New Mexico Developmental Disabilities Supports Division

Therapy Rate Study Add-on Report

Public Consulting Group, Inc
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PUBLIC CONSULTING GROUP

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EXECUTIVE SUMMARY

In July 2018, New Mexico Department of Health, Developmental Disabilities Supports Division (DDSD), contracted with Public Consulting Group, Inc. (PCG) to perform a study to recommend reimbursement rates for individuals with intellectual and developmental disabilities receiving services through three 1915(c) Medicaid home- and community-based (HCBS) waiver programs. This included the following waivers: Developmental Disabilities (DD), Medically Fragile (MF) and Mi Via (MV). In January 2020, DDSD contracted with PCG to conduct additional evaluation on specific services to recommend rates. This report is an add-on rate study tailored specifically towards the following providers to collect further data and develop new rate recommendations with the additional information. The following services were included:

- Behavioral Supports Consultation (BSC)
- Physical Therapy (PT)
- Physical Therapy Assistant (PTA)
- Occupational Therapy (OT)
- Certified Occupational Therapy Assistant (COTA)
- Speech-Language Pathology

Only providers of these services in the Developmental Disabilities Waiver and the Medically Fragile waiver would be eligible for participation. No rates were to be set for the Mi Via waiver as those are independently negotiated.

Additionally, several other consultative components were also included in this contract:

1. Analyze and inform on the use of telehealth as an appropriate and cost-effective modality for the following services: BSC and Therapy (OT, PT, SLP, PTA, and COTA) for the DD and MF waivers. This objective includes recommending language to include in the waiver service definition to ensure the use of telehealth as a modality in upcoming renewals.
2. Review and evaluate the DD waiver's tiered rates to determine if the number of tiers, and amount of nursing, on-call coverage expectations, nutritional counseling, and staffing ratios required for each tier are funded at appropriate levels.
3. Provide guidance and recommendations for how needs may be distinguished between tiered rate levels. Including:
    a. Make programmatic recommendations that leverage or incentivize the use of remote technology
    b. Recommend ways to monitor and hold providers accountable in providing appropriate levels of support
    c. Evaluate the pros and cons of a tiered rate methodology

RATE RECOMMENDATIONS

Based on the methodology and data inputs, PCG recommends the HCBS service rate options summarized below and described in the preceding sections. ***These recommendations are intended to be used as guidance and the State of New Mexico, DDSD, may accept all, some, or none of these fiscal recommendations.***

Table 1: PCG Rate Recommendations for the Developmental Disabilities Waiver

Service	Unit	Billable %	Current Rate	Current Incentive Rate	Recommended Rate	Recommended Incentive Rate
Physical Therapy Assistant	15-min	67%	$18.84	$24.71	$23.78	$31.20
Physical Therapy	15-min	51%	$22.90	$29.20	$34.93	$44.54
Certified Occupational Therapy Assistant	15-min	67%	$18.84	$24.71	$23.78	$31.20
Occupational Therapy	15-min	51%	$22.90	$29.20	$34.93	$44.54
Speech-Language Pathology	15-min	51%	$22.90	$29.20	$34.93	$44.54
Behavioral Support Consultant	15-min	54%	$18.34	$23.66	$24.39	$31.46

Table 2: PCG Rate Recommendations for the Medically Fragile Waiver

Service	Unit	Billable %	FY 2020 Rate	FY 2021 Rate	Recommended Rate	Recommended Incentive Rate
Physical Therapy Assistant*	15-min	67%	$18.84	N/A	$23.78	$31.20
Physical Therapy	15-min	51%	$22.90	$25.75	$34.93	$44.54
Certified Occupational Therapy Assistant*	15-min	67%	$18.84	N/A	$23.78	$31.20
Occupational Therapy	15-min	51%	$22.90	$25.75	$34.93	$44.54
Speech-Language Pathology	15-min	51%	$22.90	$25.75	$34.93	$44.54
Behavioral Support Consultant – Clinic Based	15-Min	54%	$11.63	$13.08	$24.39	$31.46
Behavioral Support Consultant	15-min	54%	$19.62	$22.06	$24.39	$31.46

*Denotes service not currently incorporated into MF Waiver service, but is recommended for addition to accurately reflect service delivery in the program. Current rates reflect DD Waiver.

FISCAL IMPACT

PCG has developed a fiscal impact analysis based on all claims submitted April 1, 2019 through March 31, 2020. The Table 3 and Table 4 show the impact overall and per service impact under each waiver.

Table 3: Developmental Disabilities Waiver Fiscal Impact

Service	April 2019 – March 2020 Units	April 2019- March 2020 Expenditures	Rate Recommendation Expenditures	Variance	State Share Cost of Increase (27% State Funds)
Physical Therapy Assistant	80108	$1,752,920.08	$2,029,976.03	$277,055.95	$74,805.11
Physical Therapy	136051	$3,621,694.17	$5,420,011.63	$1,798,317.46	$485,545.71
Certified Occupational Therapy Assistant	69224	$1,518,374.27	$1,804,335.04	$299,080.71	$80,755.73
Occupational Therapy	118807	$3,164,318.35	$4,548,943.21	$1,384,624.86	$373,848.71
Speech-Language Pathology	249194	$6,902,930.16	$9,277,709.67	$2,374,779.51	$641,190.47
Behavioral Support Consultant	316744	$6,554,033.84	$8,118,252.76	$1,564,218.92	$422,339.11
TOTAL		$23,514,270.87	$31,212,348.27	$7,698,077.40	$2,078,484.83

Table 4: Medically Fragile Waiver Fiscal Impact

Service	April 2019 – March 2020 Units	Expenditures Using FY 2021 Rates	Rate Recommendation Expenditures	Variance	State Share Cost of Increase (27% State Funds)
Behavioral Support Consultant – Clinic Based	249	$3,256.92	$6,071.96	$2,815.04	$760.06
Behavioral Support Consultant	1502	$33,134.12	$36,626.83	$3,492.71	$943.03

Impact Limitations and Considerations

State Share

At the outset of the rate study, the state share of expenditure for these waiver services was set at ~27% of total costs. This figure was used to estimate the state share costs of the

implementation of rate recommendations. If this percentage changes, the estimated fiscal impact may also change.

Annual Utilization Changes and Fiscal Year Choice

PCG reviewed historical claims data, but yielded no discernable service growth or contraction. Trends varied greatly over time. For this reason, PCG used the most recent complete one year's worth of service units to reprice these units under the new rate recommendations. No inflationary or growth trend has been applied to the numbers above as recent years have seen reduction, small growth, and exponential increases varied by year and service. Additionally, with service changes due to the current Covid-19 pandemic, inflation or deflation are unknown at this point. As the State is currently negotiating the waiver renewals, PCG has not applied the inflationary costs as the rates are expected to be applied sooner than one year from now.

Medically Fragile Fiscal Impact Expenditures

PCG's fiscal impact methodology for the MF Waiver deviated from the DD waiver due to the new rates implemented on July 1, 2020. In lieu of using actual expenditures as the baseline for comparison, PCG repriced the units from April 1, 2019 to March 31, 2020 using the new rates to set the baseline for expected expenditures.

Medically Fragile Therapy Services

PCG's review, along with DDSD secondary confirmation showed no Physical Therapy, Occupational Therapy, or Speech-Language Pathology services were delivered to Medically Fragile waiver clients during the time-frame in question. After consulting DDSD staff, it was determined this is not unexpected due to the low number of adults on the waiver and low provider participation due to current rates. If the latter element is a correct assessment, DDSD should be prepared to see a small increase in the fiscal impact for the Medically Fragile waiver.

TELEHEALTH REVIEW KEY FINDINGS

By drawing upon reports from the various sources considered, making analogies and using anecdotal evidence, valid general conclusions about appropriateness can be made. Appropriateness is assumed because of the prevalence of use, its use is supported by professional associations, its use is expanding, and its use is encouraged for Medicaid by CMS. However, the appropriate delivery of services via telehealth is contingent upon the regulations, standards and policies by which a state manages service delivery. Current data on cost effectiveness, which requires longitudinal study across a multitude of factors was not found and is beyond the scope of this research. Overall, the use of telehealth can

- Help alleviate provider shortages in remote areas
- Provide access to services for people living in remote areas
- Shorten or eliminate travel time by participants and providers
- Reduce transportation difficulties
- Provide for quicker support in emergent situations
- Eliminate the stress for a participant caused by disruption in routines
- Promote the Collaborative-Consultative Therapy Model
- Facilitate inter-disciplinary team meetings

Telehealth services are becoming more prevalent throughout both health and human services. Rural areas with either low or difficult access to services have been more regularly utilizing telehealth services to help alleviate a lack of providers. With the current COVID-19 pandemic,

these services have taken the forefront of innovative healthcare solutions. While the landscape of these services is rapidly changing due to the pandemic, an opportunity to review real implications and broad adoption of telehealth services is available to DDSD over the coming months. While this section contains an array of research on established policies, PCG urges DDSD to consider further real-time research over the coming months on the following topic areas:

1. Provider adoption of telehealth models
2. Client access to telehealth services (both hardware and internet access)
3. Efficacy of telehealth service delivery
4. Successful models of telehealth services
5. Pitfalls to effective telehealth service delivery

EVALUATION OF DD WAIVER TIERED RATES

Through a review of DDSD service policies and current rates, PCG believes that several key areas may lead to inaccuracy in any tiered rate methodology.

1. PCG recommends that policy language around nursing expectations be reviewed for standardized expectations under each tier. Specific hourly minimums and maximums should be developed if the State wishes to continue bundling this service into a tiered rate model.
2. PCG recommends that DDSD work with nutritional counseling stakeholders (i.e. Dietitians, Case Managers, front-line nursing staff, and physicians) to review the hourly expectations of nutritional counseling within the tiered rate system. This service can have a wide variety of needs. The tiered rate model assumption is that with a large enough client population, providers will usually even-out. This may be true, but could also lead to client selection processes if the over or underpayment on this service deviates too far.
3. PCG believes that direct service provider (DSP) staffing ratios, or 1:1 required hours are sufficient for each tier, but would recommend adding clarity to current DDSD service standard policy.
4. On-call coverage can safely be bundled into a tiered rate methodology, but further discussions with providers of on-call services may be fruitful in understanding provider operations and developing accurate costs.

While the number of tiers is sufficient for a tiered rate model, the population distribution should be monitored for increasing needs. PCG evaluated both past and present utilization data and there appears to be a marked increase in the use of the highest needs service categories. This has not become a statistically valid trend due to lack of historical data, but should be monitored.

PCG RECOMMENDATIONS ON THE USE OF REMOTE TECHNOLOGY

PCG recommends DDSD take three actions to incentivize the use of remote technology:

1. Update the HCBS waiver definitions to provide an explicit foundation for its use at home and in the community that includes coverage for an evaluation for technical support, connectivity, training, technical assistance, equipment service and maintenance.
2. Modify service standards to incorporate structure for providers and natural supports to encourage use in a way that protects participant health, safety, and privacy.

3. Execute an implementation plan to address concerns, build acceptance and create recognition for the benefits of remote technology and ensure a smooth adoption of the new benefit.

PROVIDER MONITORING RECOMMENDATIONS

PCG recommends that DDSD develop a targeted review process to complement the DOH/QMB post payment review process for Supported Living, Customized Community Support, and Community Integrated Employment. This targeted review would incorporate a tool based on the criteria defined in the Clinical Service Criteria V5. The clinical service criteria would be translated to measures for service received by a participant, including minimum staffing ratios and the range and type of support a participant needs. The targeted review would use these measures along with the recommendations in the following paragraph to determine whether a participant received the level of support purchased by DDSD.

PCG also recommends a reliable and valid participant needs assessment tool to ensure integrity of payments. The work to best align payment with participant needs begins with a thorough assessment process using a valid instrument that incorporates inter-relater reliability. The process must include a procedure to consider exceptions that effectively ties a request for increased funds to the cost factors used in developing the rates. Providers should access an online system that allows them to input actual cost factors to support a specific participant into a rate calculator. Costs that do not exceed the rate range upon which a rate was determined would not be approved. Awarding exceptions based on the increase in costs as demonstrated by cost factors provides a transparent and equitable process to support exceptional needs.

CONCLUSIONS ON THE USE OF TIERED RATE METHODOLOGIES

PCG finds that tiered rate methodologies, while widely used, often undercut and misestimate client needs and result in either over- or underpayment to providers. A tiered rate model adds two valuable pros:

1. Predictable state expenditures
2. Better service coordination

However, the cons to a tiered rate methodology with bundled services outweigh these positive aspects. The loss of data integrity, inaccuracy of rates, and inflexibility with policy changes hamper tier rate models. The value of alternatives provides better incentive to move away from these models, either towards an unbundled tier system, which would have far more accuracy in predicting base costs, or a quality based methodology where payment structures are aligned with outcomes. PCG recommends that DDSD re-evaluate the need for bundling of healthcare-oriented services, such as nursing and nutritional services within the payment structure of supported living.

RATE STUDY

In July 2018, New Mexico Department of Health, Developmental Disabilities Supports Division (DDSD), contracted with Public Consulting Group, Inc. (PCG) to perform a study to recommend reimbursement rates for individuals with intellectual and developmental disabilities receiving services through three 1915(c) Medicaid home- and community-based (HCBS) waiver programs. This included the following waivers: Developmental Disabilities (DD), Medically Fragile (MF) and Mi Via (MV). Findings and rate recommendations were made available in June 2019 at the conclusion of that study. In January 2020, DDSD contracted with PCG to conduct additional evaluation on specific services to recommend rates. This report is an add-on rate study tailored specifically towards the following providers to collect further data and develop new rate recommendations with the additional information. The following services were included:

- Behavioral Supports Consultation (BSC)
- Physical Therapy (PT)
- Physical Therapy Assistant (PTA)
- Occupational Therapy (OT)
- Certified Occupational Therapy Assistant (COTA)
- Speech-Language Pathology

Only providers of these services in the Developmental Disabilities Waiver and the Medically Fragile waiver would be eligible for participation. No rates were to be set for the Mi Via waiver as those are independently negotiated.

COST REPORT ANALYSIS

In order to effectively capture both personnel costs and revenues and expenses for HCBS providers, PCG distributed two separate workbooks to New Mexico's provider population: a program cost report and a detailed personnel roster. The cost report was requested to be completed for the provider's most recently completed fiscal year. Some providers completed cost reports for the 2019 calendar year if they operated on calendar instead of fiscal year.

As part of the verification process, PCG reviewed provider-supplied supporting documentation submitted with these workbooks to validate the data and determine if it could be included in the analysis. Though PCG reviewed each of the cost reports and personnel rosters submitted for accuracy, completeness, and reasonableness, there still may be discrepancies in data since supporting documentation was not always available. The table below provides an overview of the elements captured in both workbooks.

Table 5: Data Elements Captured by Cost Report

Cost Report*
• Provider name, tax status and contact general information • Program revenue from HCBS waivers, the state, and other sources • Aggregate average paid non-working time allocated for all staff • Total salaries, taxes, and fringe benefits paid for program staff

• Comprehensive expenses other than personnel, e.g. mileage, insurance, facilities, other taxes, etc. • An attestation from the provider claiming that the results provided were complete and accurate

*Note that the cost report requested the *total* provider information in all activities they may conduct with an automated percentage applied based on provider reported revenue coming from DD and MF waiver services. This was a result of provider feedback during the Cost Report redesign.

In total, PCG received cost reports from 21 individual providers. Through our quality assurance process and working with providers on obtaining any necessary corrections or supporting documentation, all 21 submissions were determined to be viable. Table 6 outlines the total submissions per provider-listed discipline, with some vendors providing multiple types of services.

Table 6: Provider Submissions by Services

Discipline	# of Submissions
Behavioral Support Consultant	8
Occupational Therapist	7
Occupational Therapy Assistant	7
Physical Therapist	9
Physical Therapy Assistant	9
Speech Therapist/SLP	7

Additionally, PCG captured the waivers served by each participating provider. This information is shown below.

Table 7: Provider Submissions by Services

Discipline	# of Submissions
Developmental Disabilities Waiver	21
Medically Fragile Waiver	4

PERSONNEL ROSTER ANALYSIS

PCG assessed personnel expenses for both employees and subcontractors participating in provision of HCBS services. Due to the variance of total hours worked throughout the year and salaries reported, each provider's annualized salary was normalized into an hourly rate to allow for better comparison. PCG used the personnel roster salary information unless otherwise noted in the Methodology Adjustments section. We only used personnel roster rates for subcontractors which varied across disciplines.

Table 8: Data Elements Captured in Personnel Roster

Personnel Roster
• Provider name and tax status • Names, title, profession, and employee/subcontractor status of all personnel • Total hours worked by staff annually and the percentage of that time dedicated to the HCBS program • Total annual salary and fringe benefits paid for each staff member • Administrative staff data reflecting the above

In all, PCG captured 179 direct service personnel across the 6 rate categories. Table 9 shows the findings for all disciplines as well as the employee-to-subcontractor ratios. These ratios were calculated by taking the aggregated total hours worked divided by the total hours reported for each discipline. This method controls for individuals listed on the personnel rosters who may work part time or on an as needed basis, giving greater weight to individuals who work on a full-time basis.

Table 9: Personnel Roster Breakdown

Discipline	Employees	Subcontractors	% of Hours - Employee	% of Hours - Subcontractor
Behavioral Support Consultant	3	39	11%	89%
Occupational Therapist	10	14	52%	48%
Occupational Therapy Assistant	0	4	0%	100%
Physical Therapist	7	22	28%	72%
Physical Therapy Assistant	2	12	19%	81%
Speech Therapist	20	46	48%	52%

MARKET SALARY RESEARCH

Market rate salaries were assessed and used in some pieces of rate calculations to help ensure that the rate calculations were reasonable in relation to market realities. Without evaluation, cost-based rates run the risk of propagating rate deficiencies because existing provider payment structures often dictate the salaries that providers can afford to pay personnel. For example, a provider may lose key personnel because it can only afford to pay HCBS personnel what the existing rate structure will allow. In this example, a provider's cost report and roster may reflect salaries that do not reflect the market. Based on these considerations, PCG thoroughly reviewed market salaries for each discipline and evaluated whether the market salaries should be integrated into the rate methodology for each individual service.

The first step in calculating the base rates was to calculate salary per hour. Salary per hour was calculated by:

1. Separating HCBS personnel into personnel disciplines (also called professions or positions)
2. Determining a base salary for each position

For the purposes of this rate study, direct service personnel are categorized using the disciplines listed in Table 10 below. This is not a comprehensive list of all disciplines offered through HCBS.

A salary benchmark was identified for each discipline using the May 2019 State Occupational Employment and Wage Estimates Data Published by the Bureau of Labor Statistics (BLS) for the state of New Mexico. PCG presented market salary research for the BLS Southwest Region and an alternative Southwest Region used during the previous HCBS rate study done in 2017-2018. The State and PCG decided to use the alternative Southwest Region average salaries from the states of Texas, Arizona, Colorado, and New Mexico. The table below illustrates this Southwest Region and personnel roster salary data collected and analyzed during the rate study. In some instances, we did not receive personnel roster data for certain disciplines. Behavioral Support Consultant is not a BLS defined discipline so a combination of proxy professions was used to calculate a mean regional wage. These proxy choices were derived from the 2019 Rate Study and reapproved by the State as an accurate reflection of the skill and educational requirements for the discipline.

Table 10: Bureau of Labor Statistics Alternate Southwest Regional Mean Wages

Developmental Disabilities Services	BLS Disciplines	Mean Regional Wage	Proxies (if applicable)
Physical Therapy Assistant	Physical Therapy Assistant	$26.10	*N/A*
Physical Therapy	Physical Therapist	$43.29	*N/A*
Occupational Therapy	Occupational Therapist	$42.72	*N/A*
Certified Occupational Therapy Assistant	Certified Occupational Therapy Assistant	$29.60	*N/A*
Speech-Language Pathology	Speech-Language Pathologist	$37.92	*N/A*
Behavioral Support Consultation, Standard/ Incentive	Behavioral Support Consultant	$35.89	*Clinical, Counseling, and School Psychologists*
			Psychologist, All Others
			Healthcare Social Workers

TIME STUDY

Due to COVID-19, DDSD and PCG determined that any official Time Study would not be reflective of standard operations, while also over-burdening providers who were adapting to the rapidly changing situation. Several options were discussed with the final decision being to revert to the billable percentages and time study information captured during the 2019 Rate Study.

NM DDSD service standards outline which activities are considered billable. In most cases, billable time is face-to-face contact with the recipient of a service. The reimbursement rate must consider other activities that are integral to service delivery but do not occur face-to-face, such as travel and report writing. The time study grouped activities as either billable or unbillable, which is shown below. In some instances, certain activities such as report writing were considered billable if the service standards included it as a reimbursable activity under one of the three waivers.

All Unbillable Services
Note: this is a comprehensive list of all unbillable services. After receiving stakeholder feedback, only relevant unbillable services were listed on each tool

- **Report Writing/Progress Notes**: Time spent writing a report.
- **Missed Appointment- Individual Receiving Services**: Time associated working on an activity for an individual that did not appear, making the activity unbillable. This occurs when the no-show is because the individual did not make the appointment (e.g., the family canceled the session).
- **Missed Appointment- Staff**: Time associated working on an activity for an individual that did not appear, making the activity unbillable. This occurs when the reason for the no-show is staff related (e.g., staff canceled).
- **Delayed Appointment**: Time associated with waiting for an appointment to begin.
- **Training**: Time either delivering or participating in staff training.
- **Supervision Related Activities**: Time associated with supervising staff.
- **Preparation Activities**: Time spent preparing to deliver a service.
- **Travel**: Time spent traveling for work-related activities. This may include any overnights that you do.
- **Case Conference/Clinical Consultation**: Time spent discussing an individual or consulting with other staff.
- **Other Administrative Activities** (Other Admin. Activities): Any other activity that does not fall into another category. This also includes paid time off.

The table below show the percent of billable time associated with each discipline used to estimate the billable percentage for provider agencies.

Table 11: Billable Percentage by Discipline

Discipline	Billable Hours	Total Units	Billable %
Behavioral Support Consultant	784	1,440	54%
Occupational Therapist	239.75	525.75	46%
Occupational Therapy Assistant	92	123.5	74%
Physical Therapist	148.25	284	52%
Physical Therapy Assistant	54.25	90.25	60%
Speech Therapist/SLP	945	1750.5	54%

RATE CALCULATION METHODOLOGY

The calculations are designed to capture all the expenses involved in service delivery. The average hourly employee expense for an average service delivery professional (ex. Speech Therapy) is calculated first. Tax and fringe benefits were then added to the average salary. Personnel roster data was used to adjust the salary by the proportion of employees. An average service professional subcontractor rate was then added proportionally to the employee salary and benefits sum. From there other administrative and program support expenses (except

mileage) were added based on a negotiated decision by DDSD. A billable percentage was then factored into the calculations to account for nonbillable time and expenses associated with service delivery. Mileage was then added based on travel time assumptions. Table 12 below shows the inputs of the methodology.

Table 12: Methodological Inputs- PT/OT/SLP Therapies

Line Item	PT/OT/SLP	
	$	%
Salary/Hour	$41.67	
Benefits/Hour	$12.30	29.53%
Employee Salary Plus Benefits	$53.97	43%
Contractor Cost/Hour	$60.60	57%
Portion for Employee Costs	$23.35	
Portion for Contractor Costs	$34.38	
Personnel Costs	$57.73	
Admin & Support Costs	$12.72	18%
Total Costs/Hour	$70.46	
Total Costs/Hour with Billable Factor	$138.15	51.00%
Mileage	$1.56	
Calculated Hourly Total	$139.71	
Calculated 15 min Rate	$34.93	

The following steps calculate the Home and Community Based Services rates:

- Calculate Hourly Personnel Costs (Steps 1-7)
- Calculate Hourly Administrative Costs (Step 8)
- Markup Rate to Account for Non-Billable Time in Billable Unit (Step 9)
- Calculate Mileage (Step 10)
- Add Mileage to Hourly Rate (Step 11)
- Calculate HCBS Rates (Step 12)

Table 13 below illustrates the calculations. A narrative explanation for each step is then presented after the grid. Note: Calculations were performed with Excel formulas, therefore, rounding may result in a $0.01 difference on some steps.

Table 13: Home and Community Based Services Calculation – PT/OT/SLP

Step	Line Item	Rate Calculation Modifier	Rate Calculation Details	Rate
1	Salary/Hour	N/A	Hourly salary for employees based on personnel rosters (adjusted based on proportion of hours for each profession)	$41.67
2	Fringe/Hour	29.53%	Apply fringe rate based on cost report. • $36.72 * 0.2953 = $10.84	$12.30
3	Employee Salary Plus Benefits	N/A	Add salary to fringe from steps 1 and 2. • $41.67 + $12.30= $53.97	$53.97
4	Contractor Cost/Hour	N/A	Average hourly rate for contractors based on reported roster salaries.	$60.60
5	Portion for Employee Costs	43%	Calculate portion of personnel costs attributed to employees based on steps 1-3 and cost report. • $53.97 * .43= $23.35	$23.35
6	Portion for Contractor Costs	57%	Calculate portion of personnel costs attributed to contractors based on step 4 and cost report. • $60.60 * .57= $34.38	$34.38
7	Personnel Costs		Add steps 5 and 6 for hourly personnel costs. • $23.35 + $34.38	$57.73
8	Administrative + Program Support Costs (Less Mileage)	18%	Calculate non-personnel factor based on cost report. • ($57.73/ (1 - 0.18)) – $57.73 = $12.72	$12.72
9	Total Costs/Hour with Billable Factor	54%	Divide the hourly rate by the billable factor. • $57.73 + $12.72 = $70.45 • $70.45 / 0.54 = $138.15	$138.15
10	Mileage	Mileage Calculations	Include mileage (if applicable) • $1.56	
11	Calculated Total with Mileage	N/A	Add mileage • $138.15+ $1.56 = $139.71	$139.71
12	Calculated Individual Rate		Convert to 15-minute rate (rounded). • $139.71 / 4 = $34.93	$34.93

Steps 1- 7: Calculate Hourly Personnel Costs

The rate development steps first calculate an average hourly personnel cost that accounts for service delivery from both employees and subcontractors. Step 1 shows that the average employee salary was $41.67 based on the market rates described earlier. Step 2 then applies a

fringe rate to the employee payrate based on the average fringe rate of 29.53 percent as determined by the cost report. Step 3 then adds the $41.67 and $12.30 figures to arrive at employee salary plus benefits rate of $53.97. Step 4 presents the average subcontractor payrate of $60.60 that was reported on the rosters. The rosters were used to weight the subcontractor salaries based on the total proportion of subcontractors to each profession for rates that include more than one discipline. Steps 5 and 6 then distribute the employee and subcontractor payrates proportionally based on the personnel roster distribution of employees and subcontractors. In our example, of all speech-language pathologists reported on rosters, 43 percent were employees while the remaining 57 percent were subcontractors. In applying these percentages to each hourly cost, you arrive at $23.35 and $34.34 for employee and subcontractor costs, respectively. Adding these figures together represents the total hourly personnel cost displayed in Step 7.

Step 8: Calculate Hourly Administrative Costs

The 18 percent figure in Step 8 represents all the administrative and program support expenses incurred by providers. This figure comes from the cost report and includes all administrative salaries and operating expenses other than mileage. It does not include direct service salaries, personnel taxes and fringe benefits, and subcontractor expenses. The total cost per hour should then equal $70.45 because the personnel total is $57.73 per hour with the 18 percent for administrative costs included ($12.72).

Step 9: Markup Rate to Account for Non-Billable Time in Billable Unit

This step ensures that providers are compensated for necessary administrative time that is not included in the billable unit. A billable percentage of 54 percent was applied to the speech therapy rate. This 51% was taken as an average percentage on for all three therapy professions during a 2019 Time Study. Most services utilize a discipline specific billable percentage. This means that the combined hourly rate of $70.45 represents 51 percent of the rate making the offsite total rate $138.15.

Step 10: Calculate Mileage

Mileage was the only expense not included in the previous steps because it is utilizing the State's current mileage reimbursement rate of $0.44 per mile. Due to the inability to perform a time study during the course of this process, PCG will use a mileage rate developed based on the 2019 time study. 2019 time study participants conducting home/community activities reported 10.1 percent. Direct Support Staff-Residential were excluded from the travel time percentage as the 24-hour service skewed overall data significantly. This means that on average, home/community personnel spend 6.06 minutes in the average hour traveling, at 35 miles per hour. With a New Mexico reimbursement rate for mileage of $0.44 cents the cost per hour of $1.56 for the service is calculated. Table 14 below illustrates how these calculations formulate the mileage cost per hour. Separate mileage rates for each discipline were not calculated as many professions had small sample sizes during the time study.

Table 14: Mileage Cost Per Hour Calculations

Mileage Calculations		Element Type
Average Travel Time from the Time Survey	6.06	Minutes/Hour
Percentage of Hour	10.1%	Percent
Average MPH	35	MPH
Miles Traveled	3.535	Miles
Reimbursement Rate	$0.44	Rate
Cost Per Hour	$1.56	Mileage Cost per Hour

Step 11: Add Mileage to Hourly Rate

The hourly mileage costs calculated in Step 10 are added to the hourly rates from Step 9 to arrive at the calculated total rate per hour. The rate increases from $138.15 to $139.71 with $1.56 in mileage costs added.

Steps 12 -13: Calculate Base Rates

The hourly rates must then be converted to the appropriate time-based billable units. For Speech therapy, this is done by dividing each rate by four, resulting in a $34.93 unit rate.

RATE RECOMMENDATIONS

Using the data from the market salary analysis, cost report, time study, and personnel rosters, PCG calculated recommended payment rates for the following services under the Developmental Disabilities Waiver:

- Behavior Support Consultation
- Physical Therapy Assistant
- Physical Therapy
- Certified Occupational Therapy Assistant
- Occupational Therapy
- Speech-Language Pathology (Speech Therapy)

Using the data from the market salary analysis, cost report, time study, and personnel rosters, PCG calculated recommended payment rates for the following services under the Medically Fragile Waiver:

- Behavior Support Consultation
- Physical Therapy
- Occupational Therapy
- Speech-Language Pathology (Speech Therapy)

Based on the methodology and data inputs, PCG recommends the HCBS service rate options summarized below and described in the preceding sections. ***These recommendations are intended to be used as guidance and the State of New Mexico, DDSD, may accept all, some, or none of these fiscal recommendations.***

Table 15: PCG Rate Recommendations for the Developmental Disabilities Waiver

Service	Unit	Billable %	Current Rate	Current Incentive Rate	Recommended Rate	Recommended Incentive Rate
Physical Therapy Assistant	15-min	67%	$18.84	$24.71	$23.78	$31.20
Physical Therapy	15-min	51%	$22.90	$29.20	$34.93	$44.54
Certified Occupational Therapy Assistant	15-min	67%	$18.84	$24.71	$23.78	$31.20
Occupational Therapy	15-min	51%	$22.90	$29.20	$34.93	$44.54
Speech-Language Pathology	15-min	51%	$22.90	$29.20	$34.93	$44.54
Behavioral Support Consultant	15-min	54%	$18.34	$23.66	$24.39	$31.46

Table 16: PCG Rate Recommendations for the Medically Fragile Waiver

Service	Unit	Billable %	FY 2020 Rate	FY 2021 Rate	Recommended Rate	Recommended Incentive Rate
Physical Therapy Assistant*	15-min	67%	$18.84	N/A	$23.78	$31.20
Physical Therapy	15-min	51%	$22.90	$25.75	$34.93	$44.54
Certified Occupational Therapy Assistant*	15-min	67%	$18.84	N/A	$23.78	$31.20
Occupational Therapy	15-min	51%	$22.90	$25.75	$34.93	$44.54
Speech-Language Pathology	15-min	51%	$22.90	$25.75	$34.93	$44.54
Behavioral Support Consultant – Clinic Based	15-Min	54%	$11.63	$13.08	$24.39	$31.46
Behavioral Support Consultant	15-min	54%	$19.62	$22.06	$24.39	$31.46

*Denotes service/rate not currently incorporated into MF Waiver service, but is recommended for addition to accurately reflect service delivery in the program. Current rates reflect DD Waiver.

METHODOLOGY ADJUSTMENTS

Composite Rates

To keep program consistency in rate design, PCG developed composite rates using the following procedures.

1. Wage information was taken from personnel roster reporting with a proportional mix based on expected hours worked per profession. These hours were generally equivalent to April 2019 – March 2020 billing patterns.
2. Billable percentages were taken as an average of the professional category 2019 results. These individual billable percentages can be seen in the Time Study section.
3. Proportion of employee-to-subcontractor ratios were developed based on the sum of expected workload from the personnel roster, with the ratio of total expected employee staff hours and total expected subcontractor hours taken as a percent of the whole professional population. For the PT/OT/SLP rates, employees were found to contribute 43% of the staff time to these services, while subcontractors supplied 57% of the total hours. PTA/COTA providers saw an 18% employee proportion and 82% subcontractor portion.

Certified Occupational Therapy Assistants (COTA)

Through data collection on the personnel rosters, only four COTA providers were tabulated across all participating providers. All four were listed as subcontractors with a calculated average hourly wage of $31.16. After reviewing previous rate study data, as well as market salary research, PCG determined that there are COTAs who work as employees within New Mexico's therapy providers and the personnel roster results were not valid. The low wage calculation as well as the absence of listed employees required some deviations from methodology to compensate for the low data return. The following changes were made for COTA rates.

1. The Southwest Regional Mean salary of $29.60 was used as the employee wage for the COTA component of the composite rate.
2. The reported subcontractor hourly wage of $31.16 was significantly below peer providers, resulting in a significant rate reduction. To adjust, the 2019 Rate Study average subcontractor wage of $61.64 was used for the COTA portion of the composite rate calculation.

Physical Therapy Assistants (PTA)

Data analysis resulted in a calculated hourly wage for PTAs of $44.13, which was higher than the calculated wage of Physical Therapists. This calculation was skewed by the low number of PTAs listed as employees on personnel rosters, with 81% of reported hours attributed to subcontractors. To adjust this, PCG used the Southwest Regional Mean salary of $26.10 as the employee wage for PTAs in the composite rate calculation.

Geographic Adjustments and Incentive Rates

DDSD and PCG determined that the lower response rate to both the Cost Reports and Personnel Rosters, as well as the geographic locations marked as the primary service county did not support an independent geographic adjustment factor useable for incentive rates. PCG

recommends keeping the current percent differential between standard and incentive rates on the most recent active fee schedule. Additionally, PCG recommends adding incentive rates to the Medically Fragile Waiver services to keep service and network parity with the DD waiver.

INFLATION CONSIDERATIONS

The rates calculations were based on data collected primarily from 2018-2019. PCG recommends DDSD consider the inflation factors described below when moving forward, based on the actual implementation period. For example, rates that would be implemented in 2021 instead of 2020 would require additional increases to account for the inflation in costs that would likely occur leading up to 2020. There are several mechanisms to account for inflation. PCG recommends using a reliable source such as the Consumer Price Index (CPI), which is made available by the Bureau of Labor Statistics. Specifically, the CPI-U index covers all urban consumers, representing the cost of all items to 88 percent of the U.S. population. The Western region would be most appropriate benchmark because there is no New Mexico specific CPI-U available. As Table 17 illustrates below, the average cost of items increased approximately two to three percent over the past five years, averaging to 2.78 percent annually over that period.

Table 17: Inflation Increase over Time

Year	Month	Annual	Inflation %	Five-Year Average
2015	January	238.318		
2016	January	244.600	2.64	
2017	January	250.814	2.54	
2018	January	258.638	3.12	
2019	January	265.624	2.70	
2020	January	273.340	2.90	2.78

The table below shows how the 2.78 percent inflation factor could be applied annually. Notice that the 2.78 percent factor is applied to each preceding year. This effectively increases the percentage each year as the figure is continuously applied to a larger baseline. This means that each rate should be multiplied by the inflation factor based on the implementation year.

Table 18: Inflation Factorization

Implementation Period	Inflation Factor
July 2020	100.00%
July 2021	102.78%
July 2022	105.64%
July 2023	108.57%
July 2024	111.59%

PCG recommends implementing inflation with consistent monitoring due to the Covid-19 pandemic. This has resulted in temporary deflation which is not expected to continue for an extensive amount of time. Current forecasts show a positive bounce back that could also influence inflation rates. It was for this reason, PCG did not use months after January 2020 in its inflationary calculations.

IMPACT ANALYSIS

PCG has developed a fiscal impact analysis based on all claims submitted April 1, 2019 through March 31, 2020. The Table 19 and Table 20 show the impact overall and per service impact under each waiver.

Table 19: Developmental Disabilities Waiver Fiscal Impact

Service	April 2019 – March 2020 Units	April 2019- March 2020 Expenditures	Rate Recommendation Expenditures	Variance	State Share Cost of Increase (27% State Funds)
Physical Therapy Assistant	80108	$1,752,920.08	$2,029,976.03	$277,055.95	$74,805.11
Physical Therapy	136051	$3,621,694.17	$5,420,011.63	$1,798,317.46	$485,545.71
Certified Occupational Therapy Assistant	69224	$1,518,374.27	$1,804,335.04	$299,080.71	$80,755.73
Occupational Therapy	118807	$3,164,318.35	$4,548,943.21	$1,384,624.86	$373,848.71
Speech-Language Pathology	249194	$6,902,930.16	$9,277,709.67	$2,374,779.51	$641,190.47
Behavioral Support Consultant	316744	$6,554,033.84	$8,118,252.76	$1,564,218.92	$422,339.11
TOTAL		$23,514,270.87	$31,212,348.27	$7,698,077.40	$2,078,484.83

Table 20: Medically Fragile Waiver Fiscal Impact

Service	April 2019 – March 2020 Units	Expenditures Using FY 2021 Rates	Rate Recommendation Expenditures	Variance	State Share Cost of Increase (27% State Funds)
Behavioral Support Consultant – Clinic Based	249	$3,256.92	$6,071.96	$2,815.04	$760.06
Behavioral Support Consultant	1502	$33,134.12	$36,626.83	$3,492.71	$943.03

Impact Limitations and Considerations

State Share

At the outset of the rate study, the state share of expenditure for these waiver services was set at ~27% of total costs. This figure was used to estimate the state share costs of the

implementation of rate recommendations. If this percentage changes, the estimated fiscal impact may also change.

Annual Utilization Changes and Fiscal Year Choice

PCG reviewed historical claims data, but yielded no discernable service growth or contraction. Trends varied greatly over time. For this reason, PCG used the most recent complete one year's worth of service units to reprice these units under the new rate recommendations. No inflationary or growth trend has been applied to the numbers above as recent years have seen reduction, small growth, and exponential increases varied by year and service. As the State is currently negotiating the waiver renewals, PCG has not applied the inflationary costs described in the Inflation Considerations section as the rates are expected to be applied sooner than one year from now.

Medically Fragile Fiscal Impact Expenditures

PCG's fiscal impact methodology for the MF Waiver deviated from the DD waiver due to the new rates implemented on July 1, 2020. In lieu of using actual expenditures as the baseline for comparison, PCG repriced the units from April 1, 2019 to March 31, 2020 using the new rates to set the baseline for expected expenditures.

Medically Fragile Therapy Services

PCG's review, along with DDSD secondary confirmation showed no Physical Therapy, Occupational Therapy, or Speech-Language Pathology services were delivered to Medically Fragile waiver clients during the time-frame in question. After consulting DDSD staff, it was determined this is not unexpected due to the low number of adults on the waiver and low provider participation due to current rates. If the latter element is a correct assessment, DDSD should be prepared to see a small increase in the fiscal impact for the Medically Fragile waiver.

TELEHEALTH REVIEW

Telehealth services are becoming more prevalent throughout both health and human services. Rural areas with either low or difficult access to services have been more regularly utilizing telehealth services to help alleviate a lack of providers. With the current COVID-19 pandemic, these services have taken the forefront of innovative healthcare solutions. While the landscape of these services is rapidly changing due to the pandemic, an opportunity to review real implications and broad adoption of telehealth services is available to DDSD over the coming months. While this section contains an array of research on established policies, PCG urges DDSD to consider further real-time research over the coming months on the following topic areas:

1. Provider adoption of telehealth models
2. Client access to telehealth services (both hardware and internet access)
3. Efficacy of telehealth service delivery
4. Successful models of telehealth services
5. Pitfalls to effective telehealth service delivery

PCG conducted peer state research to determine whether telehealth is an appropriate and effective cost modality for the delivery of therapies and behavioral health services in New Mexico's HCBS waivers serving individuals with intellectual and developmental disabilities (IDD). Telehealth is the use of audio and video technology to provide medical and health services. It includes modalities using real time interactive audio-video, store and forward activities, remote monitoring and health, which includes online services and phone apps. Table 21 outlines the services reviewed for telehealth policy.

Table 21: Services Reviewed for Telehealth Policy

Discipline
Behavioral Support Consultation
Occupational Therapy
Physical Therapy
Speech Therapy

Based on census data and availability of similar waiver services, the following states compare to New Mexico: Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming. In all, we reviewed 18 waiver applications and contacted key informants in the six states' agencies for intellectual and developmental disabilities services. Research also included review of information from the U. S. General Accounting Office (GAO), the federal Health Resources and Services Administration (HRSA), regional Telehealth Resource Centers, the American Telehealth Association and the national associations for each practice area reviewed.

It should be noted that CMS does not require states to specify service delivery via telehealth in their HCBS 1915(c) waiver applications when the same rate is paid for the same procedure by a qualified provider delivered otherwise. A service is allowable when it meets all the requirements for the service definition in the waiver application including the scope of work for each service and provider qualifications. An indication of telehealth *is* required when there is a rate difference or fee payment associated with telehealth. None of the waivers reviewed contained information specific to telehealth. PCG expanded its research to include the same services defined in Medicaid state plans for a wider population.

Here again, states are not required to identify the use of telehealth and states have developed different parameters around its use. We found, pre-COVID-19-pandemic, that all peer states reimbursed some Medicaid state plan services delivered via telehealth. Provider types, service types, originating sites, authorized technologies, required distances and rate methodologies differed among those states. Additionally, due to the changes in telehealth practices related to the COVID-19 pandemic, states have rapidly adopted telehealth for services wherever possible. This report did not determine what changes were made in relation to the pandemic as that information would likely be temporary and subject to change before this report is published. Material provided here is a snapshot developed with information available in April 2020.

Table 22: States with Telehealth Policies

Discipline	Colorado	Montana	North Dakota	South Dakota	Utah	Wyoming
Behavioral Support Consultation	X	X	X	X	X	X
Occupational Therapy	X			X		X
Physical Therapy	X			X		X
Speech Therapy	X	X		X		

Additionally, three states reimbursed Medicaid services delivered via telehealth in early childhood intervention programs (Colorado, Wyoming, Utah). Resourceful providers in frontier regions in every state employed various telehealth processes to deliver services to people who would not otherwise receive those services, again, in the absence of explicit telehealth regulations. For example, one occupational therapy agency provides training and on-going supervision to certified occupational therapy aides in frontier regions of their state after an initial face-to-face evaluation is conducted with the participant. Another therapist in this same state reported assessing a problem with progress in speech therapy using a camera via a secure server.

One other item of note is that the use of telehealth differed among HCBS waivers within the same state and between the state plan and waivers within the same state. Anecdotally, the differences were attributed to the fact that HCBS waivers were operated by different agencies within a state and separately from the agency operating the Medicaid state plan. These operational differences contributed to the development of the use of telehealth evolving for different services and at a different pace among the various programs.

By drawing upon reports from the various sources considered, making analogies and using anecdotal evidence, valid general conclusions about appropriateness can be made. Appropriateness is assumed because of the prevalence of use, its use is supported by professional associations, its use is expanding, and its use is encouraged for Medicaid by CMS. However, the appropriate delivery of services via telehealth is contingent upon the regulations, standards and policies by which a state manages service delivery. Current data on cost effectiveness, which requires longitudinal study across a multitude of factors was not found and is beyond the scope of this research. Overall, the use of telehealth can

- Help alleviate provider shortages in remote areas
- Provide access to services for people living in remote areas
- Shorten or eliminate travel time by participants and providers
- Reduce transportation difficulties
- Provide for quicker support in emergent situations
- Eliminate the stress for a participant caused by disruption in routines
- Promote the Collaborative-Consultative Therapy Model
- Facilitate inter-disciplinary team meetings

COSTS OF TELEHEALTH

Expanding the use of telehealth comes with some costs. Residential and day habilitation providers may need additional staff so that a participant receiving services is supported at the same time other participants served by the same provider are supported. There are costs associated with purchasing telehealth equipment and connectivity, maintaining equipment and training staff to use it. These costs need to be considered in relation to the costs incurred to support the same participants without the use of telehealth. Ultimately, provider costs are captured in the rate setting process and reimbursed on going. However, from a financial cost-benefit perspective, State programs would most likely see greater benefit by allocating dollars towards adaptive equipment and technological upgrades for clients and client homes rather than reimbursement enhancements to providers for their technological upgrade and innovation. Currently, few telehealth rate methodologies have been developed separately from base, in-person rate methodologies. As these rate methodologies have built in assumptions on time, mileage, and administrative costs that are naturally reduced by the use of telehealth modalities, it is to the provider's benefit to invest their own dollars into innovative telehealth infrastructure.

Beyond the need for individual client resources to install or pay for upgraded internet, computers, or technology to effectively use telehealth, New Mexico exhibits a lack of rural access to standard high-speed internet necessary for statewide adoption of telehealth services. The "2020 Broadband Deployment Report" published in April 2020 by the Federal Communications Commission outlines annual progress on the implementation of broadband networks. Only 77.7% of rural, non-tribal residents have access to sufficient levels of terrestrial broadband networks to support telehealth services within the home. Mobile LTE networks add another significant complication as many current telehealth applications are set to run solely via these systems. Residents with access to both terrestrial systems and mobile LTE networks sufficient to operate telehealth services falls to 45.1% in rural areas and 52.9% in rural tribal areas. While these numbers reflect the ability of internet service, they do not reflect the affordability of that service. Coupled with increased poverty percentages, the adoption of these systems is even lower, with only 67.4% adoption in non-urban core areas and 45.3% in tribal non-urban core areas.

ACCESS TO TELEHEALTH

One of the outcomes of the Covid-19 pandemic is the rise in importance of broadband internet. As businesses have shifted towards online, remote models, telehealth providers have followed suit. Greater awareness of the lack of availability and affordability in rural areas has come under increasing scrutiny. Some models have begun gaining prominence, which the State may either leverage financially or support via statewide policy development in conjunction with other state and local agencies. For example, the Covid-19 Telehealth Program recently launched in May 2020. This program allows applications for funding to develop localized telehealth programs for certain providers. While no providers included in the rate study portion of this project are eligible, several other institutions would be valuable pass-through partners to help develop

these networks. Linking therapy providers with local health departments, hospital systems, or school providers could help in leveraging federal funding to develop localized networks of telehealth service provision. On a broader spectrum, local communities have turned towards funding municipal broadband networks run as a utility. The City of Chattanooga implemented a similar system over the last decade, which has resulted in better customer service records and lower household costs for higher levels of access. On a rural basis, localized cooperatives to build broadband networks across a two to six county area have increased in popularity. These are run under a co-op model to increase local investment as well as provide the necessary services for rural communities to thrive. Efforts such as these should be supported by DDSD where possible to increase access to care and better service quality for all consumers.

A statement in the United States General Accounting Office report on telehealth and remote patient monitoring provides a good summary, "(Telehealth) may lead to better adherence to care plans, facilitate monitoring and follow-up, reduce the frequency of missed appointments and increase the frequency of on-time appointments all which increase the capacity of providers to support more individuals."[1] The use of telehealth can improve or maintain the quality of experience and care for people served in the HCBS waivers. It supports providers to operate more efficiently and supports people receiving services to get the assistance they need to achieve their best health and well-being. Healthier people require fewer health services which results in lower costs not only to the state in its HCBS waivers, but to its Medicaid state plan as well. Ultimately, the appropriateness and cost effectiveness of using telehealth to deliver therapies and behavioral services is dependent on access to connectivity, the provider's readiness to implement technology, support for the participant to use technology and the state's regulations and policies in place for allowable delivery, reimbursement and oversight.

[1] "Telehealth and Remote Patient Monitoring Use in Medicare and Selected Federal Programs", **https://www.gao.gov/products/GAO-17-365**, GAO-17-365: Published: Apr 14, 2017. Publicly Released: Apr 14, 2017.

TIERED RATE EVALUATION

As a part of the scope of this rate study, PCG was tasked to review and evaluate the DD waiver's tiered rates to determine if the number of tiers, amount of nursing, on call coverage expectations, nutritional counseling, and staffing ratios for each tier are funded at appropriate levels. Through discussions with DDSD, it was determined to provide a non-clinical evaluation on the structure of the tiers and DDSD service standards to determine sufficiency in rates.

Nursing

Nursing supports as developed in DDSD's service standards do not often apply measurable caps or expectations, with low levels of supports describing the bundled nursing services as "rare" with no developed median hours on a weekly, monthly, or annual basis. Higher levels of supported living cap nursing on a monthly basis at five hours and 10 hours for Category 2 and 3, respectively. Category 4 does not have set nursing hours through service standards, instead relying on expected service delivery measures not beholden to raw time investment. Intensive Medical Living Supports (IMLS) requires weekly registered nursing (RN) visits and daily nursing care, but set no time capped expectations for licensed practical nursing (LPN) or RN services. This creates an incongruent tier structure with some supported living categories being capped with other tiers utilizing non-standardized requirements. As nursing services do not have measurable expectations applied in each category, the sufficiency of these bundled services is questionable and will largely vary widely among individuals.

Nursing services are the most likely category to result in cost overruns for the provider. Bundled services within tiers are naturally built to create both full reimbursement plus margin for providers over an extended period of time (per quarter or per year) rather than on a daily or monthly basis. With a relatively small population compared to other shared or assisted living situations, ad hoc or unplanned nursing requirements that exceed the built-in assumptions can quickly result in provider losses and undermine the statewide provider network. Additionally, for those individuals within Category 4 of supported living services, the variability of needs and service utilization make results in a higher risk category for underfunding. Alternatively, if nursing services are not the primary medical needs for the individual, instead relying on different medical services, any bundled nursing services could result in excessive expenses for the State.

On-Call Coverage Expectations

On-call coverage expectations are largely consistent and predictable. While any active nursing or medical services are paid independently or bundled (if applicable), on-call is expected to cover a standard 24-hour period. This creates an easily bundled service once daily rates are calculated. One difficulty in bundling is the calculation of on-call rates themselves. There appears to be no standard for provider operations for on-call coverage. Varying models outlined below create third-party contractor concerns largely uncontrollable by either DDSD policy or individual providers.

- Some on-call providers operate through a standard daily on-call rate with dedicated staffing to provide services. As an example, an independent nurse may be on-call for 24-hours and paid an on-call rate of $50 for the entire timeframe, with supplemental hourly pay if a nursing visit is required.

- Many on-call providers reported during the 2019 study that staff are unpaid for on-call hours unless a visit is required. These on-call staff are operational nurses who provide assessments, reports, or nursing services during the day to their clients. On-call time is typically shared among the nursing staff and not separately paid outside of salary or wage.

These varying models create a difficulty in bundling on-call services as the payment structures will vary greatly from provider to provider. Individual data collection for these services would be recommended to more accurately bundle on-call coverage, but as on-call coverage are usually nominal costs on a daily basis for homes of two to four individuals, the cost-benefit of this research may not be in the State's favor compared to assuming the first model listed above.

Nutritional Counseling

Nutritional counseling is bundled within most supported living services, but unlike nursing services shows a standard expectation across supported living categories. All categories have a bundled five hours of nutritional counseling standard per year. Sufficiency for these hours will vary based on clients, which can skew the accuracy of a tiered rate system compared to matrix of rates developed based on needs of individual clients. Higher levels of categories require the availability of nutritional counseling as needed. However, the current tiered rate system does not provide for data collection on individual hours of nutritional counseling needed or provided. Independent data collection or individual client plans would need to be reviewed to determine if clients are regularly exceeding the cap of 5 hours. Even clients in Category 1 with low levels of direct service support may require additional nutritional counseling, so any review would need to occur across all categories of living supports.

Staffing Ratios

While DSP staffing ratios are not explicitly required in any supported living category, estimated 1:1 hours per week are mentioned in service standards. The service standard language used does not mandate any specific range or number of direct service hours, but describes the specific category of support as "routinely accommodating" a range of hours. Provision is made that the weekly numbers may be above or below this range. As this is a core cost of service provision and payment structure, firmer policy language would be required to ensure a tiered rate system is fully funded to accommodate both the State's expectations as well as the provider's obligation to provide effective and quality services.

State language is also unclear on the applicability of staffing at greater than a 1:1 level and its application towards direct service hours. The immediate question is if 12 direct service hours at a 2:1 ratio is equivalent to the provision of 24 hours of 1:1 ratio. Multiple staff would need to be accounted for in an effective tiered rate system as skillsets, licensures, wages, and level of attention may vary throughout the provision of service. This same situation would apply in situations with multiple residents and multiple staff.

Impacts of Telehealth

Most of the services listed within this section may be provided via telehealth, including nursing, on-call coverage, and nutritional counseling. Given that telehealth has a vastly different cost structure and rules have evolved rapidly over the previous six months, the bundling of services into long-term use of tiered rates will likely change rapidly. Two primary considerations should be taken into account when visualizing and enacting tiered rates with bundled services that may use telehealth.

Division of in-person and telehealth hours

The development of rates would need to take into account the expected division or practice of in-person required hours and those provided via telehealth. As telehealth has a far different cost structure, primarily through administrative costs and mileage reimbursement, the State will need clear expectations as to when each model is required, expected, or optional. Adjustment to the bundled factors would result in more reflective cost-based tiered rate models.

Connectivity of the home site

Connectivity of the home-site is one of the greatest barriers to telehealth services in today's environment. While the Telehealth section of this report details these issues, for tiered rate models incorporating bundled services, it's important to understand that even if models are developed with the expectation of a greater share of telehealth, homes may not be equipped with the necessary materials/support or have access to high speed internet in order to take advantage of telehealth services. If improper estimates are incorporated into a tiered rate model and providers are required to seek in-person care funded at a telehealth reduction, the State will see a drop in its supported living provider network in more rural areas.

Findings and Recommendations

Through a review of DDSD service policies and current rates, PCG believes that several key areas may lead to inaccuracy in any tiered rate methodology.

1. PCG recommends that policy language around nursing expectations be reviewed for standardized expectations under each tier. Specific hourly minimums and maximums should be developed if the State wishes to continue bundling this service into a tiered rate model.
2. PCG recommends that DDSD work with nutritional counseling stakeholders (i.e. Dietitians, Case Managers, front-line nursing staff, and physicians) to review the hourly expectations of nutritional counseling within the tiered rate system. This service can have a wide variety of needs. The tiered rate model assumption is that with a large enough client population, providers will usually even-out. This may be true, but could also lead to client selection processes if the over or underpayment on this service deviates too far.
3. PCG believes that staffing ratios, or 1:1 required hours are sufficient for each tier, but would recommend adding clarity to current DDSD service standard policy.
4. On-call coverage can safely be bundled into a tiered rate methodology, but further discussions with providers of on-call services may be fruitful in understanding provider operations and developing accurate costs.
5. While the number of tiers is sufficient for a tiered rate model, the population distribution should be monitored for increasing needs. PCG evaluated both past and present utilization data and there appears to be a marked increase in the use of the highest needs service categories. This has not become a statistically valid trend due to lack of historical data, but should be monitored.

TIERED RATE GUIDANCE AND RECOMMENDATIONS

As a portion of this project, PCG was tasked with providing guidance and recommendations on a variety of topics for tiered rate methodologies, in particular DDSD's use of tiered rates for supported living services. Discussions with the State asked PCG to focus on several topics, including the following:

- Remote Technology
- Monitoring providers to ensure appropriate service delivery
- Assessment of tiered rate methodology pros and cons

OVERVIEW OF REMOTE TECHNOLOGY

The term "remote technology" as used here means "personal support technology" employed by participants to support their ability to live independently, experience increased choices in their daily life and provide freedom to live, work and participate in their community.

PCG Recommendations on the use of Remote Technology

PCG recommends DDSD take three actions to incentivize the use of remote technology:

1. Update the HCBS waiver definitions to provide an explicit foundation for its use at home and in the community that includes coverage for an evaluation for technical support, connectivity, training, technical assistance, equipment service and maintenance.
2. Modify service standards to incorporate structure for providers and natural supports to encourage use in a way that protects participant health, safety, and privacy.
3. Execute an implementation plan to address concerns, build acceptance and create recognition for the benefits of remote technology and ensure a smooth adoption of the new benefit.

Personal Support Technology in HCBS

Personal support technology is a type of assistive technology provided to support increased independence for participants. It supplements direct support a participant receives from family, friends, or providers to assist with activities of daily living. Remote support technology is comprised of a set of electronic devices, training to use the devices, connectivity, and technical assistance, and includes in-person response when needed by the participant. Devices can include motion/sound/water detectors, light/voice/motion activated devices, floor pressure pads, door sensors, window sensors, interactive speaker and video equipment, cell phones, tablets and other electronic equipment used to support individuals with activities of daily living. For example, devices can assist a person with activities such as riding the bus, shopping, menu selection, cooking, cleaning, and doing the laundry. A person can use a software app to help get up in the morning, prepare for the day with prompts and get reminders for medication. Devices can help a participant see who is at the door before opening it and get reminders to close windows when left open or automatically turn off appliances when left on. Interactive devices provide the ability for a person to check in with DSP staff or natural supports and get immediate in-person onsite response when needed.

The use of remote technology to supplement personal assistance support has steadily increased over the last decade in response to the direct support professional workforce shortage. Direct support professionals (DSPs) are essential caregivers in the traditional support system for people with intellectual and developmental disabilities. The system has experienced a long-standing decline in the DSP workforce and nationwide, providers struggle to employ enough DSP staff to meet the needs of the people they support. This situation is exacerbated in rural and frontier regions that cover vast areas of land with few residents, creating a chronic DSP workforce shortage.

“The Case for Inclusion Report 2019”, released by the ANCOR Foundation and United Cerebral Palsy, identifies the national DSP workforce shortage as a crisis. According to the report, “DSPs are the backbone of community supports, but in general they are not staying in the field long enough to turn it into a career. This affects the stability and quality of supports to the point of being a crisis, affecting the health and well-being of people with IDD who rely on supports for the most critical and personal facets of their lives.” The report cites the national average turnover rate for DSP’s at 46%. Data was not found for the DSP turnover rate in New Mexico, but two peer states are used for reference; South Dakota and Utah show turnover rates of 57.3% and 41.5% respectively. Complicating the workforce shortage are vacancy rates. Nationally, average vacancy rates for full time DSP’s is reported at 9%, peer states are 9.8% for South Dakota and 8.4% for Utah.

Changes in demographics and funding shortfalls create additional pressures on the workforce. People are living longer, including people with IDD, aging baby boomers increase the need for support workers to assist in activities of daily living and fewer young people are entering the workforce. These pressures combine to negatively influence the DSP shortage. The “Case for Inclusion Report” identifies a greater use of technology as an essential element for addressing this shortage. Adding to the pressure on the system to adequately provide personal support are evolving system advancements upholding the civil rights of individuals with disabilities, influencing where they live and how they spend their days. The Americans with Disabilities Act (ADA) and the Olmstead decision established legal mandates for states to support people with disabilities to live with the greatest degree of inclusion and independence possible. The more recent HCBS settings rule further upholds civil rights for people with disabilities by requiring home-like settings and person-centered planning for every person receiving support through an HCBS waiver. The number of people living in their own homes, family homes or shared living continues to increase as the impact from the HCBS settings rule grows and state institutions close. To ensure participants receive the support they need, states must consider service models for personal support that extend beyond traditional practices involving exclusively in-person staffing support.

States increasingly turn to remote support technology to safeguard participant health and safety while offsetting DSP staffing pressures. PCG believes that the greatest incentive to using remote technology for personal service support is to make it available to individual participants. Participants, whether living on their own, with family or at provider owned or operated homes, can realize a greater sense of autonomy when using personal assistance technology. As more people adopt its use, realize its benefits and become comfortable with its use more will demand it. People will choose providers who have incorporated the use of remote technology for personal assistance support into their residential model. DDSD can create the framework for this advancement to occur in an effective, cost-efficient way.

Update to HCBS Waiver Definitions

New Mexico's current definitions for assistive technology in therapies, environmental modifications and specialized medical equipment encompass the language needed to provide the foundation for personal support service delivery that is consistent with a participant's therapy needs. In addition, the current definition for Personal Technology/On-site Response Service explicitly provides for the use of a personal response system by participants. However, a modification to the waiver that captures all aspects of remote support technology in one definition can help strengthen an increase in its use while also supporting effective waiver administration. For example, a modification to add connectivity via a jet pack or Wi-fi hot spot will support use by participants who do not have access to the internet in their homes. Increased funding limits are needed to ensure funds are available for technology device purchase and effective use. Best practice suggests the amendment include:

- Assistive technology as defined in the Assistive Technology Acts of 1988, 1998, and 2004: "Any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities."
- Provisions for stand-alone items that support one task (such as a software application for cooking) as well as for systems that comprehensively support participant independence (such as those employed for smart homes)
- Comprehensive funding for devices including smart phones, tablets and jetpacks or Wi-Fi hot spot devices, evaluations for technology to meet participant's specific needs, equipment delivery and installation, monthly service charges, training for participants/natural supports/ paid support providers, technical assistance, and equipment service and maintenance
- A provision for explicit consent by the participant and others living in the home for the use of two-way audio and video equipment Ohio's HCBS Individual Options waiver includes a definition for Assistive Technology that encompasses the use of personal support technology. It also includes a definition explicitly for Remote Support Services.

Modifications of Service Standards

Modifications to standards are required to describe how providers and natural supports will ensure participant well-being when using remote technology to supplement direct support. Some best practice standards can include:

- A requirement for a functional evaluation of technologies available to address the individual's assessed needs conducted by a Medicaid qualified technology provider
- Education before use of technology for participant, staff, and natural supports to understand how to use technology effectively and safely
- A requirement for consent by the participant and others living in the home for the use of two-way audio and video equipment
- Instituting provider requirements for:
    - Allowing use of personal support devices when included in a participant's service plan.
    - Timely coordination with a Medicaid qualified technology provider to assess, install, train participant and staff to use device(s) and implement use.

    - A provider agency Technology Plan articulating the policies and practices for staff in the use of personal support technology by participants. This plan includes definitions on how:
        - Technology is used to facilitate the DSP's role in ensuring health, wellbeing and privacy of the people supported
        - Coordination with the technology provider will occur.
        - Staff will support participants to learn and use their technology as part of natural supports rather than as an extra support
        - Support will be provided in the event of a system problem such as loss of electricity of connectivity
    - Documentation in the participant's file identifying how and when the participant uses technology support.
    - IT support to ensure that technology is maintained to operate in good working condition. This standard can include a provision for technology IT from the technology device provider.
    - Staffing pattern when personal support technology is chosen by the participant
- A new section in the standards defining technology provider requirements for:
    - The application of proper design criteria in planning and installation of devices
    - Technical support and training for the participant, provider, and natural supports
    - Maintenance and service of devices
- Structure to facilitate quality measurements and reporting to ensure participants realize the outcomes they planned in their service plans

Considerations for case managers include training to become familiar with the types of devices available and how devices are best used to protect a participant's safety and encourage well-being. Case managers will need to consider and document the interdisciplinary team recommendations for the use of technology for home, employment, education and socializing when assessing a participant's risks. Case managers will employ supported decision making with participants to help them decide whether technology, and which technology, can effectively provide the support needed. A respect for the dignity of risk for a participant is essential to the service planning process for case managers, the interdisciplinary team, and natural and paid supports. As applicable, risk mitigation plans, Medical Emergency Response Plans and Crises Intervention Plans need to include back-up and alternative plans that can be quickly implemented in case of technology interruption or failure. Monitoring includes assessment of how well the chosen technology supports a participant, whether additional training and technical assistance is needed by the participant, staff or natural supports to effectively use the devices and whether changes are needed in the type of devices chosen to best support the participant. PCG supports DDSD's use of the Human Rights Committee to review the use of audio and visual equipment for personal support technology to ensure that it is used in a way that is HIPAA compliant.

Implementation Plan

An implementation plan provides an avenue to engage stakeholders throughout the process, identify any issues as they arise and make mid-course corrections before full state-wide implementation. The implementation plan should include:

- A time-limited targeted assistance group facilitated by DDSD and comprised of stakeholders to partner with DDSD by providing recommendations for the design, development, and implementation of the personal support technology benefit. The targeted assistance group includes members representing self-advocates, families, advocates, providers, the provider association, and other interested parties. This group will make recommendations to DDSD to modify the HCBS waiver and associated standards, evaluate the progress of implementation, make recommendations for any needed changes, and assist DDSD to provide on-going education to the community about implementation.

- A testing phase restricted to a specific geographic area or sample of participants, family members, case managers and providers who are willing to become early adopters. Early adopters report outcomes to the targeted assistance group at regular intervals to determine what, if any, modifications to standards or practice are needed to best benefit participants.

- On-going education to inform stakeholders and the public about the development and implementation of the personal support technology benefit. Provide targeted education and training to assist waiver participants, case managers, providers, and others in understanding its benefit and limitations, the individualized functional technology evaluation, and the planning process for the use of technology. Education could include community town-hall meetings, listening sessions, quarterly reports and a dedicated website showing the composition of the targeted assistance group, minutes of meetings, waiver and standards drafts, public comment received, consideration of public comments and outcomes data and reports.

Additionally, PCG believes the combination of the direct service workforce shortage and system changes mandated by the HCBS settings rule that exacerbates the workforce shortage will result in an increased demand for personal support technology by participants, families, and providers. Technology will not replace staff, but it can affect how staffing is allocated. Staff time can include some direct support but will also include responding to alerts, teaching skills, and serving more people. Staff will support people to do more on their own. Increased use of personal support technology implemented with a planned process that defines an appropriate structure and includes quality oversight can decrease staffing hours in the on-call reimbursement while still ensuring participant well-being.

PROVIDER MONITORING

The Home and Community Based Services waiver application requires a Financial Accountability Assurance from states affirming they have methods to ensure payments made to providers are accurate and are for the services that were provided. States use a variety of methods to validate fee-for-service Medicaid claims to ensure that payments are made for defined services delivered by qualified providers to eligible participants. Methods vary, but often include:

- Post payment reviews of a sample of paid claims from the state's MMIS system to ensure the approved rate is paid for the procedure code submitted
- Documentation reviews to ensure service is delivered according to the defined procedure

- Certification to ensure the provider is qualified
- Quality and compliance protocols applicable to all Medicaid claims
- Specific financial audits required by federal and state legislation

According to Appendix I in the Developmental Disabilities and Medically Fragile waivers, the New Mexico "Department of Health Quality Management Bureau (DOH/QMB) conducts post-payment reviews of DD waiver provider billing to verify whether services are being rendered according to the state's rules and regulations. Post payment reviews involve a review and validation of claims from a sample of providers for a specified time period. One hundred percent of paid claims for each selected provider are reviewed and validated for: 1) correct service codes; 2) correct billed units; and 3) supporting documentation for services rendered. All reviews are conducted on-site."

Even with solid practices in place to support the Financial Accountability Assurance, these measures do not guarantee services are delivered according to the level assessed for a participant. Waiver services represent unique review challenges when a service is provided according to levels that reflect the complexity of service. Payment for services such as Supported Living, Customized Community Support and Community Integrated Employment encompass multiple levels of support, and multiple types of support within levels, considering medical, behavioral and psychological needs. A multi-pronged approach is required to determine whether a participant is receiving the type and amount of support purchased. DDSD can enhance oversight for expenditures related to the tier payment structure by implementing a targeted review process to focus accountability for a specific service type or provider type.

PCG recommends that DDSD develop a targeted review process to complement the DOH/QMB post payment review process for Supported Living, Customized Community Support, and Community Integrated Employment. This targeted review would incorporate a tool based on the waiver definition for the service and the type and amount of services required by a participant's level. The waiver definition would be translated to measures for service received by a participant, including minimum staffing ratios and the range and type of support a participant needs. The targeted review would use these measures along with the recommendations in the following paragraph to determine whether a participant received the level of support purchased by DDSD.

The targeted review would consider a statistically valid sample of participants receiving Supported Living, Customized Community Support, or Community Integrated Employment. The sample would reflect a 95 percent confidence level with no more than a 5 percent margin of error for the services reviewed. The targeted review is a post payment review that considers the provider's adherence to waiver requirements and service delivery at the level for which payment is received. For each participant, the following provider records would be reviewed for the time period considered:

- Personnel records to verify adherence to qualification and training standards for direct service providers supporting the participant
- Staffing records to determine staffing patterns and ratios throughout the day or times service was provided for the participant
- Participant care plan to ascertain whether care is consistently planned according to the level paid

- Participant care records to establish whether support to the participant was provided at the level purchased and if it assisted the participant to achieve the goals set forth in his or her Individual Service Plan
- Case management notes for the participants served by the providers in the sample to determine whether the participant received services according to the level indicated in his or her Individual Service Plan.

DDSD should work in collaboration with DOH/QMB to coordinate the sample and post payment reviews. DDSD should also work with DOH/QMB to determine how results of the target review will be handled. Findings should be submitted to DOH/QMB for resolution or handled in a manner consistent with the policies used by DOH/QMB for noticing, accountability and recovery. Providers found not delivering service indicated by the level for which they are reimbursed should be subject to due process culminating in recovering funds when service delivery cannot be substantiated. PCG recommends establishing standards to support a targeted review and educating providers, case managers, participants and their families and guardians on those standards prior to conducting any reviews. Additionally, PCG recommends incorporating requirements to participate in the targeted review into provider and case management agreements.

PCG also recommends a reliable and valid participant needs assessment tool to ensure integrity of payments. The work to best align payment with participant needs begins with a thorough assessment process using a valid instrument that incorporates inter-relater reliability. The process must include a procedure to consider exceptions that effectively ties a request for increased funds to the cost factors used in developing the rates. Providers should access an online system that allows them to input actual cost factors to support a specific participant into a rate calculator. Costs that do not exceed the rate range upon which a rate was determined would not be approved. Awarding exceptions based on the increase in costs as demonstrated by cost factors provides a transparent and equitable process to support exceptional needs.

EVALUATION OF TIERED RATE SYSTEMS

Tiered rate systems are seen widely across state programs for human services. Successful tiered rate systems often show similar characteristics or support structures, such as the following:

- *Detailed data collection with an extensive history of consistent data elements*
  The basis for any well-structured rate methodology begins with the availability of high quality data with small error rates. These are the fundamental building blocks to any rate methodology to meet federal standards that payments must be consistent with the efficiency, economy, and quality of services provided. With tiered rate methodologies, data points on the population must be consistently captured over a lengthy period of time. Specifically, in the case of supported living services under the DD waiver, as these are long-term services, it would be important to base any rate methodology on an equitable time-frame to ensure the full capture of work, cost, and expense.
- *Well-developed standardized assessments*
  Most tiered rates are entirely dependent on the level of need for individual clients. This makes a thorough, modern, and accurate standardized assessment key to the implementation of tiered rate methodologies. Consistency is the core aspect when developing rate tiers. Consistency in accurately identified and cataloguing expected

service needs to enhance independence, consistency in categorizing similar cases with similar needs within the same tiers, and consistency in applying policy to all providers and clients are the core foundations to not only implementing a tiered rate methodology, but also ensuring its continued application. Inconsistency can undermine not only policy and rates, but provider and client trust. Ensuring everyone is evaluated on the same elements, while understanding the unique circumstances and needs, is important to maintain system fidelity.

- *Knowing when to bundle and unbundle services*
  One of the most fraught discussions during the development of a tiered rate structure is which services and sub-services should be bundled and in what amounts. This is a particularly difficult problem within waiver services for several reasons.
    1. Firstly, States do not always share the same policies on these ancillary and tertiary services. This creates a bit of an unknown situation that doesn't allow a tiered rate methodology to easily be borrowed from other similar states. It also doesn't allow for greater data collection. Many advanced rate methodologies exist within healthcare primarily due to the fact treatment practices have greater consistency across political boundaries, allowing for much broader statistics and deeper analysis with less error.
    2. Waiver services are largely custom to each state and change more frequently. This creates issues when performing regression testing on efficacy on the bundling or unbundling of services.
    3. Waiver services are far more customized and client-centered than other services. While some broad categories can be applied to most individuals, the amounts of services will vary greatly. With an already undersized population, this doesn't allow for easy analysis to see if the State can create a reasonable scale of tiered service packages.
    4. The number of bundled services presents methodological problems. For each unique bundled service, deeper understanding and a new analysis is required to build in levels of need across a diverse spectrum of clients. For example, to bundle nursing services into supported living rates is rather simply done with a scaling spectrum as seen in Table 23 below:

Table 23: One Bundled Service Within Tiered System

Tier	Example Base Cost	Nursing Needs
Tier 1 – High Self-sufficiency	$100/day	Low
Tier 2 – High-Moderate Self Sufficiency	$125/day	Moderate
Tier 3 – Moderate Self-Sufficiency	$135/day	Moderate
Tier 4 – Moderate-Low Self Sufficiency	$145/day	Moderate
Tier 5 – Low Self Sufficiency or High Needs	$170/day	High

However, as the number of bundled services grows, a matrix structure is required to appropriately capture the viability of payments and ensure the needs of all individuals are met. With each newly bundled service, the need to evaluate for sufficiency grows exponentially.

Table 24: Two Bundled Services Within Tiered System

Tier	Example Base Cost	Nursing Needs	Nutritional Needs
Tier 1 – High Self-sufficiency	$100/day	Low	Low
			Moderate
			High
Tier 2 – High-Moderate Self Sufficiency	$125/day	Moderate	Low
			Moderate
			High
Tier 3 – Moderate Self-Sufficiency	$135/day	Moderate	Low
			Moderate
			High
Tier 4 – Moderate-Low Self Sufficiency	$145/day	Moderate	Low
			Moderate
			High
Tier 5 – Low Self Sufficiency or High Needs	$170/day	High	Low
			Moderate
			High

Advantages of Tiered Rate Methodologies

While tiered rate methodologies can be done within waiver programs and do come with positive aspects.

1. First and foremost is the predictability of annual expenditures and budgets. A daily rate with a known maximum expenditure per client is a desirable upside for any program. With bundled payments, the onus is shifted to the provider to maintain cost discipline rather than simply shifting that burden to the State to manage authorizations and expenditures for the minutiae of services that could be done each day. With more fee-for-service structured services, the risk for overspending expands as there is little coordination or daily oversight of either encumbered expenses or actual expenses.
2. Tiered rates could lead to better service coordination. While largely theoretical with no studies found on this particular subject, tiered rates should lead to better coordination of services. While the risk for profitability is shifted to the provider, so is the duty to provide adequate services for their clients. As discussed in the Program Monitoring section, this isn't without State duty to ensure the effective delivery of service. However, through tiered rates, providers are encouraged to both coordinate what is both necessary and cost-efficient. This bolsters the general guidance that service payments be efficiency, economy, and quality of care standards.

Conclusions on the Use of Tiered Rate Methodologies

PCG finds that tiered rate methodologies, while widely used, often undercut and misestimate client needs and result in either over- or underpayment to providers. A tiered rate model adds two valuable pros:

1. Predictable state expenditures
2. Better service coordination

However, the cons to a tiered rate methodology with bundled services outweigh these positive aspects. The loss of data integrity, inaccuracy of rates, and inflexibility with policy changes hamper tier rate models. The value of alternatives provides better incentive to move away from these models, either towards an unbundled tier system, which would have far more accuracy in predicting base costs, or a quality based methodology where payment structures are aligned with outcomes. PCG recommends that DDSD re-evaluate the need for bundling of healthcare-oriented services, such as nursing and nutritional services within the payment structure of supported living.

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APPENDIX A: RATE CALCULATION TABLES

SERVICE: PT/OT/SLP	Rate Build Up	%
WAGE: PT/OT/SLP		
Annual Salary	$86,669.82	
Hourly Rate	$41.67	
Employee Related Expenses/Benefits	$12.30	29.53%
Employee Salary + Benefits Per Hour	$53.97	
HCBS Subcontractor Cost Per Hour	$60.60	
Total Hourly Personnel Cost	$57.73	
Admin + Program Support Costs	$12.72	18%
Hourly Admin/PS + Personnel	$70.46	
Billable/Non-billable Factor	$138.15	51%
Mileage	$1.56	
TOTAL HOURLY RATE	$139.71	
15 Min Rate - Standard	$34.93	
15 Min Rate - Incentive	$44.54	

SERVICE: PTA/COTA	Rate Build Up	%
WAGE: PTA/COTA		
Annual Salary	$57,928.00	
Hourly Rate	$27.85	
Employee Related Expenses/Benefits	$8.22	29.53%
Employee Salary + Benefits Per Hour	$36.07	
HCBS Subcontractor Cost Per Hour	$54.80	
Total Hourly Personnel Cost	$51.38	
Admin + Program Support Costs	$11.32	18%
Hourly Admin/PS + Personnel	$62.70	
Billable/Non-billable Factor	$93.58	67%
Mileage	$1.56	
TOTAL HOURLY RATE	$95.14	
15 Min Rate - Standard	$23.78	
15 Min Rate - Incentive	$31.20	

SERVICE: Behavior Support Consultation	Rate Build Up	%
WAGE: Behavior Support Consultant		
Annual Salary	$50,331.78	
Hourly Rate	$24.20	
Employee Related Expenses/Benefits	$7.14	29.53%
Employee Salary + Benefits Per Hour	$31.34	
HCBS Subcontractor Cost Per Hour	$49.14	
Total Hourly Personnel Cost	$47.19	
Admin + Program Support Costs	$10.40	18%
Hourly Admin/PS + Personnel	$57.59	
Billable/Non-billable Factor	$95.98	60%
Mileage	$1.56	
TOTAL HOURLY RATE	$97.54	
15 Min Rate - Standard	$24.39	
15 Min Rate - Incentive	$31.46	

APPENDIX B: COST REPORT REDESIGN

New Mexico Developmental Disabilities Supports Division

HCBS Medicaid Waiver Programs Expense Tool (BSC and Therapies)

Please return all completed tools to NMHCBSRateStudy@pcgus.com. Providers requesting technical assistance may contact Jonathan Mattingly, Project Manager, at Jmattingly@pcgus.com or by phone at (850) 402-5138.

12 Month Reporting Period

12 Month Period Start	
12 Month Period End	

Provider and Contact Information

Provider Name		
Provider IRS Tax Status		
Provider Medicaid ID #		
HCBS Program Name (if different)		
HCBS Program Address		
City, State, Zip		
County		
Contact Name		
Contact Position		
Contact Email		
Contact Phone		
Which DDSD waivers do you serve?		
What % of GROSS revenue comes from DD/MF waiver services?		

Revenue

	Provider Total $	HCBS Program Total $	Notes/Comments
Revenue from DD or MF Waiver Programs		$ -	
Other Revenue		$ -	Ex. Medicaid, private pay, Mi Via waiver, or private insurance
Total Revenue		$ -	

Personnel

	Provider Total Full-Time Equivalent (FTE) Positions	HCBS Program Full-Time Equivalent (FTE) Positions	Notes/Comments
Employee FTEs (if applicable)		-	Standard: 2,080 hour work-year = 1 FTE
Subcontractor FTEs (if applicable)		-	
Employee FTEs Vacant (if applicable)		-	

	Provider Hours Per Employee/Subcontractor	HCBS Program Total Hours Per Employee/Subcontractor	Notes/Comments
Holiday Hours (avg per Employee)		0.00	
Vacation Hours (avg per Employee)		0.00	
Sick Hours (avg per Employee)		0.00	
Training Hours (avg per Employee/Subcontractor)		0.00	Applies to subcontractor positions ONLY if contractually required to reimburse
Total Paid Non-Working Hours		0.00	

THIS SECTION TO BE FILLED OUT FOR OWNER/OPERATOR MODEL WHO LARGELY USE SUBCONTRACTOR LABOR

	Provider Total $	HCBS Program Total $	Notes/Comments
Owner/Operator Salary		$ -	
Profit Disbursement		$ -	
Total Income Taxes Paid		$ -	
Subcontractor Expense (Total)		$ -	
Total Personal Benefits		$ -	*Note: Benefits paid by business*
Total Personnel Expenses		$ -	

THIS SECTION TO BE FILLED OUT FOR TRADITIONAL CORPORATE STRUCTURE MODEL WHO MAY USE BOTH EMPLOYEES AND SUBCONTRACTORS

	Provider Total $	HCBS Program Total $	Notes/Comments
Direct Service Employee Salaries		$ -	
Administrative Salaries		$ -	
Personnel Taxes		$ -	
Workers' Compensation		$ -	
Healthcare		$ -	
Retirement		$ -	
Other Fringe Benefits		$ -	
Direct Subcontractor Expenses		$ -	*Note: Direct Service subcontractors, for professional services (ex. Accounting), see Row 70.*
Total Personnel Expenses		$ -	

Operating Expenses *(Note: Subcontractor expenses not included)*

Estimated Total Mileage for Year (in miles)	

	Provider Total $	HCBS Program Total $	Notes/Comments
Estimated Total Mileage Dollar Cost for Year ($0.43/mile)	$ -	$ -	Expense Auto-Calculated using State Rate of $0.43/mile
Rent/Mortgage		$ -	
Property Insurance		$ -	
Utilities (including Cell service and internet)		$ -	
Supplies, Equipment, Subscription services		$ -	
Professional Service Contracts		$ -	Ex. Accounting, Legal, Office maintenance
Liability Insurance(s)		$ -	
Translation/Interpretation/Accommodation Services		$ -	
Training / Professional Development		$ -	
Transportation		$ -	Ex. Bus service fees, taxi, UBER, etc.
Travel		$ -	Ex. Airfare, hotels, etc.
Depreciation		$ -	
Other Operating Expenses		$ -	
Indirect (from Parent Organization)		$ -	*Note: Shared costs with parent company (shared HR,*
Total Other Expenses	$ -	$ -	
Total Expenses		$ -	

Attestation

By entering my name, staff title and electronically signing my name below, I attest that the information contained in this worksheet and any of its accompanying financial statements/files are both accurate and complete to the best of my knowledge, and I am authorized to attest and submit this information on behalf of my provider agency.

Authorized Attestation Name:	
Attestation Staff Title:	
Electronic Signature (Retype Name):	
Date of Attestation:	