of the savings the uniform holiday schedule was designed to achieve.

47. ***Commenters provided feedback related to the health insurance cost assumptions in the rate models, stating:***

- ***The cost assumption is not adequate and costs vary depending on the selected plan, type of insurance (that is, an employee-only or family plan), age of employees, and other factors; commenters noted a survey conducted by the Kaiser Family Foundation found the average employer contribution to health insurance nationally was $476 for an individual plan and $1,172 for a family plan in 2018,***
- ***The Affordable Care Act limits employee contributions to 10 percent of their wages and some vendors require smaller contributions given the low wages earned by many direct care workers,***
- ***The cost assumptions are realistic for larger employers with more bargaining power compared to smaller employers, and***
- ***The assumed participation rate is too low.***

As discussed in the response to comment 43, the assumed benefits package in the rate models includes $360 per full-time employee per month for health insurance. This amount is based on an

assumed employer contribution of $450 per enrolled employee and an assumed 80 percent take-up rate. The revised rate models do not include an assumed health insurance benefit for part-time staff.

The cost assumption is intended to reflect the employer share of an employee-only health insurance plan. This estimate is consistent with information from the provider survey and other published estimates. Respondents to the provider survey reported an average monthly cost of $417 (median)/ $488 (weighted average) per participating employee, which is inclusive of both individual and family coverage. According to data from the Bureau of Labor Statistics (BLS), the average employer contribution for employee-only plans in the Pacific region was $454 in 2018. Considering only employers that require an employee contribution – 82 percent of employees in the region are required to contribute to the cost of their insurance – the average employer contribution is $434 and the average employee share is $127. Information from the U.S. Department of Health and Human Services' Medical Expenditure Panel Survey (MEPS) shows the average employer contribution for employee-only plans made by employers in California was $405 in 2017. The average employee share of cost was $119.

As with all rate model assumptions, the assumed health insurance cost is intended to reflect a reasonable average so it is expected costs would be lower for some vendors and higher for others. As noted by the commenters, actual costs differ based upon various factors including employees' ages, sex, and health condition. The data from the BLS and MEPS, however, show only modest differences based on agency size except for very small agencies. According to the BLS, the average employer contribution by employers with fewer than 50 workers nationally (regional data was not broken down by firm size) was $436 while the average cost for employers with more than 500 workers was $451. According to MEPS data, the average employer contribution for firms with fewer than ten employees was $467 per month while the average for other firm sizes ranged from $361 to $438.

Although the rate models do not include a specific assumption related to employees' share of costs, the BLS and MEPS data suggest employees contribute about $125 per month or $1,500 annually. Assuming an hourly wage of $13.98 – the lowest assumption across the base rate models – for an employee working full-time, this contribution translates to just over five percent of gross wages, which complies with the requirements of the Affordable Care Act.

The take-up rate assumed in the rate model exceeds the rate reported by respondents to the provider survey. Vendors that offer health insurance reported a take-up rate of 55 percent. Rather than relying on current participation rates, which may be affected due to current payment rates that do not allow vendors to offer quality health insurance plans, the rate models rely on average participation rates across industries. For example, according to the BLS, the take-up rate by all employees with access to employer-sponsored insurance in the Pacific region is 77 percent.

The resulting cost included in the rate models – $360 per employee per month – is significantly greater than provider survey results, which found a current effective cost of $271 per employee after adjusting for take-up rates.

48. Commenters asked what is included in the 'other benefits' included in the assumed benefits package. Commenters stated some agencies will be required to provide 401k benefits and this cost is not included in the rate models.

As noted in the response to comment 43, the benefits package for direct care workers incorporated in the rate models includes $100 per employee per month for both full-time and part-time staff. This assumption is intended to cover the cost of benefits offered at the discretion of employers – such as

dental or life insurance, short-term or long-term disability insurance, a retirement plan, etc. – that are not otherwise included in the rate models. In comparison, respondents to the provider survey reported an average cost of $119 and $38 per month for full-time and part-time employees, respectively.

As noted, this funding could be used to support a modest contribution to a retirement plan although there is no requirement that employers make such a contribution. State law does require employers with more than five employees to provide access to a retirement plan or participate in CalSavers, which allows employees to contribute to a 401k-type plan, but does not require employers to contribute to the plan.

49. ***Commenters expressed various objections to the assumptions related to workers' compensation costs, including:***

    - ***The rate models rely on advisory pure premium rates established by the Workers' Compensation Insurance Ratings Bureau, but actual rates are set based on an individual vendor's actual history,***
    - ***The workers' compensation rates are tied to the incorrect WCIRB classification codes and are too low,***
    - ***The rate models assume insurers' administrative costs are 12 percent, but the WCIRB reports 18 percent.***

    As described in the rate study report, to establish workers' compensation rates the rate models rely on the approved 2019 advisory pure premium rates reported by the Workers' Compensation Insurance Rating Bureau. To reflect differences across services, Burns & Associates, Inc. selected the Workers' Compensation Insurance Rating Bureau (WCIRB) classification code that appeared most applicable to each individual service code. Then, based on the four-year trend between January 1, 2015 and January 1, 2019 across all classification codes, the rates were reduced by 11.5 percent. This reduction was deemed appropriate because it follows recent trends (a review of the specific classification codes used in the rate models actually found a larger average decrease) and because of the effect of rising wages. To the latter point, workers' compensation pays for workers' lost wages, the cost of which will increase in concert with increases in wage levels due to the rising statewide minimum wage. However, workers' compensation also pays for medical expenses, which are unlikely to grow as quickly as the increase in the minimum wage, resulting in the workers' compensation rate declining in relation to the wage level.

    Subsequent to the publication of the draft rate models, the WCIRB released advisory pure premium rates for January 1, 2020. Overall, these rates confirmed the downward trend assumed in the rate models with some rates higher than assumed and others lower. In total, the average advisory pure premium rate was slightly lower than assumed in the draft rate models. These new figures have been incorporated into the draft rate models.

    Finally, in response to comments, the administrative factor added to account for insurers' costs was increased from 12 percent to 18 percent.

    It is understood that the actual workers' compensation rates vary by vendor based on their experience. As with all rate model assumptions, the rates are intended to reflect a reasonable average across vendors of a given service although some vendors are likely to have higher rates and others are likely to have lower rates.

50. ***Commenters stated the 3.4 percent unemployment insurance rate assumed in the rate models is too low, noting, for example, information from the United States Department of Labor shows the average rate paid by California employers in 2018 was 4.33 percent.***

As noted by the commenters, the rate models include an assumed 3.4 percent State unemployment insurance rate. This assumption was set based on the rate assigned to new employers. Although this rate is less than reported in the Department of Labor document provided by the commenters, it exceeds the rates reported by respondents to the provider survey (1.2 percent median and 3.0 percent weighted average).

Direct Care Worker Productivity

51. ***Commenters objected to the assumption that all staff work 40 hours per week, stating this overstated the productivity of staff.***

As noted by the commenters, the published rate models were built on the assumption that staff work a 40-hour workweek. In response to this comment, the rate models have been adjusted to assume a proportion of the workforce works part-time.

Specifically, the rate models now assume 30 percent of employees work part-time. This is a lower proportion than reported by respondents to the provider survey – which found 55 percent of direct care workers are part-time – because it is assumed the recommended increases in rates would better support a full-time workforce. This assumption does not apply to rate models for services the rate study included in the 'professional' category and typically provided by staff who have at least a bachelor's degree; these rate models continue to assume 100 percent of staff work full-time.

As suggested by the commenters, the rate models assume part-time staff are less productive because certain productivity factors, including training and supervision and other employer time, are assumed to be fixed regardless of the number of hours worked. For example, the rate models assume staff receive one hour of supervision and other employer time regardless of whether they are full-time or part-time. This results in part-time workers spending a smaller proportion of time on billable activities, which produces a larger productivity adjustment. Other factors are assumed to be variable. For example, the rate models assume staff working part-time will spend less time on travel and recordkeeping because they will be working with fewer individuals. The productivity factors in the rate models now reflect a weighted average of full-time and part-time staff. Full-time staff are generally assumed to work 40 hours per week and part-time staff are assumed to work 22 hours, which is the average reported by participants in the provider survey excluding those who reported fewer than 10 hours or more than 30 hours.

Additionally, as discussed in the response to comment 43, the rate models also assume a less generous benefits package for part-time staff. The benefits rate is similarly weighted based on the assumed mix of full-time and part-time workers.

52. ***Commenters expressed support for including paid time off for direct care workers in the rate models, but stated the rate models do not account for the cost of substitute staff to cover the shifts of the worker who is absent.***

The rate models do account for the cost of substitute staff.

As noted by the commenters and as discussed in the response to comment 43, the rate models include an assumption that direct care workers have access to paid time off. For full-time workers, the rate models include 25 days of paid leave per year, which equals 200 hours annually or 3.85 hours per week. This assumption is treated as a productivity factor, which is the mechanism through which the cost of the primary direct care worker is funded.

For example, consider a service billed on an hourly basis and provided by a direct care worker who earns $20 per hour in wages and benefits. Assuming a 40-hour workweek and that paid time off is the only productivity factor in the rate model, it is assumed the direct care worker is providing billable services for 36.15 hours per week. This translates to a productivity adjustment of 1.11 (40 divided by 36.15). This factor is applied to the wage and benefit cost, inflating that cost to $22.20 per hour. Over the course of the year, the worker would bill for 1,879.8 hours of service (36.15 hours per week multiplied by 52 weeks) amounting to $41,732. This covers the $41,600 cost of the primary direct care worker ($20 per hour multiplied by 2,080 hours; the rate model yields a slightly higher amount in this example due to rounding).

However, it is assumed the 3.85 hours per week that the primary direct care worker is on vacation are still being provided by the vendor using substitute staff. Thus, the vendor is billing for these hours and it is this revenue that covers the cost of the wages and benefits of the substitute staff.

53. ***Commenters stated the proposed rate models do not take into account meal breaks, mandatory rest periods, or accommodations for nursing mothers.***

    As noted by the commenters, the rate models do not include a productivity factor for on-duty meal periods or rest periods. Rather, the rate study assumes schedules can be arranged to accommodate mandatory breaks and rest periods. For instance, when a staff person provides services to different individuals during their work day (for example, they work with an individual for three hours in the morning and with another individual for three hours in the afternoon), breaks can be taken between these service encounters. Or, when multiple staff persons are involved in the service, their breaks can be staggered to accommodate breaks while ensuring supervision of service participants. A provider may also use supervisory staff to provide coverage during break periods. Additionally, for meal breaks in particular, applicable California Industrial Wage Orders permit employers and employees to agree in writing to paid on-duty meal periods when the nature of the work prevents an employee from being relieved of all duty.

54. ***Commenters expressed appreciation for the recommendation to extend the training requirements for direct support professionals in residential programs to other services. Other commenters stated the training requirements are too high and will increase vendors' costs while still other commenters said more training hours should be included in the rate models. Commenters suggested the training requirements should differentiate between full-time and part-time staff and between different services. Finally, commenters noted there may not be training available for staff to meet this requirement and consideration should be given to how to meet the training requirement for both current and new staff (for example, a probationary period before the training must be completed).***

    To improve the quality of services, the rate study recommended the current requirement for direct support professionals (DSPs) working in Community Care Facilities – 70 hours of training within their first two years of employment – be extended to DSPs and paraprofessionals delivering other services. The rate models include a productivity factor of 35 hours per year for these staff (although

the training requirement only covers two years, the rate models include 35 hours every year in recognition of both the importance of ongoing education and the high turnover in the field). As discussed in the response to comment 85, this requirement was reduced to six hours for Respite services provided through an employer of record model. The assumption in the rate models for participant-directed services was also reduced to six hours. The rate models do not otherwise differentiate by service or employment status as it is assumed a well-trained workforce is an important element of a high-quality system. Although the number of training hours reported by respondents to the provider survey varied by service code, the 35-hour assumption was somewhat greater than the average reported for most services.

If this rate study is implemented, the implementation concerns raised by the commenters would be considered as regulations are developed.

55. ***Commenters suggested the rate models do not account for paying staff when they are traveling between service encounters although vendors are required to do so.***

    The rate models recognize staff must be paid when they are traveling between service encounters or between the office and service encounters. The rate models for services delivered in individuals' homes or other community locations therefore include a productivity factor for travel time. Like other productivity factors, this assumption is used to adjust the staff wage and benefit expenses so the cost of this non-billable activity is spread over the billable hours. The specific number of hours assumed for travel time varies by service.

56. ***Commenters suggested vendors should be allowed to bill for no-shows.***

    The rate models for professional services account for the cost of some level of no-shows through a productivity adjustment for missed appointments. Similarly, group-based day programs and employment services include an attendance factor to account for participant absences. Services in the personal supports and training category do not include a productivity factor for missed appointments because respondents to the provider survey reported minimal time lost to no-shows. That is, staff providing these services are redirected to another activity when there is a no-show. These other activities may not be billable, but are incorporated in other productivity assumptions (for example, catching up on training or recordkeeping).

Supervision and Program Operations

57. ***Commenters stated some rate models do not account for the cost of supervision. Commenters asked whether the supervisor specified in various rate models represents a program director or a middle manager, stating the wage assumption is too low for a program director, but if the assumption covers a middle manager there is no funding for the program director.***

    The rate models for services provided by direct support professionals or other paraprofessionals include a specific factor for the cost of first-line supervision. There are limited exceptions for services such as Housekeeping (service code 860) assumed to operate with limited supervision.

    The rate models for professional staff (generally, those who have a degree and/or are licensed) do not include a supervision factor because it is assumed these staff require less supervision. However, the program operations assumption – which is discussed in the response to comment 61 – in the rate

models for professional staff is twice as much as in the rate models for paraprofessionals to account for a level of oversight and positions such as program directors.

58. ***Commenters stated the assumption a supervisor is responsible for ten direct care workers is appropriate. Other commenters suggested the span of control is too large and should be reduced to one supervisor for every four-to-eight direct care workers to provide sufficient time for service documentation, staff training, and other development priorities. Conversely, other commenters noted the 1:10 ratio was unnecessarily restrictive, and could be increased to as high as one supervisor for every 40 direct care workers.***

    The rate models for services provided by paraprofessionals include one supervisor for every ten paraprofessionals. As described in the rate study report, this ratio is consistent with results reported by researchers and assumptions built into rate models for home and community-based services in other states. This ratio is also consistent with data reported by participants in the provider survey. For example, respondents reported about 620,000 direct care worker hours for community-based services and 50,000 supervisor hours, implying a ratio of one supervisor for every 12 direct care workers, although this ratio may be somewhat overstated because the direct care hours likely include licensed staff. Based on these results, the general supervisor ratios are unchanged, although the ratio was increased to 15 direct care workers for Respite and Personal Assistance services as discussed in the response to comment 73.

59. ***Commenters noted supervisors require a significant amount of training, but the cost of this training was not built into the rate models.***

    For rate models in which supervision is separately itemized, the rate model estimates the total annual cost of employing that supervisor based on the wage assumptions discussed in the response to comment 42 and the benefits package described in the response to comment 43. Then, rather than establishing productivity assumptions regarding the amount of time a supervisor spends on various tasks, such as training, this cost is allocated across the number of direct care workers they are assumed to supervise as discussed in the response to comment 58. The cost of supervisors' time to receive training is therefore incorporated in that per-worker allocation. Costs such as registration fees are intended to be covered by the program operations assumption discussed in the response to comment 60.

60. ***Commenters asked what was included in the program operations funding incorporated in the rate models. Commenters stated the rate models do not account for a variety of expenses, including:***

    - ***Turnover and hiring-related costs such as recruiting, screening, and onboarding,***
    - ***The cost of employing various positions including clinical directors, schedulers, risk management and compliance staff, and case managers,***
    - ***On-call payments and cellular phones for program staff,***
    - ***Office space for direct care workers and other staff,***
    - ***Travel for program staff to attend individual program plan and other meetings, support direct care workers, and perform quality assurance,***
    - ***Activity fees for participants and staff, educational materials, supplies, and equipment for day programs,***

- ***Activity fees, supplies, and other expenses in residential programs,***
- ***Vehicle inspections performed by the California Highway Patrol,***
- ***The purchase and ongoing maintenance of clinical equipment,***
- ***Certification expenses for registered behavior technicians,***
- ***Office supplies for individual-specific reports, and***
- ***Highway tolls and parking fees for staff traveling to deliver services in the community.***

As discussed in the rate study report (see pages 41 through 43), the rate models include funding for program operations including supervision (discussed in the response to comment 57), quality oversight, training, curriculum development, and other program-specific expenses such as those noted by the various commenters. The rate models do not seek to delineate specific assumptions for every individual program operations cost, however, as costs are expected to vary by service and by vendor. For example, mobile devices and parking fees are applicable to community-based services, but not center-based services while the nature of supplies used in day programs differs from those used in other services. The rate models intend to account for these expenses through the fixed daily amounts discussed in the response to comment 61.

61. ***Commenters noted the data limitations associated with the program operations expenses reported by respondents to the provider survey. Commenters also objected to the exclusion of programs that reported program operations expenses in excess of 50 percent of their reported revenue. Additionally, commenters objected to the resultant decision to establish more standardized assumptions for program operations costs, suggesting these assumptions should be tailored to each individual service code. Commenters stated the program operations cost assumptions are too low. Finally, commenters noted that, because the assumptions are established as a fixed dollar amount, they will not change over time and suggested this component of the rate models should be tied to some inflation measure.***

As discussed in the rate study report, the provider survey was constructed to collect program operations data for individual service codes. However, analysis of survey results concluded the reported data was not sufficient to develop assumptions at this level of specificity. For example, a number of vendors reported program operations expenses for a service code that exceeded 50 percent of the revenue they reported for the same code. Although it is possible some of these responses may be accurate, it is likely most are not. In particular, the average program operations rate for excluded responses was 179 percent, which would require dramatic subsidies for the programs even before direct care and administrative expenses are considered.

Once these surveys were excluded, there were five or fewer responses for 29 of 69 service codes or service code variations and another 15 service codes had no more than ten responses. With the limited number of data points for these service codes, it is unknown whether the results are representative of all vendors within each service code.

Further, for those service codes with more than ten respondents, there was significant variability in reported program operations rates. On average, the gap between the highest and lowest reported rate was 41 percent and the standard deviation in responses was 11 percent.

Since program operations rates at the service code level could not be supported, the provider survey data was considered as a whole across services and the following standardized funding amounts were established:

- Services generally provided on a one-to-one basis with a rate model that includes a supervision factor were funded at $10 per day per direct care worker,
- Services generally provided on a one-to-one basis with a rate model that does not include a supervision factor were funded at $20 per day per direct care worker,
- Services generally provided to groups are funded at $20 per day per direct care worker, and
- Residential services are funded at $10 per day per participant.

To both compensate for potential variability in program operations costs across service codes and to support critical program operations expenses, these funding amounts were set such that they significantly exceeded reported costs. Considering both these program operations amounts and the supervision assumptions discussed in the response to comment 57, the program operations funding in the recommended rate models is about 53 percent greater than the amounts reported by respondents to the provider survey. As with all rate model assumptions, the assumed program operations expenses are intended to represent a reasonable average and it is expected some vendors would have higher costs while others would have lower costs.

As noted by the commenters, the program operations amounts are fixed and are not tied to any data source subject to regular revisions. Options to inflate these amounts over time can be considered when the rate models are updated.

62. ***Commenters stated the mileage cost assumed in the rate models is inadequate to cover the cost of specialty vehicles and the cost of maintaining, insuring, and replacing such vehicles. Separately, commenters stated they cannot afford to pay staff $0.58 per mile for the use of their personal vehicles.***

The draft rate models accounted for the cost of vehicles by using the Internal Revenue Service's 2019 standard rate of $0.58 per mile. Subsequent to publication of the draft rate models, the IRS published its standard rate for 2020, which was a slight reduction to $0.575 per mile. This updated rate has been incorporated into the updated rate models. The standard mileage rate incorporates all vehicle-related expenses, including acquisition and depreciation, registration, maintenance and repairs, gasoline, and insurance.

As noted by the commenters, the IRS mileage rate is based on typical vehicles and not large vans or modified vehicles that vendors may use. Although some vendors may use such vehicles, a review of provider survey results suggest the IRS rate should be adequate for most vehicles used in residential and day programs. In particular, vendors generally reported an average purchase price of $30,000 to $40,000 per vehicle and an average useful life of 125,000 miles. Based on a $35,000 cost and a 10 percent salvage value, this suggests a depreciation cost of $0.252 per mile. In comparison, the IRS' standard mileage rate for 2020 includes $0.27 per mile for depreciation. Consequently, the mileage costs for most services are unchanged; as discussed in the response to comment 183, however, the rate model for Transportation Companies (service code 875) was updated to account for the significantly larger vehicles these vendors often employ.

As with all rate model assumptions, the assumed vehicle expenses are intended to represent a reasonable average and it is expected some vendors would have higher costs while others would have

lower costs. Further, the rate model assumptions are not prescriptive so there is no requirement that vendors reimburse their staff for mileage according to the assumed mileage rate.

63. ***Commenters stated it was their hope that Regional Centers that currently do not pay mileage reimbursement will begin to do so.***

    In general, the rate study assumes Regional Centers would *not* pay mileage reimbursement. Rather, the rate models for community-based services include assumptions related to the time direct care workers' spend driving and the number of miles traveled. These assumptions are intended to incorporate these costs into billable direct care hours so travel time or mileage would not be separately billable.

Administration

64. ***Commenters asked where overhead expenses are included in the rate models. Commenters stated the administrative cost assumption did not adequately account for various expenses, including:***

    - ***Administrative salaries for case management, billing, reporting, and other functions,***
    - ***Collective bargaining,***
    - ***Administrative facilities,***
    - ***Information technology such as billing and credential-tracking software,***
    - ***Malpractice and liability insurance,***
    - ***Financial audits,***
    - ***Office supplies, and***
    - ***Taxes on profits.***

    Commenters noted such costs will vary for each vendor.

    As discussed in the rate study report (see pages 43 through 44), the rate models include funding to support vendors' administrative infrastructure. The rate models do not seek to delineate specific assumptions for every individual administrative expense, however, as the composition of costs is expected to vary from one vendor to the next. For example, vendors with a unionized workforce have expenses associated with collective bargaining that other vendors do not. As with all rate model assumptions, the assumed administrative rate discussed in the response to comment 65 is intended to represent a reasonable average and it is expected some vendors would have higher costs while others would have lower costs.

65. ***Commenters objected to the inclusion of 12 percent of the total rate for administrative expenses, suggesting instead that the rate models should include 15 percent as allowed by statute or 16.9 percent as reported by participants in the provider survey. Commenters also noted rates are changing by varying amounts based on service and vendor so not all vendors are receiving an increase to their overall rate that justifies a reduction in the administrative rate. Finally, commenters noted the rate study will increase administrative costs and, more generally, administrative expenses will increase over time.***

Current statute (WIC § 4629.7) states vendors with negotiated rates may not spend more than 15 percent of Regional Center funds on administrative costs. Respondents to the provider survey reported an administrative rate of 16.9 percent across all developmental services. The submitted surveys were not audited so the reasons for the disconnect are not clear. There may have been errors in reporting, costs may have been misclassified as administrative (for example, expenses reported in the professional consultant services category may include the cost of clinical consultants in residential programs that are not considered administration), administrative costs may be higher for rates that are not set through negotiation and therefore not subject to the referenced statute, or vendors may shift more administrative expenses to revenues received from sources other than the Regional Centers.

As noted by the commenters, the rate models for most services include 12 percent of the total rates for administrative expenses. This assumption was intended to generally maintain existing administrative funding levels as rates increase overall. Much of the increases recommended in the rate study are associated with higher wage and benefit costs for direct care workers and greater spending on program operations. Increasing spending in these areas does not require commensurate increases in administrative spending. For example, increases to the minimum wage will affect direct support professionals, but are unlikely to have an impact on the wages of most administrative staff.

As described in the rate study report, despite a lower administrative *rate*, the administrative *funding* incorporated in the recommended rate models is roughly equivalent to current administrative funding. That is, although the 12 percent administrative rate assumed in the rate models is lower than the reported 16.9 percent rate, it is being applied to a much larger cost base due to the recommended increases in rates.

As also noted by the commenters, these figures are based on the overall rate increases across all services. The rate models would result in rate reductions for some vendors, meaning the amount of administrative funding built into their rates would also decline. Overall, the rate study is intended to increase fairness across vendors. That is, since vendors often have different negotiated rates for providing the same service in the same area, the amount of funding they are permitted to spend on administration also differs as vendors with higher negotiated rates are able to spend more on administrative expenses than vendors with lower negotiated rates. As discussed in the response to comment 20, the rate study would standardize rates within a Regional Center so vendors of the same service would receive the same amount of administrative funding.

66. Commenters stated the administrative rate does not account for regional differences in costs such as higher facility costs in Los Angeles or longer distances for staff to travel to receive training in rural areas.

As discussed in the response to comment 65, the rate models generally include 12 percent of the total rate for administrative expenses. This rate does not vary by Regional Center so it does not directly account for regional cost differences. However, since the administrative rate is calculated against all other cost factors in the rate models and because the rate models include regional adjustment factors for certain direct care expenses as described in the response to comment 30, the administrative rate indirectly recognizes regional cost differences in administrative expenses.

For example, there is a regional adjustment factor for direct care worker wages, which is a factor in every rate model. This results in higher wage assumptions in higher-cost areas and, since the 12 percent administrative rate is calculated in relation to the assumed direct care worker wage (and all other cost factors in the rate models), the amount of administrative funding would also be higher in these areas.

This is also true for rate models that include cost factors for direct care worker travel or program space. There are regional adjustments for these cost factors so the rate models that include these factors would produce more administrative funding in areas with more extensive travel or more costly real estate.

67. One commenter indicated the calculation of administrative expenses did not account for in-kind contributions or the equivalent cost of office space when vendors operate their business from their home.

In-kind contributions, such as volunteer time and donated supplies and equipment, were not accounted for in the provider survey or the rate models because they do not represent an actual cost to the vendor. Further, the rate study does not assume any changes to vendors' access to in-kind contributions although it is understood that, in the absence of donations, some of these expenses would have to be funded with vendors' earned revenues while others would simply be foregone because they represent program enhancements beyond service requirements.

It is unknown how each vendor operating from a home office reported their expenses, but it would have been appropriate to report the value of this space (based on the amount claimed on their taxes, for example) when completing the survey in which case the cost would have been counted.

68. Commenters suggested the rate models should include a factor for vendor profits or retained earnings in order to support the improvement and expansion of services, to provide for long-term maintenance or replacement of critical equipment and grounds, and to cover unexpected expenses and losses.

The rate models were designed to cover the estimated costs associated with providing services consistent with DDS' requirements and individuals' support plans. As noted by the commenters, the rate models do not include a factor for vendor profits or retained earnings although vendors have the ability to earn a profit by operating at a lower cost than assumed in the rate models.

PERSONAL SUPPORT AND TRAINING SERVICES

This section summarizes comments related to services the rate study categorized as 'personal support and training services' and generally provided by paraprofessionals on a one-to-one basis in a participant's home or in the community, including Personal Assistance, Independent Living, most Supported Living, and Respite. Note that most comments related to wage, benefit, and administrative assumptions are addressed in the Across Services section.

Various Services

69. Commenters stated that the creation of different rates and billing subcodes based on the length of the service encounter, the number of individuals served, tiered direct support professionals, and whether the service is provided in a non-English language will complicate billing for vendors.

As the commenters observed, for many services included in the personal support and training services category, the rate study recommended rates that account for various factors, including the length of the service encounter, the number of individuals served (ranging from one individual per direct support professional to three individuals per worker), and direct support professional qualifications through a tiered DSP system and higher rates for staff who serve individuals in a language other than English. As noted in the response to comment 70, the recommendations for different short- and long-term rates have been withdrawn. The other rate variants, however, remain as they advance important system objectives.

The remaining recommendations are intended to increase transparency and to better align rates with vendor costs. For example, the per-person cost of providing services on a one-to-one basis is different than the per-person cost of providing services on a one-to-three basis so the rate models reflect these differences. Additionally, higher rates for more qualified direct support professionals and those who serve non-English speakers in their language are intended to strengthen the direct care workforce and to facilitate individuals' access to high-quality staff.

Although it is true vendors would need to ensure they have the administrative infrastructure to track the 'type' of service being provided (in terms of staffing ratio and the direct support professional delivering the service) to bill appropriately, the existing reimbursement system has its own complications. For example, rates are generally not standardized with different providers receiving different rates for providing the same service, there is a lack of transparency into how rates are established, and there are inconsistencies in the use of service codes and subcodes across Regional Centers.

70. Commenters expressed concerns regarding the establishment of 'short-term' and 'long-term' rates, noting complications associated with service authorizations and billing because the length of an encounter for a given individual may change from day-to-day.

For many services included in the personal support and training services category, the rate study recommended different rates for short-term and long-term service encounters defined as more or less six hours.

In general, short-term encounters are more expensive to provide than long-term encounters. With short-term encounters, a direct support professional needs to see more than one individual to fill their workday. This results in more miles traveled, more non-billable time associated with travel between encounters and documentation, and administrative costs such as scheduling and billing. The rate study

therefore recommended higher rates for short-term encounters to encourage vendors to serve individuals who may not need extensive supports.

Despite this benefit, it was acknowledged that distinguishing rates based on encounter lengths would add administrative complications for vendors in terms of planning, tracking services, and billing. In response to the related concerns expressed by vendors, this recommendation has been withdrawn and the rate models no longer differentiate based on the encounter length.

71. ***Commenters stated the rates for shared services (one staff person serving two or three individuals) are too low. Further, commenters stated direct support professionals are paid a higher wage when providing services to a group of individuals.***

Although the services included in the personal support and training services are primarily delivered on a one-to-one basis, there are instances when it is appropriate for individuals to share supports, such as when roommates or siblings can be supported by a single direct support professional. In these instances, the vendor does not bill the full rate for each individual served as its costs have not doubled in a one-to-two setting or tripled in a one-to-three setting. However, the group rates do include a modest premium so the vendor earns more per staff hour to account for an increase in recordkeeping and reporting time when serving multiple individuals. For example, while the one-to-one personal assistance rate in the base rate model is $30.47 per hour, the one-to-two personal assistance rate is $15.48 per hour *per individual*, or $30.96 per hour.

The rate model for group services do not include a wage premium. This is consistent with rates for day habilitation and residential programs traditionally provided to groups of individuals but do not generally offer higher wages based on the specific staffing ratio.

72. ***Commenters stated most staff providing personal support and training services work part-time, which increases administrative costs. Additionally, commenters argued that because most staff do work part-time, providers should not be forced to adopt tiered DSP levels.***

As discussed in the response to comment 51, the rate models have been adjusted to account for the fact that many staff work part-time. Specifically, each rate model now assumes 70 percent of direct support professionals work full-time (40 hours per week) and 30 percent work part-time (22 hours per week). This is a greater proportion of full-time workers than reported through the provider survey, but as part of the goal to make direct care a more viable career, a higher ratio was assumed to support more full-time workers. Additionally, while administrative costs may increase with a primarily part-time workforce, staff benefits costs decline by a more significant amount so increasing the assumed proportion of part-time staff would decrease rates.

The tiered DSP framework is described in response to comment 41. If tiered DSP rates are implemented at a future time, vendors would not be required to participate.

73. ***Commenters stated supervisors' spans of control should be increased by 50 percent (that is, supervisors should be responsible for more staff). Conversely, other commenters stated supervisors' ratios should be reduced. Additionally, commenters asked whether the supervisory assumptions will become mandatory in regulations.***

The span of supervisory control assumed in the rate model is one supervisor for every ten direct support professionals. As described in the rate study report, this ratio is consistent with current ratios

reported by vendors as well as results reported by researchers and assumptions built into rate models for home and community based services in other states.

In response to comments that certain services require less-intensive supervision, the ratio was increased to one supervisor for every 15 DSPs for Respite and Personal Assistance.

As discussed in the response to comment 8, the rate model assumptions are generally not prescriptive. The rate study does not envision adding regulations relating to supervisory ratios.

74. Commenters stated travel time associated with various personal support and training services should be billable.

Rather than directly billing for travel time or mileage, the rate models for agency-provided personal support and training services 'bundle' these costs into the direct service rate through assumptions related to both mileage and non-billable travel time for direct support professionals. This approach is intended both to streamline authorizations and billing and to encourage efficient scheduling.

The mileage assumptions for DSP account both for travel to and from service encounters and for transporting individuals in the community. The rate models also include an assumption regarding DSPs' non-billable travel time. Given that the staff person must still be paid when traveling between service encounters, this 'productivity assumption' effectively spreads the non-billable expense over the billable hours.

The mileage and travel time assumptions are adjusted for geographic differences across the Regional Center catchment areas. Even with these adjustments, it is expected that some DSPs would travel more than assumed and others would travel less. As with all rate model assumptions, the travel-related estimates are intended to reflect a reasonable average.

75. Commenters stated the proposed rates for various personal support and training services are not sufficient for individuals with medical or behavioral issues and asked whether such supports may be provided under different service models.

The rate models for services in this category reflect supports provided by a direct support professional. If an individual requires more intensive support (for example, two-to-one staffing), additional staff can be authorized through Supplemental Program Support (service code 111). If an individual requires support from a staff person with specific qualifications (such as a behavior management technician or a home health aide), that support can be billed under the service codes established for those service providers.

Personal Assistance (Service Code 062)

76. Commenters stated the inclusion of mileage in the rate models is unnecessary because individuals are generally served in their homes and are not going out into the community. Conversely, other commenters stated the mileage and travel time assumptions are too low. Additionally, commenters state they reimburse staff mileage expenses at a rate lower than the $0.58 per mile included in the rate models.

As discussed in the response to comment 74, the Personal Assistance rate models include assumptions related to both mileage and non-billable travel time for direct support professionals.

Although some individuals may receive all of their Personal Assistance services in their home, the provider survey indicated some participants are transported into the community. After eliminating the proposed short-term and long-term rate structure as discussed in the response to comment 70, the base rate model assumes direct support professional travels, on average, 60 miles per week. As with all assumptions, it is expected that some staff would travel more than 60 miles and others would travel less, but the assumption is consistent with the average mileage reported in the provider survey.

The updated rate models provide $0.575 per mile for vehicle-related expenses based on the Internal Revenue Service's standard mileage rate for calendar year 2020. As discussed in response to comment 8, vendors are not bound by the rate model assumptions so they may establish their own reimbursement policies.

Unlike the mileage assumption, the productivity factor for travel time only reflects time spent traveling between service encounters as any time spent transporting an individual is billable. Thus, non-billable travel time only occurs on days in which the direct support professional has multiple service encounters. According to provider survey respondents, the average length of a Personal Assistance service encounter is between five and six hours, meaning there are many days in which a direct support professional only sees a single individual. Reflecting this finding, the base rate model includes 0.75 hours per week for travel time between service encounters, which is consistent with the average reported in the provider survey. Again, it is expected that some staff would spend more time traveling between encounters and others would spend less.

Parent-Coordinated Supported Living (Service Code 073), Parent-Coordinated Personal Assistance (Service Code 093), and Voucher Respite / Participant-Directed Respite (Service Codes 420 and 465)

77. ***Commenters indicated the standardized productivity assumptions will not apply to all clients, since some require additional support, more planning meetings, and additional recordkeeping.***

    As discussed in the response to comment 8, all rate model assumptions – including productivity – are intended to reflect a reasonable estimate of the costs of providing services consistent with the State's requirements and individuals' service plans. It is therefore expected that for any given program, some costs would be higher than assumed and others would be lower.

78. ***Commenters stated the rate models should incorporate funding for the cost of transporting clients.***

    The rate models for participant-directed services do not include any travel-related assumptions. Rather, individuals would be able to request a separate authorization for mileage reimbursement for direct support professionals at the Internal Revenue Service's standard mileage rate ($0.575 per mile in 2020).

79. ***Commenters noted parent-coordinated services do not provide reimbursement for the parent who is required to manage and administer services for an adult disabled child, a responsibility often undertaken when no agency is available.***

    The rate models for Parent Coordinated Supported Living (Service Code 073), Parent Coordinated Personal Assistance (093), Participant Directed Respite (465), and In-Home Respite Worker (864) are intended to cover the cost of the direct support professional hired by the individual or family. Given that these services do not include an agency and attendant overhead expenses, the rate models do not

include funding for program operations or administrative expenses. Although parents have certain responsibilities when coordinating these services, consistent with current and common practices, the rates do not include a mechanism for paying parents for these activities.

Independent Living (Service Code 520)

80. Commenters objected to various productivity assumptions, stating the allotted time should be increased for traveling between service encounters and recordkeeping, and assumptions should be added for missed appointments and on-behalf-of activities.

In response to this comment and recognizing Independent Living service encounters are generally shorter than many other personal support and training services, the productivity assumptions have been revised. In the base rate models for full-time staff, the assumption for recordkeeping was increased to 1.25 hours per week and the assumption for travel between service encounters was increased to 3.00 hours per week. As with other services in the personal supports and training category, no specific allotments have been made for missed appointments or on-behalf-of activities; only minimal amounts of time were reported through the provider survey for these factors. With these revisions, the overall productivity assumption is consistent with the figures reported through the provider survey.

Relatedly, the base rate model assumption for miles traveled by a full-time direct support professional was increased from 100 miles per week to 150 miles, reflecting the increase in travel time and consistent with provider survey results.

81. Commenters stated Independent Living should not be combined with service codes 055 and 063 as these services are primarily provided as day programs.

The rate study does not purport to combine Independent Living with service codes 055 (Community Integration Training Programs) and 063 (Community Activities Support Services). Rather, the rate study recommends service codes 055 and 063 be eliminated with the supports currently delivered through these codes transitioned to other service codes. As the commenters observed, service codes 055 and 063 are primarily used to provide 'look alike' day programs, which would transition to the Community-Based Day Program service codes. However, service codes 055 and 063 are also sometimes used to provide supports similar to Independent Living. In these cases, the supports would be transitioned to service code 520.

82. Commenters stated Independent Living services need to extend beyond six months.

The regulations for Independent Living do not include any time limit, but some Regional Centers have established their own limits. As noted in the response to comment 9, if the rate study is implemented, many of the recommendations would require regulations to be created or revised. The issue of service limits could be considered as part of that process.

Homemaker (Service Code 860, Repurposed as Housekeeping)

83. One commenter stated Homemaker services should include a geographic adjustment factor.

As with nearly every service included in the rate study, the rate models for Housekeeping do include geographic adjustment factors to recognize differences in costs across Regional Centers. For this service, the geographic adjustment factors for wages and travel apply.

Respite (Service Codes 862)

84. Commenters objected to the recommendation that services provided through an employer of record (EOR) model be transitioned to Participant-Directed Respite with the agency registering as a Financial Management Services (FMS) provider and billing for their supports through the FMS rates. Additionally, commenters stated providers and families utilizing an EOR model may not be able to afford the costs of CPR and first aid training and background checks.

In response to this comment, the recommendation to require services provided through an EOR model to be billed through the Participant-Directed Respite and FMS rates has been withdrawn. Instead, a separate EOR rate model has been developed. In comparison to the agency-managed Respite rate model, the EOR rate model excludes productivity adjustments for travel time and supervision and other employer time, excludes supervision costs, excludes staff meal costs, and cuts the administrative rate in half to six percent.

The EOR model accounts for direct support training costs – the requirement for which has been reduced to six hours annually for EOR services as discussed in the response to comment 85 – through a productivity adjustment. The administrative funding included in the rate model could be used to pay the cost of background checks.

If this rate study recommendation is implemented, regulations would need to be promulgated to define the characteristics of EOR services. The EOR model would be established as either a new service code or as a subcode attached to service code 862.

85. Commenters objected to the recommendation that respite workers receive 35 hours of training per year. Commenters asked whether the training requirement will be established in regulation.

The rate study recommended training requirements for direct support professionals across the service delivery system be standardized to match the requirement already in place for DSPs working in residential community care facilities, which is 35 hours per year for the first two years of employment. Recognizing the particular burden this requirement would place on services provided through an employer of record model (as well as participant-directed services), the recommendation for these services has been reduced to six hours per year.

As with existing requirements for staff providing residential services, the recommended training requirements would be established in regulation.

86. Commenters stated that because providers transport members in the community, there should be a mileage component built into the rate model. Commenters indicated the mileage assumptions built into the rate models are too low, especially in rural areas.

The Respite rate models do include mileage-related assumptions. As discussed in the response to comment 74, this mileage accounts for both travel to and from service encounters and to transport individuals in the community. After eliminating the proposed short-term and long-term rate structure as discussed in the response to comment 70, the base rate model assumes a direct support professional travels, on average, 100 miles per week, which is consistent with the average reported through the

provider survey. As with all assumptions, this is intended to represent a reason approximation and it is expected some staff would travel more than assumed and others would travel less.

87. ***Commenters stated the rate models should include a provision for appointment cancellations.***

Provider survey respondents reported very little time associated with missed or cancelled appointments, which was defined as time that could not be redirected to another billable or non-billable activity (for example, if an individual cancels an appointment and the direct support professional uses that time to catch-up on paperwork, the time would be reported for recordkeeping rather than for missed appointments). The rate models therefore do not include a productivity adjustments for missed appointments. Overall, the rate models provide more time for non-billable responsibilities than reported through the provider survey.

88. ***Commenters questioned the omission of funding for program operations.***

The rate models for agency-managed Respite include funding for the supervision of direct support professionals. The models do not include any additional funding for other program operations as it is understood that Respite services do not require the same type of program infrastructure (program development or curriculum design, for example) as other services.

89. ***Commenters stated administrative costs should be included in the Respite rate models.***

The recommended rate models for agency-managed Respite included 12 percent of the total rate for administrative costs, the same assumption incorporated in the rate models for other agency-managed services. The new rate models for respite provided through an EOR model discussed in the response to comment 84 include six percent for agency administration, reflecting the reduced workload for the agency. As described in the response to comment 79, the rate models for Participant-Directed Respite do not include administrative costs.

Supported Living Services (Service Codes 894 and 896)

90. ***Commenters expressed support for the recommended Supported Living rate models in terms of both the rates and the standardization of the reimbursement model across Regional Centers.***

Support for the Supported Living rate models is appreciated. This service is a key tool to support individuals in their homes and communities. Consistent with the requirements of the rate study, various elements of the service would be standardized – including billing on an hourly basis and 'bundled' administrative costs – which would increase accountability and transparency across the State.

91. ***Commenters objected to the elimination of a separate service for Supported Living Administration (service code 894) and bundling these costs into the Supported Living service rate (service code 896). Additionally, commenters asked how fixed costs and 'case management' are covered in the hourly billing rate, including during periods in which an individual is hospitalized. Finally, commenters asked how session rates will be accommodated.***

As noted in the response to comment 23, the rate study generally recommends hourly billing for personal support and training services, including Supported Living. Although multiple billing units (months, sessions, etc.) exist today for Supported Living, the majority of these services are already

billed hourly. Overall, the use of hourly rates within which administrative costs are bundled reflects a payment strategy that is already widespread for Supported Living and is consistent with the payment approach for other services in this category.

It is acknowledged the bundling of administrative costs into the billable hourly rate would be a change for vendors who currently receive a monthly payment for administrative expenses, but this is already commonplace across the State. Of the 21 Regional Centers, only 11 had any claims paid under service code 894 in fiscal year 2016-17. Of those 11, seven paid claims of less than $100,000, meaning the use of service code 894 is a regular practice in only four Regional Centers. Some of the Regional Centers that rarely or never use service code 894 may pay for both administrative and service costs through a single monthly payment through service code 896. However, at least 57 percent of Supported Living claims (as measured by fiscal year 2016-17 spending) were paid on an hourly basis and more than two-thirds of the individuals receiving these services did not have any claims under service code 894.

92. Commenters expressed concern about the increased Supported Living rates exacerbating the current gap with In-Home Supportive Services (IHSS) rates. Commenters noted the same employees provide both services and no administrative funding is included in the IHSS rates.

Although there is a relationship between In-Home Supportive Services and Supported Living, payment rates for IHSS were not part of the scope of work of the rate study since that program is administered by the Department of Social Services.

93. Commenters objected to various productivity assumptions, suggesting the allotted time should be increased for traveling between service encounters and recordkeeping, and assumptions should be added for missed appointments and on-behalf-of activities.

The overall productivity assumptions in the recommended rate models were generally consistent with information reported through the provider survey. The survey also found service encounters are generally lengthier than many other services included in the personal support and training category, so the productivity expectations are higher (because a staff person will often see only one person during their shift so there is less travel time and recordkeeping). As a result, other than accounting for the elimination of separate short-term and long-term rates as discussed in the response to comment 70, no changes were made to the productivity assumptions.

RESIDENTIAL SERVICES

This section summarizes comments related to services the rate study categorized as 'residential services', including Community Care Facilities (CCF) providing services through service codes 905, 910, 915, and 920; Family Home Agencies (FHA); Adult Residential Facilities for Persons with Special Health Care Needs (AFRPSHN); Community Crisis Homes (CCH); and Enhanced Behavioral Support Homes (EBSH). Note that most comments related to wage, benefit, and administrative assumptions are addressed in the Across Services section.

Multiple Services

94. ***Commenters sought clarification related to the customizable rate models for certain residential services. Commenters also suggested the rates produced by the customizable models were too low.***

    Recognizing staffing levels vary across residential programs, particularly those serving individuals with the most significant needs, the rate study recommended the establishment of 'customizable' rate models for several services. In these rate models, certain values are fixed, but others would be determined on a home-by-home basis. For example, the number of staff hours to be provided in the home would be set according to the needs of the individuals in that home, but the wage and benefits assumptions for these staff would be fixed as they are in every other rate model produced as part of the rate study. The specific factors that may be customized differ somewhat in the various rate models. For example, the customizable rate model for Community Care Facilities fixes the cost for the home administrator, but the customizable rate model for Community Crisis Homes and Enhanced Behavioral Support Homes varies the cost based on the qualifications of the staff person in that position. Additional discussion of the specific factors that may be customized in the customizable rate models for each service are discussed in the service-specific subsections below.

    The customizable rate models do not produce a complete rate until a value for each customizable factor is input. In the customizable rate models published in March, the only costs included in the 'total' rates are those that are fixed. For example, staffing levels were left blank as they are customizable; thus, this cost was not included in the total rates shown. As a result, these were not rates that would actually be paid since a home obviously cannot operate without any staff. As part of the updated rate models, the fillable Excel versions of the customizable rate models have been posted online so stakeholders may easily determine what rate would be assigned once values are reported for the customizable factors.

95. ***Commenters stated Regional Centers may impose vacancy goals (also referred to as 'empty bed' goals) for CCFs, ARFPSHNs, EBSHs, and CCHs to provide system capacity for emergency placements, but the rate models do not account for lost revenue due to forced vacancies.***

    The rate models do not include a specific provision to accommodate 'empty bed' goals and there is no specific authority to pay for vacant beds. The rate models for ARFPSHNs, EBSHs, and CCHs are 'customizable' to reflect the actual number of individuals in a given home and the staffing level for that home such that the vendor's payment reflects actual occupancy. In response to various comments, including comment 101, staffing expectations in CCFs would be prorated when a bed is not full, which would help to offset the lack of revenue for an empty bed.

96. ***Commenters stated the consultant rate is too low and the position should be treated as a contractor rather than an employee with benefits. Commenters objected to using a single occupation to***

represent consultants when they may come from a variety of disciplines, including behavior analysts, registered nurses, therapists, psychologists, etc. Commenters indicated the number of consulting hours assumed in the rate models was too low.

The consultant hours included in the residential rate models account for the professional and clinical supports required in these homes. The wage assumption for consultants reflects a behavioral specialist, which was the most common type of consultant reported by provider survey respondents. Further, the wage assumption for behavioral specialists is higher than for most other clinical positions that qualify as consultants, which means a weighted average of multiple occupations would have produced a lower wage assumption.

Vendors may provide consultant hours through clinicians they directly employ or with whom they contract. The rate models assume the clinicians are employees, but this is not intended to have an impact on the cost. The per-hour cost may be lower for an employee, but the rate model accounts for the full cost of employing that individual, including a full-time workweek, whereas contractors may have a higher per-hour cost, but the vendor will not be paying for all of the contractor's work hours (that is, the vendor would generally not be paying for the time the contractor spends on administrative tasks, on paid leave, driving time, etc.). To better recognize the full cost of employee consultants, including productivity-related expenses, the rate models now tie the hourly cost to the behavior analyst rate model before program operations and administration (since these costs are added to the total residential rate). In the base rate model, this has the effect of increasing the hourly cost from $58.49 to $107.92.

The number of consultant hours in CCF rate models reflect existing regulations and the consultant hours in the FHA rate models generally, but not exactly, track these figures. In the rate models for ARFPSHNs, EBSHs, and CCHs, consultant hours are one of the customizable factors discussed in the response to comment 94 so these hours would reflect what is actually provided in the home, subject to the minimum requirements established in statute and regulation.

97. ***Commenters stated the rate models for residential services should include a productivity factor for recordkeeping for direct care staff.***

    The residential rate models account for the entire shift worked by a direct care worker (that is, residential services are not billed on an hourly basis for direct services). Thus, the productivity factors for residential services are only intended to account for instances in which the direct care worker is away from the home and substitute staff is needed. In particular, the models include productivity adjustments associated with paid time off, attending training, and employer and supervision time. The rate models assume recordkeeping occurs during the course of a worker's shift without the need for substitute staff so a productivity adjustment is not needed.

98. ***Commenters offered feedback relating to meal costs. Comments included:***

    - ***Staff are paid for the entirety of their shift, including on-duty meal time, and staff must be fed at the provider's expense,***
    - ***The number of staff hours used to calculate the number of meals to be provided to staff should be increased,***
    - ***The cost per meal should be increased, and***

- ***Food expenses for participants may increase because of 2014 federal regulations that require that they have continued access to food.***

The rate models for residential services account for the cost of providing meals for staff.

In particular, the rate models include funding for one meal for every eight staff hours (that is, one meal for every full shift worked). For example, in a home funded for 320 staff hours per week, the rate model would include the cost of 40 staff meals during that week (320 divided by 8). The number of staff hours vary by model, reflecting either the fixed staffing assumptions in the CCF rate models based on home level or the number of staff hours approved by the Regional Center in the customizable rate models for ARFPSHNs, CCHs, EBSHs, and level 7 CCFs.

The cost per meal is derived from data from the United States Department of Agriculture (USDA), which publishes the cost of a nutritious diet at four different cost levels (thrifty, low, moderate, and liberal). These plans are further differentiated by sex and age. The rate models are based on a monthly cost of $240, which is the approximate average for the low-cost plan for the most expensive adult demographic (males between 19 and 50 years). This monthly total is converted to a per-meal cost by dividing by 30 days and then dividing by three meals per day, resulting in a cost of $2.67 per meal. Thus, in the example above, the rate models would include $106.80 per week for staff meals (40 meals multiplied by $2.67 per meal). As noted, the total cost would vary based on the number of staff hours applicable to a given home.

The rate models for ARFPSHNs, CCHs, and EBSHs also include assumptions for participant meal costs based on the same $240 monthly cost described above. The USDA's data is based on food costs for individuals without disabilities who already have 24-hour access to food so no adjustment has been made in response to the 2014 federal rules requiring people with disabilities to have similar access.

99. ***Commenters stated leap years are not factored into the rates, noting Regional Centers currently calculate daily rates based on 365.25 days to account for leap years.***

In response to this comment, the rate models for residential services reimbursed according to a monthly rate have been revised to reflect an average of 365.25 days per year.

Community Care Facilities (Service Codes 905, 910, 915, and 920)

100. ***Commenters expressed support for the recommended rate increases for Community Care Facilities. Conversely, commenters stated an existing level 4I rate of nearly $18,000 would be cut to less than $11,000.***

The support for the recommended CCF rates is appreciated. The recommended increases aim to prevent more costly placements and reduce the need for vendors to seek approval to deliver services under service code 113.

In regards to the specific comment regarding an existing $18,000 rate, it is unclear what the commenters may be referencing as the published rate for 4I homes as of January 2019 was $8,170 per person in a home with four or fewer placements and $6,953 in a home with five or more placements. The rate study recommends large increases for both rates, although the recommended rates remain substantially less than $18,000. It may be that this vendor has a negotiated rate through a different service such as an EBSH or a home authorized under service code 113. As noted in the response to

comment 94, rates for ARFPSHNs, CCHs, and EBSHs would be determined on a home-by-home basis. Additionally, as discussed in the response to comment 101, there is a customizable rate model for CCFs that require more staffing than assumed in the highest fixed rate model.

101. Commenters indicated the consolidation of the existing 12 CCF rate levels to six levels would be easier to navigate. Conversely, commenters objected to the consolidation. This latter group of commenters stated the consolidation would result in a reduced ability to meet the individualized care needs of members especially at specialized homes where certified nursing assistants, nurses, psychiatrists, behaviorists, and nurse practitioners are employed. Additionally, commenters noted a 'sample budget' for a level 7 home was not provided. Further, commenters asked how existing homes will be assigned to a new level.

As noted by the commenters, the rate study recommended the number of CCF levels be reduced from 12 to six based on the crosswalk displayed in the table. This recommendation both supports the requirement that the rate study identify opportunities to simplify the system and recognizes there were only modest differences between many of the existing levels. To the latter point, the existing difference in staffing expectations between one level and the next can be as little as four hours *per week*; the average difference is 18 hours per week, or less than three hours per day.

Current Levels	Recommended Level
Level 2	Level 2
Level 3 - 4B	Level 3
Level 4C - 4E	Level 4
Level 4F – 4H	Level 5
Level 4I	Level 6

The recommended consolidation provides more meaningful differences in staffing expectations between the levels, which should result in more consistency in how home levels are determined (that is, when staffing differences are as minimal as they currently are, there is more ambiguity in how a level is selected). Although the new levels are intended to crosswalk from the existing levels as noted in the table above, the Regional Centers would work with the vendor to determine the appropriate level for each home based on the staffing needs of the individuals in the home.

In addition to the six home levels with defined staffing expectations, there is a seventh, 'customizable' level for homes with staffing needs that exceed level 6. In the draft rate model, all values are fixed except for the number of DSP staff hours and consultant hours to be provided in the home. These two values would be input into the rate model to calculate the rate that would be assigned to that home. In response to this comment, certain homes – such as specialized residential facilities owned by a housing developer organization – would also be able to customize the mortgage cost of the home. As part of the updated rate models, the fillable Excel versions of these rate models have been posted online so stakeholders may easily determine what rate would be assigned based on the Regional Center-approved staffing levels associated with specific homes.

As necessary, other services can be approved in addition to the CCF service to meet an individual's needs. For example, Supplemental Residential Program Support (service code 109) can be used to provide one-to-one support to an individual. Similarly, other service codes are available to provide specialized supports needed by individuals, such as a nurse's assistant or behavior technician.

102. Commenters questioned the staffing assumptions associated with the recommended CCF rate levels. Specific comments included:

- ***The rate models for higher level homes should account for additional costs associated with staff time required to develop quarterly reports, attend meetings, transport individuals to medical appointments, etc.,***
- ***The staffing expectations in both the current and recommended levels are excessive,***
- ***The hours were inadequate for certain homes, such as homes serving children and currently assigned to level 4H,***
- ***Three-bed CCFs have the same staffing requirements as four-bed homes, but will receive 25 percent less revenue, and***
- ***A question as to whether the staffing assumptions subtract the amount of time individuals spend in day programs or other outside activities and, if so, suggested the assumption should be limited to four hours per day since individuals may choose to stay home or attend for only a portion of the day.***

The staffing assumptions for each CCF were derived, to a significant degree, from the staffing requirements defined in regulation for the existing levels. This staffing represents the total number of direct support professional hours to be provided within the home over the course of a week so it is intended to account for different staffing levels at different times of day (for example, overnight hours or daytime weekday hours when one or more individuals may be engaged in outside activities). The home levels provide a continuum intended to account for the varying needs of homes and individuals with higher-level homes funded for more hours to provide more intensive staffing and to accommodate other, related responsibilities such as reporting and planning.

If a vendor believes the level of staffing associated with their home's level is more than needed to meet the needs of the individuals in the home, they can work with their Regional Center to step-down to a lower level. Additionally, as noted in the response to comment 101, Supplemental Residential Program Supports (service code 109) can be used to supplement the staffing in the CCF models.

As noted by the commenters, a single rate model was developed for three-and-four placement CCFs with the same overall staffing expectations. In response to this comment, the staffing assumptions would be prorated for three-bed homes so staff are expected to provide only three-quarters of the staff hours assumed for each home level. If this rate study recommendation is implemented, regulations would be developed to clarify these requirements.

103. Commenters stated the rate models incentivize larger home sizes (five and six bed homes) due to comparatively larger recommended rate increases and reduced staffing expectations. Other commenters stated the rate study does not recommend any rate increases for homes with five or more placements.

The rate study *does* recommend rate increases for homes with five or six placements and, as noted by some commenters, these increases are larger than those recommended for homes with four or fewer placements (as noted in the response to comment 104, the rate study assumes rates for homes with seven or more placements will not change). Although all CCF rates would increase, the rate study suggested larger rate increases for five-and-six-placement CCFs based on a larger variance between existing rates and the estimated costs of services as reflected in the rate models.

104. Commenters expressed concern that rate models were not established for homes with seven or more placements. These concerns included non-compliance with federal regulations related to individual choice, the impact minimum wage increases will have on these homes, challenges in terms of pay equity across staff for providers operating both small and large homes, and the existence of operating deficits for existing homes.

Consistent with the federal, state, and community goals of serving individuals in the most appropriate integrated setting and providing individuals with full access to the benefits of community living, the rate study recommended rate increases for CCFs with six or fewer placements. The rate study did not include rate models for homes with seven or more placements so these homes will continue to be reimbursed at existing rates. Consistent with current practices, these rates will be subject to future adjustments for changes in the statewide minimum wage.

Although commenters suggested federal rules mandate that states offer "larger home settings", there is no such federal requirement and, in fact, there are a number of states that do not allow such homes.

105. Commenters stated the number of staff hours and program operations funding is understated in children's homes since children are out of school and at home during the day for several months compared to adults who participate in activities away from the home year-round. Additionally, commenters stated the rates for children's homes are inadequate to assist the individuals with the highest needs.

In response to this comment, the staffing assumptions for children's homes have been increased by 6.4 percent over the staffing in adult homes. This was calculated by assuming there would be an additional 70 shifts in a children's home compared to an adult's home (based on the difference between a 250-day 'work' year and a 180-day school year) out of 1,095 total shifts (365 days multiplied by three shifts per day).

As discussed in the response to comment 101, additional or specialized staffing may be approved to supplement the staffing and supports in the CCF rate to meet a child's specialized needs.

106. Commenters questioned whether the CCF rate models will apply to residential care facilities for the elderly (RCFE).

As is currently true, RCFEs would be reimbursed according to the CCF rates.

107. Commenters asked what would happen to existing negotiated rates for Specialized Residential Facilities.

Specialized Residential Facilities would be integrated into the rate models established for Community Care Facilities. As appropriate, SRFs may be assigned to the levels 2 through 6 rates. If the SRF's staffing exceeds the level 6 model, the customizable model discussed in the response to comment 101 would be used.

108. Commenters stated the vacancy rate assumptions were too high. Additionally, commenters stated there should be an assumption related to the percentage of time a facility bed is vacant when an assigned member has been relocated, is on vacation, or is out due to short-term illness

As discussed in the response to comment 95, the rate models for CCFs do not include a factor for vacancies. By reimbursing services on a monthly basis – consistent with current practices – the rate models do cover vendors' costs when an individual is temporarily absent. That is, as long as an

individual is absent from the home for 14 days or fewer, the vendor is able to bill the full monthly rate.

Additionally, staffing expectations would be reduced when a bed is not filled. As noted in the response to comment 102, if this rate study recommendation is implemented, the approach to prorating staff hours would be defined in regulations.

109. Commenters stated the wage assumptions for direct support professionals working the overnight shift should be the same as for other DSPs. Additionally, commenters asked about the expectations in homes in which some participants' individual plans do not require awake overnight staff and others' plans do require awake staff. Commenters suggested staff should be permitted to sleep unless an individual's plan states awake staff are needed.

The recommended rate models assumed 56 hours of staff time per week in CCFs assigned to levels 2, 3, and 4 would be paid at $13.00 per hour (the minimum wage as of January 1, 2020). This assumption was intended to reflect that one overnight shift per day could be funded at the minimum wage based on the expectation that staff have more downtime and, in level 2 and 3 homes, may be able to sleep. In response to this comment, the rate models have been revised to use the same wage assumption for the overnight shift as for daytime shifts in level 3 and 4 homes. The rate model for level 2 homes continues to use a $13 wage assumption for the overnight shift.

CCFs are expected to have awake staff during the overnight shift, which is why all of the rate models include an hourly wage for the overnight hours (including the $13 wage in the level 2 homes) rather than a lesser stipend amount or even no payment for asleep time. There would be an exception for level 2 and 3 homes in which *all* participants' plans state that awake staff are not needed. If the plan for any individual does not expressly allow an asleep shift, vendors must have awake staff. If this rate study recommendation is implemented, regulations would be developed to clarify these requirements.

110. Commenters stated there will be a negative impact if DSPs in staff-operated CCFs are no longer allowed to "live-in" as recommended by the rate study.

The rate study does not include any direct recommendations related to live-in staff models. In any staffing model, vendors would be required to comply with the staffing expectations discussed in the response to comment 101 as well as the awake staff requirements described in the response to comment 109.

111. Commenters stated the home manager payment assumed in the rate models for owner-operated homes is too high. Conversely, commenters stated the home manager's payment should be increased because it is lower than the assumed DSP wage if they work 168 hours per week, which unfairly disadvantages owner-operated homes.

The base rate models for owner-operated CCFs assumes an annual payment of $127,750 for the home manager (home owner). This assumption is tied to the highest assumed payment to certified homes in the Family Home Agency rate models. Specifically, the level 6 FHA rate assumes a daily payment of $175 per individual; since FHAs may have two placements, a home provider providing services to two individuals assigned to level 6 is assumed to receive $127,750.

The rate models for owner-operated CCFs reduce the DSP staffing level by 168 hours for the home manager (home owner). This reduction reflects the number of hours 'counted' against the staffing requirement for the given home level and are not an indication of hours actually worked. For

example, individuals may be away from the home during the day, but the home manager's time is still counted during this period. The home manager's hours are also counted during the overnight shift even if they are sleeping and there is no awake staff person in the home when permitted by all individuals' plans as described in the response to comment 109. Additionally, the home manager may opt to use a portion of their assumed payment to hire additional DSPs, but the home manager's hours would still be counted when the DSP is working even if the home manager is away from the home.

112. Commenters expressed concerns that the rate study did not recommend changes to room and board expenses, stating individuals' federal Supplemental Security Income (SSI) and State Supplementary Payment (SSP) benefits do not fully cover these costs. Commenters further noted some expenses are higher in CCFs than in other living environments, citing utilities, appliance replacement, and repairs.

Federal law prohibits the use of Medicaid funding for room and board costs. Rather, these expenses are intended to be covered by the SSI and SSP benefits that individuals receive. These benefit levels are not established by DDS and the rate study did not include any recommendations to establish room and board rates for CCFs or to supplement SSI and SSP benefits.

As of January 1, 2019, the CCF rates include $1,058.37 in SSI and SSP benefits per month per person, or $12,700 annually. In comparison, respondents in the provider survey reported annual room and board related costs of approximately $14,000 to $15,000 per filled bed, though there is significant variability in these costs, particularly driven by whether the vendor is paying a mortgage or rent. As discussed in the response to comment 101, the customizable rate model for level 7 homes would allow certain homes – such as specialized residential facilities owned by a housing developer organization – to report their mortgage expense, which would be incorporated in their payment rate.

113. Commenters stated the weekly program operations costs of $70 per individual per week are insufficient to cover activities, personal hygiene items, groceries, utilities, rent/ mortgage, house and care maintenance, etc. Additionally, commenters stated the cost of staff participation in outside activities they are required to attend with members was not accounted for in the rate study.

The program operations funding is not intended to cover the cost of most of the expenses cited by the commenters –groceries and personal hygiene items, utilities, rent/ mortgage, and home maintenance – as these are considered room and board expenses, which are discussed in the response to comment 112. As noted by the commenters, there is not a specific assumption related to staff participation fees. Rather, these expenses are intended to be covered by the program operations funding, which is discussed in greater in detail in the response to comment 60.

114. Commenters objected to counting 40 hours of the administrator's time against the staffing expectations for level 2, 3, and 4 homes, noting current regulations only allow 20 hours to be counted. Conversely, commenters stated the 40-hour offset should also be applied to level 5 homes. Additionally, commenters suggested the wage assumption should be increased to a level that allows for the position to be considered exempt or overtime hours should be added.

The rate models were revised in response to both comments.

The administrator's hours offset to the DSP staffing hours was reduced from 40 hours to 20 hours for the level 3 and 4 homes. The offset in level 2 homes remains 40 hours as it is expected that individuals in these homes are frequently engaged in activities away from the home, increasing the number of hours that can be 'covered' by the administrator. If the rate study is implemented, the

recommended home levels, associated staffing expectations, and administrator's hour offset would be further defined in regulations.

The rate models have been further updated to assume five percent of administrators' total work hours are overtime hours.

Adult Residential Facilities for Persons with Special Health Care Needs (Service Code 113)

115. Commenters indicated the ARFPSHN rate models understate the costs of operating these homes, which are much more costly than level 4I CCFs.

As discussed in the response to comment 94, there is a customizable rate model for ARFPSHNs. Once the customizable factors are completed, the ARFPHNS rate models provide significantly more funding than the CCF rates to reflect the cost of more specialized staff (that is, certified nursing assistants, licensed vocational nurses, and registered nurses). In response to this comment, however, a number of changes to the customizable rate model have been made:

- The number of hours for CNAs, LVNs, and RNs can all be customized whereas the draft rate model only allowed customization of the number of CNA hours,
- The home administrator can be reported to be a registered nurse or another staff with greater funding provided when the position is filled by an RN,
- Actual mortgage/ rent and property tax expenses can be input,
- The number of miles traveled per month in support of home operations can be customized, and
- The assumption for program operations funding is doubled from the amount included in the CCF rate models.

The administrative costs assumed in the rate model remain equal to the assumption in the four-bed level 6 adult CCF rate model, which is the highest funding level in any adult CCF rate model.

As part of the updated rate models, the fillable Excel versions of these rate models have been posted online so stakeholders may easily determine what rate would be assigned based on the Regional Center-approved staffing levels associated with specific homes.

116. Commenters stated it is difficult to analyze the expected direct care staffing hours and possible impact to current operations because the staffing methodology has not been provided.

Recognizing the significant variability in staffing needs across ARFPSHNs, the rate study did not recommend fixed rates for this service. Rather, the rate study recommended a customizable rate model in which certain cost assumptions are fixed (such as the hourly wage and benefit package for staff), but the number of direct care ('line staff') hours to be provided are established on a home-by-home basis. The rate study does not include guidance on how the staffing levels would be approved by Regional Centers and assumes such decisions would be similar to existing practices.

117. Commenters asked whether the assumption that line staff are certified nursing assistants will become a regulatory requirement.

As noted by the commenters, the ARFPSHN rate models assume line staff are certified nursing assistants. Decisions related to whether or not this becomes a requirement, whether there are other

qualifications that may substitute, and whether existing staff would be grandfathered on a temporary or permanent basis have not been made and would be considered in the development of regulations that would be needed if the rate study is implemented.

118. Commenters stated the wage assumption for ARFPSHNs is too low and suggested the standard should be 150 percent of the minimum wage.

The wage value in the ARFPSHN rate models reflects the assumption that line staff are certified nursing assistants. Specifically, the rate models assume a wage of $17.06 per hour, which is in-line with wages reported by vendors that participated in the provider survey ($14.85 median, $16.99 weighted average).

119. Commenters questioned whether the ARFPSHN rate models provide enough licensed staff to comply with California statutes. Commenters also asked whether the number of registered nurse and licensed vocational nurse hours will vary by home or if the rate model relies on an average. Commenters stated the rate model only includes one lead staff per home.

ARFPSHNs are required to have a licensed registered nurse, licensed vocational nurse, or licensed psychiatric technician awake and on duty 24-hours per day, seven days per week. The draft rate model reflected this requirement. Specifically, the draft rate model included one full-time registered nurse as the home administrator plus 128 hours per week for a lead staff, which is assumed to be a licensed vocational nurse. As noted in the response to comment 115, the updated rate model allows the number of licensed staff hours to be customized to exceed the minimum requirement based on the needs of the individuals in each home.

120. Commenters stated the rate models should include at least 2.67 consultant hours per individual per month, consistent with the requirement for level 4I Community Care Facilities.

As noted in the response to comment 94, rather than a fixed number of consultant hours based on the minimum requirement, the ARFPSHN rate models allow consultant hours to be customized to exceed the minimum based on the actual amount needed by the individuals in the home.

121. Commenters stated service code 109 is used as an in-home day program for ARFPSHNs, and a rate model should be developed to reflect services provided by a certified nursing assistant or licensed vocational nurse.

Supplemental Residential Program Support (service code 109) is used to supplement staffing in residential programs. Since these staff are intended to complement existing staff, the rate model assumes the services are provided by a personal assistant-type position rather than a certified or licensed position. In the case of ARFPSHNs, the customizable rate model allows for the total number of CNA hours to be tailored to the staffing needs of the home so there should not be a need to bill another service for in-home day programs.

Enhanced Behavioral Supports Homes (Service Codes 900 and 901) and Community Crisis Homes (Service Codes 902 and 903)

122. Commenters objected to the wage assumptions for various positions included in the rate models. Comments included:

- ***Wage assumption should not be the same across all homes, but should vary based on individual needs,***
- ***The wage assumption for registered behavior technicians (the line staff in the rate models) is too low and should not be tied to the BLS classification for psychiatric aides,***
- ***Lead staff must be registered behavior technicians or licensed psychiatric technicians so the wage assumption should not be based on the BLS classification for psychiatric aides, and***
- ***Board certified behavior analysts are often contractors rather than staff and the wage assumption is too low because it is based on the BLS classification for psychologists.***

One of the primary goals of the rate study was to establish greater consistency in rates across vendors. Thus, the rate models use a fixed wage assumption for each service as discussed in the response to comment 32. As further discussed in that response, the wage assumptions – like all rate model assumptions – are intended to reflect the estimated costs of providing services consistent with the State's regulations and individuals' service plans. It is therefore expected that for any given program, some costs would be higher than assumed and others would be lower.

As discussed in the response to comment 228, the BLS does not have a specific occupational classification for registered behavior technicians so they are often assigned to the psychiatric aide classification. In response to comments and recognizing RBTs often have greater qualifications than other staff included in the psychiatric aide classification, the wage assumption for RBTs was increased from the median wage for this classification to the 75th percentile wage. This increased the wage assumption in the base rate model to $18.48 per hour, or $38,000 annually. As also detailed in the response to comment 228, this salary is generally consistent with average RBT wages in California reported by various salary tracking firms. Similarly, the wage assumption for lead staff was increased to the 90th percentile, increasing to $21.35 per hour.

As with RBTs, there is not a standalone BLS classifications for behavior analysts and behavior management consultants. The wage for behavior analysts was tied to the median wage for clinical, counseling, and school psychologists, which is where the BLS generally includes BCBAs. The base rate model wage assumption is $52.00 per hour, or $108,200 per year. As detailed in the response to comment 228, this salary compares favorably to average BCBA wages in California reported by various salary tracking firms.

As discussed in the response to comment 96, vendors may directly employ or contract with a BCBA. The rate models assume the clinicians are employees, but this is not intended to have an impact on the cost.

123. Commenters stated the rate models do not include enough training time for registered behavior technicians. Suggestions ranged from 36 to 90 hours per year.

Individuals must complete 40 hours of training to become a registered behavior technician and there are not specific continuing education requirements. To account for employer-specific training and

additional training that may be needed due to the intensive nature of the services provided in CCHs and EBSHs, the recommended rate models included 70 hours of training for RBTs every year. This assumption is unchanged.

124. Commenters stated the rate models need to account for supervision of registered behavior technicians – including the home administrator – by board certified behavior analysts equivalent to five percent of their service hours.

In response to this comment, the productivity adjustment for 'Supervision and Other Employer Time' for both line staff and lead staff was increased to two hours per week, which exceeds five percent of their direct service time.

The rate models already account for the full annual cost of the home administrator so no adjustment was made for this position. However, the rate model was revised to allow the user to specify whether the administrator position is filled by a BCBA, a registered nurse, or some other position.

125. Commenters stated the Facility Component rate models do not include mortgage/ rent or property tax cost assumptions. Commenters stated the facility rates are inadequate. As an example, one commenter noted they have currently approved monthly facility rates of as much as $50,000, but the rate model reports a rate of less than $8,000.

The EBSH and CCH Facility Component rate models do not include fixed cost assumptions for all home expenses. Rather, as discussed in the response to comment 94, the rate study produced customizable rate models for EBHSs and CCHs. In particular, there are four customizable factors: the capacity of the home, the annual mortgage and rent cost for the home, the property taxes for the home, and the number of home-related miles traveled per month. Until all of those figures are reported, the total cost is incomplete.

The Facility Component rate models include fixed costs for the home administrator (about $82,400 per year for wages and benefits), utilities ($6,000 annually), newspaper/ telephone/ cable/ internet ($2,400 annually), and repair and maintenance ($6,000 annually).

As part of the updated rate models, the fillable Excel versions of these rate models have been posted online so stakeholders may determine what rate would be assigned based on the Regional Center-approved costs associated with specific homes.

126. Commenters stated the lead staff should be included in the Facility Component rate model because the home must be fully staffed, trained, and functioning prior to the first placement.

The rate study proposes to move the cost of the lead staff person from the Facility Component to the Individualized Services and Supports Component rate for the first individual placed in the home to provide greater transparency into per-person costs. Since the lead staff is counted as the first staff to support the first placement, but the Facility Component is spread across all participants, the cost of supporting the first placement is understated and the cost of additional placements is overstated.

For example, if there are two placements in the home who both require two-to-one support, under current practices the Facility Component rate will include the lead staff, the Individualized Services and Supports Component rate for the first placement will include their second staff person, and the Individualized Services and Supports Component rate for the second placement will include both of their staff. Thus, payments for the first placement will reflect one-and-a-half staff (one half of the lead staff in the Facility Component and one staff in the Individualized Services and Supports Component

rate) while payments for the second placement will reflect two-and-a-half staff (one half of the lead staff in the Facility Component and two staff in the Individualized Services and Supports Component rate).

Including the cost of the lead staff in the Individualized Services and Supports Component rate for the first placement ensures the cost of serving this individual reflects two staff (and that the cost of serving subsequent placements similarly reflects the staff assigned to them). Additionally, since the Facility Component cannot be billed until a placement is made, there is no negative effect on vendors' billing.

127. Commenters stated the rate models assume only one lead DSP per home, but lead DSPs should be scheduled for 24-hour care.

The EBSH and CCH rate models do not assume there is a single lead DSP per home. Rather, they assume 24-hour coverage by a lead staff person (168 hours per week), funded in the Individualized Services and Supports Component rate for the first placement as described in the response to comment 126.

128. Commenters indicated the mileage expenses should be included in the Individualized Services and Supports Component rate model rather than the Facility Component rate model. Further, commenters stated vehicle expenses, such as lease payments, should be included in the rate models.

The mileage assumption is incorporated in the Facility Component rate models rather than the Individualized Services and Supports Component rate models to allow vehicles to be budgeted for the entire home as it is assumed some portion of the mileage would support general home operations. This also eliminates the need to prorate mileage when a trip is shared by multiple individuals. The number of miles traveled in support of home operations is one of the 'customizable' elements of the Facility Component rate model.

As discussed in the response to comment 62, vehicle related expenses are reimbursed on a per-mile basis using the Internal Revenue Service's 2020 standard mileage rate of $0.575 per mile. The standard mileage rate incorporates all vehicle-related expenses, including acquisition and depreciation, registration, maintenance and repairs, gasoline, and insurance.

129. Commenters stated the rate models exclude itemized costs for insurance (e.g., commercial general liability), alarm systems, licensing and membership fees, CPP development meetings, and quality assurance.

Although not separately delineated, these costs are incorporated in the administration and program operations assumptions incorporated in the Facility Component rate models. Administration and program operations costs are discussed generally in the responses to comments 60 and 64. As it relates to EBSH and CCH rates specifically, the program operations funding is twice the amount included in other residential rate models to recognize the more intensive requirements of these programs. The administrative funding level is set equal to the assumption in the four-bed level 6 adult CCF rate model, which is the highest funding level in any adult CCF rate model.

130. Commenters stated the rate models excluded itemized costs for payroll taxes, unemployment insurance, health insurance, and other benefits.

Although not separately delineated, these costs are incorporated in the employee benefit rate associated with each staff position in the customizable rate models. The specific assumptions related to individual benefits are detailed in Appendix C of the rate models.

131. Commenters stated the Individualized Services and Supports Component rate models should not include individual's Supplemental Security Income (SSI) and State Supplementary Payments (SSP) benefits, but rather, these costs should be moved to the Facility Component rate models.

Individuals' SSI and SSP benefits were reflected in the EBSH and CCH rate models to provide transparency into how these services are funded. As the commenters note, however, these benefits should have been incorporated in the Facility Component rate model instead of the Individualized Services and Supports Component rate model. Since these benefits are considered a revenue source rather than a cost, they have been removed from the rate models, which are designed to reflect the cost of providing services and not how the services are funded.

132. Commenters suggested DDS retain the existing Community Crisis Home Transition Component (service code 899) rate model and remove the daily rate cap.

The rate study does not include any recommendations related to the CCH Transition Component service. If the rate study is implemented, the appropriateness of the existing daily cap could be considered as changes to regulations are developed.

Family Home Agencies (Service Code 904)

133. Commenters objected generally to the recommended rate models, stating the rates are less than they currently receive. Additionally, commenters stated they believe FHA rates should be aligned with CCF rates.

There are significant differences in the manner in which services are provided in Community Care Facilities and Family Home Agencies. For that reason, rate models were developed specifically for FHAs, outlining the costs associated with this service, including recruitment, home oversight (coordination), training, agency-provided direct support professionals, consultants, and the payment to the home provider.

As detailed in the remainder of this subsection, a number of changes have been made to the rate models in response to specific suggestions from commenters.

134. Commenters stated the rate study recommended 6 FHA levels, but did not provide criteria for these levels. Additionally, commenters noted at least one Regional Center has a seventh level for higher-needs individuals.

The rate study did not outline specific criteria for assignment to the six rate levels. Rather, the rate models outline assumptions regarding the intensity of supports associated with the home in terms of the coordinator's caseload, the number of agency-provided direct support professional hours, and the payment to the home. Similar to the process currently employed by Regional Centers with tiered rates, it is expected these assumptions would be used to inform the determination of the appropriate

rate level for a given placement. If the rate study is implemented, more specific guidelines would be considered as changes to regulations are developed.

The sixth level, which provides funding of more than $100,000 annually, is intended to support individuals with complex support needs.

135. Commenters stated the rate study reduces the number of direct support professional hours to be provided by the agency by six hours per month in their level 5 FHA homes and by 16 hours per month in their level 6 FHA homes.

As discussed in the response to comment 134, the rate models include assumptions for agency-provided direct support professional hours that vary based on the needs of the home. These assumptions include eight hours per month for level 1 FHA homes and 24 hours per month in level 6 FHA homes. If an existing home requires more DSP hours than assumed in the rate model, it may be appropriate to change the home's assigned level or Supplemental Residential Program Support (service code 109) could be authorized to supplement the FHA rate.

136. Commenters stated the assumption that coordinators have caseloads of 15 homes is too high.

The 15-home caseload assumption only applies to the level 1 rate models. Each higher level assumes a lower caseload; the level 5 and 6 rate models assume a caseload of only six homes. According to participants in the provider survey, the current average caseload is 14 FHA homes.

137. Commenters stated the assumption that recruiters certify 24 homes per year is too high. Commenters instead recommended the assumption be lowered to ten homes per year.

The rate models assume a *full-time* recruiter (that is, a staff person who has no other responsibilities) would be able to successfully recruit and achieve certification for 24 homes per year. According to participants in the provider survey, it takes an average of approximately 50 hours to recruit, train, and approve a home. Based on a 2,080-hour work year, this would translate to more than 40 successful recruitments per year. However, the rate models recognize not every hour worked can be attributed to a recruitment; for example, staff have paid time off, spend time driving to prospective homes, attend staff meetings, etc. The models assume 60 percent of a full-time recruiter's hours are spent on actual recruitment activities, translating to 24 homes per year.

It is acknowledged some agencies may not have full-time recruiters so they would successfully recruit fewer homes. In this case, both the work hours and the number of recruitments would change proportionally (that is, a half-time recruiter would be assumed to recruit 12 homes per month) such that the cost per home does not change.

138. Commenters stated the rate models exclude a program manager/ director position, and asked whether the recruiter position is assumed to include these responsibilities.

As noted in the response to comment 137, the rate model assumes the recruiter is dedicated to the recruitment function. It is not intended to account for a program manager position. This position would be covered in the program operations funding discussed in the response to comment 60.

139. Commenters noted the rate models did not specify a number of home visits per participant and suggested that if rates are to be standardized, the number of home visits should also be fixed.

The rate models do not include assumptions related to the number of times a coordinator or agency-provided direct support professional visits a home. Rather, the rate models include assumptions related to the coordinator's caseload (which influences the number of visits provided) and the total number of agency-provided DSP hours provided (but not whether this consists of a larger number of shorter visits or a smaller number of longer visits).

If the rate study is implemented, establishing specific expectations regarding the number of visits to be provided could be considered as potential changes to regulations are developed.

140. Commenters objected to the wage assumptions incorporated in the rate models for coordinators, recruiters, trainers, and direct support professionals. One or more of these commenters additionally stated the positions other than DSPs should be classified as exempt.

The rate models do not assume staff must be classified as exempt and the wage assumptions of an annual wage of $48,600 for recruiters and $42,900 for coordinators and trainers have only been updated to reflect the May 2018 BLS wage data. Additional discussion of wage assumptions for supervisory-type position is included in the response to comment 42. Wage assumptions for direct support professionals are discussed in the response to comment 33.

141. Commenters objected to various productivity assumptions for agency-provided direct support professionals, stating the allotted time should be increased for traveling between service encounters and supervision and other employer time, and time should be added for recordkeeping.

In response to this comment, a productivity adjustment of 1.25 hours per full-time workweek was added for recordkeeping responsibilities. The remaining factors are unchanged, except for adjustments related to the assumptions of the distribution between full-time and part-time staff discussed in the response to comment 51. With these revisions, the base rate models assume a DSP provides about 25 hours of direct care during a 35-hour workweek.

142. Commenters stated the rate models should include mileage for the recruiter and direct support professional positions.

In response to this comment, the base rate models have been revised to include 5,200 miles per year for both the recruiter and agency direct care staff positions.

143. Commenters objected to the recommendation that a minimum of 45 percent of the total FHA rate be paid to the home provider, suggesting that figure was too high. Conversely, other commenters suggested the ratio was too low.

The FHA rate models include specific assumptions related to the various costs associated with providing the service, including recruitment, home oversight (coordination), training, agency-provided direct support professionals, consultants, and the payment to the home provider. In the draft rate models, the assumed payment to the home provider ranged from 47 percent to 65 percent of the total rate. While the rate study did not recommend that agencies be required to pay the exact amounts assumed in the rate models, it did recommend that home providers receive at least 45 percent of the rate. This minimum standard was less than the amounts actually assumed in the rate models to provide flexibility for agencies to tailor supports to the individual needs of the home. The home

provider is additionally assumed to receive funding from individuals' Supplemental Security Income and State Supplementary Payment benefits for room and board expenses.

With the various changes made to the rate models, the assumed payments to the home provider now constitute 55 to 62 percent of the total base rate. Accordingly, it is now recommended that home providers receive at least 50 percent of the total rate.

144. Commenters objected to tying administrative costs for all levels of FHAs to the administrative rate for five-and-six person level 4 CCFs. It was alternatively suggested that administrative costs be tied to the four-and-fewer person CCF rates.

In response to this comment, the administrative costs in the FHA rate models are no longer tied to CCF rates. Rather, they are funded at 12 percent of the total rate, consistent with most other rate models developed as part of the rate study. This has the effect of providing more administrative funding to support the higher-level homes.

145. Commenters indicated the rate models did not include funding for relief care.

As noted by the commenters, the rate models do not include a specific assumption for relief care. Rather, it is assumed relief care can be provided by the direct support professional hours included in each rate model as discussed in the response to comment 135, or the agency may reduce the payment to the home provider for days during which they do not provide care and use that funding to pay relief staff.

Supplemental Residential Program Support (Service Code 109)

146. Commenters stated in-home day programs should not be covered through the Supplemental Residential Program Support service.

The rate study did not recommend that In-Home Day Programs be reimbursed through service code 109. Rather, it is assumed these programs would continue to be funded through service code 091.

DAY PROGRAM, TRANSPORTATION, AND EMPLOYMENT SERVICES

This section summarizes comments related to services the rate study categorized as 'day, employment, and transportation services', including Community-Based Day Programs (including miscellaneous service codes covering similar programs), Supported Employment, Work Activity Programs, and Transportation. Note that most comments related to wage, benefit, and administrative assumptions are addressed in the Across Services section.

Multiple Services

147. Commenters objected to the recommended elimination of the 'miscellaneous service codes' for Community Integration Training Programs (service codes 055) and Community Activities Support Services (service code 063), stating these services provide individualized options. For example, commenters stated they use these service codes to offer a combination of employment and independent living services, typically at a one-to-one ratio; customized employment, job exploration, and volunteering opportunities; and programs that include augmentative alternative communication. Additionally, commenters noted rate models were not specifically developed for Project SEARCH and College to Career programs. Finally, commenters stated the recommended rate models may reduce some rates by more than 50 percent.

A key requirement of the rate study was an evaluation of the number and type of service codes, including recommendations for simplifying and making service codes more reflective of the level and types of services provided. The rate study was also tasked with addressing the transparency and sustainability of services. Consistent with these charges, the rate study recommended the elimination of service codes 055 and 063, which lack regulations to define service requirements and are often used to provide supports that are duplicative of other services such as 'look-alike day programs' and supported employment services. Additionally, individuals can receive more the one type of support (for example, both day program and employment services) under the same service code, making it difficult to determine the number of individuals participating in various types of programs. Without defined requirements and consistent rate methodologies, these services are neither transparent nor sustainable.

The recommendations incorporated in the rate study still provide sufficient flexibility to meet the specific needs of individuals. There are a variety of service codes that cover many of the activities cited by the commenters, including Independent Living (service code 520) and Supported Employment-Individual (service code 952), which were activities specifically noted in the comments. The framework for Community-Based Day Programs includes rates for services provided in a center-based location or in the community at a variety of staffing levels, and for programs with a medical or behavioral focus. Additionally, other services such as Supplemental Program Support-Day Programs (service code 110) and service codes that cover specialized supports such as a nurse's assistant or behavior technician can be approved to augment the day program. The specific activities worked on in these programs should be tailored to an individual based upon their needs and goals as determined through a person-centered planning process.

If the rate study is adopted and regulations are developed, vendors and stakeholders would be engaged to determine whether guidelines should be established for programs with already-defined structures such as Project SEARCH and College to Career programs.

Although it is likely the rate models would decrease rates for *some* programs authorized under these service codes – which would be true for many service codes – the actual impact would vary by vendor based on their current rate and the service or services to which their programs would be transitioned.

148. Commenters stated the rate models for day programs that operate 100 percent of the time in the community and for Supported Employment-Individual should include facility costs.

Only rate models for services that are delivered at least partly in a center or clinic environment include a cost factor for facility expenses to account for program space. As with all services, other facility-related expenses such as staff offices are incorporated in the program operations and administrative cost assumptions discussed in the responses to comments 60 and 64.

149. Commenters expressed support for the recommendation that services currently billed on a daily basis be converted to hourly billing, including Work Activity Programs and certain day programs, stating this will support person-centered thinking and allow individuals greater choice in activities. Conversely, other commenters objected to this recommendation, stating this will create difficulties in scheduling and additional administrative burdens.

The rate study recommends a number of services currently billed on a daily basis be billed based on an individual's hours of attendance. This recommendation is intended to provide several benefits.

First, it accommodates individuals who receive multiple services in a day. For example, the rate framework for Community-Based Day Programs includes separate rates for center-based and community-based supports. The higher rates for community-based supports are intended to encourage vendors to maximize individuals' participation in the community. Or, an individual may spend part of the day in a Community-Based Day Program and part of the day receiving Supported Employment.

Second, hourly billing increases transparency into the services individuals actually receive. With daily billing, it is difficult to know, for example, whether someone is spending one hour in a day program or six hours.

Third, hourly billing better aligns payments with costs. In a daily billing model, a vendor receives the same payment regardless of whether they provide three hours of service or six hours.

150. Commenters stated the attendance rates assumed in the rate models for group services are too high. Further, commenters stated attendance rates will decline with the transition to hourly billing because a participant may arrive late or leave early. Additionally, commenters stated attendance rates are lower in behaviorally- and medically-focused programs.

The rate models for Community-Based Day Programs, Supported Employment-Group, and Work Activity Program services assumed a 90 percent attendance rate for program participants. This assumption was derived primarily from data collected through the provider survey as shown in the table below.

	Surveys	Attendance	
		Median	**Weighted Avg.**
Community Integration Training (055)			
Non- Medical/ Non-Behavioral	61	90%	88%
Behavioral	26	90%	87%
Medical	11	85%	85%
Community Activities Support (063)			
Non- Medical/ Non-Behavioral	8	94%	91%
Behavioral	9	90%	93%
Medical	1	72%	72%
Activity Center (505)			
Non- Medical/ Non-Behavioral	33	87%	87%
Behavioral	5	86%	80%
Medical	2	87%	90%
Adult Development Center (510)			
Non- Medical/ Non-Behavioral	95	88%	88%
Behavioral	20	90%	89%
Medical	13	89%	91%
Behavior Management Programs (515)	82	90%	80%
Social Recreation Programs (525)			
Non- Medical/ Non-Behavioral	6	92%	92%
Behavioral	1	85%	85%
Supported Employment-Group (950)	55	91%	91%
Work Activity Programs (954)			
Small (1-30 Participants)	18	86%	87%
Medium (31-100 Participants)	21	88%	86%
Large (101 + Participants)	7	88%	88%

Depending on how attendance is defined, transitioning from daily to hourly billing could affect the calculated attendance rate. For example, if an individual is scheduled to attend a program for six hours, but is only there for five hours, the attendance would likely be considered 100 percent under a system of daily billing, but would only be 83 percent for the purposes of hourly billing. Note that if the participant attends for five-and-a-half hours, that would be rounded to six hours for billing and attendance would still be 100 percent.

It is not clear, however, that the issue of daily versus hourly billing is impacting these reported attendance rates. First, anticipating that the system could shift to hourly billing, the survey was designed to capture hourly attendance with the instructions stating, "Report your organization's attendance rate by dividing the total hours of service provided to all individuals for the program being reported divided by the number of scheduled hours of service for those individuals." Second, some of the services included in the table above are already billed on an hourly basis: Social Recreation, Supported Employment-Group and at least some programs authorized under service codes 055 and 063. Comparing these services to those billed on a daily basis, there is not a substantial difference in reported attendance rates.

In response to this comment, however, the assumed attendance rate has been reduced from 90 percent to 88 percent in the rate models for group services. No additional adjustment was applied to medically- and behaviorally-focused programs as the data reported in the survey did not suggest substantial differences.

151. Commenters asked why attendance is reflected in both the direct support professional wages and benefits sections and the attendance sections of the rate models for Community-Based Day Programs, Supported Employment-Group services, and Work Activity Programs.

The attendance assumptions perform a similar function in both sections. Specifically, the attendance assumptions serve to recognize vendors have certain fixed costs regardless of whether an individual attends the program as scheduled. As discussed in the response to comment 150, the assumed attendance in these programs is 88 percent. Costs allocated on a per-person basis are therefore 'inflated' by dividing by 88 percent. This adjustment is applied to the cost of the direct support professional, supervision, facilities, and mileage.

152. Commenters stated the rate models assume individuals are scheduled to attend their Community-Based Day Programs, Supported Employment-Group programs, and Work Activity Programs six hours per day and five days per week, but some individuals are scheduled for fewer hours.

This issue differs from the question of attendance rates discussed in response to comment 150 as it relates to *scheduled* attendance versus *unscheduled* absences. The rate models include an attendance factor as the basis to amortize certain fixed costs, including staffing, facility, and vehicle expenses. This assumption is separate from but related to the attendance assumption.

For example, the rate models for Community-Based Day Programs assume programs operate 250 days per year for six hours per day, which translates to 1,500 hours per year. This assumption is best understood as the hours associated with a 'slot' rather than, necessarily, an individual. That is, if someone is scheduled to attend a program for three days per week, it is assumed someone else is scheduled for the other two days so the program space does not go unused.

Although this assumption relates to a slot, it is still adjusted for the attendance rate discussed in the response to comment 150 to reflect unscheduled absences that will occur. The 1,500-hour assumption is therefore multiplied by the 88 percent attendance factor so a slot is assumed to be filled 1,320 hours per year. This total is used to determine the per-hour amounts of fixed costs. Alternatively, the rate models could have assumed lower fixed costs per participant (for example, if someone is only scheduled for three days per week, they will travel fewer miles than assumed; or, if a program has a sizable number of part-time attendees, they would not need as large a physical space), but the overall rate would be effectively unchanged.

153. Commenters stated it was inappropriate to assume staff provide more than 30 billable hours of service per week when individuals are limited to 30 hours of service.

Although related, a direct care worker's billable hours are separate from the number of hours of service any given individual receives, as illustrated in the schedule below.

Time	Staff			Attendees											
	1	2	3	A	B	C	D	E	F	G	H	I	J	K	L
8:00 AM	✓	✓		✓	✓	✓	✓	✓	✓						
9:00 AM	✓	✓	✓	✓	✓	✓	✓	✓	✓						
10:00 AM	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
11:00 AM	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
12:00 PM	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
1:00 PM	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2:00 PM	✓	✓	✓							✓	✓	✓	✓	✓	✓
3:00 PM	✓	✓	✓							✓	✓	✓	✓	✓	✓
4:00 PM			✓										✓	✓	✓

In this example, the program provides services at a one-to-three ratio and operates nine hours per day (8:00 AM to 5:00 PM). The program serves 12 individuals (labeled A through L) who each attend for six hours per day, for a total of 72 attendance hours. Maintaining the one-to-three ratio requires three full-time staff working eight hours shifts (labeled 1 through 3), for a total of 24 staff hours. As shown in the schedule, staff and individuals arrive and depart at different times. However, no individual attends more than six hours per day (30 hours per week) and each staff person is providing direct care eight hours per day (40 hours per week). The actual staffing ratio varies throughout the day, translating to one-to-two during some hours and one-to-four during others, but staffing ratios are measured over the course of a month and the overall average is one-to-three. This is an overly simplistic example that does not attempt to account for productivity adjustments, absences, or other factors, and it does not purport to present an ideal model in terms of operating hours or scheduling. However, the example does demonstrate staff can provide more than 30 hours of support even when individuals are limited to 30 hours because the staff are serving different people at different times.

However, in response to a separate issue related to the use of part-time workers to provide services discussed in the response to comment 51, the rate models now assume an average workweek of almost 35 hours. With this change, it is now assumed direct care workers are providing fewer than 30 hours of direct service per week.

154. Commenters stated limiting billing for certain services to six hours per day does not recognize that some members arrive early or leave late and are onsite longer than six hours.

The rate study did not make any recommendations related to six-hour billing limits. As discussed in the response to comment 149, the rate study does recommend a number of services currently billed on a daily basis be transitioned to hourly billing, including Community-Based Day Programs and Work

Activity Programs. If the rate study is implemented, the issue of daily limits could be considered as regulations are revised or established for these service codes.

155. One commenter asked whether there was a calculation error in the formula for day programs related to administration and program operations costs per billable hour. The commenter believed the calculation should multiply by the client ratio rather than dividing by the client ratio.

The rate models for Community-Based Day Programs, Supported Employment-Group, and Work Activity Programs are presented on a per-individual basis rather than per worker. As discussed in the response to comment 61, the program operations amount is established per employee; in the case of primarily group-based services, this amount is $20 per day. The rate models for these services then spread this cost over the number of individuals served by a staff person, adjusted for the attendance rate discussed in the response to comment 150. Administrative costs are calculated as 12 percent of total costs. Since these costs are presented on a per-individual basis, no further adjustments to the administrative cost calculation are needed.

156. Commenters stated the rate models for Supported Employment-Group services and Work Activity Programs should include assumptions for facility costs related to the program as well as office space. In support of this suggestion, commenters noted Work Activity Programs may spend up to 50 percent of their time on work adjustment services such as resume development, interview skills training, and workplace safety training.

The rate models for Supported Employment-Group and Work Activity Programs are intended to account for the training provided to individuals. The models did not include a program space component because these are considered to be revenue generating programs that should include operating costs in the prices charged to customers. However, as noted by the commenters, regulations allow up to 50 percent of the time in a Work Activity Program be spent on work adjustment services and supportive habilitation services. The Work Activity Program rate models have therefore been updated to include facility space with 50 percent of the assumed cost allocated to the service rate and the other 50 percent assumed to be covered by the revenue-generating program.

As discussed in the response to comment 64, costs associated with office space are incorporated in the administrative component of the rate models.

Activity Center (Service Code 505), Adult Developmental Center (Service Code 510), Social Recreation Program (Service Code 525), Behavior Management Program (Service Code 515), and Day Programs Provided Through Miscellaneous Service Codes

157. Commenters asked whether rates would be different depending on the location of the service provided and the staffing ratio of the group. Commenters also asked whether vendors will be required to offer both center-based and community-based services. Commenters objected to rates that vary based on location and staffing ratio. Specific objections included:

- ***Concern that individuals would be 'locked' into a particular staffing ratio rather than having access to flexible staffing ratios,***

- ***Changes to staffing practices that would be needed such as adding staff or using more part-time staff, and***
- ***The additional administrative effort that would be needed to track where individuals are receiving services.***

The rate study recommends rates that vary based on where services are provided, the staffing ratio of the program, and the 'type' of program (that is, whether the program has a behavioral or medical focus or not).

The majority of Community-Based Day Programs – operated as Activity Centers (service code 505), Adult Developmental Centers (service code 510), Behavior Management Programs (service code 515), and Social Recreation Programs (service code 525) – are already required to operate at a specified staffing ratio as outlined in regulations and their respective vendorizations and program designs. The rate study continues this approach. The revised rate models include staffing ratios that range from one-to-two to one-to-ten for center-based services and one-to-two to one-to-four for community-based services for non-medical and non-behavioral day programs. As is current practice for most day programs, each program would be vendored for a specific ratio, except that the ratio may vary for center-based and community-based services.

Establishing separate rates for community-based and center-based services – with higher rates paid for community-based services – is a change that is coupled with billing for services on an hourly basis as discussed in the response to comment 149. This framework is intended to offer two key benefits. One, the higher rates for community-based services are intended to better support services provided in the most integrated environments. Two, this approach would provide more transparency into how services are being provided.

There is no requirement that a program provide both center-based and community-based services; that is, a program may offer only center-based services or only community-based services. For those programs that do provide services in both locations, some changes to vendors' practices would likely be necessary. There would be additional effort on the part of vendors to more closely track where, when, and to whom they are providing services. There could also be changes to staffing approaches for day programs, but that would be dependent on how the program is structured. For example, a program may be vendored for the same ratio for both center-based and community-based services such that staffing needs are consistent throughout the day. Or, a program could be developed that has both a center-based activity and a community-based activity scheduled in the morning and in the afternoon so that, again, staffing needs are consistent throughout the day.

Additionally, the rate study assumes – consistent with current practice – that the vendored ratios are measured over the course of a month rather than hour-to-hour. This provides flexibility to vendors to operate at different ratios at different times, as long as they deliver the average ratio over the course of the month. Ultimately, each vendor would have the opportunity to design the program – in terms of where services are provided and at what ratios – that best meets the needs of their staff and the individuals they serve.

158. Commenters expressed support for the inclusion of rate models for day programs with a medical focus. Commenters stated the recommended framework for day programs will limit opportunities for 'blended' programs serving a mix of individuals with medical or behavioral needs as well as those without such needs. Additionally, commenters asked which service an individual with both medical and behavioral needs would attend.

The rate study builds upon the existing Behavior Management Programs (service code 515) intended to serve individuals who cannot attend other day programs due to their behavioral needs by recommending the establishment of medically-focused day programs. This framework is not intended to limit access to the types of 'blended' programs referred to by the commenters. In fact, it is expected most programs would not be medically- or behaviorally-focused, but would serve individuals with a variety of needs. As is already true for existing Behavior Management Programs, behaviorally-focused programs and the recommended medically-focused programs are intended for those individuals who would not be successful in these blended programs.

It would be up to the planning team to determine which type of program is most appropriate for a given individual. As necessary, the supports provided by the day program may be augmented by other services such as Supplemental Program Support-Day Programs (service code 110) and service codes that cover specialized supports. For example, a Behavior Technician/ Paraprofessional (service code 616) may be authorized to support an individual who is in a behaviorally-focused day program.

159. Commenters stated the requirement that medically-focused day programs are staffed by certified nursing assistants and that behaviorally-focused day programs are staffed by registered behavior technicians is a positive improvement in some settings. Conversely, commenters expressed concern with this recommendation, stating it will be difficult to attract staff, particularly RBTs, and program quality will not be improved. Additionally, commenters asked whether staff with other credentials, such as psychiatric technicians, could provide the service.

As noted by the commenters, the rate study recommended medically-focused day programs be staffed by certified nursing assistants and behaviorally-focused day programs be staffed by registered behavior technicians. These recommendations were based on the assumption that programs designed to meet the medical or behavioral needs of individuals should be provided by staff with expertise in these areas.

In response to this comment and recognizing there are other credentials that demonstrate competency in these areas, the permissible staff permitted to deliver behaviorally-focused day program services has been expanded to include psychological assistants and psychiatric technicians.

160. Commenters asked whether behaviorally-focused day programs must be supervised by a board certified behavior analyst. Commenters stated if medically-focused and behaviorally focused day programs require certified nursing assistants and registered behavior technicians, respectively, the rate models need to account for supervision by registered nurses and BCBAs. Additionally, commenters stated supervision time for direct care staff should be increased. Commenters also stated the cost of BCBAs needs to be increased to reflect the fact vendors often contract with BCBAs rather than employ them. Separately, commenters objected to the requirement that the service supervisors be RNs and BCBAs, noting difficulties in recruiting these professionals and adding they may not have expertise in working with adults with disabilities or in managing staff.

The recommended rate models assumed BCBAs supervise behaviorally-focused day programs and registered nurses supervise medically-focused day programs. In response to this comment, the rate models have been revised to include program supervisors comparable to supervisors in programs without a behavioral or medical focus.

Since certified nursing assistants and registered behavior technicians must practice under the oversight of a professional, the models continue to include oversight from the relevant professional, which would depend on the certification of the direct care worker (for example, a psychological

assistant can be supervised by a psychologist or psychiatrist). Vendors may provide services through clinicians whom they directly employ or with whom they contract. As discussed in the response to comment 209, however, the rate models assume total costs are equivalent under either staffing model.

To support sufficient oversight of staff, the productivity assumptions for direct care workers in the rate models have been revised to include two hours per week for employer and supervision time.

161. Commenters stated the wage assumption for registered behavior technicians in the rate model for behaviorally-focused day programs is too low.

The use of Bureau of Labor Statistics wage data to set wage assumptions in the rate models is discussed in the response to comment 32. As discussed in the response to comment 228, the BLS does not have a specific occupational classification for registered behavior technicians so they are often assigned to the psychiatric aide classification. In response to comments and recognizing RBTs often have greater qualifications than other staff included in this BLS classification, the wage assumption for RBTs was increased from the median wage for the psychiatric aide classification to the 75th percentile wage. This increased the wage assumption in the base rate model to $18.48 per hour, or $38,400 annually. As also noted in the response to comment 228, this salary is generally consistent with average RBT wages in California reported by various salary tracking firms.

As discussed in the response to comment 159, the recommended staffing requirement for behaviorally-focused day programs has been expanded to include psychological assistants and psychiatric technicians. The wage assumption applies to these positions as well (that is, the rate models do not vary based upon whether the program is staffed by RBTs, psychological assistants, or psychiatric technicians).

162. Commenters stated the number of training hours for registered behavior technicians in the rate models for behaviorally-focused day programs should be increased.

In response to this comment, the number of annual training hours built into the rate models for the direct care staff in behaviorally-focused day programs (now including registered behavior technicians, psychological assistants, and psychiatric technicians) has been increased from 35 hours per year to 50 hours, consistent with the assumption in the rate model for Behavior Paraprofessionals/ Technicians (service code 616) that also covers RBTs. The rate models for medically-focused day programs include the same training assumption.

163. Commenters objected to limiting community-based services to ratios of no more than three individuals per direct support professional, noting existing programs operate at ratios as high as one-to-six.

The rate study recommended the staffing ratio for community-based services be capped at three individuals per DSP to ensure individuals are safe and services are integrated to the extent possible. In response to this comment, the recommendation has been amended to allow ratios of one-to-four for community-based services. In comparison, center-based services could be delivered at ratios as high as one-to-ten.

164. Commenters stated the additional staffing requirements for Social Recreation Programs are not accounted for in the consolidation of day programs.

As noted in the response to comment 163, the framework for Community-Based Day Programs includes a rate model for center-based services delivered at a one-to-ten ratio, which is the ratio specified in regulation for Social Recreation Programs (service code 525). It is unclear what other staffing requirements the commenters may be referencing.

165. Commenters stated there should be one-to-one rate models, particularly for individuals transitioning from institutional care facilities and others with heightened behavioral or medical support needs. Commenters stated the rate study incorrectly equates these one-to-one services to Independent Living. Additionally, commenters noted staff providing these services are paid higher wages.

The rate models for Community-Based Day Programs assumed these are shared services in which a direct support professional provides supports to multiple individuals. It is recognized there are instances when more staffing is needed. The rate study did not intend to imply *all* such one-to-one services should transition to Independent Living, only that *some* of these services could be converted to Independent Living depending on the nature of the supports provided. In other cases, additional staff can be authorized through Supplemental Program Support-Day Programs (service code 110).

As discussed in the response to comment 158, the rate study includes rate models for behaviorally- and medically-focused day programs for individuals who need more specialized supports. The rates for these programs are higher than the rates for programs without a behavioral or medical focus to account for higher costs, including staff wages.

166. Commenters stated the rate models do not account for existing Behavioral Management Programs (service code 515) that provide one-to-one services, operate at a one-to-three ratio in the community, or support individuals with jobs in the community. Separately, commenters asked whether there was a need for behaviorally-focused day programs given the Behavior Technician/ Paraprofessional service (service code 616) can be delivered at a one-to-two ratio.

As discussed in the response to comment 158, the rate study includes rate models for behaviorally- and medically-focused day programs for individuals who need more specialized supports. As with other day programs, the rate models for programs with a behavioral or medical focus are predicated on a group model. Existing regulations for Behavior Management Programs allow a ratio of no more than three individuals per staff and the rate model recommended maintaining that ratio for center-based services. The rate study recommended community-based services be limited to a one-to-two ratio, but in response to this comment, the recommended cap has been raised to one-to-three consistent with the facility-based services and current regulations.

More intensive staffing could be provided through the use of Supplemental Program Support-Day Programs (service code 110). There may also be some existing programs that can be transitioned to one or more other service codes, *potentially* including Independent Living (service code 520), Supported Employment-Individual and -Group (service codes 952 and 950, respectively), and/or Behavior Technician/ Paraprofessional supports (service code 616).

As implied by the commenters, there is some overlap between behaviorally-focused day programs and Behavior Technician/ Paraprofessional supports. In general, the Behavior Technician service is largely delivered on a one-to-one basis and to assist individuals in improving behaviors while

behaviorally-focused day programs are delivered to a small group of individuals with a focus on traditional day program goals such as developing community integration skills. Of course, behavioral management programs also involve behavior management and Behavior Technician services also include skill-building.

167. Commenters stated the rate models do not reflect non-mobility assistance that is currently funded for qualifying day programs.

It is assumed this comment refers to the supplemental rates for day programs serving non-mobile consumers outlined in 17 CCR § 57530. This supplemental rate provides one-tenth of the prevailing minimum wage plus 20 percent for fringe benefits for each consumer hour of attendance. The rate study assumes this supplemental rate would be eliminated. Rather, vendors would be able to access additional staff through the use of Supplemental Program Support-Day Programs (service code 110).

168. Commenters stated direct support professionals providing In-Home Day Programs (service code 091) have a productive day of less than 6 hours due to time spent traveling between service encounters and other non-billable responsibilities.

The rate models for In-Home Day Programs implicitly assume staff do not work at more than one site in a day. Thus, the rate models do not include a productivity adjustment for travel time. More generally, the rate models assume most hours worked by direct support professionals providing In-Home Day Programs are billable. Based on a 40-hour workweek and before adjustments for paid time off and training, the rate models assume DSPs are providing 37.0 to 38.0 billable hours per week, depending on the size of the group with which they work. This is consistent with the results of the provider survey in which vendors reported 36.8 hours (weighted average) to 40.0 hours (median) of billable time per week.

After accounting for training and paid time off and adjusting for the use of part-time staff as discussed in the response to comment 51, the base rate models assume staff provide 28.5 to 29.0 billable hours in a 35-hour workweek.

169. Commenters objected to various productivity assumptions, stating the allotted time should be increased for program set-up and clean-up, supervision and other employer time, recordkeeping, and program planning and review.

Before accounting for training and paid time off, the rate models assume direct support professionals in day programs provide direct services for between 34.75 and 36.75 hours per 40-hour week, depending on the staffing ratio (with lower productivity for DSPs serving more individuals). Other than adjustments for the mix of full-time and part-time staff discussed in the response to comment 51, these estimates are unchanged and are generally consistent with figures reported by participants in the provider survey as shown in the table below:

	# of Responses	Billable Hours per Week	
		Median	**Weighted Avg.**
Community Integration Training (055)			
Non- Medical/ Non-Behavioral	61	35.6	34.8
Behavioral	26	37.8	37.2
Medical	11	38.0	36.0
Community Activities Support (063)			
Non- Medical/ Non-Behavioral	8	35.4	35.5
Behavioral	9	37.7	37.6
Medical	1	-	-
Activity Center (505)			
Non- Medical/ Non-Behavioral	33	35.8	34.9
Behavioral	5	34.7	33.2
Medical	2	32.0	32.0
Adult Development Center (510)			
Non- Medical/ Non-Behavioral	95	36.7	36.8
Behavioral	20	35.4	35.8
Medical	13	34.0	34.2
Behavior Management Programs (515)	82	36.3	35.7
Social Recreation Programs (525)			
Non- Medical/ Non-Behavioral	6	32.3	34.2
Behavioral	1	35.3	35.3

As with all rate model assumptions, the productivity estimates are intended to reflect a reasonable approximation of typical operations. It is therefore expected that for any given vendor, some productivity adjustments would be higher than assumed and others would be lower.

170. Commenters stated the square footage allotted per individual in the rate models is understated, particularly for medically- and behaviorally-focused programs. Additionally, commenters stated the assumed cost of facility space is too low, noting facilities must meet certain requirements that increase overall facility costs, such as ADA accessibility and close access to public transportation.

The recommended rate models for center-based day programs that are neither behaviorally-focused nor medically-focused included 50 square feet of space per individuals. The rate models for behaviorally- and medically-focused day programs include twice as much space: 100 square feet per individual. These assumptions are only intended to account for the areas in which services are delivered (that is, program space or 'classroom' space). Other space, such as administrative offices, is

intended to be incorporated in the administrative funding discussed in the response to comment 64, which is true for all rate models.

The base rate models assume a cost of $15.00 per square foot. With the regional adjustment factor for real estate expenses discussed in the response to comment 30, the assumed cost ranges from $12.00 per square foot in low-cost areas to $19.50 per square foot in high cost areas.

The table below presents the comparable figures reported by respondents to the provider survey.

	Surveys	Square Feet per Individual		Cost per Square Foot	
		Median	Wgtd. Avg.	Median	Wgtd. Avg.
Community Integration Training (055)					
Non- Medical/ Non-Behavioral	61	87	83	$17.46	$19.91
Behavioral	26	151	144	$14.60	$17.19
Medical	11	345	277	$8.46	$12.27
Community Activities Support (063)					
Non- Medical/ Non-Behavioral	8	18	9	$13.61	$37.43
Behavioral	9	78	87	$21.46	$26.31
Medical	1	112	112	$4.98	$4.98
Activity Center (505)					
Non- Medical/ Non-Behavioral	33	81	88	$11.67	$11.91
Behavioral	5	90	107	$11.92	$13.94
Medical	2	283	390	$13.31	$17.38
Adult Development Center (510)					
Non- Medical/ Non-Behavioral	95	90	82	$16.26	$17.30
Behavioral	20	114	179	$13.92	$16.06
Medical	13	126	101	$17.25	$12.98
Behavior Management Programs (515)	82	107	106	$17.36	$19.87
Social Recreation Programs (525)					
Non- Medical/ Non-Behavioral	6	324	257	$4.71	$5.43
Behavioral	1	42	42	$6.24	$6.24

It is expected space requirements would decline as more services shift to the community to reflect individuals' preferences because a location would be able to serve more individuals because some proportion would be in the community at any given time. However, in response to this comment, the rate models for center-based day programs that are neither behaviorally-focused nor medically-

focused have been revised to include 75 square feet per individual to more closely reflect the results of the provider survey.

171. Commenters stated the mileage and travel time assumptions in the rate models are too low. Additionally, commenters stated the rate models need to account for various vehicle expenses and reimbursements for staff who use their own vehicle to transport individuals.

As discussed in the response to comment 172, the rate study recommends that any Community-Based Day Programs vendors transporting individuals to and from their program separately bill Transportation-Additional Component (service code 880). Thus, the mileage assumption included in the rate models for Community-Based Day Programs is only intended to reflect in-program transportation (that is, transporting individuals between activities in the community). This assumption is intended to incorporate both the use of agency owned or leased vehicles as well as reimbursement to staff for the use of their own vehicles.

The rate models do not specify that these are agency owned or leased vehicles or direct support professionals' vehicles. The assumption in the base rate models is that a vehicle – regardless of ownership – travels 250 miles per week (50 miles per day) to transport a given group to their community-based activities.

As discussed in the response to comment 62, the rate models account for the cost of vehicles by using the Internal Revenue Service's 2020 standard rate of $0.575 per mile. The standard mileage rate incorporates all vehicle-related expenses, including acquisition and depreciation, registration, maintenance and repairs, gasoline, and insurance.

172. Commenters stated the rate models do not account for Community-Based Day Program vendors that transport individuals to and from the day program.

Currently, payments for transportation services provided by Community-Based Day Program vendors to transport individuals to and from the day program may either be bundled into the day program rate or separately billed under Transportation-Additional Component (service code 880). The approach varies by vendor and Regional Center. In order to increase consistency and transparency in terms of understanding the specific services provided to an individual, the rate study recommends that transportation to and from the program be unbundled from the Community-Based Day Program rates. If the day program vendor provides transportation they would bill through Transportation-Additional Component. In-program transportation (that is, transporting individuals to and from an activity that is part of their scheduled day) is included in the rate models for community-based services.

173. Commenters indicated there is no need to include mileage in the rate models for facility-based programs since services are only provided in a facility.

The rate models for facility-based services do not include an assumption for travel or mileage. As discussed in the response to comment 172, transportation to and from the program provided by the day program vendor would be compensated through Transportation-Additional Component (service code 880). Additionally, as noted by the commenter, since these services are, by definition, provided in a facility, there is no in-program transportation included in the rate models. In-program transportation costs are captured in the rate models for community-based services.

Transportation Company (Service Code 875) and Transportation-Additional Component (Service Code 880)

174. Commenters objected to the development of a single rate model for Transportation Company and Transportation-Additional Component services. Commenters stated there are three primary approaches to providing transportation: 1) supplemental transportation in which day program staff transport individuals in a personal or company vehicle to and from the program, 2) transportation companies using class B vehicles such as minivans to transport a few individuals, and 3) transportation companies using class C buses to transport as many as 15 individuals, ordinarily along fixed routes.

In response to this comment, separate rate models have been developed for Transportation Company (service code 875) and Transportation-Additional Component (service code 880) services. As discussed in other comments in this subsection, the Transportation Company rate model now assumes the use of larger, more expensive vehicles driven by staff with a commercial driver license and endorsement to transport more individuals while the Transportation-Additional Component rate model reflects direct support professionals using a smaller vehicle to transport only a couple of individuals.

175. Commenters suggested that, rather than per-trip rates, transportation services should be billed on the basis of miles or vehicle service hours. Commenters stated the rate models only account for one-way trips, but they provide round trips. Additionally, commenters objected to the standardization of rates regardless of the distance of the trip and that only vary by Regional Center rather than individual and vendor. Commenters alternatively suggested the development of payment models with some fixed cost assumptions and other variable cost assumptions, competitive procurements, or the use of usual and customary rates.

As discussed in the response to comment 20, the study recommends the standardization of payment rates for in-scope services – including transportation services – within a Regional Center, with rate models intended to reflect the reasonable cost of providing services. For any given vendor, it is expected that some costs would be higher than assumed in the rate model while other costs would be lower.

In addition to reflecting the estimated costs of providing services, the rate models for Transportation Company (service code 875) and Transportation-Additional Component (service code 880) services seek to reduce complications in authorizing, tracking, and billing. The rate study determined trip-based billing best balanced these interests. As observed by the commenters, transportation services would be billed for one-way trips. In the frequent instances in which a vendor provides two one-way trips to an individual (that is, a round trip), they would bill two, one-way trip rates.

There is currently wide variability in how these services are paid, typically reflecting differences in Regional Centers' approaches.

Considering fiscal year 2016-17 payments for which the unit of service could be determined, miles were the most common billing unit for Transportation Company services, but this still only accounted for 35 percent of billings and was the most common billing unit in only four Regional Centers. This was followed by days (29 percent of spending and the most common billing unit in seven Regional

Centers), trips (24 percent, four Regional Centers), hours (11 percent, one Regional Center), and months (1 percent, zero Regional Centers). In five Regional Centers, the most common billing unit was not immediately identifiable from a review of rate and billing data.

For Transportation-Additional Component services, the most common billing unit was days (57 percent of total spending on identifiable units and the most common billing unit in 11 Regional Centers), followed by miles (13 percent, three Regional Centers), hours (11 percent, two Regional Centers), trips (11 percent, one Regional Center, and months (8 percent, two Regional Centers). In two Regional Centers, the most common billing unit was not immediately identifiable from a review of rate and billing data.

Considering days and trips in combination since they are comparable as the only difference is whether the vendor bills for the number of trips provided (likely to be one or two) or for any day in which it provides one or more trips, most transportation services are already billed based on a fixed rate for a trip or round trip.

176. Commenters objected to the assumption that there are an average of five passengers per trip as Transportation-Additional Component services often have fewer passengers while Transportation Company services often have more.

In response to this comment and reflecting the development of separate rate models for Transportation Company (service code 875) and Transportation-Additional Component (service code 880) services as discussed in the response to comment 174, the assumed number of passengers was revised to two for Transportation-Additional Component services and eight for Transportation Company services. It is acknowledged that the number of passengers may be more or less than assumed for either service. In these instances, total revenue per trip would also be more or less than assumed, but it is anticipated that costs would also be different; for example, if fewer individuals are transported, the time and distance of a trip may be shorter (noting again that – as with all rate model assumptions – this would vary from trip to trip).

When both Transportation Company and Transportation-Additional Component services are available, individuals would have choice amongst these options. There would be instances when this is not possible, however; for example, not all day programs choose to provide Transportation-Additional Component services. Transportation Assistant (service code 882) remains available for those individuals who require more intensive supports.

177. Commenters objected to the assumptions regarding the number of miles traveled per trip and the amount of time associated with each trip, stating both were underestimated for both urban and rural parts of the State. Commenters indicated their vehicles do not incur any miles without passengers. Additionally, commenters stated the assumed mileage should differ based on the number of passengers transported (for example, a trip with five passengers should be expected to cover more miles than a trip with four passengers).

As part of the development of separate rate models for Transportation Company (service code 875) and Transportation-Additional Component (service code 880), the mileage assumptions were revised. For the Transportation Company services that were the focus of the comment, the mileage assumption in the base rate model was increased to 45 miles per trip. This includes miles traveled without any passengers to account for driving to the first pick-up and returning the vehicle after the last drop-off. Assuming a vehicle performs 15 one-way trips per week, which was the average reported by respondents to the provider survey, this translates to 675 miles per week per vehicle. In comparison,

provider survey respondents reported a median of 545 miles per vehicle per week (weighted average of 561 miles).

The staff time built into the base rate model for Transportation Company services was similarly increased, to 1.26 hours per trip. When accounting for the miles traveled without passengers (which are treated as a productivity factor in the rate models rather than as 'direct time'), the rate model includes 1.69 staff hours per trip.

Since the rate model produces a per-person rate, it has the effect of assuming more miles for trips with more passengers. As noted in the response to comment 176, the Transportation Company rate model assumes eight passengers per trip. Based on the 45 miles per trip assumed in the base rate model, the rate 'pays' for 5.6 miles per passenger. Thus, if there are 12 passengers on the trip, for example, the rate model effectively assumes a total of 67.5 miles.

178. Commenters suggested the rate study relied on analyses based on traffic patterns on a Tuesday at 10 a.m. to generate average speed assumptions, but this was flawed because transportation to and from day programs usually occurs during rush hours.

As discussed in the response to comment 30, this analysis was one element used to determine regional variability in travel time and distance, but not to determine average speed assumptions.

179. Commenters stated the rate models should better account for the time it takes to load and offload individuals, indicating this can require between five and fifteen minutes per individual.

The rate models for individuals who are ambulatory included three minutes per individual per trip for boarding or drop-off time while the non-ambulatory models included six minutes per individual per trip. Since the rate models represent a one-way trip, this assumption covers only loading or unloading time. For a round trip, the total amount of time per individual is doubled (that is, the non-ambulatory rate model provides a total of 12 minutes per individual for boarding and drop-off time when two one-way trips are billed for the round trip). In response to this comment, the assumption in the ambulatory rate model was increased to four minutes per individual. As with all rate model assumptions, these are intended to represent reasonable averages and it is expected that some individuals would require more assistance (and time) and others would require less.

180. Commenters stated paying different rates based on whether or not an individual is ambulatory represents a "discriminatory billing practice" based on the disability of the individual. Commenters stated the assumption that there will be four individuals who are non-ambulatory on a trip is not reasonable for individuals using their own vehicles to transport individuals. Commenters stated there are accommodations needed by individuals beyond wheelchair modifications. For example, commenters stated there should be a higher rate for individuals who have behavioral or other challenges that require they be transported individually.

As noted by the commenters, there are distinct, higher rates for transporting individuals who are non-ambulatory, accounting for the cost of vehicle modifications and additional time for picking-up these individuals. The assumed number of passengers is unchanged from the rate models for individuals who are ambulatory as it is expected most trips would include a mix of individuals who are and are not ambulatory. As it relates to Transportation-Additional Component services (service code 880), it is not expected that staff would have modified vehicles so it is more likely that these services would involve agency-owned or leased vehicles that can accommodate more than a single individual.

There are not specific rates targeted to individuals who may have behavioral or other challenges and it is expected these individuals would be served at the recommended rates. Additionally, Transportation Assistant (service code 882) can be used to support individuals who require more intensive staffing.

181. Commenters stated the rate models assume full attendance, but should include an absence factor, stating it is inconsistent to include an absence factor for day programs but not for transportation services.

The rate models for transportation services include an assumption regarding the typical number of passengers transported: two passengers per one-way trip for Transportation-Additional Component (service code 880) and eight passengers for Transportation Company services (service code 875). As observed by the commenters, the rate models for transportation services do not include a specific absence factor. Unlike day programs – which are assumed to be vendored for a specific ratio, necessitating the need for an absence factor to account for absences that result in attendance lower than the approved ratio – the rate models for transportation services do not seek to differentiate between scheduled and actual attendance; they only seek to reflect the actual average number of passengers who will be transported.

182. Several commenters stated the wage assumption in the Transportation Company rate models are too low, noting drivers must have Class A or Class B licenses and other transportation providers (for example, city bus lines and school districts) pay higher wages.

The recommended rate model for the combination of Transportation Company (service code 875) and Transportation-Additional Component (service code 880) services used the same wage assumption as for direct support professionals in day programs. As part of the establishment of separate rate models for the two services as discussed in the response to comment 174, the wage assumption in the Transportation Company rate model has been revised to reflect the Bureau of Labor Statistics occupational classification for 'bus driver, school or special client'. This change increases the wage assumption in the base rate model from $14.89 per hour to $19.86.

183. Commenters objected to the use of the Internal Revenue Service's standard mileage rate to estimate the cost of acquiring and operating a vehicle, noting high costs associated with purchasing and modifying larger vehicles, maintenance, insurance, and fuel.

As discussed in the response to comment 62, the updated rate models rely on the Internal Revenue Services' 2020 standard rate of $0.575 per mile to account for all vehicle-related expenses, including acquisition and depreciation, registration, maintenance and repairs, gasoline, and insurance.

The IRS does not detail the individual cost estimates for each component of its mileage rate, except for the value of depreciation, which is $0.27 per mile in 2020. As noted by the commenters, however, the IRS mileage rate is based on typical vehicles and not large vans or modified vehicles that transportation providers may use. In response to this comment, the Transportation Company (service code 875) rate model was updated with a customized depreciation rate. Based on an assumed acquisition cost of $40,000, a useful life of 125,000 miles, and a 10 percent resale value, the depreciation rate is $0.27 per mile. Respondents to the provider survey for Transportation Company services reported an average acquisition value of less than $40,000 and generally reported operating vehicles for more than 125,000 miles. No changes to the IRS rate were made for operating costs.

The IRS' standard mileage rate continues to be used in the Transportation-Additional Component (service code 880) rate model as these services are assumed to generally use typical sedans and minivans.

The non-ambulatory rates for both Transportation Company and Transportation-Additional Component services additionally include depreciation costs for vehicle modifications.

184. Commenters objected to the "linking" of the transportation broker to transportation providers as brokers are unable to provide transportation services. Commenters stated Transportation Coordination is not necessary for day programs or residential providers. Commenters also stated transportation brokers should not receive all administrative funding while transportation companies absorb all the costs. Additionally, commenters stated program operations and administrative funding should be added to the rate models for transportation services to account for expenses such as depreciation; repair and maintenance; tolls, vehicle storage costs; parking fees; interior and exterior vehicle cleaning; vehicle purchase costs; general, liability, and vehicle insurance; communication devices; dispatch operations; and uniforms.

The rate study did not recommend transportation brokers be part of all transportation services or suggest brokers can provide transportation services. Rather, the rate study recommended the establishment of a Transportation Coordination service to account for the program operations and administrative costs of transportation services. It was envisioned that every one-way trip would consist of two billings: one for Transportation Coordination and one for transportation services. When the transportation was arranged through a broker, the broker would bill the Transportation Coordination rate while the transportation provider would bill the transportation services rates. For instances in which no broker is involved, the transportation provider (such as a Community-Based Day Program vendor) would bill both rates. In response to this comment, however, that recommendation has been withdrawn.

Instead, 12 percent for administration was added to the rate models for Transportation-Additional Component (service code 880) since this would be the result if transportation costs were bundled into the rate. No additional funding was added for program operations since these costs are assumed to already be included in the Community-Based Day Program rate models (that is, the program operations funding is based on a fixed daily amount per direct support professional so this assumption would not change if transportation had been bundled into the Community-Based Day Program rate models).

Both 12 percent for administration and $10 per trip for program operations was added to the rate models for Transportation Company (service code 875). These assumptions are intended to cover the non-vehicle costs mentioned by the commenters while vehicle-related expenses are intended to be covered by the mileage rate as discussed in the response to comment 183.

185. Commenters indicated not all members transported are authorized for transportation services.

Current regulations allow two different approaches for paying for transportation services provided by Community-Based Day Programs. Regional Centers and vendors may establish Community-Based Day Program rates that include the cost of transporting individuals to and from the day program. Individuals served by these vendors would not have a separate authorization for transportation. Or, Regional Centers may establish Community-Based Day Program rates that do not include the cost of transportation. In these instances, an individual receiving transportation to and from their day program would have two authorizations: one for the day program and one for transportation. As part

of the standardization of rate methodologies, the rate study assumes there would no longer be Community-Based Day Program rates that include transportation costs. So individuals receiving transportation services would have separate authorizations for their day program service and for transportation. Other than that, the rate study did not include any recommendations regarding who receives an authorization for transportation services.

Transportation Broker (Service Code 883)

186. Commenters objected to the replacement of the Transportation Broker service with a Transportation Coordination service. Commenters outlined the various responsibilities of brokers, including transportation routing and scheduling, maintaining a database of vehicle capacities by vendor across a Regional Center, overseeing transportation companies' invoices, providing vendor contract administration and contract compliance training, providing toll-free bilingual customer service, and travel training and re-training.

As discussed in the response to comment 184, the recommendation to establish a Transportation Coordination service that accounts for the operating and administrative functions of transportation services and is billed by the entity responsible for these functions (a transportation broker when applicable or the transportation provider when no broker is involved) has been withdrawn. Instead, the existing Transportation Broker service (service code 883) would be retained, reflecting their current functions.

187. Commenters stated the rate model assumptions related to program operations and administration are insufficient.

The rate models for Transportation Broker services (service code 883) include $10.00 per one-way trip for program operations and 12 percent of the cost of a trip provided by a Transportation Company (service code 875) for administration. As discussed in the responses to comments 61 and 65, respectively, these assumptions are based on data collected through the provider survey and standardized across services.

188. Commenters stated there should not be separate rates based on the mobility status of the individual.

The rate study recommends a different, higher rate for brokering services for individuals who are non-ambulatory because there are fewer options for these individuals, requiring more effort on the part of the broker to arrange transportation.

Transportation Assistant (Service Code 882)

189. Commenters asked whether the "Transportation Assistant" service was the same as the previous "Transportation Aide" service.

The rate study uses the service title found in regulations for service code 882, which is Transportation Assistant, although it is noted that regulations define the worker providing the service as a transportation aide.

190. Commenters questioned how a one-to-five ratio would work for a transportation assistant in a small car that only accommodates two or three passengers in addition to the driver.

As discussed in the response to comment 174, separate rate models have been established for Transportation Company (service code 880) and Transportation-Additional Component (service code 875) rather than a single, combined rate model based on five passengers as originally recommended. The Transportation Company rate model assumes eight passengers and the Transportation-Additional Component assumes two passengers. These passenger assumptions are intended to accommodate individuals who require an assistant, but vendors must continue to ensure the appropriateness of transportation arrangements based on the needs of individuals.

191. Commenters stated there should be a higher wage assumption for services provided to individuals with complex behaviors. Commenters stated the general wage assumption should reflect a behavioral paraprofessional.

The only regulatory qualifications for staff providing Transportation Assistance services (service code 882) is that they must be at least 18 years of age and competent in the use of equipment to transport, board, and exit individuals when applicable. The wage assumption in the rate model for the service therefore reflects staff providing personal assistance type support. If an individual requires more specialized support when being transported, those services can be billed through the service code applicable to the staff person (for example, behavioral paraprofessionals and technicians may be billed through service code 616).

192. Commenters stated the Transportation Assistant rate model should be revised to acknowledge that workers' time is only billable when an individual needing assistance is in the vehicle.

The rate study recognizes Transportation Assistance services (service code 882) can only be billed when the worker is supporting an individual. As with the rate models for nearly every service included in the rate study, the Transportation Assistant rate model includes productivity factors to account for workers' other, non-billable responsibilities. In response to this comment, an additional factor was included for time spent in the vehicle without an individual present. Before adjustments for training and paid time off, and the assumed mix of full-time and part-time staff discussed in the response to comment 51, the base rate model now assumes staff provide 37.0 hours of direct service per week compared to 36.8 hours (weighted average) to 37.4 hours (median) reported in the provider survey.

193. Commenters stated the rate model for Transportation Assistant services should include $10 per day for program operations and 12 percent for administration as in the rate models for other services.

Since the Transportation Assistant service (service code 882) is additive to other services that already account for program operations and administrative expenses (that is, Transportation Company through service code 875 and Transportation-Additional Component through service code 880), the rate model for Transportation Assistant includes a reduced amount for these factors. Specifically, the rate models include six percent for administration to account for additional costs for providing the service (such as hiring and billing) and do not include a factor for program operations.

Supported Employment-Individual (Service Code 952), Supported Employment-Group (Service Code 950), and Employment Services Provided Through Miscellaneous Service Codes

194. Commenters stated the recommended rates for individual services are lower than current rates while recommended rates are higher for group and sheltered employment services. Commenters stated these rates do not support system goals for individualized jobs in integrated settings and do not limit the approval of subminimum wage certificates. Commenters stated Supported Employment-Group rates will be reduced by as much as 62 percent.

As noted by the commenters, the base rate model for Supported Employment-Individual Job Coaching services produced a rate about two percent lower than the current rate. That said, the rate models produced higher rates for Job Coaching in some Regional Centers, Supported Employment-Individual Job Development, and Supported Employment-Group services. For these services overall, the rate study recommended an increase in rates. With the various changes to the rate models described in this subsection, all of the rate models exceed the existing rates. For Job Coaching rates in particular, the rates are at least 16 percent greater than the rate in effect on July 1, 2019, although this is moderated by the fact that vendors would no longer be permitted to bill for time spent traveling to individuals since this time is built into the rate model as a productivity adjustment. These changes emphasize the importance of employment services.

It is unclear what rates commenters may have been referencing when asserting that Supported Employment-Group rates would be reduced by more than 60 percent. Even before the rate adjustments described in this subsection, all group rates exceeded the current rate when taking into account that the rates are billed per individual served (for example, the base rate model for an eight-person group is $6.67 per person per hour, which translates to $53.36 per job coach hour compared to the July 1, 2019 rate of $36.57).

The rate study did not consider the issue of subminimum wage certificates.

195. Commenters suggested the establishment of a specialized rate for customized employment or other one-to-one integrated employment that includes enhanced rates and differing productivity, wage, and other assumptions from what was presented in the proposed rate models.

The rate models for Supported Employment-Individual services are intended to reflect the costs associated with providing one-to-one employment. As discussed in the response to comment 8, all rate model assumptions are intended to reflect a reasonable approximation of the costs of providing services consistent with the State's regulations and individuals' service plans. It is therefore expected that for any given program, some costs would be higher than assumed and others would be lower.

196. Commenters stated current funding for job development is insufficient to cover the cost of job placement, even when considering the incentive payments received upon job placement. Commenters objected to the recommendation to limit job development activities to 40 hours per individual plan year. Additionally, commenters indicated a need for a job discovery service to cover activities such as skills assessment and vocational profile development.

The rate study recognizes Job Development services – including the job discovery activities cited by the commenters – differ from Job Coaching services as it relates to the skillset, wage level, and productivity of the staff providing the services. For this reason, the rate study recommended the

establishment of a separate, higher rates for Job Development. With the various changes to the rate models described in this subsection, all of these rates are at least 48 percent greater than the existing Supported Employment-Individual rate. The rate study did not recommend any changes to the existing incentive payments.

The rate study recommended a limit of 40 hours of Job Development services per individual plan year based on a review of limits in place in other states. In response to this comment, the recommended limit has been increased to 100 hours, which was the median number of hours needed to place an individual in employment according to participants in the provider survey (the weighted average was 108 hours). There would also be a process to request an exception to this limit.

197. Commenters suggested changes to Department of Rehabilitation requirements regarding eligibility, payments, and fading.

If the rate study is implemented, the Department of Rehabilitation would be involved in the development of policies that affect their programs.

198. Commenters expressed support for the addition of a one-to-two staffing ratio for Supported Employment-Group. Separately, commenters expressed concern that the rate models favor smaller groups because the rate models for larger groups did not account for additional costs, such as the need for more program staff and more time for recordkeeping.

Support for the recommendation that Supported Employment-Group services be available at a one-to-two staffing ratio is appreciated. This is intended to fill a gap in which Supported Employment-Individual provides one-to-one support, but Supported Employment-Group does not allow for groups with ratios less than one-to-three.

The rate models do include more time for recordkeeping as the size of the group increases. As noted by the commenters, this is the only difference in the rates models for the various staffing ratios. This results in slightly more funding per staff hour for larger groups than for smaller groups. Using the base rate models as an example, a vendor delivering services at a one-to-eight ratio would bill $53.36 per hour compared to the $52.00 billed by a vendor operating at a one-to-two ratio. The rate models for all Supported Employment-Group services exceed the Supported Employment-Individual rate models to account for the additional costs associated with group services. As of July 1, 2019, vendors earn the exact same amount – $36.57 – per staff hour for one-to-one services and for group services regardless of the size of the group.

199. Commenters stated Supported Employment-Group services should be billed by job coach rather than by individual to account for potential absences. Separately, commenters asked whether a vendor's rate would change when a participant is absent (for example, if one individual in a four-person group is absent, does the vendor bill the three-person rate).

Supported Employment-Group services are currently billed according to the hours worked by the job coach. The rate study recommends services be billed by individual based on the number of hours of service that each receives. This change was recommended to increase transparency into the amount of support individuals actually receive and the cost of those supports.

An individual would be authorized for a specific group size based upon the staffing ratio of the group in which they are working. As discussed in the response to comment 150, the rate models include an attendance factor to account for absences so the rate billed by the vendor does not change when one

or more group participants is absent. If the group composition permanently changes, the authorizations for the individuals in the group can be revised to reflect the new ratio.

200. Commenters stated the wage assumption in the Supported Employment rate models is too low.

As discussed in the response to comment 32, the rate models rely upon data from the Bureau of Labor Statistics to set the wage assumptions. The wage assumption for Supported Employment-Individual and Supported Employment-Group was tied to the median wage for rehabilitation counselors although this position typically requires a master's degree and there is no such requirement for Supported Employment-Group staff. The resulting wage assumption was $16.20 per hour, which was significantly higher than the average of less than $14.00 reported by respondents to the provider survey.

In response to this comment and to provide further support for employment services, the rate model was adjusted to include the BLS classification for educational, guidance, school, and vocational counselors (also a master's level position), weighted at 25 percent of the overall wage. This increased the wage assumption to $20.81 per hour.

201. Commenters stated the direct support professional rate 'tiers' should apply to Supported Employment services.

The rate study did recommend Supported Employment-Individual Job Coaching and Supported Employment-Group services be eligible for the tiered DSP rates. The tiered DSP rates would not apply to Job Development services as these staff are providing services that are meaningfully different from direct support.

202. Commenters stated the Supported Employment rate models should include an assumption for supervision, stating the lack of an assumption implies the job coach is a professional, but the hourly wage is too low to be considered a professional.

As discussed in the response to comment 58, the rate models for services provided by paraprofessionals include one supervisor for every ten paraprofessionals. For professional staff (generally those with at least a bachelor's degree), the rate models assume less supervision is needed. As discussed in the response to comment 200, the Supported Employment rate models are based on Bureau of Labor Statistics wages for various master's level occupations. That response also notes the recommended wage assumption has been increased. Consequently, the Supported Employment rate models do not include a specific provision for supervision. However, the program operations assumption, which is discussed in the response to comment 61, in the rate models for professional staff – including Supported Employment – is twice as much as in the rate models for paraprofessionals to account for a level of oversight.

203. Commenters stated the rate models should include the cost of accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF), which is statutorily required for Supported Employment services. Commenters proposed eliminating the CARF accreditation requirement.

In response to this comment, a cost factor for CARF accreditation was added to the Supported Employment rate models. Specifically, the models assume a $10,000 cost incurred every three years (for an annual cost of $3,333) spread over five job coaches or job developers.

204. Commenters objected to various productivity assumptions, stating the allotted time should be increased for traveling between service encounters, supervision and other employer time, collateral contacts, and recordkeeping.

In response to this comment, assumed travel time in the base rate model for Supported Employment-Individual Job Coaching was increased to three hours per week for a full-time job coach. The productivity assumptions were otherwise unchanged and are consistent with the total reported in the provider survey. Before adjustments for training, paid time off, and the assumed mix of full-time and part-time staff discussed in the response to comment 51, the rate models assumed job coaches providing individual supports deliver 34.25 billable hours per week compared to 33.8 hours (weighted average) to 34.6 hours (median) reported in the provider survey. Depending on the group size, the rate models for Supported Employment-Group assume the job coach provides 36.75 to 38.25 billable hours per week compared to 36.6 hours (weighted average) to 37.5 hours (median) reported in the provider survey.

The number of miles assumed in the Supported Employment-Individual rate model was also increased from 100 miles per job coach per week to 150 miles. Respondents to the provider survey reported 66 miles (median) to 109 miles (weighted average) for job coaches.

205. Commenters stated costs to transport members to work were not included in the rate models but are incurred by their program. Commenters suggested travel time should be billable when transporting members to their worksite.

The rate models for both Supported Employment-Individual and Supported Employment Group services include a mileage assumption, which is intended to include miles traveled to transport individuals to the worksite. There is not a productivity adjustment for the job coach's time because the time spent transporting an individual or individuals to the worksite is intended to be billable.

Work Activity Program (Service Code 954)

206. Commenters objected to rate reductions they stated could be as much as 50 percent, particularly because existing rates were based on past cost statements. Separately, commenters stated the proposed rates will push vendors to higher staffing ratios, which may result in the closure of lower ratio programs.

As with all rate models, the recommended rates for Work Activity Programs are based upon specific, detailed assumptions. Based on these rate models, it is estimated rates would be reduced by an average of 17.4 percent.

Whereas current rates are based on the overall size of the Work Activity Program vendor (as measured by the total number of individuals served), the rate models vary rates based on staffing ratio. That is, vendors operating at lower ratios require more staff so the rates for these programs are higher. Thus, the actual impact would vary by vendor with programs with smaller staffing ratios (that is, fewer individuals per direct support professional) being impacted the least. For example, for a program serving individuals at a one-to-four ratio, vendors would experience a rate increase; based on the current upper limit rates and assuming a six-hour day, the base rate model is five percent higher for small vendors, 32 percent higher for medium vendors, and 68 percent higher for large vendors. Conversely, if vendors currently operate at very high ratios, they would experience significant reductions. For example, for any program operating at a ratio of one DSP for 35 individuals, the

upper limit rates translate to between $194 and $363 per DSP work hour, but the recommended rate model would pay $79.10 per staff hour.

207. Commenters objected to various productivity assumptions, stating the allotted time should be increased for program set-up and clean-up, supervision and other employer time, and recordkeeping. Additionally, commenters stated standardized productivity factors are inflexible and not responsive to individual needs.

Before accounting for training and paid time off, the rate models assume direct support professionals in Work Activity Programs provide direct services for between 35.25 and 36.75 hours per 40-hour week, depending on the staffing ratio (with lower productivity for DSPs serving more individuals). Other than adjustments for the mix of full-time and part-time staff discussed in the response to comment 51, these estimates are unchanged and are generally consistent with figures reported by participants in the provider survey: large programs reported 34.6 hours (weighted average)/ 36.1 hours (median), medium programs reported 35.3 hours (weighted average)/ 34.8 hours (median), and small program reported 34.2 hours (weighted average)/ 35.9 hours (median).

As with all rate model assumptions, the productivity estimates are intended to reflect a reasonable approximation of typical operations. It is therefore expected that for any given vendor, some productivity adjustments would be higher than assumed and others would be lower.

Socialization Training Program (Service Code 028) and Creative Arts Program (Service Code 094)

208. Commenters objected to the proposal to eliminate the separate service codes for Socialization Training Programs and Creative Arts Programs, and to bill for these services based on the rate models for Community-Based Day Programs.

In response to this comment, the proposal to wrap Socialization Training Programs and Creative Arts Programs into the Community-Based Day Program rates framework has been withdrawn at this time. Consistent with the goals of the rate study to ensure the appropriateness and consistency of rate methodologies, rates for these services may be reconsidered if the rate study is implemented and regulations are developed.

PROFESSIONAL SERVICES

This section summarizes comments related to services the rate study categorized as 'professional services', including behavioral services; Adaptive Skills Training; Specialized Therapeutic Services; Infant Development Programs; Crisis Supports; Specialized Health, Treatment and Training services; and Specialized Recreational Therapy. Note that most comments related to wage, benefit, and administrative assumptions are addressed in the Across Services section.

Multiple Services

209. Commenters stated vendors provide therapy and other clinical supports through independent contractors, not employees, who are paid at a higher rate to cover taxes, insurance and other benefits, and overhead expenses. Similarly, commenters stated some vendors themselves are independent contractors who must pay the employer share of payroll taxes and who do not receive health benefits, sick leave, retirement contributions, or vacation time.

Vendors may provide services through clinicians they directly employ or with whom they contract. The rate models assume the clinicians are employees, but this is not intended to have an impact on the cost. Regardless of whether the clinician is an employee or a contractor, the rate models seek to cover the same costs: salary, the ability to access benefits, non-billable responsibilities, administrative costs, etc. In an employment model, these are separate costs. In a contractor model, all of the costs are combined into the hourly rate charged by the contractor, which must cover all their costs (for example, covering the value of their time when performing non-billable tasks or taking time off as well as business costs such as payroll taxes and administrative functions). Thus, while there are differences in the manner in which costs are incurred (that is, as separate expenses or in a single bundled rate) and in how clinicians are paid (that is, for every hour worked or only for time spent providing the contracted service), the rate models assume total costs are equivalent.

Infant Development Program (Service Code 805)

210. Commenters expressed support for increasing standardization in payment models for Infant Development Programs across Regional Centers and further suggested various service requirements should be standardized, including credentialing, programming, documentation, and billing. Separately, commenters objected to recommended reductions in payment rates for Infant Development Programs and Early Start Specialized Therapeutic Services provided through service code 116, stating this is inconsistent with the State's goals for early intervention services.

As noted in the response to comment 20, one of the purposes of the rate study is to increase the consistency of services and payment models across California. As discussed throughout this subsection, a number of changes have been made to the rate models for Infant Development Programs and Early Start Specialized Therapeutic Services in response to public comments.

The suggestions related to standardization of service requirements are appreciated. If the rate study is implemented, these suggestions would be considered.

211. Commenters questioned whether Infant Development Programs should have been included in the rate study since the service is largely funded by Part C of the federal Individuals with Disabilities Education Act (IDEA). Additionally, commenters stated the rate study recommended

changes that do not comply with program regulations requiring a multi-disciplinary, team-based approach, which may compromise the State's ability to access Part C funds.

The funding composition for a given service was not a consideration in determining the scope of the rate study. Federal funds granted through Part C of IDEA cover only a small portion of the cost of Infant Development Programs and other early intervention services. For example, the State received approximately $55 million in Part C funds in fiscal year 2017, but spent more than $180 million on Infant Development Programs alone.

The rate study does not include recommendations for changes to service requirements for Infant Development Programs. That is, early intervention services must still be family-centered, multidisciplinary, and delivered in the most natural environment. Changes to how the State pays for services do not conflict with federal or State requirements and do not put at risk the State's Part C funds.

212. Commenters questioned why therapy services were excluded from the rate study. Additionally, commenters suggested rates should be established for therapy assistants.

As discussed later in the response to comment 221, the rate study recommended rates for therapists and other clinicians be tied to Medi-Cal's rates for these clinicians. In response to this comment, this recommendation has been withdrawn and specific rate models have been developed for therapists and therapy assistants, which are further discussed in the response to comment 213.

213. Commenters suggested vendors should continue to have a single rate regardless of the staff person delivering the service, stating this promotes an integrated and interdisciplinary service model, allows vendors to hire new staff, minimizes billing complexity, and supports flexibility in service delivery. Conversely, commenters suggested there should be different rates for different service providers, particularly for therapists.

A fundamental goal of the rate study is the development of rate models that reflect the estimated costs to deliver services. The single largest cost for most vendors is the wages of the staff providing services. In general, it is expected vendors set wages based on staff qualifications. For example, an employee with a master's degree is expected to earn more than an employee with a bachelor's degree and a therapist is expected to earn more than a therapy assistant. Since vendors' costs vary based on who they employ, the rate they are paid should similarly vary. Further, if a single, blended rate is created, it would have the impact of underpaying the 'higher-level' staff and overpaying relatively less-qualified staff, thereby disincentivizing the use of the highest-cost staff.

For this reason, separate rate models have been established for the variety of disciplines that provide early intervention services, including early intervention specialists, therapists, audiologists, family therapists, registered nurses, dieticians, social workers, and psychologists. The establishment of these rates is intended to account for differences in the cost of employing these various professionals, but does not change the integrated and interdisciplinary service model.

For therapists specifically, it is recognized these are different disciplines, but it is assumed the structure of the services – in terms of the typical length of a service, the number of billable hours that can be provided, etc. – are similar. Further, according to the Bureau of Labor Statistics data used to develop wage assumptions, the difference in the median wage for the three disciplines was only five percent so the rate models used the highest of the three wages ($50.34 per hour for a physical therapist).

Rate models were also developed for therapy assistants. As with therapists, there is a single rate model for certified occupational therapy assistants (COTAs), physical therapy assistants, and speech-language pathology assistants based on the highest median wage reported by the BLS for these occupations ($36.19 per hour for COTAs).

To better track early intervention services and spending, services that are part of the infant development program and provided by occupational therapists, physical therapists, and speech language pathologists would be billed through service code 805 rather than service code 116. Separate subcodes under service code 805 would be established for each staffing classification and tied to the appropriate rate model.

214. Commenters asked about the qualifications of staff included in the 'licensed professional', 'specialist', and' paraprofessional' rate models. Commenters stated the rates should be the same for staff with master's and bachelor's degrees because they "perform exactly the same work". Regarding the paraprofessional job type, commenters stated tying the wage assumption to therapy aides does not reflect the responsibilities of these staff and additionally noted this position would be supervised by a therapist-level staff. Separately, commenters stated requiring an early childhood specialization or certification is not appropriate for "behavioral services" and these positions should require registered behavior technicians.

In response to this comment, the rate models for early intervention staff have been reworked to reflect the definitions found in the 2010 Early Start Personnel Manual.[4]

The Early Intervention Specialist (EIS) must have at least a bachelor's degree and either a current California Education Specialist Credential granted by the California Commission on Teacher Credentialing (CCTC), a current Added Authorization in Early Childhood Special Education granted by CCTC, or a California University Certificate in Early Intervention.

The Early Intervention Assistant (EIA) must have either a minimum of an associate's degree plus a California Community College Early Intervention Assistant Certificate, or an associate's degree in Child Development or a related field plus the equivalent of an associate teacher California Child Development permit (12 units) plus coursework to meet EIA competencies including supervised fieldwork in early intervention. To better reflect the educational requirements and responsibilities of the EIA, the wage assumption is now tied to teacher assistants. The rate models for EIAs assume they are supervised by EISs.

Given the nature of Infant Development Programs, the early intervention focus of these personnel are appropriate. Different services and service codes are available for individuals who require behavioral supports, including services provided by registered behavior technicians.

As discussed in the response to comment 213, separate rate models have been developed to reflect differences in the cost of employing various types of staff, including EISs and EIAs. Further, as also noted in the response to comment 213, separate rate models have been developed for other staff who provide early intervention services, such as therapists and psychologists.

215. Commenters stated supervisors' spans of control should be reduced (that is, supervisors should be responsible for fewer staff). Additionally, commenters stated the rate models for licensed staff

[4] California Interagency Coordinating Council on Early Intervention. (November 2010). Retrieved from https://www.dds.ca.gov/EarlyStart/docs/ICC_PersonnelManual.pdf.

should include an assumption for supervision. Further, commenters stated the wage assumptions for supervisors are too low.

As discussed in the response to comment 58, the rate models for services provided by paraprofessionals include one supervisor for every ten paraprofessionals. As described in the rate study report, this ratio is consistent with results reported by researchers and assumptions built into rate models for home and community-based services in other states. Although these findings primarily relate to direct support professionals, the assumed ratio is also consistent with data reported by participants in the provider survey. For example, respondents reported about 620,000 direct care worker hours for community-based services and 50,000 supervisor hours, implying a ratio of one supervisor for every 12 direct care workers, although this ratio may be somewhat overstated because the direct care hours likely include licensed staff.

The rate models for licensed staff do not include a supervision assumption because, by definition, these staff are permitted to work without supervision. However, the program operations assumption – which is discussed in the response to comment 61 – in the rate models for licensed staff is twice as much as in the rate models for paraprofessionals to account for a level of oversight.

The rate models for Early Intervention Assistants assume they are supervised by Early Intervention Specialists and the rate models for EISs assume they are supervised by a therapist. The wage assumptions associated with the EIS and therapist positions are unchanged.

216. Commenters stated the 'specialist' position as defined in the rate study will not be qualified to complete an evaluation.

As discussed in the response to comment 214, the categorization of early intervention staff has been revised to reflect the Early Intervention Specialist and Early Intervention Assistant positions as described in the 2010 Early Start Personnel Manual. Further, as discussed in the response to comment 213, separate rate models have been established for other professionals who provide early intervention services, including therapists. The rate study does not seek to change the scope of practice – including qualifications to perform evaluations – for any staffing classification.

217. Commenters objected to various productivity assumptions, stating the allotted time should be increased for traveling between service encounters, collateral contacts, recordkeeping, missed appointments, and training. Additionally, commenters suggested set-up and clean-up time should be added to the rate models. Commenters also stated all Infant Development Program rate models, regardless of staff position, should include the same productivity assumptions.

In response to this comment, a number of changes to the productivity assumptions have been made, including:

- An increase in assumed travel time for community-based services, coupled with a related increase in the mileage assumption,
- An increase in the assumed time for recordkeeping and reporting,
- An increase in the assumed time for collateral contacts,
- The establishment of a productivity adjustment for 'interdisciplinary team case reviews/ planning', and
- The addition of time for program set-up and clean-up for center-based services.

With these changes, the assumed number of billable hours delivered by staff has decreased, thereby increasing the resultant rates. In general, the assumed productivity is now less than reported in the provider survey. For example, the rate model for Early Intervention Specialists assumes staff provide 26 hours of direct services per week – before further downward adjustments to account for training and paid time off – compared to the 27 hours (weighted average) to 31 hours (median) reported in the provider survey.

In general, the productivity adjustments are similar across the various staff who may provide Infant Development Program services. The rate models for Early Intervention Assistants provide more time for supervision and other employer time as well as training, but less time for collateral contacts.

218. Commenters indicated the square footage assumption for center-based services was too low as it does not accommodate areas for learning activities and playground space. Additionally, commenters stated the cost per square foot assumption is too low.

The rate models for center-based services include 100 square feet of program space for one-to-one services (and more space for one-to-two and one-to-three services). This assumption is consistent with the average reported by provider survey participants.

The $15.00 cost per square foot was generally derived from data collected through the provider survey across various center-based services (the average reported cost for Infant Development Programs was actually lower, about $11.00). As discussed in the response to comment 30, this cost is adjusted based on regional adjustment factors that account for differences in real estate costs across the State: the multiplier is 80 percent ($12.00) for relatively lower-cost areas assigned to category A, 115 percent for category B ($17.25), and 130 percent ($19.50) for high-cost areas assigned to category C.

219. Commenters asked whether multiple staff can bill for the same hour of service when a team approach is employed during the session (for example, two staff are working with the child and family).

More than one staff person would be permitted to bill for the same hour of service when it is determined appropriate for multiple personnel to be working with the child at the same time.

220. Commenters suggested strategies to alleviate the effects of the limited supply of early intervention specialties amidst a high demand for services. Suggestions included shortening the length of therapy sessions, approving tele-practice to reduce travel-related costs, and allowing one discipline to visit the home while devising strategies to ensure input from other disciplines through indirect interventions.

These specific strategies were not considered as part of the rate study, but could be if regulations are developed to implement the rate study.

Specialized Therapeutic Services (Service Codes 115, 116, and 117)

221. ***Commenters objected to the recommendation that services currently billed under service codes 115, 116, and 117 be instead billed under other service codes established for therapists and tied to Medi-Cal rates, stating these rates are insufficient and expressing concern about the impacts on service recipients and staff.***

In an effort to increase conformity across the Medi-Cal system, the rate study recommended services currently billed under service codes 115, 116, and 117 be tied to other service codes specifically established for therapy services (for example, service code 772 for physical therapy) with rates tied to those paid by Medi-Cal for fee-for-service. Recognizing there could be key differences in serving the DDS population – for example, to account for the cost of primarily community-based (rather than clinic-based) services and of additional training to effectively work with people with disabilities – the rate study recommended Regional Centers be able to approve a rate enhancement of up to 39.7 percent above the Medi-Cal rates.

In response to this comment, however, that recommendation has been withdrawn and specific rate models for Specialized Therapeutic Services have been developed.

222. Commenters stated the elimination of the 116 service code would prevent early intervention services.

The rate study did not recommend the elimination of service code 116 and other Specialized Therapeutic Services. Rather, the rate study recommended the payment rates be tied to Medi-Cal payment rates. As noted in response to comment 221, however, this recommendation has been withdrawn and rate models have been established for these services.

As noted in the response to comment 213, it is recommended that services provided as part of an Infant Development Program and currently billed under service code 116 would be billed through service code 805 – based on the rates established by the rate models for therapy services created in response to public comments – in order to 'capture' early intervention spending in one service code.

223. Commenters suggested speech and language pathologists should have a separate service code.

As discussed in the response to comment 213 related to therapy services within early intervention programs, there is a combined rate model for services delivered by occupational therapists, physical therapists, and speech language pathologists based on commonalities related to therapist wages and service structures. Depending on the age of the individual receiving services, the therapist may bill under service codes 115, 116, 117, or 805. Although the rates would be the same, subcodes may be established for each therapeutic discipline to track who is providing services.

224. Commenters stated the wages for licensed vocational nurses, licensed psychiatric technicians, psychiatric nurses, and licensed marriage and family therapists should be raised to the 75th percentile of the BLS wage for each occupation.

As discussed in the response to comment 32, the rate study uses the median wage value reported by the Bureau of Labor Statistics for selected occupations. Since the median represents the wage at which half of the employees in an occupation earn more and half earn less, this is assumed to be a reasonable market wage.

225. Commenters stated there should be rates for two-to-one and three-to-one staffing ratios because of the complexity of issues with some individuals.

More than one staff person would be permitted to bill for the same hour of service when it is determined appropriate for multiple personnel to be working with the individual at the same time.

226. Commenters made suggestions to narrow the scope of Specialized Therapeutic Services, including increasing staff experience and training requirements, requiring all services to follow a time-limited model with continuous caregiver training and transition planning from the outset, and establishing entrance criteria that define an extremely high level of problem behavior severity to qualify.

If the rate study is implemented, these specific strategies could be considered as regulations are developed.

Behavioral Analysts and Related Services (Service Codes 612, 613, 615, 616, and 620)

227. Commenters stated the use of subcodes for non-English rates and short- and long-term rates adds unnecessary complexities for tracking and billing services. Commenters also stated the 'tiered' rates for direct support professionals are unnecessary for these services as there is already a hierarchy of board certified behavior analysts, board certified assistant behavior analysts, and registered behavior technicians

It is acknowledged that the use of additional subcodes would add some complexity in terms of billing, but creating rates to account for differences in vendor costs based on various service characteristics would increase the fairness and transparency of the overall system and support other goals such as reducing service disparities through the establishment of non-English rates.

That said, short- and long-term rates were never proposed for behavioral services (further, this recommendation for various services in the personal supports and training category has been withdrawn). Additionally, there is no requirement that vendors bill the non-English rate when they are eligible to do so. That is, vendors delivering services in the native language of individuals who do not speak English can bill the 'standard' rates rather than the higher non-English rates.

The service codes for behavioral services already reflect the hierarchy of staff qualifications described by the commenters and the rate study includes rate models for each of the service codes. The rate study would also apply the tiered direct support professional framework described in the response to comment 41 to the rates for registered behavior technicians (service code 616) to recognize there are different skillsets associated with being an RBT and a DSP. Thus, the rate study recommends higher rates for employees who are RBTs *and* receive certification for a higher DSP tier. There is no requirement that RBTs pursue the DSP tier certifications.

228. Commenters stated the Bureau of Labor Statistics occupational classifications used to establish wage assumptions in the rate models do not reflect the requirements of these staff. Commenters stated the wage assumptions are too low.

The use of Bureau of Labor Statistics wage data in the rate models is discussed in the response to comment 32. Although extensive, the BLS' classification system does not include standalone occupations for certain behavioral positions. Rather, these positions are folded into broader

occupational classifications. In these cases, the rate study seeks to identify the occupation that is the best fit for a given position in terms of educational requirements and the occupational description.

The BLS does not have a specific occupational classification for registered behavior technicians so they are often assigned to the psychiatric aide classification. In response to this comment and recognizing RBTs often have greater qualifications than other staff included in this BLS classification, the wage assumption for line staff is now tied to the 75th percentile wage level for this BLS classification, which increased the wage assumption in the base rate model from $16.23 per hour to $18.48, or $38,400 annually. This salary is generally consistent with average RBT wages in California reported by various salary tracking firms as of August 15, 2019: Glassdoor.com ($40,300 for a behavior technician in Los Angeles), Indeed.com ($39,100 for an ABA therapist, $39,800 for a behavioral therapist), Payscale.com ($34,600 for an RBT in Los Angeles), Salary.com ($35,600 to $45,700 for an RBT in Los Angeles), and ZipRecruiter ($43,600 for an RBT in Los Angeles).

As with RBTs, there is not a standalone BLS classification for board certified behavior analysts. Rather, BCBAs are included in the classification for clinical, counseling, and school psychologists. The rate models use the median wage for this occupation, which is $52.00 per hour, or $108,200 per year. This assumption is unchanged as the salary compares favorably to average BCBA wages in California reported by various salary tracking firms as of August 15, 2019: Indeed.com ($78,587), Payscale.com ($65,740 in Los Angeles), Salary.com ($65,023), and ZipRecruiter ($88,428).

For behavior management consultants, the rate study uses the average of the median wages for the BLS classifications for mental health and substance abuse social workers and for marriage and family therapists, producing a wage assumption of $26.84 per hour, or $55,800 per year. The average wage reported in the provider survey was $19.16 per hour.

For associate behavior analysts and behavior management assistants, the rate study matches the wage assumption to the median wage for the BLS classification for mental health and substance abuse social workers, which is $23.32 per hour, or $48,500 per year. This assumption is unchanged. Although comparable data from salary tracking firms was not identified for these positions, the wage assumption is consistent with current wages based on the provider survey in which respondents reported an average hourly wage of $21.97 for associate behavior analysts (albeit based on a single response) and $18.14 for behavior management assistants (11 respondents).

229. Commenters asked whether these service codes will be limited to board certified behavior analysts and registered behavior technicians or whether psychologists, psychiatric technicians, etc. would be able to bill under these service codes. Relatedly, commenters recommended that, due to the high demand for RBTs, a rate be developed for uncertified behavior technicians (that is, someone who receives the 40 hours of training for an RBT but who does not require supervision). Additionally, commenters stated licensed marriage and family therapists can oversee behavior programs and that BCBA oversight is unnecessary.

The rate study makes assumptions about the specific staff involved in each service in order to construct rates that reflect these staff. As discussed in the response to comment 228, for example, the rate study assumes behavior analysts (service code 612) are board certified behavior analysts and the paraprofessional service (service code 616) is provided by registered behavior technicians who are supervised by BCBAs.

230. Commenters stated the rate models do not include enough supervision time, noting, for example, that registered behavior technicians must receive supervision equivalent to five percent of their hours worked. Additionally, commenters stated the wage assumption for supervisors is too low.

The rate models for Associate Behavior Analysts (service code 613), Behavior Management Assistants (615) and Paraprofessionals/ Technicians (616) all include supervision time. The rate models for paraprofessionals/ technicians include two hours of supervision per week. This equates to more than seven percent of their assumed direct care hours, exceeding the five percent minimum cited by the commenters. The rate models for associate behavior analysts and behavior management assistants include one hour of supervision per week. The rate models assume all supervision is performed by board certified behavior analysts so the supervisor wage assumption reflects the $108,200 salary for BCBAs discussed in the response to comment 228. To better recognize the full cost of the supervisor, including productivity-related expenses, the rate models now tie the hourly cost to the behavior analyst rate model before program operations and administration (since these costs are added to the total rate). In the base rate model, this has the effect of increasing the hourly cost from $57.85 to $107.92.

231. Commenters objected to various productivity assumptions, stating the allotted time should be increased for traveling between service encounters, recordkeeping, missed appointments, and training.

In response to this comment, a number of changes to the productivity assumptions have been made, including:

- An increase in assumed travel time for community-based services, coupled with a related increase in the mileage assumption for all service codes,
- An increase in the assumed time for recordkeeping and reporting for all service codes, and
- The addition of time for collateral contacts for Behavior Analysts, Associate Behavior Analysts, Behavior Management Assistants, and Behavior Management Consultants.

With these changes, the assumed number of billable hours delivered by staff has decreased, thereby increasing the resultant rates. In general, the assumed productivity is now consistent with or less than reported in the provider survey. For example, the rate model for Behavior Analysts assumes staff provide 26.25 hours of direct services per week – before further downward adjustments to account for training and paid time off – compared to the 26 hours (weighted average) to 30 hours (median) reported in the provider survey.

232. Commenters observed there is no distinction between a clinic-based program and a home-based program.

Participants in the provider survey reported these services are delivered almost exclusively in the community. Specifically, providers reported more than 95 percent of services are provided in individuals' homes or in the community. Accordingly, the rate models are based on a community-based service delivery model and all services would be billed according to these rates, whether delivered in the community or in a clinic.

233. Commenters stated the proposed rates have no flexibility to serve individuals with complex needs, providing no incentive to serve this population.

It is understood that individuals receiving behavioral services often have complex needs and the rate models are intended to reflect the estimated cost of serving this population. As described above, a number of changes have been made to these rate models, resulting in increases in the recommended rates, which generally exceed current rates.

234. Commenters noted they perform enhanced respite services under service codes 612 for behavior analysts and 615 for behavior management assistants, but believe this support should be moved to the service code for agency respite services (service code 862) with a separate subcode and an enhanced rate.

The rate models for In Home Respite Agency services provided through service code 862 reflect a direct support professional position and do not include provisions for 'enhanced' respite. Additional information would be needed to determine whether the 'respite' services currently being provided through service codes 612 and 615 are consistent with the requirements for those services.

Adaptive Skills Trainer (Service Code 605)

235. Commenters objected to the recommendation that the Adaptive Skills Trainer service (service code 605) be eliminated and the existing services transitioned to another service code, stating there are not service codes that correspond to certain staff currently providing this service, other service codes require supervision not required for this service, and that this service can be billed as a group practice.

In response to this comment, the recommendation to eliminate this service code has been withdrawn and rate models have been developed. In particular rate models have been developed for staff with master's degrees and those with bachelor's degrees. Services provided by non-degreed staff should be transitioned to other services, such as Independent Living (service code 520).

236. Commenters stated rate models are needed for greater staffing ratios to accommodate existing social skills programs that operate with larger groups under the Adaptive Skills service.

The rate models for Adaptive Skills include variants for groups of up to three individuals per trainer. There is no provision for larger groups so programs that currently operate with larger ratios would likely need to change their program design.

Crisis Team - Evaluation and Behavioral Intervention (Service Code 017)

237. Commenters offered a variety of feedback related to the rate models for Crisis Team services.

The draft rate models for Crisis Team services have been withdrawn at this time. Consistent with the goals of the rate study to ensure the appropriateness and consistency of rate methodologies, rates for these services may be reconsidered if the rate study is implemented and regulations are developed. The comments received through this comment process would be considered at that time.

Specialized Health, Treatment, and Training Services (Service Code 103)

238. Commenters objected to the recommended elimination of this service code 103 for Specialized Health, Treatment, and Training services, stating the services and staff do not translate to other services or the rates for these other services are inadequate.

There are not regulations that detail requirements for Specialized Health, Treatment, and Training Services. The limited guidance for the service states it covers 'health or dental services', but health and dental services should be provided through Medi-Cal and/or other service codes that cover specific practitioners (for example, Dentistry is covered by service code 715). The service is also inconsistently used; in fiscal year 2016-17, total payments were about $50,000 or less in 9 of the 21 Regional Centers (and there were no payments at all in four of those Regional Centers). For these reasons, the rate study recommends existing supports be transitioned to other programs or service codes.