OPEN MEETING MINUTES

Name of Governmental Body: Direct Care Workforce Workgroup, Governor's Task Force on Caregiving			Attending: Members: Todd Costello, Lisa Pugh, Margie Steinhoff, LaVerne Jaros, John Sauer, Adien Igoni, Ted Behncke, Anne Rabin, Beth Swedeen, Mo Thao-Lee, Michael Pochowksi, Rep. Wichgers By Phone: Lisa Schneider, Billl Crowley, Stephanie Birmingham Stand-in: Katie Philips for Jane Bushnell State Staff: Faith Russell, DHS, Lynn Gall, DHS, Allie Boldt, DHS, Andrew Evenson, DWD
Date: 3/5/2020	Time Started: 1:00 pm	Time Ended: 4:04pm	
Location: Community Living Alliance, 1414 Mac Arthur Rd, Madison, WI 53714			Presiding Officer: Lisa Pugh and Todd Costello

Minutes

GOVERNOR'S TASK FORCE ON CAREGIVING
Direct Care Workforce Workgroup
March 5, 2020

I. THE MEETING WAS CALLED TO ORDER AT 1:00 p.m.

II. APPROVAL OF MINUTES FROM 2/20/20

Beth Swedeen moved to approve minutes; motion seconded by Mo Thao-Lee. Motion passed unopposed.

III. WELCOME AND OVERVIEW

Co-chairs provided welcome remarks and an overview of meeting agenda and big-picture timeline.

- 3/5/20 meeting: continue to dig in on policy recommendations—including continued discussion of recommendations not yet discussed, plus discussion with staff from DHS Division of Medicaid Services (DMS).
- 3/19/20 meeting: extended to 3-hour meeting. Additional state staff will be available.
- Aim to have more fleshed-out policy proposals by end of April, to review as a full Workgroup in early May, and as a full Task Force later in May.
- An ad-hoc group will convene to start considering recommendations involving the registry. Talk Force Members of this ad hoc group so far include: Lisa Pugh, Todd Costello, Ted Behncke, Jane Mahoney, Michael Pochowski, and Lisa Schneider.

IV. DISCUSSION OF POLICY RECOMMENDATIONS, NEXT STEPS

A. DISCUSSION OF RECOMMENDATION RE: REDESIGN OF IRIS AND MCO RATES (BENEFITS), NEXT STEPS

Todd Costello reviewed questions and comments submitted by Task Force members on the following recommendation: BENEFITS: Redesign IRIS and MCO rates. *Enhanced rates for providers who offer credible health insurance, designated percentage or amount of rate increases to MCOs and IRIS that just be used for wage and benefit increases, methodology to ensure that state reimbursements for MCOs and IRIS include pass-through to workers.*

Workgroup members provided the following questions and comments:

- Lisa: Would this recommendation work in complement with an income disregard?

- Anne, Todd: The larger discussion re: how rates are determined may be where the group wants to focus its time (as opposed to this specific recommendation to increase rates for those offering credible health insurance). In other words, this recommendation could be folded into the larger rates discussion.

- Mo: Mindful that IRIS has a higher rate, and that personal care agencies face reimbursement discrepancies despite having more regulation to comply with. Will that be addressed? Also flagged the discrepancy between PCWs and supportive care workers with respect to medication administration.
    - Anne: Would be against a cut-out of IRIS participants and would want to ensure that IRIS workers are also receiving increases. IRIS is a self-directed program, and the participant takes on quite a lot of responsibility that the agency would typically provide, e.g., training and documentation. And, the Fiscal Service Agency has lower expenses for participants when family members are hired. The IRIS participant decides what they want, and how much to pay (anything above a particular rate needs to be authorized; factors in area wages).
        - Katie Philips: Sometimes, an IRIS caregiver does go through the agency to get hired, and in that case, the agency would be the one to do the training. An RN is involved in training in both settings (agency and IRIS).

- Ted: Another approach would be to address the benefits issue separately from rates. A lot of benefits are structured for possible pooling. The average match rate for a 401k in this country is 3% and in the caregiving industry that would be almost unheard of. The whole package available to many caregiving employees is not as competitive. 401k costs can be directly related to administration fees, such that a group in the state could benefit from going into together. This solution would be independent of changing rates, which is a more difficult issue. And it could be helpful for small providers.
    - Lisa Pugh: Agreement to look into mechanisms for pooling. On the IRIS side, individual workers being able to pool would also be something to consider. Co-ops are another possibility.
    - Beth: Would lean toward a state requirement vs. voluntary pooling; otherwise, if one big entity pulls out, the whole pool risks collapsing.
    - Lisa Schneider: Previously, group insurance was offered through being a member of the Chamber of Commerce. However, when looking into whether this is a possibility, was told it was no longer available (an unintended consequence from the ACA).
    - Jason: In the IRIS context, how would IRIS workers know if they are at risk of losing eligibility? E.g., if they are at 28 hours?

- Todd: An LTC advisory group looked into pooling approx. 8 years ago. Was told that some entities can "pollute" the pool due to different needs and expenses. Also, CLA prioritizes offering competitive benefits, and this requires a constant look-back re: whether people are at risk of losing benefits eligibility—depending on fluidity/availability of data, this may be an issue when considering making a larger pool.

- Adien: Emphasized the portion of this recommendation where rate increases are to pass through to workers in wage increases as an important piece. This has been discussed with DHS Secretary Palm, who indicated DHS does not intervene to ensure that rates are paid to providers such that providers can pass on higher wages. For instance, this is not part of DHS/MCO contract. There is thus no floor on what is passed onto providers and workers. Might it be easier to establish a pass-through requirement as opposed to actually increasing the rates, which is a more complex issue?
  - LaVerne, others: A pass-through requirement might not be any easier than a rate increase; for instance, would still need to determine an appropriate % or formula for the pass-through, and where it would come from (e.g., MCO administrative costs?).

- John: It is difficult to separate the issue of a pass-through from the larger discussion around Family Care rates, and the processes by which rates are determined. The current process is a black box; does not provide information about expectations around workforce development, benefits/insurance, etc. It would be difficult to discuss mandating how MCO dollars are used (e.g., for workforce development) without discussing how funds are allocated in the first place.
  - Additional context re: current process: Buried in the most recent announcement is a provision that an assumption has been made that there will be enough money to provide providers with a specified rate increase—however, there is no mechanism to ensure this, and many providers have not experienced an increase. MCOs indicate they are concerned about their own financial sustainability, but that they would like to be able to pay providers more. For providers, the only recourse where the rate is insufficient can be to drop the MCO.
    - Adien: Echoed this remark; the January 2020 rate increases are a clear example of a formal rate increase that did not pass through to providers/workers. The providers (not the MCOs) are the ones that need to compete amongst each other with wages and benefits, and there are a lot more providers than MCOs.
  - Current methodology is status-quo-oriented. Rates are determined through actuaries, which produce a report available in approximately November/December for rates that start the following year (looking at factors such as, e.g., changes to the costs of serving a certain population (such as frail elders)). There is less focus on the actual cost of care, but rather, discussions around discounting the cost of care.
    - As an example, one LeadingAge member laid out all of its costs for the MCO's input. The MCO flagged that the member had a full-time RN. But the member could not easily let the RN go, given acuity and the fact that it would be very difficult to hire a replacement RN in that area.
  - Currently, MCOs direct on average 83.7% to providers (which includes funding for case load increases, acuity increases), while 16.3% goes toward administration.

- Lisa Pugh: On the issue of ensuring a pass-through for wage increases:
  - Feasibility of this recommendation may depend on how much control the state can exert over MCOs (e.g., through contracts). Rates must also be actuarially sound and cover the cost of care.

  - This recommendation also seems related to the recommendation involving budget impact statements, though impact statements are more about increasing transparency and stop short of actually requiring a pass-through or any other allocation (e.g., X% or $Y) toward workforce development.

- Stephanie: What are MCO profit margins currently? Is there a way to restrict? Pros/cons to doing so?

- Todd: From the provider perspective, there is a real desire to pass rate increases onto workers in the form of higher wages, but there is still a lot of variation across settings, expenses, and geographies. Can see some risk to providers in mandating exactly how much to pass onto workers in light of this variation; suggests framing a recommendation to avoid boxing in providers.

- Members discussed increasing the Direct Care Workforce Fund as a possible alternative to rate increases, where funding will not be held by the MCOs. Members raised the following:
  - Questions: What are the parameters of federal/CMS concerns about this fund? Is there a limit to what the feds will approve? (Currently, approximately$6M/year).
  - Concerns: The fund doesn't address the personal care workforce. Also, the funding is precarious and thus under-utilized; where it is used, it is being distributed as bonuses. To make an impact on base wages, would need a greater sense of permanency/predictability.

- Members continued to discuss issues involving rates and rate increases in the discussion with DHS-DMS staff (see sub-section C below).

The following were identified as next steps:

- Consider reframing this recommendation—explore group purchasing options for insurance. What additional information/data can we find re: barriers and opportunities?
- Additional research re: pooling/group purchasing of benefits packages and possibilities across categories and providers. What would be helpful/needed to implement this: state seed money? Is the infrastructure already there? Is there anything legally preventing it from happening?
  - Ted will do some preliminary research.
  - Todd: will reach out to M3 (a broker that has experience with this industry).
- Engage DHS-DMS staff to discuss possible ways to ensure increases are passed onto providers and workers.

B. RECAP OF OTHER/ONGOING NEXT STEPS

The following updates relating to other preliminary workgroup recommendations were provided:

- There are two remaining topics the workgroup still needs to vet and reframe as a group in upcoming workgroup meetings:
  - Payment Standard for Nursing Homes Based on Actual Cost of Care; and
  - CBRF Hiring Age
- DWD staff will be available to consult with members at the March 19 meeting. Members with questions should send them in advance to Andrew Evenson.

- For the Regulation/Compliance recommendation involving OIG and DQA, members who volunteered at a prior meeting are to send examples/scenarios to Faith to share with OIG in advance of a meeting.
    - John: an example of overreach can be found in the facts underlying the Papa vs. DHS case. There, a home health agency provided services but failed to correctly code such services; the parties stipulated there was no fraud. LeadingAge filed an amicus curiae brief in this case along with Wisconsin Health Care Association, WHA, and others.
- All sub-groups are encouraged to meet to continue fleshing out policy proposals, and can use the Community Living Alliance space or conference lines to meet or host external speakers, etc. Members are to refer to the "Policy Recommendations Template – for Use by Subgroups" document.

C. DISCUSSION WITH STAFF FROM DHS-DMS

The workgroup heard a presentation from Krista Willing (DMS Assistant Administrator; Systems, Fiscal, and Operations) and Curtis Cunningham (DMS Assistant Administrator; Long-Term Care Benefits and Programs). Ms. Willing oversees rate-setting for long-term care and nursing homes; works with MMIS and CARS system and operations; and provides programs with support/payment mechanism. Mr. Cunningham oversees and administers long-term care programs including Family Care, IRIS, PACE / Partnership, CLTS Waiver, C-COP, Birth to 3, and more. The DMS speakers presented two PowerPoint Presentations (attached).

The DMS speakers provided a basic overview of Medicaid (MA) in Wisconsin:

- There are several delivery models within the MA program, which includes long-term care as well as models focused more on acute and primary care, plus special models for special populations.
- Total spending on MA is roughly 18-19% of the state GPR.
- There are a variety of long-term care programs and settings, e.g.:
    - IRIS – home and community-based;
    - Family Care – home and community-based, plus long-term care services;
    - PACE / Partnership – all-inclusive;
    - Robust children's programs e.g., Katie Beckett, CLTS, C-COP program, and CCS (which services adults as well as children).
- DHS-DMS not seeing a large access problem for long-term residential facilities.
- Within long-term care programs, there is variety in terms of rates and rate-setting. For adults, the state does not set rates (in contrast to programs like CLTS, where the state works over the course of year to determine rates for next year). In IRIS, the participant is the one to set the rates. In Family Care and PACE / Partnership, the MCOs are responsible for setting rates. There is not a set fee schedule for reimbursement. CMS is prescriptive and has limitations regarding HMO rate-setting; states must submit a rate-setting report explaining each and every adjustment made and why.

Workgroup members posed a variety of questions/comments, as follows:

- John: While there may not be an access issue for long-term residential care, this is falling on the backs of care workers. As an example, someone in a nursing home facility was deemed too expensive, and the MCO solution was to move that person 51 miles away.
- **Question:** Lisa Pugh: What other states have a long-term care landscape comparable to WI?

  - **DMS Response:** Very few. In the long-term care arena, it is very state-specific and also program-specific. For instance, Mr. Cunningham was not aware of a state with a more robust IRIS/self-directed program. WI's long-term care benefit is also very robust, with few non-covered services. Managed long-term care is being rolled out in some states (though plateauing recently), often through states seeking Requests for Proposals and working in partnership with other entities. The WI system evolved out of a county system; MCOs have evolved as districts have developed.
- **Question**: Stephanie Birmingham: What are the pros/cons of having (or not having) a fee schedule?
  - **DMS Response:** A benefit of not having a fee schedule is that WI can be more person-centered, rather than rates-centered: looking at the individual and what resources they need. A con is that providers may experience the rate to be insufficient. Having a fee schedule provides predictability for providers and takes out some of the financial volatility within the MCOs—the state sets the capitation rate and then MCOs are really managing on the utilization side (vs. looking at utilization AND reimbursement).
- **Question**: John: Understands that CMS approves of fee schedules. Does DHS-DMS have an opinion re: a fee schedule?
  - **DMS Response**: DHS-DMS is currently working to determine DHS's position on a fee schedule—e.g., whether there is a way to move in that direction, and if so, what would need to happen? This would likely be a multi-year process. Fee schedules can vary tremendously state-to-state (e.g., resource allocation models vs. cost-based models, vs. acuity models).
- **Question**: Are MCOs open to a fee schedule model, or do they have a preference re: rate-setting processes?
  - **DMS Response:** Unclear. At the end of the day, MCOs will get actuarially sound rates. But, there might be some back and forth regarding flexibility that would be lost if WI shifted to a fee schedule.
- **Question**: When thinking about rate-setting methods, is it possible to consider building in for wage inflation or other market components (not considered an actuarial)? What about provider costs?
  - **DMS Response**: Yes; wages could be considered within a fee schedule, and a COLA could be built in; rates could also be adjusted depending on the region. But through current MCO rate-setting, wages are not factored in—rates are determined by amounts paid and services provided over a period of time, adjusted based on acuity and other factors. Would need to think about how to build wage considerations into the current system, while complying with CMS limitations on HMO rate-setting.
  - Cont'd: The current process uses historical trends/experience to set rates (e.g., acuity, levels of need). Generally there is a ~2% increase (for acuity AND cost). This last year, an additional 1% increase was built in (though providers may not be seeing it).
- **Question**: John: does DMS have an opinion re: what would be the best return on investment (e.g., putting more into the DCW Fund? Explicitly budgeting/requiring MCOs to pass on increases to providers? Develop a fee schedule?)
  - **DMS Response**: DMS staff also offered a possible hybrid solution, e.g., establish a maximum fee schedule for certain services, and also require a certain amount of that go toward direct care workforce.
  - DHS-DMS can look further into possibility of adding funding to the Direct Care Workforce fund—including any risks and limitations of this/how high that could go.
  - It might also be possible to increase the DCW Fund while developing a max fee schedule—however, DMS would need to think strategically about how these might interplay/interact.

- Additional Member Questions/Comments re: DCW Fund
  - Is there a way to determine whether the fund has made a difference for workforce development, particularly given concerns re: intermittence of the funding?
  - DCW Funds are quarterly payments; CMS rejected an annual payment. Does funding from the DCW Fund need to be spent in the quarter it is received? This makes it hard to pass on as higher wages (vs. bonuses). Are providers essentially required to do bonuses?
    - **DMS Response:** We believe so, but will confirm.
- **Question**: any insight from DMS staff re: a recommendation involving a pass-through from MCOs to providers?
  - **DMS Response**: State has limited authority/mechanisms to control MCO funding. MCOs get PMPM and get to choose how to spend it. The state's authority is also governed by strict CMS guidelines.
- **Question**: Lisa Pugh: Thus far, the group has been discussing either (a) adding money to the DCW Fund (an imperfect solution, given need to return to request additional funding; or (b) creating a fee schedule or maximum fee schedule. What would go into that latter process?
  - **DMS Response**: Typically, start by looking at historical data. For the CLTS rate-setting, look at counties' reimbursement for respite services, acuity, and levels of need. There are a variety of methodologies—generally, cost-based methods are used for residential settings, while max fee services are used more for discrete services. Changing the rate-setting method would be a time-consuming, labor-intensive process.

DMS presenters then discussed available data regarding the workforce as well as data needs:

- The National Core Indicators (NCI) Survey surveys individuals from all long-term care programs—such as IRIS, Family Care, Partnership, etc.—to statistically significant levels.
  - NCI is one of the only data points DMS has regarding staff working within the MA program.
  - WI NCI-IPS (I/DD) survey participants answered the question about why they cannot go out or cannot go out as often as they would like; top reasons were:
    - Transportation (78%);
    - Cost or money (48%);
    - Health limitations (46%);
    - *Lack of staffing or personal assistance (39%);*
    - Other (24%).
  - WI NCI-AD (Aging & Disability) survey participants gave the following top reasons they were not as active in the community as they would like:
    - Health limitations (75%);
    - Transportation (29%);
    - Cost or money (19%);
    - Accessibility or lack of equipment (13%);
    - *Not enough staffing or assistance (11%);*
    - Other reasons had <10% of respondents reporting the reason.
  - Staff reliability issues
    - 13% of WI IPS (I/DD) survey participants said staff did not show up or were late once a month or more in the past year; 18% said they had been unable to take care of themselves or do every day activities due to lack of staff to help.
    - 16% of WI NCI-AD survey participants said staff did not show up or were late once a month or more in the past year; 24% had needed help with self-care or everyday activities in the past year and did not get it due to lack of staff.

- Data needs: DMS has very limited data beyond NCI data regarding MA workforce. Do not currently collect independent data regarding the cost associated with assisted living or home- and community-based services (HCBS) or MA enrollment; no independent access data for nursing home, assisted living, or HCBS; also lack data regarding direct service professionals' wages and benefits relative to the MA payment rates.
- One possibility for meeting data needs is the NCI Survey on Staff Stability, which asks about wages, paid time off, turnover, and more. (See attached NCI PowerPoint).
  - The data from the NCI Survey on Staff Stability can be used to help make the case before the legislature for investment in workforce development. Currently, providers and workers are saying they are underpaid, but DMS lacks the analytical resources to validate.

Workgroup members provided the following additional questions and comments pertaining to both data and rate increases in general:

- **Question:** What is the cost of adding the Survey on Staff Stability to the NCI?
  - **DMS Response:** DMS to follow-up about this.
- **Question**: Anything to be learned from utilization data?
  - **DMS Response**: Utilization data might speak to an access problem where entities are getting licensed through DQA and then registering as MA providers, but not actually taking MA patients. We know that in some instances, nursing homes/assisted living facilities do have beds (though this does not guarantee access).
- **Question**: Todd: MCOs are authorizing hours for services. Is there a comparison between authorized hours vs. billed hours?
  - **DMS Response**: Yes; however, higher level of authorization may be to afford room for if an individual gets sick, travel time, etc.
- Rep. Wichgers: As the Task Force considers how to direct more money to providers, should also consider looking at regulatory barriers that could be reduced. If within a small agency, e.g. ~30% of ~$100k wage costs is going to documentation, and we could reduce documentation costs, this is another way to get resources to providers.
  - Might another possibility be for entities to be their own MCO and get rid of the middle man?
- Rep. Wichgers: Legislature is interested in seeing evidence that investment in direct care workforce wages/benefits/etc. have returns—e.g., stability or additional revenues from businesses. Could also mean improved health outcomes or better coordination of care.
  - Other members commented that states that have made such investments have seen, e.g. reduction in ER visits, which can make a big difference.
- Todd: As the Task Force continues to flesh out proposals re: rate increases and start to estimate what it might cost, could $15/hour be used as a benchmark for developing those cost estimates?
  - Mike P: Would want clarity that this was used as a benchmark for estimates only, given concerns around agencies/providers not being able to afford that wage.
- Lisa Schneider: Is there any concern with the Maximum Hourly and 15-minute Group Rates for Supportive home care (apply for groups of 2-3 participants at all care levels). The maximum group size for one caretaker is three participants. Familiar with care workers who are getting pay cut in half because they are serving two disabled individuals in the same home - so they are no longer able to work for this family. This example is specific to CLTS.

Items flagged for DMS follow-up include:

- Follow-up re: DCW Fund, including:
  - DMS analysis re: adding additional funding; any risks; any limitations?
  - Confirmation on whether fudning from the DCW Fund must be spent in the quarter it is received (essentially requiring funding to be distributed as bonuses?).
- Follow-up re: cost of adding the NCI Survey on Staff Stability to NCI.

V. PUBLIC COMMENTS

- Mindy Ochs, Legislative Chair for the Home Care Association of America - Wisconsin Chapter, provided the following comments via the "Chat" function on Zoom:
  - To the comment regarding group/pooling insurance options for members of the Chamber of Commerce: the rule was recently changed so that "associations" can pool together for insurance so there are people looking into this. Has heard from private companies that offer health insurance that most caregivers do not take it (for instance, heard that of 85 caregivers, only five took it).
  - A big part of the problem is likely cost and the variability in hours inherent to this business. Also, many caregivers work as caregivers because it works with their family needs which can significantly change throughout the year - many of our caregivers change their desired hours and availability a lot.
  - To the discussion regarding building COLA or market indicators into the rates: this is a great idea. In the association's experience, to remain competitive with wages actually requires higher than COLA because wages are rising faster than that. It would also need to include the additional cost of wages (payroll taxes, worker's comp, etc.) to fully compensate for the increased cost of a wage increase.
  - There are major disruptions to skilled nursing right now, including due to recent Medicare payment model changes and Medicare and Medicare Advantage being aggressive about fast discharges. Anticipates more skilled closing and has heard of many who are decertifying beds.
  - This is a very tumultuous time for home care. The Home Care Assoc. of America WI Chapter just launched a Task Force in Rock Co. to try to work through all the changes with different care providers (e.g., hospital, skilled, home health, hospice and in home supportive care).

MEETING ADJOURNED AT 4:04 P.M.

Prepared by: ALLIE BOLDT, DHS OFFICE OF POLICY INITIATIVES AND BUDGET on 3/10/2020.

These minutes are in draft form. They will be presented for approval by the governmental body on: 3/19/2020