Guidehouse

South Dakota Mental Health and Substance Use Disorder Rate Study

Presented to:

State of South Dakota
Department of Social Services

Presented by:

Guidehouse Inc.

1676 International Dr, McLean | VA 22102

January 5, 2024

guidehouse.com

This deliverable was prepared by Guidehouse Inc. for the sole use and benefit of, and pursuant to a client relationship exclusively with the South Dakota Department of Social Services ("Client"). The work presented in this deliverable represents Guidehouse's professional judgement based on the information available at the time this report was prepared. Guidehouse is not responsible for a third party's use of, or reliance upon, the deliverable, nor any decisions based on the report. Readers of the report are advised that they assume all liabilities incurred by them, or third parties, as a result of their reliance on the report, or the data, information, findings, and opinions contained in the report.

Table of Contents

A. Executive Summary 6
B. Introduction and Background 9
C. Stakeholder Engagement 10
D. Service Array and Rate Structure Overview 11
E. Data Sources 13
E.1. Overview of Data Sources 13
E.2. Provider Cost and Wage Survey 13
E.2.1. Survey Design and Development 14
E.2.2. Survey Administration and Support 15
E.2.3. Provider Cost and Wage Survey Participation 15
E.2.4. Provider Cost and Wage Survey Review and Validation 16
E.3. Claims Data 17
E.4. Other Data Sources 18
F. Peer State Comparisons 19
F.1. Peer State Comparison Approach 19
F.2. Peer State Comparison Results 20
G. Rate Methodologies and Components 22
G.1. Rate Build Up Approach 22
G.2. General Cost Assumptions 23
G.3. Staff Wages 24
G.3.1. Inflationary Increases in Wages 27
G.3.2. Supplemental Pay 28
G.3.3. Final Wage Adjustments 29
G.4. Employee-Related Expenses 30
G.5. Billable vs. Non-Billable Time of Direct Care Staff 31
G.6. Supervision 33
G.7. No-Show Adjustment 35
G.8. Transportation 36
G.9. Staffing Ratios 36
G.10. Administrative and Program Support Expenses 38

G.11 Residential and Team-Based Models 40
H. Benchmark Rates and Final Recommendations 47
H.1. Rate Considerations 47
H.2. Final Rate Recommendations 48
I. Fiscal Impact Estimates 52
I.1. Fiscal Impact Overview 52
I.2. Baseline Data and Service Periods 53
I.3. Other Projection Assumptions 53
I.4. Fiscal Impact Across All Services 53

Table of Figures

Figure 1: Overview of Project Initiatives 9
Figure 2: Rate Workgroup Composition and Roles 10
Figure 3: Mental Health Services 11
Figure 4: Substance Use Disorder Services 12
Figure 5: SFY 2023 Mental Health Types of Services Mix 17
Figure 6: SFY 2023 SUD Types of Services Mix 18
Figure 7: Peer States for Rate Comparison 20
Figure 8: Overview of Rate Components 24
Figure 9: Indirect Costs 40

Table of Tables

Table 1: Overall Fiscal Impact - By Funding Source 8
Table 2: Provider Cost and Wage Survey Organization and Data Elements 14
Table 3: Survey Response Rates for all Populations 16
Table 4: Total Medicaid Spend as Representation of Survey Response 16
Table 5: Other Data Sources 19
Table 6: Community-Based Mental Health and Substance Abuse Services Peer State Rate Comparison 21
Table 7: Average Hourly Wage Reported in Cost and Wage Survey, Weighted by FTEs 25
Table 8: BLS Crosswalk for Job Types 26
Table 9: Sources of Growth Rates in Relevant Costs and Wages 28
Table 10: Calculation of Wage Adjustment Factors 30
Table 11: Billable Time by Service 32
Table 12: Supervision by Job Type 34
Table 13: Supervision by Service Type 34
Table 14: Staffing Ratio for Mental Health Services 37
Table 15: Staffing Ratio for Substance Use Disorder Services 37
Table 16 : Rate Families 40

Table 17: Therapy Services within Residential Setting 41
Table 18: Mental Health Team-Based Services 42
Table 19: SUD Inpatient and Residential Services 46
Table 20: Mental Health Rate Recommendations 49
Table 21: Substance Use Disorder Rate Recommendations 50
Table 22: Substance Use Disorder Residential/Inpatient 51
Table 23: Mental Health Team-Based Rate Recommendations 52
Table 24: Fiscal Impact by Funding Source 54
Table 25: Medicaid Substance Use Disorder Services - by Type of Service Impact 54
Table 26: Contracted Substance Use Disorder Services - by Type of Service Impact 55
Table 27: Medicaid Mental Health Services – by Type of Service Impact 56
Table 28: Contracted Mental Health Services – by Type of Service Impact 58
Table 29: Fiscal Impact by Category and Funding Sources 59

A. Executive Summary

Guidehouse contracted with South Dakota Department of Social Services (DSS) to conduct a comprehensive rate study of the State's community Mental Health and Substance Use Disorder services. In this report, Guidehouse presents the results of its 2023 rate study on behalf of South Dakota Social Services (DSS) Division of Behavioral Health. Eighteen mental health services were included: Evaluation/Intake/Screening/Testing, Psychiatric Services, Certified Nurse Practitioner/Physician Assistant Medication Management (CNP/PA), Individual, Group and Family Therapy, Child or Youth and Family Services (CYF), Juvenile Justice Reinvestment Initiative (JJRI) – both Functional Family Therapy and Evidence Based Practices, Functional Family Therapy (FFT), Collateral, Intensive Family Services (IFS).

Fifteen total SUD services were included: Assessments, Local Individual Counseling, Local Group Counseling, Local and Family Home Based Counseling, Criss Intervention, Early Intervention Services, Collateral Contacts/Referral, Interpreter Services, Recovery Support Services, Nursing/Health Services (Group and Individual), Cognitive Behavioral Interventions for Substance Abuse (CBISA) and Adolescent Substance Use Disorder Evidence Based Practices – both individual and group, Moral Reconation Therapy (MRT) – both individual and group, Intensive Day Treatment, Adolescents, and Gambling Day Treatment.

Stakeholder Engagement

Guidehouse conducted a total of five stakeholder engagement sessions for this rate study. The first stakeholder engagement session was largely dedicated to training providers related to the Provider Cost and Wage Survey ("provider survey") used by Guidehouse to collect provider cost data and administered prior to the meeting. Guidehouse discussed the goals and background context of the rate study with stakeholders, keeping an open line of communication with stakeholders throughout the process. Guidehouse conducted stakeholder engagement meetings in an effort to inform, validate, and appropriately adjust the provider cost and service delivery assumptions ultimately used in the development of benchmark rates for the proposed reimbursement rebasing of South Dakota's mental health and substance use disorder services.

Data and Methods

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

- Collect data from the mental health and substance use disorder providers to identify actual costs and wages.
- Seek input on data not available through other sources.
- Receive uniform inputs across all providers to develop standardized rate model components.

- Develop rate model inputs that are reflective of actual service delivery.
- Solicit general feedback from providers to understand service "pain-points" that could be addressed in rate updates.

The objectives of the study were to determine benchmark rates while building transparent rate models based on more current labor assumptions as well as considering publicly available information that could enhance provider reported information.

For each service, multiple data sources and calculations were used to define key cost assumptions such as wages for Individual Therapy and Local Individual Counseling. Cost assumptions for base wages, benefits, and staffing patterns were obtained from the provider survey, and indirect costs including administrative and program support cost factors were based on a combination of survey and public data. Guidehouse researched additional data points such as inflationary metrics and supplemental pay estimates obtained from industry data collected by the federal Bureau of Labor Statistics (BLS).

Rate Model Recommendations

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

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

In collaboration with DSS, Guidehouse created rate models for Mental Health and Substance Use Disorder Services leveraging Advisory Workgroup feedback and data analysis performed using the survey data in combination with public data sources. Guidehouse developed the following overall recommendations with further detail explained within the specific sections in the report:

- Established staffing ratios including multi-disciplinary teams based on American Society of Addiction Medicine (ASAM) SUD levels of care as well as DSS expectations required in the residential models.
- Developed caseload assumptions for the team-based services of Serious Mental Illness (SMI): Individualized Mobile Programs of Assertive Community Treatment (IMPACT), Forensic Assertive Community Treatment (FACT) for Mental Health Court services and Comprehensive Assistance with Recovery and Empowerment (CARE).
- Leveraged national wages at the 75th and 90th percentile.
- Included "no-show" adjustments accounting for high volume of missed client appointments, in addition to standard productivity (billable time) assumptions.

- Maintained current rate differentials for rural and frontier specific rates.
- Promoted rate standardization for cognate services, where appropriate, while recommending rate differentials where service delivery expectations varied significantly among different services.

Fiscal Impact Analysis

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

This analysis indicated that if the proposed benchmark rates were implemented based on utilization from State Fiscal Year (SFY) 2023 the system would require an additional **$6.6 million**—which includes not just State but also federal dollars—to reimburse providers at the benchmark rates recommended by Guidehouse. This dollar increase is a **9.0 percent** increase from the current rates in effect as of July 1, 2023. However, when considering the federal medical assistance percentage (FMAP), the State share would be **$5.2 million**. The State share shows a larger percentage increase due to the inclusion of non-Medicaid, State-contracted services that do not receive FMAP and for which the State is fully responsible for payment.

To facilitate transparent budget planning and prepare for the most significant likely budget scenario, Guidehouse analyzed fiscal impact under an assumption that reduced cost-based rates would be held harmless and maintained at current rate levels. Under the cost-based rate methodology employed by Guidehouse, a handful of rates would see slight reductions if implemented purely on a cost basis. The “Hold Harmless” calculation assumes these rates would be maintained at current levels, resulting in no impact to overall budget. Therefore, the fiscal impact shows only increases or budget neutral impact. These dollar estimates include the funds required for Mental Health and Substance Use Disorder Services when reimbursed at the recommended benchmark. Table 1 reflects the overall fiscal impact for South Dakota based on the proposed benchmark rates and a hold harmless approach.

Table 1: Overall Fiscal Impact - By Funding Source

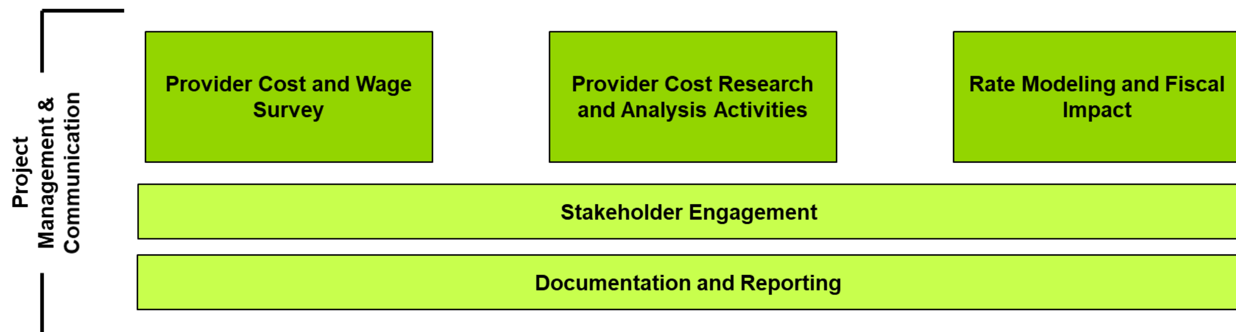
Source	Utilization Paid at SFY 2024 Rates	Utilization Paid at Benchmark Rates	Difference	Change
Federal + State Share	$73,834,509	$80,448,802	$6,614,293	9.0%
State Share	$57,116,198	$62,294,568	$5,178,370	9.1%

B. Introduction and Background

Guidehouse contracted with South Dakota Department of Social Services (DSS) to conduct a comprehensive rate study of the State's community Mental Health and Substance Use Disorder services. As depicted in Figure 1 below, the engagement scope included the following study elements:

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

Figure 1: Overview of Project Initiatives



The study utilized a multitude of data sources, including data collected through a Provider Cost and Wage Survey data, as well as providing avenues for stakeholder feedback to inform reimbursement recommendations more responsive to desired and lasting service delivery changes as well as future planning and budgeting needs. Findings and recommendations from the rate study are compared to existing provider rates to anticipate and analyze the potential implications of implementing Guidehouse's proposed reimbursement benchmarks and rate adjustments.

C. Stakeholder Engagement

To support the development of cost-based rates for community Mental Health and Substance Use Disorder providers, DSS worked with Guidehouse, providers, and other stakeholders throughout the rate development process. DSS convened a rate study Advisory Workgroup that met five times throughout the process to support the rate study. Figure 2 describes the composition of this group, their respective roles, and discussion topics.

Figure 2: Rate Workgroup Composition and Roles

Advisory Workgroup
Composition: • Membership representative of associations and providers directly impacted by rate changes. • Provider representatives who reflect the full range of services included within the rate study scope. • Members have a strong understanding of provider finances, reporting capabilities, and service costs
Role: • Provide subject matter expertise on provider survey and rate methodology development. • Review and validate rate model factors and assumptions, including wages, benefits, administration, program support and staffing. • Provide insight into how current services are delivered. • Provide recommendations for consideration in the Final Report
Discussion Topics: • Provider Survey design, administration, and results • Peer state selection for comparison • Rate build-up approach and rate components • Benchmark wages and adjustments, including supplemental pay and inflation factor. • Staffing levels and supervision ratios • Final rate models, current service utilization landscape, and fiscal impact of proposed rates • Considerations for implementation and future analysis

On top of the focused stakeholder workgroups, a provider survey was deployed to a wider provider community. Guidehouse conducted the first stakeholder meeting to serve as a training session for the wider provider community in filling out the survey. In this meeting, Guidehouse

shared the survey data collection process along with the objective and the methodologies that are used in the rate study.

D. Service Array and Rate Structure Overview

D.1. Historical Structure

Figures 3 and 4 identify the Community Mental Health and Substance Use Disorder services in South Dakota included within the scope of the rate study. Throughout the report, the service arrays are used to set the foundation for setting the rates at the individual service levels. For fiscal impact and budget purposes, these service arrays were further grouped into different service types based on shared programmatic elements or service characteristics. Figure 3 shows the mapping between the individual mental health services and their corresponding "Types of Service."

Figure 3: Mental Health Services

Mental Health Services	
Types of Service	**Service Arrays**
CARE	Serious Mental Illness (SMI) - Comprehensive Assistance with Recovery and Empowerment Services (CARE)
CNP/PA	CNP/PA Med Management Evaluation, Intake, Screening, Testing - CNP/PA
CYF	CYF Group Regular CYF Individual Regular
IMPACT	Serious Mental Illness (SMI) - Individualized and Mobile Program of Assertive Community Treatment (IMPACT)
JJRI	Juvenile Justice Reinvestment Initiative (JJRI) - Assessments Juvenile Justice Reinvestment Initiative (JJRI) - Aggression Replacement Training (ART) Juvenile Justice Reinvestment Initiative (JJRI) - Evidence Based Practices (EBP) Juvenile Justice Reinvestment Initiative (JJRI) - Functional Family Therapy (FFT)
Mental Health Courts	Serious Mental Illness (SMI) - Forensic Assertive Community Treatment (FACT)
Originating Site Fee	Telehealth Originating Site Facility Fee
Outpatient Non-Psych	Collateral Evaluation, Intake, Screening, Testing -Non Psych Evaluation, Intake, Screening, Testing -Non Psych Telemedicine Family Therapy (w/out patient present) Family Therapy (with patient present) Group Therapy (other than a multi-family group)

Mental Health Services	
Types of Service	**Service Arrays**
	Individual Therapy
Psychiatric	Evaluation, Intake, Screening, Testing - Psychiatrist Psychiatric Services

Figure 4 shows the mapping between the individual substance use disorder services and their corresponding "Types of Service."

Figure 4: Substance Use Disorder Services

Substance Use Disorder Services	
Types of Service	**Service Arrays**
Day	Gambling Day Treatment Intensive Day Treatment
Detox	Detoxification
Gambling Inpatient	Gambling Intensive Residential Treatment
Group	Adolescent Substance Use Disorder (SUD) Evidence Based Practices (EBP) - Group Adolescent SUD EBP-Group Cognitive Behavioral Interventions for Substance Abuse (CBISA) - Group Gambling Local Group Group Nursing/Health Services Intensive Meth Treatment (IMT) - Group Local/Group Counseling Moral Reconation Therapy (MRT) - Group Rural Group Counseling
Individual	Adolescent Substance Use Disorder (SUD) Evidence Based Practices (EBP) Assessments Cognitive Behavioral Interventions for Substance Abuse (CBISA) - Individual Collateral Contacts/Referral Crisis Intervention Early Intervention Services Local Home-Based Counseling Intensive Meth Treatment (IMT) Individual Nursing/Health Services Local Individual Counseling Low Intensity Residential MRT - Telemedicine-Individual Interpreter Services
Inpatient	Intensive Inpatient
Low Intensity	IMT - Low Intensity Residential
Miscellaneous	Recovery Support Services

Substance Use Disorder Services	
Types of Service	**Service Arrays**
Originating site Fee	Originating Site Fee - SUD providers
R&B Inpatient	Room and Board for Intensive Inpatient

E. Data Sources

E.1. Overview of Data Sources

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

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

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

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

E.2. Provider Cost and Wage Survey

Guidehouse prepared a detailed Provider Cost and Wage Survey based on the landscape of mental health and substance use disorder treatment services provided in South Dakota. The aim of the survey was to collect provider cost data across multiple services that would serve as the basis for the rate study. Additionally, Guidehouse aimed to utilize the survey to:

- Capture provider cost data to establish a cost foundation for the rate study.
- Receive uniform inputs across all providers to develop standardized rate model components.

- Measure changes in direct care worker wages over time.
- Determine a cost basis for evaluating rate equity for services.
- Gather needed data to understand billable vs. non-billable time and staffing patterns per service.
- Investigate differences in costs among frontier/rural/urban areas.

E.2.1. Survey Design and Development

Guidehouse designed this survey with input from DSS staff, as well as drawing on knowledge gained from conducting similar surveys in other states. The survey was designed in Microsoft Excel and included thirteen (13) sections or worksheets on topics outlined in Table 2 below. During the Advisory Workgroup meeting in September 2023, Guidehouse provided an overview of the survey including the objectives, topics, and questions on each worksheet within the survey document and solicited feedback from stakeholders. With the aim of collecting annual wage, benefit, and service delivery data from the second quarter of 2023 (April 2023-June 2023), Guidehouse collected information on the survey components highlighted in Table 2.

Table 2: Provider Cost and Wage Survey Organization and Data Elements

Survey Topics	Survey Data Points and Metrics	Example Rate Study Data Point(s)
A – Organizational Information	Provider identification, contact information, and organizational details	-
B – MH Services	Services delivered by which MH staff type	Individual therapy
C – SUD Services	Services delivered by which SUD staff type	Local individual counseling
D – Wages	Job types, staff types, hourly wages, supplemental pay, and training time	Baseline wages for rate build-up, primary job types per service, training assumptions
E – Programs and Services	Services provided by your organization	Individual therapy
F – MH Service Delivery and Staff	Billable vs. non-billable time, supervisor and staffing patterns, staff transportation and case management specific questions where applicable	Productivity adjustment, staffing ratio
G – SUD Service Delivery and Staff	Billable vs. non-billable time, supervisor and staffing patterns, staff transportation and case management specific questions where applicable	Productivity adjustment, staffing ratio

Survey Topics	Survey Data Points and Metrics	Example Rate Study Data Point(s)
H – Day Treatment - Time	Job titles, FTE positions, hours paid, hourly wages, supplemental pay, annual change in wages, paid training time, day treatment services provided	Total number of FTE positions, total overtime wages paid
I – Day Treatment – Patterns	Service characteristics, equipment and supplies, staffing, productivity, supervisor span of control, staffing patterns, staff training, non-medical transportation	How many staff or practitioners are typically served by one staff or practitioner?
J – Residential- Time	Job titles, FTE positions, hours paid, hourly wages, supplemental pay, annual change in wages, paid training time, residential services provided	Total number of FTE positions, total overtime wages paid
K – Residential - Patterns	Home and service characteristics, equipment and supplies, staffing, productivity, supervisor span of control, staffing patterns, staff training, transportation	How many staff or practitioners are typically served by one staff or practitioner?
L – Benefits	Benefits that organizations offer full-time and part-time employees who deliver services – health, vision and dental insurance, retirement, unemployment benefits and workers' compensation, holiday, sick time, and paid time off	Benefits package or Employee Related Expenses (ERE)
M – Additional Information	Clarifying comments in addition to the information covered in other worksheets or sections	-

E.2.2. Survey Administration and Support

The survey was released via meeting invite on September 19, 2023, to the entire provider community delivering services within the scope of the rate study. To conduct a successful and accurate survey, Guidehouse facilitated live provider training webinars available to all providers on September 19, 2023, 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. A link to the recording of the webinar was shared with providers.

Additionally, Guidehouse offered ongoing support and resources in helping providers to complete the survey, through a dedicated electronic e-mail inbox which providers could access to receive answers to their specific questions as well as a live technical assistance webinar held a few weeks prior to the survey deadline. Providers were allowed approximately two weeks to complete the survey, with a final survey deadline of October 6, 2023. Providers requesting extensions were given additional time to complete the survey.

E.2.3. Provider Cost and Wage Survey Participation

Guidehouse deployed the survey on September 19, 2023. A total of twenty-five (25) community mental health and substance use disorder service providers received the survey. Out of twenty-

five total providers, twenty-one providers submitted their survey responses, representing an overall response rate of 84%. Table 3 shows survey response rates for all providers who received surveys and those who responded.

Table 3: Survey Response Rates for all Populations

Total Providers	Provider Survey Submissions	Percent of Providers Responding
25	21	84%

In addition, to the count of providers, expenditures are a reliable metric to represent the financial impact of the provider on the entire SD system rather than the raw count of providers alone. Therefore, Guidehouse also reviewed the response rates by provider expenditure. As highlighted in Table 4, survey respondents represent approximately **93 percent** of SFY 2023 Medicaid claims within the scope of this survey.

Table 4: Total Medicaid Spend as Representation of Survey Response

Total Medicaid Spend (All Providers)	Total Medicaid Spend (Providers who submitted survey response)	Percentage of Medicaid Spend Represented
$28.6 million	$26.6 million	93%

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

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

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

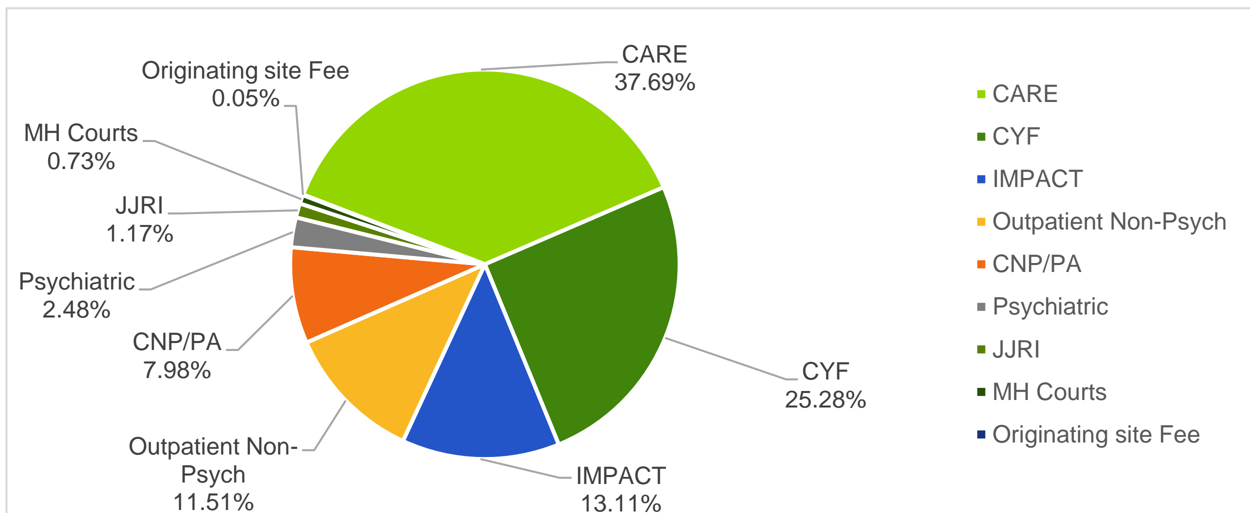
It is important to note provider survey processes are not subject to auditing processes, as an established administrative cost reporting process would be. Providers' self-reported data were not audited for accuracy, although outliers were examined and excluded when warranted, and additional quality control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

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

E.3. Claims Data

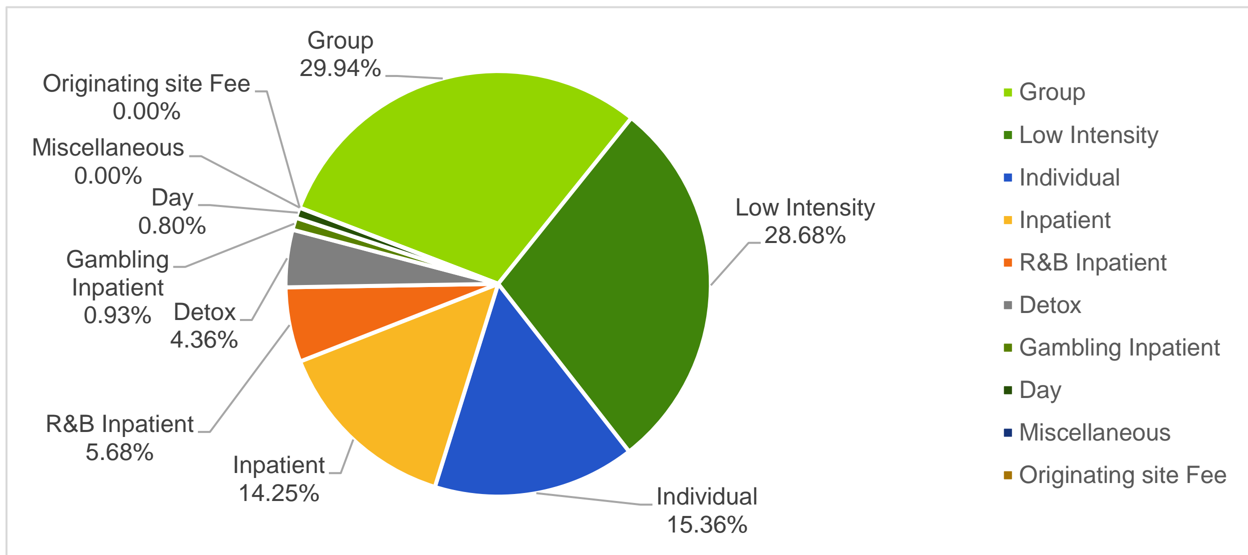
Guidehouse developed a detailed claims data request to be able to analyze community mental health and substance use disorder claims utilization for five (5) State fiscal years (SFY 2019-SFY 2023). There was minimal variation in service utilization across fiscal years for the majority of services, even when accounting for periods heavily influenced by COVID-19. The data request included all detailed claims for services in scope for the rate study. Guidehouse requested key fields such as provider detail, payment information, service identifying fields and units of measure. For clarity, Figures 5 and 6 show expenditures by service type rather than by individual service. The State's budget system also tracks services by type. A small number of service types accounted for **76.1 percent** of mental health expenditures. Figure 5 shows that for mental health services, CARE, IMPACT, and CYF accounted for three quarters of the total spend in SFY 2023.

Figure 5: SFY 2023 Mental Health Types of Services Mix



For Substance Use Disorder Services there are four service categories that account for 88.2 percent of the expenditures in SFY 2023, Figure 6 shows, Group Therapy, Low-Intensity Treatment, Individual Therapy, and Inpatient Therapy accounted for **88.2 percent** of SFY 2023 expenditures.

Figure 6: SFY 2023 SUD Types of Services Mix



Analyzing these trends is an important consideration to determine fiscal impact accurately when the new benchmark rates are applied. Guidehouse used SFY 2023 as the base year since this year represents the most recent experience.

E.4. Other Data Sources

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

While cost surveys are a rich and valuable source of information on provider costs, these tools cannot validate in themselves whether the costs reported are reasonable or adequate in the face of future service delivery challenges. Considering the possibility that historical costs may not be truly representative of the resources required to provide services in the near future or are

not comparable to or competitive with the industry, Guidehouse evaluates cost survey data against external data benchmarks whenever feasible. As a result, the cost assumptions used by Guidehouse frequently draw on national and regional standards, at least for comparison purposes, that reflect wider labor markets as well as median costs typical of broader industries, to benchmark South Dakota reported information from the provider cost and wage survey. Table 5 summarizes the additional public data sets used to inform cost assumptions used in Guidehouse's benchmark rate recommendations.

Table 5: Other Data Sources

Bureau of Labor Statistics, Occupational Employment and Wage Statistics (BLS OEWS)	Federal wage data available annually by state, intra-state regions, and metropolitan statistical areas (MSA). Used for wage geographic and industry wage comparisons and establishing benchmark wage assumptions for most wages.
Bureau of Labor Statistics, Costs for Employee Compensation Survey (CECS)	Federal data on employee benefits cost, analyzing groups of benefit costs including insurance, retirement benefits, paid time off, and other forms of non-salary compensation. Used for reference in establishing benchmark ERE assumptions.
Bureau of Labor Statistics, Consumer Expenditure Survey	Federal data on annual consumer spending. Provides potential cost assumption for food costs per meal.
Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey-Insurance Component (MEPS-IC)	Federal data on health insurance costs, including Illinois-specific data regarding multiple aspects of health insurance (employer offer, employee take-up, premium and deductible levels, etc.) Used for reference in estimating health care costs for benchmark ERE assumptions.
Other State Medicaid Fee Schedules and Reimbursement Methodologies	Data from other states on reimbursement levels for cognate services as well as overall service design. Used for peer state comparison and well as development of best-practice recommendations for improving supported employment service delivery.
Internal Revenue Service	The Internal Revenue Service is the revenue service for the United States federal government, which is responsible for collecting taxes and administering the Internal Revenue Code, the main body of the federal statutory tax law.

F. Peer State Comparisons

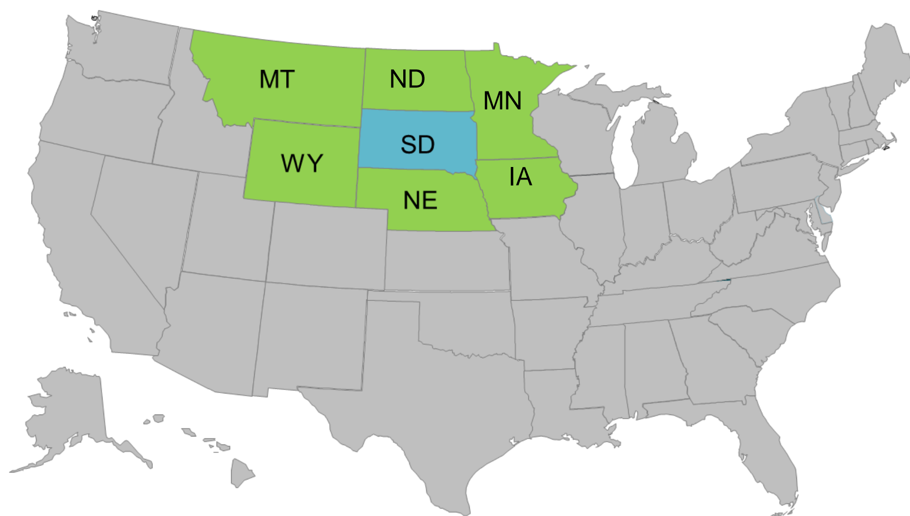
F.1. Peer State Comparison Approach

Guidehouse gathered peer state data sources to further inform rate development by establishing relevant points of comparison with community mental health and substance use disorder services in other states similar to those included in the rate study. Peer state service rates were also to compare and validate Guidehouse's proposed benchmark rates where

applicable. It is helpful to compare reimbursement in South Dakota to other states not only as a basic test of rate adequacy, but also to understand State alignment with standard or best practices, as well as whether current rates represent an outlier or whether differences can be explained by distinctive service definitions or economic conditions in the State.

Guidehouse appreciates that South Dakota is unique among other states geographically, demographically, and culturally. Therefore, we were selective in identifying peer states and the services within the states. We not only identified comparable states but then also reviewed each service definition prior to comparison to help confirm the applicability and adequacy of comparison. These services also do not normally have an equivalent Medicare or commercial benchmark to use as a fair comparison, which in turn makes finding a Medicaid equivalent even more important. Guidehouse ultimately selected six states appropriately similar to South Dakota by demographics, geography, and program design, while offering a comparable array of services to their behavioral health populations. As seen in the map shown in Figure 7, Guidehouse researched the initial peer states marked in light green.

Figure 7: Peer States for Rate Comparison



F.2. Peer State Comparison Results

When reviewing the peer states for comparable services, South Dakota's rates for most services overall appeared to be on the higher end of reimbursement. Since rehabilitative services in Medicaid and other state behavioral health programs are not always standardized but depend on state-specific criteria and program standards, it was sometimes challenging to find rates that permit an apples-to-apples comparison. Ultimately, Guidehouse focused on

standard therapy and assessment codes that follow a national standard and can be trusted to serve as reliable comparison points. Table 6 illustrates the current South Dakota rate with the peer states and their corresponding rates. For three of the services analyzed—Evaluation, Intake, Screening, Testing- Non-Psych, Group Therapy and Family Therapy—South Dakota has the highest reimbursement. The fourth service, Individual Therapy South Dakota has the second highest reimbursement.

Table 6: Community-Based Mental Health and Substance Abuse Services Peer State Rate Comparison

Service	Evaluation, Intake, Screening, Testing - Non-Psych	Individual Therapy/ Psychotherapy	Group Therapy/ Group Psychotherapy	Family Therapy/ Psychotherapy w/o Patient Present
Procedure Code	**90791 per session**	**90832 per 30-min**	**90853 per 45-min**	**90846 per 50 min**
South Dakota	$190.76	$84.78	$65.76	$169.56
Peer State Average	$152.03	$67.19	$34.29	$91.16
Difference	25.5%	26.2%	91.8%	86.0%

G. Rate Methodologies and Components

G.1. Rate Build Up Approach

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

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

  > *"…consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that care and services are available to the general population in the geographic area."*
  >
  > *-1902(a)30(A) of the Social Security Act (SSA)*

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

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

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

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

- Staff Wages

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

G.2. General Cost Assumptions

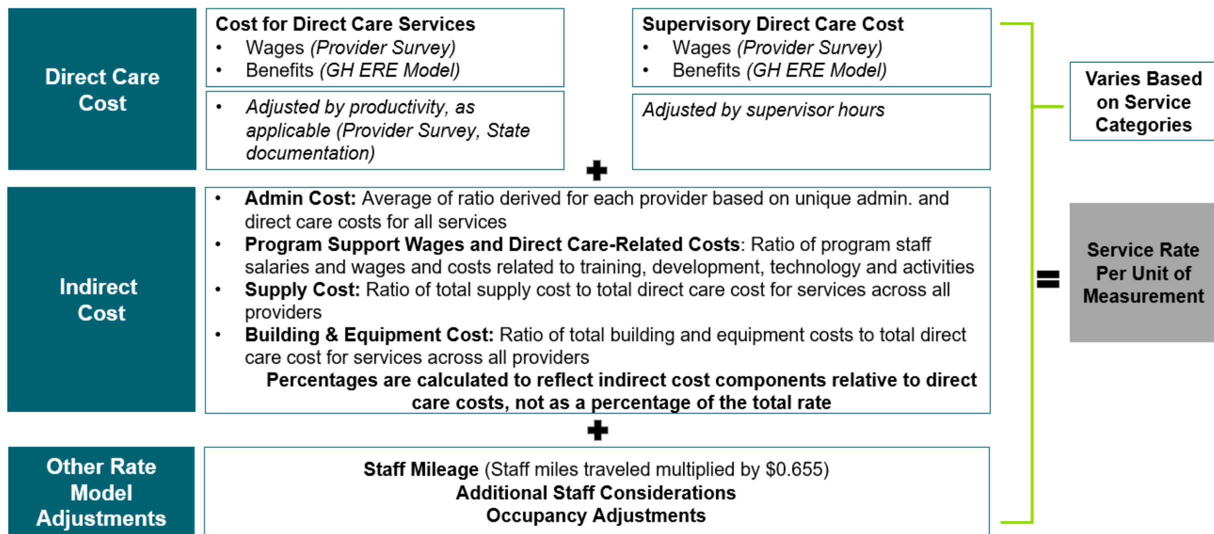
The methodology for developing a rate for a unit of service – or a rate model – varies across types of services but generally includes certain key components. A rate model starts with the wage for the primary staff person providing a service and then building upon that wage with fixed or variable cost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

Typical components of a rate methodology or rate model include:

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

Together, these components sum to a unit rate designed to reimburse a provider organization for all inputs required for quality service delivery. This approach is often called an "independent rate build-up" approach because it involves several distinct rate components whose costs are captured independently through a variety of potential data sources. These costs are essentially "stacked" together into a collective cost per unit that defines the rate needed for cost coverage. Figure 8 illustrates the "building block" structure of Guidehouse's rate development methodology for non-residential models. Although individual rates may incorporate different building blocks, each rate model follows a similar process for identifying the component blocks for inclusion, based on the service requirements and specific adjustments needed to align overall costs with the appropriate billing logic and units of service.

Figure 8: Overview of Rate Components



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

G.3. Staff Wages

Wages for direct care staff are the largest driver in the final rate and are therefore a critical element to derive from the provider cost and wage survey. It is key to align the appropriate staff type with their corresponding wage to feed into the rate models for these 18 Mental Health services and 15 SUD services. To best understand the landscape of wages in South Dakota, Guidehouse used information from the provider cost and wage survey reported by providers that deliver these services as well as industry-wide data sources.

As part of the cost and wage survey, each responding provider reported average hourly or “baseline” wages in addition to overtime, shift differential and other forms of supplemental pay for the survey time-period of April 2023 - June 2023. The staff types with the highest number of Full-Time Equivalents (FTE) reported in the survey were Case Managers and Therapist/Social Workers. Table 7 represents the distribution of FTEs with the corresponding FTE weighted average wage. The baseline wages represented in Table 7 do not include inflationary factors or supplemental pay.

Table 7: Average Hourly Wage Reported in Cost and Wage Survey, Weighted by FTEs

Staff Type List	Survey Average FTE Weighted Hourly Wage	FTEs
Case Manager	$21.16	165.69
Therapist/Social Worker	$26.55	134.97
Counselor	$21.25	112.77
Behavioral Specialist/Technician	$21.07	103.02
Registered Nurse (RN)/Nurse	$36.01	101.23
Licensed Addiction Counselor	$25.52	46.43
Inpatient Tech	$18.19	44.15
Detox Technician	$19.97	34.00
Clinical Specialist	$21.13	29.88
Residential Worker	$14.47	29.00
Licensed Clinical Social Worker (LCSW)	$28.53	28.28
Licensed Practical Nurse (LPN)	$23.86	20.19
Medication Assistant/Medication Aide	$17.21	19.16
Psychiatrist	$70.45	15.85
Certified Nurse Practitioners (CNP)	$68.96	15.50
Admissions Manager	$19.13	14.32
Peer Support Specialist	$19.76	10.91
Physician Assistant (PA)	$66.17	5.03
Psychologist	$53.70	4.91
Certified Nurse Assistant	$17.07	4.17
Paramedic	$19.96	4.04
Family Nurse Practitioner	$56.42	4.01
Addiction Counselor Trainee	$17.58	3.14
Licensed Professional Counselor	$25.82	2.50
Job Coach	$36.27	1.88
Program Specialist	$36.51	1.87
Licensed Marriage and Family Therapist (LMFT)	$28.02	1.50
Child Care Worker	$26.02	0.93

For all direct care staff types, Guidehouse applied a weighting of reported wages by the number of FTEs, then compared that wage to 75th and 90th percentile benchmark wages reported by the Bureau of Labor Statistics, Occupational Employment and Wage Statistics (BLS OEWS).

Guidehouse first looked at the BLS OEWS specific to South Dakota. However, given stakeholder feedback on the difficulty of hiring qualified behavioral healthcare workers in the current marketplace, Guidehouse also looked at the national BLS OEWS wages. Taking current provider cost as reported on the cost report, the survey results, and Workgroup feedback into consideration, Guidehouse ultimately decided to use the national 75th and 90th percentile benchmark wages reported by BLS OEWS. Table 8 shows the BLS Job Type used for each of the jobs listed within the survey, inflated by **3.0 percent** to account for the BLS wages reflecting the May 2022 time-period.

Table 8: BLS Crosswalk for Job Types

Staff Type Used from Survey and in Rate Models	BLS Job Type	75th percentile BLS Hourly mean wage *	90th percentile BLS Hourly mean wage *
Behavioral Specialist/Technician	Psychiatric Technicians (292053)	$22.63	$29.16
Case Manager	Healthcare Support Workers, All Other (319099)	$24.96	$30.47
Peer Support Specialist	Healthcare Support Workers, All Other (319099)	$24.96	$30.47
Clinical Specialist	Healthcare Support Workers, All Other (319099)	$24.96	$30.47
Interpreter and Translator	Interpreters and Translators (273091)	$36.36	$46.12
Job Coach	Rehabilitation Counselors (211015)	$26.48	$35.29
Licensed Addiction Counselor	Substance abuse, behavioral disorder, and mental health counselors (211018)	$31.89	$40.96
Licensed Clinical Social Worker (LCSW)	Mental Health and Substance Abuse Social Workers (211023)	$36.17	$48.36

Staff Type Used from Survey and in Rate Models	BLS Job Type	75th percentile BLS Hourly mean wage *	90th percentile BLS Hourly mean wage *
Licensed Professional Counselor	Mental Health and Substance Abuse Social Workers (211023)	$36.17	$48.36
Psychiatrist	Psychiatrists (291223)	$122.49	$122.49
Registered Nurse (RN)/Nurse	Registered Nurses (291141)	$50.06	$64.08
Clinical Director	Medical and Health Services Managers (119111)	$70.91	$103.99
Clinical Supervisor	Substance abuse, behavioral disorder, and mental health counselors (211018)	$31.89	$40.96

**National BLS Wages Inflated by 3 Percent*

The BLS OEWS does not have every single job type, but it has jobs that are comparable to those reported for these services that were able to be leveraged as appropriate benchmark wages. For example, Licensed Clinical Social Worker (LCSW) in the cost and wage survey was most closely related to the BLS job classification of "Substance abuse, behavioral disorder, and mental health counselors." An inflationary factor was applied to the BLS OEWS information due to the database reflecting wages from mid-2022 wages to be able to compare to the wages reported from the survey time-period of April - June 2023. Since the wages reported in the survey varied by a wide range and there was significant discussion during the workgroup session related to challenges with recruiting and retaining staff, Guidehouse decided to use either the benchmark mean, 75th and 90th percentile of the national BLS wages to determine appropriate wage assumptions. This assumption was also reviewed by the Advisory Workgroup members and with DSS staff. This assumption also allows for sustainable rates that are not leveraging current wages that are influenced by historical reimbursement to help promote a competitive behavioral health system.

G.3.1. Inflationary Increases in Wages

National data was referenced in tandem with survey data to understand how wages and costs

have trended over recent years. Table 9 includes the most recent growth rate from each source, which include:

- **BLS Current Employment Statistics (CES):** The BLS publishes CES data which looks at earnings. Across Outpatient Mental Health and Substance Abuse Centers Staff, 2022-2023 trends document an annual growth rate in earnings of **1.3 percent,** whereas the average General Healthcare for the same period was **3.0 percent**.
- **BLS Producer Price Index (PPI):** The BLS also publishes PPI data that examines costs to producers. Across Psychiatric and Substance Abuse Hospitals services, 2022-September 2023 trends document an annual growth rate of **4.3 percent**.
- **Cost and Wage Survey:** Responding provider organizations recorded wages during Q2 of CY2023 to establish a baseline. Additionally, providers recorded the average percentage increase to hourly wages after the end of the survey time-period. Across job types, the average increase was **5.3 percent**.

Table 9: Sources of Growth Rates in Relevant Costs and Wages

Source	Time Period	Growth Rate
Bureau of Labor Statistics (BLS) Current Employment Statistics (CES) Average for Outpatient Mental Health and Substance Abuse Centers	2022 - 2023	1.3%
Bureau of Labor Statistics (BLS) Current Employment Statistics (CES) Average for General Healthcare	2022 - 2023	3.0%
Bureau of Labor Statistics (BLS) Producer Price Index (PPI) average for Psychiatric and Substance Abuse Hospitals	2022 - Sept. 2023	4.3%
South Dakota Provider Cost and Wage Inflation Assumption (Assumption used in the rate models)	2022 - 2023	3.0%

Since wage growth is a primary driver of community mental health and substance use disorder services, Guidehouse determined that the CES inflation factor of "General Healthcare" was more representative and encompassed the wide array of services included in the scope of this rate study. Inflation was applied at two separate instances in the wage build up approach, first to inflate the BLS wages from May 2022 to the survey time-period of May 2023, then secondly inflated by an additional **3.0 percent** to inflate wages to the proposed time of rate implementation. This secondary inflation also allows the State the opportunity to re-evaluate wages at time of implementation and apply additional adjustments if needed.

G.3.2. Supplemental Pay

Supplemental pay – inclusive of costs such as overtime wages, holiday pay, and other

supplemental compensation *on top of* compensation from regularly-earned wages – was reported in the cost and wage survey. In analyzing survey results, a supplemental pay percentage of **3.2 percent** was calculated by dividing total supplemental pay, including overtime reported by total wages for each provider (capping one provider at **25 percent**) and then taking the median across all providers. The supplemental pay reported varied widely, ranging from **0-55 percent.** Only two (2) out of twenty-two (22) providers were over the 25 percent threshold.

As a national benchmark the BLS Employer Costs for Employee Compensation (ECEC) quarterly data series for the Health Care and Social Assistance industry, which divides costs into hourly wages as well as expense categories related to mandatory taxes and benefits, insurance, retirement, paid time off, supplemental pay, and other benefits. In the second calendar year quarter of 2023 (CY2023 Q2) – the closest available time-period to that requested in the cost and wage survey – supplemental pay for the selected labor category equaled **3.5 percent** of the average hourly wage, which has remained relatively stable over the past five-year period from 2018 through Q2 2023. The BLS ECEC data includes all supplemental cost components integral to overall compensation, and the data provides consistent and periodic trends that can be used to project a future state. The supplemental pay percentage provided within the ECEC was ultimately used by calculating the average supplemental over the past five (5) years resulting in a percentage of **3.6 percent**.

G.3.3. Final Wage Adjustments

Guidehouse analyzed wages from the provider survey as well as BLS wages specific to South Dakota. After discussion with Workgroup members, Guidehouse ultimately leveraged the national BLS wage assumptions to promote sustainability of the rates and to be cognizant of provider challenges with hiring and retaining licensed staff in the state. Table 10 displays the wage build-up approach, in which the starting wage is established at the national BLS wage standard. BLS benchmarks reflect the mean, 75th percentile, or 90th percentile wage, depending on the practitioner. These BLS wages are inflated by 3 percent to account for cost growth at the time of likely rate implementation and are further adjusted to account for supplemental pay of 3.6 percent. The base wages within the rate models in Appendix A will follow the same build up approach, but in specific instances the 90th percentile or the mean wage is used as the starting wage. The percentile chosen within models is dependent on multiple factors. Supervisory roles primarily received the 90th percentile to account for increased wages associated with additional responsibilities and length in roles. Roles that require additional licensure and education that are more difficult to recruit such as LCSWs, LACs and RNs receive the 75th percentile to promote competitive wages and enhance recruitment into the state and with other industries. Staff that have less specialized roles such as behavioral technicians receive the national mean since these roles are less challenging to replace and do not necessarily require additional training. For example, using the Licensed Clinical Social Worker (LCSW) weighted baseline wage from May 2022 of **$36.17** (as discussed above), a wage adjustment of **3.6 percent** was applied which amounts to **$1.30**, or a total of **$37.47**. From the supplemental pay adjusted wages, we inflated the wages by a year using a value of **3.0** percent, which brings the projected hourly wage in July 2024 to **$38.60**.

Table 10: Calculation of Wage Adjustment Factors

Job Type	BLS Percentile	Wage	Supplemental Pay Adjustment: 3.60%	Inflation Adjustment: 3.00%
Peer Support Specialist	Mean	$21.54	$22.31	$22.98
Interpreter and Translator	Mean	$30.57	$31.67	$32.62
Licensed Addiction Counselor (LAC)	75th	$31.89	$33.04	$34.03
Licensed Clinical Social Worker (LCSW)	75th	$36.17	$37.47	$38.60
Physician Assistant (PA)	90th	$83.25	$86.25	$88.84
Psychiatrist	Mean	$122.49	$126.90	$130.70
Registered Nurse (RN)/Nurse	Mean	$44.08	$45.67	$47.04
Clinical Director	75th	$70.91	$73.46	$75.66
Clinical Supervisor	75th	$31.89	$33.04	$34.03

G.4. Employee-Related Expenses

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

- **Legally required benefits** include federal and state unemployment taxes, federal insurance contributions to Social Security and Medicare, and workers' compensation. Employers in South Dakota pay a federal unemployment tax **(FUTA)** of 6.0 percent of the first $7,000 in wages and state unemployment tax **(SUTA)** of 1.1 percent based on 2023 base wage of $15,000. 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 0.6 percent. Employers pay a combined 7.65 percent rate of the first $160,200in wages for Social Security and Medicare contributions as part of Federal Insurance Contributions Act **(FICA)** contributions. Per the cost and wage survey, employers in South Dakota pay an average effective tax of 1.6 percent toward workers' compensation insurance.
- **Paid time off (PTO) components of ERE** include holidays, sick days, vacation days, and personal days. The median aggregate number of paid days off per year, per the cost and wage survey, was 35.5 days total. As PTO benefits only apply to full-time workers, the daily value of this benefit is multiplied by a part time adjustment factor, which represents the proportion of the workforce which works full-time for the provider organizations responding to the cost and wage survey.

- **Other benefits in ERE** include retirement, health insurance, and dental and vision insurance. Other benefits are also adjusted by a part time adjustment factor, as well as a take-up rate specific to each benefit type which represents the proportion of employees who utilize the benefit.

Based on South Dakota provider survey responses, most if not all providers responded that they offered health, vision, dental, retirement and paid time off benefits to full time direct care staff with high take-up rates in each category. The Guidehouse benefits analysis is intended to allow flexibility in updating specific components of a benefits package where there could be an observed lack of coverage. After reviewing each benefit component, South Dakota providers appear to be offering a comprehensive benefits package. Therefore, Guidehouse evaluated the cost reported within the Total Costs tab of the survey to determine the total cost spent on Total Employee Health Insurance, Total Other Insurance, Total Employee Other Benefits and Paid Time Off. This calculation resulted in the average ERE percentage of **35.0 percent**. However, ERE percentages vary depending on the yearly salary of an individual. Therefore, the lower the yearly salary the higher the ERE percentage is included in the rate models.

The specific staff type employee related expense percentage was then applied to the supplemental pay and inflated FTE adjusted wage to account for the additional costs of these benefits to providers.

G.5. Billable vs. Non-Billable Time of Direct Care Staff

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

Consider a simple example to illustrate this process:

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

While this is an exaggerated example (a typical productivity adjustment is around 1.4 for many of the services in scope for this study), it demonstrates the importance of including a productivity factor to fully reimburse for direct support time.

Provider organizations reported the average number of billable hours (out of an assumed 8-hour workday) through the cost and wage survey, which we translated into a productivity factor for staff delivering each service. For example, for Individual Therapy, providers reported an average of **57.6 percent** of time typically spent on client-facing, billable activities. This percentage equates to 4.61 billable hours per each direct care staff member’s 8-hour day. Dividing eight (8) by 4.61 (or equivalent, 1 divided by 57.6 percent or 0.576 yields a productivity

adjustment of **1.74**, which is then multiplied by ERE-adjusted wages to get productivity-adjusted compensation. Table 11 displays the productivity for each service and the final determined adjuster to be applied to the rate. The survey results were discussed with the Workgroup and Guidehouse also taken into consideration industry best practices. Final rates took into consideration an appropriate level of productivity that allowed for billable time standardization for services that have similar services delivery. The final billable time percentage was calculated using industry best practices, survey responses and comments from the Workgroup members.

Table 11: Billable Time by Service

Service	Billable Time Percentage
Evaluation, Intake, Screening, Testing	60.0%
Individual Therapy	54.9%
Psychiatric Services	74.9%
CNP/PA Med Management	74.9%
Family Therapy (w/out patient present)	54.9%
Family Therapy (with patient present)	54.9%
Group Therapy (other than a multi-family group)	50.0%
Collateral	57.7%
Child or Youth and Family Services (CYF)	50.0%
Juvenile Justice Reinvestment Initiative (JJRI) - Functional Family Therapy (FFT)	40.0%
Functional Family Therapy (FFT) Referral and Engagement	40.0%
Juvenile Justice Reinvestment Initiative (JJRI) - Evidence Based Practices (EBP) - Group	50.0%
Juvenile Justice Reinvestment Initiative (JJRI) - Evidence Based Practices (EBP) - Individual	54.9%
Juvenile Justice Reinvestment Initiative (JJRI) Assessments	60.0%
Intensive Family Services (IFS)	57.9%

Service	Billable Time Percentage
Assessments	60.0%
Local Individual Counseling	68.2%
Local/Group Counseling	68.2%
Local/HB Family Counseling	68.2%
Crisis Intervention	68.2%
Early Intervention Services	68.2%
Collateral Contacts/Referral	68.2%
Interpreter Services	87.0%
Recovery Support Services	84.4%
Nursing/Health Services	86.7%
Moral Reconation Therapy (MRT)	68.2%
Adolescent Substance Use Disorder (SUD) Evidence Based Practices (EBP)	60.0%

G.6. Supervision

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

The cost and wage survey included questions regarding the number of direct care staff supervised by one supervisor and the total number of hours a supervisor spends, on average, directly supervising staff. Survey results varied across providers with some level of consistency in staff type who are providing the service. Based on the staff type for the service as well as taking providers' current costs into consideration, the supervisor wages were set at either BLS,

Mean, BLS at 75th percentile or BLS at 90th percentile. Therefore, for the final models, supervisor wages varied across service type. For Mental Health Services, depending on the staff levels, staff were either supervised by a clinical director or a clinical supervisor. For Substance Use Disorder Services, depending on the staff levels, the staff were either supervised by a clinical supervisor or nurse supervisor/director. Table 12 shows the corresponding supervisor wage, ERE, and final supervisor hourly compensation by supervisor job type and BLS benchmark percentage.

Table 12: Supervision by Job Type

Staff Type	Clinical Director – BLS 75th %	Clinical Director- BLS 90th %	Clinical Supervisor - BLS 90th %	Nurse Supervisor/ Director – BLS Mean
Hourly Supervisor Wage	$75.66	$110.96	$43.71	$67.63
Supervisor ERE	30.0%	30.0%	31.3%	29.3%
Hourly Supervisor Compensation	$98.32	$144.20	$57.39	$87.43

The final assumptions varied across services spanning from one supervisor overseeing anywhere from **2.0** to **11.2** staff with hours per week spanning from **1.5** to **16.5** depending on the service delivery. The “Supervision Hours per Week” is the average hours reported in the survey that supervisors spend in a week on supervisory activities and “Supervisor Span of Control” is the average number of staff that a supervisor oversees. Table 13 shows supervision hours per staff per hour rate as a result of dividing supervision hours per week by supervisor span of control divided by 40.

Table 13: Supervision by Service Type

Service Type	Supervision Hours per Week	Supervisor Span of Control
SUD Assessments	6.4	5.0
Counseling & Intervention	3.4	4.7

Service Type	Supervision Hours per Week	Supervisor Span of Control
Collateral/Referral/Evidence Based Practices (EBP)/ Moral Reconation Therapy (MRT)	3.4	4.7
Interpreter Services	6.5	4.8
Recovery Support Services	4.4	8.0
Nursing/Health Services	2.6	8.0
Evaluation, Intake, Screening, Testing	16.1	10.4
Evaluation, Intake, Screening, Testing - CNP/PA - CYF Telehealth	16.1	10.4
Therapies (other than group)	15.7	9.3
Psychiatric Services	5.5	6.0
CNP/PA Med Management	1.5	3.5
MH Collateral	12.5	9.6
Group Therapy (other than a multi-family group)	13.5	9.6
Functional Family Therapy (FFT)	2.0	2.0
Intensive Family Services (IFS)	16.5	11.2

G.7. No-Show Adjustment

Provider time and revenue lost to missed appointments is a problem to be contended with across health care. However, client “no-shows” are particularly challenging in behavioral health, where missed appointments sometimes constitute as much as 30-60 percent of all scheduled appointments.[1] Mental health and SUD appointment no-shows not only adversely impact clinical

[1] For relevant studies of and variation in recent client no-show rates, see Muppavarapu, K., Saeed, S., Jones, K., Hurd, O., Haley, V. Study of Impact of Telehealth Use on Clinic “No Show” Rates at an Academic Practice. Psychiatric Quarterly 2022; 93:689–699. https//doi.org/10.1007/s11126-022-09983-6.; as well as Milicevic, A., Mitsantisuk, K., Tjader, A., Vargas, D. L., Hubert, T. L., & Scott, B.

outcomes but have a large impact on overall healthcare productivity and the ability to bill for providers' time. During the Workgroup sessions, stakeholders noted substantial additional loss to staff productivity due to clients not showing up for regularly scheduled appointments. Although it was not possible to quantify lost productivity due to client no-show rates solely through the information reported through the provider survey, with further stakeholder and DSS input, Guidehouse determined that a further no-show adjustment was appropriate.

Based on a combination of provider experience, Workgroup feedback and literature review, Guidehouse estimated that a 30 percent no-show rate is a reasonable assumption for the setting and population served in South Dakota. We inserted an additional no-show factor into the proposed rate models, augmenting the standard productivity adjustment. This adjustment is distinguished from the billable time adjuster to differentiate between other standard non-billable time elements and productive time lost to missed appointments, thereby allowing the State to implement alternative no-show targets and assumptions down the road as needed. For rate benchmarking purposes, Guidehouse applied a **30 percent** adjustment factor for all services to the hourly compensation as a no-show adjuster.

G.8. Transportation

Transportation related questions were included in the survey, but there were limited responses with varied outcomes. Although telehealth is an option, face-to-face service delivery is critical for community-based care, particularly for court ordered cases. Workgroup members communicated establishing satellite offices for the purpose of seeing patients in rural and frontier areas. Due to the limited responses to the transportation questions related to total number of miles and minutes for trips, Guidehouse extrapolated transportation mileage add-on payment assumptions based on the percentage of staff time is spent driving.

Using this methodology Guidehouse developed a standardized transportation adjustment of **$1.43** for most services to account for the additional costs related to travel. On top of the **$1.43**, there is an additional **20%** increase in rates for providers who qualify for rural or frontier rates.

G.9. Staffing Ratios

The provider survey included a question related to the number of clients served at a single point in time by a single staff member. This question was intended to help understand which services were being provided in a group setting in comparison to a one-to-one service and if provided in

Modeling patient no-show history and predicting future appointment behavior at the veterans administration's outpatient mental health clinics: Nirmo-2. Military Medicine. 2020; 185(7-8), e988–e994. https://doi.org/10.1093/milmed/usaa095. Also see: Long J, Sakauye K, Chisty K, Upton J. The Empty Chair Appointment SAGE Open. 2016;6(1):215824401562509. https://doi.org/10.1177/2158244015625094. For older studies, see Gajwani P. Can what we learned about reducing no-shows in our clinic work for you? Curr Psychiat. 2014;13(9):13–24; along with Parikh A, Gupta K, Wilson AC, Fields K, Cosgrove NM, Kostis JB. The Effectiveness of Outpatient Appointment Reminder Systems in Reducing No-Show Rates. Am J Med. 2010;123(6):542–8. https://doi.org/10.1016/j.amjmed.2009.11.022.

a group setting, the average size of the group. The median group sizes from the survey regularly reported large group sizes, therefore, to support more reasonable group sizes in service delivery smaller group size assumptions were included within the rate methodology. Table 14 shows the staff to client ratio used for the rate model compared to the median of the group setting-based from stakeholder survey responses within Mental Health Services.

Table 14: Staffing Ratio for Mental Health Services

Mental Health Services		
Services in Group Setting	**Median from Survey**	**Ratio used for the rate model**
Family Therapy (with patient present)	2.5	1.0
Group Therapy (other than a multi-family group)	7.0	2.0
Child or Youth and Family Services (CYF)	3.0	2.0
Intensive Family Services (IFS)	3.5	1.0

Table 15 shows the staffing to client ratio used for the rate model compared to the median of the group setting-based from stakeholder survey responses within substance use disorder services delivered in a group setting. Similar to the mental health services, group sizes reported for the SUD related services were substantially higher than the assumptions built into the rate methodology. For all SUD services provided within a group setting a group size of 3.5 was included. These lower staff to client ratios are intended to support better outcomes within the group setting.

Table 15: Staffing Ratio for Substance Use Disorder Services

Substance Use Disorder Services		
Services in Group Setting	**Median**	**Ratio used for the rate model**
Local/Group Counseling	15.0	3.5
Local/HB Family Counseling	4.0	3.5
Nursing/Health Services	12.0	3.5
Intensive Meth Treatment (IMT)	10.0	3.5
Cognitive Behavioral Interventions for Substance Abuse (CBISA)	13.5	3.5
Moral Reconation Therapy (MRT)	10.0	3.5

To derive a group rate, service-specific medians was applied to the rate models for individual versions of the service, thereby dividing the cost components built into the model by the group size to determine the cost per client in the group setting. For some services such as Local/Group Counseling and Local/HB Family Counseling, staffing ratios were adjusted to

remain consistent with related SUD group services. Survey responses sometimes indicated a client-to-staff ratio greater than one for services that are intended to be delivered one-on-one. Therefore, the service delivery definitions were leveraged to build a rate that reflects the intended service delivery.

G.10. Administrative and Program Support Expenses

Administrative and program support expenses reflect the indirect costs associated with operating a provider organization. Administrative expenses are costs for administrative employees' salaries and wages along with non-payroll administration expenses, such as licenses, property taxes, liability, and other insurance. Program support expenses reflect costs associated with delivering services, but which are not related to either direct care or administration, but still have an impact on the quality of care. These costs are specific to the program but are not billable, and may include supplies, vehicle costs where transportation is necessary and building and equipment. Program supports vary from service to service depending on what is required to deliver the service whereas administrative costs are intended to represent the overall costs for a set of services or a program.

Rate models typically add a component for these indirect 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 or program support add-on, Guidehouse calculated the ratio of administrative or program support costs to direct care wages by summing the specific cost elements reported in the South Dakota provider cost and wage surveys for the provider's most recent full year of costs available then dividing by total direct care wages and benefits. Within the provider cost and wage survey there were sections related to the following that were then allocated to either Direct Care Costs, Administrative Costs or Program Support Costs:

- ***Employee Salaries:*** Individual cost lines for direct care staff, administrative staff and program support that are then distributed to the appropriate cost category.
- ***Employee Taxes and Benefits:*** This cost category is allocated between Direct Care, Program Support and Administrative
- ***Non-Payroll Administrative Expenses:*** Administrative costs, net of bad debt and costs related to advertising or marketing.
- ***Non-Payroll Program Support Expenses:*** Program support costs
- ***Facility, Vehicle, and Equipment Related Expenses:*** Program support costs, except for the categories related to Utilities / Telecommunications / Etc. (administrative) and the square footage for Admin space.

Provider cost reports showed a wide range of administrative cost as a percentage of total direct care cost. The administrative percentage ranged anywhere between **0 percent** to **87 percent**, with a median of **5.8 percent**. After accounting for the extreme outliers, the admin percentage average came to **6.6 percent**. The extreme outliers represented only **.09** percent of the entire

provider universe, with most providers landing **+/- .2 percent** around the median and a few landing **+/- 4.5 percent** around the mean.

Program support including allocated facility rent and mortgage was **34.6 percent.** This percentage is within a reasonable range of what would be expected for community Mental Health and Substance Use Disorder providers. The total admin and program support is **39.2 percent.**

Guidehouse researched additional public benchmarks to compare to the administrative and program support values found within the survey to determine reasonableness of the results. However, the definition of administrative costs has variability in public research. Therefore, we also leveraged the Resource-based relative value scale (RBRVS) methodology and the RVU's from the Center for Medicare and Medicaid Services (CMS) October 2022 release as another reasonable benchmark for indirect costs for these set of services. Established as an objective standard for physician reimbursement RBRVS is considered today as the gold standard of physician reimbursement due to being scientifically validated and receiving the buy-in of physician specialty societies. RVUs are essentially a weighted value assigned to each current procedural terminology (CPT®) code.

The RBRVS calculates fees based on three criteria:

- Physician work (54%): Consumption of a doctor's time and effort to perform the work.
- Practice expense (41%): Expenses consumed to do the particular procedure.
- Malpractice expense (5%): Probability of malpractice exposure brought on by performing the procedure.

Using the practice expense plus malpractice expense divided by the physician work for the behavioral health CPT codes. The average was determined across these set of codes to determine the direct to indirect cost. This resulted in an indirect percent of **34.9 percent** which is in line with the 39.2 that was calculated using provider specific data. The RBRVS percentage and the various public benchmarks are represented in Figure 9. Based on our understanding of the literature the JAMA Network percentage only shows the administrative percentage whereas the other sources account for all indirect costs (Administrative and program support).

Figure 9: Indirect Costs

Indirect Costs	Administrative Only	Indirect Costs	Indirect Costs
Health Affairs	JAMA Network	New England Journal of Medicine	RBRVS Methodology
25-35%	15-25%	31%	34.9%

G.11 Residential and Team-Based Models

Residential rate models and robust team-based service models were evaluated as part of the larger rate study in regard to equitable wages, overhead costs, and employee benefits. Rate modeling for these service types required special development to capture the unique staff and service characteristics required for care delivery. Services were split into service families, indicating groupings of services with similarities in their rate structure, along with standardized assumptions related to specific wages, while also accounting for differences in acuity and intensity of service delivery. These families are represented in Table 16 with the family name and the corresponding individual services.

Table 16 : Rate Families

Therapies	Team-Based	SUD Residential/Inpatient*
• Group • Individual • Individual/Family	• IMPACT • FACT (Mental Health Court) • CARE	• Detoxification • Gambling Intensive Residential Treatment • Low Intensity Residential (IMT, CJI and Pregnant Women included) • Intensive Day and Gambling Day Treatment • Intensive Inpatient
*Room and Board is included for specific inpatient services and paid separately depending on Medicaid versus contract.		

Therapies

Based on current State policy there are residential services that have unbundled the specific therapies and case management from the residential room and board portion of the rate. Therefore, the individual therapies for both group, individual and individual/family mimic the methodology for the other substance use disorder services that were described in the previous sections of the report. Table 17 displays the proposed rates for these therapy services provided within the residential setting.

Table 17: Therapy Services within Residential Setting

Service Description	Current Rate	Proposed Rate	% Change
IMT - Group	$8.57	$8.75	2.1%
IMT - Individual	$30.77	$31.04	0.9%
Low Intensity Residential - Group	$8.57	$8.75	2.1%
Low Intensity Residential - Individual/Family	$30.77	$31.04	0.9%
Low Intensity Residential - Pregnant women - Individual/Family	$30.77	$31.04	0.9%
Low Intensity Residential - Pregnant women- Group	$8.57	$8.75	2.1%

Mental Health Team-Based

For team-based models representing IMPACT, FACT (Mental Health Court) and CARE, rate models are based on calculating the total costs required for the entire multidisciplinary team within a year and then determining the cost for each member within the team caseload. The service descriptions for each of these models reflect similar team structure and service delivery expectations; however, the intensity of the services delivered vary, resulting in distinct caseload assumptions. These models were developed with best practices in mind and are built to illustrate the costs to operate the team as described. Although the Workgroup noted that not all staff types are available in the current state of the service, by building prescriptive models to represent desired team composition, costs are included within reimbursement assumptions that will allow providers the to support team staffing within the service norms.

Team FTEs are the same for each of the models with the exception of licensed professional counselor, which receives an additional quarter time FTE for FACT to account for additional time spent within the court system. Team assumptions are as follows with the corresponding FTE considerations.

- Clinical Director – 1 FTE

- Registered Nurse – 1 FTE
- Psychiatrist – 1 FTE
- Clinical Specialist – 1 FTE
- Licensed Professional Counselor – 1 FTE (IMPACT, CARE), 1.25 FTE (FACT)
- Peer Support Specialist – 1 FTE
- Licensed Addiction Counselor – .25 FTE
- Vocational Specialist – .25 FTE
- Licensed Clinical Social Worker – Roughly 4 FTEs

After determining the total cost for the wages for each of the staff types listed above, the cost per member was calculated by assuming a caseload of 45 clients for the entire IMPACT and FACT teams. However, the licensed clinical social worker has a different caseload of 12 to account for the intensity of services required for this population and to ensure the appropriate number of contacts are made each month. Since CARE services are specialized outpatient services provided to adults with serious mental illness (SMI), in comparison to IMPACT which provides intensive services to adults whose serious mental illness (SMI) significantly impacts their lives, the CARE caseload is slightly higher at 50. This caseload reflects a combination of assumptions and Workgroup feedback noting that CARE clients receive services over a wide geographical area and throughout the entire catchment area in the state. Even though the intensity of services is less than IMPACT and FACT, CARE requires a greater assessment burden.

Lastly, the indirect percentage add-on is aligned with other services within the rate study, established at 39.2 percent of direct care costs to account for the additional costs related administrative and program support costs needed to deliver these robust team services.

Table 18 displays the proposed rates for the study's team-based models. The IMPACT service shows the largest increase because this service historically has received a lower rate, despite the fact that service intensity is actually greater than other services in some respects, contributing to higher costs than acknowledged in current rates.

Table 18: Mental Health Team-Based Services

Service Description	Current Rate	Proposed Rate	% Change
SMI - CARE Frontier	$120.85	$128.79	6.6%
SMI - CARE Regular	$100.70	$107.32	6.6%
SMI FACT	$104.77	$117.87	12.5%
SMI IMPACT - BMS, NEMHC, CCS, SEBH, LCBHS	$99.83	$115.59	15.8%

SUD Residential/Inpatient

When reviewing the various SUD residential and inpatient services, Guidehouse understood that the State generally intends for these services to reflect the standards associated with different ASAM levels of care. Therefore, services were evaluated according to the setting in which the service is delivered, the staff types and the appropriate team structure and staffing ratios. Occupancy adjusters were also included to account for occasions when residents are absent, but providers cannot reassign beds and, therefore, are unable to bill, resulting in lost revenue. All intensive behavioral residential models assumed a **95 percent** occupancy adjustment factor. The State's service definitions, the ASAM continuum of care, and the Advisory Workgroup feedback were all leveraged to appropriately capture the specifics of each individual level of service[2]. The residential/inpatient services are intended to be built on top of each other with higher intensity-based services as the service tiers increase.

Intensive Day and Gambling Day Treatment

This service is intended to follow the service delivery specifications described for ASAM 2.5, partial hospitalization. This is an intensive outpatient service that requires a minimum of 20 hours of therapy within a week. Key considerations when developing this model were ensuring the proper interdisciplinary team of appropriately credentialed addiction treatment professionals including counselors, psychologists, social workers, addiction-credentialed physicians, and program staff, many of whom have cross-training to aid in interpreting mental disorders and deliver intensive outpatient services. The staff type included are as follows to build the appropriate mix of team members to deliver the intensive services required in this type of day treatment:

- Behavioral Specialist/Technician
- Licensed Addiction Counselor (Individual and Group)
- Case Manager
- Psychiatrist
- Clinical Director- Supervisor

The case manager and behavioral specialist/technician wages are reflective of the national BLS mean whereas the licensed addiction counselor and the psychiatrist have the 75th percentile utilized to account for challenges in hiring those licensure levels.

This service should account for the appropriate mix of group therapies while still factoring in time for individual counseling. Considering the ASAM criteria indicates a minimum of 20 hours of a week of interaction, 4-hour sessions with **3.75** hours of group

[2] Medicaid Innovation Accelerator Program, Overview of Substance Use Disorder (SUD) Care Clinical Guidelines: A Resource for States Developing SUD Delivery System Reforms (*April 2017*). Available online: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/reducing-substance-use-disorders/asam-resource-guide.pdf

and **15** minutes of individual therapy were included to determine the final daily rate.

SUD Low Intensity Residential (IMT and CJI)

Low intensity residential services are a step up from the partial hospitalization and requires a 24-hour service environment. Since this is a lower intensity "clinically managed" model, the service does not need to be staffed with medical personnel. ASAM defines clinically managed as "services that are directed by nonphysician addiction specialists rather than medical personnel". Therefore, this model includes a Behavioral Specialist/Technician and a Case Manager to assist in effective service coordination. This service allows for the therapy services to be unbundled and paid for outside the residential rate and therefore none of that time is included in the rate. Since this is the lowest residential setting, the staffing ratio is set at **1:14,** which is then used to determine the appropriate number of annual hours required for each resident. Assuming a 1:14 staffing ratio results in **625.7** annual hours per resident with additional "substitution hours" included to account for staff training and paid time off. There are still minimum therapy considerations for these residential services but since these are paid for outside the residential rate those therapy requirements are not built into the rate but should still be considered in service delivery.

SUD Low Intensity Residential – Pregnant Women

Low intensity residential for pregnant women is structured similarly to the low intensity residential services however the staffing ratio is set at **1:10** to consider the slightly increased need of this population. There is additional nursing time included in this version of the service to allow additional monitoring for the population. Staffing includes:

- Behavioral Specialist/Technician
- Case Manager- 104 total annual hours
- Registered Nurse- 208 total annual hours

The case manager and registered nurse are half time FTEs divided over the 10 residents. Due to the staffing ratio being slightly lower the total number of annual hours increased from the non-pregnant women version of the rate from 625.7 annual hours per resident to **876.0 annual hours** per resident.

Detoxification

Detoxification follows a similar structure to the low intensity residential- pregnant women service because it requires the same 24-hour setting with a combination of support staff, licensed addition counselor for therapy, case management time for the assistance in coordination of services and a small amount of registered nurse time for any consult related to withdrawal or medication management. Staffing includes:

- Behavioral Specialist/Technician
- Licensed Addiction Counselor- 260 total annual hours
- Case Manager- 43 total annual hours

- Registered Nurse- 43 total annual hours

This is a half day rate in comparison to the other residential service which are full daily rates. Therefore, when comparing this to the other services, this rate falls between the low intensity residential and the low intensity residential for pregnant women.

Intensive Inpatient (Gambling Included):

Intensive inpatient is one of the highest acuity levels that adds the need for 24-hour “medically monitored” service delivery. Therefore, the staffing assumptions in the rate model include a more robust multidisciplinary team to create a dynamic team that is able to meet the treatment goals. The team structure includes a Behavioral Specialist/Technician, Counselor, Licensed Addiction Counselor, Registered Nurse and Psychiatrist. Each staff type has different staffing assumptions that in total account for **1,703 total hours** within the year per resident. These total hours are equivalent to roughly a staffing ratio of **1:6**. Included in the staffing assumptions there is consideration for:

- Behavioral Specialist/Technician- 260 total annual hours
- Counselor: 468 total annual hours
- Licensed Addiction Counselor: 546 total annual hours a week individual therapy
- Licensed Addiction Counselor: 137 total annual hours a week of group therapy with group sizes of 4. The group combined with individual therapy equates to 21 total hours a week of therapy.
- Registered Nurse: 260 total annual hours
- Psychiatrist: 33 total annual hours

Based on ASAM criteria, the providers included need to include a mix of physicians credentialed in addiction who are available on-site 24 hours daily, registered nurses, and additional appropriately credentialed nurses, addiction counselors, behavioral health specialists and clinical staff that can provide a combination of group and individual therapy, nursing services, counseling and clinical monitoring, medication monitoring and evidence-based practices. Depending on the intensive inpatient service the room and board costs are either included in the rate or split out as a separate reimbursable code. Intensive inpatient treatment services for gambling is a bundled rate, which equals the service and room and board rates.

Table 19 displays the proposed rates for this mix of residential and inpatient services. Compared to other rate changes within the rate study, inpatient services show some of the largest increases from current rates.

Table 19: SUD Inpatient and Residential Services

Service Description	Current Rate	Proposed Rate	% Change
Detoxification	$57.41	$81.10	41.3%
Gambling Intensive Residential Treatment (includes Room and Board and Intensive Inpatient rates)	$303.02	$336.98	11.2%
IMT - Low Intensity Residential	$77.75	$93.99	20.9%
Intensive Day and Gambling Day Treatment	$163.73	$182.84	11.7%
Intensive Inpatient	$251.80	$295.57	17.4%
Intensive Inpatient - Room and Board	$51.21	$41.41	-19.2%
Low Intensity Residential	$77.75	$93.99	20.9%
Low Intensity Residential - CJI	$77.75	$93.99	20.9%
Low Intensity Residential - Pregnant women (Room and Board)	$181.15	$189.92	4.8%

H. Benchmark Rates and Final Recommendations

Guidehouse evaluated these community mental health and substance use disorder services for adequate reimbursement based on updated cost components but also in consideration of distinctive service delivery characteristics. Guidehouse operated with the goal of consistency where service costs are typically the same, and both specificity and transparency where cost assumptions in the rate models may vary. For many of the rate components, a high degree of standardization is appropriate, even if the services themselves are differentiated based on specific nuances related to staffing ratios, team structure, staff qualification level, supervision demands, and the setting in which a service is delivered.

H.1. Rate Considerations

Standardization

Throughout the rate study process, rate development relied extensively on the provider survey in combination with public data sources to identify areas in which standardization could be appropriately applied to the services under review. Guidehouse reviewed the survey information in combination with public source data to benchmark information before applying standardized assumptions. A level of standardization was applied to individual rate components to build in consistency between rate families. Guidehouse has recommended deviation from current standardization where appropriate.

Guidehouse also took into consideration stakeholder feedback throughout the rate development process. Stakeholders expressed concerns that productivity was impacted due to a high frequency of client no-shows and the adverse conditions of rural service delivery, including significant staff travel time. Guidehouse made appropriate adjustments to account for these effects on non-billable time, as well as developing a transportation add-on to recognize additional vehicle costs associated with heightened staff travel.

Wages

Wages assumptions were established using national BLS benchmark data instead of actual costs reported within provider surveys or cost reports. Depending on the job type, wages were set using either the mean, the 75th or 90th percentile. National BLS wage trends were higher in most categories than BLS wages specific to South Dakota. Across services, the national 75th percentile was 42.9% higher than the South Dakota-specific mean, and the 90th percentile was 84.3% higher than the South Dakota specific mean. After thorough conversation and thoughtful feedback from the Workgroup, the national BLS wages were determined to be more reasonable to promote sustainability and retention of critical staff that are challenging to hire within the state. Leveraging the national wages allows for the South Dakota behavioral system to remain competitive and continue to grow the workforce with these specialized skillsets that are difficult to recruit.

Percentage Adjustments

Guidehouse recommends maintaining consistency with specific percentage adjustments depending on the service. Currently, the CNP/PA equivalent of specific services such as medicine management and Evaluation, Intake, Screening, Testing are receiving 90 percent of the psychiatry equivalent rate. The service is the same but the provider that is delivering the service is different and therefore receives a reduction in the reimbursement. In addition, there are services in which an additional rural/frontier differential of 20 percent is added to the regular rate. This percentage increase is only billable by specific providers defined by the state.

- Certified Nurse Practitioners and Physician Assistants reimbursed at 90 percent of the full psychiatry rates instead of building separate rate models that have a CNP/PA as the primary job type. This is a consistent and defensible methodology that Medicare physician pricing commonly leverages.
- Maintain the 20 percent increase for the services and providers that are eligible for the frontier and rural rates to continue to promote access and serve those in difficult to reach locations with limited healthcare options.

Inpatient and Inpatient Room and Board

Two rates are still maintained to account for the costs associated with inpatient room and board. However, the overall rate is the same between the two methodologies but how the room and board costs are split from the residential rate is more clearly defined to ensure rate equity. The Gambling Intensive Residential Treatment service is an all-inclusive rate with the room and board costs included within the final rate of $336.98 However, the Intensive Inpatient rate of $295.57 has the room and board rate of $41.41 separated. When added together the room and board plus the intensive inpatient rate sum to $336.98. This is established by re-allocating overhead costs from the room and board portion of the rate to the residential rate portion. This more accurately reflects the costs of each piece to the overall rate. On the hold harmless fiscal impact determination, these rates were assessed collectively rather than independently.

CARE, IMPACT and FACT Caseloads

Based on Workgroup feedback and caseload requirements established in the State statutory language, the final caseload assumptions for IMPACT and FACT are 45 with the additional LCSW caseload set at 12. Specifically, for CARE, the caseload assumption is slightly higher, established at 50 to account for the less intense services being provided but still accounting for the additional assessment burden and widespread geographic catchment areas that need to be served.

H.2. Final Rate Recommendations

Final rate recommendations primarily resulted in a range of proposed rate increases. However, in a few cases, Guidehouse's cost-based rate methodology resulted in observed rate decreases compared to current reimbursement. These proposed rates are benchmarks based on the survey results and Guidehouse's independent rate build-up approach. Despite the fact that current reimbursement for these services may be higher than rate benchmarks, a variety of cost assumptions—some higher, some lower—may be reasonable, and having rates higher than

cost (as benchmarked) does not always necessitate reduction. The State may choose to hold current rates harmless if within a threshold of acceptable costs, maintaining present reimbursement assumptions and minimizing rate volatility for providers. The fiscal impact calculations presented in the final section of this report are based on the assumption that reduced benchmark rates would be held harmless.

Table 20 shows the proposed benchmark rates for mental health services and the percentage change from the current rate in effect as of July 1, 2023. The average percentage change for this set of rates is **2.1 percent**.

Table 20: Mental Health Rate Recommendations

Mental Health Rates			
Service Description	**Current Rate**	**Proposed Rate**	**% Change**
CNP/PA Med Management	$85.81	$91.22	6.3%
Collateral	$42.39	$41.39	-2.4%
CYF Group Frontier	$30.67	$28.80	-6.1%
CYF Group Regular	$25.55	$24.00	-6.1%
CYF Individual Frontier	$47.82	$52.42	9.6%
CYF Individual Regular	$39.85	$43.68	9.6%
Evaluation, Intake, Screening, Testing - CNP/PA	$85.81	$114.62	33.6%
Evaluation, Intake, Screening, Testing - Non-Psych	$42.39	$40.00	-5.6%
Evaluation, Intake, Screening, Testing - Psychiatrist	$95.33	$127.35	33.6%
Family Therapy	$42.39	$43.68	3.0%
FFT Referral and Engagement Fee	$409.93	$409.93	0.0%
Group Therapy (other than a multi-family group)	$21.92	$24.00	9.5%
IFS Frontier	$42.83	$52.42	22.4%
IFS Regular	$35.69	$43.68	22.4%
Individual Therapy (Outpatient)	$42.39	$43.68	3.0%
JJRI Assessments	$35.69	$40.00	12.1%
JJRI EBP - Individual Frontier	$47.82	$52.42	9.6%
JJRI EBP Group - Frontier	$30.67	$28.80	-6.1%
JJRI EBP Group - Regular	$25.55	$24.00	-6.1%
JJRI EBP Individual Regular	$39.85	$43.68	9.6%
JJRI FFT - Rural	$360.75	$353.79	-1.9%

Mental Health Rates			
Service Description	**Current Rate**	**Proposed Rate**	**% Change**
JJRI FFT Collateral	$35.69	$41.39	16.0%
JJRI FFT	$300.61	$294.83	-1.9%
JJRI FFT-Frontier	$390.82	$383.27	-1.9%
Psychiatric Services	$95.33	$101.35	6.3%

Table 21 shows the proposed benchmark rates for substance use disorder services and the percentage change from the current rate in effect as of July 1, 2023. The average percentage change for this set of rates is **2.8 percent.**

Table 21: Substance Use Disorder Rate Recommendations

Substance Use Disorder Rates			
Service Description	**Current Rate**	**Proposed Rate**	**% Change**
Adolescent SUD EBP - Collateral Contacts	$30.77	$30.93	0.5%
Adolescent SUD EBP - Individual/Family Rural	$36.93	$37.25	0.9%
Adolescent SUD EBP-Group	$8.57	$8.75	2.1%
Adolescent SUD EBP-Individual/Family	$30.77	$31.04	0.9%
Adolescent SUD Rural Group	$10.28	$10.50	2.1%
Assessments	$30.77	$35.54	15.5%
CBISA - Group	$8.57	$8.75	2.1%
CBISA - Individual	$30.77	$31.04	0.9%
CBISA - Rural Group	$10.28	$10.50	2.1%
CBISA - Rural Individual	$36.93	$37.25	0.9%
CBISA/MRT Collateral Contacts	$30.77	$30.93	0.5%
Collateral Contacts/Referral	$30.77	$30.93	0.5%
Crisis Intervention/Gambling Crisis Intervention	$30.77	$31.04	0.9%
Crisis Intervention/Gambling Crisis Intervention - Rural	$36.93	$37.25	0.9%
Early Intervention Services	$30.77	$31.04	0.9%
Group Nursing/Health Services (PPW only)	$8.57	$9.27	8.2%
Individual Nursing/Health Services (PPW only)	$30.77	$32.44	5.4%

Substance Use Disorder Rates			
Service Description	**Current Rate**	**Proposed Rate**	**% Change**
Interpreter Services	$17.19	$18.21	5.9%
Local Individual and Gambling Home Based Counseling	$30.77	$31.04	0.9%
Local Individual and Gambling Home Based Counseling - Rural	$36.93	$37.25	0.9%
Local/Group and Gambling Counseling	$8.57	$8.75	2.1%
Local/HB Family Counseling	$30.77	$31.04	0.9%
MRT - Group	$8.57	$8.75	2.1%
MRT - Individual	$30.77	$31.04	0.9%
MRT - Rural Group	$10.28	$10.50	2.1%
MRT- Rural Individual	$36.93	$37.25	0.9%
Recovery Support Services (PPW only)	$14.93	$17.48	17.1%
Rural Group and Gambling Counseling	$10.28	$10.50	2.1%
Rural/HB Family Counseling	$36.92	$37.25	0.9%

Table 22 shows the proposed benchmark rates for the residential/inpatient related to substance use disorder with the percentage change from the current rate in effect as of July 1, 2023.

Table 22: Substance Use Disorder Residential/Inpatient

Substance Use Disorder Residential/Inpatient			
Service Description	**Current Rate**	**Proposed Rate**	**% Change**
Detoxification	$57.41	$81.10	41.3%
Gambling Intensive Residential Treatment (includes Room and Board and Intensive Inpatient rates)	$303.02	$336.98	11.2%
IMT - Group	$8.57	$8.75	2.1%
IMT - Individual	$30.77	$31.04	0.9%
IMT - Low Intensity Residential (Room and Board)	$77.75	$93.99	20.9%
Intensive Day and Gambling Day Treatment	$163.73	$182.84	11.7%
Intensive Inpatient	$251.80	$295.57	17.4%
Intensive Inpatient - Room and Board	$51.21	$41.41	-19.2%
Low Intensity Residential	$77.75	$93.99	20.9%
Low Intensity Residential - CJI	$77.75	$93.99	20.9%

Substance Use Disorder Residential/Inpatient			
Service Description	**Current Rate**	**Proposed Rate**	**% Change**
Low Intensity Residential - Group	$8.57	$8.75	2.1%
Low Intensity Residential - Individual/Family	$30.77	$31.04	0.9%
Low Intensity Residential - Pregnant women (Room and Board)	$181.15	$189.92	4.8%
Low Intensity Residential - Pregnant women - Individual/Family	$30.77	$31.04	0.9%
Low Intensity Residential - Pregnant women - Group	$8.57	$8.75	2.1%
SMI IMPACT - BMS, NEMHC, CCS, SEBH, LCBHS	$99.83	$115.59	15.8%

Table 23 shows the proposed benchmark rates for the team-based rates to mental health with the percentage change from the current rate in effect as of July 1, 2023.

Table 23: Mental Health Team-Based Rate Recommendations

Mental Health Team-Based Rates			
Service Description	**Current Rate**	**Proposed Rate**	**% Change**
SMI - CARE Frontier	$120.85	$128.79	6.6%
SMI - CARE Regular	$100.70	$107.32	6.6%
SMI FACT (Mental Health Court)	$104.77	$117.87	12.5%
SMI IMPACT - BMS, NEMHC, CCS, SEBH, LCBHS	$99.83	$115.59	15.8%

I. Fiscal Impact Estimates

I.1. Fiscal Impact Overview

As a part of determining final rate recommendations, Guidehouse analyzed how proposed rate benchmarks would affect projected expenditures in an effort to estimate the fiscal impact of increased rates for the State of South Dakota as well as providers delivering services across the State. This analysis was conducted exclusively for the purposes of the rate study, to assess the implications of increasing funding for services to the levels identified by study rate benchmarks. It does not reflect decisions made to date by the Department or final rate levels to be implemented. Based on the benchmark rates developed from the service rate models, Guidehouse conducted a fiscal impact analysis to support the proposed benchmark rate recommendations.

I.2. Baseline Data and Service Periods

Expenditure and utilization trends for community mental health and substance use disorder services did not see significant variation in the two most recent years of data. For this reason, Guidehouse did not trend utilization forward based on multiple years but used service volume from SFY 2023—the latest available full fiscal year—as the baseline utilization assumption for the projected service period.

To establish the payment baseline, Guidehouse priced each unit of service included in the data at the current rate assuming similar utilization trends from SFY 2023. Expenditures calculated at Guidehouse's benchmark rates follow suit, allowing proportionate comparison for assessing financial impact. The fiscal impact numbers also account for the State funded services as well as Medicaid services. This distinction is outlined since the State funded claims do not receive Federal Medical Assistance Percentage (FMAP) but will still be costs to the State.

I.3. Other Projection Assumptions

For the most part, the analysis' utilization assumptions reflect historical service volume, and Guidehouse did not attempt to adjust utilization patterns based on anticipated future shifts in utilization.

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

The analysis identifies fiscal impact in terms of both total expenditure increases and the additional State share dollars needed to fund services at the proposed benchmark rate. For this analysis, a blended FMAP of 58.55 percent for SFY 2024, which means the federal government will cover 58.55 percent of expenditures for standard Medicaid services, with South Dakota's State share covering the remaining 41.45 percent of reimbursement costs.

I.4. Fiscal Impact Across All Services

This analysis indicates that if the proposed benchmark rates were implemented based on utilization from SFY 2023 the system would require an additional **$6.6 million**—including both State and federal dollars—to reimburse providers at the benchmark rates recommended by Guidehouse. This dollar increase is a **9.0 percent** increase from the current rates in effect as of

July 1, 2024. However, when considering the Federal Medical Assistance Percentage (FMAP) the State share would be **$5.2 million**. Note that State share appears disproportionately large due to the fact that the Medicaid services eligible for federal matching funds compose only a subset of the services reviewed. The other subset includes contracted services that are paid entirely out of State funds. The dollar estimates in Table 24 below include the funds needed for community Mental Health and Substance Use Disorder Services. The table reflects the overall fiscal impact for DSS based on the proposed benchmark rates.

Table 24: Fiscal Impact by Funding Source

Source	Utilization Paid at SFY 2024 Rates	Utilization Paid at Benchmark Rates	Difference	Change
Total (Federal + State Share)	$73,834,509	$80,448,802	$6,614,293	9.0%
State Share	$57,116,198	$62,294,568	$5,178,370	9.1%

The overall fiscal impact shown above is a result of rates being held harmless. That is, wherever the benchmark rates are lower than the current, the current rate was used to calculate the fiscal impact. Tables 25 through 28 show proposed fiscal impact by category and types of service. Where there is no percentage change over the current spend is where the rates are proposed to be held harmless. The service categories are grouped by Mental Health services, both Medicaid and contracted and SUD services, both Medicaid and contracted. Table 25 is the fiscal impact of Medicaid Substance Use Disorder Services by type of service. Group services had the greatest number of units in Medicaid Substance Use Disorder service, but with a percentage change of **2.1 percent,** the overall fiscal impact for that service is **$37,317**. Compare that with individual services, which increased by **6.7 percent** with a fiscal impact of **$68,836.**

Table 25: Medicaid Substance Use Disorder Services - by Type of Service Impact

Type of Service	SFY 2023 Units	Utilization Paid at SFY 2024 Rates	Utilization Paid at Benchmark Rates	Difference	Change
Group	207,195	$1,776,681	$1,813,998	$37,317	2.1%
Group - Rural	10,335	$106,244	$108,518	$2,274	2.1%
Individual	33,489	$1,030,457	$1,099,293	$68,836	6.7%
Individual - Rural	3,188	$117,733	$118,747	$1,014	0.9%

Type of Service	SFY 2023 Units	Utilization Paid at SFY 2024 Rates	Utilization Paid at Benchmark Rates	Difference	Change
Originating site Fee	1	$35	$35	$0	0.0%
Inpatient	9,282	$2,492,466	$2,832,646	$340,180	13.6%
Total	**263,490**	**$5,523,615**	**$5,973,236**	**$449,621**	**8.1%**

Table 26 is the fiscal impact of contracted Substance Use Disorder Services by type of service. Unlike Medicaid services, contracted services do not have any federal dollars. These services are all paid through State appropriations. Detox services has the largest percentage increase of **41.3 percent**, while Low intensity residential services had the largest dollar amount increase of **$1.1 million**.

Table 26: Contracted Substance Use Disorder Services - by Type of Service Impact

Type of Service	SFY 2023 Units	Utilization Paid at SFY 2024 Rates	Utilization Paid at Benchmark Rates	Difference	Change
Day	1,448	$237,081	$264,759	$27,678	11.7%
Detox	16,608	$953,465	$1,346,826	$393,360	41.3%
Detox - Medical	1,767	$337,144	$378,677	$41,533	12.3%
Gambling Inpatient	909	$275,445	$306,315	$30,870	11.2%
Group	766,364	$6,567,739	$6,705,905	$138,165	2.1%
Group - Rural	40,451	$415,836	$424,736	$8,899	2.1%
Individual	103,161	$3,174,363	$3,368,595	$194,233	6.1%
Individual - Interpreter	14	$241	$255	$14	5.9%
Individual - Rural - Outpatient	3,301	$121,906	$122,956	$1,050	0.9%
Individual - Rural CJI	2,862	$105,694	$106,604	$910	0.9%
Inpatient	20,136	$5,070,245	$5,951,598	$881,353*	17.4%

Type of Service	SFY 2023 Units	Utilization Paid at SFY 2024 Rates	Utilization Paid at Benchmark Rates	Difference	Change
Inpatient LCBH	4,871	$1,727,354	$1,727,354	$0	0.0%
Low Intensity Residential	67,761	$5,268,418	$6,368,856	$1,100,439	20.9%
Low Intensity Residential - CJI	17,628	$1,370,577	$1,656,856	$286,279	20.9%
Low Intensity Residential - PPW	10,237	$1,854,433	$1,944,211	$89,778	4.84%
Miscellaneous	42	$1,477	$1,477	$0	0.0%
R&B Inpatient	32,863	$1,682,914	$1,682,914	$(260,200)*	-15.5%
Total	**1,090,423**	**$29,164,331**	**$32,098,693**	**$2,934,362**	**10.1%**

*The net of Inpatient and R&B Inpatient is an overall increase of $621,153 ($881,353 – $260,200)

Table 27 is the fiscal impact of Medicaid Mental Health Services by type of service. CYF individual was the most utilized service in SFY 2023 for Medicaid Mental Health Services, and hence with the proposed rate, has the largest dollar amount increase of **$420,469**. These utilization numbers were for Medicaid recipients and hence partially paid by the federal government through Federal Medical Assistance Percentage (FMAP).

Table 27: Medicaid Mental Health Services – by Type of Service Impact

Type of Service	SFY 2023 Units	Utilization Paid at SFY 2024 Rates	Utilization Paid at Benchmark Rates	Difference	Change
CARE	59,660	$6,007,762	$6,402,802	$395,040	6.6%
CARE Frontier	10,908	$1,318,232	$1,404,796	$86,564	6.6%
CNP/PA	16,835	$1,444,611	$1,597,206	$152,595	10.6%
CYF Group	6,801	$173,766	$173,766	$0	0.0%
CYF Group Frontier	6,684	$204,998	$204,998	$0	0.0%
CYF Individual	109,783	$4,374,853	$4,795,321	$420,469	9.6%
CYF Individual Frontier	64,880	$3,102,562	$3,400,750	$298,188	9.6%
IMPACT	30,769	$3,071,669	$3,556,724	$485,055	15.8%

Type of Service	SFY 2023 Units	Utilization Paid at SFY 2024 Rates	Utilization Paid at Benchmark Rates	Difference	Change
JJRI	607	$21,327	$22,678	$1,351	6.3%
JJRI Assessments	231	$8,244	$9,240	$996	12.1%
JJRI Collateral	121	$4,318	$5,008	$690	16.0%
JJRI EBP Group - Regular	735	$18,779	$18,779	$0	0.0%
JJRI EBP Individual Regular	155	$6,177	$6,770	$594	9.6%
JJRI FFT	841	$252,813	$252,813	$0	0.0%
JJRI FFT Frontier	171	$66,830	$66,830	$0	0.0%
JJRI FFT Rural	96	$34,632	$34,632	$0	0.0%
MH Courts (FACT)	1,089	$114,095	$128,360	$14,266	12.5%
Originating site Fee	245	$8,614	$8,614	$0	0.0%
Outpatient Non-Psych	57,929	$2,295,965	$2,372,170	$76,206	3.3%
Psychiatric	5,317	$500,044	$570,883	$70,839	14.2%
Total	**373,857**	**$23,030,290**	**$25,033,142**	**$2,002,852**	**8.7%**

Table 28 is the fiscal impact of contracted Mental Health Services by type of service. Unlike Medicaid services, contracted services do not have any federal dollars. These services are all paid through State appropriations. The vast majority of CYF individual are covered through Medicaid, hence showing a lower number of utilization in SFY 2023 for non-Medicaid Mental Health Services.

Table 28: Contracted Mental Health Services – by Type of Service Impact

Type of Service	SFY 2023 Units	Utilization Paid at SFY 2024 Rates	Utilization Paid at Benchmark Rates	Difference	Change
CARE	54,881	$5,526,517	$5,889,913	$363,396	6.6%
CARE Frontier	9,796	$1,183,847	$1,261,586	$77,739	6.6%
CNP/PA	17,809	$1,528,190	$1,689,561	$161,370	10.6%
CYF Group	3,067	$78,362	$78,362	$0	0.0%
CYF Group Frontier	614	$18,831	$18,831	$0	0.0%
CYF Individual	36,675	$1,461,499	$1,601,964	$140,465	9.6%
CYF Individual Frontier	16,153	$772,436	$846,676	$74,239	9.6%
EBP - JJRI Group	385	$9,837	$9,837	$0	0.0%
IMPACT	18,147	$1,811,615	$2,097,692	$286,077	15.8%
JJRI - EBP Individual	93	$3,706	$4,062	$356	9.6%
JJRI Assessment	137	$4,890	$5,480	$590	12.1%
JJRI EBP - Individual - Frontier	83	$3,969	$4,351	$381	9.6%
JJRI EBP - Individual - Telehealth	146	$5,818	$6,377	$559	9.6%
JJRI EBP Group - Frontier	39	$1,196	$1,196	$0	0.0%
JJRI EPB Group - Telehealth	84	$2,146	$2,146	$0	0.0%
JJRI FFT	484	$134,898	$135,126	$228	0.2%
JJRI FFT Frontier	61	$23,840	$23,840	$0	0.0%
JJRI FFT Rural	40	$14,430	$14,430	$0	0.0%

Type of Service	SFY 2023 Units	Utilization Paid at SFY 2024 Rates	Utilization Paid at Benchmark Rates	Difference	Change
JJRI IFS	622	$23,399	$28,840	$5,239	22.4%
JJRI Referral	119	$48,782	$48,782	$0	0.0%
MH Courts (FACT)	1,492	$156,317	$175,862	$19,545	12.5%
Originating site Fee	284	$9,985	$9,985	$0	0.0%
Outpatient Non-Psych	48,517	$1,989,760	$2,051,557	$61,797	3.1%
R&B	7,598	$879,317	879,317	$0	0.0%
Psychiatric	4,454	$422,686	$458,162	$35,476	8.4%
Total	**214,182**	**$16,116,273**	**$17,343,731**	**$1,227,458**	**7.6%**

Table 29 shows fiscal impact by funding source and category. A blended FMAP of **58.55%** was used for Medicaid services with no FMAP applicable to the contract only services.

Table 29: Fiscal Impact by Category and Funding Sources

Medicaid Substance Use Disorder				
Total	$5,523,615	$5,973,236	$449,621	8.1%
Federal	$3,234,077	$3,497,330	$263,253	8.1%
State	**$2,289,538**	**$2,475,906**	**$186,368**	**8.1%**

Contracted Substance Use Disorder				
Total	$29,164,331	$32,098,693	$2,934,362	10.1%
Federal				0.0%
State	**$29,164,331**	**$32,098,693**	**$2,934,362**	**10.1%**

Medicaid Mental Health				
Total	$23,030,290	$25,033,142	$2,002,852	8.7%
Federal	$13,484,235	$14,656,905	$1,172,670	8.7%

State	**$9,546,055**	**$10,376,237**	**$830,182**	**8.7%**

Contracted Mental Health				
Total	$16,116,273	$17,343,731	$1,227,458	7.6%
Federal				0.0%
State	**$16,116,273**	**$17,343,731**	**$1,227,458**	**7.6%**

These rate changes create an aggregate fiscal impact of roughly **9.0 percent** assuming a hold harmless approach. This figure is an estimate based on the proposed benchmark rates within this report. Depending on budgetary constraints there is the possibility that the full rates may not be able to be implemented. Overall, this rate study was intended to inform DSS of the various cost components and service delivery that should be considered when developing rates to support provider costs.