Health Services

Services for the Elderly and People with Disabilities

(LFB Budget Summary Document: Page 262)

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Item #	Title
6	SSI Supplements Reestimate (PR) (Children and Families -- TANF and Economic Support Paper #256)

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June, 2023 | Joint Committee on Finance | Paper #425

Aging and Disability Resource Centers
(Health Services -- Services for the Elderly and People with Disabilities)

[LFB 2023-25 Budget Summary: Page 262, #1]

CURRENT LAW

Aging and disability resource centers (ADRCs) provide information on a broad range of programs and services available to assist elderly individuals and individuals with disabilities, serve as the access point for publicly funded long-term care programs, and assist people in understanding the various long-term care options available to them and how to apply for programs and benefits.

ADRCs may serve either a single county or a consortia of counties and tribes. There are currently 47 ADRCs and seven tribal aging and disability resource specialists (ADRSs) serving residents statewide. The ADRC program became available on a statewide basis in 2013.

GPR base funding for ADRC and tribal ADRS services is $42,127,500 annually, of which approximately $36 million is used to support ADRC base contracts. In addition, DHS claims federal Medicaid administrative matching funds based on estimates of the cost of services ADRCs provide to Medicaid recipients. On average, FED accounts for 40% of ADRC costs, or approximately $23 million in additional funding annually. The amount of federal funding the state claims for ADRC services is based on time reports submitted by ADRCs that identify MA-eligible administrative services the ADRC provides, including: (a) staff discussions about MA programs or services; (b) conducting long-term care functional screens; and (c) assisting in gathering data necessary to apply for Medicaid.

While ADRCs are mainly funded with GPR and corresponding federal matching funds, some ADRCs receive support by other revenue sources, including fee revenue, county levy funding, and other grants. The Department of Health Services (DHS) provides most of the funding for ADRCs through annual, sum certain allocations. However, counties are responsible for

expenses that exceed these allocations.

Beyond the base funding available for core contract functions, ADRCs may receive additional funding for certain programs, for example the dementia care specialist program.

DISCUSSION POINTS

1. According to the DHS *Wisconsin State Aging Plan FFY 2023-25* report, "Wisconsin's population ages 60 and older totaled 1.45 million in 2020 comprising 25 percent of the state's total. Wisconsin ranked 16th nationally in this share of population... The ranking is considerably higher than in 2010 (25th, at 19 percent of population)."

2. Further, the state aging plan shows that between 2020 and 2030, Wisconsin's projected population growth rate for individuals ages 0 to 59 is 1%, compared to 21% for individuals ages 60 and older.

3. The Administration notes that current census projection estimates indicate that the 85 and older population will double in the next 20 years, even as the state population (all ages) is expected to only increase by 8% during that timeframe. Further, the Administration states that "as early as 2025, 15% growth in the very elderly population (85+) compared to 2020 heralds the beginning of unprecedented strain on the state aging system, of which resource centers are the front line."

4. AB 43/SB 70 would provide $5,654,300 in 2023-24 and $11,308,600 in 2024-25 to increase base allocations and fund expanded caregiver support services provided by ADRCs. Caregiver services could include assisting caregivers in navigating complexities relating to caregiving, education relating to available benefits both for the care recipient and caregiver, as well as facilitating support groups to connect them with others in this role.

5. Although a distribution method has not been finalized, the Department indicates that the plan would support both counties and tribes and that the current proposal provides funding to support staff that could provide caregiver support services on a per capita basis, considering all residents of Wisconsin over the age of 85. Further, additional funding would be predicated on contract amendments regarding expanded caregiver support services or through a separate caregiver support services contract for the ADRC.

6. While the pandemic has affected utilization in recent years, ADRC reported data indicates that total contacts increased by 11% from 2016 to 2019 (from 512,413 contacts in 2016 to 571,424 contacts in 2019), before leveling off somewhat during the pandemic. In calendar year 2022, ADRCs reported 535,329 contacts. Contacts do not represent the number of unique individuals served by the ADRC, since an individual may contact and receive services multiple times. Despite an increase in the number of contacts and individuals eligible for ADRC services, as a result of Wisconsin's aging population, GPR base funding for ADRC core contract purposes has not increased since ADRC services became available on a statewide basis in 2013.

7. In 2016, DHS published an analysis of the ADRCs, which found that 40.4% of people

surveyed contacted the ADRC on behalf of a spouse or relative. DHS has not commissioned a more recent formal analysis of the ADRCs. However, a 2020 report, by the National Alliance for Caregivers and AARP, indicated that more than one in five Americans are caregivers, having provided care to an adult or child with special needs at some time in the past 12 months. This equals an estimated 53.0 million adults in the United States, up from an estimated 43.5 million caregivers in 2015. For purposes of the 2020 report "caregivers" were defined as unpaid family caregivers.

8. Funding in the bill is made up of two components. First, $2,513,700 in 2023-24 and $5,027,400 in 2024-25 would be budgeted to increase ADRC base allocations to account for the anticipated increase in the number of older residents in the state. These amounts are based on the Administration's estimates regarding each county's percentage growth of their population aged 85 and older (between 2020 and 2025) multiplied by the current base allocations.

9. Second, $3,140,600 in 2023-24 and $6,281,200 in 2024-25 would be budgeted to support at least 0.5 FTE to provide caregiver support services in every county, with funds increasing proportionally for higher numbers of residents over 85 years old. Specifically, these estimates are based on counties with 1,000 or fewer people aged 85 or over in 2020, being budgeted $43,680 to support the salary and benefits associated with 0.5 non-state FTE position. Counties with more than 1,000 people aged 85 or over in 2020, would be budgeted $43.68 per person ($43,680 per 1,000 persons) aged 85 or older. While funding estimates for both components in the bill are based on estimates of county populations over the age of 85, final funding would be distributed on an ADRC and tribal ADRS basis.

10. Further, funding in AB 43/SB 70 would provide the GPR necessary for the Administration's proposal. It can be assumed that as the population served by ADRCs increases under this proposal, the number of Medicaid-eligible activities increases proportionally as well. As such, ADRCs may be able to claim additional FED match on the funding provided in the bill, depending on how exactly the funds are expended. This amount would be in addition to the increased GPR, rather than an offset.

11. The Administration notes that since caregiver support resources are not currently a core service, availability of such services depends on available funding. Dedicated funding for caregiver specialists at ADRCs would provide uniform access to caregiver assistance in navigating this role. It would also help to ensure access to caregiver services for those caring for younger adults with disabilities, as current caregiver services are often limited to caregivers for older adults.

12. If the Committee wishes to expand services that ADRCs currently provide, as well as in recognition of likely future increases in demand for ADRC services as the population continues to age, the Committee could choose to provide $5,654,300 in 2023-24 and $11,308,600 in 2024-25 to increase base allocations and fund expanded caregiver support services at ADRCs. [Alternative 1]

13. Alternatively, in recognition of the challenges facing caregivers specifically, the Committee could choose to retain only this portion of the Administration's plan. As such, the Committee could provide $3,140,600 in 2023-24 and $6,281,200 in 2024-25 to expand caregiver support and programs at ADRCs. [Alternative 2]

14. On the other hand, the Committee could choose to retain only the portion of the Administration's plan to provide $2,513,700 in 2023-24 and $5,027,400 in 2024-25 to increase ADRC base allocations to account for the anticipated increase in the number of older residents in the state. Under this alternative, no core contract services would be expanded but rather funding would support an anticipated increase in demand for current services. [Alternative 3]

15. Finally, the Committee could choose to take no action on this item, thereby maintaining the current GPR funding level for ADRCs. [Alternative 4]

ALTERNATIVES

1. Provide $5,654,300 in 2023-24 and $11,308,600 in 2024-25 to increase base allocations and fund expanded caregiver support services at ADRCs.

ALT 1	Change to Base
GPR	$16,962,900

2. Provide $3,140,600 in 2023-24 and $6,281,200 in 2024-25 to expand caregiver support and programs at ADRCs.

ALT 2	Change to Base
GPR	$9,421,800

3. Provide $2,513,700 in 2023-24 and $5,027,400 in 2024-25 to increase ADRC base allocations to account for the anticipated increase in the number of older residents in the state.

ALT 3	Change to Base
GPR	$7,541,100

4. Take no action.

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June, 2023 Joint Committee on Finance Paper #426

Complex Patient Pilot Program
(Health Services -- Services for the Elderly and People with Disabilities)

[LFB 2023-25 Budget Summary: Page 263, #2]

CURRENT LAW

Under federal law, hospital emergency rooms must provide care to stabilize any patient, without regard to ability to pay or type of insurance coverage. For other types of hospital services, admission criteria may vary by hospital type. However, admission criteria are used to verify the medical necessity of any hospitalization. Medical necessity as defined by the Centers for Medicare and Medicaid Services (CMS) means the patient has a condition requiring treatment that can only be safely provided in a hospital setting.

Once a person no longer needs hospital services, that patient is discharged from the hospital. As a condition of participation in the federal Medicare program, hospitals must have in effect a discharge planning process that focuses on the patient's goals and treatment preferences and includes the patient and his or her caregivers or support persons in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must be consistent with the patient's goals for care and his or her treatment preferences, ensure an effective transition of the patient from hospital to post-discharge care, and reduce the factors leading to a preventable hospital readmissions.

Beyond general requirements relating to discharge planning, there are additional requirements for patients in need of post-acute care services. Specifically, for those patients discharged home and referred for home health agency (HHA) services, or for those patients transferred to a nursing home (skilled nursing facility or SNF) for post-hospital extended care services, or transferred to an inpatient rehabilitation facility (IRF) or a long-term care hospital (LTCH) for specialized hospital services, the following requirements apply:

(1) The hospital must include in the discharge plan a list of HHAs, SNFs, IRFs, or LTCHs

that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, IRF, or LTCH, in the geographic area requested by the patient. HHAs must request to be listed by the hospital as available.

(i) This list must only be presented to patients for whom home health care post-hospital extended care services, SNF, IRF, or LTCH services are indicated and appropriate as determined by the discharge planning evaluation.

(ii) For patients enrolled in managed care organizations, the hospital must make the patient aware of the need to verify with their managed care organization which practitioners, providers or certified suppliers are in the managed care organization's network. If the hospital has information on which practitioners, providers or certified supplies are in the network of the patient's managed care organization, it must share this with the patient or the patient's representative.

(iii) The hospital must document in the patient's medical record that the list was presented to the patient or to the patient's representative.

(2) The hospital, as part of the discharge planning process, must inform the patient or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of post-discharge services and must, when possible, respect the patient's or the patient's representative's goals of care and treatment preferences, as well as other preferences they express. The hospital must not specify or otherwise limit the qualified providers or suppliers that are available to the patient.

(3) The discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare.

DISCUSSION POINTS

1. According to Leading Age Wisconsin and the Wisconsin Health Care Association/Wisconsin Center for Assisted Living (WHCA/WiCAL) Wisconsin nursing homes admitted almost 36,000 patients from hospital settings in 2022. Further, data from the Department of Health Services indicate that nearly 92% of all nursing home admissions are directly from hospitals.

2. Despite the large volume of nursing home admissions from hospital settings, the Wisconsin Hospital Association estimates that, at any one time, 350 to 400 people are waiting to be discharged from a hospital to a post-acute care setting, such as a nursing home. However, these patients are difficult to place due to their greater than average needs.

3. AB 43/SB 70 would provide $15,000,000 GPR in 2023-24 on a one-time basis to fund a complex patient pilot program to help facilitate the transfer of complex patients from acute care settings, such as hospitals, to post-acute care facilities, in the 2023-25 biennium. Under the proposed pilot, DHS would be required to provide payments to partnership groups designated as participating sites for care provided during the course of the pilot program under this program. All provisions relating to the pilot would be repealed effective July 1, 2025.

4. Under the bill, DHS would be required to form an advisory group to assist with development and implementation of a complex patient pilot program. Further, the DHS Secretary or designee, would be required to chair the advisory group, and members of the advisory group would be required to have clinical, financial, or administrative expertise in government programs, acute care, or post-acute care. The Department would be required to use its request-for-proposal procedure to select partnership groups that would be designated as participating sites for the complex patient pilot program.

5. The advisory group would be required to develop a request for proposal for the complex patient pilot program that includes eligibility requirements. Further, the complex patient pilot advisory group would be required to: (a) determine and recommend to DHS an amount of the funding budgeted for the complex patient pilot program to be reserved for reconciliation to ensure that participants in the pilot program are held harmless from unanticipated financial loss; (b) develop a methodology to evaluate the complex patient pilot program, including a recommendation on whether DHS should contract with an independent organization to evaluate the complex patient pilot program; and (c) make recommendations to the DHS Secretary regarding which partnership groups should receive designation as a participating site for the complex patient pilot program.

6. As it pertains to application requirements, the bill specifies that only partnerships of at least one hospital and at least one post-acute facility would be eligible to submit proposals. Further, the bill would require that each partnership group that applies to DHS to be designated as a site for the complex patient pilot program address all of the following issues: (1) the number of beds that would be set aside in the post-acute facility; (2) the goals of the partnership during the pilot program and after the pilot program; (3) the types of complex patients for whom care would be provided; (4) the per diem rate requested to adequately compensate the hospital or hospitals and the post-acute facility or facilities; (5) a post-acute bed reserve rate; and (6) anticipated impediments to successful implementation and how the applicant partnership group intends to overcome the anticipated impediments. In addition, each partnership group would be required to address its expertise to successfully implement the proposal, including a discussion of at least all of the following issues: (a) experience of the partners working together; (b) plan for staffing the unit; (c) ability to electronically exchange health information; (d) clinical expertise; (e) hospital and post-acute facility survey history over the past three years; (f) acute care partner readmissions history over the past three years; (g) discharge planning and patient intake resources; and (h) stability of finances to support the proposal, including matching funds that could be dedicated to the pilot program. While no applicant would be required to provide matching funds or a contribution, the advisory group and DHS may take into consideration the availability of matching funds or a contribution in evaluating an application.

7. The bill would specify that no later than 90 days after the effective date of the bill, the advisory group must complete development of the request for proposal for partnership groups to be designated as participating sites in the complex patient pilot program and provide its recommendations to the DHS Secretary. Subsequently, no later than 150 days after the bill's effective date, the advisory group must review all applications submitted in response to the request for proposal and select up to four partnership groups to recommend to the DHS Secretary for designation as participating sites for the complex patient pilot program.

8. The complex patient pilot would serve two main purposes. The first would be to ensure the successful transfer of these difficult to place individuals from hospital settings to more appropriate post-acute care settings. Leading Age Wisconsin and WHCA/WiCAL indicate that this would alleviate pressure on the hospital system and instead utilize excess bed capacity at Wisconsin nursing homes, in situations where discharge to a nursing home is appropriate. Further, WHA indicates that patient well-being and hospital financial issues could be served by ensuring that people are receiving care in the most appropriate setting, since hospital reimbursement for continuing to house these individuals varies greatly, depending on the individual's insurance status once they no longer require hospital care.

9. The second purpose would be to learn more about these difficult to place individuals and to identify systemic barriers to appropriate placement for these individuals, as well as future individuals with similar characteristics. Specifically, Leading Age Wisconsin and WHCA/WiCAL, indicate that the complex patient pilot program would be able to draw from the experiences of hospitals and post-acute facilities that have initiated collaborative efforts designed to better serve hard to care for patients. For example, Froedtert Hospital and Luther Manor in Southeastern Wisconsin have a collaborative history of working to address the needs of complex patients, and a hospital system and group of long-term care providers in the La Crosse area have more recently initiated similar efforts. Participants have expressed challenges related to the types of patients they are able to admit, regulatory hurdles, securing a sustainable funding source, and ensuring ongoing access to specialty care providers (such as physicians, behavioral health practitioners, and wound care certified staff). The associations indicate that complex patient pilot would be a broader and more systematic way to better identify these barriers and create solutions that could be replicated in other areas of the state.

10. Targeting that purpose, funding in the bill would be available to fund a study of the pilot. Further, the bill would specify that between six and 18 months after the effective date of the bill, the partnership groups designated by DHS as participating sites in the complex patient pilot program must implement the pilot program and meet quarterly with both DHS and the advisory group or any independent organization hired by DHS for the purpose of evaluating the pilot program to discuss experiences relating to the pilot program. No later than June 30, 2025, the advisory group or any independent organization hired by DHS for evaluating the complex patient pilot program must complete and submit to the DHS Secretary an evaluation of the complex patient pilot program, including a written report and recommendations.

11. In light of industry support and in an effort to ensure that patients are receiving the right care, at the right time, in the right place, for both psychosocial and financial reasons, the Committee could provide $15,000,000 GPR in 2023-24 on a one-time basis to fund a complex patient pilot program to help facilitate the transfer of complex patients from acute care settings, such as hospitals, to post-acute care facilities, in the 2023-25 biennium. [Alternative 1]

12. The funding in the bill does not correspond to any cost estimates provided by the Administration. Rather, it is one-time funding that would be available to support the pilot program's costs until the funding is fully expended or the end of the 2023-25 biennium, whichever comes first. Consequently, the Committee could support the pilot at a lower level of funding. For example, the

Committee could provide $5,000,000 GPR in 2023-24 on a one-time basis to fund a complex patient pilot program. If the Committee chooses this option, DHS would likely reduce the scope of the pilot project, for example by selecting fewer partnership groups and participating sites, than if Alternative 1 were selected. [Alternative 2]

13. Finally, the Committee may determine that there is no need for the state to take action on this issue, since hospitals are currently incurring the costs of caring for these patients, and hospital rates, paid by insurers, private individuals, Medicare, and Medicaid, should reflect the costs of caring for all patients, including patients who may be harder to discharge for a variety of reasons. Further, the Committee may determine that, due to the complexity of the issue, the matter should be addressed in separate legislation. [Alternative 3]

ALTERNATIVES

1. Provide $15,000,000 GPR in 2023-24 on a one-time basis to fund a complex patient pilot program to help facilitate the transfer of complex patients from acute care settings, such as hospitals, to post-acute care facilities, in the 2023-25 biennium. Incorporate the statutory provisions of AB 43/SB 70 relating to this item in the bill.

ALT 1	**Change to Base**
GPR	$15,000,000

2. Provide $5,000,000 GPR in 2023-24 on a one-time basis to fund a complex patient pilot program to help facilitate the transfer of complex patients from acute care settings, such as hospitals, to post-acute care facilities, in the 2023-25 biennium. Incorporate the statutory provisions of AB 43/SB 70 into the bill.

ALT 2	**Change to Base**
GPR	$5,000,000

3. Take no action.

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June, 2023 Joint Committee on Finance Paper #427

Adult Protective Services System (Health Services -- Services for the Elderly and People with Disabilities)

[LFB 2023-25 Budget Summary: Page 264, #3]

CURRENT LAW

Wisconsin law defines adult protective services (APS) as any services that, when provided to an individual with developmental disabilities, degenerative brain disorder, serious and persistent mental illness, or other like incapacity, keep the individual safe from abuse, neglect, or financial exploitation, prevent the individual from experiencing deterioration, or stop the individual from inflicting harm on oneself or another person.

Protective services may include: outreach, identification of individuals in need of services, counseling and referral for services, coordination of services, tracking and follow-up, social services, case management, legal counseling or referral, guardianship referral, diagnostic evaluation, and collaboration with law enforcement as necessary.

Each county designates an agency (usually the county health or human services department) that investigates reports of abuse, neglect, financial exploitation, and self-neglect, of adults at risk (AAR, ages 18 to 59) or elder adults at risk (EAAR, ages 60 and older). Tribes may designate a contact for the purpose of receiving information or inquiries about APS-related matters from tribal members, county APS units, or other interested external parties. Tribal nations often work in cooperation with county APS units to investigate cases of suspected abuse, neglect, self-neglect, or financial exploitation, or to petition for guardianships or protective services.

DISCUSSION POINTS

1. AB 43/SB 70 would provide $4,138,300 GPR in 2023-24 and $9,499,200 GPR in 2024-25 to increase funding for adult protective services training, needs assessments for tribal

adult protective services, guardian support and elder justice training grants, and other adult protective services. Table 1 shows funding that would be provided under AB 43/SB 70 for the various adult protective services projects.

TABLE 1

Adult Protective Services Funding Summary
AB 43/SB 70

	Base GPR Funding	AB 43/SB 70 2023-24	AB 43/SB 70 2024-25	Ongoing Annual Total Under AB 43/SB 70
Items Currently Funded with Ongoing State GPR				
Adult Protective Services	$4,900,600	$2,500,200	$5,000,200	$9,900,800
Elder Abuse Prevention	2,029,500	1,500,200	3,000,200	5,029,700
Domestic Violence Prevention	74,300	37,900	75,700	150,000
Guardianship Support	100,000	50,000	100,000	200,000
Other APS Training	0	50,000	100,000	100,000
Items Currently Funded with One-Time ARPA Funds*				
Data Reporting and Case Management	0	0	407,000	407,000
Adult Protective Services Online Training System	0	0	195,900	195,900
Adult Protective Services Contract Team	0	0	600,200	600,200
Tribal Demonstration Projects	0	0	20,000	20,000
Total	$7,104,400	$4,138,300	$9,499,200	$16,603,600

*These items are currently funded with one-time ARPA funds totaling $3,180,800 over three years.

2. The Department of Health Services (DHS) estimates that between 2010 and 2040, the percentage of people in Wisconsin ages 65 and older will increase from 13.7% to 23.7% and the percentage of Wisconsin residents ages 85 and older will increase from 2.1% to 4.4% of the state's total population.

3. Table 2 shows the number of completed APS incident reports between 2013 and 2021, the most recent year for which data is available, as well as the percent change in the number of cases during that time.

TABLE 2

Number of Complete Incident Reports by Year

	2013	2014	2015	2016	2017	2018	2019	2020	2021	2013-21 Percent Change
AAR Incident Reports	1,861	1,996	1,924	1,996	1,855	2,065	2,372	2,264	2,208	18.6%
EAAR Incident Reports	5,785	6,347	6,528	7,019	7,361	7,761	8,929	9,473	9,406	62.6%

Note: Calls for information only do not involve allegations of abuse, neglect, or financial exploitation, and are not included in the numbers shown in this table.

4. In 2021, the three primary reasons for completed EEAR incident reports were self-neglect (4,799 reports), financial exploitation (1,306 reports), and neglect by others (969 reports). For completed AAR incident reports during the same year, the three primary reasons were self-neglect (1,055 reports), neglect by others (460 reports), and financial exploitation (280 reports).

5. Prior to the statewide expansion of Family Care, APS units were funded with a combination of state community aids basic county allocations (BCA) funds, county funds, and funding DHS provided to counties as part of the state's previous Medicaid long-term care waiver programs. When much of this funding was redirected to support the Family Care program, state GPR was budgeted to maintain state support for county APS units, at the rate of 2% of a county's 2006-level BCA allocation. These allocations, calculated in 2009, have remained unchanged through 2022.

6. In addition to community aids allocations, EAAR agencies in APS units have access to an elder abuse direct service allocation to offset the cost of allegation response. Elder abuse direct service funds are statutorily restricted to serving individuals age 60 and older. These funds total $2,029,500 GPR annually and are routinely expended each contract year.

7. Information from completed EEAR incident reports between 2013 and 2021 show that an average of 872 people annually or 11% of the subjects in the reports have been enrolled in Family Care, while an average of 54% of the subjects of these reports (an average of 4,094 people annually) have not been served by any county or state-funded programs. For AAR during that same period, 35% (an average of 732 people annually) have been enrolled in Family Care, while 19% (an average of 390 people annually) have not been served by any county or state-funded programs.

8. Based on the number of people who have not been served by any county or state-funded programs, including Family Care, and the increased number of APS incident reports, it could be argued that there is a need for additional APS funding available to serve all individuals. Under this proposed increase, shown in Table 1, the Department intends to reformulate allocations using population and equity-based factors, while holding APS units harmless.

9. DHS distributes funding from a "domestic abuse in later life" fund to the state's three area agencies on aging, which conduct outreach, awareness and other special projects each year from this fund, which totals $74,250 GPR per year. The fund for domestic violence in later life has not increased since DHS began distributing funds consistent with current practice around 2012.

10. The Department also indicates a need for additional support to protect individual rights. As such, the bill would provide $100,000 for APS staff training relating to the assessment of client decision making abilities. The Cornell-Penn Interview for Decisional Abilities (IDA) training costs $1,000 per student, so funding in the bill would cover 100 IDA courses per year. The Department indicates that, with 400 APS staff across the state, this funding could ensure statewide training by 2027, with continued funding to account for staff turnover.

11. The Department currently provides $100,000 annually through a contract with Greater Wisconsin Agency on Aging Resources (GWAAR) to support the Guardianship Support

Center. Funding for the grant has not increased since 2004-05, when it was reduced from $250,000 GPR to $100,000 GPR annually.

12. The funding increase in AB 43/SB 70 would enable the Guardianship Support Center to add a second non-state position, to provide resources and support to guardians, informing them of their legal responsibilities and assisting them in meeting those requirements.

13. Finally, the bill would provide funding to continue one-time, federally-funded projects with GPR on an ongoing basis, beginning in 2024-25, including: the APS data system to allow for collaboration with other systems and integration with other data sets including the National Adult Maltreatment Reporting System; online training for APS staff including to maintain the learning environment and training module production; contracted state support for APS including ensuring effective use of the previously described data system and online training, as well as tribal partnerships and case management support; and support for the costs of stakeholder meetings to develop a tribe-specific APS system (to be further developed in the 2025-27 biennial budget).

14. Based on the increased utilization of APS services, and the anticipated acceleration of this trend as the population continues to age, the Committee could choose to provide $4,138,300 GPR in 2023-24 and $9,499,200 GPR in 2024-25 to increase funding for adult protective services training, needs assessments for tribal adult protective services, guardian support and elder justice training grants, and other adult protective services. [Alternative 1]

15. Under Alternatives 2a through 2i, the Committee could choose the items it wishes to retain from the previous table based on the understanding that the items in the table are not interrelated and as such could be continued on a standalone basis based on the Committee's own priorities. [Alternative 2]

16. Finally, the Committee could choose to take no action on this item. [Alternative 3]

ALTERNATIVES

1. Provide $4,138,300 GPR in 2023-24 and $9,499,200 GPR in 2024-25 to increase funding for adult protective services training, needs assessments for tribal adult protective services, guardian support and elder justice training grants, and other adult protective services.

ALT 1	Change to Base
GPR	$13,637,500

2. Select any combination of the following items.

a. Provide $2,500,200 GPR in 2023-24 and $5,000,200 GPR in 2024-25 to increase funding for adult protective services.

ALT 2a	Change to Base
GPR	$7,500,400

b. Provide $1,500,200 GPR in 2023-24 and $3,000,200 GPR in 2024-25 to increase funding for elder abuse prevention.

ALT 2b	Change to Base
GPR	$4,500,400

c. Provide $37,900 GPR in 2023-24 and $75,700 GPR in 2024-25 to increase funding for the "domestic abuse in later life" fund.

ALT 2c	Change to Base
GPR	$113,600

d. Provide $407,000 GPR in 2024-25 to fund the APS data system to allow for collaboration with other systems and integration with other data sets, including the National Adult Maltreatment Reporting System.

ALT 2d	Change to Base
GPR	$407,000

e. Provide $195,900 GPR in 2024-25 to fund online training for APS staff, including to maintain the learning environment and training module production.

ALT 2e	Change to Base
GPR	$195,900

f. Provide $600,200 GPR in 2024-25 to fund contracted state support for APS, including ensuring effective use of the APS data system and online training, as well as tribal partnerships and case management support.

ALT 2f	Change to Base
GPR	$600,200

g. Provide $20,000 GPR in 2024-25 to support the costs of stakeholder meetings to develop a tribe-specific APS system.

ALT 2g	Change to Base
GPR	$20,000

h. Provide $50,000 GPR in 2023-24 and $100,000 GPR in 2024-25 to increase funding for guardianship grants.

ALT 2h	Change to Base
GPR	$150,000

i. Provide $50,000 GPR in 2023-24 and $100,000 GPR in 2024-25 to fund adult protective services staff training on client decision making.

ALT 2i	Change to Base
GPR	$150,000

3. Take no action.

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June, 2023 Joint Committee on Finance Paper #428

WisCaregiver Careers
(Health Services -- Services for the Elderly and People with Disabilities)

[LFB 2023-25 Budget Summary: Page 266, #5]

CURRENT LAW

Nurse aides are individuals who provide routine client-related services under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).

The Department of Health Services (DHS) maintains the Wisconsin Nurse Aide Registry, which includes nurse aides who: (a) have completed a state-approved training program of 75 hours, including 16 hours of clinical work, and (b) have passed the competency exam, which includes a knowledge test and a skill test, within one year of completing a training program.

The knowledge test is taken either as a written or oral test. Candidates have a maximum of sixty minutes to complete the 75 question knowledge test on topics such as safety, infection control, mental health, resident rights, basic nurse skills, and communication. For oral tests, only the first 67 questions are read orally, the remaining eight questions must be answered without oral assistance to assess the candidate's English reading comprehension. A candidate must have a score of 71% or better to pass the knowledge portion of the exam.

For the skill test, candidates are assigned three tasks. Most of the tasks are performed on a live actor. A candidate is scored only on steps listed in the Wisconsin Nurse Aide Candidate Handbook and must have a score of 80% on each task without missing any key steps to pass the skill component of the competency evaluation. If a candidate fails the skill test, one of the tasks on the retest will be a task that candidate previously failed.

To work in a federally-certified facility, a certified nurse aide (CNA) must work for pay at least eight hours during each 24-month certification period. An RN or LPN must supervise the work. The work must occur in one of these settings: (a) a federally certified (Medicare and/or

Medicaid certified) nursing home; (b) a hospice; (c) a home health agency; (d) an intermediate care facility for individuals with intellectual disabilities; (e) a state-licensed hospital; (f) a facility for people with developmental disabilities; or (g) a rural medical center that provides one or more of these services. If an individual loses eligibility to work in federally certified facilities, the individual must retake and successfully pass the competency test. In the meantime, the individual may continue to work in hospitals, including critical access hospitals, and facilities that are not certified as Medicaid providers.

The WisCaregiver Career program is a workforce development program that provides free nurse aide training and certification testing, as well as a retention bonus after six months of employment as a nurse aide. Currently the program is funded from a $6,000,000 one-time grant DHS received under the Centers for Disease Control and Prevention (CDC) Nursing Home & Long-term Care Facility Strike Team program.

DISCUSSION POINTS

1. Overall, there has been a downward trend in the number of people on the Nurse Aide Registry in recent years. In January, 2018, approximately 61,400 individuals were on the registry. However, as of February, 2023, there were approximately 50,800 individuals on the Nurse Aide Registry.

2. The 2022 Long-Term Care Workforce Crisis Report, co-authored by the Disability Service Provider Network, LeadingAge Wisconsin, Wisconsin Assisted Living Association, and Wisconsin Health Care Association/Wisconsin Center for Assisted Living, notes CNA and direct care worker vacancy rates of 28.4% among Wisconsin's long-term care providers (skilled nursing facilities, adult family homes, residential care apartment complexes, and community based residential facilities), which is significantly higher than rates for both other healthcare sector jobs and the overall labor market. Further, according to the report, 112 organizations surveyed reported difficulty accessing CNA or other training programs.

3. Based on the types of care provided by nurse aides and the settings in which they are often employed, it is likely that the shortage of nurse aides will increase as the population continues to age. DHS estimates that between 2010 and 2040, the percentage of Wisconsin residents ages 65 and older will increase from 13.7% to 23.7% and the percentage of Wisconsin residents ages 85 and older will increase from 2.1% to 4.4% of the state's total population.

4. AB 43/SB 70 would provide $8,000,000 GPR in 2024-25 to fund the WisCaregiver Career program. As previously mentioned, the program is currently funded from a $6,000,000 one-time grant DHS received from CDC. However, this funding is set to expire one year from the end of the federal public health emergency (May, 2024).

5. Under the current WisCaregiver Career program, between May 1, 2022, and February 28, 2023, 3,171 students registered for CNA training, of which 495 completed the training and testing. Of those 495, 402 became certified as CNAs, and 120 received the six-month retention bonus. 36 individuals received a $300 mentorship bonus and 495 employers received a $300 employer bonus for having an individual complete the training and testing.

6. During that same period, in addition to the $479,175 paid by the WisCaregiver Career program to CNAs, mentors, and employers as bonuses and reimbursement, the program spent $1,105,765 on administrative costs, mentorship training contractors, marketing and media including the program website, and contracts for data collection, reporting, and accounting.

7. Funding in the bill modifies the payment amounts from the current program in various categories to align with the Administration's proposal and is based on the cost assumptions outlined in the following table, in order to fund an estimated 4,000 scholarships. While a significant portion of current funding has been expended on administrative costs, the Administration assumes that there will be existing capacity, for example within current staffing, for ongoing administrative work associated with this proposal.

Programmatic Costs for WisCaregiver Careers

Type of Expense	Estimated Cost
Training per Participant	$700
Facility Bonus per Participant	300
Bonus per Employee	500
Bonus per Mentor	500
Total Cost per Participant	$2,000
Number of Participants	4,000
Annual Cost	$8,000,000

8. Federal law states that no one who was employed by, or received an offer of employment from, a Medicaid-certified nursing facility on the date on which he or she began a facility-based nurse aide training and competency evaluation program may be charged for any portion of the program, including textbook fees and other required course materials. As such, a nursing facility is eligible to request reimbursement when the nursing facility incurred training or testing costs for an employee, or when the employee incurred training and/or testing costs within 365 days of his or her hire date.

9. Further, federal law states that nurse aides may not bear any cost of training or testing if they become employed by, or receive an offer of employment from a Medicaid-certified nursing facility within 12 months of completing a nurse aide training and competency evaluation program. In order to comply with this portion of the federal regulation, a nursing facility is required to reimburse up to the current maximum cap ($225.00 for training and $61.50 for the competency test) any certified nurse aide who independently completes a certified nurse aide program within 365 days of his or her hire date. Even though a nursing facility may not receive 100 percent of the maximum cap, they are required to reimburse the certified nurse aide the maximum cap if the CNA’s training and testing costs are equal to or greater than the maximum cap.

10. Current testing fees are: $125 for the knowledge test and skill test; $130 for the oral knowledge test and skill test; $93 for the skill test only; $32 for the knowledge test only; and $37 for the oral knowledge test only.

11. According to DHS, participants in the current WisCaregivers program have been

advised that they can either seek reimbursement through the WisCaregivers program or, if they are eligible nursing homes, through the Medicaid program, but not both. Currently, reimbursement provided through WisCaregiver Careers exceed the maximum amount that facilities can receive under Medicaid by providing $700 for certified trainees and full coverage of all trainee exam costs for up to three attempts.

12. In an effort to address the current workforce shortage facing healthcare providers particularly as it pertains to nurse aides, the Committee could provide $8,000,000 GPR in 2024-25 to fund the WisCaregiver Career program. [Alternative 1]

13. Based on current utilization, the Committee could provide $4,000,000 GPR in 2024-25 on a one-time basis to fund the WisCaregiver Career program. By providing funding on a one-time basis additional data relating to ongoing need and interest may be obtained prior to making an ongoing commitment of state resources as part of the next biennial budget. [Alternative 2]

14. Due to limitations on the use of federal monies currently funding the program, only nursing homes are eligible to participate in the present version of WisCaregiver Careers program. As such, in addition to choosing Alternative 1 or 2, the Committee could require DHS to provide priority in funding for CNAs that work in assisted living facilities, since these providers are currently unable to participate in the program. [Alternative 3]

15. Finally, the Committee could choose to take no action on this item. [Alternative 4]

ALTERNATIVES

1. Provide $8,000,000 GPR in 2024-25 to fund the WisCaregiver Career program.

ALT 1	Change to Base
GPR	$8,000,000

2. Provide $4,000,000 GPR in 2024-25 on a one-time basis to fund the WisCaregiver Career program.

ALT 2	Change to Base
GPR	$4,000,000

3. In addition to Alternative 1 or 2, require DHS to give priority to providing reimbursements payments to assisted living facilities that are currently unable to participate in the program.

4. Take no action.

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June, 2023 Joint Committee on Finance Paper #429

Office for the Promotion of Independent Living Programs (Health Services -- Services for the Elderly and People with Disabilities)

[LFB 2023-25 Budget Summary: Page 267, #7]

CURRENT LAW

The Department of Health Services (DHS) Office for the Promotion of Independent Living Programs (OPIL) is composed of three sub-offices: the Office of the Blind and Visually Impaired (OBVI), the Office for the Deaf and Hard of Hearing (ODHH), and the Office of Physical Disabilities and Independent Living.

By providing direct service supports and partner training and management, OPIL staff work to ensure that people with disabilities of all ages, abilities, and incomes have equal opportunities and access to programs and services that ensure a high quality of life, including helping people maintain their independence and the ability to live independently in the community of their choice.

DISCUSSION POINTS

1. DHS estimates that between 2020 and 2025, Wisconsin's population over the age of 85 years old will increase by15% , which will increase the prevalence of visual impairment and hearing loss, as well as other age-related disabilities.

2. In an effort to meet the anticipated need for services for Wisconsin's elderly population, AB 43/SB 70 would: (a) fund 1.0 additional rehabilitation specialist for the blind position within the OBVI ($59,000 GPR in 2023-24 and $76,600 GPR in 2024-25); (b) increase funding for the telecommunications assistance program (TAP) by $50,000 GPR annually; (c) increase funding for interpreter services by $100,000 GPR annually; and (d) increase funding for WisTech grants DHS provided to independent living centers (ILCs) by $624,000 GPR annually.

Office for the Blind and Visually Impaired (OBVI)

3. The Centers for Disease Control and Prevention (CDC) estimates that approximately 67 percent of adults with vision problems are older than age 65. Further, 2019 Census data report that 13.2% of people over the age of 85 experience vision difficulty, compared to 1.8% of the population overall, indicating that as the population ages, the need for vision related services will grow.

4. OBVI is currently staffed with 1.0 FTE supervisor, 10.17 FTE rehabilitation specialists, and 2.0 LTE special activity helpers. These positions are funded with a combination of GPR, Medical Assistance administrative federal matching funds, and grant funding the Department of Workforce Development receives from the federal Rehabilitation Services Administration and transfers to DHS to provide vision-related services to adults aged 55 and older.

5. AB 43/SB 70 would provide $59,000 GPR in 2023-24 and $76,600 GPR in 2024-25 to fund 1.0 additional rehabilitation specialist for the blind to increase number of rehabilitation specialists within the office to 11.17 FTE.

6. OBVI staff visit individuals in their homes, conduct group trainings, and teach techniques and technologies for use in daily living (home management, personal care, mobility, and communications). These specialized skills allow individuals to adapt and adjust to vision loss, enabling them to live as independently as possible. There is no charge for OBVI services.

7. The Department indicates that OBVI staff spend an average 9.5 hours with each person who receives services from OBVI. However, this time does not include staff time for travel to and from individual appointments, entering case notes and developing individual rehabilitation plans, identifying and ordering appropriate assistive technology devices, services provided by additional trainers, or follow-up information and technical assistance. Staff generally work with consumers for a few weeks at a time before closing their case. However, staff often work with the same individual over several years as their vision loss and rehabilitation needs change and thus need additional support or training to be able to live independently. On average, each OBVI position has an average active caseload of 35 individuals at a time.

8. While OBVI may prioritize services for individuals at risk of transitioning to a residential facility, the Department indicates that, based on current staffing individuals in need of services can wait several weeks for those services to be provided. However, actual wait times vary, depending on the specific services included in the individual's plan of rehabilitation training.

Telecommunication Assistance Program and Service Fund

9. According to the CDC, hearing loss is common in older adults, affecting 33 percent of people older than 60 and 50 percent of those older than 85. As with services for individuals who are blind or visually impaired, as the population ages, the need for programs providing assistance to individuals who are hearing impaired is anticipated to grow.

10. The statutes currently provide DHS with broad authority to provide assistance to hearing impaired persons to secure telecommunication devices capable of serving their needs, but limits this

assistance to individuals who: (a) are certified as deaf or severely hard of hearing by a physician or audiologist; and (b) live in families with adjusted gross income less than 200% of the federal poverty level (in 2023, $39,439.92 for a family of two).

11. Base funding for the program that supports interpreter services (the Service Fund) and telecommunications aids for individuals who are hearing impaired (the telecommunications assistance program, or TAP) is $178,200 GPR annually. DHS uses this funding to reimburse hearing interpreters and, subject to availability of funds, operate several financial assistance programs for telecommunication equipment for low-income people with hearing impairments, including the hearing aid assistance program.

12. TAP provides financial assistance to low-income deaf and severely hard of hearing individuals who need telecommunications equipment such as amplified telephones, mobile devices, signaling devices and hearing aids. Current funding for the program was set at $80,000 GPR in 1995 and has not been increased since.

13. TAP provides two types of assistance: (a) a copayment program to provide $100 for copay costs required by the telecommunications equipment purchase program (TEPP) available through the Public Service Commission; and (b) a hearing aid assistance program to provide up to $250 towards the purchase of new hearing aids, telecoils, and Bluetooth-enabled hearing devices.

14. The Americans with Disabilities Act requires certain entities to provide communications assistance, at no cost, to individuals who are deaf, have hearing loss, or are deaf-blind. The Service Fund reimburses communication access service providers when such communication support is not required by state or federal law, with certain limitations, as well as in circumstances where the provider may encounter delayed payment from the liable entity (subsequently expenditures may be billed to the liable entity as program revenue).

15. Limited by available funding, ODHH operates both TAP and the Service Fund on a first come, first served basis. Once funding has been depleted, a waiting list for services may be established by the Department. Currently, there is no waiting list for the Service Fund. However, a waiting list has been in place for TAP since November 15, 2022. As of March 21, 2023, 65 individuals were either on the waitlist or were in the process of submitting an application. As of that same date, there are 40 applications that were eligible for approval once funding is available next fiscal year. These applications are requesting an estimated $37,000 in TAP assistance.

16. The bill would provide $100,000 GPR for the Service Fund and $50,000 GPR for TAP to ensure ongoing, timely access to both of these services.

17. With the proposed increase in funding for the Service Fund, DHS estimates it could double the number of appointments and events it supports. DHS indicates that the average cost of interpreter or captioning services is $100 per hour, plus travel to and from the assignment. This means that on average DHS can fund approximately 900 hours of services (including travel) annually from the current allocation of $93,400. In 2021-22 the Service Fund was able to support 105 requests for interpreter or captioning services. Some of these requests were for one-time funding, and other requests were for ongoing services. As of March 31, 2023, the Service Fund had approved

communication access services for 137 events or appointments and as such estimates that the program will expend all of its budgeted funds before the end of the 2022-23.

18. As it pertains to TAP, DHS estimates that an additional 50 to 100 people could receive TAP services with the $50,000 increase. However, the actual number of individuals served depends on the equipment requested and the cost of these telecommunication devices.

State Assistive Technology Program

19. Independent living centers (ILCs) are community-based, cross-disability, nonresidential, private nonprofit agencies that are operated within a local community by individuals with disabilities, and provide an array of independent living services. ILC services include: information and referral; independent living skills training; peer support; individual and systems advocacy; and services that facilitate transition from nursing homes and other institutions to the community, provide assistance to those at risk of entering institutions, and facilitate transition of youth to postsecondary life. Centers may also provide other services necessary to improve the ability of individuals with significant disabilities to function independently in the family or community and/or to continue in employment.

20. The Wisconsin Assistive Technology Program (WisTech) provides information on selecting, funding, installing, and using assistive technology devices and services. This includes device loans, demonstrations, and training offered through a network of partners primarily consisting of ILCs.

21. Assistive technology is any item, device, or piece of equipment used to maintain or improve the functionality of people with disabilities, allowing them to be more independent in education, employment, recreation, and daily living activities. Assistive technology includes the services necessary to get and use the devices, including assessment, customization, repair, and training.

22. There is currently no GPR funding budgeted for assistive technology. However, the WisTech program provides each ILC $40,000 FED annually, supported by funding the state receives the Assistive Technology Act for this purpose. The Department indicates that this funding is insufficient to support both staff and the equipment necessary for training and loaning to people with disabilities.

23. Between 2018 and 2022 an average of 976 individuals annually received short-term device loans and 1,377 individuals received device demonstrations through the WisTech program. While services are available to people with disabilities, their families, employers, service providers, and other interested persons, the majority of both device loan and demonstration users are individuals with disabilities and their family members.

24. The WisTech program also offers a device reutilization and exchange program, which involves the refurbishment, recycling, and repair of assistive technology devices. Between 2018 and 2022, an average of 1,054 consumers used the device reutilization and exchange program.

25. AB 43/SB 70 would provide $624,000 GPR annually for DHS to increase WisTech grants for the eight current independent living centers. The Administration's intent is to provide each ILC an additional $78,000 annually, of which $68,000 would fund a WisTech staff member at each of the eight ILCs and $10,000 would fund equipment.

26. To address current utilization of services resulting in waiting lists and delayed services, as well as anticipated increases in utilization as the population ages, the Committee could provide $833,000 GPR in 2023-24 and $850,600 GPR in 2024-25 and 1.0 GPR position, beginning in 2023-24, to support programs within the DHS Office for the Promotion of Independent Living. [Alternative 1]

27. On the other hand, while each of the three programs discussed previously are administered by the DHS Office for the Promotion of Independent Living, the Committee could choose to provide additional funding for one or two of the programs, as operation of and funding for the programs is not interrelated. [Alternatives 2a, 2b, or 2c]

28. Finally, the Committee could choose to take no action on this item. [Alternative 3]

ALTERNATIVES

1. Provide $833,000 GPR in 2023-24 and $850,600 GPR in 2024-25 and 1.0 GPR position, beginning in 2023-24, to support programs within the DHS Office for the Promotion of Independent Living.

ALT 1	Change to Base	
	Funding	Positions
GPR	$1,683,600	1.00

2. a. Provide $59,000 GPR in 2023-24 and $76,600 GPR in 202425 and 1.0 GPR position, beginning in 2023-24, to fund 1.0 rehabilitation specialist for the blind position within the Office for the Blind and Visually Impaired.

ALT 2a	Change to Base	
	Funding	Positions
GPR	$135,600	1.00

b. Provide $150,000 GPR annually to increase funding available for the Telecommunications Assistance Program and interpretation services through the Service Fund.

ALT 2b	Change to Base
GPR	$300,000

c. Provide $624,000 GPR annually to increase funding for WisTech Grants for the Independent Living Centers.

ALT 2c	Change to Base
GPR	$1,248,000

3. Take no action.

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June, 2023 | Joint Committee on Finance | Paper #430

Alzheimer's Family and Caregiver Support Program, Alzheimer's Training and Information Grants, and Lifespan Respite Care Grants (Health Services -- Services for the Elderly and People with Disabilities)

[LFB 2023-25 Budget Summary: Page 268, #9, 10, & 11]

CURRENT LAW

The Department of Health Services (DHS) funds several programs and grants to address the needs of people with Alzheimer's disease, and programs that, while not targeted exclusively to the needs of people with Alzheimer's disease, may benefit these individuals and their caregivers.

Alzheimer's Family and Caregiver Support Program (AFCSP). Under AFCSP, DHS allocates funding to counties, tribes, and area agencies on aging (AAAs) to assist individuals to purchase services and goods related to the care of someone with Alzheimer's disease. In any calendar year, up to $4,000 per person may be available, depending on the county's priorities and the person's need for services. In some instances, the funds are used to expand or develop new services related to Alzheimer's disease, such as respite care, adult day care, or support groups.

To be eligible for the program, a person must have a diagnosis of Alzheimer's disease or a related disorder, and be financially eligible. The program is administered by the DHS Bureau of Aging and Disability Resources, and is available in every county and tribe throughout the state. Under current law, DHS may provide up to $2,808,900 annually, of which at least $1,000,000 per year must be allocated for respite care under AFCSP.

Alzheimer's Training and Information Grants. Current law requires DHS to award a grant to at least one public agency or private non-profit agency that meets the following criteria: (a) provides training and technical assistance to the staff of county social and human service departments, to the staff of agencies administering the AFCSP, and to other providers of services to persons with Alzheimer's disease; (b) determines the need for and create appropriate services to

persons with Alzheimer's disease in coordination with local agencies and service providers; and (c) collects and disseminates information on Alzheimer's disease, coordinate public awareness activities related to the disease and advise the department on public policy issues concerning the disease.

Currently, $131,400 GPR is available annually for this purpose, which DHS provides as a grant to the Wisconsin Alzheimer's Institute at the University of Wisconsin Madison.

Respite Care Grants. Under current law DHS is required to contract for the administration of life-span respite care projects with an organization that meets the following criteria: (a) the organization is a private, nonprofit organization, that is capable of operating on statewide basis and has expertise in respite care issues; (b) at least 51 percent of the members of the organization's governing board are consumers of respite care or caregivers; and (c) the membership of the organization's governing board includes providers and elected officials and represents the diverse geographical areas and cultural groups of the state.

Currently, $350,000 GPR is available annually to fund the life-span respite care program operating under a contract between a nonprofit agency, Respite Care Association of Wisconsin (RCAW), and DHS. As part of the life-span respite care program, RCAW administers the caregiver respite grant program and the supplemental respite grant program, as well as a third grant program for recruitment, outreach, and education events. RCAW is also responsible for delivery of caregiver training, maintenance of the respite care provider registry, and other activities included in the contract with DHS.

DISCUSSION POINTS

Alzheimer's Family and Caregiver Support Program (AFCSP)

1. The Alzheimer's family and caregiver support program was created by the Wisconsin Legislature in 1985, in response to the stress and service needs of families caring at home for someone with irreversible dementia.

2. Dementia refers to a set of symptoms of cognitive decline resulting from brain cell death caused by disease and injury to the brain. Symptoms may include declines in memory, judgment, perception, and reasoning, as well as other cognitive abilities. There are several causes of dementia, the most prominent of which is Alzheimer's disease.

3. According to the Alzheimer's Association, it is estimated that approximately 5.3% of people ages 65 through 74, 13.8% of individuals ages 75 through 84, and 34.6% of individuals 85 and older have Alzheimer's disease. The Alzheimer's Association estimates that in 2020, 120,000 Wisconsin residents age 65 and older have dementia, with that number anticipated to reach 130,000 in 2025. The number of people with Alzheimer's disease and other dementias is expected to increase as the population continues to age.

4. There are two main eligibility criteria for AFCSP. First, the individual must be

diagnosed with Alzheimer's disease or any of the other irreversible dementias. Second, an individual or couple must have a joint annual income of $48,000 or less. However, if the individual or couple's income is more than $48,000, the costs related to Alzheimer's disease can be subtracted from the gross income. If, following this subtraction, the net income is then less than $48,000, the individual or couple would be eligible.

5. Generally, the program funds services and items that are necessary to maintain a person with Alzheimer's disease in the community, including in-home help, respite care, adult day care, transportation, nutritional supplements, security systems, specialized clothing, home delivered meals, hobby equipment, and chair lifts. However, counties may limit the types of services covered by this program. Counties may also use program funding to start support groups, increase public awareness, purchase library books, start adult day care services, or to provide overnight or emergency respite care.

6. In calendar year 2021, 966 families received services funded by AFCSP. The program does not currently maintain a waiting list for services at the state level, although some families may need to wait until funding becomes available in their county.

7. In calendar year 2021, a total of $2,446,643 was expended through AFCSP. The following table shows 2021 expenditures under the program by service category.

2021 AFCSP Expenditures, by Service Category

Respite Services	
Adult day services	$158,990
Caregiver self-care	5,523
Homemaker/chores	242,279
In-home general respite	1,012,820
In-home personal care	122,919
Overnight facility respite	54,037
Other respite	46,902
Subtotal respite services	$1,643,470
Other	
Other goods and services	$238,074
Development of new or expanded services	3,997
Outreach activities and public awareness	143,283
Support group development or assistance	27,113
Case management	204,543
Staff training	5,668
Program administration	180,495
Total	$2,446,643

8. In calendar year 2023, DHS allocated $2,808,900 GPR for the program, including $1,645,100 to 34 counties as an allocation under community aids, and $1,163,800 to tribes and area agencies on aging as non-community aids allocations. By law, area agencies on aging are generally prohibited from providing direct services. As such, when funding is provided to area agencies on

aging the area agency on aging provides contract oversight and technical assistance but the program is still administered by the counties and tribes.

9. The amount each county or area agency on aging receives under this allocation is determined based on the state funding formula the DHS Office on Aging uses for distributing federal Older Americans Act funds. Counties are not required to contribute additional funding to the program, however, may choose to do so if they determine that additional funding is needed on occasion.

10. 2015 Act 273 established the current income eligibility limit of $48,000. Further, 2015 Act 273 provided an additional $1,000,000 GPR and increased the funding DHS is authorized to distribute under AFCSP to $2,558,900, beginning in 2016-17. 2021 Act 58 increased the funding DHS is authorized to distribute under AFCSP to the current maximum of $2,808,900, but did not change the income eligibility limit.

11. AB 43/SB 70 would modify AFCSP in two ways. First, financial eligibility would be expanded to allow an individual or couple to have a joint income of up to $60,000, after any eligible deductions for Alzheimer's related care expenses, up from the current limit of $48,000. Second, to ensure that benefits are not reduced or limited as a result of expanding eligibility, an additional $500,000 would be provided annually for DHS to distribute to counties, tribes, and area agencies on aging under the program.

12. Based on ongoing demand for services, and the anticipated growth in the number of Wisconsinites aged 65 and older anticipated to live with Alzheimer's who could therefore benefit from AFCSP services, the Committee could provide an additional $500,000 GPR annually to expand eligibility for AFCSP, as recommended by the Governor. [Alternative A1]

13. Alternatively, rather than expand the financial eligibility for the program, the Committee could instead provide $500,000 GPR annually and increase the funding DHS is authorized to distribute under AFCSP to $3,308,900 annually.

14. While the Department does not collect data on individual benefit payments, 27 counties and tribes have set maximum benefit limits below the statutory maximum of $4,000 in order to serve more eligible individuals. The Administration indicates that funding limits set by local programs are a primary reason for the rise in requests for RCAW respite grants, as discussed later in this paper, since some families may seek assistance under the RCAW after they have exhausted their maximum annual AFSCP benefit.

15. By increasing the funding available, without changing eligibility limits, counties would be able to provide more aid to currently eligible individuals. [Alternative A2]

16. Finally, the Committee could take no action on this item and retain base funding for the program ($2,808,900 GPR). [Alternative A3]

Alzheimer's Training and Information Grants

17. In addition to increasing funding for AFCSP, the bill would provide $100,000 GPR

annually to increase funding available for Alzheimer's training and information grants.

18. As mentioned, the Wisconsin Alzheimer's Institute (WAI) currently receives the full amount available for training and information grants. According to WAI staff, the funding they currently receives supports faculty with expertise in dementia-related clinical, education and outreach endeavors who collaborate with a team to sustain and further develop programs that benefit Wisconsin residents and their families facing Alzheimer's disease and related disorders. The funding supports WAI staff with expertise in education of clinicians across a wide range of disciplines (including physicians, nurses, social workers, psychologists, occupational and physical therapists); program development and evaluation to improve access to quality dementia diagnostic and care services; and community-based dementia outreach and education in diverse communities across the state.

19. The Administration indicates that any eligible public agency or private nonprofit organization that meets the previously mentioned statutory requirements relating to training and the provision of information relating to Alzheimer's disease could apply in the next granting cycle.

20. The grant was established through 1995 Wisconsin Act 464 and was funded at $132,700 GPR annually. Subsequently, the grant was reduced to its current annual amount of $131,400 GPR through a one percent across the board reduction included in 2009 Wisconsin Act 28.

21. In light of the anticipated increase in the number of Wisconsinites diagnosed with Alzheimer's disease as the population continues to age, as well as the absence of additional funding for this purpose since the creation of the grant in the 1995 legislative session, the Committee could choose to provide $100,000 annually to increase funding available for Alzheimer's training and information grants. [Alternative B1]

22. Alternatively, the Committee could take no action on this item, which would retain base funding for the program ($131,400 GPR). [Alternative B2]

Respite Care Grants

23. The respite care grant program provides respite care services for caregivers, but unlike AFCSP, not exclusively to persons who care for individuals with Alzheimer's disease.

24. DHS is budgeted $350,000 GPR annually to fund the life-span respite care program, which currently operates under a contract between a non-profit agency, Respite Care Association of Wisconsin (RCAW), and DHS. AB 43/SB 70 would provide $200,000 GPR annually to increase funding for this contract.

25. As part of the life-span respite care program, RCAW administers the caregiver respite grant program (CRGP) and the supplemental respite grant program (SRGP), as well as a third grant program for recruitment, outreach, and education events.

26. CRGP offers respite care not covered by Medicaid or other programs that provide respite services, for example AFCSP, or once respite services under those programs have been exhausted. Applicants may hire family, friends, respite agency providers, or neighbors since RCAW does not

dictate who the primary caregiver hires to provide respite care. Applicants can reapply for CRGP within a timeframe set by RCAW as funds allow.

27. As with CRGP, RCAW's SRGP is the payer of last resort for primary caregivers or care recipients who cannot be served by other caregiver support programs or those who do not qualify for other caregiver support programs that assist with respite care. Applicants can receive up to $250 for supplemental supports such as emergency response systems, grab bars, home-delivered meals, housekeeping, laundry services, lawn care, snow removal, or transportation to meaningful or respite activities or medical appointments.

28. From the $350,000 contract, RCAW budgeted $57,000 for grant awards (consisting of the CRGP and SRGP discussed above and a third grant program for recruitment, outreach, and education events), $240,600 for staff salary and fringe, and the remaining $52,400 for a variety of other business expenses. The staff and business expenses support not only the administration of the three grant programs, but also the delivery of caregiver training, the maintenance of the respite care provider registry, and other activities included in the contract with DHS, as well as the activities conducted under the federal grant.

29. Despite an annual increase of $125,000 in the 2019-21 budget, funding has not kept pace with demand for respite grant services. Specifically, by early November, 2021, RCAW temporarily suspended new applications for both CRGP and SRGP grants as they had reached or exceeded the amounts the organization had budgeted for each program. At that time RCAW had awarded 43 CRGP grants in 2021-22 totaling $40,700 and awarded the full $6,000 budgeted for the SRGP.

30. Since both programs are relatively new, with CRGP created in 2019 and SRGP in 2021, it is likely that demand for services will continue to increase as more people become familiar with the programs and the services offered by RCAW. As such the Committee may choose to increase funding available for the life-span respite care program contract by $200,000 annually. [Alternative C1]

31. Alternatively, due to the relative newness of some of the grants funded by RCAW, the Committee could provide a smaller funding increase of $100,000 annually to ensure that demand for the programs exist prior to committing additional resources. [Alternative C2]

32. Finally, the Committee could take no action on this item, which would retain base funding for the program ($350,000 GPR). [Alternative C3]

ALTERNATIVES

A. Alzheimer's Family and Caregiver Support Program (AFCSP)

1. Provide $500,000 GPR annually and increase the maximum amount of funding the Department may provide under the Alzheimer's family and caregiver support program from $2,808,900 to $3,308,900 annually. Increase the maximum income eligibility limit for the program to $60,000 per year.

ALT A1	Change to Base
GPR	$1,000,000

2. Provide $500,000 GPR annually and increase the maximum amount of funding the Department may provide under the Alzheimer's family and caregiver support program from $2,808,900 to $3,308,900 annually.

ALT A2	Change to Base
GPR	$1,000,000

3. Take no action.

B. Alzheimer's Training and Information Grants

1. Provide $100,000 GPR annually to increase funding available for Alzheimer's training and information grants.

ALT B1	Change to Base
GPR	$200,000

2. Take no action.

C. Respite Care Grants

1. Provide $200,000 GPR annually to increase funding available for the life-span respite care program.

ALT C1	Change to Base
GPR	$400,000

2. Provide $100,000 GPR annually to increase funding available for the life-span respite care program.

ALT C2	Change to Base
GPR	$200,000

3. Take no action.

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HEALTH SERVICES

Services for the Elderly and People with Disabilities

LFB Summary Item for Which No Issue Paper Has Been Prepared

Item #	Title
12	Guardianship Training