FINAL REPORT
State of New Jersey

Rate Construction for Developmental Disability Services

Submitted to:
New Jersey Division of Developmental Disabilities
Department of Human Services

Confidential and Proprietary to:
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I. Introduction

In 2013, Johnston, Villegas-Grubbs and Associates, LLC (JVGA) was contacted by Myers & Stauffer to join in assisting the State of New Jersey in the development of new rate structures for services within both the Supports Program (part of the state's Comprehensive Medicaid Waiver) and the Community Care Waiver. In addition, JVGA was asked to perform a Universal Budget Impact analysis (UBI).

Over the last two decades, many states have entered into similar projects to create and use standard rates for paying for services, and JVGA has led many of these efforts. In this introduction, we will attempt to answer a number of questions:

1. Why do this project?
2. What is a standard rate system?
3. Why would you want one?
4. What challenges have been faced by the State of New Jersey, the provider community, and the consultants to get this ready?
5. What will the future look like when this is fully in place?
6. What does it mean for the people who need these services?

Before we begin to answer these questions, we would like to start by recognizing what an ambitious and worthwhile endeavor this has been. Developmental disability services in the State of New Jersey are quite varied and complex. Over the years, the community has demonstrated a high degree of creativity in designing and providing services for people with developmental disabilities and a great deal of skill and imagination in doing everything possible to offer the best services they can to people in need. And the State has demonstrated a keen interest in helping the provider community at every opportunity and in an environment of financial pressures and regulatory requirements.

JVGA always prefers to work closely with provider agencies, believing that their contribution is vital in matters of service design and also in setting up ways to pay for services. While JVGA has completed standard rate projects in ten states, every one of those projects involved significant provider input. JVGA also strongly values the input of people with disabilities and their families in the rate setting process. The complexity of the environment and the variety of input into the design has been a challenge, but the efforts of everyone involved should pay off.

So, why set rates?

Why do this project?

1. The simplest answer to this question is that the State is seeking fairness for providers and individuals in these programs. That fairness translates to four conditions:

a) A picture of the actual or true costs will emerge.

b) The structure that is used to construct the standard fee (or rate) can be meaningful in relation to the standards of care, and it is understood by everyone involved.
c) If two people are determined to need the same supports provided in similar ways, they will get those similar supports at the same rate.
d) The quality of these services and the positive impact they have will never be left out of the measurement of the success of the program.

There are a variety of other reasons for doing this kind of project that are related to fairness. For example, if the level of supports a person receives is paid the same amount regardless of which provider provides it, then money does not become a barrier for the person if their life takes them away to new sites and settings. This concept is recognized as valuable in the federal Medicaid program and is referred to as "money follows the person." In fact, federal Medicaid has offered grants in the past to states who are attempting to accomplish this when moving people from institutional programs to community-based services and the State of New Jersey is a state that has been involved in these efforts.

Another reason that many states have moved in the same direction as New Jersey is to simplify the system. A simpler system is easier to operate and frees the community to focus on things such as portability, equity, quality outcomes, and improvements in administrative practices that affect the quality of life for individuals.

A third area of benefit for a system like this is that it is easily understood (even if it takes some time to learn the terms and concepts involved) and the components of the system are somewhat standardized by service. This makes communication with governing bodies clear and easily understood.

With regard to equity and fairness, the system provides that any two or more provider agencies who do the same thing (service) in the same way will be paid the same amount.

But the system is also very flexible and able to follow the needs of individuals in highly specific ways. We will explain how further in this report.

So, what is a standard rate system?

What is a standard rate system?

2. A standard rate system is a set of published rates for a given group of services. The rates are not negotiable; they are not unique to any provider; and if they change, they change for everybody who provides identical services. There are a variety of ways that consultants and governments create these rates. We believe that the best way to create standard rates is to start with an understanding of how the programs should work and how they should be provided in the best interests of the individual, and still obey the regulations set forth by the federal Medicaid program.

Why would you want a standard rate system?

Why would you want one?

3. A standard rate structure is more fair to the providers, eliminates barriers that sometimes prevent individuals from getting the supports they need; makes the overall spending much more predictable; and provides the ability to more accurately respond to changes in the economic environment.

What challenges have been faced by the State of New Jersey, the provider community, and the consultants to get this ready?

Challenges?

4. The biggest challenge to this or any such project is the result of the passage of time prior to the project's beginning.

In almost every state that operates long-term care programs, those programs began in similar ways. Someone would make a determination about what the person needs in supports, and someone from the state or county government would negotiate compensation for the provider who provides it. Sometimes that compensation would take the form of a total dollar amount for a month or even a year.

As time passed, often decades, the services themselves would evolve into very different services even if they had the same name. Additionally, providers would be receiving very different amounts of money for similar services they are providing because of how much was available when they opened their doors or how skilled they may have been at negotiating. This has been observed by the JVGA team in every state where we have done work. It is a natural process and should not be considered wrong-doing in any way. It is simply how things evolve over time when standardization is not in place.

But the degree of differentiation (the degree to which services that are called the same thing are really being provided differently by different providers – and the degree to which providers doing the same thing are getting paid radically different amounts) creates the single greatest challenge to the implementation of standard rates. If yesterday you were saying to all the providers that a given service can be provided in many different ways, but today you say that all who provide that service should be doing it in a similar way (adhering to the same set of standards), some will have to change, or move to a different service category. Now this does not mean that every service can be done in one and only one way. Many services can vary quite significantly based on the needs of the individual. It really addresses the situation where a possible service has varied so much from the standards and expectations that it can no longer be considered the same service.

If you say to Provider A, who has historically been paid more for the same service than Provider B, but doing the service in the same way, that Provider A will now be paid less, they may not be able to continue to operate the way they have in the past.

What will the future look like when this is fully in place?

The Future: Fairness and Equity in the Compensation for Services

5. When it is all in place, three conditions will be present, leading to the fourth, which is our hope:

a) People with similar needs will be authorized to receive similar supports.

b) Actual costs will be captured and providers who provide similar services will be paid similar amounts.

c) The system will be easier to understand by everyone because its parts are all the same for everyone.

d) Fair and equal compensation for comparable service delivery will be accomplished.

What does it mean for the people who need these services?

6. Provided that the individuals and families truly understand the components of this (or any) standard rate system and how the system operates to pay for services, they become more empowered to play a meaningful role in how these services meet their needs. Individuals and families who have the same information that provider agencies have can work collaboratively with providers more effectively. Additionally, the knowledge of the characteristics built into the rate system (e.g.; portability, fairness and equity etc.) will shape expectations on the part of the community as a whole.

What does it mean for people who need services?

II. How the Project was Conducted

In this section of the final report, we explain the analytical processes applied during the project. We will describe how each section was done and how the final results came together.

The Brick and 4 Standard Components of the Rate System

The standard rate system that JVGA used has come to be known as The Brick ™[1] method created by John Villegas-Grubbs in Arizona approximately twenty years ago. This is the same architecture that has been implemented (or is being implemented) in ten other states, although it is not exactly the same in any two states and is easily tailored to each environment.

All the costs that are incurred by the providers related to each service are split into components. Those components have historically been: Direct Care Staff (the people

[1] The Brick™ is a trademark of JVGA (Johnston, Villegas-Grubbs & Associates, LLC).

who work face-to-face and hands-on with individuals); Employment Related Expenditures (such as benefits); Program Support costs (such as equipment related to the service, professional consults, and supervisions); and General and Administrative costs (costs any company bears by being in business but not specifically related to the nature of the business, for example, legal and accounting).

"Direct Care Staff"
Direct care staff time is the time that staff spend with the individual performing the tasks associated with the service and furthering the objectives of the program. The individual is there with them and the staff member is doing what they need to do to further the objectives of the service. This is the heart of the rate system because all other expenditures needed by the program are measured and expressed in the system in relationship to direct care staff.

"Employment Related Expenditures"
These costs further break down into two categories: discretionary and non-discretionary. Discretionary employment related costs are those benefits that the employer decides to offer. Health insurance, retirement options, profit sharing, and tuition reimbursement are all examples. Non-discretionary employment related costs are those that are mandated by some government agency. Unemployment Insurance, Social Security, and Workers' Compensation benefits are all examples of this form of expenditure to the employer.

"Program Support"
This cost component varies quite a bit from one service to another, and sometimes within a specific service. It consists of all those expenditures that are needed to support the individuals, but are not usually traceable or assignable to a single individual. Staff supervision and training, program supplies, the amortization of program related equipment, and consultant costs are all examples of this category.

This is the category of expenditures that follows the differences in the service design very closely, so it is uncommon for different service groups to have exactly the same program support percentages. This is because program supports are usually different for each service group. Likewise, if two or more providers offer the same service and the individual needs are radically different even though the services are the same, the program support percentages can vary to reflect those differences. This can result in different program support percentages needed for a single service, even though the service has the same definition in the Medicaid program.

The dollars spent on each of these first three components are added up to get a total dollar amount for each component. Most of the components are divided by the total for direct care staff costs to get a percentage for each component based on direct care staff costs.

"General and Administrative"
These costs can be described as the costs of doing business but that have nothing directly to do with the kind of business the organization is in; they are costs common to

all businesses. Costs like this include Executive Director, Legal and Accounting, Corporate Office expenses and supplies, and General Liability Insurance (for example).

This component is treated differently than the others in the creation of the 'brick' (and ultimately the rate) because it is expected to be a percent of the total rate (not of the direct care staff costs) so it is calculated differently.

The New Jersey Rate Study

In New Jersey, JVGA participated in conference calls, on-site meetings, on-site presentations, and webinars throughout the project with all relevant stakeholders, including (1) various members of the Division of Developmental Disabilities, (2) members of the State's Division of Medical Assistance and Health Services (DMAHS), (3) an Advisory workgroup (comprised of both providers and family representatives), (4) a Fiscal workgroup (comprised of both providers and family representatives), (5) current and prospective 3rd party community providers, (6) families and family representatives, and (7) self-advocates. Throughout the project, the rate architecture, as well as staffing configurations, were presented and discussed with these stakeholders.

A key element of the New Jersey rate study was establishing representative Advisory and Fiscal Workgroups from the outset of the project to assist in applying New Jersey specific elements to the standard rate construction approach. To populate these committees, the Division sought out a sample group from the provider agencies currently engaged in a business arrangement with the State. Geographic differences, as well as differences in agency size, scope, and services offered were all taken into consideration when constructing the sample group. To ensure adequate representation of the entire New Jersey system on these workgroups, family members were also added to balance the membership. These workgroups were engaged in various ways (in person, webinars, conference calls, etc.) throughout the entire course of the project to offer recommendations on critical policy areas vital to a complete rate setting process.

Step 1: Determine the Cost Categories

The first step in determining an overall cost profile for any given provider is to study the service descriptions in great detail to determine if the four standard cost categories: 1) Direct Care Staff, 2) Employment-Related Expenditures, 3) Program Support Expenditures, and 4) General and Administrative (G&A) expenses, will be sufficient, or if additional categories would be needed to address service, program, or provider-specific issues in New Jersey. JVGA typically defaults to these four basic cost component categories for residential and day program rates in community settings. These are typically the same categories used in support rates as well.

The study revealed no justification for changing these basic categories nor for the inclusion of additional ones. It was our determination after a very detailed analysis that the four standard cost categories would be sufficient to establish the rate architecture for the New Jersey project.

Another area that required some detailed analysis was the issue of how the State currently funds room and board expenditures. Since Medicaid waiver programs prohibit the inclusion of room and board expenditures in rates for community-based residential services, our team studied the room and board issue to ensure standard rate funding was aligned properly between waiver eligible services and non-eligible services (i.e, room and board).

Step 2: Gather the Financial Data

The next step undertaken was to gather the General Ledgers (GLs) from the sample group of providers of the services for which rates are to be set. The team issued the request for general ledgers from the most recent completed fiscal year to be provided in Excel spreadsheet format. While the spreadsheets were being analyzed, the team scheduled calls with each of these providers to discuss the information within the spreadsheets and to get a more complete picture of the programmatic aspects of the services they provide. Upon analysis of the cost components, for example, if there were large differences in the program support percentage, the team would need to know what the programmatic pressures are that are causing those cost pattern differences.

We purposefully did not ask them to adjust, manipulate, or edit their GLs in any way from the initial request so that the GLs could be considered an independent, unbiased data source for our rate study.

We contacted each provider by email where providers were invited to send in their General Ledgers for the last fiscal year completed (2012), and all were invited to schedule a phone call to discuss their programs and information where we would respond to questions. Of the 56 in the sample group, 42 providers sent in general ledger entries that were coded and then analyzed. (We had no response from 9 providers, one provider suffered a fire and did not have access to records, and 4 providers opted not to send in data.) We were able to schedule one-hour phone calls with all 42 providers during three different weeks where extensive notes were taken about each program by provider. We gained a fuller understanding of what programs they provide, how their programs are run and also about the individuals they serve. To fortify our understanding of the New Jersey community structure and practice, providers and the two committees participated in on-site meetings in June, September, October and November of 2013 and in April of 2014. These meetings were in addition to the webinars held in August and October of 2013 and January of 2014.

Step 3: Organize and Analyze Data

In this step, General Ledger information was organized so that the cost components could be compared in a consistent manner across providers, and calculated as a percentage of Direct Care Staff costs:

A. Each account line was identified to the component of the rate system it "falls into" (Direct Care, Employment-Related Expenditures, Program Support Expenditures, or General and Administrative) and coded as such.
B. The components were sorted and summed.
C. Each component was then calculated as a percentage of the Direct Care Staff costs, with the exception of G&A costs.
D. The ledgers were returned to the providers to have them review the calculations and provide feedback as to the accuracy of the cost line item identification.

The organization of the information allowed for the successful completion of the component analysis. The final result of the component analysis approximates a true understanding of each of the cost components' relationship to Direct Care Staff costs for each of the service categories analyzed and allows for direct comparison of costs between and among providers, a key outcome of the rate study. Additionally, these components are expressed in terms of that relationship (usually as a percentage) so as to allow scenario modeling.

Results of the Study Work: Among the most prominent results of the analytical work on the general ledger data we received, as well as the discussions conducted with the provider agencies, was the appearance of program support costs that varied within individual service descriptions: individual supports (i.e., residential services) and day habilitation. Normally there is some natural deviation in this cost component category around an average program support component percentage, but there is usually no single "average." In fact, calculations of this component category sometimes reveal two very different "average" percentages (as a percent of direct care staff costs) which indicates that the service is being provided in more than one way.

Upon closer review of the nature of the individual costs that are driving these differences, it is almost always the case that the higher "average" is a result of clinical expenditures necessitated by the individuals' needs that are over and above the typical needs of individuals without clinical involvement. This is, in fact, so common that JVGA actually looks for this effect in order to determine whether a single rate for a service is sufficient or whether there will be a differentiated rate for the same service to adequately cover clinical costs for those in need. Such is the case in New Jersey. While creating a clinical (or "acuity") differential for the standard rate that is calculated is a simple matter of following the financial analytics and verifying the circumstances that create the differences by discussing them with the providers, it is more complicated to establish criteria for when and how the differential will later be applied. It is important to note that this particular effect addresses the fully-loaded value of the direct care staff time (The Brick™) and does not regard the number of hours needed by the individual. The rate system is malleable in that it provides for different levels of staff hours provided to the individual in support. But it is also flexible in the value of each hour in order to accommodate medical and/or psychiatric needs through the application of a clinical acuity factor, where appropriate.

Step 4: Aggregation of Cost Components

A wage level was determined for Direct Care Staff time (hourly wage). Usually we do this using information from the US Department of Labor Bureau of Labor Statistics. It is important to mention that we use the Bureau of Labor Statistics to obtain current wage level equivalents, the prevailing average wage, not an entry level wage.

We began by reviewing Section 1115(c) Supports Program Service Definitions (the Supports Program under the Department of Human Services' Comprehensive Medicaid Waiver) and Section 1915(c) Service Definitions and Qualifications (the Division's Community Care Waiver) prescribing the minimum standards for services and supports provided by the Division.

Using this information, we identified twenty potential occupations from the May 2012 Occupational Employment Statistics of the Bureau of Labor Statistics by occupational group, title, and code. We compiled wage data for these twenty occupations for the United States as a whole, the State of New Jersey, and for each of the seven Metropolitan Statistical Areas comprised of the 21 counties in the State of New Jersey. In the area of Support Coordination, we compiled two potential occupations from the May 2012 Occupational Employment Statistics of the Bureau of Labor Statistics by occupational group, title, and code.

Our definition of direct care staff is *an hour of program support where the objectives of the program are being considered and pursued with the individual face to face for the majority of the time (roughly 90 percent).*

The Brick™ (or the fully loaded value of an hour of direct care staff time) was then built from the chosen wage by adding the Employment-Related Expenditure (using the percentage calculated from the provider's general ledger submissions) plus the Program Support Expenditure (using the percentages calculated from the provider's general ledger submissions). This subtotal (subtotal 1) was then adjusted up for G&A Expenditures by "grossing up" the total by the G&A percentage such that:

Subtotal 1 divided by (1 – G&A Percentage) = Total Value of Direct Care Staff Hour

Step 5: Develop Total Cost by Provider for Residential Services and Day Programs

After the cost components were aggregated, the total costs by provider agency were prepared in draft and reviewed.

For the schedule of rates at different case load assumptions, please see Attachment 1: "The Rate Schedule."

Demographic Differentials

To determine if demographic differentials exist to the point that more than one rate is needed for the same service, we examined population densities, geographic characteristics, and economic conditions, and observed how these factors put pressure on wage levels, housing costs, and transportation costs. We were trying to determine if the value of the hour may be different in the counties located near New York in the northern part of the state (Bergen-Passaic-Morris-Sussex) as opposed to the southern part of the state (Atlantic-Cape May-Salem-Cumberland) and we were looking for data to verify this. While we noted that it is generally more expensive to purchase/rent properties, as well as meet general living expenses in the northern part of New Jersey versus the southern end, we felt there were not significant enough variances in costs to warrant a demographic differential. Given that many areas of the state border on metropolitan areas (New York City in the North and Philadelphia in the South), as well as resort areas (the shore counties and Atlantic City), JVGA concluded that one standard wage could be used statewide to satisfy these demographic issues. JVGA was diligent about including providers in the sample from both urban and rural counties.

Another possible demographic differential that was examined was scale. This refers to the difference in size of providers in New Jersey. As the general ledgers came in from the targeted sample, we categorized the types of service that each provided prior to analyzing. These include residential services (group homes, supervised apartments and supportive living) and employment and day services (supported employment, day habilitation, etc.). We were also looking for behavioral and medical acuity as part of the residential/day habilitation services.

The issue of transportation is particularly complicated in this analysis. JVGA conducted a number of phone calls concerning transportation and gathered concerns related to transportation in New Jersey. The challenge in transportation rate development is not the capture of the cost data; rather the determination of the billable unit. Each option for a billable unit (i.e., a mile, an individual trip, a day of enrollment, etc.) presents advantages and disadvantages and there is no perfect unit to choose. While some of the options for selection of a billable unit are very accurate (in that they follow the actual events of the transportation service very closely) they are also cumbersome and difficult to record and to bill (for the transportation provider). Other options for the billable unit are easier to track and report, but do not offer much detail about what specifically happens. After discussion with the stakeholders and the State about this issue, JVGA is recommending a two-pronged approach to reimbursement for transportation services in New Jersey. For individuals residing in licensed settings, transportation has been factored into the rate based on the figures reported in the GLs. For all other individuals, JVGA recommends using mileage reimbursement too compensate for transportation costs.

Universal Budget Impact Analysis

An important part of the rate structuring project was attempting to determine the financial impact of the proposed rates for the provider community, across all services for which JVGA constructs rates. JVGA attempted to determine the impact of the proposed rates through constructing a Universal Budget Impact Analysis (UBI).

In this budget impact phase of the project, JVGA created a master list of providers for the entire state of New Jersey. Letters were sent out by email explaining what information we were seeking and a Staffing Template was attached for each provider to fill out and return. Of our request, we received completed staffing templates from 134 providers (114 Cost Reimbursement and 20 Fixed Rates). We calculated over 2,000 discrete services for these 134 providers, services that span the entire spectrum of existing services. JVGA scheduled many calls with providers to resolve questions on their staffing templates in this phase of our analysis. JVGA also worked closely with the Division throughout this phase of the project and stayed in close communication with conference calls on a regular monthly basis, as well as emails and calls with staff as needed for input and clarification.

Results of the Study Work:

To begin the analysis, the final rates were multiplied against an assumption of units to calculate how much money would be spent if the rates were released in total across the service structure. This total was then compared to the total amount of money available to fund standard rates (the budget). If the money that would be spent is different from the budget, the difference is calculated as a percentage of the existing budget and we call it the "Funded Percentage." If the projected payments exceed the budget by ten percent (10%) for example, we express the funded percentage at ninety percent (90%), meaning that ninety percent of the rates are funded by the existing budget. The reverse is true if the projected spending is less than the existing budget.

Funded percentages less than 100% are typical in past rates studies where rates are based on true cost of care, not the amount of funding inherent in the system (as was the case in New Jersey). In these cases, JVGA often advises the community and all stakeholders throughout the project that movement to a standard fee system with new rates will not create new money. Therefore, funding percentages of less than 100% are typically addressed prospectively through advocacy and through the State's annual budget process.

In first draft the universal impact of the rates the team created (in the aggregate) was above ninety percent (90%) of the existing budget. It is extraordinary for the initial UBI to be above ninety percent in first draft. So what does this mean?

It means that the rate calculations exhibit a very high degree of accuracy. JVGA attributes this accuracy to the extensive and constant contribution of the providers in New Jersey.

Individual and Family Interests in Reforms

When a system develops a new way of determining how much money to spend for services for an individual (rate structure) and how to distribute that money to actually pay for services (individual budget allocations), it is important to keep in mind how that impacts on the individual. Therefore, the system must be connected to a set of well-defined, measureable outcome and performance indicators so that the new rates will incentivize and reward high quality services. In other words, it's important to spend money wisely, fairly and to not overlook the fact that you want to get quality results. To this end, JVGA believes it is important to include people with disabilities and their families in any process of redesigning how services are provided. As such, with help from the Division, JVGA made opportunities available to families and self-advocates to have input into this process. The following is a synopsis of the process and information shared with JVGA, Division administrative staff, families, self-advocates and providers.

Meetings and Discussions with Families

On June 11, 2013, JVGA first met with a group of family members of people with disabilities and asked them "What ways would you change services to make them better?" Their responses varied and fell into a few primary areas on which the rate setting project might impact. We can best summarize those as: Funding (sufficiency, flexibility and equality) and Flexibility and Creativity (in all aspects of service development and delivery, such as community integration of employment, housing and transportation options).

Other ideas identified were beyond the scope of this rate setting project and as such would best be addressed with other system changes. This information has been provided to the leadership at the Division for further consideration.

As a follow-up to that meeting, on August 16, 2013, JVGA hosted a webinar to provide feedback to the families and allow for further discussion. Key points of discussion during the webinar were:

Adequacy of Funding: Setting rates for services will not guarantee having adequate funding. However, it may make it easier to analyze the adequacy of funding throughout the State. Each approved provider of a service will be paid the same rate to provide that service for similar individuals. Therefore the funding that is available will be distributed in a fair and equitable manner. It establishes a "base rate." In a standard fee environment, each provider is faced with the same financial dilemmas as any business operating in an open and competitive free market. In this way, the fee for service system is transparent and open; it can be helpful should the issue of adequacy of funds want to be studied further. It can also provide a framework to help one determine at what level

services need to be funded. Other states have used their base rates as a foundation to "rebase" the rates over time.

Flexibility and Creativity: A desire for creativity and flexibility might come from a person with a disability, their family and/or the approved provider. In any instance, setting rates can ultimately have an impact on creativity and flexibility in service delivery. Services can be designed differently between providers or families as long as these services meet all applicable standards and requirements. The shift to a fee-for-service model in New Jersey is expected to provide individuals with disabilities and their families much greater flexibility and choice. It will also compel the provider community to operate more efficiently and to make better business decisions (two factors that are not emphasized in the current cost reimbursement contract model).

Staff recruitment and retention: Many individuals brought up the importance of hiring and keeping good and reliable staff. A major factor contributing to staff leaving a job is that the wages paid may not be competitive with other jobs. With the fee for service system, all providers are paid the same rate (with the same wage assumption) for each of the various services that will be delivered, but can spend the dollars they receive in any way they choose. It remains to be seen how providers might develop creative and new ways to find and keep good staff, but experience has shown in other rate setting projects that a standard fee environment allows for providers to be more creative and flexible with wages and benefits to be used to retain quality staff.

On September 16, 2013, JVGA met with the families again to explain how the rates for providers were to be developed. This was an opportunity to provide the families with realistic expectations about rate development and help them to see the rate system from the provider perspective. The families were shown how the rates are established on current, actual costs, including (1) staff wages and benefits; (2) costs that support the program; and (3) general and administrative. After much analysis, a rate is established for each service. How providers spend the funds for those same services may vary depending on the provider. Recognizing there are limitations, the provider can spend the money in a variety of ways to meet individual needs. Of course, the provider must comply with the many safety, licensing and certification requirements.

In addition to the discussion regarding construction of rates, many families took this opportunity to educate the rate setting team on the self-directed model of services currently being used in the State. This understanding is critical to developing a rate structure that will work for services paid directly to a provider (for provider-based services) and to the Fiscal Intermediary (for services that are self-directed using self-hires).

Meeting and Discussion with Self-Advocates

On November 19, 2013, Division administrative staff arranged for a meeting of JVGA and a group of self-advocate leaders in New Jersey. A national leader in the self-advocacy movement joined the discussion to help encourage local self-advocates in the importance of expressing what they want in services so that providers may learn more

about how to be flexible and creative, not only to their individual needs but also those of other individuals. Primary focus was placed on four ways an individual might have the most impact to advocate what they want for their lives:

1. Selection of a Support Coordinator: Someone you feel comfortable working with and who you feel knows you and listens to you.
2. Pick your provider: If you want to change providers for a reason, you can and the money to provide that service will follow you to the new provider.
3. Work with your provider to speak up and advocate for your needs to be recognized: see yourself as the "boss" of your own life.
4. Share with other self-advocates about creative and flexible methods that are happening with services: the more self-advocates talk with each other, the more they learn about possibilities. The more they come together, the louder their voices.

Creating new norms of what it is like to be "of" communities

People with disabilities and families have witnessed many changes in services throughout their lives. Setting a standard fee for service rates is just another change. Initially, it appears to simply be an administrative/financial change. However, it also can present opportunities to work with providers to modify services to meet the needs of all people supported by the system. This change does not mean there will necessarily be an increase in funds, but it does mean that the money will be fairly and equitably distributed for services. If the need to study sufficiency of funds arises, the rate system will allow for a clear, transparent way to look at funding levels since everyone starts from the same "base" rate.

The ultimate challenge is for people with disabilities, their families and providers to work together. As self-advocates and family members become witness to new, creative ways of providing services, it becomes important to share these ideas with others throughout New Jersey. As history has shown, by sharing what and how new ideas work, others can see new possibilities for themselves. Communities can become incubators of ideas to incentivize everyone involved in providing services to be more creative. This is what leads to innovative practices that change services on a broader level, becoming new community norms.

In the end, systems change will provide opportunities to be creative and incentivize development of more safe, inclusive communities where people with disabilities can thrive as they determine the directions of their own lives.

Quality Review - Collecting and sharing quality information on new community norms

As new community norms are developed, New Jersey will have another challenge: How does the DD community in New Jersey track and share the information about quality, creativity and flexibility that the new rate system offers? As services become more

inclusive and dispersed in communities, this will be a central challenge for the system to move forward to create these new community norms. It will be strategic for New Jersey to anticipate the need to centrally accumulate and catalog objective, well-defined, measurable information on quality indicators of services and providers. As families and self-advocates begin to "shop around" in the new, open and competitive marketplace, the Division will need to collect a variety of utilization and cost data. Such information will become valuable and will need to be easily and widely available and distributed.

More and more focus has been placed on the importance of Person-Centered Planning and individual choice over the years. JVGA suggests that placing self-advocates and families at the core of the development and implementation of a system of quality review be considered.

Provider Input

As we stated earlier in this section, JVGA believes that provider agency input is critical to success in arriving at component percentages and all the calculations that result in accurate rates. The State staff did much to foster the inclusion of the provider community and deserve the credit for making this happen. The sample provider group was asked to share their information and we appreciate their hard work in delivering it to us.

After the initial email describing the process, providers compiled their General Ledgers (GL) in Excel spreadsheets and sent them to JVGA. Each GL was then coded and returned to the providers. At that point, the JVGA team scheduled conference calls with each provider agency with multiple staff participating, including CEOs, CFOs, Executive Directors, Fiscal Officers, Program Directors, CPAs, and controllers. As we listened, we gained a fuller understanding of their programs and the individuals they serve. We heard many challenges they face: Individuals with high behavioral and medical acuity, dual diagnoses, complex nursing supports, an aging population with increasing medical services; Staffing concerns about recruiting and retaining qualified staff, dealing with negotiated wage increases with unions, high turnover rates, increased costs of benefits especially for family coverage; Transportation costs increasing; rising Property expenditures to maintain older homes, high cost of housing in geographic areas of New Jersey; concerns about Infrastructure needed to purchase computers for billing and auditing.

The Pro-Forma Effect

There is always a tension in the development of new standard fees which is difficult to describe and even more difficult to address. It is the presence of influences on spending patterns that are caused by budget restrictions in the past. For instance, sometimes we see lower wages because the budgets that the State had to operate with could not afford higher direct care staff wages. There is a similar lowering that can occur in other components as well, commonly Employment-Related Expenditures where costs like unemployment and worker's comp reside.

The dilemma presented to rate construction experts is that federal funding agencies require and expect that the rate studies are representative of what the cost characteristics ***are*** rather than what the cost characteristic ***might be*** if there were no budgetary restraints. Rates could be constructed "pro-forma" in a what-if scenario as long as the actual contingencies are known and quantified. But the study itself would still have to regard actual cost patterns rather than hypothetical ones.

The one way that JVGA steps outside the closed financial patterns in an attempt to address this situation is to anchor the direct care staff wage level from outside the general ledgers, so that if the wages are lower, it will not be institutionalized into the new rates. Beyond that, we are usually not permitted to speculate.

III. Actions Taken and Related Recommendations

Introduction

The specific values in each of the rates developed vary according to the specific service for which the rates have been set. The general recommendation is that these rates, with the value of their respective components, be accepted by the State of New Jersey. For the actual values please see "Attachment 1: Rate Schedule."

Rate Development

- JVGA elected to use the data from the Bureau of Labor Statistics (BLS) for the direct care staff wage for each of the services analyzed.

  Included in Attachment 1 are the codes for each job description selected by the JVGA team from those listed in the BLS for the State of New Jersey. Our selections were based on the information we gathered from state policies and service descriptions, provider discussions, and from other states where we have conducted similar analyses. It sometimes happens that there is no 'exact' fit for a specific agency and there is usually only one job description selected for each service unless legislation, licensure regulations, policies and procedures, or Medicaid Service Descriptions specifically direct otherwise. BLS wage levels are usually not predicated on levels of education; so it is not accurate to conclude that some job descriptions and corresponding wage levels are based on advanced degrees versus non-advanced degrees. For some services, however, the BLS does present wage levels based on certification or licensure by the respective states' licensing board for the profession in question, if one exists. Where no board certification was pertinent to the service, JVGA selected the most appropriate wage based on our experience in other states.

Supervisory staff, such as in the service of Support Coordination, is not considered a "direct care staff" type of staff time. Consequently, the job description and related wage level are not considered when selecting the direct care staff wage from the BLS. Rather, these costs are calculated in the "Program Support" category of expenditures, taken directly from the provider agencies' financial information.

At the direction of the State of New Jersey, JVGA increased the wages for each direct care staff classification by the Medicaid Individual Price Index (CPI) as follows (Note that the BLS wage levels were reported for year 2012):

For 2013, the CPI for 2011 was used.
For 2014, the CPI for 2012 was used.
For 2015, the CPI for 2013 was used.

- In many states that operate state-run facilities that employ State staff, a difference in pay levels exists between State staff and staff working for providers in the private sector. This can happen for a variety of reasons. The issue of parity of pay between State staff in these state-run facilities and staff in private sector agencies is not something that can be addressed simply as part of a rate study in general, because it involves decisions and actions on the part of state legislatures. It is outside the scope of this work.

- JVGA included a provision for absences of five percent (5%) in the individual support services that occur in group homes and supervised apartments. This represents the highest absentee percentage that the JVGA team has included in any state, with the typical percentages for absences being between three and five percent (3% - 5%). Including this absentee factor as an increase to the individual support service rates will allow agencies to manage and absorb uncompensated costs associated with out of program, non-billable events since the 5% vacancy percentage will be paid on all billable units of service. Inclusion of the absentee factor as part of the rate is the most efficient method to acknowledge the impact of out of program, non-billable events as Medicaid will only compensate for a delivered service.

- The most common percentage for the General and Administrative component across the country is ten percent (10%). The use of this percentage in standard fee systems is mandated in some Federally-administered programs in the Health Resources and Services Administration (HRSA) notably the Ryan White Care Act, and for this reason many states use this as a precedent to adopt ten percent (10%) in standard fee development on other programs. However, the prevailing percentage that the JVGA team observed in New Jersey was twelve percent (12%)

and it is our recommendation that it be selected. It is currently used in the identified rates.

- For residential services (group home and supervised apartments), the actual rate is paid on a billable unit of one individual day. The rate system, which is built on the idea of the brick (the fully loaded value of an hour of direct care staff time), is flexible in that it is possible to have more than one daily rate. The system allows for individuals to be receiving different amounts of staff time in any given day, according to their need. Some people require twenty four hours of care on any given day, while most do not. But a system that contains an infinite variety of staffing configurations can be extremely complex, and the variety is very likely to be more than is necessary.

  The best way to implement this system is to determine a few standard staff configurations based on a few different levels of staffing common in group homes and supervised apartments, and then allow for exceptions. An exception would be a person who does not "fit" into a standard configuration of a home.

  Normally JVGA proposes a set of standard configurations for residential settings based on different amounts of staffing hours in any given day, per individual. In New Jersey, the JVGA team asked the oversight committee to make a recommendation for these different standard staffing levels, based on how the homes are currently being configured and the committee returned the following five staffing hour configurations: 3 hours, 6 hours, 10 hours, 14 hours, and 18 hours.

  Budget Considerations

- When the impact on each provider was studied it became apparent that under the new rate system some providers would receive more revenue for the same level of service while others received less. It must be stressed that this is a natural result of moving to a standard compensation system and away from years of individual negotiations. It does not represent an inaccuracy in the financial information gathered from the provider community, or in the proposed rates that result from it. But it does pose a challenge for implementation that simply cannot be ignored.

JVGA considered a process for implementing this rate system that involves limiting the level of decrease in any agency's income, or increase in any agency's income, to what could be considered a tolerable change. This is necessary because the over-all budget remains fixed, and the new rates cannot exceed the existing over-all budget.

The JVGA team asked the Advisory Committee to make a recommendation as to the gain/loss percentage that will be considered tolerable to use in implementation. The State felt it was important to ask the committee (since it is comprised of mainly providers who were chosen to represent the overall provider community) to establish the percentage limitation. Since this overall project must remain budget neutral, the State believed that allowing the committee to name the percentage limit and thus influence the implementation of the rates was critical to achieve provider consensus.

After considerable discussions around the topic, the Committee opted to not offer a recommendation. JVGA recommends extending the implementation phase of the project (from 6 months to likely 12 months) and not limiting any gain or loss in any way. The most appropriate way to implement the standard rates would be to formally announce the draft rates, allow all stakeholders (the State, providers, families, self-advocates, etc.) a full year to gear up for the usage of the rates, and then when the date of implementation occurs, the rates go into motion system wide. A longer period of 12 months for vetting of implementation issues and changes to provider business practices gives the system the best chance to succeed upon going live.

Other Concepts to Consider

- Self-Hire

  In New Jersey, families and individuals are allowed to direct services by choosing the staff person(s) who provide the specific services for their family member or for themselves. JVGA recommends that the same rates as created for the agency delivered services be the basis of the rates paid for "self-hire" related services. There is a key difference, however. The self-hire services that are being purchased involve a Fiscal Intermediary for financial and employment support. Therefore, there is a need for a portion of the rate to be paid, not to the family or individual doing the hiring, but to the agency purchasing the benefits (Employment Related Expenditures) for the employees. So while the total dollar for the service would remain the same, a portion would be paid to the employee on behalf of the family or individual making the hire, and a portion would be paid to the agent funding the benefits.

IV. Closing Remarks

The providers in our sample group did a tremendous amount of work, put in a lot of time, both in person and by spending hours on phone calls with JVGA staff. There was much back-and-forth between the provider community, the Advisory and Fiscal oversight committees, and the JVGA team, so the extent to which the resulting rates are close to what is actually happening in New Jersey is largely due to the hard work of the community of providers and the input of the families and self-advocates.

The Division's staff has been indispensable in providing critical information about the nature of services. They were a tremendous help in making sure the formulas were carefully scrutinized and were a terrific assistance in all matters related to the work.

It has been a great pleasure to have been associated with the work in New Jersey.