Montana Nursing Facility Rate Study

Presented to:

Montana Department of Public Health and Human Services

Presented by:

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Executive Summary

The Montana Department of Public Health and Human Services (DPHHS) contracted with Guidehouse Inc. ("Guidehouse") to conduct a rate study for nursing facilities in Montana. The objectives of the rate study include:

- Continuing to address the needs of older vulnerable and disadvantaged populations disproportionately affected by COVID-19;
- Helping to ensure health equity and increase transparency;
- Addressing nursing facility providers' needs, especially as those providers were negatively affected by COVID-19; and
- Developing reimbursement rates for nursing facility providers who serve these vulnerable and disadvantaged populations in an effort to support providers' ability to continue serving these vulnerable and disadvantaged populations while maintaining and improving as far as possible access to the health care and human/social services these individuals need.

Guidehouse worked closely with DPHHS and the nursing facility community from April 2022 to September 2022 to conduct the rate study and develop proposed rates. Stakeholder involvement included three work group meetings held in May, July and September.

Guidehouse gathered cost, occupancy, utilization and wage data from Montana nursing facility providers and other State and national data sources to establish a cost-based rate methodology. Guidehouse made additional adjustments, including the application of an occupancy standard and an efficiency standard to indirect costs. The adjusted cost-based methodology evaluated the costs of direct patient care and indirect overhead and capital cost components. The resulting adjusted costs were trended forward to January 1, 2024, the mid-point of State Fiscal Year (SFY) 2024, which begins July 1, 2023. The resulting proposed nursing facility rates were not modified to assume a predetermined budget impact.

Highlights of the rate development methodology include:

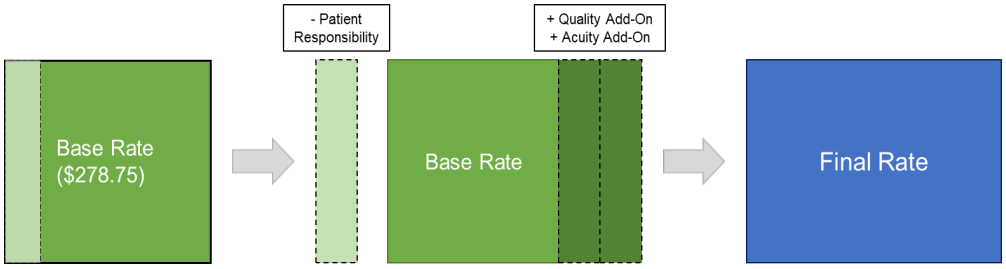
- Multiple data sources to generate a robust view of provider costs;
- Independent analyses of two different cost report years, 2020 and 2021;
- Integration of current labor market costs; and
- Actuarily built trend model considering multiple inflation factors.

Guidehouse Recommendations:

- DPHHS should continue to use the State's current cost-based methodology to develop rates for nursing facilities, with a few modifications to the methodology noted in the following recommendations. For SFY 2024, Guidehouse recommends the gross single rate for all providers **excluding** quality and acuity add-ons using 2021 cost reports of **$278.75**;
- DPHHS should continue the use of the acuity add-on to provide additional clinical support for patients with higher cost diagnoses;
- DPHHS should implement an efficiency standard and an occupancy threshold applied to all indirect costs to ensure nursing facility reimbursement is limited to reasonable costs. DPHHS should consider updates to the quality methodology; and
- DPHHS should consider the use of geographic rate groupings to target facility costs more closely.

Figure 1 below displays the relationship between the Guidehouse-developed base rate and the ultimate per diem rate paid to providers. The base rate includes costs that fall under patient responsibility, which must be subtracted out from the final per diem rate. The base rate does not include quality and acuity add-on payments, however, which must be added to the per diem rate to sum to the total State payment.

Figure 1: Base Rate and Final Per Diem Payment Components



As illustrated in the figure, the final rate includes the addition of a quality and acuity component to the base rate, minus the share of the rate that falls under patient responsibility. The quality and acuity add-ons are facility-specific and depend upon the performance and service characteristics of each facility, resulting in a unique final rate for each nursing facility.

Introduction and Background

The State of Montana had approximately 61 nursing facilities as of November 2022. A limited number of recent closures has occurred in the past year. Throughout the COVID-19 pandemic, nursing facilities have reported an increase in cost to provide services to Medicaid members. Montana's last nursing facility rate development was completed in 2001.

In 2021, the Montana Legislature passed House Bill 632 (HB632) and House Bill (HB155).

HB 632 allocated funds for a provider rate study found in the following language:

> "...*the department of public health and human services will study the impact of COVID-19 on providers and make recommendations to adjust rates, if necessary, to reflect impacts to providers in an effort to maintain services*".

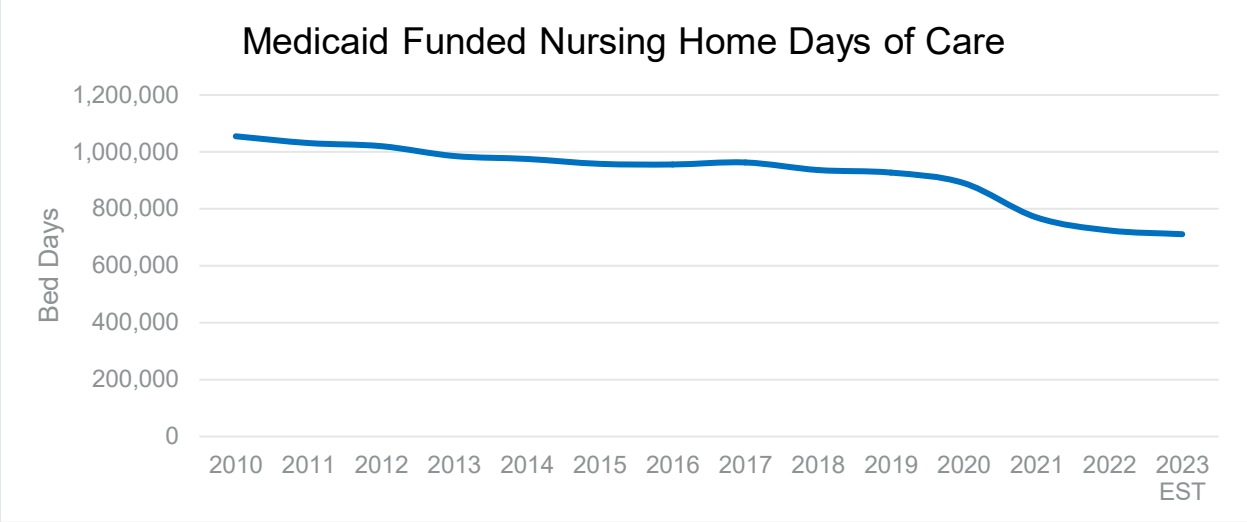
HB 155 required the:

> *"…development of a plan to collect data and analyze reimbursement rates for certain Medicaid providers – including those that provide services to the elderly, persons with mental illness, physical disabilities, and developmental disabilities for the purpose of determining rate adequacy.*"

Based on the legislation, the State engaged Guidehouse to perform a nursing facility rate study that would review the current methodology, take into account facility cost structure, occupancy, and utilization among other things, and develop new rates for SFY 2024.

While the focus of this rate study was not specifically on statewide nursing facility bed capacity and occupancy, there is an impact on rate development associated with the number of available beds. Over the past decade, there has been a steady decline in average bed occupancy in Montana nursing facilities. *Figure 2* below depicts this gradual reduction in Medicaid utilization since 2010.

Figure 2: Utilization Trend for Medicaid Nursing Facility Days of Care (2010-2023)



This decline is due to several different influences, including the COVID-19 public health emergency (PHE) as well as continued interest in home and community-based services that better permit individuals to age in place. As is apparent in the figure, the COVID-19 pandemic accelerated these trends, considering that the onset of the pandemic had a higher morbidity and mortality impact on nursing facilities than on some other provider types. This pandemic-related

impact was two-fold: first, a reduction in patient census, which lowered patient revenue, and second, a reduction in available staff, due to clinical workers becoming infected or staying home to avoid illness. This reduction in staff made fewer beds available for patients, further reducing occupancy and revenue.

COVID-19

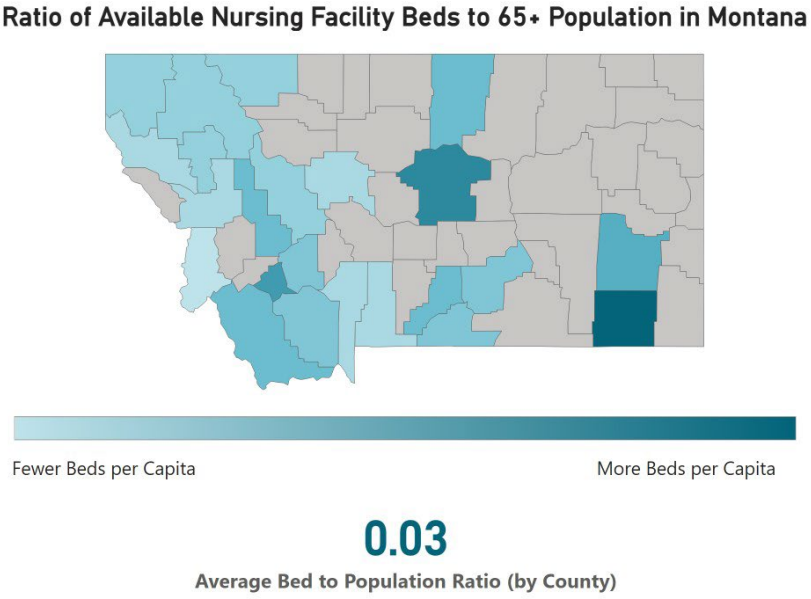
HB632 and HB155, the authorizing legislation, which funded this rate study, list as part of their objectives an assessment of the impact of COVID-19 on providers. Throughout the process of developing new rates for the nursing facilities, Guidehouse considered the challenges reported by the industry due to COVID-19. These challenges included reduced occupancy and higher wage costs. However, Guidehouse did not specifically perform analysis that correlated the impact of COVID-19 on nursing facility costs reductions.

Access to Care

Although a direct assessment of Montana's nursing facility capacity requirements and its impact on access to nursing facility care in the State was not within the scope of this engagement, the declining level of occupancy was relevant to rate development, and Guidehouse's rate recommendations are aimed at maintaining appropriate access as an important goal of the study. Lower occupancy puts pressure on facilities' ability to provide care sustainably. *Figure 3* below demonstrates the relationship within the State of the population 65 and older and the available beds by county. The figure demonstrates the wide range in the ratio of available beds to the population aged 65 or older. The mean value is 0.03, indicating that there are three beds available for every 1,000 people aged 65 or older living in each county on average. In some counties, that value is closer to 10 beds per 1,000 patients, while in other counties, the value may fall below a single bed per 1,000 patients. This study does not attempt to determine the minimum number of beds necessary to serve the population; however, such information may be valuable in an environment where facilities may be under pressure to close.

Figure 3: Availability of Montana Nursing Facility Beds per County

County	Bed to Population
Powder River	0.09
Fergus	0.07
Silver Bow	0.06
Custer	0.05
Beaverhead	0.04
Blaine	0.04
Powell	0.04
Stillwater	0.04
Carbon	0.03
Jefferson	0.03
Madison	0.03
Yellowstone	0.03
Flathead	0.02
Glacier	0.02
Lake	0.02
Lewis and Clark	0.02
Lincoln	0.02
Cascade	0.01
Gallatin	0.01
Missoula	0.01
Park	0.01
Sanders	0.01
Ravalli	0.00



Components of a Nursing Facility Rate

Cost Factors

To reimburse a nursing facility for the reasonable cost of operations, several factors are considered. Overall costs are broken down into three areas as detailed in *Table 1* below:

1) **Direct Costs**, consisting largely of clinical staff salaries and benefits, but also including patient consumables such as medical supplies and disposable items;
2) **Indirect Costs**, consisting of overhead, general, and administrative costs, both personnel and non-personnel related; and
3) **Capital Costs**, which include the cost of the facility, major equipment and renovations.

There are several ways to consider these costs in terms of provider comparability. When establishing reimbursement rates for any class of providers, considerations for grouping providers by similar attributes (e.g., geography, size and offered services) and adjusting for patient acuity is appropriate. The following sections detail these elements.

Table 1: Cost Factors

Direct Costs	Indirect Costs	Capital
• Direct Care Staff Wages • Direct Care Staff Benefits (including federal and state payroll deductions, health insurance, and retirement) • Training, Vacation, Sick Leave and Other Paid Time Off • Productivity (representing non-face-to-face time required to deliver the service)	• Indirect Staff Wages and Benefits • Administrative and General • Plant Operation • Laundry and Linen Service • Housekeeping • Dietary • Nursing Administration • Central Services and Supply • Pharmacy • Medical Records • Social Service • Nursing & Allied Health Education • Other General Service Cost	• Buildings • Major Moveable

Clinical Care Wages

Hourly wages for facility employees (e.g., direct care service workers, supervisors, etc.) are the primary component of direct care costs. Wages are driven by the marketplace, availability of workers, and the need to retain and recruit new employees. Clinical care at nursing facilities is provided by a mix of individual licensure levels including Certified Nursing Assistants (CNAs), Licensed Practical Nurses (LPNs) and Registered Nurses (RNs). Each licensure level has its own hourly rate and market availability.

Contract Labor vs. Permanent Full Time Equivalents (FTE)

Nursing facilities are required under Sections 1819 and 1919 of the Social Security Act to maintain a minimum level of staff to comply with their Medicare Certification. Federal law requires nursing facilities to provide 24-hour licensed nursing services, which are "sufficient to meet nursing needs of [their] patients" and must use the services of a registered professional nurse at least eight consecutive hours a day, seven days a week. Under routine operation, staff absences due to illness or vacation are covered by other available staff or contract employees. Nursing facilities reported a substantial increase in the number and proportions of contract personnel during the period from 2020 to 2022, due to an inability to hire the permanent staff needed fulfill federal staffing requirements. The impact of COVID-19 may likely be a contributor to this increase. The hourly cost of contract staff, as reported by the nursing facilities, is more than double the cost of permanent staff. Long term, the rate of pay for clinical staff is expected to stabilize but unlikely to decrease. The mix of permanent versus contract labor may shift back to pre-COVID-19 levels, potentially bringing the average labor cost down accordingly.

Occupancy

Occupancy reflects the percentage of a facility's beds that are occupied by patients at a given time. A facility operating at or near its bed capacity is going to be most efficient. Its fixed overhead costs can be spread across all patient days. Over the last 24 months there has been an observed reduction in occupancy in the nursing facilities in the State due in part to the COVID-19 pandemic. Historically, occupancy levels have been between 60 and 65 percent.[1] More recently, nursing facilities are reporting occupancy levels in the range of 50 percent. As occupancy declines, the cost per day increases due to the fewer occupied beds over which to spread facility costs. In developing per diem rates for DPHHS, a certain occupancy rate needs to be assumed. Guidehouse examined a range of values based on our experience in other states to determine the impact. Neglecting to establish an occupancy standard—or alternatively, setting an occupancy standard too low—risks promoting inefficiency, considering that the State finds itself in the position of paying for empty beds to maintain capacity in excess of actual system needs. Conversely, setting occupancy standards too high threatens to impose unreasonable service delivery expectations on providers, resulting in reimbursement rates that place additional financial burdens on nursing facilities by failing to account appropriately for inevitable and reasonable vacancies throughout the year.

[1] Source: DPHHS-supplied data.

Efficiency

While facility costs can vary widely depending on occupancy or size, there are costs that should be relatively consistent among providers. Limiting reimbursement below a certain threshold for these common costs incentivizes facilities to operate at an appropriate level of efficiency. While essential for operations, a facility has more discretion in how to deploy non-clinical resources. Holding a facility accountable for its indirect staffing and non-personnel costs is a means to manage overall costs.

Geographic Adjustment

The geographic location of a nursing facility within a state can play a role in facility costs and therefore in setting nursing facility rates. Depending on the state, different areas can face different cost profiles. There are several ways to use geography to classify distinct locations within the state. These classifications can be as simple as grouping facilities into urban and rural, or as detailed as Metropolitan Service Area (MSA). One method is to use the Center for Medicare & Medicaid Services (CMS) Wage Area Index. CMS assigns wage area indices to distinct locations of Montana based on wage differentials. Data included in the wage index are derived from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. These indices are a national relative measure of wage costs. For the State of Montana, five counties were determined to be unique from one another and the rest of the State, as illustrated in *Table 2* below.

Table 2: Wage Area Index

Area	Raw	Normalized
Carbon County	0.95	1.04
Stillwater County	0.95	1.04
Yellowstone County	0.95	1.04
Cascade County	0.81	0.89
Missoula County	0.93	1.01
All Other Montana Counties	0.90	0.98
Average	0.92	1.00

The normalized values are relative values within the State compared to nationwide. These wage areas reflect the different wage market in distinct parts of the State. Ranging from a low of 0.89 to a high of 1.04, a 15-point spread. This indicates that labor costs in Yellowstone County are four percent higher than the mean in the State and similar to Carbon and Stillwater Counties. Geography is not currently a part of the Montana rate setting methodology but is included in our recommendations section.

Patient Acuity

The measure of the individual illness burden for each patient translates into the cost of care. More complex patients require greater levels of nursing care and incur a higher cost. The standard in the long-term care industry for measuring acuity is the Minimum Data Set (MDS) along with either the Resource Utilization Groups (RUGs), or Patient Driven Payment Model (PDPM) to determine acuity. The methodology assigns acuity based on the level of effort, and thereby time necessary for nursing facility staff to assist a patient in performing Activities of Daily Living (ADL). This time translates into the cost to care for the patient.

There are, however, other methodologies to account for acuity and its associated cost. Currently, Montana recognizes four diagnoses and related sub-categories described in *Table 3* below that require additional care, and therefore cost. These diagnoses represent resource-intensive care, and Montana applies a per diem add-on payment to stays in which a patient has one of the recognized diagnoses. To obtain these **add-ons**, a facility must submit a separate professional claim with the patient's qualifying information. Reimbursement requires prior authorization for care to be on file. This methodology, while different than using the MDS/RUGs level of effort method, is effective as it addresses significant elements of acuity and key drivers of cost and creates a mechanism to help reimburse them.

Table 3: Diagnosis-Based Rate Add-Ons

Diagnosis	Classification	Add-on per day
Bariatric Care	350lbs - 600lbs	$2.05
	600lbs +	$5.49
Traumatic Brain Injury	N/A	$75.00
Adverse Behavior Management	Verbal and/or physical aggression	$75.00
	Inappropriate sexual behavior	$80.00
	Danger to self or others	$100.00
Wound Care	N/A	$20.00

Quality

Quality measures reflect the care delivered to patients. Such measures can reflect clinical activities while others are more administrative. Examples of the many available measures include *Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury* or *Percent of Patients Who Made Improvements in Function*.

There are a range of quality methods that are used to evaluate care. DPHHS employs the Medicare Five-Star Quality Rating System (CMS 5-Star) to measure and reimburse for higher quality care. This method is reasonable and used in other states.

Montana currently includes an add-on to each facility's Medicaid rate based on the CMS 5-Star. Facilities receive the amounts listed in *Table 4* as an add-on to the base rate based on their number of stars:

Table 4: Star Performance Medicaid Rate Add-On

Star Rating System	Add-on per day
5 Star average	$4.26
4 Star average	$3.19
3 Star average	$2.13
0-2 Star average	0.0

Under this system, each nursing facility receives a rating from one to five stars for three domains: performance on health inspections, staffing, and quality measures as well as an overall composite rating. The health inspection domain is designed to provide a comprehensive assessment of the nursing home, reviewing facility practice and policies in such areas as resident rights, quality of life, medication management, skin care, resident assessment, nursing home administration, environment, and kitchen/food services. The staffing domain evaluates nursing staffing and is made up of two components: registered nurse hours per patient per day and overall nursing staff (RN, LPN and CNA) hours per patient per day. The quality measures used as part of the rating are from CMS' ***Nursing Home Compare*** Quality Indicators. The current method has the following characteristics:

- Benefits:
  - Easy to administer
  - Transparent to facilities
  - Encourages high performance
  - Star ratings are publicly available
- Limitations:
  - CMS 5-Star may not put sufficient emphasis on measures that focus on longer stay patients
  - CMS 5-Star does not include quality of life measures

Supplemental Payments

DPHHS currently administers $10 million in direct care wage enhancements, with half of this amount available to CNAs only. This amount has been level funded since 2019. These payments are not reflected in the SFY 2024 rates developed by Guidehouse and are paid to nursing facility providers independently of reimbursement received through paid claims.

Stakeholder Involvement

To support the development of cost-based rates for the State's nursing facilities, Guidehouse and DPHHS convened a stakeholder workgroup with the help of the Montana Healthcare Association. The workgroup held three meetings (*see Table 5 below for meeting dates and objectives*). In the first meeting, Guidehouse provided an overview to the group on the process and methodology the Guidehouse team intended to use for rate setting. The second meeting focused on a presentation of initial data findings from multiple sources and gathering feedback from the workgroup and members of the public in attendance. In the third meeting, Guidehouse presented recommended rates and received workgroup and public feedback. Throughout these meetings, stakeholder engagement and feedback were robust and productive.

Table 5: Workgroup Meetings

Meeting Date	Objective
May 24, 2022	Educated the group on the process the Guidehouse team would use to set the rates along with a primer on the essentials of rate setting.
July 11, 2022	Presented initial data findings from the multiple sources and take feedback.
September 7, 2022	Presented preliminary rate proposal based on 2020 cost reports.

Data Sources

Guidehouse used multiple data sources for the development of nursing facility rates and associated trending. The approach for this study was to establish assumptions based on provider-reported data through several sources as well as extensive industry data that reflect wider labor markets for similar populations. The data collected included:

- Medicare 2540 Nursing Facility cost reports
- Montana State Medicaid cost reports
- Montana State Medicaid claims
- Provider survey of wage, occupancy, and volume
- CMS wage area index data
- The following Bureau of Labor Statistics measures:
    - Occupational Employment and Wage Statistics (OEWS)
    - Employer Costs for Employee Compensation (ECEC)
    - Current Employment Statistics (CES)
    - Producer Price Index (PPI)
- Other states' comparable rates

Although cost information used for rate development was derived from 2540 cost reports, State cost reports and provider reported survey data were required for supplemental cost data and for benchmarking purposes to establish trends in occupancy, employee mix, and wages.

Medicare Cost Reports

Facilities that bill to Medicare are required to submit annual cost reports on Form 2540 to Medicare. These cost reports are publicly available in an electronic format. Guidehouse was able to utilize these reports to calculate utilization, occupancy, direct and indirect cost, as well as capital expenses.

Guidehouse extracted FY 2018 through FY 2021 Medicare cost report data (from the CMS HCRIS database) for all Montana facilities that submitted reports. At the time of the analysis, almost all facilities had submitted reports for fiscal years through 2020, with most corresponding to calendar year (CY) 2020. Initially CY 2020 offered the most recent, complete period of costs and occupancy data. However, at the request of the nursing facility industry, DPHHS delayed the final report to incorporate data from 2021 cost reports.

For providers whose FY 2021 cost report did not cover a full year, previous cost reports were used and pro-rated, if needed, to offer cost information equating to one full year. For example, if a facility's FY 2021 report spanned only five months, Guidehouse took data from the previous FY 2020 report for that provider and pro-rated it to approximate 7 months of data to complete the year. Guidehouse calculated the pro-ration factor by taking the number of missing days divided by the number of total days in the pro-rated cost report. Combining the 2021 and pro-rated 2020 reports provided a reasonable approximation of costs and utilization for FY 2021.

Once the cost report data was downloaded and pro-rated, if necessary, Guidehouse calculated facility-specific occupancy rates as well as totals and per diems for direct care, indirect care, and capital costs. Values were taken from the following locations in the cost reports:

- **Bed Days** – Worksheet S3 part 1, line 1, column 2
- **Total Days** – Worksheet S3 part 1, line 1, column 7
- **Total Cost** – Worksheet B part 1, line 30, column 18
- **Direct Care Cost** – Worksheet S3 part 5, lines 4, 12, 13, 17, 25 and 26, column 3

- **Capital Cost** – Worksheet A, lines 1 and 2, column 7

Using the above items, Guidehouse calculated the following additional factors:

- **Occupancy** – Total days divided by bed days
- **Indirect Care Cost** – Total cost minus direct care cost and capital cost
- **Per Diem** – Costs divided by total days

Extracting and calculating this information allowed Guidehouse to compare facilities, calculate overall and average per diems, as well as perform the modeling necessary to determine rates.

Provider Wage Cost Survey

In response to provider concerns about the availability of current data, DPHHS requested that Guidehouse conduct a provider survey to collect labor cost data for two discrete periods. For the year ending December 31, 2020, and the quarter ending June 30, 2022, nursing facility providers were asked to respond with clinical wage data by licensure level for both employed FTEs and contract labor. In addition, providers were asked for bed days and occupancy. Lastly, providers submitted comments that were informative to understanding the costs they incur. Guidehouse used the survey to:

- Capture provider occupancy data to establish a cost foundation for the rate study;
- Measure changes in direct care worker wages over time;
- Receive uniform inputs across all providers to develop standardized rate model components;
- Measure changes in reliance on permanent versus contract workers over time; and
- Solicit general feedback from providers to explore employment strategies.

Guidehouse designed the provider survey with input from DPHHS staff as well as drawing on knowledge gained from conducting similar surveys in other states. The survey was developed in Microsoft Excel and implemented in Qualtrics, a web-based survey tool. The survey included three sections. The first section captures overall provider information, the second and third capture wage and occupancy data for two separate time periods: CY 2020 and the second quarter of CY 2022. Guidehouse requested specific financial data from two different time periods to capture data and the resulting changes in service costs, prior to and during the COVID-19 Public Health Emergency (PHE). SFY 2019 data was used as the base period to capture relationships between different cost components, prior to any impact of COVID-19. On the other hand, more recent data from FY 2021 was best suited for analyzing near-term trends likely to impact future rates, including responding to rising wage pressures and inflationary costs.

Participation

Out of the 68 facilities that were sent surveys for completion, 48 facilities returned surveys, resulting in a 71 percent response rate. The information that was submitted was incorporated into the rate model as an additional data point.

Review and Validation

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

- **Completeness:** Guidehouse checked the completion status within individual survey responses to determine data usability. Guidehouse followed up with providers

individually within a week of receiving the survey responses if clarification or correction was required.

- **Outliers:** Guidehouse reviewed quantitative data points (e.g., wages, hours, beds, bed days) reported across all organizations to identify potential outliers. If any outlier data points were excluded or assumptions were made for rate model inputs, the assumptions were reviewed with the DPHHS staff and the Rate Workgroup and are documented as such in this report.

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

The survey data reported by providers was utilized to develop several key rate components including baseline hourly wages, Employee Related Expenses (ERE), and administrative and program support cost factors.

Claims Data

Guidehouse developed a detailed claims data request for Medicaid paid claims for three calendar years, CY 2019 through CY 2021. At the time of the data request, Q1 of CY 2022 had just passed and the data for that period was incomplete because providers have up to 365 days to bill Medicaid. Therefore, only full year data sets were used in the rate development.

Key fields requested in the claims data included: provider detail, payment information, service identifying fields and units of measure. Guidehouse performed claims validation checks to ensure that all fields were complete and accurate. Claims were excluded based on several factors including provider types outside of the study, out-of-state providers, unpaid claims, and claims for dual eligible recipients.

Rate Methodology

Provider Cost-Based Approach

After reviewing the current Montana nursing facility rate methodology, which is a cost-based class rate with add-ons for acuity and quality, Guidehouse is recommending the same approach for the SFY 2024 rates. For future rate iterations, Guidehouse has specific recommendations detailed below.

For the rates proposed for SFY 2024, Guidehouse recommends using a cost-based class rate development approach combined with trend and inflation factors to bring the base year data to the midpoint of the rate year (January 1, 2024). The cost-based methodology relies on multiple data points to inform the overall rate development. The starting point is the FY 2021 CMS 2540 nursing facility cost reports and the SFY 2021 Montana State Medicaid cost reports. The model is further informed by the wage costs data collected from the provider survey, occupancy data and similar state comparable rates.

The rates were developed based on direct, indirect and capital costs. A reasonableness test was performed to assess any values that exceed two standard deviations from the mean. Within individual components, values were found slightly outside this range; however, none were excluded.

Direct, indirect, and capital per diems were calculated by taking the individual cost components divided by the facility bed days of each provider. An occupancy threshold and efficiency standard were then applied. The occupancy threshold is set at a minimum expected occupancy as a financial guardrail against paying for an excess of empty beds. That threshold is set at 60 percent, which is higher than the current average occupancy of 50 percent, but lower than the historical average.

The efficiency standard sets a cap on allowable indirect cost expense based on a set threshold of 95 percent. Such a standard encourages efficient use of capital. Per diem indirect costs for individual providers were capped at the 95th percentile. Component per diems were then summed to calculate an overall base cost per diem for each provider and trended to produce the final preliminary individual rates. Individual provider fiscal year end dates were considered when applying the trend to ensure that the number of months in trend applied aligned with the provider's fiscal year end. Lastly, a weighted average by days of all the individual trended facility rates was computed to produce a singular overall class rate for all nursing facilities.

Guidehouse developed inflation trends to take the base rate data from the source period to the mid-point of the rate year. The cost reports used were FY 2021 reports submitted by providers. Each facility files its cost report on its own year-end ranging from March 31 to December 31. Guidehouse trended each facility from its respective year end to January 1, 2024, the midpoint of the rate year for which the rates are intended.

Guidehouse built the trend based on a series of inputs that included historical information, nationally available data and survey data. This information informed the direction of costs over the 30-month inflation period. Different trends were used depending on each nursing facility's fiscal year end in order to standardize them to December 31, 2021, as illustrated in Table 8 (see page 20).

Guidehouse reviewed both publicly available national data from the Bureau of Labor and Statistics as well as Montana nursing facility survey data to develop trend estimates. Based on the request of the industry, FY 2021 cost reports were utilized as base data for rates effective

for SFY 2024 which spans from July 1, 2023, through June 30, 2024. Guidehouse used the following approach to develop the trend, as illustrated in Table 7 (see page 20):

- Cost report expenditure data segmented into direct, indirect, and capital costs. Each cost component was trended separately.
- Reviewed direct, indirect, and capital actual trends from CY 2021 to June 30, 2022. The midpoint of the cost reports with a December 31, 2021, end date was July 1, 2021.
- Estimated direct/indirect/capital projected trends from July 1, 2022, to January 1, 2024. Actual trends were known from July 1, 2021, to June 30, 2022, or for 12 months of trend, while the projected trends comprise an additional 18 months of trend. The combined actual and projected trends were applied for 30 months (2.5 years) of total trend.
- For each of the three categories, actual trends and projected trends were developed as follows:
    - **Direct**
        - Actual: assumed 15.4 percent trend from January 1st, 2021, through June 30, 2022. This represents the average 2020-2022 hourly wage increase from the 2022 MT nursing facilities provider survey less 6.7 percent in 2020-2021 trend from the average hourly earnings of all employees, nursing care facilities, seasonally adjusted, from Current Employment Statistics Nursing Facility Specific (CES National), to derive a 2021-2022 MT wage trend[2]. This was the average hourly wage increase from the 2022 provider wage cost survey. It should be noted that the July 2021 to June 2022 average hourly earnings of all employees in nursing care facilities, seasonally adjusted, from Current Employment Statistics Nursing Facility Specific (CES National) trend was lower, at 10.3 percent as compared to 15.4 percent, providing an additional increase to wage trend from national benchmarks.
        - Projected: 3.9 percent annually, or 5.9 percent for 18 months, was selected from CES National based on average annual increases from 2012-May 2022.
    - **Indirect/Capital:**
        - Actual: assumed 3.7 percent trend from January 1st, 2021 (July 2021 midpoint) through June 30, 2022, based on the Producer Price Index (PPI) by Industry: Nursing Care Facilities: Medicaid Patients, Not Seasonally Adjusted[3].
        - Projected: 1.9 percent annually, or 2.9 percent for 18 months, from July 2022 through January 2024, using PPI for Nursing Care Facilities: Medicaid Patients, Not Seasonally Adjusted. The 1.9 percent annual trend was the average of 1) the 2.4 percent CY 2012-2019 annual average PPI trend calculated using annual averages and 2) the 1.4 percent annual average PPI trend from CY 2012-2019 taking the June PPI divided by July prior year PPI index value. For the second method, a 2019 trend equals the June 2019 index value divided by the July 2018

[2] https://beta.bls.gov/dataViewer/view/timeseries/CES6562310003.

[3] https://fred.stlouisfed.org/series/PCU623110623110101

index value. Similarly, a 2013 trend equals the June 2013 index value divided by the July 2012 index value.
    - Guidehouse notes that the PPI trends do include a component of wage expense to a degree, using the PPI trends in addition to the direct trend inflates the labor cost increases in this trend development approach.
- The above direct, indirect, and capital trends were projected and blended using the CY 2020 median cost trends for the three splits from the nursing facility survey, trended to CY 2022, of 45.3 percent, 46.2 percent, and 8.5 percent, respectively, to produce a combined 13.7 percent trend.
- Lastly, Guidehouse completed a review of occupancy changes from CY 2020 to June 2022 using the same nursing facility survey. The average reduction in occupancy percentage, calculated as second quarter CY 2022 occupancy divided by CY 2020 occupancy – was 1.9 percent, of which half was assumed to have occurred between CY 2021 and CY 2022. An additional 1.0 percent increase was applied to the 13.7 percent increase, to produce a total **14.8 percent** increase from CY 2021 to the mid-point of the rate year January 1, 2024.
- The 14.8 percent increase is applied to December 31, 2021 cost reports. For cost reports with end dates earlier in CY 2021, the following trends were utilized by 2021 end date: 19.5 percent for March 31, 17.9 percent for June 30, 16.3 percent for September 30. These trends were computed by interpolating between the CY2020 trend of 21.2 percent and CY2021 trend of 14.8 percent. See *Table 8* (page 20) for detail.

Rate Recommendations

Recommended Provider Rates

Based on the modeling and trend above, Guidehouse recommends the following rate assumptions: An all-inclusive rate with 60 percent minimum occupancy and a 95 percent cap on indirect costs. Before individual provider trending, this combination would produce an overall base rate of $241.77. Due to the level of observed increases in labor costs over the study period from December 31, 2021, through the present period of July 30, 2022, 14.8 percent is the resulting trend, with additional trending for fiscal years prior to December 31, 2021 (see Tables 6 and 7 below). This combination results in a final base rate of **$278.75** (Table 8), which is a 34 percent increase over the current statewide average rate of $208.71. These amounts are the total gross amount **including** both federal and state shares. The quality and any supplemental payments are **NOT** included.

Table 6 below shows the components of the CY 2021 to SFY 2024 trend.

Table 6: Recommended CY 2021 Trending

Component	Actual cost Trend July 2021 - June 2022	Projected Annual Trend July 2022 – January 2024 (12 months)	Projected Trend July 2022 – January 2024 (18 months)	Total July 2021- January 2024	Percent of Total Cost*	July 2021 to January 2024 Final Trend
A	B	C	D = (1+C)^1.5 - 1	E = (1+B) x (1+D) -1	F	G = E x F
Direct	15.4%	3.9%	5.9%	22.2%	45.3%	10.0%
Indirect	3.7%	1.9%	2.9%	6.6%	46.2%	3.1%
Capital	3.7%	1.9%	2.9%	6.6%	8.5%	0.6%
Subtotal						13.7%
Occupancy						1.0%
Total – 30 Months of Trending			(1+Subtotal) x (1+Occupancy) - 1			**14.8%**

*Source: nursing facility survey

Table 7 on the following page shows the increased trends used to normalize the different fiscal years reported by providers.

Table 7: Recommended Individual Cost Report Trending Using 2021 Cost Reports

Cost Report FYE	Months of Trend	Trend Percentage
3/31/2021	39	19.5%
6/30/2021	36	17.9%
9/30/2021	33	16.3%
12/30/2021	30	14.8%

Table 8 illustrates the additional dollars applied to the base per diem rate when accounting for the cost trending to the mid-point of SFY 2024.

Table 8: Recommended Rate with Trending Using 2021 Cost Reports

Trend	Per Diem	2021 to SFY 2024 Avg. Trend %	2021 to SFY 2024 Trend Amount	SFY 2024 Trended Final Rate
2021-2024	$241.77	Varies by Cost Report Fiscal Year End	$36.99	**$278.75**

Fiscal Impact Analysis

As part of the modeling, Guidehouse estimated the fiscal impact of the updated rates compared to the existing method of two percent inflation per year. Fiscal impact for each rate was calculated as the rate multiplied by 773,719 days, an estimate of FY 2024 days. This estimate is a four-year average encompassing FYs 2020 – 2023. Since complete data for 2023 was not available, a 12-month estimate was used based on the first four months of FY 2023 data. *Table 9* below shows the modeled payments and impact of the current rate as well as SFY 2024 rates based on the existing trending method and results of models with trending.

Table 9: Final Rate with Impact

Method	2024 Trended Final Rate	Modeled Payments*	Fiscal Impact	Fiscal Impact Percent
Current Base Rate	$208.71	$161,482,892	N/A	N/A
SFY 2021 rate inflated 2%/year	$217.14	$168,005,344	$6,522,451	4.0%
SFY 2024 Proposed	$278.75	$215,674,171	$54,191,279	33.6%

*Modeled payments do not include quality component, hold harmless, or acuity payments

Other Recommendations

Throughout the course of this rate study, Guidehouse evaluated the current Montana nursing facility rate methodology and developed a series of recommendations for consideration by DPHHS. These recommendations can be grouped into three main categories pertaining to a) rate methodology, b) service delivery dynamics, and c) quality of care.

Rate Methodology Recommendations

The four recommendations outlined below are presented for consideration by DPHHS in future rate setting. The first two recommendations, to include an efficiency and occupancy standard, are already incorporated in Guidehouse's proposed base rates, but DPHHS has considerable flexibility to alter the specific assumptions used in Guidehouse's analysis. The third and fourth assumptions are not a part of Guidehouse's proposed rates, but each would be compatible with the methodology used in the study and could be applied in future rate exercises to augment the current approach.

1) ***Efficiency Standard:*** Introducing an efficiency standard for the indirect cost component is a way to provide an incentive to maintain reasonable costs in this area. To achieve this, all facilities' indirect per diems are arrayed lowest to highest along with corresponding bed days. The per diem for the provider at a certain threshold (e.g., 75th-95th percentile) is selected. All facilities with indirect costs above that level are capped. Guidehouse's proposed rates include an efficiency standard, but DPHHS could develop an alternative threshold to support specific policy priorities.
2) ***Occupancy Standard:*** It is important that nursing facilities operate at a level where most of their beds are occupied. Conversely, if a facility cannot maintain a minimum level of occupancy, then the ability to sustain operations is called into question. Setting an occupancy standard as an element of the rates ensures that the State is not paying for empty beds. Similar to the efficiency standard, Guidehouse's proposed rates include an occupancy standard, but DPHHS could develop an alternative threshold to support specific policy priorities.
3) ***Individualized Rates:*** To achieve specific policy goals, individual base rates could be set, rather than a class rate as is done today, to which the quality and hold-harmless amounts would be added. The acuity payment would be in addition to this amount. Guidehouse did not model individualized rates, but DPHHS might find this approach desirable in the future, depending on policy needs.
4) ***Geographic Adjustment:*** As discussed above, distinct parts of Montana face different labor market costs. When setting a class rate for providers, putting them into similar groups can be beneficial to recognize varying costs. This information can be used to adjust the facility rates on a zero-sum basis to reflect these market differences. Guidehouse did not develop a set of recommended geographic adjustments, but it would be feasible to devise such a framework to support varying reimbursement needs in different regions of the state.

Service Delivery Recommendations

As noted in the introduction of this report, access to care issues stemming from COVID-19 and its associated economic effects on Montana's labor market and other provider costs form an important context for the Guidehouse rate study. Even if many of the access to care issues and service delivery challenges faced by nursing facility providers are financial in nature, they are not necessarily best alleviated through statewide rate increases but may be addressed more

effectively by parallel financial interventions that specifically target needed service delivery changes or improvements within the system. Because the proposed rate is representative of current market wages, the existing appropriated funds allotted for direct care employee pay support could be reallocated in an effort to stabilize the nursing home industry in one of the following ways.

1) **Emergency Fund for distressed facilities who are vital to ensure access:** Allocate funds to distressed facilities and in danger of closing for which a loss of beds would create an access issue in the geographic area. Guidehouse did not perform a bed needs assessment as part of this rate study, however such a study could serve as the basis for identifying bed access pressure points.
2) **Bed buy-back program to facilitate closing or repurposing excess capacity:** Nursing facility occupancy has been on a decline since 2020. Demand for nursing facility beds may not return to pre-COVID-19 levels. If this is true, the potential for excess capacity exists. If so, funds can be used to assist facilities in repurposing the beds into another use, e.g., rehabilitation, short term post-acute step-down, treatment of substance use or behavioral health.
3) **Create an incentive to open a ventilator unit and/or specialty care unit:** Currently, Montana does not have any dedicated ventilator beds. Patients in need of this level of care must be sent out-of-state at additional cost and inconvenience to the families. Such a unit could displace lower-level beds that may no longer be in demand.

Quality Program Recommendations

This section summarizes several quality-focused recommendations based on Guidehouse's experience and knowledge of other state practices. In addition to the rate components already addressed in the report, DPHSS could consider augmenting its rate methodology with a broader pay-for-performance program designed in collaboration with nursing facility leaders in an effort to reward providers for excelling in or improving the quality of services they deliver to patients.

A robust quality payment program has clear and defined goals and objectives, such as:

- Improving the quality of services delivered by:
  - Creating specific numeric targets for improved performance on the facility's process and clinical measures;
  - Periodically recalculating benchmark measures to continually improve the quality of services provided;
- Improving compliance with clinical guidelines by:
  - Expanding the number of clinical measures included in a pay for performance;
  - Periodically recalculating benchmark measures to continually improve the quality of care provided to patients; and
- Developing capacity to monitor and ameliorate health inequities and disparities.

Program Design Considerations:

Values embedded within program design may include:

- A primary focus on nursing facility patients;
- The promotion of equitable care for all individuals residing in nursing facilities;
- Holding nursing facilities responsible for the quality of services provided to their patients by using appropriate measures that determine quality care;

- The selection of measures with proven efficacy and on which nursing facilities are capable of reporting; and
- Providing nursing facilities with information about the program, including the program structure, specifications of measurement, measures and benchmarks, and the payment system.

Performance Measurement and Data Source Considerations:

- Identify and select domains of measurement
- Quality of care (clinical); quality of life; access, and efficiency
- Focus on quality-of-care domain in year one
- Data Source: CMS National Health Council, long-stay measures that do not require risk adjustment

Benchmarks:

- Measure the nursing facility's performance on each measure selected against a benchmark
- Consider using CMS Montana-specific National Health Council data as the source for the benchmark
- Set the benchmark at the specific level, e.g., 75th percentile for statewide

Quality/Incentive Payment Approach:

- Pay for the higher of the following scores or use a different method that rewards both attainment and improvement. If improvement is not met, do not penalize the provider
- Pay for meeting or exceeding the State benchmark
- Pay if the nursing facility's performance rate demonstrates improvement over prior year's rate
- Pay for improvement from the median rate of all nursing facilities to the benchmark.

Acknowledgments

Guidehouse and DPHHS wish to acknowledge the participation and work of the Provider Work Group, and Montana nursing facility providers throughout this rate study. Providers' participation in the cost and wage survey allowed for an enhanced understanding of provider service delivery and costs. The Work Group members provided critical guidance and decisions regarding key rate components and spent significant time and effort throughout the project. Guidehouse and DPHHS are appreciative of the level of effort and time dedicated by all parties.

Appendix A

Wage Survey Comments

Comments submitted as part of the provider wage cost survey administered during the nursing facility rate study.

Have reduced census due to lack of staff; Have Nurse aide training class when we have enough applicants to make it worth it. We are a State operated facility so any pay/benefit adjustments must go through the State HR Process for making any changes.

We are continuing efforts with advertising in the community for help along with our company hosting CNA classes for those that have interest in working with us. We also host nursing students in hopes that they will like the facility and want to come to work with us.

Increased benefits and wages offered, referral bonuses, etc. (as we can afford) to entice more permanent staff, but we have a limited labor pool and more potential staff are being persuaded to go through a travel agency for a number of different reasons. We try to offer more flexible and nontraditional work hours/options as an enticing factor.

We are focused on recruitment and retention. We offer CNA classes and have a great training program.

We continue to host CNA classes, advertise on social media and in the local paper. We offer sign-on bonuses and a $2/hour premium for worked hours for LTC CNAs. We continue to follow up with staff who left during the pandemic to see if they would like to come back.

The facility's current approach is a cultural perspective to institute morale and foster a healthy work environment to draw in new staff and maintain current staff. Bonuses and other incentives are having to be offered to sustain staff due to inflation and COLAs that are financially damaging the facility. A desired approach would be increased funding to allow the facility to increase wages and sustain ongoing to continue to retain and recruit staff.

We are using Facebook, Indeed and job service for ads. We have plans in place for job fairs. We are in the process of holding a drive through job fair at our building. When school resumes, we will meet with high schools and nursing schools.

To increase our base wages of permanent staff to attract new hires and to hold CNA classes to increase the number of staff available in our area.

Wages - Contract staff wages are higher and enticing to facility staff away.

A revenue increase from the State to support the competitive wages that contract companies are able to offer, paired with, a restriction/regulation that limits the amount contract companies can charge facilities. This is the only way, because they set their own rates/wages. They will just continue to offer more and charge more.

Advertising, CNA class

Valle Vista Manor have increased all wages and have committed to making sure we hire the right people. Valle Vista Manor has also invested in employee job satisfaction surveys, and we have improved our onboarding processes and employee engagement practices.

1. Decreased admits reducing the number of staff needed to provide care
2. Decreased our staffing to patient ratios while still being able to provide care
3. No longer have a Restorative Therapy program to reduce the number of CNAs required
4. Increased salaries across every discipline
5. Continue to provide bonuses for any extra shifts picked up by permanent staff
6. Increased flexibility with permanent staffing

None used

We consider contract staff only when necessary. Our approach is simply to make the best effort we can to retain our employees by making our facility as desirable a place to work as possible.

We have signed up with many national recruiting companies to find permanent staff. We have not had any luck getting and keeping employees. Culbertson is a very rural area. We have a workforce shortage here. Housing is not very available, so that doesn't help to get employees to make this their home.

We have replacement positions posted, marketing on multiple online platforms, signage in front of facility, offering hiring bonuses, word of mouth, increasing salaries for retention and job offers. We also offer other perks like food, snacks, soda, etc. onsite for staff.

We are using multiple strategies to address:
- CNA training and certification process that is free to enrollees and participants are paid during the training.
- Foreign nursing program, immigration program that has been active for over 10 years, providing RN level talent. This has recently been expanded to fulfillment of CNA level talent.
- Regional and National recruitment and retention teams
- Benefit enhancements, compensation reviews and increases, sign-on and retention bonuses, longevity recognition process, leadership development training for department leadership, employee rounding processes and employee satisfaction survey processes.

We are using multiple strategies to address:
- CNA training and certification process that is free to enrollees and participants are paid during the training.
- Foreign nursing program, immigration program that has been active for over 10 years, providing RN level talent. This has recently been expanded to fulfillment of CNA level talent.
- Regional and National recruitment and retention teams
- Benefit enhancements, compensation reviews and increases, sign-on and retention bonuses, longevity recognition process, leadership development training for department leadership, employee rounding processes and employee satisfaction survey processes.

a. Multiple strategies are actively addressing the concern.
i. CNA training and certification process that is free to enrollees and participants are paid employees for the training
ii. Foreign nursing program, immigration program that has been active for over 10 years, providing RN level talent. This has recently expanded to fulfillment of CNA level talent.
iii. Regional and National recruitment and retention teams
iv. Benefit enhancements, compensation reviews and increases, sign-on and retention bonuses, longevity recognition process, leadership development training for department leadership, employee rounding processes and employee satisfaction survey processes.

Active recruiting on all social media, retaining the staff that we have, listening to current employees to recognize what they need, referral bonuses, competitive wages and benefits

Immanuel Lutheran Communities continues to focus on recruitment and retention. We hired a recruitment specialist and expanded benefit packages regularly. We have a weekly meeting to review and make sure we are doing everything we can to increase our permanent staff and eliminate contract staff entirely as the use of contract nurses is not sustainable.

We do not see the staffing crisis and the need to use contract labor changing in the near future. Therefore, we are downsizing our skilled Nursing Facility (most staff intensive part of our business) and will eventually only serve those who transition from our other areas within our system – independent living, assisted living, or At Home. We are looking to grow and look at business opportunities that require less staffing and receive appropriate reimbursement.

We have not had to use contract nursing fortunately. Our biggest approach is to create a good working environment

For CNAs we have increased the class size and frequency of CNA training program.
RN nurse residency program to onboard new nurses to the setting of skilled nursing - program offers increased orientation and learning in an effort to properly onboard, train and retain quality professionals.
Sign on bonuses offered for new hires and referral bonuses for staff that bring new staff.
Incentive shifts pay for existing staff to pick up extra shifts.

We advertise our open positions on indeed and social media as well as network with the local nursing school. We offer CNA classes and have a referral bonus program. We have recently given our staff a raise in order to retain them.

More funding in order to be competitive.

Wage increases to meet the hospital pay, referral bonuses, relocation bonuses, recruiting at local schools/ colleges, sending out recruitment info to licensed nurses and CNAs, Offered CNA Certification Classes, Media Blasts and boosts, Social Media Posts, indeed promotions and boosts,

Reduce number of patients, continue having CNA classes, sign on bonus, continue education to promote retention, job fairs

By retaining core staff and recruiting new staff.

We are utilizing CNA classes, have offered hire on bonuses, increased wages.

triple pay shifts, bonuses, increase minimum wage

Each facility is looking at systemic strategies (i.e., Promoting and growing from within, Medication aides, HSAs, reviewing for unnecessary medications and adjusting medication pass time), adjusting workloads for licensed and non-licensed staff while maintaining staff retention.

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Working on C N A class to help defray the cost of the Agency staff
Retention policy is going into place Aug 1st. to help

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Our facility has been working on updating our benefit package and wage scale in order to keep permanent staff and recruit staff. We are hoping this makes our facility more competitive in the future to help reduce the use of contract staff.

We have completed and will continue to complete wage analysis to keep our wages competitive. Ivy continues to look at ways of new retention by offering all sorts of programs for employees to keep those that we currently have and ensure to keep any new hires.

Our county has raised wages 6% in FY22 and a year-end bonus; 5% in FY23 plus a bonus of $2400 for full time staff and an additional percentage for those making less than $26 per hour. The Direct Care Wage is given as a bonus rather than being used to offset the raises. An additional Thank you bonus during COVID was given to staff in 2021. Staff have left Montana to move to states where it is less expensive to live. Staff have also left to become contract staff to make more money. The only way to reduce the reliance on contract staff is to hire your own and there are no staff to hire. Our county has excellent benefits, but the younger population as a whole does not care about or want benefits, they want the wage. Housing is hard to find and way too expensive. The situation is getting worse. I would love to have my own staff, but everyone is looking for employees and there are not enough out there.

We raised our base wage in 2021 to $19. Offer extra bonuses for picking up shifts

A revenue increase from the DPHHS (Medicaid) to support the competitive wages that contract companies are able to offer, paired with, a restriction/regulation that limits the amount

contract agencies can charge facilities. This is the only way, because they set their own rates/wages and will continue to offer more to recruit our staff and then charge us more.

Increased wages, more aggressive recruiting including larger sign-on bonuses.

Increased wages, more aggressive recruiting including sign on and referral bonuses. CNA training program in house.