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Instructions:

ARPA Adult HCBS Minimum Fee Schedule Provider Cost Survey

2022

State of Wisconsin Department of Health Services

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I. Overview

The State of Wisconsin Department of Health Services (DHS) ARPA Adult HCBS Minimum Fee Schedule Provider Cost ("the survey") is necessary for DHS to develop and publish Medicaid HCBS minimum fee schedule rates reflecting reasonable and appropriate costs for select home and community-based services (HCBS) provided in the Family Care and Family Care Partnership Medicaid programs.

DHS will require that Family Care and Family Care Partnership managed care organizations (MCOs) pay providers no less than the minimum fee schedule. MCOs and providers can still negotiate higher rates based on member needs. Minimum Medicaid rates will be set for the following services, and providers of these services are being asked to complete the survey:

- Adult family homes (AFHs)
- Residential care apartment complexes (RCACs),
- Community-based residential facilities (CBRFs)
- Supportive home care services, including supported independent living (SIL) services
- Personal care services

Owner-Occupied Adult Family Home (AFH) 1-2 bed providers and live-in SHC providers are not asked to fill out this survey.

Note that Corporate AFH 1-2 bed providers should complete the survey. For purposes of this survey instructions, the term "provider" refers to an individual or entity engaged in the delivery, ordering, or referring of the above-mentioned services.

Why is my participation important? The data that you and other providers submit will provide important insights into provider costs and wages that will be used by DHS to develop a minimum fee schedule and collect current operating costs of long term care providers to inform future policy and funding decisions. Accurate and timely data are critical to this initiative.

How do I submit the survey? After completion, save the file with your provider name in the file name, e.g., 2022 Provider Survey Tool – [provider name].xlsx. Once the workbook is complete, please email it as an attachment to WIHCBS@Milliman.com.

What if I need help completing the survey? There are a variety of avenues to obtain support when completing the survey:

- Recorded training available on-demand on DHS's website regarding this initiative (https://www.dhs.wisconsin.gov/arpa/hcbs-ratereform-feeschedule.htm)
- Dedicated email for questions (WIHCBS@Milliman.com)
- Q&A session offered two weeks after survey distribution
- FAQs posted on the DHS website as needed (https://www.dhs.wisconsin.gov/arpa/hcbs-ratereform-feeschedule.htm)

Figure 1 on the following page provides a high-level summary of the worksheets included in the survey and indicates which providers should complete each worksheet. There are two different cost structure worksheets. Worksheet D is for providers that only deliver residential care OR that deliver residential care and SHC or personal care services. Worksheet E is for providers that only deliver SHC or personal care services.

FIGURE 1: OVERVIEW OF SURVEY WORKSHEETS AND DATA COLLECTED

WORKSHEET	TITLE	DATA COLLECTED	WHO SHOULD COMPLETE?
A	General Information	Provider's identification and contact information, and organization-wide information regarding type of services, and turnover	All providers
B	Bonuses for Clinical/Direct Care Staff	Signing and retention bonuses information	All providers
C	Wages	Staffing, wages, and payment differential information	All providers
D	Cost structure – Res care only OR Res care and SHC or personal care services	Overall cost structure, including administrative and program support costs, clinical/direct care workers and supervisors' salaries and wages, employee related expenses, transportation costs, and non-allowable Medicaid costs	Agencies that provide residential care services only Agencies that provide residential care services and SHC or personal care services
E	Cost structure – SHC and personal care only services	Overall cost structure, including administrative and program support costs, clinical/direct care workers and supervisors' salaries and wages, employee related expenses, transportation costs, and non-allowable Medicaid costs	Agencies providing SHC and personal care services only
F	Feedback	Optional tab, to provide additional notes or overall feedback specific to each one of the worksheets.	All providers

The following section provides detailed instructions for preparing and reporting information for each of the worksheets, including what should be reported in each of the requested fields and definitions specific to terms used on each worksheet.

II. Worksheet Instructions

WORKSHEET A: GENERAL INFORMATION

This general information worksheet includes fields for reporting a provider's identification and contact information. It also asks several organization-wide questions regarding type of services and turnover.

Section A: Provider and contact information

Question (1): Enter the provider and contact information

Section B: Provider Type and Services

Question (2): Indicate which services your organization provides using the drop-down lists.

Question (2.1): Indicate the type of services provided by SHC and PC providers. Select the appropriate response from the drop-down lists as applicable.

Section C: Information by Service Type

Question (3): This section collects information on the number of facilities, vacancy percentage, counties served, days of residential care billed, hours of SHC and PC services billed, total unique individuals served, and total revenue for the services provided by your organization. All data reported should be from July 1, 2021 through June 30, 2022.

Section D: Claims processing for other network providers

Question (4): This question asks whether or not your organization is responsible for adjudicating claims to pay for other services provided by other providers (e.g., similar to a sub-capitation arrangement); select the appropriate answer from the drop-down list.

Section E: Employee staffing

Question (5): This section collects data to calculate the clinical/direct-care staff turnover rate for SFY 2022 (July 1, 2021 to June 30, 2022). Enter a whole number in **Rows (a), (b)** and **(c)** as applicable. **Row (d)** will automatically calculate the turnover rate.

Section F: Provider Billing Identification

Question (6): This question asks providers to list their provider identification number(s) their organization uses for billing purposes and the facilities associated with those ID number(s). Those IDs could be either a National Provider Identifier (NPI) ID or, if identifiable, a Managed Care Organization (MCO) ID number(s).

For each recorded facility, you may record up to 5 MCO IDs. If you need to record more than one NPI ID, please enter them all and separate them by commas.

If you are using your Social Security Number as ID please select "Yes" from the drop-down list in **Row (74)**.

Note: If you are using your SSN as a provider ID, you do not need to complete this survey as your organization is likely either an Owner-Occupied Adult Family Home 1-2 bed, or you are a live-in caregiver.

Section G: Attestation

This section requires that organizations complete a certification statement related to the information submitted in the survey.

Section H: Designation of Confidential and Proprietary Information

This section requires that organizations indicate which sections of the survey response they are requesting should be treated as confidential material, and affirm the definition of trade secret. An electronic signature is acceptable as the signature of the authorized representative.

WORKSHEET B: BONUSES

This worksheet collects data on retention and signing bonuses for clinical/direct care staff. Information reported should reflect State Fiscal Year 2022 (June 30, 2021 to July 1, 2022).

Question 1: Select from a drop-down list to indicate if your organization pays signing bonuses to new hires. If you select "Yes" or "Sometimes", report the percentage of new hires receiving these bonuses in **Row (a),** and the average signing bonus per new hire in **Row (b)**.

Question 2: Select from the drop-down list to answer if your organization will continue paying signing bonuses going forward.

Questions 3 and 4: Same questions as Questions 1 and 2, but specific to retention bonuses.

Question 5: Report any other information regarding monetary incentives of any type that you think might be helpful for DHS to understand.

WORKSHEET C: WAGES

This worksheet includes questions about wages, vacant and filled positions for contracted and non-contracted full-time equivalents (FTEs), and questions about payment differentials. The following definitions should be used when completing this worksheet:

- **One FTE is** one or more individuals who, combined, work 35 or 40 hours in a week, consistent with your organization's standard work week.
- **Non-contracted FTEs** represent individuals employed by the provider receiving a salary or wage and a W-2 for tax purposes, and where the work performed by the individual is under the control of the provider entity (i.e., how and where the work is done).
- **Contracted FTEs** represent individuals who are not W-2 employees of the provider entity, and generally are not eligible for employee benefits. These employees generally provide services that are billed by the employing provider entity, and they perform work under the control and direction of the provider entity, i.e., what will be done and how it will be done.

Figure 2 following provides a description of how to report hourly wages and FTEs for purposes of this worksheet.

FIGURE 2: DESCRIPTION OF REPORTING HOURLY WAGES AND FTEs

ITEM	DESCRIPTION
Reporting Hourly Wage	• The requested salary information should be reported on an hourly wage basis for non-contracted employees, and a rate per hour basis for contracted employee positions. • If employees are paid on an hourly basis, consider their regular wage rate (not including overtime adjusted wages) for purposes of reporting averages. If employees are salaried workers, their hourly wage should be reported equal to their annual salaries divided by the number of hours expected to be worked for their position for the year. • Include all wage-based compensation, such as merit bonuses, paid in addition to salaried amounts.
Identifying Number of Full Time Equivalents	• Full time equivalents, or FTEs, are a measure of the number of employees for each provider type/position. • Reporting FTEs requires the provider entity to *consider part-time and full-time positions*. For example, an employee working full time would be counted as 1.0 FTEs, and an employee working half time would be considered as 0.5 FTEs. • *For hourly non-contracted employees*, consider your organization's standard work week for purposes of determining and reporting FTEs. For example, if your organization's standard work week is 35 hours, hourly employees working 35 hours per week should be considered as 1.0 FTEs, and hourly employees working 21 hours per week should be considered as 0.6 FTEs. Similarly, if your organization's standard work week is 40 hours per week, hourly employees working 40 hours per week should be considered as 1.0 FTEs, and hourly employees working 24 hours per week should be considered as 0.6 FTEs. • *For salaried employees*, determine the number of FTEs based on your organization's expectations regarding the number of hours the salaried employee will work. For example, if a salaried employee is expected to work an average of 50 hours per week, the employee should be considered as 1.0 FTEs even though your organization may have a standard work week of 40 hours for hourly employees. • *FTEs for contracted employee positions* should be based on the same assumptions applied for determining FTEs for non-contracted employee positions. • If a clinical/direct care staff person splits their time between administrative and clinical/direct care functions, only include the time spent on clinical/direct care when calculating the FTE.

Section A: Direct Care Staff Wages

Report information for each of the clinical/direct care staff roles listed, leaving blank any rows that do not apply to your organization. **Rows 18 to 21** can be used to report information for clinical/direct care staff that cannot be assigned to **Rows 10 to 17.**

- Staffing as of 8/1/2022

  Column (A): Report the total number of filled full-time equivalents (FTEs) for each provider type (as of 8/1/2022).

  Column (B): Report the total number of vacant/unfilled full-time equivalents (FTEs) for each provider type (as of 8/1/2022).

- Non-Contracted full-time employees as of 8/1/2022

  Column (C): Report the average hourly wage for each provider type for non-contracted employees (as of 8/1/2022).

  Column (D): Report the number of filled positions for each provider type for non-contracted employees (as of 8/1/2022).

- Contracted employees as of 8/1/2022

  Column (E): Report the average hourly wage for each provider type for contracted employees (as of 8/1/2022).

  Column (F): Report the number of filled positions for each provider type for contracted employees (as of 8/1/2022).

- Overnight and Weekend Wages

  Column (G): Report the hourly weekend wage, if applicable (as of 8/1/2022).

  Column (H): Report the hourly overnight wage, if applicable (as of 8/1/2022).

Section B: Payment Differentials

Question (1): Indicate if your organization offers any hourly payment differentials for clinical/direct care workers beyond increases in payment for overtime or weekend work. Note that signing and retention bonuses are reported separately on *Worksheet B. Bonuses*. If the response to **Question (1)** was “Yes”, indicate for which provider types in **Row (a)** and describe the differential(s) in **Row (b).**

WORKSHEET D: RESIDENTIAL CARE COSTS

This worksheet collects data on administrative and program support costs using the most recent provider fiscal year as the reporting period. Data reported should align with provider financial statements and reflect costs from all payors. This tab is for (1) only residential care providers, and (2) residential care providers that also have SHC and/or PC services.

Figure 3 provides definitions of allowable and non-allowable costs, and administrative, program support, and room and board costs. Data reported should reflect these definitions.

FIGURE 3: DEFINITIONS FOR USE IN COMPLETING WORKSHEET

TERM	DEFINITION
Allowable and non-allowable costs	For purposes of this survey, allowable costs based on federal Medicaid regulations are the reasonable costs necessary to provide services to individuals eligible for the approved federal Medicaid waivers. 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. The term “necessary” relates to the necessity of the service. To be “necessary”, it must be a required element for providing care to individuals as specified by the approved federal waivers. The following are examples of non-allowable costs: • Room and board (including all client-related facility and facility maintenance costs, food, and personal expenses) • Other, e.g., bad debts, charitable contributions, fundraising costs, entertainment costs (including costs of alcoholic beverages), and Federal, state, or local sanctions or fines
Administrative costs	Expenses incurred by the provider entity necessary to support the provision of services but not directly related to providing services to individuals. These expenses exclude transportation, wages, and employee-related expenses for clinical care, and may include, but not be limited to: • Salaries and wages, and related employee benefits for employees or contractors that are not direct service workers or first- and second- line supervisors of direct service workers • Liability and other insurance • Licenses and taxes • Legal and audit fees • Accounting and payroll services • Billing and collection services • Bank service charges and fees • Information technology • Telephone and other communication expenses • Office and other supplies including postage • Accreditation expenses, dues, memberships, and subscriptions • Meeting and administrative travel related expenses • Training and employee development expenses, including related travel • Human resources, including background checks and other recruiting expenses • Community education • Marketing/advertising • Interest expense and financing fees • Facility and equipment expense for space not used to directly provide services to individuals, and related utilities • Vehicle and other transportation expenses not related to transporting individuals receiving services or transporting employees to provide services to individuals • Board of director-related expenses • Interpreter services
Program support costs	Supplies, materials, and equipment necessary to support service delivery

TERM	DEFINITION
Room and board costs[1]	Board means three meals a day or any other full nutritional regimen. Room means hotel or shelter type expenses including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services. Section 4741(a) of OBRA 1990 provides that the room and board exclusion does not include an amount established by you to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, NF, or ICF/MR. Unrelated is defined as someone who is unrelated by blood or marriage to any degree. A personal caregiver provides a covered waiver service (as defined in your waiver package) to meet the recipient's physical, social, or emotional needs (as opposed to services not directly related to the care of the recipient, i.e., housekeeping or chore services). Therefore, when a waiver service is provided by an unrelated, live-in personal caregiver, FFP is available to the waiver recipient for the additional costs he/she may incur for the room and board of such caregiver. Under Medicaid and SSI rules, for payment not to be considered income to the recipient, payment for the portion of the costs of rent and food attributable to an unrelated live-in personal caregiver must be made directly to the Medicaid recipient. You may utilize any reasonable method of apportioning the cost of rent and food, subject to review and approval by HCFA. FFP for live-in caregivers is not available in situations in which the recipient lives in the caregiver's home or a residence owned or leased by the provider of Medicaid services.

Data for this tab should be reported using data from the most recent provider fiscal year. Enter the start and end date of the relevant time period in **Row 10.** For **Rows (A)** through **(I),** record the costs in the applicable **Column** from **Total**, **Residential Care**, and **Supportive Home Care/Personal Care**. The **Other Services Column** populates the total costs less than residential and supportive home care/personal care costs automatically. Data reported, including total costs populated in **Row (I)**, should align with provider financial statements, and reflect costs from all payors. Figure 4 below provides instructions for each row on this tab.

FIGURE 4: ADMINISTRATIVE, PROGRAM SUPPORT, AND EMPLOYEE RELATED EXPENSES

ROW	INSTRUCTIONS
A	Report total clinical/direct care staff and supervisor salaries and wages
B	Report employer costs associated with clinical/direct care staff and supervisor health and dental insurance
C	Report all other employee-related expenses for clinical/direct care staff and supervisors (e.g., vision, 401K, profit sharing, federal and state taxes, retirement benefits, unemployment insurance, and workers compensation insurance)
D	Report transportation vehicle costs for clinical services, recording costs related to vehicles owned by the provider on D.i, and mileage costs or other transportation costs paid to clinical/direct care employees on D.ii. The worksheet will automatically sum D.i and D.ii.
E	Provide a breakdown of administrative and program support costs using rows E.i through E.vi.
F	Report room and board costs
G	Report bad debt and other Medicaid non-allowable costs
H	Report any additional costs on this row, using the text box below this row to provide a description in addition to reporting costs
I	This row automatically calculates total costs using the information reported in the previous rows
J	Row J populate the per diem total costs based on the reported data on this worksheet and the total residential care service days reported on Tab A.
K	Row K will populate the per diem costs excluding Medicaid non-allowable costs
L	Report additional information related to health insurance, specifically: i: This row populates automatically, using the total clinical/direct care filled positions reported on Worksheet C. Wages ii: Report the number of clinical/direct care staff eligible for health insurance as of 8/1/2022. iii: Report the number of clinical/direct care staff that take up health insurance as of 8/1/2022. iv: This row calculates the provider health insurance take up rate automatically (L.iii divided by L.ii). v: Report the employer cost of the average monthly individual health insurance premium for your organization (CY 2022 to date). vi: Report the employer cost of the average monthly family of four health insurance premium for your organization (CY 2022 to date).

[1] State Medicaid Manual, Chapter 4, 4442.3, B.12. Accessed online (July 25, 2022): https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927

WORKSHEET E: SUPPORTIVE HOME CARE AND PERSONAL CARE COSTS

This worksheet collects data on administrative and program support costs using the most recent provider fiscal year as the reporting period. Data reported should align with provider financial statements and reflect costs from all payors. This tab is for providers that only deliver SHC and/or PC services.

Figure 3 on page 6 provides definitions of allowable and non-allowable costs, and administrative, program support, and room and board costs. Data reported should reflect these definitions.

Data for this tab should be reported using data from the most recent provider fiscal year. Enter the start and end date of the relevant time period in **Row 10**. For **Rows (A) through (G)**, record the costs in the applicable **Column** from **Total** and **Supportive Home Care/Personal Care**. The **Other Services Column** populates the total costs less than supportive home care/personal care costs automatically. Data reported, including total costs reported in **Row (H)**, should align with provider financial statements, and reflect costs from all payors. Figure 5 below provides instructions for each row on this tab.

FIGURE 5: ADMINISTRATIVE, PROGRAM SUPPORT, AND EMPLOYEE RELATED EXPENSES

ROW	INSTRUCTIONS
A	Report total clinical/direct care staff and supervisor salaries and wages
B	Report employer costs associated with clinical/direct care staff and supervisor health and dental insurance
C	Report all other employee-related expenses for clinical/direct care staff and supervisors (e.g., vision, 401K, profit-sharing, federal and state taxes and retirement benefits)
D	Report transportation vehicle costs for clinical services, including costs related to vehicles owned by the provider and mileage costs or other transportation costs paid to clinical/direct care employees.
E	Report the total administrative and program support costs
F	Report bad debt and other Medicaid non-allowable costs
G	Report any other costs (please provide a description of the other reported costs in the corresponding text box)
H	This row automatically calculates total costs reported using the information reported in the previous rows
I	Report additional information related to health insurance, specifically: I.i: This row populates automatically, using the total clinical/direct care filled positions reported on Worksheet C. Wages I.ii: Report the number of clinical/direct care staff eligible for health insurance as of 8/1/2022. I.iii: Report the number of clinical/direct care staff that take up health insurance as of 8/1/2022. I.iv: This row calculates the provider health insurance take up rate automatically (iii divided by ii). I.v: Report the employer costs of the average monthly individual health insurance premium for your organization (CY 2022 to date). I.vi: Report the employer costs of the average monthly family of four health insurance premium for your organization (CY 2022 to date).
J	Report the average number for the transportation-related information, specifically: J.i: Report the average number of minutes per one-way trip J.ii: Report the average number of miles per month J.iii: Report the average number of visits per month

The last question on this tab (**Row K**) asks if your organization has a minimum length of service time per visit. If you select yes for this question, please describe in the text box beneath it.

WORKSHEET F: FEEDBACK

This worksheet allows for reporting optional notes and overall feedback about the survey. There is a row designated for each of the above tabs to add notes specific for each tab as needed.

III. Limitations

This document is intended for use by Wisconsin State, Department of Health Services (DHS) in support of the development of HCBS minimum payment rates. The terms and conditions of the Contract Agreement between Wisconsin State, Department of Health Services (DHS) and Milliman, Inc. (Milliman), effective on January 1, 2020, apply to this document and its use.

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