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Family Care Direct Care Funding (Health Services -- Medical Assistance)

[LFB 2019-21 Budget Summary: Page 179, #23]

CURRENT LAW

MA Long-Term Care Programs. There are two statewide programs that provide eligible elderly and disabled adult Medicaid recipients comprehensive long-term care services that are not otherwise available as MA card services. Under the state's self-directed fee-for-service program, IRIS (Include, Respect, I Self-Direct), individuals direct their long-term care supports and services through management of a designated budget amount. Under Family Care, managed care organizations (MCOs) receive monthly capitated payments from the Department of Health Services (DHS) to pay for long-term care services, based on individualized care plans that are designed to meet the needs of each enrollee.

Alternatively, adults in some counties have access to two additional, fully-integrated managed care programs, the Program of All-Inclusive Care for the Elderly (PACE) and the Family Care Partnership (Partnership) program.

In order to receive MA funded long-term care in Wisconsin an individual must be over the age of 65, or an adult with a developmental or physical disability, in addition to meeting both financial and non-financial eligibility criteria. As of January 1, 2019, there were 48,797 people enrolled in Family Care, 3,524 people enrolled in Partnership, and 570 people enrolled in PACE.

An individual must enroll in an MCO to receive the Family Care benefit. Enrollees have access to a broad range of services, including home and community based services, and nursing home services. In addition to long-term care services, card services that may be provided through the MCO include, but are not limited to: care provided by nursing homes, home health services, personal care services, medical supplies, physical therapy, and transportation services. Acute care services, such as physician and hospital services, are not included in the Family Care benefit.

In some counties, individuals may enroll in an MCO to receive PACE or Partnership

services. Partnership differs from Family Care in that the program is fully-integrated and therefore provides primary and acute health care, as well as long-term care services to elderly individuals and individuals with disabilities. PACE is also a fully-integrated program. However, PACE requires that eligible individuals be 55 or older in order to enroll in the program. Table 1 shows the counties in which PACE and Partnership are available.

TABLE 1

Counties Offering Partnership and PACE

Partnership Counties		PACE Counties
Calumet	Ozaukee	Milwaukee
Columbia	Racine	Racine
Dane	Sauk	Waukesha
Dodge	Washington	
Kenosha	Waukesha	
Milwaukee	Waupaca	
Outagamie		

DHS makes capitation payments to MCOs, which are funded from a combination of GPR, federal MA matching funds, and county contributions. Capitation rates are set on a calendar year basis. Two different capitation rates are paid to each Family Care MCO: a nursing home rate, for enrollees that meet the nursing home level of care standard, and a non-nursing home rate, for enrollees that need a lower level of care.

A nursing home level of care is defined as a long-term or irreversible condition, expected to last at least 90 days or result in death within one year of the date of application, and requires ongoing care, assistance, or supervision. A non-nursing home level of care is defined as a condition that is expected to last at least 90 days or result in death within 12 months after the date of application, and he or she is at risk of losing his or her independence or functional capacity unless he or she receives assistance from others.

In 2019, the monthly capitation rates for Family Care enrollees requiring a nursing home level of care ranged from $2,537.12 to $4,284.72 and from $478.46 to $538.57 for enrollees requiring a non-nursing home level of care. PACE and Partnership MCOs only serve individuals who need a nursing home level of care. In 2019, the monthly capitation rates for PACE and Partnership enrollees ranged from $2,931.68 to $5,643.21.

The capitation payments DHS makes to MCOs represent the average cost calculated across all members of each respective MCO in each geographic service area. These average costs reflect the case mix risk based on an individual's level of functional eligibility, labor costs, and administrative costs. Capitation rates differ by MCO to reflect differences in acuity of people served by each MCO.

Direct Care Supplements to Capitation Payments. 2017 Wisconsin Act 59 provided $60,731,800 ($25,000,000 GPR and $35,731,800 FED) to increase the payments DHS made to MCOs in the 2017-19 biennium in an effort to address the direct care workforce shortage. This funding was budgeted and administered as supplements, separate from the MA capitation payments MCOs received. As a condition of receiving the supplements, DHS required MCOs to pass additional funding on to providers, who in turn passed the funding on to certain direct care workers in the form of wage increases, bonuses, and additional paid time off, and to fund employer payroll tax increases that result from increasing direct care workers' wages.

As in past budgets, Act 59 provided, as part of the MA base reestimate, funding increases to ensure that DHS could establish and pay actuarially sound capitation payments to long-term care MCOs in the 2017-19 biennium.

GOVERNOR

Increase funding for Medicaid benefits by $14,763,800 ($6,000,000 GPR and $8,763,800 FED) in 2019-20 and $14,760,100 ($6,000,000 GPR and $8,760,100 FED) in 2020-21 to increase the supplemental payments DHS makes to MCOs in recognition of the workforce challenges facing the state.

The following table shows the total funding that would be budgeted for the direct care funding supplements in the bill, including: (a) the funding that would be provided under the MA cost-to-continue item; and (b) this item.

Family Care Direct Care Reimbursement
Governor's Bill

	2019-20			2020-21		
	GPR	FED	Total	GPR	FED	Total
2017-19 Increase (Part of MA Cost-to-Continue)	$12,500,000	$18,257,900	$30,757,900	$12,500,000	$18,257,900	$30,757,900
2019-21 Increase	6,000,000	8,763,800	14,763,800	6,000,000	8,760,100	14,760,100
Total	$18,500,000	$27,021,700	$45,521,700	$18,500,000	$27,018,000	$45,518,000

Under the bill, approximately $2,207 million ($837 million GPR, $60 million PR, and $1,310 million FED) in 2019-20 and $2,323 million ($880 million GPR, $59 million PR, and $1,383 million FED) in 2020-21 would be budgeted for managed long-term care services through the Family Care, PACE, and Partnership programs. Of this total, approximately $30.8 million ($12.5 million GPR and $18.3 million FED) would be budgeted annually for DHS to make supplemental direct care payments to MCOs (excluding the funding increase discussed in this item).

DISCUSSION POINTS

1. In April, 2016, the federal Centers for Medicare and Medicaid Services (CMS) issued final regulations relating to MA-funded managed care. CMS specified that capitation rates must be actuarially sound and in its commentary on the regulations, CMS reasoned that in order for capitation rates to be actuarially sound, as required by federal law, the rates must cover all reasonable, appropriate and attainable costs of providing services under the contract, including associated administrative costs. Consequently, CMS concluded that additional supplemental payments to providers that are not directly related to service delivery are not permissible.

2. Under these regulations, CMS does not allow for a direct care wage pass through. This means that modifications to the rate methodology used to establish capitation payments cannot be constructed to ensure that annual payments to a specific category of providers increase by a defined amount of funding. However, with prior approval from CMS, DHS can provide a uniform dollar or percentage increase for network providers that provide a particular service or services.

3. In response to concerns regarding workforce availability and reimbursement rates for direct care work, Act 59 included $60,731,800 ($25,000,000 GPR and $35,731,800 FED) in addition to the funding provided for capitation payments. Act 59 required DHS to work with the MCOs and CMS to develop an allowable payment mechanism, using the additional funding, to increase the direct care and services portion of the capitation rates in recognition of the direct caregiver workforce challenges facing the state.

4. As such, DHS worked with the MCOs, providers, associations, and advocates between December, 2017, and February, 2018, to develop the direct care workforce funding supplement. The proposal was subsequently approved by CMS.

5. For purposes of administering the supplement, a direct care worker is defined as an employee who contracts with, or is an employee of, an entity that contracts with an MCO to provide: (a) adult day care services; (b) daily living skills training; (c) habilitation services; (d) residential care (adult family homes of 1 or 2 beds, adult family homes of 3 or 4 beds, community-based residential facilities, residential care apartment complexes); (e) respite services provided outside of a nursing home; or (f) supportive home care.

6. Additionally, a direct care worker provides one or more of the following services through direct interaction with members: (a) assisting with activities of daily living or instrumental activities of daily living; (b) administering medications; (c) providing personal care or treatments; (d) conducting activity programming; or (e) providing services such as food service, housekeeping, or transportation.

7. DHS calculates the amount of funding available by determining the specific quarterly amount each provider is eligible to receive. The quarterly amount is calculated by dividing the total funds into four quarterly amounts, one for each quarter of calendar year 2018. Next, DHS divides the amount for each quarter by the total MCO payments to direct care providers for the quarter, in order to determine the percentage increase all direct care providers will receive. Finally, DHS multiplies the percentage increase by the payments each provider received during that quarter from the MCO it

contracts with. The result is the payment amount to each provider.

8. Once DHS has calculated the amount each provider should receive, DHS pays the MCO the determined amount. The MCOs are then contractually obligated to pay providers the entire direct care workforce payment received from DHS. Subsequently, providers receive payment from each MCO contracted with during the quarter. Providers then pay their direct care workers using the entire direct care workforce funding received from MCOs.

9. Providers may use this funding to: provide wage increases, bonuses, and additional paid time off to direct care workers. Additionally, providers may pay for employer payroll tax increases that result from increasing workers' wages. Other uses of the funding are not allowed.

10. Funding is provided to the MCOs and subsequently to providers as outlined in Table 2. The final payment does not cover a set range of service dates but rather is a final payment to redistribute any funds MCOs return to DHS because providers chose not to participate.

TABLE 2

Family Care Direct Care Workforce Funding Initiative Distribution Schedule

Quarterly Payment	Made to MCO	Dates of Service	Deadline for MCOs to Pay Providers
Quarter 1	June 29, 2018	January 1–March 31, 2018	August 15, 2018
Quarter 2	September 28, 2018	April 1–June 30, 2018	October 31, 2018
Quarter 3	December 21, 2018	July 1–September 30, 2018	February 15, 2019
Quarter 4	June 28, 2019	October 1–December 31, 2018	July 31, 2019
Final	December 20, 2019		January 31, 2020

11. Providers may choose which direct care workers receive the funding, as long as the direct care worker has provided services to a Family Care and Family Care Partnership member in Wisconsin. Any direct care worker that provided services to a Family Care and Family Care Partnership member in Wisconsin may receive the funding.

12. Preliminary feedback received by DHS shows that during the second funding quarter, 52% of providers spent the additional funding on staff bonuses, 34% provided their staff with wage increases, 9% provided employee time off, and 5% spent the funds on employer payroll taxes resulting from direct care workforce payments.

13. Results of the second quarter direct care workforce funding provider survey indicate that overall, 41% of participating providers believe the direct care workforce funds have had a significant positive impact on their ability to recruit and retain workers and another 44% believe the funds have had some positive impact. 63% of participating providers reported that they could point to one or more instances in which the funding had a direct impact on their ability to recruit and retain direct care staff.

14. The main concern expressed to DHS is about the time-limited nature of the funds, which makes it difficult for MCOs and providers to commit to providing ongoing funding and wage increases that may be unfunded in future years. Since the amounts paid out for the 2017-19 initiative are not incorporated into the calculations for capitation payments in future years, funding is only available if the supplemental funding remains in the MA cost-to-continue item.

15. The Governor's budget bill would continue the funding provided for the initiative in 2017-19 and provide an additional $14,763,800 ($6,000,000 GPR and $8,763,800 FED) in 2019-20 and $14,760,100 ($6,000,000 GPR and $8,760,100 FED) in 2020-21.

16. DHS indicates that if funding for the direct care supplement is approved, the Department would distribute the allocated funds for 2019-21 in a substantially similar manner to the way it distributed the supplemental funding in the 2017-19 biennium. However, DHS would seek feedback from MCOs and providers before finalizing the payment mechanism.

17. A 2018 survey of long-term care providers found that: more than 50% of providers indicated they were unable to compete with other employers; 54% had no applicants for vacant caregiver positions; 83% indicated that there were no qualified applicants for caregiver openings; and 25% denied admissions to their facilities due to the lack of caregivers. This survey included skilled nursing facilities, which were not eligible for funding under the Act 59 supplemental funds, and would not be eligible for the 2019-21 funding if those funds are distributed according to the same criteria. However, the Governor's budget bill includes a separate reimbursement rate increase for direct care performed in skilled nursing facilities.

18. In response to the ongoing workforce shortage and the initial positive feedback from providers who indicate that the funding provided in the 2017-19 budget had a positive impact on their ability to recruit and retain workers, the Committee could approve the Governor's recommendation to increase funding for the direct care supplement [Alternative 1]. Based on the GPR funding increase in the bill and revised estimates of the federal medical assistance percentage (FMAP) applicable for 2020-21, it is estimated that an additional $73,000 FED would be available to fund the direct care supplement in 2020-21. These additional federal matching funds have been incorporated into the alternatives before the Committee.

19. On the other hand, in light of the positive feedback provided by providers and the ongoing workforce shortage, the Committee could determine that the funding increase in the bill is insufficient. Consequently, the Committee could increase the GPR funding that would be provided for the supplement in the bill by $3,000,000 GPR annually. Under this alternative, total funding would be $22,145,700 ($9,000,000 GPR and $13,145,700 FED) in 2019-20 and $22,249,700 ($9,000,000 GPR and $13,249,700 FED) in 2020-21 [Alternative 2]. Alternatively, the Committee could double the GPR funding that would be budgeted in the bill by providing $29,527,600 ($12,000,000 GPR and $17,527,600 FED) in 2019-20 and $29,666,300 ($12,000,000 GPR and $17,666,300 FED) in 2020-21 [Alternative 3].

20. Alternatively, the Committee may determine that, based on other GPR priorities, it is not necessary to increase the amount of base funding that would be provided to fund the direct care supplement in the 2019-21 biennium. Consequently, the funding increase in the bill could be deleted

(-$30,757,900 in 2019-20 and -$30,752,000 in 2020-21) [Alternative 4].

ALTERNATIVES

1. Approve the Governor's recommendation, as modified to provide an additional $73,000 FED in 2020-21 to reflect a reestimate of federal matching funds to support the direct care supplement.

ALT 1	Change to Base	Change to Bill
GPR	$12,000,000	$0
FED	17,596,900	73,000
Total	$29,596,900	$73,000

2. Increase funding in the bill by $7,381,900 ($3,000,000 GPR and $4,381,900 FED) in 2019-20 and by $7,489,600 ($3,000,000 GPR and $4,489,600 FED) in 2020-21 to support the direct care supplement.

ALT 2	Change to Base	Change to Bill
GPR	$18,000,000	$6,000,000
FED	26,395,400	8,871,500
Total	$44,395,400	$14,871,500

3. Increase funding in the bill by $14,763,800 ($6,000,000 GPR and $8,763,800 FED) in 2019-20 and $14,906,200 ($6,000,000 GPR and $8,906,200 FED) in 2020-21 to double the funding that would be provided in the bill.

ALT 3	Change to Base	Change to Bill
GPR	$24,000,000	$12,000,000
FED	35,193,900	17,670,000
Total	$59,193,900	$29,670,000

4. Take no action.

ALT 4	Change to Base	Change to Bill
GPR	$0	- $12,000,000
FED	0	- 17,523,900
Total	$0	- $29,523,900

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