# Utah Baby Watch Early Intervention Program

## Cost and Rate Study Final Report

**July 30, 2021**

**Final Report**

PUBLIC CONSULTING GROUP

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# EXECUTIVE SUMMARY

Public Consulting Group LLC (PCG) is pleased to submit this final report detailing our findings and accompanying recommendations from our cost and rate study for the State of Utah, Department of Health (UDOH), Baby Watch Early Intervention Program (BWEIP). This executive summary condenses the report into the following components: themes, limitations and considerations, and recommendations. Calculated rates are based on data collected from state Fiscal Years (FY) 2019 and 2020, in addition to time study data collected in FY 2021.

## THEMES

PCG collected local EI program information from three primary sources: cost reports, personnel rosters, and time studies (also known as time diaries). The cost reports captured high-level service, revenue and expense information related to local early intervention programs throughout Utah in FY19 and FY20.

Personnel rosters were collected to collect additional detail regarding direct service provider and administrative staff salaries and full time equivalent (FTE) information around staff type. Local EI programs were asked to give their personnel rosters for the entireties of FY19 and FY20. These rosters provided valuable information on direct service provider rates and gave PCG a methodology to weight market rates appropriately based on actual early intervention data in Utah. PCG received 14 cost reports and 14 personnel rosters of the 15 local EI programs in the state; all submitted cost reports and personnel rosters were used in some portion for the analysis.

Time study data was requested from all personnel that deliver early intervention services in Utah. Of the 15 total local EI programs, 14 submitted time studies for their staff (including subcontractors). There were 270 total direct service providers who participated in the study, which covered 4,887 total visits throughout the State of Utah. During this time period, PCG captured children served in 17 out of 29 counties across the state. Participants measured their time based on 15-minute activity categories during a 14-day period. This information was used to calculate a billable percentage and mileage factor. The rate calculations would then account for all billable and non-billable time (including travel).

Rate calculations were completed based on the hourly cost of the billable unit for providers using market salaries and actual provider expenses. For example, an hour of billable time may cost a provider two hours of its time because of associated travel, report writing and administrative time. This is reflected in all the rate calculations. The rate calculations therefore all start with a blended market salary rate that adds all other costs and non-billable time to it. Variations for local rate group (geography/mileage modifier) and tele-intervention were also calculated, and the rates are built on 15-minute units, or in the case of Service Coordination, a per child per month rate.

## LIMITATIONS AND CONSIDERATIONS

- Time studies were designed to capture the amount of direct service time staff dedicated to BWEIP activities. These results are based on staff self-reporting time spent, and their supervisor's review and approval. Though PCG reviewed each of the 270 time studies submitted for accuracy, completeness, and reasonableness, there still may be discrepancies in data. Since supporting documentation was not submitted with most time studies, PCG is not able to independently verify the data submitted.
- Cost report and personnel roster tools were returned by 14 of 15 total programs, many of which were not accompanied with supporting documentation, so much of those data are also self-reported. However, PCG did review data that is reported monthly to BWEIP to verify accuracy of BWEIP-related expenditures.

- Figures presented in this report are rounded to the nearest cent ($0.01) or second digit. This may result in marginal differences for any calculations redone manually using figures presented in this report.
- This projected kicked off in early March 2020, just as the COVID-19 pandemic was escalating within the U.S. Because of this, PCG and BWEIP altered the approach to conduct this study, which caused delays in the initial schedule of this project as services moved to a tele-intervention format. This, however, created an opportunity to create a recommended rate for tele-intervention services.
- When PCG began this project in early 2020, the San Juan School District was a contracted early intervention program. During fall of 2020, however, they notified BWEIP that they were ending their contract by the end of calendar year 2020. BWEIP released a Request for Information (RFI) to gauge the interest of other potential programs (including the current contracted early intervention programs) to service this community. After review and evaluation of RFI responses, BWEIP assumed direct management of early intervention services in San Juan County, in a structure similar to that of the Weber-Morgan Early Intervention Program. Due to the lack of data available from San Juan School District and these administrative changes, the program was not a participant in the cost and time studies.

## RECOMMENDATIONS

### *Recommendation Rationale*

Based on an evaluation of the current funding structure and funding formula of BWEIP (which currently operates on a cost-reimbursement basis), and a detailed analysis of the cost reports, personnel rosters, time studies, and numerous other quantitative and qualitative data sources, PCG recommends the following rate structure and fiscal structure changes to BWEIP.

PCG believes it is important to emphasize here that upon detailed review of the current funding formula of BWEIP and the cost-reimbursement model BWIEP currently uses to fund local early intervention programs in Utah, PCG found a number of deficiencies and complexities in the current model which led to recommending a move to a different program structure. The complexity of the current cost reimbursement system leads local EI programs and the BWEIP to not have a full understanding of the true cost of EI service provided; in addition, the current methodology was created long before the current BWEIP staff were running the program and the original rationale for the calculations were not documented.

In response, PCG has provided an alternative, replicable, and updatable rate-setting methodology that BWEIP can utilize in later years that are based off empirical data. These rates can be used by BWEIP, Medicaid and potentially to bill private health insurance if UDOH decides to add that as a revenue source for early intervention.

These recommendations are intended to be used as guidance and the State of Utah, UDOH, BWEIP, may accept all, some, or none of these fiscal recommendations.

### *Fiscal Structure Recommendations*

**PCG recommends that BWEIP transition to a Fee-For-Service system** in order to:

1) Have a standard reimbursement methodology between BWEIP, Medicaid, and private health plans.
2) Have a fee-for-service payment methodology with Medicaid and CHIP to enable BWEIP to propose that private health plans also be required to fund early intervention services.
3) Include Fee-for service rates for:
    - Early intervention 15-minute rate
        - Include modifiers for:

  - Tele-intervention
  - Local rate group
- Service Coordination – monthly rate, per child, accommodating all Service Coordination activities done for a child in addition to direct services.

**PCG recommends that BWEIP and the UDOH begin to submit claims for direct services for early intervention to commercial insurance payors** (also called private insurance).

There are different ways to begin this process, and we suggest:

- *working directly with the payors in the beginning to identify early intervention claims and how they would be submitted and paid;*
- *submitting claims through a traditional claiming process, coding claims as routine clinical services without adding specific early intervention TL modifiers; or,*
- *in the case that commercial payors still do not respond or have high denial rates, UDOH and the state legislature can work to pass legislative mandate requiring the payors to accept, process, and pay for early intervention claims.*

Including private insurance into the mix of revenue streams for BWEIP can potentially provide a significant boost funding and reduce reliance on state funding.

**PCG recommends the following changes or improvements to the current billing process to Utah's Medicaid system:**

- Moving from the current monthly bundled rate to a fee-for-service rate, with a common 15-minute rate for early intervention services including therapies, Nursing, Special Instruction, developmental instruction, etc. This will involve determining the billing codes and modifiers (from the HCPCS – Healthcare Common Procedure Coding System) for early intervention home and community services and center and group services.
- Establishing a separate monthly Service Coordination rate.
- Conduct eligibility checks (sweeps) with all children recorded in BTOTS for Medicaid enrolled children to ensure that all EI services are billed to Medicaid for enrolled children.
- Consider a central billing system to bill Medicaid for all enrolled children.

## *Rate Recommendations*

### COMPREHENSIVE RATE RECOMMENDATIONS

| Services | In-Person Urban | In-Person Rural | In-Person Frontier | Tele-intervention |
|---|---|---|---|---|
| EI Blended (15-MIN) | $23.95 | $24.13 | $24.83 | $21.79 |
| EI Blended Rate (UT Legislative Average Number of Services, Projected Reimbursement) | $162.88 | $164.07 | $168.83 | $148.16 |
| EI Blended Rate (National Average Hours of Service, Projected Reimbursement) | $450.33 | $453.62 | $466.78 | $409.62 |
| Service Coordination (Per Child Per Month) | $157.76 | $163.36 | $185.76 | $140.96 |

PCG also has calculated specific rates for each service type (such as Speech-Language Pathology, speech therapy, etc.), details of which can be found in Section VI and Appendix C of this report.

To apply these rate recommendations and compare them to the current funding structure, the table below illustrates the difference between the current bundled Medicaid rate per child per month ($473.22), and the estimated total payment for serving a child receiving the national average of 4.7 hours of service per month with the new rates from above ($608.09).

**APPLICATION OF RATE RECOMMENDATIONS**

| Line Item | Rate | Notes |
|---|---|---|
| 1 Hour of Service | $95.81 | PCG Calculated Blended EI Rate |
| 4.7 Hours of Service Provided | $450.33 | National Average Hours of Service per Month |
| Service Coordination Per Child Per Month | $157.76 | PCG Calculation |
| Projected Monthly Average Reimbursement Per Child Per Month | $608.09 | 4.7 Hours of Service + Service Coordination |
| 1.7 Services Provided – UT Legislative Average | $320.64 | 1.7 Services + Service Coordination |
| Average between 4.7 hours/services per month and 1.7 (National Average vs. UT Statute) | $464.37 | Calculation |
| Current Medicaid Bundled per Child Rate (not contingent on number of services provided) | $473.00 | Current Rate |

As one can see, if BWEIP were to implement a Fee-For-Service payment system (which is further detailed in the recommendations section of this report), and a child receives the national average hours of service in a month (4.7), revenue would be increased per child per month by $135.09. For additional comparison, if the average is taken between the 4.7 hours of service provided figure and the expected number of sessions estimated by the Utah Legislature (1.7 sessions, or approximately 1.7 hours for this calculation), then the child per month revenue would be $464.37, which is only slightly less than the current Medicaid reimbursement rate. It is expected that children receiving early intervention services in Utah would receive much closer to the 4.7 hours of service than the Utah 1.7 sessions, or the average between the two.

## *Possible Implementation Barriers or Risks*

PCG has identified the following barriers or risks in the implementation of the recommendations detailed above. Detailed strategies to address these items are detailed further in Section VII of this report.

1. **Fee-For-Service** – while a FFS system incentivizes the provision of all services on the IFSP and may increase the average number of survives up to closer to the national average of 4.5 hours per month - as providers are reimbursed for all services provided - it could lead to the overprovision of services by programs to generate greater revenue.
2. **Fee-For-Service** – FFS could be seen by EI programs as requiring additional documentation and service logging as currently not all direct services are entered into BTOTS.
3. **Fee-For-Service** – could be seen by EI programs as less predictable for projecting revenue for budgeting
4. **Fee-For-Service** – There is a concern that moving EI Programs from a status of ‘subrecipient’ to ‘contractor’ would result in a significant change to the EI system.
5. **Medicaid** – costs may increase under a FFS system where programs are reimbursed for each 15 min service and monthly Service Coordination delivered compared to the monthly bundled rate.
6. **Private insurance** – there may resistance from policy makers and EI programs and parents to bill private health insurance.
7. **Central Billing System** – this could be seen as a costly and time intensive infrastructure change for BWEIP even if it would increase revenue.

8. **Family fees** – Family fees and other 'out-of-pocket expenses' may be prohibited in IDEA Part C under proposed federal changes*, which would reduce the BWEIP revenue by approximately $660K annually.

## CONCLUSION:

PCG concluded its analysis and drafting of this report in July 2021 and presented its final results to the steering committee on July 29, 2021. A draft report and the accompanying presentation were presented to steering committee members for feedback, and feedback from members was requested in return by August 13. One member of the steering committee provided feedback, which was subsequently incorporated into this report. The draft report was also provided to Utah Medicaid for feedback in August 2021.

PCG appreciates the opportunity to work with the State of Utah, BWEIP, and early intervention stakeholders across the state and be a part of this potentially transformational work. PCG stresses that the analysis and recommendations provided in this report have been conducted independently and have been built upon the data submitted by BWEIP and the local early intervention programs in Utah. These recommendations are informed by national best practices and data specific to Utah, and, ultimately, BWEIP, UDOH, and/or the state's Medicaid agency may adopt or accept all, some, or none of these fiscal recommendations.

# I. INTRODUCTION & METHODOLOGY

## INTRODUCTION

The Baby Watch Early Intervention Program (BWEIP) is Utah's designated Early Intervention (EI) Lead Agency under Part C of the Individuals with Disabilities Education Act (IDEA). BWEIP is housed within the Utah Department of Health (UDOH), Children with Special Health Care Needs (CSHCN) Bureau. The mission of BWEIP is *"to enhance early growth and development in infants and toddlers, who have developmental delays or disabilities, by providing individualized support and services to the child and their family[1]."*

Early Intervention is defined as programs or services selected in collaboration with parents as part of the Individualized Family Service Plan (IFSP) process. It is designed to meet the developmental needs of children birth to age three, as well as support the family to assist in their child's development.

The delivery of early intervention services to eligible children and families in Utah is set up through contracts that BWEIP has with 13 local EI programs. BWEIP also directly operates and funds and two[2] programs housed within UDOH. In 2015, a cost study was conducted to estimate the cost of early intervention services for the time period of July 1, 2013 – June 30, 2014. Since SFY14, when a new funding formula was implemented, BWEIP has been challenged with ongoing funding needs to support quality EI services for the consistently growing numbers of eligible children. It was recommended during Utah's participation in the Infant Toddler Coordinator Association (ICTA) Fiscal Initiative in 2019 for BWEIP to conduct a new cost study to address the evolving landscape. The new cost study is intended to provide information to answer questions about the current cost of EI services, as well as consider costs associated with specific BWEIP activities including eligibility determination, Service Coordination, and travel time to deliver direct EI services.

This cost study's primary outcomes have been identified to:

- provide reliable information to determine the average cost per child for BWEIP services (i.e., provider wages, service, administration, building, and travel costs);
- conduct cost studies and time diaries with local EI program staff;
- programmatic cost structure;
- provide overall fiscal recommendations for BWEIP; and,
- recommend new rates for the delivery of direct early intervention services.

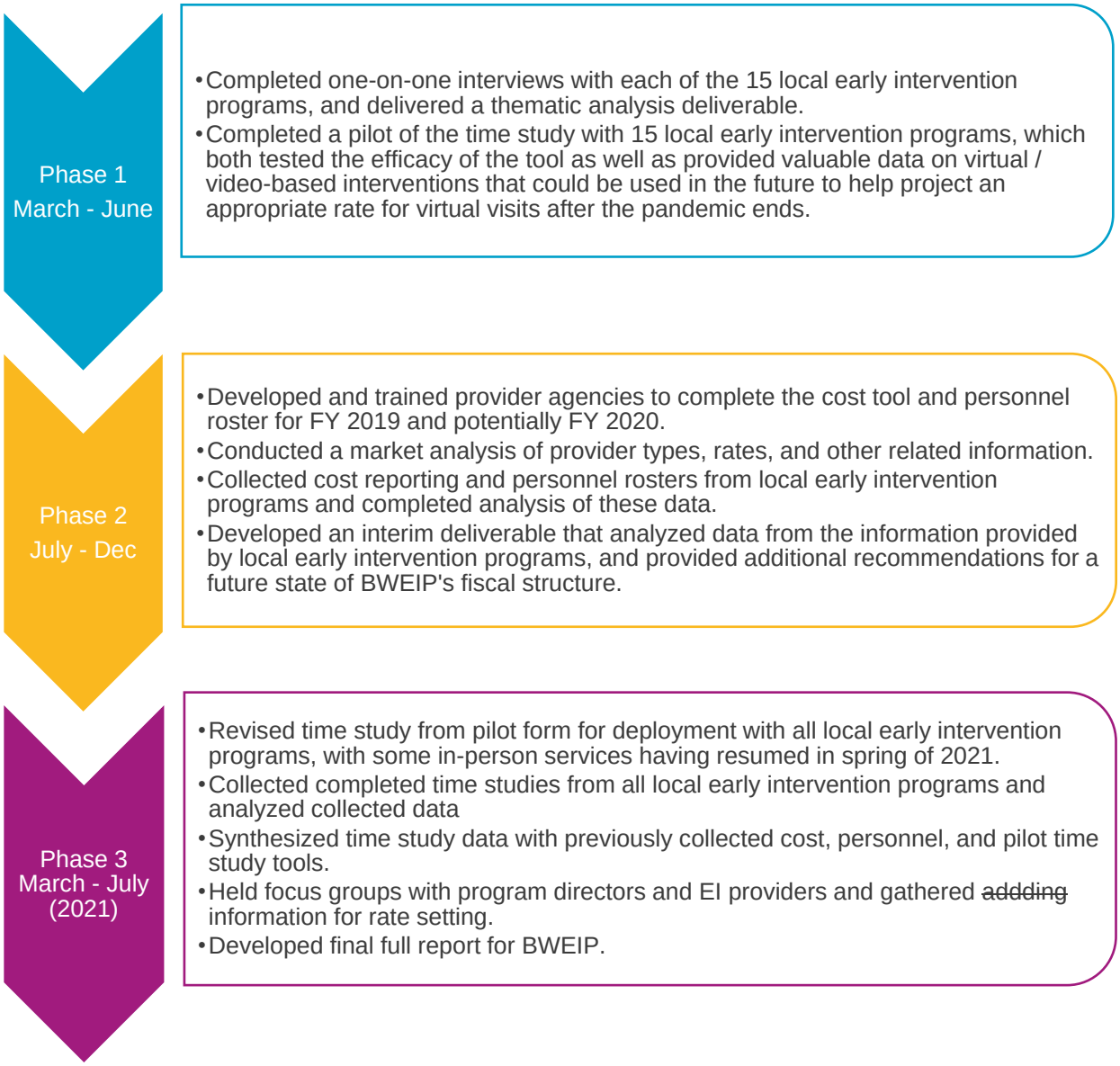
BWEIP released a Request for Proposals (RFP) in late 2019 seeking an independent contractor to complete the cost study. Public Consulting Group LLC (PCG), a national public-sector management consulting firm with extensive experience in completing early intervention rate studies in other states was selected, and work on the project commenced in March 2020.

This contract was initially scheduled to conclude on October 31, 2020; however, the COVID-19 public health emergency led to an unprecedented interruption of early intervention services both in Utah and nationally. Due to the pandemic, in-person services were interrupted, with services moving to a hybrid of phone, virtual tele-intervention, and in-person visits (if necessitated) for the remainder of calendar year 2020. Because of the change in service delivery, PCG and the BWEIP team worked to create an alternate schedule to complete the project on an extended timeline at no additional cost which included separating the 'time study' from the 'cost study'. The 'time study' is a critical component in evaluating the efficacy of established

[1] https://health.utah.gov/cshcn/programs/babywatch.html
[2] As of January 2021, San Juan Early Intervention was taken on within UDOH, and operated similarly to the Weber-Morgan Early Intervention program.

rates paid for rendered services, particularly when analyzing provider utilization and distribution of services throughout a given state

Because completion of the cost and personnel roster tools *was not* contingent on services being provided, unlike the time study, PCG and BWEIP decided the most appropriate approach to complete this project was to undergo a multi-phase approach. Below, the phases that were used to complete this project by July 31, 2021, are outlined:




This report is the final publication of the data PCG gathered and analyzed under UDOH contract number 9989, and details the results of our analysis and our additional fiscal recommendations for BWEIP.

## GLOSSARY AND DEFINITIONS

**Active Child**: A child is considered active if they have the status of 'Referred', 'Pending IFSP', or 'Under IFSP'.

**Assessment/Evaluation**: Procedures used in accordance with IDEA, Part C, to identify the child's unique strengths and needs and the early intervention services appropriate to meet those needs throughout the period of the child's eligibility.

**Baby Watch Early Intervention Program (BWEIP)**: State of Utah Part C of IDEA Lead Agency.

**Billable/Nonbillable:** A billable direct service in terms of rate setting for this project includes the direct service rendered to the child and accompanying documentation. Nonbillable has been defined as any other work, such as training, preparation time, travel, and similar support work to rendering the direct service.

**Fiscal Year (FY):** This analysis involved reviewing financial details from local EI programs in Utah during state Fiscal Years FY2019 and FY2020. When referring to Fiscal Year in this report, we mean the timeframe of July through June. For example, FY2020 took place between July 1, 2019, through June 30, 2020.

**Individualized Family Service Plan (IFSP):** A written plan for providing early intervention services to an eligible infant or toddler and their family.

**Local EI Program Rate Group**: Three tiers of per visit reimbursement rates (urban, rural, frontier) that are based on the geographical designation of the local EI program.

**Local EI Programs:** Programs employing direct early intervention service providers. These programs either contract with BWEIP or are directly operated by the Utah Department of Health, BWEIP.

**Part C of IDEA:** The section of the Individuals with Disabilities in Education Act (IDEA) that establishes a federal grant program that lays out the requirements for states in operating a comprehensive statewide program of early intervention services for infants and toddlers with developmental delays and disabilities, ages birth to three years, and their families.

**Public Consulting Group LLC (PCG)**: the contractor hired by BWEIP to conduct this cost study. Founded in 1986 and headquartered in Boston, Massachusetts, PCG helps primarily public sector health, education, and human services organizations make measurable improvements to their performance and processes. More about PCG can be found at www.publicconsultinggroup.com.

**Referral**: An infant or toddler referred to early intervention by a parent, other family members, physician, child care provider, or other individual who is familiar with the child and who has a concern about how the child is developing.

**Steering Committee:** A group of representatives from EI programs across the State of Utah who assist in guiding the direction of this project and provide feedback on tools and methodology. Local EI programs include: Central Utah Health Department Early Intervention, Jordan Child Development Center, Kids Who Count, and South East Early Intervention Program.

## PROJECT BACKGROUND AND METHODOLOGY

In Utah, there are 15 local early intervention programs, which offer the full range of early intervention, multidisciplinary direct services, including speech language pathology, occupational and Physical Therapy, Special Instruction, and other early intervention services required under Part C of IDEA. These local EI programs also provide Service Coordination (or case management) and additional required early intervention functions including child find, eligibility determination, IFSP development, transition at age 3, etc. Thirteen of the local EI programs are contracted directly with the state through a competitive Request for Proposal (RFP) process and are compensated on a cost reimbursement basis. Two programs (San Juan[3] and Weber-Morgan) are housed directly within UDOH and are operated directly by BWEIP.

From February 2020 through July 2021, PCG met with BWEIP leadership on a weekly basis to discuss the direction of the project, and to review deliverables as they were completed. PCG also met periodically with a steering committee comprised of local EI program representatives from urban, rural, and frontier rate group areas of the state to solicit feedback on project methodology and cost study tools.

PCG collected information for the rate study from three primary data sources: cost reports, personnel rosters, and time studies. As stated previously, PCG collected cost report and personnel roster data in late 2020, and conducted the time study in the spring of 2021 in response to the COVID-19 pandemic. Cost reports captured high-level service, revenue, and expense information related to early intervention services in the state for Fiscal Years 2019 and 2020. Specifically, the cost reports allowed PCG to come up with proportions of direct personnel to administrative expenses. Personnel rosters were collected to serve as a measure of quality assurance for the time studies, cost studies, and market rate research. Local EI programs were asked to provide their personnel rosters based on FY2019 and FY2020 staffing for employees and subcontractors who delivered EI services. The rosters also provided valuable information on subcontractor rates and gave PCG a methodology to weight market rates appropriately based on actual BWEIP data. PCG received 14 cost reports and 14 personnel rosters from the 15 local EI programs (see discussion on San Juan in limitations and considerations section) to whom the tools were distributed. All submitted cost reports and personnel rosters were utilized in the analysis.

The current BWEIP reimbursement rate structure is quite complex with regard to how funding for local EI programs is determined and later accounted for in monthly reporting; however, the actual rates per child reimbursed are fairly straightforward. BWEIP pays a basic rate per service per child, divided into three local rate groups based on geographical areas ‘urban’, rural’ and ‘frontier’ (see glossary), with no distinction between service type. Utah Medicaid, on the other hand, reimburses programs with a monthly bundled rate per child.

To better align how to pay for services rendered and understand the funding structure, PCG calculated rates based on the hourly cost of the billable unit using market salaries and actual expenses. For example, an hour of billable time may cost a provider two hours because of associated travel, report writing, and administrative time. This is reflected in all the rate calculations. Therefore, each rate calculation starts with a blended market salary rate that adds all other costs and non-billable time to it. We calculated rates for each discipline at 15-minute, fee-for-service units, in addition to a blended general early intervention rate, and a per month per child Service Coordination fee. Market salaries were used based on data collected by the Bureau of Labor Statistics (BLS). Due to the COVID-19 pandemic, effectively measuring time spent travelling was more complicated. However, we were able to capture some travel data in our time studies for local rate groups and through input provided from focus groups held with local EI program directors and direct EI providers, which is discussed later in this report, and applied to the rates by respective rate group.

[3] See “Limitations and Considerations” subsection on limitations regarding the San Juan program.

## Program Interviews

One component of this contract was for PCG to conduct individual meetings with all 15 local early intervention programs.

The primary objectives of these interviews were to 1) establish rapport with program leaders, 2) introduce and review the goals and objectives of the cost study, and 3) provide an opportunity for each program to share their unique experience with regards to funding, program needs, and other issues as an early intervention provider within their geographical service area in Utah. From these interviews, PCG identified common themes among early intervention programs and developed data collection procedures for completion of the cost report, personnel roster, and time study tools in conjunction with the overall cost study.

PCG utilized a virtual, video conferencing platform to conduct one-hour interviews with one to three leadership staff at each of the 15 local early intervention programs statewide. Interviews were conducted from April 13, 2020, to May 18, 2020.

Primary themes PCG heard from these interviewees revolved around:

- *complexity of the current funding formula;*
- *related difficulties in planning program budgets going into the future;*
- *need for increasing rates; and,*
- *various concerns connected to the COVID-19 pandemic.*

## Limitations and Considerations

- Time studies were designed to capture the amount of direct service time staff dedicated to Baby Watch program activities. These results are based on staff self-reporting time spent, and their supervisor's review and approval. Though PCG reviewed each of the 270 time studies submitted for accuracy, completeness, and reasonableness, there still may be discrepancies in data. Since supporting documentation was not submitted with most time studies, PCG is not able to independently verify the data submitted.
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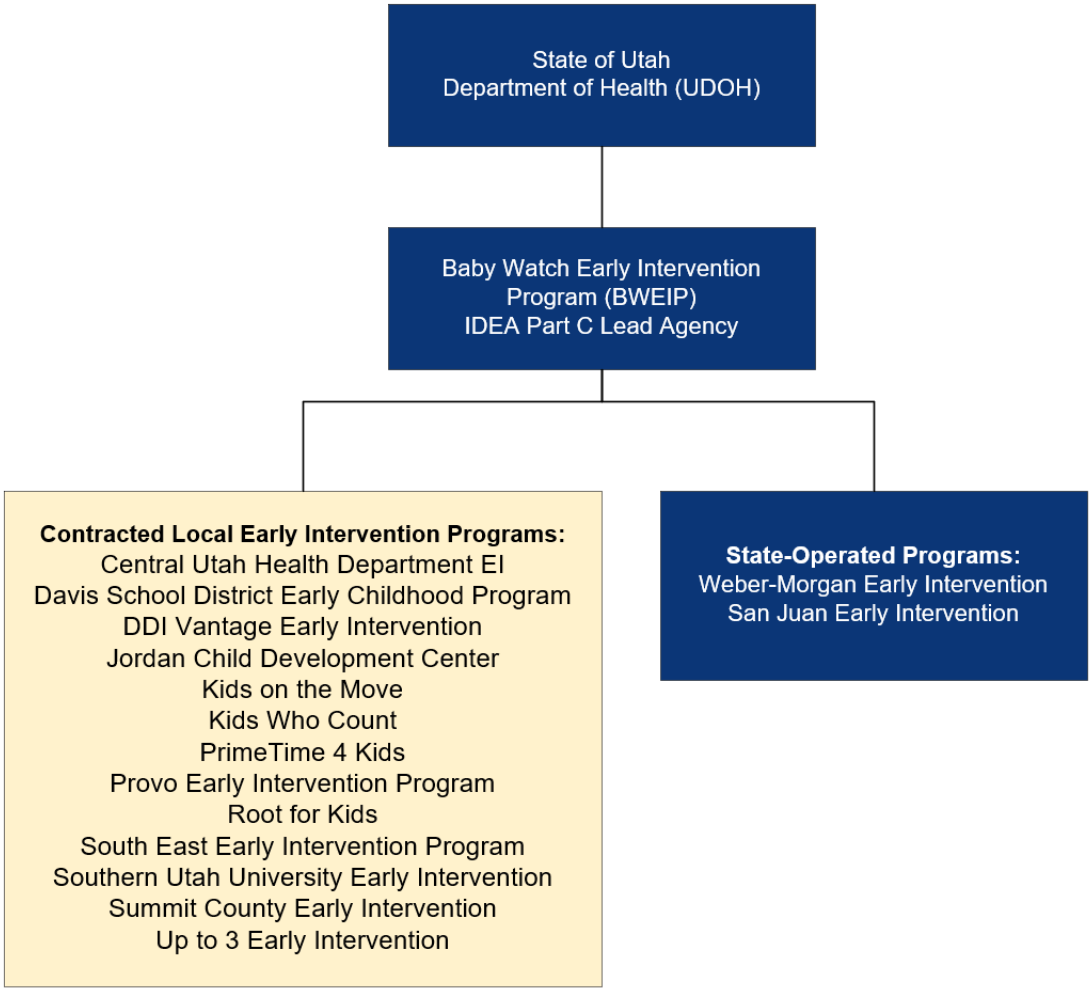
- Figures presented in this report are rounded to the nearest cent ($0.01) or second digit. This may result in marginal differences for any calculations redone manually using figures presented in this report.
- This project kicked off in early March 2020, just as the COVID-19 pandemic was escalating within the U.S. Because of this, PCG and BWEIP altered the approach to conduct this study, which caused delays in the initial schedule of this project as services moved to a tele-intervention format. This, however, created an opportunity to create a recommended rate for tele-intervention services.
- When PCG began this project in early 2020, the San Juan School District was a contracted early intervention program. During fall of 2020, however, they notified BWEIP that they were ending their contract by the end of calendar year 2020. BWEIP released a Request for Information (RFI) to gauge the interest of other potential programs (including the current contracted early intervention programs) to service this community. After review and evaluation of RFI responses, BWEIP assumed direct management of early intervention services in San Juan County, in a structure similar to that of the Weber-Morgan Early Intervention Program. Due to the lack of data available from San Juan School District and these administrative changes, the program was not a participant in the cost and time studies.

## Definitions and Organization

To illustrate the distinction between the Part C Lead Agency, Baby Watch Early Intervention Program, contracted local early intervention (EI) programs, and state operated EI programs, we have provided the organizational chart below.

### Figure 1: Organizational Chart




For the purpose of this report, PCG analyzed Utah's local early intervention programs by grouping them into three categories:

1. Detailed program type: in certain charts, PCG has grouped local EI programs under the following coding, according to 2021 State Profile for Utah from the national IDEA Infant Toddler Coordination Association. They are as follows:
    a. *Non-Profit Agencies* (Coded NP): DDI Vantage, Kids on the Move, Kids Who Count, PrimeTime 4 Kids, Provo Early Intervention Program, Root for Kids.
    b. *State and Local Governmental Employees* (Coded G): Central Utah Health Department Early Intervention, Summit County Early Intervention, Weber-Morgan Early Intervention, San Juan Early Intervention.
    c. *Other (School Districts and Universities)* (Coded S): Davis School District Early Childhood Program, Jordan Child Development Center, South East Early Intervention Program, Southern Utah University Early Intervention, Up to 3 Early Intervention.

2. Local Program Rate Group: Groupings of local early intervention programs, defined by a specific reimbursement rate for services based on geographical setting. Below is a listing of how programs are currently categorized.
    a. *Urban:* Davis School District Early Childhood Program, Weber-Morgan Early Intervention, Jordan Child Development Center, Kids on the Move, Provo Early Intervention Program, DDI Vantage.
    b. *Rural:* Summit County Early Intervention, Up to 3 Early Intervention, Root for Kids, PrimeTime 4 Kids, Southern Utah University Early Intervention, Kids Who Count, DDI Vantage.
    c. *Frontier:* South East Early Intervention Program, Central Utah Health Department Early Intervention, San Juan Early Intervention.

# II. Market Salary Analysis

In Table 1, PCG has provided a review of early intervention provider disciplines. Average annual salaries obtained from personnel rosters and reported in our cost report were compared to the Utah Department of Workforce Services (DWS) and U.S. Bureau of Labor Statistics (BLS) national and regional estimates. As reported to PCG through personnel rosters, EI personnel were compensated more on average by discipline than their inter- and intra-state counterparts.

**Table 1. Market Salary Analysis (FY2020)**

| Sources | UT DWS | Cost Report | DWS – Report | BLS | BLS Mountain Plains Region | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Discipline** | **Annual Mean** | **Reported on Personnel Rosters** | **% to UT DWS Data** | **National** | **UT** | **CO** | **KS** | **MO** | **MT** | **WY** |
| Audiologist | $73,000 | N/A | N/A | $89,230 | | $81,160 | $66,580 | $72,660 | $97,040 | $78,510 |
| Developmental Specialist | $35,730 | $58,552 | 164% | $68,110 | $41,040 | $59,930 | $58,890 | $50,080 | $72,140 | $52,900 |
| Nurse | $63,570 | $77,626 | 122% | $80,010 | $70,370 | $77,860 | $64,200 | $65,900 | $70,530 | $72,600 |
| Occupational Therapist | $84,680 | $95,410 | 113% | $87,480 | $84,160 | $91,650 | $86,540 | $78,660 | $76,200 | $81,560 |
| Physical Therapist | $81,640 | $106,371 | 130% | $91,680 | $86,780 | $87,250 | $91,850 | $84,660 | $84,600 | $90,140 |
| Psychologist | $70,740 | N/A | N/A | $89,290 | $79,780 | $99,580 | $71,850 | $91,050 | $67,120 | $78,000 |
| Registered Dietician | $55,750 | $90,875 | 163% | $64,150 | $57,060 | $61,550 | $61,790 | $60,230 | $57,120 | $69,200 |
| Service Coordinator | $60,400 | $57,013 | 94% | $75,140 | $70,200 | $88,780 | $63,820 | $64,390 | $63,510 | $62,870 |
| Social Worker | $39,350 | $66,664 | 169% | $52,370 | $48,450 | $54,210 | $47,040 | $37,770 | $41,550 | $48,700 |
| Special Educator | $35,730 | $79,685 | 223% | $68,110 | $41,040 | $59,930 | $58,890 | $50,080 | $72,140 | $52,900 |
| Speech-Language Pathologist | $78,480 | $88,421 | 113% | $83,240 | $77,630 | $91,200 | $75,880 | $81,390 | $72,220 | $81,760 |

References: BLS wage data for Utah: https://www.bls.gov/oes/current/oes_ut.htm

UT DWS wage data: https://jobs.utah.gov/jsp/almiswage/#/

Because salaries reported on the personnel rosters trended significantly higher than equivalent salaries as reported by the BLS and UT DWS, In consultation with BWEIP, PCG weighted the average hourly salary used in our rate calculations using the salaries from those agencies. To do this, we used equal weighting of all three salaries reported (those relevant to existing services in Utah) by using the following formula:

- (DWS Salary x .33) + (Personnel Roster Salary x .33) + (BLS UT Salary x .33) = Weighted salary

After weighting the salaries, we divided them by 2,080 hours – the equivalent of a full-time employee throughout a year – to get a weighted pay per hour. Table 2 shows the results of these weighted salary calculations.

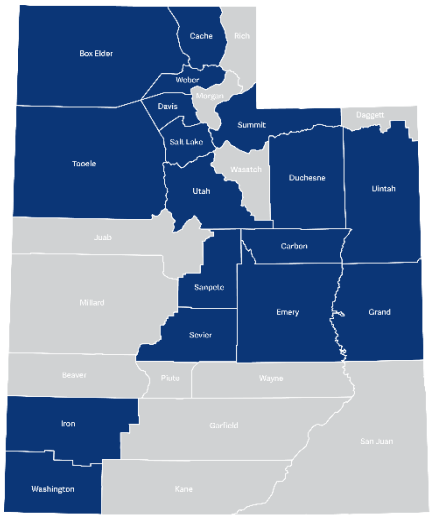
**TABLE 2. WEIGHTED SALARY CALCULATIONS**

| Discipline | DWS Salary | Reported on Personnel Rosters | BLS UT Salary | Weighted Salaries (All equally weighted) | Weighted Salaries/Hour |
|---|---|---|---|---|---|
| Developmental Specialist | $35,730 | $58,552 | $41,040 | $44,656 | $21.47 |
| Nurse | $63,570 | $77,626 | $70,370 | $69,817 | $33.57 |
| Occupational Therapist | $84,680 | $95,410 | $84,160 | $87,202 | $41.92 |
| Physical Therapist | $81,640 | $106,371 | $86,780 | $90,681 | $43.60 |
| Registered Dietician | $55,750 | $90,875 | $57,060 | $67,216 | $32.32 |
| Service Coordinator | $39,350 | $57,013 | $48,450 | $47,788 | $22.98 |
| Social Worker | $39,350 | $66,664 | $48,450 | $50,973 | $24.51 |
| Special Educator | $35,730 | $79,685 | $41,040 | $51,630 | $24.82 |
| Speech-Language Pathologist | $78,480 | $88,421 | $77,630 | $80,695 | $38.80 |
| Early Intervention Practitioner[4] | N/A | $74,880 | $58,510 | $66,695 | $32.06 |

[4] The equivalent early intervention practitioner definition used for the UT BLS salary was “Therapists, All Other,” and was equally weighted (50/50) against the single average salary of *all* early intervention direct service providers. https://www.bls.gov/oes/current/oes291129.htm

# III. Time Study Analysis

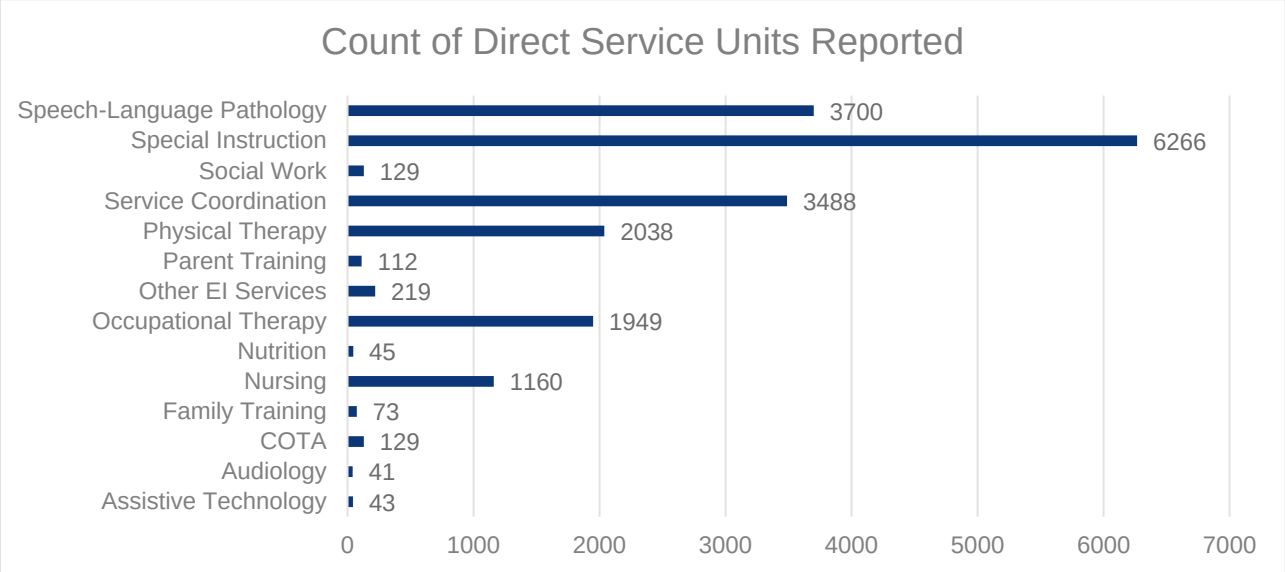
## Overall Results




Throughout April 2021, PCG engaged with Utah's early intervention direct service providers to measure time and effort of services rendered during two, two-week periods. This included staff and sub-contracted providers. Providers could choose one of the two-week periods to complete their time study. Time and services provided were self-reported by providers and reviewed by their supervisors prior to submission to PCG for analysis. Providers were expected to report their activities both," billable and non-billable," in 15-minute increments (or units) throughout their workday. There were 270 total direct service providers who participated in the study, which covered 4,887 total visits throughout the State of Utah. During this time period, PCG captured children served in 17 out of 29 counties across the state.

Overall, there were 19,392 total reported units that were identified as direct services, not inclusive of activities such as preparation time and documentation, accounting for 4,848 total hours of service provided during the four-week period. The primary services provided during this time were Special Instruction, Speech-Language Pathology, Service Coordination, Physical Therapy, Occupational Therapy, and Nursing. The total count of units reported is detailed in Figure 2.

**Figure 2: Count of Direct Service Units Reported Year/Time**



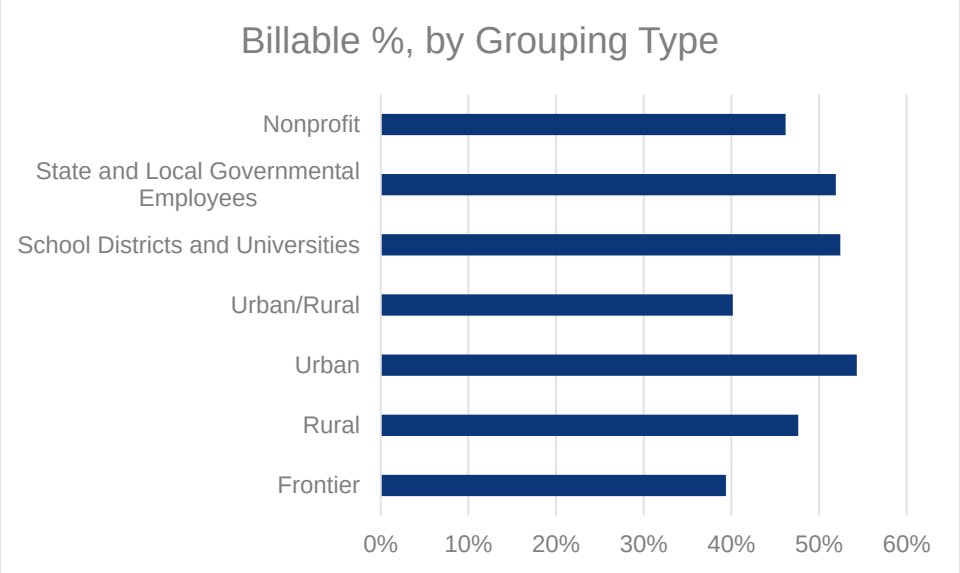

One of the primary measurements for this study that impacts a major component of our rate setting calculations (detailed in Section VI of this report) is the percent of a provider's day that is considered 'billable'. For this measurement, we defined a unit of billable time to include both the direct service with the child and family, and time spent on documentation. Documentation is often done during the service and in collaboration with the family or other team members. Table 3 describes the percentage of billable and non-billable (see description below) time by provider discipline.

### TABLE 3. PERCENT BILLABLE TO NONBILLABLE TIME BY DISCIPLINE

| Discipline | Billable | Nonbillable |
|---|---|---|
| Social Worker | 66% | 34% |
| Audiologist | 65% | 35% |
| Registered Dietician | 62% | 38% |
| Speech-Language Pathologist | 57% | 43% |
| Physical Therapist | 52% | 48% |
| Special Educator | 51% | 49% |
| Occupational Therapist | 50% | 50% |
| Nurse | 49% | 51% |
| Other Personnel | 46% | 54% |
| Developmental Specialist | 44% | 56% |
| Service Coordinator | 44% | 56% |

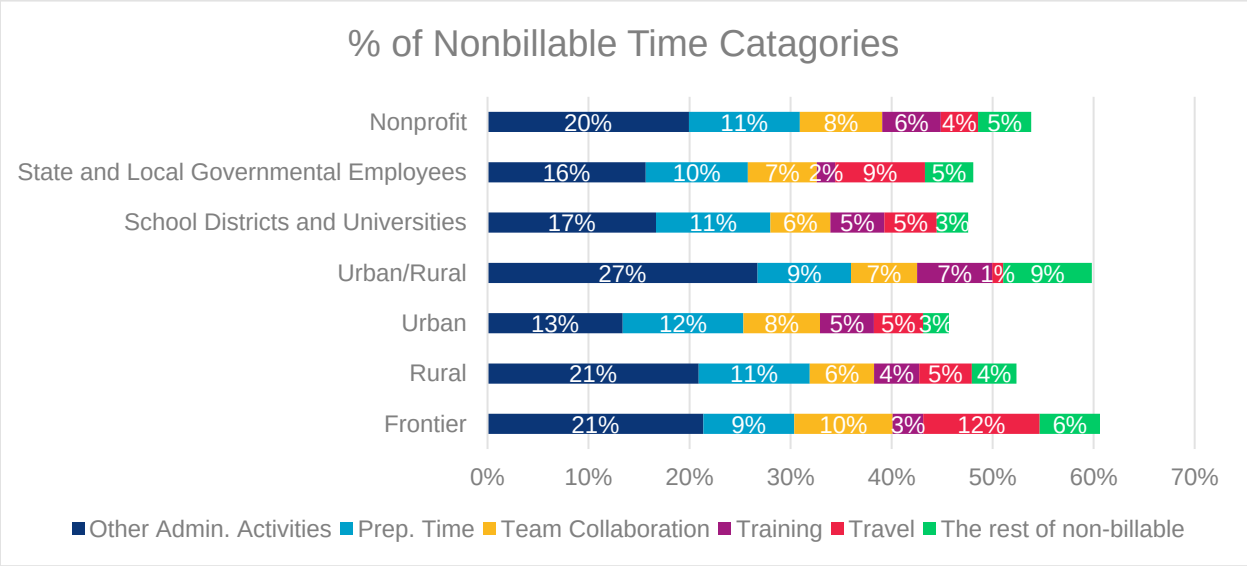
For further comparison, Figure 3 details the percentage of direct service providers' billable time on a given day by rate group (Urban, Rural, and Frontier), as well as program type (Non-profit, State and Local Government, and School Districts and Universities).

### FIGURE 3: PERCENT BILLABLE TIME BY GROUPING TYPE



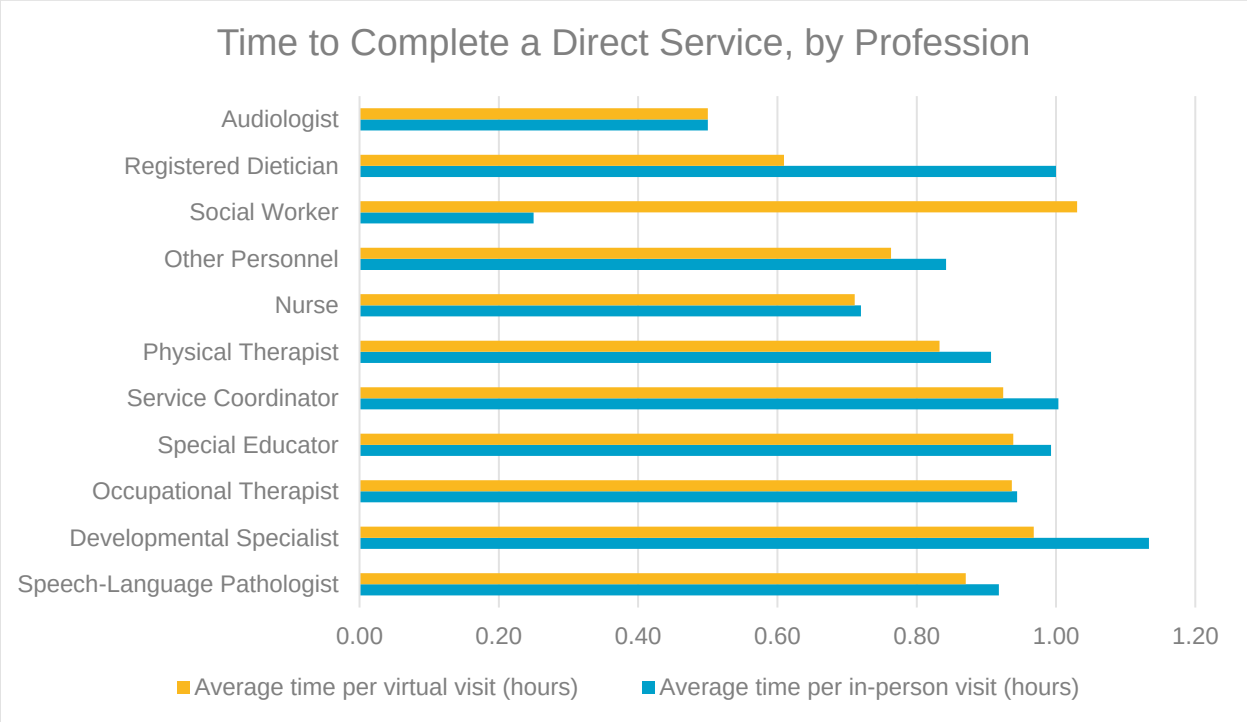

In contrast, Figure 4 further details how direct service providers reported spending non-billable time, which includes preparation time, team collaboration, professional training, travel to provide EI in the home or other community settings, other administrative activities and all leave (annual leave, holidays, sick).

**FIGURE 4: PERCENT OF NONBILLABLE TIME CATEGORIES**



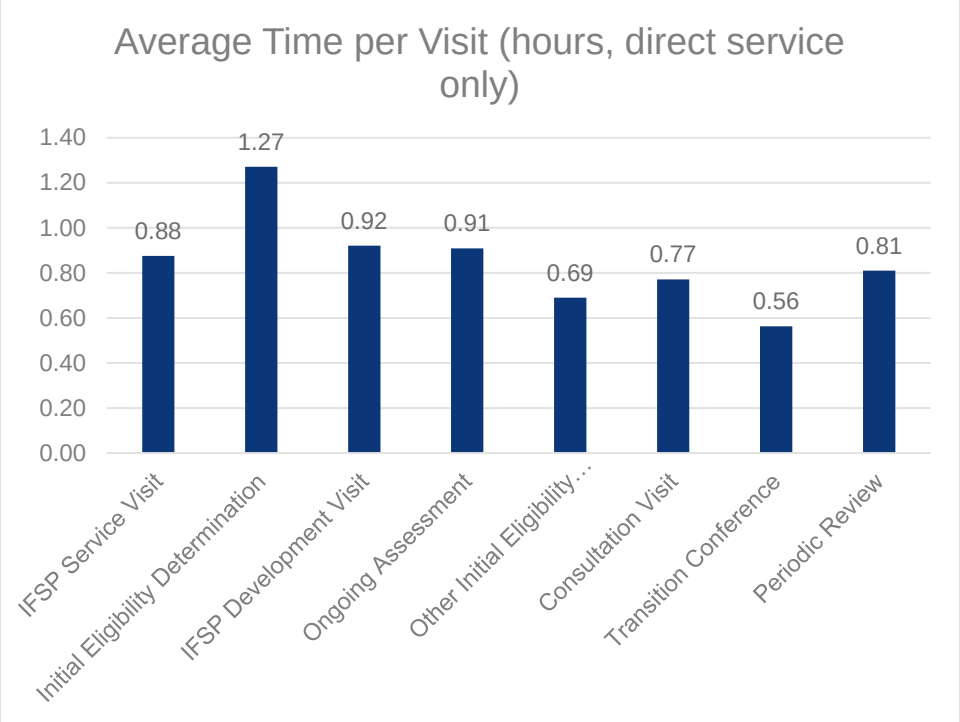

In section VI of this report, we will use the average amount of time it takes to render a service by discipline to help calculate a rate for tele-intervention services as a percentage of the time it takes to render an in-person service. Overall, for discipline types that provide the majority of early intervention services in the state, an in-person service was approximately one hour. However, tele-intervention services were generally only a few minutes shorter than their equivalent in-person service type. Figure 5 illustrates service time by profession and compares in-person visits to tele-intervention.

**FIGURE 5: TIME TO COMPLETE A DIRECT SERVICE, BY PROFESSION**



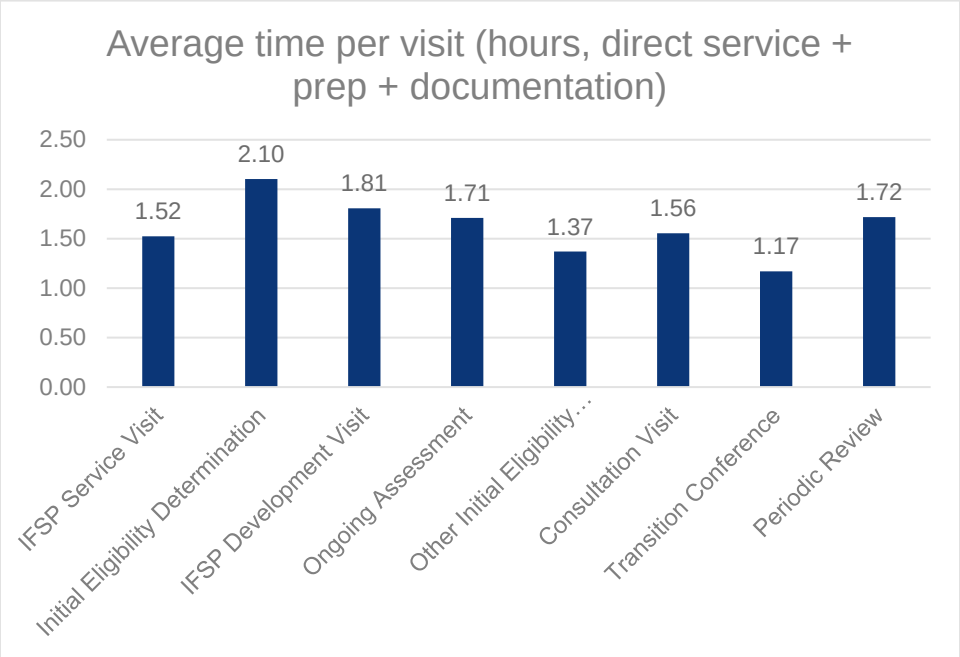
In the time study tool, we asked direct service providers to report the specific visit type being rendered for each service (e.g., IFSP Service Visit, Eligibility Determination, Transition Conference). As shown in Figure 6, IFSP Service Visits were the most common type of visit, accounting for 61% of services provided, followed by Eligibility Determinations, accounting for 12% of services. Please note that the initial IFSP meeting and annual IFSP meeting visits are included under IFSP development visit.

**FIGURE 6: AVERAGE TIME PER VISIT (SERVICE VISIT ONLY)**




When we include additional time that supports a visit (e.g., preparation time and documentation), service increases approximately 52%, with a range of 47- 60 percent, depending on visit type, as shown in Figure 7.

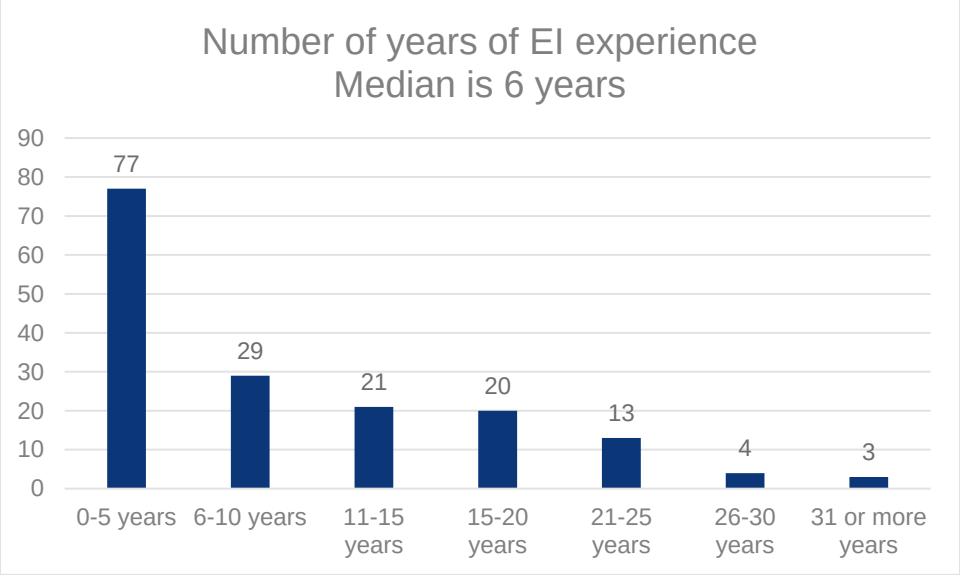
**FIGURE 7: AVERAGE TIME PER VISIT (INCLUSIVE OF PREP) (HOUR)**




***Direct Service Provider Demographics***

Providers completing the time study were asked to respond to demographic questions relating to their experience and education. Based on the information we received, the median number of total years of early intervention-specific experience is six years. This is illustrated in the Figure 8.

**FIGURE 8: NUMBER OF YEARS OF EI EXPERIENCE**



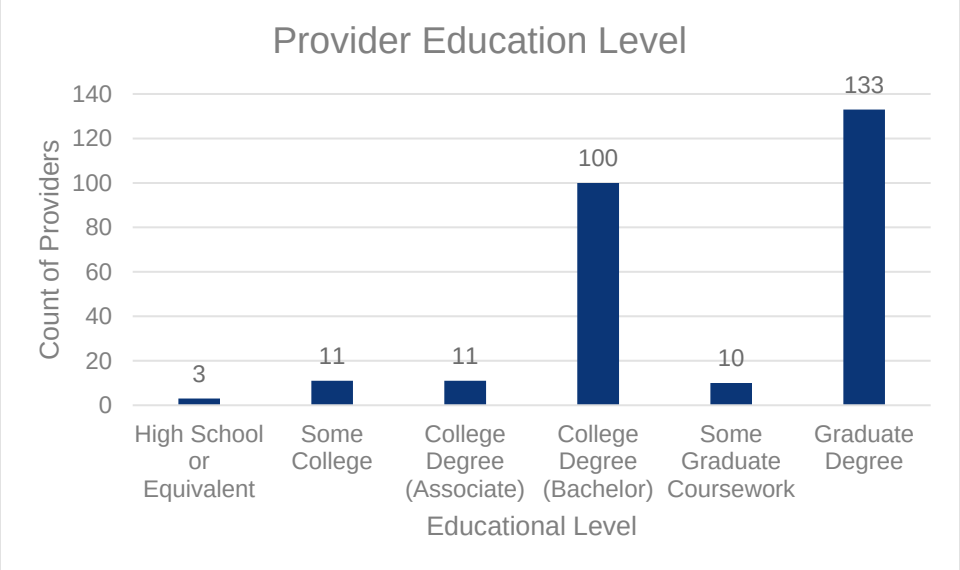

As shown in Table 4, the distribution of years of early intervention experience is most concentrated in the more specialized provider disciplines, such Occupational Therapy and Physical Therapy.

**TABLE 4: AVERAGE YEARS OF EI EXPERIENCE BY DISCIPLINE**

| Number of Years of EI experience | Count | Avg Years of EI Experience |
|---|---|---|
| All Direct Service Providers who Completed Time Study | 270 | 9.5 |
| Developmental Specialist | 54 | 9.0 |
| Speech-Language Pathologist | 47 | 8.9 |
| Service Coordinator | 33 | 8.0 |
| Occupational Therapist | 29 | 12.7 |
| Physical Therapist | 29 | 13.2 |
| Special Educator | 28 | 9.4 |
| Nurse | 23 | 6.9 |
| Other Personnel | 19 | 7.1 |
| Social Worker | 2 | 9.5 |
| Registered Dietician | 1 | 0.5 |
| Child Developmental Specialist | 1 | 5.0 |
| Audiologist | 1 | 16.0 |

In terms of provider education, most direct service providers either had a four-year degree (37%) or a graduate degree (50%), indicating EI direct service providers in Utah have a high level of education. The distribution of education is illustrated in Figure 9.

**FIGURE 9: PROVIDER EDUCATION**



## Overview of Information Gathered for In-Person Services

### Focus Groups

In recognition of the potential variations time study results can produce, PCG hosted three focus groups with service coordinators, direct service providers, and evaluation and assessment team members who could validate time study findings based on discipline expertise. The focus groups were conducted between April 6, 2021, and April 9, 2021. PCG leveraged an online video conferencing tool, Microsoft Teams, and each focus group lasted one hour.

#### Direct Service Providers

A representative sample of eight direct EI service providers attended each focus group, two from urban programs, two from rural programs, and four from frontier programs.

Multiple participants indicated the travel times captured in the time study seemed low. One participant noted they *"found it interesting that rural [direct service providers] spend less time traveling than urban [direct service providers]."* Frontier participants mentioned the notable difference season changes have on travel times, as tourists visiting the area heavily influence the flow of traffic.

Table 5 details the participants' estimated hours per day spent on three primary tasks including travel, documentation, and service provision.

**Table 5: Direct Service Provider Estimated Hours Per Day Per Task**

| | Direct Service Providers: Estimated Hours per Day per Task | Urban | Frontier | Rural |
|---|---|---|---|---|
| Task | Travel Time | 3 hours | 2-4 hours | .5-1 hour |
| | Documentation | N/A[5] | 2.5-3.5 hours | N/A |
| | Providing Services | 5-6 hours | 3-7 hours | 5-6 hours |

The discussion with this focus group hovered primarily on travel time. Rural and frontier programs indicated they often drive 70 to 100 miles, or more, each day. One participant indicated one child resulted in 270 miles per day for a client that was 130 miles away, one way. Urban participants noted that the time study travel time numbers were comparable, as they can drive anywhere from 30 to 60 (or more) miles per day.

#### Evaluation and Assessment Team

A sample of seven evaluation and assessment team members attended the focus group, with four from urban programs and three from frontier programs. Rural program representatives were not able to attend this focus group.

Participants discussed how their programs approach evaluations and assessments. There was relative consensus that assessments and evaluations fall within the 1–2-hour range, regardless of program or program location. Participants noted that discussion with parents/caregivers is an important factor that takes time during the assessment.

[5] Urban and rural providers in this group indicated that they included documentation as part of providing services.

Table 6 details the participants' estimated hours per day spent on the three primary tasks of travel, documentation, and conducting assessments and evaluations. Line items were added for nurse assessments and specialists' assessments for additional time considerations.

**TABLE 6: ASSESSMENT ESTIMATED HOURS PER DAY PER TASK**

| | Evaluation/Assessment Team: Estimated Hours per Day per Task | Urban | Frontier | Rural |
|---|---|---|---|---|
| Task | Travel Time | 1-2 hours | .5-3.5 hours | |
| | Documentation | .5-1 hours | .5-.75 hours | |
| | Assessments/Evaluations | 1-2 hours | 1-2 hours | |
| | Nurse Assessments | .5-1 hours | .5-.75 hours | |
| | Specialist Assessments (as needed) | .5-.75 hours | .5-.75 hours | |

There was a general consensus around the dedicated time for documentation and reporting after the assessment and evaluation. Some participants indicated they do most of this by hand while others mentioned using a tablet or digital tool. The participants who use the tool mentioned they felt the digital tool saved them documentation and reporting time.

### *Service Coordination*

A sample of eight service coordinators participated in the focus group, with three from urban programs, two from rural programs, and two from frontier programs.

Attendees indicated the time study was comparable to their perspective and experience, however, they felt the time study could not easily capture those who hold dual roles as both a service coordinator and a service provider. Table 7 details the participants' estimated hours per day spent on the three primary tasks of travel, documentation, and providing services.

**TABLE 7: SERVICE COORDINATOR ESTIMATED HOURS PER DAY PER TASK**

| | Service Coordinators: Estimated Hours per Day per Task | Urban | Frontier | Rural |
|---|---|---|---|---|
| Task | Travel Time | 1-2 hours | 2-2.5 Hours | 1-1.5 hours |
| | Documentation | 4-5 hours | 4-5 hours | 4-5 hours |
| | Providing Services | N/A | 3-4 hours | 3-4 hours |

The times provided by participants were mostly consistent across areas, with the main variance being slightly higher travel times for frontier direct service providers.

Due to the COVID-19 pandemic, PCG used this anecdotal information from direct service providers to help inform rate setting later in this report. This information was used to define new rate modifiers by rate group, as well as information gathered from time studies of direct service providers who delivered services in-person.

# IV. Cost Report Analysis

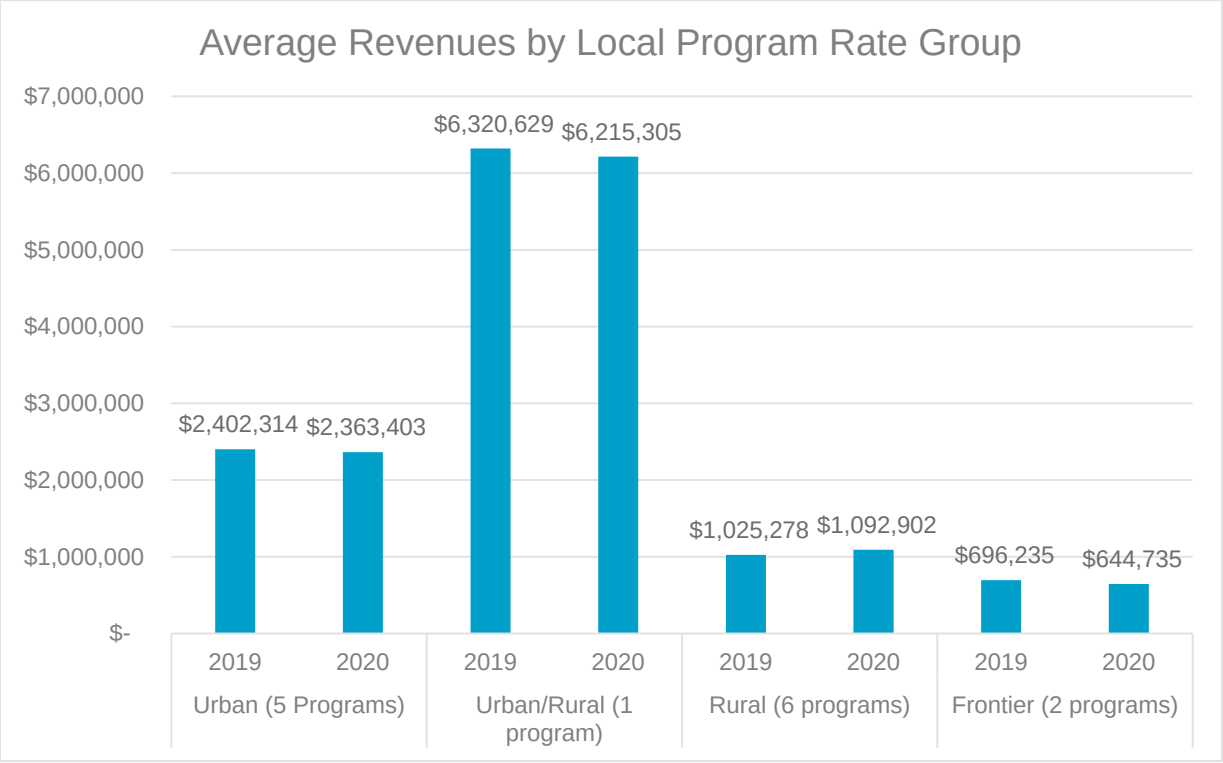
## Revenue Analysis

### *Analysis of Total Revenues*

Total revenues reported for all EI programs totaled $25.876 million in FY2019 and $25.879 million in FY2020, representing a minimal year-over-year increase in revenues.

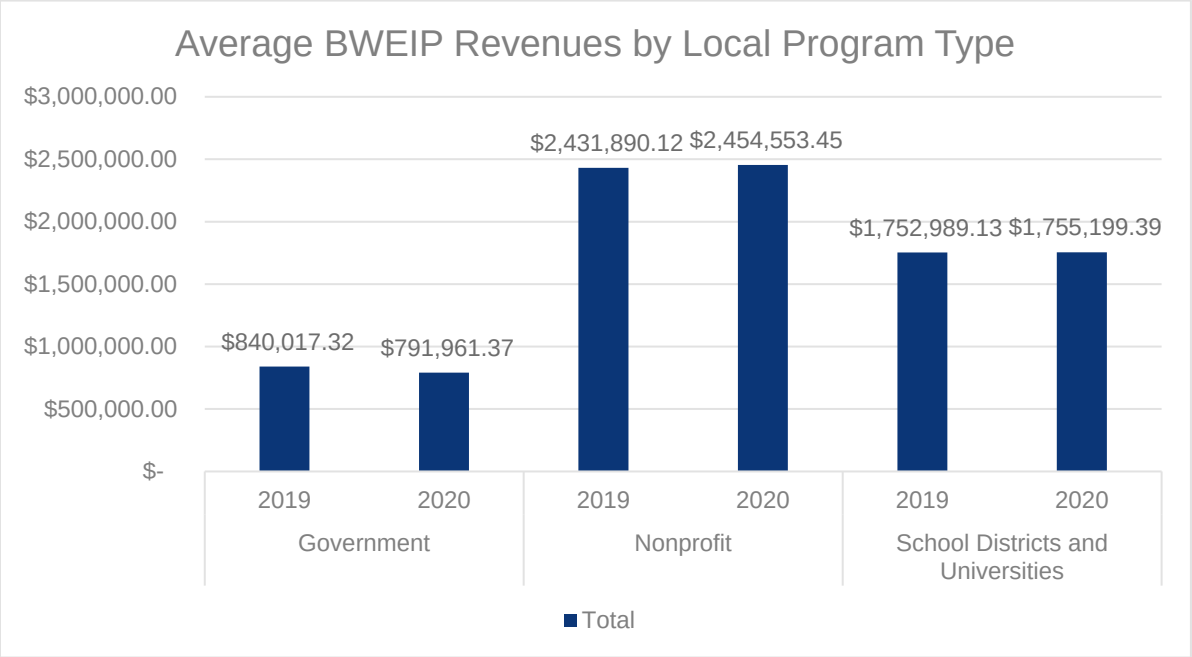
When examining average local EI program revenues by local EI program rate group (urban, rural, or frontier), most programs range in revenue between $600,000 and $2.4 million per year. This is excluding one local EI program that operates in both urban and rural rate groups and has a significantly larger amount of annual revenue. Note: Local EI programs vary in the geographical area (one or more counties) and the number of eligible children and families served. This is illustrated in Figure 10.

**Figure 10: Average Annual Revenue By Local Program Rate Group**




When comparing local EI programs by local EI program type (i.e., government, school districts and universities, and nonprofit), government programs received an average of $820 thousand in annual revenue, while nonprofit local EI programs on average received about $2.1 million, and school districts and universities received about $1.7 million (note that this disparity can be attributed to the total number of children these different programs are serving). This is illustrated in Figure 11.

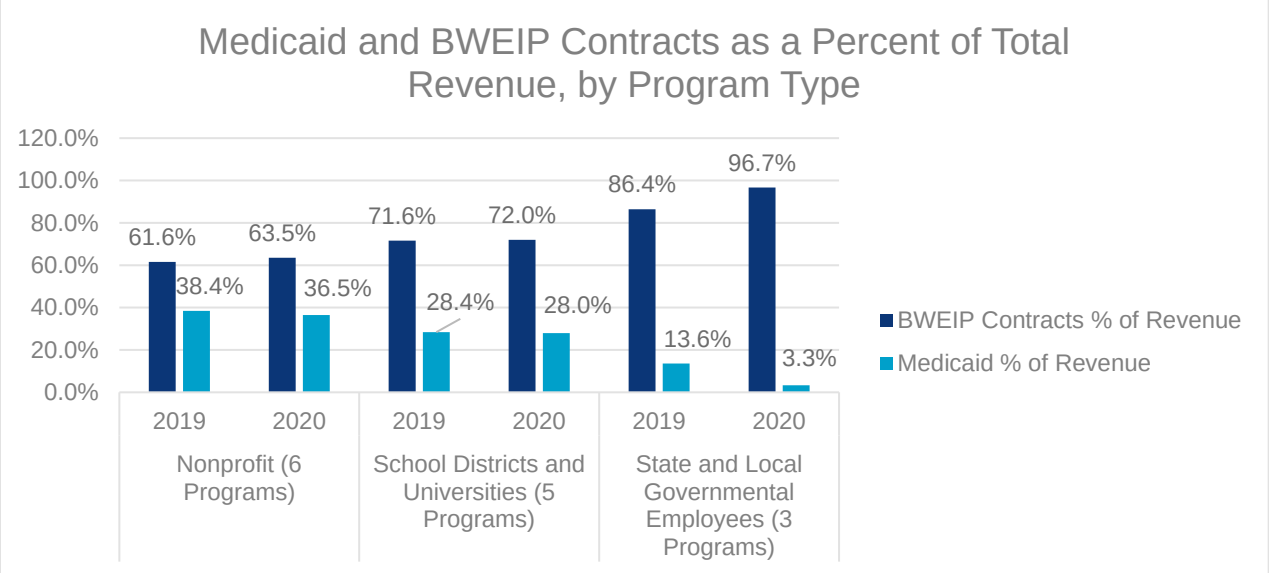
**FIGURE 11: AVERAGE ANNUAL REVENUE RECEIVED BY EI PROGRAM TYPE**




## *Analysis of Types of Revenues*

When reviewing BWEIP contract revenues and Medicaid revenues, government programs tend to have a slightly higher percentage of revenue from BWEIP contracts than non-profit, school districts, and university programs. However, FY2019 data may be slightly skewed as one government local EI program (Weber-Morgan) had no data on Medicaid revenues to report.[6] Figure 12 shows the change between FY2019 and FY2020.

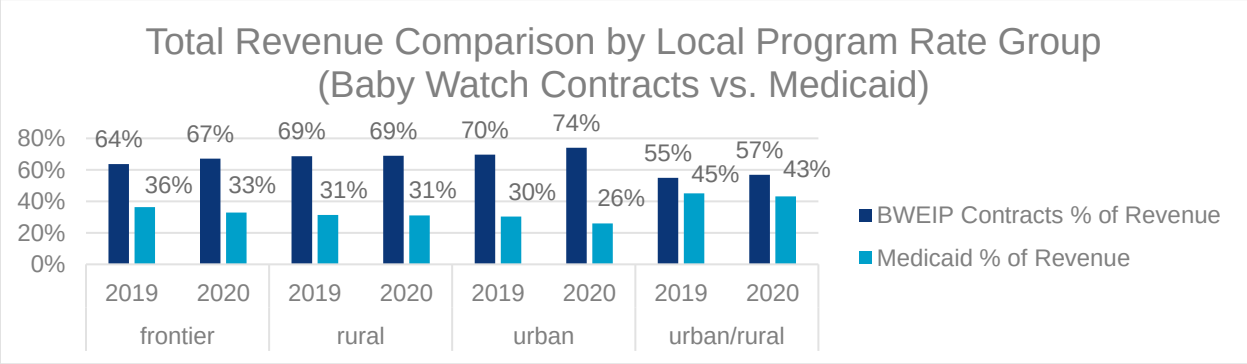
**FIGURE 12: ANNUAL PERCENTAGE OF BABY WATCH TO MEDICAID REVENUE BY LOCAL EI PROGRAM TYPE**




[6] Records on Medicaid billing were not retained by the Weber-Morgan School District before Weber-Morgan's transition to direct administration by BWEIP.

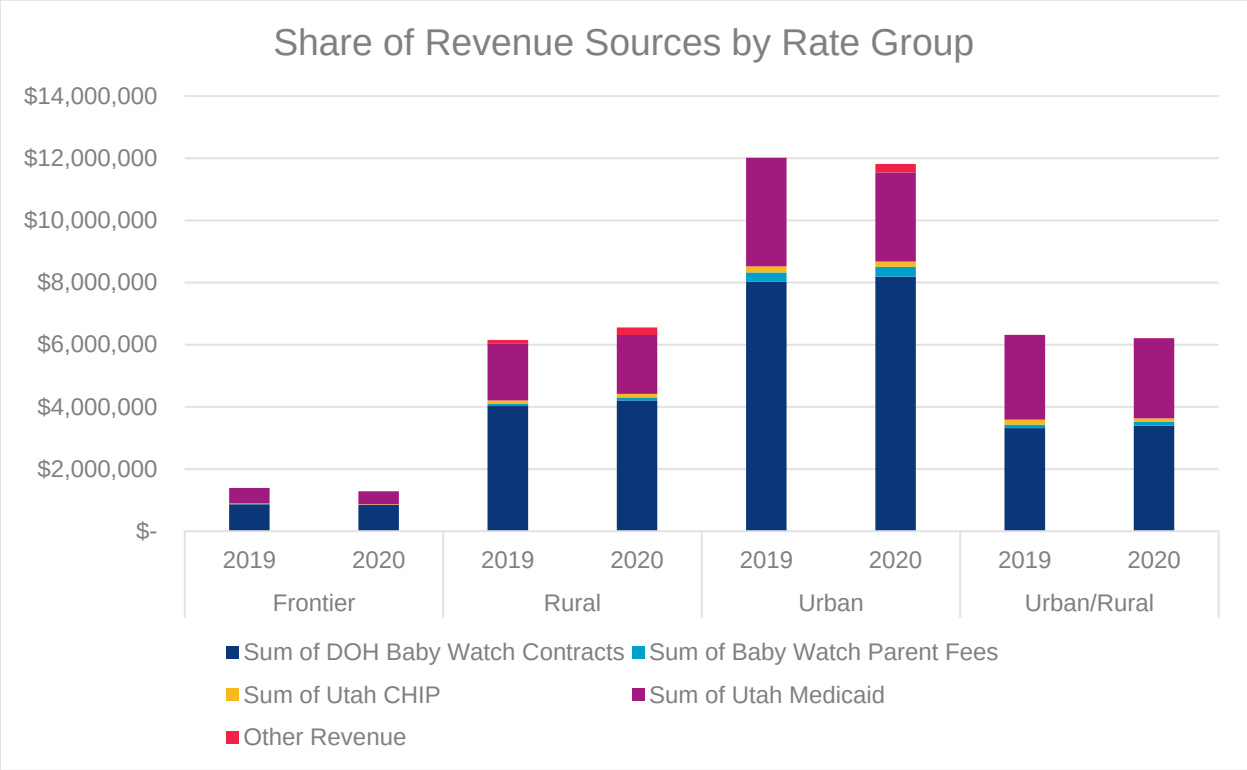
By local EI program rate group, urban, rural, and frontier local EI programs are comparable in that Medicaid makes up about 30% of total revenue between these two sources. Figure 13 shows the change between FY2019 and FY2020.

**FIGURE 13: TOTAL ANNUAL REVENUE COMPARISON BY LOCAL PROGRAM RATE GROUP**




When looking at all revenue sources contributing to Baby Watch Early Intervention Program revenues (e.g., BWEIP contracts, parent fees, Utah CHIP, Medicaid, and other revenues), Baby Watch contract funds and Medicaid make up the greatest majority of revenues for local EI programs in all rate groups. Urban local EI programs constitute the largest amount of Baby Watch related revenues in the state, about $12 million, while frontier local EI programs are the smallest, about $1.5 million. This is illustrated in Figure 14.

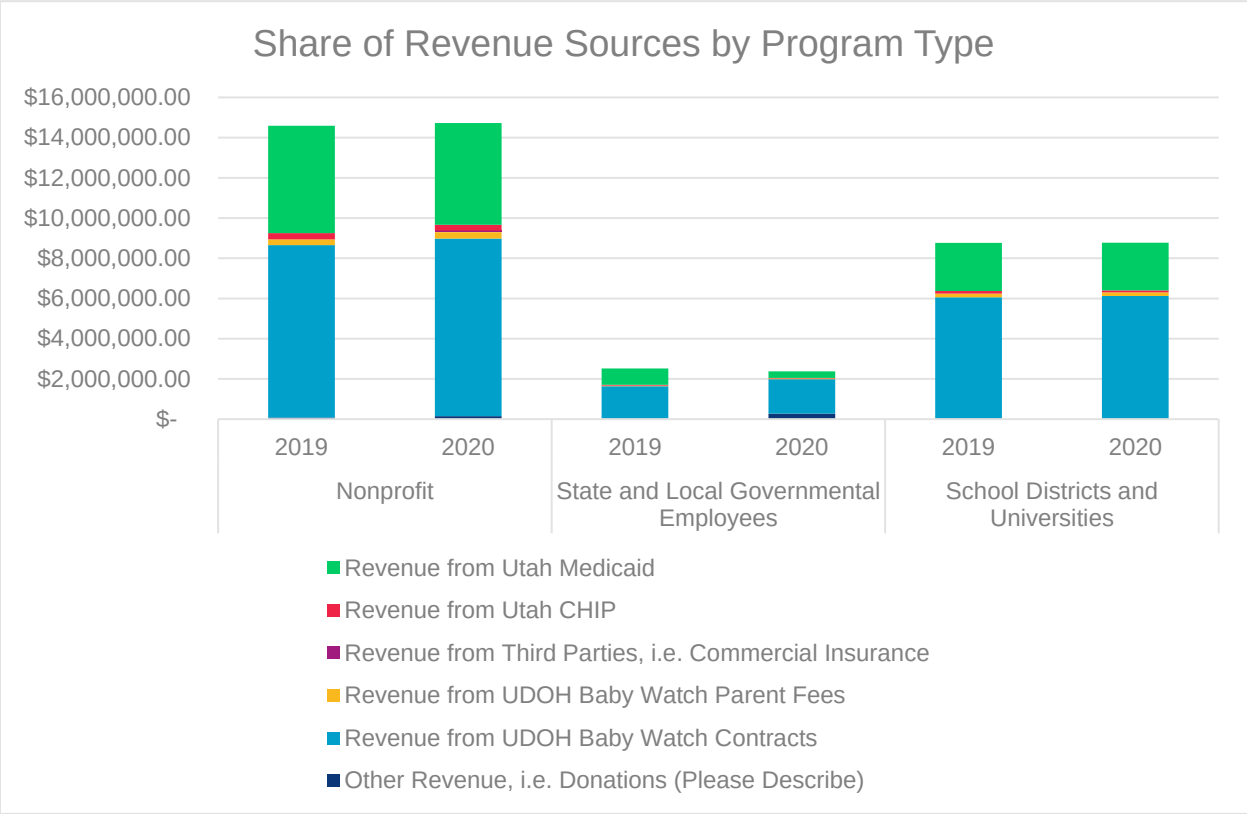
**FIGURE 14: ANNUAL BREAKDOWN OF REVENUE SOURCES BY RATE GROUP**




As shown in Figure 15, nonprofit local EI programs account for a much larger amount of revenue when compared to government local EI programs, about $17.5 million compared to about $2 million. School districts and universities split the difference at around $9 million. Baby Watch contracts and Medicaid are

the largest sources of revenue, though Medicaid dollars make up a larger proportion of revenues in nonprofits and school districts and universities, than in government local EI programs.

**FIGURE 15: ANNUAL BREAKDOWN OF REVENUE SOURCES BY PROGRAM TYPE**




In a more detailed view, Table 8 displays at the program-level the ratios to which various revenue sources make up total BWEIP revenues.

**TABLE 8: BWEIP REVENUE SOURCE RATIOS BY PROGRAM**

| Program | Detailed Program Type | Year | Other Revenue | UDOH Baby Watch Contracts | Baby Watch Parent Fees | Utah CHIP | Utah Medicaid |
|---|---|---|---|---|---|---|---|
| Central Utah Health Department | G | 2019 | 0.0% | 68.9% | 0.0% | 1.5% | 29.6% |
| Central Utah Health Department | G | 2020 | 1.1% | 67.6% | 0.6% | 2.0% | 28.7% |
| Davis School District Early Childhood Program | S | 2019 | 0.0% | 71.2% | 0.0% | 1.2% | 27.6% |
| Davis School District Early Childhood Program | S | 2020 | 0.0% | 72.9% | 0.0% | 1.0% | 26.1% |
| DDI Vantage | NP | 2019 | 0.1% | 52.5% | 1.8% | 2.5% | 43.1% |
| DDI Vantage | NP | 2020 | 0.1% | 54.6% | 2.0% | 1.8% | 41.5% |
| Jordan Child Development Center | S | 2019 | 0.0% | 68.2% | 4.2% | 1.4% | 26.2% |
| Jordan Child Development Center | S | 2020 | 0.0% | 70.1% | 4.1% | 1.1% | 24.7% |
| Kids on the Move | NP | 2019 | 0.0% | 70.2% | 3.2% | 1.8% | 24.8% |
| Kids on the Move | NP | 2020 | 0.0% | 70.5% | 3.6% | 1.7% | 24.2% |
| Kids Who Count | NP | 2019 | 2.0% | 63.0% | 2.0% | 2.9% | 30.0% |
| Kids Who Count | NP | 2020 | 8.1% | 59.3% | 2.0% | 1.4% | 29.3% |
| PrimeTime 4 Kids | NP | 2019 | 5.0% | 74.1% | 0.0% | 0.0% | 20.9% |

| Program | Detailed Program Type | Year | Other Revenue | UDOH Baby Watch Contracts | Baby Watch Parent Fees | Utah CHIP | Utah Medicaid |
|---|---|---|---|---|---|---|---|
| PrimeTime 4 Kids | NP | 2020 | 3.2% | 74.2% | 0.8% | 0.7% | 21.0% |
| Provo Early Intervention Program | NP | 2019 | 0.0% | 48.7% | 1.2% | 2.0% | 48.0% |
| Provo Early Intervention Program | NP | 2020 | 0.0% | 53.2% | 1.3% | 2.8% | 42.8% |
| Root for Kids | NP | 2019 | 0.0% | 51.3% | 1.1% | 1.9% | 45.7% |
| Root for Kids | NP | 2020 | 0.0% | 58.7% | 1.3% | 3.5% | 36.6% |
| South East Early Intervention Program | S | 2019 | 0.0% | 58.2% | 0.3% | 1.8% | 39.8% |
| South East Early Intervention Program | S | 2020 | 0.0% | 64.5% | 0.3% | 0.7% | 34.4% |
| Southern Utah University EI | S | 2019 | 1.9% | 70.2% | 1.0% | 2.1% | 24.8% |
| Southern Utah University EI | S | 2020 | 0.0% | 56.8% | 1.0% | 2.0% | 40.2% |
| Summit County Early Intervention | G | 2019 | 0.0% | 72.8% | 2.1% | 1.3% | 23.7% |
| Summit County Early Intervention | G | 2020 | 0.0% | 80.8% | 1.8% | 0.7% | 16.7% |
| Up to 3 Early Intervention | S | 2019 | 1.4% | 71.7% | 1.5% | 1.5% | 24.0% |
| Up to 3 Early Intervention | S | 2020 | 0.9% | 70.9% | 1.6% | 1.3% | 25.2% |
| Weber-Morgan Early Intervention | G | 2019 | 0.0% | 62.5% | 1.4% | 1.7% | 34.3% |
| Weber-Morgan Early Intervention | G | 2020 | 17.6% | 71.8% | 1.8% | 0.8% | 8.0% |

## Expense Analysis

PCG collected expense data for fiscal years FY2019 and FY2020 from local EI programs using the Cost Report tool. Local EI programs were requested to complete this report in October FY2020.

Each local EI program was requested to provide expense data for its entire agency, including all programs operated by its agency, as well as data for the Baby Watch EI program only. The purpose of this distinction was to determine whether local EI programs were operating EI services at a loss, and therefore supplementing Baby Watch funding through revenues from other programs operated and services provided.

Many local EI programs did not provide total program expenses. Rather, most programs provided expense data related to their early intervention program only. There are a number of limitations to being able to provide this information, such as the total program expenses for a school district or university dwarfing EI expenses and not being available to EI program managers. In this case, this information would ultimately not be relevant or helpful to the analysis. Therefore, PCG focused its analysis on early intervention costs.

### *Analysis of Salaries and Personnel Costs*

Local EI programs reported that direct service EI personnel and administrative personnel expenses were on average 89% of the total expenses for operating EI programs and services.

Figure 16 shows average annual personnel expenses for government and nonprofit programs in FY2019 and FY2020. Personnel costs include both annual salaries and fringe benefits for direct and administrative personnel. As illustrated below, school districts and university programs only reported early intervention data. Average EI personnel expenses for those programs was around $1,600,000 for both FY2019 and FY2020.

For nonprofit local EI programs, average total EI personnel expenses were approximately $2,410,000 for both fiscal years and $725,000 for government programs. These data also suggest that programs did not make personnel changes by FY2020 fiscal year end, despite many service delivery adjustments due to COVID-19. Based on conversations with local EI program staff who are members of this project's Steering Committee, local EI programs were reluctant to make personnel changes in the last quarter of FY2020 due to the uncertain nature of the pandemic. Local EI programs were initially hopeful to return to in-person visits within a few months of the pandemic onset and were hesitant to make personnel changes that could leave them without the necessary staff to support returning to in-person visits.

**FIGURE 16: AVERAGE ANNUAL PERSONNEL EXPENSES BY PROGRAM TYPE YEAR**

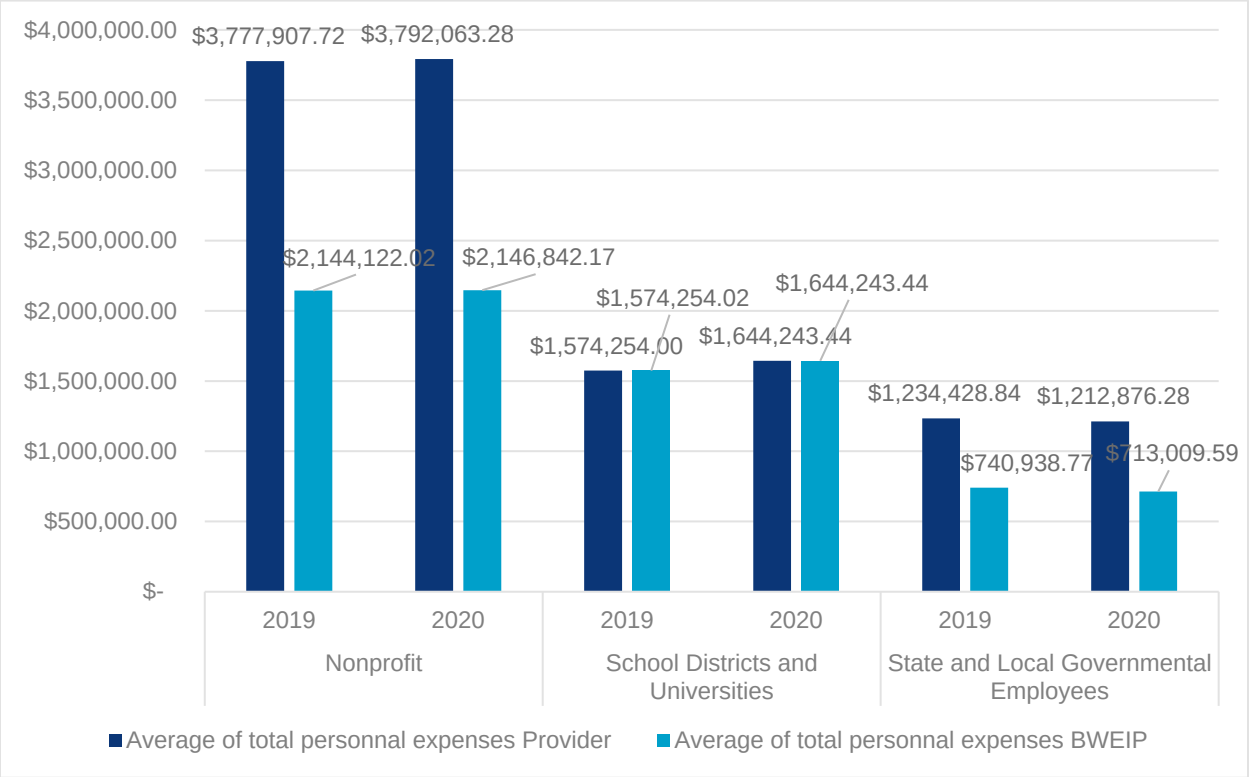



Figure 17 compares average administrative and direct service salaries among the various rate group types. Salaries paid by local EI programs in urban areas are higher for both administrative and direct EI staff than salaries in other rate groups. In FY2020 salaries paid by urban EI programs on average were $60,990 compared to salaries of $42,351 for rural and $50,502 for frontier (i.e., average urban salaries are 30.6% higher than average rural salaries and 17.2% higher than average frontier salaries).

The rural rate group, on the other hand, shows the lowest average salaries for administrative and direct service staff. Based on PCG's provider interviews earlier in the year, staff retention is a challenge for many rural programs due to low salaries.

**FIGURE 17: AVERAGE ANNUAL EI SALARIES BY RATE GROUP YEAR**

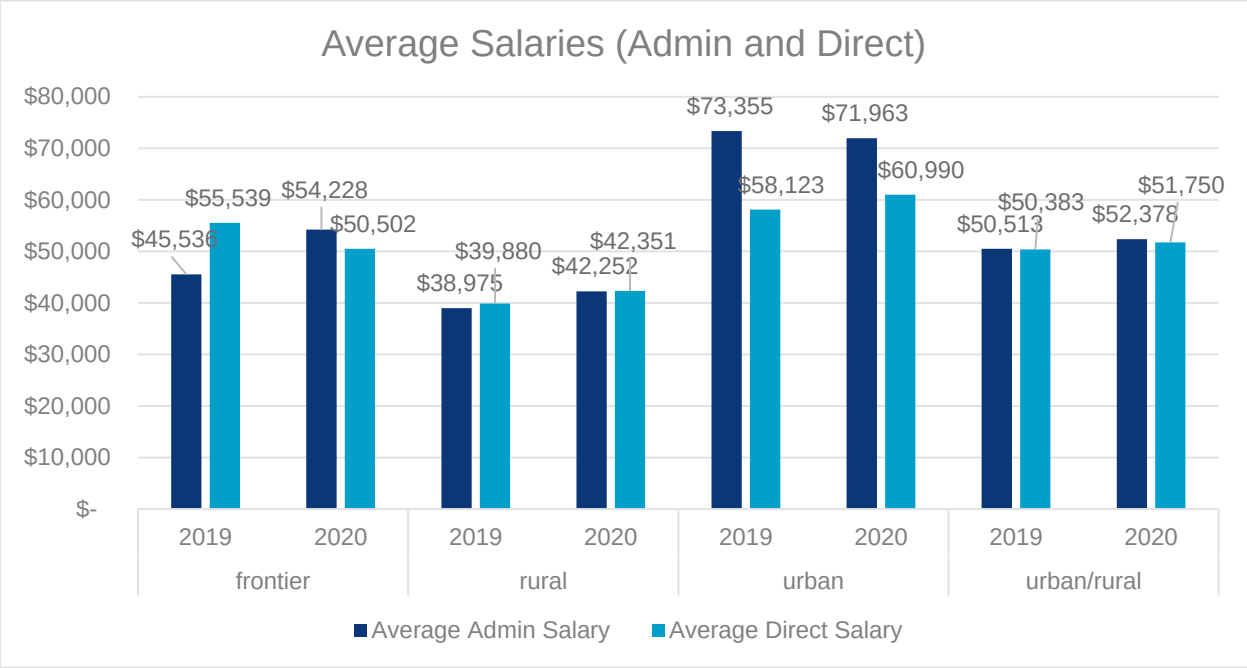
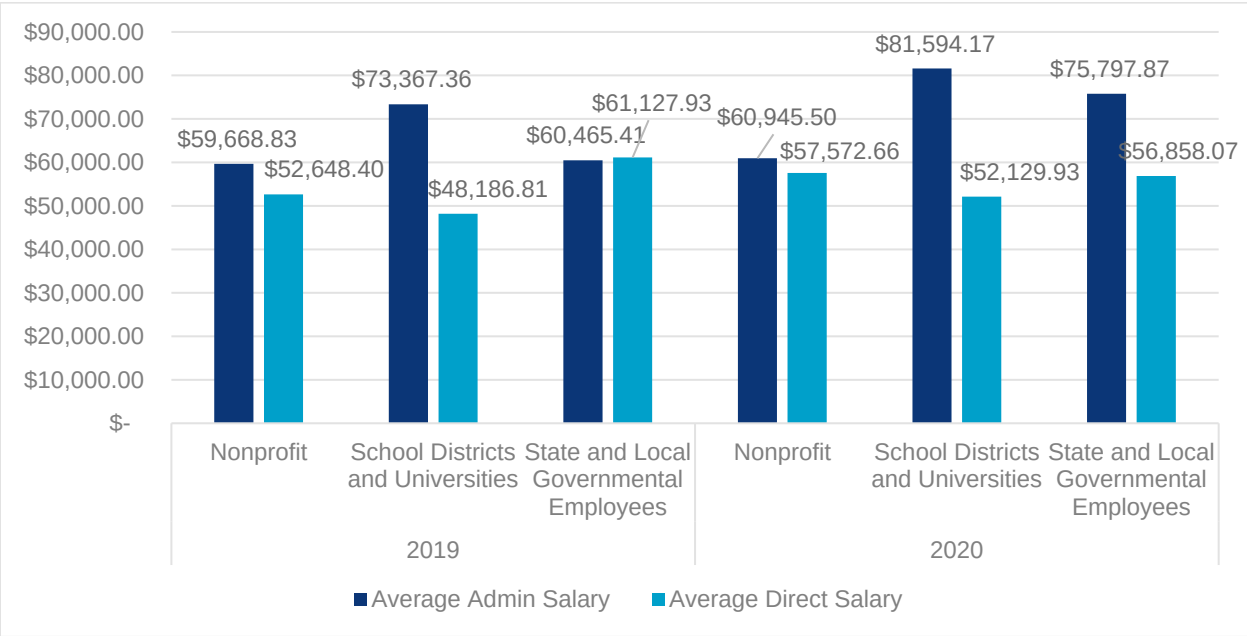



Figure 18 shows average annual salary data for administrative and direct service staff by program type. In FY2019, nonprofit salaries for administrative staff were comparable to governmental staff, while school district and university administrative salaries were about 20% higher than other programs. In FY2020, administrative salaries rose for both school districts and universities and government programs.

Direct EI service staff salaries were more consistent across all the program types, ranging from $48,186 to $57,572 over the two fiscal years. Generally speaking, nonprofit and government programs tended to pay staff more than school district and university programs.

**FIGURE 18: AVERAGE ANNUAL EARLY INTERVENTION SALARIES YEAR**



Fringe benefits as a percentage of total EI personnel expenses are shown in Figure 19. For the purpose of the below analysis, fringe benefits include personnel taxes, workers' compensation, healthcare, retirement, and contract personnel expenses. Overall, government local EI programs show higher fringe benefits as a percentage of personnel costs.

From FY2019 to FY2020, fringe benefit expenses for government EI programs increased by 6%, while school districts and universities and nonprofits decreased by 1% and 3%, respectively.

**FIGURE 19: AVERAGE PERCENTAGE OF EI FRINGE BENEFITS BY PROGRAM TYPE YEAR?**

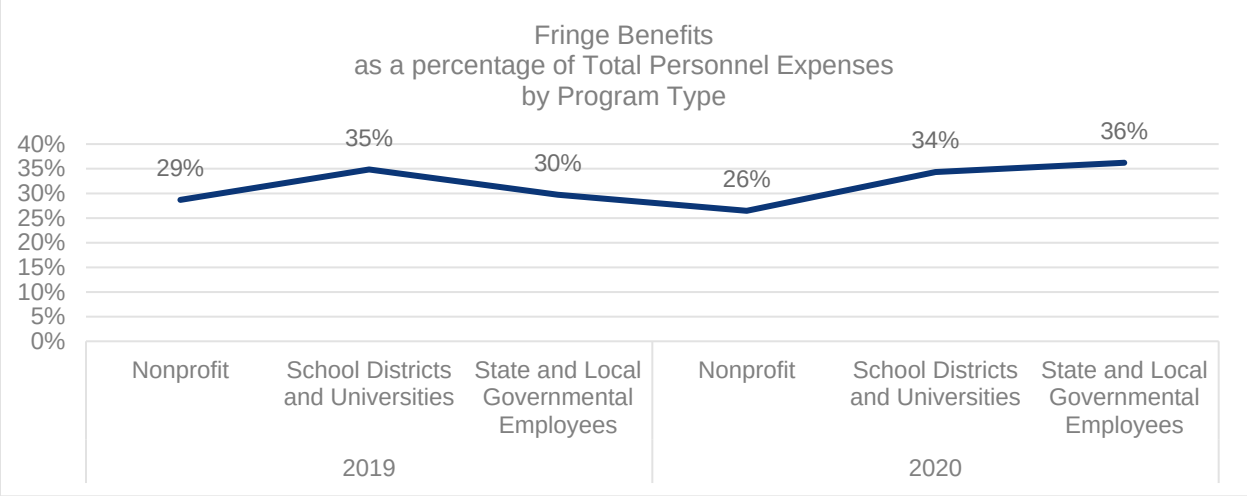



Figure 20 shows fringe benefits as a percentage of total EI personnel expenses by rate group. The frontier, rural, and urban/rural rate groups were similar in this area, maintaining fringe benefits of around 30%-32% without significant change from FY2019 to FY2020.

The urban rate group shows the lowest fringe benefit percentage with 25% in FY2019 and 27% in FY2020.

**FIGURE 20: AVERAGE ANNUAL FRINGE BENEFITS BY RATE GROUP YEAR**

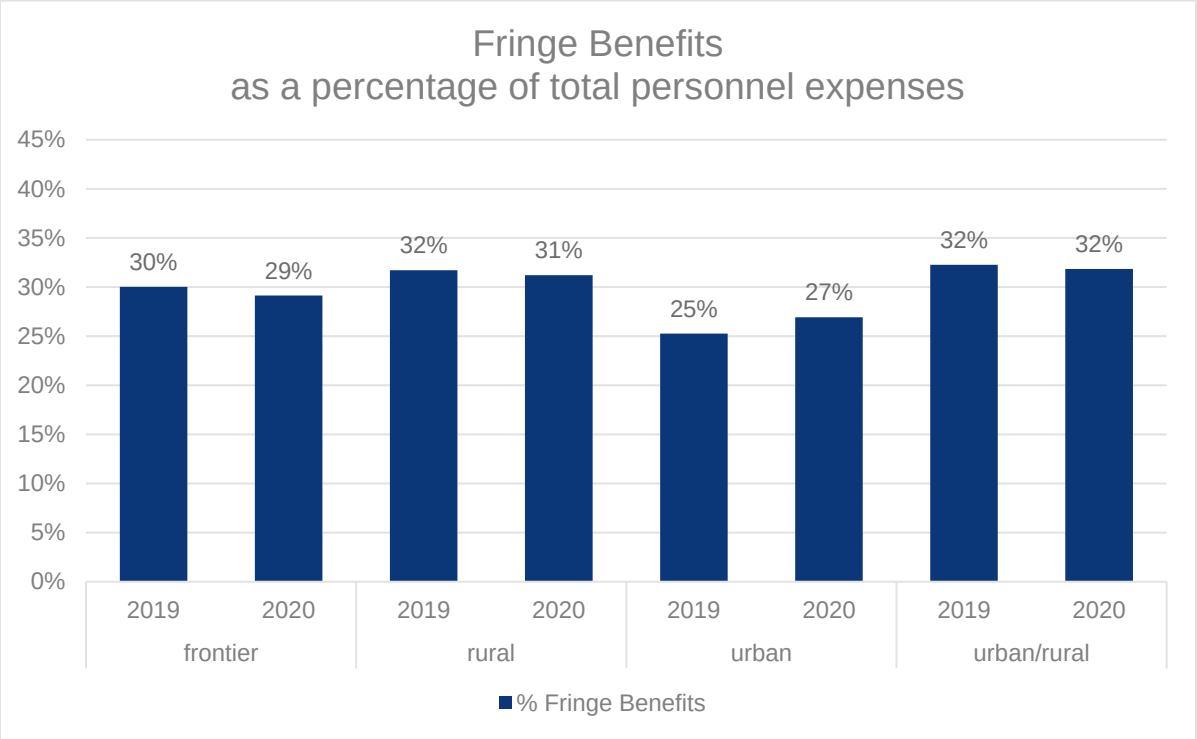



Table 9 details at a per-program level the average salaries, fringe, and total expenses per direct provider staff.

**TABLE 9. AVERAGE PER DIRECT PROVIDER STAFF SALARY AND FRINGE BY EI PROGRAM**

| Program | Detailed Program Type | Fiscal Year | Average Direct Provider Salary | Average Fringe Benefits | Average Total Personnel Expenses Per Staff |
|---|---|---|---|---|---|
| Central Utah Health Department Early Intervention | G | 2019 | $ 90,918.29 | $ 42,536.67 | $ 133,454.96 |
| Central Utah Health Department Early Intervention | G | 2020 | $ 89,632.57 | $ 52,469.12 | $ 142,101.69 |
| Davis School District Early Childhood Program | S | 2019 | $ 65,905.12 | $ 34,840.26 | $ 100,745.37 |
| Davis School District Early Childhood Program | S | 2020 | $ 70,251.19 | $ 38,563.37 | $ 108,814.56 |
| DDI Vantage | NP | 2019 | $ 50,382.93 | $ 24,050.31 | $ 74,433.24 |
| DDI Vantage | NP | 2020 | $ 51,749.76 | $ 24,302.23 | $ 76,051.99 |
| Jordan Child Development Center | S | 2019 | $ 53,308.18 | $ 23,669.16 | $ 76,977.34 |
| Jordan Child Development Center | S | 2020 | $ 62,994.78 | $ 25,957.61 | $ 88,952.40 |
| Kids on the Move | NP | 2019 | $ 53,970.86 | $ 14,781.97 | $ 68,752.83 |
| Kids on the Move | NP | 2020 | $ 61,881.19 | $ 15,924.16 | $ 77,805.35 |
| Kids Who Count | NP | 2019 | $ 57,768.81 | $ 17,699.96 | $ 75,468.77 |
| Kids Who Count | NP | 2020 | $ 58,102.21 | $ 17,064.63 | $ 75,166.84 |
| PrimeTime 4 Kids | NP | 2019 | $ 59,725.17 | $ 55,349.50 | $ 115,074.67 |
| PrimeTime 4 Kids | NP | 2020 | $ 84,208.00 | $ 54,560.20 | $ 138,768.20 |
| Provo Early Intervention Program | NP | 2019 | $ 52,111.00 | $ 9,894.60 | $ 62,005.59 |
| Provo Early Intervention Program | NP | 2020 | $ 53,548.49 | $ 10,700.61 | $ 64,249.11 |

| Program | Detailed Program Type | Fiscal Year | Average Direct Provider Salary | Average Fringe Benefits | Average Total Personnel Expenses Per Staff |
|---|---|---|---|---|---|
| Root for Kids | NP | 2019 | $ 41,931.64 | $ 19,163.58 | $ 61,095.23 |
| Root for Kids | NP | 2020 | $ 35,946.32 | $ 16,290.70 | $ 52,237.02 |
| South East Early Intervention Program | S | 2019 | $ 55,539.19 | $ 23,192.25 | $ 78,731.44 |
| South East Early Intervention Program | S | 2020 | $ 50,501.58 | $ 21,732.87 | $ 72,234.45 |
| Southern Utah University Early Intervention | S | 2019 | $ 36,315.67 | $ 30,295.10 | $ 66,610.77 |
| Southern Utah University Early Intervention | S | 2020 | $ 42,519.67 | $ 31,849.04 | $ 74,368.71 |
| Summit County Early Intervention | G | 2019 | $ 26,995.63 | $ 19,278.54 | $ 46,274.18 |
| Summit County Early Intervention | G | 2020 | $ 26,630.90 | $ 19,029.29 | $ 45,660.19 |
| Up to 3 Early Intervention | S | 2019 | $ 29,865.90 | $ 14,746.18 | $ 44,612.08 |
| Up to 3 Early Intervention | S | 2020 | $ 34,382.44 | $ 18,467.17 | $ 52,849.61 |
| Weber-Morgan Early Intervention | G | 2019 | $ 65,469.88 | $ 27,438.02 | $ 92,907.90 |
| Weber-Morgan Early Intervention | G | 2020 | $ 54,310.74 | $ 39,051.41 | $ 93,362.15 |

## *Other Expenses*

In the Cost Report tool, programs were asked to provide "other expense" data, which included all expenses not directly related to personnel costs (i.e., salaries and fringe benefits). To streamline and simplify the Cost Report for provider completion, PCG mirrored the "other expense" categories to those included in the Monthly Expense Reports (MER) that local EI programs submit to BWEIP. Local EI programs reported little to no spending in many of these categories as shown in Table 10.

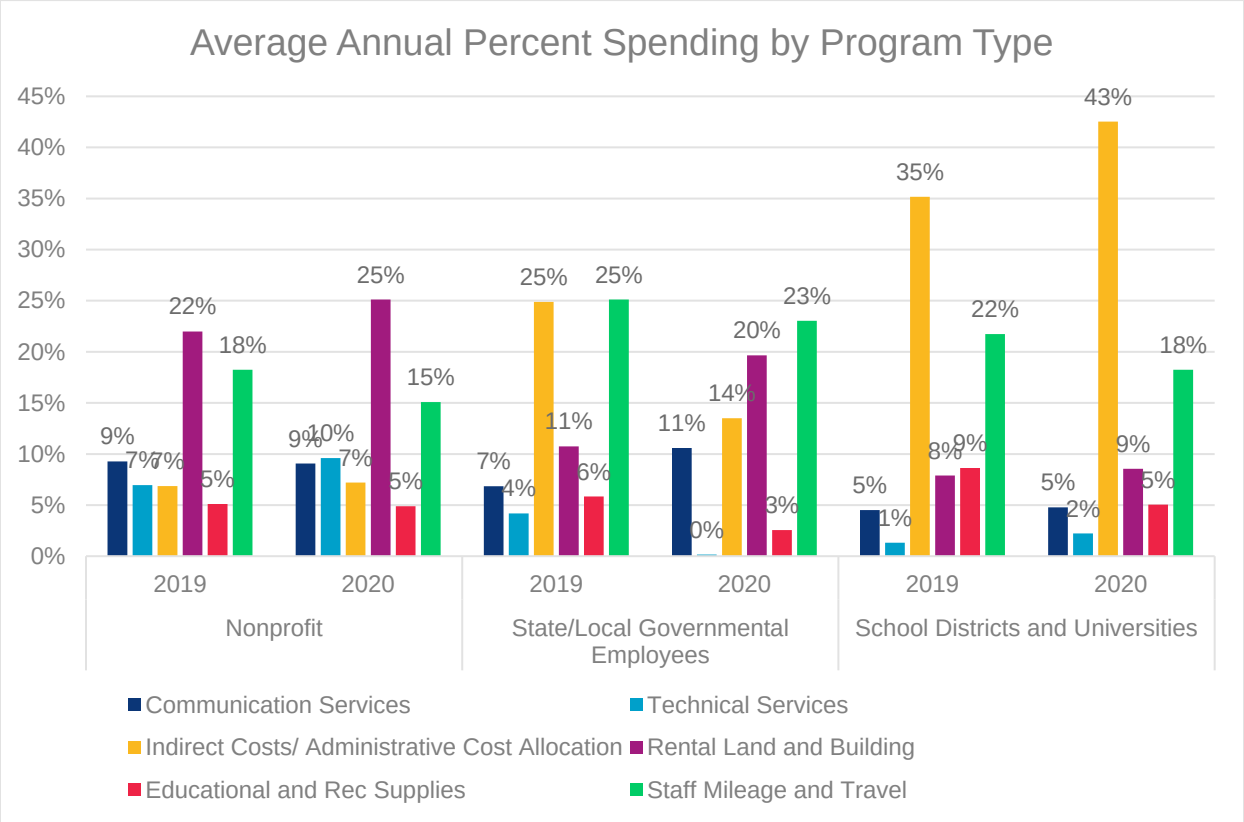
**TABLE 10: SUMMARY OF AVERAGE ANNUAL OTHER EXPENSE SPENDING**

| Other Expense | Average % FY2019 Spending | Average % FY2020 Spending | Change in % Spending | Range (All Years) |
|---|---|---|---|---|
| **Food for Clients** | 0.4% | 0.3% | -0.1% | 0-2% |
| **Advertising & Public Relations** | 0.2% | 0.1% | -0.1% | 0-1% |
| **Communication Services** | 7.1% | 7.9% | 0.8% | 0-16% |
| **Postage and Mailing** | 0.5% | 0.5% | 0.0% | 0-1% |
| **Technical Services** | 4.3% | 4.9% | 0.6% | 0-26% |
| **Indirect Costs/ Administrative Cost Allocation** | 20.8% | 21.2% | 0.3% | 0-64% |
| **Payroll** | 0.6% | 0.4% | -0.2% | 0-3% |
| **Rental Land and Building** | 14.5% | 18.0% | 3.5% | 0-43% |
| **Equipment Rental** | 0.7% | 0.4% | -0.2% | 0-4% |
| **Maintenance and Repairs** | 1.8% | 2.2% | 0.4% | 0-22% |
| **Building and Grounds** | 2.1% | 1.7% | -0.4% | 0-14% |
| **Office Supplies** | 3.1% | 3.9% | 0.8% | 0-11% |
| **Printing and Binding** | 0.4% | 0.5% | 0.0% | 0-3% |
| **Educational & Rec Supplies** | 6.5% | 4.4% | -2.1% | 0-13% |
| **Child Find/Public Awareness Materials** | 1.4% | 0.5% | -1.0% | 0-10% |
| **Books & Subscriptions** | 0.3% | 0.2% | -0.1% | 0-2% |
| **Photocopy Expenses** | 0.5% | 0.5% | 0.0% | 0-2% |
| **Small Equipment** | 0.5% | 1.9% | 1.4% | 0-12% |
| **Furniture** | 0.5% | 0.1% | -0.3% | 0-3% |
| **Utilities** | 1.3% | 1.5% | 0.2% | 0-5% |
| **Related Service Supplies & Equipment** | 2.0% | 2.1% | 0.1% | 0-15% |
| **Printed Forms and Publications** | 0.5% | 0.8% | 0.4% | 0-6% |
| **Insurance** | 1.4% | 1.3% | -0.1% | 0-5% |
| **Training and Development** | 2.3% | 1.1% | -1.2% | 0-5% |
| **Special Events** | 0.2% | 0.3% | 0.1% | 0-2% |
| **Membership Dues** | 0.6% | 0.8% | 0.3% | 0-3% |
| **Staff Mileage, Transportation, and Other Travel** | 21.0% | 17.9% | -3.0% | 0-52% |
| **Parent Mileage, Transportation, and Other Travel** | 0.8% | 0.5% | -0.3% | 0-3% |
| **Computer Equipment under $5,000 each** | 3.6% | 3.6% | 0.0% | 0-21% |
| **Computer Equipment over $5,000 each** | 0.4% | 0.4% | 0.0% | 0-2% |

In the above table PCG highlighted the expense categories where local EI programs spent more than 4% of their spending in FY2019 or FY2020. PCG has further analyzed these categories by program type (e.g., government vs. nonprofit) and rate group in the sections below.

Figure 21 shows the average annual percentage of spending for the top six “other expense” categories by program type and year.

**FIGURE 21: AVERAGE ANNUAL PERCENT SPENDING BY PROGRAM TYPE YEAR**




***Communication Services***

On average, nonprofit and school district and university local EI programs spent more on communication services than government local EI programs. However, there is not a huge discrepancy here, as all types of local EI programs spent between 5% and 11% between FY2019 and FY2020.

***Technical Services***

Government and school district and university programs reported very little spending (e.g., 1% - 2% and 0%-4%, respectively) in the technical service category, whereas nonprofit local EI programs spent 7% in FY2019 and 10% in FY2020.

***Indirect Costs/Administrative Cost Allocation***

Spending in this category varied greatly between all three program types. Government programs reported approximately 25% in FY2019 and 14% in FY2020, whereas nonprofit programs reported 7% for both years. Even greater spending was for school districts and universities, which raised from 35% to 43% over the fiscal years. The cost of these administrative staff would be captured in administrative salaries and fringe benefits rather than the indirect cost allocation category.

***Rental Land and Building***

Nonprofits’ greatest expense here is the rental for land and building expenses, ranging from 22%-25% over the two fiscal years. Government programs saw an increase of 11%-20%, and school district and university programs held steady at about 8% or 9%.

***Educational and Recreational Supplies***

Spending in this area decreased a few percent from FY2019 to FY2020 for both government and school district and university local EI programs, likely due to the virtual nature of visits during a portion of FY2020. Nonprofit spending held steady at 5%.

***Staff Mileage and Travel***

Spending in this area decreased about 3%-4% from FY2019 to FY2020 for all program types, likely due to the virtual nature of visits.

Figures 22 and 23 show the average annual percentage of spending for the top six "other expense" spending categories by rate group and year.

**FIGURE 22: FY2019 AVERAGE PERCENT SPENDING BY RATE GROUP**

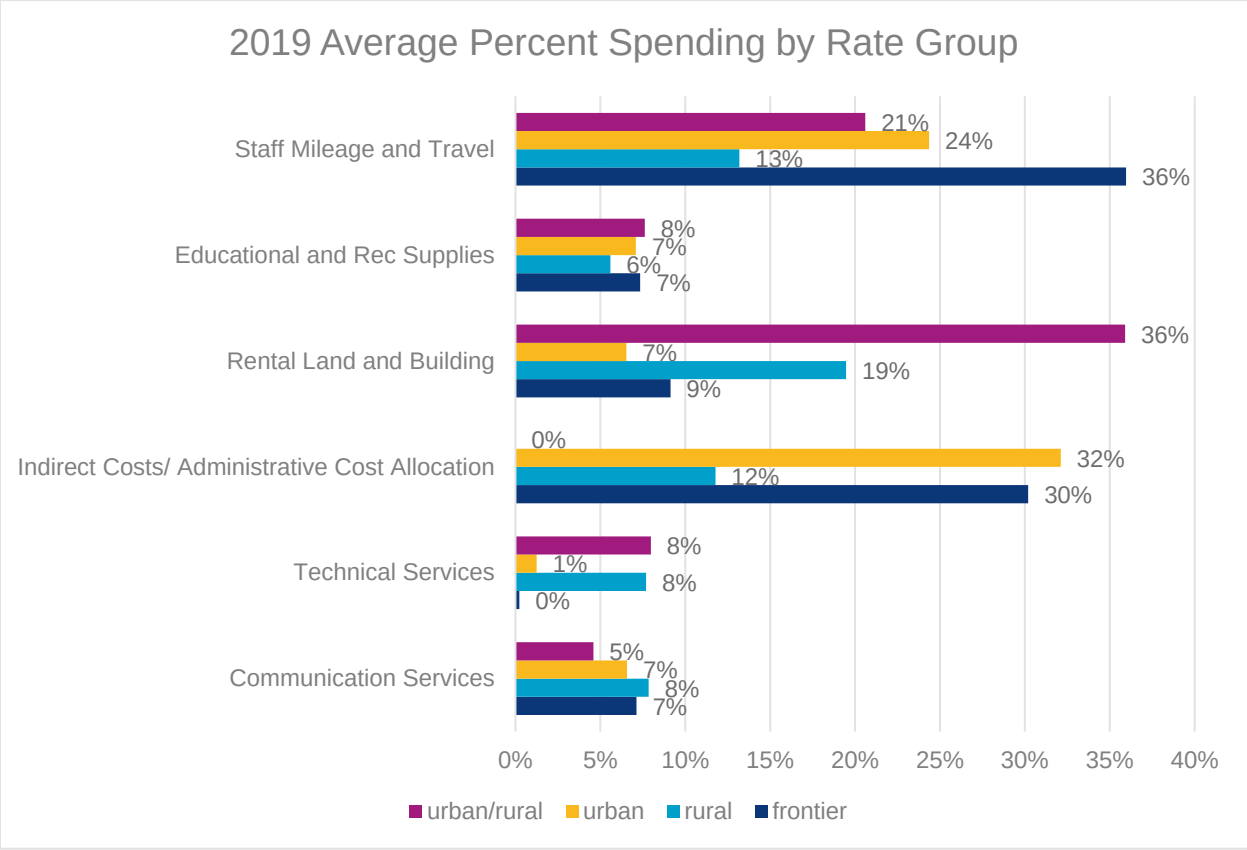
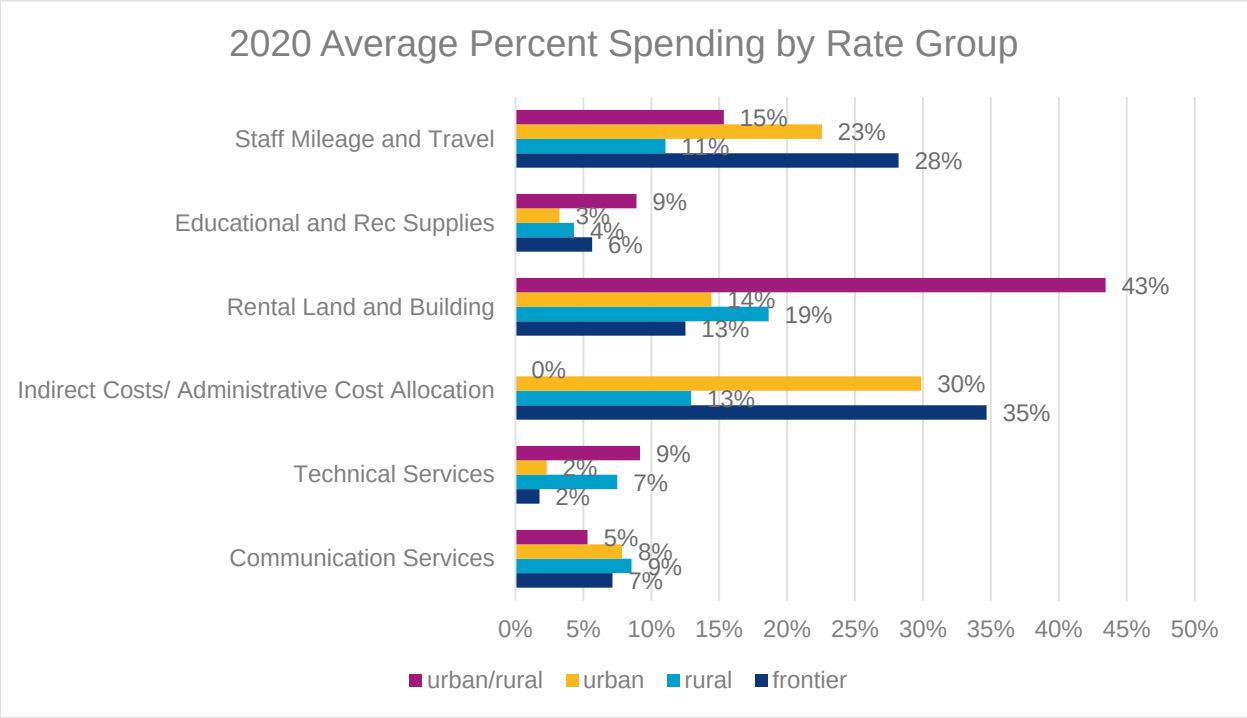


**FIGURE 23: FY2020 AVERAGE PERCENT SPENDING BY RATE GROUP**




As expected, staff travel, and mileage decreased from FY2019 to FY2020 for all rate groups.

Educational supplies, technical services, and communication services did not fluctuate too greatly year over year.

All rate groups except rural programs saw an increase in rental land and building expenses in FY2020.

Indirect costs/administrative cost allocation for frontier programs increased 16% from FY2019 to FY2020, whereas other rate groups did not see a significant change in spending in this area.

## *Other Expense Details*

PCG included an "Other Expenses Detail" section in the Cost Report to capture unique costs local EI programs may have incurred to provide additional services to children, including costs related to assistive technology, interpretation and translation, child transportation, and tele-intervention.

### *Assistive Technology*

Five local EI programs reported that they provide assistive technology (e.g., equipment) to children within their programs. In FY2019, local EI programs who offered this service reported an average of 30 children who received assistive technology and an average cost of $90.24 per child to provide the necessary equipment.

In FY2020, the average number of kids receiving assistive technology rose to 34 per program with an average cost of $212.67 per child. Local EI programs reported that revenues utilized to cover the costs of assistive technology were obtained from a range of sources, including Baby Watch contracts, Medicaid, and private donations.

### *Interpretation and Translation Services*

Displayed in Table 11, nine local EI programs reported that they provided interpretation and translation services for children and families. The number of children receiving this service decreased in FY2020.

Given the less than comprehensive data received regarding specific interpretation and translation services, these services should be further examined at a statewide level.

**TABLE 11: ANNUAL INTERPRETATION/TRANSLATION DATA**

| Year | Average # Children Receiving Interpretation/Translation per Program | Average Cost of Providing Service per Child |
|---|---|---|
| 2019 | 101 | $223.74 |
| 2020 | 74 | $460.67 |

### *Child Transportation/Family Reimbursement*

Nine local EI programs reported providing child transportation or family reimbursement for transportation. As shown in Table 12, transportation costs significantly dropped in FY2020, as services were performed virtually for part of the year during the COVID-19 pandemic. Based on PCG's work in other states and areas of the country, the average costs per child reported here are generally in alignment with other areas.

**TABLE 12: ANNUAL TRANSPORTATION DATA**

| Year | Average # Children Receiving Transportation or Family Reimbursement per Program | Average Cost of Providing Service per Child |
|---|---|---|
| 2019 | 46 | $120.97 |
| 2020 | 32 | $88.39 |

### *Tele-intervention Support Expenses*

Up to Three Early Intervention is the only EI program that reported providing tele-intervention services in FY2019. They provided these services to 12 children and did not report additional expenses to do so.[7]

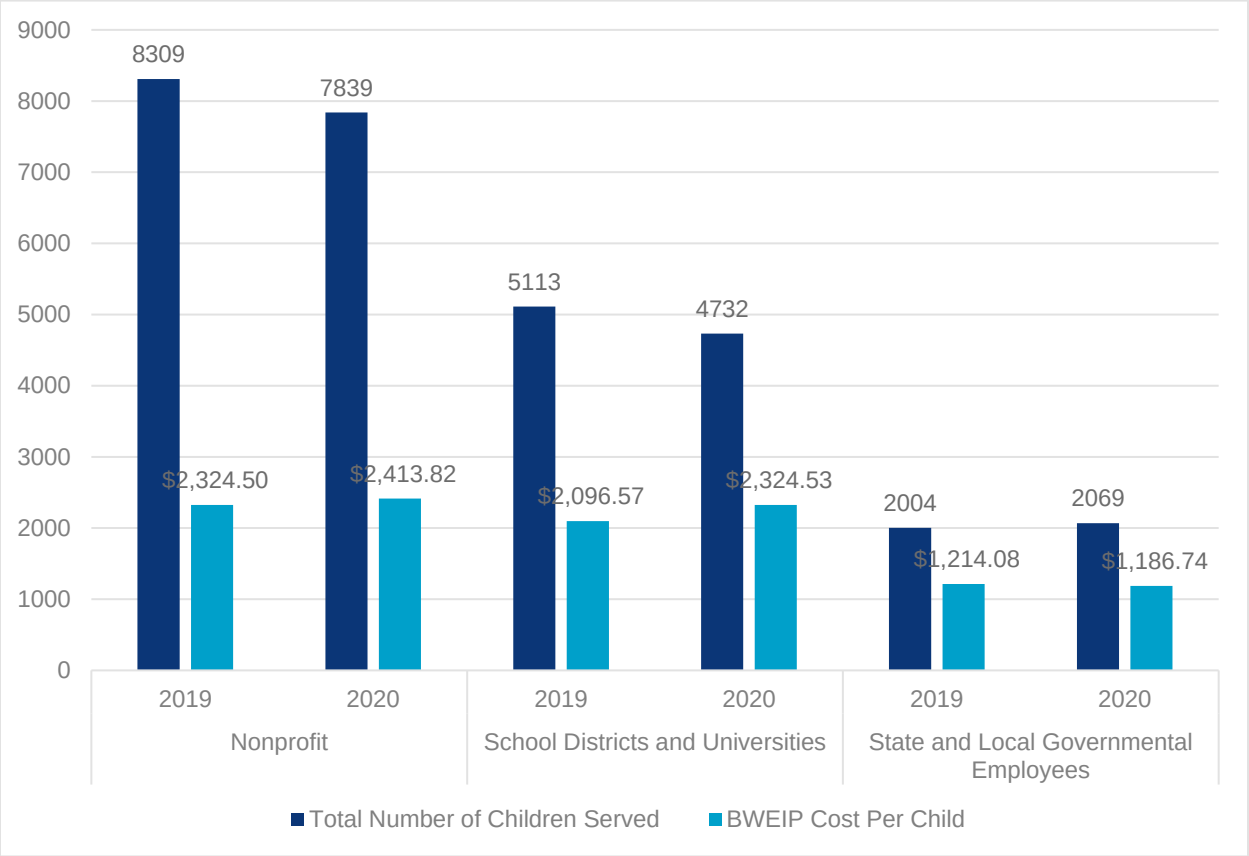
During FY2020, (e.g., mid-March through June 2020), eight local EI programs reported expense and service data for providing tele-intervention services. Minimal additional expenses were reported to provide tele-intervention services to these children. Where expenses were incurred, programs reported spending on additional equipment necessary to provide tele-intervention services. Dollars were spent from BWEIP contracts or Medicaid revenue. From PCG discussions with local EI programs during Steering Committee meetings, it is our understanding that all local EI programs have been providing tele-intervention services during COVID-19. Some programs failed to complete this section of the Cost Report, as they may have assumed they should only complete the section if they incurred expenses in addition to their regular program expenses in order to serve children through virtual means. It may be that some local EI programs already had the tools necessary (i.e., computers, tablets, etc.) to appropriately shift programming to a virtual setting.

## COST PER CHILD

As shown in Figure 24, BWEIP costs per child increased slightly for both government and nonprofit local EI programs from FY2019 to FY2020. Government local EI programs saw an increase of 5.5% in expenses per child from FY2019 to FY2020, whereas nonprofit local EI programs increased 4.6%. This could be due to the fixed cost nature of certain expenses that do not change based on the number of children served, which would increase those costs.

[7] Please note that these services were provided on a trial basis and were not approved by the Baby Watch Early Intervention Program.

**FIGURE 24: ANNUAL COST PER CHILD DATA AND TOTAL CHILDREN SERVED BY PROGRAM TYPE**




As shown in Figure 25, frontier local EI programs showed the most significant increase in cost per child from FY2019 to FY2020 at 10.8%. Frontier local EI Programs also experienced a decrease in children of 4.5% from FY2019 to FY2020. Because they have the fewest children served of any rate group, any decrease in the number of children served will significantly increase the cost per child relatively as their fixed costs remain the same.

All other rate groups also experienced a decrease in the number of children served from FY2019 to FY2020. Consequently, the percentage increase in cost per child was 6.4% for rural programs, 3.8% for urban programs, and 4.0% for urban/rural local EI programs.

**FIGURE 25: ANNUAL COST PER CHILD AND TOTAL CHILDREN SERVED DATA BY RATE GROUP**

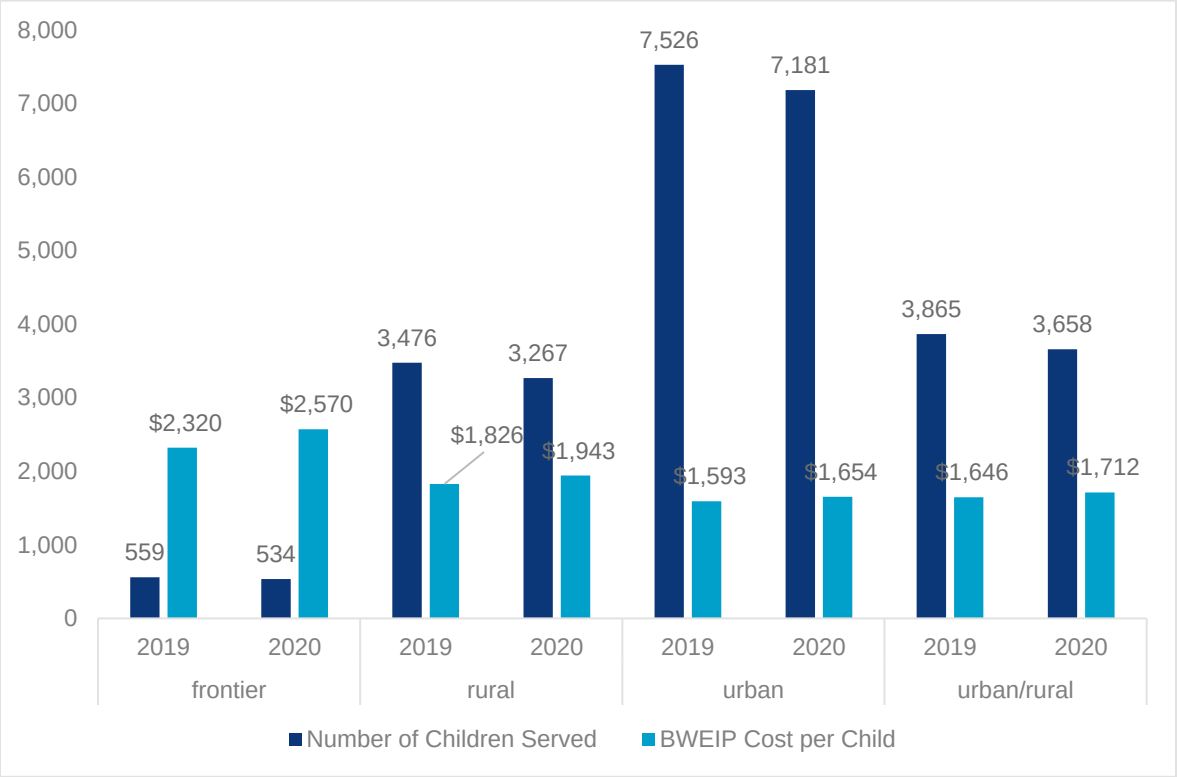
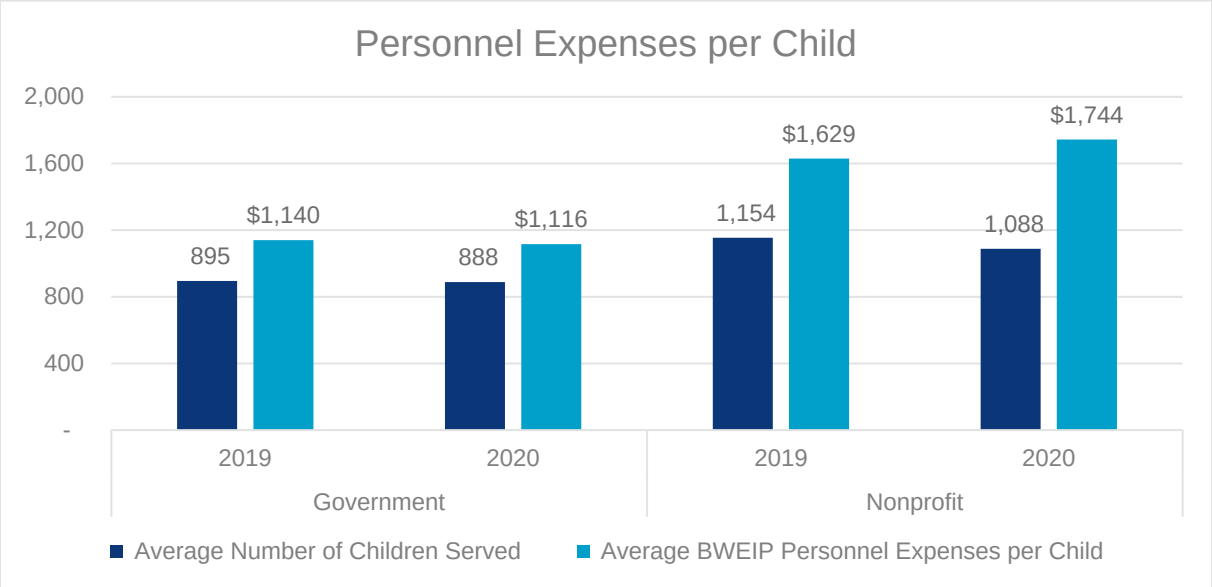



Figure 26 compares the average number of children served and average BWEIP personnel costs per child between government and nonprofit local EI programs. For both rate group types, the number of children served slightly decreased in FY2020.

BWEIP personnel costs per child for government EI programs decreased slightly from FY2019 to FY2020. It is likely that government EI programs utilized contract employees less in FY2020 as they adjusted to serving a reduced number of children for part of the year due to COVID-19.

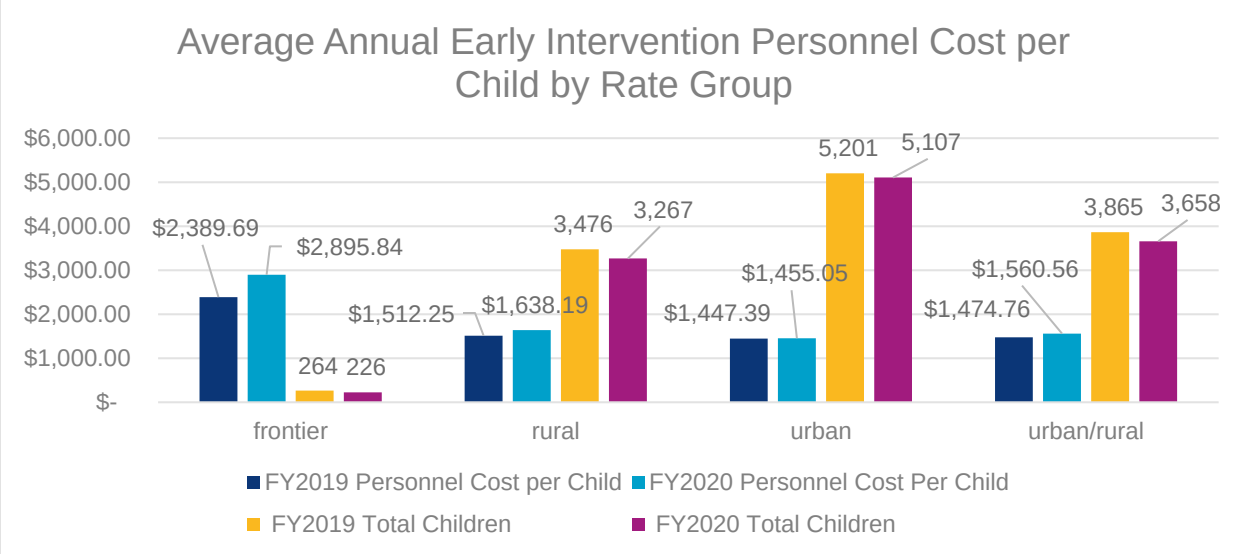
For nonprofit local EI programs, personnel costs per child increased approximately 7% from FY2019 to FY2020, which aligns with the approximate 6% decrease in the average number of children served in FY2020 compared to FY2019. As mentioned previously, upon discussion with EI programs, PCG did not hear about a significant amount of staff changes being made in FY2020 due to COVID-19, as local EI programs strived to retain their employees throughout the public health crisis to best equip them to serve their existing children and transition back to safe in-person visits as the pandemic subsides.

**FIGURE 26: PERSONNEL EXPENSES PER CHILD**




Because frontier rate group programs serve so few children across such a wide span of the frontier areas of Utah, average personnel costs per child are highest in that group as shown in Figure 27. Frontier local EI programs must hire enough direct service providers to be able to offer in-person visits to children regularly, which requires a significant amount of transportation time.

**FIGURE 27: AVERAGE ANNUAL EARLY INTERVENTION PERSONNEL COST PER CHILD BY RATE GROUP**

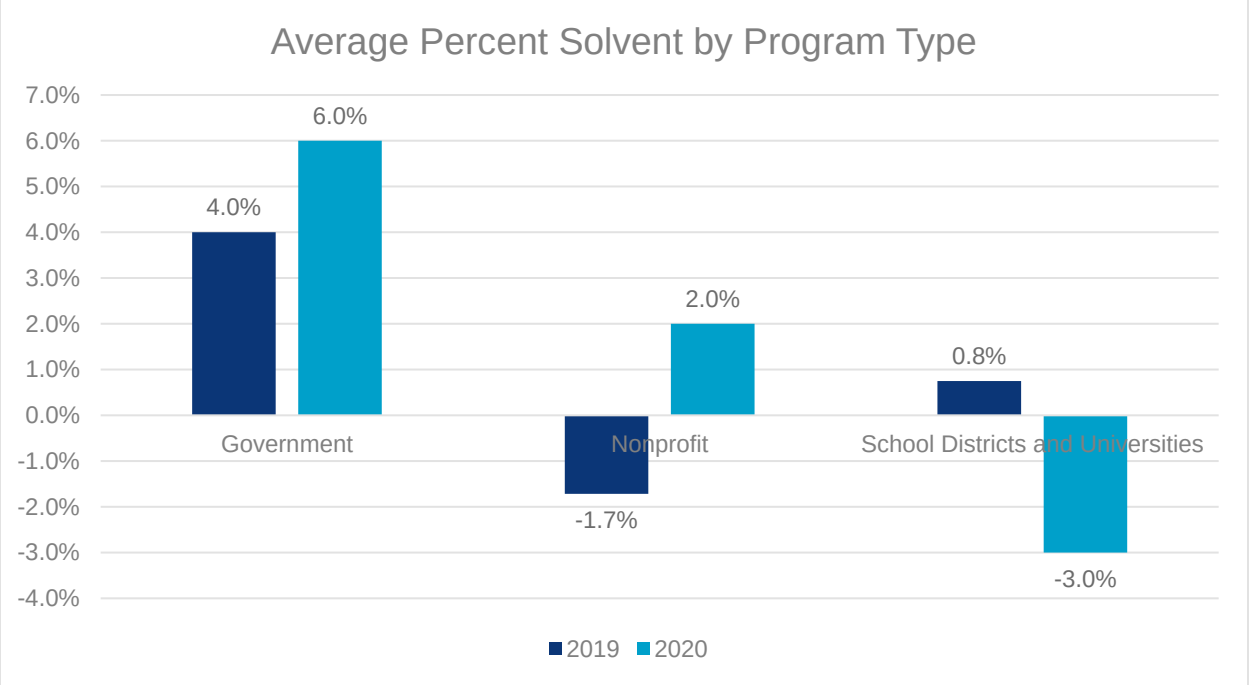


## Analysis of the Solvency of Baby Watch Programs

This section of the cost report analyzes the solvency of local EI programs. For the purpose of this analysis, program solvency is defined as a program's ability to operate early intervention services within parameters of the Baby Watch funding formula, which includes state funding, family fees, CHIP and Medicaid (e.g., are programs operating in a deficit or are they fiscally solvent).

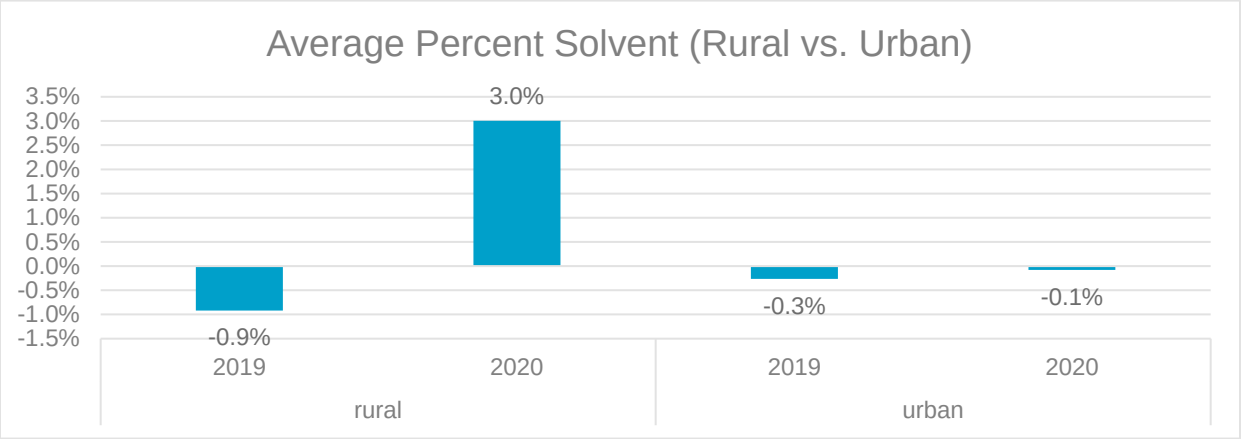
As illustrated in Figure 28, the solvency for government programs increased from 4% to 6%, while nonprofit solvency increased from -1.7% to 2%, and school districts and universities decreased from 0.8% to -3%. In FY2020, government solvency was stable, nonprofit local EI programs were operating just over 2% solvency, and school districts and universities were operating at a 3% deficit.

**Figure 28: Average Annual Percent Solvent by Program Type**




When comparing rural versus urban local EI programs we see similar trends. Shown in Figure 29, both types of local EI programs had a minor deficit of just under 1% in FY2019, while rural EI programs were 3% solvent in FY2020 and urban local EI programs were flat. Frontier local EI programs were excluded as their solvency ratios were outside of the standard deviation of solvency compared to other local EI programs.

**FIGURE 29: AVERAGE ANNUAL PERCENT SOLVENT BY RATE GROUP**




In Table 13, we have provided a detailed listing of local EI programs' percent solvent or in a deficit. In FY2019, this ranged from -8% to 8% and averaged -0.4%; FY2020 ranged -8% to 11% and averaged 0.7%. Note: Central and Summit Counties were outliers and were excluded.

**TABLE 13: IN THE BLACK ANALYSIS BY EI PROGRAM**

| EI Program | Detailed Program Type | Solvency FY2019 | Solvency FY2020 |
|---|---|---|---|
| Davis School District Early Childhood Program | S | 0% | 0% |
| DDI Vantage | NP | -1% | -1% |
| Jordan Child Development Center | S | -2% | -8% |
| Kids on the Move | NP | 2% | 4% |
| Kids Who Count | NP | -8% | 3% |
| Provo Early Intervention Program | NP | -6% | -3% |
| Root for Kids | NP | 4% | 11% |
| South East Early Intervention Program | S | 2% | -4% |
| Southern Utah University Early Intervention | S | 8% | 0% |
| Up to 3 Early Intervention | S | -3% | -4% |
| Weber-Morgan Early Intervention | G | 4% | 6% |
| Davis School District Early Childhood Program | S | 0% | 0% |

# V. Personnel Roster Analysis

## Direct EI Personnel

The number of FTE[8] by direct early intervention discipline/role is shown in Table 14. This data indicates that there was a slight decrease in the number of direct EI personnel FTEs from 254.9 in FY2019 to 246.2 in FY2020.

Some disciplines/roles entered by local EI programs are not early intervention direct service personnel and do not provide Part C of IDEA services (i.e., interpreter, Medicaid specialist, and training and compliance manager). These are other administrative functions or non EI services. Similarly, 'referral and intake' is likely a Service Coordination function.

### Table 14: Annual Local EI Program Discipline FTE Data

| Discipline/Role | 2019 | 2020 |
|---|---|---|
| Audiologist | 0.5 | 0.4 |
| COTA | 1.4 | 0.9 |
| Classroom Aide/Assistant | 4.7 | 4.1 |
| Dietitian | 0.2 | 0.3 |
| Early Childhood Special Educator | 30.2 | 28.8 |
| Early Intervention Specialist | 59.0 | 57.3 |
| Family Therapist | 0.1 | 0.1 |
| Interpreter | 3.3 | 3.0 |
| Music and Movement Classes | 0.1 | 0.1 |
| Nurse | 17.5 | 17.8 |
| Occupational Therapist | 23.1 | 24.4 |
| Physical Therapist | 22.7 | 23.6 |
| Service Coordinator | 44.1 | 44.4 |
| Social Worker | 2.8 | 3.1 |
| Speech-Language Pathologist | 41.3 | 36.7 |
| Transition Coordinator | 1.2 | 1.2 |
| **Grand Total** | 254.9 | 246.2 |

Figure 30 shows that there are seven disciplines that make up the majority of early intervention direct service FTEs statewide, including speech-language pathologists, service coordinators, physical therapists, occupational therapists, nurses, early intervention specialists, and early childhood special educators. If early intervention specialists and early childhood special educators are combined, as both provide Special Instruction, they represent 34.7% of the total direct service EI personnel.

[8] FTE (Full Time Equivalency) is calculated by dividing the total number of hours provided by 2,080 hours (i.e., the number of hours per year if personnel worked 40 hours per week)

**FIGURE 30: EARLY INTERVENTION NUMBER OF FTES BY DISCIPLINE**

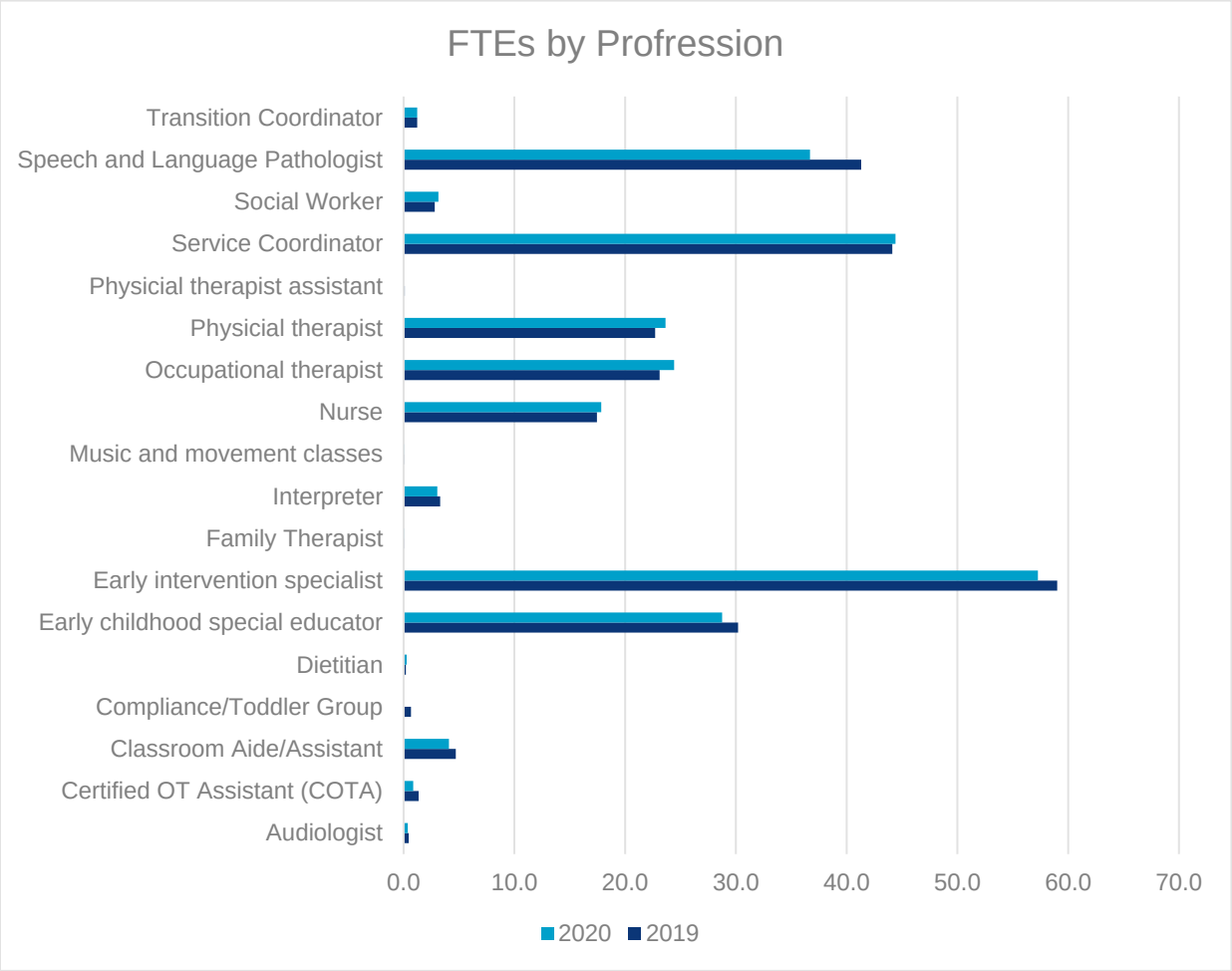



Table 15 shows the number of direct service EI personnel by discipline by local EI program. There are four disciplines that all programs have, including nurse, occupational therapist, physical therapist, and speech-language pathologists.

Two local EI programs, Root for Kids and Summit County Early Intervention, reported not having either early intervention specialists[9] or early childhood special educators, and six local EI programs, PrimeTime 4 Kids, Central Utah Health Department Early Intervention, Southern Utah University Early Intervention, Weber-Morgan Early Intervention, Jordan Child Development Center, South East Early Intervention Program, and Summit County Early Intervention, reported not having dedicated service coordinators. Many direct service providers serve in a dual role as a service coordinator, and some programs did not note service coordinator as a secondary profession.

Only one local EI program reported a few hours of family therapy and only five programs listed having social workers serving early intervention eligible children and their families. This lack of mental health providers may limit EI Program's ability to meet the social and emotional and Infant and Early Childhood Mental Health (IECMH) needs of children served in the context of parent-child relationships.

[9] Please note that titles were free to be selected by programs as "primary title" and other titles. Many providers fill different roles.

### TABLE 15: NUMBER OF DIRECT EI PERSONNEL BY DISCIPLINE AND PROGRAM

| Program | Audiologist | Certified OT assistant (COTA) | Classroom Aide/Assistant | Dietitian | Early childhood special educator | Early intervention specialist | Family therapist | Interpreter | Music and movement | Nurse | Occupational therapist | Physical therapist | Service coordinator | Social worker | Speech & language pathologist | Transition coordinator | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Central Utah Health Dept EI | | | | | | 2.2 | | | | 0.4 | 0.2 | 0.3 | | | 0.6 | | 3.7 |
| Davis School District Early Intervention Program | | | | | 3.2 | 5.1 | | | | 1.5 | 1.1 | 1.2 | 2 | | 2.2 | | 16.2 |
| DDI Vantage | | | 0.9 | | 8.9 | 13.1 | | 1.1 | | 5 | 4.8 | 3.8 | 15.3 | 1 | 5.1 | | 58.9 |
| Jordan Child Development Center | 0.4 | 0.5 | 2.4 | 0 | 11.2 | | | | | 0.9 | 4.2 | 5.6 | | | 11.3 | 0.6 | 37 |
| Kids on the Move | | | | | | 13.6 | | | | 1.5 | 4.5 | 3.3 | 7.2 | 1 | 3.3 | 0.7 | 35 |
| Kids Who Count | | | | | 1 | 4.4 | | 0 | | 0.8 | 1.3 | 1 | 1.7 | 1 | 2.2 | | 13.5 |
| PrimeTime 4 Kids | | 0.4 | | | | 2.9 | | | | 1.8 | 0.6 | 0.6 | | | 0.7 | | 7 |
| Provo EI Program | | | | 0.1 | | 2.1 | | 0.3 | | 0.4 | 0.9 | 1 | 5.7 | | 1.2 | | 11.7 |
| Root for Kids | | | | | | | | | | 1.1 | 1.5 | 0.8 | 7.5 | 0 | 2.1 | | 13.1 |
| South East EI Program | | | | 0 | 0.7 | 4.1 | 0.1 | 0.1 | | 1.3 | 0.3 | 0.5 | | | 0.2 | | 7.2 |
| Southern UT University | | | 0.4 | | | 2.9 | | | | 0.1 | 0 | 0.4 | | | 0.2 | | 4.1 |
| Summit County EI | | | | | | | | 1 | | 0.9 | 0.8 | 2 | | | 1 | | 5.6 |
| Up to 3 EI | | | 0.4 | 0.2 | 3.8 | 4 | | 0 | 0.1 | 1 | 2.4 | 1.2 | 5 | 0.1 | 3.6 | | 21.8 |
| Weber-Morgan EI | | | | | | 3 | | 0.5 | | 1 | 2 | 2 | | | 3 | | 11.5 |
| Grand Total | 0.4 | 0.9 | 4.1 | 0.3 | 28.8 | 57.3 | 0.1 | 3.0 | 0.1 | 17.8 | 24.4 | 23.6 | 44.4 | 3.1 | 36.7 | 1.2 | 246.2 |

Table 16 shows the ratio of direct EI personnel to the annual number of children served by programs*. The range is from 1:20 to 1:100 with an average of 1:64.

**TABLE 16: RATIO OF DIRECT FTES TO CHILDREN SERVED BY PROGRAM**

| Program | Detailed Program Type | Total Direct EI FTE | Annual Active Number of Children | Ratio |
|---|---|---|---|---|
| Central Utah Health Department Early Intervention | G | 3.7 | 295 | 1:80 |
| Davis School District Early Childhood Program | S | 16.2 | 1573 | 1:97 |
| DDI Vantage | NP | 58.9 | 3865 | 1:66 |
| Jordan Child Development Center | S | 37 | 2325 | 1:63 |
| Kids on the Move | NP | 35 | 2246 | 1:64 |
| Kids Who Count | NP | 13.5 | 764 | 1:56 |
| PrimeTime 4 Kids | NP | 7 | 367 | 1:52 |
| Provo Early Intervention Program | NP | 11.7 | 235 | 1:20 |
| Root for Kids | NP | 13.1 | 832 | 1:64 |
| South East Early Intervention Program | S | 7.2 | 264 | 1:36 |
| Southern Utah University Early Intervention | S | 4.1 | 296 | 1:73 |
| Summit County Early Intervention | G | 5.6 | 562 | 1:00 |
| Up to 3 Early Intervention | S | 21.8 | 655 | 1:30 |
| Weber-Morgan Early Intervention | G | 11.5 | 1147 | 1:00 |

*This table does not indicate caseload (i.e., the number of children and their families per week/month served by individual personnel, but rather is a ratio of the total children served annually to the total number of FTEs by local EI program.)

## ADMINISTRATIVE PERSONNEL

Figure 31 shows the total number of FTEs for administrative staff in local EI programs statewide. There are some positions that may not be billable to BWEIP, including sibling care, unless they are performing an administrative task rather than EI specific services.

### FIGURE 31: ANNUAL ADMINISTRATIVE FTE DATA

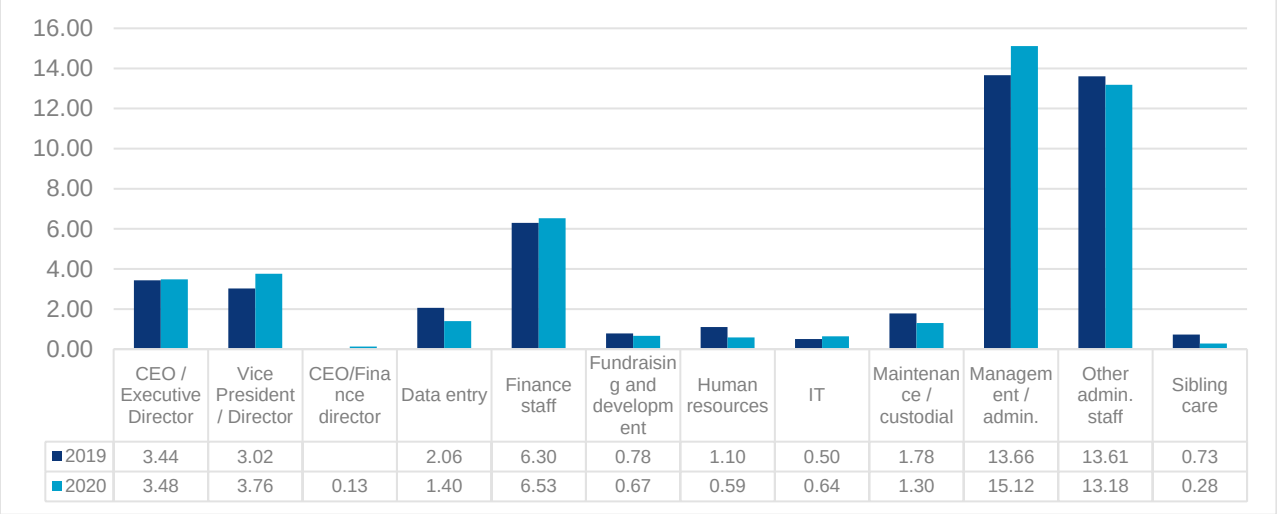



Table 17 shows the number of administrative FTEs by EI program. This table also shows the percentage of the total FTEs that are administrative staff, which ranges from 6.5% to 34.1% with an average of 18.8%.

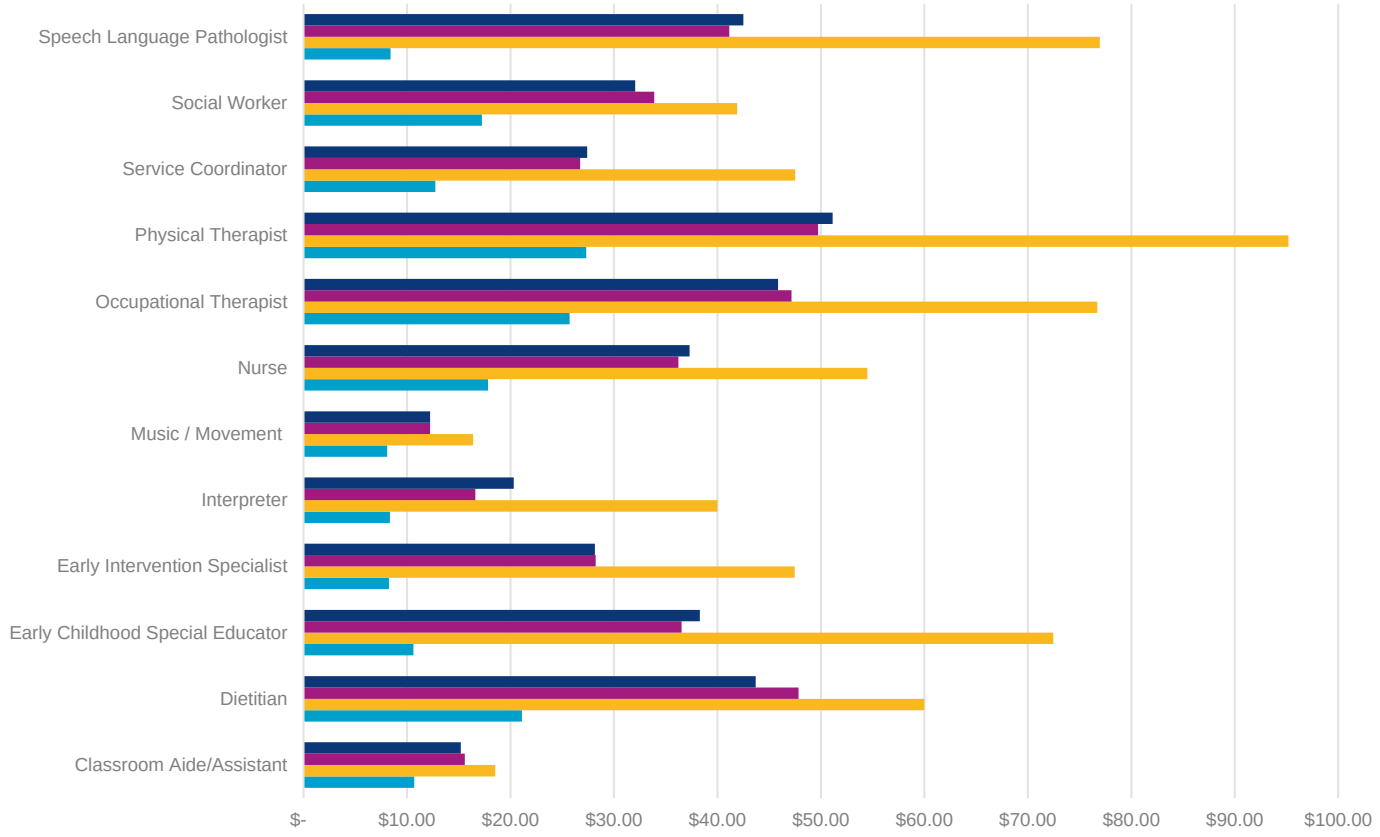
### TABLE 17: ANALYSIS OF ADMINISTRATIVE FTES TO DIRECT SERVICE FTES BY PROGRAM

| Program | Detailed Program Type | Admin FTE | Direct Service FTE | Total FTE | Admin % |
|---|---|---|---|---|---|
| Central Utah Health Department Early Intervention | G | 1.6 | 3.7 | 5.3 | 30.50% |
| Davis School District Early Childhood Program | S | 1.7 | 16.2 | 17.9 | 9.40% |
| DDI Vantage | NP | 15.1 | 59.9 | 75 | 20.10% |
| Jordan Child Development Center | S | 2.6 | 37 | 39.5 | 6.50% |
| Kids on the Move | NP | 5.1 | 35.1 | 40.3 | 12.80% |
| Kids Who Count | NP | 1.4 | 13.6 | 15 | 9.40% |
| PrimeTime 4 Kids | NP | 1.5 | 7.1 | 8.6 | 17.80% |
| Provo Early Intervention Program | NP | 1.6 | 11.7 | 13.3 | 11.90% |
| Root for Kids | NP | 4.2 | 13.1 | 17.2 | 24.20% |
| South East Early Intervention Program | S | 2.2 | 7.2 | 9.4 | 23.70% |
| Southern Utah University Early Intervention | S | 2.1 | 4.1 | 6.2 | 34.10% |
| Summit County Early Intervention | G | 2 | 5.6 | 7.6 | 26.20% |
| Up to 3 Early Intervention | S | 3.9 | 21.8 | 25.7 | 15.20% |
| Weber-Morgan Early Intervention | G | 3.5 | 12.5 | 16 | 21.90% |
| **Total** | | **48.5** | **248.4** | **296.9** | |

## HOURLY RATE BY DIRECT SERVICE DISCIPLINE

Figure 32 shows the minimum, maximum and average hourly rate paid by discipline, excluding fringe benefits. This includes rates paid to subcontractors, which for most disciplines were similar or slightly less than salaried employees. The data is for FY2020 and did not differ significantly from FY2019.

### FIGURE 32: HOURLY RATE BY DISCIPLINE




| | Classroom Aide/Assistant | Dietitian | Early Childhood Special Educator | Early Intervention Specialist | Interpreter | Music / Movement | Nurse | Occupational Therapist | Physical Therapist | Service Coordinator | Social Worker | Speech Language Pathologist |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| mean average | $15.20 | $43.69 | $38.31 | $28.15 | $20.32 | $12.23 | $37.32 | $45.87 | $51.14 | $27.41 | $32.05 | $42.51 |
| median | $15.59 | $47.84 | $36.53 | $28.23 | $16.60 | $12.23 | $36.23 | $47.16 | $49.72 | $26.74 | $33.89 | $41.15 |
| max | $18.53 | $60.00 | $72.46 | $47.47 | $40.00 | $16.39 | $54.48 | $76.71 | $95.18 | $47.51 | $41.90 | $76.96 |
| min | $10.70 | $21.10 | $10.62 | $8.26 | $8.34 | $8.08 | $17.83 | $25.72 | $27.31 | $12.74 | $17.24 | $8.41 |

Table 18 compares hourly rates paid across all direct service disciplines by government local EI programs and nonprofit local EI Programs. The data shows, on average, government local EI programs pay their personnel 16.4% more than nonprofit programs.

**TABLE 18: DIRECT SERVICE DISCIPLINE AVERAGE HOURLY RATES BY PROGRAM TYPE**

| | Average Hourly Rate Government Programs | Average Hourly Rate Nonprofit Programs |
|---|---|---|
| Maximum | $95.18 | $125.00 |
| Minimum | $8.34 | $8.08 |
| Average | $42.45 | $35.50 |
| Median | $42.69 | $32.00 |

Table 19 compares hourly rates paid by urban, rural and frontier local EI programs. It is interesting to note that frontier local EI programs pay the highest hourly rate, as well as a minimum that is higher than rural and urban programs.[10]

**TABLE 19: DIRECT SERVICE DISCIPLINE AVERAGE HOURLY RATES BY RATE GROUP**

| | Average Hourly Rates Urban Programs | Average Hourly Rates Rural Programs | Average Hourly Rates Frontier Programs |
|---|---|---|---|
| Max | $95.18 | $125.00 | $70.07 |
| Min | $8.41 | $8.08 | $20.00 |
| Average | $38.99 | $33.31 | $39.07 |
| Median | $38.66 | $31.37 | $40.00 |

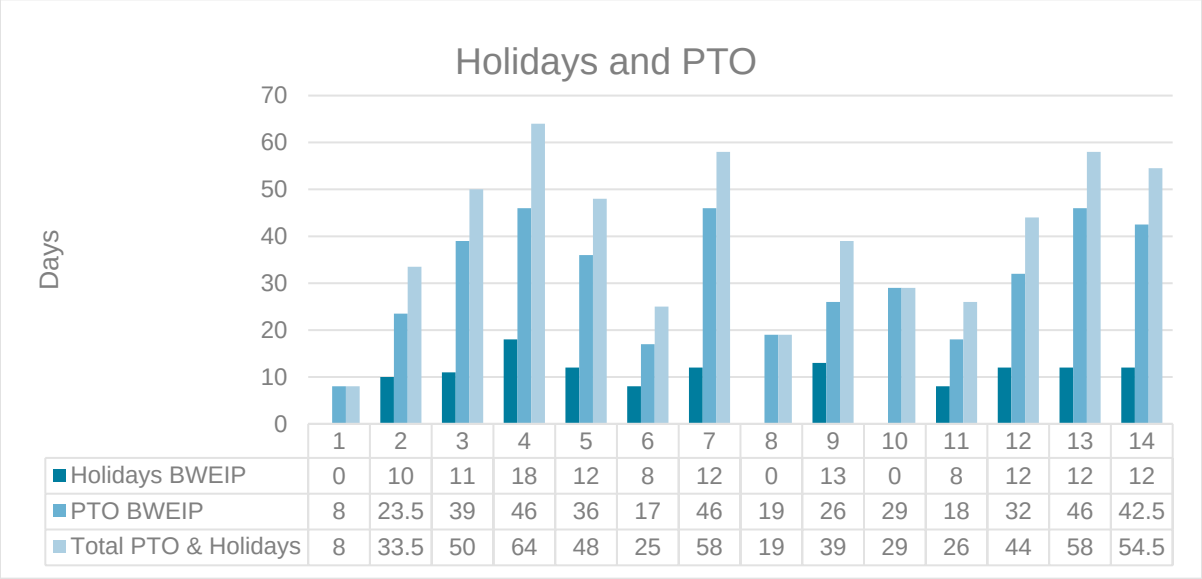
## *Holidays and Paid Time Off (PTO)*

Figure 33 shows the average number of holidays and total Paid Time Off (PTO) by local EI program for FY2020. Holiday days reported ranged from 0 to 18 with an average of 8.3. While this reflects the data submitted by local EI programs it is not logical that three programs report no holidays. Also, 18 holidays reported by one program is much higher than other programs and may capture days around the winter or spring holiday break.

PTO reported ranged significantly from 8 to 46 days with an average of 29.5.

[10] A frontier rate group local program reported that recruitment and retention of staff is especially difficult in the frontier areas. In tourist-heavy areas, housing is in short supply, and in the wake of COVID-19, there remains to be steep competition for all types of employment. For instance, PCG verified a McDonald's restaurant in Moab, UT is hiring crew members for $19/hour, including benefits and tuition reimbursement. Although early intervention professionals can be compensated at a higher rate than this, it is still indicative of a tight job market to attract therapists to serve young children in broad swaths of the frontier areas of the state.

## FIGURE 33: AVERAGE HOLIDAY AND PTO DATA BY PROGRAM

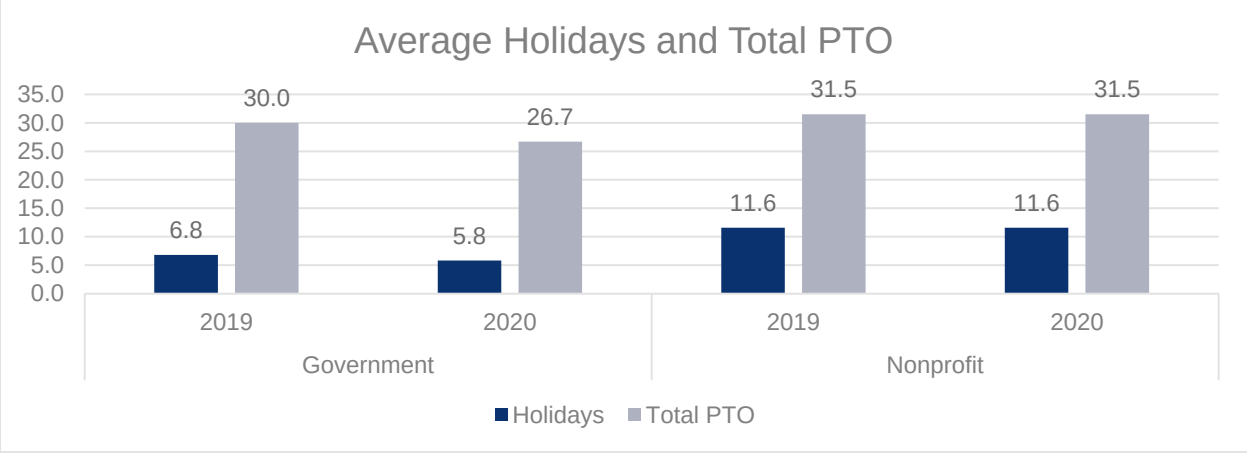



| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Holidays BWEIP | 0 | 10 | 11 | 18 | 12 | 8 | 12 | 0 | 13 | 0 | 8 | 12 | 12 | 12 |
| PTO BWEIP | 8 | 23.5 | 39 | 46 | 36 | 17 | 46 | 19 | 26 | 29 | 18 | 32 | 46 | 42.5 |
| Total PTO & Holidays | 8 | 33.5 | 50 | 64 | 48 | 25 | 58 | 19 | 39 | 29 | 26 | 44 | 58 | 54.5 |

Figure 34 shows that there was a significant difference in the number of holidays reported, with nonprofit local EI programs reporting approximately twice as many holidays as government local EI programs.

There was not a significant difference in the number of PTO days between nonprofit and government local EI programs.

### FIGURE 34: AVERAGE HOLIDAYS AND TOTAL PTO



# VI. Rate Calculations

Using the data from the market salary analysis, cost report, time study, and personnel rosters, PCG calculated recommended payment rates for the following services:

- Speech-Language Pathology
- Special Instruction / Developmental Therapy
- Occupational Therapy
- Special Education
- Service Coordination
- Physical Therapy
- Nursing
- Social Work
- Family Training
- Nutrition
- Audiology

All rates were calculated using a similar methodology with different inputs. The methodology for calculating each rate is described in the following sections. Please see Appendix B for all rate calculation tables.

## Rate Methodology

The rate calculations are designed to capture all the expenses involved in EI service delivery. The average hourly employee expense for an average early intervention service delivery discipline is calculated first. Personnel roster data was used to calculate salary data. Tax and fringe benefits were then added to the average salary. Next, other administrative expenses (except mileage) were added based on the cost report proportion of direct personnel costs to other expenses. A billable percentage was then factored into the calculations to ensure the billable rate also accounts for non-billable time (travel, prep, leave and all other administration time) and expenses associated with service delivery. To determine a rate for tele-intervention, time study data was used to determine the time spent providing a virtual service compared to an in-person service. Mileage was then added based on travel time assumptions for current rate groups; urban, rural, and frontier. Table 20 shows the inputs of the methodology, and the steps included below.

### Table 20. Example Speech-Language Rate Calculation

| Step | Line Item | In-Person Urban | In-Person Rural | In-Person Frontier | Tele-Intervention |
|---|---|---|---|---|---|
| 1 | Salary/Hour | $38.80 | $38.80 | $38.80 | $38.80 |
| 2 | Fringe/Hour | $12.61 | $12.61 | $12.61 | $12.61 |
| 3 | Employee Salary Plus Benefits | $51.41 | $51.41 | $51.41 | $51.41 |
| 4 | Administrative Costs (less mileage, plus admin salaries) | $6.43 | $6.43 | $6.43 | $6.43 |
| 5 | Admin Costs Plus Salary | $57.84 | $57.84 | $57.84 | $57.84 |
| 6 | Total Costs/Hour with Billable Factor | $101.48 | $101.48 | $101.48 | $96.40 |
| 7 | Mileage | $2.10 | $2.80 | $5.60 | N/A |
| 8 | Calculated Hourly Total with Mileage | $103.58 | $104.28 | $107.08 | N/A |
| | **Calculated Individual Rate (15-minute)** | **$25.89** | **$26.07** | **$26.77** | **$24.10** |

Table 21 shows a complete calculation for each early intervention service type as either a 15-minute fee-for-service rate or monthly per child bundled rate. These recommendations are intended to be used as guidance and the State of Utah, UDOH, BWEIP, may accept all, some, or none of these fiscal recommendations.

**TABLE 21. COMPREHENSIVE RATE RECOMMENDATIONS**

| Services | In-Person Urban | In-Person Rural | In-Person Frontier | Tele-intervention |
|---|---|---|---|---|
| Early Intervention Blended Rate (15-MIN) | $23.95 | $24.13 | $24.83 | $21.79 |
| EI Blended Rate (UT Legislative Average Hours of Service) | $162.88 | $164.07 | $168.83 | $148.16 |
| EI Blended Rate (National Average Hours of Service) | $450.33 | $453.62 | $466.78 | $409.62 |
| Audiology (15-MIN) | $20.65 | $20.83 | $21.53 | $20.13 |
| Family Training (15-MIN) | $18.71 | $18.89 | $19.59 | $15.46 |
| Nursing (15-MIN) | $26.06 | $26.23 | $26.93 | $25.28 |
| Nutrition (15-MIN) | $19.95 | $20.13 | $20.83 | $11.85 |
| Occupational Therapy (15-MIN) | $31.77 | $31.95 | $32.65 | $30.93 |
| Parent Training (15-MIN) | $18.71 | $18.89 | $19.59 | $15.46 |
| Physical Therapy (15-MIN) | $31.77 | $31.95 | $32.65 | $28.75 |
| Service Coordination (Per Child Per Month) | $157.76 | $163.36 | $185.76 | $140.96 |
| Social Work (15-MIN) | $14.37 | $14.54 | $15.24 | $13.84 |
| Special Instruction (15-MIN) | $18.71 | $18.89 | $19.59 | $15.46 |
| Special Education (15-MIN) | $18.66 | $18.84 | $19.54 | $17.23 |
| Speech-Language Pathology (15-MIN) | $25.89 | $26.07 | $26.77 | $24.10 |

The following steps calculate the early intervention rates:

1. Calculate Hourly Personnel Costs (Steps 1-3)
2. Calculate Hourly Administrative Costs (Step 4)
3. Markup rate to account for non-billable time in billable unit and apply tele-intervention modifier (Step 6)
4. Calculate mileage by rate group (Step 7)
5. Add mileage to hourly rate (Step 8)
6. Calculate early intervention 15-minute rates (Step 9)
7. Calculate early intervention bundled rate (Steps 10-11)

Table 22 illustrates the early intervention calculations for a comprehensive early intervention blended rate, that can be used rather than reimbursing at a different rate for each discipline. A narrative explanation for each step is then presented below the table.

**TABLE 22. EARLY INTERVENTION BLENDED RATE CALCULATION**

| Step | Line Item | Rate Calculation Modifier | Rate Calculation Details | In-Person Urban | In-Person Rural | In-Person Frontier | Tele-Interven-tion |
|---|---|---|---|---|---|---|---|
| 1 | Salary/Hour | N/A | Hourly salary for employees based on BLS research. | $32.06 | $32.06 | $32.06 | $32.06 |
| 2 | Fringe/Hour | 32.50% | Apply fringe rate based on cost report. | $10.42 | $10.42 | $10.42 | $10.42 |

| Step | Line Item | Rate Calculation Modifier | Rate Calculation Details | In-Person Urban | In-Person Rural | In-Person Frontier | Tele-Interven-tion |
|---|---|---|---|---|---|---|---|
| 3 | Employee Salary Plus Benefits | N/A | Add salary to the fringe from steps 1 and 2. | $42.48 | $42.48 | $42.48 | $42.48 |
| 4 | Administrative Costs (Less Mileage, plus admin salaries) | 11.12% | Calculate administrative cost modifier based on cost report. | $5.31 | $5.31 | $5.31 | $5.31 |
| 5 | Admin Costs Plus Salary | | Add steps 3 and 4 | $47.79 | $47.79 | $47.79 | $47.79 |
| 6 | Total Costs/Hour with Billable Factor | 51%, 93% | Divide the hourly rate by the billable factor.<br>Base billable: 51%<br>EI Practitioner virtual visit factor: 93% of in-person | $93.71 | $93.71 | $93.71 | $87.15 |
| 7 | Mileage | Mileage Calculations | Include In-Person mileage<br>Urban: $2.10<br>Rural: $2.80<br>Frontier: $5.60 | $2.10 | $2.80 | $5.60 | N/A |
| 8 | Calculated Total with Mileage | N/A | Add Mileage Modifier | $95.81 | $96.51 | $99.31 | N/A |
| 9 | Calculated Individual Rate | | Convert to 15-minute rate (rounded). | $23.95 | $24.13 | $24.83 | $21.79 |
| 10 | Calculated Bundled Rate (UT Legislative Mandate) | 1.7 Hours | UT EI Legislation expecting 1.7 hours per child on average of service per month.<br>Individual Rate * 4 * 1.7 | $162.88 | $164.07 | $168.83 | $148.16 |
| 11 | Calculated Bundled Rate (National Average) | 4.7 Hours | Calculated bundled rate based on national average hours of service per month (4.7).<br>Individual Rate * 4 * 4.7 | $450.33 | $453.62 | $466.78 | $409.62 |

Steps 1- 3: Calculate Hourly Personnel Costs

The rate development steps first calculate the average hourly personnel cost that accounts for service delivery from direct EI service providers. Step 1 shows that the average employee salary was $32.06 based on personnel rosters, weighted by U.S. Bureau of Labor Statistics average wage data. Step 2 applies a fringe rate to the employee pay rate based on the average fringe rate of 32.50 percent that was reported on the cost reports for early intervention personnel. Step 3 then adds the $32.06 and $10.42 figures to arrive at an employee salary plus benefits rate of $42.48.

Steps 4-5: Calculate Hourly Administrative Costs

The 11.12% figure in Step 4 represents all the administrative local EI program expenses incurred by direct service providers. This figure comes from the cost report and includes all administrative salaries, related taxes and benefits, as well as all other operating expenses other than mileage. It does not include direct service salaries, related taxes and benefits (which are all represented in the $42.48 hourly rate listed in Step 3). The total cost per hour should then equal $47.79 because the personnel total is $42.48 per hour with the 11.12% for administrative costs included ($5.31).

Step 6: Markup Rate to Account for Non-Billable Time in Billable Unit and Apply Tele-intervention Modifier

This step ensures that direct service providers are compensated for necessary administrative time that is not included in the billable unit. A billable percentage of 51% was applied to the in-person rate. The difference accounts for the travel time and other unbillable time, including leave, holidays, training etc. This means that the combined hourly rate of $47.79 represents 51% of the in-person rate of $93.71. Based on the length of time it takes to complete a tele-intervention visit compared to an in-person rate, a tele-intervention visit would take 93% of the time it takes to complete an in-person visit, leading to a calculated tele-intervention rate of $87.15.

Step 7: Calculate Mileage

Mileage was the only expense not included in the previous steps because it is applied to three different rate groups based on geographical area of in-person services and is not applied to tele-intervention services. Based on information gathered from provider focus groups about travel time prior to COVID-19, and the data gathered from time studies that did have some in-person services, mileage modifiers per hour were calculated to be $2.10 for urban areas, $2.80 for rural areas, and $5.60 for frontier areas. Table 23 illustrates how these calculations formulate the mileage cost per hour.

**TABLE 23. MILEAGE CALCULATIONS**

| Mileage Calculations | $ | Element Type |
|---|---|---|
| **Urban** | | |
| Percentage of Hour | 100.00% | Percent |
| Miles Traveled | 30 | Miles |
| Reimbursement Rate | $0.56 | Rate |
| Cost Per Trip | $16.80 | Daily Cost |
| Cost Per Hour | $2.10 | Hourly Cost |
| **Rural** | | |
| Percentage of Hour | 90.00% | Percent |
| Miles Traveled | 40 | Miles |
| Reimbursement Rate | $0.56 | Rate |
| Cost Per Trip | $22.40 | Daily Cost |
| Cost Per Hour | $2.80 | Hourly Cost |
| **Frontier** | | |
| Percentage of Hour | 110.00% | Percent |
| Miles Traveled | 80 | Miles |
| Reimbursement Rate | $0.56 | Rate |
| Cost Per Trip | $44.80 | Daily Cost |
| Cost Per Hour | $5.60 | Hourly Cost |

Steps 9-11: Calculate Base Early Intervention Rates

The hourly rates are then converted to 15-minute units, as typically fee-for-service reimbursement is 15 minutes rather than hourly. This is done by dividing each rate by four, resulting in a $23.95-unit rate for in-person urban services.

In order to provide comparison to current funding structure of Utah early intervention and alternative to a 15-minute fee-for-service rate, these were then converted to an all-inclusive per-child per-month bundled rate for each service, based on both the Utah legislatively mandated average service visits of 1.7 per-child per-month. The national average hours of service is 4.7 hours per-child per-month[11]. The Utah bundled rate for 1.7 visits would be $162.88 per month for in-person urban services, and $450.33 if it is translated to hours, based on the national average amount of services.

## *Service Coordination Rate*

PCG calculated an all-inclusive per child per month rate for Service Coordination based on an annualized estimation of the total cost to employ a service coordinator, inclusive of all costs except mileage, and then dividing that number based on the average monthly caseload of coordinators (n=34) and applying the mileage modifiers described previously. This is illustrated in Table 24.

**TABLE 24. SERVICE COORDINATION RATE CALCULATION**

| Service Coordination Line Item | Urban | Rural | Frontier | Tele-intervention |
|---|---|---|---|---|
| Personnel Costs Per Hour | $22.98 | $22.98 | $22.98 | $22.98 |
| Admin & Support | $4.67 | $4.67 | $4.67 | $4.67 |
| Total Costs/Hour Less Reported Mileage | $27.65 | $27.65 | $27.65 | $27.65 |

[11] https://www.ideainfanttoddler.org/pdf/2020-Tipping-Points-Survey.pdf

| Service Coordination Line Item | Urban | Rural | Frontier | Tele-intervention |
|---|---|---|---|---|
| Annual Work Hours | 2,080.00 | 2,080.00 | 2,080.00 | 2,080.00 |
| Annualized Cost | $57,512.00 | $57,512.00 | $57,512.00 | $57,512.00 |
| Average Number of Cases Monthly | 34 | 34 | 34 | 34 |
| Average Monthly Cost | $140.96 | $140.96 | $140.96 | $140.96 |
| Mileage Cost Per Month (assumes 1/month) | $16.80 | $22.40 | $44.80 | N/A |
| Cost Per Child Per Month | $157.76 | $163.36 | $185.76 | $140.96 |

## Inflation Considerations

The above rate calculations were calculated based on data collected primarily from fiscal years 2019 and 2020. Based on the actual implementation period, PCG recommends BWEIP consider the inflation factors described below when moving forward. For example, rates that would be implemented in FY2021 would require additional increases to account for the inflation in costs that would likely occur leading up to FY2021. There are several mechanisms to account for inflation. PCG recommends using a reliable source such as the Consumer Price Index (CPI), which is made available by the Bureau of Labor Statistics. Specifically, the CPI-U index covers all urban consumers, representing the cost of all items to 88% of the U.S. population. The Western region would be the most appropriate benchmark because there is no Utah specific CPI-U available. In addition, we recommend using the Medical Care Services index within the CPI-U to be utilized. As Table 25 illustrates, the average cost of medical care services increased approximately one to three percent over the past five years, averaging to 2.8% annually over that period.

### Table 25. Western CPI-U Inflation Over Time

| Year | Month | Annual | Inflation | Five-Year Average |
|---|---|---|---|---|
| **2016** | May | 507.337 | 3.2% | |
| **2017** | May | 511.291 | 0.8% | |
| **2018** | May | 526.890 | 3.1% | |
| **2019** | May | 544.546 | 3.4% | |
| **2020** | May | 572.427 | 5.1% | |
| **2021** | May | 579.856 | 1.3% | 2.8% |

Table 26 shows how the 2.9% inflation factor could be applied annually. Notice that the 2.9% factor is applied to each preceding year. This effectively increases the percentage each year as the dollar amount is compounded to a larger baseline. This means that each rate should be multiplied by the inflation factor based on the implementation year. For example, the $28.32 in-person urban rate would be multiplied by 102.90% for a May 2021 implementation, but 108.4% for a May 2023 implementation.

### Table 26. Inflation Factor

| Implementation Period | Inflation Factor |
|---|---|
| May 2021 | 102.80% |
| May 2022 | 105.60% |
| May 2023 | 108.40% |
| May 2024 | 111.20% |
| May 2025 | 114.00% |

# VII. Fiscal Recommendations

## Rate Structure Considerations

According to a national report by the Infant Toddler Coordinators Association (ITCA) titled *Part C System A Resource and Technical Assistance Paper for Reimbursement Methods in IDEA Part C,* a financing system as a whole and a reimbursement structure should include the following considerations:

1) Ensure Lead Agency and provider accountability, as well as provide reasonable support in a manner that is responsive to direct service providers to ensure the delivery of quality, comprehensive services to meet the needs of children and families.
2) Rates encourage & support service delivery to meet individualized child and family needs and are delivered within the context of the child's natural environment.
3) The structure should support early intervention philosophy and beliefs.
4) The structure should support best practice.
5) The structure should support the hiring and retention of qualified staff.
6) The structure should consider impact of service specific versus discipline specific reimbursement.
7) The structure should consider clustering similar disciplines at the same rate of reimbursement.
8) The structure should support a transdisciplinary approach.
9) The structure should consider the potential for higher reimbursement for home- and community-based services to account for reduced billable time and the cost of provider or practitioner transportation.
10) Rates should be rounded to the nearest whole dollar amount.
11) Reimbursement should consider the different methods across funding sources.

Upon detailed review of the current funding formula of BWEIP and the cost-reimbursement model BWIEP currently uses to fund local early intervention programs in Utah, PCG found a number of deficiencies in the current model which led to recommending a move to a different program structure. One of the key deficiencies, for example, is the ability to replicate and update the rates paid in this structure is not possible; as many of the key components of how the rates were developed are unknown to UDOH staff.

PCG has provided an alternative, replicable, and updatable rate-setting methodology that BWEIP can utilize in later years that are based off empirical data.

Below PCG has presented three potential rate methodologies for funding Part C Early Intervention, with considerations for each, as well as PCG's recommendation.

### *Fee-for-Service*

**Definition:** Fee-For-service (FFS) is a method of reimbursement whereby the provider bills for each encounter, event, or service rendered. The fee is established by the state.

**Methodology:** Service units are typically either 15-minutes or 1-hour; Service units can also be for an encounter or event (e.g., an assessment or evaluation). Note: Medicaid often requires 15-minute units and may have an algorithm to calculate the number of units to be billed (e.g., is 50 minutes three 15-minute units or four. Modifiers can be added for group verses individual service provision, or by location (i.e., home and community versus office and clinic settings). A modifier can also be applied to account for geographical differences (e.g., frontier areas).

**Considerations:**

- FFS encourages services to be provided that are on the IFSP, as all services are compensated and provide little financial risk for direct service providers delivering services because they are reimbursed for all services rendered.

- Need for controls on total expenditures (i.e., through the frequency, units, and length authorized on the IFSP to estimate financial commitment). This could include prior authorization for services on the IFSP over a certain amount.
- Unit rates can be used for Medicaid and private insurance. Having common rates can ensure that there are not disincentives for direct service providers serving children and families with differing insurance coverage as the rate of reimbursement is the same.
- A central billing system can be used to process payments. A data system needs to collect certain service log data elements in order to process payments including date of service, time in and time out, location, method (i.e., individual or group), service type, etc.
- Budgeting can be harder for EI programs as they have to estimate revenue based on utilization (i.e., the average number of service units provided to children and their families).
- Fee-for-service is the most common funding methodology nationally[12] for state early intervention Part C programs (N=51 states + DC). 27 (53%) = fee for service; 2 (4) = capitation; 11 (22.5%) = grants; 11 (22.5%) = contracts.
- FFS is used by 3 of the states surrounding UT. Fee-For-Service = AZ, CO and NM (listed as 'other' on the report); Contract = ID & WY; Capitation = NV

**PCG Recommendation:**

PCG recommends that BWEIP transition to a Fee-For-Service system in order to:

1) Have a standard reimbursement methodology between BWEIP, Medicaid, and private health plans.
2) Having a fee-for-service reimbursement with Medicaid and CHIP will enable BWEIP to propose that private health plans also be required to fund early intervention services.
3) Include Fee-for service rates for:
    - Early intervention 15-minute rate
        - Include modifiers for:
            - Tele-intervention
            - Local rate group
    - Service Coordination – monthly rate, per child, accommodating all Service Coordination activities done for a child in addition to direct services.

## *Bundled / Capitated rate*

**Definition:** A bundled, or capitated rate is single payment for the individual served and covers all the services received by the child and family. May or may not include Service Coordination.

**Methodology:** Typically, this is paid on a monthly basis for each child and family served regardless of how many services are rendered to the child and family. The rate is often developed based on the average number of units that children and families receive and is based on utilization data across the whole cohort served in a period of time (i.e., each program or provider would receive a common monthly reimbursement amount even though some individuals would receive more services units, while others would receive less).

Note: This is the current methodology used for Utah early intervention Medicaid billing

**Considerations:**

- Because the reimbursement rate is based on the average cost per child, direct service providers may limit services to more involved children and families, with the perception that they are not being reimbursed for units provided beyond the average.

[12] Infant Toddler Coordinators Association (ITCA) - State Profiles & Topical Matrices https://www.ideainfanttoddler.org/pdf/Funding-Structure.pdf

- Bundled rates are paid even if the individual receives minimal services that month, unless the billing requires a minimum services delivery (e.g., 1-hour of service must be provided in order to bill the bundled rate).
- Medicaid has moved away from bundled rates, and private insurance may not approve payment for a bundled rate.
- It is helpful for Medicaid and state funding be aligned to avoid perception of inequities in reimbursement (e.g., if Medicaid was to remain a monthly bundled rate and BWEIP move to FFS).
- Budgeting can be easier for local EI programs as they can estimate revenue based on caseload per monthly times the monthly rate.
- Can include consultation between EI professionals, as is promoted in a transdisciplinary or primary service provider model, and that is harder to reimburse under an FFS reimbursement system.

**PCG Recommendation:**

PCG does not recommend that BWEIP utilize a bundled rate methodology for contract reimbursement or Medicaid, but rather, move to a fee-for-service methodology (see above).

### *Funding Formula / Cost Report*

**Definition:** An agency-developed reimbursement system that may include information such as agency characteristics, utilization data, cost and charges, and financial expenditure data. This is typically an 'after the fact' process that can involve submission and review of costs and utilization (i.e., provision of services).

**Methodology:**

Local EI programs may be required to submit a budget for approval for the fiscal year with monthly payment adjusted based on review of data submitted on expenditures and utilization. It may involve the local EI program submitting annual budget (i.e., salaries and benefits for direct and support staff, operating costs, indirect costs, etc.) and approval by the state, with payments made against the contracted amount that is adjusted based on service utilization and actual expenditures for the month.

Note: This is the current methodology used by BWEIP, with additional adjustments for Medicaid billing and family fees.

**Considerations:**

- A Funding formula or cost reimbursement can be complex and may require additional administrative time for local EI Programs and the state BWEIP office to adjudicate costs and adjust payments.
- Adjustments may need to be made several months after services are reimbursed by third party payors (e.g., Medicaid and private insurance).
- The costs of a unit of service may be obscured and lead to perceived inequities with other funding sources (e.g., Medicaid).
- The complexity of the funding formula may confuse programs, direct service providers, funders, and advocates leading to mistrust and lack of understanding of the true cost of services.
- Involves little financial risks to local EI Programs, although they may perceive that funds 'allocated' to them in a contract are being 'taken away' if utilization or expenditures are low.
- Funding for transdisciplinary consultation between staff can be built into the formula.

**PCG Recommendation:**

PCG does not recommend that BWEIP utilize a funding formula or cost reimbursement methodology for BWEIP and rather move to a fee-for-service methodology (see above).

## POTENTIAL REVENUE ENHANCEMENTS

### *Private Insurance*

**National picture**

An increasing number of state Part C of IDEA Early Intervention programs receive reimbursement for early intervention services through private health insurance plans, generating $81.5 million nationally, and 2% of the overall revenue. However, this may be an undercount due to the fact that the state office may not know the amount of revenue collected by EI providers at the local level.

Sixteen states (46%) that responded to a national survey[13] (of 35 total surveyed) stated that they have statutory language in place requiring private health insurance plan coverage of Part C Early Intervention services. Additionally, 22 states (85%) responded (of 26 total surveyed) that there is no annual cap on payment, while four states (15%) indicated there is a cap that ranged from $3,000 to $6,500.

**Considerations:**

- Passing health care legislation at the state level that mandates payment for early intervention services increases the amount of revenue that state early intervention programs receive as compared to just billing health plans without legislation, which often results in denial of payments.
- If a state already bills Medicaid as the public health insurer the argument can be made that private health insurers should also fund these 'medically' necessary services. States often bill the private health plans the same rates and use the same codes and modifiers that they use to bill Medicaid.
- In order to pass insurance legislation, it is helpful to analyze utilization of services, (i.e., the number of services provided in a year, as well as the number and percent of children estimated to have private health insurance coverage). Public or state insurance regulators can help access these data. This can result in a calculation of the projected revenue that would be realized through billing private health plans.
- State Part C Early Intervention Programs must decide whether to include an annual cap that private health plans would pay for EI services. As Medicaid does not have an annual cap, so an argument can be made that a cap should also not be applied to private health insurance payments.
- Some state Part C Early Intervention Programs have developed central billing systems that have the advantage of removing the administrative burden on local EI programs that otherwise would need to hire and train insurance billing staff to process private health insurance claims. A central billing system collects delivered services data (e.g., date of service, time, service, location, and method that is then converted into a billable claim with the appropriate billing code and modifier. The actual claims processing, reconciliation, and follow-up can be done by state staff or a through contracted billing agent.
- State Part C Early Intervention Programs must also decide whether they will implement a 'pay and chase' system, where the state 'pays' the local EI program for the services rendered and then 'chases' the 3rd party health plan for the reimbursement, which comes to the state as revenue, verses direct payment to local EI programs.
- Medicaid often requires the billing of private health plans when there is co-insurance (i.e., the child is covered by both Medicaid and private health plan), with Medicaid being the payor of last resort.
- State insurance mandates do not apply to self-insured health plans subject to ERISA (Employee Retirement Income Security Act of 1974). Therefore, It will be necessary to research the percent of the state that is covered by fully insured employer-sponsored group health plans verses self-insured plans in order to project potential revenue for early intervention.

[13] Infant Toddler Coordinators Association - 2018 Finance Survey Report
https://www.ideainfanttoddler.org/pdf/Finance-Survey-Report-Pt-2-public-private-insurance-family-fees.pdf

**PCG Recommendation:**

PCG recommends that BWEIP and the Utah Department of Health begin to submit claims for direct services for early intervention to commercial insurance payors (also called private insurance). There are different ways to begin this process, and we suggest either working directly with the payors in the beginning to identify early intervention claims and how they would be submitted and paid or to submit claims through a traditional claiming process, coding claims as routine clinical services. In the case that commercial payors still do not respond or have high denial rates, UDOH and the state legislature can work to pass legislative mandate requiring the payors to accept, process, and pay for early intervention claims. Including private insurance into the mix of revenue streams for BWEIP can potentially provide a significant boost funding and reduce reliance on state funding.

**Resources:**

The national Early Childhood Technical Assistance Center has developed a Planning Tool and various resources for 'Building the Case to Expand Medicaid and Private Insurance for Early Intervention'

## *Medicaid*

**National Picture:**

All state Part C programs report accessing Medicaid funds to some degree. Nationally, federal Medicaid revenues are $848 million, which is 35% of the total revenue reported by states. However, it is thought that this is an undercount as not all states can accurately account for all Medicaid revenue if billing is done at the local level.

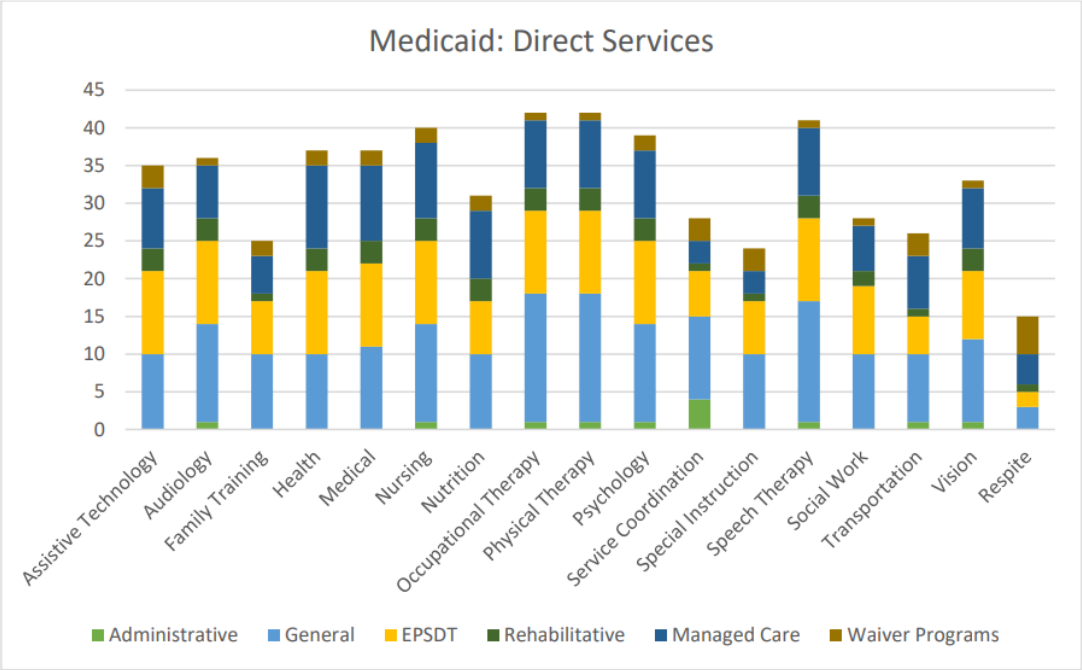
Medicaid is managed regionally by the Centers for Medicare and Medicaid Services (CMS), which approves all state Medicaid plans. State plan differences, as well as varying early intervention services and service models, often result in differences in the early intervention services that are reimbursed by Medicaid between states. Also, Medicaid funding for early intervention may be under different forms of Medicaid, including: Early Periodic Screening, Diagnosis & Treatment (EPSDT), managed care, waiver programs, rehabilitative, and general Medicaid state plan, and may also include administrative claiming. Some states need to be able to 'carve out' early intervention services from managed care systems.

In addition to therapy services, 27 (73%) states are reimbursed by Medicaid for 'Special Instruction' and 30 (81%) are reimbursed for Service Coordination.

Figure 34[14] shows the number of states (N = 37) that utilize the various forms of Medicaid to fund IDEA Part C early intervention services.

[14] Infant Toddler Coordinators Association 2018 Finance Survey
https://www.ideainfanttoddler.org/pdf/Finance-Survey-Report-Pt-2-public-private-insurance-family-fees.pdf

**FIGURE 34: SUMMARY OF STATES USING MEDICAID FUNDED DIRECT SERVICES**




**Considerations:**

- Medicaid can fund all EI services, including Special Instruction and Service Coordination.
- Medicaid is often willing to fund EI services at the same rate paid to direct service providers with state general funds and IDEA Part C funds. This is especially true for states where the state match (Federal Medical Assistance Percentage) appropriation from the legislature comes to the state EI program. Having the same rates paid by Medicaid and state general funded reduces the potential for provider to favor serving one group of children and families based on their insurance coverage.
- Some state Part C EI programs have developed central billing systems that collect delivered services data (e.g., date of service, time (minutes), service type, location, method (individual or group) that is then converted into a billable file with the appropriate billing code and modifier. The actual claims processing, reconciliation, and follow-up can be done by state staff or through a contract billing agent.
- Working with Medicaid to enable the state EI program to access the Medicaid enrollment file conduct eligibility checks for the billing of EI services for all Medicaid enrolled children, rather than relying on direct service providers to ask families whether their child is enrolled in Medicaid and obtaining the Medicaid card / number and entering into a database (which can result in data entry errors). Data sharing agreements are not needed for a billing agent to collect enrollment data as part of the HIPAA electronic transaction 270/271 'Health Care Eligibility Benefit Inquiry and Response' process (270/271).

**PCG Recommendation:**

PCG recommends that BWEIP partner with the Utah Department of Health's Division of Medicaid and Health Financing to explore maximizing federal Medicaid funding that can be accessed to fund early intervention, including:

- Moving from the current monthly bundled rate to a fee-for-service rate, with a common 15-minute rate for early intervention services including Therapies, Nursing, Special Instruction, developmental instruction, etc. This will involve determining the billing codes and modifiers (from

the Healthcare Common Procedure Coding System (HCPCS)) for early intervention home and community services and center and group services.
- Establishing a separate monthly Service Coordination rate.
- Conduct eligibility checks with all children recorded in BTOTS for Medicaid enrolled children to ensure that all EI services are billed to Medicaid for enrolled children.
- Considering a central billing system to bill Medicaid for all enrolled children.

**Resources:**

The national Early Childhood Technical Assistance Center has developed a Planning Tool and various resources for 'Building the Case to Expand Medicaid and Private Insurance for Early Intervention'.

## POSSIBLE IMPLEMENTATION BARRIERS, RISKS AND STRATEGIES

The following table 27 shows the possible implementation barriers and risk and strategies regarding how the BWEIP and the Department of Health might address them:

### TABLE 27: POSSIBLE BARRIERS, RISKS AND STRATEGIES

| Possible Implementation Barriers / Risks | Strategies to Address Barrier(s) |
|---|---|
| 1. **Fee-For-Service** (FFS) – while a FFS system incentivizes the provision of all services on the IFSP and may increase the average number of survives up to closer to the national average of 4.5 hours per month - as providers are reimbursed for all services provided - it could lead to the overprovision of services by programs to generate greater revenue. | BWEIP should ensure that monitoring of both IFSP service authorization and service utilization is reasonable. This can include reports that show service levels over a certain amount per month for auditing purposes and prior review for services levels over an extremely high monthly level. This will require that the BWEIP BTOTS data system is able to both capture and report these data. |
| 2. **Fee-For-Service** – FFS could be seen by EI programs as requiring additional documentation and service logging as currently not all direct services are entered into BTOTS. | A FFS system will encourage EI programs to enter all services accurately into BTOTS in order to be reimbursed. Programs will need to set up procedures to ensure entry of all direct services provided for paper service logs. Note: BWEIP could explore electronic service logging. Where a provider logs the service on their device (smart phone, tablet, or laptop) which is uploaded into the database.<br><br>Note: complete and accurate service logging will enable BWEIP to conduct analysis of service utilization, along with other reporting and analysis. |
| 3. **Fee-For-Service** – could be seen by EI programs as less predictable for projecting revenue for budgeting | FFS provides a direct payment for the services provided, and if used for state and Medicaid, a report in the BTOTS data system can provide an accurate picture of the reimbursement amounts the program will receive. Programs can conduct revenue forecasts month the month of the revenue projected to receive and after the first year they will have a history for comparison of month-to-month trends e.g. a dip in service provision and revenue December due to the holiday |

| Possible Implementation Barriers / Risks | Strategies to Address Barrier(s) |
|---|---|
| **4. Fee-For-Service** – Concern regarding CFR (Code of Federal Regulations) ***§200.400 (g)*** *"The non-Federal entity may not earn or keep any profit resulting from Federal financial assistance, unless explicitly authorized by the terms and conditions of the Federal award.*<br><br>Currently, BWEIP and the DOH have determined that EI Programs are 'subrecipients' rather than 'contractors'. *2 CFR § 200.93 "Subrecipient means a non-Federal entity that receives a subaward from a pass-through entity to carry out part of a Federal program; but does not include an individual that is a beneficiary of such program. A subrecipient may also be a recipient of other Federal awards directly from a Federal awarding agency".*<br><br>There is a concern that moving EI Programs from a status of 'subrecipient' to 'contractor' would result in a significant change to the EI system, including:<br>i) EI Programs no longer being able to determine eligibility and develop IFSPs.<br>ii) EI Programs being no longer be governed by federal IDEA Part C regulations, but by state policies.<br>iii) The BWEIP would have the sole 'risk' or requirement for compliance with IDEA Part C, rather than being shared with EI programs.<br>iv) Selection of EI programs would be through a competitive bid procurement process at least every 5 years with price being the deciding factor. | The following are possible strategies to address the concerns with moving EI programs from the status of 'subrecipients' to 'contractors':<br><br>i) Many state EI Part C programs across the nation contract with organizations to provide EI services, including determining eligibility and developing the IFSP. The role of the state lead agency is to provide 'general supervision' and accountability (including periodic monitoring) of the local EI programs. The Infant Toddler Coordinators Association (ITCA) can provide assistance, including connecting BWEIP with state EI Part C programs that contract for services and have local programs and teams that determine eligibility and develop IFSPs.<br>ii) As a contractor, EI programs would need to provide EI services in accordance with state regulations / policies. Arguably this is the case now as OSEP (Office of Special Education Programs) approves state regulations / polices as being in line with federal regulations (the BWEIP policies were approved in July 2019). OSEP holds the BWEIP program accountable for ensuring compliance by EI Programs with the BWEIP policies, making findings and ensuring corrective action. The requirement to provide EI services in accordance with BWEIP policies would be included in the scope of the contract with EI programs.<br>iii) Currently the 'risk' or accountability for ensuring compliance with IDEA is with BWEIP, as the lead for IDEA Part C and based on the assurances signed in the annual grant application to OSEP. The risk for the EI program is that their contract is terminated or not renewed if they are not in compliance and don't correct findings of non-compliance with the BWEIP policies.<br>iv) With an RFP – price is taken out of the scoring factors if the state utilizes a fee-for-service system, as each provider is agreeing to provide the services based on the state's established fees, and not based on a proposed fee or proposed budget. Therefore, the bid or proposal is based on a review other factors, including: organizational experience; qualifications; and understanding and ability to provide the EI in accordance with both polices and recognized best practices. ITCA can help get copies of procurements from other states, to assist in the develop of an RFP by BWEIP. |

| Possible Implementation Barriers / Risks | Strategies to Address Barrier(s) |
|---|---|
| 5. **Medicaid** – costs may increase under a FFS system where programs are reimbursed for each 15 min service and monthly Service Coordination delivered compared to the monthly bundled rate. | Meetings held between BWEIP and the Medicaid state team can include the provision of service utilization data for cost projections – including impact on the potential increase in federal revenue and state match. Meetings can also examine potential service codes and modifiers for the proposed rates for reimbursement and to enable accurate reporting; e.g. unique codes for BWEIP services that allows reporting separate from other children's medical or rehabilitative services (typically known as a TL modifier). |
| 6. **Private insurance** – there may resistance from policy makers and EI programs and parents to bill private health insurance. | ● BWEIP can explain to policy makers the increase in revenue that this could generate, and that private health plans should be seen as a funder of EI services just like Medicaid, which is the largest public health insurance plan.<br>● EI programs may be concerned with the administrative time and costs associated with billing private health plan which could be alleviated if the billing is done centrally by the state office.<br>● Parents may be concerned with increase costs of co-pays and deductibles which could be addressed in a private insurance statute for EI, that prevents copays and deductibles being charged to families. However, even without a statutory language change, BWEIP could begin to bill private insurance and issue a policy that states that co-pays or deductibles will not be collected from families; e.g., if the EI service is $115.00 and the insurance plan pays $100.00, i.e. less a $15.00 co-pay – BWEIP would just not collect the $15.00 from the family. |
| 7. **Central Billing System** – this could be seen as a costly and time intensive infrastructure change for BWEIP even if it would increase revenue. | BWEIP can consider a request for information for potential vendors prior to issuing a procurement that could establish the range of models for central reimbursement system administration and payment (including build costs, monthly administrative fee, contingency i.e. percent of revenue collected, or hybrid) that can change the upfront costs to BWEIP. |
| 8. **Family fees** – Family fees and other 'out-of-pocket expenses' may be prohibited in IDEA Part C under proposed federal changes*, which would reduce the BWEIP revenue by approximately $660K annually. | With the potential to lose revenue from collecting family fees it would be strategic for BWEIP and the Department of Health to look at: expanding other revenue sources such as Medicaid (see #5 above); pursuing new revenue sources such as private health insurance billing (see #6 above); and / or exploring billing efficiencies to maximize revenue such as a central billing system (see #7 above) to make up for this reduced revenue. |

*These same federal changes would prohibit any family cost participation that results in out of pocket expenses for families receiving early intervention (IDEA Part C) services, including copays and deductibles addressed in #6 above. This would enable BWEIP to bill private health insurance without it having an adverse effect on families.

# APPENDIX A: INTERVIEW QUESTIONS

The following guiding questions were submitted to each local EI program in advance of our interviews and were used to guide the interview itself.

**INTRODUCTION:** Each PCG member should introduce themselves (and PCG) to the Program Representative(s) by providing their name and title. PCG member may share the purpose for the interview: as PCG gears up to perform the Cost Study for the Utah Baby Watch program, these interviews are an opportunity for us to learn about your specific program's experience, as well as your perceptions of how Baby Watch visits are currently being funded and how it may be improved in the future.

1. **Funding Structure**
    a. Tell me about the challenges you see in the current funding formula and/or reimbursement methodology in which you receive funding from the state?
    b. Where do you see areas for improvement?
    c. What other major changes would you like to see?
2. **Medicaid**
    a. What difficulties do you have in engaging and billing Medicaid?
    b. Do you see any opportunities or areas that may be improved regarding insurance billing for your agency or even statewide?
3. **Hurdles from Area Served**
    a. What are the major hurdles your direct service providers face in serving children that stem from your agency's service area?
    b. What are the major hurdles your agency faces that stem from your service area?
    c. What could be done to alleviate these hurdles?
    d. Have you been utilizing telehealth/virtual sessions for seeing children? How has this been going?
4. **Child Find**
    a. To what extent do you engage in child find activities? What areas of child find would you like to see improved or what do you believe is working well?
5. **Recruitment and Retention**
    a. What are the major areas in which you may struggle in provider recruitment and retention (e.g. certain discipline areas, or specific areas)?
    b. What do you recommend to improve recruitment and retention?
6. **IFSP Requirements**
    a. Do you have difficulties in meeting the IFSP-required number of services a child is entitled to?
    b. What are your opinions on the 1.7 threshold for services?
    c. What can be done to more easily comply with IFSP requirements?
    d. How should IFSP requirements change, if at all?

# APPENDIX B. U.S. BUREAU OF LABOR STATISTICS (BLS) AND UTAH EARLY INTERVENTION DISCIPLINES

| Discipline | BLS Discipline Description | UT Regulation Discipline Service Description |
|---|---|---|
| Audiologist | **Audiologist:** Assess and treat persons with hearing and related disorders. May fit hearing aids and provide auditory training. May perform research related to hearing problems. | **Audiology Services:**<br>As described in §303.13, services that include:<br>• Identification of children with auditory impairments, using at-risk criteria and appropriate audiologic screening techniques;<br>• Determination of the range, nature, and degree of hearing loss and communication functions, by use of audiologic evaluation procedures<br>• Referral for medical and other services necessary for the habilitation or rehabilitation of an infant or toddler with a disability who has an auditory impairment;<br>• Provision of auditory training, aural rehabilitation, speech reading and listening devices, orientation and training, and other services;<br>• Provision of services for prevention of hearing loss;<br>• Determination of the child's individual amplification, including selecting, fitting, and dispensing appropriate listening and vibrotactile devices, and evaluating the effectiveness of those devices. |
| Developmental Specialist* | **Special Education Teachers, Preschool:** Teach academic, social, and life skills to preschool-aged students with learning, emotional, or physical disabilities. Includes teachers who specialize and work with students who are blind or have visual impairments; students who are deaf or have hearing impairments; and students with intellectual disabilities. | **Early Intervention Specialist:** An early intervention employee who holds a current Early Intervention Specialist credential and serves families as part of an IFSP team. All direct service providers, regardless of education or licensure, are Early Intervention Specialists. |
| Nurse | **Registered Nurses:** Assess patient health problems and needs, develop and implement Nursing care plans, and maintain medical records. Administer Nursing care to ill, injured, convalescent, or disabled patients. May advise patients on health maintenance and disease prevention or provide case management. Licensing or registration required. Includes Clinical Nurse Specialists. Excludes "Nurse Anesthetists" (29-1151), "Nurse Midwives" (29-1161), and "Nurse Practitioners" (29-1171). | **Nursing Services:**<br>As described in §303.13, services that include:<br>• The assessment of health status for the purpose of providing Nursing care, including the identification of patterns of human response to actual or potential health problems<br>• The provision of Nursing care to prevent health problems, restore or improve functioning, and promote optimal health and development<br>• The administration of medications, treatments, and regimens prescribed by a licensed physician |

| Discipline | BLS Discipline Description | UT Regulation Discipline Service Description |
|---|---|---|
| Occupational Therapist | **Occupational Therapists:** Assess, plan, and organize rehabilitative programs that help build or restore vocational, homemaking, and daily living skills, as well as general independence, to persons with disabilities or developmental delays. Use therapeutic techniques, adapt the individual's environment, teach skills, and modify specific tasks that present barriers to the individual. Excludes "Rehabilitation Counselors" (21-1015). | **Occupational Therapy (OT) Services:** As described in §303.13, includes services to address the functional needs of an infant or toddler with a disability related to adaptive development, adaptive behavior, and play, and sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in home, school, and community settings, and include:<br>• Identification, assessment, and intervention<br>• Adaptation of the environment, and selection, design, and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills<br>• Prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability |
| Physical Therapist | **Physical Therapists:** Assess, plan, organize, and participate in rehabilitative programs that improve mobility, relieve pain, increase strength, and improve or correct disabling conditions resulting from disease or injury. | **Physical Therapy (PT) Services:** As described in §303.13, services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. These services include: • Screening, evaluation, and assessment of children to identify movement dysfunction; • Obtaining, interpreting, and integrating information appropriate to program planning to prevent, alleviate, or compensate for movement dysfunction and related functional problems; • Providing individual and group services or treatment to prevent, alleviate, or compensate for, movement dysfunction and related functional problems. |
| Psychologist | **Clinical, Counseling, and School Psychologists:** Diagnose and treat mental disorders; learning disabilities; and cognitive, behavioral, and emotional problems, using individual, child, family, and group therapies. May design and implement behavior modification programs. | **Psychological Services:** As described in §303.13, includes:<br>• Administering psychological and developmental tests and other assessment procedures<br>• Interpreting assessment results<br>• Obtaining, integrating, and interpreting information about child behavior and child and family conditions related to learning, mental health, and development<br>• Planning and managing a program of psychological services, including psychological counseling for children and parents, family counseling, consultation on child development, parent training, and education programs |

| Discipline | BLS Discipline Description | UT Regulation Discipline Service Description |
|---|---|---|
| Registered Dietician | **Dietitians and Nutritionists:** Plan and conduct food service or nutritional programs to assist in the promotion of health and control of disease. May supervise activities of a department providing quantity food services, counsel individuals, or conduct nutritional research. | **Nutrition Services:** As described in §303.13, services that include:<br>• Conducting individual assessments in a) nutritional history and dietary intake; b) anthropometric, biochemical, and clinical variables; c) feeding skills and feeding problems; d) food habits and food preferences<br>• Developing and monitoring appropriate plans to address the nutritional needs of children eligible under this part<br>• Making referrals to appropriate community resources to carry out nutritional goals |
| Service Coordinator* | **Child, Family, and School Social Workers:** Provide social services and assistance to improve the social and psychological functioning of children and their families and to maximize the family well-being and the academic functioning of children. May assist parents, arrange adoptions, and find foster homes for abandoned or abused children. In schools, they address such problems as teenage pregnancy, misbehavior, and truancy. May also advise teachers. | **Service Coordinator:** As described in §303.34, the individual who is responsible for 1) coordinating all services required under Part C across agency lines; and 2) Serving as the single point of contact for the family. |
| Social Worker* | **Child, Family, and School Social Workers:** Provide social services and assistance to improve the social and psychological functioning of children and their families and to maximize the family well-being and the academic functioning of children. May assist parents, arrange adoptions, and find foster homes for abandoned or abused children. In schools, they address such problems as teenage pregnancy, misbehavior, and truancy. May also advise teachers. | **Social Worker Services:** As described in §303.13, services provided, as appropriate, by social workers, psychologists, and other qualified personnel to assist the family of an infant or toddler with a disability in understanding the special needs of the child and enhancing the child's development. |
| Special Educator | **Special Education Teachers, Preschool: Teach academic, social, and life skills to preschool-aged students with learning, emotional, or physical disabilities. Includes teachers who specialize and work with students who are blind or have visual impairments; students who are deaf or have hearing impairments; and students with intellectual disabilities.** | |

| Discipline | BLS Discipline Description | UT Regulation Discipline Service Description |
|---|---|---|
| Speech-Language Pathologist | **Speech-Language Pathologists: Assess and treat persons with speech, language, voice, and fluency disorders. May select alternative communication systems and teach their use. May perform research related to speech and language problems.** | **Speech-Language Pathology (SLP) Services:** As described in §303.13, includes:<br>• Identification of children with communication or language disorders and delays in development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills<br>• Referral for medical or other discipline services necessary for the habilitation or rehabilitation of children with communication or language disorders and delays in development of communication skills<br>• Provision of services for the habilitation, rehabilitation, or prevention of communication or language disorders or delays in development of communication skills |

BLS discipline descriptions from May 2016 State Occupational Employment and Wage Estimates published by the Bureau of Labor Statistics

Utah Department of Health Baby Watch Early Intervention Program. (2020). 2020 Glossary & Acronyms [PDF file].

Key:
Tan: no direct BLS discipline match
Pink: not found in UT Glossary & Acronyms Document

# APPENDIX C. RATE CALCULATION TABLES BY SERVICE

## BLENDED EARLY INTERVENTION SERVICE RATE

| Step | Line Item | Rate Calculation Modifier | Rate Calculation Details | In-Person Urban | In-Person Rural | In-Person Frontier | Tele-Intervention |
|---|---|---|---|---|---|---|---|
| 1 | Salary/Hour | N/A | Hourly salary for employees based on BLS research. | $32.06 | $32.06 | $32.06 | $32.06 |
| 2 | Fringe/Hour | 32.50% | Apply fringe rate based on cost report. | $10.42 | $10.42 | $10.42 | $10.42 |
| 3 | Employee Salary Plus Benefits | N/A | Add salary to fringe from steps 1 and 2. | $42.48 | $42.48 | $42.48 | $42.48 |
| 4 | Administrative Costs (Less Mileage, plus admin salaries) | 11.12% | Calculate administrative cost modifier based on cost report. | $5.31 | $5.31 | $5.31 | $5.31 |
| 5 | Admin Costs Plus Salary | | Add steps 3 and 4 | $47.79 | $47.79 | $47.79 | $47.79 |
| 6 | Total Costs/Hour with Billable Factor | 51%, 93% | Divide the hourly rate by the billable factor.<br>Base billable: 51%<br>EI Practitioner virtual visit factor: 93% of in-person | $93.71 | $93.71 | $93.71 | $87.15 |
| 7 | Mileage | Mileage Calculations | Include In-Person mileage<br>Urban: $2.10<br>Rural: $2.80<br>Frontier: $5.60 | $2.10 | $2.80 | $5.60 | N/A |
| 8 | Calculated Total with Mileage | N/A | Add Mileage Modifier | $95.81 | $96.51 | $99.31 | N/A |
| 9 | Calculated Individual Rate | | Convert to 15-minute rate (rounded). | $23.95 | $24.13 | $24.83 | $21.79 |

| Step | Line Item | Rate Calculation Modifier | Rate Calculation Details | In-Person Urban | In-Person Rural | In-Person Frontier | Tele-Intervention |
|---|---|---|---|---|---|---|---|
| 10 | Calculated Bundled Rate (UT Legislative Mandate) | 1.7 | UT EI Legislation expecting 1.7 services per child on average of service per month. Individual Rate * 4 * 1.7 | $162.88 | $164.07 | $168.83 | $148.16 |
| 11 | Calculated Bundled Rate (National Average) | 4.7 | Calculated bundled rate based on national average hours of service per month (4.7). Individual Rate * 4 * 4.7 | $450.33 | $453.62 | $466.78 | $409.62 |

## Speech-Language Pathology

| Step | Line Item | Rate Calculation Modifier | Rate Calculation Details | In-Person Urban | In-Person Rural | In-Person Frontier | Tele-Intervention |
|---|---|---|---|---|---|---|---|
| 1 | Salary/Hour | N/A | Hourly salary for employees based on BLS research. | $38.80 | $38.80 | $38.80 | $38.80 |
| 2 | Fringe/Hour | 32.50% | Apply fringe rate based on cost report. | $12.61 | $12.61 | $12.61 | $12.61 |
| 3 | Employee Salary Plus Benefits | N/A | Add salary to fringe from steps 1 and 2. | $51.41 | $51.41 | $51.41 | $51.41 |
| 4 | Administrative Costs (Less Mileage, plus admin salaries) | 11.12% | Calculate administrative cost modifier based on cost report. | $6.43 | $6.43 | $6.43 | $6.43 |
| 5 | Admin Costs Plus Salary | | Add Steps 3 and 4 | $57.84 | $57.84 | $57.84 | $57.84 |
| 6 | Total Costs/Hour with Billable Factor | 57%, 95% | Divide the hourly rate by the billable factor.<br>Base billable: 57%<br>SLP virtual visit factor: 95% of in-person | $101.48 | $101.48 | $101.48 | $96.40 |
| 7 | Mileage | Mileage Calculations | Include In-Person mileage<br>Urban: $2.10<br>Rural: $2.80<br>Frontier: $5.60 | $2.10 | $2.80 | $5.60 | N/A |
| 8 | Calculated Total with Mileage | N/A | Add Mileage Modifier | $103.58 | $104.28 | $107.08 | N/A |
| 9 | Calculated Individual Rate | | Convert to 15-minute rate (rounded). | $25.89 | $26.07 | $26.77 | $24.10 |

## Special Instruction/Developmental Therapy

| Step | Line Item | Rate Calculation Modifier | Rate Calculation Details | In-Person Urban | In-Person Rural | In-Person Frontier | Tele-Intervention |
|---|---|---|---|---|---|---|---|
| 1 | Salary/Hour | N/A | Hourly salary for employees based on BLS research. | $21.47 | $21.47 | $21.47 | $21.47 |
| 2 | Fringe/Hour | 32.50% | Apply fringe rate based on cost report. | $6.98 | $6.98 | $6.98 | $6.98 |
| 3 | Employee Salary Plus Benefits | N/A | Add salary to fringe from steps 1 and 2. | $28.45 | $28.45 | $28.45 | $28.45 |
| 4 | Administrative Costs (Less Mileage, plus admin salaries) | 11.12% | Calculate administrative cost modifier based on cost report. | $3.56 | $3.56 | $3.56 | $3.56 |
| 5 | Admin Costs Plus Salary | | Add steps 7 and 8 | $32.01 | $32.01 | $32.01 | $32.01 |
| 6 | Total Costs/Hour with Billable Factor | 44%, 85% | Divide the hourly rate by the billable factor.<br>Base billable: 44%<br>DT virtual visit factor: 85% of in-person | $72.74 | $72.74 | $72.74 | $61.83 |
| 7 | Mileage | Mileage Calculations | Include In-Person mileage<br>Urban: $2.10<br>Rural: $2.80<br>Frontier: $5.60 | $2.10 | $2.80 | $5.60 | N/A |
| 8 | Calculated Total with Mileage | N/A | Add Mileage Modifier | $74.84 | $75.54 | $78.34 | N/A |
| 9 | Calculated Individual Rate | | Convert to 15-minute rate (rounded). | $18.71 | $18.89 | $19.59 | $15.46 |

## Occupational Therapy

| Step | Line Item | Rate Calculation Modifier | Rate Calculation Details | In-Person Urban | In-Person Rural | In-Person Frontier | Tele-Intervention |
|---|---|---|---|---|---|---|---|
| 1 | Salary/Hour | N/A | Hourly salary for employees based on BLS research. | $41.92 | $41.92 | $41.92 | $41.92 |
| 2 | Fringe/Hour | 32.50% | Apply fringe rate based on cost report. | $13.62 | $13.62 | $13.62 | $13.62 |
| 3 | Employee Salary Plus Benefits | N/A | Add salary to fringe from steps 1 and 2. | $55.54 | $55.54 | $55.54 | $55.54 |
| 4 | Administrative Costs (Less Mileage, plus admin salaries) | 11.12% | Calculate administrative cost modifier based on cost report. | $6.95 | $6.95 | $6.95 | $6.95 |
| 5 | Admin Costs Plus Salary | | Add steps 3 and 4 | $62.49 | $62.49 | $62.49 | $62.49 |
| 6 | Total Costs/Hour with Billable Factor | 50%, 99% | Divide the hourly rate by the billable factor. Base billable: 50% OT virtual visit factor: 99% of in-person | $124.99 | $124.99 | $124.99 | $123.74 |
| 7 | Mileage | Mileage Calculations | Include In-Person mileage Urban: $2.10 Rural: $2.80 Frontier: $5.60 | $2.10 | $2.80 | $5.60 | N/A |
| 8 | Calculated Total with Mileage | N/A | Add Mileage Modifier | $127.09 | $127.79 | $130.59 | N/A |
| 9 | Calculated Individual Rate | | Convert to 15-minute rate (rounded). | $31.77 | $31.95 | $32.65 | $30.93 |

## Special Education

| Step | Line Item | Rate Calculation Modifier | Rate Calculation Details | In-Person Urban | In-Person Rural | In-Person Frontier | Tele-Intervention |
|---|---|---|---|---|---|---|---|
| 1 | Salary/Hour | N/A | Hourly salary for employees based on BLS research. | $24.82 | $24.82 | $24.82 | $24.82 |
| 2 | Fringe/Hour | 32.50% | Apply fringe rate based on cost report. | $8.07 | $8.07 | $8.07 | $8.07 |
| 3 | Employee Salary Plus Benefits | N/A | Add salary to fringe from steps 1 and 2. | $32.89 | $32.89 | $32.89 | $32.89 |
| 4 | Administrative Costs (Less Mileage, plus admin salaries) | 11.12% | Calculate administrative cost modifier based on cost report. | $4.11 | $4.11 | $4.11 | $4.11 |
| 5 | Admin Costs Plus Salary | | Add steps 3 and 4 | $37.00 | $37.00 | $37.00 | $37.00 |
| 6 | Total Costs/Hour with Billable Factor | 51, 95% | Divide the hourly rate by the billable factor.<br>Base billable: 51%<br>SPED virtual visit factor: 99% of in-person | $72.55 | $72.55 | $72.55 | $68.92 |
| 7 | Mileage | Mileage Calculations | Include In-Person mileage<br>Urban: $2.10<br>Rural: $2.80<br>Frontier: $5.60 | $2.10 | $2.80 | $5.60 | N/A |
| 8 | Calculated Total with Mileage | N/A | Add Mileage Modifier | $74.65 | $75.35 | $78.15 | N/A |
| 9 | Calculated Individual Rate | | Convert to 15-minute rate (rounded). | $18.66 | $18.84 | $19.54 | $17.23 |

## SERVICE COORDINATION

| Service Coordination Line Item | Urban | Rural | Frontier | Tele-intervention |
|---|---|---|---|---|
| Personnel Costs Per Hour | $22.98 | $22.98 | $22.98 | $22.98 |
| Admin & Support | $4.67 | $4.67 | $4.67 | $4.67 |
| Total Costs/Hour Less Reported Mileage | $27.65 | $27.65 | $27.65 | $27.65 |
| Annual Work Hours | 2,080.00 | 2,080.00 | 2,080.00 | 2,080.00 |
| Annualized Cost | $57,512.00 | $57,512.00 | $57,512.00 | $57,512.00 |
| Average Number of Cases Monthly | 34 | 34 | 34 | 34 |
| Average Monthly Cost | $140.96 | $140.96 | $140.96 | $140.96 |
| Mileage Cost Per Month (assumes 1/month) | $16.80 | $22.40 | $44.80 | N/A |
| Cost Per Child Per Month | $157.76 | $163.36 | $185.76 | $140.96 |
| Calculated Service Coordination Rate (rounded) | $158 | $163 | $186 | $141 |

## PHYSICAL THERAPY

| Step | Line Item | Rate Calculation Modifier | Rate Calculation Details | In-Person Urban | In-Person Rural | In-Person Frontier | Tele-Intervention |
|---|---|---|---|---|---|---|---|
| 1 | Salary/Hour | N/A | Hourly salary for employees based on BLS research. | $43.60 | $43.60 | $43.60 | $43.60 |
| 2 | Fringe/Hour | 32.50% | Apply fringe rate based on cost report. | $14.17 | $14.17 | $14.17 | $14.17 |
| 3 | Employee Salary Plus Benefits | N/A | Add salary to fringe from steps 1 and 2. | $57.77 | $57.77 | $57.77 | $57.77 |
| 4 | Administrative Costs (Less Mileage, plus admin salaries) | 11.12% | Calculate administrative cost modifier based on cost report. | $7.23 | $7.23 | $7.23 | $7.23 |
| 5 | Admin Costs Plus Salary | | Add steps 3 and 4 | $65.00 | $65.00 | $65.00 | $65.00 |
| 6 | Total Costs/Hour with Billable Factor | 52%, 92% | Divide the hourly rate by the billable factor.<br>Base billable: 35%<br>PT virtual visit factor: 92% of in-person | $125.00 | $125.00 | $125.00 | $115.00 |
| 7 | Mileage | Mileage Calculations | Include In-Person mileage<br>Urban: $2.10<br>Rural: $2.80<br>Frontier: $5.60 | $2.10 | $2.80 | $5.60 | N/A |
| 8 | Calculated Total with Mileage | N/A | Add Mileage Modifier | $127.10 | $127.80 | $130.60 | N/A |
| 9 | Calculated Individual Rate | | Convert to 15-minute rate (rounded). | $31.77 | $31.95 | $32.65 | $28.75 |

## NURSING

| Step | Line Item | Rate Calculation Modifier | Rate Calculation Details | In-Person Urban | In-Person Rural | In-Person Frontier | Tele-Intervention |
|---|---|---|---|---|---|---|---|
| 1 | Salary/Hour | N/A | Hourly salary for employees based on BLS research. | $33.57 | $33.57 | $33.57 | $33.57 |
| 2 | Fringe/Hour | 32.50% | Apply fringe rate based on cost report. | $10.91 | $10.91 | $10.91 | $10.91 |
| 3 | Employee Salary Plus Benefits | N/A | Add salary to fringe from steps 1 and 2. | $44.48 | $44.48 | $44.48 | $44.48 |
| 4 | Administrative Costs (Less Mileage, plus admin salaries) | 11.12% | Calculate administrative cost modifier based on cost report. | $5.57 | $5.57 | $5.57 | $5.57 |
| 5 | Admin Costs Plus Salary | | Add steps 3 and 4 | $50.05 | $50.05 | $50.05 | $50.05 |
| 6 | Total Costs/Hour with Billable Factor | 49%,99% | Divide the hourly rate by the billable factor.<br>Base billable: 49%<br>NURS virtual visit factor: 99% of in-person | $102.13 | $102.13 | $102.13 | $101.11 |
| 7 | Mileage | Mileage Calculations | Include In-Person mileage<br>Urban: $2.10<br>Rural: $2.80<br>Frontier: $5.60 | $2.10 | $2.80 | $5.60 | N/A |
| 8 | Calculated Total with Mileage | N/A | Add Mileage Modifier | $104.23 | $104.93 | $107.73 | N/A |
| 9 | Calculated Individual Rate | | Convert to 15-minute rate (rounded). | $26.06 | $26.23 | $26.93 | $25.28 |

## Social Work

| Step | Line Item | Rate Calculation Modifier | Rate Calculation Details | In-Person Urban | In-Person Rural | In-Person Frontier | Tele-Intervention |
|---|---|---|---|---|---|---|---|
| 1 | Salary/Hour | N/A | Hourly salary for employees based on BLS research. | $24.51 | $24.51 | $24.51 | $24.51 |
| 2 | Fringe/Hour | 32.50% | Apply fringe rate based on cost report. | $7.97 | $7.97 | $7.97 | $7.97 |
| 3 | Employee Salary Plus Benefits | N/A | Add salary to fringe from steps 1 and 2. | $32.48 | $32.48 | $32.48 | $32.48 |
| 4 | Administrative Costs (Less Mileage, plus admin salaries) | 11.12% | Calculate administrative cost modifier based on cost report. | $4.06 | $4.06 | $4.06 | $4.06 |
| 5 | Admin Costs Plus Salary | | Add steps 3 and 4 | $36.54 | $36.54 | $36.54 | $36.54 |
| 6 | Total Costs/Hour with Billable Factor | 66%,N/A | Divide the hourly rate by the billable factor.<br>Base billable: 35%<br>SW virtual visit factor: 99% of in-person | $55.36 | $55.36 | $55.36 | $55.36 |
| 7 | Mileage | Mileage Calculations | Include In-Person mileage<br>Urban: $2.10<br>Rural: $2.80<br>Frontier: $5.60 | $2.10 | $2.80 | $5.60 | N/A |
| 8 | Calculated Total with Mileage | N/A | Add Mileage Modifier | $57.46 | $58.16 | $60.96 | N/A |
| 9 | Calculated Individual Rate | | Convert to 15-minute rate (rounded). | $14.37 | $14.54 | $15.24 | $13.84 |

## NUTRITION SERVICES

| Step | Line Item | Rate Calculation Modifier | Rate Calculation Details | In-Person Urban | In-Person Rural | In-Person Frontier | Tele-Intervention |
|---|---|---|---|---|---|---|---|
| 1 | Salary/Hour | N/A | Hourly salary for employees based on BLS research. | $32.32 | $32.32 | $32.32 | $32.32 |
| 2 | Fringe/Hour | 32.50% | Apply fringe rate based on cost report. | $10.50 | $10.50 | $10.50 | $10.50 |
| 3 | Employee Salary Plus Benefits | N/A | Add salary to fringe from steps 1 and 2. | $42.82 | $42.82 | $42.82 | $42.82 |
| 4 | Administrative Costs (Less Mileage, plus admin salaries) | 11.12% | Calculate administrative cost modifier based on cost report. | $5.36 | $5.36 | $5.36 | $5.36 |
| 5 | Admin Costs Plus Salary | | Add steps 3 and 4 | $48.18 | $48.18 | $48.18 | $48.18 |
| 6 | Total Costs/Hour with Billable Factor | 62%,61% | Divide the hourly rate by the billable factor.<br>Base billable: 62%<br>NUT virtual visit factor: 61% of in-person | $77.71 | $77.71 | $77.71 | $47.40 |
| 7 | Mileage | Mileage Calculations | Include In-Person mileage<br>Urban: $2.10<br>Rural: $2.80<br>Frontier: $5.60 | $2.10 | $2.80 | $5.60 | N/A |
| 8 | Calculated Total with Mileage | N/A | Add Mileage Modifier | $79.81 | $80.51 | $83.31 | N/A |
| 9 | Calculated Individual Rate | | Convert to 15-minute rate (rounded). | $19.95 | $20.13 | $20.83 | $11.85 |

## AUDIOLOGY

| Step | Line Item | Rate Calculation Modifier | Rate Calculation Details | In-Person Urban | In-Person Rural | In-Person Frontier | Tele-Intervention |
|---|---|---|---|---|---|---|---|
| 1 | Salary/Hour | N/A | Hourly salary for employees based on BLS research. | $35.10 | $35.10 | $35.10 | $35.10 |
| 2 | Fringe/Hour | 32.50% | Apply fringe rate based on cost report. | $11.41 | $11.41 | $11.41 | $11.41 |
| 3 | Employee Salary Plus Benefits | N/A | Add salary to fringe from steps 1 and 2. | $46.51 | $46.51 | $46.51 | $46.51 |
| 4 | Administrative Costs (Less Mileage, plus admin salaries) | 11.12% | Calculate administrative cost modifier based on cost report. | $5.82 | $5.82 | $5.82 | $5.82 |
| 5 | Admin Costs Plus Salary | | Add steps 3 and 4 | $52.33 | $52.33 | $52.33 | $52.33 |
| 6 | Total Costs/Hour with Billable Factor | 65%,100% | Divide the hourly rate by the billable factor.<br>Base billable: 65%<br>AUD virtual visit factor: 100% of in-person | $80.50 | $80.50 | $80.50 | $80.50 |
| 7 | Mileage | Mileage Calculations | Include In-Person mileage<br>Urban: $2.10<br>Rural: $2.80<br>Frontier: $5.60 | $2.10 | $2.80 | $5.60 | N/A |
| 8 | Calculated Total with Mileage | N/A | Add Mileage Modifier | $82.60 | $83.30 | $86.10 | N/A |
| 9 | Calculated Individual Rate | | Convert to 15-minute rate (rounded). | $20.65 | $20.83 | $21.53 | $20.13 |