LeadingAge™ Wisconsin

Better Services for Better Aging

2015-17 State Budget in Brief

following discussions with Department of Administration budget staff and Department of Health Services Officials

Medicaid/Family Care Budget:

- 2015 Senate/Assembly Bill 21, the biennial budget bill, recommends a GPR ("general purpose revenue," or state tax dollars) budget of $15.875 billion in 2015-16, a $53.7 million, or 0.3 %, decrease from the previous fiscal year, and a $16.943 billion budget in 2016-17, a $1.1 billion, or 6.7%, increase over the previous fiscal year.

- The Department of Health Services (DHS) requested a $760 million GPR increase over the 2015-17 biennium to fund a cost-to-continue Medicaid budget; SB/AB 21 provides $633 million in new GPR over the biennium for Medicaid.

- No Medicaid rates increases were provided for nursing homes or rate increases for Family Care providers (the LeadingAge Wisconsin position is a 5% rate increase for both in each year of the biennium).

- Family Care reforms, including moving to statewide implementation and transitioning to an integrated program offering acute, primary and long term care (see below), are projected to reduce program costs by $14, 254, 400 all funds ($6.0 million GPR) in 2016-17.

- Unlike the previous two state budgets, no acuity adjustment for nursing homes was provided. Because the budget proposal fails to fund projected increases in resident acuity and dollars will be required to update reimbursement formula payouts to facilities with direct care costs (primarily) below the targets, the majority of nursing facilities likely would experience rate reductions in the upcoming biennium.

- According to DOA, only certain HMOs received a (1.5%) Medicaid rate increase in each year of the biennium; no other MA providers received an increase.

- "Improve program integrity in the use of personal care services in Medicaid while ensuring members receive essential services on a timely basis," resulting in a $19 million cut in Medicaid personal care services. Personal care services will require prior authorization.

- No change was provided in the $39.1 million cap in supplemental payments (SP) to county and municipal nursing homes.

- The budget bill did not modify the DHS request to fund increases of 3.2% in 2015-16 and 2.5% in 2016-17 for Family Care managed care organizations (MCO) to establish actuarially sound payments from DHS to the MCOs. However, the bill does not include any directive that these dollars be passed-on to providers in the form of rate increases.

Family Care

The Family Care program would be changed significantly. Among those proposed changes are the following:

- The definition of "Family Care benefit" would be amended to mean "financial assistance for long-term care and support items for an enrollee and any financial assistance, as specified by the DHS, for primary and acute health care services for an enrollee. The DOA representatives said it is still unclear what role Medicare funding will play in the expansion of Family Care to include DHS-specified acute and primary health care services.

- After the date this new Family Care benefit is made available to eligible residents of a county, the DHS may discontinue the Community Options Program (COP) and COP-W program for that county.

- The statutory definition of "care management organization" (the statute maintains the CMO designation rather than the commonly-used "managed care organization" [MCO] designation despite the fact they mean virtually the same) is modified to state:

    1. Before January 1, 2017 or the date specified in the 2015-17 state budget for changes to the Family Care program, a CMO is an entity that is certified as meeting the statutory requirements of a CMO under s. 46.284(3) and has a CMO contract with the DHS;
    2. Beginning on January 1, 2017 or the date specified in the 2015-17 for changes to Family Care, a CMO is an insurer that is licensed and in compliance with the applicable provisions of the Insurance statutes, that is certified as meeting the DHS requirements for a CMO, and that has a CMO contract with the DHS. The budget bill repeals the current law provision which excludes an entity which operates either the Program for All-Inclusive Care for the Elderly (PACE) and/or the Family Care Partnership Program from being a CMO.

- "Family Care program" is redefined to mean the program that provides the Family Care benefit, which under 2015 SB/AB 21 will include acute and primary health care services specified by the DHS.

- The statutes creating the Family Care "long-term care district" and "long-term care district board" would be repealed.

- The IRIS "self-directed services option" under the Family Care program that is operated under a federal Medicaid waiver would be repealed and replaced with a self-directed services option under Family Care.

- The DHS shall request from the secretary of the U.S. Department of Health and Human Services (HHS) any waivers of federal Medicaid laws necessary to permit the use of federal moneys to provide the Family Care benefit as redefined by 2015-17 to recipients of Medical Assistance. The DHS shall implement any waiver that is approved by the HHS and is consistent with state Family Care statutes. Regardless of whether the federal waiver is approved, the DHS may implement operation of resource centers, CMO/MCOs, and the Family Care benefit.

- The DHS waiver/amendment request shall include any provisions necessary to implement changes to the Family Care program, PACE or Partnership, including all of the following:

    1. CMO/MCO administration of Family Care **statewide, instead of by geographic region**, unless the DHS allows a waiver to a CMO/MCO to administer the Family Care benefit in a specific geographic region. DOA staff indicated the federal Centers for Medicare and Medicaid Services (CMS), which must approve of the state's Family Care waiver request, has indicated they will require at least three statewide CMO/MCOs under this waiver request;
    2. Addition of any primary and acute care health services selected by the DHS as a benefit under the Family Care program;
    3. Selection as a CMO/MCO of any applicant the DHS certifies has met its qualifications rather than the use of a competitive procurement process;
    4. An enrollee seeking to change CMO/MCOs only may do so during a DHS-specified open enrollment period;
    5. The creation of new Family Care long-term care (LTC) districts would be prohibited and existing LTC districts would be dissolved;
    6. Elimination of the requirements under Chapter 648, Wis. Stats., regulation of Care Management Organizations, which among other things requires a CMO/MCO to receive a permit from the Office of the Commissioner of Insurance to operate.

- If the HHS does not disapprove of the DHS Family Care waiver request, the DHS must ensure that the Family Care program is available to eligible residents of every county in the state by January 1, 2017, or by a date specified by the DHS, whichever is later. If the HHS does not approve of all or part of the waiver request, the DHS may administer that part of the Family Care program which failed to receive HHS approval under the applicable Family Care statutes. In addition, if the HHS disapproves of the DHS Family Care waiver request, the Department may discontinue the CIP-II program at any time after the Family Care program goes statewide.

- It would appear the MCOs will be responsible for managing behavioral health services effective January 1, 2016. This new responsibility reportedly will be required by DHS in the next calendar year and is not directly tied to new authority that may be granted by the 2015-17 budget bill provisions.

- The DHS may contract with an entity other than an Aging and Disability Resource Center (ADRC), including a for-profit entity or a nonprofit organization, to perform any of the functions of an ADRC under s. 46.283(3) and (4) as specified by the Department. That would include a determination of financial eligibility and of the maximum amount of cost sharing required for a person seeking the Family Care benefit and the ability to provide services statewide if specified by DHS contract.

- The bill would repeal the Family Care "any willing provider" provision which required a CMO/MCO to contract with any provider if that provider agrees to accept the reimbursement rate the CMO/MCO offers similar providers for the same service and satisfies any applicable quality of care, utilization, or other criteria the CMO/MCO requires of other providers when contracting for the same service.

- "If the department chooses to make primary and acute health care services part of the Family Care benefit," a CMO/MCO must have "the ability to provide or provide access to primary and acute health care services as determined by the department" in order to be certified by the DHS as a CMO/MCO.

- No new LTC district could be created after June 30, 2015; all existing LTC districts must be dissolved before June 30, 2017, or before a date established by the DHS, whichever is later.

- It is certain that the provisions to extend Family Care statewide are intended to go into effect by January 1, 2017; it is less certain whether the transition provisions to a Family Care benefit, including acute and primary health care services also go into effect on 1/117 or on July 1, 2018. We will await the Legislative Fiscal Bureau analysis of 2015 SB/AB 21, which is expected around the end of February, to clarify that uncertainty. DOA staff did indicate that California operates, with CMS approval, a program similar to the revised Family Care proposed in the 2015-17 budget bill.

Other Long-Term Services and Supports Provisions:

Among the other provisions in the bill are the following:

- "In recognition of the changing face of Medicaid," the DHS Divisions of Long-Term Care and Health Care Access and Accountability would be merged into a newly-created Division of Medicaid Services. The budget directs the DHS to submit a report of the final organization of the merger to the DOA budget office before March 31, 2016.

- Additional funding and positions would be provided to the state ombudsman program operated by the Board on Aging and Long-Term Care, including an ombudsman presence at the State's Veterans Homes and in assisting consumers of home- and community-based services.

- Additional funding would be provided to support the expansion of dementia care specialists throughout the state.

- The licensing period for occupational licenses would be lengthened from two years to four years.

- The Departments of Safety and Professional Services (DSPS) and Financial Institutions would be merged.

- Worker's compensation functions would be transferred from the Department of Workforce Development to the Office of the Commissioner of Insurance or the DOA Division of Hearings and Appeals.

- Oversight of hospice and CBRF plan reviews would be shifted from the DSPS to the DHS.

- Funding would be increased by $438,000 for elderly and disabled to local governments and nonprofit organizations for transportation services.

- All funds savings of $692,800 in 2015-16 and $1,532,000 are projected "to reflect moving pharmacy and transportation benefits into provider contracts." It is unclear if the intent is to terminate the Medicaid transportation broker contract with MTM. The current Medicaid transportation system does not include Medicaid nursing home residents or Family Care enrollees.

- The DOA-prepared *Budget in Brief* states: **"As with all skilled nursing facilities, the acuity of residents and resident care needs have continued to increase over time"** in the state's three Veterans Homes (emphasis added). Unlike the state's skilled nursing facilities, however, the budget includes additional funding for equipment and "operational improvements" for the Vets Homes.