The State of Hawai`i Med-QUEST Division (MQD)
2022 MQD Home & Community Based Services (HCBS) Rate Study
HCBS Residential Provider Survey Tool Instructions
For Providers with Less than Five Approved Substitute Caregivers

Overview

MQD is conducting a Residential HCBS Provider Cost and Wage Survey ("Survey Tool") to collect cost and wage data from HCBS providers participating in the Hawai`i Medicaid Quest Integration (QI) program. Results from the Survey Tool will inform the development of benchmark "comparison rates" for select services in MQD's 2022 HCBS Rate Study. Comparison rates from this rate study will be published for consideration by HCBS providers and QI Medicaid Managed Care Organizations (MCOs) when negotiating contracts and will be used by MQD to evaluate overall HCBS funding levels.

This provider survey is for residential providers (delivering E-ARCH and CCFFH services) with less than 5 approved substitute caregivers (both contracted and directly employed). If you do not provide residential services or have more than 5 approved substitute caregivers, you are requested to complete original HCBS Provider Cost and Wage Survey.

MQD **strongly** encourages your participation in this survey to help MQD gain a better understanding of Hawai`i HCBS provider resource requirements. Information collected through this survey process includes staffing, wages, and other cost information incurred by HCBS residential providers. Your response will be held confidential and will not be shared with other providers.

Submitting Survey Tool responses: Completed Survey Tools should be submitted no later than **October 28, 2022**. After completion, save the file with your provider's name, e.g., 2022 Residential Provider Survey Tool – [provider name]. Once the Survey Tool is complete, please email it electronically to HI.HCBS.Survey@Milliman.com.

Milliman has been engaged by MQD to conduct the HCBS Provider Cost and Wage Survey and to facilitate the Rate Study. ***If questions arise that are not addressed in these instructions, please contact Milliman at HI.HCBS.Survey@Milliman.com with a technical assistance request.***

General Tab

The *A. General* tab includes questions related to the provider identification, contact information and the nature of the services and populations served by the provider entity.

Section A: Provider and Contact Information

1. **Enter provider and contact information**
   - *Provider Name (Question 1a)*: Enter your provider/organization name associated with delivering, ordering, or referring the services under evaluation.

- *Contact Name (Question 1b)*: Enter the name of the person who should be contacted if there are any questions related to the information reported.
- *Contact Phone Number (Question 1c)*: Enter the phone number of the person listed as contact.
- *Contact Email Address (Question 1d)*: Enter an email address of the person listed as contact.
- *Contact Mailing Address (Question 1e)*: Enter the primary mailing address of the organization.

Section B: Provider Type and Services

2. **Residential Care facility type**
   - *Types of Services (Questions 2a-c)*: Select the appropriate checkbox to identify whether your residential care services are for E-ARCH – Type 1, E-ARCH – Type 2, or CCFFH by clicking on the appropriate white checkbox in the green input cell.
3. **Number of Individuals Served**
   - *Number of individuals served (Question 3)*: For each applicable service type, enter the total residents your provider organization served between July 1, 2021 and June 30, 2022. Please count each resident only once.

Costs and Wages Tab

The *B. Costs and Wages* tab includes questions on total residential costs, employee salary information, and direct care contracting cost information by Staff Type.

Section A: Direct Care Costs

1. **Enter information about your organization's ability to report residential service costs**
   - *Unable to report organization's costs (Question 1a)*: Select the checkbox if you are unable to report your organization's residential service costs.
   - *Able to report organization's costs (Question 1b)*: Select one of the four dropdown options if you are able to report your organization's residential service costs.
   - *Reporting period of your organization's costs (Question 1c)*: Select one of three dropdown options for the reporting period of your residential service costs.
2. **Cost Category**

   This section includes questions related to the total residential costs for administrative and program support costs that aligns with the provider financial statements (if available) and reflects expenditures for all payors. Requested items in the section are described as follows.

   - *Caregiver and Supervisory Salaries, Wages, and Employee Related Expenses (Including Expenses Associated with Approved Substitute Caregivers) (Question 2a):* Please enter information related to all clinical/direct care staff, supervisor salaries and wages, and all other expenses for direct care staff employee related expenses.
   - *Transportation (Excluding Administrative Transportation Costs) (Question 2b):* Please enter transportation costs related to vehicles owned by the provider and clinical/direct care employees.
   - *Room and Board Expenses (Question 2c)*: Please report into the table the total costs by type of provider agency for room and board.
   - *Non-Allowable Medicaid Expenses (e.g., alcohol, bad debt, fines, charitable contributions, etc.) (Question 2d):* Allowable costs are based on federal Medicaid regulations and are the reasonable costs necessary to provide services to individuals eligible for Medicaid services. Determinations of allowable costs must be consistent with 2 CFR § 200, and in principle, the term "reasonable" relates to the prudent and cost-conscious buyer concept that purchasers of services will seek to economize and minimize costs whenever possible.

- *Provider Administration and Program Support Expenses (Question 2e):* Please report in the table the total costs for administrative and program support costs.

Section B: Substitute Caregiver

- *Compensation to your substitute caregiver (Question 1):* Please enter whether you provide compensation to your substitute caregiver. A substitute caregiver is an individual who is trained and identified in the service plan to provide daily personal care to clients in the absence of the primary caregiver. You can skip *Question 1a* if you select No or Unsure to *Question 1*.
- *Compensation arrangement with your substitute caregiver and estimated annual compensation per Substitute Caregiver (Question 1a)*: Please select all the applicable compensation arrangements you have with your substitute caregivers, the estimated average compensation by staff type, the total estimated annual compensation, and the number of approved substitute caregivers.

Residential Care Staffing Tab

The *C. Residential Care Staffing* tab seeks information related to a provider organization's residential care facilities, the types of facilities, specific information about each residential care facility, and the average weekly hours worked (including weekday and weekends) by staff type. You may use data from August 2022 to inform the responses within this worksheet.

Section A: Residential Care Services Staffing

1. **How many Residential Care facilities do you have total? List for each of the following facility types.**
   - *E-ARCH – Type 1 (Question 1a)*: Please enter how many E-ARCH – Type 1 facilities you operate in total.
   - *E-ARCH – Type 2 (Question 1b)*: Please enter how many E-ARCH – Type 2 facilities you operate in total.
   - *CCFFH (Question 1c)*: Please enter how many CCFFH facilities you operate in total.
2. **Please report service and staffing information based upon either your average weekly occupancy between August 1-26, 2022, or an average week in October 2022.**
   - **Facilities:** Please list in the table your facility type that your provider organization operates and report the information requested in *Columns A through G* (as labeled in row 16) to reflect your experience between August 1 and August 26, 2022, or an average week in October 2022.
     - *Facility Type (labeled column A):* Please identify whether the facility is an E-ARCH – Type 1, E-ARCH – Type 2, or a CCFFH.
     - *Number of Licensed Beds (labeled column B):* Please provide the number of licensed beds.
     - *Census All Payors (Private Pay + Medicaid) (labeled column C):* Please provide the census for all payors, which includes both private payors and Medicaid, over the reporting period.
     - *Census Medicaid Only (NF Level of Care) (labeled column D):* Please provide the census for Medicaid only Nursing Facility Level of Care.
     - *Staffing Model (labeled column E):* Please provide the staffing model for your facilities. Select one of the five dropdown options, which include:
       - Owner,
       - Owner and Staff,
       - Standard Staff,
       - Standard Staff and Specialized Staff, and

- Specialized/Highly Skilled Staff

- *Staffing Adjustments (labeled column F):* Please provide adjustments made to your staffing.
- *Reason for Staffing Adjustments (labeled column G):* Please provide the reason for staffing adjustments, which include behavioral needs, medical needs, or both.

Section B: Weekdays and Weekend Staffing by Provider Type

- **Caregiver Provider Types:** Please fill out the average weekly number of hours by caregiver provider type and Level 1 or Level 2 residents (based on experience between August 1 and August 26, 2022, or an average week in October 2022) for weekdays (Monday through Friday) and weekends (Saturday through Sunday) direct care staff in your residential care facility.
  - *Residential – Direct Support Certified Nursing Assistants (CNAs) / Nurse Aides (NAs) (labeled row 1).*
  - *Residential – Direct Support Licensed Practical Nurses (LPNs) (labeled row 2).*
  - *Residential – Direct Support Registered Nurses (RNs) (labeled row 3).*
  - *Residential – Direct Support Supervisors (labeled row 4).*

Notes Tab

The *D. Notes* tab allows the reporting organization to explain certain responses and convey more information about the tabs in the Survey Tool. All feedback and suggestions will be reviewed.

Limitations

This survey is intended for the use of the State of Hawai`i Med-QUEST (MQD) in support of its 2022 Home and Community-Based Services (HCBS) rate study, and is not appropriate for other purposes. The terms of Milliman's contract with Med-QUEST signed on July 1, 2020 apply to this this survey and its use.

We understand this survey will be shared by MQD with Hawai`i Medicaid HCBS provider stakeholders for the purpose of responding to the survey. This survey should not be shared with other third parties without Milliman's prior consent. In the event such consent is provided, the survey must be provided in its entirety.

In performing this work, we relied on data and information provided by MQD and its vendors. We have not audited or verified this data and information. If the underlying data or information is inaccurate or incomplete, the results of our assessment may likewise be inaccurate or incomplete.

Milliman makes no representations or warranties regarding the contents of these instructions to third parties. Similarly, third parties are instructed that they are to place no reliance upon this information prepared for MQD by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.