WEST VIRGINIA Department of Health & Human Resources

WV NF Reimbursement Workgroup - Bi-Weekly Meetings
MEETING MINUTES

DATE AND TIME	LOCATION
Thursday, February 9, 2023 9:00 – 10:30am EST	VIRTUAL via TEAMS
ADVISORY COMMITTEE	
Member List Below	
Meeting Cadence: Bi-Weekly Meetings via Teams Meeting	

Attendees*: *Not inclusive of Call-in Users.

	Present?	Attendee	Present?	Attendee
Invitees:		Alex Montileone	X	Lane Ellis
		Andy Page	X	Lori Greer-Harris
	X	Barbara Skeen		Mandy Carpenter
	X	Cattie Mellott		Melanie Dempsey
		Cindy Beaned	X	Michelle Petty
	X	Dan Brendel	X	Regina McCormick
	X	David McCauley	X	Shawn Eddy
		Gregg Gibbs	X	Sherry Jarvis
	X	Jeanne Snow		Terry McGee
	X	Jeff Bush	X	Todd Jones
	X	Kayla McCully		Tonya Jones
		Kris Pattison	X	Tracy Mitchell
		Whitney Sharp		Marty Wright

AGENDA ITEMS	LEAD	DURATION (MINS)
1. Roll Call/Housekeeping • See above for attendees	Jeff Bush	5
• **Updated Rate Model Discussion** **M/S:** • Aware of model from provider community. • For special populations, interested in goals of workgroup. Helpful to have context to pull the right data • Agree with the ballpark estimate, once we get that 12/31 data we will re-run everything. Update all analytics **DHHR:** • In the direct care component, we think that should be at the 90th percentile. That is how much providers are paying; they do not think that is a bad thing to provide reimbursement for those costs. There will be outliers to take into account; contractors for example. So those should be not be reimbursed. On the care related column, we wrote therapy into	Alex Montileone	30

that to have one less category. In addition, added a floor of 80%. Going back to direct care adding a floor, there is been a push of minimum staffing without having a minimum staffing ratio. I think the floor takes care of the minimum staffing ratio. Perhaps the Feds may mandate the minimum staffing anyway. • Do not disagree with insurance being pass through. We do have an issue with liability insurance, maybe coming up with a certain percentile. Medicaid has never viewed loss claims as allowable costs. I do want to put that on the table. Set aside this issue and set a price or threshold we would pay. This would help limit any circumstances • The model as is does not have professional insurance, we will need to carve that out the model • As part of capital component, that stays the same. How do we transition to a four-year period to allow providers to adjust and maintain. Thoughtful transition process to allow them to go to this model. We want to try to see equity and uniformity in the new model. Cost coverage will be the key point; we have to get somewhere that is reasonable. You should be able to stay in business and invest in capital. Want to be able to tweak the model moving forward. • Look at anomalies at who is coming out different but want to make sure data has integrity. **Workgroup:** • Thought having a higher floor in direct care staffing and having a lower floor in other things would allow some efficiencies. We did change some of these groupings like housekeeping, laundry, admin being the items that are outside of our control. • One of the core pieces of this, the model shows almost 10% in quality that would be paid out. We talked about special populations and adopting a Medicare plan that did not take into account long-term Medicaid patient. By coming up with an add on with those characteristics and diagnosis, the state can tailor towards that Medicaid populationMany people might shy away from taking wounds, which would not be good for anyone. Which is why we want a state add on adding that. • With behaviors we look at days, we can match up in E section with those patients. I have certain codes I can send to you. When we get to wounds that would be a different for what we are looking for in that population. They require other items. • We see add-ons and different rate models is for ventilators, we do not see a lot of that since the reimbursement is not that great. Lot of states are using ventilators outside of rate setting. . • Part of that discussion is the concentration of larger providers; we would not use a percentile for that. You would tend towards the percentage of the median instead of percentile drive. • We need to model the 90% occupancy, second thing is we know that next 60 days we will have the 12/31 information, can do side by side analysis. Going back to transition discussion, we have to have discussion on how we treat ownership changes before and during and after transition. • Open to removing minimum occupancy understanding we might have to tweak it to bring it back to neutral.		

• Talked about moving toward an annual process, with the quality piece does it make sense looking at it on a 6-month basis? There are all kinds of nuances we need to consider		
2. PDPM Discussion	Myers and Stauffer	25
3. Cost Report Changes and Timeline Discussion **Workgroup:** • Needed more direction on what rate model was going to go. Sounds like we have a better understanding, we need to work up a budget on what we think changes will cost • We will continue to work on that	Myers and Stauffer	15
4. Clinical Workgroup Update **Workgroup:** • Looking at depression, pulling more numbers and looking at that model. • we have high turnover in long term care • Retention will be more specific, we can look at duration, from a staffing ratio standpoint it compares to state and national levels at the nursing home level. Once we establish a staffing ratio, can be higher and higher when looking at other things. We already have specialty staffing we will continue to look at; educators, therapy, practitioners. • Do not want to do rate adjustments each quarter **M/S:** • Appropriate staffing levels, retention over time, staffing hours, there are a number of considerations to look at. This is something we can look at in the future of the program. • We can look at other staffing indicators. We can revisit this when we get closer a year or two down the line. • We will be able to provide some guidance in the next few meetings	Myers and Stauffer	10
5. Open Discussion	Myers and Stauffer	5

MEETING ACTION ITEMS AND DECISIONS MADE		
Status	**Task**	**Assigned To**
Pending	**Action:**	Myers and Stauffer
Complete	**Decision Made:**	All