Senior and Long-Term Care Rate Workgroup Meeting Minutes

February 23, 2022
10:00 AM (MST) – 1:00 PM (MST)

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Agenda

1. **Welcome**

   Jackie Jandt welcomed meeting Provider attendees to the meeting
   Coy Jones with Guidehouse presented the agenda for the meeting and began facilitating

2. **Update on Survey Submissions**

   Guidehouse provided the following updates on Survey Submissions.

   - Cost and Wage Survey released on 2/3/2022
   - There have been two provider survey trainings on February 3rd and February 4th, recordings are available to the public via the DPHHS Rate Study website. (add website URL)
   - We are about halfway through the completion period. We are making good progress with three completed surveys turned in thus far
   - So far we have received one request for a timeline extension. We understand it's a tight turn around, an we welcome you raising those concerns and communicating with us via the mailbox to further discuss
   - A Frequently Asked Questions (FAQ) document was created following those meetings to answer commonly nuanced questions from participants, common themes of provider feedback and questions:
     - Clarifying scope and inclusion criteria to participate in the survey

    - Technical questions related to survey functionality
    - Determining accurate reporting and allocation methods for total costs, FTE, and productivity
    - Clarifying questions related to reporting timelines
    - Inquiries related to locating the link to the Survey and related materials
    - Concerns related to turn around time for Survey submission
- We are about two weeks out from survey submission deadline
- Submission process update: Continue submitting to the DPHHS Rates email box, but also must include calvisi@guidehouse.com to help expedite the process of receiving and reviewing the surveys.

3. Peer State Comparisons

Guidehouse presented on the Peer State Comparison. Attendees had no questions or comments on the agenda topic.

4. Key Job Types and BLS Benchmarking

Guidehouse presented on the Key Job Types and BLS Benchmarking.

- Attendee: If these numbers are correct (number of providers), it would appear that assisted living facilities are about half or slightly more than half of all the providers related to SLTC since there are over 200 licensed assisted living facilities in Montana. This speaks to the need to be sure the survey is appropriate for them to participate in and complete.
    - GH: The groups of providers included are those who are serving Medicaid waivers. The number of licensed facilities may be different than what is included in our tables since we are looking at Medicaid providers. This is a large proportion of SLTC providers, and we want to be very clear about this representation when we receive survey responses.

- Attendee: Difference between nursing assistant and personal attendants?
    - GH: Certain states have specific training requirements for nursing assistants like CNAs, whereas that's not always the case for personal care attendants/aids. There may or may not be cost wage difference between these two groups.

- Attendee: We are one of the programs that has a bundled service. We have life skill trainers who are responsible for community integration activities such as grocery shopping and relearning life skills. These people are different than personal attendants who do more direct care (ADLs vs IADLs). Transportation is a big part of this service.
    - GH: The table on slide 10 doesn't show all costs associated with this service. What we are trying to accomplish today is making sure we understand the types of staff that are involved in these services to make sure we are including the cost of their time in these rate models. Also want to look more broadly at labor markets so that our assumptions are

competitive with the industry as a whole. Will want to continue conversation on life skills trainers to understand if this is a typical part of this service delivery. If a lot of different providers utilize these life skill trainers, it will be clear that this is a significant component of the service. Many providers offer different skillsets for these services, so this may be an opportunity to bring this forward to the workgroup to discuss if this is something that is a priority to be included in the rate or if there's another way to represent the costs, such as under program support, or if it's not a required part of the service altogether. In many states, transportation is a part of bundled rate.
        - Additional Provider Response: Adaptive equipment and wheelchair maintenance may be a large component of other major services. Termed "habtech"

- Attendee: Wondering about activities staff - I think they usually have a different title - and activities is required in Montana.
    - GH: A lot of providers in other states have these types of providers at residential facilities. Will work to reflect this very explicitly in rate model. These positions may fall under a variety of job titles such as recreation therapists, etc.

- Attendee (referencing slide 11): Does this compare to home health aid or CNA or any similar person in a hospital?
    - GH: Yes this captures a variety of settings and provider types. A similar type of worker in a different setting may be paid a lot more. In this situation, the BLS will offer a good comparison of wages versus what you may see in the broader industry.
- Attendee: Re: transportation – there is a separate rate for mileage vs. time.
    - GH: In most states, milage is a part of the rate. There is a cost for travel time plus actual mileage costs and fuel to support that travel. Our rate models bake that into the rate for personal assistance services. But if there is a separate billable channel, we want to pull that out of personal assistance rates so we are not double charging.
        - Response: There are a couple different avenues for billing travel.
            - GH: We can bill in the ways that make most sense for the providers.

- **Case Management:**
    - Main concern here is understanding requirements around a case manager and if there are more complex elements to CM that may require more specialized services or workers. CM is a key job type that a lot of different types of workers can do, such as social workers, but can also be delegated down to a worker without the same certifications. We want to adequately understand the qualifications of CM to ensure we are representing that worker well as it relates to broader industry.

- **Employee Related Expenses:**

- Attendee: Keep in mind, currently Big Sky Waiver Case Managers consists of a Licensed Nurse (RN/LPN wage differential) and a Social Worker or, a Human Services oriented professional (wage differential)- The extent of case management service delivery to HCBS members can differ significantly in approach to residents residing in res. habilitation vs. the community.

- Attendee: Where do they report sign-on bonuses, retention bonuses and other incentives? travel expenses upon hire? costs of bringing people in from other countries? Is the survey clear about whether those are wages/salaries or ERE?
    - GH: None of these are treated as benefits baked into fringe percentage. In case of bonuses, we have a column in 'Compensation' since they take the form of supplemental pay. This can be a hiring or merit bonus that is not specifically tied to an hourly wage. In addition to the bonus, there are also hiring and retention expenses. Those are not always compensation to the employee so we don't treat them as benefits, but they are expenses to the employer so in our total cost worksheet we do ask specifically what a provider's hiring and retention costs are. There are also training costs we ask about, we understand that training needs may be higher for one service than another. For example, more training needed initially for less experienced new hires, and this directly relates to turnover. We are asking more about training time than cost since this will represent lost wage cost much like PTO. A new employee may get 100 hours of training a year whereas a more experienced employee may get 15-20 depending on standards. We understand this training needs to be paid for even if its not billable time. Not represented in benefits but will be considered in other components of the rate.

5. Overview of Rate Modeling Process

Guidehouse presented on the Rate Modeling Process.

- Attendee: Our administrators work about half the time filling shifts, plus doing the admin work, and if you put all of their time into indirect it may understate the direct costs. What are your thoughts?
    - GH: We distinguish between direct and indirect to understand what cost you're billing for, and indirect costs are everything that isn't billable. What do we do with people who have some amount of admin time versus direct care time? We aren't tracking down to the individual level if a practitioner has admin and direct care responsibilities. We are interested more in what is the cost of the time for the typical practitioner typically performing this service. We are indifferent if an individual spends time between the two roles, from the perspective of our rate model we just know it costs X amount to conduct this service but how you staff that may differ.

6. Cost Report Plan Development

Guidehouse presented on the Cost Report Plan Development.

- Attendee: If someone has 80% Medicaid residents, they're going to be limited on their revenue and what they can spend. So, if you have a provider with 15% Medicaid residents in their facility, they will have a lot of private money at higher rates to subsidize care so their overall costs will probably be more and maybe better reflective of the costs needed to care for people. There may be a flaw if you're only looking at 50% or greater Medicaid occupancy as a requirement.
    - GH: We hope to have further discussions on this especially as we get closer to identifying providers that fall within this scope. There are a variety of reasons why you'd want this distinction of Medicaid versus non-Medicaid, one being that this cost report is going to be used for Medicaid. If you require a lot of providers to fill out the cost report but they don't participate in Medicaid in a meaningful way, this won't give relevant data to the State for the primary purpose of the cost report. We want to limit this to providers who will really benefit from this study, however this is language from HB 155 so we can't comment on its intent.

- Attendee: Is it correct that it's the "service" that is high Medicaid, not the individual provider?
    - GH: It's based on the individual provider who sees more than 50% Medicaid clients.

7. Public Comment

- Attendee: How are we collecting data on service needs in term of unused hours? There's a really big need out there for hours going unfilled, so how do we collect that data?
    - GH: We haven't answered that question in terms of how to collect that data and how it would inform a rate. We don't have this as a formal part of the survey and aren't planning to model how vacancies might correspond to a rate – those are very complex questions. It's worthwhile to continue entertaining that question and on our end, we will think about how this might inform our rate conclusions. There's not a lot of great information out there that shows how increases or decreases in rates impact hiring/retention. There is a hope that a reimbursement rate will fill a roster. It would be great to develop an approach to capture that useful information.
        - Provider Response: You'd have to be confident that it will help the workforce, a lot of providers feel that any increase would help since so many providers are scraping the bottom of the barrel. It may not solve the problem entirely but would certainly have a positive impact. There is a lot of unmet need out there of services that are actually authorized.

- Attendee: Concerned that we are not capturing the loss of staffing during COVID, and how COVID will continue to impact the workforce.
    - GH: We are not ignoring it; we need to think about how COVID is impacting the basic data we are relying on.

- Attendee: Hoping that you're going to be putting something out there that helps people accurately report questions raised. Hung up on admin versus direct care costs: Particularly for ALFs because when I think of direct care, it's typically hands on with a client. But in AL, it's a bundled service and the required service for every client include things like laundry, supervision, recreation, etc. in addition to the ADLs.
    - GH: The document showing additional guidance on survey completion is going out today. This is a common distinction within Medicaid. For facilities of your scale, there may be a lot of overlap between the costs of indirect versus direct costs related to personnel. It's a wise distinction to make because of efficiency concerns. Whenever resources are scarce, people want to make sure that what's going into the service is as much directed toward the resources needed to provide care as possible. There may be special challenges to pulling out these costs in some settings compared to others

8. **Adjournment @ 1:00 PM (MST)**

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