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Medical Assistance -- Long-Term Care
(Health Services --Medical Assistance -- Long-Term Care)

[LFB 2023-25 Budget Summary: Page 258, #1, 2, and 3]

CURRENT LAW

Elderly, Blind, and Disabled (EBD) Medical Assistance (MA) Coverage. Wisconsin residents who are aged 65 or older, blind, or disabled, and meet income and asset thresholds may be eligible for MA coverage. These individuals are eligible to receive acute care and long-term care services covered under the MA state plan ("card services"), such as hospital, personal care, and nursing home services.

HCBS Waiver Programs. In addition to receiving MA card services, individuals enrolled in EBD Medicaid may be eligible for certain other long-term care services, based on the results of a long-term care functional screen. These other services are available only under the state's home and community based services (HCBS) waiver 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 based on the enrollee's individualized care plans.

Under Family Care, the MA program makes monthly capitation payments to managed care organizations (MCOs), which the MCOs use to pay long-term care providers that serve their enrollees. MCOs pay for services included in enrollees' individualized care plans, which are intended to meet the individualized needs of each enrollee.

Family Care enrollees have access to a broad range of services, including services provided by assisted living facilities, other home and community based services, and nursing home services.

In addition to long-term care services, services that may be provided through the MCO include, but are not limited to: home health services, personal care services, medical supplies, physical therapy, and transportation services. Acute care services, such as physician and hospital services, are not covered under Family Care.

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

Enhanced FMAP for HCBS. The American Rescue Plan Act (ARPA) included federal incentives for states to improve their HCBS programs. Under ARPA, states received a 10.0 percentage point increase in the FMAP for base HCBS expenditures during a 12-month period from April 1, 2021, to March 31, 2022. Initially, states were required to spend the state funds savings resulting from the enhanced federal matching funds to improve HCBS programs over a two-year period, from April 1, 2022, through March 31, 2024. However, the deadline was subsequently extended to March 31, 2025.

Each state was required to submit an expenditure plan to the federal Centers for Medicare and Medicaid (CMS) that identified improvements the state intended to make to its HCBS programs. In its submission DHS anticipated claiming an additional $353 million in enhanced federal matching funds for HCBS expenditures during the period from April 1, 2021, to March 31, 2022. Overall, the Department estimated that the reinvestment plan would total approximately $701 million, since an estimated additional $348 million in federal funds would be claimed on any of the $353 million spent on Medicaid eligible activities (both benefit and administrative activities).

Under Wisconsin's expenditure plan, which was approved by CMS, the Department anticipated six areas of spending: (a) Medicaid HCBS workforce, provider capacity, and fiscal stability; (b) promoting quality and innovation resources; (c) tribal long-term care systems; (d) independent living and family/informal caregiver resources; (e) access to HCBS information and services; and (f) assisted living information, analysis, and quality oversight. Of these categories, this paper discusses items in AB 43/SB 70 relating to long-term care provider rate increases, including Family Care direct care reimbursement.

DISCUSSION POINTS

1. DHS estimates that between 2010 and 2040, the percentage of people in Wisconsin ages 65 and older will increase from 13.7% to 23.7% and the percentage of Wisconsin residents ages 85 and older will increase from 2.1% to 4.4% of the state's total population.

2. The 2022 Long-Term Care Workforce Crisis Report, co-authored by the Disability Service Provider Network, Leading Age Wisconsin, Wisconsin Assisted Living Association, and Wisconsin Health Care Association/Wisconsin Center for Assisted Living, noted that the vacancy

rates for certified nurse aides (CNAs) and direct care workers was 28.4%, which was significantly higher than rates for other healthcare sector jobs and the overall labor market. According to the report "18,482 individuals sought treatment from a long-term care provider but were denied or delayed services due to a lack of staff. Respondents report significantly increasing wages, but still being challenged by having no applicants for open positions, no-call no-shows to interviews and shifts, and an inability to compete with non-healthcare providers."

3. Further, the report indicated that publicly funded programs, including Medicare and Medicaid (Family Care), are not responsive to the rapidly changing economic environment, and do not enable providers to increase employee wages and benefits to keep up with general price increases. The report also noted that long-term care providers are unable to provide the same benefits to their employees as private industries, due to low Medicaid and Medicare reimbursement rates.

ARPA HCBS Rate Increase Continuation

4. Under Family Care, DHS makes capitation payments to MCOs, which are funded from a combination of GPR, federal MA matching funds, and, to a much smaller extent, county contributions. DHS sets capitation rates on a calendar year basis. 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 the acuity of people served by each MCO.

5. In return for those capitation payments, the MCO, through its provider network, delivers covered services to its MA enrollees. Each MCO may negotiate the rates it pays to the providers with which it contracts. Except for payments to nursing homes, if the MCO can negotiate such agreements with providers, the MCO may pay providers less than Medicaid fee-for-service rates. Generally, the MCO is not permitted to pay itself or its providers more than the Medicaid fee-for-service rates for Medicaid covered services in the benefit package except when the MCO determines on an individualized basis, that it is unable or impractical to otherwise obtain the service.

6. To administer IRIS, DHS contracts with six IRIS consultant agencies (ICAs) and four fiscal employment agencies (FEAs). The ICAs are responsible for assisting individuals in developing an individualized support and service plan. The services included in the plan must: remain within the individual's approved budget, be allowable under the federal Medicaid waiver, and ensure the individual will be healthy and safe. The FEA ensures that all services are paid according to an individual's plan and assists enrollees in managing all fiscal requirements, such as paying providers and ensuring that employment and tax regulations are met. IRIS enrollees receive an annual budget, based on their functional needs and a comparison to people with similar needs in the managed care programs, as well as the historical service cost of other people with similar needs in IRIS. The individual then develops an individual support plan. Once the plan is reviewed and approved by the ICA, the person uses funds from their individual budget to purchase the services included in the plan.

7. The Department's CMS-approved HCBS ARPA expenditure plan included a 5% rate increase for certain HCBS. The Appendix shows the 42 service categories currently subject to the increase. The increase took effect on January 1, 2022 for most eligible programs, including Family Care. For others, such as IRIS, the increase took effect on January 9, 2022.

8. In order to ensure distribution of these funds to the providers, the DHS and MCO contracts for 2022 and 2023, included provisions requiring the MCOs to provide a unit rate increase to all eligible providers equal to 5% of each eligible provider's rates for Family Care covered services effective January 1, 2022, and to retain the increase for 2023 provider rates. For Medicaid fee-for-service and the Children's Long-Term Support program, DHS updated the fee schedules for all eligible services starting January 1, 2022.

9. This portion of the Department's ARPA expenditure plan was approved by the Joint Committee on Finance, with the condition that the rate increases would be funded with ARPA HCBS reinvestment funding through March 31, 2024, and that subsequently the Committee would consider whether these rate increases should be maintained after March 31, 2024, as part of its 2023-25 budget deliberations.

10. In its submission to the Committee, the Department notes that "HCBS are shown to be a cost effective alternative to higher cost institutional services, such as nursing home placements and hospital services. Providers need adequate reimbursement to recruit staff and maintain this important system that delivers such critical care. Like all health care and long-term care providers, HCBS providers have faced increasing challenges to recruit and retain qualified staff and maintain access for members." Although providers have flexibility in how they use the additional funds, the provision of long-term care services is labor intensive. Survey responses solicited from the Wisconsin Personal Care Services Association (WPSA) indicated that 83% of WPSA agencies report using the 5% rate increase to provide permanent raises to their staff.

11. Based on updated enrollment and expenditure assumptions, and prior Committee action, the estimated costs of maintaining the 5% rate increases after March 31, 2024, would be $43,707,300 ($17,194,500 GPR and $26,512,800 FED) in 2023-24 and $181,951,800 ($71,525,000 GPR and $110,426,800 FED) in 2024-25. In light of the workforce challenges facing the state, and especially long-term care providers, the Committee could maintain the rate increases for these services. [Alternative A1]

12. Alternatively, the Committee could determine that it is unnecessary to maintain the rate increases for all of the services listed in the appendix, and that provider rate increases should instead be targeted to fewer services, or programs, including the other items addressed in this paper (the direct care workforce funding supplement and personal care services) where there may be a greater need to ensure access to services. For this reason, the Committee could choose not to provide funding to make these rate increases permanent, and the current MA rates for these services would be reduced by 5%, effective April 1, 2024. [Alternative A2]

Direct Care Workforce Funding Initiative

13. 2017 Wisconsin Act 59 (the 2017-19 budget act) directed DHS to collaborate with MCOs and CMS to develop and implement an allowable payment mechanism to increase the direct care and services portion of Family Care capitation rates to address the direct caregiver workforce challenges of the state. Beginning in 2017-18, the Act provided $12.5 million GPR annually, in addition to federal matching funds the Department claimed, for this purpose. Subsequently, funding budgeted for the initiative was increased as part of the 2019-21 and 2021-23 biennial budget acts. As

such current GPR funding for the supplement is $47.5 million GPR annually, in addition to federal matching funds the Department claims for this purpose.

14. Since that time, DHS has administered the program as a matter of policy. For purposes of administering the supplement, DHS defines a "direct care worker" 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 one or two beds, adult family homes of three or four beds, community- based residential facilities, residential care apartment complexes); (e) respite services provided outside of a nursing home; (f) supportive home care; or (g) supported employment service providers.

15. Additionally, DHS defines a direct care worker as a worker that provides one or more of the following services through direct interaction with enrollees: (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.

16. DHS calculates the amount of funding available to each direct care provider by dividing the amount for each payment by the total MCO payments to direct care providers, 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 from the MCO with which it contracts. The result is the payment amount to each provider.

17. However, since participation is voluntary, some providers may decline the funding. Payment amounts fluctuate, based on the available pool of funding for each payment. Redistribution payment amounts are significantly less than other payment amounts since this funding pool is limited to ineligible and declined funding from the original payment pool. For 2021-23, eligible providers received four rounds of payments (one in calendar year 2021, two in calendar year 2022, and one in calendar year 2023), as well as two rounds of redistributive funding composed of unspent funds from calendar year 2021 and 2022. The Department estimates that, in the 2021-23 biennium, it will provide $272.2 million (all funds) under the program.

18. 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 with which they contract during the covered time period. Providers then pay their direct care workers using the entire direct care workforce funding received from the MCOs. Providers have six months to distribute each payment to workers and may claim expenditures made in the prior 12 months as appropriate uses of the direct care workforce funding.

19. 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. Some allowable COVID-19 direct care workforce expenses include, but are not limited to, additional paid time off, hazard pay, increased overtime, and increased weekend and night differentials. Other uses of the funding are not allowed.

20. Providers may choose which direct care workers receive the funding, as long as the direct care worker has provided services to a Family Care or Partnership participant in Wisconsin. Any direct care worker, as previously defined, that provided services to a Family Care or Partnership participant in Wisconsin may receive the funding.

21. Funding provided for the direct care workforce funding supplement is separate from funding provided for capitation rates as part of the MA base reestimate, to ensure that DHS establishes and pays actuarially sound capitation payments to MCOs, as required under federal law.

22. Calendar year 2023 survey data shows that of reported funds, providers spent the majority (49.4%) on wage increases, followed by retention bonuses (14.6%), and performance bonuses (12.8%). Other reported uses included COVID-19 related expenses, paid time off, payroll taxes, as well as sign on and referral bonuses. Further 51.6% of providers reported three or more instances of staff retention due to the direct care workforce funding supplement and 93.7% reported an overall positive impact (24.5% reported some positive impact and 69.2% reported significant positive impact).

23. As amended, by prior Committee action and updated assumptions regarding the FMAP, the Committee could provide the same GPR funding increase as would be provided under AB 43/SB 70, $15.0 million per year. As such, this alternative would provide an additional $38,981,300 ($15,000,000 GPR and $23,981,300 FED) in 2023-24 and $38,158,200 ($15,000,000 GPR and $23,158,200 FED) in 2024-25. In light of long-term care workforce challenges and positive feedback from providers, especially relating to workforce retention, the Committee could provide additional funds to increase the available supplement in 2023-25. [Alternative B1]

24. Alternatively, the Committee could provide $12,993,800 ($5,000,000 GPR and $7,993,800 FED) in 2023-24 and $25,438,800 ($10,000,000 GPR and $15,438,800 FED) in 2024-25 to increase the direct care and services portion of the capitation rates the Department provides to MCOs to fund long-term care services for individuals enrolled in Family Care. [Alternative B2]

25. As available funding for Family Care providers has grown in each biennium since the supplement's creation in 2017 Act 59, the Committee may determine that it is timely to increase funding for direct care workers that provide services to individuals enrolled in IRIS, as well. Currently, providers who perform the same services for IRIS participants that are eligible for recognition if performed for a Family Care participant are not eligible for recognition under the supplemental program. As such, the Committee could provide $38,981,300 ($15,000,000 GPR and $23,981,300 FED) in 2023-24 and $38,158,200 ($15,000,000 GPR and $23,158,200 FED) in 2024-25 and direct the Department to establish a payment mechanism in collaboration with the IRIS fiscal employer agents and CMS to distribute this funding to individuals performing direct care to IRIS participants. This alternative could be selected either instead of, or in addition to, Alternative C1. [Alternative B3]

26. Since there is significant overlap between the service categories that have been eligible for the previously discussed 5% rate increase and the service categories eligible for payments under the supplement, the Committee could take no action on this item and retain base funding for the direct care workforce funding initiative. [Alternative B4]

Personal Care

27. Under the state's MA program, personal care services are defined as medically-oriented activities that assist MA beneficiaries with activities of daily living that are necessary to maintain the individual in his or her place of residence in the community. Personal care services can include a range of services provided to persons with disabilities and chronic conditions that enable them to accomplish activities of daily living, such as eating, bathing, and dressing, as well as other activities that permit an individual to live independently, including meal preparation, light housework, and shopping for food and clothing. As an MA card service, personal care services are available to all MA beneficiaries.

28. Personal care services can be paid either on a fee-for-service basis as a state plan benefit or through one of the state's long-term care programs. For Family Care participants needing personal care services, such services are part of the enrollees' care plans and thus paid by the managed care organization. As previously discussed, Family Care MCOs are generally required to pay the MA fee-for-service rate or less for state plan services, unless the MCO determines, on an individualized basis, that the MCO is unable to acquire the service at the fee-for-service rate. Under IRIS, participants that need personal care services can receive them either through MA-certified providers, in which case the agency receives the fee-for-service rate, or by self-directing their personal care services. If the participant chooses to self-direct his or her personal care services, he or she can hire, train, and oversee their own personal care workers. As of January 1, 2023, the MA rate for personal care services is $5.86 per 15 minute increment billed, or $23.44 an hour.

29. Often, personal care workers are employed by a personal care agency. There are currently 299 personal care agencies certified by the DHS Division of Quality Assurance. The hourly Medicaid personal care reimbursement rate of $23.44 is paid to personal care agencies to fund all of their costs associated with providing care for Medicaid participants, including wages and benefits for personal care workers; the agencies' other direct care costs, such as nursing staff, supervisors, and travel costs; and indirect costs, such as office operations and insurance costs.

30. AB 43/SB 70 would provide $15.0 million GPR annually and associated federal matching funds to increase MA personal care rates. Based on the Committee's previous action and updated assumption regarding the FMAP, it is estimated that $38,981,300 ($15,000,000 GPR and $23,981,300 FED) in 2023-24 and $38,158,200 ($15,000,000 GPR and $23,158,200 FED) would be available to support personal care rate increases. If the Committee takes no action on Alternative A, this funding would equate to an approximately 6.5% increase for MA personal care rates effective July 1, 2023. However, the Administration indicates that the funding increase in the bill is not intended to provide a specific percentage or dollar increase to the MA personal care reimbursement rate, as such distribution of the funds would be determined by the Department upon enactment of the budget.

31. According to the Wisconsin Personal Services Association (WPSA) 2023 member survey, 44% of respondents have five or more open caregiver positions each week, which affects patients' access to care. In addition, 85% of respondents indicated that they turned away a client in the past year due to a lack of workers and 51% of respondents turned away five or more people in need of care each month. Further, WPSA survey data found that two-thirds of agencies are considering

downsizing, one-third of agencies are considering no longer providing personal care services to Medicaid recipients, and 30% of agencies are considering closing.

32. In recognition of the financial difficulties currently facing personal care agencies, the Committee could provide $38,981,300 ($15,000,000 GPR and $23,981,300 FED) in 2023-24 and $38,158,200 ($15,000,000 GPR and $23,158,200 FED) in 2024-25 to increase MA personal care reimbursement rates, with the intent that any increase be applied to personal care provided on a fee-for-service and managed care basis, as well as for personal care services provided to IRIS participants, including self-directed IRIS personal care services. [Alternative C1]

33. Following the enactment of previous budgets, the Department has indicated that due to federal requirements relating to public notice and Family Care contracts running on a calendar year basis, it is difficult to implement a rate increase with an effective date sooner than January 1, of the upcoming year. As such the Committee could choose to redistribute the funding in the bill to reflect a January 1, 2024, implementation date. Under this alternative the Committee could provide $25,987,500 ($10,000,000 GPR and $15,987,500 FED) in 2023-24 and $50,877,600 ($20,000,000 GPR and $30,877,600 FED) in 2024-25 to increase MA personal care reimbursement rates, as of January 1, 2024. If the Committee take no action on Alternative A, this funding would equate to an approximately 8.6% increase for MA personal care rates effective January 1, 2024. However, the actual rate increase may differ upon implementation. As with other alternatives, the intent would be that any increase be applied to personal care provided on a fee-for-service and managed care basis, as well as for personal care services provided to IRIS participants, including self-directed IRIS personal care services. [Alternative C2]

34. On the other hand, since personal care agencies are among the providers that have benefited from the ARPA HCBS 5% rate increase, the Committee could provide a smaller rate increase. As such, under this alternative the Committee could provide $12,993,800 ($5,000,000 GPR and $7,993,800 FED) in 2023-24 and $25,438,800 ($10,000,000 GPR and $15,438,800 FED) in 2024-25 to increase MA personal care reimbursement rates. If the Committee takes no action on Alternative A, this funding would equate to an approximately 4.3% increase for MA personal care rates effective January 1, 2024. However, the actual rate increase may differ upon implementation. As with other alternatives, the intent would be that any increase be applied to personal care provided on a fee-for-service and managed care basis, as well as for personal care services provided to IRIS participants, including self-directed IRIS personal care services. [Alternative C3]

35. Finally, the Committee could take no action on this item since rate increases for personal care services have been considered as part of the Committee's deliberations relating to long-term care rate increases under Alternative A. [Alternative C4]

ALTERNATIVES

A. ARPA HCBS Rate Increase Continuation

1. Provide $43,707,300 ($17,194,500 GPR and $26,512,800 FED) in 2023-24 and $181,951,800 ($71,525,000 GPR and $110,426,800 FED) in 2024-25 to fund costs associated with

continuing the ARPA HCBS 5% rate increase from April 1, 2024, through June 30, 2025.

ALT A1	Change to Base
GPR	$88,719,500
FED	136,939,600
Total	$225,659,100

2. Take no action.

B. Direct Care Workforce Funding Initiative

1. Provide $38,981,300 ($15,000,000 GPR and $23,981,300 FED) in 2023-24 and $38,158,200 ($15,000,000 GPR and $23,158,200 FED) in 2024-25 to increase the direct care and services portion of the capitation rates the Department provides to MCOs to fund long-term care services for individuals enrolled in Family Care.

ALT B1	Change to Base
GPR	$30,000,000
FED	47,139,500
Total	$77,139,500

2. Provide $12,993,800 ($5,000,000 GPR and $7,993,800 FED) in 2023-24 and $25,438,800 ($10,000,000 GPR and $15,438,800 FED) in 2024-25 to increase the direct care and services portion of the capitation rates the Department provides to MCOs to fund long-term care services for individuals enrolled in Family Care.

ALT B2	Change to Base
GPR	$15,000,000
FED	23,432,600
Total	$38,432,600

3. Provide $38,981,300 ($15,000,000 GPR and $23,981,300 FED) in 2023-24 and $38,158,200 ($15,000,000 GPR and $23,158,200 FED) in 2024-25 and direct the Department to establish a payment mechanism in collaboration with the IRIS Fiscal Employer Agents and CMS to distribute this funding to individuals performing direct care to IRIS participants.

ALT B3	Change to Base
GPR	$30,000,000
FED	47,139,500
Total	$77,139,500

4. Take no action.

C. Personal Care

1. Provide $38,981,300 ($15,000,000 GPR and $23,981,300 FED) in 2023-24 and $38,158,200 ($15,000,000 GPR and $23,158,200 FED) in 2024-25 to increase MA personal care reimbursement rates.

ALT C1	Change to Base
GPR	$30,000,000
FED	47,139,500
Total	$77,139,500

2. Provide $25,987,500 ($10,000,000 GPR and $15,987,500 FED) in 2023-24 and $50,877,600 ($20,000,000 GPR and $30,877,600 FED) in 2024-25 to increase MA personal care reimbursement rates.

ALT C2	Change to Base
GPR	$30,000,000
FED	46,865,100
Total	$76,865,100

3. Provide $12,993,800 ($5,000,000 GPR and $7,993,800 FED) in 2023-24 and $25,438,800 ($10,000,000 GPR and $15,438,800 FED) in 2024-25 to increase MA personal care reimbursement rates.

ALT C3	Change to Base
GPR	$15,000,000
FED	23,432,600
Total	$38,432,600

4. Take no action.

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Attachment

APPENDIX

Medicaid Services Eligible for 5% Rate Increase

Adult day care service
Alcohol and other drug abuse (AODA)
AODA day treatment
Assistive technology/communication aid
Behavioral treatment services
Care management for Care4Kids
Care management for children with medical complexities
Care management in fee-for-service
Consultative clinical and therapeutic services for caregivers
Consumer-directed supports (self-directed supports) broker
Consumer education and training
Counseling and therapeutic
Environmental accessibility adaptations (home modifications)
Financial management services
Habilitation services (daily living skills training and day habilitation resources)
Home delivered meals
Home health services
Housing counseling
Medication therapy management
Mental health day treatment
Mental health services
Nursing (in-home)
Occupational therapy (in-home)
Personal care
Physical therapy (in-home)
Prenatal care coordination
Prevocational services
Residential care
Residential substance use disorder treatment
Respiratory care
Respite
Self-directed personal care
Skilled nursing services (RN/LPN)
Speech and language pathology services (in-home)
Supported employment - individual employment support
Supported employment - small group employment support
Supportive home care (SHC)
Training services for unpaid caregivers
Transportation (specialized transportation) - community transportation
Transportation (specialized transportation) - other transportation
Transportation services under DHS 107.23
Vocational futures planning and support