COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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October 15, 2025

MEMORANDUM

TO: The Honorable Glenn Youngkin
Governor of Virginia

The Honorable Luke E. Torian
Chair, House Appropriations Committee

The Honorable L. Louise Lucas
Chair, Senate Finance and Appropriations Committee

Michael Maul
Director, Department of Planning and Budget

FROM: Cheryl J. Roberts
Director, Virginia Department of Medical Assistance Services

SUBJECT: Developmental Disabilities (DD) Waiver Rate Study

This report is submitted in compliance with Item 292.OO. of the 2025 Appropriations Act, which states:

The Department of Medical Assistance Services is authorized to conduct a rate study of Developmental Disabilities Services required pursuant to the Permanent Injunction (Civil Action No. 3:12CV59-JAG). The department shall include stakeholders as part of the rate development process and consider their feedback in the process. The department shall submit a report with the recommended rates and associated fiscal impact to the Governor, the Director of the Department of Planning and Budget, and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees by October 1, 2025.

Should you have any questions or need additional information, please feel free to contact me at (804) 664-2660.

CJR/wrf

Enclosure

Pc: The Honorable Janet V. Kelly, Secretary of Health and Human Resources

Virginia Department of Medical Assistance Services (DMAS)

Developmental Disabilities (DD) Waiver Rate Study

Community Coaching, Community Engagement, Companion Care, Independent Living Supports, In-Home Support Services, Personal Assistance, Private Duty Nursing, Respite Care, Skilled Nursing (including Congregate Nursing), Therapeutic Consultation, Workplace Assistance as listed in the Permanent Injunction: https://dbhds.virginia.gov/wp-content/uploads/2025/02/United-States-v.-Commonwealth-Order-of-Permanent-Injunction-1-15-2025.pdf

Final Report

Guidehouse

Prepared for: Virginia Department of Medical Assistance Services (DMAS)

Delivered by: Guidehouse

October 10, 2025

Guidehouse

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A. Executive Summary

The Virginia Department of Medical Assistance Services (DMAS) engaged Guidehouse to conduct a comprehensive rate study of 11 services under the Commonwealth's Medicaid 1915(c) Home and Community-Based Services (HCBS) waivers for individuals with intellectual and developmental disabilities (I/DD). These services include Community Coaching, Community Engagement, Companion Care, Independent Living Supports, In-Home Support Services, Personal Assistance, Private Duty Nursing, Respite Care, Skilled Nursing (including Congregate Nursing), Therapeutic Consultation, and Workplace Assistance. Services included in this study were identified in the Permanent Injunction (Civil Action No. 3:12-cv-59-JAG), which outlines compliance expectations for Virginia's DD service system.

In alignment with the Injunction's requirements that "the rate study shall be in accordance with best practices and designed to target rates necessary to ensure sufficient capacity to reach the goals of paragraphs 33 [therapeutic consultation services], 37 [day/community engagement services], 38 [private duty nursing services], 39 [skilled nursing services], and 48 [training and competency of direct support professionals]," the study aimed to assess the adequacy of current reimbursement rates and develop benchmark rates that appropriately reflect the cost of delivering high-quality services. The analysis was grounded in provider-reported data, the Commonwealth's state administrative data, publicly available labor and economic benchmarks, and peer state comparisons. Stakeholder engagement was central to the process, with input gathered through a Rate Advisory Workgroup, a Therapeutic Consultation Focus Group, and listening sessions with individuals with lived experience and their families. The Rate Advisory Workgroup included providers, provider associations, advocacy groups, DMAS staff, Department of Behavioral Health and Developmental Services (DBHDS) staff, legislative representatives, and other state agency officials. Over five sessions, the Rate Advisory Workgroup reviewed Provider Cost and Wage Survey ("Provider Survey") design, rate methodology, and preliminary analysis, findings, and recommendations, and provided feedback on key cost assumptions such as wages, benefits, supervision, and staffing ratios.

Methodology and Key Findings

Guidehouse employed an independent rate build-up methodology, which analyzes service costs into transparent components including direct care wages, employee-related expenses, supervision, administrative and program support costs, and geographic adjustments. The study incorporated data from 109 provider surveys, representing 19 percent of expenditures or $77.1 million for services in scope.

Key findings that informed the development of State Fiscal Year (SFY) 2027 proposed benchmark rates include the following observations:

- Direct care baseline wages reported in the provider survey were higher than Virginia wages for most job types and lower for a few compared to Virginia wage data publicly available from the federal Bureau of Labor Statistics (BLS). Higher wages in themselves are not an indicator of rate adequacy but must be interpreted within the context of total

compensation, considering many providers may continue to pay higher wages to maintain minimum market competitiveness even when forced to trim benefit offerings to contain overall service costs. In most cases, Guidehouse benchmarked rates using the more competitive wages derived from the provider survey, while further incorporating inflation and supplemental pay adjustments to project benchmark wages for SFY 2027.

- Employee-Related Expenses were calculated to reflect a competitive benefits package, averaging 30.35 percent of wages for direct support professionals. Benefit benchmark recommendations are not based on what providers offer today but on what they would need to be able to offer to support competitive staff hiring and retention.
- Productivity adjustments and staffing ratios were standardized across applicable services to reflect non-billable time, group service delivery models, and participant resource needs.
- Geographic cost differentials were applied using Economic Policy Institute data, resulting in a 16.8 percent overall difference between Northern Virginia and the Rest of State.
- SFY 2027 benchmark rates for all 11 services are projected to increase compared to the implemented SFY 2026 rates. The percentage change across individual service components and tiers ranges from 0.5 percent to 63.8 percent, with an average increase of 20.7 percent across all services.

Fiscal Impact and Recommendations

The proposed benchmark rates are projected to increase total expenditures from $657.5 million in SFY 2026 to $839.9 million in SFY 2027, a 27.7 percent increase. The corresponding state share is estimated to rise by $91.0 million.[1] The largest fiscal impacts are associated with Personal Assistance, In-Home Support, and Private Duty Nursing services, which together account for 82.1 percent of the projected increase. The proposed SFY 2027 benchmark rates and fiscal impact represent estimates based on the rate study; the actual rates will be determined by DMAS based on the funding appropriated for the services.

Guidehouse offers the following recommendations for DMAS's consideration:

- **Adopt a modular rate build-up approach** to implement proposed benchmark rates, enhance transparency, and enable targeted updates to rate components in the future.
- **Implement a regular rate review process** using publicly available inflation indices and labor market data to maintain rate adequacy.
- **Update geographic differential methodologies** to reflect current economic conditions using standardized, publicly available data.
- **Develop a provider cost reporting program** to support future rate reviews and compliance

[1] Virginia's Medicaid SFY 2027 blended FMAP is 50.1 percent, which means the federal government will cover 50.1 percent of expenditures for standard Medicaid services, with Virginia's state share covering the remaining 49.9 percent of reimbursement costs.

with the “80/20 rule” of the CMS Access Rule (Final Rule: Ensuring Access to Medicaid Services; CMS-2442-F), which requires that at least 80 percent of Medicaid payments for certain services be directed to direct care worker compensation.

B. Introduction and Background

The Virginia Department of Medical Assistance Services (DMAS) contracted with Guidehouse to conduct a comprehensive rate study of select services provided under the Commonwealth's three Medicaid 1915(c) Home and Community-Based Services (HCBS) waivers for individuals with intellectual and developmental disabilities (I/DD): the Building Independence Waiver (BI), the Community Living Waiver (CL), and the Family and Individual Support Waiver (FIS).

The study focused on 11 services identified in the Permanent Injunction (Civil Action No. 3:12-cv-59-JAG), which include: Community Coaching, Community Engagement, Companion Care, Independent Living Supports, In-Home Support Services, Personal Assistance, Private Duty Nursing, Respite Care, Skilled Nursing (including Congregate Nursing), Therapeutic Consultation, and Workplace Assistance.

The rate study directly addressed the requirements outlined in Paragraph 59 (a) i of the Permanent Injunction filed January 15, 2025, which requires rate development through a transparent process of stakeholder engagement that applies rate setting best practices to identify the resources needed by providers to maintain sufficient service delivery capacity, both generally and as measured by service-specific targets established in the Injunction. The Permanent Injunction states that, "*[a]t a minimum, the rate study shall be in accordance with best practices and designed to target rates necessary to ensure sufficient capacity to reach the goals of paragraphs 33, 37, 38, 39, and 48.*" [2-3] Beyond the capacity targets set forth in each of these paragraphs, the Injunction did not identify additional standards for measuring rate adequacy and appears to be aligned with similar rate setting requirements codified in Section 1902(a)(30)(A) of the Social Security Act (SSA), which grounds rate setting principles for Medicaid reimbursement.

The rate setting best practices informing Guidehouse's study are first and foremost designed to meet the comprehensive requirements of Section 1902(a)(30)(A), which mandates the development of Medicaid rates through "*methods and procedures relating to the utilization of, and the payment for, care and services available under the plan…as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments 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 such care and services are available to the general population in the geographic area…*"[4] It is important to note that rate adequacy for securing sufficient provider capacity is a fundamental requirement in

[2] https://dbhds.virginia.gov/wp-content/uploads/2025/02/United-States-v.-Commonwealth-Order-of-Permanent-Injunction-1-15-2025.pdf

[3] Service for Paragraphs in Permanent Injunction: 33 [Therapeutic Consultation], 37 [Workplace Assistance, Community Engagement, and Community Coaching], 38 [Private Duty Nursing], 39 [Skilled Nursing], and 48 [Training and Competency of Direct Support Professionals – Personal Assistance Services, Companion Services, Respite Services, In-Home Support Services, Independent Living Support Services]

[4] https://www.ssa.gov/OP_Home/ssact/title19/1915.htm and https://www.ssa.gov/OP_Home/ssact/title19/1902.htm

Medicaid rate development, but Section 1902(a)(30)(A) is also explicit in stating that payments must be consistent with economy, efficiency, and quality of care, while also safeguarding against the potential for unnecessary utilization. Guidehouse's methodology and proposed benchmarks were developed with all of these criteria in mind and are designed to meet the standards of the Permanent Injunction as well as the demands of CMS regulatory oversight.

One of the major challenges in determining rate adequacy for services delivered under Medicaid's 1915(c) waivers is that Medicaid is often the sole payer for most HCBS services, resulting in a dearth of independent measures of sufficiency beyond the Medicaid-dominated and defined market for services. Unlike other health and human services, such as inpatient hospital or nursing facility care, physician services or even childcare, HCBS rate adequacy and provider network sufficiency are not tested and proved through contract negotiations among commercial insurances, nor are they subject to an independent reimbursement standard like Medicare, which often serves as a common measuring stick of rate adequacy for other health programs. Rate sufficiency is almost exclusively determined by Medicaid's ability to cover providers' reasonable costs, and provider capacity standards are identified based on participant needs as measured and served by Medicaid. These circumstances become a problem because provider costs are greatly influenced by the resources available through Medicaid reimbursement, and sufficient provider capacity is measured by criteria internal to the needs of the Medicaid program, without reference to a broader "general population" for comparison to gauge availability of care more widely.

The range of best practices employed by Guidehouse in HCBS rate development are designed to leverage as far as possible the wealth of cost and service delivery data available within a state's Medicaid program to define a standard appropriate to its service system, while mitigating the risk of "vicious circularity" resulting from a relative lack of provider cost or pricing data external to Medicaid. Without an independent check and non-circular standard for measuring rate adequacy, historically low reimbursement and depressed provider costs can form a positive feedback loop that merely reinforces ongoing payment inadequacy. In our introduction, we briefly discuss the key elements of our methodology used to overcome the challenge of circularity in identifying sufficiency standards in Medicaid HCBS.

- **Independent Rate Build-Up Approach**: Guidehouse's overall rate methodology is commonly known as an "independent rate build-up." It is a standard methodology used in HCBS rate development because it is both a transparent and proven method accepted and encouraged by CMS for 1915(c) waiver approval, and because it is widely regarded as a best practice to address potential distortions in provider cost data due to historical under-reimbursement in Medicaid systems.

  As further discussed in Section F (Rate Methodologies and Components), this approach allows rate setters to harness as much independent cost data as possible from external labor markets, insurance marketplaces, and other industry sources to inform rates, either through comparison and verification against provider-reported costs, or through substitution as an alternative assumption to provider cost data too greatly affected by depressed reimbursement. The methodology is also extremely transparent, allowing all stakeholders to understand the assumptions used to identify reasonable costs and subsequent rates, thereby supporting regular update or further contestation when these

cost assumptions appear to no longer hold.

- **Multiple Data Sources Including a Provider Cost and Wage Survey**: Guidehouse's methodology does not rely on a single "source of truth" on provider costs, as the objective of the study is not to capture actual provider costs, updated in anticipation of future cost trends, but to identify "reasonable costs" in accordance with requirements to deliver services consistent with economy, efficiency, and quality of care, and sufficient to secure needed provider capacity. However, capturing actual provider costs and service delivery practices through a provider survey is vital to this objective, not only to assess the potential effects of under-reimbursement, but also to identify areas in which providers must pay above market and better than industry to deliver quality services. The survey also allows Guidehouse to capture service delivery practices and requirements unique to each waiver program and state service definition, as well as acquiring data in a form that can be more easily compared with other industry metrics and applied transparently within the independent rate build-up.

  Importantly, though, the provider survey is just one source of data informing the study. Section D (Data Sources) identifies the broad range of external data sources Guidehouse used to develop rate recommendations, while Section F.1. (General Cost Assumptions) describes in detail how these sources were used. This multi-source validation improved reliability and minimized bias or data gaps. Moreover, Medicaid rate setting is governed by state-specific methodologies, making it fundamentally different from Medicare or private payer rates, which are solely based on federal guidelines or market-driven negotiations. Consequently, Medicaid rates are not directly comparable across payer types and require reliance on provider data collection and corroboration across public data sources.

- **Extensive Stakeholder Engagement**: The rate development process included engagement with service providers, provider associations, and relevant federal and state agency representatives, as well as dedicated listening sessions with waiver participants, their families, and members of their advocacy communities. Section C (Stakeholder Engagement) details the various venues established by DMAS and Guidehouse to collect crucial stakeholder feedback and foster transparency in the process through regular communication on study progress, along with preliminary and final findings and recommendations. These exercises are considered best practices by CMS for the purposes of a transparent and participatory process to support waiver approval, but they are also a key validation mechanism for basic data integrity and quality assurance, as well as a mitigation strategy for detecting and correcting potential bias or inappropriate use of certain data sources. Harnessing the subject matter expertise of providers and their direct input on payment and service delivery characteristics within the system furnished another avenue for severing the potential positive feedback loop between low rates and reduced provider costs.

- **Peer State Comparison**: Although the HCBS market is uniquely dominated by Medicaid as a primary funding source, Medicaid programs are not all the same from state to state, and it can be helpful to review whatever market intelligence may be gleaned by comparing rates and service delivery features in different states to better contextualize how these systems

operate. Comparative analysis with peer states provided a wider perspective for assessing rates and broader industry trends. As noted by CMS in a national 1915(c) HCBS training, comparing "*rates for similar HCBS waiver services from bordering states and/or states with demographically similar programs*" may inform rate sufficiency, as it "*demonstrates to CMS that the state has assessed the market for related or similar services", "allows comparison to the broader market,"* is a *"possible indicator of acceptance of HCBS waiver rates by providers if rates are comparable to rates for similar services,"* and *"promotes equity and prevents unbalancing."* [5]

Guidehouse's peer state analysis is documented at length in Section E (Peer State Comparisons), in which we explain our rationale for selecting the states we did, as well as why we chose not to include some states that might have been considered otherwise. As noted in that section, the Commonwealth is well within the normal range of payment rates seen within the broader region, and in some cases, establishes higher rates than some of its comparison states. To draw conclusions about rate adequacy in Virginia from these facts alone, however, potentially ignores fundamental differences in the economic conditions and program characteristics of other states. Furthermore, such interpretation skews the full set of functions performed by peer state comparison in assessing rate adequacy.

It is a frequent misconception that peer state comparison should be focused exclusively on equivalent or similar characteristics among states, or that the goal is to derive a common standard for measuring performance or outcomes. Peer state comparison is as important for identifying incommensurable differences or outliers and extreme deviations as it is for assessing commonalities or uniformities for drawing analogies, developing metrics, or applying standards. In no case did Guidehouse's peer state comparison lead directly to rate assumptions developed in the recommendations, but the analysis did highlight the uniqueness of Viginia compared to its neighbors and regional peers, while providing further support for the Northern Virginia (NOVA)/Rest-of-State (ROS) rate distinction that establishes differentiated rate adequacy standards for different parts of the state.

[5] https://www.medicaid.gov/medicaid/home-community-based-services/downloads/rate-sufficiency.pdf

C. Stakeholder Engagement

Stakeholder engagement played a central role in the DD Waiver Rate Study, with multiple opportunities for individuals, providers, and advocacy groups to share their perspectives and inform the study process. Guidehouse worked with DMAS to facilitate a range of stakeholder engagement activities designed to gather input from individuals with direct experience in service delivery and service use. These activities included a structured Rate Advisory Workgroup, a dedicated Therapeutic Consultation Focus Group, and listening sessions with individuals with lived experience and their natural supports.

The Rate Advisory Workgroup brought together a broad cross-section of stakeholders to provide feedback on rate methodology, survey design, and key cost assumptions. The Therapeutic Consultation Focus Group offered a more targeted forum for providers of that specific service to discuss operational challenges and cost drivers. Meanwhile, the listening sessions established a forum for individuals and families to share their experiences with DD waiver services and reflect on how service access, quality, and choice have impacted their lives. Together, these engagement activities contributed to the development of a more comprehensive understanding of the current service landscape and the factors that influence service delivery across Virginia.

Additionally, the Rate Advisory Workgroup including the Department of Justice (DOJ) were given the opportunity to review and provide comments on preliminary drafts of this Final Report.

We provide additional details on feedback provided pertinent to the scope of the rate study below.

C.1. Rate Advisory Workgroup

Guidehouse worked with DMAS to convene a Rate Advisory Workgroup to provide structured, ongoing input throughout the DD Waiver Rate Study. This workgroup convened a diverse group of stakeholders – including providers, advocacy organizations, agency staff, and legislative representatives – to offer insights into service delivery and rate-setting considerations, as shown in Table 1 below. The workgroup focused specifically on the 11 services identified in the Permanent Injunction (Civil Action No. 3:12-cv-59-JAG), which include Community Coaching, Community Engagement, Companion Care, Independent Living Supports, In-Home Support Services, Personal Assistance, Private Duty Nursing, Respite Care, Skilled Nursing (including Congregate Nursing), Therapeutic Consultation, and Workplace Assistance.

Over the course of five virtual sessions, the workgroup reviewed key components of the rate study, including the design of a Provider Cost and Wage Survey ("Provider Survey"), rate methodologies, and preliminary findings related to provider, state, and public data analysis. Members provided feedback on assumptions related to wages, benefits, supervision, and other cost drivers, and helped contextualize the preliminary findings by sharing their on-the-ground experience. Their participation played an important role in shaping the study's approach to analyzing provider costs and service delivery realities.

Table 1: Rate Advisory Workgroup Composition, Roles and Discussion Topics

Category	Description
Composition *(Total of 13 representatives of industry associations and advocates were invited to the Rate Advisory Workgroup)*	• Provider and Provider Association Representatives • Advocacy Groups • Money Committee and Secretary's Office Representatives • Key Legislators • Department of Medical Assistance Services (DMAS) Representatives • Department of Behavioral Health and Developmental Services (DBHDS) Representatives • Representatives from Other Departments (Health and Human Resources, Department of Planning and Budget)
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 results • Rate build-up approach and rate components • Benchmark wages and adjustments, including supplemental pay and inflation factors • Staffing levels and supervision ratios • Final rate assumptions, current service utilization landscape, and fiscal impact of proposed rates • Considerations for implementation and future analysis

Rate Advisory Workgroup Session #1: The first session was designed to provide an in-depth understanding of the rate study process, focusing on essential aspects and methodologies. Roles and expectations, communication goals, and the scope of the project were discussed. Guidehouse offered feedback on how to complete and submit the survey, highlighting key sections that required input and providing further details. These discussions were essential in refining the survey to better capture accurate data.

Rate Advisory Workgroup Session #2: The beginning of the second session was spent analyzing how Virginia's rates compare with those of peer states, in an effort to contextualize rate study investigations into reimbursement adequacy and potential findings. This comparative analysis

helped to identify areas where Virginia may need to adjust its rates to align more closely with industry standards and practices. As part of this session, Guidehouse also offered a comprehensive overview of the rate study and shared a high-level overview of the rate methodology, including the rate-build up process. Additionally, Guidehouse presented a preliminary employee compensation analysis and preliminary employee-related expenses (ERE) analysis based on public data.

Rate Advisory Workgroup Session #3: In the third session, Guidehouse presented the results of our analysis of the provider survey, including a wage analysis, federal Bureau of Labor Statistics (BLS) comparisons, and the addition of inflation and supplemental pay to wages. In addition, Guidehouse shared findings on employee related expenses, billable time, and indirect cost analyses from the provider survey.

Rate Advisory Workgroup Session #4: Guidehouse continued discussing rate components based on analysis from the results of the provider survey in the fourth session, including analysis of transportation costs and differences in costs between Northern Virginia (NOVA) and the Rest of State (ROS) using survey and public data sources.

Guidehouse also shared additional feedback reported in the survey from providers around costs that are not currently incurred but would likely be incurred under adequate reimbursement, and qualitative concerns with service rates, reasons and / or issues that may impact service delivery, and why services can / cannot be provided.

Rate Advisory Workgroup Session #5: Guidehouse reviewed our analysis of transportation costs followed by proposed benchmark rate models, preliminary rates, fiscal impact analysis, and other recommendations. Following the meeting, stakeholders reviewed the draft Final Report to share additional feedback between August 8 and August 19, 2025.

C.2. Therapeutic Consultation Focus Group

In addition to the standard Rate Advisory Workgroup, Guidehouse worked with DMAS to host a dedicated virtual Therapeutic Consultation Focus Group to gather targeted feedback from providers and stakeholders delivering therapeutic consultation services under Virginia's DD waivers. The session included representatives from DMAS, DBHDS, Guidehouse, and nine provider organizations.

- Guidehouse presented an overview of the rate study process, preliminary findings from the provider survey, and key components of the rate build-up methodology.
- Participants engaged in detailed discussions on service delivery models, productivity and supervision patterns, wage and benefit structures, and challenges unique to therapeutic consultation.
- The group also provided feedback on capital equipment needs, travel costs, and barriers to service access, particularly in rural areas.

This focused engagement offered insights into the operational realities and cost drivers associated with therapeutic consultation services for rate rebasing.

C.3. People with Lived Experience and their Natural Supports Listening Sessions

As part of the rate study, Guidehouse conducted two virtual listening sessions with individuals who have lived experience with DD services and their natural supports. The sessions were held on two different days and at different times during the day to maximize participation and convenience. The purpose of these sessions was to introduce the rate study and gather direct feedback from people who receive services under the DD waiver. At the outset, participants were provided with an overview of the rate study, including its objectives, the importance of reviewing current rates, and how their feedback would inform recommendations to DMAS.

Participants were then divided into virtual breakout rooms, each facilitated by a Guidehouse team member. Each group included 7–10 participants, with one focus group specifically for people with lived experience and others including a mix of family members and supporters. In each breakout room, participants engaged in a 40-minute discussion centered around four key questions, as listed in Table 2. The conversations were highly participatory, with attendees sharing candid insights, challenges, and suggestions. Overall, the sessions were well-received, and participants expressed appreciation for the opportunity to have their voices heard.

Table 2 below includes the four questions that were asked in each focus group as well as a summary of the feedback received. While Guidehouse primarily focused on the feedback related to service rates, Guidehouse also collected feedback and documented key takeaways based on individuals' experiences. The feedback summarized in the table reflects the perspectives and experiences shared by participants during the listening sessions. It does not necessarily represent the views or positions of DMAS or Guidehouse.

Table 2: Feedback Received During the People with Lived Experience and their Natural Supports Listening Sessions

Question	Feedback Received
1. Do you feel you have choice in your providers and services? Are there services that Medicaid DD Waivers do not currently cover that you or your family could benefit from?	Rate-related takeaways: • Many participants reported that low pay rates for direct support professionals and other providers limit the pool of available providers, especially in rural areas. • Some noted that even when rates are increased, those increases are not always passed on to frontline staff. • The lack of competitive benefits makes it difficult to attract and retain quality providers, reducing real choice for families. Other takeaways: • Participants described limited provider options, especially for specialized services such as transportation, dental care, and respite. • Families often struggle to find providers who are trained to meet complex needs. • There is a desire for more flexible and comprehensive service offerings, including supports not currently covered by the waiver.
2. Do you or your family members face any challenges with accessing DD waiver services? If yes, what are the barriers to accessing DD waiver services?	Rate-related takeaways: • Low reimbursement rates for personal care attendants and services make it difficult to find and keep providers. • Delays in Medicaid payments deter contractors and providers from participating in the system. Other takeaways: • Long waitlists and delays in service approvals are common. • Families often lack clear information about available services and must rely on word-of-mouth. • Administrative complexity and need for better coordination among provider and state agencies to reduce service barriers (e.g., case managers, service providers, Medicaid representatives).
3. How has your experience with DD waiver services changed over time? What are differences in DD waiver services between	Rate-related takeaways: • Participants noted that rates have not kept pace with inflation or the increasing needs of individuals as they age.

Question	Feedback Received
children, transition-age youth, and adults?	• High staff turnover, driven by low wages, disrupts continuity of care. Other takeaways: • Transitioning from child to adult services is often challenging, with fewer supports and less person-centered care available for adults. • Families frequently bear the responsibility of navigating transitions and advocating for appropriate services • Case manager turnover and administrative burden have increased over time.
4. What supports might be helpful for people who do not have family, friends, or other natural supports?	Rate-related takeaways: • Restrictions on allowable living situations and savings limits hinder independence. Other takeaways: • Participants expressed concern about the future care of their loved ones when family is no longer able to provide support. • There is a need for more flexible housing and care models, as well as contingency planning and legal guardianship support for individuals without natural supports.

These listening sessions provided valuable insights into the experiences of individuals and families navigating Virginia's DD waiver system. The perspectives shared highlighted a range of strengths and challenges within the structure of current services and may help inform broader understanding and future considerations related to policy and rate-setting.

D. Data Sources

D.1. Overview of Data Sources

Insights from stakeholders were complemented by a robust set of data sources, which informed the rate models and fiscal projections. Cost assumptions developed as part of the rate study relied on a wide variety of data sources. Guidehouse collected and analyzed data from both DMAS providers as well as national and regional standards to arrive at cost assumptions. Our approach for this study was to establish assumptions based on provider-reported and State-recommended data when available and appropriate, as well as extensive industry data that reflect wider labor markets for similar populations. As part of the rate development process, we reviewed multiple data sources to inform rate assumptions, including:

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

Guidehouse, alongside DMAS and the Rate Advisory Workgroup conducted a Provider Cost and Wage Survey ("Provider Survey") to obtain data regarding the cost of delivering services from providers including employee salaries and wages, administrative costs, program support costs, provider fringe benefits, and additional service-specific costs. The provider survey yielded valuable and detailed information on baseline hourly wages, wage growth rate, administrative costs, program support costs, provider staffing patterns, and provider fringe benefits, as well as staff productivity for all programs included in the rate study.

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

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

D.1.1. Provider Cost & Wage Survey

Guidehouse prepared a detailed Provider Cost and Wage Survey ("Survey") based on the landscape of services provided in the community to individuals with DD in the State. The survey was aimed exclusively at collecting information on provider costs and service delivery for the 11 DD services in scope for the rate study, as noted in Section B.

During the April 2025 Rate Advisory Workgroup meeting, Guidehouse conducted an overview of the survey, including the objectives, topics, and questions on each worksheet within the survey, and solicited feedback from stakeholders to further enhance the survey. Following the meeting, Guidehouse offered providers time offline to review the survey and provide additional feedback or propose changes.

Based on Rate Advisory Workgroup feedback, Guidehouse and DMAS developed two separate surveys to better reflect the structure of services: a General Provider Cost and Wage Survey and a Center-Based Respite Provider Cost and Wage Survey. Both surveys followed an identical structure in terms of format and question types; however, the services included in each were distinct:

- **General Provider Cost and Wage Survey**: Community Coaching, Community Engagement, Companion Care, Independent Living Supports, In-Home Support Services, Personal Assistance, Private Duty Nursing, Respite Care, Skilled Nursing (including Congregate Nursing), Therapeutic Consultation, Workplace Assistance as listed in the Permanent Injunction (Civil Action No. 3:12-ccv-59-JAG);
- **Center-Based Respite Provider Cost and Wage Survey**: Center-Based Respite.

The aim of the surveys was to collect provider cost data across multiple services and programs that would serve as the basis for the rate studies. Additionally, Guidehouse used the surveys to:

- Capture provider cost data to provide cost foundation for rate studies;
- Receive uniform inputs across all providers to develop standardized rate model components;
- Measure changes in direct care worker wages over time;
- Determine a cost basis for developing rate components;
- Gather needed data to understand billable vs. non-billable time and staffing patterns;
- Investigate differences in costs between Northern Virginia (NOVA) and Rest of State (ROS);
- Solicit general feedback from providers on service delivery.

D.1.1.1. Survey Design and Development

Guidehouse designed this survey with input from DMAS staff and the Rate Advisory Workgroup, as well as drawing on knowledge gained from conducting similar surveys in other states. The survey was designed in Microsoft Excel and included 17 sections or worksheets on topics outlined in Table 3 below.

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

Worksheet Topic(s)	Survey Topics and Metrics	Time Period for Data Requested
Overview	A general overview of what to expect in the survey	-
Organizational Information	Provider identification, contact information, and organizational details	Most Recent Full Fiscal Year (Does not have to be audited)
Total Costs	Employee salaries, taxes and benefits;	Provider organization's most recent

Worksheet Topic(s)	Survey Topics and Metrics	Time Period for Data Requested
	non-payroll administrative costs and program support costs; and facility, vehicle and equipment costs	fiscal year
Staff Time and Wages	Direct care job types, staff types, hourly wages, stipends, supplemental pay, historical and anticipated growth in wages, unfilled positions, turnover rate, and geographic area for associated inputs	Q1 CY2025 (January 1, 2025 – March 31, 2025)
Programs & Services	Services delivered by the provider organization	Provider organization's most recent fiscal year
Staffing Patterns and Service Delivery	Depending on which services the provider selected, additional survey tabs included service delivery specific questions unique to the type of service. Examples include, but are not limited to, billable vs. non-billable time, supervisor and staffing patterns, transportation, attendance metrics	Provider organization's most recent fiscal year
Employee 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	Provider organization's most recent fiscal year
Additional Information	Clarifying comments in addition to the information covered in other worksheets or sections	-

D.1.1.2. Survey Administration and Support

The survey was released via e-mail on April 14, 2025 to all DD waiver providers that are in scope for the rate study. To assist providers in responding to the survey, Guidehouse facilitated two provider training webinars on April 17, 2025 and April 22, 2025 following the release of the survey. In the training sessions, Guidehouse introduced the survey, provided an overview of the survey tool and each worksheet tab, and addressed provider questions. The training was recorded and posted to

the Virginia website and a link to the recording of the webinar was shared with providers.

Additionally, Guidehouse provided ongoing support and resources to assist providers in completing the survey. This included a dedicated email inbox where providers could submit questions and receive tailored responses. Providers were given four and a half weeks to complete the survey, with the option to request a two-week extension for completing the service-specific worksheets. The final deadline for survey submission was May 12, 2025.

D.1.1.3. Provider Cost and Wage Survey Participation

Guidehouse received 109 completed surveys, representing approximately 19 percent of the total $401 million in SFY 2024 expenditures for services in scope for this rate study. The survey responses included representation from all eleven services covered in this rate study, providing a comprehensive view of cost and service delivery data across the service array. To evaluate the fiscal impact of the responses, Guidehouse assessed the representativeness of the submissions based on the number of providers, the size and scale of their operations, and the share of total state expenditures they account for. This approach supports alignment between the survey data and the broader provider landscape within DMAS. Provider expenditures were used as a proxy for service volume and impact. Table 4 below shows survey participation by service type, including each type's share of total expenditures and response rate.

Table 4: Provider Survey Participation and Expenditure Coverage by Service[6]

Service	SFY 2024 Total Service Expenditures	SFY 2024 Service Expenditures in Survey Submissions	Percentage of Total Expenditures in Survey Submissions	Response Rate Per Service by Expenditures
In-Home Support Services	$166,902,689	$22,718,512	42%	14%
Private Duty Nursing	$85,565,850	$17,127,985	21%	20%
Community Engagement	$45,643,931	$14,850,545	11%	33%
Therapeutic Consultation	$25,385,902	$8,596,692	6%	34%
Personal Assistance	$55,803,784	$5,318,476	14%	10%

[6] The response rate includes only provider-managed services and does not include consumer-directed services. Feedback from people with lived experience in captured in Section C.3.

Service	SFY 2024 Total Service Expenditures	SFY 2024 Service Expenditures in Survey Submissions	Percentage of Total Expenditures in Survey Submissions	Response Rate Per Service by Expenditures
Community Coaching	$8,007,655	$3,397,765	2%	42%
Independent Living Supports	$3,658,593	$2,222,018	1%	61%
Respite Care	$3,206,248	$974,914	0.8%	30%
Skilled Nursing / Congregate Nursing	$2,643,830	$722,592	0.7%	27%
Workplace Assistance Services	$1,147,666	$377,134	0.3%	33%
Companion Care	$3,337,936	$90,109	0.8%	3%
Total	**$401,304,083**	**$77,149,134**	**100%**	**19%**

D.1.2. Provider Cost and Wage Survey Review and Validation

It is important to note that the survey process used for this rate study differs from formal administrative cost reporting in that it is not subject to auditing. While providers' self-reported data were not audited for accuracy, outliers were reviewed and excluded when appropriate, and additional quality control checks were conducted to ensure data completeness. After receiving the survey responses, Guidehouse compiled the data and conducted the following quality checks to prepare it for analysis:

- **Completeness:** Each worksheet within the individual survey workbooks was reviewed to assess completion status and identify any missing data or issues requiring follow-up. Guidehouse contacted providers individually within a week of receiving their responses if clarification or corrections were needed.
- **Outliers:** Quantitative data points – such as wages, productivity, benefits, number of clients and caseloads, and staffing patterns – were reviewed across all organizations to identify potential outliers. When outlier data points were excluded or assumptions were made for rate model inputs, these assumptions were reviewed with DMAS and the Rate Advisory Workgroup and are documented in this report.

The data reported by providers through the survey were used to develop several key rate components, including baseline hourly wages, Employee-Related Expenses (ERE), and administrative and program support cost factors. Section F provides further detail on how the survey data informed the rate-setting process.

D.1.3. Claims Data

Guidehouse developed a detailed Medicaid claims data request to compute provider survey response rates and conduct fiscal impact analysis. This request included all detailed claims for services that were in scope for this rate study. We requested for multiple years of data spanning from SFY 2022 through SFY 2024 to validate. We requested key fields such as provider detail, payment information, service identifying fields, and units of measure. The claims data was used to calculate the survey response rate and to inform the fiscal impact analysis.

D.1.4. 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 understand the necessary cost requirements needed to promote access to quality services going forward. As will be detailed in greater depth in the sections that follow, Guidehouse's provider survey furnished the majority of our rate assumptions on employee wages, provider fringe benefit offerings, staff productivity, staff-to-client ratios and administrative and program support costs.

While provider cost surveys are a rich and valuable source of information on provider costs, these tools cannot validate in themselves whether the costs reported are reasonable or adequate to meet future service delivery challenges. Considering the possibility that historical costs may not be truly representative of the ongoing resources required to provide services or may not be comparable to or competitive with broader industry standards, Guidehouse evaluates cost survey data against external data benchmarks whenever feasible. As a result, the cost assumptions used by Guidehouse also benchmark provider survey information against national and regional standards that reflect wider labor markets as well as median costs typical of related industries. Table 5 summarizes the additional public data sets used to inform cost assumptions used in Guidehouse's benchmark rate recommendations.

Table 5: Other Key Data Sources

Data Source	Description
SFY 2024 Bureau of Labor Statistics, Occupational Employment and Wage Statistics (BLS OEWS)[7]	Wage data available annually by state, intra-state regions, and metropolitan statistical areas (MSA). Used for wage comparisons and establishing benchmark wage assumptions.

[7] Bureau of Labor Statistics, Occupational Employment and Wage Statistics (BLS OEWS). Available online: https://www.bls.gov/oes/current/oessrcst.htm

Data Source	Description
CY 2024-CY 2025 Bureau of Labor Statistics, Current Employment Statistics (CES)[8]	The Current Employment Statistics (CES) program produces detailed industry estimates of nonfarm employment, hours, and earnings of workers on payrolls. CES National Estimates produces data for the nation, and CES State and Metro Area produces estimates for all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, and about 450 metropolitan areas and divisions. Average hourly earnings for Residential Intellectual and Developmental Disability staff is used as a source for inflation analysis.
CY 2019-CY 2024 Bureau of Labor Statistics, Employer Costs for Employee Compensation (CECS)[9]	The Employer Costs for Employee Compensation (ECEC) measures the average employer cost per employee hour worked for total compensation, wages and salaries, and benefits, supplemental pay, and costs as a percent of total compensation. This data is collected through the National Compensation Survey (NCS) and provide information about average compensation in the economy at a point in time. ECEC for Healthcare and Social Assistance as well as Nursing and Residential Care Facilities is used for supplemental pay analysis.
CY 2019-CY 2023 Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey-Insurance Component (MEPS-IC)[10]	Federal data on health insurance costs, including Virginia-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.
SFY 2023-SFY 2025 Other State Medicaid Fee Schedules	Rate data from other states on reimbursement levels for cognate services as well as overall service design. Section E includes additional information on the sources used for analysis.
2025 Internal Revenue Service (IRS) Mileage Rate[11]	The IRS mileage rate provides the official mileage rates set by the IRS Service for calculating transportation costs.

[8] Bureau of Labor Statistics, Current Employment Statistics (CES). Available online: https://www.bls.gov/ces/
[9] Bureau of Labor Statistics, Employer Costs for Employee Compensation (ECEC). Available online: https://www.bls.gov/ecec/home.htm
[10] Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey-Insurance Component (MEPS-IC). Available online: https://datatools.ahrq.gov/meps-ic/
[11] Internal Revenue Service. Available online: https://www.irs.gov/tax-professionals/standard-mileage-rates

Data Source	Description
SFY 2025 Virginia Department of Medical Assistance Services, Fee Schedule (Effective July 1, 2025)[12]	Fee schedule for DD waiver services effective July 1, 2025.
2021 Commonwealth of Virginia Department of Medical Assistance Services: Waiver Regulations Manual[13]	Regulatory guidance issued by DMAS outlining requirements for Medicaid 1915(c) Home and Community-Based Services waivers, including service definitions, provider qualifications, limitations and expectations related to waiver services. Used to understand service structure, provider qualifications, and limitations.
2024 Virginia Department of Behavioral Health and Developmental Services (DBHDS) Customized Rate Provider Guide[14]	Regulatory guidance issued by DBHDS outlining requirements for all Customized Rates and including service criteria, roles, responsibilities, and expectations of providers. Used to understand customized service structure, provider qualifications, and limitations.
2024 DMAS §1915(c) Home and Community Based Services Waiver[15]	CMS approved Medicaid waiver administered by DMAS, outlining eligibility, covered services, provider qualifications, and operational requirements for Virginia's 1915(c) Home and Community-Based Services programs.
2024 Economic Policy Institute (EPI), Family Budget Calculator for Virginia[16]	Economic Policy Institute's Family Budget Calculator for 2024, released in January 2025, measures the income a family needs in order to attain a modest yet adequate standard of living. The budgets estimate community-specific costs for 10 family types (one or two adults with zero to four children) in all counties and cities in Virginia. Used in the analysis of costs for geographic differentials to further inform and validate considerations.

[12] Fee Schedules. Available online: https://vamedicaid.dmas.virginia.gov/bulletin/waiver-rate-updates-effective-july-1-2025

[13] This manual was provided to Guidehouse by Virginia's Department of Medical Assistance Services (DMAS) in November 2024.

[14] Virginia Department of Behavioral Health and Developmental Services (DBHDS), Customized Rate Provider Guide. Available online: https://dbhds.virginia.gov/wp-content/uploads/2024/10/CR-Provider-Guide-2024.pdf

[15] Application for 1915(c) HCBS Waiver: Draft VA.008.05.00. Available online:https://dmas.virginia.gov/media/6508/community-living-waiver-renewal-application-effective-july-1-2024.pdf

[16] Economic Policy Institute, Family Budget Calculator. Available online: https://www.epi.org/resources/budget/

E. Peer State Comparisons

E.1. Overview of Peer State Comparisons

Guidehouse also reviewed established approaches used in other states and drew on our experience conducting similar analyses. We reviewed peer state data to inform the development of rate build-up methodologies for comparable waiver services. Peer state rates also served as reference points to validate final pricing where applicable.

Although each state's Medicaid system is unique and direct comparisons have limitations, benchmarking against similar DD waiver rates can help to corroborate whether Virginia's current rates align with broader trends or stand out as outliers, signaling that rates may be too low or too high. Significant variation in Medicaid rate levels among states is common, though, and are often explained by differences in service definitions or disparate economic conditions and cost trends.

Recognizing Virginia's distinct geographic, demographic, and cultural characteristics, Guidehouse and DMAS selected peer states and services for comparison. The team reviewed each service definition prior to comparison to check for relevance and accuracy of the analysis.

Peer state data was included as a point of reference, particularly for states with similar service structures or labor markets. It helped provide general context using publicly available information. However, none of the cost assumptions and final rate determinations were derived from peer state rates and rate models.

E.2. Comparison Approach

First, Guidehouse identified nine jurisdictions (eight states and the District of Columbia) operating 1915(c) DD waiver programs that are comparable to Virginia in terms of demographics, geography, program design, and/or the scope of services offered to the DD population. Figure 1 highlights the comparison states below in blue. The key reasons for selecting these states for comparison and resources for conducting the comparisons are noted below.

- **District of Columbia (DC)**: A key comparison point for Virginia due to its shared labor market, similar cost structures, and overlapping service needs, particularly in the Northern Virginia region.[17]
- **Georgia (GA)**: Similar system scale by population, with a comparable mix of large rural areas and major metropolitan centers like Atlanta. Georgia yields close demographic and geographic parallels to Northern Virginia as well as the Commonwealth's diverse coastal, piedmont, and Appalachian makeup. Additionally, Georgia is often regarded as a significant model for reimbursement transformation since its 2010 Olmstead settlement with the Department of Justice.[18]

[17] https://dds.dc.gov/publication/idd-waiver-rates (As of SFY 2025)
[18] https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Fee%20Schedules/tabId/20/Default.aspx (As of SFY 2025)

- **Kentucky (KY)**: HCBS comparison state for Virginia due to shared Appalachian and rural characteristics, as well as similar Medicaid waiver structures and service arrays. The state also conducted a well-documented, comprehensive waiver rate study within the last two years, offering detailed rate benchmarks and methodologies that allow for close scrutiny of cost components and rate assumptions to determine comparability.[19]
- **Maryland (MD)**: Similar system scale by population, and close alignment with Northern Virginia in terms of demographics, proximity to DC, and overlapping labor force.[20] Maryland mirrors Virginia on several important socioeconomic metrics including per capita personal income (Maryland ranking #11 in the nation at $70,228, compared to #12 Virginia at $68,985) as well as per capita gross domestic product (Maryland ranking #16 at $77,881, compared to #17 Virginia at $76,363).[21]
- **North Carolina (NC)**: A neighboring state with similar system scale by population, diverse coastal, piedmont, and Appalachian characteristics, rural-urban mix, and other shared regional dynamics.[22]
- **Pennsylvania (PA)**: Another regional peer state with a slightly larger system scale by population (13 million people, compared to Virginia's 8.7 million), but still comparable.[23] Similar urban-rural contrast, with the Philadelphia metropolitan area approximately as large as the DC metro, and so serving as a peer to Northern Virginia. Pennsylvania has also been cross-referenced historically by DMAS owing to similar Medicaid program and service structures.[24]
- **South Carolina (SC)**: Regional proximity and shared demographic and economic characteristics, offering a useful comparison point for Virginia's non-metro areas.[25]
- **Tennessee (TN)**: Similar system scale by population, included for its comparable rural profile and urban centers that mirror Virginia's mix.[26]
- **West Virginia (WV)**: Chosen for its geographic and economic similarities to western Virginia.[27]

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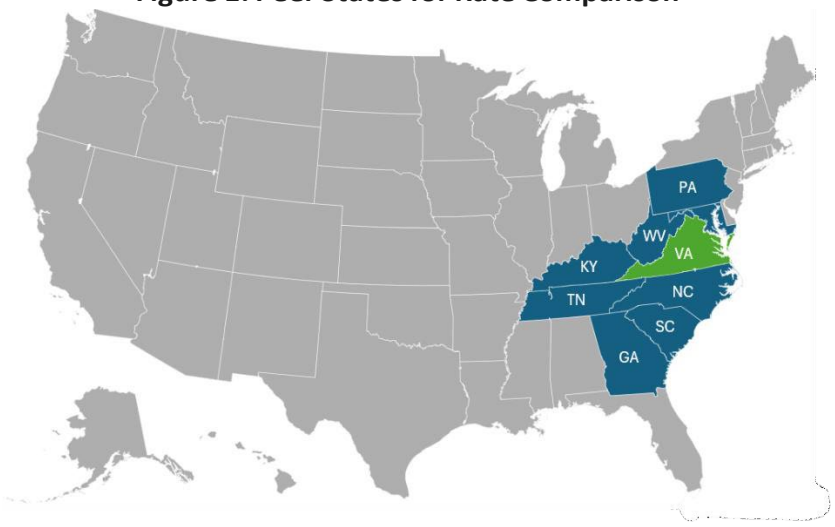
[19] Fee Schedules - Cabinet for Health and Family Services (As of SFY 2025)
[20] PT 09-25 FY25 Rates for Medicaid Waiver Programs Operated by the DDA.pdf and DDA PROVIDER Reasonable and Customary Rates Effective July 1 2024 and Updated July 5 2024.pdf (As of SFY 2025)
[21] https://jlarc.virginia.gov/pdfs/reports/Virginia%20Compared%202024-FULL%20REPORT-FINAL.pdf (2024 edition).
[22] Download Fee Schedules - DHB Fee Schedule & Covered Codes Portal (1/22/2025)
[23] https://jlarc.virginia.gov/pdfs/reports/Virginia%20Compared%202024-FULL%20REPORT-FINAL.pdf (2024 edition).
[24] select-community-based-services-rates-effective-7-1-24.pdf (As of 7/1/2024)
[25] Fee Schedules | SCDHHS (As of 11/1/2024)
[26] DDA Services and Rates FY2025.pdf (As of 1/1/2025)
[27] https://dhhr.wv.gov/bms/Programs/WaiverPrograms/IDDW/Documents/IDD%20Forms/IDD%20Policy%20Rates_10.1.24.pdf (As of 10/1/2024)

Given the internal geographic and demographic diversity of the Commonwealth, as well as its proximity to the nation's capital and unique governmental and defense industries, no state serves as a perfect "match" for comparison to Virginia. Consequently, peer states were selected for their aptness to represent different aspects of Virginia's geographic and demographic makeup, sometimes for contrast as much as comparison. Ultimately, DC, Maryland, and Pennsylvania are probably best suited for comparison to reimbursement in Northern Virginia, while Georgia, Kentucky, North Carolina, South Carolina, Tennessee, and West Virginia offer better points of comparison for the rest of Virginia.

These states were reviewed as part of the Rate Advisory Workgroup, prompting a question from a member about whether New York should have also been considered a peer state. Although the downstate/upstate distinction in New York may superficially resemble Virginia's NOVA/ROS dynamics, the scale of the differences and similarities are not really commensurable. In contrast to the roughly 30 percent of Virginia's population residing in Northern Virginia, the relationship between New York City and the rest of the state is nearly the inverse, with approximately 70 percent of the state living in the New York City metropolitan area compared to upstate. At roughly twice the total population of Virginia, New York's health and human services systems operate at a significantly larger scale. For these reasons, New York is more effectively compared with other "big states" like California, Texas, and Florida, or better aligned with states whose populations are dominated by major metropolitan areas such as Illinois or Massachusetts.

Guidehouse also contemplated including New Jersey in the comparisons. It may serve as a helpful comparison state for Virginia when analyzing rates, as both have similarly sized populations and a mix of urban and rural regions. Additionally, they share comparable economic complexity and public service infrastructures, making rate-based comparisons meaningful. However, New Jersey is less suitable for comparing 1915(c) HCBS waivers due to key structural differences. New Jersey delivers most of its long-term services and supports through managed care and has consolidated many HCBS programs under broader Medicaid authorities, such as 1115 waivers. As a result, New Jersey does not operate 1915(c) waivers. In contrast, Virginia's DD waivers operate under the 1915(c) waiver authority. These differences in waiver structure, administration, and service delivery models limit direct rate comparisons between the two states.

Figure 1: Peer States for Rate Comparison[28]

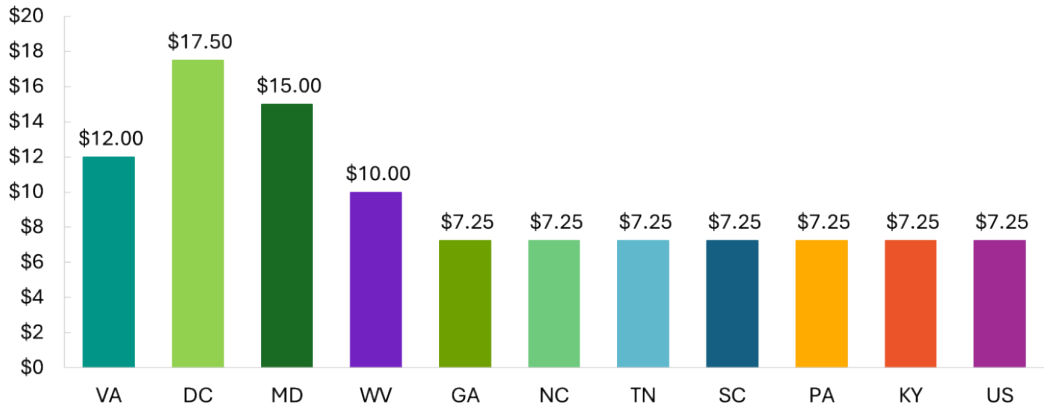


E.3. Peer State Comparison Analysis

When comparing peer states, Virginia is in the upper quartile for both minimum wage and median household income. As of 2024, Virginia's minimum wage stands at $12.00 per hour, reflecting a relatively strong wage floor among the selected peers. Cost-of-living differentials across comparable states may contribute to varying service delivery and financial needs across states.

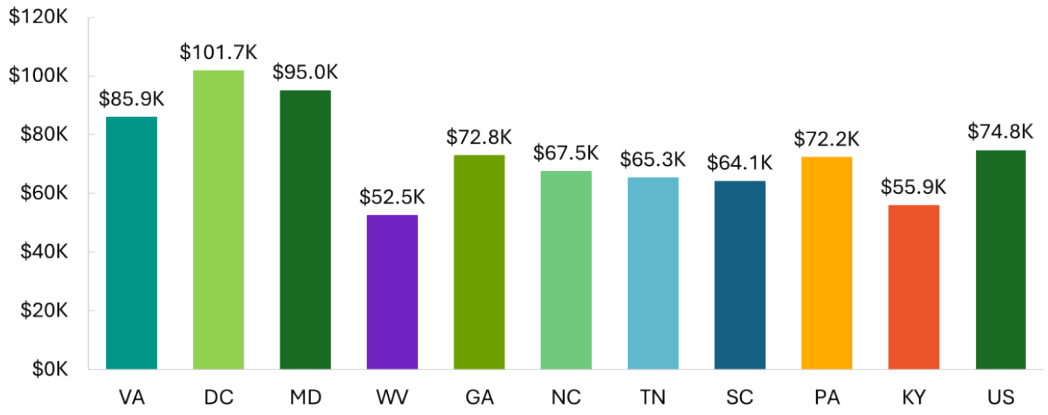
Figures 2 to 16 illustrate how Virginia compares to peer states across these two economic indicators.

Figure 2: 2024 Minimum Wage Comparison



[28] DC and MD are included in the peer state analysis and highlighted in blue on the map.

Figure 3: 2022 Median Household Income in Census



When reviewing the peer states for comparable services, Virginia's rates for most services overall appeared to be within the middle to upper end of reimbursement. The most recent rates in these states range from 2024 to 2025, with some states actively undergoing rate studies or rebasing efforts. Figures 4 to 16 illustrate the Virginia SFY 2026 rates with the peer states and the average between all rates. The individual service comparisons include only a subset of the peer states that have comparable services.

Figure 4 includes peer-state rate comparisons across six states for the Community Engagement service.

Figure 4: Community Engagement (Per Hour) – Peer States Rate Comparison[29]

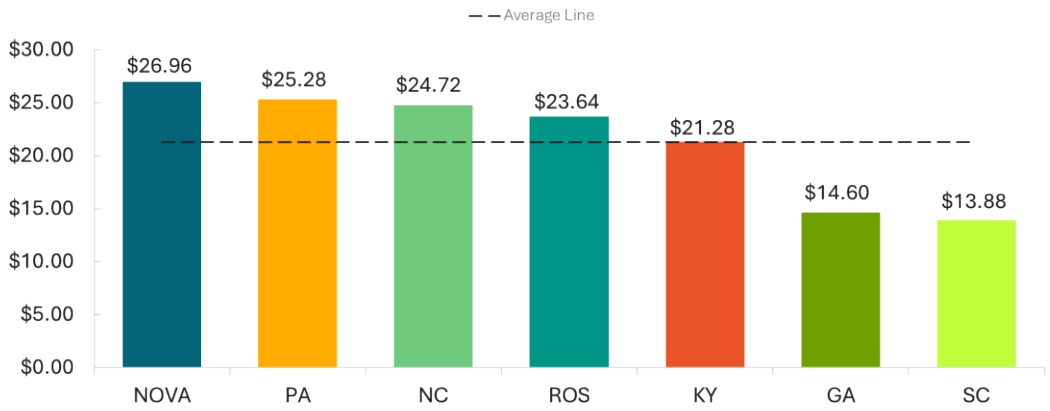
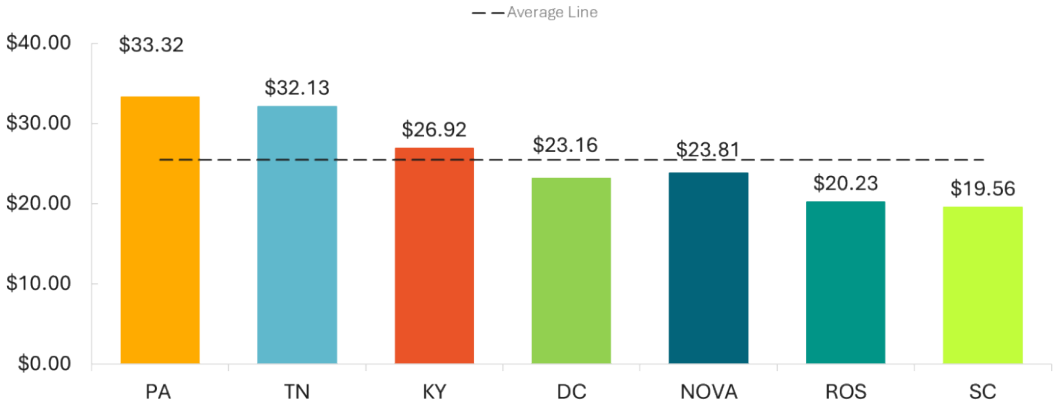


Figure 5 includes peer-state rate comparisons across six states for the Companion Care – Agency Directed service.

Figure 5: Companion Care Agency Directed (Per Hour) – Peer States Rate Comparison[25]



[29] Comparison state rates were obtained from publicly available fee schedules published between 2024 and 2025. The rates used reflect the most recent schedules available at the time the analysis was conducted for this rate study, as of June 1, 2025. Virginia rates reflect fee schedule rates effective July 1, 2025. The analysis in this section is based on public sources that are subject to change based on ongoing rate development and rebasing efforts in other states. Only a subset of comparison states offer services and rates that can be used for direct comparison to Virginia's services.

Figure 6 includes peer-state rate comparisons across three states for the Companion Care – Consumer Directed service.

Figure 6: Companion Care Consumer Directed (Per Hour) – Peer States Rate Comparison[25]

Figure 7 includes peer-state rate comparisons across eight states for the In-Home Support service.

Figure 7: In-Home Support (Per Hour) – Peer States Rate Comparison[25]

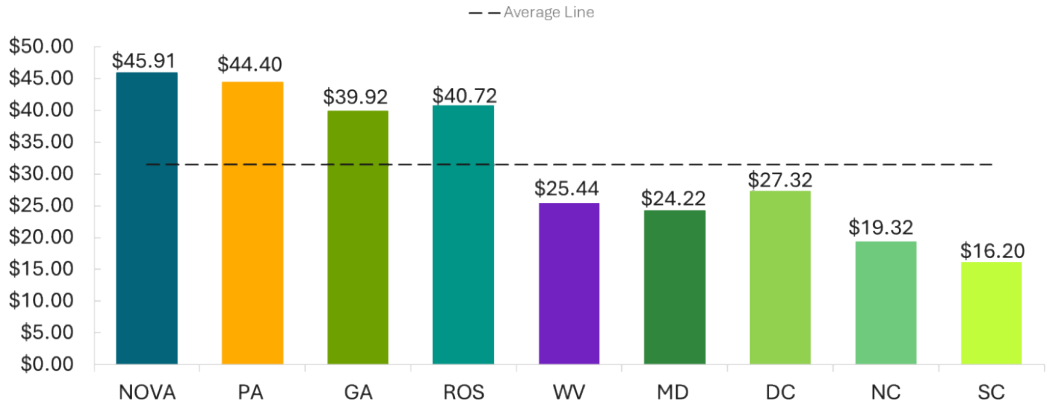


Figure 8 includes peer-state rate comparisons across three states for the Personal Assistance – Agency Directed service.

Figure 8: Personal Assistance Agency Directed (Per Hour) – Peer States Rate Comparison[25]

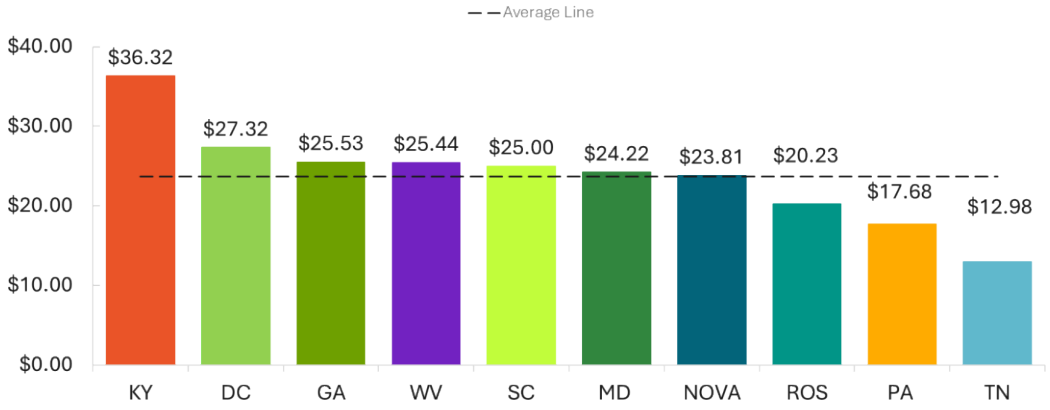


Figure 9 includes peer-state rate comparisons across three states for the Companion Care – Consumer Directed service.

Figure 9: Personal Assistance Consumer-Directed (Per Hour) – Peer States Rate Comparison[25]

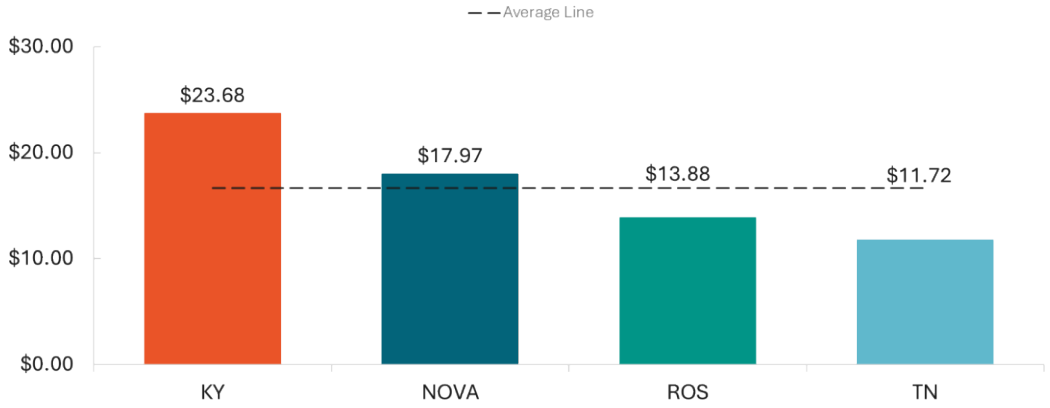


Figure 10 includes peer-state rate comparisons across eight states for the Respite Care – Agency Directed service.

Figure 10: Respite Care Agency Directed (Per Hour) – Peer States Rate Comparison[25]

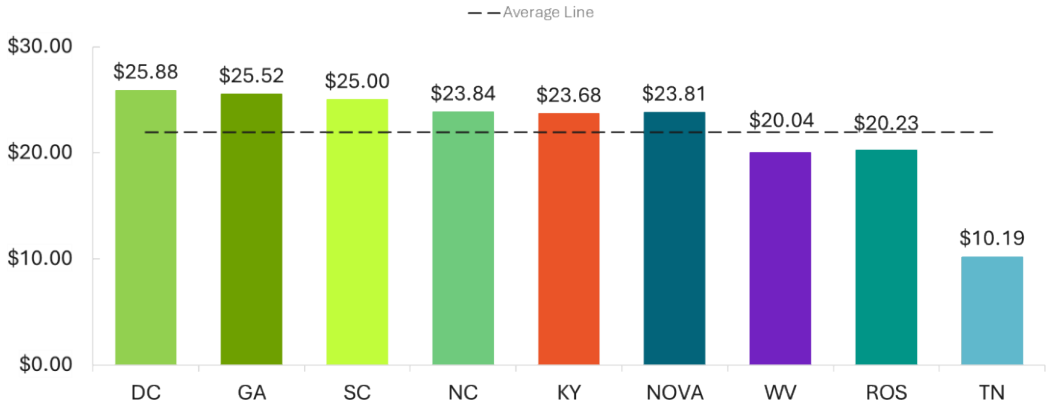


Figure 11 includes peer-state rate comparisons across three states for the Respite Care – Consumer Directed service.

Figure 11: Respite Care Consumer Directed (Per Hour) – Peer States Rate Comparison[25]

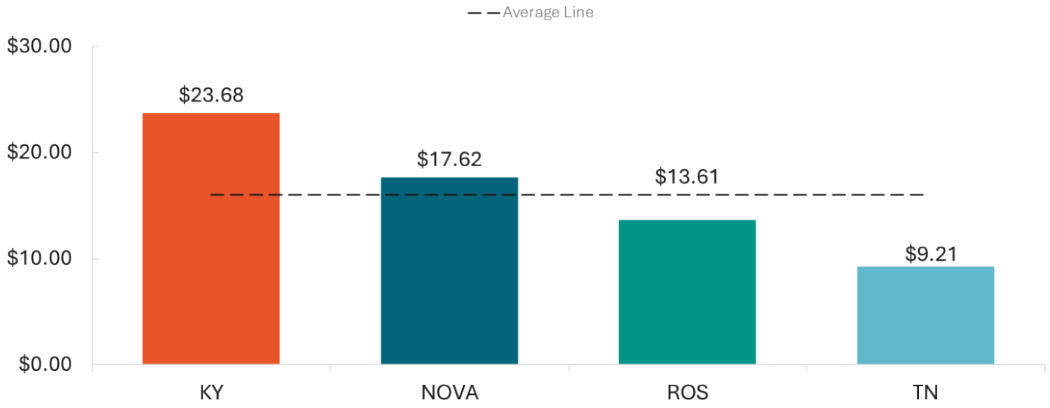


Figure 12 includes peer-state rate comparisons across six states for the Skilled Nursing – Registered Nurse service.

Figure 12: Skilled Nursing Registered Nurse (Per 15 Minutes) – Peer States Rate Comparison[25]

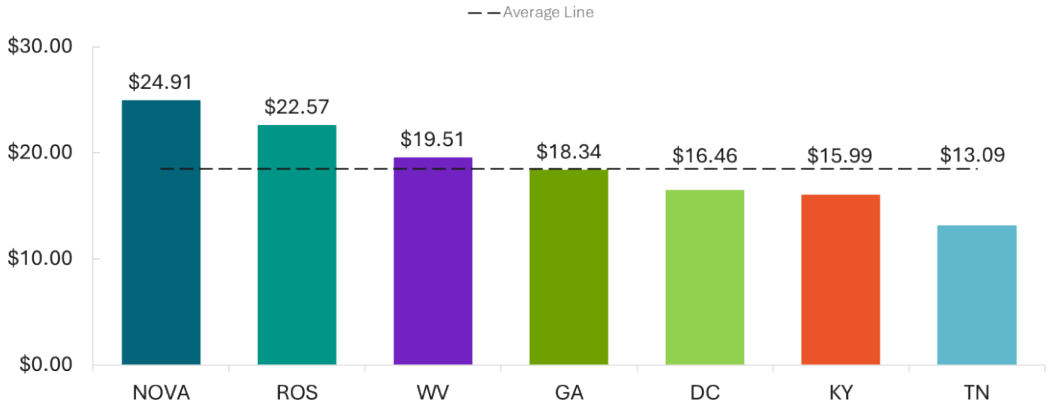


Figure 13 includes peer-state rate comparisons across five states for the Skilled Nursing – Licensed Practitioner Nurse service.

Figure 13: Skilled Nursing Licensed Practitioner Nurse (Per 15 Minutes) – Peer States Rate Comparison[25]

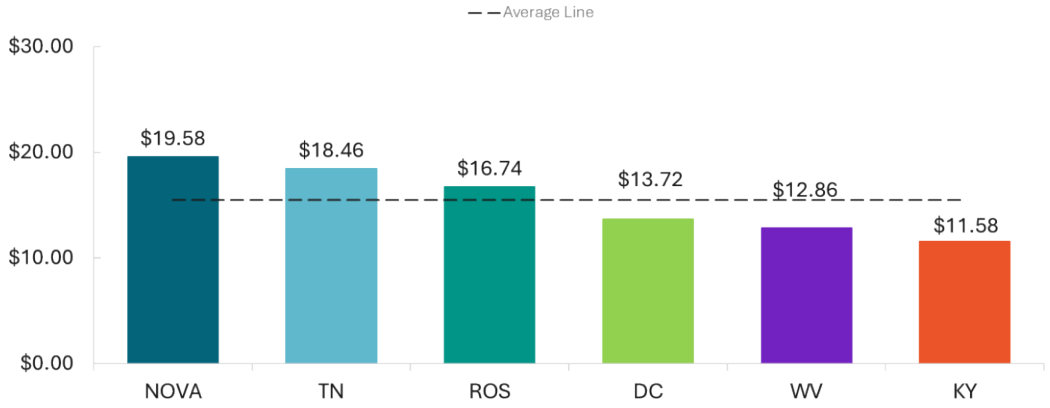


Figure 14 includes peer-state rate comparisons across three states for the Private Duty Nursing – Registered Nurse service.

Figure 14: Private Duty Nursing Registered Nurse (Per 15 Minutes) – Peer States Rate Comparison[25]

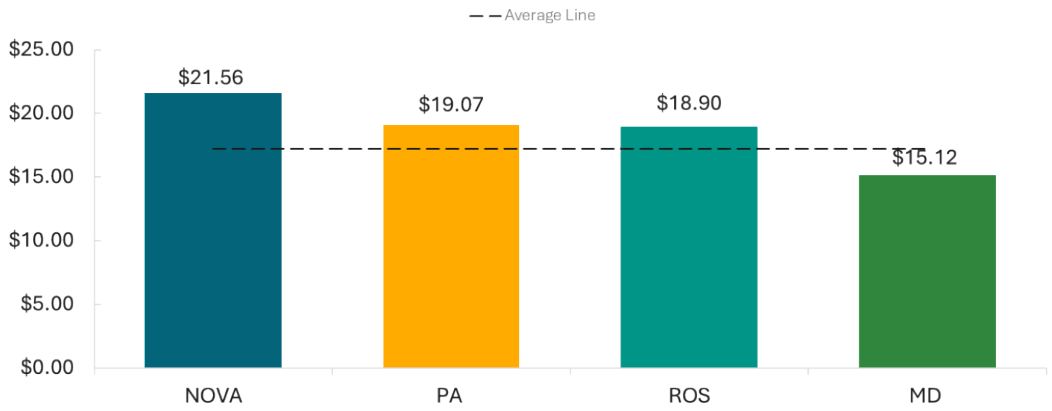


Figure 15 includes peer-state rate comparisons across three states for the Private Duty Nursing – Licensed Practitioner Nurse service.

Figure 15: Private Duty Nursing Licensed Practitioner Nurse (Per 15 Minutes) – Peer States Rate Comparison[25]

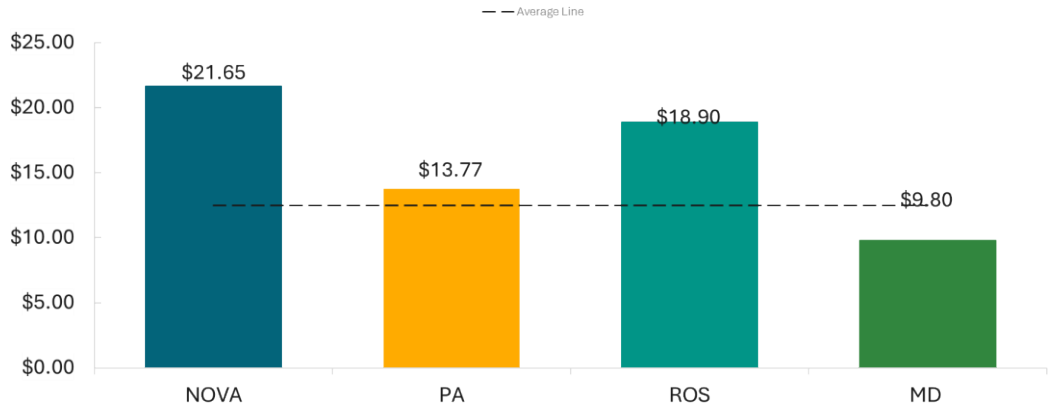
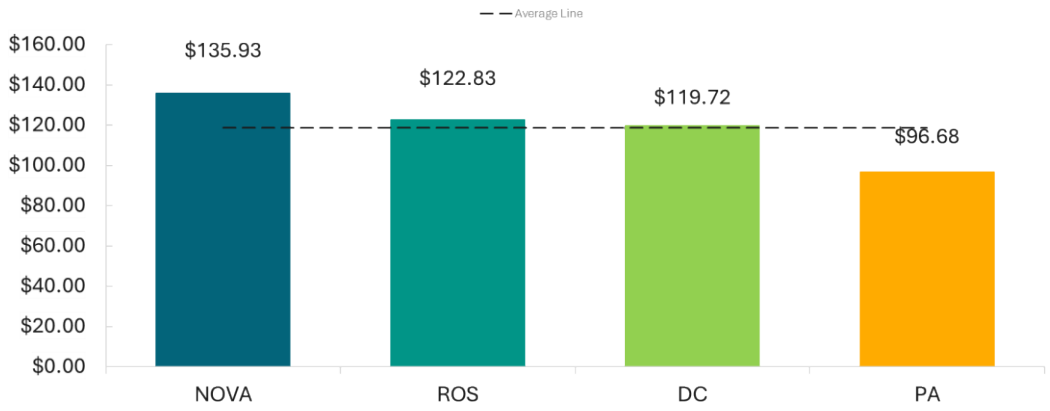


Figure 16 includes peer-state rate comparisons across three states for the Therapeutic Consultation service.

Figure 16: Therapeutic Consultation (Per 15 Minutes) – Peer States Rate Comparison[25]



F. Rate Methodologies and Components

F.1. Overview of Rate Methodologies

Guidehouse employed an independent rate build-up approach to develop payment rates for DD waiver services. The independent rate build-up approach 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 states to clearly delineate the components that contribute to rates and adjust as needed.

Guidehouse calculated the rate components for each service in the rate models, building rates from the ground up. For each service in the rate study, we identified direct care costs (e.g., direct service professional wages and benefits), determined the corresponding payment amounts, and added administrative and program support costs necessary to deliver the service.

Many of the proposed service rate benchmarks are built on a common set of assumptions for each rate component, tailored to the specific context and goals of each service. This bottom-up approach starts with core wage assumptions for direct care staff and incorporates estimated costs for supporting personnel, activities, and materials. This section outlines the methodology used to calculate each rate component and details the data sources that informed these calculations. The section is divided into the following areas:

- Staff Wages
- Employment Related Expenditures (ERE)
- Productivity of Direct Care Staff
- Supervision
- Staffing Ratios
- Administrative Expenses
- Program Support Expenses
- Geographic Adjustments

F.2. General Cost Assumptions

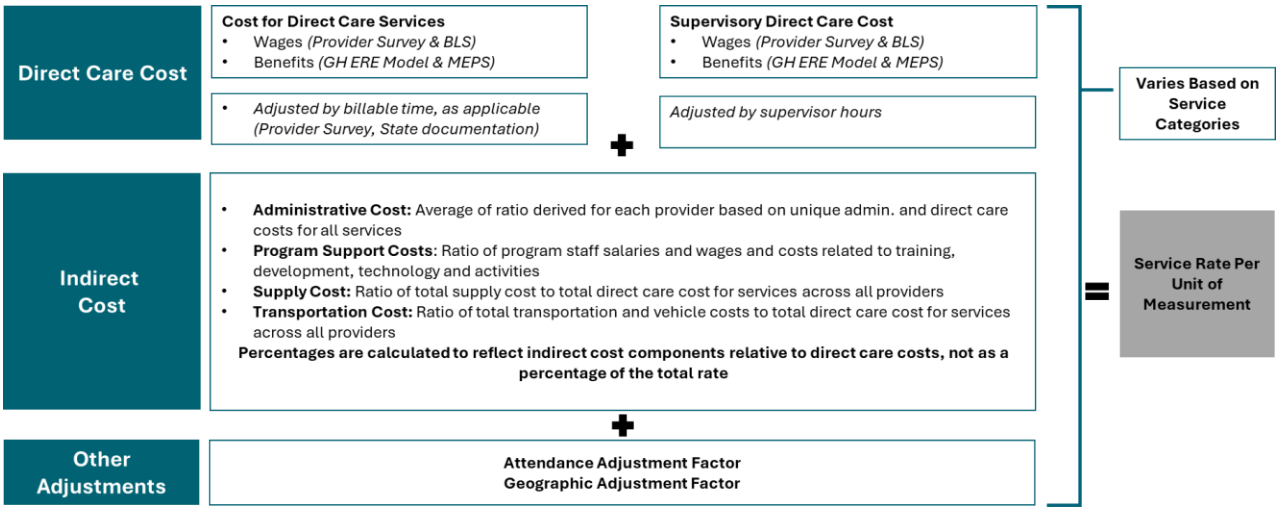
The methodology for developing a rate for a unit of service – or a rate model – varies across types of services but generally includes certain key components. A rate model starts with the wage for the primary staff person providing a service and then builds upon that wage with fixed or variable cost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

- Direct Care Compensation Costs
    - Staff Wage Costs
    - Employment Related Expenditures (ERE)
    - Supervision Costs
    - Inflation Costs
    - Supplemental Pay Costs
- Billing Adjustments to Direct Care Compensation Costs
    - Billable vs Non-Billable Time (Productivity) of Direct Service Staff
    - Transportation 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 17 illustrates the "building block" structure of Guidehouse's rate development methodology. Although individual rates may incorporate different building blocks, each rate model follows a similar process for identifying the component blocks for inclusion, based on the service requirements and specific adjustments needed to align overall costs with the appropriate billing logic and units of service.

Figure 17: Overview of Rate Build-Up Approach



Customized Rates

A customized rate is approved based on either a fixed rate or a flexible rate that varies by region (NOVA vs. ROS). For this rate study, customized rates are available for two services – In-Home Supports and Community Coaching – both of which use fixed rates. Of note, this rate study does not include flexible rates that are provided for other DD waiver services such as Sponsored Residential services. There are eight sets of fixed rates for each service, differentiated by staffing requirements and region, and we have established rates for all eight.

- 1:1 support with specialized staffing (NOVA)
- 1:1 support with specialized staffing (ROS)
- 2:1 support with standard staffing (NOVA)
- 2:1 support with standard staffing (ROS)
- 2:1 support with specialized staffing with one standard staff and one specialized staff (NOVA)

- 2:1 support with specialized staffing with one standard staff and one specialized staff (ROS)
- 2:1 support with specialized staffing for both staff (NOVA)
- 2:1 support with specialized staffing for both staff (ROS)

Specialized staff are typically Direct Support Professionals (DSPs) who support participants with behavioral health needs. Therefore, we rebased the rates using the existing rate structure and in alignment with guidance provided to providers by DMAS.[30]

F.2.1. Staff Wages

Wages for direct care staff form the largest component of any rate model, as many of the services for which Guidehouse developed rate models depend substantially on the labor time of the staff providing DD services. To best understand the landscape of wages in Virginia, we used data from the provider survey reported by provider organizations.

Ninety-three of 109 providers (85 percent) who participated in the provider survey provided direct care wages data. Each responding provider reported average hourly or "baseline" wages in addition to overtime, shift differential and other forms of supplemental pay, as well as inflationary trends in wages and other wage or salary-related information. The staff types with the highest number of Full-Time Equivalents (FTE) reported in the survey were Direct Support Professional (DSP) - Daytime, DSP – Swing Shift/Overnight and Direct Support Supervisor, with almost 2,000 FTEs between the two job categories. Direct Care Personnel, Technicians, Aides, and similar staff types are often the foundation of direct care in the study population, as evidenced by the number of positions reflected in the survey responses. However, there are additional staff that are commonly considered when building out models to account for the appropriate credentialling and licensing required to provide some of these services.

Guidehouse applied a weighting of reported baseline wages based on the number of FTEs. FTE-weighted wages are statistically robust because they account for actual work effort across full-time and part-time roles. As a result, providers employing more FTEs have a proportionally greater influence on average wages. This method helps avoid over- or under-representing part-time roles and aligns wages with actual labor contributions. Table 6 below illustrates a hypothetical calculation of an FTE-weighted hourly wage of $18.05 for the staff type "Job1". In this example, the average hourly wage is $17.60.

[30] Additional information about customized rates is available in the Virginia Department of Behavioral Health and Developmental Services (DBHDS) Customized Rate Provider Guide: https://dbhds.virginia.gov/wp-content/uploads/2024/10/CR-Provider-Guide-2024.pdf

Table 6: FTE-Weighted Average Wage and Average Wage Calculation Method Example

Provider – Staff Type	Average Hourly Wage from Provider Survey – Unweighted (a)	Number of FTEs from Provider Survey (b)	FTE Weights (d = b / c)	FTE-Weighted Wage Contribution (e = d * a)
Provider A – Job1	$14.00 (a1)	5.0	12.5%	$1.75 (e1)
Provider A – Job1	$18.00 (a2)	20.0	50.0%	$9.00 (e2)
Provider B – Job1	$18.38 (a3)	5.0	12.5%	$2.30 (e3)
Provider C – Job1	$20.00 (a4)	10.0	25.0%	$5.00 (e4)
Total	**$17.60** (a1 + a2 + a3 + a4) / 4	**40.0** (c)	**100.0%**	**$18.05** (e1 + e2 + e3 + e4)

Applying this method to the survey data, we found that the average wage for DSPs is $18.66 per hour, while the FTE-weighted average wage is $20.36 per hour. This suggests that providers with a higher number of FTEs tend to offer wages above $18.66, resulting in a higher FTE-weighted average. Similar patterns are observed for BCBAs and BCABAs. In contrast, Behavioral Specialist/Technician wages show an inverse trend: the unweighted average wage is higher than the FTE-weighted average. This indicates that most FTEs reported have wages closer to the FTE-weighted average rather than the overall average. A similar trend was noted in the RN wage, which prompted further review in comparison with Virginia public wage data.

The baseline wages represented in Table 7 do not include inflationary factors or supplemental pay and are representative of the time period requested within the survey.

Table 7: Baseline Wages Reported in Provider Cost and Wage Survey – Q1 CY 2025

Staff Type List	Survey Average FTE Weighted Hourly Wage - Q1 CY2025 (Wage Range)	Survey Average Wage - Q1 CY2025	Number of Full Time Equivalents (FTEs)
Direct Support Professional	$20.36 ($12.55 – $40.00)	$18.66	2047.6
Direct Support Professional – Specialized (for Customized Services)	$22.38 ($14.00 – $27.73)	$21.66	234.5

Staff Type List	Survey Average FTE Weighted Hourly Wage - Q1 CY2025 (Wage Range)	Survey Average Wage - Q1 CY2025	Number of Full Time Equivalents (FTEs)
Personal Caregiver	$14.31 ($12.41 - $18.38)	$14.30	71.5
Licensed Practical Nurse (LPN)	$32.21 ($20.00 – $45.38	$33.96	253.1
Registered Nurse (RN)	$35.20 ($22.00 - $50.29)	$36.07	65.1
Occupational Therapist (OT)	$49.41 ($49.00 - $50.27)	$49.64	15.5
Physical Therapist (PT)	$45.85 ($43.50 – $50.60	$47.03	6.0
Speech Therapist (ST)	$54.60 ($41.27 - $63.55)	$49.94	17.0
Behavioral Specialist/Technician	$34.01 ($16.00 - $72.00)	$42.44	96.0
Board Certified Assistant Behavior Analyst (BCABA)	$53.86 ($31.81 - $70.00)	$48.31	33.0
Board Certified Behavior Analyst (BCBA)	$78.47 ($34.10 - $87.00)	$76.79	87.0
Licensed Clinical Professional Counselor (LCPC)	Not Reported	Not Reported	Not Reported
Licensed Clinical Social Worker (LCSW)	Not Reported	Not Reported	Not Reported
Positive Behavior Support Facilitators (PBSF)	$64.38 ($60.00 - $65.00)	$64.38	8.0

Staff Type List	Survey Average FTE Weighted Hourly Wage - Q1 CY2025 (Wage Range)	Survey Average Wage - Q1 CY2025	Number of Full Time Equivalents (FTEs)
Psychiatrist	Not Reported	Not Reported	Not Reported
Psychologist	Not Reported	Not Reported	Not Reported
Direct Support Supervisor	$28.47 ($14.00 - $52.25)	$30.07	134.7
Personal Caregiver Supervisor	$19.50 ($12.55 – $22.25)	$19.50	71.5
Clinical Director	$65.09 ($27.50 - $104.60)	$63.60	6.0

F.2.1.1. Direct Support Professional Classification

Nearly half of the DSP FTEs reported by providers are classified as DSP 1, while the remainder are not further specified, as shown in Table 8. Fewer than 5 percent are designated as DSP 2 or DSP 3. Although the average wage for DSP 2 is higher – likely due to the small sample size – the overall wage range is consistent with the broader DSP group.

Table 8: Direct Support Professional Wage Analysis - Provider Cost and Wage Survey

Q1 CY 2025 DD Provider Survey					
Survey Staff Type	Median Wage (50th PCT)	75th PCT Wage	Average Wage	Average Wage Range	Number of Full Time Equivalents (FTEs)
Direct Support Professional – Combined	$18.00	$30.97	$18.66	$12.55 - $40.00	2047.6
DSP 1	$16.00	$29.81	$17.47	$14.00- $38.00	957.5
DSP 2	$18.83	$30.97	$21.09	$14.00- $40.00	139.8
DSP 3	$16.88	$20.03	$17.93	$15.00-	27.8

Q1 CY 2025 DD Provider Survey					
Survey Staff Type	Median Wage (50th PCT)	75th PCT Wage	Average Wage	Average Wage Range	Number of Full Time Equivalents (FTEs)
				$22.37	
No Additional Staffing Specification	$18.68	$30.97	$19.11	$12.55-$30.59	926.4

An analysis of wage progression across DSP levels, including daytime and swing shift/overnight within the same provider organization, revealed varied trends. Six provider agencies reported at least two DSP levels in the survey, with three providers operating in NOVA and the remainder in ROS. Some providers showed steady increases from DSP 1 to DSP 3, while others reported differing wages for the same DSP level. One provider indicated higher wages for DSP 1 than DSP 2, and a few reported identical wages across all DSP levels.

During a Rate Advisory Workgroup meeting, providers noted that not all organizations differentiate between DSP levels. Where distinctions do exist, they are at the discretion of the providers and they may reflect differences in tasks performed, experience, certifications, or the ability to support individuals with more complex needs.

DSP 1, DSP 2, or DSP 3 are not formally defined and required by DMAS, and the survey did not identify consistent patterns by and across levels. As such, the combined DSP wage was used as the most representative metric. The FTE-weighted benchmark hourly average of $20.36 per hour reflects all DSP levels and allows flexibility for differential wages if needed.

F.2.1.2. Public Data Wage Comparison and Benchmarking

We compared Q1 CY2025 FTE weighted wages in the survey to May 2024 average and median wages publicly reported by the Bureau of Labor Statistics, Occupational Employment and Wage Statistics (BLS OEWS) for benchmarking and validation purposes. The BLS OEWS releases Virginia-specific wages for occupations similar to staff that provide DD services. It is imperative to note that BLS does not include DSP as an explicit job type, and therefore comparisons used for DSP are based on historical comparisons in the Commonwealth, comparisons commonly used in other states, and discussions with the Rate Advisory Workgroup. On the other hand, BLS includes standardized job types for certified or licensed practitioners including the Registered Nurse (RN) and License Practice Nurse (LPN) that serve as commensurate comparison points to survey wages.

Table 9 compares wages reported in the provider survey ("survey wages") with BLS OEWS wages across all job types included in the rate models. Key observations:

- Survey wages generally exceeded the BLS-reported wage range above either the average or median for most roles (e.g., LPNs, PBSFs). Based on discussions with the Rate Advisory Workgroup input, FTE-weighted survey wages were used to develop proposed benchmarks for these practitioner roles, as they best represent DD waiver providers' actual practice,

align most closely with a cost-informed rate, methodology, and are more likely to support staff hiring and retention. While survey wages were higher than their BLS comparison benchmarks, they were sufficiently comparable to BLS ranges to avoid potential concerns of overpayment.

- Where survey wages fell between the average and median range of the BLS-reported wage, survey wages were used as the benchmark for purposes of methodological consistency with reimbursement based on reasonable provider costs.
- For roles where survey wages were lower than both the BLS average and median, BLS averages were used as the wage assumption to promote alignment with industry standards, reported lower wages were treated as evidence of under-reimbursement and the need to benchmark to the BLS average alternative to support competitive compensation. This circumstance applied to Registered Nurses (RNs) and Physical Therapists (PTs), where survey data fell below both benchmarks.
- For roles not captured in the survey, BLS average wages were used as the default standard for reasonable benchmarks. These roles include key positions such as Psychiatrists and Psychologists, which are essential for rate-setting in services like Therapeutic Consultation.

Table 9: Provider Survey and Bureau of Labor Statistics Virginia Comparison[31]

Survey Staff Type	BLS Job Type	Q1 CY2025 VA Provider Survey Average FTE-Weighted Hourly Wage	May 2024 VA BLS Average Hourly Wage	May 2024 VA BLS Median Wage	Percent Difference of Provider Survey from BLS Average / Median
Direct Support Professional	Home Health and Personal Care Aides (311120) and Social and Human Service Assistants (119151); *Average of both job types*	$20.36	$18.29	$17.40	+11.3% / +17.0%

[31] Therapeutic Consultation service wages blend multiple job types to account for the diverse and specific list of credentialed staff who can provide those services: (1) Therapeutic Consultation, Therapist/Behavior Analysts/Rehab. Engineers: Average of wages for Occupational Therapists, Physical Therapists, Speech Therapists, BCBA, and BCABA. (2) Therapeutic Consultation, Psychologist/Psychiatrist: Average of wages for Psychiatrist, Psychologist, LCPC, and LCSW. (3) Therapeutic Consultation, Other Professionals: Average of PBSFs, LCPC, and LCSW.

Survey Staff Type	BLS Job Type	Q1 CY2025 VA Provider Survey Average FTE-Weighted Hourly Wage	May 2024 VA BLS Average Hourly Wage	May 2024 VA BLS Median Wage	Percent Difference of Provider Survey from BLS Average / Median
Direct Support Professional – Specialized (for Customized Service)	Home Health and Personal Care Aides (311120) and Social and Human Service Assistants (119151); *Average of both job types*	$22.38	$18.29	$17.40	+22.4% / +28.6%
Personal Caregiver	Home Health and Personal Care Aides (311120)	$14.31	$15.11	$14.03	-5.3% / +2.0%
Licensed Practical Nurse (LPN)	Licensed Practical and Licensed Vocational Nurses (292061)	$32.21	$30.47	$29.96	+5.7% / +7.5%
Registered Nurse (RN)	Registered Nurses (291141)	$35.20	$43.72	$42.70	-19.5% / -17.6%
Occupational Therapist (OT)	Occupational Therapists (291122)	$49.41	$47.94	$48.34	+3.1% / +2.2%
Physical Therapist (PT)	Physical Therapists (291123)	$45.85	$49.51	$48.42	-7.4% / -5.3%
Speech Therapist (ST)	Speech-Language Pathologists (291127)	$54.60	$46.24	$45.37	+18.1% / +20.3%
Behavioral Specialist /Technician	Substance Abuse, Behavioral Disorder, and Mental Health Counselors (211018)	$34.01	$30.59	$28.08	+11.2% / +21.1%
Board Certified Assistant Behavior Analyst (BCABA)	N/A	$53.86	N/A	N/A	N/A

Survey Staff Type	BLS Job Type	Q1 CY2025 VA Provider Survey Average FTE-Weighted Hourly Wage	May 2024 VA BLS Average Hourly Wage	May 2024 VA BLS Median Wage	Percent Difference of Provider Survey from BLS Average / Median
Board Certified Behavior Analyst (BCBA)	N/A	$78.47	N/A	N/A	N/A
Licensed Clinical Professional Counselor (LCPC) - BLS only	Substance Abuse, Behavioral Disorder, and Mental Health Counselors (211018)	Not Reported	$30.59	$ 28.08	N/A
Licensed Clinical Social Worker (LCSW) - BLS only	Healthcare Social Workers (211022)	Not Reported	$32.23	$30.86	N/A
Positive Behavior Support Facilitators (PBSF)	Clinical and Counseling Psychologists (193033)	$64.38	$50.71	$41.88	+26.9% / +53.7%
Psychiatrist - BLS only	Psychiatrists (291223)	Not Reported	$129.05	N/A	N/A
Psychologist - BLS only	School Psychologists (193034)	Not Reported	$42.75	$41.88	N/A
Psychologist - BLS only	Clinical and Counseling Psychologists (193033)	Not Reported	$50.71	$38.96	N/A

F.2.1.3. Inflationary Increases in Wages

We also consulted national public data in tandem with survey data to understand how wages and costs have trended over recent years. Table 10 includes the most recent growth rate from each source, which includes:

- **CMS Medicare Economic Index (MEI).** The MEI is published by the Centers for Medicare & Medicaid Services (CMS) and reflects the projected change in the costs of inputs used to provide physician services, including wages, benefits, and practice expenses. The most recent projection for calendar year 2024 to calendar year 2025 indicates a growth rate of

3.4 percent.

- **BLS CPI-U for Elderly Home Care.** The BLS publishes wage trends for home care workers serving elderly populations. It draws from the Current Employment Statistics (CES) survey, capturing employment and earnings trends across various health care sectors. The most recent projection for calendar year 2024 to calendar year 2025 indicates a growth rate of 1.7 percent.
- **BLS Current Employment Statistics for Residential, Intellectual and Developmental Disability Facilities and Home Health Care Services.** The BLS also publishes wage and employment trends specific to sectors such as group homes, intermediate care facilities, and home health care. It offers sector-specific insight into how wages have changed over time. The most recent projection for calendar year 2024 to calendar year 2025 indicates a growth rate of 2.8 percent growth rate.
- **Cost and Wage Survey.** Responding provider organizations recorded the average growth rate of earnings between 2021 and 2022, 2022 and 2023, and 2023 and 2024Q2 for their staff. The median wage growth rate for SFY 2025-2026 is 3.6 percent, while the average growth rate was 3.0 percent.

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

Source	Time Period	Growth Rate
CMS Medicare Economic Index (MEI)[32]	CY 2024 – CY 2025 (projected)	3.4%
BLS CPI-U for Elderly Home Care[33]	CY 2024 – CY 2025 (partial year)	1.7%
BLS Current Employment Statistics for Residential, Intellectual and Developmental Disability Facilities and Home Health Care Services[34]	CY 2024 – CY 2025 (partial year)	2.8%
Virginia Developmental Disability Provider Cost and Wage Survey Median	SFY 2025-SFY 2026 (anticipated)	3.6%
Virginia Developmental Disability Provider Cost and Wage Survey Average	SFY 2025-SFY 2026 (anticipated)	3.0%

[32] CMS Medicare Economic Index. Available online: Market Basket Data | CMS
[33] BLS CPI-U for Elderly Home Care. Available online: https://www.bls.gov/cpi/
[34] BLS Current Employment Statistics for Residential, Intellectual and Developmental Disability Facilities and Home Health Care Services. Available online: https://www.bls.gov/ces/

To align potential growth in costs during 2024 and to account for economic and labor conditions that may reflect the future cost of service delivery, benchmark wage assumptions include the growth rate from the provider survey median of **3.6 percent.**[35] Applying an inflationary adjustment to wages would account for the time lag between when survey data was collected and when the proposed benchmark rates may be implemented.

F.2.1.4. Supplemental Pay

Supplemental pay includes costs such as overtime, shift differentials, holiday pay, and non-production bonuses in addition to regular wages. Guidehouse requested providers to report this information through the provider survey. Based on the responses provided, Guidehouse calculated an average overtime and supplemental pay rate of 5.1 percent and a median rate of 3.4 percent, derived from the total reported overtime and other supplemental pay relative to total wages, as noted in Table 11 below.

Reported overtime and supplemental pay varied widely from 0 percent to 11 percent, depending on the job, and was not consistently reported by all providers. Survey data also indicated that overtime pay is primarily provided to DSPs, with higher prevalence among those working swing or overnight shifts.

Table 11: Overtime and Supplemental Pay as Percentage of Wages - Provider Cost and Wage Survey

2025 DD Provider Cost and Wage Survey - Q1 CY2025 – Average Overtime and Supplemental Pay		
Metric	**Overtime Pay Only**	**Other Supplemental Pay**
Average	3.2%	1.9%
Median	2.2%	1.2%

To validate the survey findings, Guidehouse reviewed BLS Employer Costs for Employee Compensation (ECEC) data for the Health Care and Social Assistance as well as Nursing and Residential Care Facilities industries. Over the past six years, through the most recent quarter in CY2024, supplemental pay in these industries has risen to **3.4 percent** of wages and salaries, as shown in Figure 18 and Figure 19 below.

In alignment with the most recent trend and the provider survey median of 3.4 percent (2.2 percent + 1.2 percent), Guidehouse applied a **3.4 percent** supplemental pay rate. This supplemental pay assumption was further supported by the Rate Advisory Workgroup, reinforcing its appropriateness for the final recommendation.

[35] Median Definition: The median is the middle number in a sorted list of values, representing the point above and below which 50 percent of the data falls.

Figure 18: 2019 - 2024 Overtime and Supplemental Pay as a Percentage of Wages and Salaries for Health Care and Social Assistance Workers

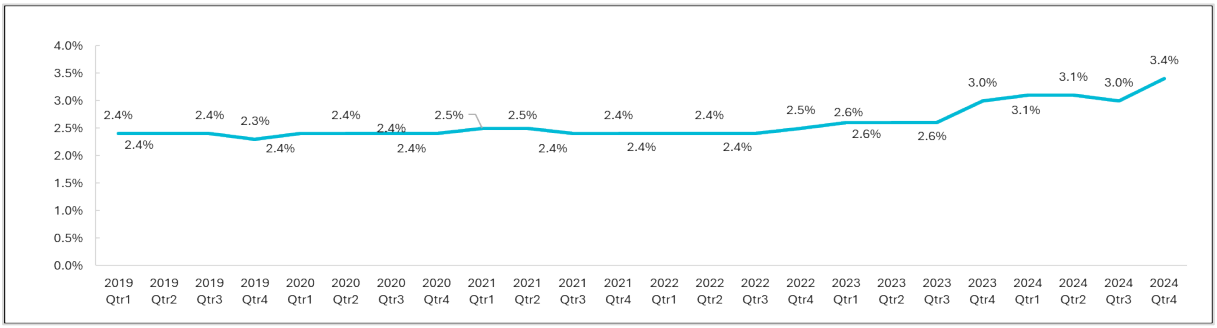
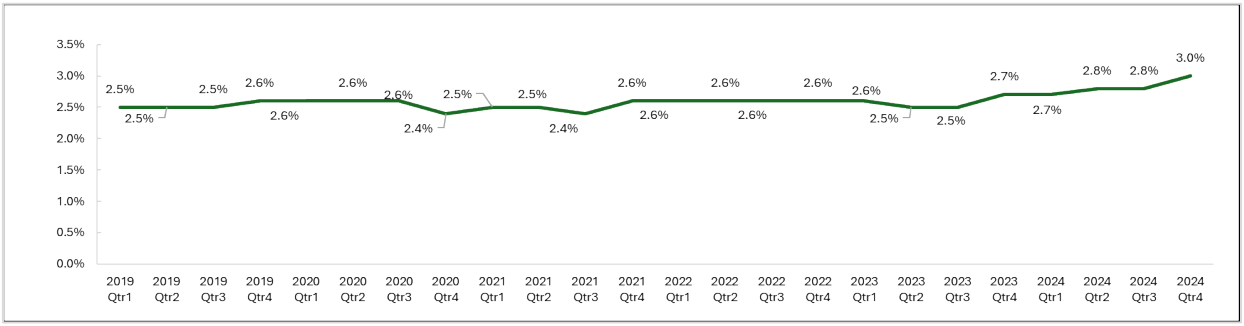


Figure 19: 2019 - 2024 Overtime and Supplemental Pay as a Percentage of Wages and Salaries for Nursing and Residential Facility



F.2.1.5. Final Wage Adjustments

We computed SFY 2027 proposed benchmark wage assumptions by inflating provider survey FTE weighted baseline wages to reflect growth in wages and then adding supplemental pay, as demonstrated in Figure 20 below.

Figure 20: Calculation of Wage Adjustment Factors

Benchmark Hourly Wage for SFY2027 (July 1, 2026) =

1. **Baseline Wage** — Baseline wage developed by Provider Cost and Wage Survey (Q1 CY2025 FTE Weighted Wage)

+

2. **Annual Cost Inflation** — Inflation assumptions derived from Provider Cost and Wage Survey (SFY2025 Median)

+

3. **Overtime & Supplemental Pay** — Overtime and supplemental as a percentage of wages from Bureau of Labor Statistics (Q4 2024) and Provider Cost and Wage Survey (SFY2025 Median)

For example, using the DSP weighted baseline wage of $20.36 from the survey, Guidehouse projected a SFY 2027 benchmark wage by applying a 5.4 percent inflation factor – based on the provider survey 3.6 percent annual rate over 1.5 years – to adjust Q1 CY2025 wages to July 1, 2026. A 3.4 percent supplemental pay adjustment, equivalent to $0.73, was then added, resulting in a proposed benchmark hourly wage of $22.20. Table 12 completes this equation for each job type and includes the number of FTEs for each job type as reported in the provider survey.

Table 12: SFY 2027 Proposed Benchmark Wage Recommendations

Job Type	Number of Full Time Equivalents (FTEs)	Q1CY2025 Baseline Hourly Wage (Average FTE Weighted Wage from Provider Survey)[36]	July 1, 2026 Inflated Baseline Hourly Wages (Baseline + 5.4 percent Inflation)	July 1, 2026 Benchmark Hourly Wages (Inflated Baseline + 3.4 percent Supplemental Pay)
Direct Support Professional	2047.6	$20.36	$21.47	$22.20
Direct Support Professional – Specialized (for Customized Service)	234.5	$22.38	$23.60	$24.41
Personal Caregiver	71.5	$14.31	$15.09	$15.61
Licensed Practical Nurse (LPN)	253.1	$32.21	$33.97	$35.13
Registered Nurse (RN) – BLS Registered Nurses (291141)	65.1	$43.72	$46.11	$47.68
Behavioral Specialist/Technician	96.0	$34.01	$35.87	$37.09
Board Certified Assistant Behavior Analyst (BCABA)	33.0	$53.86	$56.80	$58.73
Board Certified Behavior Analyst (BCBA)	87.0	$78.47	$82.76	$85.57

[36] In instances where BLS average wages are used, it is denoted noted alongside the job types in Table 12.

Job Type	Number of Full Time Equivalents (FTEs)	Q1CY2025 Baseline Hourly Wage (Average FTE Weighted Wage from Provider Survey)[36]	July 1, 2026 Inflated Baseline Hourly Wages (Baseline + 5.4 percent Inflation)	July 1, 2026 Benchmark Hourly Wages (Inflated Baseline + 3.4 percent Supplemental Pay)
Direct Support Supervisor	134.70	$28.47	$30.03	$31.05
Personal Caregiver Supervisor	71.5	$19.50	$20.57	$21.26
Clinical Director	6.0	$65.09	$68.65	$70.98
Therapeutic Consultation - Therapist/Behavior Analysts/Rehabilitation Engineers (average of OT, BLS PT 291123, and ST)	N/A	$53.31	$56.22	$58.13
Therapeutic Consultation - Psychologist/Psychiatrist (average of BLS LCPC, BLS LCSW, BLS Psychologist, and BLS Psychiatrist)	N/A	$57.07	$58.09	$62.23
Therapeutic Consultation - Other Professionals (average of BLS LCPC, BLS LCSW, PBSF)	N/A	$42.40	$44.72	$46.24

Table 13 below the staff and supervisor types for the individual services.

Table 13: Staff and Supervisor Types for Services

Service Name	Direct Care Staff Type	Direct Care Staff Wage Source	Supervisor Staff Type	Supervisor Staff Type Wage Source
Community Coaching	Direct Support Professional	Survey FTE Weighted	Direct Support Supervisor	Survey FTE Weighted
Community Coaching Specialized	Direct Support Professional - Specialized	Survey FTE Weighted	Direct Support Supervisor	Survey FTE Weighted

Service Name	Direct Care Staff Type	Direct Care Staff Wage Source	Supervisor Staff Type	Supervisor Staff Type Wage Source
Community Coaching Two-to-One, Both Specialized	Direct Support Professional	Survey FTE Weighted	Direct Support Supervisor	Survey FTE Weighted
Community Coaching Two-to-One, Both Standard	Direct Support Professional	Survey FTE Weighted	Direct Support Supervisor	Survey FTE Weighted
Community Coaching Two-to-One, One Std, One Spec.	Direct Support Professional - Specialized and Direct Support Professional	Survey FTE Weighted	Direct Support Supervisor	Survey FTE Weighted
Community Engagement Tier 1	Direct Support Professional	Survey FTE Weighted	Direct Support Supervisor	Survey FTE Weighted
Community Engagement Tier 2	Direct Support Professional	Survey FTE Weighted	Direct Support Supervisor	Survey FTE Weighted
Community Engagement Tier 3	Direct Support Professional	Survey FTE Weighted	Direct Support Supervisor	Survey FTE Weighted
Community Engagement Tier 4	Direct Support Professional	Survey FTE Weighted	Direct Support Supervisor	Survey FTE Weighted
Private Duty Nursing - RN	Registered Nurse (RN)	Survey FTE Weighted	N/A	N/A
Private Duty Nursing - LPN	Licensed Practical Nurse (LPN)	Survey FTE Weighted	Registered Nurse (RN)	BLS Average
Skilled Nursing - RN	Registered Nurse (RN)	BLS Average	N/A	N/A
Skilled Nursing - LPN	Licensed Practical Nurse (LPN)	Survey FTE Weighted	Registered Nurse (RN)	BLS Average
Congregate Nursing - RN	Registered Nurse (RN)	Survey FTE Weighted	N/A	N/A
Congregate Nursing - LPN	Licensed Practical Nurse (LPN)	Survey FTE Weighted	Registered Nurse (RN)	BLS Average
Companion Care	Caregiver	Survey FTE Weighted	Caregiver Supervisor	Survey FTE Weighted
CD Companion Care	Caregiver	Survey FTE Weighted	Caregiver Supervisor	Survey FTE Weighted
Respite Care	Caregiver	Survey FTE Weighted	Caregiver Supervisor	Survey FTE Weighted
CD Respite Care	Caregiver	Survey FTE Weighted	Caregiver Supervisor	Survey FTE Weighted
In-Home Support Services Size 1	Direct Support Professional	Survey FTE Weighted	Direct Support Supervisor	Survey FTE Weighted
In-Home Support Services Size 2	Direct Support Professional	Survey FTE Weighted	Direct Support Supervisor	Survey FTE Weighted
In-Home Support Services Size 3	Direct Support Professional	Survey FTE Weighted	Direct Support Supervisor	Survey FTE Weighted
In-Home Support Services Specialized	Direct Support Professional - Specialized	Survey FTE Weighted	Direct Support Supervisor	Survey FTE Weighted
In-Home Support Services Two-to-One, Both Specialized	Direct Support Professional	Survey FTE Weighted	Direct Support Supervisor	Survey FTE Weighted
In-Home Support Services Two-to-One, Both Standard	Direct Support Professional	Survey FTE Weighted	Direct Support Supervisor	Survey FTE Weighted

Service Name	Direct Care Staff Type	Direct Care Staff Wage Source	Supervisor Staff Type	Supervisor Staff Type Wage Source
In-Home Support Services Two-to-One, One Std, One Spec.	Direct Support Professional - Specialized and Direct Support Professional	Survey FTE Weighted	Direct Support Supervisor	Survey FTE Weighted
Personal Assistance	Caregiver	Survey FTE Weighted	Caregiver Supervisor	Survey FTE Weighted
CD Personal Assistance	Caregiver	Survey FTE Weighted	Caregiver Supervisor	Survey FTE Weighted
Independent Living Supports Tier 1	Direct Support Professional	Survey FTE Weighted	Direct Support Supervisor	Survey FTE Weighted
Independent Living Supports Tier 2-4	Direct Support Professional	Survey FTE Weighted	Direct Support Supervisor	Survey FTE Weighted
Independent Living Supports Partial Month Tier 1	Direct Support Professional	Survey FTE Weighted	Direct Support Supervisor	Survey FTE Weighted
Independent Living Supports Partial Month Tier 2-4	Direct Support Professional	Survey FTE Weighted	Direct Support Supervisor	Survey FTE Weighted
Therapeutic Consultation, Therapist/Behavior Analysts/Rehab. Engineers	OT, PT, ST, BCBA, BCABA, and Behavioral Technician/Specialist Average	Survey FTE Weighted, BLS Average for PT	Clinical Director	Survey FTE Weighted
Therapeutic Consultation, Psychologist/Psychiatrist	Psychologist, Psychiatrist, LCPC, and LCSW Average	BLS Average	Clinical Director	Survey FTE Weighted
Therapeutic Consultation, Other Professionals	PBSF, LCPC, and LCSW Average	BLS Average	Clinical Director	Survey FTE Weighted
Workplace Assistance Services	Direct Support Professional	Survey FTE Weighted	Direct Support Supervisor	Survey FTE Weighted

F.2.2. Employee-Related Expenses

Total compensation includes wages as well as employment-related expenses (ERE) – for example, Direct Support Professionals (DSPs) earn not only their wages over the course of the year, but also benefits such as days off, health insurance, and employer retirement contributions. These ERE or fringe benefits include legally required benefits, paid time off, and other benefits such as health insurance.

- **Legally required benefits** include federal and state unemployment taxes, federal insurance contributions to Social Security and Medicare, and workers' compensation. Employers in Virginia pay a federal unemployment tax (FUTA) of 6.00 percent of the first $7,000 in wages and state unemployment tax (SUTA) of a 2.50 percent employer rate. Generally, if an employer pays wages subject to the unemployment tax, the employer may receive a credit of up to 5.4 percent of FUTA taxable wages, yielding an effective FUTA of 0.60 percent. Employers pay a combined 7.65 percent rate of the first $176,100 in wages for Social Security and Medicare contributions as part of Federal Insurance Contributions Act

(FICA) contributions.

- **Paid time off (PTO) components of ERE** include holidays, sick days, vacation days, and personal days. The median aggregate number of paid days off per year, per the provider survey, was 28 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 provider survey.
- **Other benefits in ERE** include retirement, health insurance, and dental and vision insurance. Other benefits are also adjusted by a part-time adjustment factor, as well as a take-up rate specific to each benefit type which represents the proportion of employees who utilize the benefit.

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

Guidehouse compared benefits information reported in the provider survey to publicly available data from the Medical Expenditure Panel Survey (MEPS) for Virginia – a comprehensive set of large-scale surveys of families, individuals, medical providers, and employers across the United States. MEPS is considered the most complete source of data on the cost and use of health care and health insurance coverage.

The comparison revealed that the average monthly health insurance premium in Virginia for 2019 to 2023 ranged from $617 to $772. While the median premium reported in the provider survey was $621, Guidehouse applied a premium of **$694** reflecting the midpoint of the MEPS premium range (i.e., median of $617 and $772). This value was also supported by the Rate Advisory Workgroup as a reasonable and representative benchmark for rate development.

For benchmarking other benefits, Guidehouse relied on provider survey data, which included a more comprehensive list of benefits reported by providers – such as vision, dental, retirement, and several others – not fully captured in MEPS. Providers collectively reported the following additional benefits they offer, which are summarized under "Other Benefits" in

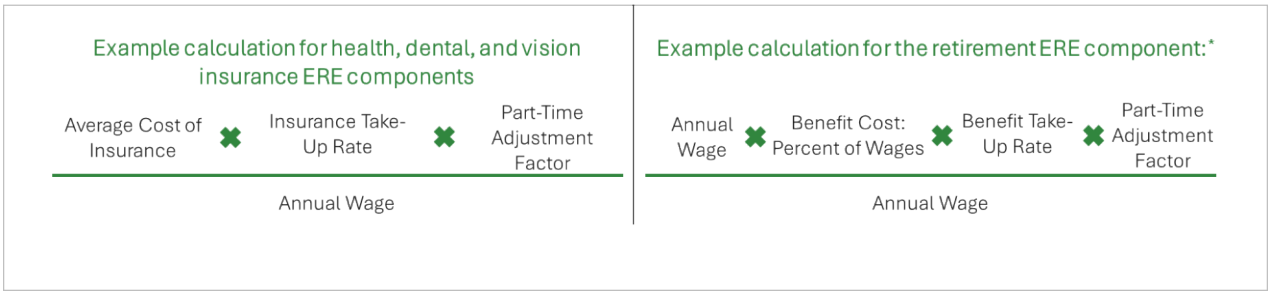
14:

- Life Insurance: Basic / Term / Group Life Insurance
- Disability Insurance: Short-Term Disability (STD, STDI) and Long-Term Disability (LTD)
- Accidental Death & Dismemberment (AD&D)
- Employee Assistance Program (EAP)
- Health Savings & Spending Accounts: HSA (Health Savings Account) and FSA (Flexible Spending Account)

- Health & Wellness: Telemedicine Services and Wellness Incentives
- Education & Tuition: Tuition Assistance and Education Reimbursement
- Supplemental Insurance: Aflac (no contribution)
- ESOP (Employee Stock Ownership Plan)

Table 14 lists the components of ERE and calculates an example ERE percentage for a Direct Support Professional using the proposed benchmark wage recommendations. Figure 21 below includes the method for calculating health, vision, dental, and retirement benefits.

Figure 21: Calculation Method for Benefits



Calculating each ERE component as a percentage of the annual wage assumption for Direct Support Professional - Daytime, or $12,853 per year, yielded a competitive fringe benefit package of **30.35 percent** of wages.

Table 14: Components of Employee Related Expenses for a Direct Support Professional

Component	Value / Calculation	
Annual Wage	$42,349 ($20.36 x 2080 hours)	
FUTA[37]	0.60% of up to $7,000	$42 (0.10%)
SUTA[38]	2.50% of up to $8,000	$200 (0.47%)

[37] For 2025, the standard Federal Unemployment Tax Act (FUTA) rate is 6.0% on the first $7,000 paid to each employee. Virginia is not a credit reduction state, so most employers can claim the maximum 5.4% credit, resulting in a net FUTA tax rate of 0.6%.
[38] For 2025, Virginia's State Unemployment Tax (SUTA) rates for employers range from 0.1% to 6.2%. New employers are assigned a specific rate, and the taxable wage base for the year is set at $8,000.

Component	Value / Calculation	
FICA[39]	7.65% of up to $176,100	$3,240 (7.65%)
Workers' Compensation (Survey Average)	2.50%	$1,059 (2.50%)
Legally Required Benefits	-	$4,540 (10.72%)
Daily Wage	$20.36 x 8 hours	$162.88
Part-Time Adjustment Factor (Survey Average)	76.60%	
Paid Time Off (Survey Median)	28 days	
Paid Time Off[40]	$162.88 x 76.60% x 28 days	$3,493 (8.25%)
Retirement & Take-Up Rate (Survey Average)	3.00% & 65.51%	$638 (1.51%)
Health Ins. & Take-Up Rate (MEPS Median for Premium & Survey for Take-Up)[41]	$694/mo. & 58.8%	$3,751 (8.86%)
Dental Ins. & Take-Up Rate (Survey Median)	$278/mo. & 67.24%	$143 (0.34%)

[39] The FICA tax rate is 6.2% for Social Security and 1.45% for Medicare, totaling 7.65% for employees, with employers matching the contribution. In 2025, the Social Security wage base increased to $176,100.
[40] PTO Days: The provider survey average for PTO is 26 days and the median is 28 days. Based on discussions with the Rate Advisory Workgroup, the median of 28 days was identified as the rate model assumption.
[41] The health insurance MEPS take-up rate ranged from 50.9 percent in 2019 to 57.9 percent in 2024. After discussions with the Rate Advisory Workgroup, the survey take-up of 58.8 percent was identified as the rate model assumption.

Component	Value / Calculation	
Vision Ins. & Take-Up Rate (Survey Median)	$59/mo. & 61.49%	$28 (0.07%)
Other Benefits & Take-Up Rate (Survey Median)	$404/mo. & 84.00%	$260 (0.61%)
Other Benefits	-	$4,819 (11.38%)
Total ERE per DSP	**Legally Required Benefits + Paid Time Off + Other Benefits**	**$12,853 (30.35% of Annual Wage Assumption)**

As wages rise, costs of contributing to certain legally required benefits and other benefits do not necessarily become more expensive. As wages increase, the proportion of ERE to wages decreases; therefore, we developed individual ERE percentages based on job type.

As an example of how the ERE percentage decreases with a higher wage, within Table 15, we display the numbers for the following job types:

- Direct Support Professional
- Direct Support Supervisor
- Occupational Therapist (OT)
- Registered Nurse (RN)

Similarly, the ERE percentage was calculated for other job types utilizing the benchmark hourly wages.

Table 15: Examples of Employee-Related Expenses Across Job Types

Metric	Direct Support Professional	Direct Support Supervisor	Registered Nurse (RN)	Occupational Therapist (OT)
Baseline Hourly Wage	$20.36	$28.47	$43.72	$49.41
Annual Wage	$42,349	$59,218	$90,938	$102,773
Legally Required Benefits	$4,540 (10.72%)	$6,253 (10.56%)	$9,472 (10.42%)	$10,673 (10.39%)

Metric	Direct Support Professional	Direct Support Supervisor	Registered Nurse (RN)	Occupational Therapist (OT)
Paid Time Off Benefits	$3,493 (8.25%)	$4,885 (8.25%)	$7,502 (8.25%)	$8,478 (8.25%)
Retirement Plan	$638 (1.51%)	$891 (1.51%)	$1,369 (1.51%)	$1,547 (1.51%)
Health Insurance	$3,751 (8.86%)	$3,751 (6.33%)	$3,751 (4.12%)	$3,751 (3.65%)
Dental Insurance	$143 (0.34%)	$143 (0.24%)	$143 (0.16%)	$143 (0.14%)
Vision Insurance	$28 (0.07%)	$28 (0.05%)	$28 (0.03%)	$28 (0.03%)
Other Benefits	$260 (0.61%)	$260 (0.44%)	$260 (0.29%)	$260 (0.25%)
Total ERE per Staff (b)	**$12,853 (30.35%)**	**16,210 (27.37%)**	**$22,524 (24.77%)**	**$24,880 (24.21%)**
Total Compensation Calculations				
SFY 2027 Hourly Proposed Benchmark Wage (a)	$22.20	$31.05	$47.68	53.88
SFY 2027 Hourly Proposed Benchmark Wage with ERE = a * (1 + b%)	**$28.94**	**$39.55**	**$59.49**	**$66.92**

F.2.3. Billable Hours and Productivity 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, like travel time to a member's home to deliver services or time spent keeping records or in training, by upwardly adjusting compensation (wages and ERE) to cover the full workday.

Consider a simple example to illustrate this process:

*A direct care staff person is paid $16 per hour and works an 8-hour day. The cost to the provider for the day is $128 ($16 * 8 hours). However, if half of the staff member's 8-hour day (4 hours) was spent on activities that are non-billable, the agency 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 in this example. This means the productivity adjustment needs to be 2.0.

While this is an exaggerated example (a typical productivity adjustment is around 1.1-1.6 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 provider survey, which then translated into a productivity factor for staff delivering each service. For example, for Community Coaching service, providers reported an average of 31.2 billable hours per each direct care staff member's 40-hour week, meaning 78 percent of their day is typically spent on client-facing, billable activities. Dividing 40 by 31.2 (or equivalent, 1 divided by 78 percent) yields a productivity adjustment of 1.28, which is then multiplied by ERE-adjusted wages to get productivity-adjusted compensation. For similar services within the developmental disability service array, productivity percentages were standardized across like services to ensure consistency where appropriate. This approach allows for a uniform evaluation of service delivery efficiency and effectiveness, facilitating a more accurate comparison and analysis of provider performance. Table 16 displays the productivity percentages calculated by each service grouping using the information provided within the provider survey.

Table 16: Productivity Assumption by Service

Service	Productivity Percentage (Billable Hours)
Community Coaching	78% (31.2)
Community Coaching Customized – Specialized	78% (31.2)
Community Coaching Customized – Two-to-one Services	84% (33.6)
Community Engagement Tier 1	66% (26.4)
Community Engagement Tier 2	68% (27.3)
Community Engagement Tier 3	70% (28.0)
Community Engagement Tier 4	72% (28.8)
Companion Care	88% (35.3)
CD Companion Care	88% (35.3)
Congregate Nursing - RN	82% (32.8)
Congregate Nursing - LPN	82% (32.8)
In-Home Support Services Size 1	78% (31.2)

Service	Productivity Percentage (Billable Hours)
In-Home Support Services Size 2	74% (29.6)
In-Home Support Services Size 3	70% (28.0)
In-Home Support Services Customized – Specialized	78% (31.2)
In-Home Support Services Customized – Two-to-one Services	84% (33.6)
Personal Assistance	88% (35.3)
CD Personal Assistance	88% (35.3)
Private Duty Nursing - RN	85% (34.0)
Private Duty Nursing - LPN	85% (34.0)
Respite Care	88% (35.3)
CD - Respite Care	88% (35.3)
Skilled Nursing - RN	82% (32.8)
Skilled Nursing - LPN	82% (32.8)
Therapeutic Consultation, Therapist/Behavior Analysts/Rehab. Engineers	65% (25.6)
Therapeutic Consultation, Psychologist/Psychiatrist	59% (22.8)
Therapeutic Consultation, Other Professionals	53% (20.4)
Workplace Assistance	77% (30.8)

Table 17 below includes the staffing hours for Independent Living Supports, based on the provider survey responses.

Table 17: Staffing Hours for Independent Living Supports

Service	Number of Hours Per Month
Independent Living Supports Tier 1	66.0

Service	Number of Hours Per Month
Independent Living Supports Tier 2-4	99.0
Independent Living Supports Partial Month Tier 1	33.0
Independent Living Supports Partial Month Tier 2-4	49.5

F.2.4. Staffing Ratios

Just as one supervisor may oversee the work of multiple direct care staff simultaneously, one direct care staff may deliver a service to multiple clients simultaneously. As services are reimbursed per-client, this means the costs associated with direct service can be split across multiple units of service in cases when the ratio of staff to clients ("staffing ratio") is more than one-to-one.

Staffing needs of each service typically vary and require examination to assign the appropriate staff wage rate assumptions. The provider survey asks for the average staffing ratios of each service, and analysis of survey results across provider organizations as well as careful readings of service definitions informed assumptions of staffing ratios. And while some services genuinely call for individualized or 1:1 (meaning one staff member to one client) staffing ratios, many allow for appropriate delivery of services to small groups. Depending on the provider, some surveys indicated groups up to 4 in size. To ensure consistency across the developmental disability service array, staffing ratios for similar services are standardized. This approach allows for a uniform assessment of service delivery efficiency and effectiveness, facilitating a more accurate comparison and analysis of provider performance. By maintaining consistent staffing ratios, we can better align our rate-setting methodology with the overarching goals of quality and access in developmental disability services. Table 18 shows the services that are intended to be provided in a group setting with the average size reported in the survey compared against the size built into the final rate models.

Table 18: Staffing Ratios by Service

Service Type	Average Staff to Client Ratio
Community Coaching	1:1
Community Coaching Customized – Specialized	1:1
Community Coaching Customized – Two-to-One, Both Specialized	2:1

Service Type	Average Staff to Client Ratio
Community Coaching Customized – Two-to-One, Both Standard	2:1
Community Coaching Customized – Two-to-One, One Std, One Spec.	2:1
Community Engagement Tier 1	1:3
Community Engagement Tier 2	1:2.5
Community Engagement Tier 3	1:2
Community Engagement Tier 4	1:1.5
Companion Care	1:1
CD Companion Care	1:1
Congregate Nursing - RN	1:2
Congregate Nursing - LPN	1:2
Independent Living Supports Tier 1	1:1
Independent Living Supports Tier 2-4	1:1
Independent Living Supports Partial Month Tier 1	1:1
Independent Living Supports Partial Month Tier 2-4	1:1
In-Home Support Services Size 1	1:1
In-Home Support Services Size 2	1:2
In-Home Support Services Size 3	1:3
In-Home Supports Customized – Specialized	1:1
In-Home Supports Customized – Two-to-One, Both Specialized	2:1

Service Type	Average Staff to Client Ratio
In-Home Supports Customized – Two-to-One, Both Standard	2:1
In-Home Supports Customized – Two-to-One, One Std, One Spec.	2:1
Personal Assistance	1:1
CD Personal Assistance	1:1
Private Duty Nursing - RN	1:1
Private Duty Nursing - LPN	1:1
Respite Care	1:1
CD - Respite Care	1:1
Skilled Nursing - RN	1:1
Skilled Nursing - LPN	1:1
Therapeutic Consultation, Therapist/Behavior Analysts/Rehab. Engineers	1:1
Therapeutic Consultation, Psychologist/Psychiatrist	1:1
Therapeutic Consultation, Other Professionals	1:1
Workplace Assistance Services	1:1

F.2.5. Supervision

While direct care staff deliver services, additional staff are often present to supervise, typically overseeing multiple staff members at one once. 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 or add-on to the primary staff wage. The supervision rate component captures the cost of supervising direct care staff based on data reported in the provider survey. 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 provider survey included questions regarding the average number of direct care staff supervised by one supervisor and the total number of hours a supervisor spends, on average, directly supervising staff; for most service groups, the average number of staff supervised by one supervisor ranged from 6.9 to 22. In Table 19 below are the average supervisor assumptions for each service grouping.

Table 19: Supervisor Span of Control by Service

Service Grouping (Source)	Average Supervisor Span of Control	Average Hours of Supervision per Week
Community Coaching (including Customized services)	1: 7.5	13.1
Community Engagement Tier 1	1: 7	17.4
Community Engagement Tier 2	1: 7	17.4
Community Engagement Tier 3	1: 7	17.4
Community Engagement Tier 4	1: 7	17.4
Companion Care	1: 10.6	8.1
CD Companion Care	1: 10.6	8.1
Congregate Nursing - RN	1:22	26.0
Congregate Nursing - LPN	1:22	26.0
Independent Living Supports Tier 1	1:10.5	8.3
Independent Living Supports Tier 2-4	1:10.5	8.3
Independent Living Supports Partial Month Tier 1	1:10.5	8.3
Independent Living Supports Partial Month Tier 2-4	1:10.5	8.3
In-Home Support Services Size 1 (including Customized services)	1: 6.9	11.2
In-Home Support Services Size 2 (including Customized services)	1: 6.9	11.2
In-Home Support Services Size 3	1: 6.9	11.2
Personal Assistance	1: 10.6	8.1

Service Grouping (Source)	Average Supervisor Span of Control	Average Hours of Supervision per Week
CD Personal Assistance	1: 10.6	8.1
Private Duty Nursing - RN	1: 12	29.0
Private Duty Nursing - LPN	1: 12	29.0
Respite Care	1: 10.6	8.1
CD - Respite Care	1: 10.6	8.1
Skilled Nursing - RN[42]	1: 12	29.0
Skilled Nursing - LPN[42]	1: 12	29.0
Therapeutic Consultation, Therapist / Behavior Analysts / Rehab. Engineers	1:7.3	2.3
Therapeutic Consultation, Psychologist/Psychiatrist	1:7.3	2.3
Therapeutic Consultation, Other Professionals	1:7.3	2.3
Workplace Assistance Services	1:12.0	18.0

F.2.6. Administrative Expenses

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

Administrative costs include several categories:

- **Payroll Administrative Expenses:** Employees and contracted employees who perform administrative activities or maintenance activities earn salaries and benefits, which count toward payroll expenses in the calculation of total administrative costs.

[42] Supervision assumptions for Skilled Nursing RN and LPN services are aligned with those for Private Duty Nursing RN and LPN services to account for broader provider experience in delivering care, as highlighted by feedback from the Rate Workgroup on service delivery.

- **Non-Payroll Administrative Expenses:** Costs, including office equipment and overhead, comprise non-payroll administrative expenses, net of bad debt and costs related to advertising or marketing.
- **Facility and Utilities for Administrative Use:** Rent, mortgage, and depreciation for administrative space factors into total administrative costs, as do utilities and telecommunication expenses relating to administrative use.

The specific survey cost lines and components included in the administrative cost include the following:

- Total Maintenance Employee Salaries and Wages
- Total Administrative Employee Salaries and Wages
- Total Salaries for Contracted Administrative Staff
- Office Equipment and Furniture (not for direct care)
- Interest Expense (e.g., mortgage)
- Non-payroll Taxes
- Licensing / Certification / Accreditation Fees
- Staff Training and Development (administrative-related)
- Insurance (excluding benefits and auto insurance)
- Information Technology Expense (e.g., computers and software)
- Office Supplies
- Postage
- Cost for Translating Materials
- Other Administrative Costs (including bank fees, claims processing fees, and employee incentives)

Direct care costs include the salaries, wages, taxes, and benefits for direct care employees.

To determine an administrative cost percentage, Guidehouse calculated the ratio of administrative costs to direct care wages and benefits by summing total administrative costs reported in the provider survey, then dividing by total direct care compensation for the period captured in the survey, as shown in the equation below.

$$Administrative\ Cost\ Factor\ (\%) = \ Administrative\ Costs\ (\$) \div Direct\ Care\ Costs\ (\$)$$

For example, if a provider's total administrative costs reported in the survey are $578,000 and total direct care costs are $3.7 million, the administrative cost factor would be 15.6 percent (i.e., $578,000 ÷ $3,700,000). Similarly, we calculated administrative cost factors for all providers who reported both administrative and direct care costs and then computed the average administrative cost factor across all providers. Overall, this calculation was based on data submitted by 71 of 109 providers (65.1 percent) who responded to the survey.

Guidehouse applied a percentage-based administrative cost adjustment using cost data reported in the survey. This approach enables standardization across services and helps administrative costs scale proportionately with compensation and inflation. Since wages and benefits in the model are inflated to reflect the SFY 2027 period, applying administrative costs as a percentage of those wages and benefits helps align administrative expenses with the same time frame and inflation assumptions.

Based on this methodology, Guidehouse calculated an average ratio of **15.33 percent**. Therefore, the recommended rate models incorporate the ratio of 15.33 percent , which adds a dollar amount to a unit rate by multiplying the rate components of productivity-adjusted direct care staff and supervisor compensation by the average administrative percentage. For example, if total direct care and supervisor compensation is $38.83 per hour, the corresponding hourly administrative cost would be $5.95 (i.e., 15.33% × $38.83).

F.2.7. Program Support Expenses

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

- **Program Support Wages, Benefits, and Supplies:** Employees and contracted employees who perform program support activities earn salaries and benefits, which count toward direct care-related expenses in the calculation of total program support costs. These may also include costs for staff training and development, activities costs, and expenses for devices and technology, all of which are related to the quality of care but not specifically billable. This also includes the costs of program supplies used by clients in, for example, community engagement services.
- **Building and Equipment**: When services are delivered in a facility, certain costs for the direct care facility may be included such as utilities and telecommunications; building maintenance and repairs; facility janitorial, landscaping, and other costs not part of rent; and non-administrative equipment costs and depreciation.

The specific survey cost lines and components included in the program support cost include the following:

- Total Program Support Employee Salaries and Wages
- Total Salaries for Contracted Program Support Staff
- Program Supplies
- Devices / Technology (for provision of direct care services)
- Activity Costs (for provision of direct care services)
- Licensing / Certification / Accreditation Fees (for direct care staff)
- Hiring Expenses (for direct care staff)
- Staff Training and Development (direct care related)

- Insurance (excluding benefits and auto insurance; direct care related only)
- Facility Rent / Mortgage
- Facility Interest
- Facility Depreciation
- Utilities / Telecommunications / Etc. (administrative)
- Utilities / Telecommunications / Etc. (direct care facilities)
- Building Maintenance and Repairs
- Facility Janitorial/ Landscaping/ Repairs/ Etc. (not part of rent)
- Equipment Costs (non-administrative)
- Equipment Depreciation
- Other Program Support Costs (including house/cleaning supplies, uniforms, and medical supplies)

Similar to the calculation for administrative costs, the program support percentage is calculated based on cost data reported in the provider survey. Program support costs reported by providers were calculated in relation to direct care costs reported in the provider survey, as shown in the equation below.

$$Program\ Support\ Cost\ Factor\ (\%) = Program\ Support\ Costs(S) \div Direct\ Care\ Costs\ (S)$$

The largest components of this percentage are building and equipment costs, which comprise of **11.03 percent** of the direct care costs, and program support supplies, wages, and benefits costs, which comprise **5.18 percent**. Using the combination of these program support numbers, Guidehouse arrived at an overall program support percentage of **16.21 percent**. For example, if total direct care and supervisor compensation is $38.83 per hour, the corresponding hourly program support supply cost would be $2.01 (i.e., 5.18 percent × $38.83).

Table 20 below illustrates the program support variables. This calculation was based on data submitted by 68 of 109 providers (62.4 percent) who provided program support cost data as part of the survey.

Table 20: Program Support Cost Factor

Program Support Factor	Total Program Support (Additive)	Percentage per Program Support Category
Wages, Benefits, and Supplies	-	5.18%

Program Support Factor	Total Program Support (Additive)	Percentage per Program Support Category
(Program Support Employee Wages, Program Support Contracted Salaries, and Program Support Taxes and Benefits, Program Supplies, Devices / Technology, Activity Costs, and Staff Training and Development)		
Building and Equipment (Facility Rent/Mortgage, Utilities / Telecommunications, Building Maintenance and Repair, and Facility Janitorial / Landscaping / Repair)	16.21%	11.03%

F.2.7.1. Transportation Cost Analysis

As an extension to program support costs, transportation costs are represented as a percentage of wages and derived from the following costs reported in the provider survey:

- Client-Related Transportation Costs
- Vehicle Licensing/ Acquisition/ Registration/ Lease Costs
- Vehicle Maintenance/ Repair Costs
- Vehicle Insurance
- Vehicle Depreciation
- Travel - Excluding client transportation and direct care vehicles

The equation below shows the calculation method for the transportation cost factor. This calculation was based on data submitted by 67 of 109 providers (61.5 percent) who provided transportation cost data as part of the survey.

$$Transportation\ Cost\ Factor\ (\%) = Transportation\ Costs\ (\$) \div Direct\ Care\ Costs\ (\$)$$

Client-related transportation cost (4.07 percent) is excluded from select services including, but not limited to, Personal Assistance, Respite, Companion, that typically take place in a client's home, as shown in Table 21.

The transportation cost per hour and the number of miles per week supported by the rate model are derived based on the total transportation costs and billable hours per week from provider survey responses, as noted in Table 21 below. This approach supports consistency across diverse service settings while reflecting the relationship between actual provider-reported transportation costs and direct care compensation.

Table 21: Program Support Transportation Costs[43]

Service Grouping	Transportation as Percentage of Direct Care Costs (a; Provider Survey)	Transportation Cost Per Hour (b = a * Hourly Compensation Per Service)	Number of Billable Hours Per Standard Week (c = 40 * Productivity Percentage; Provider Survey)	Number of Miles Per Week (d = b / IRS Mileage Rate * c)[44]
Community Coaching	7.27%	$2.82	31.20	125.79
Community Coaching Customized – Specialized	7.27%	$3.07	31.20	136.80
Community Coaching Customized – Two-to-One, Both Specialized	7.27%	$2.86	33.60	137.23
Community Coaching Customized – Two-to-One, Both Standard	7.27%	$2.63	33.60	126.22
Community Coaching Customized – Two-to-One, One Std, One Spec.	7.27%	$2.74	33.60	131.75
Community Engagement Tier 1	7.27%	$3.37	26.40	126.93
Community Engagement Tier 2	7.27%	$3.27	27.20	127.14
Community Engagement Tier 3	7.27%	$3.18	28.00	127.34
Community Engagement Tier	7.27%	$3.10	28.80	127.54

[43] The transportation costs are derived using the transportation cost as a percentage of direct care costs, hourly compensation per service, productivity factor per service, and the IRS mileage rate. The calculations are not rounded to the nearest hundredth at each step as displayed in the table. This approach allows for accurate representation of transportation costs, and the methodology is aligned across all models.
[44] IRS Mileage Rate (2025). Available online: https://www.irs.gov/tax-professionals/standard-mileage-rates

Service Grouping	Transportation as Percentage of Direct Care Costs (a; Provider Survey)	Transportation Cost Per Hour (b = a * Hourly Compensation Per Service)	Number of Billable Hours Per Standard Week (c = 40 * Productivity Percentage; Provider Survey)	Number of Miles Per Week (d = b / IRS Mileage Rate * c)[44]
4				
Companion Care	3.20%	$0.78	35.33	39.32
Congregate Nursing - RN	7.27%	$5.27	32.80	247.09
Congregate Nursing - LPN	7.27%	$4.07	32.80	190.53
Independent Living Supports Tier 1	7.27%	$2.16	16.50	50.92
Independent Living Supports Tier 2-4	7.27%	$2.16	24.75	76.38
Independent Living Supports Partial Month Tier 1	7.27%	$2.16	16.50	25.46
Independent Living Supports Partial Month Tier 2-4	7.27%	$2.16	24.75	38.19
In-Home Support Services Size 1	3.20%	$1.24	31.20	55.20
In-Home Support Services Size 2	3.20%	$0.65	29.60	27.54
In-Home Support Services Size 3	3.20%	$0.46	28.00	18.32
In-Home Supports – Specialized	3.20%	$1.35	31.20	60.05
In-Home Supports – Two-to-One, Both Specialized	3.20%	$1.25	33.60	60.23
In-Home Supports – Two-to-One, Both Standard	3.20%	$1.15	33.60	55.38

Service Grouping	Transportation as Percentage of Direct Care Costs (a; Provider Survey)	Transportation Cost Per Hour (b = a * Hourly Compensation Per Service)	Number of Billable Hours Per Standard Week (c = 40 * Productivity Percentage; Provider Survey)	Number of Miles Per Week (d = b / IRS Mileage Rate * c)[44]
In-Home Supports – Two-to-One, One Std, One Spec.	3.20%	$1.20	33.60	57.81
Personal Assistance	3.20%	$0.78	35.33	39.32
Private Duty Nursing - RN	3.20%	$2.24	34.00	108.78
Private Duty Nursing - LPN	3.20%	$1.79	34.00	86.91
Respite Care	3.20%	$0.78	35.33	39.32
Skilled Nursing/RN	7.27%	$5.27	32.80	247.09
Skilled Nursing - LPN	7.27%	$4.20	32.80	196.96
Therapeutic Consultation, Therapist / Behavior Analysts / Rehab. Engineers	3.20%	$3.57	26.00	132.52
Therapeutic Consultation, Psychologist/Psychiatrist	3.20%	$4.20	23.60	141.43
Therapeutic Consultation, Other Professionals	3.20%	$3.51	21.20	106.30
Workplace Assistance Services	7.27%	$2.84	30.80	124.96

Supplementary Analysis for Transportation Costs

We further validated the transportation costs embedded in the rate models through supplemental analysis using data from the survey and public sources. Through this method, we calculated costs based on provider-reported travel time for a standard 40-hour work week, average speed assumptions, the IRS mileage rate, and assumptions regarding vehicle purchase and operating costs, as shown in Table 22 below.

- Average percentage of time in a 40-hour standard week spent on travel to/from and between client residences/locations: Providers reported this information by service in the survey; therefore, this component varies across services.
- Average speed: 30 miles per hour based on an average of the statutory speed limit at 25 mph and maximum speed limit on unpaved roads at 35 mph.[45]
- Mileage cost per hour: 2025 IRS mileage rate of $0.70 per mile.[46]
- Vehicle transportation costs: Based on vehicle loan amount, loan rate, loan term, and ambulatory wheelchair life costs. Table 23 below includes additional information.

The transportation costs calculated through this method results in an average cost of $2.43 per hour which is similar to the average costs built into the model at $2.49 per hour.

Table 22: Transportation Costs Based on Weekly Travel Time

Miles Per Week	Percentage of Time in 40-Hour Standard Week spent on Travel (a; Provider Survey)	Hours in 40-Hour Standard Week spent on Travel to/from and between Client Residences/ Locations (b = 40 * a)	Average Speed in Miles Per Hour (c)	Total Mileage Cost Per Hour (d = b * c * $0.7 per mile / 40)	Other Transportation Costs Per Hour e.g., Vehicle Costs for Client Transportation (e)	Total Transp. Cost Per Hour (f = d + e)
Community Coaching	7.44%	2.98	30	$1.56	$1.10	$2.66
Community Coaching Customized – Specialized	7.44%	2.98	30	$1.56	$1.10	$2.66
Community Coaching Customized – Two-to-One, Both	7.44%	2.98	30	$1.56	$1.10	$2.66

[45] Virginia Department of Transportation, Speed Limits. Available online: https://www.vdot.virginia.gov/about/our-system/highways/speed-limits/

[46] IRS Mileage Rate (2025). Available online: https://www.irs.gov/tax-professionals/standard-mileage-rates

Miles Per Week	Percentage of Time in 40-Hour Standard Week spent on Travel (a; Provider Survey)	Hours in 40-Hour Standard Week spent on Travel to/from and between Client Residences/ Locations (b = 40 * a)	Average Speed in Miles Per Hour (c)	Total Mileage Cost Per Hour (d = b * c * $0.7 per mile / 40)	Other Transportation Costs Per Hour e.g., Vehicle Costs for Client Transportation (e)	Total Transp. Cost Per Hour (f = d + e)
Specialized						
Community Coaching Customized – Two-to-One, Both Standard	7.44%	2.98	30	$1.56	$1.10	$2.66
Community Coaching Customized – Two-to-One, One Std, One Spec.	7.44%	2.98	30	$1.56	$1.10	$2.66
Community Engagement Tier 1	10.54%	4.22	30	$2.21	$1.10	$3.31
Community Engagement Tier 2	10.54%	4.22	30	$2.21	$1.10	$3.31
Community Engagement Tier 3	10.54%	4.22	30	$2.21	$1.10	$3.31
Community Engagement Tier 4	10.54%	4.22	30	$2.21	$1.10	$3.31
Companion Care	6.30%	2.52	30	$1.32	$0.00	$1.32

Miles Per Week	Percentage of Time in 40-Hour Standard Week spent on Travel (a; Provider Survey)	Hours in 40-Hour Standard Week spent on Travel to/from and between Client Residences/ Locations (b = 40 * a)	Average Speed in Miles Per Hour (c)	Total Mileage Cost Per Hour (d = b * c * $0.7 per mile / 40)	Other Transportation Costs Per Hour e.g., Vehicle Costs for Client Transportation (e)	Total Transp. Cost Per Hour (f = d + e)
Congregate Nursing - LPN	11.80%	4.72	30	$2.48	$1.10	$3.58
Congregate Nursing - RN	11.80%	4.72	30	$2.48	$1.10	$3.58
Independent Living Supports Tier 1	8.36%	3.34	30	$1.76	$1.10	$2.85
Independent Living Supports Tier 2-4	8.36%	3.34	30	$1.76	$1.10	$2.85
Independent Living Supports Partial Month Tier 1	8.36%	3.34	30	$1.76	$1.10	$2.85
Independent Living Supports Partial Month Tier 2-4	8.36%	3.34	30	$1.76	$1.10	$2.85
In-Home Supports – Specialized	7.44%	2.98	30	$1.56	$0.00	$1.56
In-Home Supports – Two-to-One,	7.44%	2.98	30	$1.56	$0.00	$1.56

Miles Per Week	Percentage of Time in 40-Hour Standard Week spent on Travel (a; Provider Survey)	Hours in 40-Hour Standard Week spent on Travel to/from and between Client Residences/ Locations (b = 40 * a)	Average Speed in Miles Per Hour (c)	Total Mileage Cost Per Hour (d = b * c * $0.7 per mile / 40)	Other Transportation Costs Per Hour e.g., Vehicle Costs for Client Transportation (e)	Total Transp. Cost Per Hour (f = d + e)
Both Specialized						
In-Home Supports – Two-to-One, Both Standard	7.44%	2.98	30	$1.56	$0.00	$1.56
In-Home Supports – Two-to-One, One Std, One Spec.	7.44%	2.98	30	$1.56	$0.00	$1.56
In-Home Support Services Size 1	7.44%	2.98	30	$1.56	$0.00	$1.56
In-Home Support Services Size 2	7.44%	2.98	30	$1.56	$0.00	$1.56
In-Home Support Services Size 3	7.44%	2.98	30	$1.56	$0.00	$1.56
Personal Assistance	6.30%	2.52	30	$1.32	$0.00	$1.32
Private Duty Nursing - LPN	7.50%	3.00	30	$1.58	$0.00	$1.58

Miles Per Week	Percentage of Time in 40-Hour Standard Week spent on Travel (a; Provider Survey)	Hours in 40-Hour Standard Week spent on Travel to/from and between Client Residences/ Locations (b = 40 * a)	Average Speed in Miles Per Hour (c)	Total Mileage Cost Per Hour (d = b * c * $0.7 per mile / 40)	Other Transportation Costs Per Hour e.g., Vehicle Costs for Client Transportation (e)	Total Transp. Cost Per Hour (f = d + e)
Private Duty Nursing - RN	7.50%	3.00	30	$1.58	$0.00	$1.58
Respite Care	6.30%	2.52	30	$1.32	$0.00	$1.32
Skilled Nursing/RN	11.80%	4.72	30	$2.48	$1.10	$3.58
Skilled Nursing - LPN	11.80%	4.72	30	$2.48	$1.10	$3.58
Therapeutic Consultation, Other Professionals	11.22%	4.49	30	$2.36	$0.00	$2.36
Therapeutic Consultation, Psychologist/ Psychiatrist	11.22%	4.49	30	$2.36	$0.00	$2.36
Therapeutic Consultation, Therapist / Behavior Analysts / Rehab. Engineers	11.22%	4.49	30	$2.36	$0.00	$2.36
Workplace Assistance Services	7.50%	3.00	30	$1.58	$1.10	$2.67

Table 23 below includes the vehicle cost calculation model for client transportation.

Table 23: Vehicle Costs for Transportation

Component	Value	Source
Vehicle Loan Amount (Minivan)	$47,052	May 2025 Kelley Blue Book Average Transaction Price tables
Ambulatory Add-On (Wheelchair Lift)	$6,000	Consumer Affairs 3 Best Wheelchair Lifts for Cars of 2025: Reviewed by Customers
Vehicle Loan Rate	5.89%	Average of vehicle loan rate across Edmunds, Bank of America, and Virginia Credit Union (1) https://www.vacu.org/why-vacu/rates (5.59%) (2) https://www.bankofamerica.com/auto-loans/auto-loan-rates/ (5.44%) (3) https://www.edmunds.com/car-loan-apr-interest-rate/ (6.63%)
Vehicle Loan Term	72 months	Experian What's the Average Length of a Car Loan?
Monthly Payment (Ambulatory – Wheelchair Lift) – a	$876.39	Monthly Payment = (Wheelchair Lift × Monthly Interest Rate) / [1 - (1 + Monthly Interest Rate)^(-Number of Payments)]
Monthly Payment (Non-Ambulatory) – b	$777.27	Monthly Payment = (Loan Amount × Monthly Interest Rate) / [1 - (1 + Monthly Interest Rate)^(-Number of Payments)]
Transportation Costs Per Year (Ambulatory) – c	$10,516.67	a * 12
Transportation Costs Per Year (Non-Ambulatory) – d	$9,327.27	b *12
Total Transportation Costs – e	$9,624.62	e = (d * 75%) + (c * 25%)

Component	Value	Source
		Note: 75% weight for non-ambulatory and 25% weight for ambulatory
Hourly Transportation Vehicle Cost for Client Transportation – f	$1.10	f = e / 2080 FTE Hours / Number of Passengers Note: Average of 3-6 people in a minivan inclusive of wheelchair accessibility

F.2.8. Geographic Differential Adjustment

The average statewide benchmark rates based on standardized rate components outlined in Section F.2 are then adjusted by geographic adjustment factors to establish distinct rates for Northern Virginia (NOVA) and the Rest of State (ROS), accounting for overall regional cost differences.

Guidehouse recommends using cost of living data released by the Economic Policy Institute (EPI) for Virginia on an annual basis through its Family Budget Calculator. EPI's Family Budget Calculator released in January 2025 for estimates the CY2024 annual and monthly costs for 10 different household types (e.g., one or two adults with zero to four children) across all U.S. counties and metro areas.[47]

Guidehouse's analysis of EPI data for Virginia revealed that the geographic differential between NOVA and ROS across costs related to Transportation, Healthcare, Food, and Taxes is **16.8 percent**. Specifically, costs in NOVA are **14.3 percent** more than the average state cost, and ROS is **2.1 percent** less than average state cost, as noted in Table 24 below. These differentials are used uniformly to develop NOVA and ROS rates across all services.

Table 24: Geographic Differential Adjustment Factor

Region	Percentage Difference between Total Costs and Overall State Costs	Geographic Differential Factor
NOVA	+14.3%	1.143
ROS	-2.1%	0.979

[47] Economic Policy Institute, Family Budget Calculator Documentation. Available online: https://www.epi.org/publication/family-budget-calculator-documentation/

Recommendation H.2 includes additional information about the recommended geographic differential methodology.

F.3. Proposed Benchmarks Rates

Table 25 below includes the proposed benchmark rates for each service across all programs.

Table 25: SFY 2027 Proposed Benchmark Rates

Procedure Code and Modifiers	Service Description	Location	SFY 2026 Current Rate	SFY 2027 Proposed Benchmark Rate	Unit	Percent Change
H2025	Workplace Assistance Services	NOVA	$47.71	$57.06	Hour	19.6%
H2025	Workplace Assistance Services	ROS	$42.50	$48.87	Hour	15.0%
T2021	Community Engagement Tier 1	NOVA	$26.96	$30.22	Hour	12.1%
T2021	Community Engagement Tier 1	ROS	$23.64	$25.88	Hour	9.5%
T2021	Community Engagement Tier 2	NOVA	$32.46	$34.50	Hour	6.3%
T2021	Community Engagement Tier 2	ROS	$26.46	$29.55	Hour	11.7%
T2021	Community Engagement Tier 3	NOVA	$34.32	$41.05	Hour	19.6%
T2021	Community Engagement Tier 3	ROS	$30.21	$35.16	Hour	16.4%
T2021	Community Engagement Tier 4	NOVA	$42.07	$52.12	Hour	23.9%
T2021	Community Engagement Tier 4	ROS	$37.14	$44.64	Hour	20.2%
T2013	Community Coaching	NOVA	$47.71	$56.71	Hour	18.9%
T2013	Community Coaching	ROS	$42.50	$48.57	Hour	14.3%
T2013 U1	Community Coaching Customized – Specialized	NOVA	$54.11	$61.67	Hour	14.0%
T2013 U1	Community Coaching Customized – Specialized	ROS	$49.15	$52.82	Hour	7.5%
T2013 U1	Community Coaching Customized – Two-to-One, Both Specialized	NOVA	$91.66	$111.63	Hour	21.8%
T2013 U1	Community Coaching Customized – Two-	ROS	$82.59	$95.61	Hour	15.8%

Procedure Code and Modifiers	Service Description	Location	SFY 2026 Current Rate	SFY 2027 Proposed Benchmark Rate	Unit	Percent Change
	to-One, Both Specialized					
T2013 U1	Community Coaching Customized – Two-to-One, Both Standard	NOVA	$82.68	$102.67	Hour	24.2%
T2013 U1	Community Coaching Customized – Two-to-One, Both Standard	ROS	$74.68	$87.94	Hour	17.8%
T2013 U1	Community Coaching Customized – Two-to-One, One Std, One Spec.	NOVA	$87.27	$107.17	Hour	22.8%
T2013 U1	Community Coaching Customized – Two-to-One, One Std, One Spec.	ROS	$78.72	$91.79	Hour	16.6%
T1019	Personal Assistance	NOVA	$23.81	$34.42	Hour	44.6%
T1019	Personal Assistance	ROS	$20.23	$29.48	Hour	45.7%
T1005	Respite Care	NOVA	$23.81	$34.42	Hour	44.6%
T1005	Respite Care	ROS	$20.23	$29.48	Hour	45.7%
S5135	Companion Care	NOVA	$23.81	$34.42	Hour	44.6%
S5135	Companion Care	ROS	$20.23	$29.48	Hour	45.7%
S5126	CD Personal Assistance	NOVA	$17.97	$22.54	Hour	25.4%
S5126	CD Personal Assistance	ROS	$13.88	$19.31	Hour	39.1%
S5150	CD Respite Care	NOVA	$17.97	$22.54	Hour	25.4%
S5150	CD Respite Care	ROS	$13.88	$19.31	Hour	39.1%
S5136	CD Companion Care	NOVA	$17.97	$22.54	Hour	25.4%
S5136	CD Companion Care	ROS	$13.88	$19.31	Hour	39.1%
T2032	Independent Living Supports Tier 1	NOVA	$2,595.89	$2,865.14	Month	10.4%
T2032	Independent Living Supports Tier 1	ROS	$2,344.12	$2,454.04	Month	4.7%
T2032	Independent Living Supports Tier 2-4	NOVA	$3,987.17	$4,297.70	Month	7.8%

Procedure Code and Modifiers	Service Description	Location	SFY 2026 Current Rate	SFY 2027 Proposed Benchmark Rate	Unit	Percent Change
T2032	Independent Living Supports Tier 2-4	ROS	$3,578.28	$3,681.06	Month	2.9%
T2032 U1	Independent Living Supports Partial Month Tier 1	NOVA	$1,297.94	$1,432.57	Partial Month	10.4%
T2032 U1	Independent Living Supports Partial Month Tier 1	ROS	$1,172.06	$1,227.02	Partial Month	4.7%
T2032 U1	Independent Living Supports Partial Month Tier 2-4	NOVA	$1,993.59	$2,148.85	Partial Month	7.8%
T2032 U1	Independent Living Supports Partial Month Tier 2-4	ROS	$1,789.14	$1,840.53	Partial Month	2.9%
H2014 UA	In-Home Support Services Size 1	NOVA	$45.91	$54.73	Hour	19.2%
H2014 UA	In-Home Support Services Size 1	ROS	$40.72	$46.88	Hour	15.1%
H2014 U2	In-Home Support Services Size 2	NOVA	$26.13	$29.53	Hour	13.0%
H2014 U2	In-Home Support Services Size 2	ROS	$23.25	$25.29	Hour	8.8%
H2014 U3	In-Home Support Services Size 3	NOVA	$18.83	$21.29	Hour	13.1%
H2014 U3	In-Home Support Services Size 3	ROS	$17.37	$18.23	Hour	5.0%
H2014 U1	In-Home Supports Customized – Specialized	NOVA	$51.46	$59.54	Hour	15.7%
H2014 U1	In-Home Supports Customized – Specialized	ROS	$46.06	$50.99	Hour	10.7%
H2014 U1	In-Home Supports Customized – Two-to-One, Both Specialized	NOVA	$88.39	$109.46	Hour	23.8%
H2014 U1	In-Home Supports Customized – Two-to-One, Both Specialized	ROS	$78.77	$93.75	Hour	19.0%
H2014 U1	In-Home Supports Customized – Two-to-One, Both Standard	NOVA	$79.68	$100.65	Hour	26.3%
H2014 U1	In-Home Supports Customized – Two-to-	ROS	$71.16	$86.21	Hour	21.1%

Procedure Code and Modifiers	Service Description	Location	SFY 2026 Current Rate	SFY 2027 Proposed Benchmark Rate	Unit	Percent Change
	One, Both Standard					
H2014 U1	In-Home Supports Customized – Two-to-One, One Std, One Spec.	NOVA	$84.14	$105.07	Hour	24.9%
H2014 U1	In-Home Supports Customized – Two-to-One, One Std, One Spec.	ROS	$75.06	$90.00	Hour	19.9%
S9123	Skilled Nursing - RN	NOVA	$24.91	$26.49	15 minutes	6.3%
S9123	Skilled Nursing - RN	ROS	$22.57	$22.69	15 minutes	0.5%
S9124	Skilled Nursing - LPN	NOVA	$19.58	$21.12	15 minutes	7.9%
S9124	Skilled Nursing - LPN	ROS	$16.74	$18.09	15 minutes	8.1%
T1002	Private Duty Nursing - RN	NOVA	$21.65	$24.74	15 minutes	14.3%
T1002	Private Duty Nursing - RN	ROS	$18.90	$21.19	15 minutes	12.1%
T1003	Private Duty Nursing - LPN	NOVA	$16.83	$19.77	15 minutes	17.5%
T1003	Private Duty Nursing - LPN	ROS	$13.89	$16.93	15 minutes	21.9%
97139	Therapeutic Consultation, Therapist/Behavior Analysts/Rehab. Engineers	NOVA	$135.93	$171.71	Hour	26.3%
97139	Therapeutic Consultation, Therapist/Behavior Analysts/Rehab. Engineers	ROS	$122.83	$147.07	Hour	19.7%
H2017	Therapeutic Consultation, Psychologist/Psychiatrist	NOVA	$123.28	$201.90	Hour	63.8%

Procedure Code and Modifiers	Service Description	Location	SFY 2026 Current Rate	SFY 2027 Proposed Benchmark Rate	Unit	Percent Change
H2017	Therapeutic Consultation, Psychologist/Psychiatrist	ROS	$111.73	$172.93	Hour	54.8%
97530	Therapeutic Consultation, Other Professionals	NOVA	$103.84	$168.92	Hour	62.7%
97530	Therapeutic Consultation, Other Professionals	ROS	$94.82	$144.68	Hour	52.6%
G0493	Congregate Nursing - RN	NOVA	$12.46	$14.00	15 Minutes	12.4%
G0493	Congregate Nursing - RN	ROS	$11.29	$11.99	15 Minutes	6.2%
G0494	Congregate Nursing - LPN	NOVA	$9.79	$10.80	15 Minutes	10.3%
G0494	Congregate Nursing - LPN	ROS	$8.37	$9.25	15 Minutes	10.5%

G. Fiscal Impact Estimates

Guidehouse also analyzed trends in the detailed Medicaid 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.

G.1. Overview of Fiscal Impact

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 Commonwealth of Virginia as well as providers delivering services. This analysis was conducted exclusively for the purposes of the rate study, to assess the implications of increasing funding for services to the levels identified by study rate benchmarks. However, as we note in the sub-sections below, our analysis includes several simplifying assumptions that, while warranted for projection purposes, may not reflect eventual service utilization or future Medicaid federal financial participation. Moreover, these assumptions represent Guidehouse's best judgment based on the utilization data available, but do not necessarily reflect State legislative or executive decision-making, nor do they indicate additional commitments to future financing.

In the following sub-sections, Guidehouse describes the data sources for our utilization assumptions, including the service periods reflected in the data as well as any service exclusions or other limitations that frame the data set. The report presents the overall fiscal impact to the 11 services as well as the individual service components, detailing projected total and "state share" expenditures. The analysis also breaks down expenditure comparisons by service category to shed additional insight into the service-specific financial impacts.

G.2. Baseline Data and Service Periods

The rate study relies on expenditure data and utilization assumptions based on the most recently completed year of payments. Since State expenditures during SFY 2024 were not paid at current rates, Guidehouse adjusted the expenditure baseline grounded in SFY 2024 by repricing this utilization to reflect current rates. This adjustment is noted in fiscal impact tables in the "SFY 2026 Calculated Expenditures" columns, which indicates what the Department *would be paid* in SFY 2026 if reimbursing claims at the rates currently effective. Expenditures calculated at Guidehouse's benchmark rates follow suit, allowing proportionate comparison for assessing financial impact.

It is important to note that the underlying data captures only DD waiver services included in the rate study and does not incorporate DD waiver services not included in the rate study (for example, Group Home and Sponsored Residential are not included) or were reimbursed by the State for individuals who were not enrolled in or not eligible for the DD waiver (for example, CCC+ waiver is not included). Appendix B includes the procedure codes and modifiers included in the fiscal impact calculations.

G.3. Other Projection Assumptions

While it is possible some services experiencing substantial rate increases may see higher

utilization due to new revenue incentives to deliver these services, given the evolving economic climate and the complexity of the dynamics operating in the current labor market, Guidehouse does not make rate-influenced adjustments to utilization based on our own speculative trending assumptions.

The analysis identifies fiscal impact in terms of both total expenditure increases and the additional state share dollars needed to fund services at the proposed benchmark rate. Projected state share impacts are subject to the Federal Medical Assistance Percentage (FMAP). In SFY 2027, Virginia's Medicaid FMAP will be 50.1 percent, which means the federal government will cover 50.1 percent of expenditures for standard Medicaid services, with Virginia's state share covering the remaining 49.9 percent of reimbursement costs.

G.4. Fiscal Impact Summary

In SFY 2026, the Community Living (CL) Waiver accounts for the largest share at 40.1 percent, followed by the three consumer-direction services in the three DD waivers at 35.4 percent.[48] The Family and Individual Supports (FIS) Waiver represents 23.6 percent of the total expenditures. The remaining expenditures are allocated to the Brain Injury (BI) Waiver and EPSDT Congregate Nursing services, which together make up less than 1 percent of the total expenditures. This distribution reflects the relative scale and utilization of these programs, as shown in Figure 22 below.

[48] Consumer-direction claims for personal care, respite, and companion care may not include a waiver indicator. Therefore, they are classified as a distinct category of services spanning the DD waivers.

Figure 22: SFY 2026 Calculated Expenditures by DD Waiver Program

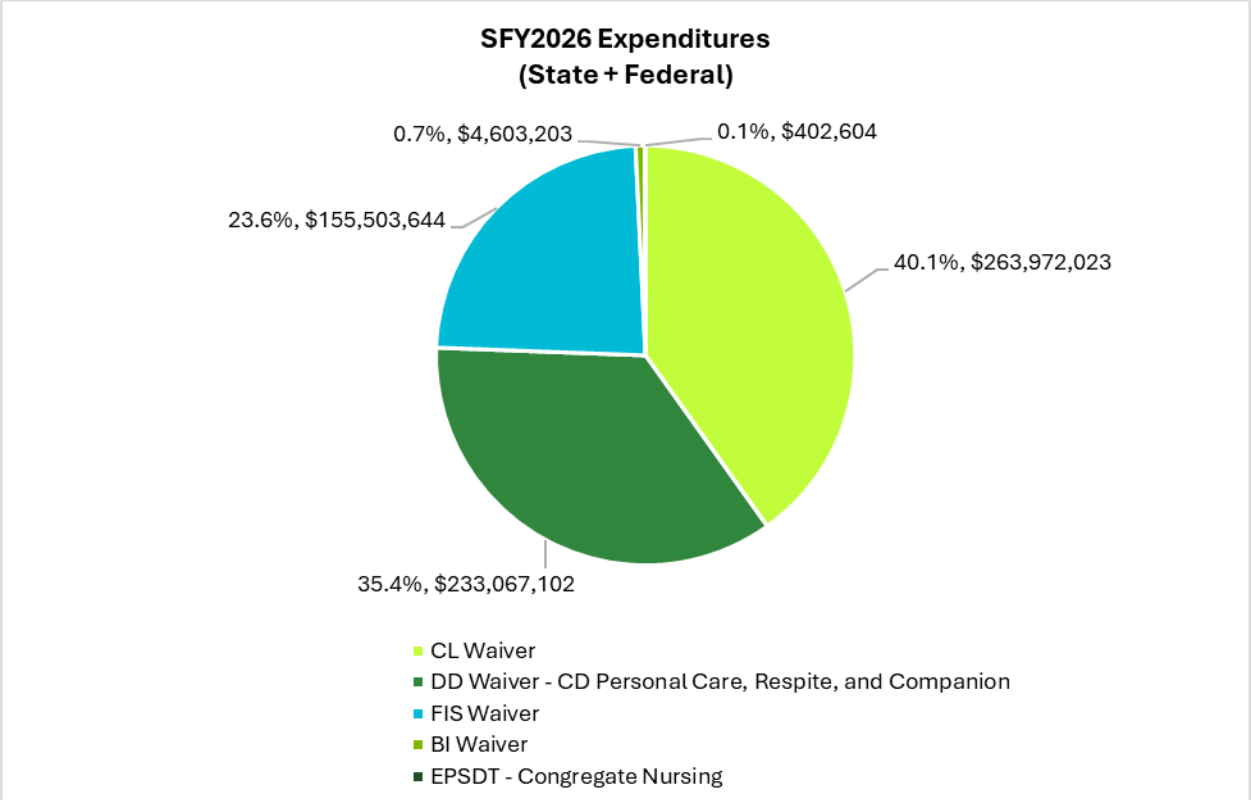
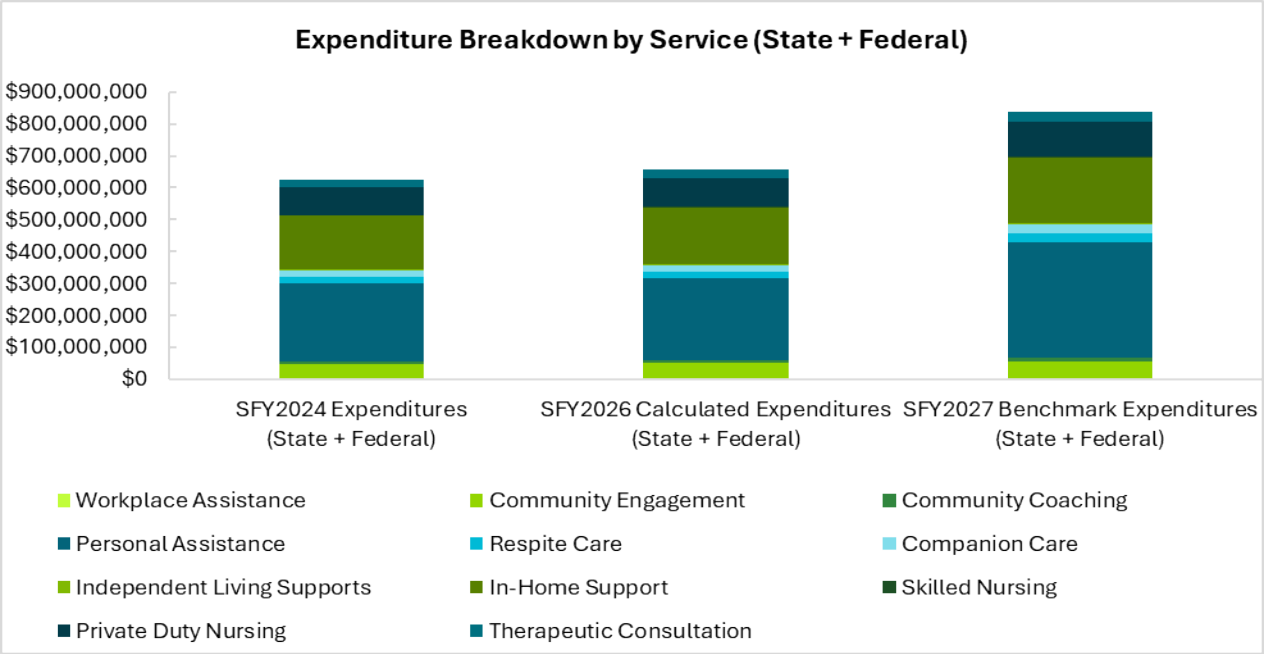


Figure 23 below indicates that expenditure increases are attributable to the growth in rates and spending for Personal Assistance, Private Duty Nursing and In-Home Supports services. Together these services represent around 82.1 percent of the total increase.

Figure 23: SFY 2026 Calculated and SFY 2027 Benchmark Expenditures by DD Waiver Service Category



Combined state and federal expenditures are projected to increase from $657.5 million in SFY 2026 to $839.9 million in SFY 2027, resulting in a fiscal impact of approximately $182.4 million, or 27.7 percent. Based on the FMAP, the Commonwealth's share is estimated at $91.0 million, as shown in Table 26 below.

Table 26: Overall Fiscal Impact – Differences in SFY 2026 Calculated and SFY 2027 Benchmark Expenditures

Metric	SFY 2026 Calculated Expenditures	SFY 2027 Benchmark Expenditures	Fiscal Impact	Percent Fiscal Impact
State + Federal Fiscal Impact	$657,548,575	$839,924,515	$182,375,940	27.7%
State Only Fiscal Impact	$328,116,739	$419,122,333	$91,005,594	27.7%

G.5. Fiscal Impact by Service Categories

Table 27 below comparing SFY 2026 and SFY 2027 benchmark expenditures shows a projected fiscal impact of approximately $182.4 million. Personal Assistance contributes the most to this increase, with a fiscal impact of $103.8 million and comprising 42.9 percent of SFY 2027 proposed benchmark expenditures. Additionally, Respite and Companion Care show the highest percentage increases at 40.1 percent each followed by Therapeutic Consultation, highlighting notable growth

in cost and corresponding rates for these services.

Table 27: Summary of DD Waiver Fiscal Impact by Service Category (State + Federal Share)

Service Category	SFY 2024 Expenditures (State + Federal)	SFY 2026 Calculated Expenditures (State + Federal)	SFY 2027 Benchmark Expenditures (State + Federal)	Fiscal Impact (State + Federal)	Percentage Fiscal Impact (State + Federal)	Percentage of SFY 2027 Total Expenditures (State + Federal)
Personal Assistance	$246,929,663	$256,934,538	$360,745,209	$103,810,671	40.4%	42.9%
In-Home Support	$166,902,689	$177,080,905	$206,157,585	$29,076,681	16.4%	24.5%
Private Duty Nursing	$85,565,850	$90,771,086	$107,603,607	$16,832,521	18.5%	12.8%
Community Engagement	$45,643,931	$48,421,707	$55,762,408	$7,340,700	15.2%	6.6%
Therapeutic Consultation	$25,385,902	$26,931,528	$33,907,829	$6,976,301	25.9%	4.0%
Companion Care	$19,870,372	$20,675,269	$28,963,599	$8,288,329	40.1%	3.4%
Respite Care	$19,542,782	$20,334,397	$28,480,562	$8,146,164	40.1%	3.4%
Community Coaching	$8,007,655	$8,495,450	$9,843,072	$1,347,622	15.9%	1.2%
Independent Living Supports	$3,658,593	$3,881,408	$4,053,429	$172,020	4.4%	0.5%
Skilled Nursing	$2,643,830	$2,804,712	$2,994,092	$189,379	6.8%	0.4%
Workplace Assistance	$1,147,666	$1,217,574	$1,413,123	$195,549	16.1%	0.2%
Total	**$625,298,931**	**$657,548,575**	**$839,924,515**	**$182,375,940**	**27.7%**	**100.0%**

State-only expenditures are projected to rise from nearly $328.1 million in SFY 2026 to $419.1 million in SFY 2027, resulting in a fiscal impact of $91.0 million, or a 27.7 percent increase. These trends mirror the overall fiscal impact observed in the table above. Table 28 below provides a detailed breakdown of the projected state share fiscal impact for DD waiver services.

Table 28: Summary of DD Waiver Fiscal Impact by Service Category (State Share Only)

Service Category	SFY 2024 Expenditures (State Only)	SFY 2026 Calculated Expenditures (State Only)	SFY 2027 Benchmark Expenditures (State Only)	Fiscal Impact (State Only)	Percentage Fiscal Impact (State Only)	Percentage of SFY 2027 Total Expenditures (State Only)
Personal Assistance	$123,217,902	$128,210,335	$180,011,859	$51,801,525	40.4%	42.9%
In-Home Support	$83,284,442	$88,363,371	$102,872,635	$14,509,264	16.4%	24.5%
Private Duty Nursing	$42,697,359	$45,294,772	$53,694,200	$8,399,428	18.5%	12.8%
Community Engagement	$22,776,321	$24,162,432	$27,825,441	$3,663,009	15.2%	6.6%
Therapeutic Consultation	$12,667,565	$13,438,832	$16,920,007	$3,481,174	25.9%	4.0%
Companion Care	$9,915,316	$10,316,959	$14,452,836	$4,135,876	40.1%	3.4%
Respite Care	$9,751,848	$10,146,864	$14,211,800	$4,064,936	40.1%	3.4%
Community Coaching	$3,995,820	$4,239,229	$4,911,693	$672,463	15.9%	1.2%
Independent Living Supports	$1,825,638	$1,936,823	$2,022,661	$85,838	4.4%	0.5%
Skilled Nursing	$1,319,271	$1,399,551	$1,494,052	$94,500	6.8%	0.4%
Workplace Assistance	$572,685	$607,570	$705,149	$97,579	16.1%	0.2%
Total	**$312,024,167**	**$328,116,739**	**$419,122,333**	**$91,005,594**	**27.7%**	**100.0%**

G.6. Fiscal Impact by Service Components

In this section, the fiscal impact for each service category is broken down by individual service components, including tiers, home sizes, and customized rates. Table 29, which compares SFY

2026 and SFY 2027 benchmark expenditures, shows a projected fiscal impact ranging from approximately $13,000 to $77.8 million, depending on the specific service component.

Table 29: Summary of DD Waiver Fiscal Impact by Service Components (State + Federal Share)

Service Category	SFY 2024 Expenditures (State + Federal)	SFY 2026 Calculated Expenditures (State + Federal)	SFY 2027 Benchmark Expenditures (State + Federal)	Fiscal Impact (State + Federal)	Percentage Fiscal Impact (State + Federal)	Percentage of SFY 2027 Total Expenditures (State + Federal)
CD Personal Assistance	$191,130,680	$198,867,604	$276,665,990	$77,798,386	39.1%	32.9%
In-Home Support Services Size 1	$165,691,248	$175,795,602	$204,689,265	$28,893,663	16.4%	24.4%
Private Duty Nursing - LPN	$76,503,894	$81,158,810	$96,655,425	$15,496,616	19.1%	11.5%
Personal Assistance	$55,798,983	$58,066,934	$84,079,219	$26,012,285	44.8%	10.0%
Community Engagement Tier 3	$22,404,012	$23,765,382	$27,760,982	$3,995,600	16.8%	3.3%
Therapeutic Consultation, Therapist/Behavior Analysts/Rehab. Engineers	$21,343,739	$22,643,337	$27,339,779	$4,696,442	20.7%	3.3%
CD Companion Care	$16,532,435	$17,201,664	$23,931,134	$6,729,470	39.1%	2.8%
CD Respite Care	$16,336,534	$16,997,833	$23,647,562	$6,649,729	39.1%	2.8%

Service Category	SFY 2024 Expenditures (State + Federal)	SFY 2026 Calculated Expenditures (State + Federal)	SFY 2027 Benchmark Expenditures (State + Federal)	Fiscal Impact (State + Federal)	Percentage Fiscal Impact (State + Federal)	Percentage of SFY 2027 Total Expenditures (State + Federal)
Community Engagement Tier 2	$14,972,108	$15,885,090	$17,589,003	$1,703,913	10.7%	2.1%
Private Duty Nursing - RN	$9,061,956	$9,612,277	$10,948,182	$1,335,905	13.9%	1.3%
Community Coaching	$7,933,464	$8,416,737	$9,750,383	$1,333,646	15.8%	1.2%
Community Engagement Tier 4	$6,871,338	$7,289,522	$8,788,662	$1,499,139	20.6%	1.0%
Therapeutic Consultation, Other Professionals	$4,019,309	$4,263,945	$6,530,524	$2,266,578	53.2%	0.8%
Companion Care	$3,337,936	$3,473,605	$5,032,465	$1,558,860	44.9%	0.6%
Respite Care	$3,206,248	$3,336,564	$4,833,000	$1,496,436	44.8%	0.6%
Independent Living Supports Tier 1	$1,765,717	$1,873,255	$1,973,635	$100,380	5.4%	0.2%
Independent Living Supports Tier 2-4	$1,760,153	$1,867,348	$1,932,744	$65,397	3.5%	0.2%
Skilled Nursing - LPN	$1,446,764	$1,534,723	$1,657,768	$123,045	8.0%	0.2%

Service Category	SFY 2024 Expenditures (State + Federal)	SFY 2026 Calculated Expenditures (State + Federal)	SFY 2027 Benchmark Expenditures (State + Federal)	Fiscal Impact (State + Federal)	Percentage Fiscal Impact (State + Federal)	Percentage of SFY 2027 Total Expenditures (State + Federal)
Community Engagement Tier 1	$1,396,473	$1,481,713	$1,623,761	$142,048	9.6%	0.2%
Workplace Assistance Services	$1,147,666	$1,217,574	$1,413,123	$195,549	16.1%	0.2%
Skilled Nursing/RN	$817,492	$867,385	$892,184	$24,799	2.9%	0.1%
In-Home Support Services Size 2	$653,509	$693,426	$763,063	$69,637	10.0%	0.1%
In-Home Support Services Customized - Two-to-One, Both Standard	$426,226	$452,151	$547,778	$95,628	21.1%	0.1%
Congregate Nursing - LPN	$379,575	$402,604	$444,139	$41,535	10.3%	0.1%
In-Home Support Services Customized - Specialized	$131,706	$139,726	$157,479	$17,754	12.7%	0.0%
Community Coaching Customized - Two-to-One, Both	$74,191	$78,713	$92,689	$13,976	17.8%	0.0%

Service Category	SFY 2024 Expenditures (State + Federal)	SFY 2026 Calculated Expenditures (State + Federal)	SFY 2027 Benchmark Expenditures (State + Federal)	Fiscal Impact (State + Federal)	Percentage Fiscal Impact (State + Federal)	Percentage of SFY 2027 Total Expenditures (State + Federal)
Standard						
Independent Living Supports Partial Month Tier 1	$72,011	$76,397	$80,790	$4,394	5.8%	0.0%
Independent Living Supports Partial Month Tier 2-4	$60,712	$64,409	$66,259	$1,850	2.9%	0.0%
Therapeutic Consultation, Psychologist/Psychiatrist	$22,854	$24,245	$37,526	$13,280	54.8%	0.0%
In-Home Support Services Size 3	$0	$0	$0	$0	0.0%	0.0%
Congregate Nursing - RN	$0	$0	$0	$0	0.0%	0.0%
Total	**$625,298,931**	**$657,548,575**	**$839,924,515**	**$182,375,940**	**27.7%**	**100%**

The State-only fiscal impact also varies widely across service components, ranging from less than 1 percent to over 40 percent, depending on the specific service. Table 30 provides a detailed breakdown of the projected state share fiscal impact for each DD waiver service component.

Table 30: Summary of DD Waiver Fiscal Impact by Service Category (State Share Only)

Service Category	SFY 2024 Expenditures (State Only)	SFY 2026 Calculated Expenditures (State Only)	SFY 2027 Benchmark Expenditures (State Only)	Fiscal Impact (State Only)	Percentage Fiscal Impact (State Only)	Percentage of SFY 2027 Total Expenditures (State Only)
CD Personal Assistance	$95,374,209	$99,234,934	$138,056,329	$38,821,395	39.1%	32.9%
In-Home Support Services Size 1	$82,679,933	$87,722,005	$102,139,943	$14,417,938	16.4%	24.4%
Private Duty Nursing - LPN	$38,175,443	$40,498,246	$48,231,057	$7,732,811	19.1%	11.5%
Personal Assistance	$27,843,692	$28,975,400	$41,955,530	$12,980,130	44.8%	10.0%
Community Engagement Tier 3	$11,179,602	$11,858,925	$13,852,730	$1,993,804	16.8%	3.3%
Therapeutic Consultation, Therapist/Behavior Analysts/Rehab. Engineers	$10,650,526	$11,299,025	$13,642,550	$2,343,525	20.7%	3.3%
CD Companion Care	$8,249,685	$8,583,631	$11,941,636	$3,358,005	39.1%	2.8%
CD Respite Care	$8,151,931	$8,481,919	$11,800,133	$3,318,215	39.1%	2.8%
Community Engagement Tier 2	$7,471,082	$7,926,660	$8,776,913	$850,253	10.7%	2.1%
Private Duty Nursing - RN	$4,521,916	$4,796,526	$5,463,143	$666,617	13.9%	1.3%

Service Category	SFY 2024 Expenditures (State Only)	SFY 2026 Calculated Expenditures (State Only)	SFY 2027 Benchmark Expenditures (State Only)	Fiscal Impact (State Only)	Percentage Fiscal Impact (State Only)	Percentage of SFY 2027 Total Expenditures (State Only)
Community Coaching	$3,958,799	$4,199,952	$4,865,441	$665,489	15.8%	1.2%
Community Engagement Tier 4	$3,428,797	$3,637,472	$4,385,542	$748,071	20.6%	1.0%
Therapeutic Consultation , Other Professionals	$2,005,635	$2,127,709	$3,258,731	$1,131,023	53.2%	0.8%
Companion Care	$1,665,630	$1,733,329	$2,511,200	$777,871	44.9%	0.6%
Respite Care	$1,599,918	$1,664,946	$2,411,667	$746,721	44.8%	0.6%
Independent Living Supports Tier 1	$881,093	$934,754	$984,844	$50,090	5.4%	0.2%
Independent Living Supports Tier 2-4	$878,316	$931,806	$964,439	$32,633	3.5%	0.2%
Skilled Nursing - LPN	$721,935	$765,827	$827,226	$61,399	8.0%	0.2%
Community Engagement Tier 1	$696,840	$739,375	$810,257	$70,882	9.6%	0.2%
Workplace Assistance Services	$572,685	$607,570	$705,149	$97,579	16.1%	0.2%
Skilled Nursing/RN	$407,928	$432,825	$445,200	$12,375	2.9%	0.1%

Service Category	SFY 2024 Expenditures (State Only)	SFY 2026 Calculated Expenditures (State Only)	SFY 2027 Benchmark Expenditures (State Only)	Fiscal Impact (State Only)	Percentage Fiscal Impact (State Only)	Percentage of SFY 2027 Total Expenditures (State Only)
In-Home Support Services Size 2	$326,101	$346,020	$380,768	$34,749	10.0%	0.1%
In-Home Support Services Customized - Two-to-One, Both Standard	$212,687	$225,623	$273,341	$47,718	21.1%	0.1%
Congregate Nursing - LPN	$189,408	$200,899	$221,625	$20,726	10.3%	0.1%
In-Home Support Services Customized - Specialized	$65,721	$69,723	$78,582	$8,859	12.7%	0.0%
Community Coaching Customized - Two-to-One, Both Standard	$37,021	$39,278	$46,252	$6,974	17.8%	0.0%
Independent Living Supports Partial Month Tier 1	$35,934	$38,122	$40,314	$2,193	5.8%	0.0%
Independent Living Supports Partial Month Tier 2-4	$30,295	$32,140	$33,063	$923	2.9%	0.0%

Service Category	SFY 2024 Expenditures (State Only)	SFY 2026 Calculated Expenditures (State Only)	SFY 2027 Benchmark Expenditures (State Only)	Fiscal Impact (State Only)	Percentage Fiscal Impact (State Only)	Percentage of SFY 2027 Total Expenditures (State Only)
Therapeutic Consultation , Psychologist/ Psychiatrist	$11,404	$12,098	$18,725	$6,627	54.8%	0.0%
In-Home Support Services Size 3	$0	$0	$0	$0	0.0%	0.0%
Congregate Nursing - RN	$0	$0	$0	$0	0.0%	0.0%
Total	**$312,024,167**	**$328,116,739**	**$419,122,333**	**$91,005,594**	**27.7%**	**100.0%**

H. Rate Study Recommendations

Guidehouse identified the rate recommendations and policy considerations highlighted in this section for DMAS to consider as it navigates the adoption and implementation of the proposed benchmark rates for the service under review. Guidehouse also considered input provided by stakeholders throughout the rate development process in arriving at these recommendations for DMAS.

H.1. Virginia DMAS should consider implementing the proposed benchmark rates while adapting an independent rate build-up approach and a process for reviewing rates regularly to propose targeted rate updates based on changing cost benchmarks across the developmental disability service array.

The proposed benchmark rates developed through this rate study are grounded in a comprehensive analysis of provider-reported data, Commonwealth's data, and publicly available sources relevant to DD waiver services. Guidehouse followed a structured, step-by-step methodology that incorporated all key rate components and was informed by extensive stakeholder engagement, including input from providers and individuals with lived experience. Based on this approach, we recommend that DMAS implement the proposed benchmark rates to support rate adequacy and alignment with current service delivery requirements.

Based on the rate study, we recommend adopting a modular rate build-up approach followed in developing benchmark rates for all services as part of this study. This approach is intended to enhance transparency and consistency by delineating the components that inform rates, aligning them with service delivery specifications and actual cost structures, and enabling review of specific elements such as wages, benefits, and training. This approach may also support a more detailed, data-informed rate-setting process by isolating and/or aggregating individual cost components such as direct care costs and overhead, and administrative expenses, tailored to the characteristics of each service. Additionally, it may enable DMAS to more effectively monitor the cost components embedded in the rates and the corresponding expenditures.

Standardize rate component assumptions across services where feasible and appropriate

Current rates do not consistently apply cost components. Cognate services requiring similar resources may include the same rate components for equivalent work. To support standardization, DMAS may consider implementing uniform wage and benefit assumptions for direct care and supervisory positions across all populations and programs. These assumptions may reflect the cost of a benchmark benefits package. While not all providers may currently offer the full range of benefits, including all benefits reported by a majority of providers in the 2025 DD provider survey may allow flexibility for future adoption.

Wages and benefits are important components in rate development, and benchmark metrics can influence final rate determinations. The standardized wages and benefits used in the development of the SFY 2027 proposed benchmark rates are designed to be competitive, based on industry comparisons and stakeholder feedback. The analysis conducted to establish these benchmarks indicates that the recommended wages are generally aligned with industry standards within Virginia and nationally.

For services that are already aligned, we have not identified evidence justifying distinct rates. However, historical differences in provider expenditures and authorized program budgets have contributed to rates that may not align with service expectations. A few examples from the DD waiver service array include the following:

- Personal Care, Respite, and Companion Services: In alignment with current rates for these three services, the benchmark hourly rates also revealed no material differences in rate structures. Therefore, we recommend aligning all rate components for the three services.
- Skilled Nursing and Congregate Nursing: Previously, the rate for Congregate Nursing group service was calculated as a percentage of the Skilled Nursing individual service rate. As part of the updated rate development approach, we standardized key components – such as wages, benefits, and supervision time – across both models. We then differentiated the two based on staffing ratios rather than relying on historical rate relationships. While the relationship between the two rates may still be evaluated and monitored, we recommend implementing and maintaining these distinct rate models to enhance transparency and facilitate future updates.

Adapt a regular rate update process that includes key economic indicators and metrics for future rate review processes that align with the DD populations served

DMAS may consider establishing a regular administrative rate update process that incorporates adjustments to wage assumptions or overall rate levels based on relevant inflation indices, in being responsive to economic changes.

If DMAS adopts the benchmark rates and the rate build-up approach recommended by Guidehouse, it may be feasible to review rate assumptions more frequently at a defined cadence. This would allow for targeted updates to specific cost components, such as wages, without requiring a full rate rebasing. Over time, a regular rate review process could provide DMAS with valuable insight into whether rate updates are warranted. Of note, rate reviews may not necessarily result in rate updates; rather, they involve revisiting the rate methodology and existing rates to assess whether adjustments are needed. As stated in the CMS 1915(c) Technical Guide, "States must review their rate setting methodology, at minimum, every five years to ensure that rates are adequate to maintain an ample provider base and to ensure quality of services." While CMS sets a five-year minimum, the frequency of rate reviews varies by state. Most states operating 1915(c) waivers conduct rate reviews annually or biennially.[49]

Currently, DMAS uses the proprietary IHS Markit (S&P Global) Virginia inflation index. As an alternative, Guidehouse recommends monitoring inflation using publicly available Bureau of Labor Statistics (BLS) Current Employment Statistics (CES) data, which provide monthly earnings information for roles comparable to those in DMAS-funded programs. Specifically, DMAS may consider tracking CES data for Residential Intellectual and Developmental Disability Staff.

[49] Centers for Medicare and Medicaid Services, 1915(c) HCBS Waivers, Waiver Financing and Payment Trends. Available online: https://www.medicaid.gov/medicaid/downloads/hcbs-wavr-paymnts-financng-trnds-sept-2021.pdf

Advantages of using BLS CES data include:

- Monthly updates to average hourly earnings, offering timely indicators of cost growth for current and future rate-setting.
- National labor market representation for DD waiver providers, making it more responsive to the unique cost structures of these programs than general healthcare inflation metrics.
- Public availability, enabling DMAS to derive point-in-time snapshots of wage trends as needed.

DMAS may also consider other publicly available sources, including BLS Occupational Employment and Wage Statistics (OEWS), BLS Employer Costs for Employee Compensation (ECEC) supplemental pay data, and Medical Expenditure Panel Survey (MEPS) insurance cost data. These sources were used in the rate evaluation to validate provider survey data and are commonly referenced by similar programs in other states.

Alignment with DD waiver services not included in this rate study

DMAS must consider alignment with other DD waiver services not included in the scope of this study. While these services may differ in structure or delivery, there is significant overlap in the provider agencies that deliver them and the DSPs who staff them. For example, staff providing Community Engagement services (included in this study) may also deliver Group Home services (not included in this study) within the same organization. It is therefore imperative to review for consistency across programs that offer similar services or service arrays, particularly where staffing and operational models intersect. Establishing alignment in rate methodologies and assumptions across all DD waiver services may help promote equity and reduce administrative complexity.

H.2. Virginia DMAS should consider updating the geographical differential methodology to better reflect economic conditions

DMAS currently provides regionally variable rates to reflect cost differences across the Commonwealth. However, the methodology used to address these geographic variations can be updated to better align with current economic conditions faced by providers. Guidehouse recommends updating the geographic differential to reflect these evolving conditions and incorporate additional cost drivers that influence provider expenses statewide. The proposed methodology:

- Enables regular reviews and updates using recent, credible, and publicly available data sources.
- Incorporates cost factors across multiple categories, including transportation, healthcare, food, and taxes. Appendix xx below includes additional information on the sources and analysis associated with each cost category.
- Accounts for household cost variations using Economic Policy Institute (EPI) data across a range of family sizes – from single adults to two-adult, four-child households.
- Adapts the existing DMAS definitions of Northern Virginia (NOVA) and Rest of State (ROS)

regions.

Current Methodology

Guidehouse's geographic differential analysis builds on DMAS's current definitions of Northern Virginia (NOVA) and Rest of State (ROS), using Federal Information Processing Standards (FIPS) codes to classify cities and counties.[50] Table 31 below maps each FIPS code to the corresponding region – NOVA or ROS – based on this classification. Some providers from the Rate Advisory Workgroup suggested reclassifying certain counties and cities currently designated as ROS into the NOVA category due to higher local costs of living. Others noted that changing these geographic definitions could have broader implications for DMAS programs and may require further consideration beyond the scope of this rate study. Therefore, we recommend reserving this matter for future review. If DMAS were to undertake efforts to modify the definitions and reclassify the counties and cities, it is imperative to consider representative feedback from programs and providers that may be impacted by a revised definition.

Table 31: DMAS's Geographic Region Definition[51]

FIPS Code	City / County	Region
510	Alexandria City	Northern Virginia (NOVA)
013	Arlington County	
043	Clarke County	
047	Culpeper County	
600	Fairfax City	
059	Fairfax County	
610	Falls Church City	
061	Fauquier County	
630	Fredericksburg City	
107	Loudoun County	

[50] nova-localities_homehealth.pdf

[51] Virginia Department of Medical Assistance Services, Localities and FIPS Codes. Available online: nova-localities_homehealth.pdf

FIPS Code	City / County	Region
683	Manassas City	
685	Manassas Park City	
153	Prince William County	
157	Rappahannock County	
177	Spotsylvania County	
179	Stafford County	
187	Warren County	
Other Codes	Other Cities / Counties	Rest of State (ROS)

Current rate differentials between Northern Virginia (NOVA) and the Rest of State (ROS) range from 8 percent to 29 percent, depending on the service. These differences are based on historical models and the funding appropriated at the time of implementation. Historically, regional rate variations have been informed by a limited set of cost components – primarily wages, mileage, and program support costs. To ensure consistency and transparency, DMAS should consider adopting a standardized methodology and set of assumptions for applying geographic differentials across all DD waiver services included in this study.

In the provider survey, a small number of providers reported distinct baseline wages for both NOVA and ROS. Most providers submitted wage data for only one region, and those with incomplete regional reporting were excluded from the wage differential analysis. Based on the average reported wages from providers in each region, excluding overtime and supplemental pay, the wage differential between NOVA and ROS is approximately 18 percent.

Leveraging the Economic Policy Institute Dataset

The most recent Economic Policy Institute (EPI) dataset covering CY 2024 serves as the foundation for this analysis. EPI publishes annual, county-specific data for Virginia across key cost categories, including healthcare, food, transportation, and taxes.[52] For the purposes of this study, we aggregated county-level data to support cost comparisons and inform geographic differential adjustments.

This dataset is a comprehensive collection of publicly available information sourced from several

[52] Economic Policy Institute, Family Budget Calculator. Available online: https://www.epi.org/resources/budget/

national organizations, including the U.S. Department of Labor, USDA (Department of Agriculture), MEPS (Medical Expenditure Panel Survey), BLS (Bureau of Labor Statistics), National Bureau of Economic Research, and the Henry J. Kaiser Family Foundation.

As shown in Figure 24, household costs in NOVA are approximately 17 percent higher than those in the ROS across cost categories. This difference is consistent with findings from the provider survey. DMAS should consider applying this cost differential for NOVA and ROS rates. The benchmark rate models developed for this study include this adjustment. DMAS can also consider monitoring and leveraging this data to track evolving cost differences across geographies in the future.

Figure 24: Geographic Differential Factor based on Economic Policy Institute (EPI) Data

2024 Economic Policy Institute – Virginia Average Annual Cost Per Household by Cost Category					
Region	**Transportation**	**Healthcare**	**Food**	**Taxes**	**Total Cost**
NOVA Household Costs	$17,782	$11,571	$12,214	$21,199	$62,765
ROS Household Costs	$18,109	$12,250	$10,506	$12,896	$53,762
Overall difference between NOVA and ROS	**+16.8%**				
State-Wide Household Costs	$18,067	$12,163	$10,724	$13,957	$54,913
Overall difference between NOVA and State-Wide	+14.3%				
Overall difference between ROS and State-Wide	-2.1%				

H.3. Virginia DMAS should consider a developing a cost reporting program to collect provider data and meet CMS Access Rule requirements in the future.

A cost report is a tool used by states in which providers are tasked with reporting the costs involved with rendering services. As identified by the Centers for Medicare and Medicaid Services (CMS), "cost reports are most often used to gauge rate sufficiency by determining whether existing payment rates are sufficient to cover provider costs, establish payment rates, and identify unallowable costs."

Additionally, CMS's 2019 training on cost factors and rate assumptions emphasizes that states are required to explain the details of rate setting methods for each service. Some of the Federal guidance for rate setting methodologies include:

- §1902(a)(30)(A) of the Social Security Act: "Payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that those services are available to the general population."
- 1915(c) waiver program Technical Guide pages 252–254 CMS Review Criteria: States must describe "methods" that are employed to "establish provider payment rates" for "each" waiver service.

42 CFR 441.303(b) requires the state Medicaid Agency furnish CMS with sufficient information that includes: "A description of the records and information that will be maintained to support financial

accountability." DMAS does not currently administer cost reports for DD waiver providers. However, establishing a process to collect provider-level cost data may support more consistent monitoring of service costs over time. This information could also inform future rate reviews and adjustments.

Cost Report Data and Access Rule Requirements

DMAS may consider introducing cost reports that include one or more of the following reporting areas:

1. Revenue: Total revenue of the provider organization.
    a. Revenue would be helpful is understanding if providers are getting their costs covered and whether there may be any duplicating payments which would be unallowable.
2. Expenses: Total costs of the provider organization for services provided under each program.
    a. Cost per Service: Costs components tend to vary from service to service. For example, the place of service delivery would impact the total cost of delivering services. Services that are provided in a facility may have different costs from those provided in the community. Therefore, capturing costs by each service would assist with developing rate assumptions in future rate setting efforts.
    b. Unallowable Costs: Unallowable costs are costs submitted for federal Medicaid reimbursement that do not comply with HCBS waiver program federal requirements. Sometimes, these costs are inappropriately included in the rate determination process or may fail to be identified in the billing validation process, resulting in unallowable Medicaid reimbursement. Common unallowable costs include room and board costs, thirty party liable costs or costs supported by external organization, and costs that are unrelated to member care. Therefore, it is imperative to design the cost report to capture unallowable costs separately.
3. Wages and Supplemental Pay: Wages and supplemental pay for each direct care, direct care supervisor, and direct care contractor position in the provider organization.
4. Audit and Certification Statement: Each template should include a certification page that requires a chief decision maker (e.g., CEO/CFO/Accounting Manager) to verify or acknowledge the submitted cost report does not contain any unallowable costs and the data is accurate.

The CMS 80/20 Rule, finalized in 2024 as part of the Medicaid Access Rule ("Access Rule"), mandates that at least 80 percent of Medicaid payments for home and community-based services (HCBS) – specifically homemaker, home health aide, and personal care services – must be spent

on direct care worker compensation.[53] This rule applies to personal care services, including Personal Care and Companion, and it covers a broad range of workers, including RNs, LPNs, home health aides, personal care attendants, and clinical supervisors.

Looking ahead, collecting provider-level cost data for these services may support DMAS's implementation and oversight of the Access Rule. Under the rule, DMAS will be required to report to CMS on key service delivery metrics, including the percentage of Medicaid payments allocated to direct care worker compensation, the presence and extent of waiting lists, and service delivery timelines for covered services.

DMAS may consider capturing the following information as part of Expenses, in relation to the Access Rule:

- Total Medicaid Payments Received: Includes both standard and supplemental payments for personal care services
- Direct Care Worker Compensation: Must include:
    - Wages and salaries
    - Overtime pay
    - All forms of paid leave (sick, vacation, holidays)
    - Benefits (health, dental, life insurance, retirement)
    - Employer payroll taxes
- Excluded Costs (not counted toward the 80 percent):
    - Training costs for direct care workers
    - Travel costs (e.g., mileage reimbursement, transit subsidies)
    - Personal protective equipment (PPE)
- Administrative and Overhead Costs: These costs must be clearly separated and should not exceed 20 percent of Medicaid payments. Moreover, administrative cost reports reported in the reports may serve as a basis for validating generous administrative costs that would serve as a common "source of truth" when assessing provider reimbursement needs and could also facilitate regular administrative rate update to promote ongoing rate adequacy.

Incorporating data points into cost reports for the 80/20 Rule compliance could offer several key benefits:

- Demonstrates Compliance: Cost reporting will help verify that at least 80 percent of Medicaid payments are directed to direct care worker compensation (wages, benefits, payroll taxes),

[53] Federal Registrar, Ensuring Access to Medicaid Services. Available online: https://www.federalregister.gov/documents/2024/05/10/2024-08363/medicaid-program-ensuring-access-to-medicaid-services

ensuring transparency and accountability.

- Supports Oversight: With full compliance required by 2030, accurate cost data may enable DOH to monitor provider adherence and mitigate risks of noncompliance or funding disruptions.
- Enables Exemption Requests: DMAS may require that providers seeking hardship or small-entity exemptions from the Access Rule must submit detailed cost reports to justify eligibility.
- Informs Future Rate Reviews: Cost data may be leveraged for future rate reviews to check for alignment between reimbursement levels and provider costs – especially for small or rural providers.

Guidehouse's recommended rate for Personal Care, Respite, and Companion services includes an administrative cost factor of 14 percent, derived from survey data collected from DD providers. This results in direct care compensation that is 86 percent of the total rate, in alignment with the federal 80/20 requirement. This approach reflects actual provider-reported operational costs, aligns with CMS expectations for transparency and accountability, and provides a defensible basis for rate setting. DMAS may consider implementing the recommended rate model and collecting and monitoring provider cost data for future review and reporting.

Since cost reporting is new to both DMAS and its providers, Guidehouse acknowledges that implementing cost reports and requiring all providers to participate simultaneously at the outset would present significant administrative, programmatic, and logistical challenges. The Rate Advisory Workgroup also emphasized the importance of a phased approach and collaborating with stakeholders to design a cost reporting approach that is practical and minimally burdensome. Of note, cost reports are typically intended to be a minimum required dataset that participating providers should be able to report in contrast to one-time surveys that tend to be more comprehensive and detailed especially if cost data may not exist within the Commonwealth.

This collaborative effort may include identifying the range of providers to be involved – both providers delivering services within the scope for this rate study and the broader spectrum of DD providers and service types. Informed by provider feedback, we also recommend exploring pilot programs, targeted cost reports tailored to specific services, and financial attestation processes prior to full implementation. It is also important that the cost reporting framework is aligned with the rate development process.

To initiate this effort, DMAS may consider launching a pilot cost reporting program in collaboration with providers. This pilot may engage a subset of providers to gather feedback on their experience and inform the development of a scalable process thereafter.

Appendix A: Geographic Differential Costs Data and Analysis

Transportation Costs

Transportation expenses include the costs of commuting, vehicle ownership, public transit, and fuel. These expenses vary based on geographical differences in transportation infrastructure and the availability of public transportation.

EPI uses data from the Center for Neighborhood Technology (CNT) and its Housing and Transportation Affordability Index (2023). Transportation costs in the H+T index comprise three major components: auto ownership, auto use, and transit use. CNT estimated these components using data from the Consumer Expenditure Survey, the 2019 National Transit Database, CNT's AllTransit database, and the Illinois Department of Natural Resources.

For the data provided to the Economic Policy Institute (EPI), CNT modified these costs to account for different family sizes in the Family Budget Calculator and assumptions about trip purposes. Adults in all family types are assumed to be working and are considered commuters. CNT adjusted the miles traveled component of their equation to include only work and nonsocial trips for the first adult in a household and only work trips for the second adult (in two-adult households). According to national data from the 2022 National Highway Transportation Survey, this equates to 75 percent of average total vehicle miles traveled for the first adult and 42 percent for the second adult, if applicable.

The 2025 update inflates the transportation data to 2024 dollars using the regional transportation Consumer Price Index (BLS 2025c).

Food Costs

Food costs encompass groceries, dining out, and nutritional programs, and can vary significantly depending on regional agricultural production, distribution complexities, and local economic conditions.

The USDA's Center for Nutrition Policy and Promotion provides data on food costs through its report, "Official USDA Food Plans: Cost of Food at Home at Four Levels" (USDA 2024). This report outlines four national standards for nutritious diets: the "Thrifty Plan," "Low-Cost Plan," "Moderate-Cost Plan," and "Liberal Food Plan." Our analysis utilizes the USDA Low-Cost Plan, which assumes most food is purchased at grocery stores and prepared at home. The data used is from June 2024, reflecting the average weekly cost (Carlson, Lino, and Fungwe 2007).

County-level food costs are adjusted using a multiplier based on 2023 data from Feeding America's "Map the Meal Gap" project. This report provides average meal cost estimates for a meal consumed by a 19-to-50-year-old male under the USDA's Thrifty Food Plan, using data from over 65,000 stores. County-level multipliers are generated by dividing these meal costs by the national average, and then applying these multipliers to USDA estimates to reflect local food price variations more accurately.

Healthcare Costs

Healthcare expenditures include medical services, insurance premiums, and out-of-pocket expenses. Cost differences arise from variations in healthcare access, insurance markets, and

regional health issues.

Health care expenses comprise ACA health insurance exchange premiums and out-of-pocket expenditures. The Family Budget Calculator assumes insurance from ACA health exchanges.

Premiums are sourced from the KFF 2024 Health Insurance Marketplace Calculator, reflecting the lowest-cost bronze plan, adjusted for family size, user age, and tobacco surcharge. Calculations assume adults are 40-year-old nonsmokers.

Out-of-pocket costs are calculated using three-year averages from the geocoded MEPS data for 2019-2021, adjusted to 2021 dollars, provided by the Agency for Healthcare Research and Quality. Costs are differentiated by region and insurance coverage, considering both adults and children separately.

Taxes

Tax rates, including income, property, and sales taxes, differ by state and locality, impacting disposable income and service rate adjustments. The National Bureau of Economic Research's TAXSIM (Version 35) is a microsimulation model for calculating U.S. federal and state income tax rates. It uses 32 input variables such as state, marital status, wage income, rent paid, childcare expenses, and capital gains. The model outputs federal tax liability, state tax liability, and FICA tax liability. Local taxes and sales taxes are not included in the calculations.

Cost Data Sources

- U.S. Department of Labor: Provides data on employment, wages, and labor market conditions.
- USDA: Supplies information on agricultural economics, food prices, and nutritional assistance programs.
- MEPS: Delivers detailed data on healthcare expenditures, insurance coverage, and medical services utilization.
- BLS: Shares extensive statistics on inflation, productivity, and other critical labor economics metrics.
- National Bureau of Economic Research: Contributes research findings on various economic aspects, including business cycles and income distribution.
- Henry J. Kaiser Family Foundation: Focuses on health policy analysis, healthcare costs, and public health issues.

Appendix B: Procedure Codes for Fiscal Impact Analysis

Table 32 below includes the procedure codes and modifiers included in the fiscal impact analysis from the SFY 2024 claims data for the three DD waivers.

Table 32: Procedure Codes and Modifiers in Fiscal Impact Analysis – SFY2024 Claims Data

Clnt_Proc_Cd	Clnt_Proc_Mod_1	Clnt_Proc_Mod_2	RECIP_EXCP_IND	Waiver Name	Service Category
T2013			S	BI Waiver	Community Coaching
T2021			S	BI Waiver	Community Engagement
T2032			S	BI Waiver	Independent Living Supports
T2032	U1		S	BI Waiver	Independent Living Supports
T2032	UA		S	BI Waiver	Independent Living Supports
T2013			Y	CL Waiver	Community Coaching
T2013	U1		Y	CL Waiver	Community Coaching
T2013	UA		Y	CL Waiver	Community Coaching
T2021			Y	CL Waiver	Community Engagement
T2021	11		Y	CL Waiver	Community Engagement
T2021	77		Y	CL Waiver	Community Engagement
T2021	U2		Y	CL Waiver	Community Engagement
T2021	U3		Y	CL Waiver	Community Engagement
T2021	UA		Y	CL Waiver	Community Engagement
S5136			R or Blank - FFS Only	DD Waiver	CD Companion Care
S5135			Y	CL Waiver	Companion Care
S5135	76		Y	CL Waiver	Companion Care
S5135	UB		Y	CL Waiver	Companion Care

Clnt_Proc_Cd	Clnt_Proc_Mod_1	Clnt_Proc_Mod_2	RECIP_EXCP_IND	Waiver Name	Service Category
G0494			Y	CL Waiver	Congregate Nursing *(included as part of Skilled Nursing category)*
H2014	76	UA	Y	CL Waiver	In-Home Support Services
H2014	U1		Y	CL Waiver	In-Home Support Services
H2014	U2		Y	CL Waiver	In-Home Support Services
H2014	UA		Y	CL Waiver	In-Home Support Services
H2014	UA	76	Y	CL Waiver	In-Home Support Services
H2014	UA	77	Y	CL Waiver	In-Home Support Services
H2014	UA	UB	Y	CL Waiver	In-Home Support Services
H2014	UB	UA	Y	CL Waiver	In-Home Support Services
T1019			Y	CL Waiver	Personal Assistance
T1019	76		Y	CL Waiver	Personal Assistance
T1019	76	76	Y	CL Waiver	Personal Assistance
T1019	76	UB	Y	CL Waiver	Personal Assistance
T1019	77		Y	CL Waiver	Personal Assistance
T1019	UA		Y	CL Waiver	Personal Assistance
T1019	UA	77	Y	CL Waiver	Personal Assistance

Clnt_Proc_Cd	Clnt_Proc_Mod_1	Clnt_Proc_Mod_2	RECIP_EXCP_IND	Waiver Name	Service Category
T1019	UA	UB	Y	CL Waiver	Personal Assistance
T1019	UB		Y	CL Waiver	Personal Assistance
T1019	UB	76	Y	CL Waiver	Personal Assistance
T1019	UB	77	Y	CL Waiver	Personal Assistance
T1002			Y	CL Waiver	Private Duty Nursing
T1002	76		Y	CL Waiver	Private Duty Nursing
T1002	77		Y	CL Waiver	Private Duty Nursing
T1002	UA		Y	CL Waiver	Private Duty Nursing
T1003			Y	CL Waiver	Private Duty Nursing
T1003	76		Y	CL Waiver	Private Duty Nursing
T1003	77		Y	CL Waiver	Private Duty Nursing
T1003	TE		Y	CL Waiver	Private Duty Nursing
T1003	UA		Y	CL Waiver	Private Duty Nursing
T1005			Y	CL Waiver	Respite Care
T1005	76		Y	CL Waiver	Respite Care
T1005	TE		Y	CL Waiver	Respite Care
T1005	UA	UB	Y	CL Waiver	Respite Care
T1005	UB		Y	CL Waiver	Respite Care
S9123			Y	CL Waiver	Skilled Nursing
S9124			Y	CL Waiver	Skilled Nursing
S9124	UA		Y	CL Waiver	Skilled Nursing
97139			Y	CL Waiver	Therapeutic Consultation
97530			Y	CL Waiver	Therapeutic Consultation
97530		59	Y	CL Waiver	Therapeutic Consultation
97530		GP	Y	CL Waiver	Therapeutic Consultation

Clnt_Proc_Cd	Clnt_Proc_Mod_1	Clnt_Proc_Mod_2	RECIP_EXCP_IND	Waiver Name	Service Category
H2017			Y	CL Waiver	Therapeutic Consultation
H2025			Y	CL Waiver	Workplace Assistance Services
T2013			R	FIS Waiver	Community Coaching
T2013	UA		R	FIS Waiver	Community Coaching
T2021			R	FIS Waiver	Community Engagement
T2021	77		R	FIS Waiver	Community Engagement
T2021	UA		R	FIS Waiver	Community Engagement
S5135			R	FIS Waiver	Companion Care
S5135	76		R	FIS Waiver	Companion Care
S5135	UB		R	FIS Waiver	Companion Care
G0494			R	FIS Waiver	Congregate Nursing *(included as part of Skilled Nursing category)*
H2014			R	FIS Waiver	In-Home Support Services
H2014	76	UA	R	FIS Waiver	In-Home Support Services
H2014	U1		R	FIS Waiver	In-Home Support Services
H2014	U2		R	FIS Waiver	In-Home Support Services
H2014	UA		R	FIS Waiver	In-Home Support Services

Clnt_Proc_Cd	Clnt_Proc_Mod_1	Clnt_Proc_Mod_2	RECIP_EXCP_IND	Waiver Name	Service Category
H2014	UA	76	R	FIS Waiver	In-Home Support Services
H2014	UA	77	R	FIS Waiver	In-Home Support Services
H2014	UA	UB	R	FIS Waiver	In-Home Support Services
S5126			R or Blank - FFS Only	DD Waiver	CD Personal Assistance
T1019			R	FIS Waiver	Personal Assistance
T1019	76		R	FIS Waiver	Personal Assistance
T1019	76	76	R	FIS Waiver	Personal Assistance
T1019	76	UB	R	FIS Waiver	Personal Assistance
T1019	77		R	FIS Waiver	Personal Assistance
T1019	UA		R	FIS Waiver	Personal Assistance
T1019	UA	75	R	FIS Waiver	Personal Assistance
T1019	UB		R	FIS Waiver	Personal Assistance
T1019	UB	76	R	FIS Waiver	Personal Assistance
T1002			R	FIS Waiver	Private Duty Nursing
T1002	76		R	FIS Waiver	Private Duty Nursing
T1002	TD		R	FIS Waiver	Private Duty Nursing
T1003			R	FIS Waiver	Private Duty Nursing
T1003	76		R	FIS Waiver	Private Duty Nursing
T1003	77		R	FIS Waiver	Private Duty Nursing
T1003	TE		R	FIS Waiver	Private Duty Nursing

Clnt_Proc_Cd	Clnt_Proc_Mod_1	Clnt_Proc_Mod_2	RECIP_EXCP_IND	Waiver Name	Service Category
T1003	UA		R	FIS Waiver	Private Duty Nursing
S5150			R or Blank - FFS Only	DD Waiver	CD Respite
T1005			R	FIS Waiver	Respite Care
T1005	76		R	FIS Waiver	Respite Care
T1005	77		R	FIS Waiver	Respite Care
T1005	UA	75	R	FIS Waiver	Respite Care
T1005	UA	UB	R	FIS Waiver	Respite Care
T1005	UB		R	FIS Waiver	Respite Care
S9123			R	FIS Waiver	Skilled Nursing
S9123	UA		R	FIS Waiver	Skilled Nursing
S9124			R	FIS Waiver	Skilled Nursing
97139			R	FIS Waiver	Therapeutic Consultation
97530			R	FIS Waiver	Therapeutic Consultation
H2025			R	FIS Waiver	Workplace Assistance Services

Virginia Department of Medical Assistance Services (DMAS)
Developmental Disabilities (DDS) Rate Study
Department of Justice (DOJ) Feedback on Report

Department of Justice (DOJ) Feedback on Draft VA DD Rate Study Report

Following the distribution of the draft VA DMAS DD Rate Study Report (*File Name: DRAFT FOR REVIEW_VA DMAS DD Rate Study Final Report_07.21.2025_Updated*) to the Rate Advisory Workgroup on August 8, 2025, Guidehouse requested that workgroup members review the report and submit feedback by August 19, 2025. This document includes Guidehouse's responses to feedback shared by DMAS, as reported by the Department of Justice (DOJ), and highlights areas where edits were made to the report based on the comments received. It also cross-references the updated version of the Final Report dated September 30, 2025 (*File Name: VA DMAS DD Rate Study Final Report_09.30.2025*).

General Comments on the Draft Report

DOJ Feedback (August 25 Letter to Virginia OAG)

"At the outset, we want to state the purpose of the rate study as required in the Injunction: Virgina agreed, and the Court ordered, that Virgina would conduct a rate study "designed to target rates necessary to ensure sufficient capacity to reach the goals of paragraphs 33 [behavioral services], 37 [day/community engagement services], 38 [skilled nursing services], 39 [private duty nursing services], and 48 [direct support professional competencies which effect person assistance, companion, respite, in home support, and independent living support services] (emphasis added). See Injunction at 16, ECF 554 (Jan. 15, 2025) (Provision 59 (a) i.)."

Guidehouse Response

The DOJ's feedback on the recommendations presented in the Guidehouse rate study begins with a note that highlights the explicit purpose of the study: "to target rates necessary to ensure sufficient capacity to reach the goals" established for each of the services under review. Guidehouse did not interpret this introduction as a contextual statement, but as a concern that the rate study may not have been conducted in accordance with the requirements of the Permanent Injunction. Detailed comments in Item 3 of the feedback letter, regarding baseline wages, in Item 5 on employee-related expenses, and in line item comments in Section F.2.6. of the report on administrative costs further support this reading.

To address any perceived concern that our study does not meet the sufficiency standards of the Injunction, Guidehouse has responded in the final version of the rate study report by inserting additional discussion in the Executive Summary (p.6), Introduction and Background (p.9-12), and Stakeholder Engagement (p.13) sections. These additions affirm explicitly that the study was designed and executed to meet the standards of the Injunction. They also explain at length how Guidehouse interprets "sufficient capacity" as identified in the Injunction and the ways in which the benchmarking methodology was applied specifically to promote the sufficiency goals of the study.

While we address the general goals and standards of "sufficient capacity" in the report additions, we would also like to call attention to the complex relationship that exists between rate sufficiency and the maintenance and growth of provider capacity that informs the detailed performance goals in paragraphs 33, 37, 38, 39, and 48. The role of rate adequacy in supporting the goals of these paragraphs, as Guidehouse understands it, is to sustain providers sufficiently to enable them to expand services, which occurs primarily through the growth and development of their workforce. The concrete implication for the rate study is that the reimbursement adequacy standard is met by developing benchmarks that can be shown to support competitive hiring and retention of staff, as well as demonstrating sufficient coverage of the indirect costs incurred by providers to maintain the needs of service delivery. The report thoroughly documents how the study met those standards.

Importantly, the extensive research literature exploring the relationship between reimbursement and access to services frequently observes that reimbursement is a major factor supporting sufficient access to services, but it is not the only factor. Increasing access depends on other conditions that are not necessarily influenced by either low or high reimbursement. What this means is that the causal link between rate levels and provider capacity is not direct, and even substantial additional investment does not necessarily predict or determine particular outcomes in guaranteeing sufficient capacity. Especially for the performance goals defined in paragraphs 33, 37, 38, and 39, building capacity requires strategic investments and targeted growth from providers, not just better rates to cover present and anticipated operating costs. For some of the goals, enhanced capacity also requires improvements in referral processes and care coordination, which are not wholly directed or dictated by rates.

Furthermore, the research literature does not speak with one voice on the level of enhanced access that can be expected based on the level of additional investment into the service workforce. The literature contains numerous studies providing evidence that wages are the primary driver of DSP retention, and some even try to quantify the extent to which additional dollars positively impact turnover rates. A 2010 ANCOR study, for example, reported a 3.61 percent decrease in DSP turnover for every additional dollar invested into entry wages.[1] However, it is also evident that significant nationwide rate increases for Medicaid DD services since the COVID-19 public health emergency have not necessarily led to a significant surge in the supply of DSP workers.

Without further consensus on how compensation directly impacts retention, or agreement beyond the evidence of the labor market itself on the wage levels needed to grow the DD workforce, Guidehouse's standard has been to propose wage and benefit benchmarks sufficient to allow providers to compete in the labor market. However, we are also cognizant

[1] Anderson-Hoyt, J., McGee-Trenhaile, M., and Gortmaker, V. (2010). *Direct Support Professional Wage Study: 2009.* Alexandria, VA: ANCOR.

of efforts by DD advocacy groups to develop independent wage standards. In recent years, the requirement for DSP wages to be set at 150 percent of state minimum wage has emerged as a common recommendation for defining a basic wage adequacy standard. New Mexico has codified the 150 percent standard in law, with a similar bill failing to pass in Oregon. Illinois maintains the 150 percent standard in its DD reimbursement methodology, while Maine recently passed legislation requiring a 125 percent standard. According to these metrics, Guidehouse's DSP hourly wage recommendation of $22.20 would be approximately 174 percent of Virginia's 2026 minimum wage of $12.77. The performance goals of paragraph 48 are probably the most directly achievable through better reimbursement alone, and we are confident we have shown how our benchmark recommendations can improve retention and training for the direct care workers that deliver the services covered in paragraph 48.

A. Executive Summary Comments

DOJ Feedback (August 25 Letter to Virginia OAG)

"1. On page 6, Guidehouse states, "Direct care wages reported in the provider survey were generally higher than national benchmarks, with inflation and supplemental pay adjustments applied to project SFY2027 benchmark wages." It appears Guidehouse is stating that the wages that providers reported in the survey – which were reported for FY2025 Q1, but then Guidehouse adjusted in Table 21 as SFY2027 benchmark wages – are generally higher than national benchmarks. Could Guidehouse please provide a reference here to the data in the report that forms the basis of this assertion?

It appears Guidehouse is comparing Figures 4-16 with the proposed benchmark rates in Table 21. While the proposed benchmark rates in Table 21 are higher than the rates of the selected states in Figures 4-16 (although not in all cases), this presentation is incomplete. It does not account for evidence provided by stakeholders in the Rate Advisory Workgroup, who repeatedly stated that current direct care wages in Virginia are too low to hire the workers they need to serve the individuals with intellectual and developmental disabilities who are protected by the Injunction.

Furthermore, the states used in the comparisons have much lower minimum wages (See Figure 2) and below-average median household incomes (See Figure 3) than Virginia. They show Virginia in a relatively better light, not because they are "peers," but because they are not as economically robust. Their use as comparators with the Commonwealth is questionable. In the same way, Guidehouse uses Figures 12-15 to indicate that Virginia's nursing rates are "generally higher" than other states. But, again, the states used as comparators do not appear to be appropriate economic matches to the Commonwealth.

More basically, Virginia stakeholders have stated for years through surveys and other means that the number one problem with meeting individuals' nursing needs is that the nursing rates are not adequate to ensure sufficient capacity. The assertion that Virginia's rates are "generally higher," and

related Figures 4-16, ignore this fact, making this assertion and the related conclusions materially incomplete."

Guidehouse Response

Our intention was to link the bullet point on direct care baseline wages to publicly available Virginia wage data released by the Bureau of Labor Statistics (BLS), a national organization. This reference was to Virginia-specific data – not national averages. We replaced the previous language in the Executive Summary on DSP wages with the following: *"Direct care baseline wages reported in the provider survey were higher than Virginia wages for most job types and lower for a few compared to Virginia wage data publicly available from the federal Bureau of Labor Statistics (BLS). Higher wages in themselves are not an indicator of rate adequacy but must be interpreted within the context of total compensation, considering many providers may continue to pay higher wages to maintain minimum market competitiveness even when forced to trim benefit offerings to contain overall service costs. In most cases, Guidehouse benchmarked rates using the more competitive wages derived from the provider cost survey, while further incorporating inflation and supplemental pay adjustments to project benchmark wages for SFY 2027."*

We appreciate the DOJ's concern that peer state comparison results may create the false impression that Virginia's current rates are adequate, but that perception was not our intention. We have tried to mitigate that misconception with additional commentary on the peer state analysis in various sections of the report, most prominently, succinctly, and directly in the Introduction and Background (p.12), but also in the detailed presentation of the comparison results in Section E (Peer State Comparisons). We believe our selected peer states are still appropriate, but we better contextualize and clarify our rationale in choosing peer states.

As noted in pages 27-29 of the report, Guidehouse identified the following states for peer analysis, each selected for specific reasons. Given the internal geographic and demographic diversity of the Commonwealth, as well as its proximity to the nation's capital and unique governmental and defense industries, no state serves as a perfect "match" for comparison to Virginia. Consequently, peer states were selected for their aptness to represent different aspects of Virginia's geographic and demographic makeup, sometimes for contrast as much as comparison. Ultimately, DC, Maryland, and Pennsylvania are probably best suited for comparison to reimbursement in Northern Virginia, while Georgia, Kentucky, North Carolina, South Carolina, Tennessee, and West Virginia offer better points of comparison for the rest of Virginia.

Of note, the focus with peer state comparisons was to identify services that would allow an apples-to-apples contextual comparison since HCBS program structures typically vary widely based on service titles, service definitions, and populations served, and are often not

susceptible to standardized reporting because states have the flexibility in designing programs.

These states were also reviewed as part of the Rate Advisory Workgroup process, prompting a question from a member about whether New York should have been considered a peer state as well. Although the downstate/upstate distinction in New York may superficially resemble Virginia's NOVA/ROS dynamics, the scale of the differences and similarities are not really commensurable. In contrast to the roughly 30 percent of Virginia's population residing in Northern Virginia, the relationship between New York City and the rest of the state is nearly the inverse, with approximately 70 percent of the state living in the New York City metropolitan area compared to upstate. At roughly twice the total population of Virginia, New York's health and human services systems operate at a significantly larger scale. For these reasons, New York is more effectively compared with other "big states" like California, Texas, and Florida, or better aligned with states whose populations are dominated by major metropolitan areas such as Illinois or Massachusetts.

Guidehouse also contemplated including New Jersey in the comparisons. It may serve as a helpful comparison state for Virginia when analyzing rates, as both have similarly sized populations and a mix of urban and rural regions. Additionally, they share comparable economic complexity and public service infrastructures, making rate-based comparisons meaningful. However, New Jersey is less suitable for comparing 1915(c) HCBS waivers due to key structural differences in their Medicaid programs. New Jersey delivers most of its long-term services and supports through managed care and has consolidated many HCBS programs under broader Medicaid authorities, such as 1115 waivers. As a result, New Jersey does not operate 1915(c) waivers. In contrast, Virginia's DD waivers operate under the 1915(c) waiver authority. These differences in waiver structure, administration, and service delivery models limit direct rate comparisons between the two states.

Overall, the Workgroup noted that these comparisons were particularly helpful early in the process for understanding the overall range of rates for similar services.

DOJ Feedback (August 25 Letter to Virginia OAG)

"2. On page 7, the following Guidehouse recommendations are particularly important. We hope that Virginia will implement them and that Guidehouse or a similar entity will assess that implementation in a future rate study.

- *Adopt a modular rate build-up approach*
- *Implement a regular rate review process*
- *Update geographic differential methodologies*
- *Develop a provider cost reporting program"*

Guidehouse Response

Noted.

DOJ Feedback (Line Item Comments in Initial Report Draft)

"Regarding statement on wages in the Executive Summary: "We assume this means that the provider survey wages, adjusted with inflation and supplemental pay to project SFY2027 benchmark wages, were generally higher than national benchmarks. But the basis for establishing the national benchmarks is not set forth, and the states selected do not compare, for the most part, economically to Virginia."

Guidehouse Response

See our response above to a similar DOJ comment on Guidehouse's use of "national benchmarks" and peer state comparisons in its Item 1 comment on the report Executive Summary.

F.2.1 Staff Wages Comments

DOJ Feedback (August 25 Letter to Virginia OAG)

"3. Baseline Wages: On page 42, Table 11, Guidehouse chose a "Baseline Hourly Wage" that reflects what providers are currently paying. During the Rate Advisory Workgroup, stakeholders repeatedly stated that current wages are insufficient, and the shortage of workers bears out those assertions. Consequently, Guidehouse's choice to use current wages as a baseline is concerning. At a minimum, the basis for Guidehouse's choice, including how it accounts for worker shortfalls and stakeholder input, should be provided.

Guidehouse started with provider-reported average wages for each of the 18 job types (e.g., Direct Support Professional, Registered Nurse, Occupational Therapist). Then it weighted those average wages based on the "proportion of time each [staff] role contributes to total staffing." The weighting resulted in Guidehouse selecting a baseline wage that was less than the provider reported average wage for 6 of the 14 job types (See Table 6). Then Guidehouse compared recent Bureau of Labor Statistics (BLS) data for Virginia to the weighted wages and the provider-reported average wages. The results varied, though they were generally similar. But the wages generated from this process are based on a methodology that appears flawed.

Most basically, this methodology is entirely based on what providers are currently able to pay workers, which is based on what the rates are now. Providers repeatedly pointed out in the Rate Advisory Workgroup that setting baseline wages on the wages currently being paid by providers is a circular, self-defeating exercise. This is because providers can only pay what the rates allow them to pay, and the current rates are insufficient to hire the workforce providers need. Thus, it appears Guidehouse chose a baseline wage that reflects the current, insufficient, baseline wage instead of a baseline wage that could attract sufficient staff to ensure sufficient capacity, as contemplated by the Injunction."

Guidehouse Response

Since these comments are aimed at the core of Guidehouse's perceived approach and assumptions, and thereby represent a fundamental criticism of the study, it is essential to address the misconceptions behind these concerns.

First, it is not the case that Guidehouse's methodology is *entirely* historical and therefore perpetuates a circular pattern of historical underfunding. The objection above severely overstates Guidehouse's reliance on historical system data, does not acknowledge the role and extensive use of multiple data sets to develop our recommendations, and discounts the explicit steps taken to control for and correct the influence of systemic underfunding. We have tried to address this concern directly in the report by inserting additional language that speaks to the challenge of "vicious circularity" and all the ways our methodology is intended to counteract that tendency. Along with close documentation of all the non-cost survey sources used in developing benchmark assumptions, we are satisfied that the report demonstrates the study was not "a circular, self-defeating exercise."

Second, while historical underfunding may exert a downward pressure on reported costs, it is not the case that provider-reported data within underfunded systems necessarily expresses depressed costs in all respects or reflects inherently uncompetitive wage standards insufficient to cost and quality service delivery. The objections to the use of survey data presented here do not demonstrate their conclusions based on concrete evidence (such as alternative wage measures derived from independent industry data), but appear to rely on a basic, unsubstantiated presumption that under-reimbursement in Virginia overall inherently skews provider-reported data in every detail.

Third, the DOJ's general concerns about data integrity, quality, timeliness and context-appropriateness of both the cost survey data and public industry data sources used by Guidehouse do not appear to be registered consistently, but are applied only to a small minority of circumstances in which Guidehouse's recommended benchmark assumption proved to be lower than another alternative benchmark available. Moreover, several of its data and methodological objections appear to be applied in sometimes contradictory ways.

In the first place, the broad objection that Guidehouse's wage benchmarking methodology is based wholly or even for-the-most-part on historical provider costs overlooks the prominent role played by BLS wage metrics specific to Virginia. Data independent of Virginia's DD system and the historical costs incurred by its providers featured heavily in nearly every service cost component reviewed by Guidehouse, not only as an independent check on the veracity and adequacy of provider-reported wage costs, but as a preferred alternative benchmark in cases in which surveyed wages appeared depressed in comparison to industry standards. Guidehouse did not take survey wages at face value or employ them uncritically but scrutinized them for signs of underpayment (or overpayment) based on industry data available from independent sources. Only on this basis did we utilize wages derived from the cost

survey as a benchmark informing rate recommendations. Guidehouse's approach held true not only for wages, but also for direct care compensation and other indirect costs more broadly.

The charge that Guidehouse's methodology is "circular" discounts several instances in which our approach reflects interventions intended specifically to correct for skewed wages suggestive of historical underfunding. For two specialized practitioner types—registered nurses (RNs) and physical therapists (PTs)—Guidehouse opted to use the BLS average hourly wage as a benchmark, not only because of the strength of the BLS data for these standardized practitioner types, but also because survey wage data showed that typical wage compensation for these positions was too low compared to available labor market standards.

In response to the second objection – that Virginia's provider-reported data is historically conditioned to reinforce inadequate reimbursement – the most important counter-evidence to this objection is the fact that the vast majority of provider-reported hourly wages were demonstrably higher than wage assumptions drawn from other Virginia-specific industry data and labor cost metrics. Of the 16 different job types reviewed by Guidehouse for wage benchmarking, 10 types allowed comparison between the hourly wages derived from the provider cost survey and metrics available from Virginia-specific BLS data. Of the six other practitioners, four were either not reported or sampled in insufficient numbers to support survey benchmarks. These practitioners reflected specialized clinical staff for whom alternative BLS benchmarks were readily available. Two practitioners were so unique to the DD system (behavior analysts and associate behavior analysts) that Guidehouse declined to identify a potentially ill-fitting, generic BLS analogue and opted to use wage costs reported in Virginia's system. Among the 10 job types directly compared, provider-reported data illustrated higher costs than BLS metrics for 7 of the 10 practitioners.

Direct comparison of survey wage data with other industry wage metrics undermines the contention that survey data is inherently biased toward lower, inadequate wages. Guidehouse findings have also been confirmed, at least indirectly, by the stakeholders commenting above on the wage assumptions. Many of the stakeholders acknowledged the fact that Virginia providers do appear to be paying their staff *above* industry averages or medians, but have reconciled this fact with the reality of historical underfunding by noting that providers must continue to pay better-than-industry wages to remain minimally competitive in the labor market while being forced to cut costs elsewhere (benefit offerings, for example) to be able to deliver services under inadequate rates. We do not dispute these stakeholder insights but argue, rather, that such observations actually support the case for privileging the use of survey costs over other wage metrics for these direct care staff and the services they deliver.

For the 7 job types in which Guidehouse benchmarked wage assumptions to the survey data, we did so because we believed not only that the survey furnished the most recent data (and thus most indicative of current and near-future costs), but also that it yielded the most

context-sensitive and relevant data. While BLS wage data may faithfully represent broader industry cost trends and standards in Virginia, it does not necessarily reflect the special needs and challenges of retaining qualified staff to deliver services in Virginia's DD system. Guidehouse relied on survey data for these assumptions not because of a methodological commitment to "historical" data, or even because it proved more favorable to providers than other alternatives, but because this data set is the most illuminating into the specific wage pressures and cost drivers confronting the providers that deliver services under Virginia's DD waivers.

To say that the cost survey was the best fit under these circumstances is not to say that it lacks any limitation whatsoever. All data sources used in the DD rate study have differing strengths and weaknesses. One of the vulnerabilities of a provider cost survey, rightfully identified in DOJ's comment here, is that it relies on historical experience and reflects all the financial biases and idiosyncrasies of that history (a condition, it should be noted, from which no historical market analysis or labor statistic is completely immune). Another vulnerability is that cost surveys are ultimately self-reported and unaudited, and so run the risk of skewing results in the reporter's interest or in ignorance of reporting standards or the lack of more rigorous review and quality assurance.

However, the advantage of cost survey data sets is that they often furnish the most recent cost metrics possible and are frequently the most suited to actual provider practice and system context. While BLS and other industry data are typically trusted and well-vetted, the process for establishing reliability also ages and decontextualizes the data, rendering it less timely, less specific, less detailed, or otherwise less appropriate to the system under review. In the small number of instances in which Guidehouse benchmarks drew on system-independent data to yield assumptions less favorable to providers than survey assumptions, resulting stakeholder comments have similarly noted the distinct virtues of employing survey data instead.

In our rate studies, Guidehouse carefully considers the relative merits of leveraging each data set available for specific services, typically through a process of triangulation that harnesses discrepancies between different data sets to identify potential bias, anomaly, or inapplicability in one set versus another. In developing our wage assumptions, we attempted to balance the tradeoffs of each data source to select the most appropriate measure of reasonable wage costs for each rate. Our methodology is clear, and in the vast majority of cases, has resulted in a wage benchmark more favorable to providers than alternative options.

For the reasons discussed above, Guidehouse has generally preferred to derive wage benchmarks from the provider-reported data, though we have identified specific cases in which we substituted a BLS alternative where strong evidence of surveyed wage insufficiency manifested itself through comparison to other industry benchmarks. In one case involving the "personal caregiver" job type, survey data yielded a wage benchmark that fell within the

bounds of industry standards but was not the highest wage among alternatives. Where comparative evidence on the adequacy of provider-reported metrics was indeterminate in this matter, Guidehouse chose to recommend the survey benchmark, consistent with our assessment of the overall relative superiority of the survey data compared to BLS, as a data set both more recent and more responsive to Virginia's system context.

Some stakeholders may question whether the higher BLS average may be a more appropriate benchmark, and we do not dispute that a methodological argument could be made to select the benchmark most favorable to provider reimbursement as a "safe harbor" in defining sufficient capacity. However, the objective of Guidehouse's study is not to maximize provider revenues, but to offer an independent, objective perspective on reasonable cost standards that both promote provider sufficiency goals as well as regulatory requirements encompassing principles of economy, efficiency, quality of care, and safeguards against unnecessary utilization.

We chose a middle-range wage benchmark in this case for several reasons. Most importantly, due to the lack of conclusive evidence that the survey wage assumption was below market or lower than industry, we believe our selection methodology shows greater integrity in meeting the balance of regulatory concerns than simply maximizing potential provider reimbursement. Furthermore, the personal caregiver wage assumption drives rates for the most highly utilized (and thus, expensive) services within the scope of the review, warranting heightened scrutiny regarding economy. The need for additional considerations around economy are compounded by the fact that personal assistance rates, unlike most other services in the waiver, are tied to other high-volume services delivered in other programs under Medicaid, which are not subject to the Injunction or within the scope of Guidehouse's review and data gathering. We believe the potential for amplified impacts beyond the services in our purview warrants a cautious approach that accounts for the risk of unintended consequences and unconsidered outcomes. So while we do not disagree that the BLS average could also serve as a reasonable wage standard for the personal caregiver job type, agreeing to the sufficiency of a higher benchmark does not thereby render a lesser benchmark "insufficient." We also believe that the 45-46 percent increase in the personal assistance rates, among the highest in the study, is at least indirect evidence that cost containment was not a dominant motivation in our choice of wage benchmark.

Guidehouse has updated the report with the following language to make our wage benchmark selection principles more explicit:

- **Survey wages generally exceeded the BLS-reported wage range above either the average or median for most roles (e.g., LPNs, PBSFs). Based on discussions with the Rate Advisory Workgroup input, FTE-weighted survey wages were used to develop proposed benchmarks for these practitioner roles, as they best represent DD waiver providers' actual practice, align most closely with a cost-informed rate, methodology, and are more likely to support**

staff hiring and retention. While survey wages were higher than their BLS comparison benchmarks, they were sufficiently comparable to BLS ranges to avoid potential concerns of overpayment.

- **Where survey wages fell between the average and median range of the BLS-reported wage, survey wages were used as the benchmark for purposes of methodological consistency with reimbursement based on reasonable provider costs.**
- **For roles where survey wages were lower than both the BLS average and median, BLS averages were used as the wage assumption to promote alignment with industry standards, reported lower wages were treated as evidence of under-reimbursement and the need to benchmark to the BLS average alternative to support competitive compensation. This circumstance applied to Registered Nurses (RNs) and Physical Therapists (PTs), where survey data fell below both benchmarks.**
  For roles not captured in the survey, BLS average wages were used as the default standard for reasonable benchmarks. These roles include key positions such as Psychiatrists and Psychologists, which are essential for rate-setting in services like Therapeutic Consultation.

Our third contention in responding to the DOJ's methodological concerns here is that its critique of Guidehouse's reliance on survey data is applied inconsistently. Systematically low reimbursement can impact provider costs in complex ways that require close attention. While the DOJ focuses critically on these impacts to the extent that they potentially lower baseline wages reported in the survey, another pernicious effect of underpayment, not addressed by the DOJ, is that it actually *drives up* provider costs in other areas, particularly in aggravating provider dependence on high-cost overtime pay. Time-and-a-half overtime wages can be a helpful "supplemental pay" benefit for staff, but they can also create staff burnout and turnover, and so are generally regarded as a sign of an unhealthy reimbursement environment and a signal to increase wages.

It is crucial, when controlling for the effects of under-reimbursement in provider-reported data, to consider how the biases and distortions of underpayment can understate costs but can also overstate costs compared to an environment where reimbursement needs are appropriately addressed. The DOJ appears less concerned with such distortions in the case of overtime and other supplemental pay, where the emphasis is rather placed on the virtues of the survey data compared to other sources. It states in the August 25 letter: "*Further, the Virginia provider data…shows that providers' average supplemental pay rate has been 5.1%, with a median rate of 3.4%. The provider data is particularly relevant, given that it reflects facts on the ground in the Commonwealth. Guidehouse's choice to ignore both the more recent data and the Virginia provider data in favor of older, national data is problematic and should be revisited.*"

The concerns specific to Guidehouse's supplemental pay benchmark assumptions will be addressed below in another section, but we think it's important to note that drilling down into

particular metrics without acknowledging how we are utilizing the different data sources in our methodology more broadly ultimately obscures questions of rate adequacy overall. By interrogating particular wage assumptions without recognizing how those assumptions fit into the overall picture of compensation, the DOJ fails to appreciate the significant increases in benefit cost allowances coming out of the study as well. For example, whereas the cost survey shows that the average provider pays a fringe benefit percentage of 22.8 percent of current wages (with a median of 19.4 percent), Guidehouse's use of the survey data to determine what providers *ought* to be paying their staff comes out to 30.4 percent for DSPs and 34.8 percent for personal caregivers, with the percentage measured not against current, depressed wages but against increased, benchmark wages. Collectively, these increases to direct care compensation constitute a major boost to building sufficient capacity, and because they come to providers as a single rate, they have the flexibility to prioritize wages or expand benefits according to their business needs and hiring and retention strategies.

DOJ Feedback (Line Item Comments in Initial Report Draft)

"What is the formula for the FTE-weighted adjustment in Table 6?"

Guidehouse Response

Section F.2.1., pages 41-42 of the report, includes additional information and examples on how FTE-weighted wages are calculated and key observations based on both weighted and unweighted wages. Guidehouse applied a weighting of reported baseline wages based on the number of FTEs. FTE-weighted wages are statistically robust because they account for actual work effort across full-time and part-time roles. As a result, providers employing more FTEs have a proportionally greater influence on average wages. This method helps avoid over- or under-representing part-time roles and aligns wages with labor contributions. Applying this method to the survey data, we found that the average wage for DSPs is $18.66 per hour, while the FTE-weighted average wage is $20.36 per hour. This suggests that providers responding to the survey with a higher number of FTEs tend to offer wages above $18.66, resulting in a higher FTE-weighted average. Similar patterns are observed for BCBAs and BCABAs. In contrast, Behavioral Specialist/Technician wages show an inverse trend: the unweighted average wage is higher than the FTE-weighted average. This indicates that most FTEs reported have wages closer to the average rather than the FTE-weighted average. A similar trend was noted in the RN wage, which prompted further review in comparison with Virginia public wage data.

DOJ Feedback (Line Item Comments in Initial Report Draft)

DSP wage levels and corresponding trends (e.g., DSP 1, DSP 2, DSP 3) in Section F.2.1.1.: "Could we see the underlying data? Our understanding is that one would see trends in each survey produced by each Company. Did Guidehouse analyze the data that way to try to uncover such trends? Wage ladders were emphasized repeatedly in the Rate Advisory Workgroup meetings that DOJ attended. Wage laggers were apparently dismissed without a deeper inquiry. This is problematic. It does not permit an analysis of trends or the ability to test stakeholders' views."

Guidehouse Response

An analysis of wage progression across DSP levels, including daytime and swing shift/overnight within the same provider organization, revealed varied trends. Six provider agencies reported at least two DSP levels in the survey, with three providers operating in NOVA and the remainder in ROS. Some providers showed steady increases from DSP 1 to DSP 3, while others reported differing wages for the same DSP level. One provider indicated higher wages for DSP 1 than DSP 2, and a few reported identical wages across all DSP levels.

During a Rate Advisory Workgroup meeting, providers noted that not all organizations differentiate between DSP levels. Where distinctions do exist, they are at the discretion of the providers and they may reflect differences in tasks performed, experience, certifications, or the ability to support individuals with more complex needs.

DSP 1, DSP 2, or DSP 3 are not formally defined and required by DMAS, and the survey did not identify consistent patterns by and across levels. As such, the combined DSP wage was used as the most representative metric. The FTE-weighted benchmark hourly average of $20.36 per hour reflects all DSP levels and allows flexibility for differential wages if needed. This information is captured in the updated report. This information has been added to Section F.2.1.1., page 44-45.

DOJ Feedback (Line Item Comments in Initial Report Draft)

Regarding Wage Analysis in Section F.2.1.1.: "What's this data set methodology? What is the universe for the dataset as compared to the 109 providers for the Provider Survey?"

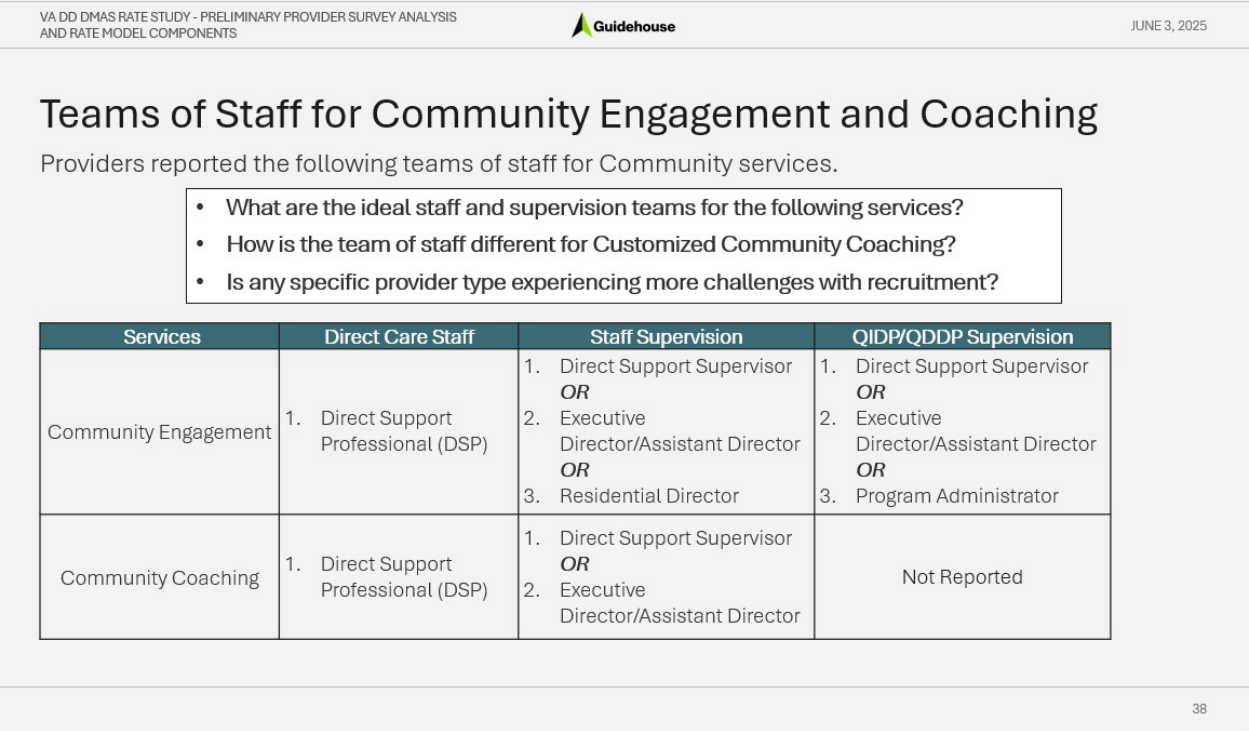
Guidehouse Response

As noted in Section F.2.1., page 41, ninety-three of 109 providers (85 percent) who participated in the provider survey provided direct care wages data.

DOJ Feedback (Line Item Comments in Initial Report Draft)

"What is the definition of "total staffing"? What staff are included and what staff, if any, are excluded?"

In Section F.2.1.5., Page 53, Table 13 has been added to capture the staff and supervision types included in the rate models. The survey included placeholders for providers to specify the types of staff employed for various services, alongside corresponding wage data (e.g., direct care staff, supervisors). Using this information as a foundation, Guidehouse reviewed the identified staffing structure with both the Rate Advisory Workgroup (see example slide below from June 3, 2025 meeting) and the Therapeutic Consultation Focus Group (May 19, 2025) to gather feedback. Additionally, Guidehouse examined relevant DMAS and DBHDS policies, including the 1915(c) waiver service and provider specifications, which offered insight into the staffing requirements for specific services.



VA DD DMAS RATE STUDY - PRELIMINARY PROVIDER SURVEY ANALYSIS AND RATE MODEL COMPONENTS

Guidehouse

JUNE 3, 2025

Teams of Staff for Community Engagement and Coaching

Providers reported the following teams of staff for Community services.

- What are the ideal staff and supervision teams for the following services?
- How is the team of staff different for Customized Community Coaching?
- Is any specific provider type experiencing more challenges with recruitment?

Services	Direct Care Staff	Staff Supervision	QIDP/QDDP Supervision
Community Engagement	1. Direct Support Professional (DSP)	1. Direct Support Supervisor *OR* 2. Executive Director/Assistant Director *OR* 3. Residential Director	1. Direct Support Supervisor *OR* 2. Executive Director/Assistant Director *OR* 3. Program Administrator
Community Coaching	1. Direct Support Professional (DSP)	1. Direct Support Supervisor *OR* 2. Executive Director/Assistant Director	Not Reported

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For example, in the case of Community Engagement services, both survey responses and feedback from the Rate Advisory Workgroup indicated that DSPs serve as direct care staff, while DSP supervisors fulfill supervisory roles. Each Therapeutic Consultation service requires distinct staff types to serve in the direct care role, as shown in Table 13 and discussed during the August 2025 Workgroup meeting. For example, Therapeutic Consultation – Psychologist/Psychiatrist services may be delivered by professionals such as LCPCs, LCSWs, Psychologists, or Psychiatrists. Accordingly, the direct care staff wage is based on blended wages reflecting these job types, with a Clinical Director designated to serve in a supervisory capacity.

F.2.1.4 Supplemental Pay Comments

DOJ Feedback (August 25 Letter to Virginia OAG)

"4. On page 40, Guidehouse chose a supplemental pay rate of 2.6%, based on "a six year industry average" using Bureau of Labor Statistic data for the Health Care and Social Assistance industry and Nursing and Residential Care Facilities. Guidehouse's use of data from institutional settings, rather than community-based settings (See Figure 19), is problematic, because the rates at issue here are for community settings. Figure 18, which is not based on institutional settings and reflects recent data (FY2024 Q1- Q4) shows rate trends higher than the 2.6% Guidehouse proposes (3.1%, 3.1%, 3.0%, and 3.4%.), making Guidehouse's proposed rate increase questionably low.

Further, the Virginia provider data, on page 39-40, Table 10, shows that providers' average supplemental pay rate has been 5.1%, with a median rate of 3.4%. The provider data is particularly relevant, given that it reflects facts on the ground in the Commonwealth. Guidehouse's choice to ignore both the more recent data and the Virginia provider data in favor of older, national data is problematic and should be revisited."

Guidehouse Response

As noted in section F.2.1.4., pages 50-51, Guidehouse used public data sources for supplemental pay because most providers did not report this information. Among those that did, the majority were larger agencies and primarily reported for swing shift or overnight staff – roles typically associated with services outside the scope of this study. Given the economic fluctuations and trends observed in the past decade, we normalized data across multiple years. The 2.6 percent figure that was initially used reflected this multi-year trend and was applied uniformly across staff and supervisors for all services to provide a stable estimate of labor market conditions.

While supplemental pay may sometimes be seen as a short-term motivator rather than a long-term solution, we acknowledge stakeholders' emphasis on the importance of recognizing the valuable work that DD staff perform – work that may warrant additional compensation from provider agencies. Supplemental pay may also be a tool for attracting and retaining talent in the DD labor market. Additionally, it is important to consider compensation holistically – including wages, inflation, supplemental pay, and/or benefits – since providers have flexibility in adjusting pay structures. These adjustments can affect both base and supplemental pay, which may be treated as separate components by some providers. In other cases, supplemental pay may not be offered at all, as reflected in baseline wage data from some provider surveys.

That said, in response to recent feedback and recommendations provided by the Rate Advisory Workgroup, Guidehouse replaced the 2.6 percent multi-year supplemental pay with 3.4 percent supplemental pay in the rate models to reflect the most recent quarter of BLS Employer Cost for Employee Compensation data that also aligns with the median supplemental pay analysis from the provider survey.

We do not agree with the DOJ's contention that the cost survey metric is a better assumption for benchmarking. As stated earlier in our response to DOJ concerns about potential distortions on provider costs due to underpayment, we believe that the supplemental pay rate is inflated to compensate for high turnover and lower base pay in the system. Given that increasing staff wages is frequently cited as the remedy for unsustainable turnover and overtime utilization, we would expect the supplemental pay percentage to lower under proper reimbursement, but not disappear to the beneficial role that supplemental pay can also play in incentivizing hiring and retention.

F.2.2 Employee Related Expenses (Benefits)

DOJ Feedback (August 25 Letter to Virginia OAG)

"5. On page 44, Guidehouse chose the providers' median survey premium for health insurance: $621. This rate is at the bottom of the average monthly premium in Virginia from 2019 to 2023 ($619-$772). The fact that premiums are clustered at the lowest level of this range (at $621) suggests that health insurance coverage is already at minimum levels. Given the need to attract workers, which is the catalyst for this study, a rate above the median is warranted to achieve the Injunction's goal of having sufficient provider capacity."

Guidehouse Response

Guidehouse revised the ERE assumptions to reflect increased health insurance costs, based on Virginia's Medicaid Expenditure Panel Survey (MEPS) data. From 2019 to 2023, the average monthly premium in Virginia ranged from $617 to $772. Based on feedback from the Rate Advisory Workgroup, Guidehouse applied a premium of $694 – representing the midpoint of the observed range – instead of the median premium of $621 reported in the provider survey.

The health insurance take-up rate was set at 58.8 percent, informed by provider cost and wage survey data. MEPS data showed take-up rates ranging from 50.9 percent in 2019 to 57.9 percent in 2024. Following discussions with the Rate Advisory Workgroup in June 2025, the survey-based rate of 58.8 percent was selected as the rate model assumption. See Table 14 on pages 57–59 for additional details on the assumptions and calculations.

ERE ranges from approximately 23 percent to 34 percent, depending on job type. As wages increase, the ERE percentage decreases, since it is calculated as a proportion of wages. However, a comprehensive and standardized list of benefits is included for all job types.

Benefit costs were analyzed in two ways to understand both what providers offer today and what may constitute a comprehensive and competitive package – even if not universally provided. First, provider-reported data from the Total Costs survey tab showed that among providers offering benefits, total benefits as a percent of direct care wages averaged 22.84 percent, with a median of 19.44 percent. This reflects current benefit expenditures across providers.

Second, the rate models incorporate a build-up methodology that estimates benefit costs as a percent of wages for key job types—30.35 percent for DSPs and 34.77 percent for Personal Care staff. The modeled benefits represent a full spectrum of benefits, including health insurance, retirement, paid leave, and other components, regardless of whether all providers currently offer them. We believe our recommendations meet the Injunction standard of promoting sufficient provider capacity.

DOJ Feedback (Line Item Comments in Initial Report Draft)

- *In reference to the benefits data: "Some of the benefits data used in the analysis appeared to be outdated. The choices made in calculating employee-related expenses (ERE) could have a significant impact on the overall percentage allocated to benefits. Suggest higher or more current values might be warranted for certain benefit categories."*
- *In reference to compensation calculation after adding ERE to wages: "This math may be incorrect. Should this be $28.51? ($22.03 x 29.41% = $28.51)"*

Guidehouse Response

The benefits data referenced in the report—specifically health insurance costs—was based on the most current available information at the time of the rate study. Guidehouse revised the ERE assumptions to reflect increased health insurance costs, based on Virginia's Medicaid Expenditure Panel Survey (MEPS) data. From 2019 to 2023, the average monthly premium in Virginia ranged from $617 to $772. Based on feedback from the Rate Advisory Workgroup, Guidehouse applied a premium of $694 – representing the midpoint of the observed range – instead of the median premium of $621 reported in the provider survey.

The health insurance take-up rate was set at 58.8 percent, informed by provider cost and wage survey data. MEPS data showed take-up rates ranging from 50.9 percent in 2019 to 57.9 percent in 2024. Following discussions with the Rate Advisory Workgroup in June 2025, the survey-based rate of 58.8 percent was selected as the rate model assumption.

All legally required benefits were revisited during the update process. While the FICA limit for Social Security increased, it did not impact the model since all modeled salaries fall below the threshold. Each benefit assumption is cited within the benefits table and again in the report's references to ensure transparency. It is important to note that benefits are calculated as a percentage of wages, meaning benefit costs scale proportionally with wage increases. See pages 56-59 and Table 14.

Hourly compensation is calculated by adding the ERE percentage to the base wage. For example, if the ERE is 30.35 percent and the benchmark hourly wage is $22.20, the benchmark hourly compensation inclusive of ERE would be $28.94 (i.e., $22.20 × 1.3035).

F.2.3 Billable hours and productivity of direct care staf f

DOJ Feedback (August 25 Letter to Virginia OAG)

"6. On page 47, Guidehouse states that it used the average number of billable hours reported in the provider survey to derive its multiplier. The percentages of "client-facing" work reported through this process seems questionably low, even if taken from a provider survey, and should be verified. It is facially problematic, for instance, that a service such as Community Engagement is reported as having a percentage of client-facing work as low as 66%."

Guidehouse Response

We understand that the reported productivity percentage for Community Engagement noted in Section F.2.3., page 61 might appear low at first glance. However, the 66 percent figure was based on survey data collected from 36 service providers, and the average and median percentages were closely aligned, indicating consistency and reliability in the responses. It was also corroborated anecdotally by workgroup members. Guidehouse does not agree that our productivity assumptions are "facially problematic," and we are unclear as to the basis of DOJ concerns and what alternative assumptions would be expected.

While a 66 percent productivity rate is on the lower end for HCBS services, it falls within an acceptable range. We have observed similar figures in several of our rate studies. Importantly, the survey response aligned with our understanding of the service and reflected expert feedback from the provider surveys. As services become more intensive (from Tier 1 to Tier 4), we expect a greater proportion of direct time spent with the client. For true community-based services like this one, productivity tends to be lower due to the non-billable time required to support participants in accessing community settings. The 66 percent assumption aligns well with this understanding, and the increase in productivity across service types is smooth and incremental, as expected. That said, we apply more rigorous scrutiny when productivity falls below 60 percent for similar services.

To further contextualize the assumption, it is important to note that Community Engagement is delivered in integrated, community-based settings and typically in small groups (maximum of three individuals per DSP), unlike most other services reviewed in the rate study, which are often one-on-one or home-based. Several factors contribute to the productivity level for this service:

- **Setting limitations: Except for planning, Community Engagement cannot take place in a person's home. Services are required to occur in natural community environments, which inherently demand more time and coordination.**
- **Group service model: The service is provided in small groups, which affects the ratio of billable time per individual.**
- **Travel requirements: Travel is a key component of this service, often involving multiple community locations.**
- **Non-client-facing but essential activities:**
  - **Planning and coordination with community partners**
  - **Documentation and compliance reporting**
  - **Training and supervision**
  - **Administrative tasks such as scheduling and outreach logistics**

The productivity built into the model reflected providers' business practices. Since the model incorporated average experience, the assumption was considered reasonable. While states

may choose to set strict requirements, we did not impose artificial thresholds, and if such thresholds were to be introduced, they would need to be applied consistently across all services. Instead, we relied on provider experience and operational realities.

While DOJ has noted in feedback area #11 below that the overall rate for this service may be low, the concern also flagged is that productivity should be higher. If the productivity percentage were increased, non-billable time would decrease, and the resulting rate would decrease accordingly.

DOJ Feedback (Line Item Comments in Initial Report Draft)

In reference to example calculation of productivity adjustment factor using an 8-hour day or 40-hour work week: "Should this reference be a 40-hour week?"

Guidehouse Response

In relation to the productivity example in the report, the narrative has been modified to reflect a 40-hour week instead of an 8-hour day.

F.2.6 Administrative Expenses and Program Support Expenses

DOJ Feedback (August 25 Letter to Virginia OAG)

"7. On page 53, it appears that Guidehouse calculates the ratio of administrative costs by totaling wages and benefits, and adjusting them upward to account for inflation for the time period in the survey, but does not similarly inflate the administrative expenses reported by the providers. It would be helpful for Guidehouse to clarify whether it is treating wages and benefits as part of providers' administrative costs. Otherwise, this approach will artificially lower providers' actual administrative costs in its rate model."

DOJ Feedback (Line Item Comments in Initial Report Draft)

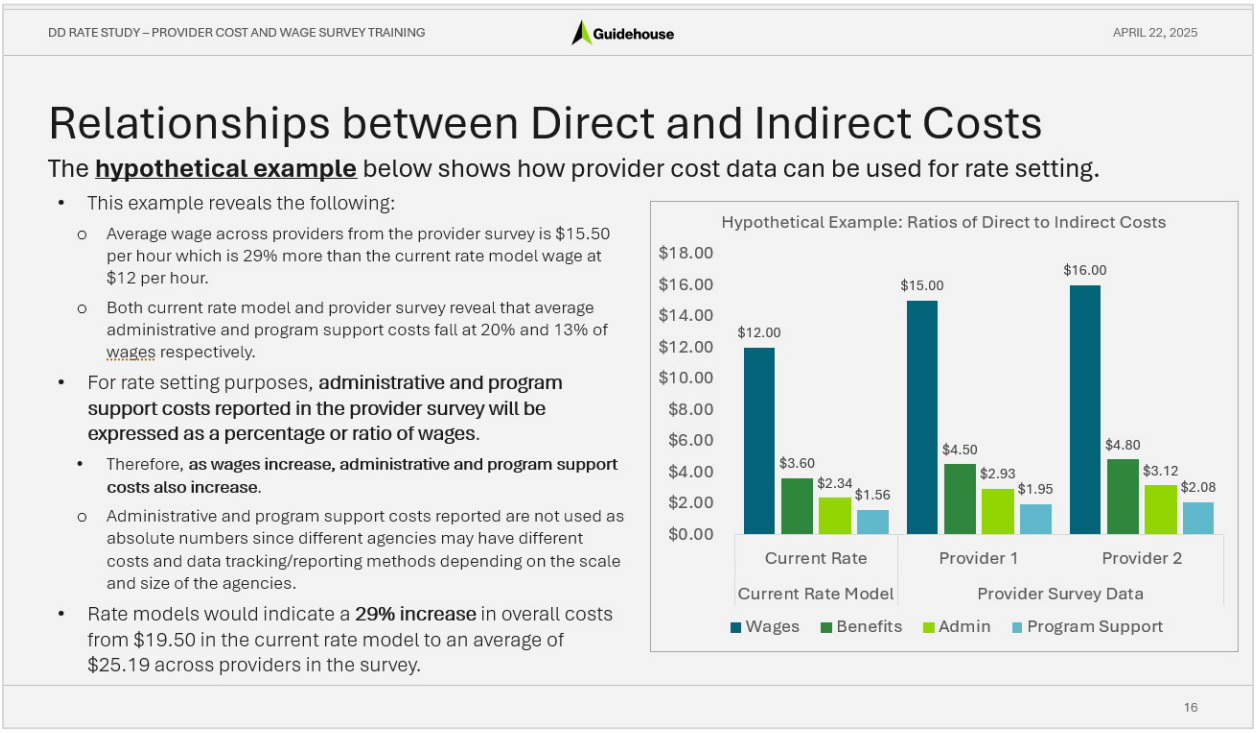
- *In reference to administrative costs: "What is the universe for the dataset as compared to the 109 providers for the Provider Survey?"*
- *In reference to administrative and program support cost factors: "Guidehouse did not show its calculations so we cannot verify how it calculated these percentages."*
- *In reference to administrative costs: "As noted elsewhere, it is not clear if Guidehouse should also inflate administrative costs as well….Were these direct care costs inflated as in the administrative section? If the direct care costs were inflated, this raises the same concerns as with administrative costs. If Guidehouse adjusted the direct care costs for inflation and then divided those costs by the actual survey-reported program support costs, it would make the program support costs appear lower than they actually were for the providers in the survey. This appears to misrepresent providers' program support costs. Then, if that percentage becomes the basis for a multiplier in the rate model, it is underrepresenting what is currently being used in the field. Furthermore, the point of the rate study is not to merely reflect the current ratio of providers' program support costs, but*

to improve the rates to encourage growth for providers so there is "sufficient capacity" to reach the goals in the injunction"

- *In Section F.27 (page 55): DOJ asked whether the 11.03% direct care cost figure and 16.21% program support cost factor are used in any of the rate models because DOJ did not see these figures in any of the models in the August PowerPoint. "Is this used in any of the rate models? We did not see it in any of the models in the August PowerPoint."*
- *Transportation Percentages: "Why did Guidehouse chose 7.27%? In other words, was there a certain service that resulted in this percentage, so that Guidehouse decided to use it as the standard (on the assumption that the survey was not reliable)? The first time we saw Guidehouse embrace this standard was the reference in the June PowerPoint, on slide 34, when it references 7.3%, but we never received an explanation why this percentage was chosen. Why did Guidehouse choose 3.20% for the less travel-heavy services?"*

Guidehouse Response

Administrative cost percentage calculation was based on data submitted by 71 of 109 providers, representing 65.1 percent of survey respondents. Since the administrative cost factor is expressed as a percentage of wages, it adjusts proportionally with changes in wage levels. As inflation is applied to project wages to SFY2027 levels, administrative costs are automatically inflated as well, due to the relationship between the two components in the model. We reviewed this information with providers during survey training in April (see example below), and the Rate Advisory Workgroup during May and June 2025 meetings.



The costs cited above, related to administrative and programs support costs, are included between the administrative and program support cost components, as noted in the report. The administrative cost components included in this calculation are: maintenance and administrative staff wages, contracted administrative salaries, office equipment and furniture, interest expenses, non-payroll taxes, licensing and certification fees, administrative-related training, insurance (excluding benefits and auto), IT expenses, office supplies, postage, translation costs, and other administrative expenses reported by providers such as bank fees, claims processing, and employee incentives.

Similar to administrative costs, the model also incorporates program support costs from specific survey cost lines, as reported by around two-thirds of providers who responded to the survey. These include: total program support employee salaries and wages; contracted program support staff salaries; program supplies; devices and technology used in direct care; activity costs; licensing, certification, and accreditation fees for direct care staff; hiring expenses; staff training and development; insurance (excluding benefits and auto, direct care-related only); facility rent, mortgage, interest, and depreciation; utilities and telecommunications (both administrative and direct care-related); building maintenance and janitorial services; non-administrative equipment costs and depreciation; and other program support costs as reported by providers such as cleaning supplies, uniforms, and medical supplies. The information is further documented in Sections F.2.6 and F.2.7 in the report.

In reference to how program support costs are incorporated in the rate models, the program support indirect cost factor is structured to reflect the nature of service delivery. This factor is divided into two distinct components:

- **5.18 percent for program support compensation and supplies**
- **11.03 percent for building and equipment costs associated with direct care**

Depending on the service delivery model, either the 5.18 percent component or the full 16.21 percent (combined total of both components) is applied. This allocation is reflected in the rate model presentation from the August stakeholder meeting, where the breakdown appears under the "program support factor" line item. For services where both components are applicable, the full 16.21 percent is included. At a minimum, the 5.18 percent component is applied for consistent coverage of basic program support costs.

An important exception to the two indirect cost components applies to consumer-directed personal care, respite, and companion services. After the preliminary draft rate models were released, stakeholders noted that all management of consumer-direction is handled through consumer-direction *facilitation* service codes for DD waivers – outside the scope of this rate study – which already account for indirect costs related to service facilitation.[2] In response,

[2] https://www.dmas.virginia.gov/media/035csnvd/sfy26-my-life-my-community-rate-file-updated.pdf

and consistent with CMS guidance, both administrative and program support indirect costs were removed from the consumer-direction service rates. This adjustment helps avoid duplicative cost inclusion and payments across services. This approach aligns with federal requirements and supports the integrity of the rate-setting process by matching cost allocations to actual service delivery structures.

With regard to transportation costs in Section F.2.7.1 (pages 71-80), the cost factors included in the rate models are derived from provider-reported cost data submitted through the provider survey. The methodology represents transportation costs as a percentage of wages – and these figures are not arbitrary. They are based on transportation-related expenses reported across multiple cost lines in the survey (i.e., Survey Tab 2. Total Costs), including client-related transportation, vehicle licensing, maintenance, insurance, depreciation, and non-client travel. This approach supports consistency across diverse service settings while reflecting actual provider-reported transportation costs and is informed by data from nearly two-thirds of providers who responded to the survey, as cited in the report. The key differentiator between the 7.27 percent and 3.20 percent figures is the inclusion versus exclusion of client-related transportation costs (4.07 percent) from select services. This adjustment applies to services such as Personal Assistance, Respite, and Companion, which typically occur in a client's home.

In the updated version of the report, we further validated the transportation costs embedded in the rate models through supplemental analysis using data from the survey and public sources. Through this method, we calculated costs based on provider-reported travel time for a standard 40-hour work week, average speed assumptions, the IRS mileage rate, and assumptions regarding vehicle purchase and operating costs. The results from this method closely align with the percentage-based figures used in the model, providing additional validation. Notably, for home and community-based services, detailed transportation data is often not readily available or consistently tracked across all providers. In such cases, total transportation costs reported in financial statements which often inform the Total Costs captured in the survey – serve as a practical starting point for estimating expenses. States typically account for transportation either within broader program support cost factors or as a standalone cost component in their rate models. In this model, transportation is treated as an explicit component, enhancing transparency around what is included in the benchmark rates and supporting future rate reviews.

F.3 Proposed Benchmarks Rates

DOJ Feedback (August 25 Letter to Virginia OAG)

"8. On pages 58-62, Table 21, Guidehouse lists its proposed benchmark rates. Some of the specific rates appear, on their face, not constructed adequately to "ensure sufficient capacity" to meet the goals of 37 [day/community engagement services], 38 [skilled nursing services], and 39 [private duty nursing services]:

- *Community Engagement Tier 1 (NOVA) from $26.96 to $29.77 an hour*
- *Community Engagement Tier 1 (ROS) from $23.64 to $25.50 an hour*
- *Community Engagement Tier 2 (NOVA) from $32.46 to $34.00 an hour*
- *Skilled Nursing, LPN (NOVA) increase from $103.64 to $105.68 an hour*
- *Skilled Nursing, RN (ROS) increase from $90.28 to $90.52 an hour*
- *Skilled Nursing, LPN (NOVA) increase from $78.32 to $80.72 an hour*
- *Skilled Nursing, LPN (ROS) increase from $66.96 to $69.12 an hour*

In light of the Commonwealth's difficulty complying with the related provisions, increases at these modest levels are unlikely to be sufficient to ensure sufficient capacity."

Guidehouse Response

The proposed rate models address several areas highlighted in stakeholder feedback. The benchmark rates are developed using a cost build-up approach that reflects both provider-reported data (e.g., administrative-to-direct care cost ratios, FTE-weighted wages) and recent industry benchmarks (e.g., health insurance costs from MEPS, geographic cost differentials from EPI, BLS wage data). For example, MEPS public data informed health insurance cost assumptions, while the provider survey helped identify a comprehensive list of benefits that providers may offer to support a competitive benefits package. That said, reviewing data alongside contextualizing it through discussions with providers added valuable insight.

Our focus throughout this study was to strike a balance between the cost of delivering services, provider experience, and service expectations – grounded in data and evidence. As a result, some services or service tiers showed relatively smaller changes in rates, which may reflect existing alignment between current rates and service expectations. As mentioned above, the objective of Guidehouse's study is to offer an independent, objective perspective on reasonable cost standards.

Other Comments in Draft Report

DOJ Feedback (Line Item Comments in Initial Report Draft)

Geographic Differentials in Section F.2.8., Section H.2., and Appendix A: "Why did Guidehouse not include housing, given that housing is a basic component of community-based services. What would these three percentages be if housing were included?"

Guidehouse Response

The rate study examines the application of standardized geographic differentials between Northern Virginia (NOVA) and the Rest of State (ROS), using definitions already established by DMAS (Source: nova-localities_homehealth.pdf). First, we computed statewide rates, and

then we applied a standardized geographic differential factor to arrive at the NOVA and ROS rates. This methodology assures consistent differentiation between NOVA and ROS across all services in the study – standardization that is not present in current rate differentials.

During Rate Advisory Workgroup sessions, some providers suggested reclassifying certain counties and cities currently designated as ROS into the NOVA category due to higher local costs of living, as also noted in the feedback above. At the same time, others noted that changing these geographic definitions could have broader implications for DMAS programs and may require further consideration beyond the scope of this rate study. Therefore, we recommend reserving this matter for future review. If DMAS were to undertake efforts to modify the definitions and reclassify the counties and cities, it is imperative to consider representative feedback from broader programs and providers that may be impacted by a revised definition.

In evaluating the inclusion of housing costs in the geographic differential calculation, the analysis found that doing so would widen the cost gap between NOVA and ROS from 16.8 percent to 26.1 percent. Specifically, NOVA differentials would increase further relative to the statewide average (change from 14.3 percent to 22 percent), while ROS differentials would decrease (change from -2.1 percent to -3.2 percent). This change could potentially reduce incentives for the majority of providers operating in ROS. As mentioned in the report, the geographic differentials recommended in the rate study are based on data from the Economic Policy Institute (EPI), specifically the Family Budget Calculator released in January 2025 for calendar year 2024 costs. This data source provides cost estimates for 10 different household types (e.g., one or two adults with zero to four children) across all U.S. counties and metropolitan areas. Notably, the dataset is publicly available, state-specific, and updated annually, allowing the Commonwealth to access and revisit evolving costs as needed. It is also one of the most recent and comprehensive sources available for assessing cost differences at the county and city level.

DOJ Feedback (Line Item Comments in Initial Report Draft)

Survey Response Rate: "We understand this to mean that the survey represented 19% of providers and NOT 19% of expenditures. However, Table 4 (p.17-18) states 19% of expenditures. Please provide clarity here."

Guidehouse Response

We've also refined the language regarding the survey response rate of 19 percent to clarify that we received 109 completed surveys, representing 19 percent of SFY2024 expenditures for services included in this rate study (see pages 6 and 22).

DOJ Feedback (Line Item Comments in Initial Report Draft)

*Inflation: "Why does Guidehouse report this 3.6% as **BLS's** percentage? Isn't this the provider survey median? See Table 9 at p.39. In Table 9, the 3.6% is the median from the provider survey."*

Guidehouse Response

Regarding the sources cited for the inflation assumption, the provider survey – not the BLS – is the basis for the 3.6 percent annual growth rate used in wage benchmarking, as noted in the updated report on pages 50 and 52.

Lastly, Guidehouse has corrected typographical errors in the final version of the report.

Virginia Department of Medical Assistance Services (DMAS)
Developmental Disabilities (DDS) Rate Study
Rate Advisory Workgroup Feedback on Report

Rate Advisory Workgroup Feedback on Draft VA DD Rate Study Report

Following the distribution of the draft VA DMAS DD Rate Study Report (*File Name: DRAFT FOR REVIEW_VA DMAS DD Rate Study Final Report_07.21.2025_Updated*) to the Rate Advisory Workgroup on August 8, 2025, Guidehouse requested that workgroup members review the report and submit feedback by August 19, 2025. This document summarizes all feedback received by Guidehouse from five provider organizations and six documents, organized by topic area. It also includes Guidehouse's responses to the feedback, highlighting areas where edits were made to the report based on the comments received. This document cross-references the updated version of the Final Report dated September 30, 2025 (*File Name: VA DMAS DD Rate Study Final Report_09.30.2025*).

1. Regular Rate Review Process Support

- *Marcia Tetterton (Virginia Association for Home Care and Hospice): "Our organization supports the recommendation that DMAS adapt a regular rate update process that includes key economic indicators and metrics for future rate review processes. Providers rely on rate updates not only for the purposes of salary adjustment but also for reinvestment into their businesses. We support an incremental approach as recommended in the report as follows:*
  - *Adopt a modular rate build-up approach to enhance transparency and enable targeted updates to rate components.*
  - *Implement a regular rate review process using publicly available inflation indices and labor market data to maintain rate adequacy."*
- *Jennifer Fidura (VNPP): "Implement a regular rate review process."; Comment: "This is always the "wish" from the provider community, but a risky proposition depending on the political landscape and the bigger revenue picture."*

Guidehouse Response:

The report acknowledges stakeholder interest in establishing a structured and recurring rate review process. If DMAS adopts the benchmark rates and the rate build-up approach recommended by Guidehouse, it may be feasible to review rate assumptions more frequently at a defined cadence. This would allow for targeted updates to specific cost components, such as wages, without requiring a full rate rebasing. Over time, a regular rate review process could provide DMAS with valuable insight into whether rate updates are warranted. Of note, rate reviews may not necessarily result in rate updates; rather, they may involve revisiting the rate methodology and existing rates to assess whether adjustments are needed. As stated in the CMS 1915(c) Technical Guide, "States must review their rate setting methodology, at minimum, every five years to ensure that rates are adequate to maintain an ample provider base and to ensure quality of services." While CMS sets a five-year minimum, the frequency of rate reviews varies by state. Most states operating 1915(c) waivers conduct rate reviews annually or biennially.

Report Reference Sections and Page Numbers: Section H.1., Pages 101-103

2. Geographic Rate Differential Approach and Recommendations

- *Jennifer Fidura (VNPP): "Update geographic differential methodologies." Comment: As this would have a much broader application across the Medicaid services, it seems unlikely (though probably a good idea)."*
- *The Arc of Virginia: "We support exploration of this recommendation, but it must be done carefully with full stakeholder involvement, to adequately review impact on providers, individuals, and families in different regions."*
- *John Salay, Deanna Rennon, & Joanne Acceto (vaACCSES): "Analysis of the same source Guidehouse cited shows several additional non-NOVA locations with cost of living figures equal to or exceeding some NOVA areas. The methodology for adjustments cannot rely on provider-reported data of how current reimbursement is spent by a small number of providers. There are several well-established federal and state indexes that are updated monthly that should be used to apply appropriate geographical adjustments across the entire Commonwealth, not just northern Virginia"*
- *John Weatherspoon (Wall Residences): "Page 59, Guidehouse notes its use of the EPI to determine the cost difference between NOVA and ROS. Several other counties appear to have a cost of living that justifies inclusion in a higher rate category."*
- *Marcia Tetterton (Virginia Association for Home Care and Hospice): "Our organization supports the recommendation that DMAS adapt a regular rate update process that includes key economic indicators and metrics for future rate review processes. Providers rely on rate updates not only for the purposes of salary adjustment but also for reinvestment into their businesses….We support an incremental approach as recommended in the report as follows: Update geographic differential methodologies to reflect current economic conditions using standardized, publicly available data."*

Guidehouse Response:

The rate study examines the application of standardized geographic differentials between Northern Virginia (NOVA) and the Rest of State (ROS), using definitions already established by DMAS (Source: nova-localities_homehealth.pdf). First, we computed statewide rates, and then we applied a standardized geographic differential factor to arrive at the NOVA and ROS rates. This methodology assures consistent differentiation between NOVA and ROS across all services in the study – standardization that is not present in current rate differentials.

During Rate Advisory Workgroup sessions, some providers suggested reclassifying certain counties and cities currently designated as ROS into the NOVA category due to higher local costs of living, as also noted in the feedback above. At the same time, others noted that changing these geographic definitions could have broader implications for DMAS programs and may require further consideration beyond the scope of this rate study. Therefore, we recommend reserving this matter for future review. If DMAS were to undertake efforts to modify the definitions and reclassify the counties and cities, it is imperative to consider

representative feedback from broader programs and providers that may be impacted by a revised definition.

In evaluating the inclusion of housing costs in the geographic differential calculation, the analysis found that doing so would widen the cost gap between NOVA and ROS from 16.8 percent to 26.1 percent. Specifically, NOVA differentials would increase further relative to the statewide average (change from 14.3 percent to 22 percent), while ROS differentials would decrease (change from -2.1 percent to -3.2 percent). This change could potentially reduce incentives for the majority of providers operating in ROS. As mentioned in the report, the geographic differentials recommended in the rate study are based on data from the Economic Policy Institute (EPI), specifically the Family Budget Calculator released in January 2025 for calendar year 2024 costs. This data source provides cost estimates for 10 different household types (e.g., one or two adults with zero to four children) across all U.S. counties and metropolitan areas. Notably, the dataset is publicly available, state-specific, and updated annually, allowing the Commonwealth to access and revisit evolving costs as needed. It is also one of the most recent and comprehensive sources available for assessing cost differences at the county and city level.

Report Reference Section and Page Numbers: Section H.2., Pages 103-106 & Appendix A, Pages 110-111

3. Provider Cost Reporting Recommendation Feedback

- *Jennifer Fidura (VNPP): "Develop a provider cost reporting program." Comment: "Applicable to this recommendation, where it appears – this is a costly and administratively burdensome recommendation; if the 80/20 rule survives, it does not impact habilitation services, which are the majority of the waiver services."*
- *Marcia Tetterton (Virginia Association for Home Care and Hospice): "Reported many concerns regarding the complexity and administrative burden that cost reporting creates."*
- *The Arc of Virginia: "We recognize the importance of demonstrating the waiver rates are sufficient and are being used to strengthen the direct support workforce but are mindful that many providers are small organization already stretched thin administratively. We recommend DMAS explore options for collecting meaningful cost and wage data that could include:*
    - *Convening a stakeholder workgroup to design an approach that is practical and non-burdensome.*
    - *Considering alternatives such as targeted surveys, financial attestation processes, or pilot programs before implementing a full cost reporting system*
    - *Ensuring any framework is explicitly designed to align rates with actual provider costs and workforce investments over time"*
- *John Weatherspoon (Wall Residences): "Implementing cost reports for all providers simultaneously would pose significant administrative, programmatic, and logistical challenges. The 80/20 rule can be quite inflexible and may not consider the unique challenges faced by*

different providers. Services highlighted in the current requirements typically do not generate higher administrative and quality assurance costs which could lead to a misalignment in resource allocation and disadvantage some providers and service lines."

- *John Salay & Deanna Rennon (vaACCSES), Joanne Acceto (vaACCSES): "While cost reporting can be valuable once base rates are validated as adequate, the proposed framework is prescriptive and risks misaligning resources. Implementing without first addressing rate adequacy may disadvantage providers and conflict with parity requirements."*
- *Marcia Tetterton (Virginia Association for Home Care and Hospice): "We do recognize that the Access Rule requires some type of cost reporting mechanism. At this time, given the poor reimbursement rates an additional burden placed on providers would likely result in significantly fewer providers and reduced access to services. While we do support a proactive approach, we do have many concerns regarding the complexity and administrative burden that cost reporting creates. As this report indicates there are many different cost centers that must be accounted for, not just personal care aide wages.*

  We support an incremental approach as recommended in the report as follows: Develop a provider cost reporting program to support future rate reviews and compliance with the CMS 80/20 Access Rule (Final Rule: Ensuring Access to Medicaid Services; CMS-2442-F), which requires that at least 80 percent of Medicaid payments for certain services be directed to direct care worker compensation."

Guidehouse Response:

As noted in the report, Guidehouse acknowledges that cost reporting is a new process for both DMAS and its provider community, and implementing a full-scale system from the outset may present administrative, programmatic, and logistical challenges. To support a phased implementation, the report further incorporates recommendations to explore pilot programs and targeted cost reports prior to full rollout. Additionally, it underscores the need to align the cost reporting framework with the rate development process to allow the use of provider cost data for future rate reviews. The recommendation also highlights that the process may involve small provider exemptions. In alignment with feedback from the Rate Advisory Workgroup, the report emphasizes the importance of a collaborative approach. This includes engaging with stakeholders to co-design a framework that is practical and minimally burdensome.

Report Reference Section and Page Numbers: Section H.3, Page 106-109

4. Wage Analysis and Assumptions

- *The Arc of Virginia: "Table 10 in the report shows that Virginia providers reported an average total of 5.1% of wages for overtime and supplemental pay, while the model uses a 2.6% national six-year industry average from the BLS. The model should use the 5.1% Virginia average for overtime and supplemental pay and / or explain why the lower national average was chosen."*
- *John Salay & Deanna Rennon (vaACCSES): "Survey data reflects wages that have not been competitive in the labor market are due to underfunding, but reality is that some providers are paying above historically low national wage medians to remain minimally competitive."*

- *Joanne Acceto (vaACCSES): "Survey data reflects wages that have been constrained by historical underfunding, not the true cost of quality care. Guidehouse did not clarify weighting of survey responses and did not distinguish staff payroll costs from purchased services. The reported methodology for wage build up represents a distortion of the standard rate needed to provide quality services."*
- *John Salay & Deanna Rennon, Joanne Acceto (vaACCSES): "Overtime: Providers must use overtime to meet regulatory staffing levels. The survey had a very low response rate but still shows current overtime at 5.1%. The draft report then recommends only 2.6% without a rationale or calculation. Reducing or maintaining underfunding of overtime risks noncompliance with waiver regulations and the DOJ injunction."*
- *John Weatherspoon (Wall Residences): "We believe it is inappropriate to include the statement, "Direct Care wages reported in the provider survey were generally higher than national benchmarks" (pg. 6) and not say that benefits are at the very bottom of Virginia's wage. Providers pay as much in wages as they can to attract staff while reducing funds available for benefits."*
- *John Weatherspoon (Wall Residences): "Page 35 states there is no clear distinction in wage between DSP levels 1, 2, and 3. For those that reported distinctions, were they examining incremental increases paid by companies between levels? Or averaging all of the DSP 2s and 3s together? Incremental increases would be the only way to identify a pattern."*
- *John Weatherspoon (Wall Residences): "Page 33 of the report states that a weighted FTE wage is used as a statistically superior way for analyzing wages. What is the weighting factor and source? Can Guidehouse provide an example of a role where the weighted wage increase and one where it decreased compared to the survey average?"*

Guidehouse Response:

***Overtime and Supplemental Pay*. As noted in section F.2.1.4., pages 50-51, Guidehouse used public data sources for supplemental pay because most providers did not report this information. Among those that did, the majority were larger agencies and primarily reported for swing shift or overnight staff – roles typically associated with services outside the scope of this study. Given the economic fluctuations and trends observed in the past decade, we normalized data across multiple years. The 2.6 percent figure that was initially used reflected this multi-year trend and was applied uniformly across staff and supervisors for all services to provide a stable estimate of labor market conditions.**

While supplemental pay may sometimes be seen as a short-term motivator rather than a long-term solution, we acknowledge stakeholders' emphasis on the importance of recognizing the valuable work that DD staff perform – work that may warrant additional compensation from provider agencies. Supplemental pay may also be a tool for attracting and retaining talent in the DD labor market. Additionally, it is important to consider compensation holistically – including wages, inflation, supplemental pay, and/or benefits – since providers have flexibility in adjusting pay structures. These adjustments can affect both base and supplemental pay, which may be treated as separate components by some providers. In other cases,

supplemental pay may not be offered at all, as reflected in baseline wage data from some provider surveys.

That said, in response to recent feedback and recommendations provided by the Rate Advisory Workgroup, Guidehouse replaced the 2.6 percent multi-year supplemental pay with 3.4 percent supplemental pay in the rate models to reflect the most recent quarter of BLS Employer Cost for Employee Compensation data that also aligns with the median supplemental pay analysis from the provider survey.

We do not agree that the cost survey metric is a better assumption for benchmarking. Just as stakeholders have expressed concerns about potential distortions on provider costs due to underpayment that lead to an understatement of costs, we believe that the supplemental pay rate is inflated to compensate for high turnover and lower base pay in the system. Given that increasing staff wages is frequently cited as the remedy for unsustainable turnover and overtime utilization, we would expect the supplemental pay percentage to lower under proper reimbursement, but not disappear to the beneficial role that supplemental pay can also play in incentivizing hiring and retention.

***Wage Benchmarking (Section F.2.1, Pages 41 - 48)*: It is not the case that Guidehouse's methodology is *entirely* historical and therefore perpetuates a circular pattern of historical underfunding. The objections above overstate Guidehouse's reliance on historical system data, do not acknowledge the role and extensive use of multiple data sets to develop our recommendations, and discount the explicit steps taken to control for and correct the influence of systemic underfunding.**

While historical underfunding may exert a downward pressure on reported costs, it is not the case that provider-reported data within underfunded systems necessarily expresses depressed costs in all respects or reflect inherently uncompetitive wage standards insufficient to cost and quality service delivery.

The broad objection that Guidehouse's wage benchmarking methodology is based wholly or for the most part on historical provider costs overlooks the prominent role played by BLS wage metrics specific to Virginia. Data independent of Virginia's DD system and the historical costs incurred by its providers featured heavily in nearly every service cost component reviewed by Guidehouse, not only as an independent check on the veracity and adequacy of provider-reported wage costs, but as a preferred alternative benchmark in cases in which surveyed wages appeared depressed in comparison to industry standards. Guidehouse did not take survey wages at face value or employ them uncritically but scrutinized them for signs of underpayment (or overpayment) based on industry data available from independent sources. Only on this basis did we utilize wages derived from the cost survey as a benchmark informing rate recommendations. This approach held true not only for wages, but for direct care compensation and other indirect costs more broadly.

In regard to the concern that Virginia's provider-reported data is historically conditioned to reinforce inadequate reimbursement, the most important counter-evidence to this objection is the fact that the vast majority of provider-reported hourly wages were demonstrably higher than wage assumptions drawn from other Virginia-specific industry data and labor cost metrics (a fact acknowledged in one of the comments above). Of the 16 different job types reviewed by Guidehouse for wage benchmarking, 10 types allowed comparison between the hourly wages derived from the provider cost survey and metrics available from Virginia-specific BLS data. Of the six other practitioners, four were either not reported or sampled in insufficient numbers to support survey benchmarks. These practitioners reflected specialized clinical staff for whom alternative BLS benchmarks were readily available. Two practitioners were so unique to the DD system (behavior analysts and associate behavior analysts) that Guidehouse declined to identify a potentially ill-fitting, generic BLS analogue and opted to use wage costs reported in Virginia's system. Among the 10 job types directly compared, provider-reported data illustrated higher costs than BLS metrics for 7 of the 10 practitioners.

Direct comparison of survey wage data with other industry wage metrics undermines the contention that survey data is inherently biased toward lower, inadequate wages. Guidehouse findings have also been confirmed, at least indirectly, by the stakeholders commenting above on the wage assumptions. Many of the stakeholders acknowledged the fact that Virginia providers do appear to be paying their staff *above* industry averages or medians, but have reconciled this fact with the reality of historical underfunding by noting that providers must continue to pay better-than-industry wages to remain minimally competitive in the labor market while being forced to cut costs elsewhere (benefit offerings, for example) to be able to deliver services under inadequate rates. We do not dispute these stakeholder insights but argue, rather, that such observations actually support the case for privileging the use of survey costs over other wage metrics for these direct care staff and the services they deliver.

For the 7 job types in which Guidehouse benchmarked wage assumptions to the survey data, we did so because we believed not only that the survey furnished the most recent data (and thus most indicative of current and near-future costs), but also that it yielded the most context-sensitive and relevant data. While BLS wage data may faithfully represent broader industry cost trends and standards in Virginia, it does not necessarily reflect the special needs and challenges of retaining qualified staff to deliver services in Virginia's DD system. Guidehouse relied on survey data for these assumptions not because of a methodological commitment to "historical" data, or even because it proved more favorable to providers than other alternatives, but because this data set is the most illuminating into the specific wage pressures and cost drivers confronting the providers that deliver services under Virginia's DD waivers.

To say that the cost survey was the best fit under these circumstances is not to say that it lacks any limitation whatsoever. All data sources used in the DD rate study have differing

strengths and weaknesses. One of the vulnerabilities of a provider cost survey, rightfully identified in these stakeholder comments, is that it relies on historical experience and reflects all the financial biases and idiosyncrasies of that history (a condition, it should be noted, from which no historical market analysis or labor statistic is completely immune). Another vulnerability is that cost surveys are ultimately self-reported and unaudited, and so run the risk of skewing results in the reporter's interest or in ignorance of reporting standards or the lack of more rigorous review and quality assurance.

However, the advantage of cost survey data sets is that they often furnish the most recent cost metrics possible and are frequently the most suited to actual provider practice and system context. While BLS and other industry data are typically trusted and well-vetted, the process for establishing reliability also ages and decontextualizes the data, rendering it less timely, less specific, less detailed, or otherwise less appropriate to the system under review. In the small number of instances in which Guidehouse benchmarks drew on system-independent data to yield assumptions less favorable to providers than survey assumptions, resulting stakeholder comments have similarly noted the distinct virtues of employing survey data instead.

In our rates studies, Guidehouse carefully considers the relative merits of leveraging each data set available for specific services, typically through a process of triangulation that harnesses discrepancies between different data sets to identify potential bias, anomaly, or inapplicability in one set versus another. In developing our wage assumptions, we attempted to balance the tradeoffs of each data source to select the most appropriate measure of reasonable wage costs for each rate. Our methodology is clear, and in the vast majority of cases, has resulted in a wage benchmark more favorable to providers than alternative options.

FTE-Weighted Wage Methodology **(Section F.2.1, Pages 42 - 45): The report includes additional information and examples on how FTE-weighted wages are calculated and key observations based on both weighted and unweighted wages. Guidehouse applied a weighting of reported baseline wages based on the number of FTEs. FTE-weighted wages are statistically robust because they account for actual work effort across full-time and part-time roles. As a result, providers employing more FTEs have a proportionally greater influence on average wages. This method helps avoid over- or under-representing part-time roles and aligns wages with labor contributions. Applying this method to the survey data, we found that the average wage for DSPs is $18.66 per hour, while the FTE-weighted average wage is $20.36 per hour. This suggests that providers responding to the survey with a higher number of FTEs tend to offer wages above $18.66, resulting in a higher FTE-weighted average. Similar patterns are observed for BCBAs and BCABAs. In contrast, Behavioral Specialist/Technician wages show an inverse trend: the unweighted average wage is higher than the FTE-weighted average. This indicates that most FTEs reported have wages closer to the average rather than the FTE-weighted**

average. A similar trend was noted in the RN wage, which prompted further review in comparison with Virginia public wage data.

Survey Dataset for Wages **(Section F.2.1, Page 41): Ninety-three of 109 providers (85 percent) who participated in the provider survey provided direct care wages data.**

DSP Levels and Wage Progression **(Edits and Additions on Section F.2.1.1, Page 44-45): An analysis of wage progression across DSP levels, including daytime and swing shift/overnight within the same provider organization, revealed varied trends. Six provider agencies reported at least two DSP levels in the survey, with three providers operating in NOVA and the remainder in ROS. Some providers showed steady increases from DSP 1 to DSP 3, while others reported differing wages for the same DSP level. One provider indicated higher wages for DSP 1 than DSP 2, and a few reported identical wages across all DSP levels.**

During a Rate Advisory Workgroup meeting, providers noted that not all organizations differentiate between DSP levels. Where distinctions do exist, they are at the discretion of the providers and they may reflect differences in tasks performed, experience, certifications, or the ability to support individuals with more complex needs.

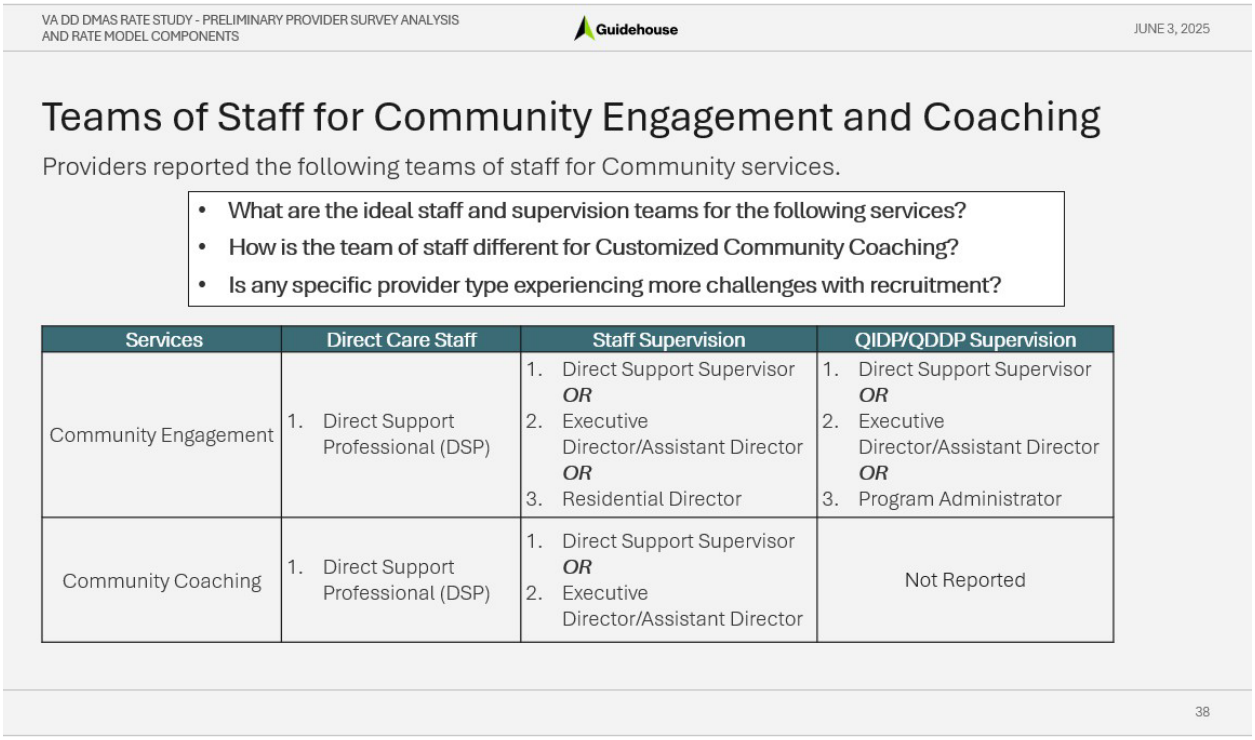
DSP 1, DSP 2, or DSP 3 are not formally defined and required by DMAS, and the survey did not identify consistent patterns by and across levels. As such, the combined DSP wage was used as the most representative metric. The FTE-weighted benchmark hourly average of $20.36 per hour reflects all DSP levels and allows flexibility for differential wages if needed.

This information is captured in the updated report.

Takeaway on Wages in Executive Summary **(Section A, Page 6): Our intention was to link the bullet point on direct care baseline wages to publicly available Virginia wage data released by the Bureau of Labor Statistics (BLS), a national organization. This reference was to Virginia-specific data – not national averages. We replaced the previous language in the Executive Summary on DSP wages with the following:** ***"Direct care baseline wages reported in the provider survey were higher than Virginia wages for most job types and lower for a few compared to Virginia wage data publicly available from the federal Bureau of Labor Statistics (BLS). Higher wages in themselves are not an indicator of rate adequacy but must be interpreted within the context of total compensation, considering many providers may continue to pay higher wages to maintain minimum market competitiveness even when forced to trim benefit offerings to contain overall service costs. In most cases, Guidehouse benchmarked rates using the more competitive wages derived from the provider cost survey, while further incorporating inflation and supplemental pay adjustments to project benchmark wages for SFY 2027."***

Teams of Staff Included for Services **(Section F.2.1.5, Pages 53- 55, Table 13): Table 13 has been added to Page 53 to capture the staff and supervision types included in the rate models. The**

survey included placeholders for providers to specify the types of staff employed for various services, alongside corresponding wage data (e.g., direct care staff, supervisors). Using this information as a foundation, Guidehouse reviewed the identified staffing structure with both the Rate Advisory Workgroup (see example slide below from June 3, 2025 meeting) and the Therapeutic Consultation Focus Group (May 19, 2025) to gather feedback. Additionally, Guidehouse examined relevant DMAS and DBHDS policies , including the 1915(c) waiver service and provider specifications, which offered insight into the staffing requirements for specific services.



VA DD DMAS RATE STUDY - PRELIMINARY PROVIDER SURVEY ANALYSIS AND RATE MODEL COMPONENTS

Guidehouse

JUNE 3, 2025

Teams of Staff for Community Engagement and Coaching

Providers reported the following teams of staff for Community services.

- What are the ideal staff and supervision teams for the following services?
- How is the team of staff different for Customized Community Coaching?
- Is any specific provider type experiencing more challenges with recruitment?

Services	Direct Care Staff	Staff Supervision	QIDP/QDDP Supervision
Community Engagement	1. Direct Support Professional (DSP)	1. Direct Support Supervisor *OR* 2. Executive Director/Assistant Director *OR* 3. Residential Director	1. Direct Support Supervisor *OR* 2. Executive Director/Assistant Director *OR* 3. Program Administrator
Community Coaching	1. Direct Support Professional (DSP)	1. Direct Support Supervisor *OR* 2. Executive Director/Assistant Director	Not Reported

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For example, in the case of Community Engagement services, both survey responses and feedback from the Rate Advisory Workgroup indicated that DSPs serve as direct care staff, while DSP supervisors fulfill supervisory roles. Each Therapeutic Consultation service requires distinct staff types to serve in the direct care role, as shown in Table 13 and discussed during the August 2025 Workgroup meeting. For example, Therapeutic Consultation – Psychologist/Psychiatrist services may be delivered by professionals such as LCPCs, LCSWs, Psychologists, or Psychiatrists. Accordingly, the direct care staff wage is based on blended wages reflecting these job types, with a Clinical Director designated to serve in a supervisory capacity.

5. Employee-Related Expenses – Health Insurance Premium and Take-Up Rate

- *The Arc of Virginia: "Guidehouse utilized the medium premium from the provider survey ($621) which falls within historic VA MEPS range. However, survey may overrepresent smaller*

providers, producing low results which fails to account for the upward trend in benefit costs that providers will face in the coming years; rates based on minimal benefits disadvantage providers. Recommends adjusting benefits assumptions by:

  - *Accounting for forecasted national trends in employer health benefit costs.*
  - *Recognize circular effect of underfunding and avoiding reliance on artificially low survey data.*
  - *Setting benefits benchmarks at levels that allow providers to offer competitive packages necessary to attract and retain a high-quality workforce."*

- *John Salay, Deanna Rennon, & Joanne Acceto (vaACCSES): "The report cites an average monthly health premium of $621, while also acknowledging the Virginia market range of $772 in 2023. It assumes only 45% of full-time staff elect coverage which grossly underestimates potential enrollment as Medicaid expansion faces continued cuts. The report suggestions would fund less than the 2023 levels of health insurance coverage for less than half of provider staff, perpetuating poor benefits for Virginia workers and impacting retention"*
- *Joanne Acceto (vaACCSES): "Revise benefit assumptions to align with realistic costs. A benefits package at or above 30% of wages is necessary."*
- *John Weatherspoon (Wall Residences): "We believe it is inappropriate to include the statement, "Direct Care wages reported in the provider survey were generally higher than national benchmarks" (pg. 6) and not say that benefits are at the very bottom of Virginia's wage. Providers pay as much in wages as they can to attract staff while reducing funds available for benefits."*
- *John Weatherspoon (Wall Residences):" Is the report implying that only 45% of individuals are taking medical insurance? This figure is low and should be higher when the $621 is adjusted up to a more accurate figure."*

Guidehouse Response:

Guidehouse revised the ERE assumptions to reflect increased health insurance costs, based on Virginia's Medicaid Expenditure Panel Survey (MEPS) data. From 2019 to 2023, the average monthly premium in Virginia ranged from $617 to $772. Based on feedback from the Rate Advisory Workgroup, Guidehouse applied a premium of $694 – representing the midpoint of the observed range – instead of the median premium of $621 reported in the provider survey.

The health insurance take-up rate was set at 58.8 percent, informed by provider cost and wage survey data. MEPS data showed take-up rates ranging from 50.9 percent in 2019 to 57.9 percent in 2024. Following discussions with the Rate Advisory Workgroup in June 2025, the survey-based rate of 58.8 percent was selected as the rate model assumption. See Table 14 on pages 57–59 for additional details on the assumptions and calculations.

ERE ranges from approximately 23 percent to 34 percent, depending on job type. As wages increase, the ERE percentage decreases, since it is calculated as a proportion of wages. However, a comprehensive and standardized list of benefits is included for all job types.

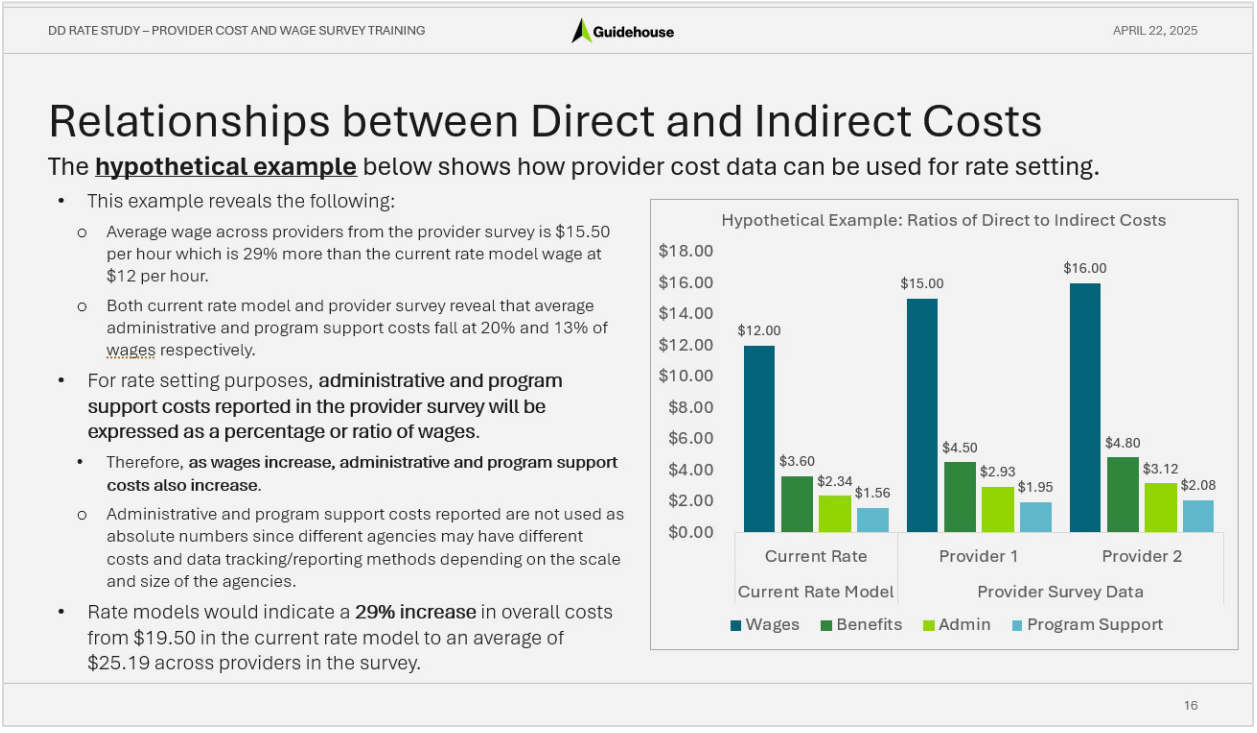
Report Reference Section and Page Numbers: Section F.2.2, Pages 55-60

6. Administrative and Program Support Cost Analysis Approach

- *John Salay, Deanna Rennon, & Joanne Acceto (vaACCSES): "The report relies on a limited number of survey responses and does reflect fixed overhead costs such as program management, training, quality assurance, technology, and billing. Using percentage-based allocations to build overhead expenses are insufficient as direct costs are undervalued in the model."*

Guidehouse Response:

Administrative cost percentage calculation was based on data submitted by 71 of 109 providers, representing 65.1 percent of survey respondents. Since the administrative cost factor is expressed as a percentage of wages, it adjusts proportionally with changes in wage levels. As inflation is applied to project wages to SFY2027 levels, administrative costs are automatically inflated as well, due to the relationship between the two components in the model. We reviewed this information with providers during survey training in April (see example below), and the Rate Advisory Workgroup during May and June 2025 meetings.



The costs cited above related to administrative and programs support costs are included between the administrative and program support cost components, as noted in the report. The administrative cost components included in this calculation are: maintenance and administrative staff wages, contracted administrative salaries, office equipment and furniture, interest expenses, non-payroll taxes, licensing and certification fees,

administrative-related training, insurance (excluding benefits and auto), IT expenses, office supplies, postage, translation costs, and other administrative expenses reported by providers such as bank fees, claims processing, and employee incentives.

Similar to administrative costs, the model also incorporates program support costs from specific survey cost lines, as reported by around two-thirds of providers who responded to the survey. These include: total program support employee salaries and wages; contracted program support staff salaries; program supplies; devices and technology used in direct care; activity costs; licensing, certification, and accreditation fees for direct care staff; hiring expenses; staff training and development; insurance (excluding benefits and auto, direct care-related only); facility rent, mortgage, interest, and depreciation; utilities and telecommunications (both administrative and direct care-related); building maintenance and janitorial services; non-administrative equipment costs and depreciation; and other program support costs as reported by providers such as cleaning supplies, uniforms, and medical supplies. The information is further documented in Sections F.2.6 and F.2.7 in the report.

In reference to how program support costs are incorporated in the rate models, the program support indirect cost factor is structured to reflect the nature of service delivery. This factor is divided into two distinct components:

- **5.18 percent for program support compensation and supplies**
- **11.03 percent for building and equipment costs associated with direct care**

Depending on the service delivery model, either the 5.18 percent component or the full 16.21 percent (combined total of both components) is applied. This allocation is reflected in the rate model presentation from the August stakeholder meeting, where the breakdown appears under the "program support factor" line item. For services where both components are applicable, the full 16.21 percent is included. At a minimum, the 5.18 percent component is applied for consistent coverage of basic program support costs.

An important exception to the two indirect cost components applies to consumer-directed personal care, respite, and companion services. After the preliminary draft rate models were released, stakeholders noted that all management of consumer-direction is handled through consumer-direction *facilitation* service codes for DD waivers – outside the scope of this rate study – which already account for indirect costs related to service facilitation.[1] In response, and consistent with CMS guidance, both administrative and program support indirect costs were removed from the consumer-direction service rates. This adjustment helps avoid duplicative cost inclusion and payments across services. This approach aligns with federal

[1] https://www.dmas.virginia.gov/media/035csnvd/sfy26-my-life-my-community-rate-file-updated.pdf

requirements and supports the integrity of the rate-setting process by matching cost allocations to actual service delivery structures.

Report Reference Sections and Page Numbers: Sections F.2.6 and F.2.7, Pages 67-71

7. Transportation Cost Component Analysis

- *John Salay & Deanna Rennon (vaACCSES): "Methodology relies on either 7.27% or 3.20% of wages instead of actual transportation data or costs, leading to validity concern."*
- *Joanne Acceto (vaACCSES): "Methodology relies on a percentage-based approach across diverse services, geographies, and staffing ratios which lacks validity."*
- *John Weatherspoon (Wall Residences): "Page 57, the 7.27% transportation was calculated as a percentage of wages. Was this figure compared against any benchmarks? Was the mileage on Table 19 in the draft report compared to any benchmarks or external data?"*

Guidehouse Response:

The transportation cost factors included in the rate models are derived from provider-reported cost data submitted through the provider survey. The methodology represents transportation costs as a percentage of wages – and these figures are not arbitrary. They are based on transportation-related expenses reported across multiple cost lines in the survey (i.e., Survey Tab 2. Total Costs), including client-related transportation, vehicle licensing, maintenance, insurance, depreciation, and non-client travel. This approach supports consistency across diverse service settings while reflecting actual provider-reported transportation costs and is informed by data from nearly two-thirds of providers who responded to the survey, as cited in the report.

In the updated version of the report, we further validated the transportation costs embedded in the rate models through supplemental analysis using data from the survey and public sources. Through this method, we calculated costs based on provider-reported travel time for a standard 40-hour work week, average speed assumptions, the IRS mileage rate, and assumptions regarding vehicle purchase and operating costs. The results from this method closely align with the percentage-based figures used in the model, providing additional validation. Notably, for home and community-based services, detailed transportation data is often not readily available or consistently tracked across all providers. In such cases, total transportation costs reported in financial statements –which often inform the Total Costs captured in the survey – serve as a practical starting point for estimating expenses. States typically account for transportation either within broader program support cost factors or as a standalone cost component in their rate models. In this model, transportation is treated as an explicit component, enhancing transparency around what is included in the benchmark rates and supporting future rate reviews.

Report Reference Sections and Page Numbers: Section F.2.7, Pages 71-81, Tables 21 and 22

8. Supervision Ratios for Skilled Nursing

- *John Salay, Deanna Rennon, & Joanne Acceto (vaACCSES): "Report includes an assumed ratio of 1:22 RN for total staff which is not supported by data or practice. The low response rate in the survey may have skewed the data and caused inaccurate references."*
- *John Weatherspoon (Wall Residences): "Page 53 reports supervisor span of control is 1:22 for RN and LPN staff. This is not realistic, and the number is likely skewed by survey responses from smaller agencies."*

Guidehouse Response:

The 1:22 RN supervisor span of control cited in the report is based on responses from the provider survey. This assumption reflects the average of ratios reported by large, medium, and small Skilled Nursing providers, including one of the largest providers in the Commonwealth. This information was also reviewed with the Rate Advisory Workgroup during the June 2025 meeting. Notably, the survey response rate for Skilled Nursing represents 27 percent of total Skilled Nursing expenditures for the DD waivers.

Based on the Rate Advisory Workgroup's feedback on the draft report, we revised the Skilled Nursing supervision assumptions to align with those used for Private Duty Nursing to account for broader provider experience. Specifically, the supervisor span of control was adjusted from 1:22 to 1:12, and weekly supervision hours were increased from 26 to 29.

Report Reference Sections and Page Numbers: Section F.2.5, Pages 65-67, Table 19

9. Customized Rates for High / Complex Needs Clarification

- *Joanne Acceto (vaACCSES): "The report proposed eliminating individualized rates for people with high or complex support needs. Folding these cases into standardized rates would leave higher acuity individuals underfunded. Families already report difficulty securing services for complex cases and the DOJ requires VA to ensure individuals with the most intensive needs can be supported in the community. Individualized funding is essential to meet that obligation."*
- *John Weatherspoon (Wall Residences): "pg. 60 shows that customized rates are no longer tailored to the individuals' needs as they are being shifted to standard rates based on staffing ratio."*

Guidehouse Response:

We would like to clarify the customized rates reviewed as part of this rate study and emphasize that no changes to the existing rate structures are being recommended, nor is there any proposal to eliminate these rates. As noted in the DBHDS provider guide, customized rates are approved based on either a fixed rate or a flexible rate that varies by region (NOVA vs. ROS). For this rate study, customized rates are available for two services – In-Home Supports and Community Coaching – both of which use fixed rates. This rate study does not include flexible rates that are provided for other DD waiver services such as Sponsored Residential services.

There are eight sets of fixed rates for each service, differentiated by staffing requirements and regions, and we have established rates for all eight.

- **1:1 support with specialized staffing (NOVA)**
- **1:1 support with specialized staffing (ROS)**
- **2:1 support with standard staffing (NOVA)**
- **2:1 support with standard staffing (ROS)**
- **2:1 support with specialized staffing with one standard staff and one specialized staff (NOVA)**
- **2:1 support with specialized staffing with one standard staff and one specialized staff (ROS)**
- **2:1 support with specialized staffing for both staff (NOVA)**
- **2:1 support with specialized staffing for both staff (ROS)**

Therefore, we developed the rates using the existing rate structure and in alignment with guidance offered to providers by DMAS. Additional information about customized rates is available in the DBHDS Customized Rate Provider Guide: https://dbhds.virginia.gov/wp-content/uploads/2024/10/CR-Provider-Guide-2024.pdf.
Report Reference Sections and Page Numbers: Section F.2., Pages 40-41

10. Other Suggestions and Feedback

- ***Overall – General***
  - *vaACCSES (all submissions):*
    - *"Ensure final rates include sufficient funding for both frontline staff and the administrative infrastructure required to deliver compliant, quality services."*
    - *"Include provider stakeholders in rate building. Provide clarity in rate analysis and modeling."*
    - *"Support workforce development through wage building blocks that account for experience, skill, and service type."*
    - *"Revise benefit assumptions to align with realistic costs."*
    - *"Adopt a cost-based build-up model (direct wages, benefits, supervision, overhead) rather than benchmarking solely to historical spending of inadequate reimbursement or national medians of single data points."*
    - *"Apply across-the-board rate increases for all ID/DD services, including overtime and benefits, and retain individualized rates for people with exceptional needs."*
- ***Support for Personal Care, Private Duty, and Respite Rate Changes***
  - *Virginia Association for Home Care and Hospice: "The Virginia Association for Home Care and Hospice was most interested in the rate study pertaining to personal care, private duty nursing and respite care. For over two decades our organization has*

advocated for fair and adequate reimbursement rates for personal care, private duty nursing and respite care. As noted in the evaluation, personal care and respite care are 41% below benchmark in Northern Virginia and 42.1% below benchmark in the rest of the state. Poor reimbursement rates along with over regulation has led to low staff wages. Over regulation on the federal level and Virginia's ever growing minimum wage increases have created significant challenges that directly impact this provider community as there has been no recognition of the growing indirect care components of providing this care. We believe strongly that without significant increases in reimbursement personal care will become more destabilized"

- **Documentation:**
  - *Joanne Acceto (vaACCSES): "The draft report does not clearly document data sources, calculations, or rationale, which prevents replication or validation and undermines confidence in the recommendations."*

Guidehouse Responses:

The proposed rate models address several areas highlighted in stakeholder feedback. The benchmark rates are developed using a cost build-up approach that reflects both provider-reported data (e.g., administrative-to-direct care cost ratios, FTE-weighted wages) and recent industry benchmarks (e.g., health insurance costs from MEPS, geographic cost differentials from EPI, BLS wage data). For example, MEPS public data informed health insurance cost assumptions, while the provider survey helped identify a comprehensive list of benefits that providers may offer to support a competitive benefits package. That said, reviewing data alongside contextualizing it through discussions with providers added valuable insight.

Our focus throughout this study was to strike a balance between the cost of delivering services, provider experience, and service expectations – grounded in data and evidence. As a result, some services or service tiers showed relatively smaller changes in rates, which may reflect existing alignment between current rates and service expectations. As mentioned above, the objective of Guidehouse's study is to offer an independent, objective perspective on reasonable cost standards.

The report includes pertinent sources cited as footnotes. Additionally, Section D.1.4 highlights key data sources used in rate development. We have expanded both the data source section and the footnotes to clearly identify all datasets or resources referenced, including the specific years, to enhance clarity. To further strengthen the report, we've added rationale and context behind key figures, detailing the methodologies and calculations used to derive them. For example, Section E.3 (Peer State Comparison Analysis) now includes the rationale for selecting each peer state, along with links to the corresponding fee schedule sources.

We've also refined the language regarding the survey response rate of 19 percent to clarify that we received 109 completed surveys, representing 19 percent of SFY2024 expenditures for services included in this rate study (see pages 6 and 22).

Report Reference Sections and Page Numbers: Section D.1.1.3 (Pages 22-23), D.1.4 (Pages 24-26)