Long Term Care Workforce Commission

Members of the Long Term Care Commission workforce, good morning and thank you for the opportunity to present information concerning the crisis in staffing in community programs serving adults and children with intellectual disability and autism. My name is Peter Kowalski and I am the CEO of John F Murphy Homes in Auburn Maine. Long Term Care is difficult work and reimbursed at a low wage making it a causality of the current labor shortage. There is no obvious technology solution to alleviate the crisis. It is a crisis. The agency I run has 80 vacant staff positions. We have closed homes, not developed any despite the growing wait list of people needing these services. We are closing homes because we cannot staff them. To date we have closed programs as people have passed away of moved on- now we are looking at reducing existing homes. The crisis is real.

In order to understand the crisis and how our rate structure is impacting it is necessary to go in depth into how our rate was developed and works. The rate was promulgated in 2007 after two years of work and testing. The rate was designed at the time to be revenue neutral and was simply a redesign of the existing structure not an attempt to solve a workforce crisis and project an adequate payment amount. The rate consists of 22 components plus the provider tax totaling 23 components. Those individual components can be summed into 4 areas besides the tax: DSP staffing (including benefits, and replacement for training), which makes up 58% of the rate, supervision and costs associated with mandated licensing and plan development activities) which makes up 23% supplies which make up 1.6% of the rate and general administrative costs which makes up 11% of the rate and of course taxes which is 6% of the rate. What makes this rate a little different and somewhat insidious is the manner in which it is calculated. It starts with the DSP rate of pay which is multiplied by a percent to get the next factor (FICA) which in turn is multiplied by a factor to get the next rate portion (unemployment) and so on. That is to say the DSP rate is multiplied by 7.99% to get the FICA and Medicare tax then that figure is multiplied by the

next percent etc. This is important as you will see later. The DSP rate was set at $10.37 in 2007. This figure was based on the average wage providers were paying in 2006, not an ideal wage. It was seen as an average wage at a time when the minimum wage was $7 an hour, therefore creating a range of $7- $13.74 an hour. The $10.37 midpoint works with the rest of the calculations as long as you stay at that mid-point- since all the other components are a multiple of it and will only yield the correct amounts if the mid-point is maintained. Today that wage amount is $11.22 an hour with a minimum wage of $11 leaving a wage range of $11-$11.44 an hour to get the average of $11.22. Remember every other factor is a multiple of that hourly rate. This is important when looking at the adequacy of the rate: because if you out of that range you are not only not being reimbursed for the hourly wage you pay you are also not reimbursed properly for the all the other components. Worse- come January 1 the minimum wage goes up to $12 while the rate remains pegged to $11.22- that means there no longer is a range and that every facet of the rate doesn't work no matter what you do. We **cannot** spend money we do not have so we are locked in to paying the minimum wage and even at that we have to use all the other factors in the rate to balance. We can't pay what we would like too- the math simply does not work. On January 1- 90% of my DSP workforce will be at minimum wage. Think about that. Just what do you expect from a minimum wage employee? Look at the job and expectations never mind the complications of a population with complex needs. They are expected to be "professional, to make judgements-...Is it any wonder why the wait list keeps growing? Is it a surprise that someone would die in these services?

To further complicate matters this rate is paid based on the direct support professionals' time. That is to say it's billed like professional services. Even in 24/7 programs we must bill by the staff hour not the "client" hour. So if you are short staffed you can't bill- and volume doesn't matter- if you can't cover costs on one hour of service you can never cover costs no matter how many hours you provide.

One final problem with the rate is the health insurance factor: In 2007 the factor allowed for a cost of $2157 for a health insurance policy per full time equivalent.

That was inadequate then. It was not based on Maine costs rather on Arizona costs which at the time were much less expensive then Maine insurance costs. State insurance costs are influenced both by state policies on what's covered and the percentage of people on Medicaid and Medicare. Since they pay less than actual cost (in the case of Medicaid much less), those expenses are cost shifted to private health insurance providers. Today the rate allows for $2335 per full time equivalent per policy. Our rate for a high deductible coverage is $5800 per policy; we are reimbursed about 40% of actual cost. Stated another way we need to use an additional 6% of our total rate just to cover health insurance.

So- come January 1 when the minimum wage goes up to $12 an hour our rate will be based on $11 and hour, meaning pay rates and all related benefits and employee costs will be reimbursed based on the $11 an hour not the actual cost (we will be underpaid for all components of salary and benefits)and health insurance will be paid at minimum at 40% of cost, so it's pretty clear to see that this is not a tenable situation. For the long term staff person who has 10 years' experience only to see someone off the street that has no idea what they are doing coming in at the same rate of pay it is insulting. And they too are now leaving. One statistic sums this up: since 2007 our rate has gone up 9% while minimum wage has gone up 71%.