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State of Wisconsin

Scott McCallum
GOVERNOR

Department of Health and Family Services

WCA/WAHSA/WHCA IGT Agreement with DOA/DHFS

- Continue current level of Intergovernmental Transfer (IGT) funds (i.e., $40.1 million and $78.1 million in FY 01 and $37.1 million and $78.1 million in FY 02 and FY 03 in nursing home base).
- Devote all new IGT funds to the Medicaid Program. The vast majority of IGT funds will be used to address nursing home funding needs.
- IGT funds received by the State will not be utilized to reduce or replace current GPR funding (as adjusted in the Medicaid base reestimate) for the nursing home payment system.
- Propose statutory language to establish an interest-bearing IGT Medicaid Trust Account that will be effective upon passage of enabling legislation. An amount equal to all IGT funds received by the State of Wisconsin during or after FY 2001 will be deposited into the trust account. The vast majority of the trust account balances will be utilized to fund current and future expenditures contemplated under this agreement.
- Counties will be identified to participate in an IGT through a wire transfer. Development and transaction costs will be paid from Trust funds (counties will be fully reimbursed for these costs).
- Increase Medicaid nursing home funding by $115 million in 2001-02 and by an additional 4% in 2002-03. The 2001-02 funds would be split $40 million to counties and $75 million for the reimbursement formula. To facilitate a reasonable determination of how the $40 million allocated to the counties will be distributed, the Wisconsin Counties Association (WCA), the Wisconsin Association of Homes and Services for the Aging (WAHSA) and the Wisconsin Health Care Association (WHCA) agrees DHFS should model the following formula parameters for distribution of the $75 million:

  1. Direct Care targets at 104% of the median.
  2. Property/Capital T2 set at 9.5%.
  3. Support Care targets at 95% of the median.
  4. Administration targets at 95% of the median.

  These percentages will be adjusted proportionally as necessary to distribute no more than $75 million. Final formula parameters regarding how the $75 million will be distributed under the 2001-02 nursing home reimbursement formula will be developed by DHFS and the Associations at a later date.
- The Associations' support of a 4% increase in 2002-03 is committed with the expectation that this level is sufficient to maintain the 2001-02 formula. In the event that this level is insufficient, the Associations reserve the right to seek additional funding from the Legislature.
- The Associations and DOA/DHFS have agreed to distribute the $40 million IGT county allocation to cover certain operating deficits of certain facilities operated by counties and other local units of government, in the priority order set forth below. (The attached provides the Associations' projected 2001-02 distribution based on this methodology.) If after covering all deficits within a higher priority category remaining funds are insufficient to cover all deficits within the next lower category, remaining funds shall be divided among

facilities within the next lower category in proportion to the amount of their respective deficits.

For 2001-02:

1. Direct care operating deficits of all such facilities.
2. Total (i.e., direct care plus non-direct care) operating deficits of such facilities operated by Sheboygan, Walworth, Rock, Outagamie and Manitowoc Counties, during the period such facilities are downsizing.
3. Non-direct care operating deficits of all such facilities.

For 2002-03:

The priority order noted for 2001-02 shall be modified so that categories #2, #1 and #3 become the revised priority order for 2002-03.

- Sheboygan, Walworth, Rock, Outagamie and Manitowoc Counties will agree to continue pursuing their downsizing plans.
- The Associations will work with DOA/DHFS to eliminate the Ourada Amendment, assuming the agreement holds and the expanded IGT program is achieved (approved by HCFA). If the parties are not successful in eliminating the Ourada Amendment, all parties agree to renegotiate the terms of this agreement.
- The Administration and Associations will work in a unified manner to secure legislative and federal approval of this agreement.

The above represents the entirety of the agreement between the Associations and DOA/DHFS and assumes that additional IGT federal payments secured by the State of Wisconsin will net approximately $260 million for SFY 01, $190 million for SFY 02 and $155 million for SFY 03. Should actual net IGT federal payments result in funding increases significantly higher or lower than projected, all parties pledge to bargain in good faith to renegotiate a revised IGT funding agreement.

Dated this 2nd day of February, 2001:

Secretary, Department of Administration

Secretary, Department of Health and Family Services

Wisconsin Counties Association

Wisconsin Association of Homes and Services for the Aging

Wisconsin Health Care Association

Hello My name is Linda Bedard and I am the parent of two children. I have an 11yr old daughter and a 4 yr. old son with special needs. Alexander was born with Prune-Belly Syndrome, Scoliosis, Kyphosis, Craniostasis, and severe hearing loss as well as many other anomalies. He has a tracheostomy and is oxygen dependent and partially ventilator dependent. He is considered medically fragile. He has spent almost half of his life in hospitals ill or having surgery. He has many more surgeries ahead of him.

Alex requires 24 HR one on one care from skilled nurses or my husband or myself who has had extensive medical training to meet his medical needs. If there is no nurse to care for him, my husband or I must take off work to be with him. When this happens we lose income from an already tight budget. He needs someone to stay awake with him all day and all night to monitor equipment and machinery he uses during the day and his ventilator during the night. This can be very tiresome for all of the family. If there is no nurse to care for him during the night, a decision must be made whether my husband or I will care for him at night and which one of us can take the time from work and which one of us can do the next day's activies for the whole family. We have to manage our time very carefully.

Our apartment is what our budget allows and is quite small. Alex's room is the living room which has cabinets of medical supplies. A cart of machinery and several large oxygen tanks. Our basement is full of supplies like a hospital.

If Alex needs to leave the house he needs to have a lot of equipment to be carried with him at all times to be ready for any emergency. It is a coordinated effort to leave the house.

Being Alex's parents has been very hard. We miss out on the little things. We cannot hire a baby-sitter for him so we can go to the movies. We take turns being out of the house for work, for groceries, for recreation. Only recently did my husband and I have the opportunity for an evening away. The first since Alex was born 4 years ago.

It is not easy being Alex's sister. My daughter has had to give up school functions and clubs because we were unable to leave the house with Alex while I cared for him alone and my husband was at work in the evenings. She has had to spend time in hospital waiting rooms and ICU units. She has had to learn about oxygen and how to help with Alex. She has missed a lot.

We applied for the Family Support Program when Alex was 6 weeks old. We were on the waiting list for almost 3 years. At one point we considered not reapplying because it seemed hopeless to keep waiting.

Family support has provided for things that Insurance or Medical Assistance does not cover. Special diapers and supplies that make things a bit easier for him and us as a family.

Family support gave us as a family help in staying together. We received marriage counseling to be able to deal with the stress of this "new family life." Without Family Support my husband and I would surely be divorced by now and have gone our separate ways and Alex would need even more help than now.

We receive information and help with our daughter. She is now able to attend activities in the community with her peers. She is making friends and feeling better about herself and her life. She is now thriving as a young child and not a little adult with a sick brother.

Family support is a wonderful program and I only wish more families could benefit from this program. It is very hard being a parent of a child with needs. Every bit of help and support is well appreciated and needed.

Thank You for Listening,
Linda Beard

Dunn County Department of Human Services

808 Main Street
P.O. Box 470
Menomonie, WI 54751
(715) 232-1116
FAX (715) 232-5987

PROMOTING THE DIGNITY AND STRENGTHS OF INDIVIDUALS AND FAMILIES WITHIN THE COMMUNITY

One County Experience – Long Term Support

Services for the Elderly and Disabled

Dunn County DHS is facing a deficit and the county is saying they can no longer accept the deficit at the level they have in the past.

Problem: In Summary

1. We are serving 10 CIP-1A and 70 CIP-1B developmentally disabled. We have approximately 20 client that are open who are on the waiting list for additional services and 60+ eligible DD individuals waiting for services.
2. The daily reimbursement rate for CIP 1A and CIP 1B is below our actual costs. In CIP 1A our average daily reimbursement rate is $130.90 per day. Our average daily cost is $177.33. In CIP 1B, of the 68 clients served, only 18 clients receive the full daily rate of $48.33 per day. Eleven clients have COP state dollars to match the Federal funding and 38 clients need total county match with the county adding match dollars in the other two groups. The average daily cost for the CIP 1B client's is $103.99. Dunn County's share of the CIP 1B costs is 28.3% of the total costs.
3. In the Family Support Program the funding has not increased for years. We are serving 21 families with 6 of them on the waiting list for additional service needs and 40 new families on the waiting list.
4. Last year we did not have a waiting list for the elderly and physically disabled. Because we were able to serve all qualified applicants. Now they need those services for twelve months. We now have a waiting list for services since we now face a projected deficit in the COP-W/CIP II funding programs.
5. Dunn County has made a decision that they can no longer fund the yearly deficit of the Human Services Dept. at the growth it has. This means the waiting list will continue to grow.
6. Our providers continue to face a crisis finding workers to provide the direct care our clients require. The pay scale is low for workers that care for the elderly and disabled. They need a reasonable cost of living increase to be able to provide the level of service we expect.

What we need to do:

1. Recognize there is a funding crisis in funding for services for the elderly and disabled and people in need cannot wait for Family Care.
2. Family Care may be an option but the state must recognize that to serve all qualified elderly and disabled is going to mean an increased financial commitment.

Direct Dial to Dennis R. Ciesielski: (715) 232-1110, ext 236

3. The Counties and State do need to talk to one another and recognize that only by working together can some solutions be found. Both need to accept their role and responsibility in working for a solution.
4. The State needs to be honest with the public on what it can really afford but first they need to ask the citizens where they, us, want to commit the tax dollars. Do we really want tax cuts or more fully serve our vulnerable citizens. Our State funding must match our State philosophy on Long-Term Care, which it is now not doing.
5. I also recognize that State and County agencies need to look at how we provide and purchase services and what we need to do to better serve our clients, our patients, our customers, our fellow citizens. For County's this means looking at cooperative relationships in coordination and purchasing of services. The Kettl Commission has introduced this issue.

Crisis is a strong word but not too strong to define the situation a number of our elderly and disabled are placed in. This coming State legislative session must make funding for Long-Term Care a priority.

Presented by: Dennis R. Ciesielski, LTS Supervisor, Dunn County Dept. of Human Services

Direct Dial to Dennis R. Ciesielski: (715) 232-1110, ext 236

Dear Members of the Joint Committee on Finance:

My name is Karen Olson. I am unable to be here to testify in person due to work commitments. However, my friend and fellow parent has graciously agreed to let our voice be heard as well.

First, let me commend you on taking the time away from your families to travel to these hearings. So many more voices are heard when you reach out as you are doing. As a parent of a child with exceptional needs this is an accommodation in the real sense of the word.

My son, Ryan, is 11 years old. He is a happy child. Well mannered and loving. He is also my hero. He has cerebral palsy, Attention Deficit Hyperactivity Disorder, autism and wears hearing aids in both ears due to partial deafness. Yet this child gets up every morning with a sunny disposition and a "can do" attitude. I don't know that I would be as graceful. He loves natural science and has tested above average for science and social studies but his language and disabilities limit a lot of what he does and a lot of what he learns. We have missed years of home therapy due to lack of equipment and resources. In the first 9 years of Ryan's life I went out socially 5 times. Yes, you heard right. 5 times. We were making ends meet but there was nothing extra to get Ryan the help that he needed.

I speak to you today to ask for funding for the Family Support Program. After many years of waiting Ryan started receiving Family Support in the fall of 2000 at age 10. I personally believe that we have lost critical years. Without Family Support my son would not have therapy equipment, access to sign language books and closed captioning. Lot of people think that there must be programs out there to just "supply" all of the things that my son needs to function and contribute to this world but there are not. Everything has a price tag and often time the prices are very high for specialized equipment. There are no magic programs out there taking care of these needs, but since fall, Family Support has sure seemed like one. Things like respite for me, books on Ryan's disabilities so that I may better raise my son to be a contributing member of our community. Adaptive software for Ryan, closed captioning, deaf accommodations, crucial therapy....the list goes on.

Long waiting lists for the Family Support Program put children with disabilities and their families at risk. According to the Survival Coalition's 2001-2003 Biennial Budget Proposal only 2900 families are currently served; 2400 are on waiting lists and an estimated 3000 more are eligible. Because funding is limited, few families receive the full $3000—the annual average for a family is $1600.

Please vote for $7.5 million for the two years of the state budget to serve the families waiting for Family Support. Don't let the children suffer. They should be the first ones that we protect. THANK YOU.

(#1)

Budget Hearings - Eau Claire

FROM: Len Meysenbourg Adm.
Rice Lake Convalescent Ctr (RLCC)
1016 Lakeshore Dr.
Rice Lake, WI 54868 715-234-9101

RE Nursing Home Funding

I am yielding my time to Jim Diegnaw, However I would like to submit this written support for the current budget proposal. I want you to be sensitive to the following needs when you look at this budget and future modifications.

Nursing homes are understaffed, needing capital for improvements, and have balance sheets and P&L Statements that make the lenders cringe. Also, eliminate future investors considering the industry (both private and public).

RLCC is understaffed because of 2000 & 2001 medicaid increases of less than 1/2 % and less than 2% in consecutive years, do not allow us to staff at a level needed to meets the needs of the increasing acuity level of incoming residents.

Understaffed because the salary levels are not attracting needed personnel into the profession. Also understaffed because many of our professional nurses and CNA's

(over)

#2

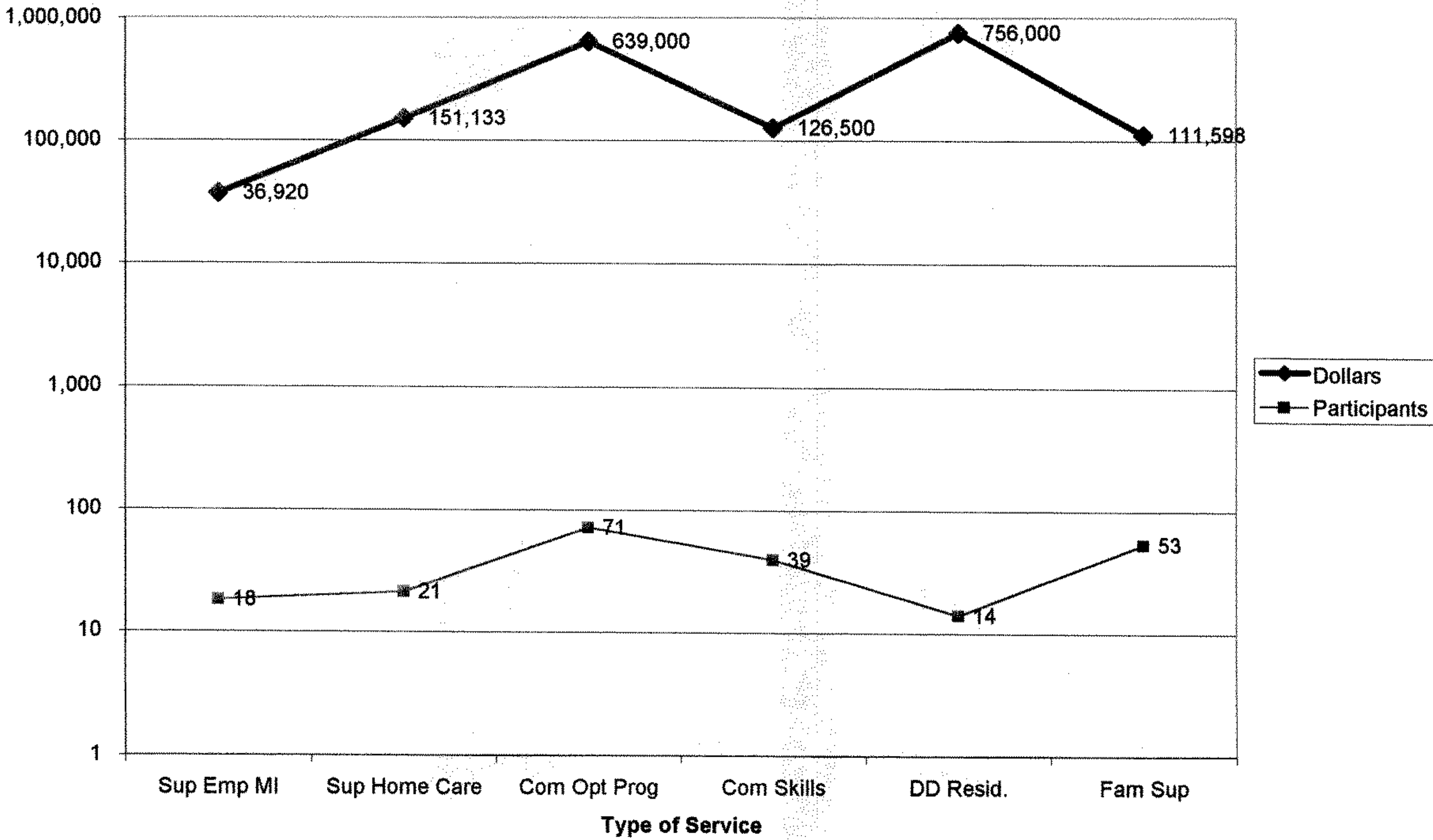
opting out of the industry for easier and much more lucritive positions. & No night, no weekends, no under staffed shifts or working with unfamiliar pool personnel. I am losing a CNA of 17 years to Menards because she has lost faith in our industry and our sensitivity and ability to care for those entrusted in our care.

All of our capital expenditures are those items that are needed for compliance with regulation. All things that will make work easier or our homes more attractive are on hold!

There is an influx of "baby boomers" on the horizon. They will demand rooms and services. Will there be investors or reimbursement that can handle this influx? Most would agree NO!

RLCC is losing money every month. The last quarter of 2000 and the first quarter of 2001 have averaged between a $15000 - $40000 loss per month. Our owner is very ~~apprehensive~~ apprehensive, with a current ratio that is slipping and financial statements are not favorable, will our lending agency re-affirm our long term loan.

Please appropriate all the provisions in current budget and assist the industry in making positive changes in the future


Eau Claire County Department of Human Services
Sept 2000 Waiting List Participants and Costs to Provide Services
1,000,000
100,000
10,000
1,000
100
10
1
36,920
151,133
639,000
126,500
756,000
111,598
18
21
71
39
14
53
Sup Emp MI
Sup Home Care
Com Opt Prog
Com Skills
DD Resid.
Fam Sup
Type of Service
Dollars
Participants

Eau Claire County Department of Human Services(DHS)
Waiting Lists

At September 30, 2000, DHS had approximately 345 clients waiting for services in 17 different categories. Dollars needed to fund these services exceed $2.6 million dollars. Below is a summary of 6 of the waiting list categories:

Waiting List Participants

	Sup Emp MI	Sup Home Care	Com Opt Prog	Com Skills	DD Resid.	Fam Sup
Sep-97	68	36	22	54	28	51
Sep-98	78	17	45	47	27	40
Sep-99	71	24	80	63	25	49
Sep-00	18	21	71	39	14	53

Funds needed to Serve Waiting List Participants

	Sup Emp MI	Sup Home Care	Com Opt Prog	Com Skills	DD Resid.	Fam Sup
Sep-97	$ 146,472	$ 387,274	$ 179,300	$ 160,466	$ 1,226,400	$ 101,308
Sep-98	$ 173,052	$ 188,366	$ 369,315	$ 143,855	$ 1,218,078	$ 79,457
Sep-99	$ 162,110	$ 273,673	$ 676,856	$ 198,443	$ 1,160,700	$ 97,335
Sep-00	$ 36,920	$ 151,133	$ 639,000	$ 126,500	$ 756,000	$ 111,598

Impact to consumers:

Besides the impact on consumers' quality of life while they are waiting for services, the reality is the majority of these people will receive services at some point in their lives. Due to the inability of the system to react early, the services eventually provided will be more intensive and costly to the taxpayer.

Joint Finance Committee Members:

The Birth to Three Program has been a life line for our family. My husband and I are proud parents of two children, a great 4 year old daughter, Shelby, and a wonderful 2 year old son, Kyle. Kyle was diagnosed with Down Syndrome prenatally. With his early diagnoses we were introduced to the Birth to Three program prior to his birth. The people who came to us were very receptive to us, our feeling and needs. This whole experience has been setting a stage for a positive, productive and rewarding future for our son and family. A future we were lead to believe was "gone" upon the diagnose of Down Syndrome.

Kyle started therapies through the Birth to Three program very early on. A massage therapist taught me how to properly administer massage so I could do this at home on my own. The stimulation of massage helped to stimulate Kyle into a more alert boy. By the time he was 3 months old he started physical therapy. I wondered what a physical therapist could do with a 3 month old baby that is very content just lying there. The physical therapist came in and started to twist him this way and that way. I was apprehensive but knew this was a part of a plan to move forward. Then our small boy started to roll and move his arms and legs in a more typical fashion for a child his age. Still with obvious delays his development was actually progressing now. That may not sound like much but to parents like us it is a bit of heaven. He brightened up at the sight of his therapists, so did we as we could see the progress he was making.

Each week Kyle continues to receive occupational therapy, physical therapy and a teacher. Speech therapy comes twice a week due to his delay in verbal skills. He continues to make progress. He has met many milestones at a later time frame than the typically developing child but he continues to make them. At this time Kyle is basically none verbal and has learned how to communicate using sign language. He uses many signs to communicate simple everyday needs and wants with his family and therapist. The Birth to Three Program has brought these professionals to us, they come in and work not only with him but our family. They teach us, including Shelby, how to incorporate activities into play and daily living to help Kyle continue to progress. The Birth to Three Program has done this and so much more for Kyle and us.

It has been proven that the first 3 years of any child's life are the most important in development and brain growth. We stimulate our typically developing children through many every day activities that do not come as easily to special needs children. We hope for health, happiness and the ability for our children to become a productive part of society. With early intervention this can happen for most all children.

The Birth to Three Program has not had an increase in state funding since 1996, however the amount of children in need of services has increased 21%. Higher restrictions for program service eligibility are being considered along with parents eligibility to pay. Changing eligibility from 25% delay to a 30% delay will eliminate about 1000 children from receiving the early intervention they need and eliminate the families from receiving the help and information they could use to help their child and themselves. Requiring parents to pay for a federally mandated service would be like asking them to pay an additional fee for their children's public education and some families simply can not afford it, again eliminating children. The program does not need to be fixed to eliminate the amount of children needing services it needs to be funded to assist the children in need.

An increase of $2 million in state funds in each year of the biennium is what has been found is needed to fund the Birth to Three program appropriately. We ask for your support of the Birth to Three Program and the funds necessary to continue with this much needed early intervention program. If the children do not receive the help they need now greater delays will be there when they start school. Getting the child the assistance at school age will not only cost more but is not as productive for the child as teaching them at the most influential time of their life....Birth to Three, which will last them a lifetime.

Thank you for your time and interest in this very important subject.

Sincerely,

Rick & Peggy Crank
18643 51st Avenue
Chippewa Falls, WI 54729
715-726-9954
Representative District #68 / Senator District #23

Why spend more money now on early intervention?

Because it will save future spending.

BRAIN DEVELOPMENT

THE FIRST THREE YEARS REALLY DO LAST A LIFETIME

Brain cells are called neurons. Neurons have the ability to reach out to other neurons and form pathways. When this happens it is called a synapse. At birth, an infant has 100 billion brain cells. All human babies are born with trillions upon trillions of brain cells with almost infinite potential.

If neurons are used, they become integrated into the circuitry of the brain by connecting to other neurons; if they are not used they may die. It is the experiences of childhood, and which neurons that are used, that wire the circuits of the brain. Early experiences are so powerful, says pediatric neurobiologist Harry Chugani of Wayne State University, that "they can completely change the way a person turns out."

The brain development of infants and toddlers proceeds at a staggering pace. By the age of two, the number of synapses reaches adult levels; by age three, a child's brain has 1,000 trillion synapses—about twice as many as her pediatrician's. By the time the child reaches school age, her brain has already begun "pruning" excess synapses that are not used regularly. This is why early experience plays such a crucial role. Through repeated stimulation, you can make contact with and strengthen the synapses in the brain. After a certain level of stimulation has been achieved, something extraordinary happens to the synapse—it becomes exempt from elimination. It can not be pruned, and it will hold its protected status into adulthood.

The implications of this understanding of how the brain develops are both promising and disturbing. They show that with the right input at the right time, almost anything is possible. But they also show that if you miss the critical period in a child's development—if you miss that window while it's still open—that you can actually stunt a child's ability to achieve.

SOME STARTLING EXAMPLES INCLUDE:

~Scientists have experimented with sewing shut one eye of a newborn kitten. Because no neurons were able to connect from the closed eye to the visual cortex of the brain, the cat was still blind in that eye when the eye was reopened. The scientists actually rewired the kitten's brain. Such rewiring did not occur in similar tests performed on adult cats. A baby whose eyes are clouded with cataracts from birth will, despite cataract-removal surgery at the age of two, be forever blind. Because of this

knowledge, eye surgeons are removing congenital cataracts much sooner, to ensure that visual acuity will not be lost.

~By the age of one, a child in an English-speaking home has a different auditory mapping of the brain than a child in a Swedish-speaking home. Already, at such a young age, a child will become functionally deaf to sounds absent from their native tongue. This is why people have accents.

~Maintaining a large number of synapses requires considerable energy. Using PET Scan Technology, scientists have documented the fact that in the early years, the brain has a significantly higher metabolic rate (as measured by its utilization of glucose) than it will have later in life. This is presumably due to the profusion of connections being formed in the brains of young children.

~Children who have lost their ability for language due to a stroke are often able to recover their abilities to speak and to understand. This is because the brain will actually transfer this function to its other hemisphere. In cases of intractable epilepsy, where it is sometimes necessary to remove an entire hemisphere of the child's brain, the remaining hemisphere will actually begin to do "double duty". In many cases the brain is able to rewire itself and compensate for the missing hemisphere. Literally left with half of a brain, many of these children were able to become virtually fully functional again.

~Some "windows" are open longer: it takes up to two years for cells in the cerebellum, which controls posture and movement, to form functional circuits. "A lot of organization takes place using information gleaned from when the child moves about in the world," says William Greenough of the University of Illinios. "If you restrict activity, you inhibit the formation of synaptic connections in the cerebellum." The window lasts for only a few years; a child immobilized in a body cast until age four will learn to walk eventually, but never fluidly.

And so in these few examples, we can see that there truly are critical periods in brain development. Periods where significant alterations to the brain's architecture appear to be possible. "Perhaps 'critical' is not a good word", Harry Chugani observes, "This is an opportunity, really—one of nature's provisions for us to change the anatomy of the brain and make it more efficient". There is ample scientific evidence showing that the brain has the capacity to change in important ways in response to experience. A child's capacities are not fixed at birth. The brain itself can be altered—or helped to compensate for problems—with appropriately timed, intensive intervention. If we miss these early opportunities to promote healthy development and learning later remediation will be more difficult, more expensive, and less effective.

Sources: A Baby's Brain is a Work in Progress by Sharon Begley and Mary Hager, Newsweek Magazine Nov 19, 1996

Rethinking the Brain—New Insights into Early Development By Rima Shore

Issue:
Nursing Home Budget Funding

BACKGROUND:

The Crisis: Wisconsin's nursing facilities are confronting a financial crisis unparalleled in history. A September 2000 report by the national accounting firm of BDO Seidman detailed the seriousness and source of that crisis:

- In 1999-2000 Wisconsin's Medicaid program reimbursed facilities $100 million less that the cost of the care they provided their Medical Assistance residents.
- 83% of the state's Medicaid certified facilities did not receive a Medicaid rate sufficient to meet their care delivery costs.
- The average nursing facility lost nearly $11 per day and $250,000 annually in providing care to its Medicaid residents.

After detailing the nature and scope of the inadequacies of the Wisconsin nursing home reimbursement system, the BDO Seidman study concluded that Wisconsin "ranks near the bottom [of all other states] in adequately reimbursing the Medicaid costs of nursing homes." Disturbingly, nursing facility losses have worsened since 1999-2000 due to further collapse of the Medicaid formula's payment ceilings. Indeed, $22 million in cuts to the current year's payment formula, have triggered rate cuts for 20% of the state's facilities and increases of less than 2% for more than half of the facilities. As a result, the average Medicaid loss experienced by Wisconsin nursing homes this year is expected to reach $300,000.

The Proposed Remedy: Since the release of the BDO Seidman report, the WHCA membership has made an extensive effort to meet directly with their elected officials to assure they fully recognize the seriousness of the Medicaid funding crisis and the severity of its impact on their ability to serve their residents, employees, and community. We have sought both understanding and support.

But our efforts have not been limited to merely presenting the problem to public officials. We have simultaneously worked with state officials to explore potential solutions. Indeed, early last summer WHCA, WAHSA, and the Wisconsin Counties Association retained national consultants to examine the potential for capturing more federal dollars through expansion of the state's Intergovernmental Transfer Program. In September of 2000, we formally presented the consultants' findings and recommendations to the Governor's Office, DOA, and DHFS representatives. In the ensuing months all organizations worked together to research and develop a new and expanded IGT program similar to a model the federal government had approved for 25 other states. On February 2, 2001, the design plan for a revised IGT program and for the distribution of funds it would generate were set forth in a written agreement between DOA, DHFS, WHCA, WAHSA, and the Wisconsin Counties Association.

On February 27th, Governor McCallum released his proposed 2001-03 state budget. The remedial relief it has advanced to address the nursing home funding crisis is consistent with the terms of the February 2, 2001, agreement. Key components of the relief envisioned both in the agreement and the budget (both are conditioned on federal approval of the state's new IGT plan) are as follows:

- $40 million in new IGT funding will be made in FY02 and FY03 to to address direct care deficits of all county nursing homes and fund the downsizing of five county facilities.
- $75 million in IGT funding will be allocated in FY02 for the Medicaid nursing home payment formula.
- IGT funds will provide a 4% increase in nursing home funding in FY03 intended to permit DHFS to maintain the parameters of the 2001-02 Medicaid payment formula.

- Establishment of an IGT Medicaid Trust Account, the balance of which will used to assure the state's ability to continue to fund nursing home and other MA provider relief envisioned under the agreement.

It should be noted the funding increases proposed for nursing home relief in the Governor's budget do not include any state GPR dollars. They are funded exclusively with federal dollars the state anticipates receiving if, and when, its new Intergovernmental Transfer Program secures federal approval. The state's IGT program proposal is currently pending before the US Department of Health & Human Services.

WHCA Position: WHCA endorses and requests that members of the Legislature support the funding increases for nursing facilities set forth in Governor McCallum's budget proposal (Senate Bill 55/Assembly Bill 144).

The extent and intensity of the current Medicaid funding crisis cannot be overstated. Neither can the urgency of the need for relief. Indeed, the funding increases proposed in the budget are absolutely essential for nursing homes to serve their residents, staff, and community. The immediate and long term consequences of a failure to provide the proposed relief are unthinkable.

WHCA

Wisconsin Health Care Association

BDO Seidman, LLP
Accountants and Consultants

Special Report

On the Financial Condition of Nursing Homes in Wisconsin

PREPARED BY
BDO SEIDMAN, LLP
ACCOUNTANTS AND CONSULTANTS

September 2000

About BDO Seidman, LLP

BDO Seidman, LLP (BDO) is an accounting and consulting organization servicing clients through more than 40 offices and 50 alliance firm locations across the United States. As a member firm of BDO International, BDO leverages a global network of resources to serve clients abroad through more than 490 members firm offices in over 80 countries.

The firm maintains a number of specialized service lines, one of which is healthcare. BDO services hundreds of long-term care facilities, of all ownership types, throughout the United States, providing accounting, auditing, tax, feasibility, and specialized consulting in areas such as reimbursement, clinical operations, and corporate compliance.

The primary author of this report is Joseph M. Lubarsky, a partner and the firm's National Director of Long Term Care Services. He personally has provided consulting services to nursing home associations in 20 states. His work includes conducting cost impact studies and studies on the adequacy of payment systems, designing and developing new Medicaid payment systems, and providing litigation support.

In the past two years, Mr. Lubarsky has served as lead consultant to associations on the redesign of Medicaid payment systems in Kentucky, Idaho, and Colorado. He is currently involved in the redesign of the Medicaid payment systems in Virginia, New Jersey, and Arkansas.

EXECUTIVE SUMMARY

BDO Seidman, LLP was engaged by the Wisconsin Health Care Association and the Wisconsin Association of Homes and Services for the Aging to conduct a study on the financial condition of nursing home facilities in Wisconsin. Specifically, we were asked to determine whether facilities are experiencing serious financial difficulties, identify the major contributing factors, and estimate the fiscal impact of establishing a more reasonable Medicaid reimbursement system.

Wisconsin's nursing facilities are in serious financial distress. We identified several factors leading to their poor financial condition, including federal Medicare payment reductions, declining nursing home occupancy levels and acute labor shortages. However, our analysis indicates, without question, that the inadequacies of the Wisconsin Medicaid payment system have had the greatest impact on the deterioration of the financial and operational condition of Wisconsin's nursing facilities.

KEY FINDINGS

Our key findings, summarized here, and more fully detailed elsewhere in this report, are as follows:

- Wisconsin's Medicaid program is the source of payment for almost 70% of the 43,000 individuals residing in Wisconsin's nursing facilities.

- State payments to the nursing facilities for providing care to Medicaid recipients are currently $100 million less than the costs facilities incur in providing that care.

- 83% of the state's Medicaid certified facilities do not receive payment rates that meet the cost of providing care to their Medicaid residents.

- In fiscal year 2000, the average Medicaid loss per patient day was $10.90. For a 100 bed facility, with a 70% Medicaid census, this translates into an annual loss of $250,000.

- Taking into account all sources of payment (Medicare, Medicaid, private payment and insurance) the average margin for all Wisconsin nursing homes in 1999 was a negative 4.79%.

- The level at which the state proposes to establish Medicaid payment ceilings for the current rate year of July 1, 2000 through June 30, 2001 is the lowest in the United States. These lower ceilings, representing the maximum cost level that Medicaid will reimburse, will result in average Medicaid facility losses increasing by an additional $2 - $3 per resident day. The average facility loss for the 2000-2001 rate year is expected to reach $300,000.

- To improve the state's present system to a level where only 40% of the state's facilities experience rates below their costs will require an appropriation of $57 million in new funds. This is exclusive of an additional $22 million needed to eliminate further reductions in payment ceilings for the current rate year of July 1, 2000 to June 30, 2001.

REDUCTIONS IN MEDICAID PAYMENT CEILINGS

Wisconsin's Medicaid payment system establishes various cost centers (most notably direct care, support services, and administrative services) and within these cost centers sets payment ceilings based on a percentage of the median of nursing facilities' costs. The median is determined by arraying per patient day costs of facilities from high to low and identifying the costs of the facility at the midpoint. By definition, payment ceilings established at the median assures that only one-half of all homes within each cost center are fully paid their Medicaid costs.

These payment ceilings have been substantially reduced over the past decade because budgeted funding for the nursing facility Medicaid payment system has failed to keep pace with increasing costs of care. These shortfalls have occasioned the collapse of the Medicaid payment ceilings within the State's reimbursement system. As a result, for the rate year ended June 30, 2000, only 17% of all nursing facilities were reimbursed their Medicaid costs; average Medicaid losses were almost $11 per patient day; and aggregate Medicaid losses for all Wisconsin facilities exceeded $100 million.

The Wisconsin State Medicaid program recently announced that further reductions in Medicaid payment ceilings will be imposed effective July 1, 2000. These reductions will make Wisconsin's Medicaid nursing home payment ceilings, expressed as a percentage of the median, the lowest in the country. As a result, 20% of facilities will receive a rate decrease for the 2001 fiscal year while another 46% will receive rate increases less than their actual cost increases. Average Medicaid facility losses will increase by an additional $2-$3 per resident day, or in excess of $300,000 per year for a 100 bed facility with a 70% Medicaid census.

Margins from other payors such as the federal Medicare program and private pay residents are not enough to subsidize losses of this magnitude. Such subsidies are declining due to Medicare payment reductions and growing competition and expanded housing and service options for private pay residents. Indeed, when comparing total revenues from all sources to total costs, the average margin for Wisconsin nursing homes in 1999 was a <u>negative</u> 4.79%.

CORRECTING THE PROBLEM

Increases in facility per diem care costs above the general rate of inflation are due to a number of factors including dramatic increases in resident acuity, the unparalleled labor shortage, record high levels in admissions and discharges, and higher vacancy rates. These factors, coupled with the recent Medicare nursing facility payment reductions under PPS, places facilities in a financially and operationally unstable

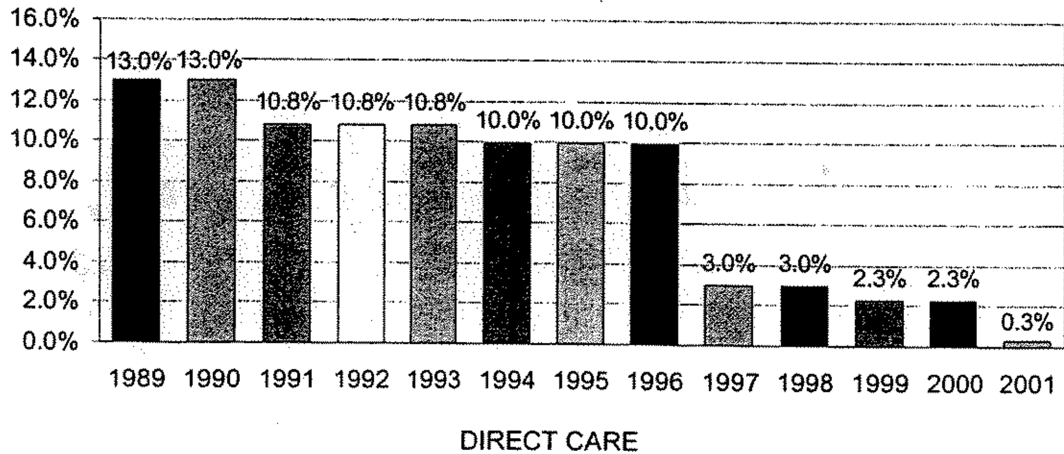
situation. In short, facilities cannot afford to lose $11 per day on each Medicaid resident and still remain financially solvent. The Medicaid program, whose patients represent almost 70% of the nursing home population, must better compensate facilities for the costs of Medicaid patients.

We modeled the impact of modifying Wisconsin's Medicaid payment system for the rate year of July 1, 1999 to June 30, 2000 to establish ceilings at levels comparable to what other states have done that have recently redesigned their payment systems. Our analysis indicates that doing so would have required an annual increase in 1999-2000 Medicaid funding of approximately $57 million ($27/GPR, or state funds). This does not include the cost to eliminate the payment cuts for the current rate year of July 1, 2000 to June 30, 2001. We project an additional $22 million will be required to achieve that end.

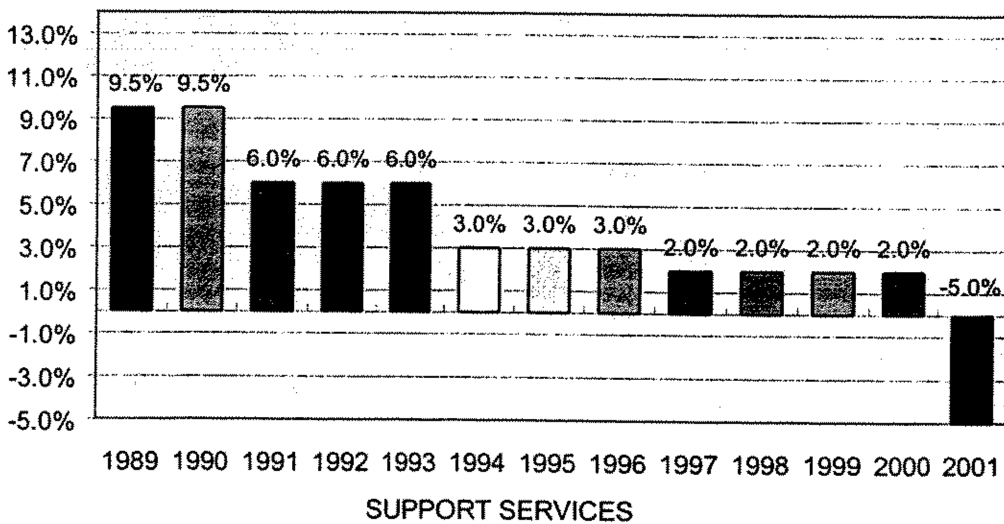
Such a system would be reasonable, but not generous, reimbursing the Medicaid costs of approximately 60% of facilities. This approach can best be viewed as maintaining the status quo; it does not provide additional funding to remedy current staffing shortages or enhance employee wage and benefit packages.

WISCONSIN NURSING HOME MEDICAID PAYMENT CEILINGS BY YEAR

CEILINGS EXPRESSED AS A PERCENTAGE ABOVE (OR BELOW) MEDIAN



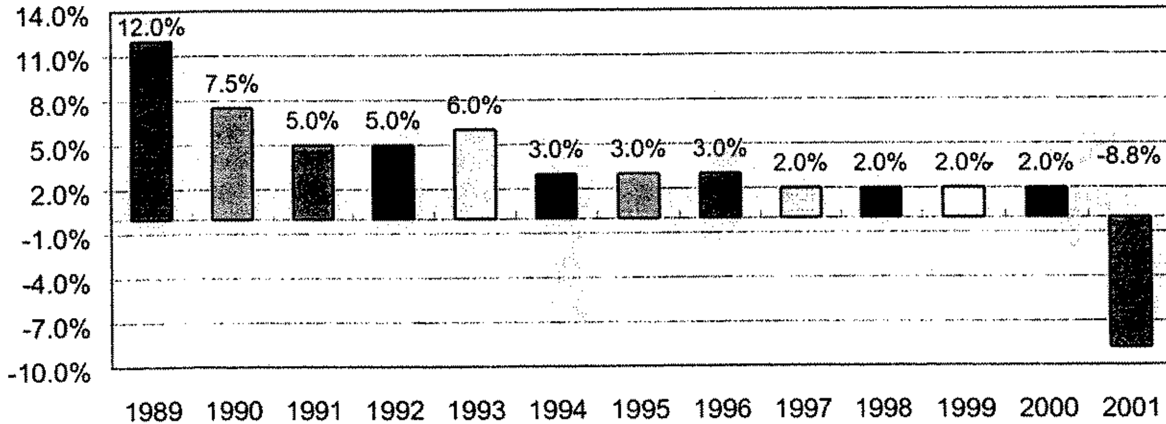
DIRECT CARE



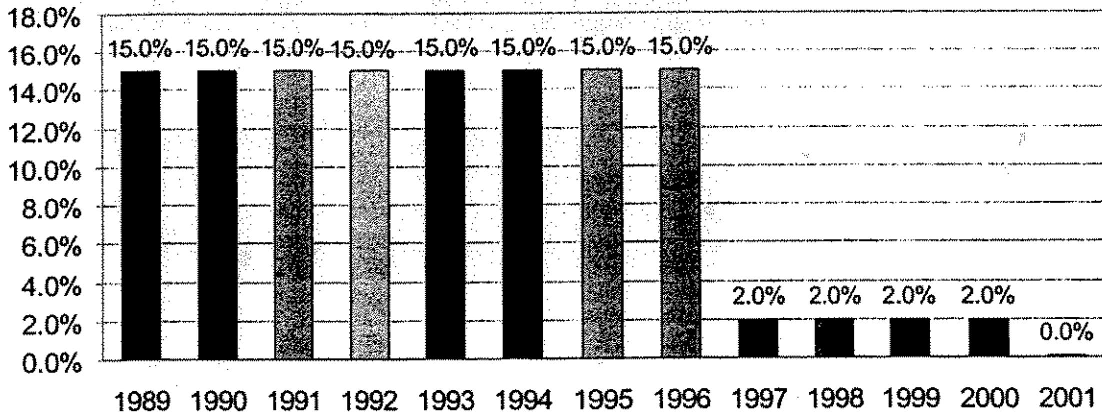
SUPPORT SERVICES

WISCONSIN NURSING HOME MEDICAID PAYMENT CEILINGS BY YEAR

CEILINGS EXPRESSED AS A PERCENTAGE ABOVE (OR BELOW) THE MEDIAN

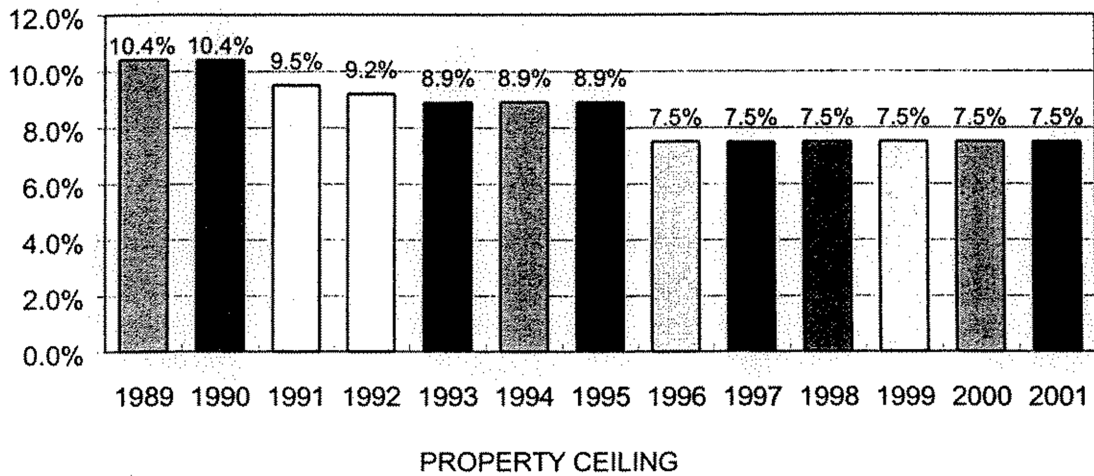


ADMINISTRATION



UTILITIES

WISCONSIN NURSING HOME MEDICAID PAYMENT CEILINGS BY YEAR



Medicaid Component Ceilings as a Percentage of Median Costs

State	Direct Care (1)	Indirect Care (1)	Operating Cost (1)
Connecticut	135%	115%	100%
Idaho	128%	123%	
Colorado	125%	120%	
Kansas	125%	130%	115%
Minnesota	125%	110%	
Nebraska	125%	115%	115%
South Dakota	125%	110%	
Wyoming	125%	105%	
Ohio	124%	113%	
Mississippi	120%	120%	109%
Missouri	120%	110%	
Pennsylvania	117%	112%	104%
Hawaii	115%	110%	
Vermont	115%	100%	
Maine	112%	110%	108%
Virginia	112%	108%	
Alabama	110%	110%	105%
Indiana	110%	100%	
New York	110%	108%	
Montana	109%	103%	
South Carolina	105%	105%	105%
Georgia	90th (2)	85th (2)	70th (2)
North Carolina	80th (2)	Flat Rate	
Maryland	75th (2)	119%	114%
Kentucky	(3)	(3)	
Wisconsin	**100%**	**95%**	**91.8%**

(1) Some states have two cost centers, while others have three; the third usually being administration.

(2) Ceiling is computed as a percentile, rather than percentage of the median. For example, 90th percentile represents that ceiling is set at a level whereby 90% of facilities are fully reimbursed their costs.

(3) Kentucky reimburses under a price system based upon a model rate for all facilities (adjusted for acuity). The model rate is set high enough so that 60-70% of facilities are fully reimbursed their costs.

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State of Wisconsin

Department of Health and Family Services

Scott McCallum
GOVERNOR

WCA/WAHSA/WHCA IGT Agreement with DOA/DHFS

- Continue current level of Intergovernmental Transfer (IGT) funds (i.e., $40.1 million and $78.1 million in FY 01 and $37.1 million and $78.1 million in FY 02 and FY 03 in nursing home base).
- Devote all new IGT funds to the Medicaid Program. The vast majority of IGT funds will be used to address nursing home funding needs.
- IGT funds received by the State will not be utilized to reduce or replace current GPR funding (as adjusted in the Medicaid base reestimate) for the nursing home payment system.
- Propose statutory language to establish an interest-bearing IGT Medicaid Trust Account that will be effective upon passage of enabling legislation. An amount equal to all IGT funds received by the State of Wisconsin during or after FY 2001 will be deposited into the trust account. The vast majority of the trust account balances will be utilized to fund current and future expenditures contemplated under this agreement.
- Counties will be identified to participate in an IGT through a wire transfer. Development and transaction costs will be paid from Trust funds (counties will be fully reimbursed for these costs).
- Increase Medicaid nursing home funding by $115 million in 2001-02 and by an additional 4% in 2002-03. The 2001-02 funds would be split $40 million to counties and $75 million for the reimbursement formula. To facilitate a reasonable determination of how the $40 million allocated to the counties will be distributed, the Wisconsin Counties Association (WCA), the Wisconsin Association of Homes and Services for the Aging (WAHSA) and the Wisconsin Health Care Association (WHCA) agrees DHFS should model the following formula parameters for distribution of the $75 million:

  1. Direct Care targets at 104% of the median.
  2. Property/Capital T2 set at 9.5%.
  3. Support Care targets at 95% of the median.
  4. Administration targets at 95% of the median.

  These percentages will be adjusted proportionally as necessary to distribute no more than $75 million. Final formula parameters regarding how the $75 million will be distributed under the 2001-02 nursing home reimbursement formula will be developed by DHFS and the Associations at a later date.
- The Associations' support of a 4% increase in 2002-03 is committed with the expectation that this level is sufficient to maintain the 2001-02 formula. In the event that this level is insufficient, the Associations reserve the right to seek additional funding from the Legislature.
- The Associations and DOA/DHFS have agreed to distribute the $40 million IGT county allocation to cover certain operating deficits of certain facilities operated by counties and other local units of government, in the priority order set forth below. (The attached provides the Associations' projected 2001-02 distribution based on this methodology.) If after covering all deficits within a higher priority category remaining funds are insufficient to cover all deficits within the next lower category, remaining funds shall be divided among

facilities within the next lower category in proportion to the amount of their respective deficits.

For 2001-02:

1. Direct care operating deficits of all such facilities.
2. Total (i.e., direct care plus non-direct care) operating deficits of such facilities operated by Sheboygan, Walworth, Rock, Outagamie and Manitowoc Counties, during the period such facilities are downsizing.
3. Non-direct care operating deficits of all such facilities.

For 2002-03:

The priority order noted for 2001-02 shall be modified so that categories #2, #1 and #3 become the revised priority order for 2002-03.

- Sheboygan, Walworth, Rock, Outagamie and Manitowoc Counties will agree to continue pursuing their downsizing plans.
- The Associations will work with DOA/DHFS to eliminate the Ourada Amendment, assuming the agreement holds and the expanded IGT program is achieved (approved by HCFA). If the parties are not successful in eliminating the Ourada Amendment, all parties agree to renegotiate the terms of this agreement.
- The Administration and Associations will work in a unified manner to secure legislative and federal approval of this agreement.

The above represents the entirety of the agreement between the Associations and DOA/DHFS and assumes that additional IGT federal payments secured by the State of Wisconsin will net approximately $260 million for SFY 01, $190 million for SFY 02 and $155 million for SFY 03. Should actual net IGT federal payments result in funding increases significantly higher or lower than projected, all parties pledge to bargain in good faith to renegotiate a revised IGT funding agreement.

Dated this 2nd day of February, 2001:

Secretary, Department of Administration

Secretary, Department of Health and Family Services

Wisconsin Counties Association

Wisconsin Association of Homes and Services for the Aging

Wisconsin Health Care Association

PA01092.MB/PERM

MEDICAID INTERGOVERNMENTAL TRANSFER (IGT) PROGRAM
A SUMMARY – FEBRUARY 2001

Background - Currently, Wisconsin's IGT program uses the public expenditures that cover otherwise unreimbursed Medicaid (MA)-allowable costs of government-operated nursing homes to claim federal matching funds under MA. Under the current system, DHFS is projected to claim $118.1 in federal IGT funds in FY01. In the fall of 2000, the federal Health Care Financing Administration (HCFA) questioned this methodology and has deferred three state claims for federal funds, totaling $31.4 mn. In addition, recent federal changes have permitted states additional flexibility in calculating the Medicare Upper Limit for non-government owned and operated facilities. This flexibility has allowed Wisconsin the opportunity to claim additional federal funds under an IGT.

Goal of DHFS/DOA activity – To protect Wisconsin's current $118.1 mn claim of federal funds under the current IGT and to request federal approval to claim additional federal funds.

What Is Being Proposed

- Replace the state's current IGT.
    - The proposed replacement IGT is based upon a wire transfer of borrowed funds from three counties (Rock, Sheboygan and Walworth) to the state. The steps of this transaction are (also see Attachment 1):
        1. The counties transfer funds to the state under an agreement with the state.
        2. These funds will be borrowed from a financial institution through revenue anticipation notes.
        3. The amount of the transferred funds from each county is identical to a special supplemental MA payment to those counties.
        4. The entire transaction takes place on one day, at a single financial institution.
        5. The state then claims federal funds (approx. 60%) on the amount of the returned payment, upon federal approval.
        6. The new federal funds, if used for the state share of future MA payments, can then be matched with additional federal MA funds.
    - The wire transfer approach is currently used by 25 other states in their IGT programs to claim very large amounts of federal funding. The federal government has acted to restrict the use of the IGT program by states. On January 12, 2001 the federal Department of Health and Human Services issued a new IGT regulation that restricts the use of the IGT program and eliminates a "loophole" that has allowed states to claim "extra federal MA funds inappropriately". The new rule will have an effective date of March 13, 2001. DHFS is planning to submit an amendment to its FY01 MA state plan in early February, prior to the effective date of the new regulation, that would implement the new wire transfer and potentially achieve the two short-term goals listed above. The federal government must act on the MA state plan amendment (i.e., either approve or disapprove) within 90 days of its submission.
    - Requires elimination of the statutory "Ourada amendment" in Sec. 49.45(6u) in FY 01 to allow new IGT funds to be distributed based on legislative review and approval of the biennial budget. .

- DOA , DHFS, the two nursing home associations and the Wisconsin Counties Association will support the Governor's proposed use of the new IGT funds in the 2001-03 biennial budget.

DOA/DHFS 02/01/01

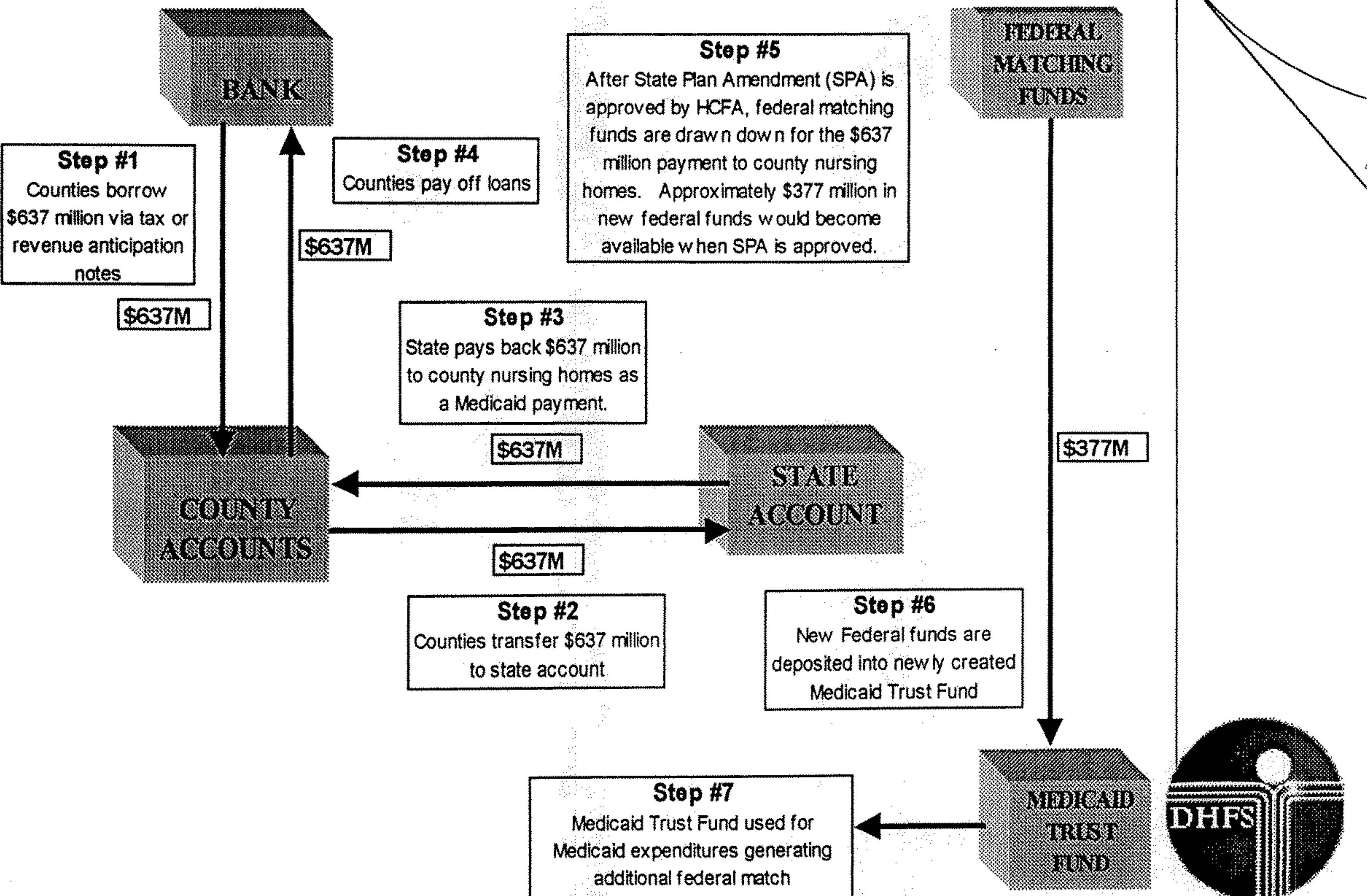
Benefits of the IGT

- Significant new funds for Wisconsin:

SFY2001	$258.7 million
SFY2002	$189.6 million
SFY2003	$155.7 million

- Provisions of agreement between NH Associations and State include:
  - Continue current level of IGT funding (including $40.1 mn in SFY01 and $37.1 mn in SFY02 and 03)
  - Devote all new IGT funds to Medicaid, mostly to NHs
  - New IGT funds will not replace current State funding
  - State will propose legislation to establish Medicaid Trust Fund for proceeds of IGT and to eliminate the Ourada Amendment

The Wire Transfer for Fiscal Year 2000-2001



ANALYSIS

THE IMPACT OF

NURSING HOMES

ON

WISCONSIN'S ECONOMY

Wisconsin Health Care Association

Prepared by:
Dennis K. Winters
Relevant Economic Analysis Limited

February 2001

Issue:
Economic Impact of Wisconsin Nursing Homes

Wisconsin's skilled nursing facilities are primarily recognized only for the importance of their role as a home and provider of quality health care for the most frail and elderly members of their community. What is often overlooked and underappreciated is the magnitude of their contribution to the economic health and vitality of the communities they serve.

To better understand and identify the magnitude of that contribution, WHCA engaged the Madison-based economic consulting firm of Relevant Economic Analysis Limited* to analyze the impact of nursing homes on Wisconsin's economy.

The firm's analysis, completed in February 2001, underscores that nursing homes provide not only an invaluable service for the elderly members of their community but also have a tremendous economic impact on the entire community, serving in many cases as the largest employer and purchaser of supplies and services. Indeed, collectively responsible for nearly 90,000 jobs and annually adding over $3.2 billion to Wisconsin's economy, every one of Wisconsin's 424 nursing homes makes an immense contribution to the economic health, and social well-being of their neighborhoods.

Nursing Facilities Contribute to Wisconsin's Economy

- In 1999, nursing homes accounted for almost $3.2 billion in economic activity in the state.
- An average 100-bed Wisconsin nursing home contributes $7.1 million to the state and local economy.
- Nursing homes generate employment for almost 90,000 Wisconsin workers.
- For every 100 nursing home jobs, another 68 are created to meet the needs of those workers both at work and at home.

Wisconsin's Nursing Homes Invest in Caring

- In 1999, the costs of operating Wisconsin nursing facilities totaled over $2.0 billion.
- The typical 100-bed nursing home employs 92 workers and spends $4.7 million per year to deliver services to the elderly.

Wisconsin's Nursing Homes Provide Employment

- In 1999, Wisconsin nursing homes directly employed 58,500 workers earning more than $1.3 billion in wages, salaries and benefits.
- Employee compensation (wages, salaries, and benefits) constitutes 64% of a facility's operating expenses.
- The average 100-bed home employs 92 workers with a total payroll of $3 million.

The financial stability of the state's nursing homes is vital to their employees, members of their community who require their services, and to the economy of the communities they serve. However, the continued viability

and existence of almost every facility in this state is presently threatened by the inadequacies of the Medicaid program - a program that pays 83% of the state's facilities a rate less than the cost of care they provide. While responsible for payment for care received by 70% of the state's 43,000 nursing home residents, Medicaid program payments to nursing homes fall a staggering $100 million short of the cost of the care facilities provide those residents.

In the year 2000, more Wisconsin nursing facilities than ever closed their doors. In the absence of budget funding to address the glaring inadequacies of the Medicaid payment system, the number and frequency of nursing home closures will surely escalate.

Summary: Wisconsin's nursing homes exist to serve the neediest members of their community through the most trying period of their lifetime. Most members of the community recognize and appreciate this. But most understandably do not recognize the additional value the facility's presence provides their community.

WHCA's economic impact study was undertaken to identify the true extent of the economic benefits a nursing home's presence brings to its community. But the study also demonstrates the magnitude of the economic void that will be created if that facility were to close.

"Nursing homes are in serious trouble, and that means trouble for all of us."

Waukesha Freeman editorial
October 5, 2000

*Relevant Economic Analysis, Ltd. is an economic consulting firm based in Madison. Dennis Winters, its President, performed the analysis of the economic impact of Wisconsin nursing homes. He has over twenty years experience in economic and market analysis and forecasting. He is a former senior economist with Wharton Forecasting and DRI/McGraw Hill (Now DRI-Standard and Poors). He is a co-author of "Wisconsin's Economy in 2010" and he authored "Sustaining Wisconsin's Economic Activity" a white paper for the Wisconsin Economic Summit in November 2000.

WHCA

Wisconsin Health Care Association

NURSING HOMES' CONTRIBUTION TO WISCONSIN'S ECONOMY

Introduction

Wisconsin's nursing homes make a highly valued contribution to not only the clientele served and their families, but also to the state and the individual communities in which they reside. In some communities, the local nursing home may be the largest employer in the area, supplying jobs, incomes and sustainability to other local area businesses. Therefore, nursing homes' economic health and value to their communities and the state cannot be overlooked.

In the Winter of 2001, the Wisconsin Health Care Association (WHCA) asked Relevant Economic Analysis Limited (REAL Econ) to undertake a brief analysis of the economic contribution nursing homes make to Wisconsin's economy. REAL Econ used data drawn from the State of Wisconsin 1999 Medicaid Cost Report as input into an economic impact model to determine the size of the economic contribution nursing homes make to state's economy.

Wisconsin's nursing homes:

- account for almost $3.2 billion in economy activity within the state
- pay out $1.3 billion in wages, salaries and benefits
- employ 58,500 workers and support another 31,000 workers in supply industries
- maintain facilities to accommodate some 45,000 residents
- are responsible for nearly $3.7 million in state income and property taxes.

The total economic contribution nursing homes make to Wisconsin's economy is large indeed. As a business resource, Wisconsin's nursing homes should remain a viable segment of the state's economic landscape. Furthermore, Wisconsin's nursing homes will become more valuable as the state's elderly population increases with the aging of the Baby Boomers. By the year 2010, Wisconsin's population over 65 years of age will be growing 3% per year. This compares to a growth rate for the state's total population of 0.5% per year. This growing elderly segment of the state's population will require an ever-increasing level of services provided by Wisconsin's nursing homes and other long-term care providers.

Direct Economic Impact

Wisconsin nursing home output in 1999 totaled over $2.0 billion. This is roughly equivalent to the size of the Primary Metals, Chemicals and Rubber & Plastics industries in the state.

Nursing homes paid out over $1.3 billion in total payroll in 1999, some 64% of total operating costs. Another three-quarters of a billion dollars were spent in the purchase of goods and services

from other supply chain businesses (B2B). Nursing home facilities paid out nearly $2.7 million dollars in real estate, property and municipal taxes and fees. Nursing home employees paid out almost $1.0 million dollars in state personal income taxes.

Direct Economic Inputs

Items	Amount
Payroll net Taxes & Benefits	$998,518,236
B2B Purchases	758,821,161
Wisconsin Personal Income Tax	977,266
RE, PP, Municipal Taxes & Fees	2,696,900
Total	**$1,761,013,563**

To fairly represent the impact nursing home employee spending makes to the state, we use only discretionary disposable income. We arrive at that figure by subtracting personal income taxes and benefits from the total payroll numbers. Federal and state income taxes were calculated using the standard Federal and State personal income tax tables. We assumed standard deductions for a married couple filing jointly with two children. We also assumed no other income, earned or otherwise. This yields a conservative estimate of personal income taxes paid as Wisconsin has a large number of two income families and no account was given for income from savings deposits, bond or equity investments or rents.

Federal income taxes paid by Wisconsin's nursing home employees in 1999 were estimated at $84.2 million. State income taxes amounted to $1.0 million. Employee benefit costs totaled almost $250 million in 1999, according to reported data. The flow of benefits payments within the state economy is unclear so the impact was not included in this analysis. Real estate, property and municipal taxes and fees totaled $2.7 million. These costs were subtracted out of the B2B expenditure totals.

Wisconsin nursing homes employed 58,459 employees in 1999. This is larger than the state's Printing & Publishing and Paper & Allied Products industries.[1] Interestingly, over half of all nursing home jobs were part-time positions, 30,590, with 27,869 full-time positions, equating to 41,122 full-time equivalent (FTE) positions.

Total Economic Contribution

The flow of dollars spent by nursing facilities within the state's economy expands as the money passes through the hands of supply chain firms. Nursing home employees spend their income on other goods and services in the local economy and the nursing homes themselves purchase goods and services from supply chain businesses. The firms along the supply chain in turn pay wages and salaries and purchase goods and services from businesses further along the chain. As a result, the total money spent by a nursing home on payroll and goods and services expands to a larger monetary impact in a regional economy. This is referred to as the multiplier effect. Some of the dollars

are lost to other regions by out-of-state purchases of goods and services by employees and supply chain businesses and is termed leakage.

Methodology

Using coefficients from input/output models of economic activity developed by Dr. William A. Strang of the University of Wisconsin—Madison, and the U.S. Department of Commerce RIMS II model as guides, the fiscal flows of payroll, taxes and business purchases are multiplied to estimate the total economic contribution that Wisconsin's nursing homes make to the state's economy.[2] The data was drawn from the State of Wisconsin 1999 Medicaid Cost Reports.

Due to the limited detail of the data used, precise quantification of the total economic contribution is not possible. Therefore, the analysis was undertaken with the intention of erring on low side and the reported results should be viewed as conservative estimates of the total economic contribution that Wisconsin's nursing homes make to the state's economy. For example, no consideration was given to the flow of federal money back to Wisconsin in terms of non-health care aids of the $84 million Wisconsin's nursing homes' employees paid in federal income taxes. In-state flows of employee benefit payments were unclear and also excluded from the analysis and total economic contribution figure.

Multiplier

One of the critical pieces of quantifying the total economic impact of dollars spent in a regional economy is the economic multiplier that is applied. A multiplier of 2.1 is applied in this analysis for the total impact of nursing home employee payroll net of income taxes. This is a conservative figure. Work done by Dr. Strang shows sales multipliers as high as 2.8 for some service sectors. Other studies using the Strang model have shown a weighted average sales multiplier across all sectors of 2.4. However, due to the limited richness of the data set and consequent limited rigor of this analysis, a conservative value for the multiplier was chosen to assure erring on the low end of expected results.

A smaller multiplier is used for the economic expansion of business-to-business spending, those nursing home expenditures for goods and services to supply chain businesses. The B2B multiplier is less than the one used for expanding the total economic impact of employee income, 1.4 versus 2.1, due to the fact that B2B purchases are generally registered at the wholesale level. This eliminates one cycle of monetary flows through the economy and reflects lower margins at the wholesale versus retail level of purchases. Also, more wholesale purchases occur to supply firms outside the state, leaking dollars out of the state's economy.

Taxes

Federal income tax payments represent leakages out of the regional economy. No assumption was made about the amount of non-Medicaid federal tax revenue that flows back to Wisconsin in this

analysis. Essentially all of the personal income tax paid to the state is spent back in the state's economy. Therefore, state income taxes are included in the total economic contribution that the firms and their employees make to state, as are real estate, property and municipal taxes and fees.

Monetary Flows

Due to the multiplier effect, the total monetary impact is larger than the nursing homes' direct expenditures of $2.1 billion suggests, even with deductions for federal taxes and benefits paid. Nursing home employee purchases of food, clothing, shelter, entertainment and other goods and services in turn pay for, among other things, the wages and salaries of the employees at the patronized business establishments and so forth. Some of the earnings are saved and some of the money leaks out of the region through out-of-state purchases, mostly by businesses' purchases of goods manufactured outside the state. B2B purchases act in the same manner, only with greater leakages through out-of-state purchases.

Total Economic Impact of Wisconsin's Nursing Homes

Category	Direct Impact	Economic Multiplier	Economic Contribution
Payroll net Taxes & Benefits	$998,518,236	2.1	$2,096,888,296
WI Personal Income Taxes	977,266	2.1	2,052,258
Corporate Taxes (RE,PP,Muni)	2,696,900	2.1	5,663,490
B2B Purchases	758,821,161	1.4	1,062,349,625
TOTAL	**$1,761,013,563**		**$3,166,953,669**

The total economic contribution to the state attributable to Wisconsin nursing homes was nearly $3.2 billion in 1999. This is a conservative figure as data limitations forced a cautious approach to the quantitative analytics. Nevertheless, it is readily apparent that Wisconsin nursing homes' activities are overwhelmingly beneficial to the state's overall economy – the private sector, workers, the government and Wisconsin's citizenry at large.

Jobs

Wisconsin nursing homes directly employ almost 58,500 workers, amounting to over 41,000 FTE positions. However, the total job impact the state's nursing homes make is far greater than their immediate employment requirements. The goods and services nursing homes demand for daily operations require a supply chain of manufacturing, processing and distribution that is manned by other businesses. As a result, the operational needs of the nursing homes indirectly employ another roughly 31,000 workers in the state.

The indirect employee figure can be derived through two different methods. One method (jobs-to-jobs) is to multiply the number of nursing home employees by a factor that relates to jobs through

the supply chain. The other method (dollars-to-jobs) applies a different factor to the dollars of output by the nursing homes. As you might imagine, the results do not match.

Using the first method, jobs-to-jobs, the 41,122 FTE nursing home jobs in Wisconsin generates another 27,963 jobs in supply chain businesses in the state.[3] The jobs multiplier used here is 1.68. That is to say that for every 100 nursing home jobs, there are another 68 jobs created in the state to fulfill the supply needs of those nursing home workers both at work and at home.

The calculus is somewhat different under the second, dollars-to-jobs, method. The estimated number of jobs generated is a function of the total output of the state's nursing homes. We use total expenses as a proxy for total output, in this case $2,095,167,615, the total expenditures figure reported by the State of Wisconsin 1999 Medicaid Cost Reports. The jobs multiplicative factor is 34.3 jobs per $1 million in expenses.[4] The result is that the $2.1 billion in Wisconsin nursing home spending creates a total of 71,864 jobs. Subtracting the 41,122 jobs employed by the nursing homes themselves indicates that an additional 30,742 workers are resident in the state due to the existence of Wisconsin's nursing homes.

As is evident, the two methods of determining the total impact of Wisconsin's nursing homes on employment in the state yield different figures. Suffice it to say, however, that the existence of Wisconsin nursing homes create about 70,000 jobs in the state.

Conclusion

Wisconsin's nursing homes make a highly valued contribution to not only their clientele and families they serve, but also to the state and the individual communities in which they reside. Wisconsin nursing homes employed almost 58,500 employees and are responsible for an additional 31,000 jobs statewide.

Direct payroll, personal income and corporate tax payments, and B2B purchases by Wisconsin nursing homes amount to over $2 billion per year. Employee payroll, including benefits, constitutes the largest share at over $1.3 billion, amounting to 64% of total nursing home expenditures. B2B purchases rank second at over three-quarters of a billion dollars. Personal state income and corporate taxes and fees combine for almost $4.0 million.

The multiplied effects of nursing home spending spotlights the enormous economic contribution Wisconsin's nursing homes make across all sectors of the state's economy, totaling almost $3.2 billion. Consumption by the state's nursing home employees contributed almost $2.1 billion in sales revenue to Wisconsin's economy in 1999. The total economic impact of nursing homes' purchases from other Wisconsin based businesses amounted to over $1.0 billion in 1999. The total economic impact of corporate and personal income taxes paid to the state by the nursing homes and their employees amounted to almost $8 million.

It is readily apparent, even with the conservative estimates made in this study, that Wisconsin's nursing home profession makes a very large contribution to the state's economic health. The nursing home profession is overwhelmingly beneficial to the state, the private sector, workers, the government and Wisconsin's citizenry at large.

Economic Impact: Typical Nursing Home

The total economic impact of the nursing home profession can be broken down to a "typical" 100-bed facility. In calculating these figures, we shared the aggregate numbers down to represent a 100-bed sized residence and then applied the same sales, output and jobs multipliers as in the statewide analysis above.

The typical 100-bed nursing home employs 92 workers with a total payroll of some $3.0 million, including benefits, or 64% of total 100-bed facility expenditures of $4.7 million. Total non-payroll facility expenditures amounted to $1.7 million.

The total economic contribution calculated for a 100-bed nursing home yields a conservative figure as no account was taken for state spending of rendered taxes in any particular community or local flows of benefits premiums. Payroll impacts were taken net of federal and state income taxes and benefits. B2B supply chain purchases were reduced by real estate taxes, property taxes and municipal fees, as they are not consistent levies across communities. The net figures are reported in the table below.

Typical 100-bed Nursing Home Facility: Expenditures and Economic Contribution

Item	Facility	Multiplier	Total Contribution
Payroll net Taxes & Benefits	$2,235,827	2.1	$4,695,237
B2B	1,699,111	1.4	2,378,755
Total Expenditures	**$3,934,938**		**$7,073,992**
Jobs ($:jobs)	92	34.3/$1M	161

The total economic contribution of a single 100-bed nursing home amounts to over $7.0 million to the state, with most of the money going to the local community through employee wages and supply chain business purchases. Each 100-bed facility, figuring $4.7 million in total expenditures, employs 92 workers on average and supports another 69 jobs ($ to jobs method) in supply chain businesses.

As was the case in the aggregate analysis in the previous section, a multiplier of 2.1 is applied to the total impact of nursing home employee payroll net of income taxes and benefits and a smaller

multiplier of 1.4 is used for the economic expansion of business-to-business spending. (See explanation above.) Leakages will be larger for smaller communities, as some facility supplies may not be available locally. The jobs multiplier reported in the above table was the dollars-to-jobs technique. The jobs-to-jobs method would yield an additional 63 supply chain jobs for the 92 jobs at the nursing home facility.

Every nursing home plays a significant role in the care of Wisconsin's elderly citizens in its area. Each also contributes to the health of the local community's economy. Both roles will increase as the Baby Boomers age and their demand for high level nursing care swells immensely in the next 10 to 20 years.

Backnotes

1) Winters, Dennis K., Strang, William A, Klus, John P., Wisconsin's Economy in the Year 2010, Wisconsin Economy Study 32, University of Wisconsin—Madison, School of Business, May 2000.

2) The input/output coefficients used in this study come from two sources: a) Strang, William A., Recreation and the Local Economy, An Input/Output Model of a Recreation-Oriented Economy, University of Wisconsin—Madison, October 1970, this model relates regional sales multipliers, b) Lefkowitz, Martin, What 100 New Jobs Mean to a Community, 1993 Edition, Economic Policy Division, U.S. Chamber of Commerce, 1993, uses the RIMS II input/output model to report on jobs multipliers for the health services industry.

3) We used the Lefkowitz jobs-to-jobs figures for these calculations.

4) We used the Lefkowitz dollars-to-jobs figures for these calculations.

About Relevant Economic Analysis Limited

The preceding analysis and report on the impact of nursing homes on Wisconsin's economy was performed by Dennis Winters, President of Relevant Economic Analysis Limited, an economic consulting firm located in Madison, Wisconsin. Mr. Winters has over twenty years experience in economic and market analysis and forecasting, encompassing everything from commodity markets to long-term policy initiatives. His firm's current focus in on regional high-tech economic development in Wisconsin.

Mr. Winters was the principle investigator and co-author of Wisconsin's Economy in the Year 2010, published in May 2000. He authored Sustaining Wisconsin's Economic Prosperity, a white paper for the Wisconsin Economic Summit in November 2000. Mr. Winters also conducted the study, MATC's Economic Contribution to the Region. He has recently provided expert testimony on Wisconsin~ s Labor Shortage and the "Brain Drain" to Joint Legislative Committees.

Mr. Winters has held senior positions at Wharton Econometric Forecasting Associates (WEFA), DRI/MeGraw-Hill (now DRI/Standard & Poors), the Executive Office of Energy Resources for the Commonwealth of Massachusetts and Clayton Brokerage Company of St. Louis. He has also served on the faculty at Fisher College in Boston and the Institute of Gas Technology (now the Gas Technology Institute) in Chicago.

Mr. Winters was educated at the University of Wisconsin Madison and Colorado State University.

Mark K. Belknap, MD
922 2nd Avenue West
Ashland WI 54806

Thank you for the opportunity to address the Joint Finance Committee. I appreciate the committee holding hearings around the state and coming all the way up to Superior.

My name is Mark Belknap, and I am a physician who practices general internal medicine in Ashland. I am a member of the State Medical Society of Wisconsin. I, for the most part, see patients who are in the age range of fifty years old and older. Daily I see the adverse effects of tobacco use in their more advanced stages. It is very evident to me that reduction in the use of tobacco will have great longstanding benefits for the health of the people of our state. I urge you to support the Wisconsin Tobacco Control Board (WTCB) funding level of $35.2 million dollars in the state's biannual budget.

I have teenage sons. The American Lung Association's programs aimed at smoking prevention have positively impacted them. I am quite convinced, therefore, that the state's investment of the tobacco settlement monies will pay great dividends in health care cost savings in future years. To not invest these funds when they are available at this time but instead to spend them for other uses unrelated to health care and specifically smoking prevention would be extremely shortsighted.

There is evidence from other states that have instituted prevention and cessation programs, such as Oregon and Florida, that teen smoking rates have dropped significantly. If this can be sustained, this will be great news for these states. The Wisconsin Tobacco Control Board program should be similarly effective in that it deals with prevention, cessation, and youth-oriented programs such as my sons have been involved in. This program also has in place ways to monitor the effectiveness of their programs.

In addition, I would encourage you to support that the remaining tobacco settlement monies be used to fund health care costs, which are rising, particularly with the successful enrollment of patients in BadgerCare. I live in a part of the state where there is a disproportionate number of patients being enrolled in BadgerCare and Medicaid. Inadequate funding will hurt health care for all of the citizens of this part of the state because of the dependence of our health care system on government funding.

That being said, I know that there is a lot of talk about the Governor's proposal to securitize the tobacco settlement payments. If the Legislature chooses to go down that path, I'd like to share some thoughts about it. The State Medical Society has discussed this issue and thinks that the following are critical components of any plan for the use of proceeds from the Master Settlement Agreement:

1. At a minimum, establish an endowment or trust for the sole benefit of the Wisconsin Tobacco Control Board (WTCB) or its successor. The endowment should be sufficiently large so those annual earnings can fund the Wisconsin Tobacco Control Board's activities at an appropriate level.

2. Establish an endowment or trust for the benefit of other health care-related items or programs such as Medicaid, BadgerCare, community health clinics, health care organizations and providers who work with populations adversely affected by tobacco use.

3. Avoid one-time use of funds derived from securitization.

4. Prohibit an endowment or trust fund created with Master Settlement Agreement funds from being invested directly in tobacco.

Again, thank you for traveling up to the Northwoods.

Mark K. Belknap, MD

WASB Issue Summary

March 2001

Health Insurance Flexibility

Background:

The 2001-03 State Budget proposed by the governor includes a provision to provide school districts greater flexibility in the choice of health care providers by allowing them to choose between providers that offer substantially similar benefit packages. The Office of Commissioner of Insurance would be responsible for determining whether benefit packages are "substantially similar."

Current law requires schools boards to solicit sealed bids prior to selecting a group health care benefits provider for school professional employees. However, there is no provision allowing boards to select from among the lowest bidders and, unless the benefit packages are identical, it is extremely difficult to change the status quo.

As a result, current law does not allow school boards the flexibility to adequately address the increasing costs of health insurance which are rapidly getting out of control for districts. The WASB is receiving reports of average projected increases of 18 to 25 percent in health insurance costs for WEA Insurance for 2001-02. Unity is expecting a 19 percent increase for 2001-02 and a 12 percent increase for 2002-03. Other plans are expecting similar increases in benefit costs.

There are a multitude of reasons for the higher rates: the population is living longer consuming more medical care goods and services; the number of insurance providers has been reduced; the rate of inflation for medical care goods and services is over twice the rate of all other items and the rate of inflation for prescription drugs is even higher; and the high benefit levels offered by the WEA Insurance Corporation Plan, which serves 85 percent of Wisconsin school districts.

In December 2000, The Wisconsin Policy Research Institute (WPRI) released a report entitled *Health Insurance Increases for Public School Teachers in Wisconsin.* In the report, WPRI asserted that, "The WEA Insurance Corporation's rate of profitability, dominant market presence, and unique affiliation with the largest teachers union in the state suggest that competition between insurers to write health insurance coverage may be severely limited in most districts...Without a change in the rules governing the negotiation of health insurance benefits, there is little reason to believe that a competitive market for teachers' health insurance can possibly exist in the future."

The report included a statistical analysis of what health insurance benefits should cost for Wisconsin school teachers. If all teachers were in the State of Wisconsin health insurance pool, for example, school districts would save $50 million or an average of $875 per teacher per year. WEAC's response was that teachers have chosen higher benefit levels over higher salaries.

Advocacy:

At the 2000 Delegate Assembly, the majority of school boards approved a WASB policy supporting legislation that would make the selection of health care providers that offer substantially similar coverage a permissive subject of bargaining. Thus, the WASB is supporting the Governor's budget provision and working to provide health insurance flexibility for school districts.

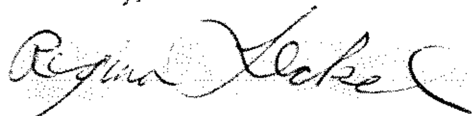
March 22, 2001

Dear Joint Finance Committee Members:

COP is important to me. I am a single mother that needed surgery and did not want my daughter in a nursing home. That my daughter could stay home with me gave me peace of mind. Without COP I would not have the help I need to do this, including the home health care for my daughter. COP also helped me put a ramp on my house. This was a great help since before I had to bounce her in her wheelchair up and down the stairs.

I feel the COP program needs more money, not less, for all the services they provide. Home Health Care helps a lot in my life. People to care for my daughter should be paid more.

Sincerely,



Regina Leckel
1918 Lamborn
Superior/WI
54880

23 March, 2001

To: Budget Finance Cmte Members

I would like to share with you a situation that could **a**ffect the senior population in this area, if the proposal in the budget to reduce pharmacy reimbursement is adopted.

My pharmacy is located in the rural area of northern Trempealeau county. The village of Eleva to the immediate west of me and the city of Independence to the near south of me no longer has pharmacy service.

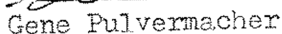
Consequently, I have been providing free delivery to the homebound seniors in this area, many of who are on medical assistance. I am able to provide this free service only because I utilize my immediate family members as delivery personnel so that the only cost involved is vehicle related. I also provide free mail service when requested, but many times mail service does not fulfill their needs because of their inability to get to the mailbox in winter conditions.

The free delivery to these elderly has been a much appreciated aspect of our service for the last number of years in that it provides secure delivery of their medications and also allows a few precious minutes of friendly social exchange. Sometimes we are even asked to assist them with other needs.

Obviously, if reimbursement is reduced I will no longer be able to provide these services. Even in my pharmacy, providing service to the elderly requires a lot more time, effort and cost because of their many special needs.

Small pharmacies do not qualify for the volume discounts larger chains receive. If the final budget includes the cuts being proposed, their is a strong possibility I would have to close this only remaining family pharmacy in the entire county.

Sincerely,



Gene Pulvermacher
PULVERMACHER DRUGS
STRUM, WI 54770

TESTIMONY OF JEAN LAIER

Member, AARP Wisconsin Government Affairs Committee

Before the Joint Committee on Finance
March 26, 2001
Superior, Wisconsin

Good morning. My name is Jean Laier. I live in Hayward and I am a volunteer member of AARP's Government Affairs Committee.

I am here today to ask you to include the provisions of Senate Bill 1, also known as Wisconsin Care, in the state budget that you are considering.

AARP Wisconsin recently invited members to describe the painful decisions that the high cost of medication forces them to make every day.

A member in Fond du Lac, herself a stroke victim, told of the daily arguments between herself and her husband about whether they can afford her daily use of the nitro patch prescribed by her doctor. The nitro patch, which costs $100 a month, is just one of seven medications she's supposed to be taking.

A member in Williams Bay told us, ""Drug costs are really killing us! We have to decide at times what we (can) do—eat, get gas, or get our medicines. Sometimes we just stay home because we can't get any of the above. We are not privileged to have drug coverage. It is too expensive!"

A member in Oconomowoc told us, ""Drug prices are so high. My medication is several hundred dollars a month. I have to decide—eat and renege on my medication or take medication and not eat. I am constantly taking from my savings. My pension does not cover all this."

It goes on and on.

Wisconsin has a proud history of leading the way on many issues of conscience, but we are lagging behind many other states on prescription drug benefit.

Some legislators have argued that Wisconsin would be penalized if it were to enact a prescription drug benefit before the federal government acts. But no federal program will pass that penalizes states that have tried to help their own seniors. States which already have a prescription drug benefit in place include Michigan, New York, New Jersey, Illinois, and at least twenty others. No one knows when the federal government will act, and Wisconsin seniors simply cannot afford to wait for help any longer.

AARP Wisconsin supports Wisconsin Care for many reasons. Most important, though, it has no deductible for low-income seniors. And it acknowledges that the cost of medication is also hurting moderate- and middle-income seniors who don't have coverage by also helping them to stay healthy and independent.

Research shows that money saved in prescription drug coverage always results in higher rates of admission to nursing homes. Untreated or undertreated conditions get so bad that people can't look after themselves any more and end up in institutional care. Those are costs that no one can contain.

Wisconsin Care is a just and compassionate response to what has become a public health emergency. Wisconsin seniors need Wisconsin Care now.

As a member in Colgate told us, "I am presently paying $456 per month for (health) insurance and have a $2000 per year deductible. My prescription drugs are supposed to be covered. However, my most important drugs, for Parkinson's, are excluded. I feel with a high premium like this, prescription drugs should be covered, especially with a Wisconsin state plan!"

On behalf of AARP Wisconsin's 734,000 members, I'd like to thank the committee for giving Wisconsin Care the serious consideration it deserves for inclusion in the state budget.

AARP WISCONSIN

AARP Wisconsin 3 S. Pinckney St. #801 Madison WI 53703 (608) 286-6307 Fax: (608) 251-7612

WHY DOES AARP WISCONSIN SUPPORT WISCONSIN CARE?

Three proposals addressing the prescription drugs emergency are presently before the Wisconsin legislature. The first bill to be presented was Senator Judy Robson's SB 1, now known as Wisconsin Care. With bipartisan support, the State Senate has now approved Wisconsin Care on a 20 - 13 vote. In the past few weeks, both Governor Scott McCallum and Rep. Steve Wieckert have developed plans of their own. AARP Wisconsin continues to believe that Wisconsin Care offers the best means of enabling the most Wisconsin seniors to obtain the medication they need. We believe that the comparisons below validate AARP's decision to support Wisconsin Care. We urge you to do the same.

		WISCONSIN CARE	McCallum	AB 120
	Annual Income Limits (Single)	$25,050	$12,943	$15,450
	Annual Income Limits (Married)	$33,750	$17,438	$20,800
	Annual Deductible	Income under 175% of FPL*: $0 Above 175% of FPL*: $500	Income under 110% of FPL*: $0 110%-155% of FPL*: $300-$600	$840
	Annual Enrollment Fee	$20	$25	$25
	How many seniors eligble?	335,000	82,600	about 170,000
	Brand-Name Meds CoPay	$10	$20	$20
	Generic Meds CoPay	$5	$10	$10
Senior #1	Monthly Income: $800 Annual Income: $9,600 Brand-Name Medications: 1 Generic Medications: 1 Monthly Meds Cost: $70	Annual Expenses: Program pays $640, Senior pays $200.	Annual Expenses: Program pays $305, Senior pays $535.	Annual Expenses: Program pays $0, Senior pays $840.
Senior #2	Monthly Income: $1,200 Annual Income: $14,400 Brand-Name Medications: 3 Generic Medications: 1 Monthly Meds Cost: $170	Annual Expenses: Program pays $1,600, Senior pays $440.	Annual Expenses: Program pays $0, Senior pays $2,040.	Annual Expenses: Program pays $685, Senior pays $1,355
Senior #3	Monthly Income: $1,400 Annual Income: $16,800 Brand-Name Medications: 4 Generic Medications: 2 Monthly Meds Cost: $240	Annual Expenses: Program pays $1,880, Senior pays $1,000.	Annual Expenses: Program pays $0, Senior pays $2,880.	Annual Expenses: Program pays $0, Senior pays $2,880.

* FPL: Federal Poverty Level