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

[LFB 2021-23 Budget Summary: Page 257, #6]

CURRENT LAW

Long-Term Care Programs. In order to receive long-term care services under the state's medical assistance (MA) program, an individual must be at least 65 years old, or be an adult with a developmental or physical disability, and meet both financial and non-financial eligibility criteria.

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.

Family Care 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: 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.

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. 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.

Direct Care Workforce Funding Initiative. In federal regulations issued by the Centers for Medicare and Medicaid Services (CMS), CMS specified that MA capitation rates must be "actuarially sound." In its commentary on the regulations, CMS reasoned that in order to meet this requirement, MA capitation rates must cover all reasonable, appropriate, and attainable costs of providing services under the contract, including associated administrative costs.

CMS requires states and their actuaries develop MA capitation rates in a manner that complies with federal law, regulations, and policy. The CMS guidance addresses special contract provisions, such as incentive and withhold arrangements between the state and the MCOs, and delivery systems MCOs may use in contracts with their provider networks. However, CMS guidance restricts states' ability to fund "pass through" payments as part of MCOs' capitation payment. 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. 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.

In 2017 Act 59, DHS was directed to develop and implement an allowable payment mechanism to provide additional funding to certain providers, separate from the capitation rates. The result of that law was the creation of the direct care workforce funding supplement to address concerns regarding direct care staff recruitment and retention.

Funding provided for the direct care workforce funding supplement is separate from funding provided as part of the MA base reestimate, to ensure that DHS establishes and pays actuarially sound capitation payments to long-term care MCOs.

DISCUSSION POINTS

1. 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. For 2019-21, the definition of direct care worker was expanded to include supported employment service providers.

2. Additionally, a direct care worker 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.

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

4. 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 2019-21, eligible providers received four rounds of payments (two in calendar year 2020 and two in calendar year 2021), as well as two rounds of redistributive funding composed of unspent funds from calendar year 2018 and 2019.

5. 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 covered time period. Providers then pay their direct care workers using the entire direct care workforce funding received from the MCOs.

6. Starting with payments in 2020, 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.

7. 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.

8. 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.

9. According to data for calendar year 2018, the most recent year for which DHS has

finalized survey data, more than a third of Family Care direct care workforce supplemental funding has been allocated to increase compensation for direct care workers. An additional fifteen percent of funds were allocated to taxes and benefits for the workforce, with the remaining half allocated to bonuses associated with recruitment, retention, and performance.

10. MCOs are contractually obligated to participate in the program, while participation is optional for providers. DHS indicates that MCOs are supportive of the funding generally, but indicate the existing payment process is administratively burdensome. Providers have been very supportive of the program, with 89% of responding providers indicating some or significant positive impact from the direct care workforce payments, and 71% of responding providers attributing one or more instances of staff retention to the direct care workforce supplement.

11. The Department calculates the payments for MCOs to issue to providers and MCOs subsequently provide proof of the checks issued under the program. Based on that reporting, the Department indicates that 96% of all checks and 98% of all funding that DHS directed MCOs to pay were issued to providers. The remaining payments were not issued for a variety of reasons, with the largest category being that MCOs are waiting for providers to return the signed provider agreements or the agreement was never returned.

12. Table 1 shows the funding that was provided as part of 2017 Act 59 (the 2017-19 biennial budget act), and the funding increase provided in 2019 Act 9 (the 2019-21 biennial budget act). Actual payments under the provision vary from the funding in Table 1 due to changes in the state's federal matching rate (FMAP) between the time of the budget and the time of implementation.

TABLE 1

Direct Care Reimbursement

	2019-20			2020-21		
	GPR	FED	Total	GPR	FED	Total
2017 Act 59 Budgeted Funding	$12,500,000	$17,773,700	$30,273,700	$12,500,000	$17,958,100	$30,458,100
2019 Act 9 Budgeted Increase	12,000,000	17,527,600	29,527,600	15,000,000	22,082,800	37,082,800
Total	$24,500,000	$35,301,300	$59,801,300	$27,500,000	$40,040,900	$67,540,900

13. Despite funding for this initiative in both 2017 Act 59 and 2019 Act 9, a 2020 survey of long-term care providers found that direct care staff recruitment and retention is an ongoing issue. Specifically, the report notes: an increase in caregiver vacancies from 19% in 2018 to 23.5% in 2020; caregiver vacancy rates in excess of 30% for adult family homes; and one in three providers limiting admissions due to caregiver vacancies. This survey included skilled nursing facilities, which have not been eligible for funding under the direct care workforce funding supplement. However, recent budgets have included separate reimbursement rate increases for direct care performed in skilled nursing facilities to address similar concerns for those providers.

14. In recognition of the ongoing worker shortage and the positive feedback and high

participation from providers, the Committee could provide additional funding for the Department to increase the funding distributed to providers under the supplement. The Department indicates its intent is to administer any additional funding provided under this provision in a substantially similar manner to funding previously provided and distributed through the direct care workforce funding supplement. Table 2 presents a number of alternatives available to the Committee in choosing how much additional funding to provide for the direct care workforce funding initiative.

TABLE 2

Family Care Direct Care Reimbursement

	2021-22			2022-23		
	GPR	FED	Total	GPR	FED	Total
Alternative 1	$10,000,000	$16,917,900	$26,917,900	$10,000,000	$15,201,600	$25,201,600
Alternative 2	15,000,000	25,376,900	40,376,900	15,000,000	22,802,400	37,802,400
Alternative 3	20,000,000	33,835,800	53,835,800	20,000,000	30,403,200	50,403,200

15. Policies adopted under the federal Families First Coronavirus Response Act (FFCRA) provide a temporary 6.2 percentage point increase to the state's federal matching rate, applicable for any quarter that the federal public health emergency associated with the COVID-19 pandemic is in effect. Based on communication from the federal Department of Health and Human Services, the 6.2 percentage point increase under provisions of FFCRA is expected to be in effect for the first six months of the 2021-23 biennium. For this reason, the alternatives presented in Table 2 assume an FMAP of 62.85% in 2021-22 and 60.32% for 2022-23.

16. The American Rescue Plan Act (ARPA), increased the federal matching rate for Medicaid home and community based services (HCBS) spending by 10 percentage points from April 1, 2021, through March 31, 2022, provided that states maintain state spending levels as of April 1, 2021. If CMS determines that the direct care workforce funding initiative as implemented in Wisconsin is an allowable activity on which the state can claim the enhanced FMAP, additional federal matching funds, beyond those shown in Table 2, could be available to the state.

17. ARPA specifies that states must use the enhanced funds to "implement, or supplement the implementation of, one or more activities to enhance, expand, or strengthen" Medicaid HCBS. States have until March 31, 2024, to spend the enhanced funds. CMS guidance regarding the ARPA provision, released on May 13, 2021, confirms that the enhanced funds must be used for activities "beyond what is available under the [state's] Medicaid program as of April 1, 2021." States are not allowed to use the additional federal funds to supplant existing state funds.

18. Alternatively, the Committee may determine that, it is not necessary to increase the amount of base funding that would be provided to fund the direct care supplement in the 2021-23 biennium, for which the GPR amounts are shown in Table 1 [Alternative 4].

ALTERNATIVES

1. Provide $26,917,900 ($10,000,000 GPR and $16,917,900 FED) in 2021-22 and $25,201,600 ($10,000,000 GPR and $15,201,600 FED) in 2022-23 to increase funding for the direct care workforce funding supplement.

ALT 1	Change to Base
GPR	$20,000,000
FED	32,119,500
Total	$52,119,500

2. As in AB 68/SB 111, provide $40,376,900 ($15,000,000 GPR and $25,376,900 FED) in 2021-22 and $37,802,400 ($15,000,000 GPR and $22,802,400 FED) in 2022-23 to increase funding for the direct care workforce funding supplement.

ALT 2	Change to Base
GPR	$30,000,000
FED	48,179,300
Total	$78,179,300

3. Provide $53,835,800 ($20,000,000 GPR and $33,835,800 FED) in 2021-22 and $50,403,200 ($20,000,000 GPR and $30,403,200 FED) in 2022-23 to increase funding for the direct care workforce funding supplement.

ALT 3	Change to Base
GPR	$40,000,000
FED	64,239,000
Total	$104,239,000

4. Take no action.

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