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EMPLOYMENT
RELATIONS BOARD

BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

STATE OF OREGON (DEPARTMENT OF HEALTH SERVICES)

And

ADULT FOSTER CARE HOME & ADULT RELATIVE FOSTER CARE HOME PROVIDERS, SEIU LOCAL 503, OPEU

Appearances:

Marc Stefan, Supervising Attorney, SEIU Local 503, OPEU, 1730 Commercial St, SE, Salem, Oregon, appeared on behalf of the Union.

Stephen D. Krohn, Senior Assistant Attorney General, Department of Justice – Labor and Employment, 1162 Court St., NE, Salem, Oregon, appeared on behalf of the State.

INTERST ARBITRATION AWARD

Adult Foster Care Home & Adult Relative Foster Care Home Providers, SEIU Local 503, OPEU, herein referred to as the "Union" and State of Oregon, herein referred to as the "State," jointly selected the undersigned from a panel of arbitrators provided by the Oregon Employment Relations Board to serve as the impartial arbitrator to hear and decide the dispute specified below, pursuant to ORS Sec. 243.748(4). The arbitrator held a hearing in Salem, Oregon, on August 8, 9, 10, 2012. Each party submitted a written argument, the last of which was received on August 28, 2012.

ISSUES

The issue for determination is whether the last best offer (herein "LBO") of the State or the LBO of the Union shall be incorporated in the parties' July 1, 2012, to June 13, 2013, collective bargaining agreement?

The parties stipulated that the sole remaining difference between those offers is the State's proposal to reduce the Developmentally Disabled providers' existing rates by 6% effective October 1, 2012. The Union's proposal is to retain the current rates.

FACTS

Oregon Department of Human Services[1] operates various human services programs, including Addictions and Mental Health ("AMH"), Aged and Physically Disabled ("APD"), and Developmentally Disabled ("DD"). The State has recognized the Union as the collective bargaining representative of all Adult Foster Care Home and Adult Relative Foster Care Home Providers paid by the State who are natural persons and who provide adult client services in their own residence. The issues in dispute, however, relate only to the DD portion of the bargaining.

A person with a "developmental disability" is a person with an intellectual or emotional impairment which affects the person's ability to function independently in society. Clients served by the foregoing programs are among the most vulnerable citizens of the State of Oregon. The Department provides services under the Community Developmental Disability Program to the developmentally disabled through group homes, certified supported living services, day programs, in-home services, and the adult foster care program.[2] These services are provided to those who are poor. Many, but not all, of those receiving services from the Department receive those services under the federal Medicaid program. Under the Medicaid program, the State has agreed to accept federal funds and federal regulation in exchange for the federal government paying about two-thirds of the cost of services.

One of the ways non-unit services is provided to DD clients are through non-bargaining unit group homes. Group homes are facilities owned by people who do not reside in the facility. They generally serve more than five clients at one home. A person must be actively awake and on duty at a group home at all times. There are extensive regulations governing the group homes. By contrast, unit providers do not ordinarily have to have someone awake and on duty twenty-four hours per day.

Oregon is a pioneer in an additional method of providing services to DD clients by its adult foster home system. Under this system, individuals agree with the State to provide services to clients in their homes.[3] The homes must meet Department licensing regulations. The providers must undergo specific training in order to be licensed to provide services. The State contacts them with prospective clients. The providers then choose from one to five clients to live in their home. Providers have the sole discretion to accept or reject clients. There is no obligation to accept any specific client. Once they accept a client the provider is fully responsible for that client's well-being and for any damages caused by the client. Providers are then reimbursed by a set monthly fee per client. The fee structure per client varies by the types of services which the client needs. In some instances, clients need one-on-one services during all of their waking hours. Some clients need to have twenty-four hour one-on-one services or, in some cases two-on-one services. Providers are paid an enhanced rate which is calculated by taking the base rate and adding $9.50 per hour for all of the required one-on-one time. One of the

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[1] When it is necessary to distinguish the Department of Human Services from the State, it will be referred to as the "Department."

[2] It also provides in-home services under a different federal program through what are termed 'brokerages." That program is not relevant to this dispute.

[3] See U-11, p. 3and S-10 for more details.

purposes of the adult foster home program is that the providers develop long-term positive relationships with clients. They provide the stability the client needs. Nonetheless, the providers have the authority to end services for a client on thirty days' notice.

This form of service is substantially less expensive than group homes. DD clients now served by group homes and adult foster care homes would otherwise wind up in jails or more expensive facilities.

As of the time of hearing there were 977 adult foster home providers in the DD services portion of the bargaining unit serving up to 2,333 clients. The number of providers has increased since January, 2010, from 881, serving 2,020.[4]

Providers are now compensated by the client for room and board at the rate of $542.70. The monthly base service fee for adults is set at $799. The rate for additional services is based primarily on the number of staff hours required to perform them. The total is the service fee. This is set at $9.50 per hour. The maximum rates are $4,969 for a combination of ADL, Medical and Behavior Need section. The total maximum rate is $7,285.[5] There may be other factors included in the total service fee such as reimbursement for counseling or other professional fees. This is the only compensation providers receive.

In 2008, the DD base rate was $528 plus $9.50 per hour for the time needed for additional services to the client.[6] Room and board was $494.74

As of 2006, counties basically set the rates of reimbursement for DD providers. In 2006, Oregon embarked on a program to restructure budgets, assessments and rates known by the acronym, "ReBar." The stated purpose of the program was to change the way the community support needs of the client were assessed. The intended results included:

1. To correlate the needs of the people served and the distribution of the resources.
2. Creating a transparent and portable assessment of client needs.
3. Have that assessment be statistically valid and derived from a proven instrument.
4. Make sure that needs are assessed on an individual basis.
5. Create a more unified approach in critical areas.
6. Insure that the system pays providers the same service rates in comparable circumstances for consumers with similar needs.
7. Creates rates which are accepted by consumers, families, advocates, providers, legislators, state and county representatives.
8. Insures that rates are regularly examined and revised to reflect fiscal and economic changes.[7]

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[4] S-36

[5] SNAP tool, U-35, maximums include $58 ordered in unfair labor practice proceedings.

[6] See U-33. Page 41 shows an additional allowance for payroll taxes for those hours of 12%. The testimony was that the service fee did not have an allowance for payroll taxes.

The State developed different assessment tools for Group Homes than the ones used for Adult Foster Homes. The Group Homes' re-assessment of all of their clients was completed by June, 2011. The result of the Group Home reassessment was a substantial increase of the average service rate per client.

The State created the Support Needs Assessment Program (herein the "SNAP" tool). This was essentially a detailed assessment checklist of client needs to be used in the assessment process specified in the paragraph above. The re-assessment under the SNAP process started in August, 2011. The parties' collective bargaining agreement specified that it would be completed by December, 2012. It is nearly completed. The assessment has resulted in a significant increase in average service rate per client which is detailed more in the "Discussion" section below.

The State's actions in response to its fiscal situation are not in dispute. The State, like virtually all of the U.S. states has suffered a downturn in state revenue as a result of the prolonged national recession. The State Legislature budgets on a biennial basis, with a budget readjustment as necessary in the off-year short session. State agencies submit their budget proposals to the Governor, who in turn proposes a comprehensive budget to the Legislature. The agencies then provide testimony before the Legislature as required.

In January, 2011, a task force group submitted a report on the effect of a conceptual 27% budget reduction for the Department.[8] It concluded that at the target budget level it could not achieve sustainable and equitable services that would protect and promote the safety, health and cultural identity of vulnerable populations. It then chose to report a "floor" level of investment above that target which would protect Oregon's most vulnerable citizens. The total recommendation indicated that those results could be achieved with a reduction in budget not exceeding 14%. As to the DD program it recommended that the Department develop a new home-based and community-based waiver that caps individual benefits below the current average cost of care for 24-hour supports and focuses on employment, housing and shared residential supports.

The Governor's budget proposals were modified during the 2011 main legislative session. The Department provided testimony to explain the changes. As it relates here, it took the position that the only way to achieve a budgetary reduction affecting the DD area was to reduce rates. It offered the following explanations:

> CBC Rates are all inclusive for 24/7 services need by client (rates do not include room/board). As a result, there are no opportunities to decrease benefit levels.
> Can't reduce eligibility (i.e., Before (sic) health reform, Oregon already eliminated services to individuals in SPLs 14-17)

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[7] See U-32, U-33 and U34.

[8] See S-12. There is some minor variation among the exhibits in this case.

It noted that that rates paid to adult foster homes were subject to collective bargaining and that any rate change would require the approval of the federal agency regulating states' compliance with Medicaid regulations, the Centers for Medicare and Medicaid Services, herein "CMS."

The Legislature approved a budget for the 2011-12, biennium that resulted in a reduction of general fund expenditures which was not as deep as had been originally recommended by the 2011 Department's task force recommendation for a budget lowered budget reduction in order to maintain a sustainable program. The portion of the budget cuts addressed to unit DD providers was 10% effective after collective bargaining which the Legislature assumed would be completed in time to effect the reduction as of October 1, 2012. The Legislature indicated that it would review the matter during its short session in 2012. Thereafter, until the facts specified in the paragraph listed below the State maintained the position in collective bargaining that it was seeking a 10% reduction in the unit DD rates.

The Legislature did meet in its short session in 2012. One of the regular tasks of the short session is to "rebalance" the State's entire budget. As it relates here, it bought back some of the reductions of the Department's budget. That change included a change from the planned 10% reduction to a 6% reduction, subject to collective bargaining. The Legislature added the following budget note:

> The Department of Human Services is to report to the Emergency Board in September 2012 on the outcome of the negotiations for the adult foster care programs. If the negotiations result in a reduction that is more than 4% below the 2009-11 reimbursement rate, DHS is to identify options for bringing reimbursement for adult foster care programs to no more than a 6% reduction for the balance of the biennium, and include its preferred option in the agency's next budget rebalance plan.

The State contends that this note requires it to modify its final offer to one seeking only a 6% reduction for DD rates. The State's last best offer is for a 6% reduction in DD rates.

POSITIONS OF THE PARTIES

UNION:

Under Oregon interest arbitration law, if an arbitrator determines that one party's LBO is unlawful, that finding precludes the arbitrator from adopting that offer. Alternatively, an offer which is unlawful cannot meet the "public interest" criterion. The State's offer is unlawful because it violates Section 30(A) of the Medicaid Act by reducing the rates of reimbursement without having first performed a comprehensive study to evaluate the impact of the cuts on, among other things, the affected clients' access to and the quality of care. This study was not done. Under Section 30(A) of the Medicaid Act, the State is precluded from implementing the proposed cuts. The State's

evidence on this point demonstrates the weakness of its case. Mr. McCormick's testimony that DHS generates routine, periodic reports that might provide some information about accessibility to care was not predicated on a 6% cut to reimbursement rates. He acknowledged that DHS had not made an effort to perform a study to evaluate the impact of the 6% cut in dispute. The State's rebuttal witness, Ms. Hittle attempted to present a legal argument that the Supreme Court's decision in *Douglas v. Independent Living Ctr. Of S. Cal., Inc.*, 132 S. Ct. 1204 (2012), had concluded that such an analysis was not necessary. However, the holding in that case is that an analysis is necessary, but that there remains an issue as to whether CMS is a proper authority to approve a rate reduction request. In any event, the State loses on this issue irrespective of whatever the law may be resolved to mean. Whether an analysis of the impact of rate cut has to be approved by the federal courts or CMS alone, the fact is that the State never did any systematic analysis. Instead, Ms. Hittle testified that DHS originally sought approval from DMS for a 10% rate request, but withdrew the request. It has not submitted a request for approval of the 6% reduction in dispute.

The statutory requirement is significant. Medicaid recipients are a very vulnerable population which Congress through Section 30(A) is trying to protect. In that regard a state should not be able to blindly impose cuts driven solely by budgetary concerns on providers and then assess at a later date whether they caused a lack of access to services and/or diminished their quality. A pre-implementation study of the effect of its proposed 6% cut is a modest, but critical, requirement that helps insure that the State's approach is reasoned and minimizes the risk of harm. Because the State has not done any study, the failure to do so renders the State's offer unlawful. In the light of the uncontested nature of the State's failure, the arbitrator need not reach whether the State's offer is, in fact, a violation of Section 30(A) of the Medicaid Act.

In any event, the application of the statutory criteria compels an award implementing the Union's final offer. The public interest criterion includes an assessment of whether and how the respective proposals impact on the pivotal purpose of the collective bargaining legislation to maintain the morale of public employees and the efficient operation of government services. Analysis also requires evaluation of the "effectiveness of the proposals," "the reasoning of the parties," and "comparability data." These factors favor the Union.

The Union's proposal goes further to protect the morale of the workforce. Providers receive no health insurance, no retirement benefits, no paid vacations, no paid time off, no sick leave and no paid respite time. The sole compensation is in the form of the service payments they receive. The actual rates have remained unchanged since 2008. Since then, the pay rate has remained at essentially $9.50 per hour. Moreover, the providers are responsible for everything and anything that happens in their home.

Provider Rhodes' testimony establishes that the $9.50 per hour is not sufficient to hire a competent employee to perform continuous one-on-one supervision of a client. He pays an average of $12.00 per hour to do so and he also pays additional benefits in order to attract and retain appropriate staff. The proposed 6% reduction effectively reduces the

reimbursement rate to $8.93, 3 cents over the Oregon minimum wage. Mr. Rhodes also testified that he recently was given the choice of some new clients. He selected the client with the lowest reimbursement rate because he would not have to hire help at costs in excess of what he would receive in compensation from the State. Mr. Rhodes testified that despite the fact that he cares deeply about his clients, the proposed cut will force him to give up this work. If he is forced out of this line of work, why is there any reason to believe anyone competent would enter it. If not, will these clients need to be sent back to institutions at a significantly higher cost?

There is no requirement that providers subsidize the State. The State seeks to parse the income of Mr. Rhodes of roughly $70,000 to argue that he is still making a "living." The test here is not whether a provider can make a living. It is whether, in all of the circumstances, a pay cut for these providers serves the interest and welfare of the public.

Mr. Groh's testimony represents providers at the other end of the spectrum of providers. They cannot afford to hire help. Therefore, they can only accept clients for whom they can personally do all of the work. When one spouse has to be away, the other must work a double shift. They provide toiletries, etc. for clients. When they go out, they take their clients with them. They pay for meals and entertainment for the clients. They have not been able to take time off together for ten years. Mr. Groh said that he guessed that even with the 6% cut they will still be able to meet their bills. However, he and his wife will not be able to afford to provide clothing and toiletries to clients or have nights out with them.

There are a numbers of problems with the Adult Foster Home program, especially its DD component. Much of it stems from the compensation structure and the inadequacy of the reimbursement scheme for one-on-one hours that are increasingly being assigned. The system is such that workers are required to go into a financial hole to deliver the care they are required to provide. In this context, adding a 6% reduction is plainly inappropriate.

The efficient operation of government services, effectiveness of the proposal and the reasoning of the parties and the comparability data criterion supports the Union's position as well. The comparison factor supports the Union's position. There are no cuts proposed for MHA or APD providers. The State's reason for its 6% cut is budget reasons. However, the APD budget has a $13.5 million hole in APD services. The bottom line is that the State is simply choosing where it want to have a budget hole and then using its own choice as a reason for its own choice. Sheila Baker of the Legislative Fiscal Bureau Office stated that the agency is free to move money from one place to another so long as it is in the same general budget line as all of the components of the DD and other AFH programs are. The State never provided an explanation for its choice.

Next the State asserts that it does not have the funds to avoid a 6% cut to DD AFH providers but acknowledged costs of some of its other DD operations and its own action in negotiation for other DD providers effectively erase any logic to such a claim.

Adult Foster Care for clients with DD is, by far, the least expensive than other available options for clients in this population. Indeed, it might well be able to move clients from other more expensive services to Adult Foster Care and make substantial savings. For example, the State pays a whopping $96.4 million or $724,812 per client to operate those homes with $268,833 per client coming from the General Fund. This is to provide for only 133 clients. When just 15% of those clients (20 clients) were transferred to other DD care facilities, the State saved $5.5 million.

Similarly, the Budget Reconciliation bill enacted in February 2012 (S-24) reflects other savings available to the Department of Health Services. About $1.3 million of General Fund expenditures will be saved by moving 30 clients into private group homes at the end of the biennium. The contrast is further reflected in so-called rate matrix (U-10). In that document it is noted that Mike Maley, the acting Director of DD Services, testified that all of the corporate group homes receive rates far in excess of those paid to unit providers. The State has provided no meaningful explanation as to why the rates are so different. Mr. Maley testified that there is no real difference in the clients who are assigned to each set of homes and, in fact, over time, the clientele is virtually the same. The State did introduce some tax regulations, but it never explained how those regulations applied.

It is difficult to understand how a 6% cut to the group of workers who are paid at the lowest level of DD providers is justified while everyone else in the DD program is paid substantially more.

The State's case is based upon the ability to pay criterion. However, the State is not even able to identify how much money is really at stake here. The Union presented straightforward calculations. A 6% cut for the eight months between November 1, 2012, and June 30, 2013, is $1.3 million. The State now alleges it is $1.7 million. The State has not been able to explain how it came up with the 6% number. It appears that the sole reason for this is that some other non-unit DD providers received a 6% cut. However, the fact is that not all DD providers received a 6% cut. Some received substantial pay increases. DHS recently agreed to pay $10.20 per hour for the newly organized Personal Service Workers who provide services to clients with physical disabilities in the homes of the clients. In any event, earlier cuts took place in unorganized settings not subject to collective bargaining and prior to the February, 2012, session. Those cuts dramatically changed the landscape for long term care including Adult Foster Home providers. Each budget situation must be addressed on its own merits and the applicable statutory criteria. The Union has outlined a number of ways that the State could save money in other areas. Meanwhile, the State has refused to even consider evaluating those options. The Union requests that its offer be adopted.

STATE OBJECTION TO UNION ARGUMENT:

The State objects to the consideration of the Union's argument addressed to the lawfulness of the State's offer under Section 30(A) of the Medicaid Act. First, the Union's argument is not based on any evidence or legislative support for the proposition

that the arbitrator has the authority to function in place of the federal courts and/or federal administrative agencies to determine whether the federal requirements in dispute have been met. The *Springfield* case cited by the Union only stands for the proposition that the Oregon Employment Relations Board would not second guess the arbitrator in that case.

Second, in any event, there is a split among the Circuits regarding the issues under Section 30(A). Every other Circuit has rejected the approach of the Ninth Circuit upon which the Union relies. CMS has also rejected that approach. CMS is revising its regulations to address the split.

Third, the U.S. Supreme Court's decision in *Douglas v. Ind. Living Center of S. Cal, Inc.*, 132 S. Ct. 1210 (2012), avoided deciding the issue of the split among the Circuits by giving deference to CMS to deal with the issue, but required the Ninth Circuit to consider giving deference to CMS.

Fourth, the Union also raises an argument that the State's offer is illegal because CMS has not approved the waiver amendment necessary to implement the rate reduction. In this regard, the Union implicitly recognizes CMS' jurisdiction to approve plan/waiver amendments. If that is true, the Union has not offered evidence that CMS views the Employer's offer as illegal.

This is a unique situation. It is not clear whether the State must seek CMS's approval before or after going through interest arbitration.

Fifth, the issue under Section 30(A) is not whether payment levels are sufficient to cover provider costs, but, rather, access and quality of care. The anecdotal evidence from the two providers focused almost entirely on their costs and their independent economic decisions, rather than the sufficiency of payment levels to meet recipient needs.

The SNAP tool in evidence in this case accurately identifies recipient needs. The parties have mutually agreed that the SNAP tool is working and the Union offered no evidence that it was inaccurate in identifying recipient needs. This is further supported by the State's data showing the rate reduction is offset when measured by the steady growth in rate to providers over the last four years.

STATE:

The "financial ability" criterion is a criterion which must be given heightened weight. It is the factor that effectively should control the result in this case. This factor is not isolated to a particular bargaining unit, but takes into account "other services" and "other priorities" and expressly recognizes that those factors are as "determined by the governing body." The Legislature's action in this matter is deliberate and based upon a reasoned choice of priorities for limited funds. In this regard, the Legislature at first planned for a 10% cut to DD services, but carefully chose to hold the cut to 6%, taking the risk that State revenues will be better than expected or expenditures will be less than expected. In this regard, the Legislative choice is the public interest.

The Legislature made budget decisions which are legally significant to the interest arbitration process. This process culminated in a budget note from the 2012 Legislature as follows:

> The Department of Human Services is to report to the Emergency Board in September 2012 on the outcome of the negotiations for the adult foster care programs. If the negotiations result in a reduction that is more than 4% below the 2009-11 reimbursement rate, DHS is to identify options for bringing reimbursement for adult foster care programs to no more than a 6% reduction for the balance of the biennium, and include its preferred option in the agency's next budget rebalance plan.

As it applies here, the foregoing is a directive to DHS to negotiate a 6% rate reduction for DD as proposed here. The Legislature faced multiple financial issues in the 2012 session as is demonstrated by the Budget Reconciliation report. In this regard, its choices are "legally significant" in the interest arbitration process. This is directly relevant to the interest arbitration statutes, particularly subsection (4)(b).

The CPI criterion also favors the State. The data submitted by the Employer shows how the growth of payments to Providers since the bargaining unit started in 2008 has kept them well ahead of the cost of living.

The criteria expressly forbid the interest arbitrator from considering the emergency fund and closing fund balance in determining what funds are available for settlement unless all the funds used for the settlement are considered. The Legislature did not allocate funds in the emergency fund for the DD program.

The State offered rebuttal evidence that addressed the assertion that projected surplus funding is based on static provider payments. The Union's position in that regard is based upon faulty assumptions. It also provided rebuttal evidence that DHS has such a large budget that there is money to use for provider rates. The rebuttal evidence as to budget shows that as of the time of the hearing that the DHS budget is in a deficit rather than having the surplus projected by the Union.

The legal setting for this arbitration presents issues. The interest arbitration statute allows the parties to submit "unresolved" issues to arbitration. Because of a difference in the language of the statute enabling collective bargaining in this unit, ORS 443.733(3) and PECBA for ordinary public employees, it is not entirely clear specifically what the "mandatory subjects of bargaining" really are. The statute only specifies "base rate and add-ons." Further, this unit is composed of small business independent contractors and not truly "employees." There is an unresolved issue as to which of the statutory interest arbitration criteria the Legislature really intended to apply to this bargaining unit. Most have no clear relationship to this type of bargaining unit. The arbitrator is bound to give highest priority to the "interest and welfare of the public"

criterion. There is also an issue as to the "burden of proof," although most arbitrators put some burden of persuasion on a party proposing to change existing contract provisions.

The "public" is a legally recognized third party to this proceeding. What the "interests and welfare" of the public is ambiguous in itself. It is not limited to the potential clients for these services. What the larger public wants is similar to what their elected officials have determined to cut in DD service fees as a whole and fairness across all providers, not just those who are not part of the bargaining unit.

The ability to pay criterion is also clearly applicable to this dispute. This is measured by what the public body has determined as its legislative priorities. What the Legislature could have funded is not relevant. It is what the Legislature actually funded. The Union is correct however, that the Legislature has a commitment to the federal government to provide the services and providers do not have an obligation to fund those services.

The Union's arguments are without merit. The arbitrator is without jurisdiction to hear the Union's argument that federal case law requires a "specific report." Alternatively, the Union has failed to show that the State's last best offer is illegal. CMS is the federal agency which administers the State's responsibility under Medicaid. The preponderance of the available evidence is that CMS is not following the federal case cited by the Union. The Arbitrator should defer to CMS's position. There is no evidence that the Union has actually challenged the proposed rate reduction in federal court.

The Union's argument that there is a surplus of funding is without merit. This is not a case where the Union has identified actual funds that the State has available. The Union is submitting a revised exhibit number U-16. The main error with the analysis is that it relies upon a 2% reduction in case load while failing to account for the fact that costs are rising for the 98% of the cases which remain. The Legislature did not fund for the extra cost per case so that the extra cost comes out of the existing lower level funding.

The fact is that there has been a large increase in the adult foster home service rates. The rates have increased 5.15% just since January 2012 to the present. From January, 2011 they have increased 16.54% and 28.9% since January, 2010. A reduction of 6% on client rates is close to the average increase received in January of this year. The foster care pool of homes went up 10.6%, from 881 homes in January, 2010 from 795 in January, 2012. The change proposed by the Employer is not likely to affect the availability of either homes or services.

ORS 243.746(4)(b) forbids the use of operating reserves against future contingencies unless there is an actual set-aside for the amounts in dispute in the arbitration. There is no dispute that the emergency fund has no such designation. The testimony of Megan Moyer establishes that it is unrealistic to rely upon the emergency fund a funding source.

The Union's argument that the fact size of DHS's budget implies that it can find money "somewhere" is without merit. The testimony of Sheila Baker shows that the specific program area was not well funded. The testimony from Mike McCormick regarding the APD budget is consistent with the budget reconciliation document showing that $40 million of the $53 million deficit was funded by the Legislature in the 2012 short session. While some programs may share savings, there were no savings identified for such an exchange that currently exist.

The Community First Option (aka K-Option) is a new program. There are only two states who have submitted requests to CMS to participate in this program, but neither has been approved. This is not a source of funding.

The State also notes that the Group Home service is not a proper comparator to the Adult Foster Home. Although they deal with similar clientele, the former has different requirements for their physical plant and staffing. The funds received by the former are not tax free.

Finally, it notes that retention data is statistical in nature. The Union only produced anecdotal evidence. The only statistical data is that the number of homes has risen in the last year which implies that it is not likely that a 6% reduction will affect the availability of the number of homes available. The State asks that its LOB be adopted.

UNION REPLY BRIEF:

Replying to the Employer's objection to the jurisdiction of the arbitrator to determine the lawfulness of a party's proposal, the Employer incorrectly reads the OERB's *Springfield* decision. The Board determined that the "Interest and Welfare of the Public" criterion would allow an arbitrator to evaluate the lawfulness of a party's final offer.

Ms. Hittle, a Medicaid Policy Analyst for DHS, testified that she called CMS and was told that CMS does not follow the decision in *Orthopedic Hospital v. Belshe.* Her testimony as to what is legal is blatantly irrelevant on this matter. The State's opinion on what the *Douglas* decision does or does not do is blatantly wrong.

The State sought approval for a 10% reduction. The State wound up withdrawing the request. It has not submitted a request to CMS to approve a 6% reduction, nor has it stated when it intends to do so. It is against this backdrop that the State now argues that the Union has not proved that the States' final offer is unlawful. The State has failed to take the steps to determine if its offer would be accepted by CMS.

The Union's position as to unlawfulness is that it is the law in the Ninth Circuit that the State must do a meaningful study of the impact of the cuts on Medicaid clients regarding access to and quality of care. The Employer could not produce such a study.

The Ninth Circuit is not alone in its decision. The Eight Circuit has also issued a decision compatible with that of the Ninth. In any event, Oregon is in the Ninth Circuit and it is bound by it law.

The procedural infirmity alone is enough to sustain the Union's position. There is no need to address the substantive violation of Section 30(A).

It is interesting what the Supreme Court chose not to hear in the *Douglas* decision. It took certiorari on the issue as to whether the Supremacy clause created an individual right of action, but decided to recommend deferral by the courts to CMS. Because it did not grant certiorari on the Ninth Circuit's procedural requirement for a study, it is clear that not even four justices believed that it was incorrect.

In any event, the State's witness, Ms. Hittel, made it clear that the State has not even sought CMS approval of its 6% reduction. It withdrew its request to CMS for approval of a 10% reduction because that request was not going to be approved.

Thus, the State's argument fails under either scenario. First, if the Ninth Circuit law applies, then the State has failed to make the required study. Second, if deferral to CMS is required, the State has not sought the prior approval of CMS.

The Union believes that the Arbitrator must determine that the State's LBO fails because it did not make the required study.

DISCUSISON

1. Authority

a. General Responsibility

The Statute which authorizes collective bargaining in this unit is different than the Public Employees Collective Bargaining Act. It is ORS 443.733. Under ORS 443.733, collective bargaining takes place with respect to "labor relations" and with respect to mandatory subjects of bargaining that". . . are, but are not limited to, base rates and add-on payments . . . ." Under ORS Sec. 243.742, either party may require that unresolved disputes as to the terms to be included in a new collective bargaining agreement be submitted to final offer interest arbitration.

The parties have submitted the issue specified above to interest arbitration pursuant to ORS Sec. 243.742, et seq. ORS Sec. 243.743 requires that I adopt the LBO of one party or the other without modification which is closest to appropriate after applying the standards specified therein. These standards are as follows:

> (4) Where there is no agreement between the parties, or where there is an agreement but the parties have begun negotiations or discussions looking to a new agreement or amendment of the existing agreement, unresolved mandatory subjects submitted to the arbitrator in the parties' last best offer

packages shall be decided by the arbitrator. Arbitrators shall base their findings and opinions on these criteria giving first priority to paragraph (a) of this subsection and secondary priority to paragraphs (b) to (h) of this subsection as follows:

(a) The interest and welfare of the public.

(b) The reasonable financial ability of the unit of government to meet the costs of the proposed contract giving due consideration and weight to the other services, provided by, and other priorities of, the unit of government as determined by the governing body. A reasonable operating reserve against future contingencies, which does not include funds in contemplation of settlement of the labor dispute, shall not be considered as available toward a settlement.

(c) The ability of the unit of government to attract and retain qualified personnel at the wage and benefit levels provided.

(d) The overall compensation presently received by the employees, including direct wage compensation, vacations, holidays and other paid excused time, pensions, insurance, benefits, and all other direct or indirect monetary benefits received.

(e) Comparison of the overall compensation of other employees performing similar services with the same or other employees in comparable communities. As used in this paragraph, "comparable" is limited to communities of the same or nearest population range within Oregon. Notwithstanding the provisions of this paragraph, the following additional definitions of "comparable" apply in the situations described as follows:

(A) For any city with a population of more than 325,000, "comparable" includes comparison to out-of-state cities of the same or similar size;

(B) For counties with a population of more than 400,000, "comparable" includes comparison to out-of-state counties of the same or similar size; and

(C) For the State of Oregon, "comparable" includes comparison to other states.

(f) The CPI-All Cities Index, commonly known as the cost of living.

(g) The stipulations of the parties.

(h) Such other factors, consistent with paragraphs (a) to (g) of this subsection as are traditionally taken into consideration in the determination of wages, hours, and other terms and conditions of employment. However, the arbitrator shall not use such other factors, if in the judgment of the arbitrator, the factors in paragraphs (a) to (g) of this subsection provide sufficient evidence for an award.

The standards require some analysis of the Legislative intent. The statutory factors include specific directions to give greater weight to the "public interest" criterion, and have specific directions to arbitrators applying the "ability to pay" criterion to not including "operating reserves." In that regard, I apply the normal techniques of statutory construction to determine the relevant legislative intent in the process of applying them to this dispute.

It is important to note that because this unit is essentially composed of entrepreneurs rather than traditional employees and labor relations in this unit primarily fall under a different statute, it is important to use sound business judgment to interpolate the statutory standards to this dispute. In this regard, the parties both agree that the "public interest" criterion applies and is to be given the highest priority. They both agree that the "ability to pay" criterion applies. They both agree that some of the other criteria apply if they are liberally construed, but, of course, they disagree as to how each of the criteria should be applied.

It is important here to discuss the "burden of proof" in this proceeding. There are two "burdens of proof." The first is the burden to come forward with evidence to support a position and the second is the burden to persuade the arbitrator. In this proceeding, it is the State that is the only party proposing to change a provision of the parties' expired agreement. It is the State's responsibility to produce evidence that the circumstances have changed such that the expired agreement's provisions need revision. It is then ordinarily the State's burden to persuade the arbitrator that its proposal is the one that is most suited to address those needs. The burden of persuasion is in issue as to the impact of the provisions of the "ability to pay" factor. That matter is discussed more below.

b. "Public Interest" Criterion

The "public interest" criterion is the factor which the statute requires that the arbitrator give the heaviest weight. It is entitled to the heaviest weight herein. The statute does not expressly state the perspective of the "public interest." The Union emphasizes the perspective of the beneficiaries of the services. The State effectively urges the position of the taxpayer. A review of the other criteria establishes a statutory intent to have a very broad perspective. Thus, under the "ability to pay" criterion the arbitrator is required to evaluate the "reasonable financial ability" of the public employer and give "due consideration" of its totality of services. [Emphasis supplied.] The perspective of these provisions is more than a mere taxpayer of the employer in dispute and certainly not limited to the consumer of the services in dispute The perspective is better viewed from that of a citizen of Oregon. The interests involved are the citizen's interest as a federal and state taxpayer. They are also one who is interested the ability of the State to provide the services which the Legislature has chosen to provide in an efficient, cost-effective manner.[9]

At first blush it might seem to be in the public interest to obtain services as cheaply as possible. In some situations, it is wise to seek goods and services from the

[9] It is the Legislature's responsibility to determine service levels.

lowest bidder. However, in other situations, it is counter-productive to do so. This depends on the specific nature of the goods and services. That determination must be made by evaluating the facts and circumstances about the services in question.

There is documentary evidence and direct testimony which explains what is the most efficient State-provider relationship. Randy Rhodes is one of the two providers to testify in this matter. He has substantial business experience in his prior role in private business and has demonstrated significant business acumen. The other provider to testify is Paul Groh. He provided information which supplements Mr. Rhodes' testimony. The Employer requires minimum qualifications either of experience or training at the nursing assistant level in dealing with persons with disabilities. Most providers in the unit use their own homes. The State has established minimum standards for using a home for this purpose. Further, Mr. Rhodes' testimony indicates that there is much more wear and tear to housing DD clients than would occur in normal family use. Mr. Rhodes also indicated that it was necessary to have access to a vehicle of the type useful to transport clients and caregivers.

Mr. Rhodes is somewhat unusual among providers. He has three foster homes instead of one. Further, he specializes in working with the most difficult emotionally disabled individuals (those who would be in prison were it not for Mr. Rhodes services). He stated that he took the basic course the State requires to start performing these services and has continued to take every course he is able to. It has taken him many years to develop his skills to the level of proficiency to deal with his clientele.

Clients need stability. Changes are highly disruptive to their progress and risk regression. It is also much safer for providers and their employees to have long-standing relationships with their clients. They gain intimate knowledge of their habits and dangers. Mr. Rhodes has been a provider since 2003. He still has clients who started with him virtually from the beginning.

Mr. Rhodes has also developed the respect and trust of the courts and criminal justice system. In this regard, the courts trust him to try to save clients who have violated the law and otherwise would be sent to prison. The importance of this relationship cannot be understated.

Mr. Groh has only a few clients in his home. In that regard, he may be more typical of providers.[10] He emphasized the caring relationship he and his wife have established with his clients. Both he and his wife go beyond what is required to make life more enjoyable for his clients. The long-term, extra effort relationships are a vital part of the success of unit services

The public interest is in maintaining the efficiency of these services. It is vital for the State to maintain business relationships which encourage providers to develop their skills and to maintain their long-term relationships with their clients and the referring public. It is not in the public interest for the State to regularly "squeeze" providers for

[10] The average is 2.5 clients per provider.

lower rates. The public interest also requires that providers have a fair degree of trust in the intent of the State to maintain appropriate business relationships with them.

The public interest is appropriately considered from the vantage of a citizen of Oregon. The public interest is served by obtaining services in a manner that promotes reasonable economy, efficiency and availability of services. The nature of unit DD providers is such that the public interest is served by developing and maintaining a stable compensation system which promotes trust between providers, encouragement to develop their skills and to provide their resources. This, in turn, requires a long-term commitment to appropriate compensation levels irrespective of the variations in State finances.

c. Arbitrability

It is virtually a tautology to conclude that it is an expectation of the "public interest" that the State, the Union and providers follow both federal and state law. While that may be true, the "public interest" criterion only applies to evaluating terms which a party seeks to incorporate into a collective bargaining agreement. Issues may arise in interest arbitration as to whether a LBO proposal would be unlawful in some regard. The statutory purpose of the collective bargaining process is to have "labor peace" between negotiation periods by having collective bargaining agreements that can be effectively administered. If a proposal is one which results in continued conflict or requires extensive replacement negotiations it tends to be inconsistent with the statutory purposes. I conclude that the proper approach is to determine: 1. if there is a legality issue; and 2. how the existence of the issue would affect the viability of the proposal if it were included in a collective bargaining agreement.

In *Orthopaedic Hospital v. Belshe.* 103 F.3d 1491 (9th Cir., 1997), cert. denied 108 S. Ct. 684, but similar orders vacated by U.S. Supreme Court on other grounds, 132 S. Ct .1204 (2012), the Ninth Circuit reviewed a decision by the District Court that the California department for setting rates for out-patient services had failed to comply with 42 U.S.C. Sec. 1396(a)(30)(A) (herein "Sec. 30(A)") in doing so. It noted that, as amended, Sec. 30(A) required that reimbursements be consistent with efficiency, economy, and quality of care" and that the rates must be sufficient to enlist enough providers to provide access to Medicaid recipients. In that case, California argued that it did not have to consider whether the rates it set were close to the hospitals' cost of providing services efficiently because federal law effectively required those services to be provided to the poor regardless of their ability to pay and state law required that they be provided at adequate quality. The Court concluded that California must set hospital rates that bear a reasonable relationship to the efficient and economical hospitals' costs of providing quality of services unless California shows some justification for rates that substantially deviate from such costs. The Court concluded that since California did not undertake a responsible cost study, its actions in setting lower rates were arbitrary and capricious. It required that California undertake a study consistent with its decision. A related matter was appealed to the U.S. Supreme Court which vacated a related decision on the basis that the agency responsible for supervising state's compliance with federal mandates, CMS, had subsequently approved the lowered rates.

It is undisputed that there is an issue as to whether a decision by the State to reduce provider rates by 6% without doing the type of study contemplated by the Ninth Circuit, is in violation of federal law. There is no dispute that the State did not conduct an independent study of the type contemplated by the Ninth Circuit. However, the State contends that its existing data is sufficient to make the required judgments. There are a number of legal issues which make it questionable as to whether the Ninth's Circuit decision might be applied by the federal courts to find that the effort to reduce rates herein violates the Ninth Circuit's holding. Those issues include whether: the Ninth Circuit's decision is viable law; it might be effectively overruled by potential CMS acceptance of these rates after the decision herein; the ruling applies to the situation herein where no District Court action was ever filed against the State; and the holding applies to rates set for providers who are free to not provide services. It is entirely too speculative to make any conclusions about the issue raised by the Union. I note that some, but not all, of the same considerations under Sec. 30(A) are considerations mandated by the arbitration statute. In this case, the basic concept of burden of proof and the proper application of those standards are more consistent with the arbitrator's authority than trying to speculate on the Union's legal theory. Nothing herein is intended to suggest that a study of the nature contemplated by the Court is not appropriate.

The "public interest" criterion is discussed more in the Summary and Conclusion section below.

2. "Ability to Pay" Criterion

There is no real dispute that the State has experienced a serious short fall in revenue. The exhibits indicate that this is a result of the national recession.[11] There is no question that the State has the legal authority to raise the money or reallocate its budget to meet the Union's last best offer.[12] This is a situation in which the State has determined that it is difficult for it to meet its past level of expenses for the Department as a whole.

A fair reading of the "ability to pay" criterion would indicate that it is the Union's duty to produce evidence of some ways in which the State might find the funds to meet the Union's proposal (burden to produce evidence). The Union has attempted to do this, but its evidence is not sufficient to show that there is any practical way beyond raising more money for the State to do so. One of the Union's main arguments is that there is an on-going decline in case loads in the Department and, therefore, the State's budget cost projections are over-stated. While there is a decline in the number of cases, there is a more than offsetting increase in the cost per case. In 2012, the average rate per client rose from $4,096.39 in December, 2011, to $4,440.29 per client in July, 2012. The Department's Budget Administrator, Ralph Amador, testified that the Department's

[11] See, for example, S-25.

[12] See exhibit S-15, p 11. The State, itself, has chosen to pursue rate reduction for providers even though the rate reduction may not be approved by CMS. Whatever the likelihood of the State's success in that regard, the State has indicated that it has the means to reallocate its budget to meet any order from CMS.

actual expenditures over budgeted expenditures are on track to show a slight deficit rather than a surplus.

The last sentence of the "ability to pay" criterion provides: "A reasonable operating reserve against future contingencies, which does not include funds in contemplation of settlement of the labor dispute, shall not be considered as available toward a settlement. I conclude that the "emergency fund" of the State is an operating reserve and that the same is not properly considered as available for funding the Union's proposal.

The more complex issue relates to the new Community First Choice Option (referred to as the "K option"). This is part of the Affordable Health Care Act. In short, it would increase the federal share of payments by 6%. Under Medicaid the federal government pays 63% of every eligible expense. Under the K option, the federal government would pay 69%. The concepts under the K plan are essentially modeled on Oregon's system of care which does not place a capitation limit on participation. Oregon has passed the Healthcare Transformation Act. Oregon is well poised to obtain a waiver under the K option. Oregon has attempted to get these funds without applying for a K option waiver, but CMS has refused. Oregon has not made its K state application, but it intends to do so. It is likely it will be approved, but it is not clear when it would be approved.[13]

Union Lobbyist Moyer testified as to K option savings for the Union.[14] She did an analysis for the Adults with Physical Disabilities program and concluded that this would bring in an additional $13 million on that side. She has not done an analysis of the effect it would have on the DD program. There is some difficulty with the analysis in that the K waiver is intended to expand coverage. Ms. Moyer believes that Oregon is already providing that coverage, but the State is investigating the extent accepting a K waiver would increase its costs. Cross examination raised an issue as to whether the DD program would qualify for a K waiver and whether the $13 million additional federal funds would be offset by an existing $13 million deficit on the APD side. I conclude that it is unlikely that the K option waiver will be completed in time to affect this agreement.

One of the difficulties in the State's ability to pay argument is that it has sought a permanent reduction in DD rates, but has not made any provision for restoring those cuts should it receive more funds than expected. K option is one such source. Another potential source is an unexpectedly high revenue projection in the future. The State bases its determination of the amount it has to spend on those projections. The better view is deal with those possibilities if they occur after they have occurred.

As with almost all ability to pay issues, the main issue with respect to the ability to pay criterion is not the financial situation, but whether it reasonably supports the method the State has chosen to reduce its costs. This is discussed in the "Summary and Conclusions" section below.

3. "Comparison" and "Cost of Living" Criteria

[13] See S-35.

[14] Recording 8, 5:33 to 15:59, cross examination Recording 9, 15:33 t0 28:30.

The comparison criterion requires comparison of the "overall compensation" of unit providers to those providing "similar services" in other communities or other states. There are no direct comparators. Both parties make comparisons of sorts to the Group Home providers for fundamentally different reasons. The State has argued that it has cut reimbursement for that group as well and this group should bear the same type of cut in provider rates as much as is possible. The Union argues that those providers have been historically paid more and, therefore, no cut is appropriate.

Group homes have client bases which are the same as Adult Foster Care. Nonetheless, a comparison of the rate of growth in average rates per client is a source of comparison. The State has implemented a 6% rate cut for Group Homes, but the same has not been implemented for unit providers pending the result of this proceeding. Adult Foster Care providers work on a lower cost basis. The preponderance of evidence indicates that it is more likely than not that they operate on a lower "profit" margin than group homes. Rates are set for the two types of providers under different evaluative systems. Nonetheless, the following chart indicates that the rate of growth of rates per individual have been relatively comparable.

Percentage Change in DD Average Rate per Individual FY over FY[15]

	ADF	%	Group Home	%
FY 07	1,601.57		5,507.35	
FY 08	2,005.68	.25	6,683.38	.21
FY 09	2,151.67	.07	7,406.93	.11
FY 10	2,302.60	.07	7,461.64	.01

[July to July change]

In short, the comparability factor tends to favor the State's position in making budget based reductions on a comparable basis. However, comparability is less important than developing a rate model which does not unduly "squeeze" the "lower" profit margin of unit providers.

The following is the rate of growth in per-client service fees for Adult Foster Homes (unit and non-unit) over the recent past.

Percentage Change in DD Average Rate per Individual in ADF[16]

		% Change	% CPI Change
FY 10	3,709.84		.011
FY 11	3,981.96	.07	.036
FY 12	4,440.29	.12	.007

[15] Source is U-9. Data extends only to 2010.

[16] Source is S-36. Data does not include Group Home. Group homes had 6% reduction implemented in October, 2010. However, U-30, p 6, The "Analysis of the 2011-13 Current Services Level, a Legislative Fiscal Office report, indicates that as of January, 2011, the REBar Program resulted in a 16% increase in Group home service rates.

[July to July change]

The foregoing indicates that average per-client service fees have risen substantially as the SNAP methodology of assessing client needs and setting rates was being implemented. As discussed more below, the average cost per client is not the same as the rates for service. Service fees have remained essentially unchanged during this period. The reasons for the increase relate primarily to changes in the amount of service per client. The amount of service per client has increased because in some instances the SNAP evaluation demonstrated that some providers were providing one-on-one services but not being adequately compensated and in other cases some clients needed more one-on-one than they were getting. The fact that total compensation per client has risen faster than inflation raises a question as to whether the service rate structure is accurate.

In summary, the comparison factor favors treating the adult foster care providers rate of change in service fees in a manner similar to the group homes rate of change in service fees. The cost of living factor raises a question as to whether the SNAP process has resulted in rates which are more rationally set, but one which are higher than is consistent with the cost of living.

4. The "Ability to Attract and Retain" Criterion

The evidence establishes that if the State's LBO were adopted it could attract new minimally qualified providers and retain existing qualified providers if and only if the reduction is a one-time correcting event. Even with a one-time reduction the confidence providers have in their relationship with the State will be shaken.

The reason the State is confident it will attract and retain providers is that it was attracting new providers and retaining providers before the SNAP review was implemented and it continues to do so. The number of providers has continued to increase as follows:[17]

	Total Clients	Total Providers
2010	2,020	881
2011	2,205	928
2012	2,329	975

Thus, the chart above shows a rise from 881 to 975 providers from January 1, 2010, to January 1, 2012.

The direct testimony of Union witnesses supports the conclusion that the State could retain existing providers during a solitary rate reduction, but that there would be negative effects on the availability of providers willing to take or retain clients who need extensive one-on-one services. The testimony of Mr. Rhodes was forthright on this subject. Mr. Rhodes benefits substantially from the fact that the payments to him as a

[17] See S-36.

provider in two of his three foster homes are tax free. They are not tax free as to the third home he operates. As it stands now, the third home has a slight profit in the form of mortgage payments and the form of net payments of the home's expenses. Essentially, he is compensated by acquiring the home as a paid asset. He is functioning profitably at the other two homes. If the State's LBO were adopted, he would reluctantly change the mixture of clients he has to ones who do not require as much one-on-one time. He believably testified that he would not stay in the business of being a provider if the State adopts a posture of repeatedly "squeezing" the finances of providers. Mr. Rhodes is a highly skilled manager who could freely enter another business.

Mr. Paul Groh is a provider who has two clients. It is likely that he is more representative of providers in general. He is representative of those providers who obtain little benefit from the tax favored treatment of most of the State's reimbursement. He and his wife have clients to supplement his retirement income. He retired from a position as a sheriff's deputy at an age before he was eligible for Medicare or other health benefits. He does not have health insurance and cannot afford the payments for policies which are available to him. The tenor of his testimony was that he would not be able to afford the quality of life things that he and his wife do for themselves and for cleints. He pays for evenings out for everyone in the household and would have to cut back on those. He supplies toiletries and sundries for his clients. He would not be able to do this and they would have to do without. He also acknowledged that he would not leave the business were the State's LBO to be adopted. I am satisfied that he would not leave the business if the State's LBO were adopted but that he would be forced out of this business if this occurred again.

There is a third class of providers, those who are small but would substantially gain from the tax advantages of this work. That group would not be significantly harmed by a one-time reduction.

It is likely that the State's LBO will result in reduction of the availability of service to that sector of clients which requires much one-on-one time. If the State's LBO is adopted Mr. Rhodes would take fewer clients who require extensive one-on-one services. He would prefer those clients who do not require much one-on-one time because he would get a greater profit by working with them. That is true because the reimbursement rate which exists now is less than the cost of providing the one-on-one service. Mr. Rhodes enjoys working with the most difficult clients, those who often require extensive one-on-one services. He has developed the skills to do so. The savings to the state from keeping the people he works with out of prison is a substantial benefit financially to the State.

There are issues as to the quality of services provided by some providers. Mr. Rhodes testified that he has received some clients from other homes who have not received proper care of clients' medical needs or provided adequate chaperoned time in the community.

In summary, the Union's LBO will better keep morale of the unit. The State's LBO of a reduction would still continue to attract and retain providers, but will have an impact on the availability of services to clients who need the most one-on-one service and may result in reduction in the quality of life for some clients.

5. Summary and Determination

As noted above, the interest and welfare of the public is the controlling factor in this matter. The services provided by the small providers in this unit are unique. They save the State considerable sums over other more expensive forms. The reason for this is that unit providers use their homes and their lower fixed expenses to provide services. Other models such as group homes must invest in larger institutions, equipment and higher paid employees.

The State has determined to pay providers on a basis which is minimally adequate to compensate competent, efficient and responsible providers. The system of compensation is still evolving. The nature of the relationship demands that a mature system must be one which is administered on a consistent basis irrespective of variations in state finances. As noted above, it is counter-productive for the State to repeatedly squeeze the finances of its providers.

Under Article 9, Section 1 of the expired agreement the parties agreed to base provider rates on the results of the SNAP process. The SNAP process itself contemplates that provider rates would be "examined and reviewed to reflect fiscal and economic changes."[18]

The State is making every effort to find ways to improve the efficiency of the system. For example, the January, 2011, report of the Human Services Workgroup suggested that it might be possible to improve the efficiency of the system with technology.[19] Some of the testimony in this case suggests that State ultimately might find other efficiencies by facilitating having non-unit and/or unit providers share services. In any event, it is highly unlikely that anything can be accomplished in that regard in the short order necessary to affect this dispute.

The State's financial situation is that it is unable to maintain its previous level of spending and must provide the DD program in as cost-efficient manner as possible. The evidence is insufficient to demonstrate that the State will have any meaningful resources to fund the Union's LBO without adding more revenue or moving funds from unrelated programs to this program. The State's obligations under federal law prevent it from making any meaningful reductions in the services in dispute.

The current fee structure together with the results of the SNAP assessments is having unexpected financial results. The preponderance of the evidence indicates that the average compensation per provider has risen more than inflation. This circumstance

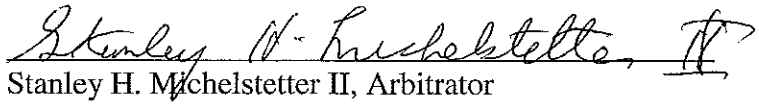
[18] See U-32, page 2. See, also, U-32, p. 1.
[19] See S-12.

raises a question as to whether the compensation is consistent with the public interest of minimally appropriate compensation.[20] There is one countervailing factor which the Union has established. The service fee is adjusted by the amount of one-on-one time each client needs. The fee is set by the State based upon $9.50 per hour for each such hour. By comparison the Oregon minimum wage is set at $8.80[21] and with employer-required taxes that translates to $9.68 without workers' compensation coverage. Mr. Rhodes' testimony establishes that the market rate for qualified labor is about $12 per hour. Notwithstanding this major disparity, the preponderance of the evidence still indicates that the fee structure resulting from the completion of SNAP reviews is higher than is consistent with the public interest. I conclude that the State's offer is closer to appropriate under the current circumstances.

AWARD

The State's offer is closest to appropriate. It shall be incorporated into the parties' agreement.

Dated at Madison, Wisconsin, this 17th day of September, 2012.



Stanley H. Michelstetter II, Arbitrator

[20] This determination is for this case only based upon the available evidence.
[21] Effective January 1, 2012