Health Services

Medical Assistance -- Long-Term Care

(LFB Budget Summary Document: Page 258)

LFB Summary Items for Which an Issue Paper Has Been Prepared

Item #	Title
1, 2, & 3	Medical Assistance -- Long-Term Care (Paper #420)
4 c thru h	Home and Community-Based Services (Paper #421)
--	Nursing Home Personal Needs Allowance (Paper #422)

LFB Summary Items Removed From Budget Consideration

Item #	Title
4 (a&b)	Home and Community-Based Services
5	Children's Long-Term Support Waiver Program

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June, 2023 | Joint Committee on Finance | Paper #420

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

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June, 2023 | Joint Committee on Finance | Paper #421

Home and Community-Based Services (Health Services -- Medical Assistance -- Long-Term Care)

[LFB 2023-25 Budget Summary: Page 261, #4c through h]

CURRENT LAW

The American Rescue Plan Act (ARPA) included federal incentives for states to improve their home and community based services (HCBS) programs. Under ARPA, states received a 10.0 percentage point increase in their federal medical assistance percentages (FMAPs) for base Medicaid funded 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.

States were required to submit expenditure plans to the Centers for Medicare and Medicaid Services (CMS) for HCBS enhancements. In Wisconsin's submission, the Department of Health Services (DHS) anticipated claiming an additional $353 million in enhanced federal matching funds for Medicaid funded HCBS expenditures during the period from April 1, 2021, to March 31, 2022. Overall, the Department estimated that its reinvestment plan could total approximately $701 million, since the state could claim an additional $348 million in federal funds on any of the $353 million spent on Medicaid eligible activities, including both benefit and administrative activities.

As approved by CMS, DHS allocated funds for various one-time and ongoing projects to improve HCBS programs. The Department's plan anticipated six main 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.

DISCUSSION POINTS

1. The table below shows: (a) the amount of funding DHS indicates will be needed in 2024-25 to continue various projects through the end of the 2023-25 biennium (the 2024-25 funding increase that would be provided in AB 43/SB 70); (b) estimates of the annualized cost of continuing each project in the 2025-27 biennium; and (c) the Administration's estimates of when the one-time funds will be fully expended. By providing state funding for these programs in 2024-25, the Administration's intent is that each of these projects would be supported with state funds on an ongoing basis in the 2025-27 biennium. As shown in the table, annualized ongoing costs in the 2025-27 biennium for some items is greater than the funding that would be provided under AB 43/SB 70 in 2024-25.

Alternative	Description	2024-25 Cost	Annualized Ongoing Cost in 2025-27	ARPA Funded Through
2a	Ongoing funding for the WisCaregiver Career IT platform to remain up-to-date with available resources for caregivers and maintain the technical quality of the website	$101,500	$203,000	December, 2024
2b	Grants to the 11 federally-recognized Native American Tribes to make improvements to tribal community facilities and tribal member housing	$5,500,000	$5,500,000	June, 2024
2c	Support the ongoing costs of the tribal aging and disability resources specialists to serve as liaisons between the tribes and the aging and disability resource centers	$1,702,800	$1,362,200	March, 2024
2d	Build a centralized aging and disability resource center website and database that is accessible to Wisconsinites statewide, providing access to information about long-term care supports and services from an individual's home while also providing aging and disability resource centers with a database that centers on the individual rather than the facility	$1,060,000	$1,060,000	June, 2024
2e	Fund continued licensure and maintenance of a system to coordinate certification status work between the department and managed care organizations	$100,000	$200,000	December, 2024
2f	Fund licensure and maintenance of a system to allow for streamlined data entry, review, and report generation to comply with a federal rule requiring states to define the qualities of settings eligible for Medicaid home- and community-based services	$100,000	$200,000	December, 2024
Total		$8,564,300	$8,525,200	

2. As shown in the table, the two largest items would be funding to: (1) provide grants to the 11 federally-recognized Native American Tribes to make improvements to tribal community facilities and tribal member housing; and (2) support the ongoing costs of the tribal aging and disability resources specialists to serve as liaisons between the tribes and the Aging and Disability Resource Centers (ADRCs).

3. According to the DHS State of Wisconsin Aging Plan for Older People 2019-2021 report, "large shares of the state's Native American population reside in a number of northern counties. Wisconsin is home to 11 tribes, with a total of more than 6,000 tribal members age 60 or older." Between 2000 and 2016, Wisconsin's Native American population ages 65 and older grew by 107%, while the statewide number of individuals over the age of 65 (all races and ethnicities) increased by 32%.

4. Tribal populations may require additional support due to the population's higher rates of chronic illness and poverty. For example, according to the U.S. Department of Health and Human Services, in 2018, Native Americans were 50 percent more likely to have heart disease and be current cigarette smokers, 10 percent more likely to have high blood pressure, and were more likely to be obese, compared to their white counterparts nationwide. Further, according to federal Centers for Disease Control and Prevention, Native Americans were twice as likely to have diabetes compared to their white counterparts nationwide. According to 2020 data from the United States Census Bureau, it is estimated that 24.6% of Wisconsinites who identify as solely American Indian or Alaska Native live below the federal poverty level, compared to 11% of all Wisconsinites.

5. Starting in January, 2023, each of the 11 federally-recognized Native American tribes received one-time, $1 million ARPA grants for improvements to tribal facilities that provide community services, and to tribal members' homes. These funds are intended to supplement benefits available under Medicaid, since Medicaid HCBS funds may only be used for items and services to provide direct assistance to individuals with disabilities and the elderly, and cannot be used to improve tribal community facilities or housing.

6. Current approved grant expenditures include one-time or short-term capital projects to support individuals receiving, or at-risk of receiving, Medicaid HCBS services to remain in their homes, including: expanding existing loan programs for durable medical equipment, purchasing generators, air conditioners, and refrigeration appliances; and other capital investments in facility and home improvements to address tribal members' access to long-term care services and supports and improve the ability of qualifying individuals' ability to remain in their homes. Additionally, funds have been approved for support staff to improve service delivery and outreach including for: community outreach events to increase awareness of available Medicaid programs and services; long-term care needs assessment and feasibility studies to determine potential funding streams, staffing levels, and training needs, that will further long-term care priorities; and conducting home safety assessments to ensure individuals can safely remain in their homes.

7. In order to facilitate the provision of tribal grants for these purposes, AB 43/SB 70 would modify the existing community aids and Medical Assistance payments appropriation to allow for grant payments for tribal long-term care system development activities as previously described. Additionally, the Department would be required to allocate not more than $5,500,000 annually to federally-recognized American Indian tribes and bands located in Wisconsin for capital improvements to tribal facilities serving tribal members with long-term care needs and for improvements and repairs to homes of tribal members with long-term care needs to enable tribal members to receive long-term care services at home.

8. Aging and disability services for the tribes are provide through an ADRC, which the

tribe may join as a full partner, or by a tribal aging and disability resource specialist (ADRS) employed by the tribe. The Bad River Band of Lake Superior Tribe of Chippewa Indians, Ho Chunk Nation, Lac Courte Oreilles, Red Cliff, Oneida, and Menominee Tribes are administering a tribal ADRS program with GPR and ARPA funds; St. Croix and Forest County Potawatomi are designating their GPR funds to the local ADRC and using ARPA funds to support their own tribal ADRS position; Lac du Flambeau and Mole-Lake Sokaogon are designating their GPR funds to the Great Lakes Inter-Tribal Council; and Stockbridge-Munsee designates its GPR funds to the local ADRC and has not yet begun its ADRS expansion.

9. Currently, each tribe receives $40,000 to $67,984 GPR, plus any associated federal Medicaid administrative matching funds, to fund a tribal ADRS. The amount of GPR funding differs based upon the size of the tribe and when services were first expanded to the tribe. These allocations were established as part of the 2009-11 biennial budget and represent funding ranging from a 0.57 FTE to a 0.97 FTE. The 2009-11 budget increase for tribal ADRS funding assumed a cost of $92,000 all funds per 1.0 FTE tribal ADRS. Allocations have not been adjusted to account for wage inflation over time.

10. Between January, 2022, and March, 2024, DHS anticipates spending $3.3 million in ARPA funds to provide additional support for tribal ADRS. Under this initiative, each tribe receives $120,000 per year to fund their programs, including one-time costs to build out program elements for tribes that previously relied solely on county ADRCs. Technical support and guidance is provided through a contracted program and policy analyst.

11. Funding in the bill would bring GPR allocations to $100,000 for each tribe with the intent to cover not only salary and fringe costs of the tribal ADRS staff, but also auxiliary costs for support and supervision of the program. Additionally, the Department notes that in order to provide tribal ADRS programs with infrastructure that would mirror the network support of ADRCs, including the potential hosting of other support services aimed at tribal members, an additional $60,100 for each tribe would fund 1.0 FTE support staff, training, and marketing. Finally, funding in the bill would maintain the contracted state tribal ADRS program and policy analyst as these programs mature, at an annual cost of $124,800.

12. In an effort to maintain and continue existing projects, the Committee could provide $8,564,300 GPR in 2024-25 to fund, through the end of the 2023-25 biennium, each of the projects noted in the previous table that were started with one-time GPR savings and federal funds the state realized under provisions of ARPA. [Alternative 1]

13. Under Alternatives 2a through 2f the Committee could choose the items it wishes to continue to support once the ARPA funds are expended. [Alternative 2]

14. Finally, the Committee could choose to take no action, thereby not using state funding to continue the previously described initiatives that DHS began with ARPA funds. [Alternative 3]

ALTERNATIVES

1. Provide $8,564,300 GPR in 2024-25 to continue, through the end of the 2023-25 biennium, a number of projects started with one-time GPR savings and federal funds the state realized under ARPA. Modify the existing community aids and Medical Assistance payments appropriation to allow for grant payments for tribal long-term care system development activities as previously described. Require the Department to allocate not more than $5,500,000 annually to federally recognized American Indian tribes and bands located in Wisconsin for capital improvements to tribal facilities serving tribal members with long-term care needs and for improvements and repairs to homes of tribal members with long-term care needs to enable tribal members to receive long-term care services at home.

ALT 1	Change to Base
GPR	$8,564,300

2. Select any combination of items under Alternative 2, each box provides only the fiscal effect of that item and should be added to any others selected by the Committee.

a. Provide $101,500 in 2024-25 to fund costs associated with the WisCaregiver Career IT platform.

ALT 2a	Change to Base
GPR	$101,500

b. Provide $5,500,000 in 2024-25 to provide grants to the 11 federally recognized Native American Tribes to make improvements to tribal community facilities and tribal member housing. Modify the existing community aids and Medical Assistance payments appropriation to allow for grant payments for tribal long-term care system development activities as previously described. Require the Department to allocate not more than $5,500,000 annually to federally recognized American Indian tribes and bands located in Wisconsin for capital improvements to tribal facilities serving tribal members with long-term care needs and for improvements and repairs to homes of tribal members with long-term care needs to enable tribal members to receive long-term care services at home.

ALT 2b	Change to Base
GPR	$5,500,000

c. Provide $1,702,800 in 2024-25 to support the ongoing costs of the tribal aging and disability resources specialists.

ALT 2c	Change to Base
GPR	$1,702,800

d. Provide $1,060,000 in 2024-25 to build a centralized aging and disability resource center website and database.

ALT 2d	Change to Base
GPR	$1,060,000

e. Provide $100,000 in 2024-25 to fund continued licensure and maintenance of a system to coordinate certification status work between the department and managed care organizations.

ALT 2e	Change to Base
GPR	$100,000

f. Provide $100,000 in 2024-25 to fund licensure and maintenance of a system allowing streamlined data entry, review, and report generation to comply with a federal rule requiring states to define the qualities of settings eligible for Medicaid home- and community-based services.

ALT 2f	Change to Base
GPR	$100,000

3. Take no action.

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June, 2023 Joint Committee on Finance Paper #422

Nursing Home Personal Needs Allowance (Health Services -- Medical Assistance -- Long-Term Care)

CURRENT LAW

"Patient liability" refers to the income elderly, blind, and disabled (EBD) Medicaid beneficiaries who reside in nursing homes are required to contribute to the cost of their nursing home care. Generally, Medicaid beneficiaries are required to pay all of their gross income (including federal social security, supplemental security income (SSI) and retirement benefits), minus certain deductions, to the nursing home to partially offset the cost of care that would otherwise be funded from state and federal funds under the state's Medicaid program.

The state's MA reimbursement payment to the nursing home equals the amount of the state payment rate, as determined by the state Medicaid program, less any patient liability that the nursing home collects from the resident. For example, if the MA reimbursement to the facility is $7,200 per month ($240 per day) and the MA beneficiary's countable income retained by the nursing home is $1,600 per month, the state's GPR/FED payment to the nursing home is $5,600. In addition to nursing home claims, patient liability is applied to hospice claims and long-term inpatient hospital claims and capitation payments involving institutional stays of 30 days or more.

In Wisconsin, most EBD Medicaid beneficiaries may retain a "personal needs allowance" equal to $45 per month from the amount that would otherwise be retained by the nursing home as the individual's patient liability. Certain individuals in facilities who qualify for supplemental security income payments retain a personal needs allowance that, under federal law, is limited to $30 per month.

DISCUSSION POINTS

1. Wisconsin's Medicaid program pays nursing homes a daily rate that is intended to

support the costs of routine nursing home services, including: (a) nursing services; (b) special care services (including activity therapy, recreation, social services, and religious services); (c) supportive services, including dietary, housekeeping maintenance, and laundry services; (d) administrative and other indirect services; (e) fuel and utilities; (f) physical plant, including depreciation, insurance and interest; (g) property taxes; (h) certain over-the-counter drugs and all diabetic supplies; (i) services for individuals with developmental disabilities; (j) durable medical equipment and disposable medical supplies; and (k) indirect services provided by independent service providers, such as pharmacists reviewing prescriptions at a facility.

2. Federal CMS policy permits nursing homes to charge MA-funded residents for items and services not included in the daily rate or separately billable by the nursing home or an ancillary provider. These items include, but are not limited to:

- A private room, unless medically needed;
- Specially prepared food, beyond food that the generally prepared by the facility;
- Telephone, television and radio services;
- Personal comfort items, including tobacco and confections;
- Cosmetic and grooming items and services in excess of those in the basic service;
- Personal clothing;
- Personal reading materials;
- Gifts purchased on behalf of a resident;
- Flowers and plants;
- Social events and activities beyond the nursing home's activity program; and
- Special care services not included in the facility's Medicaid daily rate.

3. The personal needs allowance is intended to enable Medicaid-funded nursing home residents to purchase these items and services. However, nursing homes may not require residents to pay for any items or services that Medicaid or Medicare do not cover as a condition of their remaining in the facility.

4. Federal law requires each state Medicaid program to establish a monthly personal needs allowance equal to at least $30, but less than $200. Attachment 1 to this paper lists each state's Medicaid personal needs allowance, as of January, 2023. The attachment shows that 34 states and the District of Columbia have Medicaid personal needs allowances greater than $45 per month, and 16 states have personal needs allowances equal to the federal minimum of $30 per month, up to and including $45 per month.

5. Wisconsin's personal needs allowance was last increased beginning July 1, 2001, from $40 to $45 as part of 1999 Wisconsin Act 9 (the 1999-01 biennial budget act). According to the

consumer price index inflation calculator maintained by the U.S. Bureau of Labor Statistics, $45 in July, 2001, had the same buying power as $76.27 in February, 2023.

6. To enable MA-supported nursing home residents to retain more of their income to purchase items and services not provided by the nursing homes in which they live, the Committee could increase the MA personal allowance amount. Increasing the $45 personal needs allowance would increase the state's GPR/FED funded Medicaid benefits costs because state and federal funds would offset the loss of patient liability revenue nursing homes retain.

7. It is estimated that in 2023-24, the $45 personal care allowance will apply to 274,500 months of care for Medicaid-funded nursing home residents ("member months"), and that in 2024-25, the $45 personal care allowance will be applied to 249,400 member months of care for Medicaid-funded nursing home residents.

8. This paper offers alternatives to increase the personal care allowance, effective July 1, 2024, by $10, from $45 to $55 [Alternative 1] and by $25, from $45 to $70 [Alternative 2].

ALTERNATIVES

1. Increase the monthly MA personal needs allowance by $10, from $45 to $55, effective July 1, 2024. Increase MA benefits funding by $2,060,000 ($806,100 GPR and $1,253,900 FED) in 2024-25.

ALT 1	Change to Base
GPR	$806,100
FED	1,253,900
Total	$2,060,000

2. Increase the monthly MA personal needs allowance by $25, from $45 to $70, effective July 1, 2024. Increase MA benefits funding by $5,150,000 ($2,015,200 GPR and $3,134,800 FED) in 2024-25.

ALT 2	Change to Base
GPR	$2,015,200
FED	3,134,800
Total	$5,150,000

3. Take no action.

Prepared by: Charles Morgan
Attachment

ATTACHMENT

State Medicaid Personal Needs Allowances as of January, 2023

State	Amount	State	Amount
Alabama	$30.00	Missouri	$50.00
Alaska	200.00	Montana	50.00
Arizona	137.10	Nebraska	60.00
Arkansas	40.00	Nevada	35.00
California	35.00	New Hampshire	74.00
Colorado	95.97	New Jersey	50.00
Connecticut	75.00	New Mexico	83.00
Delaware	50.00	New York	50.00
District of Columbia	100.00	North Carolina	30.00
Florida	130.00	North Dakota	65.00
Georgia	70.00	Ohio	50.00
Hawaii	50.00	Oklahoma	75.00
Idaho	40.00	Oregon	74.75
Illinois	30.00	Pennsylvania	45.00
Indiana	52.00	Rhode Island	50.00
Iowa	50.00	South Carolina	30.00
Kansas	62.00	South Dakota	60.00
Kentucky	40.00	Tennessee	50.00
Louisiana	38.00	Texas	60.00
Maine	40.00	Utah	45.00
Maryland	93.00	Vermont	72.66
Massachusetts	72.80	Virginia	40.00
Michigan	60.00	Washington	75.36
Minnesota	121.00	West Virginia	50.00
Mississippi	44.00	Wisconsin	45.00
		Wyoming	50.00

Source: American Council on Aging