



DEPARTMENT OF
ECONOMIC SECURITY

Division of Developmental Disabilities

2014 Provider HCBS Rate Rebase Study

Responses to Public Comments

Comment Period: October 10 – November 10, 2013

June 30, 2014

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Overview

The Arizona Department of Economic Security (“DES”)/ Division of Developmental Disabilities (“DDD” or “Division”) released the original version of the *RebaseBook 2014* on October 10, 2013 for public comment. That original version of the *RebaseBook 2014* contained the recommendations for the proposed Benchmark Rates from Burns & Associates, Inc. and Navigant Consulting, Inc.; collectively referred to as the Consultant Work Group (CWG). Public comments and opinions on the *RebaseBook 2014* were accepted until November 10, 2013 and are summarized in this document. Any comments submitted after the deadline are not included in this document.

In addition to releasing the *RebaseBook*, the Division held five public forums for providers, members, and families during the period of October 15 – 18, at varying locations across the State. The public comments and questions received during these public forums are also included in this document.

More than 300 comments were submitted during the public comment period. Duplicate comments were summarized into a single comment. The comments are organized into 17 topical areas, summarized, and restated for response. The 17 topical areas are:

- | | |
|---------------------------------------------|-----------------------------------------|
| 1. General | 10. Day Treatment and Training Services |
| 2. Survey | 11. Developmental Home Services |
| 3. Wages | 12. Group Home Services |
| 4. Benefits | 13. Nursing Services |
| 5. Productivity | 14. Therapy/ Therapy Assistant Services |
| 6. Administrative & Program Support | 15. Employment Services |
| 7. Other Factors | 16. Specialized Habilitation Services |
| 8. In-Home Services | 17. Transportation Services |
| 9. Individually Designed Living Arrangement | |

Table 1 summarizes the number of comments received during the comment period for each of the 17 topic areas. Many of the comments addressed multiple topics.

Table 1: Summary of Comments Received for each of 17 Topical Areas

Topical Area	Number of Comments
• General	31
• Survey	7
• Wages	10
• Benefits (ERE)	20
• Productivity	2
• Administrative & Program Support	2
• Other Factors	5

Topical Area	Number of Comments
• In-Home Services	5
• Individually Assigned Living Arrangement	2
• Day Treatment and Training Services	51
• Developmental Home Services	22
• Group Home Services	12
• Nursing Services	17
• Therapy Services/Therapy Assistant Services	176
• Employment Services	9
• Specialized Habilitation Services	2
• Transportation	5

Significant Changes to Rebased Rates Requested in the Public Comments

After the comments were submitted, they were reviewed and summarized, and the CWG and the Division conferred as to what changes were to be made to the proposed Rebase Models and resulting rates. This discussion is presented in the following two tables.

Table 2 presents highlights of the changes that were made to the proposed Rebase Rates as a result of the comments.

Table 2: Summary of Adopted Changes Subsequent to Public Comments

Service Category	Description of Change
Day Program Intense	<ul style="list-style-type: none"> Increased training from 40 to 56 hours per year (an increase in the productivity adjustment from .15 to .21) Added \$2.50 per day for itemized supplies
Day Treatment Child-Rural Rate (New)	<ul style="list-style-type: none"> Added a rural rate model for Child After School and Summer
Developmental Home (Vendor and Family)	<ul style="list-style-type: none"> Increased habilitation hours per day from 4 to 5
Nursing Supported Group Home	<ul style="list-style-type: none"> Added an absence factor of 6% (or 22 days) per year in consideration of both absences and slow placements Adjusted staffing intensity for Level II and III rates
Physical Therapists/Therapy Assistants	<ul style="list-style-type: none"> Pinal County changed from Base Area to Area 1 Navajo County changed from Area 1 to Area 2 Outlined a process to designate areas within counties to have separate geographic factors
Therapy Assistant (All other disciplines)	<ul style="list-style-type: none"> Increased wages by adding a 10% incentive factor Increased the supervisory factor Revised urban/rural classification as described above
Transportation (Most Rates)	<ul style="list-style-type: none"> Aligned absence factor to Day Treatment & Training to 85%
BCBA-D for Early Childhood Autism	<ul style="list-style-type: none"> Add a new rate model for BCBA's with Ph.D.s

The revised Rebase Rate Models that illustrate the calculations and resulting rates of these changes are included in the June 30, 2014 version of the *RebaseBook 2014*, which is posted on the Division’s website [located here](#) . However, not all of the adjustments adopted as a result of the public comments translated into new or revised rate models. For example, the reclassification of Pinal and Navajo counties resulted in rate changes for those areas but did not change any rate models.

Table 3 below presents some of the more significant issues raised during the public comment period that did not translate into revisions of the Rebase Models or Rebase Rates.

Table 3: Summary of Significant Changes Requested in Public Comments That Were Not Adopted

Service Category or Rate Component	Description of Requested Change
Wages	<ul style="list-style-type: none"> • Use <i>median</i> BLS wage • Include overtime pay consistent with DOL changes to companion exemption
ERE	<ul style="list-style-type: none"> • Apply different part-time adjustment factor to different services • Incorporate employee turnover in the calculation of ERE amounts
Urban/Rural	<ul style="list-style-type: none"> • Base rate adjustments on distance traveled
Day Treatment & Training Services	<ul style="list-style-type: none"> • Increase allotted time for ISP meetings, employer time, training time, recordkeeping • Increase Program Support factor • Change BLS job categories and mix
Group Home Services	<ul style="list-style-type: none"> • Pay for property damage caused by members with behavioral problems • Change BLS job categories and mix
Home Health Nursing Services	<ul style="list-style-type: none"> • Reduce the RN/LPN differential
Therapy Assistants	<ul style="list-style-type: none"> • Pay therapy assistants the same as therapists
Group Employment Services	<ul style="list-style-type: none"> • Adjust rates to avoid reduction

The following section presents summaries of the public comments received and a comment by comment response arranged by the 17 topic areas.

The Division's Response to Public Comments

The following pages present summaries of the public comments received arranged into 17 separate categories. Within each category the summarized comments are presented together with the CWG's and the Division's response.

1. General Comments

The 31 comments grouped into the general topic area addressed issues related to the Rebase process as a whole and were not specifically tied to components of the independent rate models or to particular services. Comments and questions in the general category concerned:

- Rebase process
- Published responses to comments
- Focus groups
- Public forums
- Website
- Comparison to the prevailing Benchmark Rates
- Adopted versus Benchmark Rates
- Use of provider input

Rebase Process

Six (6) comments were submitted that expressed appreciation for the effort and investment of the Division into the rebasing process.

The Division designed the Rebase process to be inclusive and transparent including:

- *Multiple opportunities for input into the rebasing process (provider survey, focus groups, interviews and public forums),*
- *Sharing detailed explanations of the independent rate models proposed both in writing and presentations,*
- *Responding to comments/questions regarding the proposed rate models (this document and revisions to the rate models made after the Division's consideration of comments submitted).*

The Division thanks these commenters for their acknowledgement of the effort devoted to the Rebase process.

Publish Response to Comments

Two comments asked if the Division's responses to the comments would be published.

Yes, this document.

Focus Groups

Two commenters asked for further information on the focus groups including whether the groups were specific to a service and the number of attendees.

Focus Groups were formed around eight (8) separate services or service groupings. The eight (8) service areas included: therapies, day treatment and training services, in-home services, developmental home services, employment services, group home service, nursing services, and specialized habilitation music therapy services. While there were eight (8) service groupings, the initial number of focus groups totaled 17 with multiple service specific focus groups based in various geographic areas. In summary, there were 10 initial focus groups held in the Phoenix area, five (5) in Tucson and two (2) in Flagstaff.

The focus groups were convened on four (4) separate occasions to address various areas of the rebasing process. The Division feels the focus groups greatly contributed to the rebasing process by allowing the Division and the CWG to both gather input and communicate with the greater provider community.

In addition to the focus groups, one-on-one interviews were conducted with Nursing Supported Group Home providers and other selected providers of services that were underrepresented in focus groups.

Public Forums

Several comments recommended that similar forums be provided for family members in order to get them involved in the process. The commenter believed that if the families were to work with providers, they can be effective in communicating the need for increased funding to legislators.

The Division felt that the public forums were a great tool for explaining the Rebase process and the Rebase Rates to the provider, family, and member community. All comments and questions received during the public forums were greatly appreciated and considered. The Division held five (5) public forum meetings in different locations and at different times with the hope of providing options for providers, members, family members, and the community to attend the meetings. These meetings were not specifically oriented towards family members and members, but were designed to be informative to family members and members as well as providers. The Division will consider forums specific to families and members in the future to enhance their participation and feedback.

Another commenter was not pleased with the tone and content of the general presentation, materials and message during the public forums. Instead of informing participants, the emphasis was too heavily focused on selling. The commenter noted that other participants in public forums expressed the same criticism although only one comment was received.

The Division will take steps to ensure that a “sales” message is not conveyed as the primary focus of

presentations in the future.

Post Materials for Forums on Website

Several commenters participating in public forums requested that the presentation materials used in the forums be posted on the Division's website.

The Division implemented this recommendation in October.

Comparison to Prevailing Benchmark

The recommendation was made that rather than compare the Benchmark Rates derived through the Rebase Project to the SFY 2014 Adopted Rates (which produced an overall increase of 25.6% based on the Rebased Rates as they stood at the time), the comparison should be made between the Rebase Project Benchmark Rates and the SFY 2014 Benchmark Rates.

The CWG and the Division did update materials and provided the requested comparisons during the public comment period. In the final version of the RebaseBook 2014 (published to the Division's website on June 30, 2014) the increase of the updated Rebase Rates were calculated to be 26.1% and calculations are included that indicate if the previous Benchmark Rates were adjusted for inflation and the rate decreases, the proposed Rebase Rates would be one percent (1%) lower than the adjusted Benchmark Rates.

Benchmark versus Adopted Rates

While commenters indicated that overall the increase in the Benchmark Rates for services is positive and have the potential to improve access to services, any benefit depends on the funding approved for the Division in the budget process and the resulting level of the Adopted Rates. These commenters asked the Division to explain the process of establishing Adopted Rates and asked the Division to guarantee that the Adopted Rates would not be less than the Adopted Rates currently paid.

The commenters also emphasized the importance to providers in knowing the level of Adopted Rates so that appropriate plans could be made. One commenter also asked whether the determination of the Adopted Rate would only be based on internal Division discussions.

The Division understands the importance of the Adopted Rates to providers specifically and the service delivery system as a whole. As was emphasized during the public forums, the level at which Adopted Rates are set is directly dependent upon the funding made available to the Division through the legislative appropriation process.

The appropriations process during SFY 2014 resulted in a 2% increase in funding effective July 1, 2014 to the Division for all home and community based services (HCBS) with the exception of room and board.

As a result, the RateBook published on July 1, 2014 generally increased the Adopted Rates in effect on June 30, 2014 by 2%. Room and board Adopted Rates were not adjusted. Detail on the SFY 2015 rates are contained in the July 1, 2014 RateBook which is posted on the Division's website [located here](#) .

Use of Provider Input

One (1) comment questioned whether provider input was actually used given the amount of effort they invested.

The Division believes the entire rebasing process both solicited and used input from the provider community. Through the focus groups, the provider community shaped the provider survey and the various rate models, as well as offered critiques of the compiled provider survey results. The focus group process also resulted in revisions to preliminary rate models. Finally, through the public forums and the public comment period, provider comments were solicited, reviewed, and in a number of cases, resulted in revisions to the proposed rates.

2. Comments Related to the Provider Survey

Seven (7) comments were submitted that focused on the provider survey, including the instrument itself, the representativeness of survey responses, the comparison of survey responses to other states, questions regarding whether the survey explored part-time versus full-time workers, and differences between for profit and nonprofit providers.

Survey Instrument

One question was received concerning the comparability of survey instruments used in this rebasing process and historical Rebase projects that would allow direct comparison.

While there is a great deal of overlap between current and historical provider surveys, they are not identical. The provider survey used in the current rebasing incorporated both lessons learned from previous surveys as well as input from the provider focus groups. As a result, the survey tool used during this rebasing process is not identical to the survey developed for the 2008 rebasing process.

Representativeness of Survey Responses

Two (2) commenters questioned whether the completed provider surveys received in this Rebase represented the characteristics of the providers surveyed as to size and geography. One (1) comment from a small provider agency suggested that because the survey was very demanding and difficult to complete, larger organizations with some staff flexibility were more likely to submit a survey response. Therefore, the concern was expressed that larger organizations were better represented in the survey results than smaller providers and as a result, the conclusions are weighted towards the larger providers that have better economies of scale. The same concern was expressed regarding the representativeness of the sample for both

urban and rural providers.

The Division and the CWG recognize that the provider survey was somewhat complicated and required a commitment of resources from providers to complete. The CWG also recognizes that smaller providers may have had a more difficult time responding to the survey due to time commitment, the resources required, and the data necessary to complete the survey. Although the survey was lengthy and required reporting specific information, the information requested was necessary to update the Rate Models.

The survey (which was developed with input from the provider focus groups) was sent on March 18, 2013 to 526 provider agencies. Providers were given a total of eleven weeks to complete the survey. A total of 78 providers returned a survey, which represents a 15% response rate. While the 15% response rate is low in absolute terms, it should be noted that approximately 40% of the Division's 526 providers are individual therapists or therapy groups. Viewed in terms of Division expenditures, the returned surveys represent 35% of home and community based service expenditures.

Of the 78 providers returning surveys, 12 of the top 24 providers (based on revenue) were represented and 24 of the top 50 agencies were represented. Since only 24 of the 78 responding providers rank in the top 50 Division providers, the CWG believes that the results contained a reasonable number of mid-sized or small providers.

Determining whether the survey responses contained a reasonable number of rural providers is a more difficult problem. Many providers deliver services in both urban and rural areas. Of the 78 surveys in the sample, 61 were from providers that report providing at least one service in rural areas. The survey did collect Urban and Rural locations and those results are contained in the Provider Cost Survey Final Report, October 8, 2013 available on the Division's website.

Comparison to Other States

One (1) comment requested that provider survey data be compared to other states.

A comparison of the provider survey data to other states was not and will not be performed. Making a comparison to other states is difficult, if not impossible, for two primary reasons:

- First, most other states do not conduct a provider survey comparable to the survey performed during the Rebase Project*
- Second, if such a survey existed, considerable work – primarily in the area of comparing service definitions between the other states and Arizona - would be required to ensure that the comparison is fair and accurate*

In short, the requested comparison is outside the scope of the Rebase Project.

Part-Time versus Full-Time Workers

One (1) comment asked whether the provider survey inquired about the percentage of part-time versus full-time workers.

The provider survey did collect part-time versus full-time data specific to employee benefits but did not collect such information by service. As a result, the survey does not offer insight as to the percentage of part-time versus full-time workers by service.

In order to determine this percentage, the survey would have had to be modified in a manner that would have added considerable complexity to the tool. As evidenced by some of the preceding comments, many providers feel that the survey that was deployed was already too complex to complete.

Non Profit versus For Profit Providers

Two comments recommended that data for wage and benefits be analyzed separately according to ownership status.

The provider survey did not capture the ownership status of providers and therefore the differences between nonprofit and proprietary providers in terms of wages paid cannot be easily evaluated. However, since both types of providers compete in the same labor market, the Division has no reason to believe there would be a significant difference in wages and benefits between the two ownership types. Nevertheless, the Division will consider the inclusion of ownership types in future provider surveys.

3. Comments Related to Wages

There were many comments submitted on the subject of wages. The comments that addressed wage levels in general are summarized below while the comments that addressed wages for specific services are presented in the sections summarizing those services. Comments related to the wage levels in general are addressed in the following four areas:

- Selection of BLS percentiles
- Wage variance by member need
- Increase in base wages
- Overtime

Wages, BLS Percentiles

One (1) comment suggested the wage levels used in the models should be based on the BLS median wages and not the midpoint of the BLS 25th and 50th percentiles. A second commenter noted that because the wage assumptions used this midpoint, the rate models are not really “independent rate models.”

Table 4 on the second following page displays – among other data points – the wage levels for the various services that were obtained from the provider survey and from the BLS 25th and 50th midpoints. Table 4 shows:

- *Providers are generally paying below the midpoint of the BLS 25th and 50th percentiles,*
- *For the services in which the BLS data is higher than the wage levels currently paid by providers, two of the more significant differences are in the Day Treatment and Training Services (17.1%) and Group Home services (22.1%).,*
- *There are only three(3) services where the BLS data is lower than the wage levels currently paid by providers, the amount of difference is nominal in two cases and significant in the case of therapy assistants:*
 - *Developmental Home monitoring staff (-1.9%)*
 - *Licensed Practical Nurse LPN (-3.8%)*
 - *Therapy Assistants (-27.9%)*

As a result of this and other comments (and, as discussed later in this document) the wage level for therapy assistants has been adjusted since the release of the October 2015 RebaseBook.

Based on the rather significant increase that the BLS wage rates represent over the current level of wages paid by providers, no overall methodological change was made to the wage levels used in the proposed models.

The CWG disagrees that the adoption of the midpoint of the BLS 25th and 50th wage percentiles somehow renders the rate models to be something other than independent.

Wage Varies by Member Needs

One commenter noted that wage levels should vary directly with the needs of the member.

The Division acknowledges that wages paid to direct care staff may have to increase as the member's needs become more intense and complex. However, providers are not mandated to pay the wage level used in the rate models to all employees providing a particular service. Wage levels can and should vary based on a number of factors, member needs being one. Actual wages paid to a single direct care worker by providers can be higher (or lower) than the factor depicted within the individual model.

Increase in Base Wages

Additional comments were received that urged additional increases in base wages used in the model because there had been no increase in base salaries over the past 25 years.

As previously discussed, Table 4 on the following page illustrates that the wage levels incorporated into the rate models are, with few exceptions, significantly higher than the wages currently paid by providers based on the survey results. The CWG and the Division do not believe a further adjustment to the methodology employed to determine wage levels is warranted.

Table 4: Comparison of BLS and Provider Survey Wages Inflated

	ATC	HAH ECH	HSK	RSP	HAI	HBA ²	HBC ²	HBA ³	HBC ³	HPD	HAB	HAN-RN ¹	HAN-CNA ¹	DTA DTR
Current Model (Unadjusted)	\$9.12	\$10.99	\$8.09	\$9.12	\$12.36	\$16.04	\$16.04	\$13.97	\$13.97	\$12.09	\$10.99	NA	NA	\$13.22
BLS Wages - Mid-Point 25th/Median 2014 Rebase Mix	Uninflated \$9.61	\$10.99	\$9.17	\$9.61	\$10.99	\$16.77	\$16.77	\$14.34	\$14.34	\$10.76	\$10.76	\$31.77	\$12.37	\$10.76
BLS Wages - Mid-Point 25th/Median 2014 Rebase Mix	Inflated \$10.22	\$11.68	\$9.75	\$10.22	\$11.68	\$17.83	\$17.83	\$15.25	\$15.25	\$11.44	\$11.44	\$33.78	\$13.15	\$11.44
Survey Response ⁴	\$9.68	\$9.53	\$8.91	\$9.55	\$9.42	\$16.67	\$16.35	\$15.59	\$15.54	\$9.50	\$9.36	NA	NA	\$9.77
Percentage Inc/(Dec)														
2014 Inflated : Current	12.1%	6.3%	20.5%	12.1%	-5.5%	11.2%	11.2%	9.1%	9.1%	-5.4%	4.1%			-13.5%
2014 Inflated : Survey	5.6%	22.6%	9.3%	7.1%	24.1%	7.0%	9.1%	-2.2%	-1.9%	20.4%	22.1%			17.1%

	DTC DTS	HNV, HN9 HN1, HNR (Mixed)	HNV, HN9 HN1, HNR (RN)	HNV, HN9 HN1, HNR (LPN)	OTA PTA STA	RP1 ¹	SLP ⁵	HHH ¹	CBE	TTE ¹	GSE	ISE	ESA-ISE	ESA-GSE
Current Model (Unadjusted)	\$13.22	\$20.11	\$20.11	\$20.11	\$32.83	\$20.41	\$24.62	\$8.67	\$11.17	NA	\$12.53	\$14.34	\$9.97	\$9.97
BLS Wages - Mid-Point 25th/Median 2014 Rebase Mix	Uninflated \$10.76	\$24.38	\$31.77	\$22.54	\$34.46	\$23.49	\$16.37	\$9.85	\$11.02	\$15.70	\$11.80	\$13.70	\$9.61	\$9.61
BLS Wages - Mid-Point 25th/Median 2014 Rebase Mix	Inflated \$11.44	\$25.92	\$33.78	\$23.96	\$36.63	\$24.98	\$19.15	\$10.47	\$11.71	\$16.70	\$12.54	\$14.56	\$10.22	\$10.22
Survey Response ⁴	\$10.67	NA	\$25.86	\$24.91	\$34.53	NA	\$26.56	NA	\$10.27	NA	\$10.56	\$10.81	\$10.88	\$8.97
Percentage Inc/(Dec)														
2014 Inflated : Current	-13.5%	28.9%	68.0%	19.1%	11.6%	22.4%	-22.2%	20.8%	4.9%		0.1%	1.6%	2.5%	2.5%
2014 Inflated : Survey	7.2%		30.6%	-3.8%	6.1%		-27.9%		14.1%		18.8%	34.8%	-6.1%	13.9%

	HAM	HCM Psychologist ¹	HCM Lic. Beh. Ana ¹	HCM BCBA ¹	HCB ¹ BCABA	ECM ¹ BCBA-D	ECM Lic. Beh. Ana ¹	ECM Masters ¹	ECB ¹
Current Model (Unadjusted)	\$20.53	NA	NA	NA	NA	NA	NA	NA	NA
BLS Wages - Mid-Point 25th/Median 2014 Rebase Mix	Uninflated \$18.55	\$57.34	\$25.03	\$25.03	\$19.28	\$57.34	\$25.03	\$25.03	\$19.28
BLS Wages - Mid-Point 25th/Median 2014 Rebase Mix	Inflated \$19.72	\$60.97	\$26.61	\$26.61	\$20.50	\$60.97	\$26.61	\$26.61	\$20.50
Survey Response	\$13.15	NA	NA	NA	NA	NA	NA	NA	NA
Percentage Inc/(Dec)									
2014 Inflated : Current	-3.9%								
2014 Inflated : Survey	50.0%								

¹ No survey responses

² Job Categories comprising Training Staff for Developmental Home

³ Job Categories comprising Supervision & Monitoring Staff for Developmental Home

⁴ Survey Responses reflect, "Weighted Averages, excluding Outliers for Employees, excluding Supervisors"

⁵ Current model wage reflects 75% of Therapy wage data; 2014 Rebase Mix includes 10% incentive

Overtime Wages DOL Companion Regulations

The Division received three (3) comments asking whether the overtime wage requirements of the recently released Department of Labor (DOL) companion rules were considered in development of the models.

The Division and the CWG are aware of the overtime wage requirements of the referenced Department of Labor companion rule and the guidance issued by CMS. This issue is currently under study by the Division. If it is determined that adjustments to the provider rates are necessary, those adjustments will be made.

4. Comments Related to Employee Related Expenses (ERE)

In total, 20 comments were submitted related to employee related benefits. Questions and comments included:

- Part-time benefits
- Cost of providing ERE
- Turnover
- Affordable Care Act (ACA)
- State employee benefits
- Mandatory benefits

Benefits (ERE), Part-Time

Seven (7) comments were submitted that suggested the application of the 76% part-time employee factor for determining the discretionary employment related benefits is inappropriate, in as much as the mix of full-time and part-time employees varies by service type. Based on data collected from 17 providers, the recommendation was made to use two separate part-time employee factors: 32.5% for in-home services and 87.0% for all other services. Another comment suggested that the 24% adjustment provides a disincentive for providers to use full-time employees and an additional commenter questioned the independence of rate-setting since the budget was considered in factoring in the 24% adjustment for part-time employees.

The Division and the CWG recognize the 76% adjustment made to the calculation of the ERE amounts was both somewhat crude and was made because of budget sensitivity. However, the resulting ERE factors used in the model are not considered to be unreasonable.

With respect to the lack of precision of the 76% factor for all providers for all services, the commenters' point is acknowledged. However, the provider survey did not provide sufficient information to make a part-time adjustment for each service.

The CWG and the Division examined the “adjusted” ERE rates that were used in the rate models against three alternative metrics: the amount of ERE which would have been provided without the part-time adjustment; the amount of ERE which would have been provided given provider eligibility requirements for optional benefits (waiting periods, weekly hours worked, etc.) and employee take up rates (declining coverage for various reasons); and finally, the amount of ERE expenses which would have been incurred had the results from the provider survey been applied in the models.

The result of the examination led the CWG and the Division to conclude the ERE rates used in the Rebase Models were reasonable against the three metrics because of the use of the “block” ERE percentages (35%, 30% and 23%), the assumption contained in the rate models that optional ERE benefits are available to employees on their first day of employment, and finally, the extension of optional ERE amounts to all employees (i.e., assuming no employee will decline the optional benefits). For these reasons, as well as the budgetary considerations, no change was made in the ERE methodology.

Cost of Providing ERE

A few commenters noted that their current costs for providing benefits far exceeds the assumed 35% ERE factor and the commenters costs are built around a ‘high-deductible’ health plan.

As with all factors developed for inclusion in the Independent Rate models, the factors utilized for ERE are assumed to reflect the ‘typical’ costs to a provider agency. As explained in the previous discussion, the ERE amounts are regarded as reasonable for the provider community as a whole.

Benefits, Turnover

A number of questions were submitted concerning the additional costs associated with employee turnover and whether ERE assumptions included in rate models considered turnover.

The rate models were built to allow for benefits to be fully funded for employees from the start of employment. The CWG did not include employee turnover or waiting periods because such factors would have resulted in a decrease in the amount of ERE expense. As discussed above, the 76% part-time adjustment had the result of approximating the ERE expenses that would be produced by incorporating turnover. It would be detrimental to the level of the final rates to include both the part-time and a turnover adjustment in the determination of ERE amounts.

Employee Related Expenses (ERE), ACA

A number of questions were received regarding the increased health care premium costs associated with the Affordable Care Act (ACA) and whether these costs were factored into the model. Some commenters stated that premium rates have already increased as a result of the ACA.

The CWG and the Division recognize the ACA will have an impact on providers. At this point, the CWG is unable to quantify the costs (or savings) agencies might experience as a result of the ACA. Due to this uncertainty, the costs (or savings) have not been factored in the Rebased Models. The impact of the ACA on providers may be reconsidered in the future when more information is available.

Benefits, State Employee Insurance

One commenter asked whether a direct care independent contractors could access the State of Arizona employee medical and dental plans.

There is no mechanism for direct care independent contractors to access State of Arizona employee medical and dental plans. Independent contractors can access the federal health exchange and may be eligible for a subsidy of insurance coverage.

Rate Model Benefits

A question was submitted asking if the optional benefits included in the rate were mandatory – must providers provide those benefits to their employees?

No.

5. Comments Related to Productivity

Two general comments were submitted concerning the productivity adjustments used in the Rebase Rates; both concerned training hours.

Training Hours

Two commenters stated that the 40 hours of staff training built into the models was inadequate and should be increased by .5 hours per week, to bring the total training hours to 66 per year. The rationale for the recommended increase was that direct care staff needs to be informed of frequent changes in the health and safety needs of individuals receiving services.

The CWG and the Division appreciate the commenters' suggestion but disagree with the premise that the amount of training provided in the rate models is inadequate. The 40 hours per year of training time included in the Rebase Models is sufficient to provide for all Division required training and is, for 25 of the 28 services for which responses were supplied in the provider survey, generous when compared to the reported amount of training provided to direct care staff. Overall, the amount of training hours included in the rate models averaged 173% of the amount of training reported in the survey, and ranged from a low percentage of 86% for individual supported employment to over 200% for nursing services.

6. Comments Related to Administration and Program Support Components of Benchmark Rates

Two comments were received that addressed the allowance for Administration and Program Support components in the rate models. Both comments concerned the 10% allowance for administration.

Administrative Factor, 10%

Two comments suggested that the 10% factor built into the rate models for administrative costs is inadequate. One comment indicated that the staff time devoted to some administrative requirements are the same for both small and large providers. Since large providers are in fact larger, there is a significantly higher percentage impact to the smaller providers. The commenter suggested eliminating the annual audit requirements for small providers as one way to equalize administrative costs between small and large providers. The other commenter focused on the increases in State and Federal bureaucratic requirements every year.

The Administrative and Program Support allowances were derived from an analysis of the data produced by the provider cost survey. The analysis found that overall, for all providers, as a percentage of revenue derived from the Division, Administrative costs were approximately 12% and Program Support costs were approximately 11%. Based on this analysis and other considerations (see below) the CWG recommended a 10% factor for Administration and an 8% factor for Program Support to the Division.

It is worth noting that these percentages are significantly higher than the allowances contained in the current rates. The current rates do not provide for Program Support and the method used for the Administration factor only produced an effective 8.5% allowance for those costs.

The recommendation to use lower percentages than those produced from the provider survey analysis was based on the consideration of the updated methodology and assumptions where the percentage factors of 10% and 8% are applied to higher rates than those used to calculate the percentage for the provider survey analysis, i.e., the 25% overall rate increase produced through the Rebase Project.

With respect to the comment indicating that small providers incur a greater administrative burden than larger providers, the CWG and the Division acknowledge that this may indeed be the case. As an initial impression, the commenters' proposed solution of eliminating audits for small providers seems to be contrary to the Division's obligation to ensure a stable provider network. However, this suggestion as well as the other commenter's complaint of increasing bureaucratic requirements may be more closely examined in the future.

7. Comments Related to Other Factors, EMR

Enhanced Mileage Rate (EMR)

Several comments were received that stated the enhanced mileage rate (EMR) used in certain models does not fully reimburse providers for the costs associated with fuel, insurance, and maintenance.

The EMR is derived from the Internal Revenue Service (IRS) standard mileage rate. In short, the EMR is the IRS rate adjusted to reflect the higher acquisition cost associated with the vehicles used in selected services (Day Treatment and Training services, certain supported employment services, Group Home services and Transportation services) over the acquisition cost used in the IRS mileage rate. The standard IRS rate is \$.565 per mile and the EMR is \$.82 per mile.

In researching the comments, the CWG concluded that the EMR may or may not understate the overall cost of operating the vehicles used in the services for which the factor is applied.

- The factors supporting an understatement of costs are the insurance and maintenance cost information submitted in the provider survey. If the mileage costs associated with these factors are considered and an 18 mile per gallon assumption is used, the \$.82 per mile EMR rate may be understated by between \$.11 and \$.30 cents per mile.*
- The factors supporting adequate coverage of costs by the EMR are the vehicle acquisition cost information submitted in the provider survey and anecdotal stories that providers use vehicles for a greater number of miles than the 100,000 used in the EMR calculation. Depending on the factors employed, the EMR could be overstated by as much as \$.07 per mile, but could still be understated by as much as \$.18 per mile.*

The CWG has recommended to the Division that although the commenters have a reasonably strong argument that the EMR is understated, no adjustment to the EMR be made at this time.

8. Comments Related to Home and Community Based Services

The Division received five (5) comments related to home and community based services. One (1) comment addressed the in-home service wage and overtime assumptions and four (4) comments concerned the Respite Daily Rate.

Home and Community-Based Services, Wages and Overtime

One (1) comment stated that overtime pay to direct care staff providing in-home services is an issue, although no specifics were provided.

The CWG and the Division do not believe that overtime should be an issue with respect to providing in-home services as a general matter. As previously indicated, the wage rates used in the models in most instances (and in all instances of in-home services) exceeded the survey reported wage rates. The survey

reported wage rates included all wages paid – straight time and overtime. As such, the Rebase models more than compensate for any overtime wages paid.

Viewed from another perspective, the increased wages (and associated benefits) contained in the Rebase Models should allow providers to better recruit direct care workers. To the extent that overtime is caused by a shortage of available workers, the proposed rates should alleviate the pressures causing the reliance on overtime.

Respite Daily Rate, Hours

One (1) commenter requested clarification of the number of hours included in Respite Daily rate. Another comment stated that if a participant receives 24 hour respite care, then providers' costs exceed their payments.

The Rebased Rate for Respite Daily assumes 16 hours of service delivered but is billed for respite care that is 12 or more hours in duration. In the current rate model, the daily rate for Respite Daily services is based on 13 hours of service.

The movement from 13 hours of compensation to 16 hours was motivated by the low level of utilization for this service. The increase in the number of hours compensated for the service was a primary cause of the substantial increase in the proposed rate (\$269.77) over the current rate (\$192.81).

However, the CWG and the Division recognize that it is possible for providers to lose money providing a single block of 24 hours of respite. This is an artifact of the decision to adopt a single flat rate to cover the cost of a service that can vary between 12 and 24 hours in duration. On the other hand, if providers routinely provide less than 16 hours of continuous respite, they will more than cover their costs.

If the proposed flat rate does not satisfy member demand for continuous respite, the Division may reconsider the use of a flat rate for Respite Daily.

Respite Daily Rate, Overtime

There were two (2) comments regarding overtime pay. One comment stated that the Respite Daily rate does not meet the DOL minimum requirements as a provider must pay for each hour a staff member is working. The other comment pointed out that providers must pay overtime to staff members for any hours worked over 40 hours in any given week.

Neither the CWG nor the Division dispute the fact that providers must compensate staff for each hour worked. As indicated above, the proposed Respite Daily rate is based on 16 hours of compensation, and the wage rate included in the model is \$10.22.

While acknowledging that providers could lose money in providing a 24-hour block of service, the extent of the loss is dependent on the wage paid to the staff providing the service. For example, if the staff

providing the service were paid the Arizona minimum wage of \$7.90, over 20 hours of staff time would be compensated.

The CWG and the Division also recognize that overtime must be paid for all hours worked in excess of 40 in a week. However, the provision of a 24-hour block of respite services does not necessarily indicate a staff member would qualify for overtime. The provider can arrange the staff member's work schedule to ensure that overtime will not be required.

As noted in the previous discussion of Respite Daily, should the proposed flat rate not achieve the desired results – an increase in utilization – the Division will consider a modification to the flat rate approach for the service.

9. Comments Related to Individually Designed Living Arrangement Services

Two (2) comments were submitted with questions regarding IDLA hours and travel time.

Individually Designed Living Arrangement (IDLA), Hours

One (1) commenter questioned the number of hours built into the daily IDLA rate. Another commenter questioned how much travel time was eliminated in the proposed model as compared to the current model. The latter commenter stated that travel was often required to support the independence of the member.

The proposed Rebase Rates include two hourly rates for the IDLA service. One of the hourly rates is to be used for "short term" blocks of service and the other hourly rate – the "daily rate" is to be used to calculate provider compensation for longer periods of service provision.

The "daily hourly rate" is to be used to calculate payment to the provider when:

- *16 or more hours of IDLA services are delivered in a day, or*
- *112 or more hours of IDLA services are delivered in a week*

This approach to determining the daily rate for IDLA services is a departure from the current approach in two fundamental ways:

- *Under the current approach, the same hourly rate is used to compensate providers for both short term and long term blocks of service*
- *Under the current approach there are no "break points" to distinguish when the short term or the daily hourly rates are to be used*

The use of two different hourly rates for IDLA has been proposed in recognition of the efficiencies that are realized by the provider in delivering single large blocks of service to an individual or small group of clients. For example, when delivering larger "blocks" of services the direct staff member is not traveling between client locations, is more likely to participate in ISP meetings during a time when services are

being delivered, and can update records at the time services are being delivered. The proposed rate models indicate that the efficiencies associated with the “daily hourly rate” is \$3.00 per hour.

The Rebased Model for the daily services includes 4.4 miles of in-program transportation.

10. Comments Related to Day Treatment and Training Services

Day Treatment and Training services ranked second to Therapy Assistants in the total number of comments received (51). Comments addressed the following topics:

- Benchmark rate
- Wages
- Productivity
- Absence factor
- Program support costs
- Transition staffing
- Rural
- Intense services

Day Treatment & Training Services, Benchmark Rate

A few comments expressed concern that the proposed Benchmark Rate is lower than the Benchmark Rate in the current models. Other commenters expressed concern that the proposed level of Benchmark Rates is insufficient to support Day Treatment programs. These commenters are further concerned that the lower Benchmark Rate might have a deleterious impact on providers.

In building the rate models, the CWG allowed the data and common sense to produce the Rebased Benchmark Rates without regard to the direction or degree to which the existing rates might change. Several components of the rate model, such as the productivity assumptions, were guided by input from providers received through the provider survey and the focus groups.

One of the most significant changes between the current models and the Rebased Models is in the wage levels used in the two models. When the current models were developed it was believed that the staff wages for this service were significantly higher than the wages paid for other community services. Provider surveys in both 2008 and 2013 have dispelled this belief. The current models were based on a wage rate of \$13.22 while the current provider survey indicates the actual level of wages paid is \$9.77. The Rebase Models incorporate a wage level of \$11.44.

Additionally, the current rate models incorporated a “Transitional Staffing Factor” in response to providers’ concerns in 2003 that the rates proposed at that time were insufficient. With the lower wage levels and the elimination of the Transitional Staffing Factor, the proposed Rebased Rates are modestly higher than the existing Adopted Rates are, in the opinion of the CWG and the Division, appropriate to

the costs providers face in delivering the service.

Day Treatment and Training, Wages

A number of comments questioned the Day Treatment and Training services staff wage mix and resulting rates. In particular, the commenters suggested that BLS occupational categories do not capture the teaching component of the service. Several comments were also received that explained that the provider survey reported wages that were artificially low because of wage freezes that had to be implemented under the current rates. Two (2) commenters offered alternative wage definitions using different BLS occupational categories than were used in the Rebase.

The CWG utilized BLS data to determine the wage rate used in the Day Treatment model. The wage rate in the models is set at the midpoint of the 25th and 50th percentile and represents a wage mix of 20% Rehabilitation Counselors and 80% Recreation Workers.

*In response to the comments the CWG analyzed the wage mix for Day Treatment and Training services to ensure the wage mix reflects a teaching component. The description of the duties and responsibilities of the "Rehabilitation Counselor" occupation states that one aspect is to "assess client needs and design and **implement** rehabilitation programs that may include personal and vocational counseling and training." The CWG believes the description of the duties is consistent with the services performed by staff in the Day Treatment and Training services.*

The CWG also compared the wages in the models to the wages reported in the provider survey. As indicated above, the wage in the Rebased Day Treatment and Training Model is \$11.44 while the wage rate reported in the provider survey is \$9.77 for the adult and rural programs, and \$10.67 for the children after-school and summer programs. The wage incorporated into the Day Treatment and Training Rebase Model is 17% higher than the wage levels reported by providers.

Although the CWG understands that a portion of the duties for Day Treatment and Training direct care staff includes personal care activities, the substitution of Personal Care Aide for Recreation Worker would have the effect of reducing the wage included in the Rebased Model and was not recommended to the Division.

Day Treatment and Training, Productivity

A number of comments were received about the productivity adjustments included in the Day Treatment and Training Rebase Models. These comments questioned the factors associated with Individual Service Plan (ISP) meetings, training time, employer time, recordkeeping, and set-up time. In all instances, the commenters suggested an increase in the productivity factors included in the Rebase Models.

The arguments on behalf of the suggested adjustments are summarized in the following bullet

points:

- **ISP meetings:** ISP meetings and behavioral treatment plan (BTP) meetings for those members requiring such plans can run for more than four hours each and average three hours. It was also indicated that at a minimum two staff attend these meetings and preparation time of one to two hours is required for each meeting. The comment also indicated that it was not unusual for the BTPs to be rejected the first time it is presented.
- **Training hours:** Additional training hours are required due to a high rate of incidents in Day Treatment and Training services that require in-service trainings.
- **Employer time:** This productivity factor should be increased over the amount included in the Group Home model because staff meetings are more frequent due to the fragile nature of the population, both medically and behaviorally, and due to the number of incidents that occur.
- **Recordkeeping:** This factor is inadequate because of the time required to log attendance, perform data collection on all ISP objectives, write daily communication logs to exchange with residential programs, complete incident and seizure reports, keep medication administration data, document all contacts pertinent to each participant, and chart pertinent behavioral data.

The CWG and the Division recognize that some of the arguments presented to increase the productivity factors appear to have some merit, but an examination of the provider survey results for adult day programs indicate that overall, providers reported 35.7 hours of weekly billable staff time for direct care workers. The Rebase Model for the service includes only 34.7 hours of weekly billable staff time. The Rebase Model therefore includes less billable staff time than the provider survey reported. Therefore the CWG recommended to the Division that no changes to the productivity factors be made.

Day Treatment and Training, Absence Factor

A number of comments addressed the absence factor included in the Day Treatment and Training models. In essence, the comments indicated that the absence factor used in the Day Treatment and Training Adult Rebase Model does not reflect the hours members are absent from the programs. Several commenters pointed out that the provider survey only collected information on daily absences and did not collect information on hourly absences. The commenters asserted that the appropriate absence factor to be used in the model is an hourly factor. Based on one commenter's survey of selected providers, the daily attendance factor is 90% while the hourly attendance factor is 81.6%. The models used an attendance factor of 85%.

The CWG acknowledges that the provider survey was designed to only collect daily absence factors and regrets this oversight.

Assuming the overall objective of the various commenters is for the CWG and the Division to adopt an attendance factor of 81.6%, the CWG observes that the Rebase Models contain an 85% factor, a factor that is admittedly higher, but not substantially, than the commenters recommended level. In as much as the CWG and the Division have no information on hourly attendance factors other than that based on a limited survey of selected providers reported by one of the commenters, the CWG recommends that no change be made to the absence factor of 85% included in the Rebase Models.

Day Treatment and Training, Program Support Costs

Several comments were submitted indicating that the Program Support cost component of the Day Treatment and Training program rate was too low. One commenter submitted information from his organization's financial records illustrating that rather than 8%, the Program Support percentage should be between 22% and 24% of cost, depending on whether or not vehicle costs were included in the denominator.

It is not entirely clear to the CWG if the specific costs displayed in the detailed comment are Program Support costs for Day Treatment and Training services exclusively or include Program Support costs for the entire service portfolio of the provider.

The CWG and the Division appreciate the effort the commenter expended in producing the submitted information and assumes the commenter properly allocated Program Support costs across the provider's entire service portfolio. However, this single example of costs is insufficient for the CWG to recommend a change to the overall assumptions. The provider survey indicated that the median Program Support costs for all credible reports from providers was 9.7% with a weighted average amount of 11.3%. The total of administrative and Program Support costs from credible reports had a median of 24.2% and a weighted average of 23%.

The CWG recommended to the Division that as a policy matter, the combined administrative and Program Support costs should be set at a general level of 18%. This decision was influenced by a number of factors including:

- These Rebase Models include Program Support cost factors where the existing (2003) models did not*
- Recognition that overall the Rebase Rates are increasing some 25% which will have the impact of increasing the amount of administrative and Program Support costs recovered by providers by a significant amount over an identical administrative and Program Support percentage applied to existing rates*
- Recognition that a portion of administrative and Program Support costs are separately accounted for in other portions of some models (e.g., vehicle maintenance costs, program space, supplies, etc.)*
- A hesitancy in accepting Rebased Rates that contain administrative and Program Support costs at a level greater than the general 18%*
- Recognition that to collect service specific administrative and Program Support costs would be burdensome to providers*

Day Treatment and Training, Transition Staffing Factor

One commenter inquired as to what the transition staffing factor included in the current model represents.

The transition staffing factor in the current rate models was included to partially address providers' concerns in 2003 that the rate models developed in that year's rate setting produced inadequate rates. It was an unsupported "adjustment factor" that has been removed from the Rebased Models.

Day Treatment and Training, Rural

A comment was submitted expressing appreciation that the Division maintained rural rates for Adult Day Treatment & Training Services, but suggested that a special adjustment be allowed for programs with a capacity of only three to six participants. A question of whether a rate for a rural children's Day Treatment & Training services for children would be developed.

The rate models for Day Treatment and Training programs are based upon staff ratios which are intended to be scalable to the actual program attendance; therefore, no special adjustment for programs with low capacity are required. As to a rural rate for children's Day Treatment and Training services, such a rate has been developed based on the comments received and is included in the updated RebaseBook 2014.

Day Treatment and Training, Intense

A number of comments were received about the Day Treatment & Training Intense Benchmark Rate model. A few of the comments indicated that the service is emotionally and physically more demanding for staff and requires providers to pay higher wages to keep direct care staff. The commenter indicated that it is necessary to pay \$0.50 to \$1.00 more per hour than the wage paid for staffing the regular Day Treatment & Training Services. The proposed models only provide an increase of \$0.24.

Other commenters questioned whether it was appropriate to omit a factor for the cost of supplies from the model. It was noted that the individuals participating in these programs are involved in a number of activities each day and that these individuals often damage supplies and cause property damage as a result of their behavior.

Other comments were submitted questioning the reason for an absence factor being omitted from the model, and still other comments were submitted suggesting that the training factor for this service should be increased.

The wage value utilized for this model is 19.5% higher than the current wage levels reported by providers in the provider survey for the regular Adult Day Treatment and Training services. Additionally, since this service is reimbursed utilizing the Multiple Client Ratio (MCR) calculations when the direct staff

serves two clients simultaneously, an approximate 25% increase per staff hour is available in those circumstances. These considerations have led the CWG to recommend against any further increase in wage levels for this service.

In response to the comment regarding the omission of supplies cost from the model, the model has been revised to include a supply cost of \$2.50 per individual per day.

In considering the suggestion to add an absence factor to this rate, in recognition that the Rebase Models for services provided on an individual basis do not receive an absence factor, no adjustment for absences is recommended by the CWG.

After consideration of the comments regarding appropriate training requirements for direct care staff that provide Day Treatment & Training Intense services, an increased training factor has been incorporated into the model. The increased factor will have the result of increasing the amount of training time from approximately 40 hours per year to approximately 56 hours per year. The revised model incorporating this adjustment is included in the updated RebaseBook 2014.

11. Comments Related to Developmental Home Services

The Division received numerous comments related to Developmental Home Services, with most of the comments directed to the change in methodology with respect to Respite services. These comments fell into seven (7) categories:

- Overall comments on the methodology change
- The values for Respite and other in-home services contained in the model
- The authorization process
- Liability concerns
- Impacts to developmental home agencies
- Impact to non-Division placements
- Questioning whether AHCCCS had given approval

The Rebase Project recommended a change in how Respite services for the families providing Developmental Home services would be authorized and paid for. The recommendation was to “unbundle” Respite services from the rate paid to Developmental Home providers, to require that Respite services be separately authorized per member, and that claims for Respite services be submitted directly to the Division for payment.

The recommendation was made after reviewing the results from the provider survey that indicated providers had, on average, provided less than 250 hours of Respite services to the families they supported. This amount represented about a third of the 720 hours for Respite that are bundled into the current rates, although some providers did report that they had converted the Respite allowance into increased payments to Developmental Home operators.

Developmental Home, Overall Comments on the Respite Methodology Change

Two (2) comments were received on the overall impact of the methodology change: one in support of the change because it would ensure Developmental Home operators receive the amount of Respite they need, the other in opposition because the commenter did not believe the system was “broken”, and that the change would be more burdensome than beneficial.

The CWG and the Division appreciate all the comments that were received. Overall, after considering all of the comments provided, the Division disagrees that the change in methodology is more burdensome than beneficial and will continue to develop the Benchmark Rate based on the methodology change. However, as noted in the RateBook published on July 1, 2014, the methodology will not be implemented for SFY 2015.

Developmental Home, Respite and Other Services Provided through the Model

Two (2) comments inquired as to the amounts included in the proposed models for respite and other in-home services.

As indicated in the introduction to this discussion on Developmental Home services, the 720 hours of Respite that is currently bundled into the Developmental Home model have been removed and Respite for the Developmental Home Operators providing care to the Division’s members will be accessed through a separate authorization process. The current limit on Respite services is 600 hours a year.

No other in-home services are bundled into the proposed rate model for Developmental Home providers, although the approximately \$3,000 per year amount included in the model for Program Support can be used by the agency to provide support to the families providing services.

Developmental Home, Respite Authorization Process

Four (4) comments were received regarding the authorization process for Respite for Developmental Home operators. All the comments were questions, with two (2) inquiring as to the overall authorization process, one (1) inquiring amount emergency Respite, and one inquiring about the amount of authorization available if a member moves from one family to another.

With respect to the general authorization process to be followed, Respite will be authorized in the same manner as Respite is authorized for all other Division members – through the ISP process. With respect to the other two questions posed – the need for Respite in emergency situations that has not been authorized, and the need for additional Respite when a member moves from one family to another – the member’s Support Coordinator should be contacted. Specific resolution to these two situations will depend on the specific circumstances of the situation.

Developmental Home, Impact to Agencies of the Respite Methodology Change

Several comments were received as to the impact that unbundling of Respite would have on Developmental Home providers. The comments raised topics such as the necessity of some Developmental Home providers to add Respite services to their contract, potential cost increases under the new methodology, the issue of Developmental Home provider losing control of Respite services, and the overall adverse effect of the unbundling.

With respect to the necessity of Developmental Home providers to include Respite as a service in their contract with the Division, the commenter is correct. If Developmental Home providers are not contracted to provide Respite services, they will have to amend their Qualified Vendor Agreements with the Division and to register as a provider of Respite services with AHCCCS in order to do so. A review of the Qualified Vendor Agreements with the Division indicates that 25 of the current 33 developmental home vendors are already authorized to provide Respite services. Under the new methodology, the families providing care will be free to use either their qualified Developmental Home provider or any one of the more than 200 other qualified Respite providers for Respite services.

One commenter indicated that the Developmental Home providers that do not now have a Respite contract will have an increase in administrative cost because of the addition of staff to provide Respite. The CWG and the Division acknowledge that additional costs for Respite staff may be required, but those requirements are adequately compensated within the rate paid for Respite services.

One commenter was concerned that under the new methodology the Developmental Home provider would lose control over the selection of the Respite provider. The CWG and the Division agree that the Developmental Home provider may lose control over which Respite provider is used by the Developmental Home operator, if the family does not select them to provide Respite. However, the freedom to select providers of Respite and all other services is a hallmark of the Division's program and is exercised by all of the Division's members.

Finally, two (2) comments were submitted that indicated that the methodology change will adversely impact the Developmental Home provider community. Both comments generally indicated that the rate drop (because of the exclusion of Respite services) would lead to a reduction of payments to Developmental Home operators and reduce the flexibility the Developmental Home providers have in managing their programs. The CWG and the Division recognize that some changes may have to be made in how the Developmental Home providers manage their program, but it is believed that the changes will improve accountability and enhance the provision of Respite services to the care giving families.

Developmental Home, Liability Issues

Two (2) comments were received that inquired as to liability issues when Respite services are provided by a provider other than the Developmental Home provider.

The unbundling of Respite services would likely transfer potential liability for acts or omissions occurring during the time when respite services are being delivered from the Developmental Home provider to the

Respite provider. Specific concerns that Developmental Home providers should either be posed to their legal counsel or presented to the Division in more detail.

Developmental Home, Other Agency Placements

Two (2) comments were received that inquired about the impact the unbundling would have on placements by Department of Child Safety (DCS). The commenters indicated that DCS utilizes the Division's providers when there are shortages in foster home providers, and when doing so, DCS pays the providers the Division's rates.

Placements for DCS clients are under the authority of the DCS. The question as to whether DCS will continue to pay the current Division rates or pay the Rebased Rates adopted by the Division is a matter to be addressed by DCS. The DCS is also the authority that will decide whether (and how) respite services for their clients will be authorized and paid.

Developmental Home, AHCCCS Approval of Methodology Change

One (1) commenter inquired as to whether AHCCCS had approved the unbundling of the Respite services from the rate for Developmental Home.

Yes, the Division informed AHCCCS of the change and will obtain authority prior to the implementation.

12. Comments Related to Group Home Services

Relatively few comments were received concerning the three types of Group Home services. The comments that were received are addressed in the following categories:

- Wages for Group Home services
- Transportation costs for Group Home services
- Incontinence and nutritional supplements for Group Home services
- Community Supported Protection & Treatment Group Home
- Nursing Supported Group Home absence factor
- Nursing Supported Group Home data validity

Habilitation, Group Home, Wages

Two (2) comments were received that asserted the wage level for the Group Home staff is inadequate to obtain staff capable of performing the required duties. Both commenters provided alternative blends of occupations to determine the appropriate wage level. The occupational mix (and wage components) used in the Rebase and the two proposed alternatives are presented below:

Table 5: Comparison of Proposed Group Home Wage Levels

BLS Occupation	Proposed Rebase Model		Comment Option A		Comment Option B	
	Percent	Wage Component	Percent	Wage Component	Percent	Wage Component
Mental Health Counselor			10%	\$1.84		
Rehabilitation Counselor	20%	\$ 3.02	30%	\$ 4.53	20%	\$ 3.02
Nursing Assistant			40%	\$5.26		
Personal & Home Care Aide					30%	\$ 3.07
Recreation Worker	80%	\$8.42	20%	\$ 2.10	50%	\$ 5.26
Total		\$ 11.44		\$ 13.73		\$ 11.35

The CWG and the Division appreciate the comments submitted but do not believe the occupational mixes submitted by the commenters are an improvement over the mix that was used in the Rebase Process.

With respect to the Option A mix (which results in a wage level of \$13.73), the CWG and the Division do not believe that 40% of the activities of direct care workers in Group Homes are analogous to the duties of nursing assistants, nor is it believed that 10% of those worker’s duties are analogous to those of a mental health counselor.

While the CWG and the Division may concur with the Option B mix presented above (which results in a wage level of \$11.35), the resulting decrease in the wage level for Group Home direct care workers cannot be supported.

The CWG and the Division believe the proposed Rebase occupational mix that produces a wage level of \$11.44 (an approximate 18% increase over the average wage currently paid by providers), is appropriate.

Habilitation, Group Home, Transportation Costs

The Division received one (1) comment regarding the change in methodology and the resulting decrease in the amount of transportation cost per hour in the proposed rate model. The current rate model contains a factor to allow the cost of the vehicle assigned to be recovered through the staff hourly rate. The rate model provides for the recovery of cost in a different manner, i.e., by incorporating the recovery of vehicle acquisition in the enhanced mileage rate (EMR). The two approaches produce slightly different amounts of transportation costs to be recovered per staff hour worked: the current model provides for \$1.05 per hour and the Rebase Model provides for \$.96 per hour.

The CWG determined that the previous methodology for determining the vehicle acquisition cost recovery factor was deficient. In short, it was determined that vehicle cost recovery should be tied to the vehicle’s miles and not the number of staff hours worked.

While the current methodology produces a lower amount of transportation costs per hour, the total amount of transportation cost provided for Group Homes has increased – because the number of staff hours delivered for a typical Group Home has increased since the transportation factor was included in

the rate in 2004. Data extracted from the Division's billing system and analyzed by the CWG demonstrate that the 'average' number of staff hours billed for this service has increased from approximately 240 staff hours per week in SFY 2004 to 300 staff hours per week in SFY 2012. Because staff hours increased, the total annual payments for transportation reflect an increase in the average annual transportation costs from (approximately) \$14,225 to \$18,250 per home.

Habilitation, Group Home, Incontinence Supplies and Nutritional Supplements

One commenter observed that there had been no change to the amounts allocated for incontinence supplies or nutritional supplements and indicated that using bulk purchasing, the costs of these items were 2.5 times the reimbursement rate.

The revisions to the amounts set for incontinence supplies and nutritional supplements were inadvertently omitted from the October RebaseBook published on the Division's website. In fact, rates for these items were revised. The incontinence supplies factor was increased from \$3.00 to \$4.50 and the nutritional supplements were increased from \$4.00 to \$4.25. The increases for these items did not approach the level suggested by the commenter but are appropriate given the information reviewed by the CWG.

Habilitation, Group Home, Community Protection & Treatment, (CPT)

One (1) comment was received that indicated that unless there was a greater rate differential between Community Protection and Treatment (CPT) Group Home and regular Group Home there was no incentive for providers to deliver the service. The commenter indicated that the liability and the cost of qualified staff are both greater for a CPT Group Home than for a regular Group Home.

Both the CWG and the Division are sympathetic to the commenter's point that there should be a greater differential in the rates between the CPT and regular Group Home rates.

No differential in wages has been included for the Group Home, CPT service (as compared to regular Group Home) due to the fact that the provider survey data (and the survey data obtained during the SFY 2009 review) did not yield a difference in the wages paid for staff in the CPT settings and regular Group Homes. It is the understanding of the CWG and the Division that the CPT service is being delivered to members in these settings through a general increase in staffing as compared to regular Group Home services. It is through increased staffing that providers receive a differential in reimbursement per individual placement.

The proposed rates only reflect a differential based upon the additional training for staff in the Group Home, CPT setting (versus that of a standard Group Home). The staff in Group Home, CPT settings are assumed to receive training of 56 hours per year (assumed for employees employed for a three-year period) versus the standard of 40 hours per year.

However, it is the continuing recommendation of the CWG, that the Division review and clearly define the goals, outcomes, measures and standards for the Group Home, CPT service. Once these items have been fully defined, a rate model that will more accurately reflect the service should be developed.

Nursing Supported Habilitation, Group Home, Absence Factor

Comments were received that noted the Rebase Model for Nursing Supported Group Home did not include an adjustment for short term vacancies or absences in the home. The commenters pointed out that the hour matrix that is used in determining payment rates for regular Group Home does adjust for short term vacancies or absences, and a similar adjustment should be made to the Nursing Supported Group Home Rebase Model.

After consideration of these comments, the CWG and the Division modified the rate model to provide for a 6% vacancy factor for Nursing Supported Group Homes.

Nursing Supported Habilitation, Group Home, Data Validity

One (1) comment – from the only Nursing Supported Group Home provider that submitted a provider survey – questioned the wage rates included for RNs and LPNs used in the Rebase Models and also questioned the validity of the model based on the submission of only one provider survey for this service.

The submission from this commenter was carefully reviewed. With respect to the wage levels included in the Rebase Models, the commenter was under the impression that the wage levels submitted in the provider survey – which had been reduced in order to cope with the across the board rate reductions of recent years – were the wage levels used in the model. Such was not the case. While the provider survey indicated a Registered Nurse (RN) wage of \$25.86 and a Licensed Practical Nurse (LPN) wage of \$25.91, the rate models used a RN wage of \$33.78 and a LPN wage of \$23.96.

With respect to the validity of the model, the commenter was under the impression that the models were based solely on the provider survey information which was also not the case. The Nursing Supported Group Home Rebase Model was built on both information from the provider survey as well as information gleaned from interviews with other providers and the Division's Health Care Services Unit.

However, after reviewing the comments, the CWG and the Division revisited the Rebase Models. As a result of that review, adjustments were made to the Level II and Level III models. The Level II model was adjusted by adding four hours a day of LPN staffing and the Level III model was adjusted by adding eight hours a day of Certified Nursing Assistance (CNA) staffing. As a result of these adjustments the Level II daily rate increased from \$402.84 to \$432.36 and the Level III daily rate increased from \$451.83 to \$486.10. Both the adjusted rates just cited are before the application of the 6% vacancy factor discussed in the response to the previous comment.

13. Comments Related to Professional Services - Nursing

One (1) provider submitted comments on the Nursing Services Rebase Rates. The comments from the provider were organized into five different areas:

- Separation of RN and LPN rate models
- Wage levels used in the Rebase Models
- Disproportionate percentage increases for LPN models
- Additional administrative costs associated with the split RN and LPN services
- The LPN continuous Respite rate reduction

Nursing Services, Separation of RN and LPN

A primary focus of the submitted comments was the separation of the current Nursing Services from a single rate for each specific Nursing Service that incorporated a blend of RN and LPN wage levels into two separate rates for each service with one rate for services delivered by RNs and the other rate for services delivered by LPNs. The blend of Nursing wages for the current rates (adopted in 2004) are 50% for each nurse type.

The commenter pointed out that based on the provider's records only 1% of the Division's members receiving Continuous Nursing Services required (due to medical need or diagnosis) the services of RNs. Based on this, the commenter questioned the need to separate the current single rate into separate rates for RNs and LPNs.

The proposed Rebase Models for Nursing Services do split the current "blended" models into separate models for services provided by each type of nurse. The split rates are recommended in recognition of the differences in the qualifications, supervision requirements, and wage levels between RNs and LPNs.

Nursing Services, Wages

The commenter indicated that the Rebase Models should have used the wage levels reported in the provider survey and not the BLS wage levels. The commenter indicated that the \$33.78 RN rate derived from the BLS is "drastically higher ... than was reported in provider surveys" and pointed out that wages for RNs delivering the Division's Continuous Respite Services could not be \$33.78 because the rate for the service was only \$36.72. The commenter indicated that the \$23.96 wage level for LPNs derived from BLS data was more in line with what was submitted by providers in the survey.

The CWG and the Division disagree that the provider survey reported wage levels should be incorporated into the Rebase Models. As was pointed out on numerous occasions in the provider survey, the provider focus groups and the public forums, current wage levels paid by providers reflect either static or reduced wages that providers implemented because of the provider rate reductions implemented by the Division in recent years. There is broad consensus among the provider community as well as the CWG and the Division that the more appropriate source for wages used in the Rebase Models is the BLS.

Nursing Services, Disproportionate Increases for LPN Models

The commenter points out that the percentage change for the Rebase Rates for LPN services are significantly lower than the percentage increase for RN services. The information submitted by the commenter showed the increases for RN services over the current Adopted Rates to be 85% for the visit service (with an increase for LPN visit services of 45%), 92% for the Intermittent Services (with the comparable LPN service at a 50% increase), and 46% for Continuous Respite Services (with the comparable LPN service at a 13% increase). The commenter also provided statistics that indicate the increase in LPN wage levels reported by BLS have increased faster than the wage levels for RNs.

Based on the change in wage levels for RNs and LPNs and other statistical observations, the commenter concludes that the Rebase Rates for LPN services should be increasing by at least, and possibly more than, the increase for the rebased RN services.

The CWG and the Division believe the commenter fails to recognize that the current rates for Nursing Services employ a blended wage rate that is based on 50% RN wage levels and 50% LPN wage levels. The change from this blended wage level to a discrete RN wage level is significantly greater than the change for LPN wages. Calculations displayed in the RebaseBook posted on the Division's website indicate the percentage increase in wages used for the Rebase Models are 68% for the RN services and only 19% for LPN services.

Nursing Services, Administrative Costs

The commenter indicated that additional administrative costs would be incurred by the provider in order to accommodate specific rates for RN and LPN services. These additional costs would be incurred in the areas of data entry, billing and nurse availability searches. The commenter indicated that the Rebase Models would not sufficiently compensate the organization for these additional costs.

The CWG and the Division do not believe the additional administrative costs cited by the commenter are significant. However, the Rebase Models do increase the amount of administrative costs included in the model (from an effective 8.5% to 10% of the total rate) as well as providing new factors of 4% of the rate for Program Support costs, and an additional 1% of the rate for costs associated with pursuing third party liabilities for Nursing Services.

Nursing Services, Reduction in LPN Continuous Respite

The commenter stated that the Rebased Model for LPN Continuous Respite is the only rate among a collection of services listed by the provider that is lower than the Rebased Rate that was recommended in SFY 2009.

The CWG and the Division question the specific comparison made by the commenter, but acknowledge that the Rebased Rates for LPN Nursing Services do have lower increases than many other services. This results from the splitting of the current single Nursing Service rate into unique RN and LPN rates, and the minimal increase in the wage levels for the LPN Rebase Models caused by the relatively high blended wage level used in the current rates.

14. Comments Related to Professional Services – Therapy Services

A total of 54 comments were submitted concerning Therapy Services – these comments do not include the comments submitted on the Therapy Assistant rates which are presented in the next section. The focus of the comments submitted on Therapy Services are divided into the following six areas:

- General comments on the rate models and the resulting rates
- The urban and rural adjustments
- Missed appointments
- Other factors of the rate models
- The differences in the clinic and natural rate model factors
- Miscellaneous comments

Therapy Services, General Comments

Several commenters expressed appreciation for the increases to the Therapy Service rates, although at least one (1) comment was received indicating disappointment that the rates did not vary according to the experience of the therapists.

The CWG and the Division are grateful for the positive comments but the increases to the Therapy rates resulted from the application of the independent rate model.

Unfortunately, without adding a tremendous amount of complexity to the rate schedule, it is not feasible to vary rates based on the experience of the individual therapist. However, provider agencies that employ multiple therapists can vary the compensation paid to each therapist based on experience.

Urban/Rural

A number of comments were received on the replacement of the tiered geographic rates (which were designated on the basis of zip codes) with geographic area rates (which are designated on a county basis). Some of the specific inquiries, suggestions and comments contained in the submissions include:

- The Base rate for clinic and natural rates seem appropriate
- Do the county designations for the area rates apply to entire counties, or are there exceptions for specific areas such as Native American reservations?

- A suggestion was made to establish a process to designate exceptional areas within counties, such as for some of the more remote locations on Native American reservations
- Several commenters questioned the reason for Pinal County was designated as a Base rate county in as much as very few providers reside there.
- A few commenters suggested that the distance traveled or “windshield time” should be used for determining geographically adjusted rates

After a review of the comments and inquiries, the CWG and the Division modified two aspects of the geographic area rates:

- *The geographic categorization of the counties is modified by moving Pinal County from Base Area to Area 1 and moving Navajo County from Area 1 to Area 2 – increasing the rates in both instances*
- *The Division will retain flexibility to adjust the geographic designation of specific areas (e.g., the town of Ajo in Pima County). In order for an area to have its designation modified, one or more providers will have to submit a request to the Division, which will consider the request, and if approved (as submitted or as modified), the exception will be noted in the next release of the RateBook posted on the Division’s website*

The Division will not reintroduce geographically adjusted rates based on “windshield time” as that methodology is difficult to establish (e.g., from what point(s) are distances to be measured) and fail to encourage the establishment of providers in areas that are geographically underserved.

Therapy Services, Missed Appointments

A series of comments were received from one provider that described its experience with missed appointments. The provider indicated that families cancel appointments as often as once a month (for a variety of reasons, including chronic illnesses). The provider indicated that the Division’s policy of only permitting “make up” appointments within the week of the cancelled appointment is detrimental to both the client and the provider. It was suggested that a more flexible make-up appointment policy be adopted.

The Division has no intention of continuing to support the informal missed appointment policy that allows for the billing of appointments where the member (or member’s representative) cancel the appointment. All of the Rebase Models contain a missed appointment factor which will be the sole method for providers to recoup lost time for missed appointments. The Therapy Service models all contain a quarter hour per week for missed appointments. It is the expectation of the Division that providers will redeploy staff resources to other activities once a missed appointment becomes known. Therefore the missed appointment productivity factor represents time ‘lost’ and not replaceable by any other activity (billable or non-billable).

However, the Division is reviewing the appropriateness of the policy (and associated timing) permitting

providers to provide “make up” appointments within the week canceled. Any modifications to this policy will be communicated to the provider community.

Therapy Services, Other Model Factors

Comments were received from several providers questioning various aspects of the Rebase Models.

One focus of the comments questioned the changes in the square footage allotments for office space which increased for clinic based services from 250 to 300 square feet, and decreased from 250 to 100 square feet for natural settings.

Another focus of the comments was on the percentages included in the Rebase Model for Program Support and Third Party Liability (TPL) administrative expenses. The suggestion in this comment was that the percentages should be increased from 4% and 1% to 6% and 1.5% for Program Support and TPL respectively. No specific reason was given for why the percentages should be increased.

The modification to the square footage amounts were made to better align the rate models to the expenses faced by providers and were vetted with the therapy focus group for validation. The space allotment for clinic represents both office and treatment space while the allotment for natural settings is limited to office space only.

With respect to the suggested increase in the allocation for Program Support and TPL, without a rationale for an increase, the CWG and the Division are unable to evaluate the suggestion. In lieu of specifics, the percentages included in the proposed Rebase Model were not adjusted.

Therapy Services, Comparison of Natural and Clinic Settings

Comments were received regarding perceived imbalances between the rates proposed for natural settings and clinical settings.

One commenter felt the proposed Rebase Models advantaged the provision of services in the natural setting over the clinical setting, and cited the 22% increase in the clinical rate compared to the 30% increase in the natural rate as partial evidence of this assertion. The commenter also referenced the specific factors for rent and capital costs as contributing to the advantageous treatment.

Another commenter felt the opposite of the first – this commenter felt that because more services could be performed in a clinical setting in a given time period, the rates for the natural setting should be increased.

With respect to the first commenter’s point regarding the differential of the percentage increase between

the clinical (22%) and natural (30%) settings, the commenter may not have fully taken into account the history of the rates. The current adopted clinical rate of \$56.83 is artificially high because of a Division policy decision. The current adopted clinical rate would have been \$52.06 if the Division had not established a “floor” rate of \$56.83 rate when the rate reductions of recent years were implemented. The clinical rate was “held up” by this floor and did not fall as much as the rate reduction would have dictated. Had the true rate reduction been put into effect, the current Adopted Rate would be \$52.06 and the increase to the recommended Rebase Rate would have been 33% - a slightly greater increase than the natural setting rate increase of 30%.

Regarding the rent allocation between the two settings, the commenter suggests that the office space allocated to natural settings should be covered through the administrative allowance of 10%. While this may be true, the same could be said for allocating a similar amount of expense for the clinical setting. In this situation, both settings are treated equally.

The commenter also suggests the differential between the settings for capital costs (\$3,000 for clinical and \$2,000 for natural) is not sufficient to account for the cost of equipment used in a clinical setting that is not used in a natural setting. To this point both the CWG and the Division disagree although the disagreement is largely a matter of opinion.

The second commenter took the opposite view from the first commenter. The second commenter believed the natural setting rate should be increased because the clinical setting can serve more clients in a day than the natural setting (because, for example there is no travel time associated with the clinical setting).

The CWG and the Division disagree and point out that the Rebase Models adjust for non-billable time and there is no advantage or disadvantage attributable to either model.

15. Comments Related to Professional Services – Therapy Assistant Services

More comments were received for Therapy Assistant Services than any of the other seventeen (17) topic areas. In total, 122 comments were submitted for the Therapy Assistant rate, with the vast majority of comments from the Certified Occupational Therapy Assistants (COTA) community. These comments have been organized into the following areas:

- Separation of rate models
- Similarities and differences between Occupational Therapists and COTAs
- Qualifications of assistants for different therapies
- Supervision
- Wages
- Productivity
- Availability of Services
- Provider Registration
- Billing for missed appointments

Therapy Assistant Services, Separation of Rate Models

A number of comments were submitted on the general topic of establishing two Therapy rates – one for Therapists and one for Therapy Assistants. These comments made a number of points both for and against the two rates.

The comments supporting the two rates presented a variety of reasons and nuances for their position. Some observed that the differences in education and qualifications of the Therapists and Therapy Assistants logically supported two models, while at least one comment indicated that it was not only logical, but that the two models made fiscal sense. Other comments agreed with the two model concept but suggested that the difference in the two rates should be less than the difference contained in the proposed models.

The comments opposing the two rates also presented a variety of reasons for their position. Some comments indicated that all private insurers paid only one rate, while other commenters indicated that the Division would be the only payor to have a split rate schedule. Commenters also indicated that the Therapy Assistant rate is below what other organizations would pay for assistants as either employees or contractors, with hospitals and school districts cited as examples. Finally, one commenter indicated that the Division had always paid a single rate for Physical and Occupational Therapies, and wondered why the Division felt it had to change.

The CWG and the Division appreciate the vigorous dialog contained in the comments.

The Division created separate rates for Speech-Language Pathology Assistants (SLPAs) in July 2010 when those assistants were authorized to provide services for the Division (see RFQVA Amendment 13, June 2010). At that time the Division developed a distinct methodology to determine SLPA rates. It is somewhat unfortunate that the Division did not develop a similar methodology when Certified Occupational Therapy Assistants (COTA) and Physical Therapy Assistants (PTA) were authorized to provide services in the January 2011 RFQVA.

The concept of a distinct Therapy Assistant rate is broadly supported by the licensing/certification requirements of the three regulatory bodies governing therapies in Arizona. The Arizona Board of Occupational Therapists, the Arizona Board of Physical Therapists, and the Arizona Department of Health Services (licensing agency for SLPAs) all set out different educational requirements and other qualifications, as well as specifying duties and responsibilities to differentiate Therapists from Therapy Assistants.

While those commenters opposing the separate assistant rates asserted that all insurance companies do not have separate rates for Therapists and Therapy Assistants, no evidence to support this statement was provided, and in fact, no evidence supporting the proposition that all insurance companies will even pay for the services of Therapy Assistants. A cursory examination of the Medicare and TriCare (the Department of Defense's commercial health program) policies did not reveal specific policies authorizing

payment for Therapy Assistants for either program.

Therapy Assistant Services, Similarities and Differences between Occupational Therapists and Certified Occupational Therapy Assistants

Several comments were submitted that argued both for and against the similarities of the services provided by Occupational Therapists (OT) and Certified Occupational Therapy Assistants (COTA).

The individuals arguing for the near identity of the range and value of Occupational Therapy delivered by Therapists and COTAs submitted comments that said COTAs provide the same services as Therapists, that COTAs can write therapy plans, and that COTAs do not require on-site supervision in a natural setting.

Other comments were submitted that indicated there is in fact a difference between the scope of practice of the OTs and COTAs. The comments submitted along these lines included quotations from the Arizona Revised Statutes that indicate a COTA “assists in the practice of occupational therapy and performs delegated procedures”, quotations from the Arizona Administrative Code that describe the duties and responsibilities that are exclusively therapists’ as well as an enumeration of activities and duties that COTAs are prohibited from performing. Comments were also submitted that stated COTAs must be supervised by OTs and that Therapists must accompany COTAs in a natural setting (contradicting other comments submitted).

The CWG and the Division believe the weight of evidence indicates, despite the overwhelming number of comments to the contrary, that the educational and other requirements, as well as the scope of practice differences between Occupational Therapists and COTAs, are sufficiently different so as to warrant distinctive models and rates for the two practitioner types.

Therapy Assistant Services, Qualifications of Assistants for Different Therapies

Many comments were submitted that indicated that the qualifications, requirements and scope of practice for the Therapy Assistant in the three therapy disciplines varied. The implication of these comments is that these differences should result in differing treatment among the three types of Therapy Assistants.

It was further implied by the many COTAs submitting comments that if COTAs were not to be treated in the same manner as Occupational Therapists, they should be treated differently from the other two Therapy Assistant types.

Based on information submitted as comments as well as the requirements of the three Arizona governing entities, the following requirements chart for Therapy Assistants was compiled.

Table 6: Comparison of Therapy Assistant Qualifications

Qualification	PTA	OTA	SLPA
<i>Education</i>	<i>Accredited College Program (Assoc Degree)</i>	<i>Accredited College Program (Assoc Degree)</i>	<i>Accredited College 60 hrs (w/ req'd courses)</i>
<i>Exam(s)</i>	<i>National Exam Jurisprudence Exam</i>	<i>National Exam</i>	<i>None Identified</i>
<i>Experience</i>	<i>None Identified</i>	<i>608 hours of Field Work</i>	<i>100 hours of Clinical Interaction Experience</i>
<i>Supervision</i>	<i>30% (1st 90 days) 20% (after 1st 90 days) of Billable Time</i>	<i>General (non-specific) requirements based upon individual need</i>	<i>30% (1st 90 days) 20% (after 1st 90 days) of Billable Time</i>

On balance, the CWG and the Division regard the requirements as generally equivalent.

For the purposes of constructing the Therapy Assistant Rebase Model, the supervision standards required for PTAs and SLPAs was adopted

Therapy Assistant Services, Supervision

There were many comments received regarding supervision of Therapy Assistants. These comments ranged from questions concerning how supervision would be paid to Therapist, to the amount and methodology used to account for supervision costs in the models.

The broad areas of the comments relating to supervision that warrant a response include:

- How supervision is accounted for in the Rebase Models
 - Does the amount for the Therapist compensate them for travel time and mileage
 - Does supervision vary for clinic and natural settings
 - Is supervision scaled to account for the assistants' experience
- How will therapist be paid for supervision

The Rebase Models for Therapy Assistants include a factor for supervisory time. The factor is included under the category of "Services Oversight" and is roughly based on the supervisory requirements imposed on PTAs and SLPAs, i.e., 20% of the assistant's billable time.

The original Rebase Models released in October of 2013 included 1.35 hours per day of supervision for both the clinical and natural settings. Given the varying amount of billable time between the two settings, this amount was the equivalent of 20% of a Therapy Assistant's billable clinical time and 27% of an assistant's natural setting billable time.

After reviewing the comments, particularly the comments that questioned whether the adjustment for supervision was a 'fully loaded' adjustment (i.e., accounting for wages, benefits, travel time, mileage, etc.), and the comments lamenting the administrative burden of tracking supervision time (although it is a regulatory requirement), the CWG and the Division increased the supervisory time by 15 minutes per day to provide for 1.6 hours per day of supervision. This revised rate of supervision is the equivalent of

24% of the billable time for a Therapy Assistant in a clinical setting and 32% of the billable time in a natural setting.

Supervising Therapists will receive their compensation from a portion of the Therapy Assistants' billable rate.

Therapy Assistant Services, Wages

Many comments were received noting that the wage level utilized in the Therapy Assistant rate model understates the current market wages for Therapy Assistants (particularly COTAs). Several commenters (again, COTAs) submitted wage survey information from various sources while other commenters conveyed anecdotal information relating to wage levels of COTAs. Other commenters questioned whether the BLS data separately reported wage levels for Occupational Therapy Assistants and Occupational Therapy Aides.

The CWG reviewed the two COTA wage surveys that were submitted by commentators: the American Occupational Therapy Association (AOTA) 2010 survey and the Advance Healthcare Network (Advance) 2012 survey. Both surveys reported results for Arizona with AOTA reporting a median wage of \$20.67 and Advance reporting a median wage of \$30.49. However, the usefulness of both surveys is limited for two reasons: both surveys reported median wages and both had an extremely limited number of (apparently) self-selected respondents. The problem with the median wages is that for the rebasing project, wage levels are established at the midpoint between the 25th and the median wage. The problem with the limited number of respondents is that the AOTA survey only had 13 Arizona respondents and the Advance survey only had four Arizona respondents.

The BLS reports data at both "broad" and "detail" levels. With respect to Occupational Therapy, there are three relevant occupational codes:

31-2010	Occupational Therapy Assistants and Aides	broad
31-2011	Occupational Therapy Assistants	detail
31-2012	Occupational Therapy Aides	detail

The BLS will only report the codes for which the values are relatively statistically reliable. In the case of Arizona, Occupational Therapy Assistants are reported but Occupational Therapy Aides are not. Were the wage for Therapy Assistants to be taken from the Arizona Code 31-2011 (Occupational Therapy Assistants), the resulting wage (after determining the midpoint of the 25th and 50th percentiles, adjusting for inflation and adding a 10% premium) would be \$14.40 per hour.

Rather than use the Occupational Therapy Assistants BLS codes for Arizona, the CWG used the values for Physical Therapist Assistants (31-2021). Making the same adjustments as those described above, the resulting wage rate of \$19.15 per hour was used in the Therapy Assistant Rebase Model. This wage – which includes a 10% premium – is an increase over the \$17.41 wage that was used in the originally proposed Rebase Model for Therapy Assistants.

Therapy Assistant Services, Productivity

Multiple comments were received regarding the productivity factors included in the Therapy Assistant rate model. Most of the comments noted that the documentation and recordkeeping requirements of Therapy Assistants are comparable to that of Therapists, but differ in the Rebase Models.

The CWG and the Division generally aligned the productivity factors for Therapists and Therapy Assistants. A comparison of the factors between the two models (in a clinical setting) is presented in the following table. The Table reveals an identical total of daily billable hours, although there are differences in the individual factors.

**Table 7: Comparison of Productivity
Therapists Versus Therapy Assistants in Clinical Setting Model**

Qualification	Therapist	Therapy Assistant
Total Hours	8.00	8.00
Recordkeeping & Documentation	0.65	0.53
Consultation with Providers/Family	0.40	0.32
Employer Time	0.10	0.30
Missed Appointments	0.05	0.05
Training/Continuous Educations	0.21	0.21
Average "Billable Hours"	6.59	6.59

The factors that differ between the models are:

- *Recordkeeping & documentation*
- *Consultation with providers/family, and*
- *Employer time.*

The recordkeeping and documentation factor, as well as the consultation factor, have been increased in the Therapist model under the assumption that the Therapist will spend more time documenting and following up than will a Therapy Assistant. The Therapy Assistant model contains an allowance for more employer time to provide for non-billable supervision time.

Therapy Assistant Services, Availability of Services

Many comments were received (again, predominately from COTAs) that expressed the belief that the separation of rate models – with the proposed Rebase Rates – will result in a significant reduction of COTAs providing services to the Division’s clients. This reduction will produce a commensurate reduction in access to services for members. These comments asserted that the low rebased Therapy Assistant rate will not allow therapy agencies to recover the costs of supervision and administration for Therapy Assistants.

Clearly it is not the intent of the CWG and the Division to reduce the number of Therapy Assistants providing services to members. With the revisions to the Therapy Assistant model that have been made in response to the comments submitted, the clinical setting rate has increased by 11% from \$48.00 to \$53.24 per hour and the natural setting rate has also increased by 11%, from \$64.14 to \$70.99. These revisions leave the Therapy Assistant rate at 77% of the Therapist rates.

The Division intends to monitor the participation of Therapy Assistants to assess whether the new Rebased Rates have a deleterious effect on these Therapy Assistant providers.

Therapy Assistant, AHCCCS Provider Registration

Several comments were received inquiring as to whether Therapy Assistants will be required to obtain an individual AHCCCS provider identification number to bill for services under the proposed rate structure.

The Division does not desire to alter the current billing processes for the OTAs or PTAs. At this time, the OTAs and PTAs are required to bill utilizing their individual supervising Therapist's AHCCCS provider ID number. However, if AHCCCS updates any processes for Therapy Assistant registration, it is the expectation of the Division that all Qualified Vendors will comply with the appropriate changes.

Therapy Assistant Services, Billing for Missed Appointments

Comments were also received that related to billing for missed appointments. Evidently, there has been an informal policy allowing Therapists providing services in the natural setting to bill for a scheduled appointment, even if the member was not available for the service. The Division has announced that this practice will not be continued. Some commenters requested that the practice be reinstated.

The Division has no intention of reinstating the informal missed appointment policy. All of the Rebase Models contain a missed appointment factor which will be the sole method for providers to recoup lost time for missed appointments. The Therapy models all contain a quarter hour per week for missed appointments. It is the expectation of the Division that providers will redeploy staff resources to other activities once a missed appointment becomes known. Therefore the missed appointment productivity factor represents time 'lost' and not replaceable by any other activity (billable or non-billable).

16. Comments Related to Employment Services

Nine comments were received concerning Employment Services. The areas addressed have been organized into the following groups:

- Individual Support Employment (ISE)
- Transition to Employment

- ISE implementation
- Group Supported Employment
- Center-Based Employment
- Affordable Care Act

Employment, Individual Supported Employment, General Comment

Three commenters were complimentary regarding the Employment Services rate structure that incentivized Individual Supported Employment Services for Job Coaching and Job Development. The comments expressed the hope that the Division will continue to promote these services as alternatives to Group and Center-Based Employment services. One of the commenters erroneously noted that the incentives for ISE appeared to have come at the expense of Group Supported Employment.

Individual employment is the focus of the new rate structure and the Division expects that the Rebased Rates encourage these services. The changes to the Group Supported Employment model are addressed in a subsequent comment.

Employment, Transition to Employment

One comment was received stating that the new Transition to Employment Service is favorably received by parents and family members.

The comment is appreciated.

Employment, Termination of Employment Support Aide

One commenter questioned the Division as to the transition process associated with the elimination of the current Employment Support Aide (ESA) service. This service is proposed to be eliminated from the service array. Similar, if not identical, services are available through attendant care. The commenter wanted to know if any remaining unused authorizations would be transferred to Individual Supported Employment or to Attendant Care.

The Rebase Model for Employment Support Aide has been developed and is included in the updated RebaseBook 2014.

Employment, Individual Supported Employment, Time Limits

A question was received inquiring whether a time limit would be placed on Individual Supported Employment services (ISE).

ISE Job Development Services are, by nature, time limited and terminated post job placement. A one year limitation is proposed for ISE Job Coaching services although the Division will consider reauthorization

and extension of the service if warranted for the individual.

Group Supported Employment, Rate Reduction and Methodology

Three comments were received regarding the proposed Rebase Model for Group Supported Employment (GSE). One comment opposed the reduction to the proposed Rebase Rate because some individuals will still need or desire the service. The commenter indicated a belief that the Group Supported Employment rates for selected group sizes were reduced as an offset to rate increases for other services. Two comments questioned two methodological issues in the rate model including the rationale for the decrease in the 1:2 ratio in the Group Supported Employment model and the rationale for exclusion of capital costs from the Group Supported Employment model.

The Division continues to support a service array that allows individuals access to the services that are desirous and appropriate for their individual needs. A comparison of the SFY 2014 rates to the proposed Rebase Rates that were presented during the public comment period showed that the rates for three of the ten group size/location rates were reduced (for group size of 2, both rural and urban as well as for rural group size 3). The Division has reviewed this Rebase Model with the CWG and several providers and decided to adjust the rates for this service. The Division supports this service and did not intend to discourage GSE services through a decrease in rates. The final Rebase Model for GSE reflects:

- *An increase in the number of miles for program-related transportation,*
- *An increased cost for the supplies per individual per day, and*
- *The reintroduction of the factor for capital costs to reflect that providers may have space available for storage or for individuals to congregate before or after completing work with an employer.*

With these revised assumptions, the rebased GSE rates for all group sizes show increased Benchmark Rates as compared to the current Adopted Rate levels.

Center-Based Employment

One comment expressed concern that the decrease in the Center-Based Employment Benchmark Rate will serve as a disincentive to move members from this program to the next level and given the national emphasis placed on the importance of employment of persons with developmental disabilities, this would seem to be a step backward.

As mentioned above, the Division continues to support a service array that allows individuals access to the services that are desirous and appropriate for their individual needs. The design of the employment services rate models is intended to incentivize providers and individuals to 'graduate' through the continuum of employment services. Additionally, the commenters concern regarding the decrease to the Center-Based Employment rates appears to be erroneous in that the proposed rates for the 1:6 staff ratio (only historical comparable ratio) for Urban settings is \$6.16 versus the current Adopted Rate of \$4.99 and the proposed rates for the 1:6 staff ratio for Rural settings is \$6.54 versus the current Adopted Rate of \$5.48.

Additionally, while the current Center-Based Employment rate models allow providers to bill for only a staff-to-client ratio of 1:6, the proposed rate models allow providers to bill a range of ratios. The CWG developed rate models for a 1:3 as well as a 1:9 staff-to-client ratio to provide for more flexibility in service design and delivery on the part of the providers. When compared to the current Benchmark Rates for the 1:6 ratio, the Rebase Rate is an increase of approximately 11.8%. The increase in the Rebase Rates is primarily a function of increases in the wages and productivity adjustments as well as the addition of Program Support costs.

Employment, ACA

A commenter asked two questions regarding Employment Services as they pertain to the requirements of the Affordable Care Act. Specifically, would members participating in employment programs be counted as full-time employees for the purpose of determining whether the agency qualifies as a large provider (50). And, are part-time employees counted?

The Division is not an ACA authority. Specific concerns that providers may have should either be posed to their legal counsel or presented to the Division in more detail.

17. Comments Related to Specialized Habilitation Services

Habilitation - Music Therapy

Two comments were received addressing Habilitation Music Therapy rates. Both comments were appreciative that the proposed Rebase Rate for Habilitation with Music Therapy Service contains a substantial increase over existing rates. The comments also pointed out that the proposed rates will still be below the previous Benchmark Rate, and suggested that the service be “first amongst equals” in terms of receiving funding after the Division’s budget is resolved.

The Division is grateful for the comments, but attributes the significant increase for this service to the operation of the independent rate models, rather than any intervention of the Division. The CWG and the Division note that changes in various BLS wage values are the primary reason that the proposed Rebase Rate does not equal or exceed previous benchmark rates.

As to the request for priority funding of the service, the Division is generally awarding a 2% increase to Adopted Rates for SFY 2015 based on the appropriations made available by the Legislature.

18. Comments Related to Transportation Services

Five (5) comments on Transportation Services were received. The comments addressed rate increases, wheelchair transportation, and absence factors.

Transportation, Rate Increase

One (1) comment was received expressing appreciation for the proposed increase in Transportation rates.

The Division is grateful for the comments, but attributes the increase for this service to the operation of the independent rate models, rather than any intervention of the Division.

Wheelchair Transportation

Several comments were received focusing on wheelchair transportation. The specific areas of the comments included:

- What considerations were given to funding specialized equipment, including harnesses, seatbelts, and other safety equipment as well as insurance costs in the Rebase Models
- Whether consideration had been given to separating wheelchair and able bodied program related (i.e., to and from programs as well as “in program”) transportation

One commenter also indicated their organization had to turn away wheelchair bound people because of the cost of transporting.

The CWG and the Division did consider some costs associated with wheelchair transportation, but not to the extent outlined by the commenters. There was no consideration given to separating wheelchair and able bodied clients into separate Transportation Services.

With respect to the costs associated with transporting individuals in wheelchairs, the Rebase Process developed an Enhanced Mileage Rate (EMR). The EMR captures the extraordinary costs incurred by agencies in purchasing relatively heavy-duty vehicles and equipping them with lifts to accommodate wheelchairs. The EMR is used in determining reimbursement for transportation expenses in the Day Treatment and Training Services, Group Supported Employment, Group Home and Transportation Services.

The Rebase Models do not have factors for additional specialized equipment for wheelchairs, nor do they contain factors for extraordinary insurance costs.

Transportation Services Absence Factor

The Division received one (1) comment pointing out that the absence factor in the Transportation Services models is lower than the absence factor in the Day Treatment and Training Services models. The commenter stated that providers experience a higher absence rate for transportation services than in their Day Treatment and Training Services programs.

The CWG and the Division recognized the inconsistency of the absence factor between the Day Treatment and Training Services and Transportation Rebase Models during the Town Hall meetings. As a result, the Transportation Rebase Models have been adjusted to replace the 90% absence factor with a factor of 85%. This adjustment increased the rebased daily transportation rate from \$12.85 to \$13.31.