Montana DPHHS Steering Committee for Provider Rate Studies
Meeting Minutes

April 21, 2022
9:00 AM (MST) – 12:00 PM (MST)

This meeting was a hybrid meeting with the option to attend in person or join by Zoom. The following is the information to connect into the meeting:

Meeting Room Location:

Montana State Capitol
1301 East Sixth Ave, Helena, MT – Room 152

Zoom Invite Information:

Join Zoom Meeting
https://mt-gov.zoom.us/j/88591607442?pwd=Q0N1UWdSZGt4d2J6UGxNY2V4U0E5QT09

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Agenda

1. **Welcome**

- Jackie Jandt with DPHHS welcomed attendees to the meeting
- Introductions were completed
- Coy Jones with Guidehouse presented the agenda for the meeting and began facilitating

2. **Provider Cost and Wage Survey Updates**

- Guidehouse presented on Provider Cost and Wage Survey updates.

3. **Rate Workgroup Updates**

- Guidehouse noted these will be provided as we move along.

4. **Wage Analysis**

- Guidehouse presented an update on Wage Analysis.

- Comment: Since 2016/2017, budget cuts have created a crisis in children's mental health, not from a lack of beds but a lack of staffing. As the crisis ripple moves into the adult world, they will have to pay more for those services. Those rates that are high for the children's care will go up in senior and long-term care and adult care because we will have to move from the facility setting to community care.
- Q: What titles of jobs are under the direct service professional category?
    - GH: There was a controlled menu of job services in the survey, and many labeled workers as direct service professionals, so it would be difficult to share exact job titles. There were a few where caregiver was the title, but they were marked as direct service professional. The vast majority have used "direct service professional." Nursing assistant and personal care aide also reported and similar numbers.
- Comment: The wages we pay for urban areas have to be looked at different than the state aggregate. We start at $22 for CNA, RNs is $38.
    - GH: We appreciate comment, and we see some variation in different parts of the state.
- Comment: We have seen a problem with acute care where wages have always been higher than behavioral health. We need to equalize this as the work is same in BH versus a hospital setting.
    - GH: We will speak to this more when we get to this slide.
- Q: Did DPHHS participate in this study? Is there competition with state facilities?
    - GH: They did not participate, and the services we're establishing rates for is private providers.
    - Montana Staff: We are in the process of looking at our own rates, but the timing was off to include in this study, as it could skew the data.
- Comment: This is good aggregate data, but we have to raise wages in Kalispell to keep up
- Q: How do we represent geographic differences in survey? Cost of living issues in Kalispell is more significant than other areas. With inflation, how do we account for this as we move forward in our study?
    - GH: In rate development, through CMS authority, we have the ability to do geographic variances, such as rural versus urban.
- Q: How do we account for quarterly changes in numbers going forward based on inflationary pressures?
    - GH: Submit rate methodology rather than just rates to CMS. It is an evolving formula that we can tinker with the parts as circumstances change, such as

inflation. We are able to play with base formula to make a case to CMS to allow adjusting rates with monetary justification. Inflation is changing but with ARPA we have ability to make modifications, but they need to be reasonable and backed with data.

- Q: The data collected today was through BH arena?
    - GH: Just for community services.
    - Follow-Up: In our world, the number of RNs and RPNs are miniscule compared to direct care workers, so it may be a clarification that could help.
    - GH: Benchmarks we use like BLS captures typical cost for a typical nurse regardless of the setting they are in. Important to look at the industry which is why we do the comparison. This system is paying higher for LPN, and lower for RN compared to the state, but the survey is lining up with what we are seeing on a broader scale. We will be walking through inflation details and how to regularly update rates based on inflationary indexes, which is an important part of cost reporting we are working on.
- Comment: We can't afford contract staff.
    - GH: That is a significant issue. Most of the information reported were employees so we didn't have to worry about contractor data.
- Comment: There is difficulty getting services to the reservations and rural areas. Getting people to come see my daughter is difficult, especially with having to get gas with the price and nearest station, which is 20 mins away. It is very expensive to live in rural areas and the services are lacking as we can't get people to take the jobs.
    - GH: This is why there isn't a simple urban rural split. This is a serious issue we need to continue to look at.
- Q: Does our Medicaid department have enough to pay different for geographic regions? A lot of complexity, but is it realistic?
    - GH: There are some services already with a fee schedule reflecting geographic differences, so it is doable. There are tiers for certain localities and rural parts of the state that qualify, but it is still an outstanding factor we are looking into.
    - Montana Staff: Children's mental health does this in three programs. They have the abilities.
- Q: What is included in job titles? Rates seem high as personal assistants are typically in the $13 range rather than $15. Does this include a variety of positions that are all being included in?
    - GH: We had this reported in the survey, something that had providers report as personal assistant. Some variation in the population, but we could see differences in SLTC. A $13 wage is something we saw in these ranges. SLTC falls into the $13 range, and the scope and nature similar, so there is some standardization.

5. Benefit Analysis

- Guidehouse presented on Benefit Analysis.

6. Employee-Related Expenses

- Guidehouse presented on Employee-Related Expenses.
- Q: How will the final Guidehouse report and Montana Medicaid work as it relates to the costs of contract travel staff, because in some parts of the state that is becoming the going rate due to inability to retain staff at these low rates?
    - GH: We will be developing assumption on mileage so the program support cost will be based on mileage for different services. Don't see this as a concern for contracted staff versus non-contracted staff. Some services have more travel than others, going from site to site. Client transportation will be a larger factor for residential rate models.
    - Follow-Up: Just to clarify I am meaning the contract (travel) staff wage rates (not mileage) vs. our employee rates and working those costs into the salary assumptions, i.e., Employed CNA = $18.00 who we are unable to retain vs Contract CNA = $42.00 who we are forced to contract with for 13 or 26 weeks to stay operating. Employed RN $32.00 vs Contact RN $90, etc.

7. Administrative and Program Support Cost Assumptions

- Guidehouse presented on Administrative and Program Support Cost Assumptions.

8. Residential Rate Models

- Guidehouse provided an update on the Residential Rate Models.
- Montana Staff: When these rates were developed, we moved into a congregate tier.
- Comment: The rates are stunning, as we are used to 1-2% rate increases once every seven years. Since 2017 the amount of money that is spent on higher levels of care and sending children out of state has grown, so if we can better use that money on these rates, it would keep people in community and keep all of these increases and not spend it elsewhere.
    - Montana Staff: These rates reflect reality, but Montana state hospital is necessary and there is no backup plan for Montana state hospital. Idea that if you do this, you can remove care from elsewhere is not consistent with what we have seen over the years.
- Montana Staff: Our goal is a data driven approach on how to build a continuum and are not shocked on seeing these rates. We didn't get here overnight but gives us a data informed starting point to make strategic investments in infrastructure through rates and others. Need to level set expectations and will take money to fund this but will be strategic investment. Have to have a community of providers along with state hospital in all service lines. Inflation is hitting everyone, and workforce has been struggling, especially due to covid. This is a data informed starting point to compare across the board, and we have not had a comprehensive rate study in a long time.

- Comment: At the end of 2019 behavioral health alliance developed PACT programs in Montana and miniature analysis of rates and these rates seem to match. Gave a lot of confidence.
- Q: I appreciate Director Meier's comments very much. That said, unless I missed it, I didn't hear if we could anticipate these recommendations to be reflected in the Governor's budget proposal?
    - Montana Staff: Priority is putting a budget request together that is data informed.

9. Cost Reporting Plan

- Guidehouse provided an update on the Cost Reporting Plan.

10. Timeline and Next Steps

- Guidehouse presented on the timeline and next steps.

11. Public Comment

- Q: Can you provide an update on your work to get input from HCBS/Medicaid Participants on the Provider Rate Study?
    - GH: This kicked off last night, and we got some engagement and shared where our rate recommendations are going. Two tracks are coming: listening sessions with advocacy organizations and participant lobbying groups occurring throughout May. There is also a series of town hall presentations focused on the DDP population and a survey underway on this subpopulation for those with employer authority in self-direction, and the relationship to rates. Our plan is to keep all engaged and aware of opportunities. There is also a targeted webinar to provide appropriate level of information to continuously encourage people to submit questions and comments.
- Q: Can you provide an update on the meeting with Union representatives on the Provider Rate Study?
    - Montana Staff: We met with union participants and had good engagement. General comments felt the analysis and information were right in line. Some questions on state facilities and how that interacts with study, and we provided information on how it differs from Home and community providers.
- Q: Please address the employee cost vs contact staff cost question previously asked. I am concerned that there will not be a well thought out response in the final report.
    - GH: We may want to take offline if we can follow-up via email. From a data perspective, if providers reported their contractor data, we can analyze the real difference in cost. Today's data of employee cost can be done in a comparison where the contracted rate would include wages, admin cost, and travel cost built into contracted rate that we would call program support. This would give a good idea on employee rate versus contracted rate to show how much more

money being paid if you are going with a contractor, and how much more expensive it is. The key question is will rates be good enough to attract employees rather than contractors with a markup? This is a more difficult issue, and we would like more feedback on our assumptions.

- Q: This particular study is on MH, BH, DD providers? We don't have a lot of contract-based providers. When will hospitals and facilities rate studies?
    - Montana Staff: This is broad scope and multi-year, and we have not started on hospital or acute hospitals. Nursing homes are upcoming. This area is extremely fluid and as the PHE winds down and FEMA reimbursement drop down, rates will begin increasing and shift back to employment versus contracting and contracting demand will go down as well as rates. Very fluid area.
    - GH: Under this timeline we are concurrently looking at physician and professional services. Looking at others not within strict scope but tangential. At this point we are looking at fiscal impact and broader expenditures, and balancing institutional mental health versus community mental health, where the rate are high compared to standard benchmarks. We will look at potential savings by adjusting rates in those services in relation to these rates and where there are funding opportunities.
- Q: I know it's a lot of work, but have you considered what each community is also paying employees in service industry jobs? I think it would demonstrate what providers are forced to compare too to hire and retain staff. I've seen fast food jobs for example with 18.00 an hour signs in their windows for example.
    - GH: Great question. The work we are doing, and from the BLS, is with numbers that are from 2021. We are not seeing the increases in 2021 that this industry pay is falling behind. However, since the 2021 numbers a lot has happened. Average weekly wage is another area we are comparing broader service industries but not seeing anything that is leading us into a concern that this industry is being drained of people due to other wages. Work we have not done at this point is to look at compensation, and data sets that will give us an understanding of the benefits piece. Some broader service industries have benefits significantly lower with higher wages compared to healthcare. Need both sides to determine comparison.

Adjournment @ 12:00 PM (MST)

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