Rate Study Webinar Video Transcript

All righty! Thank you very much for waiting! We're going to get started.

Good morning. Thank you very much for joining today.

Today... we are here in the DDD Waimanu training room.

We really appreciate all of you being here.

We know that... this is an important topic, and... we hope that this webinar... is very informative to you.

The majority of everyone... attending today is on Zoom.

So, what we have done is...we've put everybody... off camera and on mute.

So we appreciate your patience... as our presenter... goes through his presentation.

We'd like to hold questions until the end of the presentation.

At the end, we will take a look at the... Q&A and at the chat.

You're welcome to... post any of your questions there.

We will have... enough time for questions. That's my understanding.

So... feel free to put your questions there.

I appreciate you're...

You're welcome... thank you!

I appreciate your help doing that.

So... now I'd like to introduce our speaker.

Stephen Palowski is here. He's from the Burns Associates.

Many of you already recognize him.

You may recognize him from previous webinars, or if you've... been... in person meetings with him.

He is here on Oahu today (actually this week).

So, we're very fortunate to have him... here to present.

Also... in the room... she's kind of blurry... she'll have to come up to... Stephen's camera... but Mary Brogan is here (our DDD administrator).

Mary's here in room with us today. Hi Mary!

Mary: Good morning everybody.

Thank you so much for joining us from... wherever you are across the state.

I see that I'm a little fuzzy in the image, but I do look better like that (little fuzzy).

So... thank you for... coming along on this journey with us, and... working with us to understand what goes into every single rate and every... aspect of our analysis to... make sure that our service system is whole.

And, I'm going to turn it over to Stephen. Thank you!

Stephen: Great! Good morning everyone!

I am Steven Palowski with the Burns and Associates Division of Health Management Associates.

We are the consulting firm that's been... working with DDD over a number of years-- but most recently on the rate study (here in 2024). Actually, we got started earlier in 2023.

So, I do have a presentation that I'm going to be walking through presently.

In addition to the presentation, we'll provide a quick overview of the rate model packet itself.

And, both of these materials (the presentation as well as the rate model packet) will be posted online-- I think both on... the division's website, as well as on a website that we established specifically for this project.

And, we're also recording this webinar-- so that folks who don't have the ability to attend this morning can access it at their convenience.

As Stacy said, that's the reason for asking for questions to be held until the end.

I'm certainly not going to talk for three hours straight.

So, there will be time for us to get to those questions.

But, so that we have a clean webinar for the folks who... listen after the fact-- they're able to hear the beginning to the end of the presentation, and then... as they desire, they can listen to the questions after that.

[No Audio]

So, wanted to start with an overview of why it is we've asked folks to attend today's presentation.

There's really about three things we're trying to get out of our conversation here today.

Fundamentally, we'd like to make sure that we're... providing a full articulation of the recommendations that we're putting forward from this rate study.

We'll talk a little bit more in a slide or two about the impetus for the rate study (why we're doing it and when we're doing it), but... the bottom line is we spent a fair amount of work, a fair amount of time over the past... eight or nine months evaluating services, collecting data from providers and from other sources of information, and now we're putting forward our recommendations for adjusting those payment rates.

That being said, you'll see on that first bullet that I've italicized the word "initial"—because these are our proposals. They're not final recommendations.

This presentation also kicks off a public comment process—so we're going to walk through the materials. But then we're going to give you (give or take) four weeks to evaluate the proposals that we're putting forward and offer feedback to us in writing.

So that segues into the second bullet-- which is we want to make sure that during this comment period you have resources that you need... in order to offer informed commentary on these proposals.

So, we want to make sure you understand what it is we're proposing, why we're proposing it, and how it is we got to these proposals.

I'll note that my team and I will be available during the public comment period to respond to any technical questions that you have.

So, if you have comments about the rate models (things you think ought to be changed)-- submit those in writing.

But if you have questions about the mechanics-- how things are calculated, what the data sources... we're using are, and where they came from-- please feel free to reach out to us during this comment period, so we again, provide you those resources that you need in order to fully appreciate the entirety of these recommendations.

And then, lastly, through this webinar (but then also through your advocacy)-- we're hoping to encourage participation in the public comment process.

I always like to point out that this is not a requirement.

So, if you look at the regulations that the federal government puts forward about doing rate studies like this-- there's not a requirement to do a public comment process (just like this).

So, we're not checking a box. We are really truly interested in your feedback.

I'm not going to suggest that every... piece of feedback or every suggestion that we receive is going to result in a change.

In fact, I can almost guarantee that not every piece of feedback will result in a change to our recommendations.

But I also strongly suspect that some of that commentary will result in us making some adjustments.

So... we want to make sure that folks, again, understand what it is we're putting forward, and then are engaged to submit those pieces of feedback that suggested to edits to our proposals and the like.

And so I'll note-- in as much as you work with your colleagues and other stakeholders-- we certainly encourage you to make sure they're aware that this public comment process (when the draft rate models has opened), and direct them to the materials posted (again not at the moment, but by the end of the week or perhaps on Monday on both the division's website and a website that HMA Burns has established.

In terms of what I'll cover in the PowerPoint, it's only about 36 slides., but I want to spend a little bit of time providing background on this rate study. I think for many of you listening in-- you'll have some familiarity-- because you would have heard from us about the provider survey (for example).

But for those of you who might be coming into this for the first time, we want to tell you why it is we're here today and what it is we've done.

Then we'll spend some time talking about both our general approach to rate setting and the specific steps that we employed for this particular project.

Then I'll wrap up the bulk of the presentation by providing an overview at a fairly high level the recommendations that we're putting forward in this rate study.

Then we'll wrap up with a discussion of next steps, and in particular, how the public comment process is going to work.

So, with that... I'm going to dive right into the material beginning with why is we're doing the rate study and why is we're doing it now

So, the simple answer to the question of why we're looking at provider rates is because we have to.

So, the waiver program for folks with intellectual developmental disabilities (that is how the division of Developmental Disabilities pays for services) is governed by federal regulations-- because Medicaid funding covers the majority of the expenses of this program.

And so, since we're using Federal money we have to play by federal rules. And one of those Federal rules is that rate methodologies must be evaluated at least every 5 years.

The division's been adhering to that schedule here over the last several cycles.

So we conducted the first rate study actually in quite some time back in 2015 and 2016 in alignment with a waiver renewal that made some significant changes to the program.

Then we did a subsequent study in 2019 and 2020, and I will note that the recommendations that came out of both of those projects were ultimately implemented (not necessarily immediately, not necessarily within the first year)-- but ultimately both of those projects had significant price tags attached to them.

And given the support of the executive and the legislature and the advocacy of the division stakeholders, additional funding was appropriated so that we could Implement those suggested rate increases.

And, I'll note that both my organization and myself personally have been involved in both of those two previous rate studies.

So that's the first part of why-- as we're doing it again because we have to.

Second question of why are we doing it now is because we want to align with the state's budgeting process.

So, without spending a lot of time going into these particular weeds we're planning for the biennium or the two-year budgeting cycle (I'll call it) that begins next July.

So, the state budgets on a two-year cycle were wrapping up towards the end of the second year of the current cycle.

The next cycle starts July 1 of 2025.

So, if we want to consider additional funding as part of this cycle, the division and the department need that information sooner rather than later--because the way the budget process works is there are internal deliberations within the Department of Health about what initiatives are going to go forward).

They have to make those proposals to Executive leadership. The budget and finance office-- ultimately the governor will make decisions about what gets included in the budget in January, and then the legislature makes ultimate decisions about how to fund programs (including any particular adjustments during the legislative session... that will convene in early 2025.

So with all that timing a couple of things that we wanted to point out is that the earliest that implementation could occur of these changes would be July of 2025.

But as I've said, and I will say one or two more times during this presentation, the implementation will require additional appropriated funding.

So, interestingly to take it back to that first bullet, the federal government says you have to review rate methodologies every five years, but it doesn't actually say you have to fund the results of those reviews every five years.

So, you'll see later in this presentation that the proposals that we're putting forward would increase costs by a not insignificant amount.

And the division doesn't simply have that money in its current budget.

As a result any implementation is going to require additional funding through that budgeting process.

And as a result again, the earliest that could potentially occur (and there's certainly no guarantees that it will occur)-- but the earliest that could occur would be in July of 2025.

The other thing that we wanted to be sensitive to, and the reason that we're moving forward this rate study a little bit (not dramatically, but we were doing it probably a year earlier than we had to) was because we know that the minimum wage is going to increase again in January of 2026.

So, for those providers listening to this call this morning, you'll note that the last couple of rate increases have been tied to increases in the state's minimum wage--including the most recent increase here this past January when it increased from 12 to $14 per hour.

I'll talk a little bit more about this later in the presentation, but again, the thought here is that we didn't want to delay another year (because we need to be sensitive to the fact that that minimum wage increase in January of 2026 is going to have, of course, pressure on the wages that providers pay their direct support professionals).

I have just a couple of slides to talk a little bit about my organization-- so you know who it is you're listening to for the next hour and a half or so.

Burns and Associates is a health policy consultancy who have always emphasized our work with State Medicaid agencies and their sister agencies-- that is those behavioral health and intellectual and developmental disability authorities that are delegated to operate some of the Medicaid funded services.

Our organization our company was founded back in 2006. Since that time we've consulted in more than 30 states.

The reason that I now have different fonts and labels and colors in my presentations because we sold our firm to a larger consulting firm (Health Management Associates) in September of 2020.

But, it's still the same team working with the same clients doing the same type of work as it always has been.

And really, as I said, our emphasis now at the Burns division of HMA is to continue to support our State Medicaid agencies and their partner departments within the Medicaid space.

We do an awful lot of different things—but one of the areas that we've developed specific expertise and experience in is the field of intellectual and developmental disabilities.

And then, furthermore, within that space we do an awful lot of different work.

Now we're most well-known (for in as much as a consultant can be well known for the work that we do) on provider rate setting-- because when we're talking about how much to pay somebody for something that's going to generate a fair amount of Interest.

However, we do an awful lot of other work as well that includes policy work, helping design services and write service definitions, helping states work through the waiver application process with the federal government, and similar sorts of policy-driven activities.

We also help states including--Hawaii's Division Developmental Disability implements and tie funding decisions to assessment instruments.

So, one of those big changes that I made a vague reference to in the 2016 Waiver Reauthorization was the adoption of the Supports Intensity Scale.

So, everyone in the system receives a CIS assessment. And for certain shared services like residential habilitation or adult day health-- the CIS is used to determine the specific rate that a provider is going to be paid (with the intent being that folks with more significant needs require more intensive supports, and it costs providers more to deliver those more intensive supports).

I mentioned already a couple of times that we've led the previous two rate studies with Hawaii DDD.

And I've been involved since our relationship with DDD began (back in 2015).

So this is about my ninth year working with DDD on rates and other related topics.

We just like to show a map if folks are interested in where it is we've been, and what it is we've done.

You can take a look at this and research a little bit further.

But talking specifically about today's focus, provider rate studies, we've done comprehensive rate studies for intellectual and developmental disability services in about 13 states and the Commonwealth of Puerto Rico here over the last almost 20 years now.

So, we've done a awful lot of work in this space specifically related to rate setting.

But as I said, we've done a number of other projects unrelated to rates that could include assessment or budget-driven projects-- helping develop pilot programs for young adults with autism (for example).

So... a variety of different things.

And you see those states shaded in the more charcoal color here on the slide given the experience that we have in doing rate studies like this we've developed what we think is a methodical and well thought through approach.

We've labeled this approach over time “an independent rate model approach” or “an independent approach to provider rate setting”-- and all that we're really trying to convey with that expression is that we're not dependent on any single source of information.

And sometimes we get questions about, “Well, why aren't you just using providers financial statements in order to set payment rates?”

And the reason for that, particularly in the world of Home and Community Based Services and even more particularly in the world of HCBS for people with intellectual and developmental disabilities, is because the state's DD Authority and Hawaii DDD is really the only game in town as it relates to paying for these types of services.

Medicare doesn't cover these services. Commercial insurance doesn't cover these services in any significant manner.

There's very few individuals the ability to privately pay for services-- so providers are dependent almost entirely on the payments they're receiving from the state DD Department.

As a result, if we're only looking at provider cost data, it would become a circular argument (right?)-- because your costs are going to reflect the rates that you're currently being paid.

And all that we would produce is an answer that current rates are working, because this provider is still in business.

If we then look at this... these rates in five more years, we'd reach the exact same conclusion (right?) because providers have to make two ends meet.

And so, if we were only looking at providers financials we'd be ignoring a lot of the market pressures that providers operate in (right?).

They don't operate in a vacuum. They have to compete with other industries that are trying to employ similar staff.

They have to (obviously) account for general growth in costs (and the like).

And so, the middle part of this slide talks about where it is we get that information.

And I'll talk about each of these in a little bit more detail as we work through the presentation.

But in addition to gathering information directly from providers and stakeholders through things like a provider survey and a public comment process, we also look at the statutes and regulations that govern a given program.

We want to make sure that we have an understanding of what a state is requiring their providers to do within each of these services.

We collect information from independent published sources of information (like the Bureau of Labor Statistics).

We use the Internal Revenue Service or IRS's mileage rate to fund the cost of vehicles, etc.

And we'll talk about some of those sources of information throughout our presentation here this morning.

And then, at times, we conduct other studies around things like rate benchmarking-- are we paying rates that are comparable to what other folks are paying for similar services?

So, moving back up to the first bullet on the slide.

That really articulates our fundamental goal when we're doing this type of work-- which is... we want to build rates that reflect the reasonable cost that providers incur to deliver services consistent with the state's standards (their requirements and individual service plans).

It's the state's job to define their services—to tell providers what it is they need to do.

But once they do that, we believe (as consultants) that states ought to pay rates that allow providers to deliver on those promises.

And then the last part point that I'll make on this slide (at the very bottom) is that when we do these projects, we're not looking to target any specific budgetary amount.

In fact, we pass up on a project... we pass on projects (I should say) if a client tells us we want the results to fit into this box.

We want to make sure that the process itself is credible.

As I said, we're not just looking at what you're currently being paid or what your current expense profile is.

We want to build rates that we think are representative of the true cost of delivering quality services.

And so, that's what we're going to put forward.

That's what we're putting forward here today.

And we weren't given a target to say... “you have to live within this amount of money now.”

My background prior to working in consulting was in state budgeting.

So, I'm certainly sensitive to the state budgetary considerations-- which you heard me talk about earlier in the presentation.

So ultimately, we're going to have to have a conversation about what this would cost and whether or not it can be fully implemented based upon the resources that will be made available.

But the rate models themselves are not meant to back into any specific dollar amount.

So, when we talk about building rate models (and that's a term you're going to hear me use a lot this morning), we're really looking to build a spreadsheet effectively that list the various cost drivers for a given service.

Rather than simply saying that we think a bottom line rate ought to be $40 an hour or $300 a day, we're going to tell you exactly how we got to those amounts.

It's based upon this assumed wage for a direct support professional and this benefit package and this level of agency overhead expenses etc. etc.

And that allows us to have an informed conversation-- rather than simply arguing about whether the rate ought to be 40 or 42.

We're able to evaluate the adequacy of the wage assumption that we've built in.

So is that wage assumption going to allow you to recruit and retain the staff that you need in order to deliver services.

I always like to highlight for my provider partners that the assumptions that we make and the rate models (generally speaking) are not meant to be mandates.

We have to build rate with assumptions in order to get to the bottom line, but we understand for any given provider some of your costs are going to be lower than what we've assumed and some of your costs are likely to be higher than what we've assumed.

Tying it back to the previous slide, our goal is to build rates that reflect the reasonable cost that providers incur.

For some providers, that's going to look a little bit different.

So, we're not telling you that you have to pay exactly this amount or that we always know exactly how many miles your staff are going to be traveling in a given week--but we think that we're putting forward estimates that reflect that reasonableness.

Other point that we like to make when we're talking about rate models is that when we talk about building a rate for a service, more often than not, we're talking about building rates in the plural for a service.

And within a given service, the rates can vary for a variety of reasons.

And, in fact, this generic example that we use whenever we're doing a project like this applies each of these... boxes on this generic example apply... to Hawaii.

So, at times, we build rates that vary based upon individual need.

And, I made reference to that in my introduction to the organization-- that Hawaii (almost a decade ago now) adopted the Supports Intensity Scale that's used to assess individual needs.

And, for shared services we pay differentiated rates.

So, if you think about Adult Day Health (as an example), folks that are relatively capable might be served reasonably in a one to five or one to six environment.

Whereas if you have folks with really significant needs (whether that's based upon their needs with activities of daily living or medical needs or behavioral needs)-- one to five or one to six just isn't going to work for them.

They're probably not going to be safe and they're not going to be able to get the sort of supports that they need.

So, they probably need to be stated at a one to two or a two to three (or something along those lines).

Now, if you're a provider, it's going to be a lot more costly to deliver more intensive supports, right?

You're going to pay-- you're going to have to pay for more staff in order to support the individuals within your program.

And so, we have rates that recognize those differences and pay greater amounts-- to make sure that people with more significant needs have access to services.

For some services (including here in Hawaii), we also differentiate based upon where the service is delivered.

So, the examples of that are PAB and CLSI-- which are kind of sort of two sides of the same coin.

We have higher rates for CLSI because there's more travel associated with transporting people in the community and helping them access those community supports than delivering services in their home.

Same thing is true for ADH and CLSG, right?

Again, two coin... two sides of the same coin.

For a generic Day program, sometimes supports are delivered in a center-based environment-- sometimes in a community -based environment.

But it's going to be (generally speaking) more expensive to deliver services in that community-based environment, because you need more staff (since it's less in control, a less controlled environment).

You likely have greater overhead costs-- because it takes more to plan community-based activities.

In some States (including in Hawaii), we differentiate rates based upon geography or region.

So, what we've done historically (although I'll come back to this point later in my remarks this morning) is establish rates for the big island versus other islands.

And, we started doing that back in the 2015-2016 rate study to recognize that on the Big Island (as the name implies), you're traveling greater distances.

And, those greater distances mean that you're going to be delivering fewer hours of service, and having more non-billable time (because you can't bill for that travel).

So, we wanted to reflect that reality--that you're going to have more wear and tear on vehicles, more staff time associated with non-billable transportation.

So, we have higher rates for the big island.

And then finally, rates can vary based upon who's delivering the service.

So training and consultation is a good example of this.

We have different rates for registered nurses versus therapists, versus psychologists etc.-- because the typical amounts that those staff earn vary.

The typical or average wage of a therapist is not the same as a nurse.

It's not the same as a BCBA. It's not the same as a BCABA and the like.

So, we want to make sure we're taking those cost differences into account-- so that providers are being fairly compensated based upon who it is they're employing.

This graphic illustrates the five major components that we include in all of our rates for Home and Community-Based Services.

The first three shaded in the blue are related to the direct care worker--the direct support professional, right?

Their wages, their benefits, and their productivity--that is, how many hours they can bill for during a typical week.

And then, the two items in the neon green color relate to agency overhead / expenses which we divide between program support and administration.

So, nearly all of our rate models are going to include some combination of those expenses in order to get to that total rate that I talked about.

In addition to those five key factors, other factors will be included based upon the specific service that we're talking about.

So, if we're talking about a group service—we'll consider things like staffing ratios and attendance rates.

If we're talking about Home and Community Based Services (delivered away from the provider's Location), we'll have to account for transportation expenses.

If we're talking about site-based services (like center-based day programs or clinic-based therapy services), we'll take into account the costs of the bricks and mortar (the actual physical plant or the building expense).

On the next couple of slides, I show you an example of a rate model from another state.

Now, we intentionally chose another state to keep this generic.

We're not yet sharing the specific recommendations for Hawaii.

We'll get to that in a little bit, but we wanted to not focus on numbers on this slide, but more focus on concepts.

So, this service is an in-home support service in a state in the northeast.

And we actually set this about (I don't know) six or seven years ago now-- so quite some time ago.

You can look all the way to the bottom line and the rate is $9.49 per 15 minutes which is about $38 per hour.

But rather than simply publishing a few schedule that says $38--as I mentioned before we're going to detail all of our assumptions.

So we're assuming that at this time in the state that $14.20 per hour was an adequate wage for a direct support professional, and then 35.9% was a cost (their benefits).

We then measure productivity-- which is the evaluation of how much time folks are able to bill for (because most staff delivering direct care or direct support have non-billable obligations).

That could be things like traveling to the people that they provide services to.

It could include things like recordkeeping back at the office.

It could include attending a staff meeting once a month, attending their training, hopefully taking time off on a...

So, you're still (as a provider) incurring expenses when folks are on the clock, but you can't bill for that time directly.

So, we layer that expense in over their billable hours through these productivity adjustments.

I'll note, we spent a lot of time on this top portion of the box—the direct support staff wages and benefits (because that is the single largest component of effectively all HCBS providers costs, right)?

Because it's not like a hospital, where it's not really doctors and nurses that are driving expenses.

It's the expensive buildings, it's the MRI machines and the prescription drugs, and all the things that flow through a hospital.

In the world of HCBS, though, what we're effectively paying for is an hour of somebody's time.

That is the driving... the primary cost driver.

So, we want to make sure that we're being thoughtful about what that is.

And, of course, having fairly compensated staff is also important to delivering quality services-- and helping ensure that providers [are] able to recruit and retain the staff that they need to deliver those services.

So, that's a big emphasis of our work.

And, when I get into the specific recommendations and the overview of the methodology, you'll see more slides about those topics than any other.

In addition to those direct support expenses, we account for other agency-wide expenses-- which we divide between program support and administration.

So, program support are functions that are directly associated with a program or a service, but not tied to a specific individual service recipient.

So, that could include things like first-line supervision-- the supervisors of the direct support professionals.

It could include work around curriculum development or program design.

It could include quality assurance functions.

These are all things that are intrinsic to delivering services, but they're not on behalf of a specific individual and therefore they cannot be billed for.

The other part of these overhead expenses is administration.

So, those are expenses that occur not at the program level-- but at the organizational level.

So, you can think about that as executive leadership, the business office, human resources, information technology (IT).

Doesn't really matter what service you're delivering or really what field you're in-- you're going to have these administrative expenses.

So, we like to make sure we divide those up-- because if we lumped everything into an overhead or administrative bucket, it's going to overstate the amount of money that's going to those overhead costs.

Whereas, much of that program-related expense are certainly tied to delivering high quality services.

And then other costs vary by service (as I mentioned a couple of slides back).

Because this is a home-based service, the other factor we've included here are mileage expenses.

This is the mileage for individual workers to get out the people they provide services to.

And at least, when we built this rate model (although this has, I believe since gone away or is going away soon), they had a service provider tax of 6% that was built in here (at the bottom line).

But again, we chose a simple rate model so that I could cram it into a PowerPoint slide.

But if you were looking at Adult Day Health as an example or CLSG, there would be quite a few more moving pieces.

Because then, we'd also be accounting for staffing ratios, and supply costs, and facility expenses, and the like.

So, I wrap up this section of the presentation just by highlighting what we think are some of the key benefits to this approach to rate setting.

Fundamentally (and we hope folks agree with this, if nothing else) is that it's a transparent approach.

Like I showed you on the previous slides, we're not simply saying that we think that service ought to be reimbursed at $38 per hour.

We're showing you exactly how it is we got to that bottom line.

And so, then we can talk about whether or not that $14.20 wage assumption for a DSP is appropriate whether or not 35.9% for benefits are appropriate whether 15% for administration is appropriate.

So, by outlining our assumptions, we're allowed to have those informed conversations.

When you've outlined rate models at that level of detail, you're also able to make adjustments for various reasons.

For example, there might be a policy goal that the state's looking to implement.

The example that I like to give in these presentations is-- perhaps they increase training requirements.

So, although I didn't go through line by line on the previous slide, if you were to look, we actually have a line item for training.

So in this state at this time, we included 50 hours of training per year.

Let's say the state wants to add a new module on some emerging topic within the field and rather than 50 hours it's going to become 58 hours.

You don't have to go back through a time-consuming and costly rate study (like we... you're doing

right now).

You're able to replace that number 50 within the rate model with 58 and automatically recalculate the bottom line.

And then similarly, the rates lend themselves be maintained over time.

Now, I'm always quick to add in every state that I work, that's not a guarantee that actually happens, right?

Because it still has to go through the state's budgeting process.

There are very, very few States (fewer than a literal handful) that have any automatic regular updates to their rate models themselves.

Instead, what happens is the rate increases have to compete with other initiatives through the state's budgeting process.

However, by documenting our assumptions and where the numbers came from, folks will be able to determine whether or not those rates and those cost assumptions remain adequate.

So, for example, that state... a slide back where we recommended a DSP wage assumption of $14.20-- I think that was appropriate at the time.

We're actually engaged at... with that state currently, and I can tell you that we're going to be recommending a pretty big increase to that $14.20 per hour (because time has passed since we built that originally).

We have new data... there's new labor market conditions, and we can take that into account.

In fact, though... as recently as this past November, we did make adjustments to Hawaii's Waiver Rates for, in that example, accounting for the higher cost of minimum wage, right?

So, we made an adjustment back in November to account for the increase... here in January to $14 per hour.

So we were able to do that relatively quickly on behalf of the division-- so that they could get those rate models out and begin paying on them (rather than having to do a lot more data collection).

So talked about generically how we think about doing rate setting.

Now, we're going to talk a bit about the process that we employ.

This graphic illustrates the three phases of our HCBS rate setting approach.

The first phase shaded in blue relates to the background work that we do simply to get a project kicked off.

That's making sure that we understand the environment in which we're coming into.

Then, in the tealish color, we do data collection.

And, that is both primary data collection (gathering information directly from providers) and secondary data collection (where we're researching and analyzing some of those independent data sources).

Those two work streams come back together, and we begin the development of rates themselves (which is where we're at right now).

We're putting forward our recommendations.

We're going to provide an opportunity for you to offer comments.

And then, we'll make our final recommendations to the division (after considering those comments).

So, taking each of those phases and the individual tasks in turn-- I mentioned earlier that one of the sources of information that we rely upon is a review of existing requirements.

And, although I showed you a slide where the map shows that there's a lot of states in which we've done this work, every State's service requirements are different.

It's not like when we're doing work for say hospitals or physicians-- where there's a standard of care and the support itself looks almost identical from one state to the next.

In the World of HCBS, because there's not a standard of care (because there's very few evidence-based practices), states have wide latitude in defining their service requirements.

So, I always like to use day habilitation programs (or what we call Adult Day Health here in Hawaii) as my example.

Every single state covers a day habilitation service for people with I/DD, but the requirements of those services can vary pretty significantly from one state to the next.

In some states that we work in, the maximum allowable ratio is one to three. In other states, the maximum allowable ratio is 1 to 10.

It's going to be a lot more costly to deliver services at a one to three ratio than a 1 to 10-- because you're going to have to employ a lot more staff.

Some states bundle transportation into the rate.

Some allow to be billed separately.

Some states expect a day provider to deliver transportation (get people back and forth from their homes).

Other states require the residential provider to get people back and forth from their day programs.

And so we need to understand the specifics of that day habilitation program.

I can't simply say I've done rates in Maine or California or New Mexico or Georgia or anywhere else and say now we're just going to drop those into Hawaii (because the requirements in Hawaii are going to look different from each of those other states).

So we fill in our knowledge by doing an awful lot of reading waivers and regulations and manuals and previous reports, and then we supplement that with feedback directly from stakeholders (including our partners with DDD) where we have lots of in-depth meetings about service requirements and then from providers through things like an Advisory Group as well as this public comment process we are we're kicking off today.

From here, as I said, we move on to data collection and analysis—which includes a provider survey.

So, I mentioned before, that we don't only look at provider cost data.

But that's not to say that we don't look at it at all.

We absolutely do look at provider costs as well as service design topics and use that when we're making and formulating our recommendations.

So, for you providers on the call, you were given an opportunity to participate in the survey.

For those of you who did complete the survey, thank you very, very much.

We know it's in-depth. It covers information that goes beyond simply cost reporting.

It asks for things like the productivity of staff, miles driven, staffing ratios, etc. etc.

So we know it's a pretty big effort in order for you to complete it.

As a result, we try to provide technical assistance through a variety of different channels throughout the process.

In terms of participation, this go round, there were 59 providers that delivered one or more dollars of billable services in fiscal year 2023.

Of those 59, 20 of them completed our provider survey and they accounted for 34% of the total service delivery in fiscal 23.

We've completed an analysis of those results.

We actually shared it with the provider advisory group.

And, that will be one of the other pieces of material that is posted online-- as well as this presentation and the draft rate models themselves.

So, as I said, we complement the primary data collection with information from other sources / examples.

This is not an exhaustive list, but examples include wage data from the Bureau of Labor Statistics (should say Hawaii specific).

I will make sure I clean that up here.

It's not Georgia-specific, it's Hawaii-specific Health Insurance data from the medical

expenditure panel survey and then the IRS is standard mileage rate.

So not an exhaustive list-- but just a handful of examples.

One of the other things that we did for this particular project-- is look at some work that MedQuest has had done for their program for people who are older / have physical disabilities.

So, they also... did some evaluations of their payment rates.

And for the most part, we've not aligned on payments for a variety of reasons.

The programs, of course, themselves are different.

But for things like... BCBAs and RBTs, we are using the work they've done as our starting point to adjust those payment rates.

From there (relying on the data we get from both the provider survey as well as that independent research and analysis), we develop our draft rate models.

And, that's what we'll be spending a little bit of time talking about (after I get through this presentation).

I will note (because we're not starting from scratch, it's not a brand new project) that this is actually our third... time partnering with DDD on this rate study.

We didn't burn things down, and start from the beginning.

We started with what was already in place, right?

So, we were taking a look at the rate models.

If we thought adjustments to the underlying foundations were appropriate, we made them.

But, for the most part, we're updating the structures that are already in place-- because they seem to be doing a reasonably effective job of capping the cost drivers.

It's the costs themselves (how much) we're assuming that we needed to make changes to.

We'll have a public comment process.

I'll talk... a little bit more about the details later in the presentation.

But the bottom line here is that... after we've posted the materials, you're going to have about four weeks to submit your comments to us in writing.

We're going to review everything that gets submitted, and then we're going to produce a (again transparent and public facing) document that walks through all of that commentary.

So, for those of you who are familiar with Federal rule, you can think about this as analogous to the Federal Register.

An agency puts forward a proposed rule, they accept comments, and then later in the Federal Register, they say we heard X Y and Z.

For every one of those comments, they provide a response.

If they make a change in response to the comment, they tell you what that change is.

If they don't make a change, they provide the rationale for not having done so.

We're going to do the same thing.

We're going to summarize all the comments that we received, and we're going to provide a... answer to each of those comments-- with the discussion of any changes or the reason no change was made.

From there, we move on to finalizing the recommendations.

We'll post the final materials online for everyone to see.

And, then we're available to work with our clients (including DDD) on implementation support (as necessary).

So, this varies based upon the state's... needs.

It could include fiscal modeling. It could include providing briefing materials or participating in brief... things like this one.

It could develop a phase.

It could involve developing a phase-in-plan to ultimately Implement those rates over a period of time.

And of course, there are other examples in addition to this as well.

So, a lot of background material.

I've asked you to sit through about 45 minutes of conversation before I've actually told you the results of this work.

So, that's what we're going to spend a little bit of time talking about now.

So, we have the full-rate model packet available.

I'm going to actually wrap my presentation up and walk through, not all 60 or 65 pages, but a handful of pages-- to provide an orientation to that.

But in the PowerPoint, we wanted to highlight a couple of highlights-- highlight some highlights.

We wanted to emphasize a couple of highlights.

So, first (as I mentioned a moment ago) that we're primarily building upon existing rate models by updating cost assumptions.

We're not starting from scratch.

We're using the rate models that are already in place (for a handful of reasons).

Again, when we look at the stab... the provider Network, we're seeing that it's been pretty stable.

So, that suggests that rates are doing their job.

We also took into account the fact that there haven't been a lot of changes at service definition.

So, there's not a reason to make a lot of foundational changes to the rates that are aligned with those service definitions.

And then also, with the provider survey-- although we got 20 responses (about a third of the provider community), when you break that out on a service-by-service basis-- for some services that might have represented only three or four or five providers.

And, it's hard to make big foundational changes based upon that small sample size.

But, the public comment process does afford you an opportunity to tell us if there's something more substantial that we need to be considering in our recommendations.

If you think something does need to be fundamentally reworked, we want to hear about that.

We're not seeing that-- but that's why we're looking for your feedback.

So, I mentioned earlier in the presentation, that back in 2016 we established differentiated rate for the big island.

What we're proposing now is that we continue to have rates that vary by Island.

But, rather than big island versus all the other Islands, we're proposing instead to have rates for Oahu and then a separate set of fee schedules higher rates for the neighbor islands.

We're doing that for a couple of reasons.

The first is the reason that the Big Island rates were established in the first place.

There is more travel incurred on the big island.

We did an analysis back in 2015 and 2016 that showed that.

We measure the distance between providers and the people that they're serving, and there is significantly more difference in the Big Island communities than there are... outside of the big island.

But then we also did some another some other analysis this cycle.

And we looked at say... wage differentials-- and one of the things that we found is wages on or in Maui County for PA professional type staff are higher than they are on Oahu (and really anywhere else in the State).

So, different reasons why the cost... might look a little bit different.

But, bottom line is that they do have higher costs than other islands.

And so, it made sense to kind of move them over to that higher rate bucket.

And then, furthermore and perhaps lastly in terms of our rationale here is that there are just fewer people receiving services on the neighbor Islands.

As a result, there's less volume to be had and there are fewer providers.

We want to make sure that we're offsetting the lack of volume with somewhat higher rates to account for those (both real cost differences like travel time on the big island, like wages on Maui)-- but then also to account for the fact that there's fewer people... available to deliver services too.

So, it's important to emphasize that Oahu rates haven't lost anything.

They're still increasing a lot as well, but what we've done is we've moved... Maui and Kauai and the other neighbor Islands into the Big Island framework.

Next major assumption relates to the direct support professionals, and I'll provide more detail about this here in a couple of slides.

But the bottom line is we propose a rate model assumption of an average wage of $21.33 per hour.

This is just the wage piece-- it doesn't include the benefit expense.

We still also include a comprehensive benefit package for direct support professionals.

I shared with the DDD team that if you look at the rate studies that both my firm and other consultancies have done, there's a pretty obvious demarcation point (which is right around that pandemic).

In the years prior to that, we saw DSP wage assumptions in a ballpark of 14, 15, 16 (sometimes less than 14 maybe a little bit higher than 16)-- but right around that ballpark in each state.

After the pandemic, we're now much more likely to see rate model wage assumptions of 20 or 21 or $22 per hour.

So, although this is a pretty large number (represents a pretty big increase), from where we're at today which is around $17.00 to $17.75 (and a lot more than what we did back in 2015-2016)--it's certainly in line with what we're seeing across the country.

And, for those of you who are providers listening to this webinar, I'm sure you can attest that there's just been a deepening of the challenges of recruiting and retaining workforce (the workforce coming out of the pandemic).

And so, we think this is a representation of what it takes to hire staff.

I'll also note what I said earlier is that this is meant to be an average.

It's not meant to be a mandate on providers.

We wouldn't expected everyone to make $21.33--because there also ought to be some opportunity for advancement.

So maybe you start your team at $18 per hour, and then after they get more experience, they are earning 23 or $24 per hour.

The $21.33 is meant to be an average, but it's not meant to take away your flexibility to manage your organization, to establish an internal career path for your staff, and of course, there's also opportunities for you to trade off.

It could be that your staff value the wage more than benefits.

So, maybe you offer less generous benefits than what we assume, but pay even higher wages than this $21.33--or the opposite could be true.

Maybe you offer more generous health insurance benefits than what we have built in the rate model.

You pay a little bit less to pay for that.

Obviously, we want you to be able to design your compensation package for your team that's going to allow you to meet their needs.

Couple other highlights that we wanted to... note for AFHs.

And I will briefly touch on this rate model here in a little bit.

But we don't fund that on an hourly basis, right?

We include assumed payments or include assume stein for the AFH home provider that has not been increased in a significant way for some time now.

But with the costs increasing for DSPs-- it made sense for us to do something compatible for the AFH Homebase provider.

So those are tiered rates-- where previously we assumed that on an annual basis the home-based provider was getting 25, 35 or $45,000 per year based upon who they're serving, we increased each of those amounts by $10,000.

Now it's 35, 45, and $55,000 per year.

A new proposal is the sub bullet here that with that big increase in the assumed payments on the home provider we are recommending that a floor be established where agencies have to pay at least 60% of the total payment to their home provider.

There's still some flexibility built in-- because if you do the math on the rate models, we assume that the payment of the home is between 65 and 70% of the total rate.

But again, just like with your employment staff, your direct support professionals, your contracted home providers might have different priorities.

Maybe they value more hands-on support.

And so, you give them more hands-on support, but pay them a little bit less than what we've assumed in the rate.

So, the recommendation to establish that 60% floor maintains some flexibility, but it also ensures that the bulk of the increase and the bulk of the rate itself is going to the home-based providers (who after all, are the ones who are delivering care for the participants).

Another thing that we're recommending (although there's more details to be filled out) is the establishment of some... supplemental payments or enhanced payments.

We're still working through potential options--from how to process payments like this, but let's call it value-based options or outcome-based options.

These are all meant to be additive-- is the first thing that I'll say.

So, sometimes when people hear about value-based care, they talk about things like capitation or two-sided risk.

We're not asking that anything be put at risk.

Instead, we're identifying areas where we think additional Investments would support the types of outcomes that we're looking for.

So, these would all be payments on top of the standard fee schedule.

The three areas that we internally have thought about and are interested in your feedback on are establishing a bonus payment effectively for the establishment of new adult foster homes on the neighbor Islands.

If you take a look at the capacity, it's really very, very slim outside of Oahu.

There are very few AFHs out there.

So that's an identified need-- to make sure there's an array of options for people.

And so, what we're proposing here is that if an agency gets a new AFH certified, and a placement is made into that AFH, there's going to be a bonus payment.

Again, we haven't quantified what that might look like.

We're open to feedback on that-- but the idea here is some sort of incentive for the development of more capacity on the neighbor islands.

Similarly, if you take a look at Hawaii's performance on getting people with disabilities into individual... supported employment or competitive integrated employment, it trails a bit the national average.

So again, another identified need that... there's opportunity for us to do a better job of helping people get employed.

And so, we're proposing that there would be an incentive payment for successfully placing people in employment.

We met with our provider advisory group a couple of days ago to preview this presentation, and they pointed out-- how are you going to successfully.

Again, something else we don't have the details for you here today-- but if you have suggestions, let us know.

It's not simply they get a job on Monday and you get the bonus payment on Tuesday.

There needs to be some... mechanism to continue to support people in the job so that it's a good fit for them.

So maybe that is they have to retain their job for 30 days or 90 days or 180 days.

We don't know exactly what is going to be the right number. We also don't know what the payment amount will be-- but we're looking for feedback in those areas as well.

To reemphasize my first point in this section-- this would be on top of what already can be billed for job development.

So, we already have rates that are built to help agencies get people employed.

That's going to continue--but what we want to add to that is... something that would be an enhanced payment or supplemental payment when we're actually successful in moving people into employment.

So, that's why I'm saying nothing is being taken away.

Job development is still there, and would still be billed under the existing rules.

But this would be something that on top of that to continue to provide incentives for providers to deliver employment supports and help people get jobs that are well matched to their needs and desires.

The other thing that... there's been an awful lot of talk about over a couple of years now (because it's being funded through the American Rescue plan act or ARPA funds) is some Workforce... a Workforce Development initiative.

And I don't have all the details to share with you today-- because they're not fleshed out.

But conceptually, what we're talking about is the establishment of some sort of certification or lure framework.

And ultimately, once DSPs move through that and become certified (or complete the training that we're talking about), there will be a mechanism to pay providers an enhanced amount for employing VSPs.

With that additional credential and delivering services, a number of different mechanisms that we were kicking around about how that could work, but conceptually the division is committed to trying to align payments with the qualifications of staff.

Now the rates that we're talking about represent a floor-- nothing's being taken away.

But for those providers who invest in their staff and the DSPs who invest in themselves, there would be a mechanism for more payments (and hopefully for the DSPs, higher wages).

A marker that I needed to put down is there are some significant changes that the Honolulu Department of Transportation Services are proposing relating to HandyVan and other partnerships they have with provider agencies.

I frankly don't yet have a comprehensive appreciation for what all those changes mean.

So, we're looking to schedule some meetings over the next couple of weeks with providers on Oahu to talk about that and then... likely make some adjustments to our rates.

But, we haven't had those conversations yet-- so I can't tell you what the adjustments might look like.

But, we just want to make sure that folks... aren't surprised (that we're being transparent).

That's one of the things that we know still has to be done.

But, we also didn't want to delay this presentation and the public comment process any further—because as I talked about, the budget process is going on right now.

So, we want to make sure that the division (the departments) have the information they need to start entertaining conversations about next steps.

And, in a classic example of bearing the lead, I'm finally getting to the bottom line of how much.

And so if (and I'll say "if" one more time)... if fully implemented, the draft rates would increase by an average of about 24 cents... 24% (excuse me)--varies a little bit from one service to the next.

Some are a little bit less than 24%. Some are a little bit more than 24%.

But on average, we'd be looking at a 24% increase.

Because I've said it once already, but because it's important I bolded and italicize the last bullet here which is... implementation would require additional appropriated funding.

So, it's very important for us to continue to highlight that the department does not have those resources currently available.

It's going to have to go through the budget process and implementation cannot occur unless additional funding is made available.

So, this rate study is talking through what we think is an appropriate rate.

But as I said, we can't amongst ourselves commit to paying those higher rates.

That's going to require decisions and funding from the policymakers from here.

Now, I spent a little bit of time talking about some of the key assumptions the rate model is really focusing on-- those five key elements.

And then, we'll talk briefly about the public comment process, and I'll then pivot to the rate models themselves.

So, within the rate model packet, Appendix A covers how it is we get at the wage assumptions for direct support professionals.

But all other staff for which we're building a rate, we use information from the Department of Labor Bureau of Labor Statistics for a number of reasons.

As you'll see, It's comprehensive. It's a broad-based employer survey which really makes it kind of the gold standard in wage estimation.

Lots of people use it for lots of different reasons-- it's cross industry.

So that's the point I made much earlier in the presentation-- where we're not just relying on what agencies are able to afford to pay their staff today.

We're actually looking at what people who are doing similar work earn across industry.

So that we're not engaged in that circular reasoning it's regularly updated-- which is not to say that it's always exactly current (because it's never exactly current).

But it is something that gets published on an annual basis, and then it's also state / local specific.

So, at times, people jump to the conclusion that we're using Federal data, and therefore we're using National figures.

And hey, cost of living in Hawaii is higher than it is... average across the United States.

That's true, but we're not using National figures. We're using Hawaii specific data.

So, although it's a federal office and they're doing a national survey—when they publish the data, they do break it down to the state level and then even at the sub-state level (which is how I can tell you that those PA Professionals in Maui tend to earn higher wages than they earn in other... on other Islands within the state).

So, I made the point that it's regularly updated, but that's not the same thing as saying that that BLS data is always current.

And it's never current-- it's always published... in the spring (has historically been March, the last two years it's been April... and then it reflects the previous May).

So, we're relying on the April 24 data set (reflects May of 23 by the time these rates might be implemented).

A couple years may have passed.

So, we need to account for changes in wages over that period of time.

We're looking at two drivers of wage growth.

The first is that aforementioned increase in the minimum wage going from 14 today to 16 in January of 2026.

I want to note that I spent a lot of time in these presentations talking about how minimum wage impacts direct support professionals.

I do not want to give the perception that I believe or the division believes that direct support professionals are minimum wage workers-- they're not.

And that's why you saw a couple of slides back that we're assuming a wage of $21-- which is a fair amount more than the minimum wage.

However, it's also true that they earn relatively lower wages.

So, as the minimum wage goes up for truly minimum wage occupations, providers are going to have more and more challenges getting people to do the very difficult work of direct support (if they can do an easier job at a similar wage).

And so, even though DSPs don't earn the minimum wage (we don't think they should earn the minimum wage), they're impacted by the minimum wage going up because they have more options at that point in time.

This is something that's happening across the country.

Burns actually wrote a report for the national provider trade association about minimum wage impacts.

It’s a pretty good read-- so I encourage you to go and read it.

But, because a lot of states are encountering this issue, the federal minimum wage hasn't increased for something like 20 years now.

State Ed off doing their own thing (including Hawaii).

And so, because we work in a lot of states, we've had to estimate what the implications would be for a higher minimum wage, and we've developed and tested a formula to do that.

It's fairly in depth which is why I don't cover it in detail in this presentation, but it does account for the fact that minimum wage has spillover effects.

It's not just people [who] earn the minimum wage that are impacted.

It's people [who] earn a little bit more than the minimum wage that you need to continue to offer a little bit of a premium.

When I do my length... the presentation, I like to use my example-- if you have a worker who started yesterday at $5.50 an hour and another worker who's been on the job for let’s say...the...

I'm sorry the worker that just got hired was hired at say $14 (the minimum wage) and the worker who's been on the job for five years (and is now earning 16 and a quarter)-- when the minimum wage goes up to $16 an hour you have to increase the first staff person's wage (right?) from 14 to 16.

You don't legally have to do anything for the second worker... the person who's been on the job for 5 years and is now earning 16 and 25.

They're earning more than 16, but you're going to have a pretty unhappy experienced employee if you don't do anything for them.

They're going to look across the office-- see someone who just got a $2 an hour pay raise even though they were hired yesterday.

They've been working here for five years and they're only making 25 cents more.

So, there are practical business reasons why you have to take that into account.

You also have compression factors, right?

So, you need to make sure that supervisors earn more than the people they supervise (in most cases).

So, our formula tries to take all that into account.

And because a lot of states have been off doing this, we're... we've been able to test it with real world data, and we have found that our formula does a pretty good job of modeling what those impacts are.

Outside the minimum wage, we know that rates and wages just grow over time.

And so, we're applying or evaluating a general wage inflationary factor as well-- based upon a different federal office (the Bureau of economic analysis with the Department of Commerce).

But again, it's Hawaii specific data.

And for what they call “net earnings” (which is roughly wage income [and] excludes like investment income), they're showing a 10-year average growth rate in Hawaii about 3.7%.

So, if we're going from May of 23 to January of 26-- I think my math is that's 31 months (31 months at 3.7% is 9.84% in total).

So, we did these calculations for every single wage estimate in the BLS stat-- said what does our formula produce for the minimum wage adjustments and what does our formula produce for General wage inflation of just shy of 10%, and we apply the larger of the two factors.

So, that's how we took this May 23 data and inflated it to represent what we think will be the reasonable wage in January of 26.

Continuing to talk about BLS data, I didn't go into detail a couple of slides back, but the BLS publishes wage estimates for about 800 occupations.

So, there's a lot in there.

Most of them don't apply to what we're talking about-- because it doesn't matter how much a hotel front desk clerk makes or a chemical engineer or a librarian.

Those are all occupations within the BLS data set.

But we do pull out those occupations that have some relationship to Home and Community Based Services.

In some instances, there's a one-to-one match-- which I'm always ecstatic about.

So, if we're setting a rate for a nursing service, we simply look at the nursing wage.

There's a registered nurse and a licensed practical nurse set of occupations within the BLS data.

But what there is not, is an occupational classification limited to direct support professionals.

DSPs are absolutely part of the BLS survey, but they're combined with other folks doing similar work

So you can't go to the BLS and search for... direct support professional.

Instead, the department labor classifies them as home health and personal care aids.

They're in the survey (they're part of the data set), but they're combined with other folks.

We also (as a consultancy) have long believed (really since we've been doing this) that that undervalues the varied tasks that DSPs perform.

Absolutely-- they're doing Personal Care work.

Absolutely they're helping doing home health type tasks.

But they have other responsibilities as well.

Often times, they're called upon to help manage challenging behaviors.

Certainly, we want them to help people engage within the community and provide training about how to support themselves in their activities of daily living and instrumental activities of daily living.

And so, rather than simply using the home health and personal care aid (which is the occupation that the BLS uses), we're looking at a variety of occupations, and that's indicated here on the chart at the bottom of the slide.

So, we've chosen three occupations.

Home health and personal care is the heaviest weight--because that is how the BLS classifies them.

And that is a big part of their job.

But we also include the psychiatric technician position. We also include the recreation worker position to represent the variety of tasks that they perform.

And so, the weight to average is how we get to that $21.33.

Again, what I wanted to emphasize is that even looking at that $21.33, we'll show you exactly how we got to that number--so that you're able to evaluate whether or not you think the assumptions that we've made are good or bad.

And something like this (the mix of different occupations)-- there is admittedly as much art as there is science involved with it.

But, we think this is a fair representation of those very tasks.

Moving on to benefits. Pretty straightforward here.

We account for mandatory costs like FICA the unemployment (excuse me) the Social Security Medicare payroll taxes, unemployment insurance workers comp.

We include 23 days of pay to leave.

That's the combination of holidays, vacation and sick for health insurance.

We include $5.54 per employee per month.

And that, again, is built upon a couple of other assumptions.

We assume an overall participation rate of 67%, and we assume that spread over different types of health insurance plans-- an employee only plan, an employee plus one plan, and a family plan.

We then make cost assumptions for each of those different plan types--in terms of how much the employer is going to contribute to that health insurance plan.

So, when you look at the $5.54, it's actually a mix of different plan types and different participation rates.

It's important for me to note that... that's an average across all employees (regardless of whether or not they participate in health insurance).

For health insurance, in particular, we know there's going to be some folks who do not participate--because they have health insurance through a spouse or another payer like Medicare, the Veterans Administration, or they just consider themselves being invincible, and are not going to participate in health insurance (because they don't want to pay their share of the premium).

So, if you were to look at just the cost per participating employee, it would be closer to a little bit more than $800 per month.

But when we're talking about just those who participate including (excuse me) all of your employees (including those who do not participate)-- the average across everybody include the one-third of employees we assume do not participate.

The average is $5.54.

I know that sometimes creates a little bit of angst. People say “Well that's not enough... my costs are higher.”

They probably are, but you need to think about all of your staff (not just the staff that are enrolled).

And then we include $100 per month for other kinds of undefined benefits.

It could be retirement contribution... Vision or dental insurance.

It could be reimbursement--anything else that you offer at your discretion.

Another technical point, and I know I'm spending some time getting into the weeds, but it is important to us that you understand how these rate models work-- is we assume the same benefit package for all employees.

Everyone gets the same health insurance options.

Everyone gets the same 23 days of paid leave, etc.

But we then have to translate that to a percentage of wages to fit it onto one page within our rate model packet-- because some of the benefit costs are fixed (health insurance being the best example).

There's a relationship between your wage and your benefit rate.

So, health insurance, I said, was about $550 per month.

That's $6,600 per year.

If I'm a DSP making say $21 per hour $6,000 is still pretty big chunk of my compensation, right?

That... that's a big benefit in terms of how much I get out of that employment relationship.

If I'm a nurse, however, who's making $75 per hour, the amount that I get for health insurance is a really small portion of my total compensation, right?

I'm getting $150,000 a year in salary as a nurse-- so $6,600 for health insurance is pretty small.

So, it's important for us to take that reality into account-- that there's an inverse relationship in other words between the benefit rates and the employee wage.

The higher their wage, the lower... the higher the wage, the lower the benefit rates.

And then vice versa, the lower their wage the higher the benefit rate.

Everyone gets the same benefit package. That's what's important. That's how we define fairness and equity.

But, when we translate that to a percentage of wages, we need to take into account that the denominator (the $21 or the $75) is different productivity (I've mentioned a couple of times).

So, I'm just going to focus on the example here--in terms of how this works mathematically.

If you have an employee who works 40 hours per week, and your cost is $20 per hour for wages and benefits--your cost as their employer is $800.

But, you probably can't bill for all 40 of those hours (for the reasons I mentioned earlier)-- training, supervision time, the medical documentation, travel time between people that they're providing services to.

But, every hour that they're working, they're on the clock and you're paying them.

If you can only Bill for 32 of their hours, we need to pay you indirectly for the eight hours that you cannot bill for.

And we do that by calculating a productivity adjustment--which is no more complicated than work hours 40 divided by billable hours (in this example... 40 divided by 32 is 1.25).

We use that to inflate the wage and benefit value.

So, rather than paying you $20 per hour (which is your true cost), we're paying you $25 per hour to layer those non-billable hours and those non-billable costs (on top of what you are able to bill for).

So, the rate model then funds the wages and benefits for billable time at $25 per hour rather than $20 per hour.

In terms of what's built into the... productivity assumptions, we have 184 hours for paid time off.

That's the 23 days of holiday vacation and sick.

We have 40 hours built in for training.

We have 45 minutes... or 75 hours built in for supervision and employer time.

So those are more or less standard across all rate models.

Other rate models have varying amounts built in for other factors.

This is not an exhaustive list, but that includes things like travel time, participating in planning meetings, setup and cleanup time.

If you're talking about, say, a center-based program-- recordkeeping and reporting, and the like.

Last of my five key... rate model assumptions are administration and program support.

I've already defined those-- so I won't define them again for program supports.

We have not increased that over the last cycle or so.

So we went from funding that at $15 per day to $20 per day.

So just like we talked about direct support professionals, and we talked about the AFH home providers--it's important that we recognize it's not just the DSPs whose wages are growing.

It's others as well.

And, because both program support and administration are mostly (not entirely, but mostly) wage driven, it was important that those assumptions get increased as well.

For administration, we're maintaining the same 10% for... administration.

That's 10% of the total cost (pardon me).

So, if you had a rate of $38 per hour (like in the example) much earlier $3.80 would be associated with administration.

The 10% hasn't changed, but I mentioned earlier that rates have increased by about 24% (on average) which means the amount of funding for administration would increase by 24% as well, right?

Because it's as all the base costs increase administration as a percentage of total is increasing as well.

So again, just because I've done these presentations a time or two before folks will say you're... not accounting for our growing administrative costs.

We think that we are-- because if these rates were implemented, the amount of funding you have for administration would increase by about 24%.

We think that's sufficient to account for the cost growth since the last rate adjustments.

And then, finally, we include... the general excise tax of 4.5% in all models as well.

So that concludes the PowerPoint-- just spending one or two slides talking about the public comment process.

We've said that this is the opening of the public comment process.

We'll get these materials posted online in the next couple of days.

I'm sure there'll be a push announcement that is letting you know about that, and we'll accept comments through August 16th-- which is give or take four weeks (I think) from tomorrow.

I ask that you submit those comments to one of my colleagues at Burns and Associates-- that's Alisher Abdul (you see his email listed here).

He was the same point in contact for the provider survey, and he's just much better at keeping track of emails than I am.

I encourage you to be as detailed as possible when you're submitting your comments.

Now, I always tell people-- you can tell us whatever you like.

If you just want to say “I don't like your rates. I don't like your tie.”

Whatever the case might be-- you can submit that to us.

But it's unlikely to result in us making changes to what it is we've recommended.

We've been very detailed in (I like to think)... at least in putting our recommendations forward.

If there's something that you disagree with, we're asking to be similarly detailed in your response.

In other words, if you say that “I don't think the rate ought to be 38. I think it ought to be 40.”

Most likely-- I'm going to say “no” and I'm going to move on.

But if you say that “I don't think $14.20 per hour is sufficient, and furthermore, I can tell you that I posted a job at $15 per hour and I got zero... hits on that on that advertisement, and it wasn't until I increased wages to $18 per hour... that we got staff that were willing to reply to our job postings.”

That's the sort of thing that we can respond to.

Simply saying that we think it ought to be higher is very unlikely to result in changes.

So, we want this to be a meaningful process.

Part of making it meaningful is for you to be detailed in your feedback.

And if you want to provide any supporting documentation to us, we're certainly going to read that as well.

As I mentioned earlier in the presentation, we spend a lot of time reading (although at the end of the day this is a mathematical exercise).

We spend a lot of time reading in order to make sure we get the math right.

So, a couple other things that we ask that you focus on-- in addition to the rate models themselves.

Again, you can comment on whatever you'd like.

So, we're not we're not trying to short-circuit any feedback that want to provide.

But there are things that we're particularly interested in.

One of the things that we heard from our provider advisory group is the need for group home rates or licensed home (the DD-DOM rates) or Arch rates (in other words) that are predicated upon shift staff-- that is people who no staff live there.

They're all working, say, an eight-hour shift working and the home operates three shifts per day.

As I'll show you here in a couple of minutes our rate model is built upon an assumed live-in home manager.

But that has a different cost profile than employing hourly staff to work these shifts.

So, if that's something that you think that we need, we're looking for your feedback about what you think that would look like—what level of staffing you think is appropriate, etc.

We also note that this set of recommendations represents a pretty significant provider rate increase and provider rates have increased pretty significantly during the last cycle already.

So, if you look at what... where these compared to where we were at in 2016 or even 2020, it's a pretty significant investment that the state of Hawaii has made in the I/DD provider community.

So, one of the things that we're curious about, and has been inspired by what a lot of other states have done-- is whether or not there ought to be any sort of accountability or reporting measures built in.

If these rates were to be implemented and we see this (again) infusion of cash, should (for example) there be a wage flow that if we're paying for at least $2.21 per hour should we say that all staff have to earn at least $8 or $19 per hour.

Other states have absolutely done that.

They've said for rate increases (particularly during the pandemic)—that that money has to be passed through in whole or at least in large part to direct support professionals.

We haven't put forward any proposals like that here today, but it's something that we're considering.

So, if you have thoughts about how accountability could be enforced--how we ensure that the sorts of outcomes that we're hoping for with this set of recommendations actually comes to fruition we'd like to hear about that additionally.

We've spent a fair amount of time brainstorming about potential outcome-based payments, and we've come up with three: the AFH... payments outside of Oahu that support employment, the successful placement employments and then the Workforce Development initiative (none of which are fully fleshed out yet).

So, feedback on those would be great.

But if you have other ideas for outcome-based payments other issues that you see in the system that maybe we could... partially address through provider reimbursement, we'd like to hear about those ideas as well.

And then I mentioned that the comments are going to be reviewed and the rate models will be revised as needed (based upon this feedback).

So that takes me to the end of the presentation.

Here's my contact information if you need to reach out to me.

But again... when you're submitting your comments, I encourage you to submit those to Alisher—because he'll keep track of it.

And as we need to get involved and work together on things, he and I will do so.

And ultimately... once we provide our... overview and summary, we'll be meeting again with the division to walk through final decisions on the response to each of those comments.

So, you're almost done listening to... listening to my monologue, but I'm going to stop sharing this file now and provide a (hopefully, reasonably quick) orientation to the rate model packet.

Want to be sharing screen in a moment, show the bar...

And, as we said... we'll be taking questions shortly after I walk through this rate model packet.

If you've been submitting questions in the chat or Q&A, we'll start with those, and then we'll open it up to raised hands.

And here we are.

So, as I said, this is 60 pages long.

I'm not going to... walk through all 60 of those pages, but I did want to provide an overview so that folks are able to navigate this on their own after the meeting.

I'm just trying to (very sensitive mouse)... today make this fit on my screen a little bit better.

There we go.

We'll put this to work as best we can then I need to...

So, I'm hoping to navigate pages, but I might... have to quickly tab through—so I apologize if I give anyone vertigo while I do that.

So, I just want to start by providing an overview of the comparison page.

So, this is important-- because it shows you the current rates and the rates that we're proposing--as well as the percentage change.

The other thing that makes this important is there are some of the notes-- and those notes we like to think are relevant (otherwise we wouldn't have put them there).

So, if there's anything else that we think require some additional contextualization-- that's what we've tried to include in the notes document.

So, for example, for residential services--we know that that's reimbursed on a daily basis.

But, and I know a lot of providers are familiar with this, we actually build our rates on an abbreviated billing year (344 day billing year).

That's no different than what we've been doing since 2016-- so I didn't cover that in-depth in this... presentation.

If folks have questions about it, I'm happy to take those questions here this morning.

But, we just reemphasize that there's a 344 day billing limit.

So, we don't want folks multiplying these rates by 365, and thinking that's the annual revenue (because it wouldn't be).

So, I'm not going to walk through (certainly) the individual pages here.

I just wanted to show you that we do have (at the very front of the packet) a detailed comparison (at the service and code level) about current rates proposed rates and what that percentage change is-- so that if you are looking at the very top of this a PAB provider on Oahu you can see that your rates are be increasing by 21.4% (for example).

So using PAB, I wanted just to again highlight a rate model for you.

I'm not going to go through it top to bottom.

This is very similar to the example that I included in the presentation from another state-- but I want to make sure folks understand how to read this.

So, for nearly every service, there's (I think) just one or two exceptions.

We have rates for Oahu versus other islands, right?

And so, you're going to see two columns for most of these rate models.

It's also going to lay out the unit of service-- so you'll see that right below (kind of the labeling of the island).

So this PAB is built in 50-minute increments.

Again, that's something that hasn't changed. We haven't recommended any changes to billing units as part of this rate study.

Then, we get to the direct support professional wages and benefits.

So, the $21.33 that you saw-- the 31.5% (which is based upon the benefit package that I covered earlier and then the productivity adjustment).

So, for PAB workers on Oahu, we're assuming they're doing about 32 billable hours in a 40-hour work week (or about 80% of their time is billable).

For the other Islands, because there's more travel time built in, we're assuming a little bit less than 30 hours--so a little bit less than 75% of their time would be billable.

We have mileage built-in. We also have nursing support-- again, something that.. I could have perhaps (in retrospect) should have emphasized during the PowerPoint presentation.

But for a number of services, we are proposing to build nursing supports back into the rate model.

For those of you who've been in the system for a while, you know that this has been a little bit of a seesaw going back and forth.

We took nursing supports out, and we wanted that to be done through training and consultation.

Some providers embraced that. Others did not.

And so, what we're proposing in the rate study now, is that nursing support would be bundled back into the rate.

So, in other words, the nurse delegation would not be a separate billable activity-- it would be part of the payment rate itself.

And then, because this is a straightforward service, outside of that we have program support funding.

That was the increase of $15 to $20-- that I mentioned earlier.

Another very small change (and when I say very small, it's literally pennies in most of these models)-- is building ongoing costs of PPE and infection control supplies in the rate models themselves.

So, as part of the (I think it was under Appendix K Authority), we were making payments to providers offset those expenses.

We're now bundling that into the rate (for administrative simplicity reasons).

So, on a per person basis, that's $25 per person per year.

When we spread that over all the billable hours, it comes out to just a couple of cents.

But, we wanted to demonstrate that it is part of the rate, and so that does get funded now in the rate model.

And then we have the 10% for administration, the 45% for the general excise tax, and that's how we get to these bottom-line rates.

So, for PAB at $48.50 per hour or $12.04 on Oahu and then a little bit less than $56 or just about $14 per hour... outside of Oahu (on the neighbor islands).

Skipping ahead again... just highlighting a couple of the services we started with.

An easy one. We're going to go to a couple that are a little bit more complicated.

First we have ResHab in licensed homes.

So, other than AFH, is again a change we made in the 2020.

I want to say... reauthorization.

We had previously just a single rate for ResHab.

But, ultimately we want to recognize cost differences for licensed homes versus AFHs.

This is one of those rates with tiered services that I mentioned earlier, right?

So, we have three tiers.

This is tied back to that Supports Intensity Scale.

And you'll see (as I mentioned), this home (or this model, I should say) is predicated upon having a live-in home manager (which not all homes do).

In addition to live-in home manager, we do have some shift staff-- but it doesn't cover three shifts running 24 hours a day.

So, the number of hours increases as the level of need increases.

That's... what's driving the differential in the tiered rates is... if you have a home manager.

It doesn't matter what the needs of the individual... or that home manager needs to be there all the time.

So, that cost is the same.

But the supplemental staffing (that person... the staff who are helping the home manager) increases as costs increase for residential.

We also build in mileage expenses (just like we did for PAB).

A little bit of an aside for mileage, we are building in enhanced mileage rates.

Because, whereas we think PAB is likely going to be a lot of staff's own cars or if you were to provide a fleet car to your staff it's almost certainly going to be a standard sedan.

But for group homes, there's a greater likelihood that it's going to be a heavier Duty vehicle such as a van-- and that has higher acquisition costs.

So, rather than just using the IRS mileage rate, we're building in a little bit of a premium for the... the higher costs of vehicles like vans.

Other than that though, the other components of the rate model are like you saw nursing supports program support plus PPE... in infection control as well as admin administration and the general excise tax.

This is reimbursed on a daily basis with the 344-day limits.

Again, just to show you mathematically how this works-- if we were to divide by 365 here, this is level one on Oahu.

The daily rate would be $155, but we're not dividing by 365, we're dividing by 344, right?

Because we want to cover you for up to 21 absences per year by allowing you to build higher rates, but then stopping billing at 344 days.

So, rather than billing 365 at $155, you'd be able to build up to 344 at $164.

Those two numbers work out exactly the same 365--$155 is the same as $164 times 344.

I know--there's a lot of numbers in that sentence.

I'm sorry about that, but the bottom line is that's meant to be revenue neutral.

The benefit here is if you have a 365 billing policy-- once someone is absent for one day, you start losing money right and you lose $155 per day you never make that up.

But, if we have a 344-day billing policy, you don't lose any annual money until they're absent for more than 21 days, right?

Because we're paying you a higher rates for 344 days, you get fully paid for one year worth of service after you billed for 344 days.

You don't start losing out on revenue until that person has been out of the home for more than 300-- more than 21 days (I should say).

Next page is AFHs.

This is the one instance where we don't differentiate the rates by islands, but... and that's because mileage is such a small portion of the service.

However, this is where we have that incentive payment paid for new certified homes on the neighbor Islands after a placement occurs.

So, there's still more revenue in play on the neighbor Islands than there is on Oahu.

This rate model though you is substantially different than what you saw for the licensed homes -- because the service delivery model is different.

Rather than you effectively... making accommodations for the internal staffing pattern of the home, you're relying on your contracted home providers.

So, we have the home payments here in the middle of the slide (in the middle of the model, I should say).

That's the increase of $10,000 from the current model that I talked about.

But, then we also include agency expenses to provide supervision and oversights.

From there though, we get back to the other expenses that you've seen in other rate models.

The nursing the program support plus the PPE, the admin and the... General excise tax.

So, there's nuances with these in terms of this is supervision and a payment to the home provider rather than a home manager with DSPs that you presumably employ.

So, it's structured a little bit differently.

But once you start to get through these, I think it starts to become a little bit more intuitive as you work through the models.

Last Model I wanted to show you was CLSG.

And this is going to be similar for say... ADH as well.

Again, much like we talked about on the ResHab services, both licensed home and AFH, is we have tiered rates tied back to... the levels of need.

Couple of unique features of the CLS and ADH models are that we have staffing ratios, right?

So for people in tier one--those are the folks that have the fewest relative needs.

Everyone has needs-- otherwise they want to be receiving services.

But comparatively speaking, they have fewer needs and people in the higher tiers we assume that in CLSG 1:3 ratio makes sense.

But then from there, the ratio goes down one to two at tier two.

And for people with the greatest needs, we're assuming one and a half.

Yes-- I know there's not no such thing as half people.

So what this is really getting at is a 3-2 ratio (or a two to three)-- two staff for three participants.

We also account for attendance-- because we're talking now about a shared service.

You have to staff for the group who scheduled to show up.

If someone chooses not to show up that day-- it's not as if your cost have changed,

You can't lay off one-third of a staff person, right?

That staff person is there-- regardless of whether or not all three people in their group show up, or only two of them show up.

So, we build the cost those absences into the rate as well, and this is predicated upon an 85% attendance rate.

So, out of 250 days per year that they're scheduled to attend, we assume they actually attend about 22.5 days.

And we use that to make sure that we're appropriately amortizing costs that are fixed-- like mileage and facilities, as well as just accounting for the staffing expense of not everyone being there, and the fact that you have to pay that staff their full wage regardless of who shows up.

So those are the kind of nuance differences across the rate models.

I know I've gone through these (relatively quickly).

As part of questions, if folks want me to spend more time on that, I'm happy to do so.

But, we wanted to provide this orientation of what's in the rate model package-- because the PowerPoint is just an overview.

With that... all the actual numbers are in these rate models.

So, finally, in the rate model packet-- I'm not going to cover any more of the models themselves.

But, I did want to get into some of the appendices (starting with appendix A) for wages.

So, this first page is information from the BLS website.

So, although it's not structured quite like this, anyone who is interested could go out and download the information and put this table together.

In other words, none of this is my data.

This is all information that we've downloaded from the BLS's website.

Again, I didn't go into a ton of detail, but I talked about how there's 800 occupations.

We're not going to publish all those in our packet—because most of them don't have any bearing on delivering Home and Community-Based Services.

Instead, what we have here is about 30 or 35 occupations that we have used at some point in the past for one or more Home and Community-Based Services.

So that's what's listed left to right.

As I talked about, they have some occupation specifically for say a registered nurse or a licensed vocational nurse.

So, we don't need to do any guess work.

We don't need to do any of these composites or weighted the averages.

But for others, VSPs are classified here as home health and personal care.

Again, as I talked about, that's not we think fully indicative of all of the responsibilities that they have.

And then the right hand part of this table covers some of the typical job requirements-- so things like how much education folks in these occupations typically have, whether or not there's any experience requirements (again typically), and whether or not there's any on the job training that is offered on a standard basis.

The next page just briefly summarizes our adjustments to account for that timing difference.

Right? So, the minimum wage when the BLS data set was published (not today but when it was published) was $12.

So, we need to assume that all these wages are in relation to $2 an hour minimum.

But we need to get to a $16 an hour minimum.

And so, although I'm not spending time today going through the really detailed and lengthy conversation about our methodology, it... it's kind of briefly summarized here in this table.

In addition to that minimum wage adjustment, we talked about General wage inflation and where we gathered that data from (which is also footnoted).

And this is that 9.84% General wage inflation factor we talked about.

So it's 3.7% for 31 months-- which is between May of 23 and January of 26.

This repeats the table on the first page, but it now adds those inflationary factors, right?

So, I think the home health and personal care aid (if I remember what it said on the previous page) was somewhere in the ballpark of $17 and some change and now it's $19.60 (because we've implied... either the minimum wage adjustment or the general wage inflation adjustment).

From here we go do the work of identifying which occupation or occupations we think apply to each service.

So, I showed you already how it is we did the composite for the DSPs that deliver say PAB or ADH or ResHab.

So, 60% using the home health and personal care aid, 15% using the recreation worker and 25% at the psychiatric technician.

But, for every other service, you can see what it is we've targeted as the appropriate wage benchmark.

So, once we would to get... once we get to say the registered nurse for training and consultation, you're going to see that we used the unsurprisingly registered nurse... BLS classification.

And also, same thing is true for nursing RESPITE.

So once again, this is our work.

The first page is the BLS's data, but then we apply our inflationary adjustments.

We apply our crosswalk of BLS occupations to... individual services and that then culminates in the final page within Appendix A--which is just the mathematical culmination of taking those... sets of assumptions (the wage levels and the job mix assumptions) to come up with an assumed wage for each service).

So, this again is where you see the $21.33--based upon our BLS data with inflation plus the $25.60 15% mix as you saw in the previous page.

Another thing that I haven't highlighted in my remarks is that there weren't big differences--but there were some differences in the wage assumptions for DSPs across different services.

As a team, we had a conversation about whether or not that remains appropriate.

The position that we took is that direct support is direct support--regardless whether or not it's in say a ResHab home, whether or not it's in a ADH program, whether or not it's delivered in someone's home, through PAB in the community through CLS.

So, we wanted to standardize those wage assumptions.

The other thing that we included in that mix was... I think it's on here (next page) was RESPITE services.

So, some of the feedback that we got from the provider advisory group is that the RESPITE rate was too low, and part of the reason for that is... because we assumed a lower wage assumption for the... delivering that service.

The reason for that was... we thought that would be more of a personal-care driven service (have less expectations for habilitative activities).

But oftentimes, it's the same staff that are doing RESPITE that are doing other services, right?

They're also PAB workers or ADH workers.

So, from our perspective, based upon that feedback from our advisor group, we thought it made sense to standardize the wage assumptions for DSPs across all of the DSP-delivered services.

Moving on briefly, Appendix B covers the benefit assumptions.

I don't want to spend a lot of time on this because the PowerPoint was pretty detailed, but what you do see here is... I talked about the overall participation rate of 67%.

This page breaks it down by plan type-- so you'll see that 42% are assumed to be an employee only plan 11 in a plus one plan and 14 in a family plan.

Then you see the specific cost assumptions that were including for each plan.

So, the employer share of cost of $575 for an employ only plan $1,000 per month for a plus one plan and $1450 per month for a family plan.

That's how we get to the $554 average.

It's based upon the 67% takeup rate across those three plan types with those assumed employer cost assumptions.

So again, we've already heard some preliminary feedback that folks think those numbers are too low.

Appreciate that... but what we're hoping to get as part of the comments are what specific numbers do you think ought to be adjusted?

Is our take-up rate too low?

Is our contribution on the employer side too low, etc.?

Then the second page in appendix B just crosswalks these assumptions to benefit rates in $1 wage increment.

So, in the PowerPoint we show this as a line graph, right?

The inverse correlation... this is just showing it to you in actual dollar terms.

So, at $16 per hour the benefit rate (without PTO) would be 37.4%.

As you get to say $30 per hour-- it's 26.2%.

Last thing I wanted to share before I open it up to questions is the productivity appendix.

So, one thing I just wanted to mention here is this table actually works in two steps.

The first step is to look at what we think is reasonable productivity assumptions for a typical work week.

And, we have “typical” in parentheses for a couple of reasons.

The first is for quotations... I should say the first is because we know that in the world of direct support no day is really typical.

No week’s really typical. It changes on a day-to-day, hour-to-hour basis.

But more importantly, what we want to do (account for) is the fact that most people don't do training every single week, or they don't take... paid time off every single week.

Most of us don't take a half day every Friday.

We take a week off at a time, right?

So, we wanted to build what we thought was a reasonable work week without those kind of exceptional times-- the training and paid time off.

And then, we put in the training hours (the 40 hours that I highlighted in the presentation)--184 that for PTO and debit those hours against all the activities.

So, now we have an adjusted work week.

So, we start with the typical work week-- where most people don't have training or PTO.

But, we have to pay for those costs.

And so, we have the adjusted work week. And the adjusted work week is what you ultimately see in the rate model packet itself.

So, we wanted to leave plenty of time for questions.

And, I also didn't want to talk for three straight hours.

So, I'm going to stop here.

I'm going to keep the rate model (I think) packet up in case folks have specific questions about individual rates.

But, I think I'm going to get some assistance on going through any chat or questions that submitted.

And then are we giving people the ability to raise hands as well?

[Inaudible]

Okay!

Do I need to stop sharing for that to happen?

So, I'm not sure folks are hearing all the audio.

What we're going to do is... we're going to be...posting the questions on our... on the page-- which requires me to stop sharing my screen.

[Inaudible]

Stacy: Okay. Thank you very much. Just a second.

Let me share my screen.

I'm going to be putting up the questions from the Q&A. Share here...

Here is the first question.

Mary: Your audio is off... you know.

Stacy: Just a second. Okay.

Okay... So, the question here is... “will these rate increases fix the observed issue with the previous rate increases?

The increase rate negatively impacted the individual support budgets.

That resulted in direct reduction of services for participants. Or will these new increases further the impact on individual support budgets and further reduce services?”

Stephen: So, I will say... that it would be our intent that with these... if these rates were implemented-- that would require us to make adjustments to the waiver itself.

And we would, at the same time, seek to adjust the ISBs as well.

The idea is that we don't want to penalize participants based upon provider rates increasing.

So, in order for them to get the same quantity of supports that we built into the service mixes that underlie the ISB we would adjust that... to make sure that they can buy the same the same total amount of services.

That would be the intent... I guess.

I don't have an answer--as to the recent rate increases.

That has been our practice, I understood, for a time.

As rates have gone up, ISBs have been adjusted as well.

But nonetheless, going forward if these rates were implemented, we would also (I believe) increase the ISB amounts.

Mary: Great, if there's a question about... whether... there was a reduction in services because of... rates... we can... we'd be glad to have a discussion about that.

Because that is (of course) was never our attempt, but was also never our practice.

So, if there is a question specific to that (I don't know if it's a staff or provider question), we can take that-- email us.

[Inaudible]

Stacy: You can turn the one back on your computer (if you want).

I think that's sort... there's a little bit of an echo on there.

We'll try it again, okay.

Moderator: Okay...for the next question...

Stacy: Okay, hang on a second. Okay.

Do these rates reflect the key... the CMS rates?

Wait, we still have a... hang on a second.

Sorry about that.

[Inaudible]

Okay. Let's see. Sorry about that. Okay.

Do these rates reflect the CMS rate provisions goal from last year--where CMS proposed broad new managed care and excess requirements? Stated last year that they are looking to see 80% of reimbursement would go to supporting the direct service professional. If not, will it change dramatically if this becomes law?”

Stephen: Short answer is no. We have not accounted for the final rule (actually) in the access rule about the expectation of 80% of funding for certain services to... be paid directly to the frontline staff with some broad definitions of what that qualifies for.

CMS has said that they're going to issue some sub regulatory guidance (to use the technical term).

In other words--although the rule has been finalized, the implementation of the rule (the guidelines) for that have not.

It's also unclear whether or not that's going to apply to all of the services covered by the waiver--because the targeted services are pretty narrow.

So, there's still a fair amount that's unknown.

There's also a long lead time on that.

I think it's something like six years before that rule would... formally take effect.

So, we're... we've not yet taken that into account.

It's something that we're certainly aware of. We're going to continue to... make sure that we're keeping on top of whatever guidance CMS releases.

We'll probably... the division is probably going to engage with them directly at some point in the future about applicability across services.

So, no. It's not accounted for yet. We are aware of it.

As necessary, we will make adjustments in order to... reflect those expectations.

Mary: And, just a technical point-- the regulation has already been promulgated (which means it... has taken effect).

It has been published in the Federal Register, but there is a roll-in of different provisions of the access rule.

And this is one that doesn't take effect for a while--but allows states to get ready to... to be able to measure it and put it into effect.

And then we're waiting for the sub-regulatory guidance.

And... of course, we will follow Medicaid regulations.

Stephen: The last thing I'll note is that the headline for the access rule really was around that 80/20 provision.

But there's a lot of other provisions in there--including transparency and rate setting.

So... the... one of the nice things about the approach that DDD adopted a decade ago with the 2015/16 rate study is that we're likely largely complying with some of those transparency expectations (in terms of how rates are developed).

[Inaudible]

Stacy: Ok… thank you very much!

Ok… can you turn that one off Stephen? The volume on it…

Okay the next question: “is there a way to increase the rates to reflect the unknown?”

For example, when the last rate study was done (not this one), it did not, nor could we have imagined that insurance rates, medical liability, and auto, etc. have all gone up.

We have seen increases since the wildfires as high as 25% (just for insurance)-- increases we did not plan for when the rate study was done.

This doesn't reflect [payroll] taxes and increases with rate wages.

Stephen: So, I think by definition, the first part of the question (Can we plan for the unknown?) is not exactly.

That being said, and that's why I have that slide that talks about the benefits of setting rates in this fashion… is by detailing our assumptions, if something dramatic changes, we have the ability to go in and quickly quantify what the effect is on the bottom line.

So something that we didn't know at the time of the 2020 rate study (I don't think) at least was what the minimum wage adjustments were going to look like.

But we didn't have to know.

We built the foundation.

We knew what wage assumptions we had built in.

We knew what our data sources were.

So, when that legislation was enacted, we were able to go in and make adjustments a couple of times now-- in order to account for each of those increases.

So, because things are unknown, we can't prospectively include them in the rate models.

But, because we have those specific values outlined-- if we need to go in and make targeted adjustments, we have the capability to do so.

Although I will say-- that it's largely outside of the division's ability to do that unilaterally-- because if you increase rates, you're increasing costs.

And their budget typically doesn't have the level of flexibility that allows them to do that (without additional funding from the legislature).

Stacy: Okay. Okay, next question: “What do you suggest the participants and their families do to advocate for funding of these rate increase? Could their advocacy maybe help at legislature or with the agencies where they receive services from.”

Mary: Just in terms of process of… we include… the rate increases (the proposal) in our DD budget.

That goes through the department and then goes to BNF-- and gets included in the governor's budget, and then, gets looked at by the legislature.

So, those are the steps in the process.

All of those points in the... in the process are all times that...we see as being important to educate people.

Even though we are seemingly a small program, we really are big in terms of... because we are a long-term care and people stay in services... usually for... throughout their lives.

And so, it's really important to talk to who you can-- your own legislator, your communities... to educate them about... our program as well as why it's important... to fund it.

And... and we are required to pay what it costs to provide the service. And, that's why we're always doing the rate studies and adjusting our rates-- which has not always been the practice.

And, it's not the requirement for all programs, but the more that you can yourself get educated, educate others, the more it's... helpful for us as a service system to be whole and be able to provide access to good services.

Stacy: Okay, thanks Mary.

Okay next question.

Sorry, I was adding more questions here.

Okay, next question... question about the 80% Stephen mentioned.

The rate study showed employee DSW rate was calculated by using between 60 and 80%--

but that will change if CMS changes the rule to reflect a minimum of 80% being spent on the employee.

So, will there be a change in the rate study?

Are you already looking at that?

Stephen: So, this is a repeat of the question asked a moment ago. It's something that we're certainly tracking.

But, there's still questions about applicability.

There's questions about...(although they've provided some clarity on what counts and what doesn't count as direct support), there's still (I think) some additional guidance that's going to need to be issued around that.

So, yes. If it turns out that the 80% applies to the services covered by the waiver, we'll absolutely have to comply with that.

And that will require some adjustments to the rate models-- because for the most part, they don't currently meet that 80% threshold.

Mary: And at the same time, there's certain... costs that go into the rates that are not included in... the 2080 calculation.

For example, training would not be included in the calculation. That would be a separate cost that would be included in the rate.

So, all those are well-defined in the regulation. Again, we need to work with... in terms of really understanding how that impacts our rates.

Stacy: Okay, thank you. Next question: "My understanding is that the health insurance cost used in the rate models reflects the cost of medical only coverage. What is the reasoning for using the cost of medical only versus the cost of a full benefit package including medical, dental, drug vision and life insurance?"

We have found this to be one of our critical recruitment and retention strategies.

Stephen: So, a couple things here.

The first is... what we find is that medical is the most commonly offered benefit.

A lot of those other benefits are offered less regularly.

And of course, there's also requirements around medical insurance (with the Affordable Care Act from some time back).

So, it's true that that when you see the cost for medical insurance, that's ... help insurance is for the medical component.

It's not (I don't think) entirely accurate to say though that the others are not included.

That's why we have that $100 per month for other discretionary benefits.

So, we didn't want to get into a position where we're listing dozens of potential benefits that any given employer could offer, and then showing very low offer rates and participation rates-- that (you know) maybe it's only 2% of providers offer tuition reimbursement, and... someone offers pet insurance and a lot of other things.

So, rather than getting into the weeds about any other benefit that could possibly be offered, we included that catch all of $100 per employee per month.

That is meant to cover other benefits that are offered at the discretion of the employer-- such as things like vision or dental or life insurance or a retirement contribution or disability and the like.

That being said again... as with all aspects of the rate model, if there are specific suggestions that folks would offer to adjust the rate models or the assumptions that we made.

We're certainly open to that.

And that's-- why we're seeking your feedback.

Stacy: Okay... thank you!

Next question: how did you come up with the program support and administrative cost assumptions.

Would those two costs combined be equivalent to overhead?

We look at overhead as a combination of service supervisors, QA, staff billing, staff, administrative staff, physical offices, program software, etc.

Stephen: So, the numbers that are in there were first established back in the 2015-2016 rate study.

We've continued to do data collection to evaluate those figures.

I will say that on the provider survey analysis, there was... some... indication that perhaps they should have been increased-- which is why we increase the program support amount from $5 to $20 (which is a per day... depending upon the models)... either per DSP or per... individual receiving services.

That's a 33% increase to demonstrate that there was the reporting of higher program support costs.

The administrative rates-- we kept at 10%-- because of the fact that the rates themselves are going up by the 24%.

So, by keeping the percentage the same, we're still providing substantially more funding (24% more funding) for administrative functions.

In terms of the definition of overhead-- I'd leave that to you.

If I were in your shoes-- I think I would probably have a similar definition.

And if you look at our rate models-- for me, I would probably take the nursing supports, the program support amounts, and the administrative amounts.

And those three buckets really represents what I think of as is kind of the overhead piece of the rate model.

But your mileage may vary.

Some agencies might include like... the facility cost as an overhead expense--whereas in our ADH models (for example) we treat that as a... as a direct expense.

So, it really is a matter of you identifying what you bucket as overhead, and then seeing what elements of the rate model fall into your definition and....that's going to look a little bit different I think from one agency to the next.

Stacy: Okay... thanks Stephen!

The next question is asking about the topic of reduction in participants schedules... individual support budgets due to the rate increases.

Not sure what the question was. Maybe that was just a comment.

Stephen: Well, I think Mary addressed this earlier.

It's certainly not our intent for folks access to services to be adversely impacted as provider rates go up, right?

So, if budgets stayed flat (for example) and the rates go up, if you have the same fixed pot of money to work with, higher rates mean fewer units.

I mean the math's not complicated, right?

You multiply rates times units, you add it across services-- that gives you the ISB.

And, so it's been our practice (as far as I'm aware) to increase the ISBs as rates have been adjusted.

As Mary said, if there's something… that folks are aware of that hasn't worked as intended… you can reach out to the division and that's something that we could look into.

But it would certainly be our intent that if these rates were implemented and we go through the amendment process that we would similarly amend those ISB amend (where we'd be increasing the budgets).

So that the amount of support that an individual could access would be unchanged.

Stacy: Great! I believe those are all the questions we had.

We received a several comments… so I've… collected them all here.

“Mahalo for your thorough presentation-- all of the thoughtful and comprehensive input in the rate study. “

“Thank you, Stephen. This is a lot of information shared.”

“I agree… this is a great webinar.”

“Thank you Stacy and Stephen and Mary for this Zoom.”

“The Hawaii waiver providers Association will once again work to advocate for the increased appropriations in the state budget.”

Other comments… “great to hear that incentives… such as bonuses, etc. are being looked at to hopefully help with addressing the very limited number of DDD or DD/ID AFH foster home placements (especially on the… neighbor Islands).”

Sorry, people are sending them faster than I can get them here.

And wait, there was something else…

“Mahalo for this presentation. Appreciate the rate increases and the consideration towards the need for higher rate increases for all… the neighbor Islands.”

Just a couple of navigation questions.

Is the proposed model posted somewhere?

How do we access it and… email… who… which email… will those come… through?

Email for those concerns.

So, let me stop sharing this, and I can... reshare... the screen from Stephen's presentation (just a second).

Mary: In the chat (as always), we will always post our... your comments. Welcome your comments today and (you know) let's not the... we are not saying that we are going towards the appropriation from... is with our appropriation

Still making some adjusts, cool.

And so this... a couple

And so is deep... our about that really appreciate your attention.

You're consuming these.

Many of you have seen this presentation so many times you could give it yourself.

Stephen: Just a reiteration or two of the points that I raised before the comment process... really is meant to be value added.

So, I certainly appreciate all the feedback around things like ISBs around medical insurance costs.

Please make sure you submit them... that to us and then be as specific as possible.

Tell us why you think there's an issue.

And then, if you have a different recommendation-- tell us what you' recommend and if you have data or other documents that support your suggestion.

Send that to us as well.

That's going to be to our mutual benefits that we understand where you're coming from, what your position is, and what you would propose to change.

As folks have said-- we'll make sure that you have access to the materials.

We'll have it in a couple different places.

And if you need any... if you have any questions that are more technical in nature, you're welcome to reach out to Alisher, myself...

And, of course, you know how to reach a hold of your friends at DDD, and they know how to get a hold of us as well.

So there's kind of no wrong door.

We're trying to funnel things to Alisher... to make sure that we have everything in one place, but... yeah... make sure you get that feedback submitted somehow some way.

Stacy: Yes, sorry. Okay.

Okay the question was asking Stephen... are you willing to share the link to the article that you wrote... regarding minimum wage impacts?

Stephen: I am... assuming it's still there.

I mean... so I don't own that.

But the last time I looked... the N it's the National Provider Association or ANCORE... that commissioned it, and they had it posted on their website.

So, presuming that it's still there-- I will... I'm happy to share that.

Stacy: Okay, I don't see any more questions-- so I think we're okay... I think we're okay Mary... to... conclude today's webinar.

Thank you so much.

We... pretty... pretty maintained a pretty high... participant and attendee number throughout... this Zoom this morning.

So, thank you very much for your time.

If you have any more questions... feel free... to submit them.

You can share them to us at... the training unit.

We'll be happy to... route them.

The information for rate study and how to submit your public comments... is on the screen.

And like Mary said, we will make sure that we get the recording... and all of the handouts and this information up on our DDD website.

And we will... let you know... through email when it is there.

So, you can... access it and distribute it.

Thank you very much for your time, and have a great rest of your day for...