South Dakota In-Home Services Rate Study

Presented to:

South Dakota Department of Social Services and South Dakota Department of Human Services

Presented by:

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A. Executive Summary

In this report, Guidehouse presents the results of its 2022 rate study on behalf of South Dakota Department of Social Services and South Dakota Department of Human Services for Medicaid and State In-Home services: Personal Care, Homemaker, Adult Companion, Chore, Respite and Nursing provided within the Home & Community Based Options and Person Centered Excellence (HOPE) Waiver, Assistive Daily Living Services (ADLS) Waiver, Long Term Services and Supports State Funded Services, Medicaid Private Duty Nursing and Medicaid Home Health Nursing Services. The comprehensive rate study involved the tasks described under South Dakota's Codified Laws (SDCL) for Rate Setting for Community-Based Health and Human Services[1]. One of the major goals of the rate study was to develop a payment methodology that would be transparent and representative of the current costs to providers related to delivering quality services.

Stakeholder Engagement

At the inauguration of the rate study, Guidehouse discussed the goals and background context of the rate study with stakeholders, providing detailed information on the history of the current reimbursement system. We also explained the need to revise the current payment methodology, identify current and anticipated provider costs, and account for changes in wages and inflation due to the changing labor market. Guidehouse conducted stakeholder engagement meetings in an effort devised to inform, test, correct, and validate the provider cost and service delivery assumptions used in the development of benchmark rates for the proposed revisions to the in-home payment system.

Data and Methods

The rate study process drew on a wide array of data sources to develop rate assumptions and benchmark rate recommendations for each of the individual waiver services. Guidehouse relied on objective, publicly available data sources, standard administrative cost reporting, as well as additional provider-reported costs specifically collected via a Provider Survey. Guidehouse conducted the survey to achieve the following goals:

- Collect data from in-home service providers to identify actual costs and wages;
- Seek input on data not available through other sources;
- Receive uniform inputs across all providers to develop standardized rate model components;
- Develop rate model inputs that are reflective of actual service delivery;
- Solicit general feedback from providers to understand service "pain-points" that could be addressed in rate updates.

[1] South Dakota Legislature, Rate Setting for Community-Based Health and Human Services (Chapter 28-22) Available online: Codified Law 28-22 | South Dakota Legislature (sdlegislature.gov)

The objectives of the study were to determine benchmark rates based on more current labor assumptions as well as taking into account publicly available information that could enhance provider reported information.

For each service, multiple data sources and calculations were used to define key cost assumptions such as wages for Personal Care and Homemaker staff. Cost assumptions for base wages, benefits, and staffing patterns were obtained from the Provider Survey and indirect costs including administrative and program support cost factors were based on Cost Reports. Guidehouse researched additional data points such as inflationary metrics and supplemental pay estimates that were obtained from the industry data collected by the federal Bureau of Labor Statistics (BLS). This report also describes the potential options for further evaluation for transportation and the further standardization to pay a single rate for all in-home services, with the exception of nursing.

Rate Model Recommendations

The approach used to establish the Department's benchmark rates is an "independent rate build-up" methodology commonly applied by states for setting rates for HCBS populations. It is an approach recognized as compliant with specific CMS regulations and guidelines and congruent with Medicaid rate setting principles more generally.

In alignment with this independent rate build-up approach, the study identified appropriate cost assumptions for each value component used in the rate models, allowing rates to be built from the bottom up and calculated according to the relevant unit of service for each of the waiver services included in the rate study. This modular approach requires a comprehensive analysis of the types of costs incurred by delivering a service and then representing these costs through a reasonable standard cost assumption, which serve as "building blocks" added together to form a cost-based rate for the service as a whole.

Based on feedback from the Advisory Workgroup, Guidehouse identified rural transportation and wage standardization as two key areas of concern to the in-home providers. Also, during discussions with DSS and DHS there was a desire to split the Nursing rate into individual Registered Nurse (RN) and Licensed Practical Nurse (LPN) rates to better align with the current Medicaid reimbursement.

Fiscal Impact Analysis

Based on the benchmark rates developed from the service rate models, Guidehouse conducted a fiscal impact analysis to support the proposed benchmark rate recommendations.

This analysis indicated that if the proposed benchmark rates were implemented based on utilization from SFY19 the system would require an additional $6.8 million—which includes not just state but also federal dollars—to reimburse providers at the benchmark rates recommended by Guidehouse. This dollar increase is an 18.2 percent increase from the current rates in effect as of July 1st, 2022. However, when considering the FMAP the state share would be $3.6

million. These dollar estimates include the funds required for in-home services under DSS and DHS. Tables 1 and 2 reflect the overall fiscal impact for DHS and DSS based on the proposed benchmark rates.

Table 1: Overall Fiscal Impact- Federal + State Share

Fiscal Impact - Federal + State Share				
Funding Source Split	**Utilization Paid at SFY23 Rates**	**Utilization Paid at Benchmark Rates**	**Change**	**Difference**
DHS	$30,324,675	$35,953,803	18.6%	$5,629,128
DSS	$7,125,966	$8,335,893	17.0%	$1,209,927
Total	**$37,450,640**	**$44,289,696**	**18.3%**	**$6,839,055**

Table 2: Overall Fiscal Impact - State Share

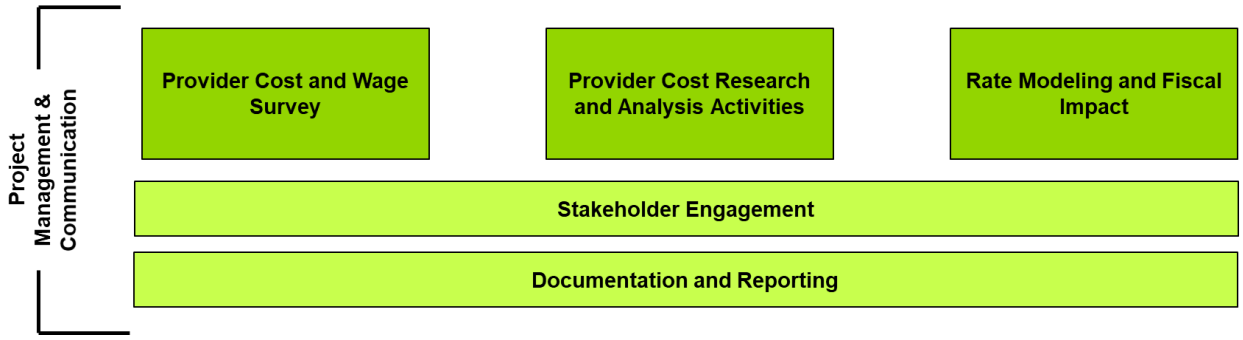
Fiscal Impact - State Share				
Funding Source Split	**Utilization Paid at SFY23 Rates**	**Utilization Paid at Benchmark Rates**	**Change**	**Difference**
DHS	$17,095,244	$20,190,960	18.1%	$3,095,716
DSS	$3,208,898	$3,750,871	16.9%	$541,973
Total	**$20,304,142**	**$23,941,831**	**17.9%**	**$3,637,689**

B. Introduction and Background

Guidehouse contracted with South Dakota's Department of Social Services (DSS) and South Dakota's Department of Human Services (DHS) to conduct a comprehensive rate study for Medicaid and State In-Home services as described under Rate-Setting for Community-Based Health and Human Services in South Dakota's Codified Law (SDCL) Chapter 28-22[2]. As depicted in Figure 1 below, the engagement scope included the following study elements:

- Provider Cost and Wage Survey: Gathering data from providers for rate review and rebasing efforts.
- Additional Cost Research and Analysis: Performing research on other state, regional, and national data sources to inform rate development.
- Rate Modeling and Fiscal Impact: Developing rate models through research and cost analysis on the current model and alternative models for in-home services and assessing the fiscal impact of transitioning to new service rates.
- Stakeholder Engagement: Facilitating engagement with stakeholders including provider representatives, legislature representatives, and state staff to solicit feedback throughout the rate development process.

Figure 1: Overview of Project Initiatives



The study utilized a multitude of data sources, survey data collection, and avenues for stakeholder feedback to develop rate structure recommendations more responsive to desired and lasting service delivery changes as well as future planning and budgeting needs, as further

[2] South Dakota Legislature, Rate Setting for Community-Based Health and Human Services (Chapter 28-22) Available online: Codified Law 28-22 | South Dakota Legislature (sdlegislature.gov)

described in this report. Findings and recommendations from the rate study are compared to existing provider rates to anticipate and analyze the potential implications of implementing Guidehouse's proposed reimbursement benchmarks and rate adjustments.

C. Stakeholder Engagement

To support the development of cost-based rates for the State's in-home service, DHS/DSS worked with Guidehouse, providers, and other stakeholders throughout the rate development process. DHS/DSS convened a rate study Advisory Workgroup that met three times throughout the process to support the rate study. Figure 2 describes the composition of this group, their respective roles, and discussion topics.

Figure 2: Rate Workgroup Composition and Roles

Advisory Workgroup
Composition: • Membership representative of associations and providers directly impacted by rate changes • Provider representatives who reflect the full range of services included within the rate study scope • Members have a strong understanding of provider finances, reporting capabilities, and service costs
Role: • Provide subject matter expertise on provider survey and rate methodology development • Review and validate rate model factors and assumptions, including wages, benefits, administration, program support and staffing • Provide insight into how current services are delivered • Provide recommendations for consideration in the Final Report

Advisory Workgroup

Discussion Topics:

- Provider Survey design, administration, and results
- Peer state selection for comparison
- Rate build-up approach and rate components
- Benchmark wages and adjustments, including supplemental pay and inflation factor
- Staffing levels and supervision ratios
- Final rate models, current service utilization landscape, and fiscal impact of proposed rates
- Considerations for implementation and future analysis

D. Service Array and Rate Structure Overview

D.1. Historical Structure

In-home services in South Dakota have historically been separated into six services: Homemaker, Personal Care, Respite, Chore, Adult Companion, and Nursing. These six services are currently grouped into three categories for reimbursement as follows:

- Homemaker/Personal Care
- Adult Companion/Respite/Chore
- Nursing

While each of these categories of service deals with different tasks, some are closely related in service definition, difficulty, and skillset of the job type. Guidehouse determined based on the service definition and information obtained from the provider cost and wage survey that these service categories still seemed appropriate however there is flexibility for the state to decide to use one rate for all services except for Nursing. Nursing rates have also historically been grouped into a single rate regardless of the level of certification of the providing nurse for the HOPE and ADLS waivers. However, in contrast for the Medicaid services for Private Duty Nursing and the Home Health program the nursing rates have had the Licensed Practical Nurse (LPN) versus Registered Nurse (RN) distinction. Additional nursing rate recommendations are discussed later in this report.

E. Data Sources

E.1. Overview of Data Sources

Cost assumptions developed throughout the rate study relied on a wide variety of data sources. Guidehouse drew from both DHS provider data as well as national and regional standards to arrive at cost assumptions. Our approach for this study was to establish assumptions based on provider-reported and State-recommended data when available and appropriate, as well as extensive industry data that reflect wider labor markets for similar populations.

Guidehouse conducted a cost and wage survey to obtain the cost of delivering services from providers including employee salaries and wages, provider fringe benefits, and additional service-specific costs. The cost and wage survey, in particular, provided valuable and detailed information on baseline hourly wages, wage growth rate, provider staffing patterns, and provider fringe benefits, as well as staff productivity for all programs included in the rate study. Guidehouse also analyzed trends in the detailed claims data for services that were in scope for this specific rate study from each of the programs to determine the fiscal impact of implementing the new benchmark rates resulting from the rate rebasing process.

Although a majority of cost assumptions used for rate development were derived from provider-reported survey data and provider cost reports, publicly available sources were required for supplemental cost data and for benchmarking purposes to establish a comprehensive rate for some services.

We describe the key features of the provider cost and wage survey as well as the other sources used in the rate development process in the section below.

E.2. Provider Cost & Wage Survey

Guidehouse prepared a detailed Provider Cost and Wage Survey (“Survey”) based on the landscape of in-home services provided in South Dakota. The aim of the survey was to collect provider cost data across multiple services and programs that would serve as the basis for the rate studies. Additionally, Guidehouse aimed to utilize the survey to:

- Capture provider cost data to provide cost foundation for rate studies;
- Receive uniform inputs across all providers to develop standardized rate model components;
- Measure change in direct care worker wages over time;
- Establish baseline cost assumptions for comparing and standardizing services operating in different programs and with different state plan and/or waiver authorities;

- Determine cost basis for evaluating rate equity for services;
- Gather needed data to understand billable vs. non-billable time and staffing patterns per service;
- Investigate differences in costs among frontier/rural/suburban areas.

E.2.1. Survey Design and Development

Guidehouse designed this survey with input from DHS/DSS staff and Advisory Workgroup members, as well as drawing on knowledge gained from conducting similar surveys in other states. Guidehouse and the Department worked with the Advisory Workgroup to develop, review, update and release the survey. The survey was designed in Microsoft Excel and included six (6) sections or worksheets on topics outlined in Table 3 below. During the Advisory Workgroup meeting in August 2022, Guidehouse provided an overview of the survey including the objectives, topics, and questions on each worksheet within the survey document and solicited feedback from stakeholders. With the aim of collecting annual wage, benefit, and service delivery data from the second quarter of 2022, Guidehouse collected information on the survey components highlighted in Table 3.

Table 3: Provider Cost and Wage Survey Organization and Data Elements

Survey Topics	Survey Data Points and Metrics	Example Rate Study Data Point(s)
A – Organizational Information	Provider identification, contact information, and organizational details	-
B – Service Areas	Geographic areas where programs are operated	Regional-based rates
C – Services	Services delivered	-
D – Wages	Job types, staff types, hourly wages, supplemental pay, and training time	Baseline wages for rate build-up, primary job types per service, training assumptions

Survey Topics	Survey Data Points and Metrics	Example Rate Study Data Point(s)
E – Service Delivery and Staffing Patterns	Billable vs. Non-Billable time, and supervisor and staffing patterns, and transportation	Productivity adjustment, staffing ratio
F – Provider Benefits	Benefits that organizations offer full-time and part-time employees who deliver services – health, vision and dental insurance, retirement, unemployment benefits and workers' compensation, holiday, sick time, and paid time off	Benefits package or Employee Related Expenses (ERE)
G – Additional Information	Clarifying comments in addition to the information covered in other worksheets or sections	-

E.2.2. Survey Administration and Support

The survey was released via e-mail on August 5, 2022, to the entire provider community in scope for the rate study. A detailed instruction manual accompanied the survey to assist providers with responding to the survey questionnaire. To conduct a successful and accurate survey, Guidehouse facilitated live provider training webinars available to all providers on August 9, 2022, following the release of the survey. In the training sessions, Guidehouse introduced the survey, provided an overview of the survey tool and each worksheet tab, and addressed provider questions. A link to the recording of the webinar was shared with providers, and a frequently asked questions (FAQ) document was distributed to address common questions submitted by providers.

Additionally, Guidehouse offered ongoing support and resources in helping providers to complete the survey, through a dedicated electronic e-mail inbox which providers could access to receive answers to their specific questions as well as a live technical assistance webinar held a few weeks prior to the survey deadline. Providers were allowed two weeks to complete the survey, with a final survey deadline of August 26, 2022.

E.2.3. Provider Cost and Wage Survey Participation

In total, Guidehouse received surveys submissions from 26 of 65 in-home service providers eligible to complete the survey. This response rate demonstrates **40 percent** of all providers, or 62 percent of all "large" providers, which are providers whose expenditures total over $100,000, and 26 percent of all "small" providers, or providers whose expenditure total is under $100,000. According to leading experience management firm, Qualtrics, typical survey response rates fall between 20-30 percent, though response rates depend heavily on survey design, medium, and population size[3]. Tables 4 and 5 below includes a detailed view of the survey response rates by providers and provider expenditure perspectives.

Guidehouse measures "representativeness" by the number of providers, the relative size and scale of providers operations, and total State expenditures represented by surveyed providers. "Large" providers typically have greater capacity than "small" providers to complete cost surveys. Although fewer in number than small providers, large providers tend to receive a substantially higher share of total expenditures. Consequently, their costs are more representative of system costs as a whole. Table 4 includes the percentage of both large and small providers that responded to the survey based on SFY22 claims.

Table 4: Survey Response Rates for all Populations

Provider by Size	Total Providers	Percentage of Large and Small Providers	Provider Survey Submissions	Percent of Providers Responding
Over $100k	26	40%	16	62%
Under $100k	39	60%	10	26%
Total	**65**	**-**	**26**	**40%**

Provider expenditure is a reliable metric to represent the financial impact of the provider on the entire DHS system rather than the raw count of providers alone. Therefore, Guidehouse also reviewed the response rates by provider expenditure. As highlighted in Table 5, **71 percent** of providers by expenditure participated in the survey.

[3] Qualtrics, Survey Distribution Methods, How to Increase Survey Response Rates Available online: https://www.qualtrics.com/experience-management/research/tools-increase-response-rate/

Table 5: Survey Response Rates by Expenditure for all Populations

Provider by Size	Total Expenditures	Percentage of Large and Small Provider Expenditures	Expenditures Captured in Survey Submission	Percent of Expenditures Captured in Surveys
Over $100k	$18,459,550	93%	$13,685,438	74%
Under $100k	$1,350,687	7%	$358,232	27%
Total	**$19,810,237**	**-**	**$14,043,671**	**71%**

E.2.4. Provider Cost and Wage Survey Review and Validation

After receiving the survey responses, Guidehouse compiled responses and conducted the following quality checks to prepare the data for analysis:

- **Completeness:** Checked the completion status in all worksheets within individual survey workbooks to determine whether follow up was required to resolve any issues and missing data. Guidehouse followed up with providers individually within a week of receiving the survey responses if clarification or correction was required.
- **Outliers:** Reviewed quantitative data points (e.g., wages, productivity, benefits, number of clients and caseloads, staffing patterns) reported across all organizations to identify potential outliers. If any outlier data points were excluded or assumptions were made for rate model inputs, the assumptions were reviewed with the Department and the Advisory Workgroup and are documented as such in this report. Additionally, Guidehouse performed outreach to individual providers to confirm submissions and accepted amendments to data provided.

It is important to note cost survey processes are not subject to auditing processes, as an established administrative cost reporting process would be. Providers' self-reported data were not audited for accuracy, although outliers were examined and excluded when warranted, and additional quality control checks were conducted to ensure data completeness. The absence of an additional auditing requirement is ultimately a strength rather than a weakness of the cost survey approach, as it allows providers to report their most up-to-date labor costs, a key concern for rate development at a moment of heightened inflation.

The survey data reported by providers was utilized to develop several key rate components including baseline hourly wages, Employee Related Expenses (ERE), and administrative and program support cost factors. Section G further outlines how the survey data was utilized for rate setting purposes.

E.3. Provider Cost Reports

Data from the fiscal year SFY2021 (7/1/2020-6/30/2021) South Dakota In-Home Provider Cost Reports ("Cost Reports") were used to inform the rate methodology determination process and the rate models. The 2021 cost reports were used to account for the most recent administrative and program support costs in calculating the Administrative and Program Support cost factors. Table 6 below captures the cost report components that were used in rate modeling.

Table 6: FY2021 Cost Report Components Used in Rate Modeling

Rate Component	FY2021 Cost Report Item
Administrative Cost Factor	2110 Administrative Personnel Salaries 2140 Clerical Personnel Salaries
	2500 Administrative / Financial Professional Fees
	Other Administrative Components: • 3520 Dues/Memberships/Subscriptions/Trainings
Program Support Cost Factor	2100 Support Staff
	Other Program Support Components: • 2600: Supplies • 3100: Occupancy related • 3275: Professional Liability Insurance • 3300: Travel and Transportation

E.4. Claims Data

Guidehouse developed a detailed claims data request to be able to analyze the Medicaid claims utilization for 4 state fiscal years (SFY19-SFY22). This request included all detailed claims for services that were in scope for this specific rate study for the six in-home services. Within the request 12 unique service codes were ultimately requested to capture the variation dependent on the program in which the service was provided, such as the Medicaid Private Duty Nursing and Home Health Nursing are identified using different service codes. We requested key fields such as provider detail, payment information, service identifying fields and units of measure. After reviewing claims information, we recognized that the MMIS claims data was only accounting for the Medicaid portion of the services provided and was not inclusive of the Long Term Services and Supports state funded services. Therefore, an additional data summary was requested to account for these services to ensure the entire mix of services was being accurately accounted for. Analyzing these trends is an important consideration to determine

fiscal impact accurately when the new benchmark rates are applied. We want to ensure we are capturing a normal utilization year to properly project overall fiscal impact.

E.5. Other Data Sources

Cost assumptions developed throughout the study rely on a wide variety of data sources. The objectives of the rate study aim to establish benchmark rates based on a combination of publicly available resources as well as understanding the necessary cost requirements required to promote access to quality services going forward. As will be detailed in greater depth in the sections that follow, Guidehouse's provider cost and wage survey furnished the majority of our rate assumptions on employee wages, provider fringe benefit offerings, staff productivity, staff-to-client ratios, and transportation requirements for the array of services.

While cost surveys are a rich and valuable source of information on provider costs, these tools cannot validate in themselves whether the costs reported are reasonable or adequate in the face of future service delivery challenges. Considering the possibility that historical costs may not be truly representative of the resources required to provide services in the near future or are not comparable to or competitive with the industry as a whole, Guidehouse evaluates cost survey data against external data benchmarks whenever feasible. As a result, the cost assumptions used by Guidehouse frequently draw on national and regional standards, at least for comparison purposes, that reflect wider labor markets as well as median costs typical of broader industries, to benchmark South Dakota reported information from the provider cost and wage survey. Table 7 summarizes some of the additional public data sets used to inform cost assumptions used in Guidehouse's benchmark rate recommendations.

Table 7: Other Data Sources

Bureau of Labor Statistics, Occupational Employment and Wage Statistics (BLS OEWS)	Federal wage data available annually by state, intra-state regions, and metropolitan statistical areas (MSA). Used for wage geographic and industry wage comparisons and establishing benchmark wage assumptions for most wages.
Bureau of Labor Statistics, Costs for Employee Compensation Survey (CECS)	Federal data on employee benefits cost, analyzing groups of benefit costs including insurance, retirement benefits, paid time off, and other forms of non-salary compensation. Used for reference in establishing benchmark ERE assumptions.

Bureau of Labor Statistics, Provider Price Index (PPI)	Federal index of inflation across multiple industries for Medicaid populations. Updated monthly and includes data series for Residential Developmental Disability Homes, Home Health Care Services, and Nursing Care Facilities. Used for reference to understand annual inflation for provider costs and for recommendations on recurring rate update.
Bureau of Labor Statistics, Consumer Expenditure Survey	Federal data on annual consumer spending. Provides potential cost assumption for food costs per meal.
Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey-Insurance Component (MEPS-IC)	Federal data on health insurance costs, including Illinois-specific data regarding multiple aspects of health insurance (employer offer, employee take-up, premium and deductible levels, etc.) Used for reference in estimating health care costs for benchmark ERE assumptions.
Other State Medicaid Fee Schedules and Reimbursement Methodologies	Data from other states on reimbursement levels for cognate services as well as overall service design. Used for peer state comparison and well as development of best-practice recommendations for improving supported employment service delivery.
Internal Revenue Service	The Internal Revenue Service is the revenue service for the United States federal government, which is responsible for collecting taxes and administering the Internal Revenue Code, the main body of the federal statutory tax law.

F. Peer State Comparisons

F.4.1. Overview

Guidehouse's recommendations for the current study are comprised of existing approaches used in other states, and Guidehouse's experience conducting similar studies and analyses in these states. Guidehouse gathered peer state data sources to assist the development of the rate build-up methodologies for comparable in-home services included in the rate study. Peer state service rates were also used to compare and validate final rate pricing across similar services where applicable. It is helpful to compare South Dakota's waiver rates to similar waiver rates in other states to understand whether current rates represent an outlier, or whether differences can be explained by distinctive service definitions or economic conditions in the State.

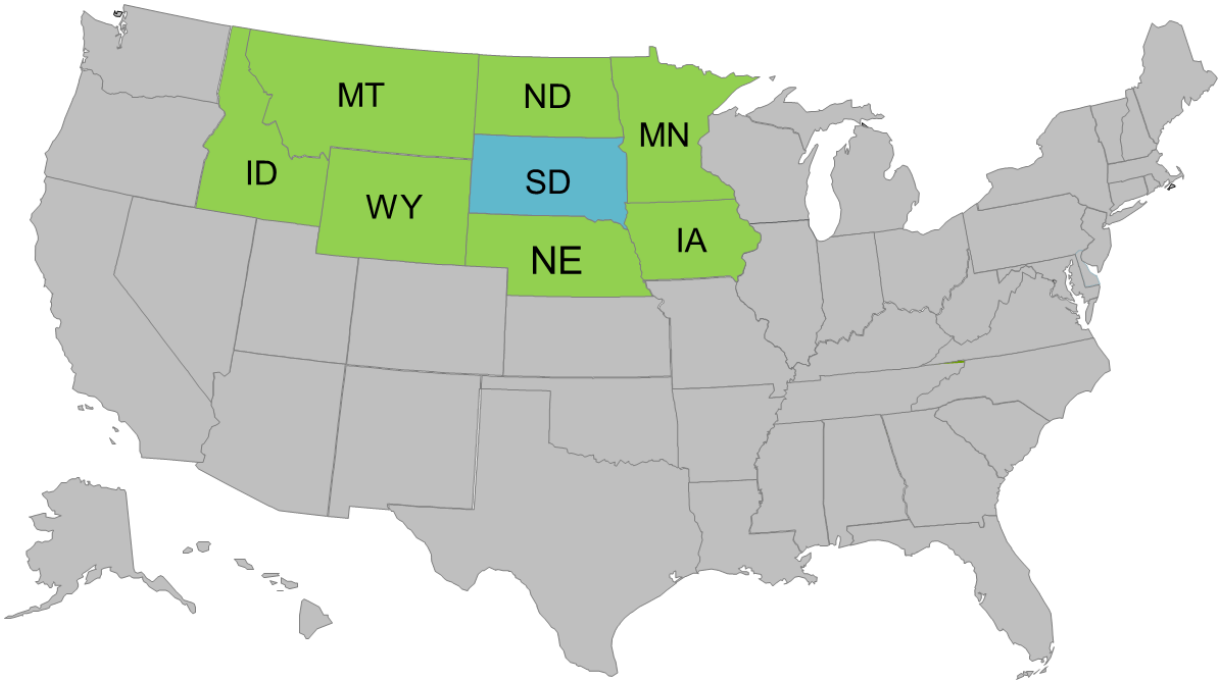
Guidehouse appreciates that South Dakota is unique among other states geographically, demographically, and culturally. Therefore, we were selective in identifying these peer states and the services within the states. We not only identified comparable states but then reviewed each service definition prior to comparison to help confirm the applicability and adequacy of comparison. These services also do not normally have an equivalent Medicare or commercial benchmark to use as a fair comparison, which in turn makes finding a Medicaid equivalent even more important.

With the initial review of the peer state comparison, there was not an immediately clear pattern of systematic underfunding across most of the programs. Rather, the apparent overall trend is that South Dakota's rates usually fall at the higher end in comparison to other state rates.

F.4.2. Peer State Comparison Approach

First, Guidehouse identified states that seemed similar to South Dakota by demographics, geography, Medicaid program design, and scope of services offered for this specific population. As seen in the map shown in Figure 3, Guidehouse researched the initial peer states marked in light green.

Figure 3: Peer States for Rate Comparison



F.4.3. Peer State Comparison Results

When reviewing the peer states overall South Dakota's rates for comparable services were the highest or the second highest within each service. Table 8 illustrates the current South Dakota rate with the peer states and their corresponding rates. The cells highlighted in red represent the peer state with the highest rate within that service. For Nursing, Homemaker and Personal Care South Dakota has the highest rate and for Adult Companion, Respite Care and Chore Services they have the second highest rate after North Dakota and Wyoming. However, when comparing to a peer state average South Dakota's rates are higher by 25-55 percent depending on the service. When comparing against the highest peer state wage (highlighted in red) South Dakota's rate for Adult Companion, Respite and Chore falls just short of the highest peer state, less than 1 percent higher for Nursing and has a substantial margin for Homemaker and Personal Care. This relationship suggests that, in comparison to its peer states South Dakota appears to have been able to keep better pace with growing provider costs than other states.

Table 8: In-Home Services Peer State Rate Comparison

Services						
State	**Nursing**	**Homemaker**	**Personal Care**	**Adult Companion**	**Respite Care**	**Chore Services**
South Dakota	$19.56	$8.49	$8.49	$7.33	$7.33	$7.33
North Dakota	$16.63	$6.73	$7.48	$6.73	$7.48	$7.48
Wyoming	$19.38	$6.49	$7.22	$7.45	$7.35	
Montana	$11.62	$4.53	$5.51	$5.78	$4.53	
Idaho	$10.19	$4.74	$5.28	$4.99	$4.99	$4.47
Iowa		$5.20		$1.89	$4.78	$4.05
Nebraska	$10.89				$6.10	
Minnesota		$5.04	$4.90	$2.92	$6.07	$4.50
Average - Comparison States	$13.74	$5.46	$6.08	$4.96	$5.90	$5.13
South Dakota Comparison to Peer State Average	42.3%	55.6%	39.7%	47.8%	24.3%	43.0%
South Dakota Comparison to Highest Peer State Rate	0.93%	26.15%	13.50%	-1.61%	-2.01%	-2.01%

G. Rate Methodologies and Components

G.5.1. Service Array

The current In-Home service array currently offers six (6) services: 1) Adult Companion, 2) Respite, 3) Chore, 4) Homemaker, 5) Personal Care, and 6) Nursing. Each of these services is performed in the home of the client. All services are reimbursed based on their reimbursement rate that can be found on the state fee schedules. Most of the services in this rate study are all billed in 15-minute increments except for the Private Duty Nursing Medicaid rates which are billed in hourly increments.

G.5.2 Rate Build Up Approach

Guidehouse employed an independent rate build-up approach to develop payment rates for covered services. The independent rate build-up strategy allows for fully transparent models that take into account the numerous cost components that need to be considered when building a rate. The foundation of the independent rate build-up is direct care worker wages and benefits, which comprise the largest percentage of costs for these services while also considering the service design and additional overhead costs that are necessary to be able to provide the service. This approach:

- Uses a variety of data sources to establish rates for services that are:

  "…consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that care and services are available to the general population in the geographic area."

  -1902(a)30(A) of the Social Security Act (SSA)

- Relies primarily on credible data sources and reported cost data (i.e., costs are not audited, nor are rates compared to costs after a reporting period and adjusted to reflect those costs)
- Makes additional adjustments to rates to reflect state-specific policy goals – for example, incenting specific kinds of services

The rate build-up approach is commonly used by states for setting rates and is an approach recognized as compliant with CMS regulations and guidelines. This approach also yields a transparent rate methodology, allowing DHS/DSS to clearly delineate the components that contribute to rates and make adjustments as needed.

The values for each component of the rate models were calculated, and rates were built from the bottom up for each of the services included in the rate study. Guidehouse determined each cost component associated with the direct care provided for a service (for example, direct service professional wages and benefits), identified the corresponding payment amount(s), and

added on payment amounts reflecting administration and program support costs required to deliver the service.

Many of the service rate benchmarks we propose follow a series of general assumptions for the components of each rate, adjusted according to the specific context and goals for providing each service. This rate build-up approach is based on a core set of wage assumptions for direct care staff, supplemented by estimates of the cost of other supporting staff, activities and materials needed to support direct care provision. In this section of the report, we describe in detail the methodology for calculating various components used in the rate models. In addition, we describe the data sources used to determine the component. The section is divided into the following areas:

- Staff Wages
- Employment Related Expenditures (ERE)
- Billable vs Non-Billable Time of Direct Care Staff
- Supervision
- Staff Mileage
- Administrative Expenses
- Program Support Expenses

G.5.2. General Cost Assumptions

The methodology for developing a rate for a unit of service – or a rate model – varies across types of services but generally includes certain key components. A rate model starts with the wage for the primary staff person providing a service—for example, a Homemaker, Adult Companion, or Nurse, depending on the service—and then building upon that wage with fixed or variable cost factors to account for additional program support costs.

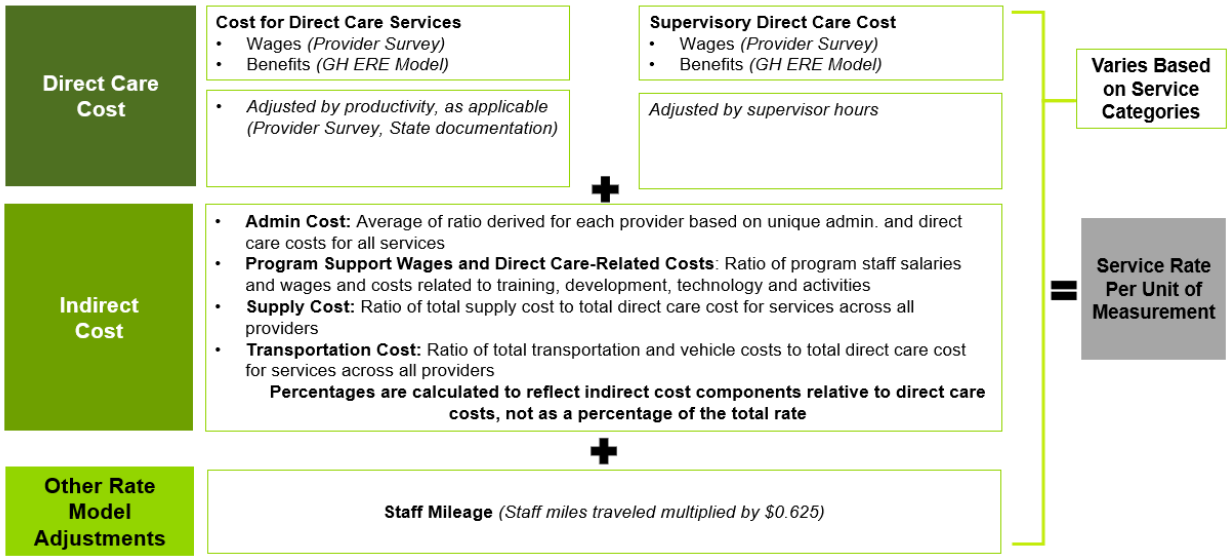
Typical components of a rate methodology or rate model include:

- Direct Care Compensation Costs
    - Staff Wage Costs
    - Employment Related Expenditures (ERE)
    - Supervision Costs
- Billing Adjustments to Direct Care Compensation Costs
    - Billable vs Non-Billable Time (Productivity) of Direct Service Staff
    - Travel Expense
- Administrative Expenses
- Program Support Expenses

Together, these components sum to a unit rate designed to reimburse a provider organization for all inputs required for quality service delivery. This approach is often called an “independent rate build-up” approach because it involves several distinct rate components whose costs are

captured independently through a variety of potential data sources. These costs are essentially "stacked" together into a collective cost per unit that defines the rate needed for cost coverage. Figure 4 illustrates the "building block" structure of Guidehouse's rate development methodology. Although individual rates may incorporate different building blocks, each rate model follows a similar process for identifying the component blocks for inclusion, based on the service requirements and specific adjustments needed to align overall costs with the appropriate billing logic and units of service.

Figure 4: Overview of Rate Components



This figure represents various costs that can be considered when developing a rate. Of note, transportation costs were developed separately from other indirect costs and are treated as a mileage add-on dollar adjustment to the base rate. The different cost components schematized here are discussed in further detail in the following sub-sections of the report.

G.5.2.1. Staff Wages

Wages for direct care staff are the largest driver in the final rate and are therefore a critical element to derive from the provider cost and wage survey. It is key to align the appropriate staff type with their corresponding wage to feed into the rate models for these 6 services. To best understand the landscape of wages in South Dakota, Guidehouse used information from the provider cost and wage survey reported by providers that deliver these services as well as industry-wide data sources.

As part of the cost and wage survey, each responding provider reported average hourly or "baseline" wages in addition to overtime, shift differential and other forms of supplemental pay for the survey time period of April 2022- June 2022. To account for rapidly changing wage increases the survey also asked if providers had increased their wages since the end of the survey time period, and if so, by how much to help estimate the impact of wage growth. The staff types with the highest number of Full-Time Equivalents (FTE) reported in the survey were Personal Care and Homemaker, accounting for 61 percent of total FTEs. Table 9 represents the distribution of FTE's with the corresponding FTE weighted average wage. The baseline wages represented in Table 9 do not include inflationary factors or supplemental pay.

Table 9: Average Hourly Wage Reported in Cost and Wage Survey, Weighted by FTEs

Job Type	Number of FTEs (Survey)	Provider Cost and Wage Survey (FTE Weighted Baseline Wage)
Homemaker/Personal Care Staff	401.96	$15.93
Adult Companion/Respite Staff/Chore	41.55	$15.36
Registered Nurse (RN)	73.11	$32.99
Licensed Practical Nurse (LPN)	40.68	$26.89

For all direct care staff types, Guidehouse applied a weighting of reported wages by the number of FTEs, then comparing that wage to benchmark wages reported by the Bureau of Labor Statistics, Occupational Employment and Wage Statistics (BLS OEWS) specific to South Dakota for mid-2021. The BLS OEWS does not have every single job type but it has jobs that are fairly comparable to those reported for these services that were able to be leveraged as appropriate benchmark wages. For example, Homemaker/Personal Care staff in the cost and wage survey was most closely related to the BLS job classification of "Home Health and Personal Care Aides". An inflationary factor was applied to the BLS OEWS information due to the database reflecting wages from mid-2021 wages to be able to compare to the wages reported from the survey time period of April- June 2022. BLS benchmarks are used to confirm that potentially deflated wages due to an underfunded system are not used in prospective rate development. Since the wages reported in the survey were consistently higher than those in the publicly available data, Guidehouse decided to use the information collected in the survey to determine appropriate wage assumptions. This assumption was also reviewed by the Advisory Workgroup members and with DHS/DSS staff.

Analysis revealed no distinct trend in variation in wages between providers primarily serving in

rural regions of South Dakota compared to more urban regions.[4] However, this outcome may be due to the fact many of the providers surveyed offer services across the state, so regional cost disparities may not be visible when considering wage costs in aggregate. The baseline wage assumptions, therefore, did not account for differences in geography, as the analysis did not find a justification to differentiate wages based on the location of the provider.

G.5.2.1.1. Inflationary Increases in Wages

National data was referenced in tandem with survey data to understand how wages and costs have trended over recent years. Table 10 includes the most recent growth rate from each source, which include:

- **BLS Current Employment Statistics (CES):** The BLS publishes CES data which looks at earnings. Across Elderly and Persons with Disabilities Staff, 2021-2022 trends document an annual growth rate in earnings of **5.28 percent**.
- **BLS Producer Price Index (PPI):** The BLS also publishes PPI data that examines costs to producers. Across Medicaid Home Health Care services, 2021-2022 trends document an annual growth rate of **2.40 percent**.
- **Cost and Wage Survey:** Responding provider organizations recorded wages during Q2 of CY2022 to establish a baseline. Additionally, providers recorded the average percentage increase to hourly wages after the end of the survey time period. Across job types, the average increase was **6.25 percent**.

Table 10: Sources of Growth Rates in Relevant Costs and Wages

Source	Time Period	Growth Rate
Bureau of Labor Statistics (BLS) Current Employment Statistics (CES) Average for Elderly and Persons with Disabilities Staff	2021-2022	5.28%
Bureau of Labor Statistics (BLS) Producer Price Index (PPI) average for Home Health Care services – Medicaid patients	2021-2022	2.40%
South Dakota DHS/DSS Provider Cost and Wage Survey	2022	6.25%

Since wage growth is the primary driver of In-Home services, Guidehouse determined that the

[4] The classification of a county as rural or urban was based on the definition from OMB for the metropolitan statistical areas surrounding Sioux Falls and Rapid City.

CES inflation factor was more representative of the economic conditions faced by providers. To align potential growth in costs during 2022 and to account for economic and labor conditions that may reflect the future cost of service delivery, our wage assumptions include a wage adjustment from the survey of **6.25 percent** from July 1, 2022 – December 31, 2022, and an inflation adjustment of **2.64 percent**, reflective of 6 months of inflation, from January 1, 2023 – June 30, 2023 at the time of rate implementation. The wage adjustment with the additional **2.64 percent** inflationary factor increased wages from July 1st, 2022, to July 1st, 2023, by **9.05 percent** in a single year.

B.5.2.1.2. Supplemental Pay

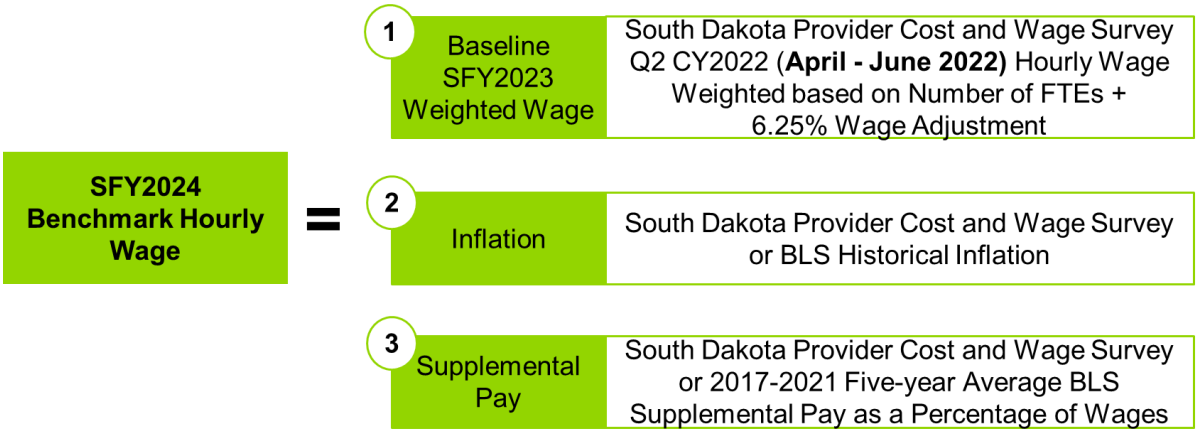
Supplemental pay – inclusive of costs such as overtime wages, holiday pay, and other supplemental compensation *on top of* compensation from regularly-earned wages – was reported in the cost and wage survey. In analyzing survey results, a supplemental pay percentage of **3.42 percent** was calculated by dividing total supplemental pay, including bonus reported by total wages for each provider (capping one provider at **25 percent**) and then taking the median across all providers. The supplemental pay reported varied widely, ranging from **0-25 percent.**

As a national benchmark the BLS Employer Costs for Employee Compensation (ECEC) quarterly data series for the Health Care and Social Assistance industry, which divides costs into hourly wages as well as expense categories related to mandatory taxes and benefits, insurance, retirement, paid time off, supplemental pay, and other benefits. In the first calendar year quarter of 2022 (CY2022 Q1) – the closest available time period to that requested in the cost and wage survey – supplemental pay for the selected labor category equaled **3.36 percent** of the average hourly wage, which has remained relatively stable over the past five-year period from 2017 through Q1 2022. DHS, DSS and Guidehouse determined to use the five-year average supplemental pay percentage of **3.62 percent** to account for a longer trend history that accounts for market fluctuations and the impact of COVID-19 on the rates. The BLS ECEC data includes all supplemental cost components integral to overall compensation, and the data provides consistent and periodic trends that can be used to project a future state.

B.5.2.1.3. Final Wage Adjustments

Guidehouse calculated the benchmark wage assumptions by adjusting the CY2022 Q2 survey wages by the **6.25 percent** indicated within the survey, inflating the adjusted weighted wage by the 6-month CES inflation rate of **2.64 percent** and then finally adding the additional supplemental pay percentage of **3.62 percent**. This wage build up is demonstrated in Figure 5.

Figure 5: Calculation of Wage Adjustment Factors



For example, using the Homemaker weighted baseline wage from 2022 of $15.93 (as discussed above), a wage adjustment of 6.25 percent was applied which amounts to $0.99, or a total of $16.92. From the inflated wages, now in January of 2023, we add a 3.62 percent supplemental pay increase of $0.61, which brings the projected hourly wage in January 2023 to $17.53. Then, to move the wage forward to July 1, 2023, the wage is adjusted upward by the 2.64 percent inflation factor (discussed above), increasing the projected wage by $0.47 to a total of $18.00 per hour. Table 11 completes this calculation for each job type. The two rows labeled as "supervisory staff" are for the job types of Agency Director/Manager and Care Coordinator – are supervisory positions while the rows above those are direct care positions.

Table 11: Benchmark Wage Recommendations

Job Type	Direct Care vs. Supervisory Staff	Baseline Wage (Q2 CY2022)	January 2023 Projected Wage (Baseline + 6.25% wage adjustment)	January 2023 Benchmark Hourly Wage (January 2023 Hourly Wage + Supplemental Pay)	July 2023 Benchmark Hourly Wage (January 2023 Benchmark Wage + 2.64% inflation Factor)
Homemaker/Personal Care	Direct Care	$15.93	$16.92	$17.53	$18.00
Adult Companion/Respite/Chore	Direct Care	$15.36	$16.32	$16.91	$17.36
Nursing RN	Direct Care	$32.99	$35.05	$36.32	$37.28
Nursing LPN	Direct Care	$26.89	$28.57	$29.60	$30.39
Agency Director/Manager	Supervisory Staff	$29.62	$31.48	$32.62	$33.48
Care Coordinator	Supervisory Staff	$22.73	$24.16	$25.03	$25.69

This methodology results in a total of **9.05 percent** inflation applied to the survey reported wage as of July 1st, 2022, to incorporate wages that would be in effect at the time of rate implementation on July 1st, 2023.

G.5.2.2. Employee-Related Expenses

Employee related expenses, or fringe benefits, are costs to the provider beyond wages and salaries, such as unemployment taxes, health insurance, and paid time off (PTO). These fall into three distinct categories of benefits. These ERE or fringe benefits include legally required benefits, paid time off, and other benefits such as health insurance.

- **Legally required benefits** include federal and state unemployment taxes, federal insurance contributions to Social Security and Medicare, and workers' compensation. Employers in South Dakota pay a federal unemployment tax **(FUTA)** of 6.00 percent of the first $7,000 in wages and state unemployment tax **(SUTA)** of 1.00 to 1.20 percent of the first $15,000 in 2022 wages. Generally, if an employer pays wages subject to the unemployment tax, the employer may receive a credit of up to 5.40 percent of FUTA taxable wages, yielding an effective FUTA of 0.60 percent. Employers pay a combined 7.65 %rate of the first $142,800 in wages for Social Security and Medicare contributions as part of Federal Insurance Contributions Act **(FICA)** contributions. Per the cost and wage survey, employers in South Dakota pay an average effective tax of 1.60 percent toward workers' compensation insurance.
- **Paid time off (PTO) components of ERE** include holidays, sick days, vacation days, and personal days. The median aggregate number of paid days off per year, per the cost and wage survey, was 33 days total. As PTO benefits only apply to full-time workers, the daily value of this benefit is multiplied by a part time adjustment factor, which represents the proportion of the workforce which works full-time for the provider organizations responding to the cost and wage survey.
- **Other benefits in ERE** include retirement, health insurance, and dental and vision insurance. Other benefits are also adjusted by a part time adjustment factor, as well as a take-up rate specific to each benefit type which represents the proportion of employees who utilize the benefit.

Not all providers who responded to the provider cost and wage survey have historically offered a "full" or competitive benefits package. To determine competitive contributions for benefits which are not legally required, the paid time off components were analyzed in aggregate and data on other benefits only from providers *who contribute to their full-time employees' benefits*. Analyzing these contributions and take-up rates for providers offering "other benefits" yielded median annual contributions per employee.

Benefits information reported in the survey was compared to the publicly available Medical

Expenditure Panel Survey **(MEPS)**. MEPS is a set of large-scale surveys of families and individuals, their medical providers, and employers across the United States. MEPS is the most complete source of data on the cost and use of health care and health insurance coverage which is also state specific. During this comparison the average monthly premium reported in the State of South Dakota was $746 after applying an inflation factor. This premium came in materially higher than the average of $483 reported in the survey. Guidehouse ultimately decided to use the MEPS information over the survey data, both because this source is grounded in a wider response base, and because it provides a more representative standard for determining competitive insurance offerings for South Dakota employers overall. Therefore, the information provided within the cost and wage survey was used to develop the assumptions for vision insurance, dental insurance, and other benefits, while the data from Medical Expenditure Panel Survey (MEPS) was utilized for determining a take-up rate and monthly premium assumption for health insurance.

Calculating each ERE component as a percentage of the annual wage assumption for Homemakers/Personal Care Staff, or $33,134 per year, yielded a competitive fringe benefit package of **32.63 percent** of wages as outlined in Table 12.

Table 12: Components of ERE for a Homemaker

Component	Value / Calculation	
Annual Wage	$33,134 ($15.93 x 2080 hours)	
FUTA	0.60% of up to $7,000	$42 (0.13%)
SUTA	1.2% of up to $15,000	$180 (0.56%)
FICA	7.65% of up to $142,800	$2,535 (7.65%)
Workers' Compensation	1.60%	$529 (1.60%)
Legally Required Benefits	**-**	**$3,286 (9.92%)**
Daily Wage	$15.93 x 8 hours	$127.44
Part-Time Adjustment Factor	74.02%	
Paid Time Off	33 days	

Component	Value / Calculation	
Paid Time Off	**$127.44 x 74.02% x 33 days**	**$3,113 (9.39%)**
Part-Time Adjustment Factor	74.02%	
Insurance Take-up Rate	55.9%	
Retirement	2.96%	$397 (1.20%)
Health Ins.	$746/mo.	$3,707 (11.19%)
Dental Ins.	$116/yr.	$42 (0.13%)
Vision Ins.	$56/yr.	$19 (0.06%)
Other Benefits	$491/yr.	$248 (0.75%)
Other Benefits	**-**	**$4,413 (13.32%)**
Total ERE per Homemaker	**Legally Required Benefits + Paid Time Off + Other Benefits**	**$10,811 (32.63% of Annual Wage Assumption)**

Under the employment structure for many provider organizations, Homemakers/Personal Care staff represent baseline staff. However, as wages rise, costs of contributing to certain legally required benefits and other benefits do not necessarily become more expensive. As wages increase, the proportion of ERE to wages decreases; therefore, individual ERE percentages were developed based on job type utilizing the baseline wage.

As an example of how the ERE percentage decreases with a higher wage within Table 13 we display the numbers for the remaining job types:

- Homemaker/Personal Care
- Adult Companion/Respite/Chore
- Nursing (LPN)
- Nursing (RN)
- Agency Director/Manager
- Care Coordinator

Table 13: Employee-Related Expenses across Job Types

Component	Homemaker/ Personal Care	Adult Companion/ Respite/Chore	Nursing (LPN)	Nursing (RN)	Agency Director/ Manager	Care Coordinator
Hourly Wage	$15.93	$15.36	$26.89	$32.99	$29.62	$22.73
Annual Wages – SFY2023	$33,134	$31,949	$55,931	$68,619	$61,610	$47,278
Legally Required Benefits	$3,286 (9.92%)	$3,176 (9.94%)	$5,393 (9.64%)	$6,567 (9.57%)	$5,918 (9.61%)	$4,593 (9.72%)
Paid Time Off Benefits	$3,113 (9.39%)	$3,001 (9.39%)	$6,446 (9.39%)	$6,446 (9.39%)	$5,788 (9.39%)	$4,442 (9.39%)
Other Benefits	$4,413 (13.32%)	$4,399 (13.77%)	$4,686 (8.38%)	$4,838 (7.05%)	$4,754 (7.72%)	$4,582 (9.69%)
Total ERE per FTE	**$10,811 (32.63%)**	**$10,576 (33.1%)**	**$15,334 (27.42%)**	**$17,851 (26.01%)**	**$16,560 (26.72%)**	**$13,617 (28.8%)**
Hourly Wage with ERE	**$21.13**	**$20.44**	**$34.26**	**$41.57**	**$37.53**	**$29.28**

G.5.2.3. Billable vs Non-Billable Time of Direct Care Staff

While direct care staff can only bill for the time during which they are delivering services, they perform other tasks as part of their workday. Productivity factors account for this "non-billable" time, such as travel time to a member's home to deliver services, time spent keeping records or in training, by upwardly adjusting compensation (wages and ERE) to cover the full workday.

Consider a simple example to illustrate this process:

> A direct care staff person is paid $16 per hour and works an 8-hour day. The cost to the provider for the day is $128 ($16 * 8 hours). However, if half of the staff member's 8-hour day (4 hours) was spent on activities that are non-billable, the provider would only be able to bill for 4 hours of the staff member's time. Therefore, a productivity adjustment would have to be made to allow the provider to recoup the full $128 for the staff cost. The adjusted wage rate per billable hour would need to be $32 resulting in a productivity adjustment of 2.0.

While this is an exaggerated example (a typical productivity adjustment is around 1.4 for many of the services in scope for this study), it demonstrates the importance of including a productivity

factor to fully reimburse for direct support time.

Provider organizations reported the average number of billable hours (out of an assumed 8-hour workday) through the cost and wage survey, which we translated into a productivity factor for staff delivering each service. For example, for Homemaker/Personal Care, providers reported an average of **76 percent** of time typically spent on client-facing, billable activities. This percentage equates to 6.08 billable hours per each direct care staff member's 8-hour day. Dividing 8 by 6.08 (or equivalent, 1 divided by 76.0 percent or .760) yields a productivity adjustment of **1.32**, which is then multiplied by ERE-adjusted wages to get productivity-adjusted compensation. Table 14 displays the productivity and productivity adjustment for each direct care job type. All non-nursing job types had productivity values that were closely clustered while nursing was materially lower. This observation was confirmed by the Advisory Workgroup, noting that nurses spend proportionally more time in travel and note taking for clients than other in-home services.

Table 14: Productivity by Job Type

Job Type	Productivity	Productivity Adjustment
Homemaker/Personal Care	76%	1.32
Adult Companion/Respite/Chore	76%	1.32
Nursing	70%	1.43

G.5.2.5. Supervision

While direct care staff deliver services, other staff are often present to supervise, usually multiple staff at one time. Wages for supervisors are often higher, but proportionate, to the wages of the direct care staff they supervise and are therefore included in independent rate models as a separate component to the primary staff wage. The supervision cost component captures the cost of supervising direct care staff. It should be noted that supervision costs are distinct from administrative costs related to higher-level management of personnel. Supervision is time spent in direct oversight of and assistance with care provision and is frequently conducted by staff who are themselves providing direct care as a part of their role.

The cost and wage survey included questions regarding the number of direct care staff supervised by one supervisor and the total number of hours a supervisor spends, on average, directly supervising staff. For the majority of services, the average number of staff supervised by one supervisor ranged from three to ten. Developing this add-on accounts for the costs of employing supervisors to help assure appropriate delivery of services. Table 15 displays the

calculations for supervision components for each job type. The “Supervision Hours per Week” is the average hours reported in the survey that supervisors spend in a week on supervisory activities and “Supervisor Span of Control” is the average number of staff that a supervisor oversees.

Table 15: Supervision by Job Type

Line Description	Nursing	Homemaker/Personal Care	Adult Companion/Respite/ Chore
Hourly Supervisor Wage	$33.48	$25.69	$25.69
Supervisor ERE	26.72%	28.52%	28.52%
Hourly Supervisor Compensation	$42.42	$33.02	$33.02
Supervision Hours per Week	6.67	9.70	6.80
Supervisor Span of Control	4.73	9.93	7.79
Supervision Hours per Staff per Hour	0.04	0.02	0.02
Supervision Cost per Staff per Hour	$1.49	$0.81	$0.72

G.5.2.6 Transportation

Guidehouse understands that with the rural element with the state of South Dakota staff transportation is an important consideration when developing these in-home rates. The cost and wage survey asked a handful of questions related to the number of miles traveled, the time spent to travel and the average number of trips made per day for staff. These survey questions provided a wide range of results as well as being sparsely populated. However, the survey also asked the percentage of a work week that is spent traveling between client sites. Due to the limited information provided in the individual survey questions Guidehouse used the percentage of travel time to create mileage assumptions. The data showed that non-Nursing travel requirements were similar across services, but Nursing services required materially more time spent on travel. This finding is consistent with the information provided for the billable vs non-billable time mix. The average percent of a workday spent on travel for Nursing and non-Nursing were 9.5 and 7.9 percent respectively. A transportation cost per hour was then calculated based on that average. As an example, the Nursing average of 9.5 percent is multiplied by 40 hours per week to give 3.82 hours spent in transit each week. Based on an average 30 MPH to take

into account the combination of highway driving versus urban in city driving, equating to 114.55 miles driven each week and 5,956 miles per year for a nurse. Using the updated IRS mileage rate effective July 1st, 2022, of $0.625 per mile, which is equivalent to $3,723 per year per full time staff. We divided the average miles by 2080, which is the hours that a full-time staff member works in a year, to arrive at a cost per hour of $1.79. Non-Nursing transportation is similarly calculated in Table 16.

Table 16: Transportation Cost Calculation

Line Description	Nursing	Non-Nursing
Average Time Spent on Travel	9.5%	7.9%
Hours in Transit (Based on a 40-hour work week)	3.82	3.17
Average Miles per Week (Based on an average 30 MPH)	114.55	95.03
Average Miles per Year	5,956	4,941
Cost per Year ($.625)	$3,723	$3,088
Cost per Hour	$1.79	$1.48

The mileage add-on is designed to reflect an average across the state. The Advisory Workgroup communicated concerns related to instances in which direct care workers are sometimes required to drive over 100 miles one way to provide services to a client. These situations can create financial challenges for the provider that render service provision unsustainable for staff travel to client sites over a certain distance. Since the frequency of these service conditions is unknown, Guidehouse does not recommend establishing a rural differential rate at this time, but advises a single baseline rate that reflects average travel throughout the state, including urban and rural travel. DHS/DSS may wish to develop a rural differential rate that provides additional reimbursement for services that must be delivered beyond a certain threshold of staff travel distances (+60 miles, for example), but implementing such a rate would depend on additional data availability, the ability to operationalize multiple rates within its system. The State of North Dakota has established rural rates that might serve as an example for South Dakota's system. In North Dakota's case, the State has implemented additional Respite rates depending on specific groups of miles driven. This type of model requires additional administrative support to authorize specific caregivers to a client's care plan before the enhanced rate could be approved.

G.5.2.7. Administrative Expenses

Administrative expenses reflect costs associated with operating a provider organization, such as costs for administrative employees' salaries and wages along with non-payroll administration expenses, such as licenses, property taxes, liability, and other insurance. Rate models typically add a component for administrative expenses to spread costs across the reimbursements for all services an organization may deliver; our recommended rates reflect this methodology by establishing a percentage add-on for each service rate.

To determine an administrative add-on, Guidehouse calculated the ratio of administrative costs to direct care wages by summing administrative costs reported in the South Dakota collected SFY2021 cost reports, then dividing by total direct care wages and benefits inflated according to new wage and fringe assumptions for direct care workers for the time period captured in the survey.[5] Administrative costs include several categories:

- ***Payroll Administrative Expenses:*** *Employees and contracted employees who perform administrative activities or maintenance activities earn salaries and benefits, which count toward payroll expenses in the calculation of total administrative costs.*
- ***Non-Payroll Administrative Expenses:*** *Costs including office equipment and overhead comprise non-payroll administrative expenses, net of bad debt and costs related to advertising or marketing.*

Direct care costs include the salaries, wages, taxes. and benefits for direct care employees. After dividing administrative costs by direct care costs for each provider, an average and median ratio of **20.2** and **18.1 percent** were calculated, respectively. Guidehouse determined to incorporate the higher ratio of **20.2 percent**, which adds a dollar amount to a unit rate by multiplying the direct care related expenses by the average administrative percentage. Table 17 illustrates the application of the administrative percentage to the direct care related cost to create the hourly add-on.

Table 17: Administrative Add-On

Line Description	Homemaker/ Personal Care	Adult Companion/ Respite/Chore	Nursing RN	Nursing LPN
Total Hourly Compensation	$32.21	$31.12	$68.60	$56.81

[5] The calculation to determine median and average administrative expense ratios excluded providers that did not report administrative or direct care costs or reported costs such the ratio of administrative costs to direct care costs was above 45%.

Line Description	Homemaker/ Personal Care	Adult Companion/ Respite/Chore	Nursing RN	Nursing LPN
Administrative Overhead Percentage	20.2%	20.2%	20.2%	20.2%
Administrative Overhead Hourly Factor	$6.51	$6.29	$13.86	$11.47

G.5.2.8. Program Support Expenses

Program support expenses reflect costs associated with delivering services, but which are not related to either direct care or administration, but still have an impact on the quality of care. These costs are specific to the program but are not billable, and may include:

- **Medical Supplies**
- **Other Supplies and minor equipment purchases**

Similar to the calculation for administrative costs, the program support percentage is calculated based on cost data reported in the provider survey. Program support costs reported by providers were calculated in relation to direct care costs reported in the provider survey. Guidehouse arrived at a total program support add-on of 2.1 percent to account for additional supplies required for service delivery. Table 18 illustrates the application of the program support percentage to the direct care related cost to create the hourly add-on.

Table 18: Program Support Add-On

Line Description	Homemaker/ Personal Care	Adult Companion/ Respite/Chore	Nursing RN	Nursing LPN
Total Hourly Compensation	$32.21	$31.12	$68.60	$56.81
Program Support Percentage	2.1%	2.1%	2.1%	2.1%
Program Support Hourly Factor	$0.68	$0.65	$1.44	$1.19

H. Benchmark Rates and Final Recommendations

Guidehouse organized the in-home services into three service categories to stay consistent with current reimbursement. These service categories were developed to group similar services together in the provider cost and wage survey to support efficient and standardized reporting that would support the rate development process, as well as to identify similar service designs and rate model structures for closely related **services. Figure 6** captures the 6 services included in the rate study.

Figure 6: In Home Service Array

H.6.1. Rate Considerations

Standardization

Throughout the rate study process, rate development relied extensively on the provider cost and wage survey in combination with public data sources to identify areas in which standardization could be appropriately applied to the services under review. South Dakota's current rate structure already features significant standardization of the rate structure, to the extent that Adult Companion, Respite and Chore are reimbursed at equivalent rates, as are Homemaker and Personal Care. In reviewing the information provided within the cost and wage survey it was determined that this standardization still seemed reasonable. For key rate components such as wages, billable time, supervision and mileage assumptions, there was consistent information provided within each service category. As discussed in the previous rate component sections where similar metrics were found this consistency was maintained and used in the rate development.

Wages

When reviewing wages across the direct service professionals that deliver these services, we observed that there were providers that pay their staff the same wage regardless of the service being performed for all services except for Nursing. However, there were also providers within the cost and wage survey that paid a higher wage for Personal Care and Homemaker job types in comparison to the Adult Companion and Respite staff for providers that reported all job types. There were also survey responses that did not provide Adult Companion and Respite staff, but

their Personal Care and Homemaker wages were on average higher than the average of all providers reported Adult Companion and Respite. For this reason, Guidehouse recommendation is to differentiate the wages between the staff type. The wage differential ultimately dictated the variation in the rates resulting in a slightly lower rate for Adult Companion, Respite and Chore. If at a later date, DHS/DSS determine that they would instead prefer to pay the higher rate for all services this could still be considered a reasonable consideration due to workgroup feedback and staff availability.

Nursing RN versus LPN

The historical Nursing rate for the DHS Nursing services under the HOPE waiver has not had a distinction between RN and LPN. However, the DSS Medicaid services for Private Duty Nursing and the Home Health program have created this split. DSS/DHS and Guidehouse agreed to create separate rates for LPN and RN to create consistency between the services. This adjustment is not a change in how the service is delivered but instead a change in how the state would authorize and bill for the service based on the licensing of the nurse providing the service. The cost and wage survey did show that registered nurses account for roughly 65 percent of the FTEs that provide the nursing service. The differentiation between rates is driven by wages with all other components staying constant.

Benchmark rates for each service across all programs, outlined in Table 19, were developed using the rate build-up approach. Appendix A includes the rate models for individual services along with the appropriate sources and calculations for each rate component that contributes to the benchmark service rate.

Table 19: Overall Rate Impacts for In-Home Services

Code	Description	Department	Unit of Measure	Rate as of 7/1/2022	Proposed Benchmark Rate	Percent Difference
S5135	Adult Companion	DHS	15 minutes	$7.33	$9.89	35%
T1005	Respite Care	DHS	15 minutes	$7.33	$9.89	35%
S5120	Chore Services	DHS	15 minutes	$7.33	$9.89	35%
S5130	Homemaker	DHS	15 minutes	$8.49	$10.22	20%
T1019	Personal Care	DHS	15 minutes	$8.49	$10.22	20%
S5125	Personal Care	DHS	15 minutes	$8.49	$10.22	20%
T1000	Nursing - RN	DHS	15 minutes	$19.56	$21.42	10%
T1000	Nursing - LPN	DHS	15 minutes	$19.56	$17.82	-9%
S9123	Private Duty Nursing-RN	DSS	1 hour	$78.23	$85.68	10%
S9124	Private Duty Nursing-LPN	DSS	1 hour	$51.64	$71.28	38%

G0299	Hhs/Hospice Of Rn Ea 15 Mins	DSS	15 minutes	$16.49	$21.42	30%
G0300	Hhs/Hospice Of Lpn Ea 15 Min	DSS	15 minutes	$11.80	$17.82	51%

I. Fiscal Impact Estimates

I.7.1. Fiscal Impact Overview

As a part of determining final rate recommendations, Guidehouse analyzed how proposed rate benchmarks would affect projected expenditures in an effort to estimate the fiscal impact of increased rates for the State of South Dakota as well as providers delivering services across the State. This analysis was conducted exclusively for the purposes of the rate study, to assess the implications of increasing funding for services to the levels identified by study rate benchmarks. However, as we note in the sub-sections below, our analysis includes several simplifying assumptions that, while warranted for projection purposes, may not reflect eventual service utilization or future Medicaid/State federal financial participation. Moreover, these assumptions represent Guidehouse's best judgment based on the utilization data available, but do not necessarily reflect State legislative or executive decision-making, nor do they indicate additional commitments to future financing.

In the following sub-sections, Guidehouse describes the data sources for our utilization assumptions, including the service periods reflected in the data as well as any service exclusions or other limitations that frame the data set. The analysis also considers factors that influenced utilization assumptions and our approach to addressing these factors, including COVID-19 service impacts, utilization patterns sensitive to reimbursement increase, or adjustments to utilization stemming from proposed changes to service definition. With these caveats in mind, the report presents the fiscal impact to the services overall as well as split by department, detailing projected total and "state share" expenditures.

I.7.2. Baseline Data and Service Periods

While rate studies typically rely on expenditure data and utilization assumptions based on the most recently completed year of payments, data concerns or service delivery anomalies sometimes warrant exception to this general preference for more recent utilization data. In the case of the present study, the public health emergency prompted by COVID-19 led to a systemic disruption of service delivery that significantly altered patterns of utilization, resulting in claims data unrepresentative of prior service volume as well as likely utilization in the future. Although Guidehouse collected data from SFY 2019 through 2021, we ruled out the SFY 2020 and SFY 2021 service periods as a base period for projection due to reduced utilization evident, as well as other distortions in the mix of service provision due to the emergency. The service period reflected in SFY 2019 is the only annual period entirely free of COVID-19 impacts and looked to have the more comprehensive utilization than SFY 2020 for the full range of services. For these reasons, Guidehouse chose to use the SFY 2019 period as the baseline for fiscal projection.

The only exception to the SFY 2019 source data period is the utilization for Adult Companion, Private Duty Nursing- LPN and Home Health Nursing- LPN showed lower utilization in SFY 2019 than SFY 2022. Guidehouse addressed this gap by developing trend factors that increased SFY 2019 to the more recent SFY 2022 utilization.

Since State expenditures during SFY 2019 were not paid at current rates, Guidehouse adjusted the expenditure baseline grounded in SFY 2019 by repricing this utilization to reflect current rates. This adjustment is noted in fiscal impact tables in the "Paid at SFY23" columns, which indicates what the Department *would have paid* in SFY 2019 if reimbursing claims at the rates currently effective. To establish the payment baseline, Guidehouse priced each unit of service included in the data at the current rate without mimicking all the claims adjudication nuances that can yield a final payment amount below the Medicaid allowed amount, such as reductions due to third party liability or other determinations. Expenditures calculated at Guidehouse's benchmark rates follow suit, allowing proportionate comparison for assessing financial impact. The fiscal impact numbers also account for the state funded services as well as Medicaid services. This distinction is outlined since the state funded claims do not receive Federal Medical Assistance Percentage (FMAP) but will still be costs to the state.

I.7.3. Other Projection Assumptions

For the most part, the analysis' utilization assumptions reflect historical service volume, and Guidehouse did not attempt to adjust utilization patterns based on anticipated changes stemming from rate increases or post-COVID shifts in service provision. While we expect utilization will increase over usage levels observed in SFY 2021 and 2022, expected increases in volume are already captured, to some extent, in the SFY 2019 baseline data, in which growth in utilization is modeled as a return to "normal" pre-COVID service delivery.

While it is possible some services experiencing substantial rate increases may see higher utilization due the monetary incentives driven by the increased rates to deliver these services, it is too soon to predict whether rate adequacy alone is sufficient to address workforce shortages that may have contributed previously to depressed utilization or challenges to access to care. It is our understanding that workforce challenges as well as lower rates of reimbursement may have caused some providers not to be able to deliver the volume of services that were demanded. With increased rates, providers may be in a position to hire and retain more staff than current levels, resulting in a greater volume of services delivered than historical utilization trends. Given the uncertain economic climate, the complexity of the dynamics operating in the current labor market, and the difficulty in gauging consumer and provider behavior post-COVID, Guidehouse declined to apply speculative adjustments to utilization projections specifically to model potential upticks in utilization influenced by a rate increase. However, Guidehouse based fiscal projections on SFY 2019 utilization both to account for higher utilization post-COVID as well as higher utilization stemming from a rate increase and greater access to services.

The analysis identifies fiscal impact in terms of both total expenditure increases and the additional state share dollars needed to fund services at the proposed benchmark rate. Projected state share impacts are also subject to simplified federal participation assumptions that may deviate from actual Federal Medical Assistance Percentage (FMAP) levels depending on several factors, including time of implementation and the persistence of the federal emergency declaration, as well as the relative proportion of Medicaid expansion and non-expansion beneficiaries receiving services.

In SFY 2024, South Dakota Medicaid FMAP will be 55.42 percent, which means the federal government will cover 55.42 percent of expenditures for standard Medicaid services, with South Dakota's state share covering the remaining 44.58 percent of reimbursement costs. This 55.42 percent is a blended percentage calculated by the State to estimate aggregate federal participation across multiple services and populations. It is a blend of the State share of the FMAP for 1 quarter of FFY2023 (July – Sept) and 3 quarters of FFY2024 (Oct – Jun) to align with State fiscal year. While these ratios hold true for the vast majority of services and Medicaid members included in the rate study, there are several exceptions to this relationship, in which federal reimbursement may be substantially higher than the standard FMAP. These exceptions include:

- Services covered under the CHIP program. This population receives an enhanced FMAP of 68.52 percent (based on a similar blending exercise as used for the regular FMAP);
- Services delivered to the IHS Care Coordination populations, which are subject to a 100 percent FMAP; and
- State funded services receive no FMAP

Recent FMAP enhancement due to the COVID-19 public health emergency that are authorized by the Families First Coronavirus Response Act (FFCRA) are set to expire as well as the HCBS 10 percent enhancement. The FMAP percentages listed above take into the reduced percentages due to the recent changes.

Each of these enhanced FMAP conditions potentially exerts an influence on the ultimate state share of total expenditures. Our fiscal impact accounts for the enhanced FMAP for services delivered under CHIP and IHS Care Coordination programs.

I.7.4. Fiscal Impact Across All Services

Comparisons between current rates and the benchmarks developed by Guidehouse included only the reimbursement rate included in the DHS/DSS effective fee schedules, without considering other payments the Department may make to providers as a part of total reimbursement.

Table 20 shows the fiscal impact of funding rate changes to the full rate benchmark for all

services included in the rate study, and also analyzed by program. The table includes a projection of expenditures if service utilization were to be paid at benchmark rates (the column labeled "**Utilization Paid at Benchmark Rates**", which is compared to a set of baseline current expenditures "**Utilization Paid at SFY23 Rates**" to identify the overall fiscal impact, a figure that reflects new expenditures needed to finance benchmark rates (representing the "Difference" between benchmark and current spending). Utilization Paid at SFY23 Rates represents claims paid at current fee schedule rates.

Table 20: Total Fiscal Impact (Federal + State Share)

Fiscal Impact - All Programs Total							
By Program	**Funding Source Split**	**Utilization Paid at SFY23 Rates**	**Utilization Paid at Benchmark Rates**	**Change**	**Difference**	**SFY23 Percent of Total**	**Benchmark Percent of Total**
Total		**$37,560,139**	**$44,409,841**	**18.2%**	**$6,849,701**		
ADLS - Attendant Care Title XIX	DHS	$6,159,546	$7,420,179	20.5%	$1,260,633	16.4%	16.7%
Family Support	DHS	$437,349	$566,588	29.6%	$129,239	1.2%	1.3%
LTSS - Medicaid	DHS	$17,262,915	$20,442,012	18.4%	$3,179,098	46.0%	46.0%
LTSS- State Funded	DHS	$6,464,866	$7,525,024	16.4%	$1,060,158	17.2%	16.9%
CHIP - Medicaid	DSS	$109,499	$120,145	9.7%	$10,646	0.3%	0.3%
CHIP - Non-Medicaid	DSS	$660	$857	29.9%	$197	0.0%	0.0%
Medicaid - EPSDT Treatment	DSS	$6,948,002	$8,103,148	16.6%	$1,155,146	18.5%	18.2%
Medicaid - Other Medical	DSS	$177,305	$231,888	30.8%	$54,584	0.5%	0.5%

Analysis suggests the system would require an additional $6.8 million—which includes not just state but also federal dollars—to reimburse providers at the benchmark rates recommended by Guidehouse.

While the fiscal impact analysis indicates the system would require $6.8 million annually to increase reimbursement to the benchmark rates, the additional dollars the State of South Dakota would need to raise represents a substantially lower proportion of those total funds. The collective impact of these state share reductions is a price tag of $3.6 million for the State of South Dakota, assuming full funding of the benchmark rates. Table 21 details the state fiscal impact across all services, with expenditure breakdowns by population.

Table 21: Total Fiscal Impact (State Share)

Fiscal Impact - State Share							
By Program	**Funding Source Split**	**Utilization Paid at SFY23 Rates**	**Utilization Paid at Benchmark Rates**	**Change**	**Difference**	**SFY23 Percent of Total**	**Benchmark Percent of Total**
Total		**$20,304,142**	**$23,941,831**	**17.9%**	**$3,637,689**		
ADLS - Attendant Care Title XIX	DHS	$2,745,925	$3,307,916	20.5%	$561,990	13.5%	13.8%
Family Support	DHS	$194,970	$252,585	29.6%	$57,615	1.0%	1.1%
LTSS - Medicaid	DHS	$7,689,483	$9,105,436	18.4%	$1,415,953	37.9%	38.0%
LTSS – State Funded	DHS	$6,464,866	$7,525,024	16.4%	$1,060,158	31.8%	31.4%
CHIP - Medicaid	DSS	$34,470	$37,822	9.7%	$3,351	0.2%	0.2%
CHIP - Non-Medicaid	DSS	$208	$270	29.9%	$62	0.0%	0.0%
Medicaid - EPSDT Treatment	DSS	$3,097,419	$3,612,383	16.6%	$514,964	15.3%	15.1%
Medicaid - Other Medical	DSS	$76,801	$100,396	30.7%	$23,595	0.4%	0.4%

The Department of Human Services funds a large portion of these in-home services but does not account for all. The Table 22 represents the DHS portion of the service pool with a combination of Medicaid and state funded.

Table 22: Department of Human Services (DHS) Fiscal Impact (Federal + State)

Fiscal Impact - DHS							
By Program	**Funding Source Split**	**Utilization Paid at SFY23 Rates**	**Utilization Paid at Benchmark Rates**	**Change**	**Difference**	**SFY23 Percent of Total**	**Benchmark Percent of Total**
Total		**$30,324,675**	**$35,953,803**	**18.6%**	**$5,629,128**		
ADLS - Attendant Care Title XIX	DHS	$6,159,546	$7,420,179	20.5%	$1,260,633	20.3%	20.6%
Family Support	DHS	$437,349	$566,588	29.6%	$129,239	1.4%	1.6%
LTSS - Medicaid	DHS	$17,262,915	$20,442,012	18.4%	$3,179,098	56.9%	56.9%
LTSS – State Funded	DHS	$6,464,866	$7,525,024	16.4%	$1,060,158	21.3%	20.9%

To increase reimbursement to the benchmark rates the services underneath the DHS programs would require a total increase of $5.6m. However, these programs receive the 55.42 percent FMAP as well as a small portion of claims with the enhanced 100 percent FMAP for the IHS Care Coordination program. Table 23 shows that by taking into account the federal dollars DHS would need an additional $3.1m increase to reimbursement to achieve the proposed benchmark rates.

Table 23: Department of Human Services (DHS) Fiscal Impact (State Share)

Fiscal Impact - DHS State Share							
By Program	**Funding Source Split**	**Utilization Paid at SFY23 Rates**	**Utilization Paid at Benchmark Rates**	**Change**	**Difference**	**SFY23 Percent of Total**	**Benchmark Percent of Total**
Total		**$17,095,244**	**$20,190,960**	**18.1%**	**$3,095,716**		
ADLS - Attendant Care Title XIX	DHS	$2,745,925	$3,307,916	20.5%	$561,990	16.1%	16.4%
Family Support	DHS	$194,970	$252,585	29.6%	$57,615	1.1%	1.3%
LTSS - Medicaid	DHS	$7,689,483	$9,105,436	18.4%	$1,415,953	45.0%	45.1%
LTSS – State Funded	DHS	$6,464,866	$7,525,024	16.4%	$1,060,158	37.8%	37.3%

For this mix of services DHS has the largest number of claims but DSS has a smaller portion for the Nursing dollars that would be impacted by the proposed benchmark rates. The CHIP program receives the enhanced FMAP of 68.52 percent with the remaining receiving the same 55.42 percent as the DHS services. The total fiscal impact for the federal and state share is $1.2m displayed in Table 24.

Table 24: Department of Social Services (DSS) Fiscal Impact (Federal + State)

Fiscal Impact – DSS (Federal + State)							
By Program	**Funding Source Split**	**Utilization Paid at SFY23 Rates**	**Utilization Paid at Benchmark Rates**	**Change**	**Difference**	**SFY23 Percent of Total**	**Benchmark Percent of Total**
Total		**$7,235,464**	**$8,456,038**	**16.9%**	**$1,220,573**		
CHIP - Medicaid	DSS	$109,499	$120,145	9.7%	$10,646	1.5%	1.4%
CHIP - Non-Medicaid	DSS	$660	$857	29.9%	$197	0.0%	0.0%
Medicaid - EPSDT Treatment	DSS	$6,948,002	$8,103,148	16.6%	$1,155,146	96.0%	95.8%

Fiscal Impact – DSS (Federal + State)							
By Program	**Funding Source Split**	**Utilization Paid at SFY23 Rates**	**Utilization Paid at Benchmark Rates**	**Change**	**Difference**	**SFY23 Percent of Total**	**Benchmark Percent of Total**
Medicaid - Other Medical	DSS	$177,305	$231,888	30.8%	$54,584	2.5%	2.7%

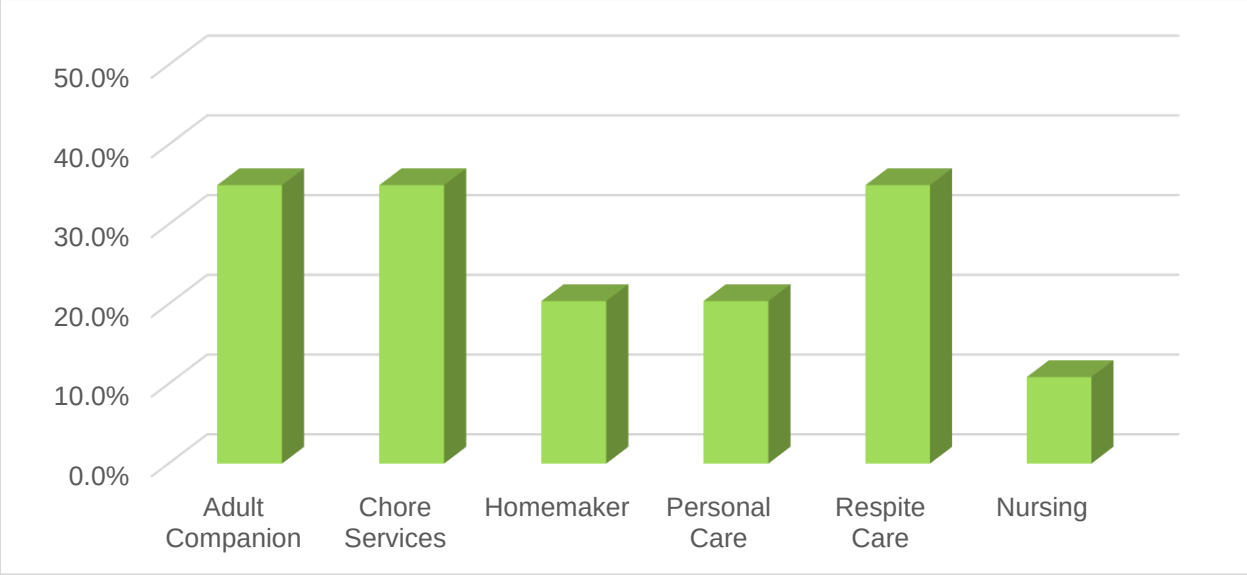
When reviewing the state share using the enhanced and regular FMAP the state share is roughly $541k displayed in Table 25.

Table 25: Department of Social Services (DSS) Fiscal Impact (State Share)

Fiscal Impact – DSS (State Share)							
By Program	**Funding Source Split**	**Utilization Paid at SFY23 Rates**	**Utilization Paid at Benchmark Rates**	**Change**	**Difference**	**SFY23 Percent of Total**	**Benchmark Percent of Total**
Total		**$3,208,898**	**$3,750,871**	**16.9%**	**$541,973**		
CHIP - Medicaid	DSS	$34,470	$37,822	9.7%	$3,351	1.1%	1.0%
CHIP - Non-Medicaid	DSS	$208	$270	29.9%	$62	0.0%	0.0%
Medicaid - EPSDT Treatment	DSS	$3,097,419	$3,612,383	16.6%	$514,964	96.5%	96.3%
Medicaid - Other Medical	DSS	$76,801	$100,396	30.7%	$23,595	2.4%	2.7%

Across the six services there was a range of impact with Personal Care and Homemaker showing roughly a 20 percent increase, Adult Companion, Respite and Chore with a 35 percent increase and Nursing had varied rate changes with the recommended split between RN and LPN from the single Nursing rate. Figure 7 illustrates the proposed benchmark rate differential.

Figure 7: Percentage Change in Expenditures by Service



These rate changes create an aggregate fiscal impact of roughly **18.2 percent**. This differential is due to the service mix of these services being heavily weighted towards Personal Care and Homemaker. Even though the Adult Companion, Respite and Chore services have the largest proposed rate change the utilization of these services is much lower and therefore Personal Care and Homemaker are influencing the overall fiscal impact. The current Nursing rate under the HOPE waiver does not currently have separate RN and LPN rates. Within the fiscal impact tables a blended rate was used to be able to create a proxy for the estimated fiscal impact. Table 26 displays the relative change in expenditures for each service where you can see the overall percentage change of 18.2 percent is more closely aligned with the Personal Care/Homemaker proposed rate change of 20 percent.

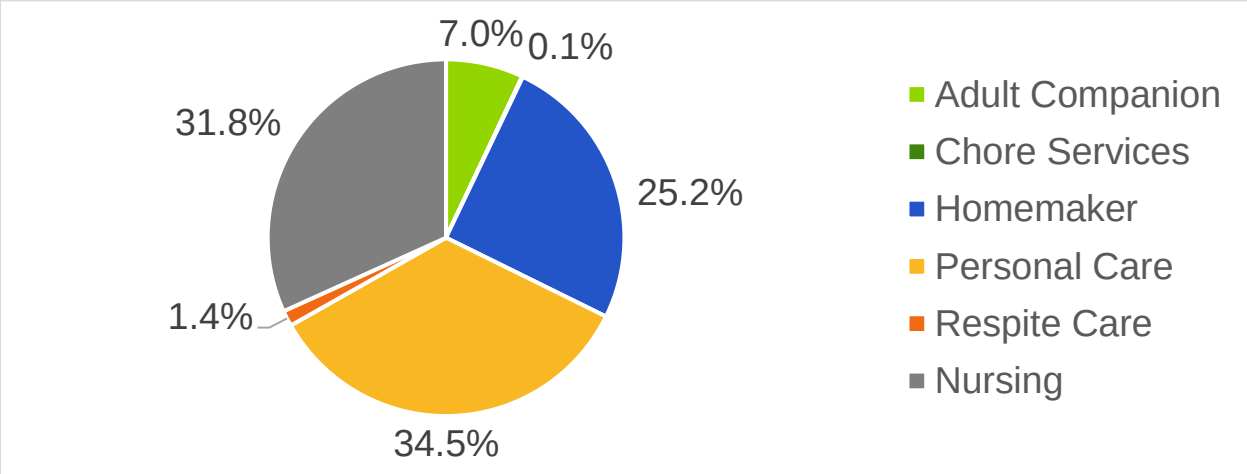
Table 26: Total Expenditures by Service Category (Federal + State)

State and Medicaid Funded Services - All Populations						
By Service Category	**Utilization Paid at SFY23 Rates**	**Utilization Paid at Benchmark Rates**	**Change**	**Difference**	**SFY23 Percent of Total**	**Benchmark Percent of Total**
All Services	**$37,560,139**	**$44,409,841**	**18.2%**	**$6,849,701**	**100.0%**	**100.0%**
Adult Companion	$2,310,636	$3,117,625	34.9%	$806,989	6.2%	7.0%

State and Medicaid Funded Services - All Populations						
By Service Category	**Utilization Paid at SFY23 Rates**	**Utilization Paid at Benchmark Rates**	**Change**	**Difference**	**SFY23 Percent of Total**	**Benchmark Percent of Total**
Chore Services	$24,629	$33,230	34.9%	$8,602	0.1%	0.1%
Homemaker	$9,294,378	$11,188,286	20.4%	$1,893,907	24.7%	25.2%
Personal Care	$12,737,157	$15,332,596	20.4%	$2,595,439	33.9%	34.5%
Respite Care	$467,749	$631,110	34.9%	$163,361	1.2%	1.4%
Nursing LPN	N/A	$4,420,717	N/A	N/A	N/A	10.0%
Nursing RN	N/A	$9,686,277	N/A	N/A	N/A	21.8%
Nursing	$12,725,591	$14,106,994	10.9%	$160,830	14.6%	31.8%

Figure 8 graphically displays the influence of the utilization on overall fiscal impact. Homemaker and Personal Care account for almost 60 percent of the projected total expenditures under the new benchmark rates.

Figure 8: Total Expenditures by Service Mix



These figures are estimates based on the proposed benchmark rates within this report. Depending on budgetary constraints there is the possibility that the full rates may not be able to be implemented. Overall, this rate study was intended to inform DHS and DSS of the various cost components and service delivery that should be considered when developing rates to support provider costs.