TO THE MEMBERS OF THE JOINT FINANCE COMMITTEE

My name is Eunice Boyer. I am a county supervisor, chair of the Human Services Committee and Human Services Board of Kenosha County. I am also a senior citizen in my own right, as well as a member for many years of the Kenosha County Commission on Aging. I am here to urge a $4.00 increase in the Medical Assistance Personal Care rate. In my capacity as chair of the Human Services Board, and from the experience of many friends who are older and more incapacitated than I, I realize to remain in one's own home is a priceless privilege. To be forced to give up that home is the beginning of mourning for one's own death. In an era (and area) of relatively full employment, it is almost impossible to recruit, train, and keep good personal care workers--and yet they MUST be good because we entrust our most vulnerable citizens to their care. Furthermore, the lack of good in-home care contributes to the use of more expensive nursing home care.

Please support the adequacy of community care funds in the budget. My husband and I pay fairly high income taxes--yet I would prefer adequate funding in this area to a tax cut.

4/8/99

TESTIMONIAL TO THE JOINT FINANCE COMMITTEE

Thank you for allowing me the opportunity to speak to you today. I ask for your support for a $4.00 increase in the Medical Assistance (MA) Personal Care rate.

Personal Care Services are provided to people with disabilities and illnesses of all ages by certified Personal Care Workers (PCW's). PCW's provide basic assistance with activities of daily living which include bathing, dressing, eating and toileting. Personal Care Services are provided to thousands of people in Wisconsin on a daily basis. Without these vital services which provide quality of life for the frail elderly and adults and children with disabilities, many people would be institutionalized.

As Director of Home Care Services for Society's Assets, Inc., an Independent Living Center, I administer a Personal Care Program to over 600 residents of southeastern Wisconsin on an annual basis. Over 60% of the consumers are older people and the average care provided to each person is approximately 1.5 hours of personal care services daily. This currently amounts to an estimated $17.25 per day per person or approximately $6,296 per person on a yearly basis. It would cost more than six times this amount for nursing home care. The cost effectiveness and sensibility of this program speaks for itself.

Programs like the one I manage need your help if they are to survive. **There is a crisis in Personal Care Services.** Many home health agencies that provided this service in the past have discontinued this program entirely or limit service to existing clients. It has been necessary for home health agencies to do this because the reimbursement rate of $11.50 an hour is well below the average cost of providing this service which is $16.40 per hour based upon a survey of home health agencies conducted in 1998 by the Wisconsin Homecare Organization (WHO).

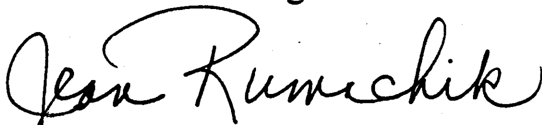
Personal Care only agencies, like the one I work for, are also having difficulty continuing to provide personal care services under the current reimbursement rate. Personal Care Agencies surveyed throughout the state estimated their actual cost of providing this service at $14.00 per hour in

1998. The rate for this service was frozen at $11.05 from 1990 through June of 1997, seven years. In July of 1997 and in July of 1998, this service was given a 2% increase which results in a 4% increase over 9 years. There is only a 1% increase in the budget earmarked for this program and scheduled to go into effect 2001. Most Personal Care only agencies will not be able to survive with only an 11 cent increase in the year2001. Any business would have difficulty surviving in this environment.

Currently agencies like mine are not able to recruit and retain enough qualified Personal Care Workers. Because of the current low reimbursement and unemployment rates, we are not able to provide competitive wages and benefits and have difficulty staffing new referrals for service as well as staffing existing consumers. Many of our Personal Care Workers are single parents who have to leave this type of work because they need a living wage and benefits.

Personal Care Workers are at the heart of community-based long-term care. We must pay them better wages and benefits in order to keep them. Wisconsin has made a commitment to assist the elderly and people with disabilities to live independently in their own homes. This service is vital to the success of the Family Care initiative.

I appreciate your support on this issue and thank you most sincerely for your time and consideration regarding the need for a $4.00 increase in the MA Personal Care Program.



Jean Rumachik
Director of Home Care Services

SOCIETY'S ASSETS, INC.
5200-Washington Ave. Suite #225
Racine, Wisconsin 53406

Wisconsin Personal Services Alternatives, Inc. (WPSA)
Member Survey
on
PCW Services
August 25th, 1998

Respondents = 56% of Membership (20 Organizations)

1. **Is your agency certified to provide Medicaid PCW services?**
   Yes = (85%) No = (15%)

2. **Are you a: Personal Care only Agency?** (55%)
   Home Health Agency? (20%)
   County Agency? (25%)

3. **Do you currently provide Medicaid PCW Services?**
   Yes = 100% No = (0%)

   RN Supervision?
   Yes = (90%) No = (10%)

4. **How many hours of service <u>per month</u> does your agency provide for the Medicaid Personal Care Worker Program?**
   Total # of hours = 156,279 7,814 Average # Hrs./month

5. **How many consumers do you provide personal care services to on an <u>annual basis</u>?**
   Total # of consumers 2507

6. **What are your average # of hours per visit?**
   1 – 2 = (15%) 2 – 4 = (55%) 4 – 6 = (25%) +6 = (5%)

7. **What is your current cost per hour to provide this service?**
   $13.96 = Average cost per hour
   Note: This is the best estimate available; however, the majority of agencies do not provide many benefits.

8. **What rate of pay on average do you offer for this level of work?**
   $7.29 = Average wage

9. **Are you considering or planning to discontinue Medicaid PCW participation?**
   Yes = (0%) No = (75%) Don't Know = (25%)

10. **Have you received referrals from Home Health Agencies who have discontinued to provide MA PC services?**
    Yes = (50%) no = (45%)
    How many times? Average 16 per year
    Note: Agencies receive many referrals directly from discharge planners, county human service departments and consumers because these referral sources know that many home health agencies are not taking new referrals or have discontinued the provision of MA PC services.

WISCONSIN MEDICAL ASSISTANCE PERSONAL CARE (MAPC) SERVICES
FACT SHEET

WHAT REIMBURSEMENT RATE HAS BEEN PAID BY THE WISCONSIN MAPC PROGRAM TO PROVIDERS SINCE THE INCEPTION OF THIS PROGRAM?

JULY 1, 1988	$9.00 Per Hr. PCW	$38.72/Supervisory Visit
JULY 1, 1989	$9.33 Per Hr. PCW (4% increase from 1988)	$38.72/Supervisory Visit
JULY 1, 1990	$11.05 Per Hr. PCW (18% increase from 1989)	$38.72/Supervisory Visit
JULY 1, 1997	$11.27 Per Hr. PCW (2% increase from 1990)	$39.49/Supervisory Visit
JULY 1, 1998	$11.50 Per Hr. PCW (2% increase from 1997)	$40.28/Supervisory Visit

WHAT ARE OTHER STATES CURRENTLY PAYING FOR MAPC SERVICES?

- ILLINOIS — $41.45 PER VISIT
- INDIANA — $14.70 PER HOUR
- MICHIGAN — $12 - 13.00 PER HOUR
- MINNESOTA — $12.36 PER HOUR
- MISSOURI — $15.50 PER HOUR (in 1996)

WHAT ARE THE REASONS WHY THE NUMBER OF INDIVIDUALS RECEIVING MAPC SERVICES HAS NOT SUBSTANTIALLY INCREASED BUT THE UNITS OF SERVICES ARE INCREASING?

If this is indeed true as the State of Wisconsin reports, although we have not seen statistics to support this theory, the following are all reasons for the increase in MAPC units of service:

- The population of MAPC consumers is aging and needing more service. The MAPC population of recipients is chronically ill, getting older and sicker as the disability progresses.

- Consumers are referring themselves directly to MAPC agencies. They have already been in the system.

- The Balanced Budget Act of 1997 will see more consumers utilizing MAPC

services/cost shifting as Medicare pays for less and less.

- The changes in the MA PC regulations from 1992 at which time more and more home health aide hours were "bumped" down into the MAPC category.

- Natural support systems are aging, gone, dying.

- Some counties have such high waiting lists for county services, MAPC services have been maximized.

- Counties have expanded MAPC services and to Group Homes and CBRF's the last couple of years. Most of these individuals have already been in the Medical Assistance system.

- Most counties have always encouraged full utilization of MAPC services involvement to maximize MA card usage.

- The move towards cost containment by counties have cost shifted waiver costs to MA card costs.

- Agencies and counties have attempted to maximize the use of family members to provide increased services needed to existing cases. Agencies have difficulty opening new cases due to serious staff shortages in all parts of the state.

WHY IS THERE A DESPARATE NEED FOR A RATE CHANGE IN THE MEDICAL ASSISTANCE PERSONAL CARE RATES?

1. Home Health agencies, Personal Care agencies, County agencies currently have costs on the average which are higher than the MAPC reimbursement rate of $11.50/hr.(costs to provide services on average range from $13.96 to $16.40/hr).

2. There have been home health agencies who have discontinued their MAPC programs or will take no new MAPC referrals making it difficult for consumers to receive services.

3. Low unemployment rates throughout the state are causing serious personal care worker staff shortages and higher wages and more comprehensive benefits are needed in order for agencies providing personal care services to stay competitive in this labor market.

Prepared by: Jean Rumachik
Legislative Chairperson
Wisconsin Personal Services Alternatives, Inc. (WPSA)
9/30/98

DATE: APRIL 8, 1999

FROM: HOWARD YANDELL
1619 FRANKLIN ST. #A
RACINE, WI. 53403

TO: JOINT FINANCE COMMITTEE

RE: **PUBLIC TESTIMONY TO SUPPORT $4.00 PER HOUR INCREASE IN MEDICAL ASSISTANCE (MA) PERSONAL CARE RATE**

My name is Howard Yandell. I live in Racine County. Thank you for having this hearing today. I am speaking to ask you to please support a rate increase for MA Personal Care of $4.00 per hour in this budget. This program helps me stay at home at a much lesser cost than if I had to go to a nursing home. And I would have to go to a nursing home if I did not have help with my personal cares everyday.

I am 73 years old and have been disabled all my life. I have a loving family who cared for me as long as they could. My sister, Mary, who is older than I am, still cares for me and helps me stay at home, in my apartment. But I cannot survive at home without the daily help of MA Personal Care Workers.

I have a Personal Care Worker (PCW) who comes in the A.M. to get me up, cleaned and dressed, feed me breakfast, and brush my teeth. The PCW also makes my bed and straightens my room. About 3:00 P.M. another PCW comes to fix my supper, do dishes and make me comfortable. Then about 8:00 P.M. an aide comes, feeds me a snack, dresses me for bed, makes me comfortable, sets me up for the evening – making sure I can reach the phone and the glass of water by my bed. Then I am fine until the next morning when the PCW comes again.

I know how hard it is for the agency that sends the PCW's to get workers and keep them because they cannot pay them good enough wages and benefits. I know the agency only gets $11.50 per hour and has to pay the PCW, Registered Nurses who must supervise this program, training for the PCW's, workers' compensation costs, costs for gloves and other OSHA

required equipment, scheduling and 24 hour on-call costs, and a lot of other expenses needed to run this program.

I know there was no increase in the Medicaid rate for this service from 1990 to 1997 which is one of the reasons the agencies doing this type of work cannot compete with other businesses.

I am grateful that I have been able to receive MA Personal Care Services all these years. This program has allowed me to live independently in my own apartment and not have to go to a nursing home. Please do whatever you can to help this program continue to send all the wonderful PCW's to the homes of the elderly and people with disabilities to help keep them in their own homes.

Thank you for your time.

April 8, 1999

Ms. Anita R. Toomajanian
1100 Fountain Hills Drive, #103
Racine, WI. 53406-3769

RE: SUPPORT FOR $4.00 INCREASE IN MEDICAL ASSISTANCE PERSONAL CARE RATE

Dear Joint Finance Committee Members:

I am here today to ask for your support for a $4.00 an hour increase in the Medical Assistance Personal Care rate. I am aware that the governor's budget has only approved a 1% increase (11 cents) in this rate for the year 2001. I cannot imagine why only a 1% increase in this rate has been recommended when this service is so critical to the lives of people with disabilities and the elderly.

Many agencies that provide this service can barely keep up with rising overhead costs now much less give workers the increase in wages and benefits needed. Workers are harder and harder to find who will do this work, not because they don't want to but because they can work at a fast food chain or store and make more money. With unemployment very low everywhere, competition for home care workers becomes more and more difficult.

Let me briefly enlighten you on my life and my utmost concerns on this matter. I am sure you will see how vital these personal care services are to the disabled.

I have had Cerebral Palsy since birth and have many physical limitations. I use a wheelchair to get around as I have very little use of my arms and legs. I am also nonverbal. I need help with all of my personal care needs. For example, I need assistance with bathrooming, bathing, eating, preparing food, dressing, grooming, getting in and out of bed, house chores, shopping, transportation, etc. I will need Medical Assistance Personal Care Services all of my life in order to live independently and be an active member of our society.

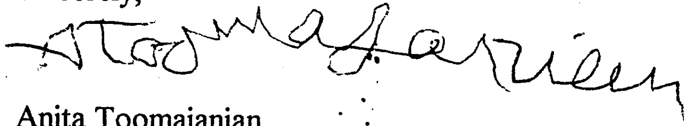
I am a vibrant young woman of 40. I do not need to be in a nursing home. Please remember that Medical Assistance Personal Care will cost the state far less than resorting to a nursing home.

Please, we need your support in order to help the Medical Assistance Personal Care Program continue. Please support the $4.00 an hour increase in the reimbursement rate of this service so workers can receive better wages and benefits and so we can find and keep quality Personal Care Workers.

This program is vital to our independence.

Thank you for allowing me to give this testimonial. People with disabilities and the elderly need your full support!

Sincerely,



Anita Toomajanian

DATE: APRIL 8, 1999

TO: JOINT FINANCE COMMITTEE
PUBLIC HEARING

FROM: DEBRA HARRIS
1121 – OREGON
RACINE, WI. 53405

RE: ***WRITTEN TESTIMONY***
SUPPORT FOR $4.00/HOUR RATE INCREASE FOR MA PERSONAL CARE SERVICES

I have cerebral palsy and receive personal care services funded by Medical Assistance. Personal Care is a service that allows thousands of Wisconsin older persons and persons with physical disabilities to remain living at home. The service provides help with bathing, dressing, meal preparation and other daily living tasks for people who have chronic health conditions. The state has seriously under-funded the Medicaid rate for this service for years causing some home care agencies to discontinue to provide this service and others to struggle with the problem of recruiting and retaining qualified staff because they cannot pay competitive wages and benefits.

I am concerned to see that Governor Thompson's biennial budget would increase the Personal Care rate in 2001 by 11cents when experts have said that at least $4.00 per hour increase is needed now so that agencies can attract workers with a living wage and benefits.

I know that the agency which provides my care can't find enough workers to care for all the people like me who need help. And the workers they do get don't stay with the job because they do not get paid enough money to live on. If the agencies that provide in-home personal care can't find workers now because of low reimbursement rates in Medicaid, what will the situation be like in 2001 with only a meager increase?

Your readers should call their legislators and tell them they must do something to help the home care agencies that provide personal care services to stay in business. A substantial rate increase in MA Personal Care must be a priority for the governor and legislators if they really want to keep older persons and people with disabilities out of nursing homes.

Sincerely,
Debra Ann Harris
Debra Harris
Racine, Wisconsin

April 8, 1999

Testimony before the Joint Finance Committee

Re: Medical Assistance reimbursement for nursing homes.

I am Dennis Gralinski and I am the president of Saint John's Home of Milwaukee and Sunrise Care Center of Milwaukee. I would like to address one of the issues about which there has been considerable discussion. The issue, which has been advanced by a coalition of nursing homes, nursing home associations and those representing nursing home employees, is the addition to the budget of a "wage pass through" for nursing home workers.

The provision, if adopted, would increase the reimbursement rates paid to nursing homes under the Medical Assistance program. This increase would be targeted to provide increased staffing and/or wage and benefit increases for nursing home employees.

Given today's tight labor market it has become very difficult for nursing homes to attract and retain quality employees at the compensation levels that can be offered. Other than working in a foundry, there is probably no more difficult job than that done by the nurses, nursing assistants and food service, housekeeping and maintenance workers. These are the people we depend on to take care of our mothers, fathers and other family members close to us. Yet they are among the lowest paid people in the community.

While this combination of hard work and low wages leads to significant turnover among nursing home staff, many nurses, nursing assistants and other front line people stick it out because they are committed to providing the best possible care to those for whom they are responsible. Unfortunately, they are sometimes handcuffed in their efforts when nursing homes are forced to operate with less than ideal size and quality staff. As difficult as this issue will be from a financial standpoint for the state, it must be addressed. We owe it to the employees of our nursing homes and, even more importantly, to our mothers, fathers, and other loved ones for whom they provide care.

Dennis Gralinski

Date: 4/8/99

To: Joint Finance Committee Members

From: Patricia Ringwell, PCW *Patricia Ringwell*
600 11th Avenue
Union Grove WI 53182

Re: Support the $4.00/hr. MA Personal Care Rate Increase.

Thank you for the opportunity to speak to you today. I am a Personal Care Worker (PCW). I go into consumer's homes to help them with personal cares they need to maintain an independent life. I have worked for Society's Assets, a private non-profit independent living center for three years. Without my husband's job, I could not make a living on my check. I can only do this work because my husband's check pays our bills. My check buys, gas, oil changes and maintenance on my car. Without my car, I can't work. I live out in the county where there are no buses. Many PCW's don't have the extra income from a spouse and are the sole support of a family. Most PCW's make under $8.00/hr. with few benefits.

Some early mornings I get a call to fill in for another aide. As you can imagine, that is difficult to do when I drive out to Waterford, Burlington, or Bohnner's Lake. It is a 20 – 25 mile drive. If I didn't go, there would be an elderly couple or quadriplegic lying in bed all day in urine, and unfed. Of course I go. They count on us to get them out of bed, bathed, dressed, and fed.

I could work as a grocery clerk for $10.00/hr. with benefits. I can collect garbage for $12.30/hr. with benefits. Most of the aides/PCW's have a second job to supplement their income. Is it right that the people we rely on to care for our elderly and disabled are valued so low in wage?

If you or your loved ones ever fall into the situation where you must rely on someone else to help you eat, bathe, dress, get out of bed, or use the bathroom, don't you want a professional? If we want to keep the good aides/PCW's, we have to pay them what they are worth, and give them some decent benefits

Please support the $4.00/hr. MA/Personal Care Reimbursement rate increase so Personal Care Workers can be paid competitive wages and benefits.

Don't let down the elderly and people with disabilities. Help them stay at home and help me continue to do a job I love.

Chair
George L. Johnson
Reedsburg

Chair-Elect
William D. Petasnick
Milwaukee

Immediate Past Chair
Mark V. Knight
Milwaukee

President/CEO
Robert C. Taylor

Joint Finance Committee Hearing
Testimony from the Wisconsin Health and Hospital Association
Tuesday, April 13, 1999

My name is Bob Taylor and I am the President/CEO of the Wisconsin Health and Hospital Association.

WHA is a trade association representing over 130 hospitals and health systems in this state.

There is no question that health care in general and medical assistance in particular did not fare well in this budget. Specifically, the budget proposes to essentially freeze medical assistance rates for care provided in Wisconsin hospitals for the biennium. It also begins the first two years of an ongoing process to cut back on the state's financial support for training the physicians Wisconsin will need in future years.

These proposals come at a time when a number of other important dynamics are occurring in the state.

First, the Legislature has recognize that Wisconsin has not traditionally fared well in its fair return of federal dollars. A legislative committee has actually been looking at ways to improve Wisconsin's track record in this area.

Medical assistance, because it is a matching program with the federal government, has the potential to return 60 cents of federal dollars for every 40 cents committed by the state. The state's freeze in MA base rates and cuts in medical education funding mean that Wisconsin will forfeit almost $14 million of federal money as exhibited in Chart A attached.

Second, the MA proposals are playing out at the same time Wisconsin hospitals and health systems are bracing for huge cuts in Medicare payments under the Balanced Budget Act of 1997. These cuts began in FY 1999 and will play out through FY 2002. Over that timeframe, this will result in cuts of around $770 million. Over the state's biennium alone, Medicare is projected to take about $347 million out of Wisconsin's health care system. **[[RT—could add Chart B and make reference if desired.]]**

The combined impact of these simultaneous freezes and cuts by Medicare and Medicaid is staggering. Wisconsin's health care system will have a significant challenge determining how to absorb the cuts imposed by Medicare; additional shortfalls coming out of Medicaid make an already difficult situation more so.

Cuts of this magnitude will have troubling implications for care in our communities. They cannot simply be absorbed through "becoming more

Wisconsin Health & Hospital Association, Inc.

5721 Odana Road
Madison, WI
53719-1289

608/274-1820

FAX: 608/274-8554

http://www.wha.org

efficient." Based on federal Medicare data, Wisconsin health care providers are already some of the most efficient in the country.)

These cuts can only be dealt with in one of two ways:

The first is eliminating or reducing needed services to the community. While our members are currently analyzing the impact of these cuts on their projected bottom lines, they are of such a magnitude that many may have no choice but to limit service areas or eliminate financially marginal services.

The second is to shift costs to individual patients or employers who provide and pay for health insurance coverage for their employees.

Currently, almost $80 million in MA payment shortfalls alone are shifted to the private sector annually. This budget proposal will increase that number to about $88 million in the first year of the biennium and about $93 million in the second.

Finally, these cuts come at a time when health care, like other industries in Wisconsin, is finding it difficult to recruit and retain qualified personnel to serve our patients.

A freeze in MA rates makes it difficult, if not impossible, to give our staffs even a cost of living increase, much less make it an attractive place to work for new employees.

We are asking your help to achieve the following on medical assistance:

a) an inflationary increase of 2.4% in the first year and 2.6% in the second for medical assistance hospital inpatient and outpatient rates ($7.1 million GPR);

b) restoration of the medical assistance funding for medical education ($2.5 million GPR);

c) maintenance of the $2.4 million in the proposed budget to fund a medical assistance supplement, which is designed to assist those providers experiencing increases in charity care due to welfare reform; and

There are two other elements in the budget on which we need your help. We need to institute a reasonable system of doing criminal background checks and, once and for all, developing a fair and consistent funding source for the health data initiative with the Board of Health Information.

Thank you for the opportunity to share some of our thoughts with you today. These are important issues to consider in maintaining a quality health care system in Wisconsin.

Chart A

	State Share	Resultant Federal Loss	Total Shortfall
Base Rate Freeze			
FY 2000	(2,300,000)	(3,400,000)	(5,700,000)
FY 2001	(4,800,000)	(6,800,000)	(11,700,000)
Subtotal	(7,100,000)	(10,200,000)	(17,400,000)
Medical Education Cuts			
FY 2000	(900,000)	(1,300,000)	(2,300,000)
FY 2001	(1,600,000)	(2,300,000)	(3,800,000)
Subtotal	(2,500,000)	(3,600,000)	(6,100,000)
TOTAL	(9,600,000)	(13,800,000)	(23,500,000)

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…treet
…nt, Wisconsin 54481-3548
…401

…15) 346-1632
…15) 346-1418
…mation & Assistance: (715) 346-1405
…ail: dept.aging@co.portage.wi.us

Testimony for Joint Finance Committee
Public Hearing 4-13-99

My name is Janet Zander. I am the Director of the Portage County Department on Aging, a board member of the Wisconsin Association of Aging Unit Directors, an advocate for older adults, and a member of a family with aging relatives. I want to thank the members of the Senate and the Assembly for their ongoing support of aging programs and request that this Committee take into consideration the following recommendations:

1.With nearly 11,000 people currently on the waiting list for COP funded services, increasingly narrowing definitions of services covered by Medical Assistance, vast geographical differences in service availability and waiting lists varying from days to years, long term care (LTC) funds not following individuals - if someone moves they may have to go to the bottom of a new waiting list, an obvious institutional bias -forcing some persons into more expensive and more intensive care prematurely, and dramatic growth in the older adult population on the horizon - THE LONG-TERM CARE SYSTEM MUST BE REDESIGNED NOW. We are looking at major changes in a very large system. This will not happen overnight. If we do not begin now, the current system will never be able to handle future needs. Funding to begin piloting all components of Family Care - Care Management Organizations (CMO) and Resource Centers (RC) must be made available in this next budget. The current situation of entitlement to nursing home care for low income individuals in need of skilled care and long waiting lists for those same individuals choosing community based services, just doesn't make sense. **All** persons in need of long term care should be able to access the LTC system for both case management and access to negotiated provider rates. It makes no sense to have individuals making decisions without full knowledge of their choices and without being able to benefit from cheaper service rates negotiated by CMO's. Inability to do these two things results in the spending down of assets more quickly and becoming dependent upon public subsidies to pay for needed care.

Family Care should:

A) adequately fund pilot counties- capitated rates for individuals enrolled in CMO's, as well as the I & A, screening, and prevention functions of Resource Centers.

B) be renamed to more appropriately describe who the program is designed to serve.

C) not require pilot counties to undergo major structural changes during the pilot period (while the program is still being tested and refined).

D) give pilot counties adequate time to truly test these new concepts. Once pilot counties begin receiving capitated rates they should be guaranteed 4 to 5 years without competition.

E) restore the requirement that pilot counties must create local LTC Councils to assure local accountability and control.

2. With only nine counties participating in CMO demonstrations and Resource Center pilots it is imperative that funding for COP be increased in this next budget to address the 63 counties that are not yet participating in Family Care pilots. **A $45 million increase over the next two years will create approximately 5,000 new COP slots.**

3. Rising costs; an increasing population of frail, older adults; and increased demand for home-delivered meals (HDM) makes it critical that state funding for the Elderly Nutrition Program be increased. There has been a 99.4% increase in the demand for HDM. Over 80% of HDM participants and over 50% of congregate participants are in the moderate to high nutritional risk category. A study conducted by the U.S. DHHS revealed that 80% to 90% of HDM recipients are low income. Despite this, participant donations account for 27% of the total cost of the program.

   The HDM program is considered the corner stone of the LTC service delivery system. **Delivery of a daily meal provides a cost effective deterrent to premature nursing home placement for some individuals.** It also allows family members the ability to focus their energies on other needs an individual may have. **I ask you to support the Wisconsin Association of Nutrition Directors (WAND) request for an additional $3.6 million.** Over the past 11 years, there has been only a 23 cent per meal increase in funding for Nutrition.

4. **I am requesting your support of the Wisconsin Personal Services Association proposal to increase the Medicaid rate for in-home Personal Care for the elderly and disabled by $4.00/hour.** The $.11/hour increase in the year 2001 proposed in Governor Thompson's budget does not begin to address the critical shortage of workers home care agencies are currently facing. The ability of home care agencies to pay a living wage and offer valued benefits will aid their efforts to recruit and retain quality workers.

   In the past several years, many home care agencies have been forced to close their doors. This current trend is contradictory to Wisconsin's goal of helping people who need care to remain in their own homes. It now costs the State $782/month for the average Medical Assistance Personal Care client. If the State funds the $4.00/hour increase the average per client amount would increase to $906/month. If even 10% or 650 of the 6500 persons currently receiving personal care have to go into a nursing home due to the lack of available workers, the cost of providing care for these clients increases to nearly $3,000/month for a total increased State cost of $15.7 million. It makes good sense to provide the services people need to remain in their own homes. For individuals choosing to be cared for in their own home, over 80% of their care needs are met by family members and friends. These contributions of human resources are lost when an individual is forced to move from their home prematurely.

Four home health agencies in Portage County no longer offer MA Personal Care services because their costs exceeded the reimbursement rate. Long term care service providers at all ends of the spectrum must be able to recruit and retain quality workers to provide this very basic and essential care needed by some of our state's seniors.

5. Over the past several years, the total state and federal transportation budget has increased by astronomical proportions. Yet, increases for Elderly and Disabled Transportation programs have been minuscule with no increase at all in 1997 and 1999. A growing older adult population coupled with a trend toward development of regional speciality medical services have placed increasing demands on transportation programs. Transportation programs have been forced to place increasing restrictions on the amount of available transportation service for medical appointments, nutrition needs, and other critical needs. As the population of frail, older adults continues to increase we must be ready to offer those who have needed to give up the privilege of driving some reasonable access to needed services. **I am asking you to consider an $8 million increase in each year of the next biennial budget.**

I appreciate your willingness to hear my testimony. We cannot afford further erosion of services that were developed to protect our state's vulnerable elderly. Tax cuts are not a priority at any expense. If cuts in state taxes means an increase in local property taxes, an erosion of critical services, increased out-of-pocket expenses to those that cannot afford to pay, a shortage of much needed front line workers, or forcing families to forego employment so that they can struggle to meet all of the needs of a chronically ill family member; then that is not in the best interest of either the health and well-being of individual citizens or our communities. It is time to re-prioritize the state budget to offer increased funding for programs that support our state's most valuable resource, human beings.

Thank you.

Testimony to the Joint Committee on Finance
April 14, 1999
Osceola, Wisconsin

Jeffrey K. Meyer
Chief Executive Officer
Osceola Medical Center
301 River Street
Osceola, WI 54020
715 294-2111

The Osceola Medical Center is a consolidated clinic, hospital, and nursing home. As such we are concerned about issues that affect physicians, hospitals, and nursing homes. We are especially concerned about the impact of the proposed 1999-2000 state budget in the following areas.

Nursing Home

- The proposed budget has an increase of 1.77% for the first year and 1.0% for the second year.
- 70% of our nursing home residents are on Medical Assistance so we are quite dependent on Medical Assistance.
- Nursing home residents have increasing needs for care. For example, 34 of our 40 residents are in wheelchairs. Ten years ago those numbers were reversed. Another example is that our residents are on an average of six medications per day and these have to be administered by nursing staff. The increasing medical complexity of the residents requires more time to care for them.
- It is becoming increasingly difficult to hire staff, partly because of a strong economy and partly because of wages. A starting salary for a nursing assistant is $8 per hour and goes to $11.00 per hour. When nursing assistants leave for another job they often leave for a position in a business where the salaries are higher and they do not have to work weekends.

As the needs of nursing home residents are changing to require more care, it is becoming increasingly difficult to find the staff to provide them the care they need. For these reasons we would like to see a greater increase in Medical Assistance and we would especially urge support for the wage pass through proposal for nursing home employees.

Hospital

- The proposed state budget essentially freezes rates for inpatient and outpatient services. This is especially difficult because it comes on top of reductions in Medicare funding resulting from the federal Balanced Budget Act of 1997.
- Wisconsin already receives less in Medicare payments on an individual basis than states such as Florida and New York.

We recognize that healthcare providers have a responsibility to control costs. We are doing that by implementing various expense reduction measures in the short term and over the long term, working to improve community health and reduce the incidence of disease.

When rates are frozen or there are minimal increases it makes it difficult to maintain service levels. Our ultimate concern is for the people we serve and that requires resources.

DATE: 4-14-99

FROM: Vikki Jameson
987 Island Drive
Somerset, Wi. 54025

TO: Joint Finance Committee

RE: Public testimony to support a $4.00 per hour increase in the Medical Assistance Personal Care Reimbursement rate.

Good morning, my name is Vikki Jameson. I am the office manager in one of the seven counties that Indianhead Home Health Care Agency provides services in. I am here today representing the 400 personal care workers and the 500 clients that they care for.

We are looking for your support for a $4.00 per hour rate increase for Medical Assistance Personal Cares. With a reimbursement rate of only $11.50 and a proposed eleven cent increase, the task of keeping elderly and disabled people in their homes will be overwhelming. Indianhead Home Health Care Agency is a private non-profit agency. We give our workers as much as we can out of the $11.50. When I tell prospective workers what the starting wage is, they laugh at me. The competition for qualified, caring personal care workers is fierce. The only thing we would have going for us is a competitive wage. We cannot offer competitive wages, the money just isn't there. With families now needing two incomes to survive, we cannot offer a livable wage that will attract workers.

Our elderly and disabled clients deserve a chance to remain in their homes. The people who can and want to provide for them are getting scarce. We need to be able to train and retain workers. If there isn't a substantial increase in our reimbursement rate we will soon be turning down care to folks who just want to be home.

At some point in our lives we will be facing the difficult task of caring for our own aging parents. I hope that when the time comes for you and I to look for the help we need to keep our parents in their own homes, that we can find a worker who can earn more money helping them with their personal cares than working at the local McDonald's.

Thank you for your support of the $4.00 rate increase.

April 13, 1999

To: Joint Finance Committee

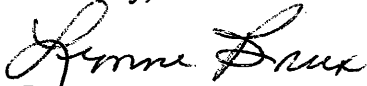
Re: Securing Rate Increase For Medical Assistance Personal Care

Since 1991, I have worked in two Home Health Agencies and have personally seen the impact that the seven year freeze on Medical Assistance/Personal Care has had on the agencies, and their decisions to discontinue providing PCW services. One agency totally closed, and the other one discontinued providing PCW services. The closure and discontinuation of PCW services was based strictly on economics due to the low rate of reimbursement received for MA/PCW services. This resulted in a major trauma for clients who needed to be transitioned to other agencies. Some clients received less services and some clients were not able to be served and consequently were placed in alternative care arrangements.

We need your Help. It is becoming a crisis and now is the time that the MA Personal Care rate be increased by $4.00 or more per hour. The additional revenue made available would be used as a wage pass-through that will allow community-based long-term care providers first and foremost the chance to raise wages to a level that affords all of the direct care workers a "living wage". It is becoming very difficult to compete for workers with our current state of low unemployment and the pressures to increase wages in many of these service industry jobs. As a supervisor in a PCW program, I feel a responsibility to be able to offer a "living wage" to the PCW worker and also run a solvent agency. I do not want to compromise the quality of care received by elderly and disable residents and feel that the state should make this a budget priority by increasing the MA/PWC rate. The increased MA/PCW rate will allow personal care agencies to continue to provide personal care services to the elderly and people with disabilties.

We are asking for your support in this effort to raise the MA/PCW rate. Thank you for your time and consideration.

Sincerely,



Lynne Brux
HomeCare Partners
Program Coordinator
WPSA member
(715-855-2487)
2154 East Ridge Center
Eau Claire, WI 54701

To whom it may concern:

My husband and I have provided a home for challenged people for 25 years. Last year our man received an even bigger challenge - brain surgery Twice! This eliminated his mobility as well as the use of one arm - his right one. Being right handed, he could no longer draw or work. Do you have any idea what effect this has on someone who is mentally challenged to begin with to lose his ability to work and do things he has done his whole life? He cannot even cast his rod for fishing!! He needs assistance to get out of bed, dress, bathe, eat, brush his teeth, comb his hair, and to do everything you all do every day for yourself. His self esteem dropped and the confusion of what in the world has happend to him is asked Every day many times.

The gentleman from homecare visits three times a week to shower, shave, dress and do his exercise regimen and he is very understanding, compassionate, caring and explains the same problems every visit - "You had surgery 2 times on your head and you can't help it that you aren't able to do

these things for yourself any more".

Homecare services are a God send!! If this service was not available there would be a possibility that our man might have to be in a nursing home; this I'm sure would mean a death sentence for him as 19 years of his life were spent Very miserably in the Northern Center and a nursing home would only intensify his horrible memories of the "Center".

The services provided by homecare agencies can be long term or short term, but which ever is needed - it is a very Needed service by many and it has been a "life raft" for me so I would not "burn out"! 24 hour care is hard to maintain indefinately! Please continue to provide all necessary funding to maintain these agencies.

Janet Franks
2108 Bradwood Ave.
Altoona, Wi 54720

I need
personal care
to get me
fed and getting
ready for
bed during
the week.
On weekend
I have to get
up and
dressed & fed,
and ready for
bed at night.
If I didn't
have personal
care, I couldn't
(over)

get up in the
morning &
dressed. Then
I couldn't go
to church on
Sunday and
then sleep at
night.

Anna
Schend

PS: I couldn't
get laundry
done either!

4-13.99

Our mother Mildred Redman has been with Home Care partners since November of 1998. We have had other agencies which weren't always too dependable, as Home Care partners. We have had a few small problems but it is always worked out fast with very good results.

Home Care Partners has been by far the most reliable agency and the girls have been real ~~good~~ with our Mom, they also like ~~her~~ working with her, too.

We never want our Mom in a nursing home, she would not get the one on one relationship or the help she needs. It is also very nice knowing that when our shift is over, her daughters, 7-3 M-F + S&Sun we can rely + feel comfortable knowing she is in good hands with Home Care Partner girls.

We could not have done any of this without Liz Bushbeck, from E.C. County Dept. of Human Services, who lined us up with Home Care Partners. She also helps with anything we ask or need.

The COPS program is one of

the best programs keeping elderly in their own homes instead of ~~any~~ institution.

Thank you

Mitzy Redman
Jodie ~~7 City~~

I know Nursing Home first hand having been there for 1½ years. Having Personal Care has completly changed my outlook on life. I now live in an apartment and personal care workers who are very caring and helpful in all my needs. Personal care workers has made my life worth living Please increase MA/PAW rate

Shirley Moore
839-7256

April 13th 1999

To Whom It May Concern:

My name is Myona Mikottis and I am a 61 yr. old widow who has progressive M.S. I live alone in my apt in Eau Claire, WI.

Due to my M.S. I need help daily from my personal care workers to put on and take off my ted hose. I also need help bathing twice a week. The PCW people are very kind and good to me. They help me to walk when they are here, to get dressed, and bathe. They work very hard and deserve a pay raise. If I didn't have the personal care workers daily, I would have to live in a nursing home and I don't want to do that.

Sincerely,

Myona Mikottis

I am Joe Olson. I started out with Combined Nursing Program 8 years ago and have been with several agencies since. I am now with Northwest Home Care and well satisfied with services, but I do miss my people that were with me while with Combined Nursing. I especially appreciated services with my long time partner, Barb Yorger, + her worker, Lynne Bruze. It was very uneasy for me to change organizations, being that I was with Combined Nursing for 15 years. These services make it possible for me to remain in my own home + I hope this continues.

Joe Olson 4/13/99

Golden Age Manor

POLK COUNTY
220 Scholl Street
AMERY, WI 54001
(715) 268-7107
FAX (715) 268-6167

BOARD CHAIRMAN
CARL McCURDY

ADMINISTRATOR
GARY TAXDAHL

April 14, 1999

To: Joint Committee on Finance
From: Gary Taxdahl, NHA
Re: Nursing Home Employee 7% Wage Pass-Through Proposed

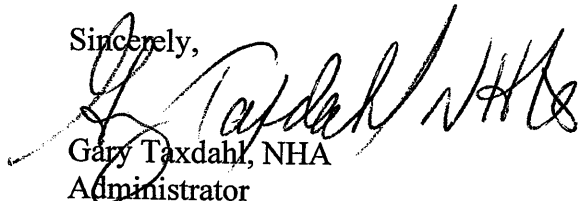
On behalf of Golden Age Manor, I would like to express our urgent need for relief to MA under-reimbursement. My future budget is in serious threat of not paying expenses. My 1999 budget has a deficit balance and I can't cut staff to take care of our residents.

The 7% wages pass-through should be passed on to all staff because the resident's clothes, meals, and facility environment are as important in our residents lives as the nursing care they receive. The care of our residents by good quality employees is wholistic not price-meal.

Golden Age Manor was in the high labor region for direct care reimbursement but this year we go to the moderate labor region or Metropolitan Service Areas (MSA's). On July 1, 1999 we are projected to take a rate cut and I am not meeting costs now. A 7% wage pass-through would help to offset this future rate cut.

In conclusion, we need your support for this 7% wage pass-through because we need dedicated staff to do some of the most difficult jobs that majority of people will not do.

Sincerely,



Gary Taxdahl, NHA
Administrator

GT:wj

LADIES AND GENTLEMEN OF JOINT FINANCE, MY NAME IS MAUREEN REED, I SERVE ON THE KENOSHA COUNTY COMMISSION ON AGING. I AM HERE TODAY TO TELL YOU THAT I'M NOT INTERESTED IN SELLING MY GRANDMOTHER FOR A $75 TAX BREAK.

NEITHER AM I INTERESTED IN BENEFITTING IN ANY WAY FROM THE REDUCTION OF SERVICES TO ANY OF OUR MOST VULNERABLE PEOPLE; MENTALLY ILL, PHYSICALLY CHALLENGED, THE POOR, THE UNEMPLOYED, THE ELDERLY, THE CHILDREN.

I'VE LIVED IN WISCONSIN ALL MY LIFE AND HAVE BEEN PROUD OF OUR NATIONALLY RECOGNIZED CHARACTER AS AN INDEPENDENT PEOPLE WITH A TREMENDOUS WORK ETHIC, A STRONG FAITH, AND COMPASSION FOR THOSE WHO NEED OUR HELP.

NOW, FOR THE FIRST TIME, I AM ASHAMED TO SAY I'M A WISCONSINITE.

THE LONG-TIME LEADER OF OUR STATE HAS BETRAYED OUR PRINCIPLES AND ERODED OUR COMPASSION BY USING EACH BI-ENNIAL BUDGET TO SET POLICY, TO MANDATE REDUCTION OF SERVICES TO OUR NEEDIEST POPULATIONS, AND TO GAIN PERSONAL PRESTIGE AS AN ECONOMIC "WIZARD."

THIS "WIZARD" HAS MADE THE POOR DISAPPEAR FROM WISCONSIN BY THE WAVE OF A PEN.

HE HAS CREATED A CLASS OF SUCCESSFUL AND PROSPEROUS BUSINESS OWNERS THROUGH "REDISTRIBUTION OF WEALTH" VIA TAX MANIPULATIONS AND MANDATED "FEES" IN EVERY BUDGET, ALL THE WHILE CLAIMING HE IS CUTTING TAXES AND PROVIDING TAX "GIFTS" TO WISCONSIN TAXPAYERS, WHO OF COURSE SUPPLY THE MONEY IN THE FIRST PLACE.

WE ARE PAYING DEARLY FOR THE MAGIC SHOW PUT ON BY THE "WIZARD OF OZ"; A SMALL MAN SHELTERING UNDER A LARGE STATE-CAPITOL DOME, USING INTIMIDATION AND QUESTIONALBE TACTICS AND INFLUENCE TO MAKE HIMSELF ATTRACTIVE AS A CANDIATE FOR NATIONAL OFFICE.

WE CANNOT CONTINUE TO PROSPER BY CUTTING QUALITY OF LIFE THINGS SUCH AS FISHING LICENSES FOR THE ELDERLY, A MERE $4 WAGE INCREASE FOR PERSONAL CARE WORKERS TENDING THE HOMEBOUND, OR BY INCREASING THE BASE OF TAXATION FOR SOCIAL SECURITY PAYMENTS TO 85%!!

YOU HAVE THE UNENVIABLE JOB OF ATTEMPTING TO CURTAIL THE ACTIONS OF THE EMPEROR, OF MAKING IT CLEAR THAT HIS BEAUTIFUL NEW CLOTHES ARE, INDEED, INVISIBLE, AND WE CAN ALL SEE HIS NAKED

GREED AND LUST FOR POWER.

PLEASE MAKE THE EFFORT, FOR ALL OUR SAKES AND GOD GIVE YOU STRENGTH.

To: All Legislators

From: Robert W. Lyons, Executive Director, AFSCME Council 40
Richard Abelson, Executive Director, AFSCME Council 48
Dan Iverson, President, SEIU, Wisconsin State Council
Phil Neuenfeldt, Secretary-Treasurer, Wisconsin State AFL-CIO
John Sauer, Executive Director, Wisconsin Association of Homes and Services for the Aging
Thomas P. Moore, Executive Director, Wisconsin Health Care Association

Subject: **Support For a Wage Pass-through for Nursing Home Employees**

Our varied memberships share a common goal: To ensure the quality of care and the quality of life of each nursing home resident in Wisconsin. We also share a common concern: Namely, that the heavy dependence of nursing homes on increasingly inadequate Medicaid funding, combined with the State's extremely tight labor market, make it increasingly more difficult for nursing homes to recruit and retain caring and competent staff. To avoid a potential crisis in care, the above organizations, which represent both nursing home operators and the caregivers they employ, unite under the name "Coalition for Quality Nursing Home Care" and seek your support for a 7% nursing home employee wage pass-through.

The proposed Medicaid rate increase for nursing homes contained in SB 45/AB 133, the biennial budget bill, simply magnifies the problem. The $15 million "rebasing" of the nursing home formula in FY 1999-00 and the 1% rate increase proposed for FY 2000-01 fall far short of meeting the costs facilities already have incurred to serve their Medicaid residents. Indeed, Data Resources, Inc. (DRI), the firm the State uses for its own economic forecasting, has projected a 3.3% increase in health care costs due to inflation for 1999.

If the rate increases provided in SB 45/AB 133 fall below the rate of inflation in health care costs, which we anticipate, then many facilities will be facing rate cuts and the possibility of staff freezes or cuts. Without an adequate Medicaid rate increase, the benefits of a wage pass-through will be lost because facilities facing a rate cut would be forced into the perverse position of rewarding one employee with a wage increase funded by the pass-through and by the termination of a position(s). Even with a 3.3% rate increase, some facilities will experience rate cuts and would need to utilize funds from a wage pass-through to retain current positions.

In order to maximize the benefits to our caregivers of a wage pass-through, we also respectfully request legislative support for a 3.3% rate increase for Medicaid-certified nursing homes in each year of the biennium.

Coalition for Quality Nursing Home Care Wage Pass-Through Proposal

Under the Coalition proposal, all nursing home employees except the administrator and home office staff would be eligible for the wage pass-through, which could be used to increase wages, benefits, the number of staff and/or to offset potential nursing home rate cuts that would occasion staff reductions.. The wage pass-

through would be in addition to the 3.3% rate increase proposed above. A nursing facility would be required to apply to the Department of Health and Family Services (DHFS) in order to receive the wage pass-through; a DHFS review of the facility's Medicaid cost report would ensure that the funds are spent for the intended purposes. Failure to expend the wage pass-through funds for their intended purpose would result in the recoupment of those funds by the DHFS.

The benefits of this proposal are clearly illustrated in the following table, which highlights the wage increases for selected nursing home employees that would be generated if the 7% wage pass-through were to be used to increase wages (rather than increase benefits, increase staffing and/or offset facility rate cuts and corresponding staff cuts):

Position	1997	1997	7%	1997 Annual
Registered	$17.38	$36,150	$1.22	$38,688
Licensed	12.86	26,749	.90	28,621
Certified Nurse	8.32	17,306	.58	18,512
Food Workers	8.12	16,890	.57	18,075
Maintenance	11.04	22,963	.77	24,565
Housekeeping	7.56	15,725	.53	16,827
Laundry	7.54	15,683	.53	16,786

Annual Projected Cost: The projected cost of this proposal admittedly is hefty: We estimate a 7% wage pass-through would cost approximately $17 million GPR and $41.3 million all funds in FY 1999-00. With the inclusion of a 3.3% rate increase, which we estimate would cost an additional $5.4 million GPR and $13.1 million AF over SB 45/AB 133 levels, the total request is estimated at $22.4 million GPR and $54.4 million AF in FY 1999-00 over the amounts included in SB 45/AB 133. But the members of the Coalition for Quality Nursing Home Care firmly believe both our wage pass-through and our rate increase requests are needed and justified.

Why is a Wage Pass-Through Critically Necessary?

The reasons we request this wage pass-through proposal are numerous. Consider the following:

- **The nursing home formula was cut nearly $47 million in 1997-99.** Although the Governor and the Legislature approved Medicaid rate increases for nursing homes of 5% in FY 1997-98 and 3.5% in FY 1998-99, the dollars generated by those rate increases do not flow directly to nursing homes, but rather fund the nursing home formula. The formula distributes those funds to individual nursing homes based on each facility's historical costs and whether those costs fall above or below the formula's maximum payment limits established for six service areas (direct care, support services, administrative and general,

fuel and utilities, property taxes, and capital). The 5%/3.5% Medicaid rate increases provided in 1997 Act 27, the biennial budget bill, resulted in a lowering of those maximum payment limits by $46.9 million. The end result: Nearly $47 million in Medicaid costs incurred by nursing homes in 1997-99 went unreimbursed.

- **Direct caregivers bore the brunt of those cuts.** Of the $46.9 million cut from the nursing home formula in 1997-99, $41.8 million came from the direct care cost center. This is the nursing home formula cost center which provides the wages and benefits for nurses and certified nursing assistants (CNAs) in nursing homes. A cut resulted because the maximum payment for facility direct care costs was reduced by the Legislature from 110% of the statewide median to 103%. Our wage pass-through proposal is intended to restore the funding cut from the nursing home formula in 1997 Act 27. The additional dollars will be utilized to increase staffing, to boost the wages/benefits of nursing home employees, or to retain current positions.

- **SB 45/AB 133 will not provide the funds needed to either significantly increase staffing or boost wages.** Indeed, as noted above, the end result of the rate increases provided in SB 45/AB 133 would be a rate decrease and possible staff cuts for some facilitites. For the remainder of facilities, this proposal basically allows them to tread water.

- **Nursing homes rely heavily on Medicaid funding.** Medicaid is the primary source of payment for 69% of the residents in Wisconsin nursing homes. If the funding provided through the Medicaid program is not sufficient to allow facilities to recruit and retain competent staff, quality of care inevitably will suffer.

- **Unfunded mandates inhibit a facility's ability to recruit and retain caregivers.** Last session, the Legislature passed bills which increased nursing home minimum staffing levels and which require employee criminal background checks. Neither bill contained additional funding.

- **Decreased Medicare funding only will exacerbate the problem of Medicaid underfunding.** In past years, expanded Medicare coverage of nursing home stays has reduced Medicaid patient days and expenditures. However, a Prospective Payment System for Medicare skilled nursing facilities (SNF), which was mandated by the federal Balanced Budget Act of 1997, went into effect 7/1/98 and is expected to reduce Medicare payments to SNFs by 17%, or $12.8 billion, over the next 5 years. This reduction in Medicare revenues will place additional pressure on the already underfunded Medicaid program and will limit a SNF's financial ability to provide necessary wage and staffing increases.

- **CNA wages do not do justice to the difficult work they do.** CNAs comprise over two-thirds of the employees who provide direct hands-on care to nursing home residents. The average wage for a CNA in Wisconsin is $8.32/hour, or an annual salary (52 weeks x 40 hours) of $17,306 before taxes. Because of their significant reliance on the Medicaid program for reimbursement of costs incurred, nursing homes are severely constrained in their ability to provide better wages for their workers. Are we comfortable in the thought that those caring for our fathers and our mothers, or our grandparents, are being paid $8.32/hour on average, which is less than a telemarketer or a door-to-door salesman? Is an annual salary of $17,306 sufficient to raise a family for the many CNAs who are single parents? We think not.

- **Facilities are facing a critical shortage of competent CNAs at a time when the labor market is extraordinarily tight.** Staff recruitment and retention is the #1 problem facing nursing facilities in

Wisconsin. Keeping in mind the average wage of a CNA in Wisconsin is $8.32/hour, and that CNAs must complete a minimum training program of 75 hours, pass a competency test and undergo a criminal background check, consider the following findings of an October 1998 study of job openings conducted by the UW-Milwaukee that was updated in January of this year:

1) The number of full-time and part-time jobs open during the week of May 18 in the Milwaukee-area was the highest since 1995; employers were looking to fill 19,259 full-time positions and 15,263 part-time positions. Those figures had risen to 21,515 open full-time positions and 15,476 open part-time positions when a similar survey was conducted during the week of October 19, 1998.

2) For entry-level jobs demanding a high school diploma but little else, employers were paying an average of $7.90/hour last May; that figure rose to $8.07 in October.

3) Companies offered at least $8/hour for nearly half the beginning-level, full-time positions they were trying to fill – jobs that required neither a high school diploma nor any work experience.
4) When employers are attempting to fill positions with job responsibilities that include caring for extremely frail elderly people, many of whom suffer from dementia or are otherwise behaviorally difficult, at a wage that is comparable to a fast-food restaurant employee or other beginning level jobs, **is it any wonder the UW-Milwaukee study placed the position of CNA at the top of its list of the most difficult positions to fill?**

5) Once again, keeping in mind the wage and the job responsibilities of a CNA, the dilemma facing nursing homes is clearly illustrated in this recent Milwaukee Journal Sentinel quote from John Metcalf, director of human resources policy for Wisconsin Manufacturers and Commerce (WMC), in response to the UW-Milwaukee study: "People can easily walk across the street and find another job for 50 cents more. Workers, for whatever reason, are not staying long in one place. Jobs are plentiful. They can choose when they want to work and when they don't want to."

- **The turnover rate for CNAs in nursing homes is threatening quality care.** According to the most recent data compiled by the DHFS, the turnover rate for full-time nursing home CNAs is 54%; for part-time CNAs, that figure shoots to 76%. And high turnover, according to the DHFS Center for Health Statistics, hurts quality care. In a 1994 report, the Center noted: "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 to 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." It certainly is within reason to argue that a fairly low wage for a difficult job in a tight labor market results in high turnover. In the case of nursing homes, the DHFS itself concludes that high turnover can compromise quality of care.

- **Can we avoid a reoccurrence of the Mount Carmel situation?** On October 19, 1998, the DHFS moved to delicense Mount Carmel Health and Rehabilitation Center in Greenfield. In Mount Carmel's case, there appears to be a clear link between a shortage of staff and quality of care. Indeed, one of the key reasons Mount Carmel was able to retain its license in early February of this year was because of its efforts to bolster its staff. We submit that in order to avoid future reoccurrences of the Mount Carmel situation,

facilities must be afforded the funds necessary to provide for staffing increases or to boost the wages/benefits of their current employees, where needed.

The Minnesota Legislature last session passed nursing home wage pass-through legislation similar to what we are proposing. In a 3/10/98 editorial in support of that measure, the Minneapolis Star Tribune wrote:

> **"Every day, someone must feed, bathe and clothe many of the people who live in nursing homes. Someone must help many of them walk, or get into a chair, or move their wheelchairs. Someone should greet them cheerfully, listen sympathetically, and offer the simple comforts of a smile and a tender hand."**

We Need Your Support

We ask members of the Legislature to join members of the Coalition for Quality Nursing Home Care in support of a wage pass-through proposal which seeks to ensure that each nursing home resident will be compassionately served by that "someone" envisioned in the Star Tribune editorial.

We appreciate your consideration and look forward to working with you on this proposal.

POSITION STATEMENT ON FAMILY CARE, THE GOVERNOR'S BUDGET PROPOSAL TO REDESIGN THE LONG-TERM CARE DELIVERY SYSTEM

The Long-Term Care Provider Coalition consists of the following organizations:

Wisconsin Assisted Living Association (WALA)
Wisconsin Association of Homes and Services for the Aging (WAHSA)
Wisconsin Association of Residential Facilities (WARF)
Wisconsin Health Care Association (WHCA)

Collectively, our members provide services to a majority of the recipients of long-term care in our current system. We have worked with Department of Health and Family Services (DHFS) Secretary Joe Leean and many others over the past three years in seeking to identify ways to improve our long-term care delivery system.

The Coalition strongly supports the Administration's long-term care goal: To develop "a comprehensive long-term care system that maximizes an individual's choice of services, providers and care settings as long as such care is necessary and meets a minimum level of quality standards and is cost effective."

In addition, the Coalition continues to support the compelling need for Resource Centers to serve as one-stop shopping service centers for consumer information and assistance with long-term care service availability, benefits, options and eligibility. We also support addressing the current institutional bias of the Medicaid program and replacing this bias with a system that enables care and services to be provided in the most appropriate setting, consistent with the above stated goal. The Coalition embraces a system that fully recognizes the appropriate roles of all providers in addressing the varying and changing long term care needs of individuals.

The Long-Term Care Coalition Position on Family Care

The Coalition was encouraged by the January 11th announcement by Governor Thompson and Secretary Leean to pilot test DHFS' Family Care proposal. We concurred with the Secretary's recommendation to the Governor that given "the significant concerns" that had been expressed by all parties affected by the proposal it was "prudent to use the pilot approach to Family Care at this time."

However, the language presented in the Governor's budget bill (1999 Senate Bill 45/Assembly Bill 133) cannot be reconciled with what we perceived as an intent to pursue and evaluate Family Care's pilot performance prior to proceeding with any further phase-in. Indeed, s.46.281(1)(e) of the budget bill gives DHFS full authority to proceed with statewide implementation of Family Care, without any further legislative review and irrespective of the performance, outcomes and cost of the "pilots".

Coalition members have argued consistently throughout the three-year Family Care developmental process that a thorough and extensive evaluation of the data collected by the resource center and CMO pilots prior to statewide implementation is the only prudent approach to protect state taxpayers, county property taxpayers and, most importantly, the elderly and disabled persons who will utilize the long-term care services Family Care is intended to provide. **Consistent with that position, Coalition members seek your support for revisions to SB 45/AB 133 to address the following concerns:**

- **The Family Care budget proposal should be deleted as a statutory provision and placed in SB 45/AB 133 as a nonstatutory provision to ensure that Family Care does not proceed statewide until the Resource Center and CMO pilot projects are conducted, completed and evaluated. In addition, s.46.28(1)(e) of the bill should be deleted.**

- **An analysis of the DHFS' Family Care cost model and assumptions by a reputable actuary or actuarial firm must be concluded prior to the adoption of the Family Care budget proposal. Among other things, the actuary/actuarial firm should recommend how long the pilots should operate to provide policymakers with the data necessary to determine whether to proceed statewide with Family Care, to revise the proposal or to scrap it entirely. Our proposed "Required Elements of the Family Care Pilot Projects and Evaluation" is attached.**

- **The Coalition supports the proposed expansion of the number of CMO pilots to 9 counties and the selection of 2 of those counties to test the concept of integrating physician and other acute care services with long-term care services.**

- **The data collected from the pilots upon the conclusion of their operation should be analyzed thoroughly before the Legislature considers either a phased-in or a statewide implementation of Family Care. Enabling legislation to expand Family Care must incorporate the findings and recommendations that result from that evaluation, if the data suggests Family Care should move forward.**

- **When this objective is achieved, Family Care will have been tested, analyzed, and modified based on accurate cost data obtained through the pilots.**

- **Statewide implementation could then be phased-in as appropriate.**

Policymakers should not confuse our support for piloting Family Care, however, with either support for the proposal or belief that Family Care will work as intended. To the contrary, Coalition members continue to believe that Family Care as proposed in SB 45/AB 133 is based on assumptions which range from unsupported by available data to out-and-out faulty. From our perspective, the benefit of the proposed pilots is that previously unavailable data will be collected and analyzed to either confirm, refute or modify the DHFS' Family Care assumptions. Among the DHFS assumptions we challenge and we hope the pilots will address are the following:

1) **Data is insufficient to support the claim that in-home care is less expensive than congregate care.** What may be the key tenet espoused by Family Care proponents is that given the exact same needs, preferences and health status, it is less expensive to provide long-term care services to an individual at home than it is in a congregate setting. The Coalition strongly argues that neither the DHFS nor Family Care proponents have the data available to support that claim. (Please see the attached "Conclusions and Recommendations" from an April 1995 study of the Community Options Program conducted by two UW-Madison professors which we believe supports our contention.) For example, while each nursing home resident's health status is identified by a level of care determination established by the DHFS, COP and waiver clients receive no similar health status determinations. While the Family Care proposal will provide a uniform functional screen which should provide an apples-to-apples cost comparison between congregate care and community care, no similar comparisons can be made today because of the insufficient data compiled for COP and waiver clients. Thus, the DHFS Family Care cost model could actually be an apples-to-oranges comparison

which ultimately reflects vastly overstated savings from a shift to community care. Coalition members believe Family Care should not be implemented fully until the data necessary to support or refute these claims is collected and analyzed.

2) **The average nursing home resident is older, more frail and in need of more costly services than his/her counterpart in the community.** In a 1996 profile of long-term care clients developed by the DHFS Office of Strategic Finance, the executive summary stated: "As a group, nursing home residents tend to show more adverse conditions, functionally or mentally, than their community waiver counterparts. Relatively more nursing home residents are at a higher level of skilled nursing care need, have many more functional impairments in activities of daily living ..., and show signs of memory loss or cognitive problems. They also are more likely to exhibit problem behaviors, show signs of mental distress, and have problems with incontinence." It appears to the Coalition that it may cost more to provide facility-based care, not because community care itself is less expensive, but rather because facility-based residents on average have greater needs and require more costly services than community-care clients.

3) **The cost implications of the "woodwork" effect are unknown.** Under the Family Care budget proposal, all persons meeting its comprehensive level eligibility standards will be entitled to expanded benefits under the Care Management Organization (CMO). The envisioned CMO benefit package is expressly designed to attract enrollees through the promise of expanded choices and benefits. This prospect of entitlement to more extensive publicly-financed long term care services will have a "woodwork" effect that will attract more individuals into the system and accordingly increase aggregate program costs. The pilot projects should be utilized to measure the impact such induced demand will have in increasing program service utilization and cost.

4) **The DHFS cost model used to develop Family Care is based on questionable, if not faulty, assumptions.** The inadequacy of the DHFS database is not the only concern the Coalition has with the assumptions the DHFS identified in its Family Care cost model. We disagree with or dispute their assumptions related to, among other issues, the cost impact of a healthier elderly population, the bias against congregate care settings, the time and cost to conduct a functional screen, the frequency of client functional/eligibility redeterminations, "outreach" funding, the reliance on "gross cost" averaging, the effect of redesign on Medicaid card costs, the projected reduction in nursing facility utilization, the permanency of initial placements, capitation rates, blended rates, applicability of the Oregon experience, quality assurance programs, cost of payments to family members and authority of care managers.

5) **Waivers from the federal Health Care Financing Administration, which would be required under Family Care, are dependent upon a showing of "budget neutrality;" in other words, Wisconsin would have to show that within a certain timeframe (i.e., 5 years), implementation of Family Care would cost the federal government no more than the cost of continuing the current system.** The State believes it can meet this test; Coalition members disagree because we believe the State is relying on faulty cost assumptions and that the true cost of Family Care will be significantly greater than the DHFS projection. What if we are right: will the federal waivers be granted? Data collected through the pilots could be the determining factor.

6) **The county property taxpayer ultimately may be asked to subsidize Family Care.** Under Family Care, CMOs eventually will be required to accept the same risk as HMOs: a monthly capitation rate will be paid to the CMO for each enrollee and the CMO will be required to manage the care of each enrollee within that capitation rate. If the cost of services exceeds the capitation rate, additional

funds will have to be found. Unlike the COP or waiver programs, there will be no option to create a wait list or suspend services when funds expire. If counties are to serve as CMOs, those "additional funds" almost certainly would have to come from the local property taxpayer, unless additional state tax dollars can be found. Are counties prepared to accept that kind of risk? Without the ability to review the data collected by the pilot counties, we believe the answer to that question is "no".

The attached contains what Coalition members believe at the very least (pending the findings of an actuary) should be the required elements of the Family Care pilot projects.

3/4/99

1 **(5)** "Family care district" means a special purpose district created under s.
2 46.2895 (1).

3 **(6)** "Family care district board" means the governing board of a family care
4 district.

5 **(7)** "Functional and financial screen" means a screen prescribed by the
6 department that is used to determine functional eligibility under s. 46.286 (1) (a) and
7 financial eligibility under s. 46.286 (1) (b).

8 **(8)** "Nonprofit organization" has the meaning given in s. 108.02 (19).

9 **(9)** "Older person" means a person who is aged at least 65.

10 **(10)** "Resource center" means an entity that meets the standards for operation
11 under s. 46.283 (3) or, if under contract to provide a portion of the services specified
12 under s. 46.283 (3), meets the standards for operation with respect to those services.

13 **(11)** "Tribe or band" means a federally recognized American Indian tribe or
14 band.

15 SECTION **1069.** 46.281 of the statutes is created to read:

16 **46.281 Powers and duties of the department and the secretary;**
17 **long–term care. (1)** DUTIES OF THE DEPARTMENT. The department shall do all of the
18 following:

19 (a) Provide training to members of the council on long–term care who are aged
20 65 or older or who have physical or developmental disabilities or their family
21 members, guardians or other advocates, to enable these members to participate in
22 the council's duties.

23 (b) Provide information to the council on long–term care and seek
24 recommendations of the council.

1 (c) Request from the secretary of the federal department of health and human
2 services any waivers of federal medicaid laws necessary to permit the use of federal
3 moneys to provide the family care benefit to recipients of medical assistance. The
4 department shall implement any waiver that is approved and that is consistent with
5 ss. 46.2805 to 46.2895. Regardless of whether a waiver is approved, the department
6 may implement operation of resource centers, care management organizations and
7 the family care benefit.

8 * (d) Before July 1, 2001:

9 1. Establish, in geographic areas determined by the department, a pilot project
10 under which the department may contract with a county, a family care district, a
11 tribe or band or the Great Lakes inter–tribal council, inc., or with any 2 or more of
12 these entities under a joint application, to operate a resource center.

13 2. Contract with counties or tribes or bands under a pilot project to demonstrate
14 the ability of counties or tribes or bands to manage all long–term care programs and
15 administer the family care benefit as care management organizations.

16 * (e) After June 30, 2001, contract with one or more entities certified as meeting
17 requirements under s. 46.284 (3) for services of the entity as a care management
18 organization and one or more entities for services specified under s. 46.283 (3) and
19 (4).

20 (f) Prescribe and implement a per person monthly rate structure for costs of the
21 family care benefit.

22 (g) In order to maintain continuous quality assurance and quality
23 improvement for resource centers and care management organizations, do all of the
24 following:

Required Elements of the
Family Care Pilot Projects and Evaluation

Prior to either a phase-in or a statewide implementation of Family Care, the following activities must be undertaken:

- Engage the services of an actuary to identify data that must be collected by the pilot counties to permit an actuarial assessment and comparison of the fiscal and operational risks Family Care will present for state and county governments and their respective taxpayers. In addition, the actuary should recommend the optimum length of time the CMO pilots should operate in order to provide the data necessary to evaluate those financial and operational risks.

- Engage the services of an actuary to assess the adequacy of the current database of the Department of Health and Family Services (DHFS) and proposed costing methodology for purposes of projecting Family Care costs and capitation levels.

- Commission an actuarial study to determine the number of CMOs that could be reasonably sustained under state-wide or regional implementation of Family Care.

- Require participating counties to collect detailed and uniform client data to assist in the evaluation of Family Care pilots.

- Mandate and validate that the functional and financial screening tools are completed for all long term care clients. This will ensure that complete baseline information has been gathered regarding the LTC needs of all clients.

- Establish the cost of and time required to complete the functional and financial screening tools and the overall administrative costs associated with the Family Care pilots.

- Evaluate whether the functional and financial screening tools and the resultant client's score (which establishes the CMO's capitation rate) are an accurate predictor for the actual cost of the client's LTC service plan.

- Determine the overall cost-effectiveness of Family Care: The evaluation should reflect each client's health, functional and behavioral status and the total cost of her/his service plan. The evaluation should include the impact of Family Care on all health and long term care expenditures, including acute and primary care. Expenditures should include all funding sources, including Medicaid, Medicare, COP, home and community-based waiver programs, community aids, and all other federal, state and local expenditures. Findings should include a determination of whether Family Care creates an incentive for CMOs to shift costs to the acute/primary care system. The evaluation should directly assess which service settings/options are most cost-effective and appropriate given a client's health, functional and behavioral status.

- Evaluate the quality of care, life and services provided to Family Care clients in all settings (in-home care, nursing facilities, congregate care settings, etc.,) The evaluation should determine if the client's service setting enables the client to achieve her/his highest practical health, social, psychological and functional well-being.

- Evaluate the impact client advocacy and appeal systems have on the availability, provision and cost of recommended service plans.

- Evaluate the timeliness of securing necessary client services, including the presence of any decision-making bottlenecks (e.g., delays in obtaining services for hospitalized clients).

- Evaluate whether a sufficient number of paid and volunteer caregivers are available to meet the LTC needs of Family Care enrollees. In particular, can the current and future labor market support a non-facility-based long term care delivery system, as envisioned under Family Care, or is a greater emphasis on congregate settings more realistic?

- If the evaluation of the data collected through the pilots is to have any value, the pilots must be run as if Family Care were operational. Counties (CMOs) should not be granted programmatic "shortcuts" as an incentive to participate in the pilots. By the same token, we believe participating counties/tribes should be held harmless for the costs they incur pilot testing these programs. The pilots should expressly test whether CMOs are able to arrange or provide quality long term care and services for its clients within the capitation rates authorized by the DHFS. Finally, to avoid any real or perceived research biases within DHFS relative to Family Care, the Family Care pilot evaluation should be conducted by a qualified, independent third-party.