Guidehouse

South Dakota Rate Study

Substance Use Disorder Prevention Services

Presented to:

South Dakota Department of Social Services (DSS)

Presented by:

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A. Executive Summary

The State of South Dakota Department of Social Services (DSS), Division of Behavioral Health engaged Guidehouse Inc. (Guidehouse) to conduct a comprehensive rate study of Substance Use Disorder (SUD) prevention services to develop benchmark rates. The purpose of this study is to evaluate the adequacy and structure of current reimbursement for prevention services, assess alignment with provider costs and program objectives, and develop rate and methodology recommendations that support the State's long-term prevention strategy while maintaining compliance with federal funding requirements. The study equips DSS with information needed to develop a sound payment and rate-setting methodology based on observed reasonable and justifiable costs incurred by providers to deliver services. Proposed rates reflect a reasonable expectation to reimburse the direct and indirect costs that providers experience. The outcome of the study is that DSS now has a methodology for all services that can be adjusted in the future as needed without completing a full rate study that requires State and provider time and resources.

This rate study supports DSS's goals as outlined in South Dakota's 2023–2028 Behavioral Health Prevention Services Five Year Strategic Plan and reflects the State's continued investment in evidence based prevention services designed to reduce risk factors for substance use disorders and improve population level behavioral health outcomes across South Dakota. The study considers both the unique characteristics of prevention services and the funding constraints associated with the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS Block Grant), including the requirement that at least 20 percent of block grant funding
be dedicated to primary prevention activities.

South Dakota's SUD prevention program is structured around six primary prevention strategies established by the Center for Substance Abuse Prevention (CSAP): Information Dissemination, Education, Alternatives, Problem Identification and Referral, Community-Based Process, and Environmental strategies. These services are delivered statewide through a network of contracted providers, including 18 community providers and four Prevention Resource Centers. In addition, providers may bill for other necessary services to support costs that are not otherwise captured within the core prevention strategies.

Although prevention services in South Dakota are reimbursed using a fee-for-service (FFS) framework similar to Medicaid, the program differs from traditional clinical service models in important ways. Prevention activities are typically population based rather than individual level interventions, funding is subject to fixed grant allocations, and reimbursement explicitly allows for the billing of indirect costs. These characteristics create both challenges and opportunities for rate setting and necessitate an approach that balances fiscal stewardship, provider sustainability, and accountability for outcomes.

Guidehouse employed an independent rate model approach to evaluate current reimbursement and develop rate recommendations for SUD prevention services. Key elements of the study included:

- **Provider data collection and analysis**, including the development and administration of a customized provider cost and wage survey to capture information on staffing, compensation, productivity, benefits, and indirect costs.
- **Review of DSS administrative and utilization data** to understand service delivery patterns and program operations.
- **Use of publicly available benchmarks**, such as Bureau of Labor Statistics (BLS) wage data and other national data sources, to contextualize provider reported costs and support rate assumptions.
- **Stakeholder engagement**, including structured outreach and technical assistance to providers to ensure accurate data submission and to gather qualitative input on rate development.
- **Peer state research** and review of national best practices related to prevention service policy and reimbursement.

Consistent with best practices used in other Guidehouse rate studies, the analysis focuses on identifying reasonable costs required to deliver high quality prevention services in South Dakota's geographic and operational context.

Recommendations and Fiscal Impact

Guidehouse formulated four related recommendations addressing prevention service reimbursement. Guidehouse's recommendations include developing one rate for all six CSAP strategies, incorporating some program support and administrative reimbursement, including staff time for professional development, into the direct service rate, reviewing available funding through the Block Grant, and considering best practices from other states.

Guidehouse developed a fiscal impact analysis that utilized MOSAIX claims data, current prevention fee-for-service rates, and the proposed benchmark rates. The fiscal impact compares the financial impact on State expenditures with and without the updated benchmark rates. Using these sources, Guidehouse is estimating a fiscal impact of **$533 thousand annually, which is a 24 percent funding increase to the program overall.** Guidehouse also considered the limitations of grant funding in making program recommendations.

B. Introduction and Background

South Dakota Department of Social Services (DSS) Division of Behavioral Health engaged Guidehouse Inc. (Guidehouse) in a substance use disorder (SUD) Prevention Services Rate Study to review costs associated with prevention services, develop a robust rate methodology, and explore payment models to promote high-quality, cost-effective strategies. This study aims to generate actionable recommendations that enable DSS to support providers in delivering effective prevention services. DSS strives to reduce the risk factors for substance use disorder conditions that impact the quality of life of those living in South Dakota and provide the support needed to expand and enhance critical SUD prevention services across South Dakota.

South Dakota SUD Prevention Services Offerings

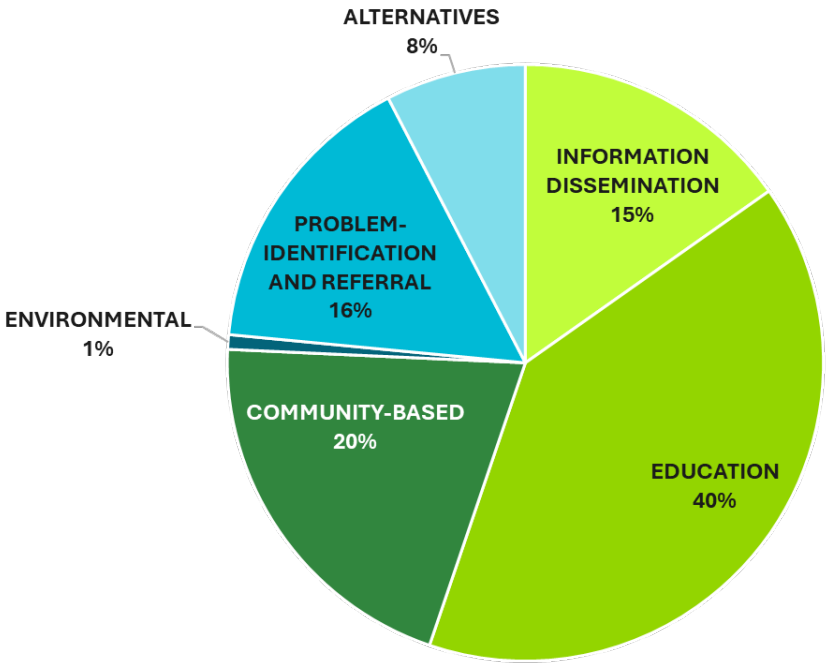
This study focused on services funded through the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS Block Grant), specifically the six prevention strategies outlined by the Center for Substance Abuse Prevention (CSAP): Information Dissemination, Education, Community-Based Processes, Environmental Strategies, Problem Identification and Referral, and Alternatives. These strategies form the foundation of South Dakota's prevention framework. We reviewed the services[1] listed below as a part of the rate evaluation.

- **Information Dissemination** - Provide knowledge and awareness of the impacts of alcohol, drug use, and addiction on individuals, families, and communities. Increase awareness of available prevention and treatment programs and services.
- **Education** - Build critical life and social skills through structured learning processes.
- **Alternatives** - Provide opportunities to participate in healthy activities that exclude alcohol and other drugs.
- **Problem Identification & Referral** - Identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol, or drugs and determine if they would benefit from treatment.
- **Community-based Process** - Provide networking activities and technical assistance to community groups or agencies.
- **Environmental** - Establish written and unwritten community standards, codes, and attitude to influence the communities use of alcohol and drugs.

[1] Substance Abuse Prevention & Treatment Block Grant (SABG) | SAMHSA

Currently, 22 providers across South Dakota deliver these prevention services, with varying levels of offerings across CSAP strategies. According to the provider cost and wage survey data, nearly all providers offer Community-Based Processes and Information Dissemination, while Education services are provided by approximately 80% of agencies. In contrast, Environmental strategies and Alternatives are less common, offered by 55% and 30% of agencies respectively. Two providers deliver all six strategies, highlighting the diversity in service capacity statewide. **Figure 1** shows the utilization data from Contract Year 2025, that Education is the most heavily used strategy, accounting for 40% of services followed by Community-Based Processes and Problem Identification and Referral. Environmental strategies represent the smallest share of utilization statewide.

Figure 1. Contract Year 2025 Utilization by Service Category



DSS currently reimburses prevention providers using a rate-per-unit methodology, where each unit equals 15 minutes of service. Rates are set by strategy, and providers report both direct and indirect staff time to receive payment from the State. Additionally, DSS currently allows providers to bill an administrative fee of 5% on all reported staff time and allows providers to bill at cost for other necessary services, including resource development, ancillary services, evaluation and travel.

Focus Areas for South Dakota SUD Prevention Services

The rate study focused on exploring opportunities to build a more sustainable framework for SUD prevention services across South Dakota. Facilitating continued progress toward expanding and enhancing services is central to this effort, which involves developing rates that accurately reflect the costs of delivering evidence-based prevention strategies in community settings. This approach supports providers in maintaining high standards while fostering independent and healthy children, adults, and families through behavioral health services. The study recognizes:

1. SAMHSA grantees must spend no less than 20% of their SUPTRS Block Grant allotment on substance use primary prevention strategies.
2. Prevention services pose unique challenges as they typically do not conform to conventional fee-for-service models.

Finally, this study aligns rate recommendations with South Dakota's 2023–2028 Behavioral Health Prevention Services Strategic Plan and long-term fiscal priorities. This alignment creates a robust foundation for sustainable prevention services that are cost effective and adaptable to changes in future funding

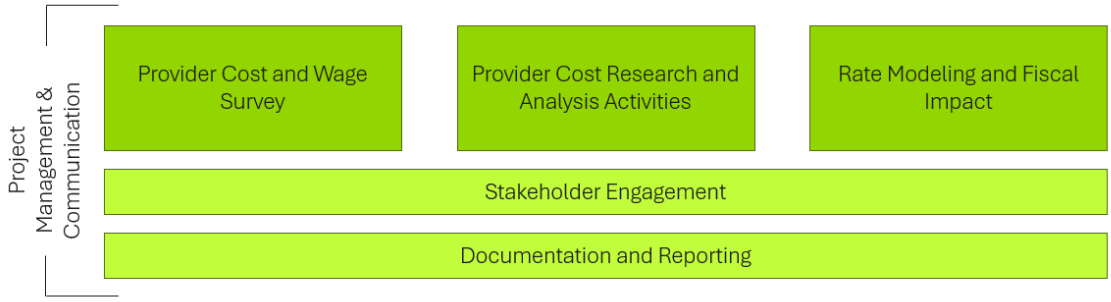
Key Study Components

Guidehouse used several tools and practices to facilitate the study and develop recommendations.

- Provider Cost and Wage Survey: Gathering data from providers for rate review and rebasing efforts.
- Additional Cost Research and Analysis: Researching peer states and national data sources to inform rate development.
- Rate Modeling and Fiscal Impact: Developing rate models through research and cost analysis on the current models and assessing the fiscal impact of the benchmark rates.
- Stakeholder Engagement: Facilitating engagement with stakeholders including provider representatives, coalitions, Prevention Resource Centers, and State staff to solicit feedback throughout the rate development process.

Figure 2 illustrates the overview of these project initiatives and Guidehouse's approach for each activity as it related to one another.

Figure 2. Overview of Project Initiatives



C. Recommendations

Based on the rate study process and results, Guidehouse identified the rate recommendations and policy considerations highlighted in this section for the DSS to consider as it navigates the adoption and implementation of our proposed benchmark rates for SUD prevention services. Guidehouse also considered input provided by stakeholders and DSS staff during the rate development process in arriving at these recommendations.

C.1. Align Rates Across Prevention Services

Findings did not demonstrate a need to differentiate staff across the six included strategies. Based on survey results and stakeholder feedback, Guidehouse recommends **creating one standard rate to promote rate equity across the prevention system**. To achieve an equitable system, it is important not to look at services within the siloes of each population, but to view the rate structure across the system as a whole. Parity helps make sure that one prevention strategy is not favored over another and promotes providers offering multiple prevention services, as appropriate. Given that stakeholders noted that typically the same staff serve all strategies, Guidehouse recommends implementing standardized wage assumptions, benefit assumptions, staffing and supervisor ratios, and productivity assumptions for prevention and supervisor positions that are identical across all populations and programs. To that end, Guidehouse developed one rate for all six CSAP strategies.

C.2. Incorporate Administrative and Program Support into Direct Rate Reimbursement

Currently, DSS pays separate rates for administrative, ancillary, resource development, evaluation, and travel services outside of direct prevention service provision. Currently, providers can bill for a maximum of 5% administrative fees on top of the direct service codes. Since that effectively translates into providers billing the maximum of 5% on all direct services, Guidehouse recommends **building in the administrative percentage directly** into the rate. In addition, providers can currently bill for professional development time through the Resource Development code. Feedback demonstrates that this method creates inconsistencies across providers, only some of whom bill for their support services. Guidehouse recommends **building in a robust program support factor directly** into the rate to eliminate the need to bill separately for staff time associated with prevention services. We built in 5% administrative costs based on current service definitions and 7% program support costs based on provider reported costs (including costs associated with professional development, utilities, equipment, and building) in the cost reports.

We also recognize that different providers have significant variation in their use of certain ancillary services, such as meals and mileage. For these support components, the “typical” experience may not adequately represent costs for different providers. Therefore, Guidehouse did not include travel, supplies, and food costs into the program support percentage, allowing providers to continue to bill the cost of those services directly as they have historically.

C.3. Review Grant Funding Mechanisms for Available Funding

Best practices suggest that DSS consider **a regular process for administrative rate updates** that includes adjusting either wage assumptions or overall rate levels based on applicable inflation indices. DSS could rely on provider data but could also periodically review the other industry data sources discussed in this report. If DSS were to implement the benchmark rate methodologies recommended by Guidehouse, it would be possible to review rate assumptions annually or less frequently to assess the need for administrative updates of specific types of costs, such as wages, without requiring comprehensive rate rebasing. The independent rate build-up approach for developing the rates would allow DSS to consider specific components of rate (e.g., wages, benefits, administrative costs, program support costs) for further review and updates.

While this report represents a cost-based model, we recognize the fiscal reality that rate **implementation is limited to available funding**. DSS receives federal funding from SAMHSA through the SUPTRS block grant. The block grant is federally designed and changes to the budget are subject to federal decisions. At present, additional state funds have not been allocated to support prevention services.

Guidehouse recommends that DSS consider available funding and **implement the benchmark rates** described in this report to the extent possible. That may result in a percentage of benchmark or other partial implementation of the rate recommendations.

C.4. Review Practices from Other States

During the virtual peer state interviews discussed in detail in **Section F**, peer state representatives identified multiple promising practices that have improved their service delivery process and provided additional support to prevention service providers. Some of those practices may be beneficial for South Dakota to consider as DSS seeks to make improvements to prevention service delivery. Specifically, three practices stood out as potentially useful for South Dakota:

1. **Consider Longer Contract Periods:** Colorado and North Dakota rely on longer contract periods of 3-5 years for their prevention providers. In South Dakota, stakeholders noted that changes in funding on an annual basis can lead to challenges with recruitment and retention. Longer contract periods may increase stability for South Dakota's prevention staff by offering a more predictable commitment to providers and may reduce administrative burden for DSS staff as there could be more time between contract renewals.
2. **Consider Reimbursement Strategy:** South Dakota currently relies on a 15-minute unit of reimbursement for prevention services. For many of the activities that fall under the six CSAP strategies, a 15-minute unit does not align with true service provision. For example, a provider may create a radio advertisement as part of the Information Dissemination strategy. There are multiple costs, such as designing the ad and paying for the radio space, that might be better suited to a fixed activity cost. North Dakota reimburses their prevention services based on the cost of each individual activity, which might be a more direct and targeted way for DSS to spend available resources.

3. **Consider Funding to Align with Priorities**: North Dakota reserves $10k at the beginning and end of each contract period to conduct a needs assessment and evaluation of program impact, respectively, as part of their block grant funding contracts. The additional dollars are provided to prevention service providers in a lump sum and allow the partner to confirm the three-year plan developed as part of the contracting process meets the needs of their local community. Setting aside block grant dollars to assess the need for prevention services will help to shape future direction for the program and will help DSS to clearly prioritize particular services and demonstrate the impact of the services overtime.

Guidehouse recognizes that local factors such as rurality, state priorities, and DSS staff and provider capacity may impact whether the practices listed above are a good fit for South Dakota. Guidehouse recommends that DSS evaluate these practices and implement those that would improve prevention outcomes and/or provider and State staff experience.

D. Stakeholder Engagement

Guidehouse and DSS found it critical to facilitate engagement with providers and associations to secure successful rate evaluation and implementation. Guidehouse deployed a robust engagement and communications effort through establishment of a provider rate workgroup to support rate survey development, completion, and development of rate recommendations. These stakeholder efforts provided detailed insights and feedback from providers on specific costs and overall service delivery for SUD prevention services.

D.1. Rate Workgroup Structure

To support the development of rates based on the true cost of services, Guidehouse worked with DSS to determine a workgroup of providers able to offer perspectives representative of varying provider demographics and regions of the State. DSS invited all 22 contracted prevention service providers to participate in the workgroup, and representatives from 13 providers opted into the workgroup. Guidehouse and DSS convened a workgroup for four engagement sessions to provide updates and receive feedback ensuring communication, transparency, and buy-in throughout the rate study process. The list below describes the composition of the Rate Workgroup, their respective roles, and discussion topics.

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 who have a strong understanding of provider finances, reporting capabilities, and service costs

Role:

- Offer guidance on provider costs and service delivery practices.
- Review and validate rate model factors and assumptions, including wages, benefits, administration, program support and staffing
- Support DSS in encouraging peer organizations to fill out the provider cost and wage survey

Discussion Topics:

- Project introduction and overview of the rate study and process
- Overview of the draft rate study
- Peer state comparisons
- Rate build-up approach and rate components
- Benchmark wages and adjustments, including supplemental pay and inflation factors
- Survey responses
- Peer state interview findings
- Rate assumptions, methodology, and recommendations

Rate Workgroup Session #1: The first workgroup session focused on introducing the project and a comprehensive overview of the rate study and process. We discussed in detail the scope of the current rate study, roles and expectations, communication goals, and the scope of the project. Guidehouse reviewed the services included in the rate study and requested feedback on what types of staff provide these services. These discussions supported further refinement of wage and benefit methodologies for the rate study.

Guidehouse also reviewed the goals, design, and topics of the Provider Cost and Wage Survey. Followed by a full walk-through of the draft survey. The goal of this conversation was to adjust the survey to best fit the information available to South Dakota providers without being too administratively burdensome in order to inform the rate study but still meet the State's needs.

Rate Workgroup Session #2: The second workgroup included a review of public data sources and peer state comparisons. Guidehouse reinforced that participation in the Provider Cost and Wage Survey is an opportunity to provide critical information that will help inform the development and rebasing of rate setting methodologies and service rates. Guidehouse reviewed the evaluation criteria for a desk review of states that have commonalities with South Dakota to analyze their corresponding rates and service delivery and gathered feedback from workgroup members about the selection of peer states.

The session focused on the approach to rate-building and how survey data allows Guidehouse to incorporate the true provider experience with publicly available sources culminating in a validated model that is representative of the current cost of providing the services. This heavily relies on accurate costs of staffing, including wages, benefits, and market impacts. We reviewed a peer-state wage analysis using the Bureau of Labor Statistics (BLS) across multiple job types. Guidehouse shared that some job types may not directly align with BLS job classifications and requested input from both DSS and workgroup members to ensure alignment and inclusion for the rate model. We also determined that most providers use a single job classification of Prevention Specialist to facilitate all six CSAP strategies, with some using certified and others using non-credentialed. Benefit benchmarking showed the average private sector healthcare coverage costs for South Dakota for 2020 – 2024. Finally, we showed several possible inflationary data sources which along with the advantages and disadvantages of each.

Rate Workgroup Session #3: The purpose of the third workgroup was to discuss survey results and peer-state interview findings. Guidehouse shared that 91% of providers responded to the survey accounting for 96% of contract year 2025 expenditures. This marked a significant response rate that supports high credibility and transparency in the survey results and ultimately rate models. We reviewed responses to additional questions to be transparent about the service access, recruitment, and retention barriers faced by providers.

Guidehouse continued discussion on the rate build up approach displaying and requesting feedback on prevention services staff wages and benefits submitted via the survey. We also discussed points of clarification regarding administrative and program support factors reported. We discussed how South Dakota comparatively has higher funding per person than peer states.

Rate Workgroup Session #4: The purpose of the fourth and final workgroup was to wrap up the rate study by reviewing the benchmark rates and methodologies and associated fiscal impact with providers. Guidehouse shared how we built the rate and emphasized how collaboration from the rate study impacted the model. Providers offered feedback on the draft rates including concerns about the administrative and transportation costs. Providers also requested use of national BLS wages as opposed to South Dakota-specific wages and noted their concerns that existing provider cost reports and cost surveys are limited by the current funding structure. Guidehouse and DSS made significant changes to the rates, including relying on national BLS wages, based on the feedback from this session.

E. Data Sources

Guidehouse developed cost assumptions as part of the rate study that relied on a wide variety of data sources. Guidehouse collected and analyzed data from both DSS SUD prevention providers as well as national and regional standards to arrive at model 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. As part of the rate development process, we reviewed multiple data sources to inform rate assumptions, including:

- **Provider Data:** Information collected directly from providers through provider surveys and cost reports, offering insight into current service delivery and cost structures.
- **State Data:** Supporting data such as MOSAIX claims and reimbursement manuals that reflect policy and operational standards.
- **Public Sources:** National datasets used to benchmark labor and healthcare cost trends (e.g., Bureau of Labor Statistics data).

Guidehouse, in partnership with DSS, conducted a Provider Cost and Wage Survey ("Provider Survey") to obtain data regarding the cost of delivering services from providers including employee salaries and wages, provider fringe benefits, and additional service-specific costs. The provider survey presented valuable and detailed information on baseline hourly wages, wage growth rate, staffing patterns, and fringe benefits for all prevention services.

In addition to reviewing cost assumptions from provider-reported survey data, we also reviewed publicly available sources for supplemental analysis and for benchmarking purposes to establish a comprehensive rate.

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 sections below.

E.1. Provider Cost and Wage Survey

Guidehouse prepared a Provider Survey based on the landscape of SUD prevention services provided in South Dakota. During the Stakeholder Workgroup meeting in September 2025, 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 to refine the survey. Guidehouse made changes to the survey following the initial workgroup meeting based on the feedback we received during that meeting. The aim of the survey was to collect provider data across all services that would serve as the basis for the rate study. Additionally, Guidehouse aimed to utilize the survey to:

- Receive uniform inputs across all providers to develop standardized rate model components
- Measure change in wages over time
- Gather needed data to understand billable vs. non-billable time and staffing patterns per service
- Solicit general feedback from providers to explore service delivery improvements and efficiencies

The survey was aimed exclusively at collecting information about provider costs incurred in delivering SUD prevention services included in the rate study.

E.1.1. Survey Design and Development

Guidehouse designed this survey with input from DSS staff and the Stakeholder Workgroup, as well as drawing on knowledge gained from conducting similar surveys in other states. The survey was designed in Microsoft Excel and included twelve tabs on topics outlined in **Table 1** below.

Table 1: Provider Cost and Wage Survey Organization and Data Elements

Worksheet Topic(s)	Survey Topics and Metrics	Time Period for Data Requested
Overview	A general overview of what to expect in the survey and the color coding throughout the survey	-
Organizational Information	Provider identification, contact information, and organizational details	-
Services & Counties	Services delivered by the specific organization and the counties where those services are delivered	June 1, 2024 – May 31, 2025
Service Specific Delivery and Staffing Patterns	Service delivery specific questions unique to the type of service and the relevant CSAP strategy. Examples include: Billable vs. Non-Billable time, supervisor and staffing patterns, and number of members served	June 1, 2024 – May 31, 2025
Wages	Job types, staff types, hourly wages, supplemental pay, and other time	June 1, 2024 – May 31, 2025

Worksheet Topic(s)	Survey Topics and Metrics	Time Period for Data Requested
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	June 1, 2024 – May 31, 2025
Additional Questions	Clarifying comments in addition to the information covered in other worksheets or sections and specific questions about employee recruitment and retention challenges	-

E.1.2. Survey Administration and Support

The survey was released via e-mail on September 24, 2025, to the entire provider community in scope for the rate study. To conduct a successful and accurate survey, Guidehouse facilitated a live provider training webinar available to all providers on October 1, 2025, following the release of the survey. In the training session, Guidehouse introduced the survey, provided an overview of the survey tool and each worksheet tab, and addressed provider questions.

Additionally, Guidehouse offered ongoing technical assistance and resources to support providers in completing the survey through e-mail and one-on-one meetings. E-mails including survey deadline reminders and frequently asked questions (FAQ) to address common questions submitted by providers. Providers were given three weeks to complete the survey with a final survey deadline of October 17, 2025. Guidehouse and DSS granted providers an extension option of two and a half weeks if additional time was needed to complete the service specific tabs.

E.1.3. Provider Cost and Wage Survey Participation

In total, Guidehouse received 20 completed surveys which constitutes roughly 90.9% of eligible SUD prevention providers. Guidehouse measures "representativeness" by the number of providers, the relative size and scale of providers operations, and total State expenditures represented by surveyed providers. Provider expenditure is a reliable metric to represent the financial impact of the provider on the entire DSS system rather than the raw count of providers alone. Therefore, Guidehouse also reviewed the response rates by provider expenditure. When considering Medicaid expenditures, providers had an approximate survey response rate of 96.3%.

E.1.4. 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 if clarification or correction was required.
- **Outliers:** Reviewed quantitative data points (e.g., wages, productivity, benefits, and 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 DSS and the Stakeholder Workgroup and are documented as such in this report.

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 we examined and excluded outliers when warranted, and additional quality control checks were conducted to facilitate data completion. 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** of this report further outlines how the survey data was utilized for rate setting purposes.

E.2. 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 to understand 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 survey furnished many of our rate assumptions on employee wages, provider fringe benefit offerings, and staff productivity.

While provider 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 also draw on national and regional standards that reflect wider labor markets as well as median costs typical of broader industries, to benchmark South Dakota reported information from the provider survey. **Table 2** summarizes the additional public data sets used to inform cost assumptions used in Guidehouse's benchmark rate recommendations.

Table 2: Other Data Sources

Data Source	Description
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 comparisons and establishing benchmark wage assumptions for most wages.
Bureau of Labor Statistics, Current Employment Statistics (CES)	The Current Employment Statistics (CES) program produces detailed industry estimates of nonfarm employment, hours, and earnings of workers on payrolls. CES National Estimates produces data for the nation, and CES State and Metro Area produces estimates for all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, and about 450 metropolitan areas and divisions. Average hourly earnings for Outpatient Mental Health and Substance Abuse Centers, Health Care and Social Assistance, and Individual and Family Services staff are used as a source for inflation analysis.
Bureau of Labor Statistics, Consumer Price Index (CPI)	The Consumer Price Index (CPI) measures the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services. Indexes are available for the U.S. and various geographic areas, and average price data for select items (such as utilities, automotive fuel, and food) are also published. The CPI is the most widely used indicator of inflation and is frequently used for cost-of-living adjustments.
Bureau of Labor Statistics, Provider Price Index (PPI)	Federal index of inflation across multiple industries. Updated monthly and used for reference to understand annual inflation for provider costs and for recommendations on recurring rate updates.
Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey-Insurance Component (MEPS-IC)	Federal data on health insurance costs, including South Dakota-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 Employment Related Expenditures (ERE) assumptions.
Other State Reimbursement Methodologies	Data from other states on reimbursement levels for similar 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 (IRS) Mileage Rate	The IRS mileage rate provides the official mileage rates set by the IRS Service for calculating transportation costs.

F. Peer State Comparisons

Guidehouse reviewed the substance use disorder prevention services offered in nine peer states to compare their service delivery model to South Dakota's current structure and to identify potential practices South Dakota could leverage with prevention providers across the State. The research confirmed that prevention service reimbursement structures are largely state-specific to meet the needs of the local community and to align with each state's legislative requirements. When evaluating whether to adopt promising practices from the peer states, DSS should consider fit with the local community and with state-wide SUD prevention priorities, and potential impact on the capacity of DSS staff and prevention providers.

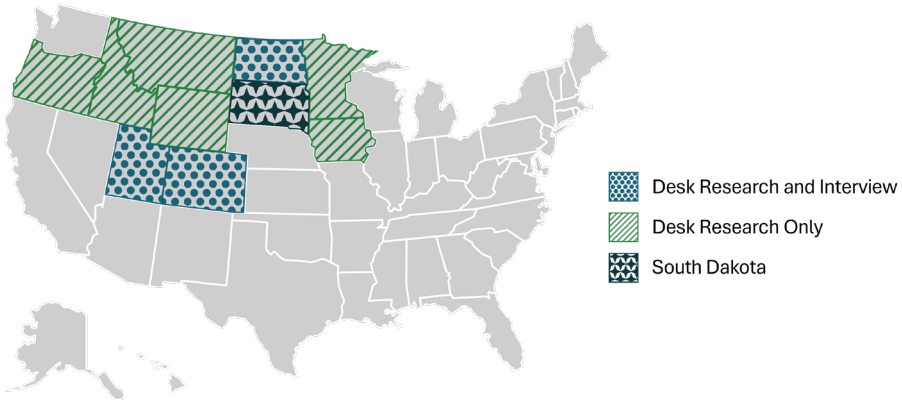
F.1. Comparison Approach

Guidehouse began the peer state comparison process by identifying states to include in the study. Guidehouse considered the following factors for state selection:

- Geographic location (i.e., whether the state is a regional neighbor)
- Demographic similarities (e.g., population living in non-metro areas)
- Prevention service reimbursement approaches, service structure, and specifications
- Whether the state was within the same SAMHSA region as South Dakota (i.e., Region 8) and therefore served by the same Prevention Technology Transfer Center

Based on the selected factors, Guidehouse identified nine states to include in the comparison. Guidehouse conducted desk research on state-wide SUD prevention programs and grants for all nine of the states. In addition to the research, DSS and Guidehouse facilitated virtual interviews with prevention services departments in three of the nine states. States included in the peer state comparison process are identified in **Figure 3** below.

Figure 3: Peer States



Listed in **Table 3** below are the demographics of each state included in the peer state comparison. North Dakota and Montana are the most demographically similar to South Dakota out of the nine states included in the comparison based on the factors included in the table.

Table 3: State Demographics

State	Population Size[2]	Percentage of Pop. In Non-Metro Area[3]	Percentage of Pop. American Indian / Alaska Native[4,5]	Percentage of Pop. with SUD[6]	SAMHSA Region[7]
South Dakota	**887 K**	**49.8%**	**8.8%**	**17.5%**	**8**
Colorado	5.8 M	12.3%	1.3%	22.4%	8
Idaho	1.8 M	26.4%	1.4%	17.4%	10
Iowa	3.2M	38.4%	0.5%	16.2%	7
Minnesota	5.7 M	22.1%	1.2%	18.3%	5
Montana	1.1 M	44.7%	6.2%	20.2%	8
North Dakota	779 K	39.3%	5.0%	17.1%	8
Oregon	4.2 M	15.2%	1.5%	21.5%	10
Utah	3.3 M	12.1%	1.3%	12.8%	8
Wyoming	577 K	68.9%	2.4%	17.9%	8

[2] Census.gov. 2020 Decennial Census.
[3] Rural Health Information Hub. State Guides.
[4] Census.gov. 2020 Decennial Census.
[5] American Indian and Alaska Native alone.
[6] SAMHSA Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (2022 and 2023). SUBSTANCE USE DISORDER IN THE PAST YEAR (12+).
[7] SAMHSA Regional Offices.

F.2. Comparison Results

Desk Research Findings

Guidehouse conducted a robust review of publicly available online resources to gather information on SUD prevention services provided by the nine peer states. Information reviewed encompassed grants and programs supported by the state, agencies and service providers offering the services, and background information on program funding and operations (e.g., outcome goals, key performance indicators, and reporting requirements). Below we outline key findings from the research:

1. **Most of the SUD prevention programs / grants are funded by SAMHSA (i.e., funded leveraging Federal Dollars):** All nine states use SUPTRS Block Grants and Partnership for Success (PFS) Grants to provide prevention services to their communities. Additional sources of funding include American Rescue Plan Act (ARPA) funds, opioid settlement dollars, appropriations from local legislative bodies, and taxes or surcharges from cannabis sales or on tickets from drunk driving incidents.
2. **Like South Dakota, many of the state's prevention programs focus on substance use prevention among youth:** Many states identified decreasing student substance use as a key performance indicator. Additionally, some states (e.g., Colorado and Iowa) base their State's Prevention Program goals on findings from state "Healthy Kid"/ Youth Behavior surveys.
3. **Most states partner with either county or tribal health departments or local community organizations to provide prevention services**: Examples of community organization include local Big Brother Big Sister chapters, YMCAs / YWCAs, and substance use or abuse councils. Additional partners often included law enforcement agencies and schools or school districts.

Detailed information on program funding and reimbursement methodologies was not always readily available via online resources. Leveraging the SUPTRS Block Grant applications, Guidehouse collected high-level information on Block Grant funding for seven of the nine states and detailed information on prevention service funding by CSAP strategy for four of the nine peer states. **Table 4** contains a detailed summary of the findings by prevention strategy.

As demonstrated within the table, funding percentages differ greatly between states. For example, North Dakota spends over 20 percent more on *Information Dissemination* than other states and Montana is the only state using over ten percent of their budget on *Section 1926 Tobacco Use Prevention* services. Differences in funding percentages could be explained by differences in state funding priorities or by specific strategies receiving supplemental funding from sources outside of the Block Grant (e.g., *Section 1926 (Synar) – Tobacco*).

Table 4: SUPTRS Block Grant Funding by Prevention Strategy

State	Block Grant App. Year[8]	Total Prevention Funding	Funding per State Resident[9]	*Information Dissemination*	*Education*	*Alternatives*	*Problem ID and Referral*	*Community-Based Processes*	*Environmental*	*Section 1926 (Synar) – Tobacco*
SD[10]	**May 2024 – June 2025**	$2.1M	$2.36	$306K (15%)	$806K (39%)	$144K (7%)	$375K (18%)	$444K (21%)	$15K (1%)	$0 (0%)
CO[11]	**FY 2026 / 2027**	$4.6M	$0.80	$551K (12%)	$1.3M (29%)	$413K (9%)	$321K (7%)	$1.5M (32%)	$505K (11%)	$40K (1%)
MT[12]	**FY 2022 / 2023**	$2.0M	$1.82	$441K (22%)	$118K (6%)	$201K (10%)	$69K (4%)	$819K (41%)	$93K (5%)	$236K (12%)
ND[13]	**FY 2026 / 2027**	$1.9M	$2.42	$1.1M (58%)	$55K (3%)	$55K (3%)	$73K (4%)	$183K (10%)	$366K (19%)	$50K (3%)
OR[14]	**FY 2022 / 2023**	$4.1M	$0.97	$559K (15%)	$374K (9%)	$374K (9%)	$187K (5%)	$1.4M (33%)	$1. 3M (30%)	$0 (0%)

[8] Years vary based on most recently available grant application at the time of research.

[9] Census.gov. 2020 Decennial Census.

[10] Values represent South Dakota's actual prevention services spend between May 2024 and June 2025. Values were provided by DSS.

[11] Colorado Behavioral Health Administration. Invitation to Comment on 2026-2027 Behavioral Health Block Grant Application (Aug 2025).

[12] Montana Behavioral Health and Developmental Disabilities Division. Substance Abuse Block Grant Application: FY2022/2023.

[13] North Dakota Health & Human Services. Community Mental Health Services Block Grant and Substance Use Prevention, Treatment and Recovery Services Block Grant. Information shared directly with Guidehouse by North Dakota on November 5, 2025.

[14] Oregon Health Authority. Substance Abuse Block Grant Application: FY2022/2023.

Interview Findings

To address gaps in publicly available data on the prevention service programs, DSS and Guidehouse facilitated virtual interviews with prevention service department administrators in Colorado, North Dakota, and Utah. During the discussions, Guidehouse asked questions related to prevention service reimbursement and auditing processes, department priorities and prevention service providers, and SUPTRS Block Grant administration. The sections below provide an overview of findings from the discussions.

Prevention Service Reimbursement and Auditing Processes

All three states, along with South Dakota, use a monthly invoicing process to reimburse service providers. Each state uses state-specific tools to collect information for invoicing; South Dakota and Colorado use excel sheets sent via email and North Dakota and Utah use online tools. South Dakota requires providers to submit receipts or proof of services as part of the invoicing process. Colorado and North Dakota confirmed providers are not required to submit receipts or proof of services as part of the invoicing process. North Dakota, however, does request providers include images of services provided (e.g., flyers, pictures of events) when submitting the monthly invoice. North Dakota also requires providers to identify the activities and impact of activities (e.g., number of people participating in activity) in the invoice.

Each state leverages vastly different reimbursement processes. South Dakota's process relies on 15-minute increment utilization for its reimbursement process and is notably distinct from the states interviewed and from other peer states we researched. Of the states interviewed, Utah has the least prescriptive model, allowing county partners to develop their own units or categories for the invoicing process. Utah asks their prevention providers to break down invoices by CSAP strategy to assist with Federal reporting requirements. While the model is very collaborative and allows county partners to tailor Utah's prevention services programs to local needs, the lack of standardization can add administrative burden for State staff.

Colorado's reimbursement process leverages budget categories (e.g., personnel, supplies / operating costs, travel) rather than utilization for invoicing. The State collaborates with prevention service providers to develop a budget outlining the funds by CSAP strategy. Similar to Utah, Colorado's process is highly collaborative; the State allows providers to shift up to 25 percent of their budget to a different strategy without submitting a budget amendment.

North Dakota has the most prescriptive reimbursement model. The State developed a menu of prices for potential activities service providers can offer to their local community under each CSAP strategy. Activities are separated into categories, and the State has a limit on the amount providers can spend on each category each month. North Dakota provides higher monthly limits for strategies they wish to prioritize (i.e., up to $7,000 per month for Modifying/Changing/Implementing Policies, a high-priority topic for the State versus up to $1,500 per month for "Parents Lead" activities). The State noted that developing the menu of prices was a time-consuming process.

All states conduct regular audits of invoices. Colorado and Utah provide ongoing review of invoices as they are submitted and conduct annual formal reviews. North Dakota facilities annual in-person audits and quarterly virtual audits with service providers. The State indicated a desire to conduct more in-person audits but noted that in-person visits can be administratively burdensome. We summarize additional details in the list below, which shows prevention service reimbursement and auditing processes by state.

Invoice Frequency and Format

Colorado

- Monthly invoices via Excel spreadsheets
- Providers are not required to provide receipts / proof of services to the State. Providers are encouraged to maintain documents in case they are audited.

North Dakota

- Monthly Survey via Qualtrics
- Providers identify activities and impact for each prevention strategy.
- Providers are not required to provide receipts / proof of services but are encouraged to upload pictures of flyers, posters, commercials, etc.

Utah

- Monthly invoices using in-house tool.

Reimbursement Process

Colorado

- Reimburse by budget category (e.g., personnel, supplies / operating costs, travel). Utilization is not tied to payments.
- At the start of each contract, providers develop an action plan outlining use of funds by strategy and percentage of funding.
- Providers have flexibility for 25% of their budget to move freely without a budget amendment.

North Dakota

- Provides standard prices for prevention activities and monthly limits for each strategy. The state conducted extensive research to develop the pricing.
- Providers must collaborate with the State to develop a price for items not on the list of standard prices (i.e., actual cost plus a 10 percent administration fee).

Utah

- Providers use service codes to break down invoices by CSAP strategy.
- Counties do not use standardized units / categories for the invoicing process.

Audit Process

Colorado

- Random formal desk audits
- Ongoing real-time review of invoices

North Dakota

- Annual in-person site visits
- Quarterly virtual calls

Utah

- Annual audits (Legislative requirement)
- Ongoing review of invoices

Department Priorities and Prevention Service Providers

Similar to South Dakota, Colorado and Utah focus their prevention services on younger populations by implementing programming to prevent underage substance use and by providing resources and tools to caregivers and families. Both Colorado and Utah indicated interest in providing more services to adults, including older adults, but noted that they are currently limited by available funding. Both states have elected to focus on younger populations in response to established research indicating that prevention efforts have the biggest impact among youth and adolescents. North Dakota prioritizes preventing underage drinking and binge drinking among adults. Providers in North Dakota have the option to focus on substance use if desired but must receive approval from the State.

South Dakota's substance use prevention services are provided by 22 providers, four of which are designated as Prevention Resource Centers (PRCs). Prevention service participation is a non-competitive process. Prevention service providers and provider selection processes differ between South Dakota and the three states interviewed. North Dakota and Utah partner with County and Tribal entities to provide prevention services. Participation is non-competitive. Colorado, however, conducts a competitive Request for Proposal (RFP) process to select prevention service providers. Local community prevention programs and prevention coalitions are required to submit proposals to the State. Prevention service provider contracts vary from state to state ranging from one year in South Dakota and Utah to five years in Colorado. We summarize additional details in **Table 5** below.

Table 5: Department Priorities and Prevention Service Providers by State

Priorities and Prevention Service Providers	Colorado	North Dakota	Utah
Department Priorities	Youth, young adults, underage use; Caregivers, families	Underage drinking; Adult binge drinking	Younger demographics / children and adolescents
Prevention Service Providers	Prevention programs and local coalitions	County Public Health Units and Tribes	County / region departments that align with the Medicaid regions
Provider Selection	Competitive RFP	Non-competitive purchase of service agreement	Non-competitive grant
Length of Agreement	5-year contract	3-year contract	Annual grant

SUPTRS Block Grant Administration

South Dakota, Colorado, North Dakota, and Utah also have different approaches to administering the SUPTRS Block Grant and the funds available through their prevention programs. SAMHSA requires states to reserve at least 20 percent of the SUPTRS Block Grant funding for prevention services. South Dakota reserves 20 percent of their grant for prevention services. Colorado also reserves the minimum amount (i.e., 20 percent) of the Block Grant funds for prevention services. North Dakota and Utah go beyond the 20 percent minimum, reserving 25 percent and 28 to 30 percent of their Block Grant funds respectively for prevention services.

South Dakota leverages a provider-led model to reimburse providers for prevention services. At the beginning of each contract year, DSS requests PRCs and other providers to submit a proposed budget to implement prevention services. As providers complete activities, they submit invoices to DSS for reimbursement. DSS does not set a limit for the amount of funding available to Prevention Resource Centers or other providers in a given contract year.

To determine the amount of funding available to each prevention service provider, Colorado and Noth Dakota set an upper limit for funding based on program type. In both states, providers must outline the services they intend to offer, and the associated budget required to provide the services (up to the state-determined maximum) at the beginning of each contract period. In North Dakota, there is a higher maximum budget for Tribal partners than for County Public Health Units due to the high level of need among the Tribal community.

Utah uses a formula to calculate the funding available to each county partner based on population size, population under the age of 18, and rurality. Program funding remains consistent during the contact period for all three states.

Neither South Dakota nor Utah specifically prioritize any of the CSAP strategies. The two most common strategies deployed by providers in South Dakota are Information Dissemination and Community-Based Processes. Utah indicated that provider capacity influences which of the strategies are implemented by service providers. Utah's urban counties, with more staff and more available funding, are more often

able to deploy all six strategies, whereas Utah's rural counties, typically with fewer staff, rely more heavily on Community-Based Processes and Education. Both Colorado and North Dakota prioritize policy-focused Environmental CSAP strategies as they indicated the strategy provides the greatest long-term impact. Colorado also noted that the Environmental and Education strategies are unique in that they can be deployed independently of the other strategies. **Table 6** below offers additional detail about how the block grant is administrated in each state.

Table 6: SUPTRS Block Grant Administration by State

Categories	Colorado	North Dakota	Utah
% of Block Grant for Prevention Services	20%	25%	28 – 30%

Funding per Provider

Colorado

- Evidence-based Programs: up to $200k/yr
- Priority Populations: up to $175k/yr
- Funding consistent during 5-year contacting period

North Dakota

- Public Health Units: up to $62,500/yr
- Tribes: up to $80,000/yr
- Providers receive $10k to conduct needs assessment and $10k to evaluate the program
- Funding consistent during 3-year contracting period

Utah

- Funding amount is determined based on a population-based formula. The formula considers the under 18 population and includes a rural county differential.
- Funding adjusted annually as required by the State Legislature.

CSAP Strategy Prioritization

Colorado

- Environmental and Education strategies
- The state noted that these strategies can be implemented alone and maximize the available dollars.

North Dakota

- Environmental strategies (i.e., policy-focused activities)

Utah

- Urban counties have the capacity to focus on all six strategies.
- Rural counties focus on community-based processes and education strategies.

G. Rate Methodologies and Components

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 consider the numerous cost components that need to be considered when building a rate. The foundation of the independent rate build-up is staff 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.

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

Guidehouse calculated the values for each component of the rate models and built rates from the bottom up for each of the services included in the rate study. Guidehouse determined each cost component associated with the direct services needed for a CSAP strategy (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. This rate build-up approach is based on a core set of wage assumptions for prevention staff, supplemented by estimates of the cost of other supporting staff, activities and materials needed to support service 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
- Inflation
- Employment Related Expenses (ERE)
- Productivity of Prevention Staff
- Administrative Expenses
- Program Support Expenses

Using these cost components, findings did not demonstrate a need to differentiate staff across the six included strategies. Based on survey results and stakeholder feedback, Guidehouse developed one rate for all six strategies. This section also shows the benchmark rates that result from these cost components and rate buildup.

G.1. General Cost Assumptions

The methodology for developing a rate for a unit of service generally includes certain key components. A rate model starts with the wage for the primary staff providing 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:

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

Together, we add these components together to result in 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. **Table 7** illustrates the "building block" structure of Guidehouse's rate development methodology. The rate model identifies 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.

Table 7. Rate Components of the Service Rate Per Unit

Cost Type	Rate Component	Description
Direct Care Cost	**Direct Care Staff**	• Wages • Benefits • Hours/Days/Weeks of Service • Productivity Factor
Direct Care Cost	**Supervision Staff**	• Wages • Benefits • Hours/Days/Weeks of Service
Indirect Cost	**Administrative**	Includes costs associated with operating a provider organization, such as: • Costs for administrative employees' salaries and wages • Non-payroll administration expenses, such as licenses, property taxes, liability, and other insurance.
Indirect Cost	**Program Support**	Includes personnel and non-personnel supplies, equipment, and utilities costs associated with service delivery.

G.1.1. Staff Wages

Wages for prevention staff form the largest component of any rate model, as the CSAP strategies depend substantially on the labor time of the qualified, dedicated staff who provide these services. To best understand the landscape of wages in South Dakota, we used data from the cost and wage survey reported by provider organizations as well as data from the Bureau of Labor Statistics (BLS).

As part of the cost and wage survey, each responding provider reported average hourly or "baseline" wages in addition to overtime and other forms of supplemental pay, as well as inflationary trends in wages and other wage or salary-related information. The staff types with the highest number of Full-Time Equivalents (FTE) reported in the survey were for Prevention Specialists, with providers reporting 25 Certified and Non-Credentialed Prevention Specialists. Other commonly reported job types included Addiction Counselors (14 FTEs) and Counselor/Therapist (11 FTEs). These staff types often serve as the foundation of prevention services, as evidenced by the number of positions reflected in the survey responses.

The baseline wages represented in **Table 8** do not include inflationary factors or supplemental pay and are representative of the time period requested within the survey, June 2024 through May 2025.

Table 8: Average Hourly Wage Reported in Cost and Wage Survey, Weighted by FTEs

Staff Type List	Survey Average FTE Weighted Hourly Wage	FTEs
Non-Credentialed Prevention Specialist	$21.80	16.00
Addiction Counselor	$18.39	14.00
Counselor/Therapist	$29.38	11.00
Certified Prevention Specialist	$24.61	9.00
Program Manager/Director	$41.29	7.00
Admin/Program Assistant	$19.29	2.00

For all prevention staff types, Guidehouse followed the practice of weighting reported wages by the number of FTEs, then comparing that wage to benchmark wages reported by the BLS OEWS specific to South Dakota as well as national numbers for 2024, inflated to match the survey time period. For example, a Certified Prevention Specialist in the cost and wage survey mapped to a Health Education Specialist BLS job classification while an Addiction Counselor mapped to a Substance Abuse, Behavioral Disorder, and Mental Health Counselors BLS job classification. This served to act as a comparison point to review the representativeness of the wages reported through the survey compared to general market. We recognize that the job types available in BLS may not exactly match the job types and titles that South Dakota providers use. As discussed in **Section D**, we worked with the Stakeholder Workgroup to validate the comparisons between survey job types and BLS job types that we felt most closely mirrored their organizations. **Table 9** shows the comparison of BLS wages to those reported in the survey.

FTE weighted wages calculated from the provider cost and wage survey indicated that staff wages are trending below the South Dakota mean reported in BLS. **Table 9** illustrates the comparison between the survey reported wages, South Dakota BLS Mean, South Dakota 75th percentile and the National 75th percentile wages. As seen in the table, South Dakota specific survey and BLS reported wages were substantially lower than the 75th percentile National BLS wages. As part of conversations with DSS, the decision was made to rely on the 75th percentile National BLS OEWS data to align with behavioral health treatment rates that were set in the last three years. The finalized assumption is highlighted in the blue box in **Table 9**.

Table 9: Bureau of Labor Statistics South Dakota and National Comparison

Survey Staff Type List	BLS Job Type	FTEs	Survey Average FTE Weighted Hourly Wage	South Dakota Mean Hourly Wage BLS[15]	South Dakota 75th Percentile Hourly Wage BLS[16]	National 75th Percentile Hourly Wage BLS[17]	South Dakota Survey vs. National 75th BLS Percent Difference
Non-Credentialed Prevention Specialist	Community Health Workers	16.00	$21.80	$24.93	$25.93	$30.46	40%
Addiction Counselor	Substance Abuse, Behavioral Disorder, and Mental Health Counselors	14.00	$18.39	$26.98	$28.83	$36.77	100%
Counselor/Therapist	Substance Abuse, Behavioral Disorder, and Mental Health Counselors	11.00	$29.38	$26.98	$28.83	$36.77	25%
Certified Prevention Specialist	Health Education Specialist	9.00	$24.61	$28.79	$29.32	$40.74	66%
Program Manager/Director	Business Operations Specialist	7.00	$41.29	$37.48	$43.46	$52.23	26%
Admin/Program Assistant	Social and Human Service Assistants	2.00	$19.29	$18.22	$20.63	$25.59	33%

As demonstrated by the FTE count, the majority of providers staff Prevention Specialists for prevention services. Although certification is not required for staff to offer the service, providers noted in the Stakeholder Workgroup sessions that they often aim to hire Certified Prevention Specialists or support non-credentialed staff to obtain their certification. Therefore, Guidehouse relied on the Certified Prevention Specialist job type as the main job type with associated wages used as the basis of the rate model.

G.1.2. Inflationary Increases in Wages

We also consulted federal data 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 includes:

- **BLS Producer Price Index (PPI).** The BLS publishes a PPI for Medicaid populations including psychiatric and substance abuse hospitals which are specific to the populations and services in scope for this study. The most recent PPI data from Calendar Year (CY) December 2020 – December 2024 produces an annual growth rate of 4.92 percent.

[15] Inflated by 0.34% per the Consumer Price Index for All Urban Consumers (CPI-U) to match the survey time period
[16] Inflated by 0.34% per the Consumer Price Index for All Urban Consumers (CPI-U) to match the survey time period
[17] Inflated by 0.34% per the Consumer Price Index for All Urban Consumers (CPI-U) to match the survey time period

- **BLS Current Employment Statistics (CES).** The BLS also publishes CES data which looks at earnings rather than costs. Across relevant employee categories (e.g., Outpatient Mental Health and Substance Abuse Centers and Health care and Social Assistance), CY2020 to CY2024 trends show an annual growth rate in earnings of 4.64 percent.
- **BLS Consumer Price Index (CPI).** The BLS also publishes CPI data which looks at the average change over time in prices paid by urban consumers for a market basket of consumer goods and services. The most recent CPI data from Calendar Year (CY) December 2020 – December 2024 produces an annual growth rate of 4.22 percent.

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

Source	Time Period	Average Annual Growth Rate
Bureau of Labor Statistics (BLS) Producer Price Index (PPI) for Psychiatric and Substance Abuse Hospitals	Dec 2020 – Dec 2024	4.92%
Bureau of Labor Statistics (BLS) Current Employment Statistics (CES) Average for Outpatient Mental Health and Substance Abuse Centers, and Health care and Social Assistance	Dec 2020 – Dec 2024	4.64%
Bureau of Labor Statistics (BLS) Consumer Price Index (CPI)	Dec 2020 – Dec 2024	4.22%

Guidehouse used these inflation factors for informational and comparison purposes but did not apply inflation to final rates at this time.

G.1.3. Employee-Related Expenses

Total compensation includes wages as well as employment-related expenses (ERE) – for example, Certified Prevention Specialists earn not only their wages over the course of the year, but also receive benefits such as days off, health insurance, and employer retirement contributions. 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 a 1.20 percent employer rate. Generally, if an employer pays wages subject to the unemployment tax, the employer may receive a credit of up to 5.4 percent of FUTA taxable wages, yielding an effective FUTA of 0.60 percent. Employers pay a combined 7.65 percent rate of the first $176,100 in wages for Social Security and Medicare contributions as part of Federal Insurance Contributions Act (FICA) contributions.

- **Paid time off (PTO) components of ERE** include holidays, sick days, vacation days, and personal days. The average aggregate number of paid days off per year, per the cost and wage survey, was 32 days annually. 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 actually 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, Guidehouse analyzed paid time off components 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.

We compared benefits information reported in the survey 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. During this comparison we found the average monthly premium reported in the State of South Dakota was $843.37 after applying an inflation factor. This came in slightly higher than the average of $720.44 reported in the survey. Guidehouse ultimately decided to use the survey information over the MEPS data. The provider survey data was a better source for health insurance costs than the Medical Expenditure Panel Survey (MEPS) for SUD prevention services in South Dakota because the provider survey captured current, localized cost data directly from prevention services providers operating in South Dakota, offering a more accurate and relevant reflection of actual insurance reimbursement rates and service delivery costs within the state's unique context. However, reported information in the survey was largely in line with costs identified in the MEPS data, corroborating the accuracy of the benefits data submitted by providers and confirming the applicability of the MEPS data as an appropriate benchmark for identifying health insurance costs. This assumption is in line with our other assumptions of vision insurance, dental insurance, and other benefits which come from information reported through the cost and wage survey.

Table 11 lists the components of ERE and calculates an example ERE percentage for a Certified Prevention Specialist using the provider reported wage.

Table 11: Components of ERE for a Certified Prevention Specialist

Component	Value	Calculation
Annual Wage	$51,180 ($24.61 x 2080 hours)	$51,180 ($24.61 x 2080 hours)
FUTA	0.60% of up to $7,000	$42 (0.08%)
SUTA	1.20% of up to $49,700	$96 (0.19%)
FICA	7.65% of up to $168,600	$3,915 (7.65%)
Workers' Compensation	2.50%	$1,280 (2.50%)
Legally Required Benefits	**-**	**$5,333 (10.42%)**
Daily Wage	$24.61x 8 hours	$196.88
Part-Time Adjustment Factor	79.01%	79.01%
Paid Time Off	32 days	32 days
Paid Time Off	**$196.88 x 79.01% x 32 days**	**$4,915 (9.60%)**
Insurance Take-up Rate	Dental 76.34%, Vision 67.13%, Health 85.44%, Other 42.41%, Retirement 86.29%	Dental 76.34%, Vision 67.13%, Health 85.44%, Other 42.41%, Retirement 86.29%
Retirement	86.29%	$1,221 (2.39%)
Health Ins.	$720/mo.	$5,836 (11.40%)
Dental Ins.	$554/mo.	$334 (0.65%)
Vision Ins.	$195/mo.	$103 (0.20%)
Other Benefits	$1/mo.	$0 (0%)
Total ERE per Certified Prevention Specialist	**Legally Required Benefits + Paid Time Off + Other Benefits**	**$17,742 (34.67% of Annual Wage Assumption)**

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, we developed individual ERE percentages based on job type.

As an example of how the ERE percentage decreases with a higher wage within **Table 12** we display the numbers for Program Manager/Director.

Table 12: Examples of Employee-Related Expenses Across Job Types

Metric	Certified Prevention Specialist	Program Manager/Director
Hourly Wage	$24.61	$41.29
Annual Wage	$51,180	$85,882
Legally Required Benefits	$5,333 (10.42%)	$8,555 (10.31%)
Paid Time Off Benefits	$4,915 (9.60%)	$8.247 (9.60%)
Retirement Plan	$1,221 (2.39%)	$2,049 (2.39%)
Health Insurance	$5,836 (11.40%)	$5,836 (6.80%)
Dental Insurance	$334 (0.65%)	$334 (0.39%)
Vision Insurance	$103 (0.20%)	$103 (0.12%)
Other Benefits	$0 (0%)	$0 (0.00%)
Total ERE per Staff	**$17,742 (35%)**	**$25,425 (30%)**
Hourly Wage with ERE	**$33.14**	**$53.51**

G.1.4. Prevention Staff Productivity

While prevention 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. Non-billable time includes time spent traveling to deliver services, maintaining records, or billing activities. The productivity factors upwardly adjust compensation (wages and ERE) to cover the full workday.

Consider a simple example to illustrate this process:

> A prevention 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 agency would only be able to bill DSS 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 in this example. This means the productivity adjustment needs to be 2.0.

While this is an exaggerated example, it demonstrates the importance of including a productivity factor to fully reimburse providers for the time spent.

Provider organizations reported the average number of billable hours (out of an assumed 8-hour workday) through the cost and wage survey, which then translated into a productivity factor for staff

delivering each service. In discussion with the Stakeholder workgroup, some providers noted lost time associated with traveling to conduct prevention services across the State. To account for this, Guidehouse assumed that 3.5 hours per week would be spent on non-billable time, or 36.5 hours out of a typical 40 hour week would be able to be billed. This translates to a 91.25% productivity percentage or a 1.10 adjustment factor. This productivity adjustment factor may be a lower value than providers who offer treatment services have seen used in other rate studies because the prevention service definitions already allow providers to bill for indirect time as part of the CSAP strategy reimbursement, which is different than reimbursement for traditional Medicaid services.

G.1.5. 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 cost percentage, Guidehouse relied on the service definition that allow for up to 5.0% administrative expenses to be billed on top of direct services.

Direct services costs include the salaries, wages, taxes, and benefits for prevention employees. Our recommended rate models incorporate the ratio of 5.0%, which adds a dollar amount to a unit rate by multiplying the rate components of productivity-adjusted prevention staff and supervisor compensation by the average administrative percentage. Adding administrative costs directly into the rates may help reduce administrative burden for providers and DSS as the administrative billing would no longer be a separate calculation and could allow for a streamlined invoicing process.

G.1.6. Program Support Expenses

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

- **Program Support Wages and Direct Services-Related Costs**: Employees and contracted employees who perform program support activities earn salaries and benefits, which count toward direct services-related expenses in the calculation of total program support costs.
- **Building and Equipment**: When services are delivered in a facility, certain costs for the direct services facility may be included such as utilities and telecommunications; building maintenance and repairs; facility janitorial, landscaping, and other costs not part of rent; and non-administrative equipment costs and depreciation.

As part of currently structured services, providers are able to bill separately for certain indirect services, such as staff time for indirect activities such as conference attendance or training, meals, and mileage. Guidehouse recommends that all staff time, including indirect time, be incorporated into the direct rate, while still allowing providers to bill separately for at-cost items, including meals and mileage. To do this, Guidehouse incorporated all support staff wages into the program support percentages, but kept transportation, food, and supply costs separate from the calculations.

The program support percentage is calculated based on cost data reported in the SUD Prevention Services column within the 2024 cost reports provided by DSS. To do this, we calculated an average of provider-specific program support percentage based on their reported costs.
Program Support percentages are calculated using the total reported indirect costs (Support Staff, Occupancy, Utilities, Equipment, Depreciation, and Building costs) plus allocated taxes and facility/rent/mortgage costs, all of which is divided by the direct services costs. To account for outliers, Guidehouse removed any providers with 0% program support reported through the cost reports. We then excluded any providers who fell outside of one standard deviation from the mean. We also excluded providers who did not report any support staff costs. Program support costs reported by providers were calculated in relation to direct services costs reported in the provider survey. Guidehouse calculated an average ratio of **7.0 percent**. As described in **Section H**, with this methodology change providers will be reimbursed for indirect costs above their current reimbursement levels.

G.2. Benchmark Rates

Utilizing the independent model approach Guidehouse developed proposed benchmark rates. The proposed benchmark rates can be found in **Table 13** below.

Table 13: SUD Prevention Services Benchmark Rates

CSAP Strategy	Procedure Code	Current Rate	Proposed Benchmark Rate	Percent Change
Information Dissemination	H0024	$12.75	$17.23	35%
Education	H0025	$12.75	$17.23	35%
Community-Based	H0026	$13.75	$17.23	25%
Environmental	H0027	$12.00	$17.23	44%
Problem Identification and Referral	H0028	$15.00	$17.23	15%
Alternatives	H0029	$12.00	$17.23	44%

H. Fiscal Impact Estimates

The fiscal impact analysis aims to use historical utilization to project prospective costs for the overall SUD prevention services. The fiscal impact scenario assumes consistent utilization from the prior year, based on the information that was available at the time of the rate evaluation. However, it is important to note that if there are substantial shifts in utilization due to rates adjusting or additional providers entering the system these numbers may change.

H.1. Utilizing State Contract Year 2025 Claims Data

One of the foundational elements of our fiscal analysis is the use of claims utilization data from Contract Year (CY) 2025 as this was the most recent full year available at the time of the rate evaluation. By leveraging this data, we can project future costs under the new benchmark rates. This historical claims data provides insights into patterns of service use and expenditure, allowing us to forecast future financial impacts in a structured and evidence-based manner. It is important to note that substantial changes in utilization due to things like provider capacity, access changes and policy decisions will not be reflected in the underlying data.

H.2. Other Projected Assumptions

Inflation metrics and grant funding levels are subject to change over time and may differ from the baseline assumptions used in this analysis. Depending on the timing of implementation, rates may require inflationary adjustments to reflect contract-year conditions. Similarly, shifts in grant funding may influence the final fiscal impact experienced by the state and providers. The proposed benchmark rates result in positive changes at the individual service level for all services.

The fiscal impact estimates reflect all funding needed to support Benchmark rate recommendations. As described in **Section A,** prevention services are grant funded using SAMHSA grant dollars. Any additional funds needed beyond the available grant funding would need to be legislatively appropriated and would not be eligible for a Federal Medical Assistance Percentage.

H.3. Fiscal Impact Summary

As described in **Section B,** in CY 2025, Education accounted for the largest share of utilization at 40 percent, followed by Community-Based Processes, Problem Identification and Referral and Information Dissemination. The remaining utilization is for Alternatives and Environmental, which together make up around 9 percent of the total utilization. This distribution reflects the relative scale and utilization of these programs.

Table 14 below compares CY2025 and CY2026 benchmark expenditures and shows a projected fiscal impact of approximately **$533 thousand**. Administrative costs have historically been paid outside of the CSAP service strategy rate, but with the updated methodology the expenditures are accounted for within the CSAP service strategy rate. Therefore, Table 14 shows no projections for in the administrative line, but in total there is an overall increase to the expenditures.

Table 14: Summary of Fiscal Impact by CSAP Strategy

CSAP Strategy	Contract Year 2025 Units	Contract Year 2025 Paid Amount	Projected Expenditures Using Benchmark Rates*	Fiscal Impact	Percent Difference between Current and Projected Expenditures
Information Dissemination	24,015	$306,446	$413,778	$107,587	35%
Education	63,035	$806,282	$1,086,090	$282,396	35%
Community- Based Processes	32,330	$444,536	$557,044	$112,508	25%
Environmental	1,250	$14,808	$21,538	$6,538	44%
Problem – Identification and Referral	25,029	$375,435	$431,250	$55,815	15%
Alternatives	12,000	$144,000	$206,760	$62,760	44%
Administrative Costs	-	$94,242	-	$(94,242)	-100%
Total	**157,659**	**$2,185,749**	$2,716,459	$533,361	24%

The updated methodology aims to reduce the number of services that are billed outside of the CSAP service strategy rate to reduce administrative lift. However, DSS also understands that for certain services such as Travel and Meals there is a large difference in the expenditures depending on provider and therefore have kept those service codes separate. **Table 15** below demonstrates Contract Year 25 had $127 thousand billed in Ancillary and Resource Development services, inclusive of staff time as well as supplies and meals. Our model covers $170 thousand of ancillary reimbursement, which includes some aspects of services currently billed under Ancillary and Resource Development (such as professional development time for training or conferences) but excludes meals and supplies. Therefore, the benchmark rates build in substantial additional dollars for indirect costs that historically have been billed outside of the CSAP strategy service rate. The intention is to reduce the administrative lift for DSS and the providers as it reduces the number of services that must be billed and reported to DSS.

Table 15: Comparison of Direct and Indirect Reimbursement

Expenditures	Current South Dakota Payment Based on Current Rates	Estimated Reimbursement Based on Benchmark Rates	Difference ($)	Difference (%)
Total Direct Calculated Expenditures	$2,088,856	$2,425,369	$336,513	16%
Total Expenditures: ADMIN	$94,242	$121,287	$27,045	29%
Total Expenditures: RESD + ANCL	$126,693	$169,802[18]	$43,109	34%
Total Expenditures: EVAL	$39,726	$39,726	-	-
Total Expenditures: TRVL	$122,279	$39,726	-	-
Total Estimated Expenditures	**$2,471,796**	**$2,794,334**	$322,538	**13%**

The proposed benchmark rates outlined within this report are based on agreed upon inputs between DSS and Guidehouse. The proposed rates are based on provider reported costs complemented by public information. However, the rates are dependent on the state's available funds through grants and the state general fund and are therefore not a guarantee.

[18] The estimated ancillary costs may be lower than actual costs, given that there will be additional expenditures associated with meals, supplies, and travel that will continue to be billed separately and at cost.

Appendix A: Prevention Services Rate Model

Table 16. Prevention Services Rate Model

Category	Input	Input Description	Source / Formula	Rate Model without Inflation: Information Dissemination (Service Code H0024)	Rate Model without Inflation: Education (Service Code H0025)	Rate Model without Inflation: Community Based (Service Code H0026)	Rate Model without Inflation: Environmental (Service Code H0027)	Rate Model without Inflation: Problem Identification and Referral (Service Code H0028)	Rate Model without Inflation: Alternatives (Service Code H0029)	Notes
Wages	a	Hourly Wage	Provider Survey	$40.74	$40.74	$40.74	$40.74	$40.74	$40.74	n/a
Wages	b	Annual Wage	a * 2080	$84,739.20	$84,739.20	$84,739.20	$84,739.20	$84,739.20	$84,739.20	n/a
Wages	c	ERE (% of Wages)	Provider Survey	35.00%	35.00%	35.00%	35.00%	35.00%	35.00%	n/a
Wages	d	Hourly Compensation *(Wages + ERE)*	a * (1 + c)	$55.00	$55.00	$55.00	$55.00	$55.00	$55.00	n/a
Wages	e	Annual Compensation *(Wages + ERE)*	b * (1 + c)	$114,397.92	$114,397.92	$114,397.92	$114,397.92	$114,397.92	$114,397.92	n/a
Productivity	f	Total Hours	Standard Week	40.00	40.00	40.00	40.00	40.00	40.00	n/a
Productivity	g	Productivity Percentage	Provider Survey	91.25%	91.25%	91.25%	91.25%	91.25%	91.25%	3.5 hours of travel time
Productivity	h	Productivity Adjustment	1 / g	1.10	1.10	1.10	1.10	1.10	1.10	n/a
Productivity	i	Billable Hours	f * g	36.50	36.50	36.50	36.50	36.50	36.50	n/a
Productivity	j	Hourly Comp. after Adjust.	d * h	$60.27	$60.27	$60.27	$60.27	$60.27	$60.27	n/a
Productivity	k	Annual Comp. after Adjust.	e * h	$125,367.58	$125,367.58	$125,367.58	$125,367.58	$125,367.58	$125,367.58	n/a
Supervision	l	Supervisor Hourly Wage	Provider Survey	$52.23	$52.23	$52.23	$52.23	$52.23	$52.23	n/a
Supervision	m	Annual Supervisor Wage	l * 2080	$108,638.40	$108,638.40	$108,638.40	$108,638.40	$108,638.40	$108,638.40	n/a
Supervision	n	Supervisor ERE	Provider Survey	30.00%	30.00%	30.00%	30.00%	30.00%	30.00%	n/a
Supervision	o	Hourly Supervisor Compensation	l * (1 + n)	$67.90	$67.90	$67.90	$67.90	$67.90	$67.90	n/a
Supervision	p	Annual Supervisor Compensation	m * (1 + n)	$141,229.92	$141,229.92	$141,229.92	$141,229.92	$141,229.92	$141,229.92	n/a
Supervision	q	Supervision Hours per Week	Provider Survey	1.88	1.88	1.88	1.88	1.88	1.88	Uses mean per stakeholder feedback
Supervision	r	Supervisor Span of Control	Provider Survey	2.51	2.51	2.51	2.51	2.51	2.51	Uses mean per stakeholder feedback
Supervision	s	Supervision Hours per Staff per Hour	q / r / 40	0.02	0.02	0.02	0.02	0.02	0.02	n/a
Supervision	t	Supervision Cost per Staff per Hour	o * s	$1.27	$1.27	$1.27	$1.27	$1.27	$1.27	n/a
Supervision	u	Hourly Total Compensation	j + t	$61.54	$61.54	$61.54	$61.54	$61.54	$61.54	n/a
Supervision	v	Annual Total Compensation	u * 2080	$128,012.13	$128,012.13	$128,012.13	$128,012.13	$128,012.13	$128,012.13	n/a
Staffing	w	Number of Clients per Staff	Provider Survey	1.00	1.00	1.00	1.00	1.00	1.00	n/a

Category	Input	Input Description	Source / Formula	Rate Model without Inflation: Information Dissemination (Service Code H0024)	Rate Model without Inflation: Education (Service Code H0025)	Rate Model without Inflation: Community Based (Service Code H0026)	Rate Model without Inflation: Environmental (Service Code H0027)	Rate Model without Inflation: Problem Identification and Referral (Service Code H0028)	Rate Model without Inflation: Alternatives (Service Code H0029)	Notes
Staffing	x	Hourly Compensation per Staff per Client	u / w	$61.54	$61.54	$61.54	$61.54	$61.54	$61.54	n/a
Staffing	y	Annual Compensation per Staff per Client	v / w	$128,012.13	$128,012.13	$128,012.13	$128,012.13	$128,012.13	$128,012.13	n/a
Admin and Program	z	Administrative Overhead Percent	Cost Report	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	n/a
Admin and Program	aa	Administrative Overhead Hourly Factor	x * z	$3.08	$3.08	$3.08	$3.08	$3.08	$3.08	n/a
Admin and Program	ab	Administrative Overhead Annual Factor	y * z	$6,400.61	$6,400.61	$6,400.61	$6,400.61	$6,400.61	$6,400.61	n/a
Admin and Program	ac	Program Support - Total	Cost Report	7.00%	7.00%	7.00%	7.00%	7.00%	7.00%	n/a
Admin and Program	ad	Program Support Hourly Factor	x * ac	$4.31	$4.31	$4.31	$4.31	$4.31	$4.31	n/a
Admin and Program	ae	Program Support Annual Factor	y * ac	$8,960.85	$8,960.85	$8,960.85	$8,960.85	$8,960.85	$8,960.85	n/a
Transportation	af	Number of Miles	Service Description	-	-	-	-	-	-	Zero miles as mileage will continue to be billed separately
Transportation	ag	IRS Mileage Rate	2025/2026 IRS Mileage Rate	$0.70	$0.70	$0.70	$0.70	$0.70	$0.70	Confirmed high mileage rate
Transportation	ah	Hour Transportation Factor	af*ag	-	-	-	-	-	-	n/a
Rate	ai	**Proposed Benchmark Rate**	(x + aa + ad + ah) / 4	$17.23	$17.23	$17.23	$17.23	$17.23	$17.23	n/a
Rate	aj	**Proposed Benchmark Rate with Percentage of Benchmark**	ai * Percentage of Benchmark	$17.23	$17.23	$17.23	$17.23	$17.23	$17.23	n/a
Difference	ak	Current Rate	Service Description	$12.75	$12.75	$13.75	$12.00	$15.00	$12.00	n/a
Difference	al	Current Rate Unit	Service Description	15 minutes	15 minutes	15 minutes	15 minutes	15 minutes	15 minutes	n/a
Difference	am	**Percent Change**	ai / ak - 1	**35.00%**	**35.00%**	**25.00%**	**44.00%**	**15.00%**	**44.00%**	n/a
Difference	an	**Rate Change**	ai - ak	**$4.48**	**$4.48**	**$3.48**	**$5.23**	**$2.23**	**$5.23**	n/a
Fiscal Impact	ao	CY25 Units	CY25 Utilization Data	24,014.96	63,034.80	32,329.91	1,250.00	25,029.00	12,000.00	n/a
Fiscal Impact	ap	Current Calculated Expenditures	ao * ak	$306,190.68	$803,693.70	$444,536.32	$15,000.00	$375,435.00	$144,000.00	n/a
Fiscal Impact	aq	Projected Benchmark Expenditures	ao * ai	$413,777.68	$1,086,089.60	$557,044.42	$21,537.50	$431,249.67	$206,760.00	n/a
Fiscal Impact	ar	**Percent Change**	aq / ap - 1	**35.00%**	**35.00%**	**25.00%**	**44.00%**	**15.00%**	**44.00%**	n/a
Fiscal Impact	as	**Fiscal Impact**	aq - ap	**$107,587.00**	**$282,395.90**	**$112,508.10**	**$6,537.50**	**$55,814.67**	**$62,760.00**	n/a