Nursing Home Workforce Stabilization Council
Meeting Minutes

Date Thursday, January 26, 2023, 1:00 P.M. – 4:00 P.M.

Location Virtual, Staff in Conference Room 1B, 333 S. Grand Ave, Lansing, MI 48933

Council Attendance

Name	*Representing*	*Attendance*
Alison Hirschel	Residents	Present
Dian Palmer	Workforce	Not Present
Mark Berger	Employers	Present
Nancy M. Hebert	Workforce	Present
Erica Holman	Employers	Present
Jannice L. Lamm	Employers	Present
Mary McClendon	Workforce	Not Present
Michael Munter	Employers	Not Present
Martha M. Nichols	Workforce	Present
Robert L. Norcross	Employers	Not Present
Jennifer Root	Workforce	Present
Terence Thomas	Residents	Present
Yvonne M. White	Advocates	Present
Salli Pung	Residents	Present

Michigan Department of Health and Human Services (MDHHS) Staff:
Farah Hanley, Nicole Hudson, Kate Tosto, Kenny Wirth, Sott Werner, Mark West, Scott Wamsley, Amy Epkey, Teressa Long, Mark West, Neila Sanders, Lauren Swanson, Erin Emmerson
Licensing and Regulatory Affairs (LARA) Staff:
Adam Sandoval, Jennifer Belden, Courtney Adams, Larry Horvath
Labor and Economic Opportunity (LEO) Staff:
Valerie Jemerson
Guests:
Lisa Cooper (AARP), David LaLumia (Area Agencies on Aging Association of Michigan), David Schneider (Health Management Associates), Clare Luz (IMPART Alliance)

Minutes: The Nursing Home Workforce Stabilization Council meeting was held virtually on January 26, 2023 with ten (10) council members in attendance. **Quorum was fulfilled.**

1. **Council Business**
   Presented by Farah Hanley and Kate Tosto
   A. Meeting called to order at 1:02 P.M.
   B. Welcome and Introductions
   C. Virtual Meeting Housekeeping

2. **Nursing Home Reimbursement Presentation**
   Presented by Scott Werner (with Teressa Long and Mark West), MDHHS
   A. Presentation

- Nursing home rate setting is very complex, presentation will be high level view of process.
- Michigan utilizes prospective, annually adjusted facility-specific cost reimbursement methodology – costs drive rates in this model.
    - Annual cost report submitted by every nursing facility for a reporting period that aligns with their fiscal year end to gather "cost information."
    - Filed data from annual cost report creates new "interim rate" that is updated and effective every October 1st.
- Providers given detailed guidance on Cost Report Requirements
- Each cost report includes itemized list of all expenses reported consistent with Medicare Principles of Reimbursement
- Annual Cost Reports contain proprietary data and are therefore not made public. Summary level data can be shared, but facility-specific data not publicly available.
- Rate Components
    - Variable Cost Component – includes nursing facility base and support costs incurred for routine nursing care.
        - On average, variable cost component represents ~87% of costs in Nursing Home
        - Base costs cover activities associate with direct patient care.
        - Support costs cover allowable activities not associated with direct patient care (e.g., housekeeping, maintenance, medical records, administrative costs, etc.)
    - Plant Cost Component
        - Major items include asset purchases, depreciation, interest expense, real estate and property taxes, etc.
        - Wide range in scale of component between facilities
    - Quality Assurance Supplement (QAS)
        - Monthly supplement determined by multiplying variable cost component by 21.76%
        - Statewide average is $46.34 per person, per day.
        - QAS can be applied to expenditures of facility's discretion.
- Michigan Nursing Home COVID Response
    - Nursing Facility Support Payments – additional $23.00 per day to facilities that experiences 5% or greater decline in census.
    - Nursing Facility Support Payments – supplemental payments to address economic impact of COVID response.
    - Direct Care Wage Increase – increased reimbursement to essential workers.
    - Mandated Testing Program – support provided to nursing facilities.
    - Regional Hub and Care & Recovery Center (CRC) strategy
    - MDHHS has collectively provided over $712 million in COVID relief funding to Nursing Homes throughout the pandemic in form of relief funds, direct care wage premiums, and COVID testing support.
- Audit Overview

    - Each cost report is audited by MDHHS to obtain assurances that filed cost report information is accurate and allowable for Medicaid reimbursement rates.
- Settlement Overview
    - Based on changes to "Final Audited Rate," Department will determine if an underpayment or overpayment occurred – called a "settlement."

B. Questions & Answers

- M. Berger – State of Michigan is cost-reimbursed and is attractive part of system in Michigan. Encourages those who want to spend money to spend and report it for a higher reimbursement. Those who don't want to spend money, won't be reimbursed for services not provided.
    - One struggle with reimbursement process in Michigan – if spend dollars in January, don't see reimbursement until October of following year.
    - Thinks we need to look at a combination of cost AND acuity in future.
    - How do we stabilize a workforce and build on that to give them career growth in an inflationary environment?
    - Argues that the current process works, but that because of COVID, 2020 cost reports were frozen. In 2020-2021 we were being reimbursed on 2019's costs. In 2022, cost reports are still frozen, but an agreement has been made with the state to go through FY22 and make a settlement in FY23 or FY24.
    - In our current environment where inflation is 15-20%, it is impossible to float the day-to-day operations and to consider what else we can do past the day-to-day when working off of a reimbursement that is based on 2019's cost report.
- F. Hanley – Lots of conversations going on regarding existing and new methodology for cost reporting. Have just started to explore what those new methodologies could look like and is happy to present on that when there is a better idea of what those could be.
- A. Hirschel – What would impact be of acuity-based reimbursement? Would there be winners and losers? Are there reasons that an acuity-based system might be better able to respond to the workforce crisis?
    - S. Werner – Patient Driven Payment Model (PDPM) being looked at and currently in use in many states. Focus is on care and acuity of the patients. If Michigan were to go to full PDPM, see significant changes. Acuity does not necessarily correlate to cost.
    - A. Hirschel – current payment model doesn't seem to reward good patient care or positive outcomes. Trying to figure out what the best road forward would be for a payment model that can address the current crisis and reward positive outcomes.

3. BREAK

4. **State Strategies Crosswalk Presentation**
Presented by Dr. Clare Luz, IMPART Alliance
A. Presentation
- Policy Recommendations Workgroup
- Leadership
  - Establish strong state leadership based on participation of all stakeholders.
  - Immediate goals: continue to support DCW Advisory Committee
  - Longer-term: establish working unit with staff and resources to implement strategies recommended by DCW Advisory Committee – partner w/ MDHHS
- Professionalization – Wages/Benefits
  - Prioritize standardized, higher wages/benefits for all DCWs as a mechanism for growing and stabilizing the DCW
  - Immediate goal: increase wage rate by $4.00 for most DCWs – ensure annual COLAs in general budget and yearly appropriation.
  - Longer-term: add health benefits, PTO, paid sick leave, overtime pay, other projections.
- Professionalization – Competency, Professional & Ethical Standards
  - Professionalize the DCW
  - Immediate: Establish standardized, state supported DCW Competency, Professional and Ethical Guidelines
  - Longer-term: Majority of employers/DCWs adhere to guidelines, establish DCW Professional Association
- Creating a Roadmap for Action
- Next Steps
  - Continuing to search recruitment and retention strategies in other states.
  - Complete draft of recommendations for each category, all goals, action items for goals.
  - Will present recommendations and action plans to MDHHS DCW Advisory Council.

B. Questions & Answers
- L. Swanson-Aprill: This workgroup will be meeting in two weeks to continue this work.
- L. Cooper: Stakeholders recognize critical shortage of reliable training for DCWs. Many possible solutions considered.
- J. Root: Who is participating other than stakeholders, are there actual Direct Care Workers at the table?
  - C. Luz: Not in this particular workgroup, but the DCW Advisory Committee, Professionalization Committee, the Credentialling Workgroup all have DCW representation. One recommendation is to develop a DCW professional association to increase DCWs

voice. The State supported competency guidelines that recently came out were from a special taskforce of all DCWs.

5. Council Discussion

A. Subgroups

- N. Hudson: proposes that Council form subgroups on topics of Council's choice to investigate issues further before next Council meeting. Each subgroup will need Council member to serve as leader to coordinate meetings.
  - Subgroups will not be staffed by MDHHS and will need to have less than 7 Council members participating at any one time to avoid forming a quorum outside of an official Council meeting.
- A. Hirschel: Does the Department have suggestions for what topics the workgroups might focus on?
- N. Hudson: Previous council discussion has included Staffing & Pay (Agency Staffing, Staffing Ratios, etc), Nurse Aid Training Program Lockouts to address gaps in training programs, State Crosswalk deep dive, Wages & Benefits (COIVD pay, Medicaid redistribution impacts, food assistance, childcare subsidies, etc.) are some high-level possible subgroups for the Council to consider for recommendation report due in December 2023.
- E. Holman: Notes she would be interested in chairing a group focused on Retention, Professional Development, and Mentoring.
- C. Luz: DCW Advisory Committee currently has a lot of work going on around professionalization and mentoring, perhaps this Council could join forces. We could have Erica or others join our work or be in good communication with each other.
- K. Wirth: As long as the subgroup has under 7 members or less of the Council on it, that subgroup may pull in any experts or professionals that they like, so Dr. Luz could join.
- Dr. Luz: And vice versa if anyone wants to join our work email me.
- S. Pung: There is an opportunity to add a group to focus on quality. Specifically, the impact this can have on the quality of care and the quality of their life living in NH settings. Would be willing to Chair this subgroup.
- N. Hudson: After the meeting MDHHS Staff will send a list of workgroups and Chairs and other Councilmembers can reach out to express interest and join.
- J. Root: Agrees there should be a subgroup on Wages and Benefits. I'm not sure she's the right one to lead it, but thinks it needs to exist. So please send out the list with the recommended subgroups so we can consider who should lead them.
- N. Hebert: Where do we find the DCW Guidelines for Competency that Dr. Luz mentioned?
- L. Swanson-Aprill: I can send them out to Nicole again to get them sent out.

- K. Wirth: We can get them sent out next week. Would that be a subgroup people would be interested in? Looking at the list and applying it to NH workers?
- L. Swanson-Aprill: We are already working on developing a vetting tool for the competencies so we may want to collaborate on that idea.
- K. Wirth: Maybe we can task a council member on being a liaison between this group and that group. Any volunteers?
- N. Hudson: List of subgroups will be sent to Council members for volunteering to lead and participate in subgroups.

B. Future Meeting Dates

- N. Hudson: If there are no topics the Council is interested in going over in February, we can cancel to allow the subgroups time to meet and dig in on that work during that time instead.
- J. Root: Support canceling the February meeting to give time for subgroup work.
- A. Hirschel: It would be helpful to understand what the expectation is of the subgroups. What will come out of them, what format the recommendations might be in, what timeline would this be, just so everybody is working on the same page. In the AG's Elder Abuse Task Force there were clear expectations and workload. It was a lot of work, but we were able to deliver on our deliverables.
- N. Hudson: Opportunity for Councilmembers to start working together to begin drafting recommendations that will go into the final report. Our thought was workgroups will allow time to dig into these topics. These groups will hopefully drive some building out of recommendations in a way the full-Council meetings aren't conducive to.
- K. Wirth: Adding that any recommendations that come out of the subgroups will need to come back to the full group for final vote.
- K. Tosto: One expectation is once subgroups form it would become a regular agenda item each month that we get reports back from each of the subgroups. This will help us monitor if we need to assist bringing in other experts to help with subgroup subject matter, but we also hope the councilmembers and chairs will bring in experts on their own.
- N. Hudson: We will email out the subgroup information requested. Another meeting date update, the March meeting needs to be rescheduled from March 23 to March 30. Is there preference if you would like to hold the meeting virtually or go back to hybrid meetings?
- T. Thomas & Y. White voiced the preference for joining virtually.
- Y. White: Once the workgroups are formed, could you post the meeting dates so if we have time we can listen in and hear with other work groups are discussing?
- N. Hudson: We can send that information around via email. We can plan for a hybrid meeting in late March and monitor the weather and consider moving it to fully virtual if needed.

***6.* Public Comment**
Public comment facilitated by Kenny Wirth

None.

7. Adjourn
Meeting adjourned at 3:33 pm.

Next meeting scheduled for March 30, 2023 at 1:00pm. Virtual meeting.