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ASW... ASW... ASW... ASW... ASW... ASW...

AUTISM SOCIETY OF WISCONSIN
519 N. Union St.
Appleton, WI 54911-5031
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March 27 1995

To: Senator Leean, Representative Brancel,
Members, Joint Committee on Finance:

The members of the Autism Society of Wisconsin have long supported community services for their family members who have autism. For children, this has meant access to education and some Family Support services. For adults, this has meant vocational opportunities for the majority and day services for a few who are the most severely disabled. As parents age, residential and support services are essential for our citizens who have lifelong disabilities. These community services are usually less than half as expensive as care in an institution and preferable for most, if not all, individuals with autism.

The proposed budget is an attack on community services. The most devastating proposal is the elimination of about 17000 elderly and disabled Wisconsin citizens from SSI. Those who live independently will lose 10 or 15% of their already low income and will also lose access to their MA health care. Many will not be able to apply every six months for Medicaid and those that do will add to the administrative costs for the counties. The counties will also lose funding for those who lose their SSI who are in county funded residential placements. The SSI recipients will lose their incentive to work. This is also a time bomb for young adults with disabilities. Even those who do not lose their SSI this time will be at risk as their parents die. At that time many will be eligible for increased Social Security Dependent benefits and they will be apt to lose their SSI and their Medicaid eligibility.

Parents who have never placed their children in one of the Wisconsin Centers are penalized and their fears for their children are increasing. Community Aids have not kept up with inflation, now SSI will be cut and more social problems are being pushed back to the county level. This is placing increased pressure on the property tax. In contrast, the Centers are subject to federal inspections for quality of care and CIP IA has a guaranteed daily rate.

We beg you to KEEP THE COMMUNITY PROMISE and recognize that this budget is undermining long term community services and putting increased pressures on the county levy. This is not property tax relief!

Thank you,

Frances Bicknell
Legislative Chairperson

Wisconsin Association of Homes and Services for the Aging, Inc.
204 South Hamilton Street • Madison, Wisconsin 53703 • 608-255-7060 • FAX 608-255-7064

March 27, 1995

To: Members, Joint Committee on Finance

From: John Sauer, Executive Director
Tom Ramsey, Director of Government Relations

Subject: 1995 Assembly Bill 150

The Wisconsin Association of Homes and Services for the Aging (WAHSA) is a statewide membership organization of not-for-profit corporations principally serving the elderly and disabled. Membership is comprised of 188 religious, private and governmental organizations which own, operate and/or sponsor 142 not-for-profit and 46 county-operated nursing homes, 23 facilities for the developmentally disabled, 55 community-based residential facilities, 90 independent living facilities, 11 licensed home health agencies and over 300 community service agencies providing programs ranging from Alzheimer's support, adult and child day care, hospice and homecare to Meals on Wheels.

The attached position papers outline in greater depth WAHSA's positions on the following items contained, or suggested for inclusion, in AB 150. Those positions include the following:

- **Support for the Medicaid nursing facility rate increases of 4.25% in FY 96 and 5.0% in FY 97, as described under Item #16 on Page 229 of the Legislative Fiscal Bureau (LFB) Budget Summary.**

- **Restore the proposed cut in the Nursing Home Payment Formula pertaining to the 91% minimum occupancy standard, as described under Item #8 on Page 223 of the LFB Budget Summary.**

- **Amend s.49.45(6m)(a5)1a, Wis. Stats., to require the DHSS to maintain the nursing home formula's direct care maximum at 110% of the statewide median.**

- **Expand the Medicaid Intergovernmental Transfer Program (Please see the attached proposal).**

- **Support for the Assisted Living initiative, as described under Item #8 on Pages 329-330 of the LFB Budget Summary.**

- **Maintain the current nursing home bed moratorium contained in Chapter 150, Wis. Stats., but eliminate the remainder of the Chapter 150 Resource Allocation Program, the nursing home equivalent to the Cost Containment Commission.**

- **Restore the funding cuts in spousal impoverishment (Item #5 on Pages 219-220 of the LFB Budget Summary) and personal care (Item #4 on Page 218 of the LFB Budget Summary) as well as the funding for the Ombudsman Supervisor position in the Board on Aging and Long Term Care (Item #5 on Page 83 of the LFB Budget Summary). Restoration of those cuts are justified but would not be supported if they were restored through a reduction of the MA nursing facility rate increase.**

WAHSA members strongly support those arguing in opposition to the cuts in spousal impoverishment, personal care and the other proposed Medicaid eligibility modifications. Our concern, however, is not that many of these people might be "forced" into nursing homes; the real concern should be that many of these people will have nowhere to go for their care, not even the nursing home, because they fail to meet nursing home admission requirements.

While WAHSA members believe there is ample justification to restore the spousal impoverishment and personal care cuts, they feel even more strongly that there is equal justification for the 4.25%/5% MA rate increases proposed for nursing homes in AB 150. With that in mind, WAHSA members would strenuously oppose any efforts to reduce those proposed rate increases in order to fund other programs, no matter how worthy the alternative program(s) might be. The rational for that justification is as follows:

- **Nursing facilities will not receive a 4.25% rate increase in FY 96 nor a 5% rate increase in FY 97. AB 150 contains cuts in the nursing home payment formula (Items #8 and # 9 on Pages 223-224 of the LFB Budget Summary) that we project will result in a net rate increase of 1.97% in FY 96.**

- **The DHSS projects Wisconsin-specific nursing home inflation of 5.3% in FY 96 and 5.8% in FY 97. Whether one accepts the AB 150 proposed rate increases of 4.25%/5% or the "real" FY 96 rate increase of 1.97%, facility costs will continue to outpace Medicaid reimbursement under AB 150. To state this budget contains no pain for nursing home providers simply is not correct.**

- **Almost all hands-on direct care to nursing home residents is provided by certified nursing assistants (CNA), which comprise 68.5% of the nursing home workforce statewide. According to the most recent available Medicaid cost averages, a CNA in Wisconsin makes $6.93/hour, the equivalent of many fast-food restaurant employees in this state. If Medicaid reimbursement does not at least keep pace with nursing home inflation, how can nursing homes compete in an already saturated service sector? Who will care for our loved ones in the future?**

- **Any assertion that salaries of nursing home administrators are not under constraints also is incorrect. Key employee salaries fall under the Administrative and General (A & G) cost center of the Nursing Home Payment Formula. Under the formula, Medicaid will not pay for A & G costs in excess of 103% of the statewide median. That cap plays a significant role in establishing the salaries of nursing home administrators. That is borne out by a 1994 wage survey conducted for WAHSA which indicated the average annual salary of a WAHSA not-for-profit nursing home administrator was $48,715.**

Wisconsin Association of Homes and Services for the Aging, Inc.
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MEDICAID REIMBURSEMENT – CRITICAL LINKAGE TO QUALITY CARE IN WISCONSIN NURSING HOMES

An Analysis of the Long Term Care Provider Components of Assembly Bill 150 The 1995-97 Executive Budget Bill

OVERVIEW

1995 Assembly Bill 150, the 1995-97 biennial budget bill, would authorize several significant changes in the long term care portion of the State Medicaid program. Collectively, these changes would weaken an already inadequate reimbursement system and, for the facilities which would be adversely affected by these changes, could compromise the quality of care they are able to provide their residents.

AB 150 would:

- **Provide a Medicaid rate increase for nursing homes of 4.25% in FY 96 and 5% in FY 97** (Total Cost: $46.5 million GPR and $115.3 million AF over the biennium). (Section 2961 of AB 150, Page 1058).

- **Reduce the current Nursing Home Payment Formula by $15.3 million GPR and $37.9 million AF over the biennium through the following proposed changes:**

  -- **Hold Harmless**: AB 150 amends s.49.45(6m)(av)4, Wis. Stats., to modify the "hold harmless" provision. Under that provision, a facility receives a new Medicaid per diem rate based either on the rate determined by the Nursing Home Payment Formula or its previous year's rate, whichever is greater. AB 150 would "hold harmless" a facility to its June 30, 1994 rate. (Sections 2966-2967, pages 1059-1060).
  -- **Minimum Occupancy Standard**: Nursing facilities with an occupancy rate below 91% would have their Medicaid rate calculated assuming an occupancy rate of 91%. (Part of Medicaid base reestimate. No statutory change contained in AB 150.)
  -- **Medicare Reclassification**: Nursing facilities which participate in the federal Medicare program would have certain residents classified as meeting the Intensive Skilled Nursing (ISN) level of care under Medicaid. (Part of MA base reestimate. No statutory change contained in AB 150.)
  -- **Interest/Investment Income Offset**: Under this proposal, the DHSS would be authorized, in accordance with Medicare principles, to consider the interest and investment income of nursing facilities and all affiliated entities as an offset to their Medicaid costs. (Section 2970, Page 1060)

-- **Property Payments**: Medicaid payments associated with the capital cost center would be reduced through a cut in the capital cost share -- the difference between the target in the nursing home formula and a facility's actual property expense -- from 50% to 40% (Part of MA base reestimate. No statutory change contained in AB 150.)
-- **ED Supplement**: The supplement payment to facilities which serve emotionally disturbed residents would be cut in FY 96 and eliminated by June 30, 1997. (Section 2964 on Page 1059, Section 2968 on Page 1060 and Section 9426(9) on Page 2474.)

AB 150 proposed Formula reductions are summarized by the following table.

	1995-97 Biennial Fiscal Effect	
Formula Reductions	**GPR**	**All Funds**
Hold Harmless	-$802,500	-$1,990,600
91% Occupancy Rate	-12,093,700	-29,999,900
Medicare Reclassification	-1,083,300	-2,687,300
Interest Income	-401,200	-995,200
Property Payments	-561,700	-1,393,400
ED Supplement	-351,100	-870,800
TOTAL:	-$15,293,500	-$37,937,200

WAHSA Position on Long Term Care Provisions in AB 150

- **Support the nursing facility Medicaid rate increases of 4.25% in FY 96 and 5% in FY 97.**
- **Restore the proposed cuts in the Nursing Home Payment Formula pertaining to the "hold harmless" provision and the 91% minimum occupancy standard.**
- **Amend s.49.45(6m)(ar)1a, Wis. Stats., to require the DHSS to maintain the direct care target at 110% of the statewide median.**
- **Expand the Medicaid Intergovernmental Transfer Program (ITP).**

I. A rate increase for nursing homes of 4.25% in FY 96 and 5% in FY 97 is more than justified.

- Unlike other Medicaid providers, a rate increase of 4.25%/5% does not mean each nursing facility will receive rate increases of 4.25%/5% in the next 2 years. Funds appropriated as rate increases for nursing homes by the Legislature are distributed to each facility through the Nursing Home Payment Formula, which looks at historical and prospective costs. As such, the 4.25% rate increase proposed for nursing homes in FY 96 under AB 150 could result in a 6% rate increase for one facility and a 1% increase for another, based on their costs and the formula parameters. Indeed, while the Legislature provided a 3.57% rate increase for nursing homes in FY 95, the nursing home formula which distributes those funds actually was cut by approximately $9 million. The reason: The costs nursing homes are incurring to care for Medicaid residents are outpacing the governmental funds being provided to pay for that care.

- When the proposed nursing home formula cuts contained in AB 150 are factored in, WAHSA projects the real rate increase provided under the budget bill would be 1.97% in FY 96.

- While rate increases of 4.25% and 5% appear to be quite generous, they still will be outpaced by Wisconsin-specific nursing home inflation, which is projected to increase by 5.3% in FY 96 and 5.8% in FY 97.

- The difference between the costs a nursing facility incurs to care for its Medicaid residents and the funds it is reimbursed for that care is referred to as the facility's Medicaid deficit. Under the July 1, 1994 - June 30, 1995 Nursing Home Payment Formula, only 19% of the state's Medicaid-certified nursing homes were fully paid their operating costs to care for their Medicaid residents. For WAHSA's not-for-profit members, that figure was 13%.

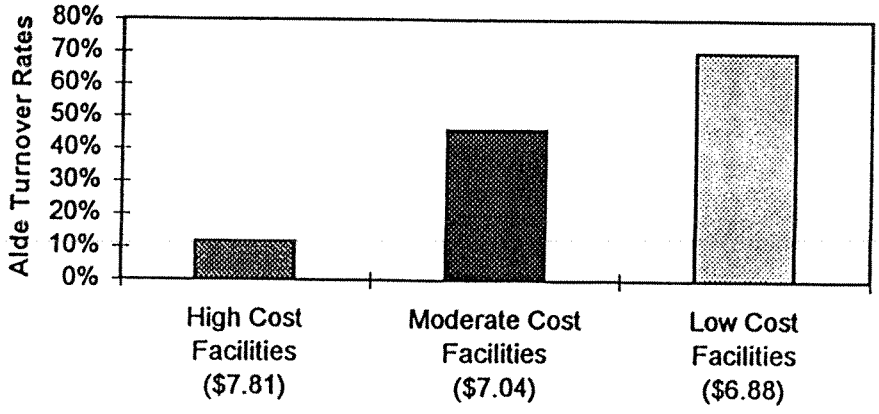
- The nursing home industry, through its willingness to support a provider assessment, an occupied bed tax and the intergovernmental transfer program, has attempted to provide quality care to its residents within the budgetary constraints of the state. It simply would be inaccurate to state we have not "bitten the bullet" during tough economic times.

- **68.5% of the employees who provide hands-on direct care to nursing home residents are nursing assistants. The average wage of a certified nursing assistant in the State of Wisconsin is $6.93/hour (1993 cost reports). Is it an outrageous request to seek to pay those who care for our loved ones more than the princely sum of $7 an hour?**

- If Medicaid reimbursement fails to keep pace with nursing home inflation, facilities will be facing cuts or freezes either in staffing or in wages and benefits. Since 73 cents of every dollar spent by Wisconsin nursing homes is spent on employee wages and benefits and direct care providers comprise over 53% of the entire nursing home workforce, it is not difficult to conclude where these cuts/freezes would come. Not only would we be unable to raise that average nursing assistant wage above the $7/hour mark; of greater concern is the potential impact on resident quality of care.

- The following table shows nursing assistant turnover rates according to "high, moderate and low" cost facilities. As shown below, facilities which pay low wages had nearly one and one-half times the turnover rate (70%) as moderate cost facilities (46%) and almost six times the turnover rate as high cost facilities (12%).

Facility Costs and Turnover Rates



(Amounts in parentheses represent average nurse aide wages for facilities grouped according to Medicaid costs.)

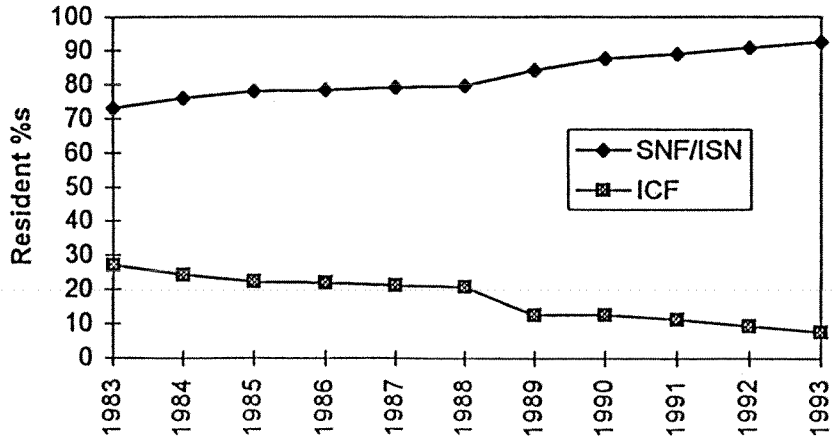
The significance of this correlation and the correlation between turnover rates and quality of care was noted in a report published in 1994 by the DHSS Center for Health Statistics: "One important aspect of quality of care in nursing homes is the continuity of employment among the nursing staff. Low continuity can lead to staff shortages, which in turn allows less time for resident care. A time lag usually occurs between the date an employee leaves a facility and the date a replacement begins work. Training of new employees also absorbs time. **Therefore, it can generally be assumed that the lower the turnover among nursing employees in a nursing home, the better the quality of care will be."**

- If the Legislature lowers the rate increases for nursing homes proposed in AB 150, facilities will be unable to keep pace with inflation. Nursing assistant wages on average will continue to be mired in the under $7/hour range. What impact would this have on facility turnover and, more importantly, what impact would this have on quality of care?

- The use of the terms "low cost" or "efficient" facilities and "high cost" or "inefficient" facilities is truly relative. These so-called "high cost" or "inefficient" facilities pay their nursing assistants on average $7.81/hour. For the challenges and the importance of the work performed, it would be hard to characterize such wages as excessive. Keep in mind that these facilities are <u>above</u> the direct care target and, therefore, are not fully reimbursed for their direct care costs.. Yet, they continue to strive to pay their nursing assistants a living wage. In contrast, the "low cost" or "efficient" facilities, which on average pay their nursing assistants under $6.70/hour, are <u>under</u> the direct care target and, therefore, will be fully reimbursed for their direct care costs (after an 18-24 month time lag).

- Nursing home costs continue to increase primarily because resident acuity levels continue to increase. As shown below, the number of residents in need of the higher, Skilled Nursing or Intensive Skilled Nursing levels of care (SNF/ISN) at the time of admission has increased from 72.9% in 1983 to 92.4% in 1993. At the same time, the lower, intermediate level of care (ICF) has decreased from 27.1% in 1983 to 7.6% in 1993. Those numbers confirm that the "quicker-sicker" syndrome continues. Due to the hospital DRG payment system, individuals are entering nursing homes from hospitals quicker (over two-thirds of nursing home admissions come directly from hospitals) and at higher acuity levels, or sicker.

Resident Acuity Increases



II. The proposed Nursing Home Payment Formula cuts in the modification of the "hold harmless" provision and the imposition of the 91% minimum occupancy standard should be restored.

- By holding harmless a facility to its June 30, 1994 rate, AB 150 could eliminate rate increases facilities have anticipated and budgeted for in 1994-95. Indeed, some facilities would receive either no rate increase or rate decreases over the biennium.

- As noted earlier, these potential "hold harmless" facilities are the "high cost, inefficient" facilities which are paying their nursing assistants on average $7.81/hour. Should we be penalizing facilities which are attempting to pay a living wage?

- It has been stated that the current "hold harmless" provision shelters "high cost" facilities from cost containment measures because their rates are guaranteed at the previous year's rate. It could be argued that one person's rate "guarantee" is another person's rate "freeze." And while that rate is frozen, their costs continue to increase. How will cutting their rate improve the quality of care they are able to provide?

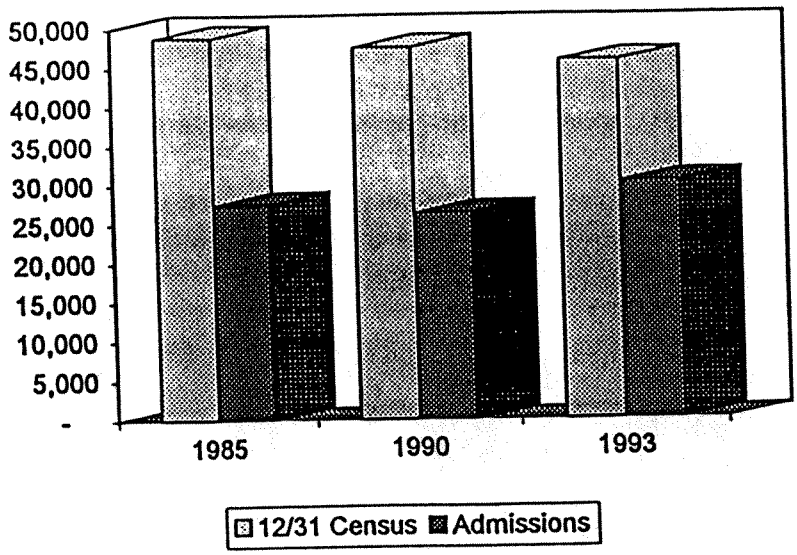
- **It also has been argued that eliminating or modifying the "hold harmless" provision could encourage more efficient operations of "high cost" homes. Once again, is providing a nursing assistant $7.81/hour a sign of inefficiency? If we don't provide our direct caregivers in nursing homes a living wage, who will care for our loved ones in the future?**

- The hold harmless modification particularly would impact county nursing homes. If their Medicaid deficits increase, as they surely would under this provision, the county property taxpayer will end up footing that bill. So much for property tax relief!

- County nursing home deficits were used last session as the state match to generate significant additional federal Medicaid dollars through the intergovernmental transfer program (ITP). The ITP has benefited not only county homes but also <u>all</u> nursing homes, their residents and the State's general fund as well. To penalize those same counties through this proposed "hold harmless" provision would be a harsh and unnecessary deviation from the historical partnership developed between the state and counties in the provision of elderly and disabled services.

- **The 91% minimum occupancy standard may have the unintended affect of keeping nursing home residents in a facility longer than necessary.** Many of today's nursing facilities specialize in subacute care or intensive rehabilitation services. Efforts to reintegrate residents back to their place of residence are reflected in facility admission and discharge data. As shown by the following graph, while the number of nursing home residents has declined over the past several years, the number of admissions has risen sizably. These types of facilities (subacute and rehab) have relatively short lengths of stay and usually operate at less than the 96% maximum occupancy of a geriatric facility. The AB 150 proposal could create a disincentive for facilities to aggressively pursue discharge planning if doing so would increase what is likely to be an already significant Medicaid operating deficit.

Facility Census and Admissions



- If retained, this provision should be amended to take into consideration the historic occupancy levels of a facility. A facility should not be penalized for having one "bad" year. In addition, alternatives less severe than the significant number of bed closures that this provision would result in should be explored. Among them: "banking" beds over a specified period of time or limiting the bed closures to the number necessary to attain the 91% occupancy level.

III. State statute should be amended to shelter direct caregivers from any cuts in the Nursing Home Payment Formula.

- WAHSA seeks legislative support to amend s.49.45(6m)(ar)1a, Wis. Stats., as follows:

  "The Department shall establish standards for payment of allowable direct care costs that are at least 110% of the median for direct care costs for facilities that do not primarily serve the developmentally disabled and separate standards for payment of allowable direct care costs that are at least 110% of the median for direct care costs for facilities primarily serving the developmentally disabled. The standards shall be adjusted by the Department for regional labor cost variations. ~~The Department may decrease the percentage established for standards only if the amounts available under par. (ag)(intro) are insufficient to provide total payment under par. (am), less capital costs under subd. 6.~~"

- This proposed change basically means that the target for the direct care cost center, which provides for nurses and nursing assistants, would not be cut if the funds appropriated by the Legislature for nursing homes are insufficient to fund a cost-to-continue nursing home formula.

- In its 8/18/94 draft of the July 1, 1994 - June 30, 1995 Nursing Home Payment Formula, the DHSS proposed to decrease the direct care target from 110.8% of the statewide median to

105.65%, at a projected savings of $11.9 million. This cut was proposed because the 3.57% rate increase provided by the Legislature under 1993 Wisconsin Act 16 was subsequently estimated by DHSS to underfund a cost-to-continue formula by $19.7 million. Although the direct care target ultimately was set at 110%, the intent of this proposed statutory change is to avoid that situation in the future.

- The funding of the direct care cost center always has been the top reimbursement priority of WAHSA members. This proposed change would guarantee that shortfalls in the Nursing Home Payment Formula similar to those experienced last year would not be borne by those who provide hands-on care to Wisconsin's nursing home residents. Any shortfalls in the formula would have to be made up through reductions in the other five cost centers.

IV. The intergovernmental transfer program (ITP) should be expanded.

- Expansion of the ITP may be the best way to preserve or augment the wages and benefits of nursing facility staff. The ITP, authorized by the Legislature under Act 16, allows county nursing facilities to use their county-supported operating deficits to secure additional federal Medicaid matching funds. The ITP has proven to be extremely effective in reducing county property tax subsidies for governmental facilities and other nursing facilities which historically have offered higher wages and benefits to staff and, as a result, have the lowest direct care staff turnover rate. WAHSA members believe counties should be authorized to utilize additional operating deficits as a way to maximize the receipt of available federal funds and that those additional funds should be directed to eliminating the subsidization of county nursing facilities by the county property taxpayer.

The Wisconsin Association of Homes and Services for the Aging (WAHSA) is a statewide membership organization of not-for-profit corporations principally serving the elderly and disabled. Membership is comprised of 188 religious, fraternal, private and governmental organizations which own, operate and/or sponsor 142 not-for-profit and 46 county-operated nursing homes, 23 intermediate care facilities for the mentally retarded, 55 community-based residential facilities, 11 licensed home health agencies, 90 independent living facilities and over 300 community service agencies providing programs ranging from Alzheimer's support, adult and child day care, hospice and homecare to Meals on Wheels.

Intergovernmental Transfer Program
Amendment to AB 150

On Page 1062, delete lines 20 thru 25 and lines 1 and 2 on page 1063.

Substitute the following:

Section 2976. s.4945(6u)(Intro) of the statutes is repealed and recreated to read:

49.45(6u) Supplemental Payments to County Homes. Notwithstanding s.49.45(6m), the department shall, from the appropriation under section 20.435(1)(o), distribute not less than $37,100,000 in each fiscal year to provide supplemental payments for care to recipients in county homes established under s.49.14(1) or in nursing facilities owned and operated by a city, village or town. The secretary of the department of administration, in consultation with the department, shall determine the annual supplement to be distributed under paragraph (a). The department shall perform all of the following:"

Section 29.76a. s.49.45(6u)(e) of the statutes is repealed.

AMENDMENT SUMMARY

Under current law, county and municipal nursing homes receive $37.1 million in supplemental funding. This funding is authorized under two separate provisions (see attached):

1) 49.45(6a) provides up to $18.6 million for these facilities; and

2) 1993 Wisconsin Act 16, the 1993-95 biennial budget bill, provides up to $20.0 million in supplemental funding to county facilities (see nonstatutory provision, Section 9126,15(v) Supplemental Payments to County Homes). Under this provision, DHSS allocated $18.5 million of the $20.0 million authorized by Act 16.

Under the proposed amendment, the two provisions listed above would be consolidated into one supplemental Intergovernmental Transfer Program (ITP). The total ITP supplement would remain at $37.1 million unless the DOA Secretary determines that additional federal Medicaid matching funds are available to offset facility operating deficits which would otherwise be paid for by the local property tax payer.

RATIONALE

Expansion of the ITP may be the best way to preserve or augment the wages and benefits of nursing facility staff. The ITP, authorized by the Legislature under Act 16, allows county nursing facilities to use their county-supported operating deficits to secure additional federal Medicaid matching funds. The ITP has proven to be extremely effective in reducing county property tax subsidies for governmental facilities and other nursing facilities which historically have offered higher wages and benefits to staff and, as a result, have the lowest direct care staff turnover rate. WAHSA members believe counties should be authorized to utilize additional operating deficits as a way to maximize the receipt of available federal funds and that those additional funds should be directed to eliminating the subsidization of county nursing facilities by the county property taxpayer.

tion of the success of the family preservation services funded under paragraph (b), submit an interim report of that evaluation to the governor and to the appropriate standing committees under section 13.172 (3) of the statutes by July 1, 1996, and submit a final report of that evaluation to the governor and the appropriate standing committees under section 13.172 (3) of the statutes by January 31, 1998.

Vetoed in Part

(15v) SUPPLEMENTAL PAYMENTS TO COUNTY HOMES. Notwithstanding section 49.45 (6m) of the statutes, as affected by this act, the department of health and social services shall, from the appropriation under section 20.435 (1) (o) of the statutes, distribute not more than $20,000,000 in fiscal year 1993-94 and not more than $20,000,000 in fiscal year 1994-95, to provide supplemental payments for care to recipients of medical assistance provided in county homes established under section 49.14 (1) of the statutes.

(15w) NURSING HOME PAYMENT FOR DIRECT CARE COSTS. From the appropriation under section 20.435 (1) (b) of the statutes, as affected by this act, the department of health and social services shall pay not less than $751,300 in fiscal year 1993-94 and not less than $753,900 in fiscal year 1994-95 and from the appropriation under section 20.435 (1) (o) of the statutes the department of health and social services shall pay not less than $1,148,700 in fiscal year 1993-94 and not less than $1,146,100 in fiscal year 1994-95, for allowable direct care costs under section 49.45 (6m) (ar) 1 of the statutes of facilities that are providers of medical assistance services.

(15x) PRIOR AUTHORIZATION FOR PERSONAL CARE SERVICES; RULE MAKING. By September 15, 1993, the department of health and social services shall submit to the legislative council staff for review under section 227.15 (1) of the statutes proposed rules establishing requirements under which providers of personal care services under the medical assistance program shall obtain prior authorization to provide the services.

(16b) JUVENILE CORRECTIVE SANCTIONS.

(a) *Advisory committee.* The secretary of health and social services shall appoint a committee under section 15.04 (1) (c) of the statutes to advise the department of health and social services regarding the development of the correction sanctions program under section 48.533 of the statutes, as created by this act. The committee shall consist of juvenile justice professionals, law enforcement professionals and representatives of county departments of human services or social services under sections 46.215, 46.22 and 46.23 of the statutes, as affected by this act.

(b) *Report.* By April 1, 1995, the department of health and social services shall submit a report to the joint committee on finance evaluating the development and performance of the corrective sanctions program under section 48.533 of the statutes, as created by this act. The report shall include information regarding the services provided to participants in that program, new offenses committed by those participants during the period of their participation in the program and the use of short-term detention as a sanction under the program.

(16c) BOOT CAMP. The department of health and social services shall conduct a study of residential boot camp and wilderness challenge programs for juvenile offenders, including the Nakomis challenge program provided by the department of social services of the state of Michigan, and, by August 31, 1994, submit a plan to the joint committee on finance for the establishment of a boot camp and wilderness challenge program for juvenile offenders to be operated or contracted for by the department of health and social services.

(16d) COUNCIL ON AMERICAN INDIAN HEALTH MEMBERSHIP. Notwithstanding the length of terms of the members of the council on American Indian health specified under section 15.197 (22) of the statutes, as created by this act, the members initially appointed to the council shall be appointed for the following terms:

(a) Four members, including at least 3 members selected from names submitted by the Wisconsin American Indian tribes or the Great Lakes inter-tribal council, for a term that expires July 1, 1995.

(b) Four members, including at least 3 members selected from names submitted by the Wisconsin American Indian tribes or the Great Lakes inter-tribal council, for a term that expires July 1, 1996.

(c) Five members, including at least 3 members selected from names submitted by the Wisconsin American Indian tribes or the Great Lakes inter-tribal council, for a term that expires July 1, 1997.

(16g) RULE MAKING; REGIONAL POISON CONTROL CENTERS. The department of health and social services shall submit the proposed rules required under section 146.57 (4) of the statutes, as created by this act, to the legislative council staff for review under section 227.15 (1) of the statutes no later than March 1, 1994.

(16h) EVALUATION; STATEWIDE POISON CONTROL SYSTEM. The department of health and social services shall evaluate the statewide poison control system that is implemented under section 146.57 (3) of the statutes, as created by this act, and shall, by July 1, 1995, submit a report containing its findings and recommendations to the appropriate standing committees in the manner provided under section 13.172 (3) of the statutes and to the governor.

Vetoed in Part

(16i) COUNCIL ON THE STATEWIDE POISON CONTROL SYSTEM. Notwithstanding the length of terms specified for the members of the council on the statewide poison control system under section 15.197 (18) (intro.) of the statutes, as created by this act, the initial members of the council shall be appointed by the first day of the 3rd month beginning after the effective date of this subsection for the following terms:

(a) The registered nurse, the pharmacist, and one of the 2 members who are specified under section 15.197

:iving skilled, intermediate or limited levels of nursing care as :vels are defined under s. HSS 132.13, Wis. adm. code.

2. Payment for personal or residential care is available for a erson in a facility certified under 42 USC 1396 to 1396p only if he person entered a facility before the date specified in subd. 1. nd has continuously resided in a facility since the date specified n subd. 1. If the person has a primary diagnosis of developmental lisabilities or chronic mental illness, payment for personal or resi- lential care is available only if the person entered a facility on or before November 1, 1983.

(j) The department may develop a separate rate of payment, under this subsection, for persons requiring intense skilled nursing care, as defined by the department.

(k) Notwithstanding pars. (ag) to (b), (bp) and (br), the department may participate in a demonstration project on case mix nursing home reimbursement authorized under 42 USC 1315 (a) and may modify the payment system under this section, on an experimental basis, as necessary for participation in the demonstration project.

(6r) ASSESSMENTS TO PROVIDERS. (a) In this section:

1. "Ambulatory surgery center" has the meaning given under 42 CFR 416.2.

1g. "Facility" means a nursing home as defined in s. 50.01 (3) or a community–based residential facility that is licensed under s. 50.03 and that is certified by the department as a provider of medical assistance.

1m. "Provider" means a facility or an ambulatory surgery center, except that "provider" does not include a facility or ambulatory surgery center that is state–owned or state–operated, federally owned or federally operated or located outside the state.

1r. "Services" means services or items under this section that provider directly provides and does not reimburse a 3rd party providing.

2. "State share" means that portion of the medical assistance payments made to a provider under this section for the provision of authorized services that is not reimbursed by federal funds, unless no federal financial participation is available for these services. If no federal financial participation is available for a service that is payable under this section, "state share" means that portion of the payments that would be the state share if federal financial participation were available.

(b) For the privilege of doing business in this state, there is imposed on a provider an assessment at the rate of 6.98% in fiscal year 1991–92 and 13.10% in fiscal year 1992–93 that shall be deposited in the general fund. The assessment shall be made on the state share of payments made to a provider for services provided beginning on July 1, 1991, except that assessments imposed on ambulatory surgery centers shall be made for services provided beginning on January 1, 1992.

(c) The department shall send an invoice to each provider on October 31, 1991, for the amount due for the 3 months preceding that month and shall, thereafter, send an invoice to each provider by the end of every month for the amount due, which shall be based on payments received for services to which the assessment is applicable for the month preceding the month during which the invoice is sent, except that, for an ambulatory surgery center, the department shall first send an invoice by February 29, 1992. Each provider shall pay the amount shown on the invoice on or before the last day of the month after the month in which the invoice is sent. The department may provide to a provider an alternative to payment by invoice under which a provider may elect to have the assessment amounts deducted from net payments made for services.

(d) The interest and penalty provisions under ss. 71.82 (1) (a) and (b) and (2) (a) and (b), 71.83 (1) (a) 1., 2. and 7. and (b) 1., (2) (a) 1. to 3. and (b) 1. to 3. and (3) and 71.85 as they apply to the taxes under ch. 71 and to the department of revenue apply to the assessment under this section and to the department.

(e) The department shall levy, enforce and collect the assessment under this subsection.

(f) Sections 71.74 (1) to (3), (6), (7) and (9) to (15), 71.75 (1), (2), (4), (5) and (6) to (10), 71.76, 71.77, 71.78 (1) to (8), 71.80 (1) (a) to (d), (3), (3m), (6), (8) to (12), (14) and (18), 71.87, 71.88, 71.89, 71.90, 71.91 and 71.93 as they apply to the taxes under ch. 71 and to the department of revenue apply to the assessment under this subsection and to the department.

(g) This subsection does not apply after September 30, 1992.

(6u) FACILITY OPERATING DEFICIT REDUCTION. Except as provided in par. (g), from the appropriation under s. 20.435 (1) (o), for reduction of operating deficits, as defined under criteria developed by the department, incurred by a facility, as defined under sub. (6m) (a) 2., that is established under s. 49.14 (1) or that is owned and operated by a city, village or town, the department shall distribute to these facilities not more than $18,600,000 in each fiscal year, as determined by the department, and shall perform all of the following:

Recreate New language

(a) Estimate the availability of federal medical assistance funds that may be matched to county funds or funds of a city, village or town for the reduction of operating deficits incurred by the facility.

(b) Based on the amount estimated available under par. (a), develop a method to distribute this allocation to the individual facilities that have incurred operating deficits that shall include:

1. Development of criteria for determining operating deficits.

2. Agreement by the county in which is located the facility established under s. 49.14 (1) and agreement by the city, village or town that owns and operates the facility that the applicable county, city, village or town shall provide funds to match federal medical assistance matching funds under this subsection.

2m. Identification by the county in which is located the facility established under s. 49.14 (1) of all county funds expended in each calendar year to operate the facility, and certification by the county to the department of this amount.

3. Consideration of the size of a facility's operating deficit.

(c) Distribute the allocation under the distribution method that is developed, unless a county has failed to comply with par. (b) 2m.

(d) If the federal department of health and human services approves for state expenditure in a fiscal year amounts under s. 20.435 (1) (o) that result in a lesser allocation amount than that allocated under this subsection, allocate not more than the lesser amount so approved by the federal department of health and human services.

(e) If the federal department of health and human services approves for state expenditure in a fiscal year amounts under s. 20.435 (1) (o) that result in a lesser allocation amount than that allocated under this subsection, submit a revision of the method developed under par. (b) for approval by the joint committee on finance in that state fiscal year.

Delete

(f) If the federal department of health and human services disallows use of the allocation of matching federal medical assistance funds distributed under par. (c), the requirements under sub. (6m) (br) shall apply.

(g) If a facility that is otherwise eligible for an allocation of funds under this section is found by the federal health care financing administration or the department to be an institution for mental diseases, as defined under 42 CFR 435.1009, the department may not allocate to that facility funds under this section after the date on which the finding is made.

(6v) (a) "Facility" has the meaning given in sub. (6m) (a) 3.

(b) The department shall, by September 1 of each year, submit to the joint committee on finance a report that provides information on the utilization of beds by recipients of medical assistance in facilities for the immediate prior 2 consecutive fiscal years.

ASSISTED LIVING

AB 150 allows for the operation of "assisted living facilities." Section 3221 (page 1116) of AB 150 creates s.50.01(1d), Wis. Stats., which defines an "**assisted living facility**" to mean "**a place where 5 or more adults reside that entirely consists of independent apartments, each of which has an individual lockable entrance and exit and individual separate kitchen, bathroom, sleeping and living areas, and that to a person who resides in the place provides not more than 28 hours per week of services that are supportive, personal and nursing services.**"

- Under AB 150, assisted living facilities would not be required to be licensed.

- S.50.034(1) of AB 150 states: "No person may operate an assisted living facility that provides supportive, personal or nursing services to recipients of Medical assistance unless the assisted living facility meets requirements as a provider of Medical assistance and is so certified by the department under this subsection. Certification shall be for a term not to exceed 12 months from the date of issuance and is not transferable."

- Standards for operation of certified assisted living facilities and procedures for application for certification, monitoring, decertification and appeal of decertification, as well as the definitions of "supportive services," "personal services" and "nursing services," shall be under rules promulgated by the DHSS, with the approval of the Department of Administration (DOA). The DHSS is to submit those rules to the DOA for review no later than December 1, 1995. The DHSS is to submit the proposed rules, as approved by the DOA, to the Legislative Council staff for review no later than January 1, 1996.

- Funding for supportive, personal or nursing services that a person who resides in a certified assisted living facility receives may be provided only under the COP-W and CIP II programs. That funding may not exceed 85% of the statewide nursing home reimbursement rate. The DHSS is to calculate the statewide nursing home reimbursement rate by July 1 annually and submit that rate to the DOA for review and approval.

WAHSA POSITION

WAHSA supports the AB 150 assisted living initiative described under Item #8 on Pages 329-330 of the Legislative Fiscal Bureau Budget Summary.

The impetus for assisted living is consumer preference. It is the type of care that consumers across the country are asking for. Its focus is on resident autonomy, personal decisionmaking, risk sharing, a less restrictive regulatory environment and affordability.

While assisted living may be a new certification category, it is not a new concept. From a philosophical perspective, assisted living can be viewed as "COP in congregate housing." It espouses an "aging in place" philosophy in an apartment setting. It allows the consumer to select from a wide array of services the services he or she wishes to receive. It is driven by consumer preference rather than government mandate.

Assisted living differs from care in a community-based residential facility (CBRF) in three key ways: 1) In order to foster "aging in place," it would allow significantly more nursing care to be provided; 2) Its focus is on an apartment-style setting; and 3) Unlike the 93-page rule that will soon regulate CBRFs in Wisconsin, assisted living, because of its focus on flexibility, affordability and resident antonomy, would exist in a much less restrictive regulatory environment.

Some have expressed concern with the lack of regulatory oversight in the AB 150 assisted living initiative. But that begs this question: If you or I have the funds available to pay for the services we wish, we wish to have those services provided in our "home" (i.e., apartment) and there are service providers available and willing to provide those services, why should government be involved at all, especially since government involvement inevitably leads to increased costs? The AB 150 assisted living initiative would rely on the licensure standards of the individual professional care providers to guarantee quality of care rather than the creation of a new bureaucracy, both of which should serve to benefit the consumer.

WAHSA members would suggest two changes to the AB 150 assisted living initiative:

1) On line 14 of Page 1116 of 1995 AB 150, delete the word "entirely."

   There are a number of nursing homes which are quite interested in converting to assisted living facilities but would be precluded from doing so because of the prohibitive costs to convert to apartments. However, it might be feasible to convert a wing of the facility into assisted living, at a potentially significant savings to the Medicaid program, if the flexibility that this proposed amendment would afford is allowed.

2) AB 150 proposed no new funds for assisted living. The program would be forced to compete for "available" COP-W and CIP II funds. WAHSA members suggest that the Legislature consider the voluntary "banking" of nursing home beds as a potential source of assisted living funding. If a nursing home considering a conversion to assisted living were able to voluntarily "bank" some or all of its beds, the Medicaid dollars that otherwise would flow to the nursing home could be used to fund assisted living, once again at a potential savings to the MA program.

The Wisconsin Association of Homes and Services for the Aging (WAHSA) is a statewide membership organization of not-for-profit corporations principally serving the elderly and disabled. Membership is comprised of 188 religious, fraternal, private and governmental organizations which own, operate and/or sponsor 142 not-for-profit and 46 county-operated nursing homes, 23 intermediate care facilities for the mentally retarded, 55 community-based residential facilities, 11 licensed home health agencies, 90 independent living facilities and over 300 community service agencies providing programs ranging from Alzheimer's support, adult and child day care, hospice and homecare to Meals on Wheels.

Nursing Facility Capital Projects: Elimination of the Chapter 150 Resource Allocation Program

Overview

The nursing facility Resource Allocation Program (RAP) was established under 1983 Wisconsin Act 27, which repealed and recreated Chapter 150, Wisconsin Statutes. The RAP replaced the long term care section of the former Certificate of Need Program.

Under RAP, the Department of Health and Social Services is authorized to review and approve or disapprove the following:

- The construction or total replacement of a nursing facility;
- A capital expenditure that exceeds $1.0 million by or on behalf of a nursing facility;
- An expenditure total that exceeds $600,000 for clinical equipment by or on behalf of a nursing facility;
- The partial or total conversion of a nursing facility to a facility primarily serving the developmentally disabled (FDD) or of a FDD conversion to a nursing home;
- An increase in the bed capacity of a nursing home (including increases involving the relocation of existing nursing facility beds).

Also, under s.150.31(1) of the statutes, the state has imposed a moratorium on the maximum number of nursing facility and FDD beds. The maximum number of nursing facility beds presently is 51,795 and for FDD beds is 3,704.

The Governor's biennial budget proposal (Assembly Bill 150) would eliminate the Chapter 150 Capital Expenditure Review Program and its requirement that hospitals and home health agencies receive prior-approval for major capital expenditures, purchases and acquisitions. AB 150 would correspondingly eliminate the Cost Containment Commission to reflect termination of this program.

WAHSA Position

WAHSA members urge the Legislature to eliminate the Chapter 150 Resource Allocation Program. The nursing home bed moratorium should be preserved; in addition, the current DHSS authority requiring prior approval of certain projects involving the reallocation of nursing facility beds or the creation of new beds should be retained.

WAHSA Analysis

In its 1/31/95 report to the Legislature, required under 1993 Wisconsin Act 16, DHSS writes: "The intent of the RAP Program is to contain nursing home growth and costs in Wisconsin and to promote the appropriate use of health care dollars. Since over 70% of the people residing in Wisconsin nursing homes in 1983 had their care paid for through the Medicaid Program, RAP was viewed as a major MA cost containment measure."

WAHSA members argue that the RAP has failed to meet its intended goals and has increased, rather than decreased, Medicaid spending.

Please consider the following points:

- A significant portion of Wisconsin's 470 nursing homes were constructed in the 1960's and are, not surprisingly, in need of significant capital improvements or replacement. These improvements are aimed at improving the quality of care and services nursing facilities provide their residents. However, the RAP forces providers to participate in a costly, drawn-out review process which does little more than needlessly postpone a needed

project. **Under the current system, many facilities must expend limited resources simply to secure DHSS approval to undertake projects necessary to improve residents' quality of life and/or to achieve compliance with state and/or federal regulations.**

- The DHSS 1/31/95 report suggests that administrative rules should be promulgated to allow 2-3 nursing homes to pursue designs which would foster a more homelike atmosphere. These designs, among other benefits, would allow facilities to provide more private rooms for residents, including separate bathrooms. According to DHSS, of the existing nursing homes replaced in the past seven years, only 10% of the beds were in private rooms and only 22% of the rooms did not require a resident to share a bathroom. The fact that DHSS says these "innovative" designs, which promote resident rights and privacy, should be piloted on an extremely limited basis is precisely why the RAP program should be eliminated -- It truly is out of touch with the needs and desires of today's long term care residents.

- The RAP does not curtail Medicaid costs (indeed, the current program results in increased Medicaid spending); the capital component of the Nursing Home Payment Formula does. Strict payment limits are imposed on capital expenditures by the nursing home formula. If nursing homes wish to go on a renovation, remodeling or replacement "binge," the state's participation in that "binge" will be limited not by the RAP but by the Nursing Home Payment Formula.

- The RAP has become a bureaucratic nightmare for providers facing the expenditure of limited resources which ultimately must be paid for by private and public payers. WAHSA estimates the average RAP application takes approximately 110 person-hours to prepare, at a cost in the $8,000 - $13,000 range. This includes the time of a professional RAP consultant who coordinates the application process, an architect and a C.P.A. It does not include the time of an attorney or bond counsel, which may be required later in the RAP process. If a nursing home administrator or someone else unfamiliar with the RAP process attempts to complete the application without the aid of a RAP consultant, the preparation time may more than double. **This costly and drawn-out process results in the expenditure, rather than the savings, of Medicaid dollars since the cost of preparing a RAP application** is a reimbursable cost under the Nursing Home Payment Formula.

In summary, WAHSA urges the Legislature to eliminate the RAP and to retain the nursing facility/FDD bed moratorium and DHSS oversight regarding the reallocation of beds or the creation of new beds.

The Wisconsin Association of Homes and Services for the Aging (WAHSA) is a statewide membership organization of not-for-profit corporations principally serving the elderly and disabled. Membership is comprised of 188 religious, fraternal, private and governmental organizations which own, operate and/or sponsor 142 not-for-profit and 46 county-operated nursing homes, 23 intermediate care facilities for the mentally retarded, 55 community-based residential facilities, 11 licensed home health agencies, 90 independent living facilities and over 300 community service agencies providing programs ranging from Alzheimer's support, adult and child day care, hospice and homecare to Meals on Wheels.

Dear Joint Senate members:

I want to register my opposition to the elimination of Medical Assistance Personal Care. I need personal care to live in my apartment and pay my workers. Please do not cut this program — I love living in the community and riding the mainline bus.

Sincerely

Susan Epperson

I'm here to speak in support of the Wisconsin Area Health Education Centers, or AHEC. My name is Judy Stewart and I am the Program Manager for a small office called "REACHOUT", which stands for "Resident Education in Access to Health Care: Office of Underserved Training." At REACHOUT, we are addressing the problem of unequal distribution of health care in Wisconsin. We are working on this from the vantage point of primary care medical resident education. Medical residents are in the last stages of training before becoming physicians. They have completed medical school, and are involved in "on-the-job" training. They are at this point making critical career decisions -- not only deciding about the type of medicine they will practice, but also looking for jobs, and deciding what kinds of communities they will settle in. REACHOUT's main task is to arrange training opportunities for primary care medical residents in communities outside the medical school, and AHEC has provided us with critical support to do this.

AHEC's overall goal is to "improve access to care in Wisconsin's underserved communities, through the development of community-based, client-oriented, culturally relevant, collaborative health professions programs. The Wisconsin AHEC System accomplishes this mission by fostering cooperation and collaboration among Wisconsin's health professions educational institutions and communities."

What strikes me most about AHEC is how efficiently their dollars are spent. Health care distribution is a big problem, but AHEC rationally subdivides it, providing relatively small amounts of money to programs that have clear objectives and therefore are likely

to succeed in increasing access to health care. Target educational levels of AHEC programs vary from elementary school to graduate medical education. From "grow-your-own-health-professional" programs to those demonstrating the potential attractiveness of rural practice to imminent physicians, AHEC-supported programs are practical, based when possible on hard data as to what has been shown to "work". AHEC also requires rigorous evaluation, to ensure that supported programs are actually accomplishing what they set out to do.

Not only does AHEC require that its dollars are well-targeted, it promotes activities that get people and programs with similar goals talking to each other. This "networking" invariably leads to cooperation, and less expense for all involved. For instance, AHEC encouraged REACHOUT to establish informal ties with the Office of Rural Health, which is involved in helping communities recruit health professionals. There are several ways now that our two offices work together; for instance, when an internal medical resident comes into my office looking for a rural training site, I can recommend one where I know an internist is actively being recruited. The benefit of this kind of collaboration, both to the communities and the potential recruit, should be obvious.

Another very important thing that AHEC does is to promote the concept of interdisciplinary team care. Rural communities will be much more successful in attracting and keeping health care professionals if all involved begin to realize that our old model of the all-knowing, and always-available, physician is not the only answer to

the health care distribution dilemma. Allied health professional such as nurse-practitioners, physicians' assistants, and nurse-midwives have an important role to play, especially in rural communities. Recognizing how these professionals can all work together to meet a community's health care needs is critical. The interdisciplinary care concept permeates most, if not all, AHEC-supported programs, and teaching not only communities (and patients) but also the practitioners themselves that this model can work, and in fact may be the only logical solution to the health care access problem, is one important task that AHEC continually encourages.

REACHOUT operates on a pretty small budget, and is typical of the kinds of programs AHEC supports. We've been operating less than a year, so I can't claim that we've produced "x" number of physicians who are now practicing in rural Wisconsin. We feel pretty strongly, however, that with continued support from such agencies as AHEC, we **will** be able to make such claims in the near future. I urge you to continue funding the Wisconsin Area Health Education Center system, as it is a very cost-effective way for you to address the important problem of access to health care in this state.

Here are my opinions about Bill 150 - the budget of Governor Tommy Thompson:

1) I have read that Medical Assistance Personal Care has been dropped from the budget cuts. Thank you very much for that decision. This program should be expanded not cut — it saves the state much money because people stay in their homes ~~and~~ rather than to a nursing home. There are people on waiting lists for these funds.

2.) The elimination of SSI for at least 17,000 people may not be devastating to all of them but it will to many. The loss of Medical Assistance with it could be tragic. Please reexamine this cut - it wouldn't save very much money for the state but has the potential to hurt many.

3.) I am not trying to shirk my duties as a taxpayer. We all need to do our share. About 30% of my check or more goes to taxes. I don't mind paying for services that I don't personally use. I feel that the wealthy also need to pay their share. I don't receive welfare nor do I think the wealthy should receive it in the ~~form~~ of tax cuts. In a time when revenue is important

please expect the wealthy to pay proportionately. The middle class can only pay so much. The added "fees" will also hit the middle class harder because everyone – no matter what their income, pays exactly the same fee. This is called regressive taxation. Please work for no change for those who are earning $100,000. (on their taxation)

4.) The family support program is essential to some families with children with disabilities. Some could perhaps function but I fear that child abuse could be the result of a lack of money for a washing machine in a family where a child wears diapers until they are 18yrs of age or money for gas for doctor visits etc. Some parents will find it impossible to keep their children at home and institutions will again become the answer. Please continue to fund this program.

5.) The plan to change the amount of money a spouse may keep (from ±$72,000 to ±$13,000) when the other goes to a nursing home is dificult to comprehend. With taxes of $3,000/per year for a house, plus the rising costs of medical care could send a spouse who is younger by 5 or 10 years to the poor farm. Please do not change this.

6.) I'm not sure if this is included in Bill 150 but I do not want to see the office of public intervener eliminated. We need this office to protect our state's resources and quality of life.

7.) Please do not eliminate the DNR board and have instead a secretary appointed by the Governor. Again we need to have a buffer to protect our Natural Resources.

8. Please do not eliminate The Department of Public Instruction nor the Superintendent of Schools. We need to have an elected official to have a balance of power.

I see 6-8 as attempts to have a person appointed by the Governor, who then would have the power to dictate what happens to our natural resources + educational system. This is inconsistent with the Governors plan for less power for the government and more for the people.

Stan Learned

Darwin Ness
616 E. Dayton
Madison, WI
53703

Darwin Ness

With the help of my attendant, I would like to express the views stated above.
STANLEY LEARNED

TESTIMONY OF JEFF MYERS 3/27/94: JOINT FINANCE COMMITTEE BUDGET HEARINGS

WHO AM I AND WHY I AM HERE?

My name is Jeff Myers. I have lived in Wisconsin most of my life. I went to high school and college in Kenosha. I went to graduate school in Green Bay. I have worked for the state of Wisconsin for 10 years. I now work at the DNR as an environmental toxicologist, trying to help people understand the impacts of air pollution on public health. I am dedicated to my work as well as to the residents of Wisconsin that helped me get my education and I am happy to serve them. I am also a member of the Wisconsin Science Professionals, which represents about 1,200 state employees who are scientists in many different agencies. My colleagues are also dedicated to their work and to the residents of the state and while I do not speak for each and every one of them, I echo many of their concerns here today.

I am also here as a father of two girls, a husband, and a son. Like a lot of other families in Wisconsin, our family is concerned about the impacts of this budget on our well being and its impacts on other residents - people that I don't even know.

I am here because I believe that many provisions in the budget bill (both AB 150 and Assembly Substitute Amendment 1) adversely affect me and my family and my fellow state employees and are not good public policy choices.

IMPACTS ON MY FAMILY

I am concerned about the impacts of the budget on my family. My father is elderly and has recently been ill, resulting in large medical bills. His "safety net" is medical assistance and Medicare and one day he may need general assistance as well. I am afraid that changes to medical assistance, general assistance, home health care or visiting nurse care programs will adversely affect him. My two children are ages two and five. The oldest will be going to school this fall in McFarland. I believe that the school spending caps, the dismantling of the Dept. of Public Instruction and general lack of support for teachers and their profession is misguided and will negatively impact my child as well as many others. Wisconsin has held a prominent position in education for many years. I think this budget erodes public education instead of supports it.

IMPACTS ON OTHERS

I have heard about the impacts of the budget on the poor, sick, and disabled. I don't want my $302 decrease in property taxes to cause other people to suffer the way this budget does.

Like a lot of other people, I want my property taxes to go down. I expect government to be run efficiently and effectively. I also expect school districts to do the best job they can with limited resources and believe they try to accomplish this difficult goal.

However, I did not expect my desire to have lower property taxes to result in a budget that is so "mean spirited." This budget, as originally drafted, helps increases funding for building roads, bails out dog track owners, and benefits some business interests and higher income taxpayers at the expense of economically disadvantaged groups. I believe that we need incentives for people to become self sufficient, if they are capable of supporting themselves, but I do not think it is humane to treat people the way this budget does. I believe Wisconsin taxpayers would be better off without the proposed property tax relief if it means that children will suffer and the basic needs of food and shelter are not being met.

IMPACTS ON MY WORK

There are three main budget issues that affect my agency - DNR. The suggestion to make DNR a cabinet agency and make the secretary and staff appointed officials is the most significant. I believe a large part of our high quality of the environment is due to the structure of the organization that allows citizens to make decisions on natural and environmental resource issues. I do not support making DNR a cabinet level agency. The natural and environmental resources of the state are held in trust for all citizens of the state. For many years, a citizen board has helped guide the Department to do just that. While politics is always present in any state agency, allowing the Governor to directly appoint the secretary and administration staff will result in a "captured" agency which is more concerned about the short term electoral cycle rather than the long term view that is needed to care for the land, water, air and the web of life that depends on a healthy environment. One hundred years from now no one will care about who held which political office, but they will care if resources are degraded and are over developed to maximize potential short term yields rather than considering long term stewardship. Over one years ago, it was belief in long term stewardship that helped establish the National Parks system even in the face of strong opposition. Today, it is hard to find anyone that thinks the establishment of the National Parks system was a bad idea. Taking the long term view, I think the citizen board is a better structure for shared decision making and should be retained.

The second issue of concern is the transfer of the parks function away from the DNR to a new Dept. of Parks and Tourism. The parks can be promoted by the tourism department, but DNR has the expertise and infrastructure to manage the parks. Our parks are very special places. There are scientific areas that need to be protected as well. I am very concerned that transfer of these properties to a tourism oriented organization will alter the purpose and biota of the parks forever.

The third issue of concern is the transfer of the regulated storage tank program from DNR to the new Dept. of Commerce. The Commerce Dept. has a promotional function rather than the regulatory nature of the storage tank program. This would set up a potential conflict of interest. The storage tank program is an environmental program and like all DNR programs, strives for customer service. There would be disruption in service and confusion among the regulated community if the storage tank program was moved to the new Dept. of Commerce and there is no cost savings to be gained by making this change.

CHANGING GOVERNMENT FOR THE WORSE

This budget makes government less responsive to the needs of its citizens.

- Politicizing State Government: This budget will result in more political appointees. How will this improve state government? **The answer is it won't.** Most changes will do little to save money. Examples: Removing Dept. of Revenue and Regulation & Licensing from civil service, eliminating elected state officers and replacing with appointees, making numerous career executive positions unclassified and making DNR and DATCP cabinet level agencies. My view from the trenches is that people enjoy their work in state government - it can be very rewarding - but do not like the increasing influence of politics in many facets of decision making. My perspective is that political considerations have crept more and more into daily decision making at DNR and this is a warning to everyone in the state who cares about good government that we are moving in a dangerous direction with many of the changes proposed in this budget.

- In my opinion, the Department of Administration is micro managing state government and centralizing power when it should be allowing more decisions to be made at the lowest level possible. Example: An agency must ask for DOA approval for new positions and is often told that instead of hiring a more advanced position, the agency must announce the position at a lower level and may not be able to get the type of help it needs to get to get the job done. DOA, instead of the agency closest to the decision, is effectively making decisions as to the type of skills that are needed for the job. In an era when management consultants talk of reinventing government, total quality improvement and empowering the workforce, DOA's tendency to monopolize every aspect of state government will increase bureaucracy and decrease productivity in the state work force at the time when we need it most. DOA controls the purse strings and will not allow agencies to manage their own budgets to the best of their ability. This micro management hurts us all.

- Adding Bureaucracy: In this budget bill there is a proposal to create an environmental science council, under DOA. The citizen boards in DNR and DATCP already have processes which filter out good public policy from bad. Citizens have always played an important part of developing science policy in Wisconsin and this is how it should be. Adding an environmental science council to the existing process is redundant and costly. When controversial scientific issues have arisen in DNR rules, the Board has requested ad hoc technical committees to come to consensus on the validity using one scientific approach vs. another.

- DOA also has a plan to take control over the communications and computer resources of the state. DOA wants the educational communications board and wants to be able to control the communications of state agencies by centrally controlling the state computer network . In addition, instead of requesting positions in the budget to get needed work done, DOA can take needed resources and people from other state agencies to work on its projects at the expense of agencies that need the computer expertise in that agency to finish priority work. **Coordination is essential in communication. Control is not.**

PROCESS

- The Governor's budget development process was mainly handled by a very limited number of people close to the Governor. The legitimization of public policy is what I am here for today - the process used to develop the original budget bill was not a public process.

- In my opinion, most state agencies developed 5% & 10% budget cuts in good faith. DOA and the Governor took some of the recommendations from various agencies but made more cuts based on their own agendas. Often the DOA budget analysts did not fully understand the programs that were cut -some were later labeled "unintentional" or "inadvertent" - but there are many other programs that will not receive public debate due to the sheer volume of items placed into the budget bill. The public was not served because recommendations of agency secretaries who are closest to the issues of agency budgets and where cuts in programs could be made were rejected in many cases. **Many of the cuts show that the people who worked on this budget may have known the cost of everything, but the value of <u>nothing</u>!**

- This budget in particular is deceptive in the way cuts, reorganizations, and funding is provided and the way that agencies are defunded, eliminated and positions are transferred or not transferred. The deliberate way the impacts on agencies and programs were hidden does not speak well for people's belief in good government and honesty.

In summary, the only way I can describe the budget is "mean spirited." The state has a responsibility to all of its citizens regardless of whom they are and whether they are rich or poor. There is a saying that when the fecal matter hits the fan, it is never distributed equally - the budget surely uphold that adage. The same budget that cuts tens of millions from social service and health care needs from the sick, poor and elderly, gives increased funding to the rich. This is not the Wisconsin I grew up in. This is the leaner, **<u>MEANER</u>** Wisconsin.

DON'T FIX IT IF IT ISN'T BROKE

- RETAIN OUR EXCELLENCE IN PUBLIC EDUCATION
- DON'T REDUCE SUPPORT FOR CHILDREN, POOR, SICK OR DISADVANTAGED GROUPS WHILE GIVING INCREASED SUPPORT TO GAMBLING, ROAD CONSTRUCTION AND UPPER INCOME TAXPAYERS
- THE EXISTING BOARD STRUCTURE AT DNR AND DATCP ARE WORKING FINE - NO NEED TO CHANGE
- RETAIN CIVIL SERVICE PROTECTIONS FOR EVERYONE, ESPECIALLY THE DEPT. OF REGULATION & LICENSING AND DEPT. OF REVENUE AS WELL AS FOR MANY CAREER EXECUTIVE POSITIONS SLATED TO BECOME APPOINTED POSITIONS
- REORGANIZE OR TRANSFER ONLY WHERE COSTS WILL BE SAVED AND REDUNDANCY REDUCED - DON'T JUST MOVE PEOPLE
- IF TRANSFERS ARE NECESSARY, ENSURE ALL THAT THE INCUMBENTS ARE TRANSFERRED TO THE NEW AGENCY AND WILL RETAIN THE SAME RIGHTS AS IN THEY HAD IN THE AGENCY THEY TRANSFERRED FROM
- THE PRIVATIZATION OF UW-HOSPITAL IS AN IMPORTANT POLICY ITEM AND SHOULD BE PULLED OUT OF THE BUDGET TO PASS OR FAIL ON ITS OWN MERITS
- DO NOT PRIVATIZE GAMBLING, THE UW-HOSPITAL, OR OTHER PARTS OF STATE GOVERNMENT UNLESS: A) SAVINGS CAN BE SHOWN; B) NO CONFLICT OF INTEREST EXISTS; AND C) DOA GUIDELINES FOR WHEN CONTRACTING FOR SERVICES IS ALLOWED ARE FOLLOWED
- GIVE AGENCIES A TOTAL SPENDING AND POSITION AUTHORITY AND LET THEM MANAGE THEIR OWN AGENCIES WITHIN THESE LIMITS INSTEAD OF GOING TO DOA ALL THE TIME FOR APPROVALS

SSI COALITION

c/o Wisconsin Coalition for Advocacy, 16 N. Carroll St., Suite 400, Madison, WI 53703 (608) 267-0214

Date: March 27, 1995

To: Joint Finance Committee

Subject: AB 150 Proposal to Eliminate 17,000 People from SSI

The 71 organizations that make up the SSI Coalition strongly oppose the Governor's proposals to eliminate SSI payments to 17,000 elderly and disabled people who receive the state SSI supplement but do not receive any federal benefit. The SSI coalition supports continued eligibility for these people, and a full pass-through of cost-of-living increases.

This change is described in budget documents as "targeting to people in greatest need." **There is no difference in the level of need between the 17,000 elderly and disabled people who will lose benefits under the budget and other SSI recipients who are slated to get an increase.** Everyone on SSI must meet the same test for being either elderly or severely disabled. SSI operates by bringing recipients up from whatever income they start with to a set income level. A person with $100 in outside income ends up with exactly the same total income as a person with $500 in outside income. (Work incentives may give people who work somewhat higher incomes.)

The only thing that distinguishes the 17,000 losers under this proposal is that they have outside income which reduces their SSI to the point where they are only receiving the state portion of SSI. For the vast majority, this outside income comes from Social Security disability or retirement benefits. For some, the earnings come from work. This will produce odd results:

- An elderly person who has worked and qualifies for Social Security over $478 per month will end up with up to $180 less income per month than a person the same age and having the same support needs who never worked.
- An adult who has been disabled since birth will suddenly lose up to $180 in income per month because his or her parent dies or retires and the child becomes eligible for Social Security over $478 on the parents' account.
- An SSI recipient who has Social Security near the federal SSI limit and is working enough to put his or her income over the federal limit will in many cases be able to increase his or her income by cutting back on work--reversing work incentives that have been part of the SSI program for over 20 years.

Stop Stealing our Income

A Statewide Coalition of Citizens Who Rely on SSI: elderly people, people with disabilities, people with mental illness, and people with substance abuse problems

The primary effect of this proposal is to punish people for working, or for having a spouse or parent who worked. The typical person affected is elderly or severely disabled and is living at about 85% of the poverty level. The average person affected will lose over 10% of his or her income; some people will lose over 25%.

The SSI budget proposal is most remarkable for what is left out:

- **How will counties absorb the cost of 17,000 Medical Assistance applications?** The primary reason for the proposed cut-off is to avoid state administration of 17,000 SSI applications. Most of the projected cost of handling SSI applications is the time of county income-maintenance workers ($4.7 million per year). The vast majority of the 17,000 people affected will now be making Medical Assistance applications to those same county income maintenance departments. **Exactly the same information about age, disability, resources and income will have to be collected for Medical Assistance as would have to be collected for SSI.** For people who must do a spend-down, substantially more information is needed. Nowhere does the budget take this cost into account.

- **How many of the people affected are using SSI to pay for residential and other services, and how will these services be funded?** For people who live in Adult Family Homes or Community-based residential facilities the SSI payment, less a $60-80 personal living allowance, goes entirely for room, board and services. Other people use SSI-E payments for cost-sharing for other services. This budget change will produce a monthly funding gap of up to $180 in residential and service budgets. There is no explanation in the budget either of the total impact on counties and service providers or of how this funding gap will be filled.

- **What will be the impact of federal changes?** Federal budget changes this year will almost certainly significantly tighten eligibility for children and for adults who are disabled based on substance addiction and increase state flexibility in other ways. **This is not the time to arbitrarily dump 17,000 people for administrative purposes.** It makes more sense to reassess caseload and future costs after the federal changes occur.

For these reasons, the SSI coalition urges you to:

- **Retain federal administration of the state supplement.**

- **Retain SSI eligibility for people on the state supplement.**

- **Pass through the federal cost-of-living increase to all SSI recipients and provide a cost-of-living adjustment to the state supplement.**

SSI COALITION

2/21/95

c/o Wisconsin Coalition for Advocacy, 16 N. Carroll St., Suite 400, Madison, WI 53703 (608) 267-0214

MEMBER ORGANIZATIONS

ABC for Health Project
ABLE Coalition
Access to Independence
Advocates for Retarded Citizens
AIDS Resource Center of Wisconsin
Alliance for the Mentally Ill - Eau Claire
Alliance for the Mentally Ill - Ozaukee County
Alliance for the Mentally Ill - Waukesha County
Alliance for the Mentally Ill - WI
Alliance for the Mentally Ill - SW
Assoc. for the Developmentally Disabled of Manitowoc Co. Inc.
Autism Society of WI
Brown County Association for Retarded Citizens, Inc.
Cerebral Palsy, Inc. - Green Bay
Center for Independent Living for Western Wisconsin, Inc.
Consumer Advocates for Mental Health
Coalition of WI Aging Groups
Consumer Council
Creative Community Living Services, Inc.
Creative Employment Opportunities, Inc.
Curative Rehabiliation Center - ILP
Eisenhower Center
Epilepsy Center So. Central
Family Support & Resource Center
Goodwill Industries of SE WI
Grand Avenue Club, Inc.
Great Rivers Independent Living Services, Inc.
Independent Living Center - N. Central WI
Kenosha ARC
Meda-Care Vans, Inc.
Milwaukee Center for Independence
North Central Health Care Facilities
North Country Independent Living
New Horizons North
People First of Dane County
Prader-Willi Association of WI
PREVAIL, Inc.
Repairers of the Breach
Southeastern Wisconsin Center for Independent LivingSupport People Now
The Arc - Columbia County
The Arc - Dane County
The Arc - Dunn County
The Arc - Eau Claire
The Arc - Neenah/Menasha
The Arc - Racine County
The Arc - Outagamie County
The Arc - Winnebago County
The Arc - WI
Transitional Living Services
United Cerebral Palsy of Greater Dane County
United Cerebral Palsy of South Central Wisconsin
United Cerebral Palsy of Southeastern Wisconsin
United Cerebral Palsy of West Central Wisconsin
United Cerebral Palsy - WI
UW-Stout ILC
Waukesha County Coalition for Human Services
Wisconsin Association on Alcohol and Other Drug Abuse
Wisconsin Association of Alcohol and Drug Abuse Counselors
Wisconsin Association of Residential Facilities
Wisconsin Chapter - National Multiple Sclerosis Society
Wisconsin Coalition for Advocacy
Wisconsin Coalition of Independent Living Centers
Wisconsin Community Action Program
Wisconsin Council on Children & Families
Wisconsin Council on Developmental Disabilities
Wisconsin Council on Mental Health
Wisconsin Family Ties, Inc.
Wisconsin Interfaith IMPACT
Wisconsin Personal Service Alternatives
Wisconsin TASH
Yahara House

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