

Governor’s Task Force on Caregiving: Draft Policy Proposals for Consideration by the Task Force on September 10, 2020

September 1, 2020

Table of Contents

Family Caregiving Proposals	2
One-year Pilot of the Caregiver Screening/Assessment tool, TCARE.....	2
Aging and Disability Resource Center (ADRC) Reinvestment	7
Legislative Change: Family Medical Leave Act Amendments.....	10
Legislative Change: WI Credit for Caring (The Caregiver Tax Credit)	13
Legislative Change: The Care Act	16
Direct Care Workforce Proposals: Rates.....	20
Rates Band Proposal.....	20
Nursing Home and Personal Care Payment Reform.....	23
Medical Loss Ratio.....	27
Direct Care Worker Fund.....	30
Direct Care Workforce Proposals: Benefits	33
Medicaid Expansion.....	33
Earnings Disregard.....	39
Direct Care Workforce Proposals: Untapped Workers	44
State-Wide Direct Support Professional Training.....	44
Recognition and Recruitment of Direct Support Professionals.....	52
Background Check Policies	55
Medicaid Provider Regulatory Guidelines.....	60
Home Care Provider Registry:.....	65
Home Care Provider Registry Recommendation	65

Family Caregiving Proposals

One-year Pilot of the Caregiver Screening/Assessment tool, TCARE

Policy Title: One-year Pilot of the Caregiver Screening/Assessment tool, TCARE

Primary Contact for the Proposal: Lisa Pugh & Jane Mahoney

Other Members Who Worked on the Proposal: Sue Rosa

Brief Description, with Bullets Showing the Specific Components of the Policy: One-year Pilot of the Caregiver Screening/Assessment tool, TCARE

- Description of TCARE and How It Works
 - Tailored Caregiver Assessment and Referral (TCARE) is an evidence-based care management protocol designed to support family members who are providing care to adults of any age with chronic or acute health conditions. (TCARE may also be called a family caregiver survey.) It includes both a Pre-Screening Tool and a full Assessment that asks questions of the family or informal caregiver in order to assess their health and well-being, stress levels, challenges, skills needed to perform care, informal support system and strengths that enable them to provide care. (https://acl.gov/sites/default/files/programs/2017-03/Tailored_Caregiver_Assessment_and_Referral_ISR_08_20-2014.pdf)
 - The Pre-screening Tool is available to any community agency that interacts with family caregivers and is used to identify high-risk caregivers who are then referred for a full TCARE Assessment.
 - The Assessment is then completed by staff who are trained and licensed by TCARE. The Assessment produces a list of recommended services tailored to meet the specific needs and preferences of the caregiver. The Assessment is repeated at three-month intervals in order to adjust the care plan as appropriate.
 - The caregiver is then referred to appropriate caregiver supports such as, for example, NFCSP, AFCSP, and ADRC programs.
 - This two-step process helps prioritize limited caregiver support resources so that they are available to those caregivers with the greatest need.
- Implementation of the pilot program
 - DHS will seek applications to participate in the TCARE Pilot program from a consortium of provider agencies. The pilot will include 3-6 consortiums from both urban and rural areas. DHS should support and encourage the development of consortiums in areas with the greatest need.
 - Each consortium must include both a Medicaid and a non-Medicaid agency in order to allow for data collection and assessment of TCARE success in both. Agencies such as ADRCs, MCOs, IRIS consultant agencies, tribal and county aging units,

independent living centers, and health care organizations are seen as potential partners.

- Participation on the part of caregivers is voluntary.
- When the TCARE assessment is used, it will replace other caregiver needs assessments currently being used to avoid any duplication.
- This proposal covers the cost of training and licensing 25 people to be TCARE Assessors, a minimum set by TCARE.

- Evaluation

- Data will be collected and analyzed prior to and at the end of the pilot period to determine success of the program.
- Measures of success will include an increase in the number and diversity of caregivers referred to supportive services, particularly in underserved areas; delay of nursing home placement and related Medicaid cost reductions; decrease in the number of emergency calls and reduced requests by caregivers for crisis services; documented reduction of caregiver reports of stress/depression; increase in use of less costly caregiver support services.

Analysis -- Describe the Following Items in as Much Detail as Possible:

- Anticipated benefits:

- Caregivers who are supported with resources specific to their needs will be able to provide care for a longer period of time, delaying placement of their loved one in a LTC facility. ([Effects of the TCARE® Intervention on Caregiver Burden and Depressive Symptoms](#))
- One research study has shown an 18-24 month delay of placement in a long-term care facility that resulted in a 20% reduction in Medicaid Services. The same study also showed an 84% reduction in stress/depression among caregivers within 6 months.
- The Family Caregiving Alliance National Center on Caregiving reports that , the assessment process itself is beneficial to caregivers in that they feel their needs are heard, taken seriously, and attended to. ([The State of the Art: Caregiver Assessment in Practice Settings, Lynn Friss Feinberg, MSW - September 2002](#))
- An anticipated benefit is a decrease in the number of emergency calls from families in crisis.
- Results from two randomized, longitudinal studies conducted with 20 organizations in four states have shown that the TCARE® lowers intentions to leave the caregiving role, among other benefits. ([Effects of the TCARE® Intervention on Caregiver Burden and Depressive Symptoms](#))

- Health Equity/Disparities considerations:
 - TCARE is currently being used within tribal nations (most recently on the Seneca Nation in New York) and has been translated into Spanish, Vietnamese, Chinese, Mandarin, Cantonese, French and Korean.
 - TCARE was developed with cultural sensitivity in mind and the developers have told us they are willing to address issues that may arise when using the tool with any specific population.
 - Caregiving affects women and non-white populations disproportionately:
 - According to AARP's Caregiving in the U.S. 2020 report, three in 5 caregivers are women (61 percent) and 2 in 5 are men (39 percent).
 - AARP reports that nationally, the growth in caring for an adult relative is up markedly among African American caregivers (88 percent compared to 77 percent in 2015) and Hispanic caregivers (92 percent vs. 85 percent in 2015).
 - AARP reports that African American caregivers are providing more hours of care each week (31.2 hours on average) than either White (21.2 hours) or Asian American (24.1) caregivers. Hispanic caregivers provide 26.0 hours of care weekly (significantly more than White caregivers).
 - According to the 2016-2018 Family Health Survey, 85.4% of caregivers in Wisconsin were White, 6.8% Black, 3.8% Hispanic, 1.7% American Indian with the remaining 2.3% other races. AARP data analysts have estimated that in Wisconsin, 87% of caregivers as non-Hispanic White; 7% non-Hispanic Black; 3% Hispanic; 3% other/multiple races. Their findings also showed that the rate of caregiving in the Black population is higher than the White population (27% vs 18%, statistically significant).
 - We know from anecdotal evidence and interviews that some African-American caregivers feel invisible and that their opinions are not valued when interacting with healthcare professionals. They feel they must prove themselves in order to be taken seriously as reliable, trustworthy, and capable caregivers. ([Panel Discussion: Impact of Systemic Racism During a Personal Caregiving Experience - Denise Brown](#)) A structured, comprehensive assessment of caregiver needs could go a long way in helping to ensure a better experience for all caregivers and increase the chances that their needs are met.
 - Consortia will be located in areas serving rural and underserved populations. DHS will support and encourage the development of consortia in areas with the greatest need.
- Potential funding options/cost savings/benefits
 - Some states have used federal CARES Act funding to invest in caregiver assessments; ADRC reinvestment fund proposal includes caregiver support and assessment enhancements, and if adopted, would be a source of funds to support the

TCARE Pilot. Current staff supporting caregivers should be redirected to this role in pilot counties.

- A pilot study involving 2300 people in Washington state serving 2,300 people showed the implementation of the TCARE assessment contributed to a 20% reduction in Medicaid Services which equates to \$10 million savings. ([Has the use of Tailored Caregiver Assessment and Referral® System Impacted the Well-being of Caregivers in Washington? Report to the Washington Aging and Long-Term Support Administration, May 2014 - Rhonda J.V. Montgomery, PH.D](#))

A 2010 study in Georgia indicated that use of the TCARE® tool by care managers or a family specialist could simultaneously promote the well-being of the family caregivers and efficient use of scarce resources. ([Effects of the TCARE® Intervention on Caregiver Burden and Depressive Symptoms](#))

- Cost Estimates
 - One-time implementation fee: \$10,000
 - Licenses for a minimum of 25 trained staff to carry out assessments: \$50,000 (\$2,000/license) per year.
 - Additional DHS staff time would be needed to manage the project and support coordination with TCARE and pilot-agency staff. DHS should be encouraged to look across all Task Force recommendations impacting caregivers and the direct care workforce for additional ways to utilize this staff person in implementing recommendations in order to maximize utilization of this new position. LTE contractors could be used to save funds.
 - Staff at the local level could be diverted from using current family caregiver assessments or include the TCARE family caregiver assessment as part of their typical care management practices.
 - It is possible that proper implementation of the pilot project would include some base infrastructure funding for pilot agencies to complete data collection and participate in project evaluation
- State agency or other entity responsible for implementing the proposal, if it were approved (e.g. DHS, DWD):
 - The Department of Health Services (DHS) would administer the pilot program. Agencies that would be encouraged to apply include ADRCs, MCOs, Aging Units, IRIS agencies, tribal agencies, and health care providers.
- Public Input
 - Strong public support was found for this proposal: 83% of those responding to a survey indicated support for this proposal with almost 80% of family caregivers showing support.

- Respondents felt that caregivers should have the option to participate in the pilot, and that the pre-screen should not duplicate other screenings. Both issues have been addressed in this proposal.
- Respondents commented on the importance of having resources available to caregivers after they are screened. The implementation fee includes resource mapping and will be an important method of identifying available resources as well as detecting gaps in caregiver supports. The resource mapping itself will be beneficial to caregivers and providers across the state.

Aging and Disability Resource Center (ADRC) Reinvestment

Policy Title: ADRC Reinvestment

Primary Contact for the Proposal: Lisa Pugh

Other Members Who Worked on the Proposal: Jane Mahoney, Sue Rosa

Brief Description, with Bullets Showing the Specific Components of the Policy:

Support additional investment in ADRCs to provide increased attention to and support for family/informal caregivers. Currently there are only programs for caregivers of older people and people with dementia. This funding would make services and supports available to all caregivers including caregivers of adults age 19-59. Specific components of the proposal include:

- Expand caregiver support services to include and address the needs of caregivers of adults age 19-59 with disabilities by providing the same resources and services that are provided by the National Family Caregiver Support Program:
 - **Respite care** (in-home or facility-based)
 - **Supplemental services** - adaptive equipment, assistive technology, home modifications, transportation, and other resources or supplies necessary to care for the person in their home
 - **Support groups, counseling and training** to help caregivers in solving problems related to their caregiver role
 - **Information to caregivers about available services** (marketing and outreach)
 - **Assistance to caregivers in gaining access to services** (limited case management)
- Every ADRC will designate a specific “Caregiver Coordinator” to manage caregiver program funds.
 - The Caregiver Coordinator should ideally manage NFCSP and AFCSP funding as well. If a different agency holds those funds, every effort must be made to coordinate with that agency.
 - The Caregiver Coordinator must maintain close communication with the Dementia Care Specialist.
- ADRCs will be required through their contract to create a marketing plan to increase knowledge of Caregiver and other programs at the ADRC and measure impact, particularly within underserved communities.
- The ADRC would determine how to use the additional funds to meet the requirements above, utilizing other sources of funding (local funds, partner agencies, etc.) whenever possible.

Analysis -- Describe the Following Items in as Much Detail as Possible:

- Anticipated benefits:
 - More caregivers will be served by expanding services to caregivers of all adults, not just those age 60+.
 - A designated staff person will manage the caregiving program, ensuring more complete support is offered.
 - Emphasis on coordination of all caregiver support programs will increase efficiency and reduce duplication of services

- Health Equity/Disparities considerations:
 - Caregiver supports will be made available to all caregivers. ADRCs will be required to demonstrate connections and outreach partnerships with agencies supporting underserved populations and to coordinate the development of outreach and marketing materials with these agencies. ADRCs will also be required to partner with these agencies in training and other activities that ensure cultural sensitivity in service provision.
 - Cultural competency training of ADRC staff working with caregivers should be required as part of the ADRC contract.
 - Analysis of data collected from ADRCs will be used to direct the implementation of improvements to ensure transparency around disparities/in-equities.

- Potential funding options/cost savings/benefits:
 - According to a report published in 2016, help staying in the home is the main issue of concern for one in four ADRC customers (24.6%). Data collected in 2016 concluded that Wisconsin ADRCs help prevent or delay entry into Medicaid long-term care programs. In a 2015 customer satisfaction report almost one in three respondents (29.6%) said that the ADRC helped them stay in their home when they might otherwise have gone to a nursing home or assisted living facility, which costs considerably more. Often caregivers provide critical support to a person with a disability or older adult that ensures care in the home can continue. (<https://www.dhs.wisconsin.gov/non-dhs/dph/cust-srvc-satis2008-2015.pdf>)
 - Expanded ADRC marketing efforts are essential to reach and support caregivers: The ADRC Customer Satisfaction report from 2015 shows a majority of customers first heard of the ADRC through word of mouth and were facing a pressing concern or emergency. Expanded marketing efforts will save money by convincing customers to request help sooner. (<https://www.dhs.wisconsin.gov/non-dhs/dph/cust-srvc-satis2008-2015.pdf>)
 - When ADRCs partner with outside agencies to provide required services, not only are there cost savings, but these partnerships also expand outreach to more caregivers. For example, a health care organization might facilitate a caregiver training class or support group and the local Independent Living Center could offer adaptive equipment.

- Providing support such as respite, adaptive equipment, support groups and training prevents or delays long term care placement. Connecting caregivers with services before a crisis also reduces the need for more expensive emergency supports.
(https://www.dshs.wa.gov/sites/default/files/AL TSA/stakeholders/documents/Washington%20Report_May%202014_Montgomery.pdf)
- Because caregivers and those they care for are a high-risk population impacted by the pandemic, CARES Act and other federal COVID-19 funding to support caregiver outreach and improvement should be tapped.
- Cost estimates:
 - Caregiver support enhancement is estimated to cost \$4M, including support for tribes. These funds shall ensure all services listed above are provided including a designated Caregiver Coordinator staff person and marketing plan. Efforts should be made to distribute these funds equitably throughout the state.
- State agency or other entity responsible for implementing the proposal, if it were approved (e.g. DHS, DWD):
 - DHS, ORCD
- Public Input:
 - 70.8% of respondents to the Task Force public input survey strongly support the proposal.
 - In response to comments in the public input survey, the following items have been added to this proposal:
 - a marketing plan to increase awareness of the ADRC and its programs,
 - cultural competency training for ADRC staff, and
 - emphasis on distributing funds equitably throughout the state.

Legislative Change: Family Medical Leave Act Amendments

Policy Title: Family Medical Leave Act Amendments

Primary Contact for the Proposal: Helen Marks Dicks hmdicks@aarp.org

Other Members Who Worked on the Proposal:

Susan Rosa sue.rosa6744@gmail.com

Kathy Bernier sen.bernier@legis.wisconsin.gov

Deb Kolste Debra.Kolste@legis.wisconsin.gov

Brief Description, with Bullets Showing the Specific Components of the Policy:

- Expand the coverage in the Wisconsin Family Medical Leave act to include chronic conditions and caregiving responsibilities. Currently the law covers serious health conditions under the care of the physician which typically addresses only acute conditions.
- Expand the list of people covered to include grandparents, grandchildren and siblings.
- Expand the examples of how care can be used to include attending training and education on caregiving duties and responsibilities, discharge planning meetings, and care planning meetings.

Under current law, an employer that employs at least 50 individuals on a permanent basis in this state is required to allow an employee who has been employed by the employer for more than 52 consecutive weeks and who has worked for the employer for at least 1,000 hours during the preceding 52 weeks to take the following: (a) six weeks of family leave in a 12-month period for the birth or adoptive placement of a child; (b) two weeks of family leave in a 12-month period to care for the employee's child, spouse, domestic partner, or parent with a serious health condition; and (c) two weeks of medical leave in a 12-month period when the employee has a serious health condition that makes the employee unable to perform the employee's employment duties.

Analysis -- Describe the Following Items in as Much Detail as Possible:

Anticipated benefits:

This expanded FMLA policy would benefit working family caregivers by ensuring they can attend the necessary meetings and interactions with health care providers that are essential for them to continue to provide care to a loved one. Population trends indicate there are additional groups of people who now require leave flexibilities from their employment while they serve as a main caregiver. While some employers do allow for caregiving leave for chronic conditions, many do not, and this would clarify that coverage and ensure that more employers allow it.

- According to a 2020 AARP report, sixty-one percent of caregivers were employed at some point in the last year.¹
- Six in 10 employed caregivers work full time (60 percent) and another 15 percent work between 30 and 39 hours. One in 4 caregivers work fewer than 30 hours a week. On average, employed caregivers work 35.7 hours a week
- According to 2017 data 28,000 (2%) children in Wisconsin are living with a relative with no parent present.²
- 74,457 (5.7%) of children under 18 are living in homes where householders were headed by grandparents or other relatives.
- 26,895 of Wisconsin grandparents are householders responsible for their grandchildren who live with them; 63.9% of these grandparents are in the workforce and 18.1% are in poverty.
- An increasing number of siblings of adults with intellectual and developmental disabilities are taking on care responsibilities for their brothers and sisters as their parents age. In Wisconsin currently, 64% of people with intellectual and developmental disabilities in Wisconsin live with family and 25% of these family caregivers (typically parents) are over 60 years old.³
- In the United States, over 5 million people have assumed – or expect to assume – responsibility for a dependent sibling, and that number is growing as baby boomers age.⁴
- Health Equity/Disparities considerations:
 - Men are more often employed while caregiving (67 percent vs. 58 percent women) and, on average, they work more hours per week (38.7) than do women caregivers who are employed (33.5).⁵
 - Younger caregivers more often work while providing care and work more hours weekly, on average: 72 percent of caregivers ages 18 to 49 work (36.1 hours weekly) and 67 percent of those ages 50 to 64 work (37.0 hours weekly), compared to just 24 percent of those ages 65 and older who work, reporting 26.4 hours of work weekly.
 - Caregivers who live together with their care recipient less often report working (54 percent vs. 67 percent of those not co-residing).
 - Of the 26,895 Wisconsin grandparents who were providing care to their grandchildren in 2017, 66.3% were white; 17.9% were black; 9.0% were Hispanic or Latino; 4 % were American Indian and 1.6% were Asian.

¹ <https://www.aarp.org/content/dam/aarp/ppi/2020/05/full-report-caregiving-in-the-united-states.doi.10.26419-2Fppi.00103.001.pdf>

² <https://www.grandfamilies.org/Portals/0/State%20Fact%20Sheets/Grandfamilies-Fact-Sheet-Wisconsin.pdf>

³ Tanis, E.S., Lulinski, A. & Wu, J., Braddock, D. & Hemp, R. (2020). The State of the States in Intellectual and Developmental Disabilities, Department of Psychiatry, University of Colorado. www.stateofthestates.org

⁴ <https://wisconsibs.org/who-we-serve/adult-siblings/>

⁵ <https://www.aarp.org/content/dam/aarp/ppi/2020/05/full-report-caregiving-in-the-united-states.doi.10.26419-2Fppi.00103.001.pdf>

Potential funding options/cost savings/benefits: There is no additional governmental funding needed.

Expanded FMLA policies can sustain a qualified workforce by allowing caregivers the relief they need to keep employment.

- Cost estimates: No additional cost to the state
- State agency or other entity responsible for implementing the proposal, if it were approved (e.g. DHS, DWD):

DWD

- Public Input: In the survey the FMLA expansion proposal received high support: 82% strongly support with another 10 % somewhat supporting it. There were two areas of concern expressed in both the comments at the public hearing and in the survey. One was that the benefit is too meager and should be for more time and pay. The other was **that** this would be too burdensome for small businesses. The proposal was not changed for either of these concerns because (1) most small businesses are not covered by the current WI FMLA and (2) the Task Force group viewed this expansion as a parity issue making caregiving for chronic conditions equal to the benefit for caring for someone with an acute health issue. In addition, Wisconsin population changes indicate the growth in kinship care, including the increasing number of grandparents caring for grandchildren. This updated FMLA policy addresses these trends.

Legislative Change: WI Credit for Caring (The Caregiver Tax Credit)

Policy Title: Wisconsin Credit for Caring (The Caregiver Tax Credit) 2019-2020 legislative session bill SB 126/ AB 126

<https://docs.legis.wisconsin.gov/2019/proposals/sb126>

Primary Contact for the Proposal: Helen Marks Dicks hmdicks@aarp.org

Other Members Who Worked on the Proposal:

Susan Rosa sue.rosa6744@gmail.com

Kathy Bernier sen.bernier@legis.wisconsin.gov

Deb Kolste Debra.Kolste@legis.wisconsin.gov

Brief Description, with Bullets Showing the Specific Components of the Policy:

The AARP publication *Valuing the Invaluable* shows that the average caregiver spends \$7,000 of their own money annually providing care for family members. For those taking care of family long distance, the money spent is approximately \$14,000. ⁶

- This proposal supports legislation to create a nonrefundable individual income tax credit for qualified expenses incurred by a family caregiver to assist a qualified family member. To be qualified, a family member must be at least 18 years of age, must require assistance with one or more daily living activities as certified by a physician and must be the claimant's spouse or related to the claimant. This proposal was previously introduced as legislation in the 2019-2020 legislative session as SB 126/AB 126.
- Subject to a number of limitations, a claimant may claim 50 percent of the costs of qualified expenses the claimant paid for in the year to which the claim relates. These expenses include amounts spent to improve the claimant's primary residence to assist the family member, equipment to help the family member with daily living activities, and obtaining other goods or services to help the claimant care for the family member.
- The maximum amount of credit that may be claimed each year for a particular family member is \$1,000 or \$500 if married spouses file separately. If more than one claimant may file a claim related to that family member, the amount of credit each may claim is based on the percentage of the family member's qualified expenses for which each claimant paid during the year. No credit may be claimed by a claimant whose Wisconsin adjusted gross income in the year to which the claim relates exceeds \$75,000 if the claimant is single or \$150,000 if the claimant is married and files jointly.
- Generally, in this proposal, qualified expenses may not include general food, clothing, transportation, or household repair costs, or amounts that are paid or reimbursed by an insurance company or the government.
- Because the credit is nonrefundable, it may be claimed only up to the amount of the claimant's tax liability.

⁶ <https://www.aarp.org/ppi/info-2015/valuing-the-invaluable-2015-update.html>

Analysis -- Describe the Following Items in as Much Detail as Possible:

Anticipated benefits:

- This proposed bill would give some financial relief to family caregivers who are incurring expenses in keeping their loved ones in the community and out of institutions. Family caregivers often spend their own personal savings and forego their own employment income to provide care.
- This proposal was first introduced as a bill in the 2019-2020 legislative session. The bill's sponsors expressed the hope that in the long run it would reduce the number of people reliant on Medicaid and keep people out of government funded programs for as long as possible. Medicaid payments, particularly institutional care, is very expensive and avoiding or even delaying institutional care would save the program significant money. While there are many variations on how the Medicaid rate for nursing homes is set, the average monthly rate per person is \$5,212.
- Supporting family caregivers to meet caregiving costs can ensure family caregivers themselves remain healthy and have the funds they need to retire. Survey data show that nationally 1 in 6 family caregivers have reduced the money they set aside for retirement, 1 in 7 have spent less on their own health care, more than 1 in 10 have gone into their retirement savings and another 1 in 10 have taken out a loan.⁷

Health Equity/Disparities considerations:

- Available estimates suggest that the race/ethnicity background of Wisconsin caregivers is:

87% non-Hispanic White

7% non-Hispanic Black

3% Hispanic

3% other/multiple races

- The rate of caregiving in the Black population is higher than the White population (27% vs 18%, statistically significant).
- AARP Public Policy Institute statistics show the following income distribution for Wisconsin caregivers:
 - 150,000 under \$25k/year
 - 150,000 \$25-\$50k/year
 - 100,000 \$50-\$75k/year
 - 150,000 more than \$75k/year
 - 50,000 don't know/refused

⁷ <https://www.khi.org/assets/uploads/news/14680/family-caregiving-cost-survey-res-ltc.pdf>

- Potential funding options/cost savings/benefits:

This proposal is a revenue loss not a savings. However long term return on investment would eventually significantly reduce Medicaid costs. Nursing home annual payment by Medicaid at an estimated \$62,539 is much greater per care recipient than the \$1,000 tax credit paid to the caregiver.

Cost estimates:

When legislation was introduced, the Department of Revenue (DOR) estimated a \$125M revenue loss.

State agency or other entity responsible for implementing the proposal, if it were approved (e.g. DHS, DWD):

DOR

Public Input:

- In the Task Force survey this proposal received 66% strong support and 24% somewhat support. Concerns have been expressed that in this time of anticipated budget shortfalls that this is a significant revenue loss. However the charge of the task force is to address the issues of caregiving and while this proposal may not be immediately feasible in the next budget, the long term benefits to both the caregiver and the return on investment for the state are too great to not advance this proposal.
- In an AARP 2019 survey, about nine in ten Wisconsin registered voters age 40 and older support the provision of a state income tax credit to family caregivers who incur expenses for the care and support of a family member living in Wisconsin.⁸
- When this proposal was advanced as legislation in the 2019/2020 session, the following organizations registered their support (no organizations registered opposition):
 - AARP
 - Alzheimer's Association
 - American Heart Association
 - Coalition of Wisconsin Aging Groups
 - Greater Wisconsin Agency on Aging Resources
 - Home Care Association of America
 - The Arc Wisconsin
 - Wisconsin Association of Local Health Departments and Boards
 - Wisconsin Coalition of Independent Living Centers, Inc.
 - Wisconsin Nurses Association
 - Wisconsin Public Health Association

⁸ https://www.aarp.org/content/dam/aarp/research/surveys_statistics/ltc/2019/wisconsin-caregiving-survey-caregiver-tax-credit.doi.10.26419-2Fres.00259.092.pdf

Legislative Change: The Care Act

Policy Title: The CARE Act (2019-20 Legislative session SB 516/AB584)
(<https://docs.legis.wisconsin.gov/2019/proposals/sb516>)

Primary Contact for the Proposal:

Helen Marks Dicks hmdicks@aarp.org

Other Members Who Worked on the Proposal:

Susan Rosa sue.rosa6744@gmail.com

Kathy Bernier sen.bernier@legis.wisconsin.gov

Deb Kolste Debra.Kolste@legis.wisconsin.gov

Brief Description, with Bullets Showing the Specific Components of the Policy:

This proposal is modeled after legislation introduced in the 2019-20 legislative session as SB 516/AB 584 and would:

- Ensure that a family caregiver is recorded when a loved one is admitted to the hospital.
- Ensure that the caregiver is notified if a loved one is transferred to another facility or discharged back home.
- Ensure that a facility provides an explanation and live instructions on medical tasks caregivers are expected to perform.

Analysis -- Describe the Following Items in as Much Detail as Possible:

Anticipated benefits:

- In a 2019 AARP Wisconsin survey of Wisconsin voters age 40+, 76% of responding caregivers said their loved one had been admitted to the hospital while under their care; 34% of these current or former caregivers said they had not received education or instructions on the follow-up medical tasks and care for their loved one during the hospital discharge process, even though these were tasks they would need to perform at home.
- Because this legislation would require hospitals upon discharge to provide the training and education in medical/nursing duties that the caregiver is expected to perform after discharge, there would be better follow-up care provided by the caregiver.
- This bill should reduce hospital readmissions. Caregivers caring for a recently hospitalized son, for example, who requires more complex care may be at higher-risk for LTC placement outside the home and therefore, could benefit from supports that have been shown to help delay placement.
- The more hours of care a caregiver provides, the more often they help with medical/nursing tasks: 84 percent of caregivers who provide 21 or more hours of care weekly are helping with medical/nursing tasks (compared to 45 percent of those providing 20 or fewer hours of care). A similar pattern emerges for the level of care

index, where caregivers in higher-intensity situations more often do medical/nursing tasks.⁹ Supporting high-hour caregivers in their roles is essential to sustain their ability to provide care.

- This proposal will reduce caregiver stress. Caregivers report that one source of stress is not feeling adequately trained/prepared to carry out nursing/medical tasks, indicating the need for more support with instruction.¹⁰
- How hospitals communicate with caregivers is becoming more important as the population ages, people with disabilities live longer and the number of unpaid family caregivers increases. An estimated 44 million Americans have cared for a relative in the past year.¹¹

- **Health Equity/Disparities considerations:**
 - In 2016, 85.4% of caregivers in Wisconsin were White, 6.8% Black, 3.8% Hispanic, 1.7% American Indian with the remaining 2.3% other races.
 - According to AARP's Caregiving in the U.S. 2020 report, three in 5 caregivers are women (61 percent) and 2 in 5 are men (39 percent). Six in 10 caregivers report being non-Hispanic White (61 percent), 17 percent are Hispanic or Latino, 14 percent non-Hispanic African American or Black, 5 percent Asian American and Pacific Islander, and 3 percent some other race/ethnicity, including multiracial.¹²
 - Nationally, the growth in caring for an adult relative is up markedly among African American caregivers (88 percent compared to 77 percent in 2015) and Hispanic caregivers (92 percent vs. 85 percent in 2015).
 - AARP reports that African American caregivers are providing more hours of care each week (31.2 hours on average) than either White (21.2 hours) or Asian American (24.1) caregivers. Hispanic caregivers provide 26.0 hours of care weekly (significantly more than White caregivers).
 - 58% of Caregivers (6 in 10) assists with Medical/Nursing tasks. African American and Hispanic caregivers (67%0 often help with medical/nursing tasks than do White caregivers (52%)
 - Those caring for a spouse/partner more often help with medical/nursing tasks (72 percent) than all other caregivers (56 percent). Similarly, caregivers who live with their recipient more often help with medical/nursing tasks (70 percent) than those who do not live together (49 percent).

⁹ <https://www.aarp.org/content/dam/aarp/ppi/2019/04/home-alone-revisited-family-caregivers-providing-complex-care.pdf>

¹⁰ <https://healthjournalism.org/blog/2019/07/report-caregivers-tackling-complex-medical-tasks-with-little-training/>

¹¹ <https://www.cdc.gov/aging/agingdata/docs/caregiver-brief-508.pdf>

¹² <https://www.aarp.org/content/dam/aarp/ppi/2020/05/full-report-caregiving-in-the-united-states.doi.10.26419-2Fppi.00103.001.pdf>

- Caregivers of recipients who live in a rural area more often report helping with medical/nursing tasks (62 percent vs. 56 percent of those caring for someone living in a non-rural area).
- Hospitalization is more common when the care recipient is age 50 or older (50 percent vs. 37 percent when recipient is 18 to 49).
- Caregivers in higher-intensity care situations more often report their recipient has been hospitalized (56 percent medium-to-high intensity vs. 38 percent low intensity). Similarly, those providing 21 or more hours of care each week more often report their recipient has been hospitalized (56 percent vs. 44 percent of those who provide care for 20 hours or less each week).
- The CARE Act has been implemented in over 40 states and the implementation studies show wide support. Both by caregivers and hospitals.

- Potential funding options/cost savings/benefits:

There would be no cost to the state taxpayers. No state funding is needed.

- Cost estimates:

There would be no cost to the state taxpayers. As for increased cost for hospitals, it is difficult to gauge and is outside the purview of the Task Force. In those hospitals where this type of caregiver identification and education is currently being provided there should be no additional cost. For those where it is not, the costs to the hospitals are most likely offset by the reduction in readmissions.

- State agency or other entity responsible for implementing the proposal, if it were approved (e.g. DHS, DWD):

DHS

- Public Input:

During the last legislative session, the Wisconsin Hospital Association (WHA) opposed the CARE Act legislation. Task Force members invited WHA to formally present their concerns on May 6. A panel from WHA highlighted the best practice work of one major Milwaukee Hospital system to incorporate caregivers in the hospital experience of the care recipient. WHA also provided data from a CMS survey of patient satisfaction which showed that Wisconsin hospitals ranked high, this year ranking number 1, in providing discharge instructions to patients. Unfortunately, this data did not address the questions and concerns of a designated caregiver. The WHA satisfaction survey data tracked the provision of written instructions to the care recipient but did not address caregiver concerns about their ability to perform complex medical and other care tasks post-discharge nor the desire expressed by caregivers for hands on task demonstrations.

While WHA also contended that implementation of new discharge planning requirements would be expensive, Task Force members suggest that incorporating this additional and

necessary conversation with a designated caregiver is essential to prevent costly re-admissions and to delay placements in other institution settings.

In both the public hearing and the public input survey the CARE Act proposal received wide support with 470 providing their feedback. In the survey 77% registered strong support with 13% Somewhat Support. Of the nearly 200 caregivers or family members who responded to this question in the public input survey, more than 90% indicated support for this proposal.

Direct Care Workforce Proposals: Rates

Rates Band Proposal

Policy Title: Rates

Primary Contact and Names of Other Members Who Worked on the Proposal:

Beth Swedeen, John Sauer, Margie Steinhoff, Ted Behnke, Bill Crowley, Lisa Pugh, Todd Costello

Brief Description, with Bullets Showing the Specific Components of the Policy

1. DHS should develop and implement by December 2023 a statewide minimum rate band based on a **comprehensive and transparent rate evaluation** that results in transparent, equitable and sustainable rates for home and community-based long-term care supports. The new rate bands system:

- a. starts with evaluating and establishing equitable and sustainable direct support professional wages,
- b. is transparent and consistent across programs and settings;
- c. has built-in increases based on Consumer Price Index (CPI) annually,
- d. is developed with a workgroup comprised of providers and an independent outside entity with expertise in rate analysis across the spectrum of service categories from the beginning;
- e. includes a tiered system to recognize acuity levels/complexity of care that reflects the needs of the participant in a consistent, quantifiable and transparent process;
- f. holds harmless existing provider rates;
- g. develops a process for identifying cost outliers; and
- h. is in compliance with CMS rate band guidance.¹³

DHS must direct actuaries to reflect the realities of a new provider rate system. DHS must also direct the IRIS consulting agencies to reflect the realities of a new provider rate system in their usual and customary parameters. Statewide public comments must be gathered and considered before a final rate band is established. Minimum rate bands must incorporate certificate/tier training completion of direct support professionals (DSPs), resulting in higher wages for DSPs with advanced training.

2. In the interim years of 2021 and 2022, direct care provider agencies with direct support professionals whose wage categories are less than \$15/hour (personal care, supportive home care, residential and day-program supports, pre-vocational and vocational support workers) receive an 8% increase per year to reflect recognition of wage stagnation experienced by all WI low-wage earners during the past 20 years, and the essential nature of work performed by direct

¹³ “CLTS Waiver Program Service Rates Initiative.” *Wisconsin Department of Health Services*, 1 July 2020, www.dhs.wisconsin.gov/hcbs/ratestructure.htm.

support professionals. All providers should be able to demonstrate how this rate increase directly benefits direct support professional wages.¹⁴

Analysis -- Describe the Following Items in as Much Detail as Possible:

1. Anticipated benefits: how will this help benefit family caregivers, the paid direct care workforce, and people needing care in WI?

Establishing a consistent, transparent statewide rate band that starts with direct support professional wages, incentivizes additional training/service years, and recognizes the inadequacies of existing wages increases the likelihood that the direct support professional is adequately compensated; that the provider network is adequately compensated; that the rates reflect current costs; that less time is invested in rate negotiations; that consistency across the state and across providers is established; and that increasing costs (CPI) are built in so that rates do not become stagnant. It avoids the current “look back” model that becomes a self-fulfilling prophecy of inadequate rates based on the past. This benefits the direct support professional with an adequate wage, the provider network by ensuring robust business models, ensures transparency to the care recipient and to taxpayers with a publicly-accessible set of rates; and increases the likelihood that people needing care have an adequate network of adequately compensated providers.

In 2017 the Government Accountability Office issued a report on the need for improved oversight in rates paid for long-term services and supports:

<https://www.gao.gov/assets/690/681946.pdf> Their report identified the need for rates to take workforce dynamics into account, noting that the payment rates set by MCOs to community-based providers, such as home care workers, could have an impact on access to services. CMS issued an informational bulletin in August 2016 that encouraged states to be mindful of the relationship between access to care and wages for the Medicaid home care workforce. In its [2016 Bulletin](#) “Suggested Approaches for Strengthening and Stabilizing the Medicaid Home Care Workforce” – the Center for Medicare and Medicaid Services (CMS) said: “Wages paid to individual workers are often slow to be adjusted in response to inflation and economic growth, and can lag behind wage increases in other health and service sectors. Analyses of how the home care industry relates to the larger marketplace within a state are encouraged when states establish rate-setting methodologies to providers, and when providers determine the wage structure for their employees.”

2. Potential funding options/cost savings/benefits.

¹⁴ Walther, Anna. “Declining Returns to Low-Wage Work in Wisconsin.” *INSTITUTE FOR RESEARCH ON POVERTY*, University of Wisconsin–Madison, Sept. 2019, <https://www.irp.wisc.edu/resource/declining-returns-to-low-wage-work-in-wisconsin/>.

[4] S. Baron. State of the States Report 2014: Local Momentum for National Change to Cut Poverty and Inequality. Center for American Progress Fund, December 2014; T. M. Smeeding and K. A Thornton. Wisconsin Poverty Report: Treading Water in 2017. Institute for Research on Poverty, University of Wisconsin–Madison, June 2019.

Benefits exist through the likelihood of ensuring an adequate provider network, increasingly the health and safety of people needing care and avoiding costly health care crises that occur when care networks are inadequate.

3. What state agency or other entity would be responsible for implementing the proposal, if it were approved? (e.g. DHS, DWD)

DHS and an independent, third-party rate evaluation contractor/service.

4. Cost estimates:

DHS will need funds to increase contractual services for a. actuarial re-adjustment; to perform a comprehensive, independent and market-driven rate analysis of the existing system; and c. to determine what increased investment in rates is necessary to achieve an accurate reflection of true costs that reflect current competitive market wages.

The 8% increase in the years of the rate analysis will require an estimated increase of \$45 million in the first year, \$92 million GPR in the second year.

- 5. Public Input:** Overall, public support was strong: 85% approved and 7% were neutral. 6.2% opposed. The updated proposal takes into consideration multiple public input comments that: 1. Any rate band changes directly impact the worker (thus starting with a rate evaluation to establish equitable and adequate wages; 2. Consider tiers of acuity to account for higher levels of need in the participant, and thus higher wages/skills from DSPs; and 3. Quicker implementation than originally proposed (end of 2021). Thus, we propose immediate 8% increases during the rate analysis to address the magnitude of the wage crisis; 4. Ensure there are no “winners and losers” by implementing hold harmless on wages and infuse additional revenue into the system.

Equity lens: Recent data on the direct support professional workforce in Wisconsin from the PHI Data Report Center shows that 22% of DSPs working in people’s homes are Black, compared with a statewide Black population of only 5.5%. 49% of DSPs overall earn less than 200% of poverty, and 23% of DSPs working in home health earn **below 100% FPL**. 89% of Wisconsin’s DSPs are women, and the average age nationally is 45. This field is not entry-level when considering the level of training and expertise required, as well as who is in the field. DSPs are disproportionately women of color who, even while working in the field, earn so little that 40% of home-based DSPs are eligible and are on public health insurance benefits in Wisconsin.¹⁵ Wisconsin DHS should analyze data collected from DWD and other sources about the workforce and use that data to ensure policies developed address the needs of this population to reduce inherent inequities. Wisconsin DHS should participate in the National Core Indicator Staff Stability Survey each year to use in developing policies about workforce and compare Wisconsin to other states.

¹⁵ PHI, . [“Workforce Data Center.”](https://phinational.org/policy-research/workforce-data-center/) PHI, 11 Oct. 2019, phinational.org/policy-research/workforce-data-center/.

Nursing Home and Personal Care Payment Reform

Policy Title: Medicaid Nursing Home and Personal Care Reform

The Wisconsin Medicaid nursing home and fee for service personal care reimbursement systems should be reformed to create payment standards that are reflective of the actual cost of care.

Currently, the Medicaid program establishes payment rates for nursing homes and personal care workers according to the funding levels made available by the Governor and Legislators through the State Budget process. As proposed, budgeting for these services in the future would be more directly tied to: (1) paying for a specified percentage of the actual cost of care (for nursing homes) and (2) an estimated hourly wage to be paid to personal care workers.

Primary Contact and Names of Other Members Who Worked on the Proposal:

John Sauer (primary), Beth Swedeen, Margie Steinhoff, Ted Behnke, Bill Crowley, Lisa Pugh, Todd Costello

Analysis -- Describe the Following Items in as Much Detail as Possible:

Background

Nursing Facilities: Wisconsin's nursing facilities are in financial crisis, a fact that is well documented. The reality is: (1) According to a January 2019 Legislative Fiscal Bureau report, "75% of facilities experienced direct care nursing costs in excess of the rates provided for that cost center, after factoring in direct care-related provider incentives. However, when Medicaid costs across all cost centers are considered, 97.1% of nursing homes reported total costs that were greater than the total fee-for-service reimbursement rate, largely due to significant deficits in the support services cost center."ⁱ; (2) National reports indicate Wisconsin has the second worst nursing home payment system in the country (relative to covering the actual cost of care)ⁱⁱ; (3) A national accounting firm's study reported Wisconsin nursing homes had an *overall net operating margin of -3.5%*, considering all funding sourcesⁱⁱⁱ; (4) Since 2016, Wisconsin has faced 41 nursing facility closures and thousands of additional beds have been delicensed as facilities have implemented strategies to cope with ever-increasing Medicaid losses^{iv}; (5) Wisconsin's nursing facilities report a caregiver vacancy rate of 23% and facilities have been forced to deny admissions due to lack of staff^v; and (6) Wisconsin hospitals are experiencing difficulties in placing Medicaid-eligible patients^{vi}.

Personal Care Rates, which support community-based personal care workers, have been underfunded for decades. Consistent rate increases are needed to support an adequate provider network and a quality workforce— both of which are in jeopardy because of chronic underfunding (This remains true despite the personal care increases provided in the 2019-2021 State Budget). The current personal care rate is estimated to be \$18.77 per hour and this amount must fund all of the agencies' costs associated with providing care, including: (a) wages, health insurance and related benefits for personal care workers; (b) the agencies' other direct care costs, such as nursing staff, supervisors, and travel costs; and (c) indirect costs, such as office operations and insurance costs.^{vii} Thus, rate increases provided to personal care agencies must

cover several operating expenses in addition to direct care workers' wages and benefits. As a result, the personal care worker average hourly wage is estimated to be about \$12.00 per hour. Some have estimated the personal care rate results in an operating loss of at least \$2.00 hour, meaning the current system is unsustainable.

The well documented long-term care workforce shortage so severe that it is jeopardizing the health, safety and welfare of older adults and people with disabilities. The Legislative Fiscal Bureau's May 2019 budget paper reported: "WPSA found that 84% of the personal care agencies surveyed as part of its 2018 member survey downsized in the past year and that one out of two agencies are considering no longer providing MA personal care services. 83% of the members surveyed found it difficult to fill job openings and one out of three agencies were experiencing turnover rates above 50%. 6. In 2016, Survival Coalition surveyed over 500 long-term care recipients and their families and found that 85% of long-term care recipients do not have enough direct care workers to work all of their shifts." ^{viii} In the past six years, over 80 personal care agencies have closed or stopped providing Medicaid personal care.^{ix}

Brief Description, with Bullets Showing the Specific Components of the Policy

The Current Medicaid nursing home payment formula significantly under-reimburses nursing facilities for the actual cost of care, and these inadequate payment levels suppress hours, wages and benefits paid to direct support professionals (caregivers and related personnel). Personal care agencies also are limited in their ability to increase direct support professional wages and benefits due to low Medicaid rates.

If we are to expect nursing facilities and personal care agencies to increase wages, benefits, and hours, then the unacceptably low Medicaid rates for nursing homes and personal care workers must be addressed (increased). This remains true despite the nursing facility and personal care funding increases authorized in the 2019-2021 Biennial Budget.

Recommendations: The Task Force recommends the following actions to address nursing facility and personal care caregiver challenges:

Nursing Facility Payment Reform: The recommendation is to link nursing home reimbursement rates to the actual cost of care (i.e., rates should be set at payment standards based on the statewide median (50th percentile) plus a percentage, for the cost of Direct Care and Support Services. When allocating dollars to the **Direct Care- Nursing Cost Center** (primarily CNA, RN and LPN expenses) it is important to note that these funds must be spent directly on the workforce. That is, facilities will be paid at the *lessor* of the payment standard or the provider's actual cost. In short, facilities would only receive the full rate allowed under this payment standard if they incur caregiver costs equal to or greater than the standard.

The recommendation would also establish separate payment standards for the **Direct Care- Other** (primarily personal comfort and medical supplies, over-the-counter drugs; and activity/recreation, social worker, volunteer coordinator religious and therapy aide personnel) and **Support Services** (primarily housekeeping, dietary, laundry, maintenance and administrative services) cost centers under the current payment system. As noted above,

increases in these cost centers are necessary because without overall rate increases (in addition to Direct Care- Nursing) many nursing facilities will not be able to fund critical operational expenses, threatening the sustainability of the facility. Furthermore, some low-cost facilities may choose to use increases provided outside of Direct Care-Nursing to more quickly fund direct care expenses because there may be a 12-18 month time lag between when a facility increases Direct Care- Nursing costs and when these costs will be reimbursed by the Medicaid program.

Each payment standard should be annually adjusted by the appropriate cost index, similar to the Consumer Price Index (CPI). Lastly, the nursing facility recommendation would increase and fund Direct-Care Nursing payments to those facilities in the lowest **labor regions** within the current nursing home reimbursement system. Presently, about one-half of all Medicaid resident days fall within these lower labor regions and facilities located in these labor regions receive lower Medicaid rates, limiting their efforts to increase Direct Care- Nursing related hours, wages and benefits^x (Note: The nursing home payment recommendations noted in this section are generally based on the State of Minnesota's nursing home payment reforms adopted in 2016-17).

Personal Care Rate Recommendation: This recommendation is relatively straightforward in nature due to the way agencies are reimbursed under the Medicaid program. As proposed, the State Budget would explicitly allocate dollars to personal care agencies to fund an estimated hourly wage for personal care direct care workers similar to the approach used in the 2019-2021 Biennial Budget.

Building off the current State Budget assistance for personal care workers, the proposal is to establish payment standards such that rates paid to personal care agencies for direct support professionals reflect necessary market adjustments and CPI increases. The personal care agency payment standard would be applied to personal care provided on a fee-for-service and managed care basis, as well as for personal care services provided to IRIS participants, including self-directed IRIS personal care services.

Consistent with the Task Force's Family Care recommendations, the nursing home and fee for services personal care payment standards should be annually adjusted by CPI. The goal of reimbursement adjustments is to prioritize increases in worker wages to reflect market dynamics.

Potential funding options/cost savings/benefits.

If Wisconsin hopes to improve wages and benefit to caregivers serving nursing home residents, the overall nursing home payment system must be reformed. One cannot happen without the other. This investment is necessary to preserve CNA jobs and improve wages, benefits, and hours.

Personal Care Agencies, and those they serve, would be greatly assisted if the State of Wisconsin committed to a payment standard reflective of market trends and the need to offer competitive wages and benefits for direct care workers.

What state agency or other entity would be responsible for implementing the proposal, if it were approved? (e.g. DHS, DWD)

The Department of Health Services would be responsible for implementing both the nursing home payment standard and personal care payment standard proposals. The actual payment standards would be developed with stakeholder involvement from the very start, following a fully transparent and open process.

Cost Estimates

The fiscal effect of the nursing home and personal care agency proposals is obviously dependent on the payment standards selected (for example, payments tied to the cost centers' median plus a certain percentage). As a phased-in payment standard is considered, it is worth noting that increasing nursing home funding by \$20/resident day (\$10/resident day for the Direct Care- Nursing payment standard a \$5/resident day increase both for the Direct Care- Other and Support Services payment standard) would require an annual increase of approximately \$66 million all funds (\$26.4 million GPR). The cost of the nursing home labor region proposal is estimated to annually cost no more than \$4.0 million GPR.

The 2019-2021 State Budget provided a 12% increase to the Medicaid Personal Care Reimbursement Rate: The rate increased by 9% on July 1, 2019 to about \$18.23 per hour and it is estimated the rate will increase by 3% in July 2020 to about \$18.77 per hour. The cost of this initiative was \$15.3 million GPR in 2019-20 and \$21.6 million GPR in 2020-21. These amounts offer some insights as to the cost of increasing the personal care rates similarly in the future.

Equity Lens

According to the RCI and PHI presentation to the Task Force on September 19, 2019, 93% of nursing home direct caregivers are women; almost one in four is a person of color; and 32% rely on some form of public assistance. Personal Care/home care direct caregivers also are disproportionately women; almost one in three is a person of color; and 45% rely on some form of public assistance^{xi} Wisconsin DHS should analyze data collected from DWD and other sources about the workforce and use that data to ensure policies developed address the needs of this population to reduce inherent inequities. Wisconsin DHS should participate in the National Core Indicator Staff Stability Survey each year to use in developing policies about workforce and compare Wisconsin to other states.

Public Support

Nearly 90% of the public comments supported the Task Force's recommendation to pursue nursing home and personal care payment reform (only 3% opposed). Clearly, these recommendations are valued by those who support building a stronger and more sustainable direct care workforce^{xii}

Medical Loss Ratio

Policy Title: Rates: Require a Medical Loss Ratio (MLR) of at least 85% for direct care and services, limiting the Managed Care Organizations (MCOs') administration and case management expenses to 15% of the capitation rate received from DHS.

Primary Contact for the Proposal and other Members Who Worked on the Proposal: Beth Swedeen, John Sauer, Margie Steinhoff, Ted Behnke, Bill Crowley, Lisa Pugh, Todd Costello, and Mike Pochowski

Original Proposal: Include in the Family Care contract (FC, FCP, Pace) a requirement for an 85%/15% medical loss ratio. Provide that case management expenses cannot be included in the direct care and services cost component of the calculation.

Note: Very recently, MCOs and the Department of Health Services (DHS) raised concerns that imposition of the proposed 85%/15% MLR may not fall into compliance with the federal managed care regulations. Because the Centers for Medicare and Medicaid Services (CMS) has not ruled on this matter, the Task Force recommends advancing the proposed 85%/15% rule and, should CMS subsequently determine that the proposal is not allowable under the federal rules, then DHS should pursue additional MCO accounting and oversight controls to ensure proper maximization of dollars are available to fund the direct care and services portion required of Family Care participants. In addition, the proposed MLR would ensure the MCOs' administrative and related costs are in line with an efficiently and economically operated insurance company, consistent with the goals of the Family Care program.

Analysis -- Describe the Following Items in as Much Detail as Possible:

A medical loss ratio in managed long-term services and supports (MLTSS – programs like Family Care and Family Care Partnership) is the percentage of capitation rate dollars a managed care organization spends to provide medical services and health care quality improvement activities for its members. “Health plans that spend a higher proportion of the premium on medical services are viewed as providing better value for the payer and consumer than plans that spend a higher proportion of the premium on administrative expenses and profit margins.” (Dominiak and Libersky 2012).

The Center for Medicare and Medicaid Services (CMS) published a final rule on May 6, 2016, that requires Medicaid MCOs (like those in Badgercare) to calculate, report, and use an MLR to develop capitation rates. The final rule requires that the capitation rates for MCOs be set for a minimum MLR of at least 85 percent. States can also apply MLR standards in managed care within long-term services and supports, but there is no requirement to do so.

In its 2016 report on MLTSS, the National Council on Disability, which visited Wisconsin during the investigation for its report, states that “Advocates should provide details on the kinds of activities that should be included as a community integration activity for purposes of the MLR numerator.”

The Family Care contract <https://www.dhs.wisconsin.gov/familycare/mcos/2018-generic-final.pdf> - includes no MLR percentage requirement – only a reporting requirement. Also, all care management expenses are included in the service cost component and are not delineated from direct services to participants.

- “The MLR calculation for the FC, FCP and PACE programs includes care management service expenses in the service cost component of the calculation.”

The federal Health and Human Services (HHS) Office of Inspector General (OIG) conducted an analysis of Wisconsin MLR in 2017. Two Family Care MCOs were included, and their MLR was above 90%, however, including care management costs in the calculation may not provide a clear picture of expenditure on direct services.

<https://oig.hhs.gov/oas/reports/region5/51500040.pdf>

In 2020, in part to address the direct care workforce crisis, DHS directed the actuaries who develop capitation rates for Family Care, to include in the 2020 MCO capitation rates, “a rate adjustment to increase average provider reimbursement rates by 1% for waiver services provided in mature GSRs (i.e., all GSRs other than GSR 12) above the unit cost trend included in the rate development. With this rate adjustment is the expectation that certain Family Care MCOs will implement corresponding provider rate increases effective CY 2022.” See:

<https://www.dhs.wisconsin.gov/non-dhs/dms/fc-2020capitationrates.pdf>, page 16.

Despite this specific rate adjustment, not all Managed Care Organizations passed along rate increase to providers, nor was there required reporting to identify whether this had occurred.

Wisconsin DHS posts the MCO quarterly financial summaries at:

<https://www.dhs.wisconsin.gov/familycare/mcos/financialsummaries.htm>. The MCOs’ financial statements for the full calendar year 2019 are provided below, identifying the proportion of capitation rate spent by each MCO on care management (ranging from 9.4% to 14.0%) and member service expense (ranging from 78.0% to 89.8%).

Per the table below, it is important to note that currently three of the five MCOs would meet or be very close to meeting the 85%/15% proposed MLR under consideration by the Task Force.

	Inclusa	LCI	MCFCI	CCI	CWF	Total
Key Ratios (as % of Revenue)						
Member Service Expense, Net	78.0%	81.2%	84.3%	82.7%	89.8%	82.7%
Care Management Service Expense	14.0%	11.7%	12.2%	9.4%	10.6%	11.7%
Total Member Service Expense	92.0%	92.9%	96.5%	92.1%	100.4%	94.4%
Administrative Expense	4.3%	3.6%	3.2%	2.3%	3.9%	3.5%
Total Operating Expense	96.3%	96.5%	99.7%	94.4%	104.3%	97.9%
Income (Loss) from Operations, CY	3.7%	3.5%	0.3%	5.6%	-4.3%	2.1%
Net Income/(Loss)	3.9%	3.9%	2.30%	5.7%	-2.2%	2.9%

Potential funding options/cost savings/benefits: Requiring an MLR in the Family Care contract and removing case management expenses from the calculation should offer greater transparency into the rates paid to providers who offer direct services. More attention to efficiency in case management expenditures could save funds over time. Any directed increase in the capitated rate for a specific service component, including direct care, should be reflected in the member services portion of expenditures.

Cost estimates: The requirement should not increase costs.

State agency or other entity responsible for implementing the proposal, if it were approved (e.g. DHS, DWD): Department of Health Services/Division of Medicaid Services

Public Input: Imposition of MLR was widely supported (80%) by the public comments submitted to the Task Force.

13. Rates: Medical Loss Ratio (MLR) - How strongly do you support or oppose this policy proposal?



Value	Percent	Responses
Strongly support	69.2%	117
Somewhat support	10.7%	18
Neutral	11.8%	20
Somewhat oppose	5.3%	9
Strongly oppose	3.0%	5

Conclusion: Should CMS not approve the 85%/15% Medical Loss Ratio as proposed by the Task Force, DHS should audit the MCOs’ administrative and case management expenses to determine if additional dollars should go towards the direct care and services portion of the capitation rate. This audit should also include a review of the Family Care participants’ satisfaction level with the respective MCOs’ case management services, including information about the type and level of case management support provided to meet member goals.

Direct Care Worker Fund

Policy Title: Direct Care Funding Initiative

Primary Contact and Names of Other Members Who Worked on the Proposal:

Ted Behncke, Lisa Pugh, John Sauer, Beth Swedeen, Todd Costello

Brief Description, with Bullets Showing the Specific Components of the Policy

- Propose that annual increases be provided to the existing Direct Care Workforce Funding program to ensure dollars are allocated directly to the long-term care providers for caregiver wages and benefits. Further, direct and support DHS' efforts to secure CMS approval allowing total Direct Care Workforce Funding to be allocated via annual payments.
- The measure would provide immediate assistance to directly support the caregiver workforce until such time that a Family Care rate band is implemented (estimate January 1, 2022)
- This recommendation does not negate the mandate that the Family Care MCO capitation rate must be actuarially sound, taking into account, at a minimum, member acuity, client mix and the cost of care and services

Analysis -- Describe the Following Items in as Much Detail as Possible:

- For the past two years the Legislature approved, and the Governor signed into law, the \$67,985,100 (all funds, 2020-21) Direct Care Workforce Funding program. This program, which was subsequently approved by CMS, provides critically necessary funding for providers to help offset expenses for direct caregivers. The payments have been provided in quarterly installments, passed-through to the provider by their respective MCO.

Because the payments have not been provided quarterly as planned (2019/2020 payments came near the end of the fiscal year), and with no assurance these dollars would be available on a continual basis in subsequent years, many providers have elected to use the money for one-time bonuses (see below from DHS) to employees rather than wage increases (and thus not solving the wage issue for caregivers). Recipients of direct care workforce payments reported how payments were allocated by category via a survey tool. Survey information has been collected for CY 2018 quarters 2 through 4. This data includes all provider submissions and may not accurately reflect the actual dollars allocated due to the self-reported nature of the data.

Allocation Category	Q2 Percent	Q3 Percent	Q4 Percent
Wage Increases	33%	39%	40%
Retention/Longevity Bonuses	28%	26%	27%
Performance Bonuses	28%	23%	20%
Employee Paid Time Off	9%	9%	9%
Staff Referral Bonuses	1%	2%	2%
Signon Bonuses	2%	2%	2%
Total	100%	100%	100%

- Annual increases to the Direct Care Workforce Funding program would ensure dollars are allocated directly to the provider and are not retained by the MCOs.
- By switching the payments to annual ones, the initiative would be used to support immediate wage increases (as a gap measure) to caregivers until such time the rate band funding mechanism is established (Estimated: January 2022).

Potential funding options/cost savings/benefits.

Because annual increases to base Direct Care Workforce Funding would be set by the Legislature and the Governor, with operational and program assistance from DHS, overall funding levels would be clearly identified using the average wage paid to DSPs in the State and the difference required to bring them up to an effective living wage. The money would be earmarked, giving the provider community confidence that these dollars will be available to fund ongoing caregiver expenses. Again, the MCOs would be required to pass on these dollars directly to the providers.

What state agency or other entity would be responsible for implementing the proposal, if it were approved? (e.g. DHS, DWD)

DHS would be responsible.

Cost estimates: Include any known information on what types of costs there would be, including staffing needs, and whether they would be one-time or ongoing. As possible, include as close an approximation of the likely costs as is available (e.g. several million dollars annually; \$500,000 on a one-time basis; \$100 to \$200 million annually).

As mentioned above, the Direct Care Workforce Funding appropriation for 2020-21 is \$67,985,100 all funds (\$27.5 million GPR). Under the proposal, this amount would be increased to meet market demands for caregiver wages. For example, it is roughly estimated increasing the Direct Care Workforce Funding by 5% in each year of the 2021-23 biennium would cost approximately \$28.1 million GPR in 2021-22 and \$57.7 million GPR in 2022-23 (Note: DHS certainly would be able to provide more precise estimates on the cost of providing 5% annual increases in 2021-23).

Once the rate band system is established, the Direct Care Workforce Funding could either be continued or folded into the new system.

Equity:

State data clearly demonstrates that a great proportion of the direct care workforce is made up of minority communities. Nearly all Direct Support Professionals in Wisconsin earn incredibly low wages with an average wage of \$12/hour. This is not a living wage and workers continue to

struggle with access to other work benefits that most Wisconsin workers enjoy, including affordable health insurance, retirement plans, transportation and childcare. Additionally, the Department should prioritize parity throughout long-term care programs, including IRIS, regarding direct increases in funding to attract and retain qualified caregivers. The department should create a simple and transparent process to adjust IRIS budgets to reflect the ability for IRIS employers to increase wages for workers to mirror the direct care worker fund. The Department should request necessary funding increases to meet this parity.

Public Input:

The public has expressed support for continued investments in the Direct Care Worker fund, however, the wage pass-through program in its current state, while appreciated, is cumbersome and untimely. Research indicates that many pass-through designs may have a questionable impact, but in the public input survey 67.1% showed strong support with a further 18.8% saying somewhat support. There were 544 individuals registering an opinion on this proposal with only 2% were strongly or somewhat opposed. The rest indicated neutral. Individual comments showed support for changing to an annual payment. The Wisconsin Long-Term Care Workforce Alliance provided comments saying the payments have been extremely helpful for providers in allowing them to give additional pay increases, bonuses, and other incentives that they may have not been able to give due to reimbursement. We also heard from IRIS providers/consultant agencies that the department must prioritize parity throughout long-term care programs, including IRIS whose workers do not receive payments currently, regarding funding to attract and retain qualified caregivers. Currently, the direct care worker fund does not apply to increases in IRIS. Commenters requested that DHS develop a simple, user-friendly mechanism to access those funds that is consistent with employer authority under IRIS.

Direct Care Workforce Proposals: Benefits

Medicaid Expansion

Policy Title: Wisconsin Medicaid Expansion per the ACA

Executive Order Charges

- Analyzing strategies to attract and retain a strong direct care workforce;
- Assessing compensation and fringe benefits for caregivers including ways to make caregiving more affordable for the caregiving workforce through employer-sponsored plans, Medicaid buy-in-plans, or other health insurance plans;
- Exploring and Developing solutions, in collaboration with other relevant departments and agencies, to support and strengthen the direct care workforce, increase access, and improve the quality of caregiving in Wisconsin.

Primary Contact for the Proposal:

Anne Rabin

Other Members Who Worked on the Proposal:

Jane Bushnell, Lisa Pugh

Brief Description, with Bullets Showing the Specific Components of the Policy:

- Wisconsin is in a caregiver crisis
- Expanding Medicaid eligibility offers comprehensive health coverage to low-wage caregivers
- Expansion of Medicaid allows caregivers to work more hours
- Low-wage workers which include caregivers are disproportionately impacted by the COVID-19 recession
- Workers who lose their employer-based insurance are predicted to be uninsured in non-expansion states
- Increased revenue of a full Medicaid expansion would bring in an additional \$1 billion in revenues
- Premiums in the private market will decrease 7-11% as a result of Medicaid expansion
<https://www.rwjf.org/en/library/research/2020/07/changes-in-health-insurance-coverage-due-to-the-covid-19-recession--preliminary-estimates-using-microsimulation.html>

Analysis -- Describe the Following Items in as Much Detail as Possible:

Expanding Medicaid eligibility offers comprehensive health coverage to low-wage caregivers. Caregivers in Wisconsin are low-wage earners:

- 37% are on public assistance, expanding Medicaid would allow the 60% of caregivers to obtain health insurance
- 49% of caregivers who are in or near poverty
- Median Annual Income is \$18,600
- Median Wage is \$12.28 (includes CNAs and home care workers)

- Work Force in 2019 was 101,180
- 2016-2026 projected job openings of 173,900

https://phinational.org/wpcontent/uploads/2017/09/wisconsin_home_care_landscape_phi_2017_0.pdf

Expanding Medicaid directly affects the caregiving workforce by allowing those who unwillingly work part-time to work more hours and not lose their health insurance coverage. Full Medicaid Expansion under the ACA to cover “newly eligible adults” with income up to 138% or more of the FPL would enhance state revenue. (Newly eligible adults are non-disabled adults who were not covered by the state at the time of expansion).

In 2020 the FMAP was 90% while the FMAP in Wisconsin is 59%. Increasing the FPL to 138% allows the 30% of the caregiving workforce who are currently enrolled in BadgerCare to work an additional shift per week, or 457 more hours a year. Caregivers could work more hours because they could maintain their health insurance. Expanding Medicaid would also add 8,000 more caregivers to the workforce.

[BPDD Task Force on Caregiving](#)

The goal is to expand Medicaid in Wisconsin to 138% or more to strengthen and stabilize the health care access of low wage caregivers. Unpaid family caregivers who have taken on care by leaving the workforce or reducing their hours, losing employer provided insurance, would also benefit from expansion. In non-expansion states only 42% have the option to receive Medicaid coverage, as compared to 75% in expansion states.

www.workingpoorfamilies.org

49 % of caregivers are low-wage workers and they are more affected by COVID-19. On April 14, 2020 the CDC reported over 9,000 health care workers had contracted COVID-19. The pandemic complicates this as some low-wage workers did not have employer-sponsored coverage while they were working. As higher percentages of people lose their employer insurance then they will become uninsured in states that have not expanded Medicaid eligibility. <https://www.nytimes.com/2020/04/14/health/coronavirus-health-care-workers.html>
<https://www.rwjf.org/en/library/research/2020/07/changes-in-health-insurance-coverage-due-to-the-covid-19-recession--preliminary-estimates-using-microsimulation.html>

Unemployment in Wisconsin is between 8-14%, Wisconsin ranks 20th in unemployment nationally. Implications of COVID-19 are that unemployed people who have lost their employer sponsored plans may turn to Medicaid for health coverage. 31% of people report that if they or their spouse lost their jobs they would turn to Medicaid. 55% of Americans say that Medicaid is important to them. 23% anticipate that they or a family member will require Medicaid in the coming year.

<https://www.kff.org/report-section/kff-health-tracking-poll-may-2020-health-and-economic-impacts/>

Should unemployment reach 20% in expansion states it is estimated that 9 million would enroll in Medicaid. In comparison to non-expansion states with 20% unemployment, only 3 million who lost their employer coverage would be able to enroll in Medicaid.

<https://healthpayerintelligence.com/news/ok-becomes-first-state-to-adopt-medicaid-expansion-during-covid-19>

The costs of treating a person infected with COVID-19 vary. The uninsured, those with private health insurance, Medicare and Medicaid, vary in deductibles and cost sharing. However, the cost of treating a person hospitalized with Covid-19 is estimated to be around \$30,000. 15% of people infected require hospitalization with 20% of those spending more than 20 days in intensive care.

<https://www.cnn.com/2020/04/09/heres-what-you-need-to-know-about-coronavirus-treatment-costs.html>

Wisconsin Office of Commissioner of Insurance finds that Medicaid expansion lowers insurance premiums in the individual market by 7 to 11 percent compared to non-expansion states.

<https://oci.wi.gov/Pages/PressReleases/20190507Expansion.aspx>

Anticipated benefits:

Wisconsin would realize an increase in revenue from increased FMAP through Medicaid expansion.

Wisconsin's caregiver workforce shortage could be improved by allowing people who are already working to work more, earn more money and retain their health insurance. These additional hours would reduce staff shortages and provide care to people needing care.

Caregiver retention is improved because caregivers have health insurance. The cost to agencies and providers is decreased because of lower turn-over and thus reduced training expenditures.

The more people who have health insurance, the less uncompensated costs there are.

Medicaid expansion will lower private health insurance premiums.

Health disparities/Equity considerations:

There are disparities in access to health care among various ethnic, racial, elders and disability populations. The caregivers are impacted by lack of access to health care. Health disparities in the caregiving workforce have been exasperated by COVID-19.

- Nine in 10 caregivers are women
 - One in four direct care workers is a person of color
 - Two in four direct care workers has less than a high school education
 - Care gap for care recipients is greater in rural areas than urban areas
 - Older people in Wisconsin are 23% of COVID-19 cases, are 87% of deaths
 - Older people of color, Blacks are diagnosed nine times the rate of Whites, Hispanics are diagnosed at ten times the rate of Whites and Asians at four times the rate as Whites
- [“Community Resilience, Equity and Mental Health Considerations in Rapid Response”](#)
[“COVID data BADR Populations – PowerPoint”](#)

Potential funding options/cost savings/benefits:

“Administration's Estimated GPR Fiscal Effect of Full Medicaid Expansion, by Eligibility Group, Income Level, and Fiscal Year (\$ in Millions)

Group	Income Level	Fiscal Year	Childless	Adults	Parents	Total
0% to 100% FPL	-\$256.5	\$0.0	-\$256.5	100%	to 133% FPL	16.7 80.3 97.0
Net Change	-\$239.8	\$80.3	-\$159.5	2020-21	0% to 100% FPL	-\$265.0 \$0.0 -\$265.0
100% to 133% FPL	17.2	82.8	100.0	Net Change	-\$247.8	\$82.8 -\$165.0
Biennial Total	0% to 100% FPL	-\$521.5	\$0.0	-\$521.5		

100% to 133% FPL 33.9 163.1 197.0 Net Change -\$487.6 \$163.1 -\$324.5 For the purposes of these estimates, the administration assumed increased average enrollment of approximately 82,000, composed of 52,000 parents and 30,000 childless adults. Currently, there are approximately 154,000 parents and 150,000 childless adults enrolled in MA.”
[Governor’s Budget Report](#)

Increased revenue from Medicaid expansion is estimated at \$1 billion.

Those losing their employer health insurance due to unemployment as a result of Covid-19 will turn to Medicaid for themselves and their families. Wisconsin does not avail itself of the full 90% FMAP. In many cases, researchers have found that Medicaid expansion generates savings to the state in comparison to the cost to the state.

Expansion also increases economic activity; thus, more taxes are collected. Work-related injuries are common in the caregiving field. Nursing assistants were among the group with the highest days off in 2015 due to on the job injury, according to the Bureau of Labor Statistics. The average injury days off were six days.

<https://www.americanprogress.org/issues/healthcare/reports/2019/04/10/468290/state..>
https://www.bls.gov/news.release/archives/osh2_11102016.pdf.

Worker retention is improved through the extension of health care coverage benefits.

- Caregivers are typically caring for the highest cost Medicaid populations. Home and Community Based caregivers working in Medicaid-funded long-term care programs- Family Care, IRIS, Pace and Partnership are keeping aging adults and people with disabilities living in their homes and out of more expensive Medicaid-funded institutional settings. Improving worker retention also provides administrative savings to personal care agencies which may be passed on as increased wages to caregivers.
- Currently, 70% of personal care agencies are unable to staff all hours of care needed on a daily basis, and 93% of agencies find it difficult to fill job openings. The annual turnover rate is more than 50% and can be as high as 67%.

http://www.survivalcoalitionwi.org/wpc/content/uploads/2019/02/FAQ_WorkforceMedicaidWaiver_022019.pdf

- Medicaid expansion in Wisconsin will decrease premiums for those with private insurance.
<https://www.healthaffairs.org/doi/10.1377/hblog20190605.87178/full#:~:text=Medicaid%20Expansion%20in%20Wisconsin%20Would%20Lower%20Premium>

State agency or other entity responsible for implementing the proposal, if it were approved (e.g. DHS, DWD):

- Legislature
- DHS
- State Medicaid Department
- CMS

Public Input:

In public comments to the Governor's Taskforce on caregiving, 80.2% of respondents strongly supported Medicaid expansion and 9.8% somewhat supported Medicaid expansion as a recommended a strategy to attract and retain a strong direct support workforce.

Comments:

- IRIS participant lost caregiver of 81/2 years who left for a job which provided health insurance
- Family of a 40-year-old daughter living in an Adult Family Home where they are always short staffed and over worked
- A Certified Therapeutic Recreation Specialist sees the high risk for contracting illness and injury for caregivers. She also notes the “insane” amount of turn-over and burn-out in caregivers
- A family in Dane county sees quality of care issues for her son poor care by low-paid staff
- ADRC of Portage County sees extending Medicaid as resulting in additional hours of caregiving for adults and people with disabilities in LTC programs
- A community program worker sees a decline in residential care for people with disabilities because caregivers have poor health insurance. Additionally, many have contracted COVID-19
- Primary family caregiver of a daughter with disabilities recognizes benefits providing benefits is critical to allowing her daughter to remain home remain at home
- The Survival Coalition enumerates benefits to Medicaid expansion by making this work more attractive, promoting retention and increasing caregiving hours
http://www.survivalcoalitionwi.org/wp-content/uploads/2020/07/SurvivalCoalition_PublicComment_CaregiverTaskForce_062620.pdf
- Disability Rights Wisconsin placed expanding Medicaid as their number one priority to benefit caregivers and address the caregiver crisis
<https://www.disabilityrightswi.org/wp-content/uploads/2020/07/DRW-Comments-to-Caregiving-Task-Force-070720-acc.pdf>
- Many direct care workers are dependent on BadgerCare for health care insurance because low reimbursement rates do not allow providers to offer affordable coverage. The Paraprofessional Healthcare Institute (PHI) estimates that 36% of Wisconsin's direct care workforce relies on Medicaid for health insurance coverage. WPSA suggests that Wisconsin accept federal funds to expand Medicaid to expand coverage. All funds received from Medicaid expansion should stay within the Medicaid budget to support sustainable provider rates and program improvements. 75% of WPSA members surveyed receive more than half of their revenue from Medicaid funding, yet agencies are still required to provide health insurance coverage to full-time workers. The current reimbursement rates are not high enough to help agencies provide health insurance coverage.

<https://static1.squarespace.com/static/5af1fcb25bf0239ef4c73f7/t/5c90fce26e9a7f1b8a39714a/1553005795145/WPSA+2019-21+Budget+and+Legislative+A>

Earnings Disregard

Policy Title:

Establish Earnings Disregard for Direct Support Professionals (DSPs) when determining eligibility for specific public assistance programs

Executive Order Charges:

- Analyze strategies to attract and retain a strong direct care workforce
- Assessing compensation and fringe benefits for caregivers including ways to make healthcare affordable for the caregiving workforce through employer-sponsored plans, Medicaid buy-in plans, or other Health insurance coverage options
- Developing a plan to implement recruitment and retention programs to expand the pool of providers
- Exploring and developing solutions, in collaboration with other relevant departments and agencies, to support and strengthen the direct care workforce, increase access, and improve the quality of caregiving of Wisconsin.

Primary Contact for the Proposal:

Jane Bushnell

Other Members Who Worked on the Proposal:

Anne Rabin

Brief Description and Policy Components:

An earnings disregard allows DSPs the ability to work, gain income and self-sufficiency and disregard a portion of this income without the fear losing their much-needed public assistance.

Policy Components:

- Allow DSPs the ability to disregard \$10,000 of DSP earnings when applying for BadgerCare benefits through a potential waiver or pilot program
- Allow DSPs the ability to disregard \$10,000 of DSP earnings when applying for Wisconsin Shares childcare subsidy program
- Allow DSPs the ability to disregard \$10,000 of DSP earnings when applying for funding through the FoodShare program (Wisconsin's name for the Federal SNAP program)
- DSP earnings consist of wages earned while supporting recipients in Wisconsin Medicaid programs

Analysis and anticipated benefits:

Direct Support Professionals are essential workers and vital to the health and well-being of seniors and people with disabilities. Wisconsin is facing a caregiver workforce crisis as DSPs face many challenges such as low wages and lack of benefits. While DSPs are caring for others, many times DSPs do not receive benefits or adequate wages to cover their own basic needs so

public assistance is vital. A Wisconsin Study on the Direct Care Workforce by PHI [Wisconsin-DCW-2019-PHI.pdf](#) showed the following due to sub-standard wages within the DSP field:

- Median annual earning - \$18,600
- 49% in or near poverty
- 37% on public assistance

Studies show lack of benefits are a main reason why workers leave their place of employment. This causes caregivers to leave the field. The Wisconsin Personal Services Association (WPSA), an organization representing 73 personal care providers, surveyed its members in 2015 and 2016 and found that 93 percent of personal care providers reported difficulties in filling job openings, and 70 percent were unable to staff all authorized hours. The annual turnover rate is more than 50% and can be as high as 67%.

In addition, people with disabilities do not have access to care due to the workforce shortage. People needing care and provider agencies are faced with significant recruitment challenges.

The \$10,000 earnings disregard equates to approximately 54% of a caregiver's salary based on a 2019 PHI study showing the direct care workforce median annual earnings of \$18,600. [Wisconsin-DCW-2019-PHI.pdf](#)

Key Benefits:

- Allows the approx. 40% of DSPs currently on BadgerCare the ability to work more hours without losing insurance
- Allows the approx. 40% of DSPs who receive Wisconsin Shares childcare assistance the ability to work more hours without losing this assistance
- Allows the approx. 40% of DSPs who receive FoodShare the ability to work more hours without losing their assistance
- Allows DSPs currently not receiving assistance the ability to gain assistance

Additional Benefits:

- Additional workforce hours gained to meet the caregiving needs as more hours could be worked without fear of hitting the benefit cliff or losing their much-needed assistance. The risk of hitting the benefit cliff is reduced. A benefit cliff occurs when total income drops (even though wages increase) due to a drop in benefits, leaving the family with less resources
- DSPs are essential workers who endure health risks daily in their job tasks, particularly during pandemics like COVID-19; therefore, it is vital that they have access to health insurance and other public assistance to cover their own basic needs
- DSP worker retention is improved because DSPs have access to public assistance to meet their day-to-day needs without leaving the caregiving workforce
- The cost to agencies and providers is decreased due to lower turnover. This is important because the rates paid to agencies and providers have remained stagnant and do not reflect the cost of providing care Do you want these to have periods or not? First sentence has periods, others don't
- Makes direct care work more economically sustainable by enhancing the quality of life for workers and their families

- Recognizes the value and contributions of these essential workers who help Wisconsinites in need of cares to live with the independence and dignity they deserved
- Provides an incentive and opportunity to work more hours without losing benefits, creating a bridge to economic self-sufficiency
- If families can find a bridge to economic self-sufficiency they will likely stay employed, increasing the pool of workers

Studies show the following:

- Childcare is of significant importance to low income families and one of the largest items in a household budget
<https://ascend.aspeninstitute.org/reducing-the-cliff-effect-to-support-working-families/>
- A significant support for low income families come from the SNAP benefits
<https://ascend.aspeninstitute.org/reducing-the-cliff-effect-to-support-working-families/>
- <https://ascend.aspeninstitute.org/reducing-the-cliff-effect-to-support-working-families/>
- Benefits are key to attracting and retaining workers and health insurance is the most important benefit to workers
<https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/alter-benefits-attract-retain.aspx>
- Hitting the benefit cliff creates a disincentive to work and creates an anchor, rather than a ladder out of poverty. It also serves as a disincentive to work
http://www.ncsl.org/documents/cyf/Benefits_Cliffs_Brief_32099.pdf
<https://webcache.googleusercontent.com/search?q=cache:zFW68lIztAJ:https://www.acf.hhs.gov/sites/default/files/oro/wholefamilypolicybrief.docx+&cd=1&hl=en&ct=clnk&gl=us>
- Policies that enable workers to continue receiving public benefits while their income increases are seen by some policymakers as a way to simultaneously increase employee retention and family stability. For businesses, such policies help keep employee turnover in check and mitigate the negative effects of worker shortages. For workers, income disregards help them stay in the workforce and provide for their families. Earned income disregards allow certain types and amounts of income to be excluded for purposes
http://www.ncsl.org/documents/cyf/Benefits_Cliffs_Brief_32099.pdf
- Development of earnings disregards in Minnesota:
https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=CM_001818

Health Disparities/Equity considerations:

- The DSP population is made up of minorities from all areas. Data from the Paraprofessional Health Institute shows that 37% of DSPs are people of color
<https://phinational.org/policy-research/workforce-data-center/#var=Race+and+Ethnicity&states=55>
- This proposal gives DSPs who are doing essential work an avenue to access much-needed public assistance and creates a path to self-sufficiency

- DSPs are disproportionately women of color who, even while working in the field, earn so little that 40% of home-based DSPs are eligible and are on public health insurance benefits in Wisconsin

<https://phinational.org/policy-research/workforce-data-center/#var=Gender&states=Wisconsin&tab=State+Data>

Potential funding options/cost savings/benefits.

- Increased retention produces continuity of care for recipients
- Decreased administrative costs to provider agencies. This is important because the reimbursement rates paid to provider agencies have been stagnant, are sub-standard and do not reflect the cost of client care. Savings in administrative costs could be shifted to DSP pay
- Increased retention and number of DSPs keeps people in their homes versus that of a higher cost alternative

What state agency or other entity would be responsible for implementing the proposal, if it were approved? (e.g. DHS, DWD)

- DHS
- Legislature
- Medicaid
- Wisconsin Shares program
- SNAP program

Costs:

DHS will need funds as there will be an increase to these public assistance programs. However, a decrease may occur when DSPs work to self-sufficiency. A complete and comprehensive analysis is necessary to achieve an accurate reflection of true costs.

Barriers:

After the development of this proposal, we were informed by DMS that “adding a disregard for BadgerCare Plus eligibility is erroneous. The Affordable Care Act eliminated all flexibility for states to adopt additional deductions or disregards in determining financial eligibility under the Modified Adjusted Gross Income methodology. There still remains some flexibility under 1902 (r)(2) of the Act for SSI-related, but that was removed for the AFDC-related populations.”

Based on this feedback, we are still seeking the earnings disregard for Wisconsin Shares and FoodShare, and the exploration of waiver options or a pilot program for the earnings disregard related to BadgerCare since Health Insurance is vital to DSPs and the benefit most needed for these essential workers.

Public Input

- Public input collected from the Governor’s task force actions on this proposal suggests strong support as follows:
 - Strong support 69.9%

- Somewhat support 15.4%
- Neutral 6.8%
- Somewhat oppose 3.9%
- Strongly oppose 3.9%
- Many of the objections to the proposal referred to raising the wages or reimbursement rates so benefits could be purchased or provided
- Much concern that Health insurance access and affordability is crucial for DSPs
- Many comments asked that SNAP benefits be included which this proposal now addresses
- Public comments supporting this proposal include:
 - *“It would encourage entrance into DSP jobs”*
 - *“Implementation of an Earnings Disregard for Direct Support Professionals would help to eliminate the current disincentives for working additional hours and make additional income in our current system. Many workers who wish to work more and earn more and whose service is desperately needed are unable to do so as the loss of critical health, food, and childcare benefits far outweigh any benefits of the additional income earned.”*
 - *“Staff who receive assistance often limit their hours they work because they don’t want to lose their benefits.”*
 - *“I want to work but can’t because I’ll lost my benefits. Can’t afford to lose my benefits but I want to contribute to society.”*

Direct Care Workforce Proposals: Untapped Workers

State-Wide Direct Support Professional Training

Policy Title: Statewide Direct Support Professional Training

Primary Contact for the Proposal: Stephanie Birmingham

Other Members Who Worked on the Proposal: Todd Costello, Mo Lee, Lisa Pugh, Beth Swedeen, Lavern Jaros

Brief Description, with Bullets Showing the Specific Components of the Policy:

- The Direct Support Professional (DSP) workforce in Wisconsin consists of a variety of caregiving professions and care settings, each with different training requirements and competency standards. Currently there is limited consistency and portability of training for Direct Support Professionals.
- This training proposal recognizes that multiple training options exist within the industry (facility and community based). Therefore, this training proposal encourages flexibility to accommodate proven effective training options that are consistent with the identified standards of practice. The recommendation is to pilot a program, which would provide:
 - A person-centered direct support professional training to achieve consistent standards of practice.
 - A collaboration between DHS and DWD, along with the Wisconsin Technical College System and providers.
 - Identified standards of practice to allow providers the flexibility to apply these standards to their existing training while also meeting the needs of clients in both community- and facility-based settings.
 - Trainings that are consistent with regulatory requirements.
 - Develop a career ladder leading to potential CNA certification.
 - Tier 1 to be inclusive of the requirements designated within DHS 105.17 regulations¹⁶, the Direct Care Competencies developed by the Wisconsin Personal Services Association (WPSA)¹⁷, additional soft skills, and cultural sensitivity principles.
 - DSPs who complete Tier 1 may earn credit towards CNA certification or a badge similar to the existing Technical College continuing education badge system.¹⁸
 - In addition to the Tier 1 requirements, Tier 2 would provide additional training and an avenue for credentialing Direct Support Professionals with the option to

¹⁶ Wisconsin State Legislature. 2020. https://docs.legis.wisconsin.gov/code/admin_code/dhs/101/105/17

¹⁷ Wisconsin Personal Services Association, DCC 1. 2020. <https://www.wpsa.us/dcc-i>

¹⁸ Madison Area Technical College. 2020 <https://madisoncollege.edu/digital-badges>, Madison, WI

identify this within their registry profile. It also would provide for advancement opportunities for DSP's. These opportunities could be available across all care settings. Examples of advanced roles include client education and coordination of community resources, DSP peer mentoring, job coach, etc.

- [Center for Healthcare Strategies, Inc.](#)'s initiative for training and supporting healthcare workers may be a helpful resource as well as a possible funding source
 - *“Community health workers and promoters-members of the community who connect patients to needed health-related and social services in a culturally competent manner- are increasingly recognized as valuable contributors to the health care system.*
 - *Recognizing the value of health workers, many states are developing policies to support their deployment, yet no uniform training or certification standards exist for this valuable workforce. “¹⁹*
- Tier 3 would be achieved through successful completion of the minimum 75-hr. training requirements leading to eligibility of CNA certification.²⁰ (Contingent on successful passing of state exam)
- A web-based or e-learning training option. (Explore opportunities to incorporate the Wisconsin Technical College system and WisCaregiver Career program technology to support web-based access and testing capability).²¹
- Outreach to Job Centers to ensure they are aware of the Direct Support Professional career ladder.

Analysis -- Describe the Following Items in as Much Detail as Possible:

Anticipated benefits:

Family caregivers, individuals with disabilities, older adults and others who rely on support to be able to live independent, fulfilling and self-directed lives within their homes and communities will have access to a more highly trained workforce regardless of where they live in Wisconsin. Direct Support Professionals will have opportunity to be credentialed and have access to a statewide, recommended training that reflects the best standards of practice. Training will reduce turnover of Direct Support Professionals as they will feel more prepared and have the tools to successfully complete tasks. Offering a career ladder option allows flexibility for Direct Support Professionals who wish to advance their career.

Health Equity/Disparities considerations:

- Nearly 9 in 10 home care workers are women, and their median age is 45.

¹⁹ Center for Healthcare Strategies, Inc. 2020 <https://www.chcs.org/resource/training-and-supporting-community-health-workers-and-promoters-lessons-for-states/> Madison, WI

²⁰ Wisconsin State Legislature. 2020 https://docs.legis.wisconsin.gov/code/admin_code/dhs/110/129/II/07, Madison, WI

²¹ Wisconsin Department of Health Services. 2020 <https://www.dhs.wisconsin.gov/caregiver-career/index.htm>, Madison, WI

- While people of color make up one-third of the total U.S. workforce, they comprise more than half of all home care workers.
- Over one-quarter of home care workers were born outside the United States.
- More than half of home care workers have completed no formal education beyond high school.

We recommend training that incorporates cultural competency to honor the varied diversity of not only race and ethnicity, but also age, gender identity and expression, religion and spirituality, and other facets of one's identity. This component is necessary due to the reality that 1 in 4 direct care workers are immigrants.²²

Given that research tells us that more than half of home care workers have completed no formal education beyond high school, and thirty-seven percent of home care workers report speaking English "not well" or "not at all", we find it imperative that any training be sensitive to the limited English language needs and educational attainment levels that many caregivers face.²³

Potential Funding Options/Cost-Savings/Benefits:

- Any DHS work to update rates for providers must include tiers recognizing providers that are aligning training for their workforce that aligns with this new standard and supporting workers who achieve the credential
- Direct Care Workforce funding should support the funding of the approved college credit for those who achieve this level of training, adding a significant new benefit that can be promoted to potential workers;
- Require DWD to allocate \$1,000,000 from the Department Workforce Training Grant GPR appropriation ("Fast Forward grant") in the 2021-2023 fiscal biennium budget for grants to develop the training tier and to train new DSPs.
- Early implementation could benefit from the available "Fast Forward" grant:
 - (5i) Fast Forward grants for personal care workers. Of the amounts appropriated under s. 20.445 (1) (b) in the 2019-21 fiscal biennium, the department of workforce development shall allocate moneys for a grant program that promotes the attraction and retention of personal care workers who provide home-based care and community-based care and that focuses on providing quality care.
 - 106.27 (1) (g) Grants for programs that promote the attraction and retention of personal care workers.²⁴
- PHI – Explore grant opportunities available.
- Center for Healthcare Strategies, Inc. - Explore grant opportunities related to their, "Training and Supporting Community Health Workers and Promoters and their lessons from work with California and other States".

²² PHI. 2018. https://phinational.org/wp-content/uploads/2018/09/DCW_ImmigrantWorkers_PHI_2018.pdf. Bronx, NY: PHI.

²³ PHI. 2017. <https://phinational.org/resource/u-s-home-care-workers-key-facts/>. Bronx, NY: PHI.

²⁴ WI State Legislature. 2020. <http://docs.legis.wisconsin.gov/2019/related/acts/9/9150>

- Maximize use of any continued WisCaregiver Career program funding or infrastructure.²⁵

Savings / Benefits Include:

- Hiring entities may benefit from cost savings associated with decreased turnover and recruitment expenses.
- Empowering DSP through training to handle new responsibilities such as assisting with “observation” and reporting, educating clients on health promotion and supporting the Care Team with coordination across disciplines would improve quality of care and potentially reduce cost.²⁶
- Providers or organizations may also experience cost savings by mitigating risk and cost associated with liability, workers compensation claims, and retention of client base through client satisfaction.
- A higher quality workforce could reduce hospitalization, emergency room utilization, and costs associated with poor care to individuals. Families and individuals will benefit from the assurance that a worker has a standardized base level of knowledge and skill that includes essential components that are not currently consistently required or prioritized.
- The ability to include DSP training credentials and recognize these standards of practice within a registry will help individuals, families and agencies in the hiring process. An avenue for credentialing Direct Support Professionals with the option to identify this within their registry profile.
- Partnerships with existing training options that align with state regulatory requirements (DHS 105.17) such as DCC developed by WPSA. Collaborating with the Technical Colleges and other accredited state educational facilities for transferable credit will reduce the cost of continued education for DSP’s.²⁷

Cost Estimates:

- The cost to increase wages for Direct Support Professional who complete each tier.
- Consistent with Rate Band Proposals that would support incentive payments to providers who hire a certain percentage (For example: 5% Tier-One DSPs, 8% Tier-Two DSPs, and 10% Tier-Three DSPs.) of DSPs with certificates
- DHS staff time.
- To provide technology for e-learning, testing, and tracking of data.
- Administrative costs related to:
 - DSP competency testing,
 - DSP and trainer continuing education,
 - Training evaluation,

²⁵ Wisconsin Department of Health Services. 2020 <https://www.dhs.wisconsin.gov/caregiver-career/index.htm>, Madison, WI

²⁶ PHI. 2017. <https://phinational.org/issue/training-advanced-roles/>. Bronx, NY: PHI.

²⁷ Wisconsin State Legislature. 2020. https://docs.legis.wisconsin.gov/code/admin_code/dhs/101/105/17

- Review and approve provider-training programs to ensure that they meet the regulatory standards and tiered requirements.

State agency or other entity responsible for implementing the proposal, if it were approved (e.g. DHS, DWD):

- DHS
 - To determine how licensing and authority of training sites will be determined.
 - To certify the components of the training and standards of practice.
 - To extend the technology of the WisCaregiver Career Program to assist in developing online training and testing options.²⁸
 - To collaborate with training sites to identify options for tracking and housing DSP certification data.
 - To offer guidance related to certification data sharing with the registry.
- Wisconsin Technical College System
- Community-based personal care/supportive homecare providers
- Facility-based providers
- IRIS participants
- Family Care participants
- CLTS participants
- Other Long Term Care participants
- Non-HCBS/LTC funded recipients of care

Public Input:

86% of the public comments indicated support and recognition of the value of a consistent statewide training. From those comments as well as comments submitted by DQA and DHS, adjustments to this proposal include:

- Further define the 3 tiers as the attachment indicates.
- Take existing training into consideration such as:
 - A statewide Geriatric Nursing Assistant program, integrating credit-based learning through technical colleges. Base training for all licensed CNAs should include increased training in dementia, end of life, and hospice. This aligns with the Dementia State Plan, 2019-2023.²⁹
 - Add courses such as dementia specialist, person centered assessment and planning, crisis interventions/managing challenging behaviors to the CBRF training program.³⁰

²⁸ Wisconsin Department of Health Services. 2020 <https://www.dhs.wisconsin.gov/caregiver-career/index.htm>, Madison, WI

²⁹ Wisconsin Department of Health Services. 2020 <https://wcltc.wisconsin.gov/wcfiles/state-dementia-plan.pdf> Madison, WI

³⁰ Wisconsin Department of Health Services. 2020 <https://www.dhs.wisconsin.gov/regulations/cbrf/training.htm>. Madison, WI

- Use WPSA’s DCC Best Practice training program as a tier to laddering to CNA. DCC is a proven successful model since 2005. Working with WPSA professionals as a team to incorporate this training model, SAVING DOLLARS, rather than reinventing a training program would benefit all.
- Realizing that portability exists for Certified Nursing Assistance, this proposal encourages equity among all care settings. Therefore, training focus is on the needs of caregivers associated with CBRF, AFH, RCAC, and community based Personal Care Agencies settings.
- Continuing education opportunities to support skills demonstration/evaluation.

Additional Material for Direct Support Professional Standardized Training

These training topics are to be applicable to meet certification requirements across all categories of care settings – including long-term care residential facilities (i.e. nursing homes) and home and community based settings (i.e. homes, apartments, and other supported living environments).

Furthermore, the compensation ascribed to each tier shall increase with each additional tier as training and skill develops.

Tier 1

‘Standards of Practice’:

- Bathing
- Toileting
- Grooming
- Dressing
- Skincare
- Feeding and assistance with feeding (oral only)
- Non-mechanical supported transfers
- Hoyer and other mechanical supported transfers
- Ability to recognize obvious home safety hazards and remediate them
- Basic fire safety (e.g. operate handheld fire extinguisher, knowledge of fire escape plan, etc.)
- Respond to medical emergencies (e.g. calling 911, emergency contacts, etc.)
- Infection control
- Universal precautions
- Hand washing techniques
- Proper use and disposal of personal protective equipment (PPE)
- Housekeeping (e.g. vacuuming, sweeping, dusting, washing dishes, etc.)
- Meal preparation (e.g. safe handling of raw food, use of oven, microwave, stove, etc.)
- Grocery shopping
- Laundry (e.g. operation of washer/dryer, use of liquid/powder detergents, folding clothes)

‘Soft Skills’:

- Active listening (e.g. eye contact, body language, nonverbal cues, etc.)
- Problem solving
- Critical thinking
- Responsible
- Team-oriented(their role in a multidisciplinary team)

Training on the following:

- Cell phone/social media etiquette
- The family unit and family member “roles” (parent, child, sibling, etc.)
- Death, dying and end of life
- Cultural competency
- Client Rights under WI State Statute
- Caregiver/DSP ethics
- Confidentiality, Privacy and HIPPA
- Reporting abuse and neglect (e.g. Mandated Reporter)
- Caregiver misconduct consequences
- Client Grievance Process via DHS’ Department of Quality Assurance
- Person-first language
- Independent Living Philosophy
- Awareness of all Long Term Care target groups: (physical disability, developmental disability, older adults, children)
- Disability rights history
- Trauma Informed Care
- Addressing challenging behaviors and conflict
- Record keeping (as designated by the State EVV training requirements) Timesheet documentation protocols / provider protocol

Tier 2 Topics

- Empowering DSP through training to handle new responsibilities such as assisting with “observation” and reporting, educating clients on health promotion and supporting the Care Team with coordination across disciplines would improve quality of care and potentially reduce cost.
- Record keeping (2 locations – EVV Documentation, timesheet, etc)
- Reporting critical incidents and events
- Verbal de-escalation
- Mentoring skills
 - Peer to peer / workforce
 - Client mentoring
- Job coaching techniques (Direct Support Professional– DSP)
- Knowledge of Long Term Care and other community resources
- Care Coordination

- Procedures for handling complaints
- Alzheimer's/dementia/memory loss
- Traumatic Brain Injury
- Working with children and adolescents with disabilities
- Strategies for DSP and caregiver wellness

Tier 3 Topic

- Successful completion of minimum of 75-hr. training requirements leading to CNA certification.
 - Develop a statewide Geriatric Nursing Assistant program as the top tier, integrating credit-based learning through technical college. - Base training for all licensed CNAs should include increased training in dementia, end of life, and hospice. This aligns with the Dementia State Plan, 2019-2023.

Recognition and Recruitment of Direct Support Professionals

Policy Title: Recognition and Recruitment Campaign for Direct Support Professionals

Primary Contact for the Proposal: LaVerne Jaros

Other Members Who Worked on the Proposal: Margie Steinhoff, Lisa Pugh

Brief Description:

This proposal provides a statewide marketing strategy to recognize and recruit direct support professionals, timing its roll out to recognize the impact of the COVID pandemic on state revenue and the primacy of worker compensation reforms to an adequate workforce.

- Phase one would develop and disseminate marketing tools to community and facility-based provider agencies, trainers, health care employers and other stakeholders for their use in social media, on websites and other outlets to attract prospective employees.
 - Tools will be designed that can be easily customized and replicated by various employer agencies to use in their recruitment efforts. DHS, providers, ADRCs, associations and others will help to create awareness about and disseminate these free templates.
 - Materials will be developed in consultation with community leaders of underserved groups to assure cultural appropriateness.
 - Assets already developed for the DHS WisCaregiver Careers Program and other sources may be adapted to create customizable templates for print material, social media and other tools, highlighting diversity of professionals and consumers in age, gender, ethnicity and disability across care settings. Currently these materials are geared toward Certified Nursing Assistant (CNA) positions in institutional care settings. Specific attention will be given to expanding materials relevant to community-based care.
 - Permission may be sought from organizations in other states to use/purchase and distribute the excellent videos they have developed featuring diverse consumer and professional populations in various support settings.
- Phase two would be launched after other reforms take effect that would make careers in direct care more attractive (i.e. better wages, benefits). The WisCaregiver Careers program would be leveraged to create a statewide initiative to recognize and attract direct support professionals for care positions in nursing homes, assisted living, in-homecare, personal care and self-directed supports. DHS would administer the program, manage a revised WisCaregiver Career website and oversee amended contracts and interagency agreements for marketing and tracking.
 - Using the tools developed in phase one and protecting against racial bias in media algorithms this will include: website, a social media marketing launch.
 - This phase must include an evaluation component. This may include extending the collaboration between DHS and UW Oshkosh to provide a tracking system for two years that will provide data about the success of program components, who it is reaching, whether enrollment in training and jobs has increased and how long people are remaining in their jobs. This will include: Survey data from participating

students, training programs and employers; Secure login that will give participants access to certain information such as marketing assets, toolkits, etc.; program evaluation

- Alternatively, the Department should evaluate whether extending its current National Core Indicator survey contract to include the [Staff Stability Survey](#) would provide comprehensive and essential ongoing information about the effectiveness of marketing and recruitment investments and other investments in the workforce. The Stability Survey is helping states track reliable data on turnover, wages, benefits, and recruitment/retention strategies. More information here: <https://www.nationalcoreindicators.org/staff-stability-survey/> Evaluation efforts/surveys would need to be inclusive of workers supporting all populations in Wisconsin's long-term care system.
- Phase two may also include administration and evaluation of mini-grants to providers or provider coalitions to develop high intensity local/regional campaigns that may include the above marketing materials in addition to local assets and strategies.

Analysis

- **Anticipated Benefits**

Compensation, training and other task force proposals are key to stemming Wisconsin's critical shortage of staff to care for citizens with disabilities and older adults. However, the urgency to fill our care gap also requires concurrent messaging and outreach to untapped workers so that they can learn about the need, value and variety of settings in which they could make a difference in peoples' lives. That messaging will also tell current workers that they are valued by their communities.

- The previous WisCaregiver campaign, focusing on nursing assistant careers, attracted over 9,000 people to register for the program.
- [Community Living Connections](#), a statewide non-profit provider agency, generated 20 new applicants a month through a targeted social media campaign in 2019. Agencies are finding social media recruitment efforts to be both successful and cost-effective.
- Using digital media campaigns Minnewaska Community Health and Mother of Mercy in Albany MN significantly increased hires with increased retention and reduced turnover.
- Small employer providers with limited marketing budgets will benefit from the investment in free template materials that are customizable to their market and needs.

- **Health Equity/Disparities Considerations**

- Low income consumers are affected disproportionately by care worker shortages as they are more likely to be in Medicaid funded facilities or programs where low MA rates have contributed significantly to the worker shortage. Increasing the pool of workers through wages, training and intensive recruitment will help.
- Relative to potential new workers, registrations for the WisCaregiver program were from individuals of whom 45% were white, 45% black or African American, 5% Hispanic or Latino and 5% other races.

- The expanded WisCaregiver Careers campaign will provide potential candidates with information about alternative care settings and training paths to best meet their individual circumstances.
- Recruitment materials will be informed by best practices in outreach to diverse populations, and in consultation with diverse community leaders, and should include guidance on how to best reach targeted populations within a community.

Costs and Potential Funding

Phase One Estimate: \$25,000-\$75,000 depending on breadth of assets/tools redesigned for template use.

Phase Two Estimate: \$200,000 over two years; plus
\$100,000 over two years for tracking and evaluation
\$100,000 for mini-grants (\$25,000 x 4)

Public Input:

72% of the 346 individuals who responded to the public Feedback Survey, strongly supported this proposal; 15% somewhat supported it. There were over 125 comments. Many were reminders that recruitment, and subsequent retention of direct support professionals will only be successful if we improve their wages and compensation. A number of comments cautioned about the need to assure cultural diversity and protect against racial bias in media algorithms relative to the marketing campaign. Several commenters were concerned about cost and whether dollars would be better spent on wages. This input was reflected in the final proposal and its' separation into two phases. There were many other excellent suggestions that can be utilized in planning and implementation, should this proposal be approved.

Policy Title: Background Check Policies

Executive Order Charges relating to this proposed policy:

- Analyzing strategies to attract and retain a strong direct care workforce
- Supporting families providing care for their loved ones through respite services and other supports
- Developing a plan to implement recruitment and retention programs to expand the pool of providers
- Exploring and developing solutions, in collaboration with other relevant departments and agencies, to support and strengthen the direct care workforce, increase access, and improve the quality of caregiving in Wisconsin.

Primary Contact:

Jane Bushnell

Names of Other Members Who Worked on the Proposal:

Todd Costello, Jason Endres, William Crowley, Margie Steinhoff

Brief Description and Policy Components:

There are many untapped workers in Wisconsin that possess the skills/experience or could be trained to provide quality caregiving. This proposal looks to expand the Direct Support Professional (DSP) pool of applicants by eliminating barriers to hiring related to background checks and creating consistent hiring criteria across all adult Long-Term Care programs.

Policy Components:

- Uncover the existing barriers and inconsistencies that prohibit the hiring of individuals with similar background check findings in IRIS.
- Recommends that IRIS adopt the background check process and criteria that agencies and self-directed clients use within the Family Care System
- With safety being of utmost importance, a risk agreement would be developed based on informed consent disclosed by the background check. This would be similar to Act 172 used within the Family Care system. This agreement would provide an avenue for disclosure of certain (non-barred) convictions between the parties and reduce risk while allowing the participant the choice of hiring a qualified caregiver.
<https://docs.legis.wisconsin.gov/2007/related/acts/172>
- Increased quality-monitoring initiatives and standards would be developed to support the health and wellbeing of consumers who choose to hire individuals with a risk agreement. These standards would be followed by Managed Care Organizations and IRIS Consultant Agencies. Recurring analysis would be required to ensure this change creates the desired effects and does not increase risk to the individuals needing cares.

- Targeted recruitment strategies to address this untapped workforce.
- Allow the use of the Rehabilitation review process for all Adult Long-term care programs

Analysis and Anticipated benefits:

- This proposal could increase the applicant pool of Direct Support Professionals (DSP) by 5,000-7,000 based on the following:
 - Fiscal agent supporting IRIS estimates that 10% of IRIS worker applicants have background check issues that make them ineligible for hire.
 - As of December 1, 2019, the IRIS enrollment map shows 20,044 participants/consumers.
 - A fiscal agent reached out to DHS and gave an estimate of 2.5 workers for each IRIS participant.
 - Calculation of $20,044 * 2.5 = 50,110$. $50,110 * 10\% = \underline{5,011}$
 - In addition, a fiscal agent supporting IRIS estimates that 5-10% do not even apply for positions due to background check criteria.
 - Calculation of $20,044 * 5\% = \underline{1,002}$
- Current experience suggests that the request to hire individuals are often family members or friends who are currently providing unpaid support for these same services. However, these same caregivers might be barred as a paid DSP based on past convictions which may have occurred several years ago or do not relate to client care. This leaves the participant to find a caregiver not as skilled or knowledgeable. This proposal creates an equitable avenue to allow friends or family members to continue to provide needed supports and earn wages.
- Eliminates barriers to obtain workers
 - The workgroup created a crosswalk across all adult programs. Findings showed there were 40+ additional convictions in the IRIS program that make applicants ineligible for hire. (Note that in some cases the applicant can appeal this based on the conviction.)
However, these same applicants could be hired by self-directed individuals within the Family Care system.

Potential cost savings & benefits:

- Support the choice of individuals who wish to hire applicants with prior convictions where the convictions are several years old and/or do not directly relate to client care.
- Creates equity and consistency among all adult Long Term-Care programs and recipients.
- In some instances an IRIS participant could hire the same Direct Support Professional at a lower cost with this proposal because if that person cannot be hired through IRIS due to the extensive barred list, then could possibly be hired through an agency at a higher cost.

- WI State Medicaid Program could achieve cost savings through the efficiency of IRIS participants hiring DSP's directly, reducing the amount of IRIS consumer budget amendments.
- Allow for employment for rehabilitated individuals with a criminal history that could minimize their use of other public funded services and increase the tax base.

What state agency or other entity would be responsible for implementing the proposal, if approved.

- DHS
- DWD
- State Rehabilitation Program
- IRIS Consulting Agencies and Fiscal Employer Agents
- Self-Directed IRIS Participants
- Provider Agencies
- Wisconsin Dept. of Justice/Criminal Justice System

Cost estimates:

- Potential low administrative costs associated with:
 - Recruitment and onboarding of this workforce
 - Develop system wide risk agreement criteria / process
 - Data collection and any related quality initiatives to ensure the health and safety of consumers employing individuals with a risk agreement.
 - Increased administrative costs with additional Rehabilitation review processes

Equity and Inclusion:

- This proposal supports equity and inclusion principles by reducing bias and discrimination for individuals who have convictions and are attempting to reenter the workforce and make a positive contribution to their community.
- Statistics show African Americans and minorities have higher crime and incarceration rates. African Americans are incarcerated in state prisons at a rate that is 5.1 times the imprisonment of whites. In five states (Iowa, Minnesota, New Jersey, Vermont, and Wisconsin), the disparity is more than 10 to 1. Data from Paraprofessional Health Institute shows that 37% of DSP's in Wisconsin are people of color. This proposal would remove barriers and inequities for these populations to enter/re-enter the workforce. <https://www.sentencingproject.org/publications/color-of-justice-racial-and-ethnic-disparity-in-state-prisons/#III.%20The%20Scale%20of%20Disparity>
<https://phinational.org/policy-research/workforce-data-center/#var=Race+and+Ethnicity&states=55>
- In 2017 The Arc of the United States provided funding to seven different states to develop family support coalitions, included in Wisconsin. In a summary report, participants in the Wisconsin Family Support Coalition event hosted at the Wingspread

facility in Racine, WI in August 2017 identified many linguistic and cultural barriers preventing families from diverse backgrounds from accessing services and navigating the system. Participants heard from a panel of Wisconsin experts in supporting families that are African American, Hispanic, Native American, and Hmong. Panelists shared stories of individuals forgoing care because they were unable to hire a family member and could not find or did not trust another person to provide care. The Wisconsin family support coalition developed six strategies to improve supports to all families of people with disabilities and older adults in the state, including a recommendation to “*amend current caregiver background check policies and ensure families can hire the care providers they want.*”

- 2015 – 2017 Family Support Research and Training Center (FSRTC) State Coalition Report - <https://fsrtc.ahslabs.uic.edu/wp-content/uploads/sites/9/2018/06/18-033-FSRTC-Family-Support-Summary-Technical-Report.pdf>

Barriers:

- DHS is seeking to change the background check statutes across all Long-Term care programs. At this time, the criteria/process has not been determined. The statute request may or may not align with this proposal.

Public Input:

- Public input collected from the Governor’s task force actions on this proposal suggest strong support as follows:
 - Strong support 58.1%
 - Somewhat support 17.1%
 - Neutral 9.4%
 - Somewhat oppose 7.7%
 - Strongly oppose 7.7%
- Public concerns and opposition included that of safety concerns; therefore, this proposal was enhanced with components to include the development of a risk agreement and quality monitoring initiatives
- Public comments regarding the need for consistency across programs and the need to enhance recruitment efforts by offering choice, equity, and inclusion.
 - “*The current background check process is highly unfair to IRIS participants. The two systems should align.*”
 - “*This proposal is a good first step. I would like to see more action taken to explore and support recruitment of the formerly incarcerated and/or those with a criminal record. This is a large untapped labor pool, and most of these individuals were charged with "petty" or victimless crimes (in other words, they were not convicted of violent crimes or other offenses which would bar them from working with vulnerable populations). Even so, these individuals are too often*

discriminated against or passed over for employment opportunities. The provider I work for has long supported the idea of giving people a second chance or a fresh start, and it has worked well for us. I believe it's worth exploring on a larger level."

- *"Again, I support background checks for caregivers. However, the current process is biased against people of color. This must change. So too, the sexual offender registry disproportionately affects people of color that don't have access to effective legal counsel so end up on the registry as an unintentional result of a plea bargain."*

Medicaid Provider Regulatory Guidelines

Policy Title: Medicaid Provider Regulatory Guidelines

Work Group Members: Mo Thao-Lee and Adien Igoni, Rep. Chuck Wichgers and Mike Pochowsk

i

Brief Description, with Bullets Showing the Specific Components of the Policy:

Direct care providers support efforts to fight waste, fraud and abuse in the state’s Medicaid program. However, inconsistent rules and policy interpretations used by both the State Division of Quality Assurance (DQA) and the Office of Inspector General (OIG)-- have made it difficult for providers to navigate the regulatory landscape, led to direct support professionals leaving the profession and limited access to care for consumers.

Burdensome and inconsistent regulatory policies can negatively impact small business providers and direct support professionals. Direct care providers and professionals are increasingly choosing to leave the Medicaid program. This directly harms individuals in need of caregiving services by either limiting their choices about who provides their care or, in some areas of the state, leaving them with no choices at all. Immigrant direct support professionals, with limited English proficiency or administrative skills, can feel ill-equipped for the rigorous documentation required by their jobs, and thus turn away from the profession. Unfortunately, if direct support professionals cannot meet the strict paperwork standards needed for regulatory approval, they are at risk of losing their job. This leads to quality direct support professionals leaving the workforce. A *Wisconsin State Journal* [article](#) highlighted the stories of several private duty nurses who left the profession as a result of these issues.

The Wisconsin Supreme Court ruled unanimously on July 9, 2020, that the Department of Health Services Office of Inspector General’s (DHS OIG) audit and recoupment “perfection policy” goes beyond statutory authority. The Court directed DHS OIG to limit recoupment activities to situations where DHS OIG cannot verify one of the following: 1) that services were actually provided; 2) that the reimbursement claim is appropriate for the service provided; 3) that the reimbursement claim is accurate for the service provided.

The Wisconsin Supreme Court ruling is limited to OIG’s ability to recoup payments. This presents an opportunity for stakeholders and DHS staff to work collaboratively on enacting additional reforms aimed at enhancing provider education and quality efforts and to streamline policies between regulatory entities. **Strengthening collaboration and adopting consistent policies will increase quality, improve access to care for consumers and allow direct support professionals to focus on providing hands-on care.**

- 1. Establish a collaborative workgroup of DHS staff, direct support professionals and providers to implement the Wisconsin Supreme Court’s Papa vs. DHS ruling and develop practices that support high-quality providers through enhanced education efforts and corrective action processes. The workgroup should:**

- a. **Be guided by the Papa vs DHS ruling** as they work to evaluate and address any pending recoupment efforts.
- b. **Ensure that Regulatory Interpretations are Consistent between Regulatory Entities DQA and OIG.** According to a 2020 survey of Wisconsin Personal Services Association members, 42% of respondents said that OIG ordered them to pay back money for a regulatory issue that was in direct conflict with advice from DQA. The interpretation of policies need to be consistent between DQA and OIG to ensure that DHS staff are consistently interpreting regulations and to ensure that Medicaid providers and direct support professionals understand the regulations.
- c. **Develop a corrective action process** to fix documentation or clerical errors instead of implementing penalties for paperwork mistakes that do not impact consumer care (i.e. bad penmanship, missed signatures, etc.). 76% of WPSA agencies surveyed said that OIG did not provide them with any guidance on how to fix the “errors” for which they were being required to return their pay.
- d. **Develop a process to give providers at least 30 days** from the date they receive DHS’s preliminary audit results to provide additional documentation not provided to DHS during the audit.
- e. **Look at creating administrative flexibilities.** Currently, DHS OIG can and has penalized agencies for **scheduling RN supervisory visits** outside of the normal plan of care hours. **Agencies should be given flexibility** to work with the client, the direct support professional and the RN supervisor to schedule a time for this administrative visit to occur when it works with everyone’s schedule.
- f. **Limit recovery window to one year.** An emphasis should be placed on proactively working with providers and direct support professionals to address potential errors early on with the opportunity to correct mistakes. Given the high client and direct support professional turnover rate, an extended look-back period creates budgetary uncertainty for agencies and direct support professionals. Providers have already paid their direct support professionals for services rendered. It is not financially sustainable for providers to be required to pay back money years later. There have been audits where hundreds of thousands of dollars were recouped in situations where the client was either deceased or discharged months, or even several years, before the

audit took place. The workgroup should develop the following look-back windows.

1. **External Audit:** the look-back period should not be more than 90 days for external audits related to client hospitalization.
2. **Internal Audit:** (OIG onsite at the agency to perform the audit): the look back period should *not* be *more than* 12 months from dates of payment.

2. Establish a Collaborative Workgroup with DHS Staff, direct support professionals, Consumers and Providers to Develop Consistent Processes Across Medicaid Programs and Payers.

Steps need to be taken to improve communication and care coordination in our long-term care system. Direct care providers and direct support professionals contract with many different programs and payers (Family Care, IRIS, BadgerCare, MCOs, HMOs etc.), most of which have their own unique policies and procedures in place. These often-duplicative administrative functions take scarce resources and funding away from direct support professionals' wages and retention investment. In addition, some processes such as prior authorization delay consumers receiving care and create a lag in providers and direct support professionals receiving pay. The workgroups should evaluate and find solutions for creating:

- a. Consistent **service authorization** processes (i.e., prior authorization period should be at least 1 year across all programs)
- b. **Consistent discharge/change of service processes** and timeframes when a client is either discharged or has a change in authorized hours. This would help prevent disruption in services.
- c. **Prior Authorization Consistency to ensure continuity of care.** Clients enrolled in Medicaid often have their insurance plan changed--sometimes without their knowledge or the provider's knowledge. Consistent prior authorization processes across Medicaid will prevent unnecessary disruptions to client care.
- d. **Electronic Signature Capture.** Providers should have the flexibility to use electronic signatures for documentation of services rendered for personal care services. This will lead to faster service delivery.

Analysis -- Describe the Following Items in as Much Detail as Possible:

Benefits:

- **Puts direct support professionals' focus back on providing care.** The emphasis placed on documentation and paperwork increasingly pulls direct support professionals' focus away from providing hands-on care. As we work to make regulations and policies consistent across programs, direct support professionals can get back to doing what they do best---caring for their clients. Addressing over-regulation and moving away from the documentation "perfection policy" will also keep qualified immigrant direct support professionals in the workforce and allow them to advance, alleviate burnout experienced by direct support professionals. Rigorous documentation requirements in charting place extra stress and administrative burdens on direct support professionals.

- **Supports Quality Providers and Keeps them in the Medicaid System.** Providers across the Medicaid system struggle to meet increasing, unfunded administrative mandates in the face of low reimbursement rates. Provider are increasingly choosing to leave the Medicaid program due to excessive administrative requirements, which impacts consumer access to care. Streamlining regulations across programs will alleviate administrative strain on providers. In return, providers will have more time to focus on providing quality care to consumers and more time in educating and updating direct support professionals on most up to date skills.
- **Increases Access to Care for Consumers.** Wisconsin is experiencing a severe shortage of direct support professionals, which is limiting consumer access to care. Regulatory practices that are burdensome for small employer providers have forced some agencies out of business or caused direct support professionals to leave the profession, increasing the shortage in some areas of the state. As Wisconsin takes steps to retain quality Medicaid providers, consumers will benefit from having more options to choose. In addition, adjusting current Medicaid prior authorization guidelines will increase continuity of care for consumers.

Health Equity/Disparities considerations: Wisconsin direct care providers have increasingly relied on direct support professionals who come from minority or immigrant communities to fill their positions.

These individuals are negatively impacted by regulatory policies that do not have an equity focus. In addition, rural areas often struggle with a lack of providers, and are disproportionately impacted by policies that lead to providers exiting Medicaid.

1. Diminishing Immigrant Provider Network:

- a. Immigrant providers often provide holistic services to address the need of non-English speaking population, making their work more complicated and costly.
 - i. The need to have seamless communication with immigrant consumers means hiring native-speaking direct support professionals.
 - ii. Many immigrant direct support professionals struggle with penmanship, documentation such as filling complex timesheets, and care plans.
 - iii. Immigrant direct support professionals are often excellent direct support professionals but may not be proficient at the reading and writing-even in their native language
 - iv. Providers have to advocate as translator/interpreter for the consumer and their family members with the wider community on a broad-range of social services (i.e. bill payments, annual Medicaid/Medicare renewal application, MD appointments, housing, transportation, etc.) because provider is the only resource or outlet for the client and client's family members.
 - v. Often clients or direct support professionals do not read or write; Bilingual documents alone do not help.
 - vi. Interpreting/translating services offered by MCOs and HMOs help some, but are often inadequate, if the interpreter is not adequately

trained. (i.e. jaundice/pale--there is not a specific word so often time it's translated as "yellow ear")

- e. **Diminishing provider network in rural areas:** 24 of Wisconsin's 72 counties have five or fewer personal care providers. As agencies continue to close due to low reimbursement rates and unfunded mandates, consumers in rural parts of the state are left with fewer and fewer options for receiving care.
- **Potential funding options/cost savings/benefits:**
 - These regulatory changes **do not require funding**.
- **Cost estimates:** Include information on whether costs would be one-time or on-going, and as close an approximation as is available (e.g. several million dollars annually; \$500,000 on a one-time basis; \$100 to \$200 million annually)
 - These regulatory changes do not require funding. It will result in providers retaining more of their hard-earned payments, which will support provider and direct support professionals' operations and wages. It will also lead to increased retention of direct support professionals.
- **What State agency or other entity would be responsible for implementing the proposal, if it were approved?**
 - DHS (DQA) and OIG
 - DHS

Public Input:

219 individuals provided feedback about this proposal through the Task Force public input survey. 71.2% indicated strong support and 14.2% indicated somewhat support. Those who expressed caution were concerned about fraud and waste. The proposal was updated to emphasize the intent to maintain a strong fraud, waste and abuse oversight process, while addressing concerns that negatively and unnecessarily impact direct support professionals and small business employers. Many commenters supported the idea of helping to better educate both provider agencies and direct support professionals to avoid infractions.

In a meeting with Task Force subgroup members on August 13th, OIG staff expressed willingness to work collaboratively with providers on audits and claims. DQA provided written feedback to the Task Force on August 11 stating that DQA and OIG are working on a more unified application/enrollment process for personal care providers. In addition, they clarify the focus of DQA's regular review of providers (done in accordance with state statute) is to evaluate whether clients are receiving quality care and treatment as outlined in their plan of care.

Home Care Provider Registry:

Home Care Provider Registry Recommendation

Policy Title: HCBS/Care Worker/Care Recipient Matching Registry

Governor’s Charge:

Establishing one or more registries of home care providers and developing a plan to provide referral or matching services for individuals in need of home care.

Primary Contact for the Proposal: Lisa Schneider

Other Members Who Worked on the Proposal: Todd Costello, Lisa Pugh, Jane Bushnell, Tod Behnke, Stephanie Birmingham, Jason Endres, William Crowley

Brief Description, with Bullets Showing the Specific Components of the Policy

Brief Description/Policy Goal:

Establish a free, safe, secure statewide registry to serve as a platform to ‘connect’ people looking for care/support for children with disabilities, adults with disabilities and older adults as well as others with chronic conditions and/or family caregivers in need of Home and Community Based Services (HCBS) with Direct Support Professionals (DSP - Care Workers) interested in providing HCBS. Individual consumers/employers and prospective employees will be responsible for performing their own due diligence, conducting background checks and interviews, and establishing clear expectations to best ensure the needs of the care recipient will be met. The registry is not intended to replace the employer tasks needed to hire a DSP, nor will it create an employer/employee relationship of any kind. The registry will not be responsible for the authorship or accuracy of DSP profiles, nor will it endorse any profile listings. Participation in, and utilization of the registry is voluntary and will be useful for those who use either public or private funds to pay a direct support professional to provide care in their home or community.

Specific Components/Policy Strategy:

The following strategy is based on an RFI process of which the [Lightest Touch](#) was a respondent. The Registry Workgroup viewed a demo of the Lightest Touch, in addition to several others. The following strategy is based on the learnings and understanding of the workgroup that best meet the goals of the policy above. **Lightest Touch will work with DHS/DWD to:**

- **Pilot the Lightest Touch software platform** statewide for 1 year and provide all users full functionality and advanced features for free for the first 3 months. After the first 3 months, users can continue to use the software for free and/or pay for the advanced, optional features. No care workers will be dropped from the registry, regardless if they choose to pay for advanced features or not. **(See text box section on page 5 below that describes which users may incur fees for optional features such as agencies wanting to*

post job openings. The platform is always free for individual care recipients seeking workers and individual workers looking for care hours)

- **Facilitate the sharing of data** contained within DHS/DWD to populate Lightest Touch's registry at no cost to the state.
- **Perform quarterly user evaluations** to determine the utilization, effectiveness, and other key metrics to assess the platform and usefulness. It is recommended a workgroup of volunteer stakeholders be formed to support the evaluation process.
- **Provide the state with the necessary information** to issue member bulletins or memos statewide to promote the Lightest Touch platform which houses the Care Worker Registry.

Analysis -- Describe the Following Items in as Much Detail as Possible:

Anticipated benefits:

[Lightest Touch](#) software platform supports In-Home and Community-Based Long-Term Care Supports. ICA's, MCO's, ADRC's, Private Pay Clients, Provider Agencies, Independent Care Workers, and Vendors of the Care Service industry are supported on the platform. Lightest Touch is a HIPAA compliant database with a platform that allows everyone in the industry to join and then find each other. The Lightest Touch is a robust platform that provides:

- A database of organizations that support this industry, each with their own contact pages, with the ability to market their services & products to clients.
- A registry of people providing respite, attendant care, daily living skills, home services, community integration, housekeeping, transportation, job coaching, companionship, personal cares, and so much more.
- Search tools for all users to find what they are looking for with filters to refine matches.
- Ability for funded clients, private pay clients, the client's natural supports, and the client's funding sources to search for the right caregiver, service, and/or products the client needs
- Vetting systems and verifications of attributes such as background checks & certifications
- Training and career paths for providers of respite and Caregiving
- Client outcome goals and caregiver career goals to help the software suggest opportunities to reach them
- Resources such as transportation, durable medical equipment, home monitoring devices, etc.
- Provider agencies with access to better training for their employees and more opportunities for their employees to find additional hours near them.
- Independent caregivers/providers and provider agency employees to search for the right client
- Funding source care teams with more (and better) options for their clients

- User friendly interface accessible from personal computers, tablets, and smart phones
- Reports and monitoring tools for provider agencies and funding sources.

It is worth noting that many HCBS agencies throughout Wisconsin have seen a demo of Lightest Touch and there is strong interest in this platform naturally.

Users of the registry:

[Lightest Touch](#) is designed to support the clients, care workers, and the support systems needed, such as funding sources, natural supports, provider agencies, and other agencies that support the industry. Care workers can use the Lightest Touch system regardless if they work for an agency or if they work independently. Likewise, clients can benefit from Lightest Touch platform regardless if they are private pay or funded by an MCO, HMO, IRIS, Insurance, etc. Each user account for a caregiver that is uploaded (with permission) to the registry database will hold metadata related to that user's role such as background checks, certifications, training, and services needed to refine and improve search results. Again, it is the responsibility of an individual employer to verify the accuracy of this information to the degree needed.

Equity/Disparity Lens:

Worker Impact: The Wisconsin Personal Services Association (WPSA), an organization representing 73 personal care providers, surveyed its members in 2015 and 2016 and found that **93 percent of personal care providers reported difficulties in filling job openings, and 70 percent were unable to staff all authorized hours.**³¹ In the absence of paid caregivers, people needing in-home support typically rely on families and friends for assistance. However, family caregiving can be arduous and costly, forcing relatives to limit their work hours and pay for health care costs out-of-pocket.³²

Consumer Impact: The Survival Coalition, representing people with disabilities throughout the state, found that among their constituents surveyed in 2016, **95 percent reported difficulties in finding home care workers.** Moreover, 85 percent of the respondents reported not having enough workers to fully cover open shifts. The Survival Coalition also gathered personal stories to humanize these trends. In one, a short-staffed Florence county resident attempted to transfer into bed without assistance and fell. The resident stayed on the floor for nine hours until a worker began her shift the next morning. Another story involved a Winnebago county resident who could not find a replacement for a sick home care worker and was forced to stay in bed for 15 hours

³¹ WPSA, 2017a. <http://wpsa.us/sites/default/files/WPSA%20Talking%20Point.pdf>.

³² https://phinational.org/wp-content/uploads/2017/09/wisconsin_home_care_landscape_phi_2017_0.pdf

without access to the restroom.³³

The importance of having a comprehensive statewide platform ‘connecting’ workers and consumers is critical to the economic vitality of the care worker and the quality of life of the consumer.

Research tells us that more than half of home care workers have completed no formal education beyond high school, and thirty-seven percent of home care workers report speaking English "not well" or "not at all", we find it imperative that access to the registry be user friendly and be sensitive to the limited English language needs and educational attainment levels that many caregivers face.³⁴

Potential funding options/cost savings/benefits:

- **No funding is required by the state** for any aspect of the implementation or the ongoing management of the care worker registry – other than initial technology ‘handshakes’ set-ups between platforms to transfer data.
- The state will only need to endorse/promote the software, add a link to their websites and marketing tools, and provide the software company access to the data, which includes a minimum of the care workers name and email address.
- Lightest Touch will then invite the Care Workers to join and update their own data and settings.
- Funding for the platform will come from Agencies that wish to post job openings within a dedicated ‘care’ platform, MCO’s/ICA’s who desire to add clients (with client’s approval) to the database (clients can add themselves for free and do not have to be added via an MCO or ICA or any other agency).

Cost estimates:

There will be no significant costs to the State other than staff time to assist with technology connections from state platforms to Lightest Touch. DHS will already be responsible for maintaining their own database information for various long-term care related programs.

³³ Survival Coalition, 2016. <http://www.survivalcoalitionwi.org/wp-content/uploads/2016/11/SurvivalSurveyFactSheet.pdf>.

³⁴ (Source: PHI. 2017. <https://phinational.org/resource/u-s-home-care-workers-key-facts/>, Bronx, NY: PHI.)

*To recap - **Costs will only be incurred by the following:**

1. **Agencies** who wish to use the platform to post job openings in a care specific platform;
2. **MCO's/ICA's** who wish to import all their client into the system – and they can limit who has access to the information they import. If an individual client wanted greater access, they can create their own account for free. Lightest Touch will control what those costs will be based on volume/demand.

There will be no cost to:

- the State
- Care workers looking for employment
- Clients/Consumers and it will also be free to whomever they invite to their profile
- HCBS agencies to list their services

State agency or other entity responsible for implementing the proposal, if it were approved (e.g. DHS, DWD):

- DHS would work with Lightest Touch to determine which data sources, i.e. CLTS Provider Management System, EVV, CNA Registry, CBRF, IRIS workers, etc., where individuals have the option to be included in the data transfer or sweep into Lightest Touch.
- DHS form a workgroup to explore and identify how to repurpose the use of WisCaregiver Careers website, information & marketing materials to promote the registry and other related resources
- DWD and Lightest Touch to explore ways to collaborate to enhance DSP recruitment

Public Input:

Considerable public feedback and interest was expressed for this proposal. Many who submitted comments were concerned about privacy, use of data, the “freshness” and accuracy of data and the ability to opt-in. These issues were discussed and are reflected in the final proposal. In the public input survey this proposal generated 314 responses total – showing more than 80% overall in strong or somewhat support. More than a third of survey respondents on this issue were family members or caregivers – with 84% in support; people with disabilities in need of care also showed support at 82%. All public input related to a statewide HCBS and employment matching registry supported the net for such a platform.

https://docs.legis.wisconsin.gov/misc/lfb/informational_papers/january_2019/0041_medical_assistance_and_related_programs_informational_paper_41.pdf, January 2019

ii

https://www.ahcanca.org/facility_operations/medicaid/Documents/2017%20Shortfall%20Methodology%20Summary.pdf)

iii <https://www.claconnect.com/resources/white-papers/2019/34th-snf-cost-comparison-and-industry-trends-report>

iv <https://leadingagewi.org/media/90586/nh-closures-2016-2020-updated-8-17-20.pdf>

v : [2020 Workforce Crisis Report](#)

vi Interviews with WHA officials and meetings of the LTC Subcommittee of the State Disaster Medical Advisory Committee (<https://publicmeetings.wi.gov/view/bd456ac6-02fe-4eec-9b34-2ac974a4baf5>)

vii <https://www.wpsa.us/legislative-criticalupdates>

viii https://docs.legis.wisconsin.gov/misc/lfb/budget/2019_21_biennial_budget/102_budget_papers/370_health_services_personal_care_reimbursement_rate.pdf

ix <https://static1.squarespace.com/static/5af1fcbb25bf0239ef4c73f7/t/5cf01061d34fe70001fc5120/1559236705439/MAPOfCountiesImpactedbyClosuresandDownsizings.pdf>

x <https://leadingagewi.org/media/90576/labor-region-handout-updated-8-17-20.pdf>

xi <https://gtfc.wisconsin.gov/gtfcfiles/meetings/direct-care-sept19.pdf>

xii <https://gtfc.wisconsin.gov/gtfcfiles/docs/survey-summary-report.pdf>