



## Department of Health Services - State of Wisconsin Town Hall Results

### Do you have any cost savings suggestions for the Department of Health Services?

#### Ralph

By using an interoperable CEM (Competitive Electronic Marketplace) costs and budgets are decreased and sustained by changing the way care is delivered because doctors, pharmacists and beneficiaries have the tools to make better decisions. It is where the free marketplace, through competition, is allowed to decrease cost and increase services which in the prescription drug arena can combine for a 68% decrease in cost.

#### Bill

Exploration of direct contracting to oral health school-based providers.

#### Health Affairs Article

The systems costs have been relatively flat in recent years, as most health systems have seen their costs steadily rise. Bellin estimates that the FastCare Clinics have delivered care outside regular business hours to 124,781 patients. If those people had sought care at emergency departments, they would have cost the system an additional \$52.9 million based on average emergency department costs.

#### Laurel

Examine the records of the northern WI counties. They are very prudent with the funds and are cutting down wherever they can.

#### Steven

The \$500 million in planned Medicaid cuts not be taken in a manner in which would decrease overall access, but from services that are currently overvalued or unneeded. Health policy initiatives are currently being developed (such as Medicaid Accountable Care Organizations with global capitation) which can accomplish this goal. Indiscriminate Medicaid cuts would likely lead to increased barriers to primary care services, such as increased copayments, deductibles, and/or decreased reimbursements. This would all translate into further decreases in access to primary care services.

#### Thomas

Utilize a reduced fee model based upon Access Affordable Healthcare, a private, reduced fee clinic that began in January of 2010. Having patients pay for services at the time of each visit greatly decreases administrative overhead associated with billing and insurance claim filing, allowing the clinic to lower fees by over 50% in most cases. One way this program can be instituted is by issuing a debit card from the county social service department for each member with incentives for its use, such as decreased premiums, co-pays, etc. By utilizing this card for direct payment for primary care services, a reduced fee schedule can be honored that reflects the elimination of administrative overhead.

## **Gary**

Change the rules and charge providers with the responsibility of managing the behavioral health of a population effectively and efficiently rather than paying for generating volume. Providers should be evaluated (and paid) based on ability to keep that population out of the hospital, out of jail, off the streets and employed.

## **WHA Medicaid Reengineering Group**

Recommend using option 3.

## **WHA Medicaid Reengineering Group**

**COST SHARING:** 1. Increase cost sharing for Medicaid recipients by increasing premiums on a sliding scale. 2. If Medicaid includes copayments for services, make copayments payable to the state (like premiums). Because copayments can often be difficult to collect, they essentially amount to a reimbursement cut for providers, especially for hospitals that are under greater obligation to care for patients regardless of payment. Further, requiring copayments to be paid to the state will decrease the potential for reductions in access to care due to nonpayment. 3. Do not support allowing providers to deny care if a recipient does not pay the copayment. Should the department move toward increasing copayments, a Health Savings Account should be created for Medicaid recipients.

## **Nancy**

Journal of the American Dietetic Association study revealed a savings of \$4.25 for each dollar spent on MNT, which was much less than the cost of drug therapy. The Journal of Occupational and Environmental Medicine revealed that for every dollar an employer invests in the lifestyle modification program for employees with diabetes, the employer would see a return of \$2.67 in productivity.

## **Samantha**

By covering homebirths and free standing birth center births attended by CPM or LM under BadgerCare, tax payers would be spared paying the extra thousands of dollars PER BIRTH more that it costs to have a baby in a hospital with an OB or CNM.

## **WI Assisted Living Association (WALA)**

1. Eliminate case management through the MCO's for elders who live in SNFs and all assisted living settings. 2. Reduce redundancy, an RN evaluation should not be required of the MCO if the assisted living facility already has an RN who is managing the assessment and care plan development process. 3. Rate & service inclusions should be negotiated on an annual basis and are not subject to change during the contract period without agreement from both the Provider and the MCO. The current requirement to include transportation as part of the rate will simply reduce the amount of Family Care recipients get to be out of their facility since transportation costs were never part of the rate negotiation with the MCO. 4. Encourage CMS to issue a waiver to allow bed holds in settings other than the SNF. 5. Tighten and strengthen divesture rules. Money is wasted by members and families during spend down to achieve the eligibility threshold. 6. Reinstate the nursing home diversion program rather than utilizing the nursing home relocation program. 7. Require more consistency between MCOs. Their policies should support streamlining processes for providers who contract with more than one MCO.

## **Erin**

I personally had a hospital birth while on the equivalent of Badger Care in another state several years ago. Had I been given the option of using a Licensed Midwives, the state would have saved about \$8,000 for the birth of my child. Licensed Midwives undergo specialized training to deliver babies in out-of-hospital settings, provide safe and cost-effective care that is proven to reduce low-birth weight and preterm births, two of the leading causes of infant mortality as well as the long-term costs associated with maternity care.

## **WI Assisted Living Association**

1. Eliminate the duplication of case management and RN management services. About 1/3 of all Family Care members live in Nursing Homes or Assisted Living Facilities including CBRF's, RCACs & AFHs. Case management as well as care planning is required by regulations in these settings. The duplication of expense of the efforts of the MCO does not result in better outcomes. 2. Educate and enforce better ADRC financial screen utilizing all State and Federal benefits, not just the Family Care, Family Care PACE, Family Care Partnership and IRIS benefits. ADRC's are not adequately investigating coordination of other benefits like Long Term Care Insurance, VA Time and Attendance Benefits, HUD Vouchers, Food Stamps and others. 3. Closer management of automatic 30 day orders for disposable medical supplies and DME equipment. Providers report that some MCO members who receive incontinence products and dietary supplements have received more product than is needed.

## **Barbara**

Decrease spending for inpatient and emergency department services for people with mental illness by improving access to community based services and supports, and diversion.

## **KIT**

MAPP PROGRAM. PLEASE LOOK AT THIS TO BE A LEGITIMATE WORK PROGRAM. IF 20% OF CLIENTS ARE DISABLED AND THEY ARE INCURRING 80% OF THE COSTS, THIS WOULD BE A HUGE COST SAVINGS. CURRENTLY THERE IS A LOOPHOLE THAT TO MEET WORK REQUIREMENT YOU CAN USE IN KIND INCOME FOR 1 HOUR A MONTH. SO WE HAVE MANY CLIENTS KNITTING A POT HOLDER IN EXCHANGE FOR A COOKIE AND PRESTO THEY ARE ELIBILE FOR MAPP WORK PROGRAM. TODAY I HAD CLIENT WHO ORGANIZES PICTURE FOR HER DAUGHTER AND IN EXCHANGE HER DAUGHTER STYLES HER HAIR ONCE A MONTH. THIS IS NOT INTENTION OF WORK PROGRAM.

## **Phyllis**

More efficiency and easier communications in Madison with providers of care service and people who are on Medicaid.

## **Falon**

The Department of Health Services could cut costs by covering services offered by Licensed Midwives in the state of Wisconsin. Deliveries under the care of licensed midwives are less likely to result in unnecessary cesarean sections and the use of multiple costly interventions. Birth in an out-of-hospital setting is cheaper overall. Women who would otherwise choose birth in an out-of-hospital setting are choosing costly and risky hospital birth because it is covered by their state insurance. If Licensed Midwives were a choice for women receiving Medicaid health benefits there would be a cost savings for the Department of Health Services.

**kara**

Allow home birth with a Certified Professional Midwife to be covered in the state of WI. The home birth option for birthing is extremely less expensive than hospital births but just as safe when the mother is low risk.

Don't offer BadgerCare to adults who are offered health insurance thru their employer, but they don't want the premium deducted from their paycheck. Don't we all wish for that? Have the employee at least pay state the cost of employee health insurance for the better coverage.

**Patti Jo**

Yes, work with probation/Pavok, Courts, CJ system to use diversion programs, alternatives to incarceration, to assist an individual to secure safe housing - job training, connections to community programs. Use evidence based practice models for recovery - utilize PACT models for recovery.

**Adam**

Fund enhanced community programs

**Underwood**

Delicense unused beds at CWC if there is no intention of using them. There are currently in excess of 75 licensed beds not being used -- bed tax of about \$770 per licensed bed per month, occupied or unoccupied. A waste.

**Dylan**

Have more Pact providers to save dollars.

**Nancy**

Add staff to review program effectiveness in state. Evaluate/compare hospital/jail/prison days of people in evidence-based programs vs. non-evidence based and/or not in programs. Employ peer specialists when and where appropriate cost savings involves ongoing continuity of care. Without Medicaid & Medicare my family member would not be in the community functioning as well as he does, given that he has a brain disorder of schizoaffective disorder.

## **Nancy**

Services for severe and persistent mental illness: We have a model called ACT (assertive community treatment) or PACT (program of assertive community treatment) that research shows is effective as well as cost effective. Community Support Programs (CSPs) in our state are loosely modeled after ACT but only a handful get the cost effective results because out of all the CSPs throughout the state only this handful follows the model. Create means to train CSPs to follow ACT model and to educate community on benefits of utilizing ACT model. Create incentives for fidelity to the model. We are referred individuals with severe mental illness who have had multiple (up to 80) hospitalizations prior to coming into our program. After admission (to ACT) these hospitalizations go down drastically. Over the past 10 yrs 87-92% of our clients (who all live in their own homes in communities) have been hospital free. Hospital days cost over \$800/day up to \$1200. ACT model is a win-win as it combines state of the art comprehensive, individualized treatment with cost effective sources for this population.

## **Underwood**

Justify, and make public, the special nursing home rate reimbursement formula used by the State Centers for the DD to be reimbursed for the cost of care and operation of the Centers. Is any of this money used for operations of the Department not specifically related to operations of the State Centers? Department personnel have been known to refer to the State Centers as cash cows. Does that mean WI has been pulling in extra Medicaid funds through the use of this special / enhanced nursing home rate formula?

## **Georgie**

Look at what AZ has done for the mentally ill, let's have something like that in WI.

## **Underwood**

Re-evaluate the ICF/MR Restructuring Initiative. It is costing money -- not saving money as the program was sold on. In FY06, 306 persons relocated from an ICF/MR. The ICF/MR average cost per person was \$231.73/day AF. Following the relocation, the average cost per person increased to \$263.97/day. The Department has estimated the aggregate increase was over \$1.6 million dollars. The Department has rationalized that the increased spending on community placements -- even though the relocation might not be voluntary in the true sense of voluntary -- is that the money saved by deaths of individuals in the ICF/MR can be used to offset the increased cost of community placement -- as long as the Department stays within the global ICF/MR budget. Please remember that the ICF/MR cost includes room and board. The community cost does not, so room and board becomes an added cost to the already increased MA costs. In FY 07, 143 persons relocated from an ICF/MR. The ICF/MR average cost per person was \$189.19/day. ICF/MR costs are inclusive and include room and board. Following the relocation, the average cost per person in community setting increased to \$293.58/day -- again not including room and board. Aggregate amount of increase not provided by the Department. In FY08, 39 persons were relocated from an ICF/MR. ICF/MR average cost per person \$187.82/day. The average community cost increased to \$260.02/day/per person. Aggregate amount of increase not provided. In FY09, 37 persons were relocated from an ICF/MR. ICF/MR average cost \$203.78/day/per person. The average community cost increased to \$273.99/day/per person. Aggregate amount of increase not provided. FY10 -- average ICF/MR cost \$203.42/day/per person. Average community cost increased to \$276.30/day/per person. Again remember that room and board is a cost shifted to a different taxpayer source in community settings while in the ICF/MR room and board is an included Medicaid cost. As long as the Department has stayed within the global ICF/MR budget due to deaths of persons in the ICFs/MR, the money saved from these deaths can be used to support increased costs in the community. What are we thinking or who was not paying attention? The above data is available in the Relocation Reports available on the DHS website.

**Pam**

Prevent instead of react. We need long term treatment facilities for the truly mentally ill, it's better than putting in jail or having them live on the streets.

**Becky**

Review the restrictive regulations, codes, and policies dictated by the state. Trying to provide care by licensed, credentialed provider and adhere to rules imposed by the state bureaucracy.

**Sharon**

One size does not fit all - only the ones in need. Take out waste and fraud.

**Kathy**

Greater use of peer specialists, both in-unit and in the community. Peer specialists should be part of the first response teams and intake process. They should be on staff at MHC. The presence of peer specialists throughout the process may facilitate treatment, reduce time spent on the unit, and reduce the numbers and frequency of release. Follow up in the community eases the workload of caseworkers. As many peer specialists work part time, there is the potential for tremendous cost savings for the mental health services target.

**Gladys**

Fill the car up when transporting consumers.

**Wendy**

Divest money from insurance claims related to LTD and put that money towards the consumer who needs it. A lot of money is spent on bureaucratic red tape of claims having to go through several people, which costs money, skip all those people. Refine the process and create a rubric with more straight forward benchmarks that help people to get assistance faster and more streamlined. Why is it a yes/no decision nothing in between. I received LTD once and had problems with work and was denied the second time. I've had to go back to work not really ready and able to, but had no choice. How are we going to help treat people with mental illnesses? The solid care of people with mental illness is not wholly available in WI. With services being cut more and more, quality of life continues to decrease, which causes more of a loss of hope for a day to day survival.

**Mary Lou**

The Yale University study has shown a 44% decrease in hospitalizations for members of Optum Health Services (HMO). If I would have had specialists available to me I wouldn't have had as many hospitalizations which might have saved me from bankruptcy. By not integrating specialists into mental health service systems there has been an overreliance on expensive often less effective treatment options. Those systems are generated toward crisis management rather than crisis prevention. Please mandate the hire of specialists throughout the system including DOC, DVR, & all HMO's contracted by the dept. of health. Specialist need to be paid a living wage with benefits. The consumer can be identified early in the ER or hospitalization thus being provided with the knowledge that specialists have regarding after care. This intervention by the specialist can stop the revolving door many consumers experience without the proper CSPs.

**Sheryl**

Cost effective would be to institute the Health Homes as indicated in the Affordable Health Care Act.

**sandra**

drop the hmo programs and handle claims directly.you are paying a middle man which is raising costs and they need all approvals from the state any way ,they make the provider contact the state they do nothing except collect your money.

**Mike**

Make the new National Mental Health Law work to attract more psychiatrists to our state to eliminate the wait times that drive up costs.

**Richard**

Kenosha County has a KARE center where people can be placed instead of hospitalizing them in semi-emergencies. These should be expanded and established in every county.

**Ann**

I feel the state needs to know who is getting the states programs, food stamps, BadgerCare, IRIS, Family Care, etc. I have heard that there are people in prison getting many of these programs. Why do they get these services, how do they qualify, or do they. This is probably fraud and I feel these programs need to be scrutinized very carefully. I'm sure these people are selling their benefits to outsiders or are giving them away to outsiders who somehow didn't qualify. This would certainly be cost effective. Somehow get across to people with mental illness when in times of crisis call the crisis center, warm lines, peer specialists and/or ask a nurse instead of running to a hospital ER since thats all they know where to go for help & Medicare pays - very costly choice over the other four.

**Elissa**

No, I think Medicaid & BadgerCare should be expanded to cover more people.

**Diann**

When setting up the insurance exchange change the financial incentives for hospitals and doctors so that the new health care system will result in cost savings.

**Crystal**

With peer support and self direction and respite care homes in 72 counties they are evidence based that work instead of going to ER or psychiatric hospitals before we have a crisis. Have them peer specialist ran. We need CIT officers.

**Justin**

1. Rewarding individual disease and illness prevention measures. 2. Point of delivery evaluation to ensure that all medical intervention and charges correspond with services rendered.

**Paulette**

Find more ways to employ people who are able to contribute to society, and provide them more opportunities to work. They want to work, help them do this.

**Alice**

Increase funds for crisis intervention centers which decrease need for county funds (for Chapter 51 or hospital costs) keep people out of ER & hospitals! Model program exists in La Crosse.

**Pattie**

Open up more positions for Peer Specialists. Have more concrete accountability for funds being used for mental health.

**Phil**

Continue to support programs that aid people at home. Focus on local support through county funding. Avoid cuts that impair preventative care for mentally ill children and aged.

**Marilyn**

Hundreds of \$ are being thrown in the trash just in the hi rise in my neighborhood alone. These are crutches, walkers, lift chairs, shower chairs, etc. Why not loan instead of buy. Most of these items can be sterylized. Also people call an ambulance for any reason because its free of charge. If they were charged even a small amount they wouldn't be quite so quick to call especially when there are other ways to get transportation.

## Robinson

Research shows that mothers who deliver under the care of a Licensed Midwife experience as much as a five-fold decrease in cesarean surgery. Cesarean surgeries now account for over 1/3 of deliveries nationwide, many of which are both preventable and a major contributing factor to the rising costs of maternity care.

## Sherry

This has been on my mind because we have a good IT team who should be able to complete the above and really save the state time and money once this is implemented. This would also be less painful because the systems are already set up and ready to use.

## Anonymous

Understanding End of Life Choices--- Save big dollars. There is a need to teach the public: understanding the end of life there is so much done for those who don't want it. CPR: given too often and to those who don't want it anyway. Basic meds and other forms of treatment to prevent the need to intervene in a crisis and having to give CPR and resuscitation. Promote Living Wills (Children's Hospital is a great example on the proper use of them for families) Different levels of Nursing. LPN basic level of skill, RN 2 yr program higher level, BSN 4 yr program: involves management skills Independent Care requires more monitoring and audits. A lot of the LPN's have a lack of work ethic and supervision, LPN's are currently regulated by State License only and need more supervision and accountability. Currently there is no form of reporting or auditing to correct the LPN's medical errors or mistakes. The lack of nurses causes the individuals/families that need them to be at the mercy of any independent LPN that is caring for them. Examples of LPN abuse: Parents are not allowed to see their child's binders of medical information, No documentation, Lack of education/work ethic/will to be able to take action for prevention, Child with feeding tube and a ventilator, i.e.: LPN let the child sit in the high chair for over 8 hours. The alert on the machine was sounding off a ½ prior before the case manager RN arrived and the LPN found it to be ok to turn off the alarm and did not try to correct the issue. The child was having trouble breathing and all that needed to be done was to have the tube of the ventilator adjusted. Administering medication without consulting a physician. i.e. a child was given a medication hours before it was supposed it and when the family called the LPN, she asked the family to spell it so that she could Google it and gave them direction. She never once consulted with the doctor to see what steps should be taken. Family's case manager have no say over the work or lack there of the LPN's that are hired independently. Most are not willing to work with the case manager and the family plan only doing what they see fit. Issues on LPN's: Hours are not regulated Documentation is not reviewed They are not supervised by the physician or the case manager .Mandatory Reporting Process is abused by the teachers and school officials .Bullied by the school staff to force a report to be done. Difficulty between the flow process and reality. The trust of families, their lack of resources which prevent them to provide the right environment, medication, or support. Planned Parenthood Cutting this program is not an option. i.e. 11 year old girl pregnant and is from a family where the mother, grandmother and sister were pregnant at a young age. Education needs to continue regarding safe and smart sex. School setting in an open room with staff/students coming in and out is not an appropriate place to talk a 5th grader about her pregnancy School Nursing Program: Every school should have a nurse. Last year there were 4 MPS related deaths and 3 were asthma related. Schools have no space for proper treatment of the students. Lack of privacy and time to properly document each encounter. Principles currently have the final say (over the RN's) they are not medically qualified to base an appropriate decision and they have their own agendas to meet. School RN's are risking their licenses everyday just to do their jobs and keep up with the demand of service required by the students. Dental Access: Frustration in finding a dentist for the children. Case where a teen boy was suffering from a headache and didn't realize that he had an upper tooth abscess and it spread to his brain. Suffered from headaches and he passed away from it. There is a desperate need for dental services for the children. Prevention is important and schools have the captive audience waiting for them

**Michael**

Allow families on BadgerCare Plus to utilize professional midwives outside of the hospital. Licensed Midwives, who undergo specialized training to deliver babies in out-of-hospital settings, provide safe and cost-effective care that is proven to reduce low-birth weight and preterm births, two of the leading causes of infant mortality as well as the long-term costs associated with maternity care.\* In northern Wisconsin Medicaid women who have been denied Licensed Midwife services are being air-lifted to give birth in Minnesota hospitals due to the closing of OB units in Wisconsin and the severe shortage of OB providers in many rural and low-income areas, costing the state thousands of dollars each year and diverting tax dollars over the border to Minnesota.\* Washington State, whose Licensed Midwife program is approximately the same size as Wisconsin, commissioned an independent audit of the program which found that LMs saved the state \$3.1 million per budget cycle while providing excellent outcomes for low-income mothers and babies.

**Tracy**

With my first birth the total cost of the prenatal and delivery was over \$8000 dollars, this was a simple vaginal birth. My second birth at home with prenatal costs = \$2000. Seems pretty simple to me that the state could save a lot of money by covering home births. Not only are home births less expensive the outcomes are better and save even more money with the reduced risk of complications due to over medicalized birth procedures in hospitals.

**Elaine**

Yes, several. The first is in regard to the above comment. The nursing home daily rate is 2X that of a group home. It does not make sense to allow nursing home funding but not group home funding. It should actually be the other way around.

Our group home services many of the same clients that the nursing home does- but for one half the cost. Many of the residents in the nursing home could actually be placed in a group home without any change in care or quality. This was and I thought still is the premise behind family care. The provision that would require private pay residents to leave the group home and be admitted to a nursing home when private assets are spent down at the group home is fiscally insane. The second issue is with the double dipping currently being done at MPS. I have several friends working in MPS. They have pressure placed on them to increase the number of Medicaid eligible students who receive speech therapy, so that the therapy can be billed through T19. The school already receives special education funding from both the state and federal governments. How is this ok that they can also bill the Title 19 program? This is not a minor happening. My guess is millions are being spent on this double dipping scam.

**Smith**

HOME BIRTH COVERAGE is a cost saving mechanism! Please cover homebirths!!! Our women and state deserve this.

## **Prown**

Independent Study Demonstrates Significant Cost Savings and Improved Outcomes Under the Care of Licensed Midwives Washington State Data Demonstrates Cost Savings to Medicaid and Private Insurance Under Licensed Midwife Care for Babies Delivered in Out-of-Hospital Settings. Total savings to Medicaid of over \$3 million per budget cycle. Medicaid cost savings of nearly half a million dollars per budget cycle in cesarean reduction alone. Combined savings to public and private insurance of over \$2.5 million per budget cycle in cesarean reduction alone. Total cost savings to the state from the care of Licensed Midwives is approximately 10 times the cost of administering the program. Cost savings achieved with under 2% of births in the state taking place in private homes and freestanding birth centers under the care of a Licensed Midwife. Subsequent analysis by Washington State shows \$3939 in savings for each out-of-hospital birth. Improved Outcomes for Women and Infants Under Licensed Midwife Care. Significant reductions in low-birth weight and premature births, two of the primary contributing factors to infant mortality and the long-term costs of maternity care. Significantly reduced rates of cesarean section surgery, one of the largest costs associated with maternity care in the U.S. Lifetime health benefits to babies reflected in significantly higher rates of breastfeeding under the care of Licensed Midwives. Improved outcomes achieved with neonatal mortality rates equal to those of low-risk hospital births. About The Study: Commissioned by the Washington State legislature to determine whether the costs of administering the state's Licensed Midwife program are offset by the economic benefits of Licensed Midwife Care. Conducted by the independent firm, Health Management Associates, under contract by the Washington State Department of Health. Analyzes all costs associated with Licensed Midwife care, including those associated with hospital transfers when necessary. Research team included a health economist, physician, obstetric nurse, public health professional, and other experts. Health Management Associates used the Department of Health's First Steps Database of Medicaid claims and other healthcare economic indicators, as well as a thorough literature review, to perform the study and establish its conclusions. 'Midwifery Licensure and Discipline Program in Washington State: Economic Costs and Benefits,' [www.washingtonmidwives.org/assets/Midwifery\\_Cost\\_Study\\_10-31-07.pdf](http://www.washingtonmidwives.org/assets/Midwifery_Cost_Study_10-31-07.pdf)

## **Maureen**

Please consider offering reimbursement to Medicaid/Badger Care recipients for maternity care through a Licensed Midwife (LM) in the home setting. This would result in significant cost savings to Wisconsin taxpayers, improved safety and outcomes for mothers and babies, and it would actually indirectly improve care for all birthing women & families. Let me explain why...I am an RN, working in OB at a high-risk hospital. We serve countless families on Medicaid/Badger Care who choose hospital birth over home birth with a licensed midwife because the latter is not covered by their plan. Although I work in a hospital setting, I am a strong advocate of home birth under the care of a (LM) because, simply put, their care results in better outcomes - fewer unnecessary cesarean sections, fewer low birthweight babies, fewer postpartum infections, improved breastfeeding and the health promoting effects of breastfeeding. Along with these better outcomes is a significant cost savings. This may seem like backwards logic - a hospital-based OB nurse promoting reimbursement for out-of-hospital care, but this policy change would actually benefit the private pay clients I serve as well. In addition to saving our state loads of money, if DHS will reimburse for the care of a LM to Medicaid/Badger Care mothers, OB physicians will be encouraged to practice in a safer way when their clients opt for alternative care. The 'safer way' I speak of is not a mystery - it is clearly spelled out in an abundant body of research that supports best practices in maternity care. It is the way midwives practice by their training and their philosophy. It is also less convenient and less lucrative - therefore less appealing - to many physicians. In addition to saving taxpayer money and increasing safety, this reimbursement will create a form of healthy competition that will lead to better outcomes for everyone. This is a multi-faceted issue, involving details that are too long for this simple request. I hope I have explained this in an understandable way.

## **James**

If Licensed Midwives were eligible providers, individuals that would prefer (if they had the badger care option) to work with an LM and that also meet the risk criteria to birth with an LM, could. This would save the state thousands of dollars

## **Audrey**

Each time a Medicaid/BadgerCare Mother who seeks to give birth at home or in a Freestanding Birth Center under the care of a Licensed Midwife is denied access to her services, it costs taxpayers thousands of dollars in unrealized savings.

Economist David Andersen calculated that a modest increase in out of hospital maternity care nationwide would save the health care system over 9 BILLION annually through reduced costs, improved outcomes, and increase competition in the maternity care market.

## **Melo**

Cover the cost of home births!

## **Scott**

Develop and implement performance based contracting. If a program meets the outcome benchmarks there could be modest funding incentive (e.g. +10%), however, if the outcome benchmarks are not met the program would only be reimbursed 70-80% (as an example).

## **Savita**

Licensed Midwives, who undergo specialized training to deliver babies in out-of-hospital settings, provide safe and cost-effective care that is proven to reduce low-birth weight and preterm births, two of the leading causes of infant mortality as well as the long-term costs associated with maternity care. Each time a Medicaid/BadgerCare mother who seeks to give birth at home under the care of a Licensed Midwife is denied access to her services, it costs the state thousands of dollars in unrealized savings.

## **Nancy**

1. Identify people who exceed \$100,000 in payments during a specified time period. 2. Display their expenditures by hospitalization, ER, surgeries, pharmacy, and by diagnosis. 3. Look at historical expenditures. 4. Work with consulting agencies to identify the 20-25 cases that would benefit from greater individual case management. Start with these 20-25.

## **Alicia**

I have heard people comment that BadgerCare is the best insurance they've ever had and will do whatever they can to stay on it. If it is better coverage than what you can get if you're working, what incentive do you have to get off of BC+. I also know that there are several families the size of mine that receive \$600+ in FoodShare. Our budget for food is \$300 per month and my husband and I both have good jobs.

## **Kathy**

Reduce levels of admin fees which lower funds available to clients. Improve technology for both public staff and caregivers or clients. Use internet more, reduce paperwork. Internal - involve fiscal staff during program implementation.

**Chuck**

In the past we have had student groups/classes from UW Platteville work on projects for us and develop things that are then implemented throughout the division. We should take advantage of this type of assistance. This partnership provides free solutions for us and good experiences for our students.

**Scott**

See to it that SBIRT is fully implemented in the Wisconsin healthcare system.

**Christine**

Management at MCO's appears to be heavy. It seems that MCO's have multiple managers who do similar roles. This is expensive and confuses members on the roles of those on their teams and at meeting.

**Jennifer**

Return to traditional MA covered long term care services and eliminate family care. The level of administration and RN/SW case management is duplicating services county based, non-profit agencies were already providing. It is inefficient to have a whole other level of management. Strongly restrict the IRIS/self-directed option. Many are not appropriate to direct their own care and that is why they require assist in the first place. How can we pass along more responsibility to patients to direct their own care when the individual is asking/in need of help? Plus, through the prior authorization process, traditional MA services provided were limited. It seems that the nurse that authorizes self-directed is seeing a patient one time and making judgement on what the patient needs for services. That decision might be best left to someone that knows the patient for more than one hour and can follow up with the patient on an ongoing basis.

**Amy**

It is much more cost efficient to provide MA Personal Cares to someone still living in the community than to provide LTC MA. By the time someone is down to MA income and asset limits, they encounter waiting lists for services so they have little choice but to go to a nursing home and apply for LTC MA. Being proactive rather than reactive with benefits could be a huge cost savings.

**Reggie**

Do the cares they person want it done not the they should be done.

**RITA**

Keep the family wavier plan, if familys choose to have more than 2 children, they shouldn't continue to get the benefits. Years ago a women had to have a tubal when she had her 3 child. We need to teach that you have to think before you have children, most people can't afford them in this day and age. Bring back the badgercare work program that Thompson started. Also if people make more than 250,000 per year per person and or are over the money limits they should not get SS# checks or benefits because they can afford to pay and live with out them.

## **Brad**

1. Focus on what works, specifically evidence-based practices. 2. Build synergies with partners, FQHC's, local. 3. Assure basic health care for all who are impoverished and unemployed. 4. Assist in the development of data-driven systems which can measure outcomes, congruent with federally accepted evidence-based care. Beware of introducing cumbersome bureaucracies. 5. Help tribes to maximize use of federal dollars to promote good health care. 6. Minimize cost shifting to localities but help communities to be responsible with health care dollars. Beware of potential abuses to de-regulated systems of care. Although IRIS is a wonderful option, it does open the door to abuse.

## **Wilmot**

Investigate and eliminate fraud and abuse, without unfairly targeting or prosecuting innocent people. Insistute policies that reimburse/reward outcomes in care settings, rather than reward activities only.

## **John**

Permit the group of IRIS participants to be considered a single workers compensation insurance employer permitting a single base premium of \$220 per year. Currently the 2,800 IRIS participants if purchasing WCI would need to expend \$616,000 to purchase 2,800 base premiums.

Make IRIS look at Medicaid's personal care hours before approving a plan. E.G. One IRIS person (age 19) had authorization for 130 hrs/week which employed her sister & mother, while she attended high school full time. What a waste, especially since IRIS also funded many hours of supportive home care. Duplicative services.

## **Will**

Build data systems to compare service delivery at client level county to county. Promote models from counties with more efficient per capita systems. Community aids \$200 million - county levy \$500 million, on who? for what? how often? We can't say much about where the money is spent.

## **Barb**

I would like to advocate for better coordination between divisions. Many of the committees/groups I've been involved in have come about because of personal connections that have been forged.

## **Houston**

Expand COP & CIP, IRIS, & Katie Beckett. These programs have proven that community based care is less costly than institutional care, never mind that people can more easily participate in the community as fully as they are able to if they are not in institutions. Disabled man on Title 19 has wife attendant with no health insurance. The wife became sick finally went to the ER too late and died.

**Jamie**

Web based contracting with integrated bases, regular rebid of contracts, more training for municipalities on alcohol license management, use of ipads for field data collection.

**Kim**

Eliminate the inefficiencies that are currently in practice. There are systems now in place that can be enhanced to communicate information and interface with each other more effectively.

**Charles**

We know that fraud and abuse is a large problem across the country in the Medicaid and Medicare programs. We should develop edits on the incoming data that could identify potential fraud (such as deceased people receiving benefits for more than 2 months, our application has this edit with a one month limit). I believe we should accept the data and flag it so a fraud analytical team could investigate the claims and recoup monies where appropriate.

1. Re-evaluate the cost of BadgerCare Plus Basic. It seems like not enough admin cost was built into the premium. 2. Put more emphasis on cost/benefit analyses in making decisions and/or contracts.

**Marjorie**

MN has a provider tax. The state uses the provider tax to draw down more federal Medicaid dollars. This additional funding is used for increased provider reimbursement so that providers are more willing to serve Medicaid members. This tax is across all providers not just nursing home and hospitals. If they serve Medicaid members they will get their tax payments back.

**Lori**

Stop sending duplicate mailings out on healthcare coverage and benefits.

**Leibfried**

I know that Badgercare helps lower income persons, but perhaps some measures would be: Increasing co pays for services, especially ER visits- could waive the fee if the person is admitted. Perhaps this is already a policy- but generic drugs unless MD prescribes must be name brand. Some health insurance plans do a mail order pharmacy service 3 months at a time for maintenance prescriptions that do not often change.

## **Kathryn**

1) Transportation: Currently handi-vans (taxis, vans, etc. who provide transportation to services) are allowed to charge the state full mileage for EACH person in the van, even if there are 6 riders, along the same route. I would make more sense for the state to pay the longest mileage and then a flat rate for each additional rider the van has on board. 2) Medication: Currently BadgerCare makes decisions based on cost for medication reimbursement to providers (drugstores, Wal-Mart, etc). No advance warning is received by the consumer that the change is coming, they find out when they pick up the prescription. Due to many substitutions not working, this program leads to higher costs in the form of: additional doctor visits to find out what to do about the change in behaviors, additional hospital stays due to regression of behaviors and additional doctor/provider charges when they have to process the brand name medically necessary forms. For example, recently my grandson's \$47/month medication was changed---a savings of \$3/month for his script. While I realize that \$3/month times each person who takes the meds may be substantial, the change in his behaviors due to the changed medication required a 212 mile trip to meet with his doctor (BadgerCare paid for the mileage-\$52-and the doctor's charge-I'm sure over \$50). We then had to get the paperwork processed through the provider and he went an entire month with medication that didn't work (you can only get a 30 day supply of meds-even if they are the wrong ones-through BadgerCare). So, BadgerCare spent over \$100 to save \$3--clearly not viable in attempting to save money--and it could have been worse if my grandson had decompensated to the point where he needed to be hospitalized--a cost of several hundred dollars/day). 3) Co-Pays: I am more than willing to help the program save money by paying co-pays on the hospital and office visits. While we do not have a lot of money, I think if you would charge everyone a nominal amount--say \$5 to \$10 per visit, it will help provide some savings to the program, especially when you consider the number of people who visit doctors/dentists/hospitals/pharmacies each month.

## **Kristina**

---Require that Medicaid managed care organizations have provider networks with vision providers available to all Badgercare recipients in their own communities, and redo contracts so that people are able to go to the same place for eye exam

## **Andrew**

(1) Psychotherapy costs less than psychiatric medication long-term, AND is more effective, according to a large body of research.(2) Psychotherapy reduces other medical expenses, reduces medical and psychiatric hospitalizations, and improves people's ability to get jobs and stay employed.(3) Peer support is an effective service that reduces the amount of medical, psychological, and other treatment that people with serious mental illnesses need.

## **Abby**

Reduce the exorbitant costs of people with mental illnesses being housed in jail, hospitals, and nursing homes by increasing community support services, such as comprehensive community mental health & AODA treatment/housing/employment, such as ACT or CST programs.

### **jennifer**

many people are selling their foodshare at 50 cents on the dollar to make cash, i know people who receive over \$500 for two adults and an infant (who receives wic) this is ridiculous-this funding should be cut not only to save money, but our country is struggling with an obesity/diabetic epidemic and food share is only adding to it by giving excess funds to over indulge esp on processed high fat foods (we spend about \$300-\$350 a month for a family of five (plus wic for a 15 mo old) and we both work f/t plus do foster care) if you care not working full time you have extra time to cook homemade meals vs ready to eat, processed foods; the children in these homes are eligible for free/reduced lunch as well, although that is very unhealthy food as well, but cut these funds to a reasonable amount. Also I work in a healthcare setting most of the people come in with MA and they smoke, are obese, have chronic conditions and don't care that they cost a lot of money to taxpayers because their copays are so low or nonexistent--this needs to change; children should be covered up to age 18 as well as have better dental coverage; adults should be expected to be more responsible for their health and have copays esp for using er for regular clinic use-\$25/er visit would still be ridiculously cheap and same for clinic visits, we have multiple pts (not all, but a lot that abuse the benefits)that come in 1-3x a week (even with no concerns) because they will say they don't care, they don't pay for it plus they use the mileage reimbursement forms and make more money by coming to the dr or go to visits an hour+ away so that they get more mileage and food vouchers and aren't afraid to share this with us when they come in. Also it is common that the roommate is actually the boyfriend so that the mom and kids get better benefits or the divorced parents lie and say the kids are shared 50/50 to make both parents eligible for BC then one parent that I know of buys her groceries and her ex-husbands with the foodshare (he pays her extra cash on the side for food and for lying and saying they share the kids so he can get BC too) and then the leftover money on the foodshare this lady sells to her sister for 50 cents on the dollar

### **Dorinne**

Centralized medical records. Aurora is an excellent example of this. Information is available for all physicians to access, tests and procedures can be ordered or eliminated based on a full patient history.

### **Mike**

What would save the state is at Shopko and Kmart, Medicine shops and at local medical shops the Attents BRW 103072 with waist band style works excellence during the day. Depend Fitted Briefs Maximum Protection are excellence for night time use and Tranquility AI through the night are good too. You get 300 disposable briefs a month and some of us are paying out of pocket when they run out. Some people need both. BRW 103072 cost \$11/bag at Shopko, Depend \$13.99/bag at Kmart.

### **Julie**

Reduce overhead and all the layers of administrators that currently bog the system with illogical rhetoric and bureaucratic nonsense making those who need to make such tough decisions even more difficult without accurate or truth driven data.

### **Dianna**

scrutinize provider MA/BC claims better to avoid fraudulent claims

## **Southwest Dane County Outreach**

Govt cost in 2009 per enrollee for SeniorCare was \$588, while Medicare Part D subsidy by the govt was \$1,690. SeniorCare negotiates lower drug prices and saved \$50 million in 2009.

Restructuring departments to reduce government costs.

## **Kim**

Medical Nutrition Therapy (MNT) provided by a Registered Dietitian is both cost effective and in the best interests of Medicaid patients. It is estimated that expenses associated with diabetes treatment are \$174 billion/year. Data shows that \$6 can be saved for every dollar spent on nutrition intervention to treat diabetes. The cost of providing a statin therapy for one year is about \$700-\$2100, compared with the cost of MNT to reduce cholesterol levels, only about \$217/year. Data shows that 1-2 hours of counseling by a Registered Dietitian and 15-20 minute follow up can produce sustainable weight loss in obese and overweight individuals.

## **Ellen**

Make HMO selection process less confusing for individuals - privatizing has not eliminated or reduced the need for state and county workers to help correct errors in HMO selection. Or the confusion of having an HMO that is not accepted in the consumer's area -

## **Kathryn**

Thank you for this opportunity to share my perspective on the state's Medical Assistance program. I am a breast cancer survivor and tomorrow will mark 8 years since I was diagnosed. I am also a volunteer with the American Cancer Society. My cancer was found at a relatively early stage, thanks to a screening mammogram covered by insurance I had through my employer. My doctor has told me that even a one-year delay would have probably meant a different outcome for me. Many people are not as fortunate as I. They rely on Wisconsin Medical Assistance programs for screenings and exams. A strong Medicaid program is vital in providing access to care for these people, access that is so necessary to fight cancer.

Delays in diagnosis and treatment result in increased costs associated with later-stage cancers. Today we know that as many as 60% of cancer deaths could be avoided if we apply our knowledge about cancer prevention and detection. This would create huge savings for our health care system. People who have a regular source of care, including those enrolled in Medicaid, are more likely to access prevention services, get their recommended screenings, and have health problems identified early. Tools such as reminder systems, quality measures and provider accountability should be developed to further encourage the use of preventive services. An emphasis on proven prevention and wellness strategies in our health care delivery systems can help curtail health care costs and save lives. However, increased cost-sharing for preventive services can create barriers that discourage working families from accessing those services, ultimately increasing the incidence of late-stage disease and their associated costs. Many people who have chronic medical conditions see several health care providers. A lack of communication can sometimes lead to duplication of services and conflicting prescriptions. Studies have shown that having a regular source of coordinated care with the same provider over time leads to better quality of care, better outcomes, and lower costs. Over half of current Medicaid benefit expenditures in Wisconsin are still fee-for-service payment systems that reward volume and may not provide incentive for communication and coordination across providers. I also am the co-guardian of my sister who has Down Syndrome.

She relies on Family Care for transportation and supportive services so she can continue to live in her home in the community. Over the past 7 months, because of fluctuations in the hours she worked, her eligibility and the amount of her premium for Medical Assistance changed almost weekly. Without the eligibility grace periods and the staff to work with me on these issues on her behalf, she may have been without coverage at a time when she needed medical care for her multiple health issues. I urge you to keep people like my sister in mind when you consider changes to these programs. Thank you.

## **Cyndi**

Our group offers a program Rest Assured which offers technology based monitoring through cameras, sensors, and virtual drop in visits adaptable to the needs of the elderly and developmentally delayed in a home care setting. This could work well in rural areas where staffing is limited as well as working with higher functioning individuals who are able to remain in their homes with minimal cueing and support.

## **Angela**

IRIS makes better cost savings sense because you only get what you need to pay for the care. Also, the caps proposed beginning June 2011 should not result in nursing home placement. Nursing home care costs the state \$6000-7000 per month. Assisted living rates are \$2800-4000 per month.

## **Maria**

Allowing Milwaukee County Department of Family Care (MCDFC) to serve as the sole Managed Care Organization in Milwaukee County is projected to save the State's Medicaid budget over \$600,000 in one year due to the difference in payment of admin costs to other MCO's. MCDFC offers a self-directed supports (SDS) option through Family Care through the Supportive Home Care Employment Services (SHCES) model. The model was created to allow members the freedom to hire preferred workers through the co-employment model of SDS. The self directed supports program has been able to save millions of dollars by contracting with SHCES agencies for co-employment services.

## **Dan**

Quality residential support services can save millions per year through serving individuals that were previously in institutions. Convene a task force of providers that have successfully transitioned individuals out of your institutions. They know what works and how to save money.

## **Carol**

Keep the eligibility determinations at the local level so that they can be monitored more closely & don't let the private sector get their fingers in the pot of money to administer programs. Each community has better knowledge of their clients than could ever be obtained by using centralized eligibility workers.

## **John**

Most MCO's have employment specialists-these are positions that all community rehabilitation providers have and the staff are working directly with individuals receiving the services. These positions could be eliminated from the MCO's. Reduce admin costs in MCO's. Allow for larger caseloads for case managers who work for the MCO's. Currently caseloads range in the mid 30's to low 40's with the exception of one MCO that exceeds 50. Provide regulatory relief to long term care providers.

## **Crystal**

Is there a way to provide incentives for appropriate use of the ED? I'm not sure which programs are affected, but parents of my students have told me they have a co-pay if they go to their doctor, but not if they go to the ER. Private insurance has a higher co-pay for using the ED than PMD and if it's found to be non-emergent, the co-pay is raised still further. Parents also sometimes end up in the ED because of having to wait too long to see the PMD, during which time the health situation deteriorates or they lose patience, as they can't stay home from work for long with a sick child & keep their job. Is there a way to help avoid this scenario? Also a friend working in the ED has told me patients come in by ambulance, then decline care & demand a ride home, since hospitals are required to provide rides home for T19 patients. Is this true? If so, that could use some revision, as it increases costs for DHS, hospitals, and perhaps others.

## **Rhonda**

Health Centers are ready to be a partner and a solution to address health care needs.

## **Christine**

1)Eliminate system redundancies. 1/3 of family care recipients living in nursing homes, CBRF's, AFH's, & RCAC's. Regulations require case management services delivered by the provider in each of these settings. Case management services are also provided by MCO's. Providers and MCO's have an opportunity to work collaboratively. 2)Educate and enforce better ADRC financial screen utilizing all state and federal benefits including VA & long term care utilization. 3)Closer management of auto 30 day orders for disposable medical supplies and DME equipment. Medicaid definition of useful life needs to be revised or providers could be consulted before auto orders are placed. 4)There may be opportunities to centralize MCO functions (billing, contracting, document repository, etc) and realize cost savings.

**Rolf**

Transfer people from waiver programs to family care, it could save 13 million over 3-5 years.

**Connie**

BadgerCare should be income based and asset based.

**Theresa**

Eliminate need for a resident/individual to go to nursing home for a different source of money for assistance because family care is not available. This process costs the state more in the long run when it could be handled more efficiently by moving the money not the individual.

**Mike**

Admin and care mgmt expenses for MCO's are unnecessarily high and take away money from direct services. They should be capped at 15%. MCO's have employment specialists on staff who duplicate the work of the Division of Vocational Rehabilitation and Community Rehabilitation Programs like ASPIRO. These positions should be eliminated. Lastly, rescind the revised Prevocational Services definition developed by the DHS Office of Independence and Employment Pathways to Independence. These guidelines restrict consumers from making the informed choice to be employed at a Work Center and place time limits on consumers currently employed in these settings. People with disabilities are worthy of the dignity that comes with earning a regular paycheck regardless of the setting they work in. In developing policy options, we should be guided by the principle of self-determination and informed choice.

**Mary**

Eliminate cost reporting system and the many duplications of paperwork. These reports now have almost no affect on reimbursement and most probably represent both a significant cost to providers and state govt alike. Use the resources at hand, for example vacant apartments. Allow the MCO's and other payers to use these apartments for care of individuals. Shift our focus back to care and not administration. 30% of MCO's costs are not going to direct patient care.

**Wes**

Boosting the state sales tax by just 1% would bring \$860 million dollars per year in revenue. This method of sharing would be fair to all income levels. We need to create a revenue to solve our budget crisis not cut services from people who need them the most.

**Jackie**

Investigate fraud within family care & IRIS programs. Reduce executive pay at MCO's. Reduce paperwork, decrease caseloads of nurses, increase caseloads of social workers.

**Tony**

Raise sales tax by \$.01. Generate more money, don't cut programs.

**Lisa**

People should be required to pay a higher copay for office visits, urgent care, and emergency appointments as well as prescriptions.

**Underwood**

Lift the freeze on LTC admissions to the State DD Centers. With more resident days, the state may actually realize more federal dollars flowing into the State due the enhanced reimbursement rate for care provided at the Centers. The State Centers have long been recognized as cash cows. Maximize the receipt of federal dollars by lifting the freeze on LTC admissions. We have more suggestions but the leadership of our statewide parent organization has not been allowed to meet with leadership from the Department.

**Underwood**

Reduce layers of bureaucracy for administration for State Centers for the DD. Both SWC and CWC have a facility director plus deputy director who report to the director of the bureau of center operations who reports to the division of long term care who reports to DHS Secretary Smith. What does the bureau of center operations do that could not be done by each facility director & deputy director? As the centers have been downsized, CWC and SWC will have an average daily population of less than 450 residents, the layers of bureaucracy have actually INCREASED, ultimately driving up the daily rate fueling calls for the closure of these facilities.

**WI Personal Services Association, Inc.**

Paperless process with prior authorizations for Medicaid Personal Care. Medical Assistance Personal Care (MAPC) services are restricted to hands on cares only. Individuals with dementia, Alzheimer's or a developmental disability may not require hands on assistance but require supervision and verbal cueing. When using MAPC screening tool, this individual would not be authorized for personal care service hours due to minimal hands on cares, thus should this individual need supervision and support, they would likely go directly to more costly nursing home, residential facilities or institutional placements. MCO's should only use a registered nurse on the care team when there are chronic or unstable conditions needing their expertise.

**Mary**

Family Care- eliminate the requirement that in MCO's a nurse must be assigned to each member, as members all have nurses and MD's in the community. Southern Centers budget could be decreased if community placements were used and if unused land and buildings were sold.

## **Laura**

WIC Nutritionists, those that are Registered Dietitians (RDs) are able to provide nutrition counseling to pregnant women and PP women (up to 60 days PP), that are enrolled into the Prenatal Care Coordination Program. One of the criteria for enrollment into PNCC, is that the enrollee must be on Medicaid. In Sheboygan County, WIC Nutritionists make referrals to public health nurses (RNs) that act as case managers. Once the nurse has determined that a pregnant woman meets the criteria to be enrolled into PNCC, (there are criteria that need to be met, in addition to being on Medicaid), we, as WIC Nutritionists can bill our nutrition counseling for each 15 min. of nutrition assessment, counseling and documentation that we provide from the time a woman is enrolled, up until 60 days post partum. We bill our follow-up high risk WIC appointments. Unfortunately we do not have any documentation related to the cost benefits of RDs following these women via the PNCC program. In terms of fiscal benefits of being enrolled into the WIC Program, for every \$1.00 spent on the WIC Program, there is a savings of up to \$4.00 in Medicaid benefits. It is unknown how much of the dollar estimate can be attributed entirely to the nutrition counseling received by RDs but it does have an impact. Other medical diseases and conditions requiring nutritional counseling by RDs could be pursued.

## **Jill**

Approve licensed midwives as a medicaid payable provider.

## **Heidi**

Yes, minimize the cost putting into schools NOT BY necessarily cutting funding to the teachers [or do so, personally I don't see their complaint...] but instead of putting those who SHOULD BY ADA IDEA PART C SPECIFICALLY SECTION 504; KEEP 2-YEAR-OLDS or less(!) such as my son in their homes with evidence based ABA intensive-level at home treatment services for autism--instead of 'fitting them all in' a special education program, and letting them fall behind. NO CHILD LEFT BEHIND! Early intervention? Birth to Three? I receive many services being on both Disability and TANF; and NO ONE ONCE referred me [rather my son] where to go. He should have gotten an IFSP prior to an IEP @the age of 2! I am outraged! When I complain of this, people at these so called 'agencies' have no clue what I'm talking about. Ex: at the Social Security Office, I have been told not only once, but perhaps 5 times by DIFFERENT people that my son does not qualify for DISABILITY INCOME other than SSI!!! Um, HELLO!!! He has autism! I don't 'need' that little amount because I 'need' extra money for groceries, I NEED Government workers who know the law-at the local, state, and I would HOPE Federal level!

## **Betsy**

1. CHARGE AN EMERGENCY ROOM CO-PAY FOR ANY VISITS NOT RESULTING IN AN INPT OR OBS BED ADMIT-granted, this will probably hit the hospitals when the copays aren't paid, but we see too many folks seeking ER care for inappropriate reasons. 2. Heighten oversight of the fee for service program-we see that providers do abuse or at least misuse the benefit 3. Provide the same basic care for all Badgercare/SSI Medicaid folks-make the cost adjustments through premiums and copays. It is very challenging to manage multiple benefit structures and leaves a wide open door for abuses of the system. People are smart and it doesn't take much to figure out loopholes--this system has tons of them! 4. Don't cover 'frills' such as gastric bypass, plastic surgery after gastric bypass, 'doctoring' via ER without negative consequences, etc. The Medicaid/Badgercare benefit is richer than most all commercial plans...cut back and provide GOOD BASIC care. Mirror a good basic commercial insurance plan a little closer, except eliminate the huge deductibles and copays.

**Jane**

Support service provider agencies who provide cross-categorical services, client-centered supports and have a philosophy that promotes independence and quality of life for individuals with disabilities, should be the norm not the exception. Research Todd Steven and Associates of Oshkosh and discover what 'Support Without Walls' looks like. Also, make full use of the newly released Medicaid rules designed to make the program more flexible, efficient, and provide better care for lower costs. Wisconsin is one of 15 states that has a chance to make good choices and promote the least restrictive environments with flexible programming. It is the duty and the responsibility of the Wisconsin Department of Health Services to not only utilize these federal funds, apply the guidelines of the new rules to all of its current policies and newly innovative services, but to be accountable to the people who will benefit from a service system that believes all people have a place in our communities. 'Cost savings' does not mean 'cut services'. It means develop what works and trim what does not.

**Ron**

1) Reduce the number of CMO's. 2) Limit the admin costs and case mgmt. costs to no more than 15%. 3) Support the Governor's budget increase for Medicaid. 4) Standardize salaries for CMO staff. 5) Revise procedures for the functional screen.

**Thomas**

Operating deficits & excessive management costs.

**Melody**

Preserve Medicaid benefits for pregnant women including presumptive eligibility backdating. Prenatal care associated with improved birth outcomes, money spent on prenatal care has a significant return of investment.

**Emily**

Midwife care costs a fraction of hospital care for births. I'd like my baby's July birth to be covered under a midwife.

**Mikayla**

Licensed Midwives, who undergo specialized training to deliver babies in out-of-hospital settings, provide safe and cost-effective care that is proven to reduce low-birth weight and preterm births, two of the leading causes of infant mortality as well as the long-term costs associated with maternity care. Each time a Medicaid/BadgerCare mother who seeks to give birth at home or in a freestanding birth center under the care of a Licensed Midwife is denied access to her services, it costs the state thousands of dollars in unrealized savings. Research shows that mothers who deliver under the care of a Licensed Midwife experience as much as a five-fold decrease in cesarean surgery. Cesarean surgeries now account for over 1/3 of deliveries nationwide, many of which are both preventable and a major contributing factor to the rising costs of maternity care. Washington State, whose Licensed Midwife program is approximately the same size as Wisconsin's, commissioned an independent audit of the program which found that LMs saved the state \$3.1 million per budget cycle while providing excellent outcomes for low-income mothers and babies.

**Tehmina**

Thank you so much for requesting of the public various solutions on how to close the \$500 million budget deficit. I'd like to take this opportunity to propose creating a DHS provider category to reimburse Licensed Midwives services in out-of-hospital settings as a solution to the deficit. This will not only save the state significant amounts of money but improve outcomes for low-income women and offer options to all women in this state, regardless of coverage. Research shows that mothers who deliver under the care of Licensed Midwife experience as much as a five-fold decrease in cesarean surgery. These surgeries now account for over a third of the deliveries nationwide, many of which are both preventable and a major contributing factor to the rising costs of maternity care. Washington State, whose Licensed Midwife program is approximately the same size as Wisconsin's, commissioned an independent audit of the program which found that LMs saved the state \$3.1 million per budget cycle while providing excellent outcomes for low-income mothers and babies. I am asking you to please consider categorizing LMs as a DHS provider in order to save our state thousands of dollars.

**Carol**

Certain supplies are given to enrollee (i.e. Depends). Be sure these supplies are used. If they are not wanted, don't give them. Many items were thrown out and a perceived better quality product was purchased.

**Jessica**

I would like to offer you a time tested well established method of considerable cost savings for Badgercare. Midwives for maternity care. There are Certified Professional and State licensed midwives who work and serve the community throughout the state of Wisconsin. This is a negative budget proposal. The use of Certified Professional Midwives as paid providers with Badgercare will certainly save the state large sums of money. The cost savings will be both short term and long term. Prenatal care, labor, birth and postpartum care is far less costly with midwives since we are accustomed to serving low income clients. Ways in which we work with clients to maintain good health has always focused on cost effective methods and ease of accessibility. Long term cost effectiveness hinges on factors such as very low cesarean section rates. This has an enormous effect on future childbearing costs for women and obviously the state. The Certified Professional Midwife extensively educates women in the childbearing year and in so doing empower them to create and maintain robust health in their lives and the lives of their families!! would love to speak with you further regarding the profound cost effectiveness and overall benefits of the Certified Professional Midwife as Badgercare provider.

**Gretchen**

Not only would MA reimbursement for LM be a cost saving measure for WI, LM have a low rate of preterm deliveries and provide patient centered care to families. Consumers of color across the nation are demanding increased access to this safe cost effective patient centered care, because they believe that it has the power to reduce the disparities in birth outcomes and empower women to care for their families and rebuild their fractured communities.

**Tracy**

You are asking for ways to close the budget deficit? Covering Licensed Midwives through the BadgerCare program would cut costs by thousands of \$ per pregnant woman! Please consider that 1/3 of all hospital births result in cesarean. Research has shown that women who deliver with midwives show a 5-fold decrease in cesarean! Thanks for your consideration.

## **Sue**

Badgercare doesn't have to be the Cadillac of plans. There should be higher co pays for office visits, at least \$10.00 or \$15.00. Many office visits could be avoided, with no negative consequences. They might do like I do & call the nurse line and try other alternatives before going to the doctor. Why does someone automatically qualify for the best of plans just because they have a child? Keep good coverage for children and pregnant women. Limit the coverage for others. There needs to be an asset test for Badgercare. I know of a couple of families that have had assets in excess of a quarter of a million dollars and still qualified for BC. If someone has good health insurance, they shouldn't be eligible for Badgercare just because their income happens to be under 150% of the poverty level. I recently had a family with a government job and good insurance but didn't have dental coverage. Because they have several children and their income is under \$150% of the poverty level they qualify for Badgercare. Even though they only need the dental coverage, the state is paying a premium for each of them to the HMO when they don't even need the insurance. Better yet, the HMO doesn't even cover the dental. Get the Feds to change the Food Share rules! Candy, soda and junk food should not be allowed with Food Share dollars. If they want to buy it with their own money, that is their choice. I know a person with an addiction to Mt Dew. She drinks at least a 6 pack a day, every day. She can't sleep. The dr has prescribed sleeping pills. She just learned she is also diabetic. She is at the dr all the time and we are paying for it. She buys her Mt Dew with Food Share.

## **Johanna**

1)JB Medical - we should be using a WI based company and allowed to purchase superior products for less money than what JB allows. 2)We should investigate cost savings that could be generated from repurposing durable medical equipment and augmentative communication devices no longer in use (Katy's Klostet). 3)Privatization doesn't always mean cost savings. Need a single, consolidated intake for programs and waivers. 4)Deeply concerned about county and state services reaching some of the most at risk, underserved people. Many low income participants don't have access to supports and computers. 5)Find ways to more fully include children with disabilities in typical classrooms and school programs. Early intervention and supports are everything. 6)Emergency rules should not go into effect because this will remove the voices of consumers of the programs from the process. The disability community has a saying Nothing about us, without us .

## **Deb**

Family Care is a great program. Members are getting their needs met very nicely in a cost effective manor. The State will save money with this program and members will have quality care.

## **Stacey**

I'm writing to weigh in on a significant common issue that would help our state: Saving money on births - and more specifically, home births. Did you know that research shows that mothers who deliver under the care of a Licensed Midwife experience as much as a five-fold decrease in cesarean surgery. Cesarean surgeries now account for over 1/3 of deliveries nationwide, many of which are both preventable and a major contributing factor to the rising costs of maternity care. I personally have had both a hospital birth and two home-births. I can tell you that the home births combined did not cost near what the hospital one did and the outcome was significantly better with the home births and a better experience overall, considering all the hospital regulations and such. Procedures were performed in the hospital setting that I later learned through education and my other home-birth experiences that would have been unnecessary and actually created implied risk that tends to bring on even more additional expenses. I also am a Medicaid covered person and would have loved to have had that service covered, but it was important enough to still have a home birth without coverage for the home-births. Washington State, whose Licensed Midwife program is approximately the same size as Wisconsin's, commissioned an independent audit of the program which found that LMs saved the state \$3.1 million per budget cycle while providing excellent outcomes for low-income mothers and babies. It truly is a great cost saving measure and I am a living testament to that experience. I urge you strongly to let it be supported and covered under our state's health care system by creating a DHS provider category to reimburse for Licensed Midwife services in out-of-hospital settings. Also, it is noteworthy that as a northern Wisconsin resident, our health-care facilities do not have OB centers and therefore mothers are being airlifted to larger hospitals in Minnesota that are deemed high-risk. This is money that is not being captured in our part of the state and having this choice of LM's would keep it in Wisconsin.

## Timothy

1ST IDEA. I am not someone with a child, but I am an adult with a disability on Medicaid. I think we can reduce costs by actually not going to things like iris and family care. All these are is middlemen, and middlemen always take a chunk of the money. Why should companies be getting money for their profit line that can be going to the people who need it or actually saving money. Medicaid could just as easily hire people that would be responsible for people with permanent disabilities that would normally qualify for iris or family care. Companies are more concerned with profits and will ration as much as they can. Why should we give money to their profit line? You can still give as much money as say iris does for their members and still save money because money isn't going to a company's profit line. And even large nursing homes are farms for profit. Even non-profit nursing homes would rather put the money into needless yearly remodeling rather than pay for more staff to make life better for their patients and to make healthy patients.

2ND IDEA. I believe people with severe disabilities, adults and children, should be able to have their spouse or parents and even parents of children under 18 be their PCW. Where it might seem this would spend money, actually this will save money. See you don't have to pay a family member quite as much as you would a medical professional from an agency or such. Pay them enough so that they can even stay home as their job and this still would be cheaper than paying a professional. And also you would get a definite better quality of care and from people that actually care personally about the person with disability needing care. Of courses you can't always be guaranteed quality of care from family members but the odds are more that way.

3RD IDEA. Through Medicaid (not iris or family care) allow adults and parents to get some of their supplies through, for instance, the grocery store. Many products can be purchased cheaper than if they were considered medically related and again they don't take cost as much as a Medical Supply place. I mean things like adult diapers and diapers. Also Medical Equipment like blood pressure cuffs and also oxygen meters can also be bought cheaper at the store or pharmacy and doesn't consider raising the price just because it is through Medicaid. If people could purchase these items themselves they would be the consumer and the supply places or stores would not try raising the price simply because it is through Medicaid. Even Amazon.com has blood pressure cuffs.

4th IDEA This relates somewhat to my third idea. I needed an oxygen meter. I searched on-line for a good one and with reasonable cost. I find one that was \$144. I had to go through the prior authorization process. When the prior authorization finally came through Medicaid decided to pay 13 months for \$30.00 a month instead of buying it outright. So instead of paying \$144 they actually paid \$390. I'm not sure if the prior authorization people thought I was going to get better before the 13 months were up or if they thought I would die first. It doesn't seem like the people who are doing prior authorizations are actually reviewing the case. So I propose that prior authorizations actually review the case with the reasons indicated for needing something and also ask the Physician questions if they need more information. People who do the prior authorizations can have a little education and common sense. This will save money by not spending more when they can spend less for something. For instance, again supplies from grocery stores like diapers and blood pressure cuffs. Even Amazon.com as great deals on blood pressure cuffs.

5th IDEA Allow people on Medicaid to get married and not have to worry about the spouse having assets. You'd think that this would cost more money because people will be coming off of Medicaid if you don't change it because we're over our resource limit. Well actually we just don't get married so we don't come off of Medicaid so you don't save money you just keep people down. People just get divorced to go on Medicaid. Plus keeping people from getting married is just not right. Also many just live in sin rather than lose Medicaid. And don't forget again care from a spouse means healthier people on Medicaid. And for the whole our economy the spouse and doesn't have to go into poverty just to put someone back on Medicaid. And this saves money in government programs for the poor with regard to welfare.

6th idea. if you absolutely have to bring back institutions don't bring back large ones. Also most nursing homes only follow Medicaid rules when there is somebody from Medicaid there and they fudge their documents. Make the nursing homes more like assisted living with only three or four to a building. And there should be people on staff to be able to take residents into the community to do things like to socialize with people who aren't handicapped. They have these types of homes in other states and they have found healthier and happier people. To tell you the truth, people feel regular nursing homes are much like prisons. People who are happier have been proved to be healthier and need less medical attention which is also savings to Medicaid. I would rather be in my home and I think Home Care could be cheaper in the long run. Even if you have to have a CNA for someone with Alzheimer's 24/7 it's still cheaper than an institution would charge.

7th idea. if governor walker actually made it so that seniors who meet the Medicaid spend down would not have to pay property taxes they would be able to keep their homes longer. Also provide Home Care. The state would lose money on property tax but have more savings keeping Elders out of nursing homes. Many Elders on Medicare actually go to Medicaid because they have small problems with daily chores like a simple shower or remembering medications. It would be a lot cheaper having someone coming in to giving their medications and than an institution or nursing home. And keeping Elders out of nursing homes as long as possible will help save tons of money and have healthier Elders. Also with less people going to nursing homes institutions would automatically have to be smaller with less maintenance then a humongous building with all that can go wrong there. Also you wouldn't have people needing who need rehabilitation right next to people there for

psych reasons. And why can't rehabilitation be done in the home with physical therapy. Again healthier patients mean less Medicaid costs and people in their homes much more cost savings. Elders on Medicaid obviously can't afford taxes. Also if you keep people not having to pay their property tax so they can keep their homes you have spending more of their own money on their care because they are on Medicare instead of on Medicaid. Setting their money on care of on spend down.8th IDEA. Make programs like Mapp easier to understand and less complicated. Also make it the norm for people with disabilities that are permanent.

Many are afraid of going to work because they have to sign up for a different program than regular Medicaid and they are afraid there could be the possibility of a gap in coverage. And for instance, when you have over \$360,000 in medical costs a year like myself you cannot afford to have a gap in coverage. I would be happy to pay into Medicaid if I was making a reasonable amount of money. As long as I end up with more than I have on SSI. But again the possibility of lack in coverage scares me of course institutions scare me even more. Another reason I'm afraid of going on Mapp is because I have a business making websites. Some years I have more sites to create than other years. And I don't try to get too much work because I would have too many assets. If there was something that causes less apprehension people would be more apt to work and pay into the system. Also people with disabilities would actually help the economy with their hard work. We don't want to take from society, but in many cases we have to. And also the current system is obviously not working. I believe this is because the rules are keeping us down and if the rules were changed we might actually pay some of the money back. My grandmother always said even if you know you can't finish a task try and you might finish most of it or you might surprise yourself and finish the whole task. I have heard many of my friends say they are not allowed to work when on Medicaid. Having mapp rules AT the starting gate instead of some seemingly far distance away will make for incentive. Also many of us can only do so much in a day. And those with heart problems have all they can do to finish the day in those with severe retardation will never be able to work. But many will.

## **BEVERLY**

Why do parents automatically qualify for the Badgercare? We should have the children on the Badgercare but just because you have a child or children you should not automatically get badgercare. Parents should always have a premium for badgercare and not just automatically get badgercare. Why do we not make people responsible instead we give them badgercare and they continue to keep having children because they have no cost. Should not the mother and father pay for the birth costs of the children they decide to have. Unmarried people once paternity is established qualify for badgercare as long as they have the children 40 percent of the time. Should this just be automatic? Children and pregnant women should have medical but adults should not just expect to have medical and they keep having more children and have the best health care coverage. People that choose not to work get the best health care and they just keep having more children because we keep paying. How wrong we are.

## **Michele**

Increase co-pays that enrollees are asked to contribute Continue funding of family planning only services at least 250% above the Federal Poverty Level; however institute a nominal co-pay for every office visit and/or RX

## **Kay**

Reduce the amount of paper by sending the clients their letters through their email.Charge higher premiums for families as their income goes over 300%.

## **IRENE**

1)COUNT INTEREST INCOME FOR MEDICAID PROGRAMS2)LOOK AT ASSETS AND HAVE A \$10000 ASSET LIMIT FOR BCP3)FUNERAL ELIG. (IF LIFE INS POLICY, AND IT IS ENOUGH TO COVER THE BURIAL, THEN IT SHOULD BE USED ON ANY TYPE OF MA CASE. SPOUSAL CASES THAT HAVE ASSETS OVER \$5000 SHOULD NOT BE ELIG. FOR HAVING BURIAL PAID.4)FOR FAMILIES THAT QUALIFY FOR BCP, BUT HAVE INS, BUT WANT BCP FOR DENTAL AND EYE, THEN HAVE JUST A SEPARATE PROGRAM FOR THOSE TWO AND CHARGE A MINIMUM PREMIUM. THEY SHOULD NOT GET FULL COVERAGE WHEN THEY HAVE FULL COVERAGE EXCEPT FOR THE DENTAL AND EYE.5)BADGERCARE+ WHEN A WOMAN HAS A CHILD AND NOT MARRIED, THE MOM AND THE FATHER OF THE CHILD SHOULD HAVE TO BOTH PAY LYING IN COSTS. PLUS THEY SHOULD HAVE TO PAY FOR EACH CHILD THAT IS BORN OUT OF WEDLOCK NOT JUST THE FIRST ONE AND ONLY THE FATHER PAY.(IT TAKES TWO TO HAVE A CHILD AND THEY ARE BOTH RESPONSIBLE)MAYBE IF THEY WOULD BOTH HAVE TO PAY AND PAY ON EACH CHILD THEY MIGHT GET SMART.6)IRIS NEEDS TO IMPROVE THEIR TURN AROUND TIME ON ELIGIBILITY BEGIN DATES. THEY ALSO NEED TO HAVE SOMEONE COMPLETE THE GRP C WORKSHEET OR HAVE THE ADRC DO THE FIRST ONE AND IF IRIS DOES NOT AGREE THEN THEY CAN SEND A CORRECTION. NOW WE HAVE A CUSTOMER THAT HAS BEEN DENIED WW ELIG. BECAUSE IRIS HAS NOT COMPLETED AND FAXED THE GRP C WORKSHEET TO US. IT HAS BEEN OVER 4 MONTHS. THIS PERSON NEEDS SERVICES.7)CUSTOMERS GOING ON FC SHOULD HAVE THEIR ASSESSMENT COMPLETED WITHIN 1 MONTH NOT UP TO 90 DAYS. THEY NEED THE SERVICES. 8)SENIORCARE SHOULD STAY. PEOPLE SHOULD NOT HAVE TO FIND ANOTHER PART D CARRIER. THERE IS ALOT OF PART D'S THAT DO NOT COVER ALL MEDICATIONS AND CUSTOMERS DO NOT UNDERSTAND WHAT THEY NEED TO BE ASKING FOR AND THERE IS ALSO ALOT OF PEOPLE THAT DO NOT HAVE ANYONE TO HELP THEM. THEY WILL BE GOING WITHOUT PRESCRIPTIONS.

## **LISA**

1. When a person has a baby why do they automatically get a substantial increase in food share. Most of them are on WIC and how much can a baby eat? 2. Why don't they do an asset test for Badgercare+? Someone who owns a business but has lots of write offs and has thousands of dollars in the bank and we pay for their health insurance? 3. Why is it when a paternity is established the father pretty much automatically gets MA? 4. Why is it when you are not married and after the second child is born they don't need to pay for any birthing costs. The system encourages and rewards those that don't work to continue to have children they can't pay for and the working people who want to work are penalized. Yes, alot is wrong with the system!!!! Whoever writes these programs obviously doesn't work with them...

## **Community Alliance of Providers of WI**

Standard residential & vocational rate setting based on needs and costs. Process to identify and adequately set rates for outlier members. Reasonable bed hold process to preserve members services when temporarily absent. Shared info systems. Regard the residential setting as a home and a care setting. Eliminate extraneous licensing regulations that have limited value added service benefit. Utilize technology as a supplement/replacement for certain types of staffing levels. Develop flexible licensing regulations. Engage providers. Provide adequate PMPM capitation rates. Develop a means to pay one time environmental modification costs in order to maintain high-cost members in community. Provide incentives to providers who invest in program expansion to guarantee adequate resources to meet member needs. Utilize a valid assessment tool for elig. determination. Establish best practices models of MCO management practices.

## **Suzanne**

1. These suggestions are for Children's Long-term Waiver, specifically addressing Autism Services Create a tiered system where families can decide what number of hours of intense therapy they feel best serves their child. Keep in mind that research dictates the more hours the greater progress but some children and families cannot tolerate this intense level. Families are pressured to get 20-30 hours a week when they may not want that many hours. 2. Investigate the family cost share and the family income to qualify for the Long term waiver. Would increase in copayments or restricted income requirements save the state money? 3. Increase waiting lists for services may save some money but realize it is very stressful for families to receive a diagnosis and then have to wait. 4. Reduce hours gradually during the 3rd year of intensive service to help the family move into post intensive phase. 5. Discharge children earlier from post intensive services or do a gradual reduction of hours throughout intensive to post intensive such as Year 1 -25 hours Year 2- 20 hours Year 3-15 hours Year 4-10 hours Year 5-5 hours

## **Terri**

Allowing funding for family and consumers to mentor each other, organize, and share info about new strategies, cost effectiveness, employment, networking, training, etc. WI DHS PATHways to Independence. Microboards are cost effective way to cut down the cost fo middle person bureaucracies.

## **Ted**

I believe there are several areas that should be evaluated for their cost effectiveness. First, a significant amount of resources are expended on administration and all the other processes that touch service dollars before they get to the individual receiving the service. Family care was described as a system that is cost effective, provides quality services, eliminates the waiting lists, and improves consumer outcomes. I support those goals, however the current system falls short of adequately supporting many individuals with a developmental disability or people who are elderly. When Family Care was introduced, the county system for the provision of these services was eliminated for the most part. However, many of the costs for administration of Family Care were simply transferred from the county to the MCO. The county buildings did not get smaller, the infrastructure did not go away, and in many situations the employees from the counties transferred to the MCO at their same salary and benefits. In addition, MCO's built their own infrastructures, leased new office space, and replicated the administrative supports that were present and still present in the county. Second, there is the need for improved collaboration between the Department of Regulation, the Department of Health, the MCO's and the providers. Increased regulation adds cost and complexity to an already complex system of delivery. The MCO's are cutting service rates because the costs are too high. The Department of Health only has so much money to pay for services and looks for ways to be more efficient. In the end, the provider is faced with increased costs and under pressure to reduce them. It would seem that perhaps there is common ground that could be found between all the players who are invested in making sure that the services are delivered in a quality manner.

## **Quinton**

Integrate more health promotion and risk reduction strategies into overall approach of DHS and refine data system so that billing and actual patient care align.

## Morris

What does Governor Walker's Budget revision mean for BadgerCare and Medicaid members who are currently serviced by our local county and tribal employees that administer these programs? Healthwatch Wisconsin (ABC for rural health) states; the revisions in the budget regarding our health care will take the power over BadgerCare/Medicaid away from elected officials and give it to the department of health services (DHS). It allows the secretary of the DHS to make broad changes to BadgerCare/Medicaid eligibility and services behind closed doors, without public comment or legislative review. It will allow a certain elimination of Badger Care coverage for single childless adults who have waited for years for access to health care. I have seen many people in the middle age bracket where their children are grown and yet they are too young for Medicare. These people have been in the employment sector but in jobs that had no benefits that include retirement or/and health care. Now they find themselves with nothing at a crucial time in their life where their health needs the extra care after working manual labor for years. This budget limits coverage for certain BadgerCare eligible infants and pregnant women, it changes the current BadgerCare/Medicaid benefits. It will create more barriers than there already are through limited access for the rural tribal/county populist and create more paper work and red tape for enrollees. According to WBP (Wisconsin Budget Project) most state spending supports local services. The majority of state spending doesn't go to support state services and programs. Local services as a general fund actually supported \$7.2 billion in the fiscal year of 2010 and of that total 1.3 billion of the state money were spent on Medicaid and BadgerCare Plus. For every \$1 the state spends on these programs, federal government generally gives Wisconsin about \$1.50 in matching funds. Which means if we cut state spending on Medicaid or BC+, we lose the federal dollars as well. How will this be an improvement on the budget if we lose the federal dollars by cutting the spending locally to the Medicaid and BadgerCare programs? (found in the Governor's 2011-13 Biennial Budget [provisions Relating to Counties/Tribes]) By proposing the privatization of Health Care our Red Cliff residents who are in danger of losing eligibility for medical care and food assistance will face much longer waits for those services among other increased barriers. The proposed budget prompts fears that people served by tribes and counties, (generally some of Wisconsin's poorest residents), could face significantly longer waits and in some cases could be cut off from needed services because of errors. As proposed, recipients would be responsible for applying for various programs instead of receiving assistance from tribal or county staff trained for that work. The fear is that some people aren't going to get the services they need because they can't navigate the system. Example; A client 18 years old with a 5th grade education asked for help after attempts of filing on line for BadgerCare/Medicaid. She is an expectant mother with a difficult pregnancy that needs specialty care. She is unemployed and does not own a computer, hasn't a phone or reliable transportation from her rural home to our lobby area that offers access to apply for service on line. Even when she found a ride from someone she had difficulty in the navigation and her comprehension level is low. She is not able to apply successfully on line. There is no money for contract health to offer her vouchers to cover the care. The results were immediate; our ES workers helped her fill out the BadgerCare application registered and enrolled her in both BadgerCare Plus and FoodShare. If this mother did not have access to the health care or food to promote care or good nutrition for the complicated pregnancy it would have certainly put both unborn child and mother at risk. This would have been a certain possibility if we did not have our local agency on the tribal reservation. Our tribal economic staff now assists the clients that are unable to access those services on their own. Currently the Tribal ES workers prompt the head of household in case loads 1. To keep annual and 6 month reviews to keep them eligible by letters and phone calls. 2. We go into homes of those who cannot drive or do not have physical or mental ability to make face to face visits. 3. There is comfort of knowing the caseworker in our tribal community especially for those who find the terminology confusing and are not able to navigate in internet access. Often there are people not able to understand the letters from the DHS telling them what their case qualifications are. People who are not literate or have learning disability or other barriers will be lost. In the most serious instances, people who rely on medical services provided by those programs could face serious health impairments and possibly death because of delays. Count another example of a family among those who will suffer who is educated and can use a computer. But they are not able to navigate through the terminology and are unfamiliar with the challenges navigating the benefits system to procure benefits. How will they know if they have those benefits without the help of their tribal human services? They certainly will not get them as quickly as they can now. Current recipients of BadgerCare Plus already face the possibility of losing that coverage because Walker's proposed budget includes changes to eligibility standards that would reduce the number of people who qualify. Budget talk of raising premiums changes level of income eligibility, if true; it will cause many that already qualify to not continue to have the ability to keep their current level of health care. How are these changes cost effective for the state? There are other circumstances that will arise if the Governor's 2011-13 Biennial Budget provisions relating to counties and tribes are passed. 1. Tribal and County employees careers will end, many who currently administer Income Maintenance programs will be applying for the very benefits they assist others with. 2. Many will not be eligible because of unemployment benefits; but will not be able to afford their families own health care coverage. 3. This will raise the state unemployment percentage and cost the state more money through a new target

group in need of services. When a person or food unit is eligible for priority services and expedited issuance at this time even collateral contact is acceptable. How will private vendors or DHS establish eligibility and offer effect and speedy assistance? When a tribal community member applies for the first time they can immediately walk into our office and instantly obtain foodShare if they are without income or within the guide line or/and have no food. At this time our Tribal agency personally can assist applicants in obtaining verification. When there is over issuance because the group did not timely report a change and/or we discover an over issuance for other error we can establish immediate attention to this and are in instant communication with client. We can go directly into their case and repair it in a timely cost efficient manner. There is less oversight and very few appeals because there is more individual attention given to each case.

1. Who will and when will they be correcting the errors from the mistakes which will undoubtedly be made when first time applicants who have trouble navigating in Access, or with disabilities, illiteracy, or who haven't access to Internet or phone attempting to navigate BadgerCare access or trying to reach someone on phone attempt to get assistance applying?
2. How many cases will be pending because they don't have the available information on hand and cannot reach a caseworker on the phone when they call back? Many of our elders in the community will only talk to people they know. Many will not or cannot come into the office so we go out to their home to meet their needs. Example: In one situation; a married elderly couple both faced with medical issues and were both eligible for Medicaid but had never applied or did not realize they could apply, until a relative had told them. They did not feel comfortable with the case worker who would be assigned to them; as they did not know the individual or her family. But we did have an employee who was their granddaughter. She was willing to accompany the new caseworker to the elderly couple's home. The granddaughter helped the elderly couple feel comfortable, she assisted in finding their proper verification needed and established trust between the new caseworker and clients. Right now our home visits and face to face reviews and registrations/intakes help to establish communication and trust between client and caseworker. We are able to tell when someone has made an error and is not intentionally trying to fraud the program. It keeps state appeals and hearings down which in turn cuts the cost of state employee travel and extra hours spent on the road showing a cost in the state budget. Currently there are already complications with BagerCare Access on line if the vast majority (of the rural communities) have to access these services through the Internet there will be many complications. Even if you design a way to transition this style of services it will take many dollars to train and inform these individuals. In the time period that the BadgerCare Plus Core program has been established which provides medical coverage for low-income, uninsured, childless adults we have been able to reach a group of our tribal community that desperately needed medical care.

1. We have watched the example of administrative shifts through the current state and private business test program in Milwaukee County and it makes us very cautious to believe those administrative shifts would be cost effective or successful in assisting those qualified.
2. The program in Milwaukee County is administered by the state and private businesses. An analysis has shown that fewer than 20 percent of cases are processed in a timely fashion, and at a rate far less than the rate our tribal economic support specialists can attain with their clients.
3. It has been said that allowing private businesses oversight the system would streamline the program. But the proposal Walkers legislation is trying to promote would lead to multiple levels of benefits confirmation, causing delays in clients receiving services. Which we have already seen happen since the introduction of ACCESS.wi.gov and badgercareplus.org eligibility Support for Health and Nutrition Internet Access. Our eligibility workers here can do all of that with fewer steps. We still take care of the same steps, but we can do it more efficiently without the extra layer to go through. Example: Several years ago a single mother requested a Badgercare application for her and her family. She had a preteen son who had been diagnosed with brain cancer. She could not just rely on Indian Health or Contract Health. (CHS) is not an entitlement program and American Indian's must use alternate resources (Medicare, Medicaid, VA, private Insurance, charity, etc. Before it is even considered an option. Furthermore the woman did not drive and hadn't a driver's license and had issues with leaving her home she was not able to come into the office of our human services. Her case worker came out with the proper paperwork and found her and her children eligible for BadgerCare. Her son had many trips to Minneapolis Children's hospital and he survived until his high school senior year primarily because his mother was able to reach out to her tribal services representatives and they were able to show compassion and help her access the program on a very personal level. The result was excellent health care that helped extend and improve the quality of her son's life. In the provisions relating to counties it also talks about cutting funding by 10% to certain GPR funded mental health, substance abuse, and public health grant programs. All of these areas are already difficult to administer to the people who fall into the categories and live in the rural areas in the northern tribes and counties. In the past I had the privileged to be invited onto case management teams where we assisted someone with mental health barriers. When dealing with issues such as this we find there is more than one barrier. Often if there is mental health issue there usually are employment (income) issues, housing issues, nutritional issues, and sometimes you are working with someone who has been in the criminal system so you may have felony barriers. There are so many hoops to leap through even as a team of professional staff that we found ourselves beating our heads against the brick walls of bureaucracy. Can you imagine what it would be like if you had any mental health barriers? Picture yourselves living hours away from any urban community trying to find

shelter, therapy, the proper medicine that can help you cope within the community that you reside in or any of the necessary things a person needs to get back on their feet. This difficulty is experienced with the current funding that is available we can only imagine how horrendous it could become with the new cuts to this budget. Currently we were able to find services to help the individuals who were in this category. What will it be like for these citizens, tribal members and residents of the state of Wisconsin if these types of funding are gone? These delicately balanced people will in most situations end up in our correctional institutions where the state will have to pay out tax dollars to support the incarceration through attendants, security, meals housing physicians and medications. I think we all can agree that there is a need to improve our budget but how can anyone expect the tribal and counties residences that are the backbone of northern Wisconsin to survive without these services you are planning on cutting; for the services to be so little that they give no relief? If you need to draw from a source I would think; instead of cutting programs that help the populist of Wisconsin's blue collar and the unemployed - consider the cooperate businesses who have the abundance to offer and are getting better brakes at this time then those who cannot support themselves.

### **Romeo**

Families take elders to an elder law attorney and learn how to divest money to family in order to collect LTC payments from Medicaid or FC. States that have eliminated FC programs and reverted to nursing homes have saved huge sums. Other states have actively promoted their LTC partnership programs and are seeing savings as people pay for their own care with LTC ins they purchased because they learned the benefits provided by the partnership program. If the Partnership program were promoted and more WI residents learned of the benefits they would purchase LTC ins. The Medicaid savings would help the budget and allow for the expansion of FC.

### **Bev**

1)FC-look at the huge amin cost of these organizations. They have the best everything (offices, salaries, equipment, etc). Turnover is tremendous. Every staffing chews up the time of 2 professionals doing same thing. RN's never do any RN work. If a participant is in a nursing home long term, disenroll them from FC. 2)High cost people-auto assign them to a case manager/med team who has the ability to give them options. 3)Acute care resources used frivolously-Need to create financial incentives/penalties for misuse. 4)Education-healthy diet, exercise, etc. 5)Couple MA benefits with real incentives to work. 6)Continue to pay for family planning. 7)Continue to pay for in-home services at a resonable rate. 8)Use system resources to track fraud and prosecute. 9)Use resources to prove which medical procedures are beneficial. 10)Pay for preventative dental care at more reasonable rates. 11)Create more incentives for counties to get their wards out of the state mental health institutes.

### **Harriet**

Provide medical care so people don't have to use expensive emergency rooms for care that is not an emergency.

### **David**

DHS should create clear incentives to HMO's and health care providers to identify early all patients with chronic conditions, strategically target resources on the small percentage of high cost hot spot patients who account for over 50% of costs, and whose care is frequently mismanaged, provide effective primary and preventative care to the balance of those with chronic illnesses.

## **Barbara**

1)Purchasing drugs more efficiently, limiting the formulary. 2)Care management. 3)Changes in reimbursements to providers and hospitals. 4)Outsourcing services.

## **Carol**

Over 10-15 years there could be very gradual reduction in government support. This should be contingent upon increase in employment especially in minority populations.

## **Cindy**

I would like to take this opportunity to recommend use of Medical Nutrition Therapy (MNT) provided by Registered Dietitians as a tool to decrease Medicaid costs while providing the best care for Wisconsin residents. MNT is legally defined by Medicare as nutrition counseling provided by a Registered Dietitian. It is evidence based component of the medical treatment for managing specific disease states and conditions. Multiple chronic diseases are amenable to MNT and studies have shown the cost benefit of such intervention: Diabetes: Cost- estimates are that 57 million Americans are at risk of developing diabetes a disease that costs the US approximately \$174 billion a year -for every dollar spent on nutrition intervention, \$6 can be saved in diabetes treatment The Diabetes Prevention Program Study (Diabetes, 54,2404-2414,2005) demonstrated that training provided by RD's in diet improved insulin sensitivity at the end of one year and reduced the risk of developing diabetes by 58%. Wisconsin Dietetic Association's Type 2 Diabetes Outcome Study (Journal of the American Dietetic Association, 104,1805-1815,2004) found that Wisconsin residents who received counseling from a Registered Dietitian had a 1.7% decrease in hemoglobin A1C over a 3 month period, lost 2.8 kg over 6 months and improved their lipid profiles which was sustained over a 5 year period. Cardiovascular Disease: Every year over 30,000 Wisconsin residents are hospitalized for hypertension, stroke, congestive heart failure and heart attack. The cost of MNT to reduce cholesterol levels is about \$217 compared to the average statin therapy cost for one year of \$700-2100. In addition, diet counseling to reduce sodium intake for persons with congestive heart failure reduces readmissions to hospitals for exacerbation of that condition. Obesity: Over 35% of Wisconsin residents are obese. (BMI > 30). Obesity is estimated to indirectly cost the US \$65 billion a year. Obese individuals are more likely to develop diabetes, heart disease, some cancers, high blood pressure and increase the cost of hospitalizations. Dietary interventions with an RD involving 1-2 hours of nutrition counseling coupled with 15-20 minute follow up have shown sustainable weight loss in obese and overweight individuals. As the Wisconsin Medicaid program moves toward bundled payments and self directed care by individuals, it is imperative that health care providers are trained and qualified to provide those services. Registered Dietitians have a proven record of saving healthcare dollars allowing the best care for less dollars. Registered Dietitians have the training to provide evidence based counseling for chronic conditions. Thank you. References:Thompson, T. (2004), Report to Congress on Medical Nutrition TherapyThe Diabetes Prevention Program Research Group (2005), Role of Insulin Secretion and sensitivity in the evolution of type 2 diabetes in the Diabetes Prevention Program. Diabetes, 54:2404-2414Trogon, J.G. et al (2008) Indirect costs of obesity: a review of the current literature. Obesity Reviews 9:489-500Delahanty,L.M. et al (2001) Clinical and cost outcomes of medical nutrition therapy for hypercholesterolemia: a controlled trial. Journal of the American Dietetic Association 9:1012-23

## **Kay**

Self directed supports in family care is a wonderful option for individuals and could save money.

## Laura

I have no idea whether this is feasible, but it seems a shame to have brand new windows installed when it appears that the windows themselves are fine - it was how they were installed that is problematic. Maybe the money would be better spent (and less) if it went to fixing the walls and window cases and installing the existing windows properly. Assuming that would be less expensive, (which my idea rides on), it would have the added benefit of retaining opening windows which are a great asset in terms of the environmental health of the building and for the people who work in it.

## Amy

I would like to take this opportunity to recommend use of Medical Nutrition Therapy (MNT) provided by Registered Dietitians as a tool to decrease Medicaid costs while providing the best care for Wisconsin residents. MNT is legally defined by Medicare as nutrition counseling provided by a Registered Dietitian. It is evidence based component of the medical treatment for managing specific disease states and conditions. Multiple chronic diseases are amenable to MNT and studies have shown the cost benefit of such intervention: Diabetes: Cost- estimates are that 57 million Americans are at risk of developing diabetes a disease that costs the US approximately \$174 billion a year for every dollar spent on nutrition intervention, \$6 can be saved in diabetes treatment. The Diabetes Prevention Program Study (Diabetes, 54,2404-2414,2005) demonstrated that training provided by RD's in diet improved insulin sensitivity at the end of one year and reduced the risk of developing diabetes by 58%. Wisconsin Dietetic Association's Type 2 Diabetes Outcome Study (Journal of the American Dietetic Association, 104,1805-1815,2004) found that Wisconsin residents who received counseling from a Registered Dietitian had a 1.7% decrease in hemoglobin A1C over a 3 month period, lost 2.8 kg over 6 months and improved their lipid profiles which was sustained over a 5 year period. Cardiovascular Disease: Every year over 30,000 Wisconsin residents are hospitalized for hypertension, stroke, congestive heart failure and heart attack. The cost of MNT to reduce cholesterol levels is about \$217 compared to the average statin therapy cost for one year of \$700-2100. In addition, diet counseling to reduce sodium intake for persons with congestive heart failure reduces readmissions to hospitals for exacerbation of that condition. Obesity: Over 35% of Wisconsin residents are obese. (BMI > 30). Obesity is estimated to indirectly cost the US \$65 billion a year. Obese individuals are more likely to develop diabetes, heart disease, some cancers, high blood pressure and increase the cost of hospitalizations. Dietary interventions with an RD involving 1-2 hours of nutrition counseling coupled with 15-20 minute follow up have shown sustainable weight loss in obese and overweight individuals. As the Wisconsin Medicaid program moves toward bundled payments and self directed care by individuals, it is imperative that health care providers are trained and qualified to provide those services. Registered Dietitians have a proven record of saving healthcare dollars allowing the best care for less dollars. Registered Dietitians have the training to provide evidence based counseling for chronic conditions. Thank you.

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## David

It takes 3 people to take a credit card? How many people does it take to change light bulb?

## Guy

Cancel the July 1, 2011 start of LogistiCare broker program. A state wide caller and scheduling of trips will be a big problem and costly. Allow more trips to keep clients active enough to stay out of nursing homes(to work, social, food pantry). Consider help with fuel costs before there is no service. Have MCO's accept another MCO's agreement. Why another 55 page agreement & 17 signatures for one out of area transport.

## **Kevin**

Look at areas where service duplication may be occurring between the CMO's and residential and other providers of service.

## **Wanda**

As a provider I see duplication of effort that is not cost effective. One example relates to family care. When an MCO member is in a long term care setting such as a nursing home, the professionals are tripping over themselves to manage the residents care. Per NH regulation, we have a team of professionals managing their stay and assisting in discharge. In addition, a social worker and a nurse from the MCO are doing essentially the same tasks. The quarterly staffings are attended by the NH team, family, resident, MCO, SW, & RN. These are costly meetings and are a duplication of effort. Another example is related to State and federal regulations. The federal regulations are quite comprehensive. Why does there need to be a companion State regulation? If a facility is cited under the federal regulation why does there need to be a corresponding State deficiency. These are frequently the same language and examples as cited under the federal tag. The violation will be corrected by citing once - twice is time consuming and costly to the State with no improved outcome and it uses valuable resources in staff time and duplicative fines that could be better utilized to improve care to the residents.

## **Rena**

1)Reduce each member to have either a nurse or a social worker assigned. Make referrals as needed for specific needs. 2)Reduce requirements needed for members in SNFs or CBRFs where the care is already being provided and the plan of care developed. Why duplicate the work? 3)Evaluate how much money a member is allowed to have each month. Some members are coming out way ahead and this is not being monitored. They should have to apply more money toward their care if they are over a certain limit each month. They should not be allowed to buy un-needed gadgets to spend down their money. Who audits this? 4)Require families and POAs to be more involved with the members care - if they want to receive this benefit then they should have a commitment to be more involved in the day to day involvement with the member.

## **Tara**

While I don't have an answer how to monitor this, people are putting their children and themselves on Badger Care because it's basically free versus paying the premiums for their employer provided health insurance. This is maddening. No employer can compete with basically free, making Badger Care way too attractive versus their employer coverage. There needs to be \$25.00 copays and monthly fees like insurance. I know of far too many people with fancy vehicles with their kids on Badger Care all because they can. People are choosing to spend no money on health care because Badger Care is too attractive. Also, there needs to be a maximum lifetime period of time a person can be on Badger Care, not forever. For example, 48 months total lifetime. Co-pays, monthly administrative fee of at least \$25.00/person and a maximum lifetime cap. Thank you for your time.

## **Darci**

As a medicaid provider I called Forward Health and asked if our agency could not receive the paper form of the approved PAs or when there is any need for more information the paper form sent out. When an approved PA is sent there is cost of the paper, envelope and stamps. The rep at Forward Health told me that it was automated and they could not grant me my request, but they would put it in their suggestions box. Providers are allowed to download the information off of the Forward Health portal. If all paper PAs were stopped a lot of money could be saved.

**Marie**

A suggestion for eliminating some cost is to allow people to send documentation to county and state levels through a secure internet site to you. Secure site would be the other person has virus scan and firewall on their computer. Many people have scanners on their printers which they can scan the documentation in and eliminating paper information being sent to you. Less handling of paper, postage and information is on the receivers computer to process in a faster manner. The Department of health services would be able to confirm the information through the internet, sometimes if they feel a problem exists they could initialize a person to connect in person with a case worker. Faxes have been to shown that they leave an imprint for anyone to manipulate in a negative way. I have worked with surveys to find out information, perhaps one could be created for people to answer on line or paper form to find people who are manipulating the system. Perhaps scare the providers and indicate they are all under review, hopefully the people who are using the system will realize they will be dealt with legally. I enjoy seeking out information on the web/internet to find information for others. I have not seen or found employment that would utilize this process. I think it would be interesting employment.

**Joanne**

Due to Wisconsin's autism insurance requirement, passed in 2009, the state saved at least \$30,000 in Medicaid expenses for my daughter in 2010. In 2008 and 2009, she received intensive autism therapies via the Children's Long Term Support Medicaid waiver. In 2010, our insurance paid in full for 8 months of intensive therapy that would otherwise have been borne by CLTS. Unfortunately, two bills that have been drafted but not yet introduced (LRB0373 and LRB1529) would neutralize not only the autism insurance requirement but all Wisconsin's other insurance mandates as well. DHS should oppose this proposed legislation, as it would shift significant costs back to the state's Medical Assistance programs.

**Marilyn**

Do not cut benefits. I do not support budget cuts to necessary entitlement programs. This is particularly egregious given the poor employment conditions. Stop balancing budgets on the backs of the poor and middle class. I do not support Ryan's budgets and tax cuts for corporations. Raise revenues= stop your draconian cuts.

**Tito**

Support FQHC's which have demonstrated lower cost alternatives to quality care.

**Jean**

Let young (55 yr old) retirees buy into medicare. We would have healthier clientel and less cost.

**Heather**

Addressing the emotional and behavioral needs of young children and recognizing how infant mental health services are supported by research as being more cost effective over a child's lifespan. Recognizing and reimburse in-home therapy as a preventative service to reduce long term mental health coverage that could be addressed during the years 0-5.

**Jessica**

We would be happy to pay higher premiums, copays, deductibles, etc. We just need affordable health care available to us.

**Mazen**

The new transportation concept will save the state 15%, current providers are willing to give 15% cost savings.

**Patricia**

Encourage you to support waiver applications which provide additional revenue to support 0-3 dollars.

**nancy**

Use the social security determination that they are disabled. family care sends nurses out to see if people are ok charging about \$80.00 per hour. that could be something done by someone not charging that much. the disabled and elderly already go to the doctor. Sometimes 2 social workers visit at the same time.

**Shirin**

The statewide impact of the DBS program is \$55 million, of which 75% is federal dollars. WI is currently ranked among the lowest states for receiving federal dollars. We urge DHS to ensure that the number of DBS's in each county are adequate based on a county by county needs assessment based on the number of poor people in the county.

**Ajit**

Specialty care should be tied to referrals from primary care providers. Consumers MUST be held responsible for compliance - some consumers do not value a service that is being provided at no cost to them. This leads to high 'No Show' rates, failure to follow instructions, overusage of ERs, disregard for adopting healthy lifestyles, etc. There is abuse in the use of ancillary services - personal care workers, DMEs, prescription drugs, etc. Monitoring of associated costs needs to be expanded. Reimbursements to providers must be improved. If not, there will be continuing access issues while quality providers opt not to see these patients. Providers should be given financial assistance in acquisition of electronic medical records. Just the data garnered from EMRs should help recoup the costs.

**Jason**

Use of peer run services & peer implemented services.

**Susan**

From the numbers I have heard, requiring Part D to be purchased will save \$15 million. If you just charge \$60 per year instead of \$30, you could save \$3+ million. Also, the copays for name brand are very low. Increasing them would also save quite a bit. Try and do some cost savings within the current structure before you mess with a highly liked program. You will make 100,000+ seniors unhappy with the requirement of Part D.

**Jamie**

Do not cut reimbursement rates to MA providers so people can't get services. Kids need care. Instead, implement cost share for the adults on MA. People without kids have to secure private insurance or pay all their medical costs, so people on Badgercare for having children should pay at least some of their costs. Especially to motivate them to make good choices, like paying a higher copay for name brand prescriptions if a generic is available, higher copay for ER visits than urgent care, etc.

**Mansfield**

Consider utilizing a web based full service procurement firm that specializes in working in the public sector. By using a dynamic means of price delivery our firm on average saves 14 % on purchases over \$ 100,000 on most goods / commodities and services.. all at NO DIRECT COST to the state of WI.. BUT SOME WITHIN THE STATE (DOA) are not in tune with technology and would rather continue to use the same old methods to procure product or select vendors.. but somehow expect a different result. we need to change course.. the biggest part of the ice berg is BELOW the surface.. Please contact me if you have any interest in looking alternative ways to save \$\$

**Rachel**

Badger Care Plus assists young adults so that they do not have to resort to emergency room care when they are sick. It fills a distinct need and saves money in the long run. We need to keep Family Care because care in the home is far cheaper than care in nursing homes.

**Stephanie Sue**

Reduce amount of resources in managed care office's. It is all Medicaid money which they are earning interest on. Share risk 50/50.

**ARC of Greater Milwaukee**

Keep family care.

**iCare**

Possible savings with iPal (co-enrollment between Family Care & iCare's Medicare SNP product), amend the family care 1915(c) waiver to require ADRC and care team information sharing on co-enrollment.

**bayer**

see above. One point to gather info and to review info. Share it in an electronic system. Stop re inventing the wheel and wasting time and money to gather the same information.

**Bethany**

Screen people who are on these programs more. Make sure services are being used the way they should be.

**Michael**

reduce paperwork/forms, utilize computer technology for efficiencies, better interagency coordination for reduction in duplicity, more efficient use of 'health teams' for patient care, use of health care coordinators for more frequent users in the system, more user friendly program qualification guidelines.

**waleed**

helping the provider to get real time information by having EMR and connecting it to Health information exchange. This will minimize duplicating diagnostic tests. Minimizing ER visits. Improving outpatient care to minimize hospitalizations.

**Shawn**

Instead of paying 1:1 support for a person with behavior problems...we need to build or rebuild homes where 4-8 people can be served with 2-4 staff...even those with behavior issues. NOT to mention we need to build more homes around the person and not putting people in a predetermined home. This WILL NOT work with the growing population of autism in our state. So if we want to minimize the amount of money we are paying for adults with autism we need to start building state of the art facilities that meet their needs and minimize the need for staff. Because 1:1 is not an affordable option for the state in the long run.

**Joanne**

SeniorCare has been very successful due to the fact that they run the program very much like the VA runs their drug program, by making deals with the drug companies in the form of rebates and etc. Consider making changes in Medicare Part D in order to drive down the prices of drugs by again running the program more like the Veterans Administration does. Medicare Part D currently has too many choices for seniors. The majority of my seniors do not have computers and thus are unable to pick the most cost saving plan for themselves.

**fern**

With the family care we are paying too much money to the case manager and the whole large administrative team for what they do for the person.

**don**

Educate our consumers as best we can so that they make solid decisions and get the most out of what is available to them.

**Christine**

I think having LOW premiums and LOW Co-payments would be fine and everyone would respect the system just a little bit more and not take it for granted.

**Woodall-Thompson**

Reduce duplication in determination of eligibility by accepting DVR, SSDI assessments. Simplify and standardize report requirements and frequency

**Christine**

Peer Specialty saves money. Peer specialists are mental health consumers with jobs. They work in many settings, including hospitals and community settings. Training peer specialists is not costly and is time-effective. Peer specialists embody recovery and this leads to recovered consumers on a wide scale. Recovered consumers integrate in society free of supports.

**Pam**

Utilize RCAC's.

**Kevin**

Self directed services = preventative care at lower rates.

**Tiffany**

Collect tax on business and professional services, surcharge on incomes, increase sales tax by \$.01, tax multistate and national businesses, increase WI beer tax.

**peter**

decrease the amount paid to the political representatives and cut back on travel expenses for these individuals

**Sally**

Coordinate all benefits between Medicaid services for recipients, child welfare, foster care, and day care, etc. Family Care has been proven to be cost effective. It appears that FC is being set up to fail so that everyone goes into IRIS without any accountability. Creation of a web based Medicare Consultant & Home Health/Hospice Agency Referral System for hospitals and CMO/IRIS. Creation of a web based Medicare Expert Consultant Services for FC & IRIS care managers. Do not stop enrollment in FC, IRIS is a duplication of FC without accountability, limit IRIS enrollment. Develop a 24/7 telemedicine call center.

**Julie**

Decrease spousal impoverishment asset limits. Stop all divestments and trust. County community spouse IRA accounts as an available asset. Eliminate FC non-nursing home eligibility. Allow us to put liens on homes for consumers in alternate care. Eliminate lodging and meal expenses as a MA billable. Reduce nursing home personal allowance to \$30/month. Restructure alternate care rent expense .

## **Jari**

1)Ensure participants have access to cancer screenings to detect cancers early. 2)Provide counseling services, medications and other proven strategies to help participants quit smoking. 3)Counsel participants about healthy eating and physical activity. 4)Provide participants with a regular source of care.

## **Amber**

Maintain the track of implementation of Family Care & IRIS to be able to provide the right amount of service at the right time to prevent the need for more costly services or placement, like nursing homes.

## **Megan**

Continuing to provide universal care for pregnant women in WI regardless of legal status will save money by avoiding the greater expense of health care for premature & low birth weight infants. Also, Medicaid reimbursement for non-nurse midwives (certified professional midwives) is a low cost, safe alternative to hospital birth which is associated with high patient satisfaction.

## **Mary**

Maintain Family Care/IRIS/Pace/Partnerships. Put more money into prevention programs. Maintain economic support at the local level. Continue ADRC services to allow for people to use their personal money more wisely to plan for their longterm care.

## **John**

Change SeniorCare decutable to co-ins, this will make drug company rebates available.

## **Nancy**

The family care MCO seems to be about making money versus spending dollars wisely. Eliminating layers of management at the MCO level would appear to provide substantial cost savings freeing those dollars to be used for the individuals that need care. Eliminate duplicated services. Align rates for all provider agencies. There appears to be no consistent rates for supportive home care between provider agencies. Self directed supports may be fine for some clients but for others it's a recipe for disaster. Often when a frail elderly person's family is told they have to be in charge of hiring, firing, scheduling, for their parent they will place that individual in a nursing home as the family does not have adequate time to undertake that degree of supervision. There is still need for agency involvement. By eliminating layers of management there may be a way to let the system work more efficiently.

## **David**

Improve ADRC screening process to best eliminate inappropriate divestiture and ensure appropriate coordination of other benefits like LTC insurance, VA time & attendance, HUD vouchers, etc. Eliminate care plan case management redundancy between provider and MCO. The providers care plan should be adequate.

**Margaret**

While offering coverage from BadgerCare to have a LM (licensed midwife) the state would save millions. Washington State, whose LM program is comparable to WI saved \$3.1 million per budget cycle, while providing excellent outcomes for low-income mothers and babies.

**Carol**

Must let Family Care programs run their course to balance the cost and see the benefits.

**Paul**

No, I can not say that I do right now. Please continue, however, to offer your department's services in a manner that is respectful of the people you are serving. Thank you.

**Sandy**

The WI County Human Services Association is drafting a plan that will decrease the cost per Medicaid application by almost \$100 compared to the current cost associated with processing an application centrally at the Enrollment Services Center. County error rates are 1/2 of what the error rate currently is at the ESC.

**Henze**

Get rid of the J&B Medical Supplies contract that's in Michigan and move it locally. The company does not have good customer service and wastes lots and lots of depends on Medicaid's dime. They are always sending out too many depends and never want to reduce the number being sent. They have a no return policy and say to just throw out the depends that didn't fit a client. MA dollars going to waste.

**Jill**

The draft statewide income maintenance model is a \$33 million dollar cost savings from the current system.

**Marcia**

1)Raise copays. 2)Have all recipients assigned to HMO's. 3)Lower the income limits for BadgerCare. 4)Lower percentage that employer must pay for health insurance (it's now 80%) before customer has to accept the employer insurance.

**Jeff**

Streamline the billing process and requirements for MA HMO payers. The requirements are inconsistent and at times require paper filing which is inefficient. Rural areas without internet have trouble verifying eligibility.

**Becky**

For years studies consistently show community services are more cost effective than institutional/nursing home care.

**Julie**

Reinstate a asset limit for Badgercare. We have clients who have three and four million in assets on Badgercare! Limit the time a family can be on Badgercare Plus and Food Share. All adults on Badgercare plus should have to pay a monthly premium. Fix the software problems in worker web to cut back on processing time. As of now they only have work arounds which usually don't work. Exclude soda and junk food from the Food Share eligible food list. Make FSET mandatory. Most young people think they will never have to work as long as they can get benefits.

**Paul**

Mechanism to provide 17-OH Progesterone from compounding pharmacists for each patient with history of prior preterm birth. Weekly dose for \$15. Ridiculous alternative is Makena for \$695 per weekly dose. Make sure contraceptive services are covered benefits for all Wisconsin women.

**Zwier**

Make sure the people receiving the funds deserve them. As a parent of children with chronic illness, I see many others who receive support for special services that aren't really necessary. The funds go to their personal expenses. I've seen motor homes purchased, vacations taken, video game systems purchased, etc. Does anyone ever meet the recipients? So many lies, so much money wasted and consequently, fewer truly needy people helped because of the lack of funds.

**Tina**

I feel by requiring dual eligible (Medicare and Medicaid) clients to take the Medicare part B benefit no matter what their income is, that it would save Medicaid money by making Medicaid the payer of last resort. As stated above I have many clients who drop the Medicare part B when they become eligible for Medicaid, Badgercare for families, family care, nursing home MA and so on.

**Heather**

Reduce or eliminate alien emergency (AE) services.

**Christina**

Cover all medications, Part D does not cover all of her meds and she is afraid this will cause me to go to the ER which is more expensive. Also, my nurse and case worker are paid \$400/month for my care but I only see them quarterly.

**Marsha**

Hospice programs can save these programs (BadgerCare & Family Care) money because we keep patients at home and cover all the needs like meds, medical supplies, equipment, and visits from hospice team.

**Nathan**

With this new methodology when an individual has a positive change this triggers a reduction in the pay to the home that is giving quality care. In turn the home may need to remove the resident because it can no longer pay the bills. This creates instability and insecurity in the residents life which leads to behaviors that increase costs. This system is counter intuitive. The solution is that once a resident is rated for a home that the rate is not reduced for positive changes to his/her condition.

**Shawn**

People should have the right to move from long term care to IRIS to save money.

**Lisa**

Eliminate the contract with J&B for incontinence products!! There is NO WAY it is saving money for Wisconsin. Please re-evaluate this contract.

**Cheryl**

Subrogating liability claims with accident insurers.

**Paul**

Eligibility. Implement the required asset verification solution to apply a system tested and proven by the Social Security Administration to find undisclosed assets for individuals applying for publicly funded programs. Implementation of this system should reduce Medicaid spending for the aged, blind and disabled population by 5 or more percent.

**Lynn**

I think the problem that exists is the same problem that Medicare faces. We get gouged. What is the actual cost of a service compared to what we pay....look at what we pay for a ride someplace and back, for what we pay for incontinence products, day services etc... Man, almost makes me want to become a provider. Look at how much business we give our providers. We should be able to negotiate some good rates. The providers of services right now rake us through the coals. But no one looks at that. It is a free market after all. The way we want it. Providers should after all be able to make a profit, right? Problem is, it is at the tax payers expense. Providers get the profit. Members get the shaft and MA is in trouble. It's the American way. What can you say? Again, I don't know what to tell you except to really take a look at the benefits of this program, of the cost savings it does provide and to consider the alternative before making any cuts. Thank you for your time and consideration.

**Margaret**

Budgets and services based on providing basics acknowledging participants have an income, medicaid and Family Care/IRIS. The basics being shelter, food and healthcare first then looking to see what can be added and remain fiscally responsible to the tax payer. Budgets for any group residing with family members should not be as generous as those who live by need in substitute care. My concern is we pay for socialization for DD because they need it . Everyone absolutely everyone could use help with costs for socialization and programming for maintaining health. I find it offensive to see camp, gym membership, extensive day programs paid for by taxpayers who cannot afford these things for themselves. There needs to be a means test for young disabled adults that looks at parent income the same way it is applied to families of nondisabled to get government assistance. Something along the lines of the FAFSA. Double dipping into school and community funding from 18-21 should end with a choice to use one program or the other.

**Wendy**

Raise taxes on products such as beer or tobacco. Review enrollment in BadgerCare Plus to ensure that people who are working and able to obtain coverage from their employers are doing that. Every State agency should be accountable to minimize waste and streamline their processes. Private companies are often mandated, and able to find ways to make cuts. State agencies should be no different.

**Kate**

If a member of the public is eligible for public assistance for groceries, there should be limits on what kind of foods are eligible. For example, if we as taxpayers are paying for their groceries, then their purchases should be regulated and only be used for healthy food choices, not processed and junk foods.

**Patricia**

by discussion with the patient, with good information given, most people want to help save our government money where we can, sometimes we are treated as though we just want to get things, this is not so, we care about how government money is spent and used. We may be older citizens, but we still have brains.

**Griep**

Allow MA participants to receive a statement from providers showing the procedures that were done and Medicaid covered. This could be a check point for mistakes in billing or billing for procedures/meds that the participant never received. The mailing expense would be a provider expense. Reporting could be done on line or through local fraud contacts. Tighten estate recovery rules and allow some agency discretion to determine if assets were divested to become eligible for Medicaid paid institutionalization. Place high co pays on visits to the emergency room that are not deemed necessary by the ER staff.

## **Marge**

Family members should not be paid to care for family members on IRIS. The door is wide open for abuse of the program in that Family members are using money to remodel their homes, mileage to places they would be going anyway, hours not available. Family members may not have the experience or training needed to provide for their family member. Quite often this is a 24/7 job for the family member providing care. Respite care is requested to give them a break at additional expense. Although Social workers are assigned to the cases the reality is the monitoring of these cases is too little. It can be an ideal situation for elder abuse with no one needing to be fully accountable to anyone for the quality of care the patient is receiving. The balance of power between an Elderly Blind or Disabled person and their caretaker is lacking when the caretaker is a direct family member. Patients are reluctant to get their children in trouble by reporting abuses. They may also be intimidated by their family member. Unnecessary money is being spent because of this

## **Rebecca**

Consolidate the State Centers for the DD onto 1 campus at Central Center which has the availability of UW Hospital and Clinics. While it appears that the goal of DHS has been and continues to be to close/end long term care at all 3 campuses, the reality is that community (geographically defined) services are not adequate for those with the most severe disabilities. Individuals with the most medically complex issues or self-abusive or aggressive behaviors moved to community settings have a higher chance of isolation and non-involvement outside of their home. Plus the guardians do not want isolated community services for their family member / ward. There will be challenges to combining campuses but there are a significant number of licensed, unused beds at Central Center. Eliminating multiple administrations will be cost effective. Let's at least talk about it.

## **Liza**

Early intervention is critical. Health problems need to be identified early on so further deterioration or critical incidents are minimized. If medical disorders are not caught early on, the cost can be astronomical, which if the individual cannot afford to pay the bill, then the cost gets passed on to taxpayers. People who cannot afford insurance will usually not go to the doctor and then if their condition is very bad, they utilize emergency rooms for care, when preventative care/early intervention would have been much more affordable.

## **Carolyn**

Cover Medical Nutrition Therapy (MNT) provided by Registered Dietitians in all plans for all medical diagnoses. MNT has been repeatedly shown in studies to prevent the onset of diabetes and/or to delay the complications of such chronic conditions as diabetes, heart disease and kidney disease. I am writing a chapter on the Cost-Effectiveness of Medical Nutrition Therapy in Diabetes Care for the American Diabetes Association and can specifically cite many references documenting the \$ savings.

## **Simonson**

Yes, do not listen to Walker, do not apply any of his/ALEC groups proposed programs. The other cost saving idea I have is to help remove Walker from office. He has cost the state enough.

## **Berg**

Claims History report - question whether it is useful. Services are not listed in any order to make it easy to review/double check. Also patient does not receive a bill from the doctors office and pharmacies no longer record the cost of the drug so there is no way in knowing if what was charged is correct. It's like they don't get any calls from people to question what's on the report. Glad to see they now use small envelopes which saves on postage. Encourage parents to keep their disabled children under the age of 26 on their health plan - offer assistance if necessary. Consider starting a stakeholders committee/council of medicaid participants which can constantly work at ways for improvement and to save money.

## **M**

Limit one replacement food share card ( with a \$25 cost) per calendar year. No exceptions. Increase cost of free lunches in the school system. Increase the co-pays for medical assistance services. No co-pay , no service. If cost sharing is not paid not only should the individual lose the service but a penalty period of 6 months for program eligibility should be imposed. Do not increase food share or child care program payment for and individual already on the program if they have more children, the working class does not get a raise with increase in family size. Also any payment for child care should only be to licensed facilities.

## **Amy**

Vote democrat so your budget doesn't get gutted. And raise taxes on the top 1%, which is the only effective and moral thing to do.

## **Karen**

I think people on any health insurance plan should pay more for being a smoker, overweight, etc. Perhaps a tax deduction for anyone within their BMI range is also an incentive for being healthier. I think the government should also change the food stamp/quest program by allocating so much money on the card for vegys/fruit, another amount for healthy grains, etc. These people tend to be making poor food and health choices and are a drain on the states resources. With todays computer systems, you would think this would be easy to implement.

## **DeAnn**

Programs should be available based on need not on the number of persons in the household and income. If someone is in need of medical treatment they should be able to obtain affordable healthcare. It is not difficult to determine if someone is sick. Many communities including Richland County have set up Free Clinics for their residents who are w/o insurance. Many people donate their time because it is an undeniable need. A referral from a medical professional should merit available and affordable Medical Treatment. A doctor's referral to a dentist should justify available and affordable dental treatment. We are the United States; we do not need to provide every low income family with full medical coverage, housing assistance, energy assistance and all other resources that are available merely because of how many people are in the household and their income. As a Disability Benefit Specialist, I talk to individuals who have worked their entire life and they face losing everything they have worked for due to an illness or injury. They cannot get any help once they become injured until they exhaust all of their resources. This type of assistance does not promote self sufficiency or the welfare of ALL. If programs were in place for individuals to maintain self sufficiency there would be a cost savings across the board within the DHS in WI. The national government created a dependent class of people. Are we going to climb the mountain ahead or focus our attention on the past? I pray for an equitable outcome to the budget. Together we stand.

## **John**

The Department of Health Services will have more money if corporate tax loopholes are closed and when the wealthiest of Wisconsin pay their fair share of taxes.

## **Emily**

Overall, health insurance and case management services help people stay out of emergency care systems and institutionalized settings. At a meeting of enrollment services providers in Milwaukee, Medicaid Director Brett Davis stated that he would like to work toward getting people out of ERs and into Primary Care. He stated that ERs were the most expensive cost to the State. I agree with this statement. Working the budget in order to provide insurance for Primary Care and preventative care through Family Care will, overall, save money for the State.

## **terri**

1. The State needs to support the CMU's when there is a smell of fraud. I have several members who I know are presenting fake illnesses to receive services...primarily supportive home care. I am not a private detective, and do not have time to spend proving the fraud this is obvious to me as a professional. The CMO has never been supportive.2. SHC by families - needs to be strongly looked at - again, fraud is happening. We are a good, attentive CMU - but MOST cases transferred to us from other CMUs have REDICULOUS amounts of SHC hours. IT IS EASIER TO SAY YES THAN TO SAY NO to request for DME, DMS and SHC....we work very hard to stick to our values and beliefs, but most CMU's do not.3. The resource center - a sieve. They do a terrible job screening. Their LTCFS are RARELY accurate. They need a complete overhaul...I'm serious. They are a chronic problem for us, and they need education on the FC program and LTCFS.THANK YOU FOR ASKING FOR SUGGESTIONS. I WILL ENCOURAGE MY PEERS TO ALSO THINK ABOUT WHAT COST SAVINGS COULD BE GOOD OPTIONS.

## **Jason**

I would produce a debit card system for the average adult consumer of medicaid. Per year, allow 3 days in an ICU, 1 day surgery procedure, 3 ER visits, 2 ambulance calls, 8 family doctor visits, 4 dental appointments, 1 emergency dental, etc. In situations that someone needs additional healthcare, a simple internet application could be used. For example, if a female gets pregnant, she can apply for pre-natal care, and an OB stay. If there are complications with the pregnancy, another application could be filled out for a Neo-natal ICU stay, this may sound overly complicated, but I believe it may help stop some of the chronic abusers of the current system. As a provider in Milwaukee, I can tell you we often see the same group of people that come in to the ER for every minor healthcare concern that ails them. Most americans would get a cold or flu remedy from Walgreens, but those abusers take a free ride in an ambulance to be treated for free in the Emergency room. One more suggestion I would have, would be to add on and enforce co-pays. I understand that the poor that use medicaid already to not have money for co-pays but that would make the user think twice before going to the ER for the sniffles.

## **susan**

Shop at Walmart. And, sadly, I'm not really kidding about this. They have a \$4 perscription list. Ask them what's on it. Also, insulin (NPH and REG) is \$24.27 / vial there out of pocket with NO insurance, whereas, a vial filled anywhere else with Medicare, is now over \$30 anywhere else. This is crazy, but true.

**John**

One idea may be consolidation of Southern and Central Centers. There is a definite need for this facility for the residents. There certainly is duplication of administration and the other services.

**Ramirez**

Big ticket items should be property of the county such as scooters and when a recipient passes away Milwaukee county should take possession and reloan this item.

**Barbara**

1.) Purchasing Drugs more efficiently, limiting the formulary. In the experience of our provider network, the limitation of the formulary for Medicaid and SeniorCare has been reasonable and workable. In those few instances, when a brand name medication is needed in preference to a generic, we have found the prior authorization process accommodating to the need, as long as the trials of the generics (or the reason for not trying the generics) can be documented. The ability of SeniorCare to negotiate pricing for medication has been key in keeping costs down for seniors, much lower in SeniorCare than for the Medicare Part D plans. Continuing to make this program available is key for us! We appreciate not needing to serve the elderly population. We appreciate having a resource to direct people to, when they come to us because of the costs of their medications. 2.) Care Management. HMOs need to be held accountable for care management.

**julie**

Be more aggressive in investigating badgercare applicants. One I know of lives in a half million dollar house owned by a relative, chooses to work part time on the books, and makes several times that off the book. She also owns two free and clear rental properties. I very much doubt if fully audited she would qualify.

**Stephanie**

Training is generally cut out of the system to save money, and over the past 5 years, the services and knowledge of economic support workers, HP enterprises, and the ESC has greatly declined. Because there are individuals who are not properly trained and supported, there is more work, communication and follow-up time required to get cases fixed and clarified. This time is wasteful for both the workers and community partners. CARES is not a perfect system, and going back to making sure that the workers understand the various Medicaid, FS, and other programs would likely save time. There was a time when all the economic support workers knew how the programs worked, could recognize errors better, and mistakes were fixed much more quickly. Training may be expensive up front as well as the presences of onsite supervisors who are knowledgeable of the programs, but it will likely save money in the end to implement these two things.

Currently, many providers must contact supervisors to get answers, to question incorrect information and decisions being made by economic support workers and ESC workers. I feel that this is costly for everyone and a great disservice to consumers. The providers work hard to understand the information and the rules mainly because things slip through the cracks more and more each year. A combination of large caseloads, workers with a lack of critical knowledge of programs, and a growing bitterness, makes the process wasteful and everyone loses time that could be better used serving individuals.

## Johanna

I am the extremely proud mother of my son who is a fabulously witty child who also happens to be a medically involved child with Down syndrome. We are here today as a gentle reminder to everyone that most people don't set out to be disability advocates. In fact, at any given moment, any of us is just a heartbeat away from needing Medicaid. We came to the disability world the day I gave birth. I delivered at St Joseph's Hospital in Milwaukee and 6 hours later he was shuttled to Children's Hospital for his first life-saving surgery, while my husband drove back and forth between two hospitals with no family in town to support us. We had no idea about disability or the medical world we got thrust into, but we were extremely grateful for the support we received from Katie Beckett, a Medicaid supplemental insurance, which covers a myriad of medical costs, prescriptions, co-pays, therapies and related costs that are associated with a medically involved child with Down syndrome. Despite multiple medical challenges and ten surgeries, our son is fully included in a first grade classroom; he is learning to read and to write simple math sentences; he can tell a mean knock-knock joke; he dances and sings with utter abandon and we think he may be put on this planet to resurrect vaudeville singlehandedly. Asking me which cuts to Medicaid and the Children's Long Term Waiver I endorse is like asking me which keys from my computer keyboard I am willing to part with. My son has been on and off waiting lists for Family Support and the Children's Long-term Waiver for a number of years and is still waiting to receive benefits from the Children's Long-term Waiver Program in Milwaukee County. I seriously doubt the waiting lists have been caused by overfunding. I also know that children with disabilities are better served than adults with disabilities, so if there are wait lists for children there must be massive ones for adults. However, it's vitally important to include parents as reliable and effective resources and stakeholders as we consider how to make programs run more efficiently. As the advocate for a consumer of these programs I can suggest a few areas where funds may be better repurposed, repurposed, maximized, and better serve consumers:

- 1) JB Medical: As a consumer and a state of Wisconsin resident, I don't understand why I am required to pay an out of state medical company double or in some cases triple the amount for inferior, off-brand diapers that do not work or for formula for a child with a g-tube. We should be using a Wisconsin-based company and allowed to purchase superior products for less money than what JB allows. If you need additional information about this issue, just speak to any parent of a child with Down syndrome and you will hear cost-saving alternatives to JB Medical.
- 2) We should investigate cost savings that could be generated from repurposing durable medical goods and augmentative communication devices no longer in use. Katy's Kloset, a non-profit agency run by parent volunteers of children with disabilities in Waukesha ( W246S3244 Industrial Ln Unit B Waukesha, WI 53189.) is a wonderful program that recycles and loans, cost-free, durable medical goods not just for children but for adults as well. For a surgery last year I was able to borrow, at no cost, every piece of equipment I needed for my recovery. Walking through Katy's Kloset is also a testament to the creativity and ingenuity of individuals with disabilities and their parents, caregivers, therapists and providers.
- 3) Privatization doesn't always mean cost-savings. In the process of getting my son on the Children's Long-Term Waiver, we have been passed through four separate professionals/screenings at two different agencies and we're still on a wait list. It seems to me that a single, consolidated intake for state and county programs and waivers would save time and money. Also, when we reapply for a program, it would be helpful, save time and money not to change the form from year to year without a good reason.
- 4) I am deeply concerned about my county and state services reaching some of the most at-risk, vulnerable, and underserved people in the City of Milwaukee. I developed and ran a monthly mentoring group for parents and caregivers of children with Down syndrome at Penfield Children's Center for 2 years. There is a huge divide between the people who have access to supports and those who do not. Many of the low-income participants of the mentoring group had no computers to access information or to connect with other parents. I suggest developing a more formal mentoring program connected to Birth-to-Three Centers and all stages of life for our at-risk families in the city.
- 5) In some of your presentations, Secretary Smith, you've discussed the importance of non- medically based services to support independence and employment. I couldn't agree more. If we apply the same philosophy to education, then that would mean we should not cut aid for children with disabilities in school classrooms, and we should find ways to more fully include children with disabilities in typical classrooms and school programs. Education is outside of your purview as HHS, but the point cannot be avoided that when massive cuts occur to our children's education, they will be further impeded as young adults seeking employment. Early intervention and supports are everything. This past month I learned of two inclusive classrooms in MPS that have lost SAGE funding and state funding and will now cease to exist. This is a move backwards, away from independence and self-determination; this is a move away from future employment and personal freedom.
- 6) Lastly, I recommend that emergency rules should not go into effect because this will remove the voices of consumers of the programs from the process. Not only is it un-democratic to ignore the voice and experiences of users of the systems, but it is not fiscally or morally sound. Mistakes will be made that will be costly to undo. In the disability community we have a saying: 'Nothing about us, without us.' Please keep this in mind before enacting emergency rules which would prevent invested parties from participating in the decision-making process and would instead place all of the most significant Medicaid decisions of the state in one person's hands. It is my great hope that

you will see my son as a bright promise I have dreams that he will be gainfully employed and that he will have the privilege of someday becoming a taxpayer because that will mean he is truly fully included in his society. That is my American Dream.

### **Renee**

The cost savings would/could be achieved by cutting the BadgerCare Benchmark and Core plans from the program. Also, eliminating the HMOs and Southeast Dental Associates from the dental portion of Medicaid, as well as returning the entire state to a consistent system; a fee for service system, would save significant money.

### **Sharon**

The price that most vendors charge for items that special needs clients get are outrageous-oftentimes triple the amount charged at retail stores for the exact same product. Also medical supplies are much inflated and need to be addressed.

### **Maurer**

1) Increase the lookback period for MA/Badger Care eligibility determinations to at least 10 years. Far too many folks are legally divesting, and then having their parent going on the public dime - while refusing to believe that it IS public assistance

### **Mulholland**

There should be a family cap on the amount of money paid just as there is for W-2, the military, and other programs. Instead, in Wisconsin a family of six, all on SSI can receive 674.00 per person from the federal government, 83.78 from the state, assistance with housing, energy and food stamps. All non-taxable income. While there are many severely disabled children whose families need this assistance, there are also a substantial number who are approved for mild mental retardation, and learning disabilities. The actual situation is that Mom typically started having children at the age of 15, does not know who the various fathers are, and there is no home structure to provide the nurturing and care these otherwise normal children need. Throwing money at the Mother to spend as she pleases does not change this situation. If the children just received Medicaid, since their learning disabilities are handled by the schools, there might be an incentive to change this culture. The state also wastes vast amounts of money contracting out to benefit specialists, and other groups to assist people filing for SSI. We have seen the dollars spent, and the results are minimal. Federal workers and state workers are appalled at the low case loads these contractors have for many taxpayer funded programs, while federal and state workers can barely keep up with the thousands of cases each worker must handle. As a taxpayer, I would like to see an overhaul of this entire system. You do not need to pay children the same full dollar amount you pay to their mothers (who then file phony tax returns for the EITC). I would like to see it stopped.

### **Jennifer**

1. I don't understand the need for RNs in the Family Care model in counties that do not have Partnership program. 2. I would like to see the B-3 MOE requirement lifted - enrollment in this program fluctuates and the MOE requirement can easily become an unnecessary burden. Counties want to provide high quality services to all B-3 clients-especially considering the long-term benefits that early intervention services have in these children's lives.

## **Amy**

Below is an excerpt from an article found in the Journal of American Dietetic Association ([www.eatright.org](http://www.eatright.org)) regarding the cost-effectiveness of registered dietitians providing integrated Medical Nutrition Therapy. Consistently inserting and reimbursing for these proactive methods of treating chronic disease could save BadgerCare and SeniorCare a great deal of monetary output. Integration of Medical Nutrition Therapy and Pharmacotherapy Volume 110, Issue 6, Pages 950-956 (June 2010) Abstract It is the position of the American Dietetic Association that medical nutrition therapy (MNT), as a part of the Nutrition Care Process, should be the initial step and an integral component of medical treatment for management of specific disease states and conditions. If optimal control cannot be achieved with MNT alone and concurrent pharmacotherapy is required, the Association promotes a team approach and encourages active collaboration among registered dietitians (RDs) and other health care team members. RDs use MNT as a cost-effective means to achieve significant health benefits by preventing or altering the course of diabetes, obesity, hypertension, disorders of lipid metabolism, heart failure, osteoporosis, celiac disease, and chronic kidney disease, among other diseases. Should pharmacotherapy be needed to control these diseases, a team approach in which an RD brings expertise in food and nutrition and a pharmacist brings expertise in medications is essential. RDs and pharmacists share the goals of maintaining food and nutrient intake, nutritional status, and medication effectiveness while avoiding adverse food-drug interactions. RDs manipulate food and nutrient intake in medication regimens based on clinical significance of the interaction, medication dosage and duration, and recognition of potential adverse effects related to pharmacotherapy. RDs who provide MNT using enhanced patient education skills and pharmacotherapy knowledge are critical for successful outcomes and patient safety.

## **Mike**

Registered Dietitians are critical to cost-saving and effective healthcare. If we are to truly focus on cost savings, it is paramount that efforts be made to provide preventive care. All health professionals seem to talk prevention and health promotion but regulations and legislation do not seem to mirror these ideas. Licensure of Registered Dietitians in Wisconsin can bring dietitians to the table. Current language in the health reform bill speaks of licensed health professionals. Without licensure for dietitians, RDs may not be seen as valued members of health care teams, when in fact they are THE NUTRITION EXPERTS. Good nutrition IS THE PRIMARY PREVENTION PROGRAM, and the Registered Dietitian is the nutrition expert and needs to be involved in all decisions that affect the health and wellness of the public. The Registered Dietitian can help the public effectively treat, manage and ideally prevent chronic illness related to diet and nutrition habits. This WILL save countless dollars. We must turn our focus away from treatment and management, and focus more on prevention or we will continue to be plagued with the same morbidities. The Registered Dietitian is the key to prevention and health promotion.

## **joseph**

as above

## **Daniel**

Allow individuals who qualify for medicaid through receiving SSI to retain their medicaid if they return to work and their income exceeds SSI limits. However, require the individual to pay a premium of 5-10% of their income less employer provided premiums. I understand there are programs to assist with this, such as MAPP or PASS. However, these programs are often unknown, confusing or have income restrictions that exclude individuals who could work full-time in good paying fields like law, finance, computer science, etc.

## **Myra**

Co-Pays

## **Pamela**

I am the co-owner of a company that manages senior housing properties including assisted living facilities. We started our company based on the belief that all seniors, regardless of income, are entitled to live in high-quality residential environments and to receive the services they need at a price they can afford. Our management team has been working in some form of senior housing or long term care for over 20 years each including independent senior housing, assisted living, dementia care and skilled nursing. We appreciate the opportunity to offer information about a cost saving model that already exists for seniors in Wisconsin. The Wisconsin Affordable Assisted Living program is a relatively new, innovative initiative that was created through the cooperation of the Wisconsin Housing and Economic Development Authority (WHEDA) and the Wisconsin Department of Health Services (DHS). This program combines housing through the low-income, tax credit rental housing program (also referred to as Section 42) and services that are either paid for by the resident or through the Family Care program. Section 42 senior apartments are built to Residential Care Apartment Complex (RCAC) standards and are certified and regulated through DHS. Seniors love this alternative because the rents are based on their income level and are affordable. They have their own apartment unit and services are delivered to them within their unit. We are one of a number of operators around this state that has embraced this model. We accept income-qualified residents who are enrolled in Family Care directly into our buildings. We also have residents who are paying for services out of their own funds. If our private-pay residents run out of funds and qualify for Family Care, they can remain in our community and not have to move out to a higher cost, skilled nursing facility in order to continue receiving the same services. Furthermore, we have established levels of care based on assessment by our Register Nurse of the staff time required to deliver the customized service plan for each resident. This way seniors and Family Care MCOs only pay for required services. This allows residents to move up and down the service continuum as their needs and healthcare situation changes. We do, in fact, reduce the level of care if we find that individuals have improved in their functionality and can do more for themselves. Family Care MCOs like this option because it is cost effective for them and seniors can afford to pay for their room and board costs themselves. Seniors and their families like it because it is residential, offers privacy and dignity and is affordable for them also. This creates a win-win situation for everyone! There are currently only a small number of these affordable RCAC models of assisted living operating in the state. However, a number are currently under construction or are under consideration for funding by WHEDA is the 2011 tax credit allocation round. We are concerned about the proposed cap on enrollment for the Family Care program starting in July of this year. As we understand it the only way new enrollees will be able to access the Family Care program will be when another enrollee leaves. For seniors this would mean that potential new members will be waiting for current member to die in order to gain access. We believe that it will cause seniors who cannot access the program to deteriorate in their homes and apartments without the services they need to maintain their independence and manage their healthcare situations. Seniors who need services and who qualify for Medicaid will end up going directly into a skilled nursing facility and will by-pass the lower cost assisted living alternatives. If Family Care caps enrollment -- then WHEDA will be reluctant to support this proven cost-effective model of care. DHS will also lose an option that seniors want and is cost-effective for them. As it stands now, the reimbursement rate by Family Care MCOs for skilled nursing is approximately twice the rate for those in assisted living facilities. By establishing caps, the costs for providing care to seniors will go up not down as they are directed into Medicaid-certified, skilled facilities. We urgently request that DHS NOT put a cap on enrollment for seniors in counties where Family Care is already an entitlement. This will only create waiting lists and force seniors into unwanted, higher-cost alternatives. The Affordable RCAC model already exists and is cost effective alternative for all stakeholders including seniors, their families, the Family Care MCOs, DHS and the state of Wisconsin.

## **Zirk**

Elimination of chiropractic and podiatric benefits. Stronger emphasis and higher payments for preventive care (e.g, immunizations, well child visits, nutritional and dietary counseling). Consider the Oregon model for Medicaid coverage (I strongly urge you to consider this). Lean on the federal government to utilize the federal governments power to reduce Medicare drug prices the same way they do under Medicaid drug rebate program. Adopt ambulatory care group pricing for ambulatory services.

## **Willborn**

Make BadgerCare more like other insurance types where the co-pays could be higher for medications and going to the doctor, no more transportation reimbursement, and I think BadgerCare to families with dependent children should have a premium across the board. It does not have to be large, but they should have to pay something and make them responsible. The services that BadgerCare offers are overly used and something has to be implemented to cut the use down and I think a co-pay would make people think about going to the doctor for every little bump. I also think orthodontics is over used as well because it is free. There should be a co-pay for this as well. Nothing is free anymore, and we are creating unnecessary entitlement by offering things for free when certain populations could pay more. The elderly and disabled populations often have fixed incomes and it is difficult to take on more cost but working families could pay more.

## **Maria**

The Family Care program was implemented during the Thompson administration to improve access, choice and quality of life services for members. The goal was to create a stable and sustainable long-term care system through the development and implementation of cost-effective practices. The Milwaukee County Department of Family Care (MCDFC) Managed Care Organization (MCO) has achieved these goals. The MCDFC has a diverse provider network, excellent member satisfaction scores and was noted in the December 2010 'Family Care Financial Evaluation' by APS Healthcare to be '... among the most financially stable of the Family Care MCOs.' The MCDFC has identified potential savings to the State Medicaid Budget through consolidation of Family Care operations in Milwaukee County to one MCO. Allowing MCDFC to serve as the sole MCO in Milwaukee County is projected to save the State's Medicaid budget over \$600,000 in year one due to the difference in payment of administrative costs to MCDFC and Community Care Inc (CCI), the second Family Care MCO in Milwaukee County. An additional \$1.2 million dollars in savings potentially could be achieved through consolidation of CCI clients into the MCDFC. At over 7,600 enrolled members (roughly 86% of the Family Care enrollees in Milwaukee County), the MCDFC is a large enough operation to absorb an additional 1,200 or so members currently enrolled in CCI without any need for additional administrative staff. Only 3 of the 57 Family Care counties have more than one Family Care MCO: Milwaukee, Washington, Waukesha. Since 95% of participating counties are served by one MCO, and all counties have IRIS, the State's Self Directed Supports Waiver, available as an option, there is no sound operational reason to expend additional Medicaid dollars on multiple operations. The MCDFC has worked hard to negotiate cost-effective rates with providers that allow them to continue to provide high-quality service to our members. We have worked with members to develop care plans that truly meet their desired outcomes and have pioneered a Self Directed Supports co-employment model that allows members to self direct their home care. This co-employment model saved approximately \$7,575,988 in 2010 compared to what would have been paid using a traditional home health agency model. We look forward to partnering with both the Department of Health Services and the Legislature to continually improve Family Care and are very confident that as the sole MCO in Milwaukee County we could help the State save significant Medicaid dollars while insuring our members receive the highest quality, cost effective services necessary to meet their outcomes. Further, the MCDFC is willing and able to manage the IRIS benefit in Milwaukee County. This would reduce the State's administrative costs, increase the cost effectiveness of the program and insure quality services are provided to members.

## **LaVerne**

1. Invest in preventing falls among elderly living at home and in group homes. 40% of persons admitted to Wisconsin nursing homes have had a fall in the past 30 days. The majority of persons admitted to Wisconsin hospitals because of a fall are discharged to nursing homes. Many of them end up staying there long-term and must turn to Medicaid when their assets run out. Wisconsin has initiated several evidence-based programs to prevent falls among the elderly. With a relatively small investment, those programs could be expanded to have greater impact on falls reduction. 2. Keep in-person enrollment for Elderly, Blind and Disabled and Long Term MA at the county level to avoid misappropriation of elder persons' assets and avoid divestment. EBD MA eligibility determination is more complicated than other MA. Asset and divestment information must go back five years. Without careful review of documentation older persons could be more vulnerable to misappropriation of their assets, and the Medicaid program subject to divestment. ADRC, Adult Protective Service and Economic Support staff currently work together to identify misappropriation of an older person's assets. Furthermore, local workers help to avoid enrollment disruptions which could result in nursing homes not being paid, increasing debt and being less likely to accept MA. 3. Do not restrict access to prescriptions that work for persons with mental illness as these have helped to stabilize hospital placements and keep people out of jails. 4. A relatively small investment in CIT and CIP training for law enforcement, teachers and other community persons can stave off more costly incarceration or hospitalization of persons with mental illness.

## **Greg**

Wage rates for state employed enrollment specialists are much higher than our local county offers.  
[https://wisc.jobs/public/job\\_view.asp?annoid=50865&jobid=50380](https://wisc.jobs/public/job_view.asp?annoid=50865&jobid=50380)

## **Linda**

Keep costs at an affordable level for low income families and the elderly. I know that isn't a cost saving suggestion but I think it is vital for all involved.

## **Abigail**

I had badgercare+ when I was unemployed and had no insurance. It was wonderful as a bridge when I was between jobs, and I am so grateful it was available to me. I never would have been able to go to the doctor when I was sick if I hadn't had Badgercare+. I was on it for about 7 months, as I became employed full time and had benefits. One thing you could do to save money is make it easier for people to leave the program. When I no longer needed Badgercare+, I wanted to get off of it quickly to open up a spot for someone else. It was so hard to figure out how to do that. I was on the phone a lot trying to get an answer, and no one could believe I was actually following the rules and opening up a spot instead of staying on it, even though I had gotten a job with benefits. In the end, all I think I had to do was fax my desire to be taken off of Badgercare, but I wonder if some people never find out and just stay on it because they don't know how to remove themselves. So, that would be my suggestion. It's a fantastic program for people without health care, and I think it could benefit even more people if those who no longer needed it knew how to transition out of it.

## **Danielle**

Do not advocate for reduced eligibility guidelines or increased co-payments and premiums. This will prevent access and deny coverage to many Wisconsin children and families. The uninsured still get medical care when they need it, shifting costs to those who pay with private insurance. The state needs to find additional ways to raise revenue instead of cutting services from those who need it most.

## **Adams**

Pay providers more when they have better outcomes. Use indicators already established to determine what good outcome means i.e. low rates of infection during hospitalization. Promote midwifery- they are cheaper and are better at prenatal and postnatal care in uncomplicated cases, and have fewer caesareans and medical interventions, which are costly.

## **Tracy**

Utilize the best nurses and caregivers in one or two facilities for the most profoundly retarded, and neediest clients instead of farming them to costlier group homes with poor quality of care at a high price.

## **Randy & Jo**

I understand the need for Wisconsin to get it's fiscal house in order. If we don't, the system will collapse and the programs will all fall apart. With that said, I would like to see the budgets rolled back to sustainable fiscal levels. This will put pressure on resources, and some of the people getting those services will be pinched. Better pinched, than gone completely. To sustain the programs the state needs private sector jobs! The more people we have earning income, the more revenue generated to support programs. We have two adopted children that were abused with drugs and alcohol by their mothers while still in the womb. They are in the program and their lives will completely unravel without the medication they are on. When I had a good job, with Health Insurance, they needs were taken care of. Today, the job is gone, and the health care with it. It will be a balancing act, and I pray the smart minds and cool heads will prevail. Help those who can't help themselves' and create opportunity for the rest. I am ok with the able bodied among us getting off the couch and into a good job!

## **Christine**

1) System fixes. 2) Asset limits after a certain income limit. 3) Reduce duplication - too many entities are involved in application process to avoid increasing staffing levels and this only increases confusion and duplication.

## **Anna**

Utilize a yearly pre-authorization process vs. continued paperwork & pre-authorization. Continue to have private insurance companies cover services rather than shift to taxpayer in Wisconsin.

## **Herb**

Do not pay bonuses to MCO's for doing a good job. Do not allow non-citizens to be put on Medicaid. Delete earned income credit for taking care of disabled family member at home. Do not allow for elective surgeries.

## **Pamela**

Count the assets of the household for BadgerCare+ recipients during eligibility determination. Count the interest and dividend payments received by the household. Have premiums due in advance. Eliminate the free month. Stop coverage when people move out of the state. Enforce restrictive re-enrollment periods due to late payments. Raise copays. Mirror private ins (deductibles).

## **Kathleen**

1) Many Generic drugs are available at the following pharmacies: Walmart, Target, Sam's Club (no membership needed for pharmacy) and K-Mart. A few remaining independent pharmacies also offer these great prices. \$4 per month or \$10 for 90 day supply is affordable for most people up to three or four prescriptions per month. Why offer drug coverage with a \$5 co-pay and paper work, when the patient could buy it for \$4 cash?2) Earlier access to care prevents serious long term complications of diabetes, hypertension, and other illnesses and saves dollars in the long run.3) Physicians have the training and knowledge to make the best decisions on behalf of their patients. Trust them. Support those who are trying to make a difference.4) Physicians need to be educated about patient drug assistance programs and need support in helping their patients access them. System employed physicians often are insulated from the financial issues of both their practices and their patients. 5) Some feel that electronic medical records are a cost saving measure. The huge cost of the software and tech support would make me question its return for the dollar.... What it helps is data collection, but how does that touch the patient at street level.

## **Judith**

As DHS Director Dennis Smith said at the Madison hearing before the Joint Finance Committee on April 6, five percent of the population uses 58% of BadgerCare dollars. A high percentage of those expenses are attributed to Wisconsin citizens who have diabetes and other chronic illnesses. We agree that there are some healthcare interventions and management protocols that can considerably decrease costs associated with diabetes and other chronic disease management. We submit that Medical Nutrition Therapy (MNT) provided by Registered Dietitians can decrease Medicaid costs while providing the best care for Wisconsin residents. MNT is legally defined by Medicare as nutrition counseling provided by a Registered Dietitian. It is an evidence based component of the medical treatment for managing specific disease states and conditions. Multiple chronic diseases are amenable to MNT and studies have shown the cost benefit of such intervention. Diabetes and obesity are two such chronic diseases. Diabetes: Estimates are that 57 million Americans (over 17% of the population) are at risk of developing diabetes, a disease that costs the US approximately \$174 billion a year. For every dollar spent on nutrition intervention with pre-diabetes, \$6 can be saved in diabetes treatment. The Diabetes Prevention Program Study (Diabetes, 54,2404-2414,2005) demonstrated that training provided by Registered Dietitians on diet improved insulin sensitivity at the end of one year and reduced the risk of developing diabetes by 58%. Obesity: Over 35% of Wisconsin residents are obese. (BMI > 30). Obesity is estimated to indirectly cost the US \$65 billion a year. Obese individuals are more likely to develop diabetes, heart disease, some cancers, high blood pressure and increase the cost of hospitalizations. Dietary interventions with a Registered Dietitian involving 1-2 hours of nutrition counseling coupled with 15-20 minute follow up have shown sustainable weight loss in obese and overweight individuals. I urge the DHS to focus its service delivery improvements to systematically and consistently provide evidence based Medical Nutrition Therapy (provided by Registered Dietitians) for pre-diabetics and other BadgerCare clients with chronic diseases. A strategy to provide early and effective evidence based Medical Nutrition Therapy for clients with pre-diabetes and obesity can save considerable Badgercare dollars (\$6 in savings for every \$1 spent).I would be happy to provide sources and additional information on evidence based Medical Nutrition Therapy.

## **Tom**

For seniors it is not having to enroll in an additional drug program.

**Susan**

During the spring, summer & fall, DHS should require managed care companies to evaluate if medicaid/medicare member is ambulatory and would understand how to take mass transit, the bus system, and if yes, the member should be required to take the bus for their medical appointments. This state needs to get creative to continue programs for those truly in need but stop robbing the tax payors blind and start spending responsibly and sensibly, we owe it to ourselves, every citizen of this state.

**Hansen**

2 items that could save money for Family Care:1-CMU's should only serve Family Care members that live in their county. Out of county members should be transferred to a Family Care CMU in that county. This would save on mileage reimbursement and billable time. 2-Do all Family Care members under the age of 60 really need a nurse? I understand if the person has a medical condition like seizures or diabetes, but a healthy young 18 year old coming into the Family Care program really doesn't need a nurse checking up on him as well as a case manager.Those are my thoughts.

**Marjean**

Update the health insurance system so it correctly shows when people have insurance. The system now is kind of hit & miss on correctly updating.Charge co-pays for services like doctor visits. This could slow down the abuse of the folks who run to the doctor constantly.

**Teresa**

The income limits for Badgercare could be increased and a larger monthly premium assessed for those eligible. Also, there could be some larger copays as families need to be more responsible for their care costs. Also, we should be covering preventative medicine and alternative cares as options.

**Jeannie**

Yes, completely eliminate divestment. Bring all IM cases back to the counties where benefits are issued timely, families receive links to other services to raise them out of poverty, where fraud is controlled through local means, and where accurate benefits are issued to eligible families.

**Sarah**

Invest in more primary care at the schools- Nurse Practitioner's. They are able to see students sooner and address health care issues before they become out of control or severe enough to require Emergency Department care. This would be a huge cost savings in the long run and less unnecessary use of the Emergency Department and hospitalizations. This is easier to access for parents and families also due to being right in the school where their children are. It does not necessitate leaving work, losing hours, potentially being under scrutiny of management in the work place. I work in the schools and there are many parents who are not able to leave work unless it is truly an emergency so they do wait to have their children seen.

## **Trisha**

Lower the income limit for Badgercare Plus and premium income limit. Increase premiums and copays. Eliminate coverage for non citizens. Change the way access to insurance is looked at, for example if the employer pays at least 60% of the premium require they take employers insurance. Improve the insurance verification system as many times the information populated is incorrect, example: major medical policy is marked no when it should be yes. Eliminate grace periods for late payment of premiums. Change backdating to only 1 month vs 3 months

## **Jean**

I believe more taxes should be raised from corporations and put toward human needs.

## **Janet**

1. Self-employment - Don't have 2 self-employments offset each other. 2. If health care is offered by employer - must take and not apply for BC+ 3. Lower income limits for eligibility and premiums. 4. Have higher co-pays for vision, dental, chiropractic. 5. Stop offering BC+ to illegal aliens.

## **DuBord**

Recognize the community-based psychiatric crisis intervention services provided by the Crisis Resource Center as a level of service covered by Medicaid HMOs. This will reduce unnecessary emergency room and inpatient hospitalizations - which are covered services, but at much higher costs than the CRC and a much better service for consumers.

## **Marge**

Recycle unused unwrapped medications. There is a huge amount of waste. Why do we need teams of 2 with MCO? We already have a nurse on our staff. CHP is a slow middle man. As a program manager I could easily get the services in line for my residents. We did this before CHP took over.

## **Pat**

1) Co-pay's for BadgerCare Plus 2) Charging BadgerCare Plus consumers a fee for the insurance.

## **Susan**

MNT will reduce costs associated with diabetes, cardiovascular disease, and obesity.

## **Kitty**

Map & streamline enrollment processes to resolve inefficiencies. Involve public health nurses, they know what will be helpful and wasteful. Assure access to contraceptive methods. Invest in making the prenatal care coordination benefit available to all pregnant women on Medicaid. Reinstate provision of early periodic screening, diagnostic and treatment services by public health nurses.

Agency with choice may be an alternative to total SDS.

**Donna**

The oversight from Madison (OFCE) has been more micro-management of the MCO's. Let the MCO's run their business rather than the OFCE taking more control. Too much centralization of dept staff, reduce staff at the dept. A centralized information system for all MCO's in Madison OFCE offices is not where the system should reside. MCO's could unify & share existing systems without dept purchase. Admin staff at MCO levels could be reduced if MCO's were structured across broader regions. Provide partnership in all regions as an additional option of choice so we can deliver more care management for those needing integrated primary care, reducing costs of Medicaid programs. More dual eligibility to bring in more federal dollars to the state.

**Julie**

I believe the FPL should be lowered on BC+ and the self employment rules changed. Maybe higher premiums for self employed, the rich have found a loop hole and are using BC+ as their health insurance at little or no cost, they should be using private health insurance, not taxpayers dollars.

**Sue**

The SeniorCare drug program should be kept as is. It works and serves Seniors in WI. It started before Medicare Part D. Please keep this program as is. We need BadgerCare as is. Farmers need it, low wage workers need it. Please keep counties (public workers) in charge of helping aging and disabled people. They know what to do to help.

**Amy**

Fight. Fight for us. Don't let this mogul of a business man turn our state into a for-profit enterprise. This is not a business like he is used to being so successful with. These are people's basic rights. Stop him....I don't know how, but stop him.

**Marcia**

Allow credible providers to bill Medicare directly.

**Lori**

Standard residential and vocational rate setting methodologies beased on consumer needs and costs. Process to identify and adequetly set rates for outlier members whose needs don't fit the standard formula. A resonable bed hold process to preserve members residential services when they are temporarily absent. Shared info systems to provide economies of scale and uniform data collection and reporting.

**Linda**

Continue preventative services in the area of oral health and allow dental hygienists to access children and adults in settings without the oversight of a dentist. Particularly the underserved populations that are MA participants.

**Sylvan**

Yes, do not allow family members to be reimbursed (paid) for care to family members unless they are employed by a licensed home care or personal care agency and at rates that are consistent with what the agency pays its regular employees. If the IRIS program is to be expanded, contract with local non profit social service agencies to provide oversight and surprise visits

**Gina**

A lot of money could be saved if the formula that is used to set up a budget for IRIS would change to include personal care received via T-19. Clients on IRIS are able to maximize T-19 services and get an IRIS budget on top. It is fraudulent because 30% of PCW in a home health care agency is allocated for Supportive home care, which is covered under IRIS.

To save money the IRIS funding should include cost of t-19 services that are covered under Family care and the budget should be capped at the same capitated rate. Another cost saving strategy would be to make sure that an outside agency/vendor assess clients for home health services ( t-19) instead of the agency that gets paid to provide the care. This is counter intuitive. Obviously the assessment is going to maximize the hours because of the profit made on each hour of services provided goes to the agency doing the assessment. There is no checks or balances.

**Mark**

This above mentioned model is the model to go with, i've personally researched every model I can find and this one is the cheapest and best model available, i already have permission to use it and implement it, from the creator of the model. I would be ready at anytime to give a presentation. The people that are working with me on this project are clinicians, providers, consumers. and peer specialists. We want to help the addicts of the great state of Wisconsin!!!

**Sally**

Refurbish equipment (wheelchairs), reuse vehicles (wheelchair accessible).

**Mary**

People who cope daily with mental illness need safety nets, especially when leaving a hospital or when discharged from jail. Without these processes for housing, appointments with psychiatrists, etc. in place, costly hospital expenses occur or incarceration can happen. Racine County with NAMI Racine have Crisis Intervention workshops twice per year for their police officers. When minor infractions occur if someone is off their medications or undiagnosed, these officers diffuse the situation and get medical help for the person. These training sessions could be implemented throughout the state. The cost is minimal in comparison to incarceration, and best of all, the person is helped.

**edward**

Maintain the mental health care system as it stands; from the Bureau of Mental Health to the front line evidence based practice Community Support Systems. They reduce preventable hospitalizations as well as unneeded jail and prison costs. It would cost far more to re-invent it than to keep it going. Maintain the evidence based practice Clubhouse Model programs within the state. They reduce preventable hospitalizations as well as unneeded jail and prison time and get their members jobs in which they pay taxes. Start treatment for mental illness earlier. It costs far less to get an adolescent with mental health issues federal grants to go to a 2 year college than to hospitalize them. Treat co-occurring disorders of substance abuse and mental illness together. It costs less to deal successfully with problems than to deal with them separately and unsuccessfully. Maintain insurance programs for WI citizens, they are cheaper than drastic, short term measures that tax the entire system. In conclusion, be very careful about ending programs that need to be maintained, particularly evidence based practice ones. As well, recognize the importance of Peer Support Specialists on treatment teams.

**Kimberly**

Make drug companies less powerful in this country! Drug companies and medical supply providers make such huge profits! I feel that all providers of health care must protest regarding the lobby power of drug companies. This will lower overall medical costs.

**Lazarus**

Cut down the choices of providers, have all people who are eligible complete a health survey, raise co payments \$5-\$10 and before they can receive health care that must select a Primary Doctor and take an annual check up to keep their insurance. I think this would cut down on ER visits

**William**

Recent outcome findings paid for by the World Health Organization and the NIMH show that a significant number of long term mental health patients are able to become independent and return to work and support their own families if they are not on a continuous regime of neuroleptics. There is now a long-term mental health outcome project now before the Council on Mental Health's Policy and Legislative Committee. Our new Secretary, Dennis Smith has been advised of this effort, strongly supports every effort to make our health services more cost effective. For more information about the status of this project see the [danecountyalmanac.blogspot.com](http://danecountyalmanac.blogspot.com)

**Jennifer**

Early intervention is the key to obesity treatment and prevention thus decreasing prevalence of cancer, hypertension, diabetes and heart disease which are complications of obesity.

**Steven**

We are a professional staffing organization that has saved our clients in Michigan hundreds of thousands of dollars in the cost of their operations. Our software and staffing solutions lend themselves to implementation in Wisconsin, and we would like to chat with you about the process we need to follow to make our services available to your providers.

**Karen**

Many health related problems today are related to poor nutrition & obesity. It has been shown that improving nutrition improves health. Our current food stamp program allows clients to purchase any food/beverage; healthy or not. If our food stamp program was changed to resemble the WIC program; which limits use to nutritious foods, it would likely have a huge impact on health & wellness. I realize the food stamp program is from a different agency; but in the big picture, they are very much related. I am a registered dietitian who has seen how the current food stamp program is not always used to promote healthy eating. As a tax payer, I don't like to see my tax dollars spent to allow poor nutrition, which in turn will cost more tax dollars to fix later health problems.

**Robert**

The system is sucking up valuable staff time with rate setting negotiations. The MCOs drag out these rate setting meetings for months, wasting valuable time, causing great uncertainty as to what our revenue will be. And then some of us just cut our rates without a negotiation violating a basic tenet of the Family Care system that rates are agreed to by both parties, not summarily set. MCO salaries are of concern. I have had staff come to my agency claiming they were paid by the MCO almost 30% more than I was offering. Another provider told me that the staff that were moving over from her agency to an MCO for a similar position also received substantially increased compensation. I am not sure how the state monitors MCO costs. MCOs seem to be run by people with no background in managed care. They are not doing anything to raise the quality of service, reduce unnecessary institutionalization, reduce falls and other incidents that save money in the long run and improve care. They just seek rate cuts and shift responsibilities like transportation. The goal of Family Care was to find efficiencies and put care under management, we seem to be slipping into putting paperwork under management, but people.

**Kari**

Focus more on preventive care, education and the management of chronic health conditions like diabetes. Increase the number of providers so consumers can access care early on in the course of an illness.

**Carla**

I would like to take this opportunity to recommend use of Medical Nutrition Therapy (MNT) provided by Registered Dietitians as a tool to decrease Medicaid costs while providing the best care for Wisconsin residents. MNT is legally defined by Medicare as nutrition counseling provided by a Registered Dietitian. It is an evidence based component of the medical treatment for managing specific disease states and conditions.

**Leona**

We do not fund free clinics. Our costs are about \$400 per client. Offer matching funds to communities. The communities need to match the state dollars one to one.

**Kristi**

By providing medical nutrition therapy with a registered dietitian, DHS could save a lot of money. Registered dietitians can help to prevent diseases from worsening and prevent future doctor visits. In addition, obesity is the biggest concern in our nation right now and a significant expense. Dietitians can help patients to lose weight safely and effectively through diet and exercise. Weight loss through lifestyle modifications is significantly cheaper than weight loss surgery such as gastric bypass surgery.

**Susan**

The three proposals by the WPTA deserve consideration for their potential to improve cost effectiveness - best utilization of funds for optimal outcomes and fewest/no delays. The three proposals are 1) outsource to private HMOs, 2) tiered benefits, and/or 3) sample 10% of PAs to review. Details are available from the WPTA and have been shared with the Secretary. The WPTA has been an active participant in improving processes between providers and DHFS for years. However, suggestions at cost containment that target streamlining the PA process fall on deaf ears because they target bureaucratic positions that would then be at risk. I propose that we spend the funds on the recipients' needs by creating a streamlined fair and equitable benefit system and improve or eliminate the PA process.

**Erin**

Close enrollment service center and allow the counties to administer all programs. Regionalize services.

**Hilary**

Make ESC more efficient. A lot of time is wasted on employees attempting to contact consumers when they were previously on the phone with ESC and they do not set up appointments with the consumer.

**Charlene**

Eliminate requirement of ADRC's to do pre-admission consultation (PAC). It is a waste of valuable staff time.

**Danita**

Cost savings could come by looking at the management costs associated with the CMO's that are contracted to provide the family care services and putting a salary cap on those management people. CCCW and potentially other CMO's have a very top heavy management team, pays the management very well and then nickle and dimes the consumer - thus taking away services. Retaining Senior care as an option for those persons already enrolled would be a positive program versus forcing the elderly to enroll in Medicare Part D. Badger Care Plus is a wonderful program that supports young adults struggling to get by in this world. He has allowed people to access medical care and focus on preventative services versus trying to deal with something after the fact and much more costly. I would also suggest retaining support of Family planning services. They provide much more than abortions. The alternative is lack of access to female health care and pregnancy preventative options, the alternative women not taking care of themselves and those that end up pregnant as teenagers or having an unwanted child and abusing or neglecting these children - a much costlier social problem than just paying for birth control.

**Erika**

Continue SeniorCare as credible coverage. It is nationally recognized as a viable, cost effective program that supplies vital coverage for seniors.

**Ardyth**

Peer run centers that are alternatives to hospitalization (such as those in Georgia & Nebraska).

**Jane**

Social workers should not be paid to administer benefits.

**Mark**

By utilizing existing IDD systems capacity in the private sector, the state can reduce costs as South Wisconsin Center and provide more appropriate services.

**Lynn**

Going to cost care meds. Only cover 2 children.

**Fred**

Continued effort with State/County partnership re: IM Administration. Concerns regarding cost shifting to counties if family care caps are imposed.

**Joanne**

Look at Minnesota and Vermont for potential cost savings and complete coverage for all.

**Ruth**

Streamline system & lower admin costs. Family/consumer self direction - make this meaningful within the CMO's & IRIS. Streamline & coordinate audit oversight of Family Care/IRIS. Reduce use of institutions, money should follow long term care in community. Keep people in their own homes as much as possible for the individual and family. Eliminate prior authorization process.

**Rick**

Improve systems to stop unnecessary refund checks when a nursing home facility forgets to bill, causing a credit in the system.

**Arnold**

Use Peer Specialists.

**Ronald**

Create 7 administrative regions statewide. Counties within these regions would be contractors for income maintenance services in the specified region.

**Jordon**

Agrees with caps.

**Ed**

Have the DNR get out of the construction. Each county has anywhere from 60-80 funding sources, reduce it to 5.

**Chris**

Enroll all homeless, unemployed and uninsurable to stop rising emergency room costs.

**Karley**

My suggestion relates to the children's autism waiver. I would suggest that parents of full time school aged children have the OPTION to reduce the number of hours during the school year. The current requirement of 80 hours per month, while at a therapeutic level is very beneficial, I think for children in school full time, it puts a lot of pressure on them. I do stress that parents be given the option and not that the reduction of hours be mandatory. I know many school aged children with autism have modified school days based on their disability, and many that are home-schooled. These children would have no problems meeting the 80 hours per month and it would be a great disservice to reduce their hours. My son has received services for the past year and has made some great gains. I do worry as he gets older (he is currently in 1st grade), how he will cope with school full time, increased academics, full time therapy, and homework. I know of other families with older children on the waiver that have the same concerns.

**Amy**

Yes, eliminate the tax breaks for the wealthiest Wisconsinites that Gov Walker keeps enacting. Instead, take care of the hard working citizens of Wisconsin who need help because they are unable to afford insurance.

**Marianne**

Registered Dietitians can provide preventative nutrition care, allowing for cost savings.

**Tonya**

Freezing the waitlist will cause unnecessary nursing home placements that will cost more medicaid dollars than participation in Family Care or IRIS. Counties will not be able to provide services with the current budget reductions they are facing. The only other option will be institutions which increase costs.

**Natasha**

Allowing in school clinics for acute care. Incentives for nurse practitioner's to practice in schools. Offer more free community events where they are needed most. Continue to monitor trends and provide evidence based care based on the trends.

**Trudy**

Create insurance system that uses a card similar to the food stamp card system.

**Tami**

Changing or eliminating Medicaid would eventually cost the state more by increasing medical bills and the need for durable goods.

**James**

Families should help pay for cost of care. Get assistance from the VA.

**John**

More self direction, no wait list.

**Amy**

Too many services are offered that are not necessary under Badger Care. Her Mother refused services that she didn't need.

**Deborah**

Look at salaries of state government legislators and administrators. Everybody should contribute based on their income/resources. Stop picking on the poor, working poor and middle class. Stop wasting \$. Stop making foolish decisions that give BIG BUSINESS more tax breaks. Increase state sales tax. Increase income taxes for people making more than \$250,000/year. Stop this favoritism and good ole boy club politics...I am very close to the point where I am embarrassed to say I live in Wisconsin.

## **Judith**

As Director Smith said at the Madison hearing last week, 5% of the population uses nearly 60% of BadgerCare dollars. A high percentage of those expenses are attributed to Wisconsin citizens who have diabetes and other chronic illnesses. We agree that there are some healthcare interventions and management protocols that can considerably decrease costs associated with diabetes and other chronic disease management. We submit that Medical Nutrition Therapy (MNT) provided by Registered Dietitians can decrease Medicaid costs while providing the best care for Wisconsin residents. MNT is legally defined by Medicare as nutrition counseling provided by a Registered Dietitian. It is an evidence based component of the medical treatment for managing specific disease states and conditions. Multiple chronic diseases are amenable to MNT and studies have shown the cost benefit of such intervention. Diabetes: Cost- estimates are that 57 million Americans are at risk of developing diabetes, a disease that costs the US approximately \$174 billion a year. For every dollar spent on nutrition intervention, \$6 can be saved in diabetes treatment. The Diabetes Prevention Program Study (Diabetes, 54,2404-2414,2005) demonstrated that training provided by Registered Dietitians on diet improved insulin sensitivity at the end of one year and reduced the risk of developing diabetes by 58%. Obesity: Over 35% of Wisconsin residents are obese. (BMI > 30). Obesity is estimated to indirectly cost the US \$65 billion a year. Obese individuals are more likely to develop diabetes, heart disease, some cancers, high blood pressure and increase the cost of hospitalizations. Dietary interventions with a Registered Dietitian involving 1-2 hours of nutrition counseling coupled with 15-20 minute follow up have shown sustainable weight loss in obese and overweight individuals.

## **Nancy**

Decrease the levels of admin. there isnt a need for a OC,Mentor, Guode and IC. That is too many layers of admin. Each doing a piece of the same job

## **Beth**

Eliminate the care teams for all frail elder Family Care members who live in nursing homes and all assisted living facilities (RCACs, CBRFs, AFHs). They duplicate the work already done by facility staff. Elders in these settings who convert to Family Care are simply a change in payor -- no different than the nursing home experiences in a change from private pay to T-19. The care teams do not add value. An MCO should be able to validate the care they are paying for. Therefore, assign a MCO employee to each provider and complete a semi-annual visit to the facility to review their member's status. Private pay consumers and consumers who use LTC insurance to pay for their care rarely have outside case management unless they represent the interests of an out-of-state family member. Facilities are required to provide case management and care planning by regulation.

## **Elizabeth**

Please see #8. To paraphrase:1. eliminate paperwork that leads to increased costs or imposes costs on other healthcare partners such as the Prior Authorization requirements.2. Eliminate schools from being able to charge for medical services.3. Streamline, streamline, streamline but do not impose costs on other entities that increase the cost of healthcare for others.Thanks so much for reading/listening and please do not hesitate to call me if you have questions with anything that I have written. Sincerely, Elizabeth Ivankovic

## **Lane**

1. Educate families on how to use the ER verses doctor office visits. Many families use the ER for visits rather than using their primary doctor.2. Have a fee for everyone for the insurance as well as doctor visits. Even as little as \$5 a month for the insurance and \$1 for doctor visits and \$30 for ER visits.

**Dennis**

Eliminate all of these so called deputy positions that just cost money I hear WI doesn't have. Start cutting from the top end so we can provide assistance to the people who need it in WI.

**Mary**

Why are contraceptive devices limited to one in three years? If one is on Medical Assistance, births should be avoided until a parent can financially afford to raise a family. Why is contraception limited? 8-1-10 effective date of regulation. The state should not continue to pay for multiple births and subsequent support of children while parents cannot afford to have those children and are receiving state welfare. Entitlement has become a way of life for multiple generations in Wisconsin. Some believe having babies is a means of income and a way of life in Wisconsin. Basic should be eliminated and Core Plan should be premium driven. Everyone should pay something, ie. a premium. Copays never get paid to the provider. They are not enough. A premium should be required to stay in the program. Medicaid should be reserved for our sickest, most needy residents, or it will not be there for anyone. Besides looking for fraud on the part of health care providers, let's make sure that recipients are really needy and motivated to find work. If it is a part time job, fine, supplement that job to a living wage. But all should work at something. MacDonalds is hiring!

**Mel**

Yes. Collect the more than 1 billion in taxes now owed by various Wisconsin Corporations; raise the state tax rate on incomes over \$200,000 and corporations, sufficient to cover the shortfall. DO NOT CUT human services, education etc.

**Roberta**

Change MA eligibility for LTC & waiver programs in the following ways: For spousal impoverishment cases have only one asset limit of \$52,000 or less. Get rid of the half a loaf divestment loophole that only rich people who go to certain lawyers know about. Make it a divestment if POA's use their parent's money to hire an attorney so that they can receive half the loaf of their parent's nest egg. The attorney is not helping the parent, they are helping the child POA so using the parent's money to pay the attorney should be a divestment. Make a person in a CBRF pay more of their income towards their care. The MCO's are charging a fixed amount of rent based on a person receiving SSI. (\$750 per mo) People with higher incomes get to keep lots of money & many struggle to keep under the \$2000 asset limit. Rent could be based on the person's income rather than a flat fee.

**Prunckle**

A moderate increase in co-pay would be tolerable. Offering access to more services online or via touch-tone phone menus may generate more cost savings. Ideally the original Universal Healthcare proposed by the Obama Administration would have solved a lot of these problems. Further cost savings could be achieved through streamlining the medical billing process. This would create savings on both ends.

**Thomas**

Too much family care money is going to the middle man .

**Jane**

Yes, please ensure that those who receive services have a disability that prevents them from functioning in the community on their own. Services should be provided based upon severity. Thank you!

**Linda**

Those who can pay should not be charged an amount in order to cover those who don't pay anything. Our premium is high and our son doesn't even get the help he needs. We are forced to have him on BadgerCare because our insurance will not cover him because of his diagnosis of autism. He is one of the healthiest children we have but we pay for a service he really doesn't even benefit from. He gets no help with therapy which is what he does need. If traditional health insurance would cover autism and specific needs rather than putting them all in the same category and then raising premiums so high you can't afford it BadgerCare wouldn't even be a need for us.

**Ben**

Find a way to cover preventative measures for health care i.e., colonoscopies, mammograms, diabetes testing through community health centers.

**Jeff**

More preventative care.

**Craig**

Increase IRIS enrollment.

**Sarah**

I think the RAD (Resource Allocation Decision) Method is highly beneficial to cost savings, especially in the department I work for. I help manage care specifically for people with developmental disabilities, and the majority of my members are high needs, requiring a number of services to meet those needs. I don't know if the RAD Method is used outside of Family Care, but I've found it to be an incredibly helpful tool to determine the most cost effective way to meet a need. I think it would be worth using across the board, if it is not already, and I think providing another training to CMUs on using the RAD method and why it is important would also be beneficial.

**Edna**

The above would be cost saving.