



Department of Health Services - State of Wisconsin Town Hall Results What could the Department of Health Services improve?

Laurel

Give the responsibilities back to the counties that know their constituents and their resources the best. A person has no idea what is needed if they are not from that area. I could not claim I would know what is available in Milwaukee just as they could not be aware of what the people of northern WI. needs.

Bill

A proven cost-effective method of delivering oral health care to children is through school-based services. Smart Smiles in Milwaukee will serve 6,000 children this academic year, 70% are BadgerCare. The program could be expanded if it were financially sustainable. Direct contracting is a possibility that could assure that more funding went to service provision than to insurance program administration.

Health Affairs Article

Bellin Health, based in Green Bay, serves a market of 600,000 patients. The foundation of the system is a network of 117 primary care physicians - along with 41 employer-based clinics, 40 retail clinics in stores, a 220-bed community hospital, a critical-access hospital, a psychiatric hospital, and hospice. Bellin takes a life and health cycle approach stressing prevention and minimizing the likelihood that those who use the system will ever need costly acute, inpatient care. It seeks to engage basically healthy people in new ways and to structure services so that patients can easily access appropriate care at the lowest cost. An example is FastCare Clinics inside retail stores, which are affiliated with medical practices and connected through a system of electronic health records.

Ralph

A Coordinated Pharmacy Program for measurable savings. BidRx + PartnersRx combines old and new. It is the best of old - a traditional prescription benefit with convenient service at over 60,000 pharmacies and new - an online internet based, transparent, information rich, competitive auction system that gets bids from participating pharmacies across the street and across the United States.

Gary

Providers that provide in-patient care for people with very acute behavioral crises and are paid by the admission. They are incented to admit more patients. They provide crisis care for that same population and are paid by the hours of crisis care provided. They are incented to generate as many hours of care as is justifiable. They provide community mental health services in the form of Community Support Programs, Comprehensive Community Services and Targeted Case Management and are paid for every episode of care, incented to provide as many episodes of care. They provide out-patient services in the form of counseling, group therapy and Psychiatry, and paid by the visit.

WHA Medicaid Reengineering Group

It is expected that all hospitals will have one percent of base funding withheld. All funding would be redistributed to hospitals based on a specified formula. Option 1 - Benchmark using Statewide Average: Use of the statewide average does not recognize and reward hospitals for improvement. By using the statewide average, 50% of all hospitals would not have the ability to score for each measure. Assign a dollar value to each measure. If the hospital exceeds the statewide average for that measure, the hospital receives a portion of the funds assigned to that measure. Option 2 - Modified Value Based Purchasing Based on Past Performance: DHS should adopt the same general methodology used for the CMS Value Based Purchasing Program. Credit would be given for high achievement or improvement; whichever is higher. Basing on past performance is not consistent with the principle of providing timely communication to all stakeholders, or with the principle that financial incentives must be tied to the ability to affect outcome. Hospitals could lose funding based on prior years when they did not know what the performance measures were. Benchmarks performance should be the state 75th percentile; achievement thresholds should be the state 25th percentile. Hospitals can achieve the maximum earn back on the measures that are applicable to their patients (i.e. hospitals are not penalized because they don't care for patients in all of the measures). Option 3 - Modified Value Based Purchasing Based on Current Performance: Withhold funds beginning 7/1/12, use 09-11 data as the benchmark, measure performance based on 2012 data, funds withheld beginning 7/1/12 would be distributed by 6/30/13.

WHA Medicaid Reengineering Group

PRIVATE COVERAGE OPTIONS: 1. Strengthen the Health Insurance Premium Payment Program, including using HIPP to subsidize the employer's level of benefits (eliminate wrap around feature), rather than being required to buy up an employer's plan to a Medicaid level of benefits. Allow Medicaid to have different packages of benefits for different populations of enrollees. Explore opportunities to provide other coverage options for Medicaid recipients, including children at higher income levels; and strengthen employer verification of health ins and current crowd out process. 2. Reduce BadgerCare Plus eligibility income limit for children from higher income families. 3. Require 18-26 yr olds to enroll in their parents health ins policy rather than Medicaid. 4. Require DHS to inform all applicants about other coverage options outside of Medicaid/BadgerCare Plus, and promote adequate and affordable private coverage options for low income individuals. .Maximize coordination with federal funding sources such as Medicare Part D in order to find savings in the SeniorCare program. PROGRAM INTEGRITY vs. INCOME ELIGIBILITY REDUCTION: 1. Do not support an automatic reduction in the income limit for purposes of Medicaid eligibility. Decreases in eligibility and enrollment should be targeted to individuals and families that have other coverage options and all efforts should be made to first improve the accuracy of eligibility. 2. Implement processes for enhanced verification of residency by requiring proof of residency at application and/or by reviewing out of state addresses on a regular basis. 3. Implement processes that would better ensure that presumptive eligibility is used for individuals who have significant and immediate health care needs as identified by their provider. Do not eliminate presumptive eligibility for pregnant women whose prenatal care is vital to ensuring a healthy pregnancy. 4. Implement processes related to eligibility for qualified immigrants, such as verifying sponsor income. 5. Implement processes for verification of income of household members, and other self-declared information to improve the accuracy of eligibility determinations. 6. Streamline and consolidate verification process so that rules and policies are implemented consistently. 7. Review the spend down provisions.

Nancy

Any serious discussion of the state's Medicaid program needs to consider the positive impact that Medical Nutrition Therapy (MNT) provided by Registered Dietitians can provide related to cost savings and improved health outcomes. It is an evidence-based component of the medical treatment for managing specific diseases and conditions. Several chronic diseases are amenable to MNT and studies have shown the cost benefit of such intervention: Cardiovascular disease, diabetes, obesity.

Steven

Increased recognition of the value of primary care services. There is a growing body of evidence demonstrating fewer emergency room visits and hospitalizations as well as a decrease in high cost surgical interventions as a result of improved access to high quality primary care services. There are fewer physicians entering primary care fields in recent years, an ongoing and unacceptable trend for the future, both near-term and long-term.

Gwen

I write you today to implore you to stop any efforts either led by yourself or the Wisconsin Legislature that would jeopardize Federal funding for food stamps. Nearly 800,000 Wisconsinites rely on Federal funding to help feed their families, and all the resources used by Wisconsin families participating in FoodShare Wisconsin come from Federal dollars. I am aware that the USDA has informed your administration that efforts to privatize administration of FoodShare Wisconsin would lead to the withholding of Federal funding. We know that there are no state funds to make up for any loss and losing these funds would be catastrophic for low-income Wisconsinites. Participation in FoodShare Wisconsin has nearly doubled over the past few years. The average number of monthly recipients has grown from 372,308 in 2006 to 743,836 in 2010.

Thomas

Utilize a reduced fee model based upon Access Affordable Healthcare.

Survival Coalition

LONG TERM CARE: A. Increase integrated employment services in Long Term Care B. Reduce administrative costs in Family Care, IRIS and Partnership C. Increase utilization of self-directed supports in Long Term Care D. Implement the recommendations of the Wisconsin Council on Children with Long Term Support Needs to streamline services E. Implement a standardized set of performance and outcome indicators for LTC services to improve outcomes and generate cost efficiencies F. Reduce the use of institutions G. Strengthen partnerships with the Dept of Public Instruction and improve accountability and supports for appropriate transition programs ACUTE & PRIMARY CARE: A. Improve integrated care coordination B. Take advantage of savings in health care reform C. Explore arrangements with federally qualified health centers D. Study cost-benefits of referring WI Veterans to federally funded VA benefits E. Explore expanded access to private insurance benefits F. Explore the capacity of private health plans to continue coverage past childhood G. Improve continuity of care and access to eligible benefits for released inmates H. Explore strategies to keep Medicaid recipients from going on and off the program I. Improve the prior authorization process J. Allow direct purchase of durable medical supplies and equipment K. Re-examine the Medicaid hotline L. Keep the door open for consideration of provider assessments COMMUNITY BASED MENTAL HEALTH SERVICES: A. Provide alternatives to existing inpatient and emergency department services B. Increase the use of certified peer specialists C. Increase the use of wraparound services for youth and parent peer specialists D. Expand consumer run recovery centers E. Implement county system changes

Samantha

Cover care by licensed midwives, certified professional midwives, homebirths, and free standing birth center births.

Kari

We have 2 women in our dept alone who work full time. Because they are single moms with young children, they also qualify for badgercare. They are both offered insurance through our employer. They earn a decent paycheck. Why then, are they allowed to keep their children on Badgercare. I see how this system is abused. Our employer does offer very good insurance benefits. Granted, family coverage is \$225 a month. Maybe instead of having these kids on badgercare til they are 18, why not pay their monthly premium for their insurance. I think this would save our state a lot of money.

WI Assisted Living Association (WALA)

1.Providers need predictable rates over an extended period of time or at least through the contract period. When rates change during the contract period providers lack the ability to budget and manage costs over a period of time. 2.An increase in a resident's health due to proper care can result in a reduced provider rate. No pay for performance options in the contracts. 3. Frustration over the duplication over Case Management and RN Management between MCO care teams and provider staff. 4.Concerns regarding the management of waiting lists in counties whose start up or entitlement will be delayed in the next budget. Providers struggle with the destructive impact of the Nursing Home relocation rules which require a stay in the nursing home prior to relocation. Moving people from the AL facility to the SNF to meet a SNF stay requirement only to move back in 90 days is destructive to the person and poor use of taxpayer money.

Erin

I strongly suggest reimbursing Licensed Midwives for services in out-of-hospital settings such as home or free standing birth centers. It will not only save the state significant amounts of money but improve outcomes for mothers and babies.

WI Assisted Living Association

None

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. Examples of successful programs that could serve as models for expansion: PeerLink Project - designed to match a Certified Peer Specialist who is successfully managing his or her own recovery with peers who have been identified by Optum Health (United Health) and who are currently receiving services in identified inpatient facilities or who are engaged in services at the identified out-patient facilities. The primary function is the development of a supportive and trusting relationship between the consumer and Certified Peer Specialist. Milwaukee Crisis Resource Center (CRC) is a community based, recovery oriented alternative to inpatient hospitalization and emergency department visits, that is not only cost effective, but a better service option for individuals experiencing a psychiatric crisis that does not require medical treatment. Provide access to lower cost outpatient mental health services. Expand the mental health benefit in the BadgerCare Core plan to include other mental health services, beyond expensive and often limited psychiatrist visits. The change in this benefit should include coverage for services provided by a mental health or AODA provider (no longer specifying psychiatrist) for a limited number of times outpatient per year, and require Prior Authorization to go above that number. Work with Milwaukee stakeholders to advance the HSRI Plan for redesign of the adult mental health system.

KIT

None

Kathy

Communication between recovery team and consumer is often non-existent. Stop treating consumers as parts on a conveyor.

Sharon

Governor Walker is on the right track, doing a good job. Bring more psychiatrists to WI.

Becky

Stop cutting funding. Money not spent for care of addictions and mental health illness will be money spent in ER, urgent care, and other medical areas for care that is inappropriate, expensive, and does not solve the problem.

Gladys

Transportation to work shops.

Joshua

I am a veteran currently in the VA system. Before I was in the VA system I was in a county DHS. They did a horrible job. They failed to inform me that I was eligible for VA benefits, now which I am 100% compensated for. I went through 3 different doctors, all of them bad. One had terrible bedside manner. The second suggested I stop all medications completely. After pleading with him to stay on, did he only keep me on the meds. Overall my experience with the DHS was disappointing at least. My VA providers are much better.

Wendy

Help employers understand the effects of mental health on their employees, how mental health issues affect work performance, how they may not be able to continue to work and then to provide long term disability so the person does not have to live in poverty, or struggle to survive both mentally, emotionally, and financially.

Nancy

Add more PACT programs for people with serious & persistent mental illness - cost saver. Retain/add Medicaid \$ for persons with mental illness is cost savigns. Enhance community programs to prevent hospitalization.

Jessica

One location to contact where all services help and information can be easily located.

Bobbie

We need care & treatment of our mentally ill.

Adam

Maintain Medicaid for mental health programs

Georgie

Dental care - people need teeth to eat healthy foods. Why let peoples teeth rot? I once was proud of my nice teeth but not any more. Eating well helps mental illness for sure.

Mary Lou

Integrating Certified Peer Specialist into mental health services. As a consumer and advocate I believe the specialists have been important part of my recovery. I plan to become a specialist very soon in order to give back to my community.

Nancy

None

Pam

I think there should be more of a proactive approach to prevent serious breakdowns rather than waiting for someone to hurt themselves or others, and then treating them. The costs of hospitalizations, crisis intervention, police involvement, all cost more than it would to take preventative steps.

Patti Jo

Providers based on outcomes

None

Underwood

Lift the freeze on extended care admissions to Central Wisconsin Center for the DD. We are already paying a bed tax on the unused beds. Putting some of these beds to use should bring in more in federal reimbursement than might be incurred for any necessary increased staffing. The newly expanded and remodeled medical short term care unit at Central Center is sitting unused -- a waste. Is there no longer a need for it or is Family Care refusing to allow families access to it?

William

Balance between needs of people (i.e. those who cannot help themselves) and those who pay the bills - (i.e. govt & business/special interest), and those able to pay taxes but at the same time best able to avoid some.

Sara

Call for a task force in Dane County, lets get moving forward. (consumers & advocates) We need to get moving on the exchange program in Dane County. Lets not get behind! 2013 is coming.

Phyllis

I have received referrals as a nurse provider from Community Care of Central WI for people who have Medicaid. Working with CCCW has been much more easier and efficient than working with the offices in Madison.

Alice

None

Pattie

Continue Mental health dialouge. Comprehensive Community Services in Wausau is a system which effectively helps to move back to independence.

Marilyn

The new privacy law went to far and tons of people are falling through the cracks because no one can get help until they are in crisis and parents and friends are held in suspension unable to connect with professionals.

Falon

The Department of Health Services could provide more choice to women giving birth.

kara

Allow home birth with a Certified Professional Midwife to be covered in the state of WI. It is a safe and cost saving method to provide births that is family friendly and safe.

Sheryl

Make any increases in copay means tested. Any copays is difficult for those who have virtually nothing. If they can't get services because of lack of money for copays, access to proper medications (treatment) is worthless and a waste of money if there can't be consistent treatment. Medicaid patients don't have choices in treatment providers so they aren't empowered (in self direction). Penny wise, pound foolish would be to restrict or eliminate services to acheive cost savings and then have to pay for more jail services, pay more for emergency room services, etc. We need to expand the PACT program for consistent treatment in the community.

sandra

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

Underwood

ICF/MR Restructuring Initiative is costing increased Medicaid funds. The relocations are not necessarily voluntary -- voluntary is a misnomer if you have to relocate because your home is closing due to inadequate Medicaid reimbursement and the ICF/MR bedtax is financially strangling the ICF/MR to death.

Dylan

Add more Pact programs

Carrie

Knowledge of and increased support/finances on agencies/programs that support/advocate and assist individuals with mental illness. In the long run, these programs save a lot more \$ as these individuals are less likely to have as many crisis situations, therefore will not need as many hospitalizations.

Mike

Regionalize the services in WI. 72 counties create way too much overlap. For instance, reorganize around Lake Winnebago Area from Fond Du Lac to Green Bay and combine services.

Richard

Wisconsin should be planning the Insurance Exchange for the new federal insurance program.

Elissa

rTMS (repetitive transcranial magnetic stimulation) should be covered for depression. It is safe and effective.

Diann

Get going on setting up the insurance exchange needed for when the Affordable Care Act takes effect. Set up the exchange so it is fair to people with mental illness and addiction issues.

Terry

Utilize peer specialists where possible. This really does work and is cost effective.

Crystal

Better treatment & approachable care

Justin

Information dissemination

Self direction generally good model - need to consider however when people are most ill and need most help they are the least able to appropriately direct their own services.

Phil

Keep level of funding to medical services at same level, particularly to those with greatest needs: mentally ill, poor, and children.

Paulette

Please don't stop funding medicaid for people who have been identified with a severe mental illness. My son didn't ask to have this terrible illness and he needs this money in order to get his medication. His life would be greatly changed if he cannot get this benefit. Work on research to help mental health diseases.

Ava

My largest fear is that I will lose MAPP. I do pay a premium for my Medicaid premium (\$25/month). About a year ago I went off of SSDI and returned to work full time. It is because of a medical procedure I receive that I am able to work full time. But if I no longer had MAPP which pays for these treatments, I am certain that I would once again have to go back on SSDI, would no longer be able to work, would have to move back into subsidized housing and be back to an in and out of the hospital lifestyle. Please do not end these programs and the access to these programs. Persons with mental illness can and do recover, but we still need our medications and ongoing care to maintain our wellness.

Ann

Be sure folks who have very low income (especially with children) have continued Badger Care pretty much as is for health and dental care. Try to get more dentists to accept BadgerCare.

Underwood

Reevaluate the special nursing home rate reimbursement formula negotiated with the federal government decades ago by which the State Centers for the DD are reimbursed at a higher rate than non-state ICFs/MR. Are non-state facilities providing the same level of care as the State Centers and thus would also qualify for the same level of reimbursement?

Terri

I would like to suggest two items as budget efficiencies that could be adopted by the Department, 1) require a minimum amount of time from an internship/fellowship/etc. before accepting student or other non-paid volunteers and 2) have a minimum dollar amount threshold for the receipt of gift and grant funds. In order to accept student interns or volunteers and give them the network access they need; they must be entered into PIVS (Payroll/Personnel Input Verification System). There is paperwork involved in obtaining network access, HR staff time entering them into PIVS, keeping track of the arrival and departure dates and ensuring that related costs are charged to appropriate programs. With HR staff already stretched thin, it seems as though it is not the most productive use of time for them to be doing paperwork and PIVS entry for people who are only working a couple hours a week or may only be with DHS a couple of weeks. I suggest that before unpaid staff be brought on board, there be a requirement to do a minimum number of hours of work per week and/or for at least a minimum number of months. Or conversely, DES or some other entity come up with a less cumbersome way for them to get network access. While there is value to having these students/fellows/etc. there are also costs. Though they are not salaried, they are not free. It is likely that there would be push back from UW School of Medicine and Public Health, since this is how students and a future workforce get some practical experience, but is it cost effective? It also takes staff time to train and supervise. Is it an affordable cost? All gifts, interagency funds and federal grant funding provided to DHS need to be reviewed in a manner that evaluates not only the benefit of DHS receiving the funds but also the costs of receiving such funds. It seems that there should be a minimum level of funding coming to DHS to make it fiscally responsible for the department to accept funds (i.e. gifts or grants smaller than \$10,000 or \$25,000 or some other figure cannot be pursued or accepted). When analyzing the cost benefit ratio, it must be recognized that all grants and gifts received hold inherent and minimal level of costs (BFS processing, Operations staff time, DOA infrastructure costs, etc.) and one of the most overlooked costs, staff time to write, review and submit grant requests and process the resulting paperwork. With less and less staff available, it is time to make some difficult decisions. DHS must critically assess the cost/benefit ratio of each grant application and determine if pursuing the grant and gift funds is the most prudent use of scarce staff and resources.

Sherry

I would like to suggest overall Admin efficiencies in the area of technology. With less staff and more work there is efficient technology currently in use that we could utilize and we are not. I think PTAWeb should be incorporated throughout the department. DPH, doesn't currently use PTAWeb because of the nursing schedules or some issue with differential, but DOC has the same issues and they have PTAWeb up and working for them. DCF has set up a system to allocate costs based on PTAWeb. This would eliminate DOHAAS altogether. Once the funding string was entered into PTAWeb, the system allocates the cost/fringe to that particular funding string. The only manual entry would be the JV's. This would free up a lot of time and quite frankly, be more accurate than DOHAAS is right now. DWD has a system set up called PAL (procurement accounting log). DCF is currently purchasing it from DWD. This makes the whole aspect of pcards electronic. Currently, each unit has to have several pcards because the cards are funding string specific. The billing process is cumbersome and problematic. In PAL, you can use one card for several different funding strings. The charges come through in a clearing account (electronic from DOA) and the card holder can go into the system and apply the funding strings to the specific charges. Then the supervisor electronically approves and it is complete. This would free up a couple positions. There only needs to be one person managing this system instead of three. Electronic signatures travel reimbursements by supervisors and employees can be electronically approved via email. The employee can forward a reimbursement to the supervisor and the supervisor electronically approves it by sending it to BFS. This can be the process for other things such as travel.

Chris

During the last biennium, the Doyle administration had set forth a proposal to consolidate all Human Resources functions. To that end, a realignment of HR services was initiated and was well underway. As part of that process, a committee was formed to discuss standardization of policies and practices, efficiencies, and overall operational improvements. The committee compiled a lengthy list of ideas, all of which appeared to be feasible and easily implemented. However, when the realignment process fizzled away, so did further discussions of any changes to established policies and procedures. In short, any talk about improving HR operations was shelved. Even in the absence of a mandated realignment, there appears to be nothing that precludes implementation of the proposed changes. While these changes may not have a direct budgetary impact, they will improve operational efficiency. My suggestion is that we continue to move forward with discussion and implementation of the improvements within the Department.

Kristine

1. Consider the state health plan, Healthiest Wisconsin 2020. It builds on the scientific analysis from the HW2010 effort to address the drivers of costly and high impact illness rather than specific illness by analysis looking at both prevalence and severity. The plan addresses both health and infrastructure priorities to help Wisconsin work toward being a more healthy state (which translates also into more productive and less health care costs.) The issue of 'implementation of the plan' calls for increased working partnerships with multiple entities and partners (including non-traditional partners such as business) to carry forward known best practices and work collaboratively in alignment to mitigate these major health drivers.

DHS alone cannot 'fix' these issues, but can be instigators and conveners to initiate collaborative efforts. 2. Wisconsin is number 1, regrettably in binge drinking (including youth and pregnant women). The data and multiple painful realities of the costly impacts of this has documented for a long time. I somewhat recall that Wisconsin has one of the lowest beer / alcohol tax rates in the nation and has not raised said taxes since sometime in the 1960's. There could be a large amount of money made available, perhaps justifiably so, by increasing taxes on this non-essential product that has proven so damaging to state citizens. You might consider talking with OPIB for further information about the costly impact of AODA in our state. 3. Wisconsin ranks extremely high as a state with lead poisoned children. The taxpayer cost savings of fixing this problem would be in the hundreds of millions, some projections indicate billions of dollars over time. In January, a report was submitted to address a legislative joint resolution to discern some possible solutions to this problem. The hidden and unexpected costs of lead poisoning include increased violent crime and incarceration rates as well as increased school costs as the brain damage caused by poisoning both reduces learning capacity and capacity for focused behavior. 4. Data exists to support that public dollars are saved when people with disabilities are able to hold jobs rather than simply being 'supported'; also they are valuable contributors to society. We also see the same with efforts to help people who are deaf and / or blind to become as self-capable and independent as possible. 5. Some of the newest impressive research coming from Canada and other states is the HUGE cost savings that businesses can accrue by being mentally healthy work places and providing mental health care parity. The statistics are startling that at any time one in four / five people is grappling with some mental health issue. Granted this is inclusive of more than only the serious and persistent mental illnesses like schizophrenia and bi-polar, but can have a profound impact both on worker capacity as well as the bottom line. In a societal climate of stress as during a financial recession, stress-related concerns are inevitably high. 6. The original state Community Options Program was lauded broadly years ago and successfully replicated in Australia. While I am less familiar with Family Care, with the burgeoning population of elders, safe and less costly home and community options to nursing home care will be essential. Talk with DLTC who can provide more current detail. 7. Grants. A mistake made during a period of the Doyle administration, was to not allow any staff increases EVEN IF the money came from grants. This resulted in the loss of thousands (more?) from grants that would have been fully funded by outside sources, provided in-state employment, AND helped to address an issue of importance to the state and our department. The issue was later rescinded clarified by DOA but was addressed but only after grants were lost. Judicious care in stating policies is warranted to avoid a similar costly error.

Robert

I suggest we move towards converting our accounting system over to the state-wide accounting system. It would be a difficult task as people are familiar with the current system and would have to adjust to a different system, as well as information being presented in a different manner but in the end I believe it would be to the benefit of the department to do so. Some of the benefits: Reduced mainframe processing time (we are currently charged for processing transactions through both systems). Reduced storage costs (the same accounting data is stored in both system albeit in a different format). No reconciliation between two systems to ensure that everything that goes into one goes into the other correctly. Would free up technology folks currently operating the internal accounting system for other worthy IT projects. Ability to accept transfers from other state agencies who are readily familiar with a system used state-wide. Some of the costs: Confusion with new system would likely slow processing down initially (perhaps for a few years). Staffs that deal with the accounting information would need to learn a new and different chart of accounts. Many automated feeder systems would need to be re-engineered to feed a different system. Once our staff becomes savvy with the state-wide system their ability to change jobs to another state agency is enhanced. The long and short of it is I don't see short term savings and there may be increased costs and confusion as something like this is attempted but long-term it would position us to be more efficient, have better information and be on the same page when another accounting system is installed since the state's solution could be our solution.

Steve

FAMILY CARE: Reduce the number of nurse care managers. This is frequently duplication with what agencies can provide and with the social work care manager; they do not do any real nursing, and many enrollees do not have complicated medical concerns. One director of nursing and one or two assistants, depending on how large the enrollment base is, would be sufficient to provide the nurse care management consultation. The caseloads for all care managers can be increased. Create single service care managers with very large caseloads-100 or more. When an enrollee gets all or almost all of their services from a single agency such as a CBRF, AFH, or nursing home or just gets home health, personal care, or workshop services, there is little case coordination needed since that is all provided by the agency serving the person. The CM needs to monitor for quality, participate in care planning, and review the services provided. Given this the caseload can be specialized for these types of enrollees and be significantly larger. Sub-capitated arrangements with contract agencies should be tried. Under this arrangement a provider would receive a capitated rate for X number and types of participants and would then have the flexibility to determine the best way to provide and pay for the services. The provider becomes much more of a partner in developing cost effective service strategies. Administrative costs of the MCOs should be defined and limited to a reasonable percentage. The costs of the MCOs keep increasing while provider contracts are reduced. In the long run, there will be many fewer providers and much less consumer choice. Reduce the number of MCOs. Are 11 really needed or would one per DHS region and Milwaukee be sufficient? This would help reduce overhead costs. Reconsider the franchise approach. One system for all MCOs for billing, monitoring and reporting costs, auditing, etc would be cost effective and make it easier for providers to work with multiple MCOs. MCOs need to work with providers and cover reasonable costs. If this does not occur, the number of quality providers will substantially decrease and costs would then have to go up. For some providers where direct care staff is making around \$8.00 per hour, there have been no raises for the last three years. DHS should consider completing the state for Family Care. This lowers the cost for the current waiver participants and would eliminate sooner the need to maintain the management of a number of HCB Waivers for adults. If funding is an issue, the waitlist could be addressed over a 4 or 5 year period except when more people could be added through attrition. Maintaining two adult LTC systems is very inefficient. Consideration should be given to privatizing the administration and management of Family Care and Partnership. Only a few contract managers would then be needed at the state. Just like EDS does claims for Medicaid because they specialize in this, an experienced managed care management agency could manage Family Care and Partnership. CBRFs should begin at 7. This would allow for AFHs up to six people and reduce costs without impacting quality. Reduce the regulatory burdens on CBRFs, relocation procedures, Personal Care, and the many other provided long-term care services that would help to decrease costs. A provider, state, consumer, and MCO taskforce could help to determine where this should occur. Better communication between CMs and provider agencies would help improve the program. Providers, participants, guardians, etc need to be very involved in care planning, functional screens, personal care screens, etc. At times these items are performed without anyone involved who really knows the person. In order to capture all of the possible Medicare funding that may be available and use it to offset state Medicaid costs, a model that integrates long-term care and acute and primary care may need to be considered for all participants. It has long been documented that Family Care saves acute and primary funds more than long-term care funds. If this continues to be the case, then gaining more Medicare funds would even be more cost effective while reducing the overall usage and need for acute and primary care. IRIS: ADRCs need to be much better informed about IRIS and make sure all possible Family Care enrollees are fully informed about IRIS. Every ADRC should have at least one staff person who is intimately knowledgeable about IRIS on staff to help those interested in knowing more about and then possibly enrolling in IRIS. Quality monitoring of the ADRCs needs to occur around this. The functional screen process needs to be uniform. There appears to be inconsistency in functional screen outcome for similar participants. For IRIS to work effectively, the functional screen must be very accurate. IRIS enrollees or potential enrollees may need more help to get started or even on an ongoing basis than can be provided by the Independent Consultant (IC). Private support brokering services should be encouraged in these instances, which may make many potential participants/guardians much more comfortable with IRIS. The cost of the support broker service would come from the participants' IRIS budgets. Periodic review of all IRIS costs should be completed on a regular basis. Creative strategies should be used to reduce the need for higher cost services such as when 24 nursing is authorized but not needed, but a lesser service such as supportive home care or personal care cannot be authorized. There have been frequent comments made about the IRIS Fiscal Agency. A review of the cost effectiveness of this agency is needed. Possibly this service could be provided more efficiently and at less cost. Timeliness with changes can also be a problem. The IRIS program should develop ways for participants to contract with agencies for packages of services. The participant could still terminate the agency if they were not satisfied and go with a different provider. The state would need to help develop agencies that could do this. This package could also include service coordination. This may also give potential participants/guardians more comfort with the IRIS program. Only agencies that see the participant as a partner could be involved this way. Participants would be better served by a

directory of potential provider agencies and by being able to speak directly to provider agencies. IC staff also needs more information about provider agencies. ADRCs: Some costs may be able to be reduced by reviewing the caseloads and the volume of inquiries to the ADRCs. Also a review of how the initial calls are processed, either by an I & A staff person or the receptionist, may lead to a method that would be the most efficient. As noted under IRIS, more knowledge by all ADRC staff about IRIS is needed and at least one staff person is needed who specializes in IRIS. The state should also consider providing more flexibility in the management of the ADRC. Combining ADRC management with the Aging program or another county agency program may help reduce costs. It is very positive that the remainder of the state is being funded for ADRC services. This will help to support more people choosing IRIS if done right.

Carolyn

Limit the number of burial trust and burial insurance a member can have. There should be stricter penalty when a customer sells or divests their property or home while in the programs and they fail to notify the agency of the sell or divestment timely. Review the number of hours each customer is receiving, put some kind of checks and balances in place to make sure a member is not getting more hours for care and work than needed. Often ESS hear of member being given hours for work and the work is not getting done or work is done by the customer and the customer and employee splitting the check. This is one of the biggest rip-off out of the 3 programs. Iris should be over hauled right now we have a number of people applying because they think that they are going to be getting the checks to do whatever they want with them. Some customer look at Iris as extra income to use as they please. Maybe the agencies need to explain Iris better. People reapplying for Iris should be assessed especially the disabled child and young adults who have not been assessed since they were determined disabled. Some have grown out of their disability or improved and do not need a lot of care. But due to not being assessed they continue to get a lot of hours for their care because they were determined disabled. The guideline for senior care needs to be changed, member should be tested as any other Medicaid program. There should be stricter penalties for members who do not disclose all of their income and assets when applying for Senior Care.

Elaine

Recently, I received information from the County that new applications for Family Care will be placed on a waiting list. What about the private pay resident who has been paying privately for CBRF services for years, and now has depleted his/her assets? Many of these residents have lived in the group home (CBRF) for years, paying privately and now are turning to Family Care. If the proposal should stand as is, these residents would need to leave the group and have as their only option, placement in a nursing home. I own a 20 bed CBRF. Twelve of the 20 residents are private pay. One 85 year old man has lived here since 2002. He has done the right thing- paying privately for his services, but is now at the end of his assets. His daughter called me frantically when she heard about the proposed change in application waiting periods. He will be forced into a nursing home, as he will be on the bottom of the waiting list for family care. His daughter stated that he will die if this happens. Please, provide a provision for grandfathering those residents who have paid privately in a CBRF and now consider the group home their home. There must be a way that these individuals can have services funded without having to enter a costly nursing home. It would be immoral to have it otherwise. Thank you

Tracy

Cover out of hospital births with Licensed Midwives.

Michael

Providing access to licensed professional midwives outside of a hospital setting (birth center or home-birth) is a healthy, low cost option for the vast majority of expectant mothers, and would not only improve outcomes for mother and baby, but save money as well.

Robinson

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. I had my baby at home with a Licensed Midwife, it was the best experience of my life (and very cost effective). I have friends with Badger Care who were not able to deliver their baby home because of their insurance. This system is completely backwards, if a woman chooses to birth at home she should have that option.

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 to 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: o Hours are not regulated o Documentation is not reviewed o 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. Principals 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

Christi

Require individuals who receive Medicaid to prove their US citizenship. Find a way to prevent Medicaid recipients from receiving increased benefits when they continue to have children they cannot afford. Individuals who are truly disabled can earn some money every year without their Social Security Disability benefits being reduced; can't we do something similar with Medicaid? Might this not encourage capable people to work rather than stay home and receive benefits? Re-evaluate Medicaid recipients eligibility and give a reasonable timeframe for them to 'get off' Medicaid. Require Medicaid recipients to contribute to the community in a way that is feasible for their individual medical or family circumstances. Require Medicaid recipients to make co-pays for Rx and Dr visits, eyeglasses, medical equipment etc.- a parallel to what working citizens have. Eliminate emergency room access for medical issues that do not meet 'emergency standards'.

Otis

Explore more cross agency collaboration in using information technology. Explore what other states have done. Pennsylvania is a great model of efficient use of IT. They are paperless and they have a lot of resources. Their processes really help the entire state. There should be more collaboration between states to learn from one another so we aren't always recreating things. This would make us more efficient. If we could better use technology to deliver what we need to do.

Scott

There is little to no accountability for the delivery of quality mental health and substance abuse services. Public sector programs (and private sector too) are reimbursed for services - no questions asked - based on a unit of service, not outcome. There is a gap between what works (evidence based services) and what is typically delivered.

Brad

1. Incentive for adhering to medical care (e.g. missed appointments, missed meds, etc). 2. Telehealth 3. Services to persons in the criminal justice system and to homeless: e.g. mental health courts, SOAR, expedited disability determination. 25-30% of homeless are persons who are mentally ill. 15-20% of persons in jails and prisons are persons with mental illness. 4. Supplemented employment is an evidence based practice which could be expanded substantially in WI. 5. Efficiencies in documentation at the provider level (e.g. redundant care plans). 6. Caveat in performance based contracting is the potential for creaming: taking easier clients without serving the deep end folks. 7. Fund family planning.

Liz

We need to do a better job as a state and department at managing outcomes for vendor contracts. Invest in business process improvements -we have spent lots of money on duplicated or redundant work. If we were staffed properly we wouldn't have professional staff spending too much time doing administrative work.

Eleanor

Seen very little hiring and still doing just as much work if not more than we were doing 6 years ago. We are spending too much time manually entering time. DOHAAS it is a reporting burden that is a waste of time. There needs to be a more efficient way so people can spend more time doing their job. Tracking grant money and time put in -no accurate way to determine how we charge for time and how will be paid until year end.

Ted

Studies were done by DOA and found that sharing resources for campuses did save money. In one example the VA was not interested in sharing, so they did not follow through. It seems like something we should push again to do because of the benefit.

Ted

All of our campuses are shared with other departments. We could look at sharing functions within the facilities too. We share maintenance, we could also share HR or Admin functions too. Sharing support would share dollars and save. Food service operations are something else that could be shared.

Rita

Studies were done by DOA and found that sharing did save money. In one example the VA was not interested in sharing, so they did not follow through. It seems like something we should push again to do because of the benefit. Work with DOA to share vehicles. We have saved costs with teleconferences and such, but sometimes traveling is necessary. When state cars are taken away from the department people are forced to take their own separate cars. We are reimbursing individuals for this instead of saving together. DOA won't let DHS own our own cars.

Karyn

A few years back the state was asked to do a cost analysis of contracted verses public staff. At times it seems cheaper, but not always. It seems like there has been an increase in contract staff. As we look to the future will we continue to look at the cost analysis again? Why do we use contract workers when sometimes they are more expensive?

Audrey

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 prterm births, two of the leading causes of infant mortality as well as the long term-cost associated with maternity care.

James

The department of Health Services could include Licensed Midwives as Badger Care providers.

Savita

Please include WI Licensed Midwives as eligible badger care providers.

Melo

Maternity & Childbirth

Smith

DHS should allow coverage for direct entry, licensed Practical midwives to provide maternity and delivery services to women in their homes. Home birth is safe, efficient and will save tax payers thousands of dollars. By not allowing home birth (which costs only btwn \$1500-3800 in Milwaukee compared to the \$7000+ bill a hospital charges) women are at a disadvantage and discriminated against for making their own medical choices. Women who are on Badgercare and desire a homebirth are encouraged to spend more tax dollars due to not being able to afford health care.

Maureen

None

Prown

By authorizing reimbursement for Licensed Midwife Services under BadgerCare, the Department could save taxpayers thousands of dollars in unrealized savings each year as well as improve birth outcomes for low-income families, which in turn lowers the long-term costs associated with maternity care. Please see a summary of the research in question 9 below. Note that the State of Washington's Licensed Midwife program referenced in question 9 is of the same size and scope as Wisconsin's program, but Washington spends roughly ten times as much as Wisconsin does in administrative costs, yet the program still saves the state ten times the cost of paying for it. So the Washington numbers are a conservative estimate of the savings that can be realized in Wisconsin.

Tehmina

I am writing to you today to request that the Department of Health Services offer Licensed Midwives(LM) to be an eligible Medicaid provider in the state of Wisconsin. 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. This is not only a cost saving suggestion but also increases women's access to quality care, providing more choices and a healthier community. Thank you for your consideration.

Carrie

Residential rate setting (to get costs under management), NH relocations, care transitions, prevention activities (evidence based very promising)

Katherin

electronic time sheets, consolidate fiscal services for grants and awards from federal agencies, conserve paper, fewer printers, get rid of styrofoam in cafeteria, we will save money by funding family planning and reproductive health services across the state, preventing unintended pregnancies, STD's, health screenings for men and women. Slashing Medicaid/BadgerCare will deeply affect our poor people.

Gerald

I would like to add the following suggestion about how the DHS websites are administered and maintained. DHS needs to stop using the current de-centralized system of content publishing and put into place a system where trained professional, department web coordinators and technicians work efficiently using professional web authoring tools to design, develop, and maintain the DHS internet and intranets as examples of exceptional standards-based web sites. This work needs to be done by professionals in full-time positions. This will help the Department's budget efficiency efforts through added efficiencies in time, cost of labor, reduction in travel and training costs as well as other economies-of-scale in staffing. As of now, DHS uses a de-centralized system of content publishing with most web author duties assigned for a very small percentage of time daily or weekly. Web authors are trained to use the outdated program Microsoft FrontPage 2000. Consequently the WYSIWYG ('What you see is what you get') editor FrontPage 2000 has made the DHS website display correctly only in older, non-standards-compliant versions of Internet Explorer (IE6 and earlier), while resulting in the DHS websites not being compliant with the web standards of today's world. Note: the browser loaded on your computer here at DHS is IE7 which is not a standards-compliant browser. More and more, the internet is moving toward standards-based web design as defined by the World Wide Web Consortium (W3C) (<http://www.w3.org/Consortium/>). As the web has evolved, so have the needs and expectations of our department web coordinators, authors and technicians. We need to take the DHS websites to the next level by transitioning very soon to standards-based practices based on today's standards and technologies. With more and more of our population depending on the web for information exchange and training we need to be on the front edge of the 'internet technology' bell curve. We can not be a leader when we are using web-authoring software that was first released for sale in 1999 and is so out of date that it is not even supported by Microsoft anymore!

Kathy

For clients - allow for trained staff to provide care for adults (older kids) with autism. This group of people need specifically trained staff to teach daily living skills and job coaching. Using evidence based providers BCBA's will improve outcomes. Our current model does not pay a professional wage.

Chuck

Use of UW Platteville Engineering students.

Scott

SBIRT is an evidence based, cost effective approach to reducing risky drinking and illicit drug use. Because of it's cost savings and contributions to a more productive workforce, the Wisconsin business community would like to see SBIRT in health plans. There is currently a Medicaid benefit for SBIRT, however, there are no quality assurance mechanisms in place to ensure that services are being delivered adequately.

Alicia

I would suggest that we invest money into our fraud and investigation units. I think the public views our programs as a joke, they're not afraid to lie and commit fraud because they know people get away with it everyday or they themselves test the limits and get away with it. I think we would decrease enrollment significantly if we concentrated on this effort.

RITA

We need to cut back on who gets coverage, WI. is broke and we need stricter laws to ensure the person is no illegal and also not reward females for getting pregnant in order to get on Medicaid and get coverage with a ss#. We have our own we need to tend too and not take on any more mouths to feed.

Reggie

The guides line in the funtional tool. Saying it should only take 5 mins to clean and wask the floor of a bedroom when it take a half hour. Some of the time you set are not working for me. They are cutting my hours and it is not working for my daughter and my self.

Jennifer

IRIS -Self-directed care is heading in the wrong direction. For a few it may be helpful, although for many it is putting them in a tough position. Many are elderly, forgetful, and/or vulnerable. They are suffering from chronic health issues and in no position to direct their own care. Their workers may not show up or do a good job but they rely on them in order to remain in their own homes thus do not report them. Also, who do these independent workers report to? In a licensed home health agency, there are strict regulations and licensed nurses providing oversight. We are surveyed and held to high standards. It is concerning to see IRIS workers not following any infection control standards (glove use etc) or not having anyone to report skin breakdown and ulcers to. In the end, there are patients that may not be making the best decisions now in charge of directing their workers whom are unsupervised, unlicensed, and can easily take advantage of the clients. Also, for amounts of time authorized - IRIS or self directed PC is allowing a significant increase in personal care hours in comparison to what agencies were saying was reasonable and necessary. We are seeing workers out in the homes, using such time to read papers, talk with clients, watch tv with them, bake cookies, etc. Yet another reason that a client will choose to protect the worker and their self-directed time. A client would much rather bake cookies than complete ROM exercises. FAMILY CARE -Adding RN and SW case managers plus supervisory/administration oversight via Family Care to the MA system is wasteful and just duplicating services already being provided. For our county, we are very small. We used to be able to walk across the hall, discuss a client, and solve a problem. Now we have to share all information with another case management team and wait for them to tell us if a service is reasonable and necessary. Physicians now have case managers calling and making requests in addition to providers. Overall, it has just made the process complex and has not provided any cost savings at all. Locally, our care management organization saw a budget shortfall and ironically turned that around the following year. How? By cutting services and equipment to it's members.1. Require that state administrative costs for Family Care be identified/segregated going forward (currently buried in T-19 general), so you can know the real cost. This includes state staff time/task reporting (just adding a seperate code for Family Care).

Wilmot

Identify and provide services to individuals who truly need it.

Dan

If eligibility for BadgerCare+ will change, it would seem prudent to have a provision that permits persons who pass the LTC or MH/AODA Functional Screen remain eligible for Medicaid. These persons may or may not meet MAPP criteria for Medicaid eligibility because they may earn too much money. If they lose eligibility and are no longer able to afford necessary medications or treatments they may decompensate or medically or physically deteriorate to a point where they become disabled (which also may result in a loss of employment and payment of taxes). I believe this would result in higher costs long term for the state, as well as an undesirable outcome for the persons. It may be appropriate to consider including persons who have received MH or AODA services from a county or may be viewed at risk of passing the functional screen as well.

Streamline the appeals and grievance system, implement lean government standards & provide staff with efficient training to be effective workers, quality oversight on IRIS. Align screen with eligibility requirements in statute, improve data systems so we have real time data vs. 6 months old.

Christine

Ensure individuals do not linger in nursing homes due to lack of case management, adequate discharge planning, or just lack of paying attention. Analysis of cost effectiveness of purchasing durable medical equipment and doing home modification compared to cost of PCW's and supportive home care over time.

While you like IRIS, the program has huge problems. I would suggest a LAB review ASAP, especially before you increase IRIS 3X. There is a huge lack of oversight, consistently in funded care, etc.

Lisa

Increased funding for prevention based early intervention programs. What are your strategies to engage entire community representation?

Barb

Evaluate independently the need for personal care services rather than allowing providers to do this. Coordinate similar services, homemaker services, from waiver services. It is confusing to providers and members about which program covers what. Refocus on using home health agencies for providing multiple levels of care vs. private duty nursing independently.

Nancy

Identify high \$ catastrophic cases and outsource their managed care to specialists who manage catastrophic cases as a business.

Margaret

Look to nursing to provide quality care, reduce health care costs, and treat the whole person in collaboration with other members of the health care team. Evidence for nurse run clinics around have data to prove outcomes: Silver Spring, House of Peach Nursing Center. Since people live in communities and not in institutions, can we look to strong health care delivery system that aligns FQHC's, local health depts, advance practice nurses and primary care docs.

Houston

Keep BadgerCare, SeniorCare, IRIS, Long Term Care via COP, CIP, and Katie Beckett.

Margaret

Improving the health of individuals and families contributes to the health of the community, and improving the health of the community contributes to the health of individuals and families. This relationship is interdependent and interwoven. Leadership on this speaks to the core of the DHS mission.

Tammy

Can you set up a website so people can submit their story or response to proposals?

Brad

Focus on Medicaid homes or health homes to ensure that physical, mental and substance use health conditions are treated in an orchestrated and coordinated care management system. Focus on outcomes. Focus on community care over institutional care. Do not introduce system or policy changes without ample input from the public, from localities, and from experts.

Jamie

Follow up on SCAODA letter to chancellors on the need for more AODA/MH therapists. Substance abuse prevention, intervention, and recovery are growth industries. More web based meetings and trainings.

Rich

Look at how we can better partner with employers on how we can offer health care. Most of the people on our programs are employed so if we provide incentives to employers that could help with cost savings. Maybe provide tax incentives. We could have a collective approach. Preferred drug list could help save money with negotiating. Have higher co-payments for non preferred drugs. Do cost savings, don't increase premiums. Administrative savings: if directors had more control over their own budgets and positions they may be able to help with maintaining savings goals.

Kim

Streamline the eligibility and enrollment process for customers accessing managed long term care and IRIS.

Charles

A couple of items from an IT prospective is data governance and naming conventions. These may not seem huge, but when data elements are called many different things or the name is confusing, there is much time spent in researching what it is. For example would you say county_res is county of residence or county of responsibility? Should county code be three digits or two? Should county be county or cnty? Without consistency within databases that should be talking to each other there is repetitive interpretation and research that needs to take place with multiple analysis involving different resources. Even with good documentation there is still effort lost to ensure what the data element is representing if it is not intuitive or consistent. I believe there would a cost savings in development and analytical work with an aggressive data governance effort to address ownership, consistency and impact on department goals both short term and long. The decisions for consistency and naming conventions should apply also to vendors doing development work for DHS as part of the contractual agreements. Identify redundant functions or development of applications. Since the state, particularly DHS, has paid for the development of many applications by vendors, the code should be owned by the department and the department should have access and be able to reuse it for other applications. For instance, if an application has a great client registration entry screen(s) and the department needs to develop a new application or enhance an existing one, it seems logical (hopefully legal) to take existing code and plug it in or use it as a starting point (not necessarily using the same vendor). If most client registration screens had the same or very similar code it would be easier to maintain and enhance.

John

Better/increased utilization of Workers Compensation Insurance for participants.

Will

We could collect better data by requiring client level data reporting to draw down state aid to counties (community aids).

Amy

If the asset and income limits could be higher for eligibility of Medicaid programs, so that consumers wouldn't need to be impoverished before they become eligible for benefits, consumers would have more options to staying in their homes or apartments and prevent institutional medicaid.

Lori

Get doctors to treat and find the cause of an ailment on the first visit instead of having the patient come back multiple times for the same problem. The office visits for repeat health problems has to be a huge expense. I feel it is an abuse of the system by doctors who knowingly not treat the person who is on state health insurance and do not do the lab work or other necessary tests on the first visit for that problem. These doctors are eating away at the system and patients are suffering too. I strongly feel that there needs to be a better system for mental health patients. Not providing/approving through the pharmacy the medications which were prescribed by the psychiatrists at DHS is only incurring further medical visits, paper work trail and costs per patient. It is increasing the patients risk for excacerbating their mental illness due to delay in getting medications and or therapies. Patients cannot just STOP taking their medication. St Croix county is growing and developing fast and there needs to be an improvement in access to care in this county. Dentists which take the Badgercare is desperately needed as well as inpatient mental health facilities and therapy centers.

Marjorie

Significan savings could be achieved in home care etc, by adopting the Family Care program statewide, especially in Dane County. By capping Family Care we will experience higher costs because people will have only one option - going to a nursing home - when they need long term care services. IRIS is often not as cost effective as Family Care.

Leibfried

None

Kathryn

1) Timely, accurate information in simple language for changes that will be happenning to the program.2) Timely, accurate information to providers about upcoming changes, so they can be shared with consumers PRIOR to implementation.

Kristina

SIMPLIFY enrollment, higher reimbursement for dentists so that more people have access to preventive dental care-would save the money we spend for Medicaid emergency dental care (abcessed teeth, root canals,etc)

Andrew

(1) Fund services that give the most bang for the buck. (2) Pay enough so that mental health providers can afford to see patients who are covered by state programs and Medicaid in general. Medicaid and state programs pay about 25% of usual and customary rates, reducing my income to slightly more than minimum wage after expenses.

jennifer

Iris-some people get a ridiculous amt of money and the guardian is becoming greedy and pays themself double as what another respite provider gets and claim the person needs 24 hr care but actually does not...some of the funds are used for \$300/mo worth of doll clothes, toys and another chunk like this for clothes for the daughter. Excessive and waste of taxpayer money in this case. BC-All children should be eligible with no copay for visits. All adults should have copays on every clinic, urgent care, ER, specialty visit. They should be allowed to pay extra if they are putting themself at high risk for disease by being obese, smoking, etc. My insurance goes up with this. I think leave the medication co pay on the lower end but even that could be a dollar or two higher for adults. If there is extra money saved use a portion to give children better BC dental coverage, we see children in pain with decay that the parents don't treat because they don't want to pay. Foodshare-no one needs to eat that much food a month as what the state gives, no wonder so many people are obese

Abby

Develop a continuum of care for adults with mental illness that includes early intervention and access to uninterrupted treatment.

Close ODHH offices and have staff relocate to a central office. Utilize the better use of brainpower within one office, better supervision, promote one stop center concept as well as pooled skills together to find outside money.

Mike

We are not happy with J and B Medical Supply. They give us disposable briefs that don't workout or adult diapers. The BBB-30, BR30 from Attends Brand and others they give us products that don't hold up. They leak, fall off, hold wetness next to skin. Double or triple them for night use for heavy wetters.

Jefferson County

1. Lower the asset limit for spousal impoverishment
2. do not allow special cases to have more than one house
3. give workers access to IRS records to verify assets
4. count community spouse individual retirement accounts (IRAs) as an available asset
5. have family care MCOs reduce their administrative costs
6. eliminate non-functional eligible family care
7. reduce nursing home personal allowance
8. restructure family care rent expense
9. change MAPP work requirement
10. expedite process for veterans aid and attendance eligibility
11. asset test for BadgerCare Plus
12. lower the income limit for BadgerCare plus
13. not cover certain drugs
14. eliminate client meals, lodging and medical transportation
15. end BadgerCare when a child turns 18 instead of 19
16. raise co-pays
17. enact nmore benefit limits
18. have all recipients assigned to an HMO
19. lower the percentage an employer must pay for health insurance before customer has to accept the employer insurance

Dorinne

Fully implement the program as it already stands. Starting with a primary care physician/family doctor. A relationship develops and changes in health are quickly detected avoiding costlier treatment. Call centers need to be adequately staffed and trained, too much time is wasted, time consumers could be earning income. Also, case workers need to be fully trained, there are too many mistakes being made in the paper work consumers receive which needs to be corrected, again wasting time for the consumer.

J

The Governor's budget adjustment bill calls for the Department of Health Services to seek waivers from the federal government that will help the state reform the way it administers Medical Assistance programs. Given that the waiver requests may impact nearly every aspect of Medical Assistance programming it would be prudent to open the waiver process to the public.

Doug

I currently take 11 generic and 2 brand name medications. My total cost per year under SeniorCare is \$1,465. Under Governor Walker's proposal, if I had to sign up for a Medicare Part D plan, my yearly cost would be \$4,446.34. The Medicare Part D premiums alone would be \$74.70/month. The difference between what SeniorCare currently costs me and what a Medicare Part D plan is \$2,981.34. That's an incredible difference.

Southwest Dane County Outreach

Very concerned about the possibility that SeniorCare will be dismantled. Enrollment in Medicare Part D is just one time a year. Typically it takes an individual 1.5 hrs and a computer program for an enrollee to select a drug program that best fits their situation from over 40 options. Most seniors need professional assistance to complete the selection process. Premiums vary between \$180-\$1,308 annually. Med D has gaps in coverage, called the donut hole .

Dianna

require assets to be verified

Julie

With the assistance of the Department of Health Services, we can better our economy and reduce the healthcare burden of unplanned, unwanted pregnancies through prevention, reduce abortions, and continue reproductive health to improve the lives of Wisconsin families who cannot afford children during these economic pressures and difficult times. By being proactive instead of reactive we can save money, and more importantly lives of the people we serve.

Diane

There is NO affordable health care for the middle age, middle income couple. I am 58 years old and make a little too much money to qualify and we make not enough money to pay 800.00 a month for a premium. Hence we are stuck with a 16,000.00 bill for a detached retina. What are options for couples in our age group suppose to do for affordable health care??

Kathryn

Thank you for this opportunity to share my perspective on the state's Medical Assistance program. I am a breast cancer survivor—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.

Ellen

I believe that both the CORE and Basic plans should continue and be expanded. The opportunity to seek preventative care and get control over chronic issues that having either CORE or Basic offer low-income individuals with no dependent children will help lower costs for emergency treatments and major health failures. I believe it can become cost effective through low premiums and long-term overall savings from preventing high-cost medical situations. The number of people who qualify and are on the waitlist is a testament to the need for this program.

Taylor County Board of Supervisors

The current biennium budget calls for the centralization of Medicaid programs, eliminating local access to economic support services. Without the knowledge and experience of local personalized assistance many citizens will lose their benefits.

Recovery Implementation Task Force

Assertive Community Treatment (ACT) Programs should be added to the WI Mental Health System. The wide range in quality of Community Support Programs (CSP) across the state does not afford WI consumers access to equal services. Person Centered-ACT standards require service coordination across time and setting. 24/7-ACT standards require evening and weekend coverage and availability of 24/7 face to face crisis intervention by ACT team members. Integrated Care-ACT standards require RN's as part of the treatment team and directly address the integration of physical health and mental health. Employment-ACT standards require vocational specialists on the team and employment related services with a focus on meaningful community based jobs through supported employment. Use of Peer Supports-ACT standards require peer specialists on the team. ACT standards specify a staffing pattern that ensures coverage and depth allowing prompt response to increased consumer needs and ensures coverage of scheduled contacts.

Helen

Please don't abandon seniors and poverty families or those on the border.

Kathy

All around communication, staff is not knowledgeable on available resources.

Jackie

More transparency-put individual MCO's contract with DHS on the website. Talk to IDT team staff to learn exactly what's going on at the MCO with administration management and the processes they are implementing within organizations to reduce choice and options for members.

Connie

Consider a single payer plan for health care. Do not cut Medicaid programs or family planning. The 36 countries who have better and less expensive care have either a single payer or some hybrid of a single payer plan.

Theresa

Allocation of funding.

Rhonda

Has seen peoples condition improve while being on BadgerCare. It enables them to seek treatment, use medication, and receive regular care that they otherwise wouldn't if uninsured. This reduces hospitalization, increases access to dental care, prevents people from waiting until they are very sick to get help.

Wes

Cutting funds to programs like IRIS for people with disabilities is no the place to find cost saving ideas.

Tony

Support community health centers. The freeze on BadgerCare basic leaves many uninsured who still have health problems.

Invest in education strategies about teen/unplanned pregnancies. Public employees didn't cause shortfall.

Mary

Eliminate the control functions that only serve to hurt providers (pre-authorization function). Licensure regulation for adult family homes, community based residential facilities, and residential care apartment complexes has become excessive. Many of the regulations have nothing to do with client cares. Change the focus of survey process. They survey process should transform into a practice of supporting homes to achieve a best practives type of environment not a form of punishment or forced closure. In health care the competitive model is not working, change it. There are permanent clients in

the system, eliminate the monthly/annually evaluation process and get staff into proper programming that doesn't require purely administrative checks.

Jane

Need to continue with IRIS program funding to maintain daily care needs and support for those with physical and cognitive disabilities. Without IRIS funded transportation there would be no access to the community. Prior authorization, covered goods, accessible communications/benefits for durable medical equipment are lacking for the needs of the consumer. Medicaid equipment coverage is extremely minimal. With the financial support from the federal government WI has a chance to make good choices and ensure that citizens have the supports they need to make a life in the community.

Angela

Family Care becomes a huge waste of money once the member enters assisted living. The necessity for a team (RN, NP, SSC) to manage a member's care becomes obsolete because of the support structure already inherent within the assisted living facility. Reconsider the necessity of the 20 bed limit for IRIS funding in a CBRF.

Underwood

Make public the federal Medicaid reimbursement for the State DD Centers. The DD Centers reimbursement rate is an enhanced rate negotiated decades ago with the federal government in recognition of the complex needs, and thus higher costs, of serving this unique population. This enhanced rate allows DHS to request the maximum allowable reimbursement which is significantly higher than the rate non-state facilities receive for care. This reimbursement difference is creating a rift and fueling calls for the closure of the State Centers and the forced relocation of individuals with the most severe and profound level of mental retardation / intellectual disability who also have complex medical issues or aggressive or self-abusive behaviors who are a danger to themselves or to others.

Underwood

Eliminate the position of Director of Center of Bureau Operations and return those duties to the facility directors who previously did them. Resident populations are decreasing. Reduce, not increase, administrative layers accordingly.

Suzanne

Children's Long Term Waiver: 1)Create a tiered system where families can decide what number of hours of intense therapy they feel best serves their child. 2)Investigate the family cost share and the family income to qualify for the LTC 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 when they have to wait. 4)Reduce hours gradually during the 3rd yr of intensive services to help the family move post intensive phase. 5)Discharge children earlier from post intensive services or do a gradual reduction of hours throughout intensive to post intensive.

Ann

Dollars used for multiple meetings & screenings as well as administrative staff positions would be better used on direct care services for persons with disabilities.

Carol

Take the program out of a for-profit organization & have it run by county employees. The Alliance did nothing but prolong my husband's stay in a nursing home because the cost for him to be at home would have eaten into their profits for the year! So instead of him being able to spend at least a year at home, he passed away in a nursing home just 11 months after Family Care started working with him . What a joke!

WI Personal Services Association, Inc.

None

Lynn

Dietitians should be certified as Medicaid providers. Without the services of a dietitian, the state spends unnecessary health care dollars on long term complications such as heart disease, kidney disease, retinopathy and peripheral vascular disease. The Institute of Medicine has estimated that for every dollar spent on diabetes medical nutrition therapy provided by a registered dietitian, \$6 is saved on treatment of preventable complications.

Heidi

The employment of educated people, if not up-to-date with MINIMUM the past decade or more of federal legislation regarding their own jobs!

Emily

I would like licensed midwife care to be approved as a BadgerCare provider.

Susan

Absolute focus in health improvement.

Thomas

Family Care needs to have a mid-course correction. Cap MCO admin and care mgt costs, etc.

Kim

Improve efforts to diagnose and treat Alzheimer's disease and related disorders sooner. Improve integrated care coordination. Study cost benefits of referring WI veterans to federally funded VA benefits. Provide alternatives to existing inpatient and emergency department services. Consider the unintended costs of freezing family care.

Jane

Continue to provide the flexible, self-directed, funding through the IRIS program. People who have choices about their lives, will be more happy, healthy and productive. Medicaid funding/restrictions/process for acquiring durable medical equipment is full of barriers and discriminatory practices for the people who depend on this funding.

Laura

Approve (fund) the provision of Medical Nutrition Therapy (MNT) to Medical Assistance patients (regardless of age), by registered dietitians. Especially look at the provision of preventative nutrition education, through programs such as Prenatal Care Coordination.

Ron

The Family Care delivery system. We are balancing the budget on the backs of providers.

Betsy

Take the policy and benefit management of the Badgercare/Medicaid system away from politicians and give it to medical and financial professionals. We have a limited \$\$ amount and need to get the most benefit out of the limited money. Scrap the expensive extras and vaccinate more children and focus on preventative care-INCLUDING DENTAL CARE! Get rid of the issue that mandates that dentists, once they see someone regardless of payor source, must be willing to treat them for life. Entirely too many negative health issues are relating to poor dental care-infections, nutrition, pain, etc. and it just keeps snowballing. If we took better care of our WI resident's teeth (along with vaccines, preventative visits, etc.), we'd be paying much less in narcotics, antibiotics, ER visits for dental pain and other health issues and have an overall healthier population.

LISA

They could improve on how they write these programs. See below.

Carol

My family is very pleased with the care provided for our aunt. She could not have survived without the help from the state and Fond du Lac county. Her final years were pleasant and we wish that for all elderly. Don't alter the program so that others might not have the benefits she enjoyed.

Peg

Crisis Resource Center (CRC) a program of TLS Behavioral Health in Milwaukee. We are very proud of this innovative and creative behavioral health service, that was initially funded by the Robert Wood Johnson Foundation, Greater Milwaukee Foundation and the Healthier Wisconsin Partnership Program. I would like to emphasize that the CRC is unlike any service offered in WI at this time. It is not a 'Crisis Intervention - County carve-out' service. The CRC is a sub-acute residential setting, that was specifically developed and is successful at reducing unnecessary emergency room visits, inpatient hospitalizations and is a step down from inpatient hospitalization once the patient does not need acute hospitalization, but requires further stabilization, especially for medication stabilization. Of our 340 admissions in 2010; 54% were diversions from Emergency Rooms, 22% were step-downs from costly inpatient hospitalizations and 24% were referrals from community behavioral health providers that most likely would have been either ER or inpatient stays. The Reimbursement Issue: The current behavioral health service continuum lacks an intermediate level of sub-acute care that would allow the CRC to bill the Medicaid HMOs and Medicaid FFS for care provided. This missing level of care drives clinical inpatient hospitalization and emergency room costs, when less restrictive and more cost effective care could be provided by the CRC model. Proposals for Resolution: 1. Increase the Medicaid rate for the crisis stabilization per diem code S9485 to a level capable of sustaining sub-acute residential care in an environment that is less restrictive than inpatient care and inappropriate emergency room care. 2. Identify a new Medicaid code for sub-acute residential care that would allow the T19 HMOs to include clients served under this code in the T19 HMO contract encounter data. TLS clearly believes in the CRC, is defining a research model to prove this is an 'evidenced based best practice' and is willing to open more CRC facilities, but clearly needs resolution to this reimbursement issue.

Renee

badgercare is important to a lot of families and under on of obamas laws is that health care is to be available to all. some people cant afford to pay for it but still need it for their kids to be seen by a doctor. if you take this away where does that leave the families that are struggling? food stamps are also important as well for families to be able to get food for thier kids. we are supposed to help people not take the help away

Vicki

In recent months we have had funding cuts from our MCO which has made it challenging to deliver quality services to meet the needs of those we currently serve. In addition, we have had to turn down referrals for people with high needs as we cannot adequately serve them with recent rate cuts. Funding cuts resulted in a reduction of our current staffing levels, wage cuts and loss of benefits. We fear that we will not be able to maintain our qualified staff. When employment opportunities become more available we anticipate losing staff thus deteriorating the quality of services to people with disabilities. We lost 20% of our Case Management staff to our MCO who offers better pay and benefits. The MCO continues to solicit our case management staff for open positions within the MCO. Our staff have talent, experience and longevity in working with our population which makes them a prime target for the MCOs. We cannot accept further cuts and at the same time compete with them for the best staff. Due to rate cuts, we are seeing group homes closing and residential support services in our area shrinking. We recommend that further rate cuts from MCO's cannot take place without the approval of DHS. It will cripple the service provider base and people will be left without adequate services. We propose that DHS make changes that will allow for more Family Care money to be spent on services for members and adequate reimbursement for providers rather than paying for duplicative and unnecessary administrative and care management services. Specifically: Cap administrative costs for MCOs at 15%. Eliminate the requirement that all DD members have a nurse care manager. We have not seen that this adds value to the member's outcomes. The nurses are restricted in what they actually do and often sit in meetings along with care managers which is more duplication. In addition, most DD members have routine medical care and follow-up from residential providers and/or family members. We have seen no proof that having a nurse on the team saves money or is beneficial to most members. Increase the caseload number for care managers (currently averaging 35). Our case managers at RCS carry higher caseloads and have daily interaction with members. Under the previous system, county case managers had higher caseloads than MCOs and spent more direct service time with the people on their caseloads. Reduce the wage and benefit packages for MCO staff which are significantly higher than those found in service providers who employ staff with equal or better education, experience and talent. Eliminate other duplicative services from MCOs such as behavior specialists and employment specialists. Eliminate the requirement for the proposed Prevocational Report. We are committed to moving people directly from school into Community Employment or from prevocational services to Community Employment. The report will create one more bureaucratic burden on service providers. In addition, it will create one more requirement for the care managers to review and follow up on. Instead, our staff need to spend time developing talents and natural supports for members to become more independent so they will succeed in Community Employment. Eliminate duplicative functions from multiple MCOs such as payment and information systems. Increase infrastructure for Iris. This needs to include outreach and training for families. It also needs to include a process for providers to be notified if a person makes changes to their plan, specifically, a reduction or elimination of services. Providers are not always notified by families that the plan is changed which results in services continuing to be provided and payments being denied. The elimination of waiting lists has been needed for thousands of people throughout Wisconsin. We cannot afford to regress to make people wait for needed services. We appreciate the funding that the Governor has directed to Medicaid Services and implore that DHS takes to heart the fact that the money has got to get to the people who need services.

Bobbi

Badger Care is a critical safety net for Wisconsin. My divorced daughter, mother of 4 children, works long hours to make ends meet. Without Badger Care, her children would have no medical coverage. My friend works 2 jobs to pay her bills. She is a cancer survivor. But her small employer had to stop offering health care insurance because after she had cancer, the insurance rates skyrocketed and the owner could no longer afford to offer coverage to her handful of employees. People like her who work hard should have medical care--it should not be a privilege for only the wealthy. Don't take funding away from Badger Care. People in Northern WI struggle just to put food on the table. This is not a recession; it is a way of life here. Add co-pays for Emergency Room visits, but don't take the safety net away from the state's most vulnerable.

Debbie

I am the mother of a 30 year old musician who is currently insured by Badgercare. NO ONE would insure him before this, (after he was dropped out of the blue - no reason given- never missed a payment etc.). Though we and he could pay for it, no one would take our money! It was a parent's nightmare - no insurance for their child. Yes, he is an adult - but apparently not a good risk . Badger care was our only hope and once applied for, he was insured! WHEW! Now it's all in jeopardy again. . . PLEASE DO NOT TAKE AWAY BADGER CARE! It really is the only place who would insure my son. I beg you! I know so many people his age who only WISH they'd signed up like my son did. . . . so now they have nothing. PLEASE - this is not right in the wealthiest nation on earth. We can do better!

Deb

Keep the Family Care Program active and allow new members into the program.

Jessica

I am concerned for the programs that are being considered to be cut with the budget. I need all the services that Iris provides and medical assistance provides because without them I will not have a quality of life! I used medical assistance for my medical appointments and care providers reimbursement for pay. I also use Iris to supplement my freedoms and quality of life. It was working with you years ago and I am requesting assistance again on not only my behalf but for others that do not have a voice. I am all for trying to balance budget but please do not take away or decrease funding for these programs thank you

IRENE

DO NOT REMOVE THE ES OUT OF THE COUNTIES. OUR

Michele

Streamline paperwork to enroll in HMOS for MA

BEVERLY

The income maintenance should be left at the county level. These services we provide should not be made more difficult for the people who really need them by not having access to an economic support specialist person.

Judi

There are MANY reasons for me to ask for midwife services to be covered by Badgercare, because it makes so much sense, economically and medically. As more and more small town hospitals close their maternity units, women are cut off from local care. It doesn't make sense, economically or medically, to send a healthy mom to an unfamiliar hospital, hours from home. She should be near her family and friends for this joyous event. Licensed Midwives undergo specialized and extensive training to deliver babies in out-of-hospital settings. They 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. 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. Economist David Anderson 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 increased competition in the maternity care market. 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.

Valerie

Please pay Licensed Midwives for low risk deliveries in the Badger Care/Medicaid system. It only makes sense. The cost is so much less and the outcomes are so much better for the women and babies. Everyone should have the option of an out of hospital birth. 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. Economist David Anderson 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 increased competition in the maternity care market. I just wanted to share that my daughter in law wanted a home birth but was denied because Badger Care does not pay for Home birth with a Licensed Midwife in attendance. She ended up having 4 unnecessary ultra sounds for a low risk pregnancy. It ended up being a hospital birth that was sped along with pitocin. She then had an epidural that took 4 tries to get in place and a baby that went into stress since she could not feel anything to successfully push him out. We then had an additional 4 emergency room visits after discharge for blood patches so she could endure the spinal headaches. Lots of unnecessary expense. Why is there no limit to the costly ultrasounds being done unnecessarily? Why do women on Badger Care and Food stamps/ WIC have the option whether to breast feed? If they have no medical reason why they can't and they cannot afford to buy formula, why are they not being told they have to breast feed?

Richard

I wish to comment on any possible cuts in Wisconsin medical assistance programs. Cuts would create a hardship. My wife has multiple sclerosis, and has been in a nursing home since November of 1998. She is bedridden, but is totally mentally aware. As you can imagine her monthly expenses are huge. Without the state long term care aid I don't know what I would do. My resources, I'm retired, couldn't keep her in for a week. I don't know if Medicare would cover anything else. I'm going from payday to payday and would not be able to take over any payments. I need the help I currently get! Don't take it away from me, and all the others who need it.

Gretchen

At this time Medicaid does not cover care with a licensed midwife (LM). In Washington State LM's are covered by MA and attend 2% of the births each year, it has been demonstrated that the total savings to WA MA are approx 1.6 million per year when facility fees and reductions in costly medical procedures are factored in. (Midwifery Licensure and Discipline Program in Washington State: Economic Costs and Benefits

http://www.washingtonmidwives.org/assets/Midwifery_Cost_Study_10-31-07.pdf).

Johanna

Son is a medically involved child with Down syndrome. We were extremely grateful for the support we received from Katie Beckett. 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. I seriously doubt that the lists have been caused by over funding.

Amy

By creating a DHS provider category to reimburse Licensed Midwife services in out-of-hospital settings will not only save the state significant amounts of money but improve outcomes and access for low-income mothers as well. 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. As a Badgercare recipient, I highly value out-of-hospital Midwifery health care for my pregnancies and believe that it should be included in Badgercare coverage. Thank you for your time.

Community Alliance of Providers of WI

There are areas of Family Care that need improvement: 1)The lack of consistency and uniform processes among FC MCO's. 2)The balancing act of fiscal constraint, consumer choice, and quality care. 3)Program sustainability.

Whitman

Take a look at the services provided by free clinics at the local level and help with the funding of these clinics. We provided over \$1,000,000 worth of services here at my free clinic with an actual cost of less than \$350 per client served. This included all labs, medication, diagnostic services including CT/MRI scans. The previous administration left us out of the loop for funding and the Obama plan left the free clinics out of the loop too. Free clinic support provides more services and may be a better way to spend the dollars on healthcare over time.

Morris

Compassion for fellow wisconsin population who cannot afford to provide their families the services our programs provide. DHS should think about how the affects of the changes Govenor Walker's bieannual budget will directly concern the many who do not have voices or feel like they can not speak out on their own. They should tell him and his backers that this will not be affective and actually cause the State more money in the long run if he should centralize Income Maintenance programs.

Quinton

The Department of Health Services could improve by assuring that all of Wisconsin residents have needed access to health coverage and promoting healthy lifestyle choices. In particular, the Badger Care program provides much needed support to our most vulnerable families. At minimum, the program should be maintained at the current level.

Ellen

15 yr old Grandson diagnosed with Reactive Attachment Disorder, Oppositional Defiant Disorder, PDD-NOS, and severe depression. Currently he receives assistance from the Katie Beckett program which provides financial assistance for the high cost of his medication, as well as mentoring services through Co. HHS. If it weren't for his medication, the services provided by the County, and special education, it would be a gloomy outlook. We have had 10 yrs of counseling and training to help handle issues at home. We are very concerned that with a loss of services we may need to alter his meds and he would no longer receive mentoring. Monthly meds are \$1500, even with ins it's more than our budget can handle. We also don't know what to expect when he turns 18, without available programs, he may fall between the cracks.

Ted

I have spent my entire 35 year career supporting people who have sought services from our non-profit agency. Children, Families, Persons with Disabilities, Elderly, Those with a Mental Illness, Offenders in the Correctional System, Men, Women, Adult and Adolescent. Never in my career have I witnessed such change in the delivery of services as those that are currently happening. Never in my career has the economy been so stressed. Never in my career have we experienced a state budget that has been so challenged, and never have I witnessed some many people in our state that are living each day on the edge. It has been stated many times that Every Person and Every Department needs to feel some of the pain of this budget and the cuts that are necessary. I agree. However, I also know that there are many groups of people who are not able to 'tolerate' the same level of pain that others may be able to tolerate. As an example, I am able to get up each morning, get out of bed on my own, take care of my personal needs, get into my car and find my way to work. I support a number of people who strive to follow a similar routine, but require assistance to achieve those goals on a daily basis. They are not able to tolerate that same level of budget cuts and reduced services as I am. Care/Funding for our State's most vulnerable citizens needs to be a priority over other State programs where the users of those services can tolerate the pain better. If my services are cut and my taxes are raised, I have the means to deal with that pain. A person with a disability, a frail elderly person, a homeless individual, etc. has far less means to adapt. Cuts need to be made and services need to be evaluated. Consider who can least tolerate the pain as decisions are being made.

Suzanne

Continue to educate and train county workers so all of the counties provide the same information to families.

Ann

My aunt has Prader Willi. I am greatly concerned that IRIS will not provide the care she requires for a safe and happy life. A support system of knowledgeable, caring, and competent professionals is needed and this is not cheap. Remember those few in our state who were born with Prader Willi Syndrome and don't let them reside in the shadows of life. Public funding for the adequate care of these fragile individuals is important to us all, especially to those who know, care, and love them.

Romeo

Promote Partnership program.

Terri

Inefficiencies of the contracted fiscal agent services that people with disabilities and family members have to deal with on a daily basis.

Chris

BC+ allowed CVFC to spread its resources further and also for the individuals enrolled in BC to receive a higher quality of care. CVFC is the first free clinic to partner with the local health dept. to offer adult immunizations. It is cheaper to immunize an uninsured individual than to pay for an ER visit. My brother lived in group home, caretakers were not adequate enough to provide level of care he required.

John Joseph

I am presently unable to work due to health, have a medical condition. I am not covered by any insurance due to being unable to work and I need education among many other things. I have had to turn down some due to cost.

Elizabeth

SeniorCare is a great program. Family Care allows people to stay in their homes and have care in a comfortable safe environment.

Thomas

Against all cuts to poor and tax cuts to the rich.

Kay

Would like you to consider lifting the caps on family care. There are so many people who have been waiting a long time for services with disabilities. Family care was supposed to help get some people off of waiting lists.

Darlene

I just want our SeniorCare prescription drug coverage to stay in place. Maybe an increase in the yearly premium could be increased.

David

Takes over 20 min to make payment on phone, plus it takes 3 people to take a credit card.

David

Protect BadgerCare eligibility, benefits, and affordability. Cuts don't save money, they just shift costs. The primary goal should be to sharply curtail the ineffective management of high risk patients with chronic illnesses. BC must reduce the number who over-utilize hospital emergency rooms and over utilize hospitals in general.

Rena

It is not needed to have a nurse and a social worker for each member. A nurse can do assessments and make social worker referrals as needed or vice versa. It is a waste to pay a social worker and a nurse to each member. The nurse does not do any hands on care for the member.

Guy

MCO program is working good-as a critical partner to the MCO by providing their client transports we have become a part of the team by watching the home & advising when a MCO team member visit may be needed. Also, different vans match different client needs (rear load, mini bus, etc). A broker system would destroy this and cost more.

Marie

Give more information on what is going to happen to the people who are on disability. How these changes will affect us? What parts will be eliminated? What parts will be improved upon for the people who have a disability? Why employers do not hire people with disabilities (because they cost more for medical coverage)?

Patti

Stop teaching learned helplessness. I had a small budget but worked full time when I went to University. I was At or near the poverty level. But I managed to keep health insurance on myself. By providing Medicaid to those at or below 133% of the Federal Poverty Level, you are encouraging an entitlementality that encourages people to sit back and let the government do for them what they need to do for themselves. Quite frankly between income tax, property tax and purchase tax, I can't afford more. But as a tax payer, I am the government and in spending more, you are holding me hostage. What reason do I have left to continue to work hard? So stop teaching learned helplessness.

Harriet

The Department of Services is needed in place to help people who cannot afford health care because of the wages they are receiving. It is less expensive to help them that to always pay for emergency room services when they could use a doctors office for illnesses that aren't emergencies. We need to care for our youngest and oldest citizens.

Barbara

1)Changes in eligiblity requirements, don't decrease the FPL. 2)Cost sharing with patients - we can't ask patients already living at or below the FPL to pay premiums, deductibles, or copays. 3)Changes in scope of benefits. 4)Coverage of specific populations (parolees and young adults with chronic illness).

Carol

Retain Medicaid for low income people especially mother's, children. employee's without insurance, unemployed men. If the amount of support is reduced people will be ill and die to lack of access to care.

Laura

I understand that the windows at the 1 West Wilson building, where I work, were installed incorrectly and have caused the deterioration of the surrounding walls and window casings. I have also heard that the windows are to be replaced this year. My suggestion is in the next box...

Denis

BadgerCare+ saved my life. I was diagnosed with lymphoma, went through treatment, and now I'm in remission. Please don't reduce funding for BadgerCare because it is truly a life saver.

William

I work full time and wife part time. We are covered by BadgerCare because the private ins offered by my employer is 50% of my salary. Family is willing to pay higher copays/premiums to keep BadgerCare.

Jeff

Concerned about family care, T-19, and vulnerable adults under ch. 54 & ch. 55. With family care frozen, I will be forced to put people in nursing homes, the most expensive setting. As an adult protective service worker, I has to find options, now the only option is nursing homes.

Kevin

I am concerned about the budget proposal to cap family care enrollments by July of this year. I think DHS & the legislature need to look at and develop creative ideas that will allow for continued expansion of the family care and IRIS programs.

Ronald

In 2008 my son joined family care program due to a traumatic brain injury. I retired from the State early to care for my son. Family Care with MCO's involved is more of a business model of health care not a consumer model. The primary goal is no longer the welfare of my son but cost control.

Joanne

Improvements & cost savings: streamline prior authorization for MA; expand the Compass Wisconsin single-point-of-entry pilot.

Marilyn

Expand services. Without universal health care, adults without minor children will not receive benefits.

Felix

Some people who utilize home health care pay privately, but many need assistance. When you receive care at home you have faster recovery rates. Freezing programs leads to increased waiting lists, institutionalization, and admission to nursing homes.

Nealy

I have been on a family care waiting list since 2002. Would like FC cap lifted. My mother and brother care for me now, but they will not always be around to do so.

Tom

Diagnose and effectively treat alzheimers sooner. As alzheimers numbers increase, public health issues arise. Early diagnosis helps detect other illnesses that share the same symptoms. Need improved care coordination. The unintended cost of freezing family care is going to be huge. If people are forced into nursing homes you are doubling the cost. Also, MA beds will be taken up and they are already difficult to find.

Milwaukee County Dept of Family Care

Self Directed Support (SDS) demonstrates access, choice, cost effectiveness, and quality.

Tito

Diversify access by supporting lower cost providers and health facilities that desire to care for vulnerable populations - Community Health Centers.

Cynthia

Thank you for FC and IRIS. It provides her with a chance to live in her community and not a nursing home.

Shirin

Assisting people become eligible for federal benefit programs through the Disability Benefit Specialist Program (DBS). Benefit specialists are located in the ADRC and provide assistance to people with disabilities with navigating the complicated public benefits program.

Patricia

Birth to 3 services help children overcome their developmental delays and disabilities become productive members of society. Medicaid support is vital for the success of the 0-3 services.

Susan

Without BadgerCare adequately funded people will get sicker, costs will go up and children will die. School nurses see broken bones, abscesses, undiagnosed genetic disorders. People will still go to doctor no matter what, so without coverage, health care costs will go up.

Jean

The cost of health ins for seniors.

Mazen

Do not implement the transportation concept in the state. Work with DOT and ask how to implement programs. Get ideas from providers and not logisticare.

Jessica

I understand there are concerns and costs that need to be addressed, but I think BadgerCare+, as a national model, can be restructured and improved. There are already many great qualitiites, but rather than drastic cuts, I think there must be ways to save money. My family of four is eligible for BadgerCare+ because our only health care option through my husbands employer would cost \$15,000 anually just for the premium.

Debbi

Home care is better and cheaper than institutional care.

Dorothy

Inner city people need ins, can't afford to go to private doctors. What do you expect people to do when you cut their ins?

Rachel

You should continue to emphasize the use of generic drugs and negotiation of drug prices.

Jamie

Consolidate energy assistance and other income maintenance / economic support programs to reduce duplicitous administrative costs of employees verifying income at both locations.

Ajit

Sharing data with providers - eligibility, usage (esp. ERs), prescription medications, etc.Educating consumers about the actual costs associated with healthcare.Encourage compliance by consumers.

Heather

Mental Health Services for young children experiencing emotional and behavioral issues. Assisting medicaid in recognizing the field of infant mental health and the benefits of early intervention. Early intervention helps identify kids at risk for maltreatment and severely emotionally disturbed children that later experience problems in academic and community setting. Taking a look at the classification of intensive in-home therapy. Infant mental health services for children 0-5 are most effective while addressing mental health issues in the home environment. Research shows that addressing issues of attachment, emotional regulation, and aggressive behaviors at home can yield positive results for children and their parents.

Bridget

Cutting programs and restricting eligibility limits access. One on one interactions are necessary.

Molly

Can't ask people living in poverty to pay premiums or copays.

ARC of Greater Milwaukee

Better training for social workers and nurses. Place an emphasis on case management and social and medical assessments.

Stephanie Sue

Funding promised to family care. Quality and fiscal review of IRIS.

Barbara

Peer like program, crisis resource center, Hilltop care coordination model.

iCare

Upload inpatient discharge plans into the Wisconsin Health Information Exchange (WHIE) system to reduce reliance on patient self reporting. Avoid creation of uninsured pool by offering a 90 day grace period for reinstatement. Maximize private voluntary contributions to LTC but utilizing LifeReserv to maximize private voluntary contributions toward LTC benefits.

Melinda

Do not discontinue allowing new enrollees in family care. On average the wait was 8 years, we can't go back to that system. If a person is at home waiting for services their condition may decline. This can cause family members to stop working to care for them which takes people out of the work place.

Dan

Crisis Resource Room - innovative and cost effective model for those requiring a mental health service. Reduces unnecessary ER visits and patient stays as well as recidivism. Current service levels lack services for those that need an interim level of care. Increase MA rate of per diem code SN5.

Megan

People who can't afford health ins, can't afford meds, therefore their conditions deteriorate.

Joanne

Don't require seniors who are on the very successful and cost saving state pharamcy assistance program called SeniorCare to also have a Part D plan. This will hurt many seniors who can not afford Medicare Part D in addition to all their other expenses.

Woodall-Thompson

Let providers do case management for people they are serving as required by Medicaid if they are the only unit providing long term support.

Bethany

Keep medical assistance programs available for people even with the budget issues we are facing, people who are on them, need them!!

Nikole

Better pay on mileage reimburstment

Nicole

How accesible the website is, when applying for family planning care.

waleed

improve access by providing transportation even after hours. work with IPN to help manage and improve the over all care. improve the reimbursement to providers to make it financially possible and sustainable to deliver the best care.

Shawn

The department is throwing a lot of money at individuals with behavior problems so that they can live independently in the community. Unfortunately, this 1:1 support in a efficiency is costing tax payers A LOT of money. We need to revisit the use of ICF-MR's and rebuild this program to be more successful than it was before.

Christine

Help with getting better Dental Services. Dentist are generally not willing to accept BadgerCare and you often have to travel very far away. It stand to reason that if you have BadgerCare you really can't afford to travel. I know the state will pay for mileage. I think that if the state reimbursed Dentists a little but more there would be no need for for mileage reimbursement. Also with better Dental Care, health care cost might go down.

fern

Stop with the plan to take away programs that keep people in their homes. As a daughter of aged parents the cost for nursing homes is crazy compared to what staff to assist the elderly in their homes but so much has been cut that both my parents and mother-in-law did have to go to the nursing home. The young people come out of a great education system to nothing with the wait list for community services. After sitting at home for 5 to 6 years they have lost so much they learned at school this is a waste to everyone.

don

Continue to explain all our programs to the best of our abilities. I find many people enrolled in programs and they really have no idea how they work, or how it may be able to help them further.

bayer

begin one point for assessment/intake info and then share that info. Do not waste money re evaluating someone with down syndrome for example their disability will be there year after year there is no cure we do not need re evaluate. Offer some dental care that badger care covers. People need dental care.

Pamela

Better dental care, La Crosse has no dentist that will accept Badger care, La Crosse is full of low income people in need of dental work.

peter

Financially support job coaches and senior care workers more appropriately to coincide with this economy

Doug

Reinstate my perscription coverage. For some reason it has been canceled and I was not contacted regarding that.

Peggy

It was my understandig that all Wisconsinites would be able to get better health care, what happened to this?

Tiffany

There is no money but we need to shift money around and share the responsibility.

Sally

Prosecute employees & members when they commit fraud. Make sure DHS talks to licensure departments (draft scope of services in Community Residential Settings for ADF, CBRF, & RCAC's is wrong but Community Care is using it). Have open meetings and keep all players involved in upcoming changes. Create a community database for all providers to have access to on a state level and include IRIS enrollment, mandate that all providers check this database. Make sure that FC & IRIS is the payor of last resort. Maximize federal match dollars. Redefine and limit IRIS enrollment to only those that can truly self direct. Create a board of private family care providers to listen, review, & recommend savings & policies before DHS makes changes. Utilize LPN's in MCO's.

Barb

State should work with non-profits & charities, they know how to serve poor/less fortunate/disabled with little resources. Innovation is essential to solving these problems. Pursuing a partnership with the govt. and non-profits worlds would surely create thinking outside the box.

Pam

Utilization of the existing cost saving models like the affordable Residential Care Apartment Complex (RCAC). Concerned about the cap on family care because WHEDA will be reluctant to support the WI Affordable Assisted Living program.

Kevin

WI doesn't have a good baseline, needs to be on national core indicators.

Christine

Use of peer specialists.

Geri

Invest in community mental health services, including community-based programming such as targeted case management, the community support program, and outpatient services. Restructure Medicaid, increase the number of good primary physicians, mental health clinicians, and dentists. Consider the idea of a medical home model. Consider creative ways to support non-institutional supportive services such as crisis services, crisis respite and mobile crisis.

Jeff

Consider the Healthy Job Initiative being introduced liked by Murtha & Moulton. Consider the effort of lower regulation of IRIS on quality of care and the potential for fraud.

David

Continue support of BAL's work on the Wisconsin Coalition for Collaborative Excellence in assisted living. Improved communication between Office of Family Care Implementation and the LTC provider community.

John

Remove IRIS cap, allow more people to sign up. IRIS is less expensive than a nursing home.

Sarah

Continue the course, BadgerCare is a great program.

Nancy

Improve communication between DHS i.e. BQA, Family Care, Medicaid Personal Care. Improve communication between DHS and MCO; MCO and CMU. Improve communication & training at ADRC.

Debbie

Additional provider category for licensed midwives who are trained to deliver babies in an out of hospital setting, provide safe & effective, and cost effective care that is proven to reduce low birth weight and preterm births (2 of the leading causes of infant mortality), as well as long term costs associated with maternity care.

Carol

Not all BadgerCare recipients are free loaders and not wanting to work. For example daughter is single mother going to school and needs the coverage for her son. There is no broadband access in rural areas, and seniors can't use computers so who will help them? Concerned about waiting list when programs are capped. You will either be serving people on the front end (programs) or back end (ER visits).

Randy

Don't freeze family care. Son is aging out of K-12 day system. His biggest concern is that his son stays at home so that parents can care for him.

Becky

Waitlist for Family Care & IRIS is devastating for families. Continue with implementation of family care and IRIS. Centralized IM - poor, untimely service.

Sandy

Medical Assistance consumers, especially those in crisis, need services from their local agency on a one-to-one basis. Over 30% of all Medicaid applicants request or require personal face to face interviews.

Kathleen

Provided 26,000 medical visits to poor & uninsured, free clinics are not the solution to budget issues. Solutions can come from those who work at the service level. Prevention/access/treatment is constant challenge.

Jill

Reduce costs by ending BadgerCare coverage at age 18.

Cathy

With push toward self directed programs, removing everyone from straight MA would like to see some kind of quality control systems in place to insure staffing is appropriate. Have seen lack of adequate supervision with PCW & SHC workers being delegated skilled nursing tasks. These skills are outside their scope of practice for these supportive home care workers. Many of their clients are most vulnerable and lack support systems. They have no one to voice concerns and file complaints. Clients are afraid to call ombudsman to voice issues because they are afraid there will be repercussions and care will be removed if they voice complaints. Clients are between a rock and a hard place.

Zwier

Better oversight of who is receiving support.

Paul

Better lists of drugs/brands covered.

Julie

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. Most people that use Access have a lot of problems understanding the language used and the questions asked. Fraud is rampant through the system. There needs to be more emphasis on fraud enforcement. I have even seen clerks/check out people override the system to make a item eligible for Food Share purchases.

Tina

I personally feel that anyone eligible for Medicare and Medicaid MUST be required to take Medicare part B and make Medicaid the payer of last resort. I have several clients who drop the Medicare part B when they become eligible for Medicaid and then Medicaid picks up the cost.

Catherine

Medicaid Depends Provider J and B will not take products back when they make a mistake resulting in Medicaid money wasted on unused products.

Henze

Get rid of the contract with J&B Medical Supplies that's currently in Michigan. Move it some where local!

Murray

Everyone should have free healthcare. Take money used on sports and sporting events and use it for healthcare.

Paul

My wife receives Medical Assistance. Her experiences with this system have been quite good, for which we are thankful. Please continue to offer Medical Assistance services in an honorable way.

Margaret

Create a separate provider category for licensed midwives.

Marcia

Keep IM workers in county still with changes made.

Anne

Some program requirements don't make sense. Requiring a vendor who either does not accept medicaid or operates on a cash basis only and does not bill for services, to fill out the Medicaid provider form, causes access problems. The FSA requires these forms to be filled out but they are not applicable in all situations. My latest experience has been that they are requiring the provider form to be filled out by a sponsor of a training program that I am sending one of my son's staff to. This is not a medical support. We end up getting stuck in certain situations and go round and round trying to resolve these issues. These types of stories deter people from using self determination in long term care.

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.

Kate

The screening process to determine who actually qualifies for public assistance. There are so many cases that people hide assets or falsify information in order to receive public funding. These measures need to be assessed to ensure the funds are being used for people who truly are in need and are not subject to abuse and fraud. A lot of time and resources are used to watch and audit health care providers for fraud, but it appears little is being done to monitor eligibility fraud.

Lynn

You have a tall order. Cut Medicaid Costs. This is difficult for me. I am a proud case manager who works for 1 of 3 Family Care Case Management Units who serves Frail Elders and DD population, most of whom have correlating mental health/behavioral issues ranging from schizophrenia, major depression, anxiety, bi-polar personality disorder to personality disorders unspecified. This population has great needs. Needs that go beyond even what MA will cover. Mental health services are greatly lacking for this population. Providers of services pull out or won't enlist because reimbursement is low. BUT, we do our best. What I would like to be considered for our Member's is the fact that this Family Care program already saves the State an astronomical amount of money. You are right. We are on the front lines, Everyday. We save tons of money by assessing services needed, authorizing only those services that are needed and not services that are just wanted. We keep people in their homes for as long as possible. This is much more cost effective than having these people reside at the Mental Health Complex or in nursing homes or in jail. We are the bridge between their challenges, disabilities, struggles, hardships to some measure of Quality of Life. I don't know. I honestly don't know. I know that whoever reads this, would not want for one day to change places with any of my Member's. It is not just political verbage to say that the people we serve are our most vulnerable, it is fact. And, I believe that we really do measure our greatness and humanity, NOT by how we treat those who are doing well, but rather by how we treat those who are most in need. I don't know where we are headed as a society. Are my Member's destined to become throw away people? I know times are tough. You just have to turn on the t.v. or read a newspaper to know that. And, since it is on t.v. and in the newspapers, it must be true. So where do you cut. Again I say...I don't know. What I do know however, is my Member's for the most part did not choose to be needy. Did not choose to end up dependent on a system to which their every need is beholden. They would trade their lives in an instance if they could for something better...If you look at how much money this program actually saves the State of Wisconsin, then you will know that cuts have already been substantially made. This program is a gift to the State. Maybe there are other programs where cuts can be made. This is not one of them. If cuts are made, I venture to honestly say, it will end up costing more in the long run. You will be paying much more money in Mental health care/housing, hospitalizations and housing people in jail. The way to look at this program is to realize you are already saving.

Wendy

Look for ways to streamline other state programs, or raise taxes on products such as beer or tobacco rather than freeze enrollment in either Family Care or Senior Care. Our elderly deserve to be able to stay in the community instead of having to enter nursing homes, which are more expensive for the State Medical assistance program than CBRF or in-home support.

Margaret

Programs must always keep in the forefront that these are tax supported programs and the tax payers should not be held responsible to provide a better life for anyone on a program than they can afford for themselves. Services should be equal across all groups. The amount of money and help given those lucky to have there brain dysfunction Developmental Disability over those who present the same type of challenges in the community from brain disorders mainly categorized as mental health. Services and budgets should be the same for an elder with the same functional screen marks as a developmentally disabled as a physically disabled

Shawn

Quality of IRIS workforce is lower. Invest in workforce, pay workers well. WI Quality Home Care Authority set up training structures that the budget repair bill abolished.

Beth

Adult behaviors in adult family homes don't get captured in screening. Rate methodologies make it hard for providers to provide care and have quality workers. Set rates and fair rates are important. Mid contract rate decreases should not be allowed. Rate should not decrease because client is doing better.

Dave

The govt. must protect the ability of those who are truly needy to be able to receive health care, but adding huge numbers of people to the public system will encourage those who can provide for themselves to leave their own ins. to accept public assistance, and will reduce the amount of money available to those who truly need the care. Current eligibility requirements for health care encourage people to live together without marriage so that the spouse can receive better benefits. The growing numbers of unmarried people living together accelerates the number of children in unstable, non-contractual relationships. The current policies are not encouraging more responsibility in regards to health care, but are increasing the costs of health care.

Larry

Limits for Family Care & IRIS - concern is can we get exemption in budget for mandated services? We no longer have the money but state statute requires that we provide mandated services.

Christina

More coverage for home care.

Kathleen

Return the entire bed tax to nursing homes to fund a rate increase. Return the CPE Funds to County nursing homes to ensure their continued operation and therefore, the state's continued qualification for federal match funds. Stop funding new programs but fund current programs adequately.

Marsha

Keep hospice programs alive. It prevents patients from going to hospital and symptom management issues. Reduces nursing home admissions.

Nathan

The rate methodology that is being implemented encourages a lack of care toward independence and punishes good care. For example when an AFH creates a stable environment and promotes family values, and personal independence, behaviors that cost money are reduced. This includes aggressive behaviors, doctor visits, calls to emergency services, and physical healing.

Jane

Make functional screen more transparent and reflect whole circumstance.

Marie

Many seniors can't afford Part D. Many people will be completely lost and don't understand applications. SeniorCare is more comprehensive and less expensive.

Simonson

By not implementing any of Walkers proposed ideas.

Amy

Organize recall efforts against Walker and the republicans.

Patricia

Try to get the needs and input from the seniors and people that are being served by this program, and in a more efficient and timely manner, also a more respectful attitude to us. When we have a prescription from our doctor, that should be enough to show that a need is apparent. When I was visited by the nurse and social worker, I was told that just because I have a prescription from my doctor, doesn't mean that I will get what he or she has written for.

M

I realize that badgercare core plus was to be a self sustaining program. You could give individuals the option of paying the premium needed to sustain the program. This would give our state more accurate figures on the actual cost of medical care in our area. And present an option that at this time does not exist. If people don't have health care it costs more on the back end to tend to them than the front. I would think there has to be some federal dollars with the president looking for health care change. Family care/IRIS, family care is a managed care program servicing individuals in the community rather than in an institution. Iris also serves individuals in the community. Right there it is a money saver. It gives folks the opportunity to stay in their homes, which is where they prefer to live. I am not sure that I agree that a parent should be able to be paid to care for a disabled adult child, or a son or daughter to care for their parent under the programs. But I am sure the advocates would disagree. I don't think any IRIS budget should exceed the average cost of a nursing home bed paid by medical assistance. Lastly, Senior Care. It works, leave it alone. It is creditable coverage for those with no medications. It is affordable coverage for those who may receive no other benefit from the system, it allows them to spend their money on food, rent etc. Currently Senior care can service as a supplement in the donut hole. Part D is just plain too expensive. My mom wouldn't be able to afford her rent if she had to use part D.

DeAnn

I see most working class individuals who are in great need of Short Term Assistance to keep their housing, obtain food, clothing and medial treatment. Unfortunately, government programs are not set up to encourage self sufficiency and welfare for ALL. They are set up to maintain a non-working class in society. It is an ineffective way to spend tax payer dollars.

Arica

Staff appropriately and have better response time - as an advocate for an agency, I waited 1 1/2 hrs for a foodshare question. Plus, be able to meet deadlines, with better communication to consumers.

Berg

I agree with most the suggestions from Survival Coalition. Also, I have never been able to speak with anyone intelligent enough to answer my questions at the 800 number. I won't even call there anymore. Make it easier for someone to report possible fraud or misuse of medicaid. Start an on-line sign up for caregivers, etc. like there is for the Children's waivers.

horton

A 50-something single woman was paying the \$130/month premium while on the Core Plan Waiting list. She has been out of work for two years, and on the verge of homelessness since her benefits do not cover her bills. She cannot afford to pay the new \$200 premium and has had to drop the coverage. Imagine the fear! She is working hard to get a job and does not deserve to bear the brunt of our economic trouble. My suggestion is to stop treating those who need help like second-class citizens! Our government needs to stop favoring the rich!

Karen

None

Carolyn

Allow Registered Dietitians (RDs) to enroll as providers in Medicaid plans. I see many MA patients every day and there are hurdles to providing Medical Nutrition Therapy for conditions such as diabetes, heart disease, morbid obesity, etc. that are hindered by the current lack of credentialing as a provider.

John

Provide either 1) free universal health care for the citizens of Wisconsin or 2) a government-run public option to compete with insurance companies in Wisconsin.

Liza

Providing access to health insurance to more people in Wisconsin. The Basic Plan was eliminated, leaving many people waiting to get on the Core Plan, which as you know, has a very long wait list.

Marge

Supervise in home health care of Iris participants

Griep

Allow Patients needing very minor medical services (sore throat, cough, follow-up cuts etc to be screened through the county health department and save time and costs at medical centers. Allow Health department to perscribe limited medications such as antibiotic and minor pain/fever relievers.

Rebecca

The training requirements for care workers in adult family homes serving individuals with developmental disabilities. The individuals with the highest level of care needs are being placed into adult family homes that currently have the lowest required training. AFHs were originally broken off from CBRFs to serve those with lower, and thus less costly, needs. This is no longer the case. The vast majority of AFHs are serving individuals with developmental disabilities. Who in their right mind would agree to have their loved one who requires intensive skilled nursing care placed into an adult family home where the care giver is not required to have training for the first 6 months of employment and after that only a mere 15 hours of training. This is why the AFHs are so cheap and the Department prefers them for the population with developmental disabilities.

Pamperin

I have been an AFH care provider for over 5 years. I lost my client after her parents went with Iris when our county went to family care in July. My husband and I have a beautiful home with 2 openings for special needs adults. I am a full time provider. My question is, if it is less expensive for the state to place clients in AFHs instead of nursing homes why has my home been empty for so long? I would like for DHS to make sure that all people who would enjoy living in an AFH have a chance to do so.

Jason

The largest improvements that need to be made is in oversight and education. Too many people using Medicaid use ambulances and emergency rooms as their front line of health care. More efforts need to be made in educating people about the health care system, and preventative care, and education those same people on what constitutes appropriate use of ambulances and emergency rooms. This also goes hand in hand with the fraud department. People who use and abuse the system need to be dropped from the program, I would highly push mandatory drug testing for those on medicaid and welfare.

terri

Don't require seniors who are on the very successful and cost saving state pharamcy assistance program called SeniorCare to also have a Part D plan. This will hurt many seniors who can not afford Medicare Part D in addition to all their other expenses.

Anne

My severely developmentally disabled son is enrolled in the IRIS Program. He has intensive care needs and can not be left unattended, thus he resides in our home. He has thrived in the IRIS program. We have experience with various long term care settings: a residential school, short term care at Bethesda Lutheran Homes, REM group home, a local adult family home and Family Care. These settings were expensive, restrictive and did a poor job of caring for him emotionally and physically. We use the employee leasing model to provide his care. Suggestions to reduce costs in Medicaid: Reinstate the waiver for the 60 day visitation from the nurse in situations where the participant is judged to be stable and has adequate supervision. Request a waiver from the Federal government to simplify Medicaid paper work completed by home health care staff. Simply documenting time spent with a consumer, a check off box that the care plan was followed, and a place for date and signatures should suffice. Discontinue Medicaid billing by school districts and sheltered employment programs for personal care and therapies. Prior authorization process for equipment and wheel chair repairs needs to be speeded up so that the physical condition of the participant does not deteriorate while waiting for service. It can take six months to a year for certain repairs. Suggestions to containing costs in Family Care and IRIS: Freezing enrollment in Family Care and IRIS could force counties to turn from community settings to more costly institutional settings. Approve short term expenditures which have long term cost savings i.e. cover the cost of a medication lock box as opposed to scheduling staff to wait for unpredictable medication delivery. Family Care: A team member nurse was redundant and unnecessary. We even had a nurse through the home health care agency. We needed minimal assistance. The Fiscal component, as administered by MCFI, is doing a poor job of record keeping, paying bills correctly and submitting accurate monthly participant reports. Feed back and action on participant inquiries is practically non existent. This is very time consuming to follow up on. Encourage IRIS participants to employ their support staff through IRIS to save agency overhead costs. Address concerns around recruitment (maintain a list of background checked, qualified direct support staff) and concerns of employer/family liability in regard potential accidents involving vehicle operation. Require IRIS consultants to have relevant professional or personal experience, an understanding of available resources and increase their pay. This is critical to improve participation by those who are not knowledgeable about the system, but still want to avail themselves of self directed supports. Support participation in therapies which prevent health deterioration and costly physical deterioration and injuries.

Donna

IRIS and fiscal agency are incompetent. I spend inordinate amount of time following up on things, from mistakes in payroll (almost every payroll period) to getting plans approved. They make excuses that they are overworked, which is true, but the bottom line is the consumer suffers.

Emily

It is understandable that we have a budget deficit. We also have 85,000+ on the waitlist for BadgerCare Core and a general waitlist for FamilyCare. This represents a huge number in Wisconsin's population that are hurting and, overall, spending more money to get the emergency care that they need.

susan

Insist on drugs that cost a reasonable amount. It is a shame that Walmart can now get lower cost drugs than Medicare. The state could now actually lower their drug costs by getting their prescriptions filled at Walmart. This is a shame. How a corporation can actually get more buying clout than a State tells me something has really gone amuck with the plan.

Rosalyn

Require that hospitals and clinics STOP spending billions of dollars on Television, Radio, Newspaper and magazine Ads and pass savings on to Consumers and save billions of dollars for Medicare, Advocare and Badger Care along with co-pays being lots lower. Require that Hospitals & Clinics STOP paying doctors based on the number of procedures, surgeries or tests. This causes too many unnecessary procedures. Require that doctors not make profit depending on numbers or kinds of prescriptions they order for patients. This Department needs to Negotiate price of drugs with pharmaceutical companies

Barbara

I bring comments from the Free and Community Clinic's which provide free and low cost medical services to uninsured or underinsured individuals in our communities. A variety of models of support are embraced among our members; support from government monies and hospital systems, and clinics that are directly hospital affiliated. What brings us together is common commitment to accessible high quality health care for the uninsured and underinsured. Thank you for the opportunity to share our ideas and concerns with you regarding our experiences with patients and the issue of Medicaid coverage in Wisconsin. We begin with expressing our concern about the use of the Federal Poverty Level as a measure of minimum income for healthy living in the United States. The FPL was a standard established 50 years ago as 'the minimum amount an individual or family needed to live in an emergency.' It was never intended to be a chronic state. While the total amount has increased with inflation over the past 50 years, the formula for calculating the amount needed has never changed, leaving individuals and families with unrealistic income limits, particularly when they live there chronically. From this understanding of the FPL then, there arise several concerns around proposals for cost savings in Medicaid. 1.) Changes in Eligibility Requirements. A change from 200% (current Wisconsin limit) to 133% (federally required limit) has been discussed. Based on our understanding of the problems associated with the FPL, even at 200% of the FPL, it is impossible to ask patients to cover the cost of care for chronic illnesses. This particular group of patients will end up in the free clinic safety net, and we fear that that net cannot support the weight. A woman is a widow of a mentally disabled, abusive husband. She was unable to work while married to him for six years and she was convicted of a felony for writing two bad checks shortly after she got married. She fortunately did not have any children from the marriage, but because she is childless, her resources are bleak. For the year following her husband's suicide, she lived without a job, and was a recipient of Food Share. Her also widowed mother gave her the money to get BadgerCare for childless adults as well as paying for her rent, and paper, soap, laundry products and transportation. She was left penniless, depressed, and without much help except from her mother. She finally found a job paying \$7.25 per hour in the fast food industry, but she doesn't always get full time hours nor any benefits. She was evicted from her apartment while her mother was in the hospital following surgery. She moved her things back into her mother's house where she currently lives, but she wants to live in her own place. She cannot afford rent and utilities. She lost food share after finding the job she has held for six months. She suffers from severe arthritis of the ankle, and needs a neuropsych evaluation. If BadgerCare income level is lowered to 133% of FP, she could lose BadgerCare when she gets extra hours at work. If she refuses extra hours, she could lose her job. With the cost of gas and mandatory car insurance, she is barely able to get to work. She suffers from frequent infections from living with constant stress. 2.) Cost sharing with patients. We cannot ask patients, already living at or below the FPL to pay premiums, upfront deductibles, or higher copays. (Even just copays are cost prohibitive!) People certainly are not able to gather tens or hundreds of dollars at one time. We know from experience in Milwaukee county that even charging a minimal fee for enrollment can be cost prohibitive, and the patients who really need the coverage/care never get it. Increasing fees to patients will certainly increase revenue to the program, but only with the undesirable effect of reducing services provided. Patients simply will not be able to pay the additional costs in order to access care, and will most certainly then go without care until they are more critically ill, and require more expensive care. A woman worked in a food court clearing tables. Her job paid her borderline wages, and she worked two hours per month too many to qualify for the Milwaukee County GAMP (General Assistance Medical Program), prior to BadgerCare. She was proud; it was important to her to live independently and pay all of her bills; she needed all the money she earned to live. She suffered from severe hypertension, but she could not afford both her medicine and a doctor visit. Her doctor finally refused to continue writing her prescription without seeing her and referred her to the Greater Milwaukee Free Clinic. Within three months of seeing her for the first time, the GMFC (with the donation of lab and radiology from Aurora West Allis Memorial,) diagnosed her with an inoperable tumor, which encased her pulmonary artery. She died at age 48, 10 months after the diagnosis. Earlier intervention for the severe hypertension might have saved her life. \$15.00 per month separated her from GAMP assistance the \$15.00 that she felt she needed to pay her bills and maintain a sense of pride. 3.) Changes in scope of benefits. While we are concerned about restricting benefits further,

we do believe there may be a rational way to offer some limitations while still providing necessary coverage. The question is: who should make those decisions? A year ago, there was a physician's council to consider changes to coverage, and we believe that decision-making body should be reestablished. Providers, who are responsible for patients, may be in the best position for decisions regarding absolutely necessary care and more 'expendable' care. A 54 year old man had been incarcerated for 12 years. He arrived at the clinic on referral from his Department of Corrections' parole officer. He had had severe hypertension that had gone untreated for years before his incarceration, and while treated after incarceration, the renal disease was already in process and could not be stopped. He ultimately lost all kidney function. However, his Medicaid coverage while in prison covered a kidney transplant. Suddenly he was standing in a 'free clinic,' requesting assistance in obtaining his medications, which would prevent his body's rejection of the transplanted kidney. They cost \$1200/month to purchase. The alternative was the loss of the kidney. As per their policy, the DOC covered only 2 weeks of medications after his release. We can argue about whether he should have had a kidney transplant or not, but the reality is: he did. The free clinic worked to obtain medications for him.4.) Coverage of specific populations. Two vulnerable populations of patients end up on the doorsteps of the free clinics or the ERs, where care may be more appropriately and less expensively covered by Medicaid/ Badger Care. Patients released from incarceration have little hope for a job, depend on family and friends for housing, and struggle to take care of chronic illness without any health coverage. Even a brief period of coverage (6 mos) for those with chronic illness would allow them time to make other arrangements for care before their untreated blood pressure or diabetes sends them into the hospital. 2 weeks of medications, the current arrangement by the DOC, does not allow time to make such arrangements. The second group of patients are those young adults with chronic illness (Type I diabetes, in particular), who 'age out' of Badger Care at 19 years old. There is no realistic expectation that they can purchase health insurance, and they are unlikely to find jobs that will offer insurance. Since private insurers are required to cover young adults on their parents' health insurance until they turn 26, shouldn't the state of Wisconsin be required to provide that for young adults they have previously covered, as well? A 22 year old man with Type I diabetes mellitus was valedictorian of his high school class and was accepted at the UW Madison. He started college with high hopes, planning on medical school and returning to the community where he grew up. Unfortunately, he had had BadgerCare as a child, but lost that coverage when he turned 19. He could not afford his insulin, so he tried to reduce some doses and save. He was hospitalized several times in the first semester for diabetic ketoacidosis. He was unable to finish the semester and withdrew. He returned home, and found his way to one of our clinics. He has reenrolled in UWM, and is working his way through their program, but the man with such high hopes that things will be different. He now lives with much more awareness of his limitations, and recognizes that he probably cannot consider medical school. If he had had BadgerCare to cover his medical costs for a few years might have made the difference for him, stable health care for a chronic illness.

julie

My step kids have full insurance through my employer - why is the state also paying for badger care?

Pamela

Reconsider the proposed caps for enrollment into the Family Care program in counties where this is currently an entitlement.

Lori

When we have seniors who qualify for MA spenddown or qmb/slmb and especially slmb+ the process for application has to be repeated which is confusing and overwhelming to the senior but also makes for extra work for human services. Many times it could be avoided if the application was more inclusive and directly asks for the slmb benefit and processers asked the clients about the benefit. We often get them later in mid cycle of their food share benefit and repeat the process all over. Also, Dane County switches workers on clients repeatedly. They also submit volumes of notifications that could be streamlined saving postage fees and paper.

Mulholland

I recognize that poor families do need Medicaid coverage for their children when there is no other source of insurance, however savings could be made by recognizing that Wisconsin does not have to pay a state supplement to every man, woman and child in addition to the federal dollars they receive from the SSI program. We are only one of a handful of states that provide this benefit, and we do see many people deliberately move here to get the supplement in addition to the federal Supplemental Security Income payment. This causes an unfair burden to Wisconsin tax payers.

Renee

The DHS could improve how dental services are provided and reimbursed.

Jennifer

Relationships with counties. In order to provide quality services efficiently, the relationship between counties and the state must be strong.

Amy

Implementing evidence based, registered dietitian implemented weight management practices promoting healthy lifestyles through both Badger Care and Senior Care programming would save health care dollars while empowering a more productive employment base. See cost data below. Cost of Obesity http://www.usatoday.com/yourlife/health/medical/2011-01-12-obesity-costs-300-bilion_N.htm

Mike

License Registered Dietitians in order to have RDs at the table and focus on prevention and health promotion. good nutrition is the best prevention program.

joseph

I see service abuse on a daily basis, ambulance rides for minor issues, constant over utilization of medicines and tests by the medicaid patients, lack of personal responsibility to even make primary care appointments, and narcotic abuse etc.

You can't believe the number of toothaches ER docs see! heck, we aren't even dentists. Reimbursement for ER docs is a disgrace as well- \$18-\$38 depending on if we do nothing or save a life (and it costs us to bill and collect that little amount. Solution- penalties for over use of services, small co-pays, drug test enrolled patients, reimburse dentists better

Zirk

Improve public and provider access to the Wisconsin Immunization Registry and better coordination between the registry and other Wisconsin registries such as lead screening results. Reduce prohibitively restrictive access requirements to the registry. Reduce data restrictions to sharing health data between within and among the state and federal government data bases, allowing health quality analyses more freedom. Improve the time it takes to implement coordination of these data bases. Better coordinate analysis between the state and the university campuses in the state. Provide the public with the results of health data analysis in easily understood language and table formats.

Myra

I would suggest that a person (or family) must be a resident of Wisconsin for one year before they are eligible for any medical assistance (Badger Care, Medicaid). I work in the health care field and recently heard of a woman who moved here from Chicago because she needed surgery. It was easier for her to get insurance in Wisconsin than Illinois.

Ramirez

Require consumers who enter programs to remain in the program for at least 6 months. I've had many consumers inform me they are disenrolling from 1 program to go to another because the other program pays more money. Many consumers jump from program to program to determine who is going to pay their caregiver more money. Perfect example, people who enroll in Family Care only to be informed that their caregiver is not going to get 40+ hours of employment only to inform me that they are going to enroll in IRIS because there is no oversight and can pay their caregiver as much as they want.

Maurer

1) Exempt those areas that have already begun Family Care programming from the freeze - it's unfair to consumers who were promised this new program and saw the county long-term care waiver infrastructures dismantled as Family Care began. 2) Keep the local county workers, who have a customer service focus, involved in eligibility determinations rather than repeating the messes created in other states by trying to privatize these functions and creating a profit motive.

Tracy

A real cost savings would be to stop trying to push community based care for the most profoundly retarded residence of state Centers for the Developmentally disabled. There is no proof that putting them in a community setting saves money-- unless you don't give them the quality care they are currently getting in long term care at Intermediate Care Facilities like Southern Wisconsin and Central Wisconsin Center. Stop wasting valuable resources and realize you have a cost effective, highly trained and high quality care-- benchmark facilities that could be a role model for quality care that others vendors and that other states could learn from.

Randy & Jo

Be an active part of the fiscal responsibility process in Madison. Better to stabilize the programs, than to lose them altogether.

Willborn

I believe there should be some type of asset limit for this program. Many times people are applying for BadgerCare, are self-employed, and have the biggest toys in the County (i.e. large trucks, multiple ATV's, boats, other land, etc.). We get complaint calls from the community questioning how someone can be on BadgerCare and have a \$200,000.00 house, \$50,000.00 truck, etc. This is very discouraging and a sign that people do not budget their money properly to ensure their needs are met before their wants. If this can be addressed better and force the public to meet their needs before their wants, it would force people to be responsible. Public benefits are a great thing for the Elderly and Disabled as well as children but we need to get better about who has access to the benefits and enforce accountability in my opinion.

LaVerne

1 If caps are set on Family Care, allow counties to maintain their own wait lists and do not require separate lists for Family Care, IRIS and Partnership.2. Please don't try to move everyone into IRIS. It's a good program for some people who are able to manage their own care but not everyone is able to do so and some people would be at greater risk of abuse or financial exploitation.3. SeniorCare--In addition to additional costs to older adults, ADRCs will have difficulty keeping up with the added time required for assistance with Medicare D which takes about 2 hours vs. 10-15 minutes for SeniorCare. SeniorCare application is much easier and many older people can complete their own applications.

Lori

Thank you for the opportunity to comment on the Wisconsin Medicaid program and its current need for cost-saving measures. I have been involved as a physical therapy provider and a member of the Wisconsin Physical Therapy Association's MA Committee in discussions with DHS representatives for the past 10+ years. The WPTA has offered cost-saving suggestions to MA Director, Brett Davis, and Bureau of Benefits management Director, Jim Vavra, in another venue. I commend this and past Departments for their efforts to solicit stakeholder input through the Rate Reform discussions and hope many of those fine suggestions will soon be put into place. I come today, though, to speak as a Wisconsin citizen and taxpayer. When I think about the fact that the majority of my Wisconsin income taxes paid in the next 2 years will go toward funding the MA program, leaving many other important programs without funding, I am very concerned. I have tried to count the number of MA funded programs from the DHS website and they are too numerous to even keep track of. My hope is that the state begins to revert back to funding MA for what it was intended in the first place coverage for the elderly over 65, blind, and disabled and those of low income who are U.S. citizens or legal immigrants. We have created an MA 'Mecca' in this state, now covering 20% of the entire state population with some form of Medicaid insurance. Our coffers just cannot sustain this anymore. I am concerned that we have created such an entitlement state that tough decisions will need to be made. But, as a self-employed individual who is married to another self-employed individual, tough healthcare choices are a part of life. My husband and I purchase our own insurance and have become much better healthcare consumers as a result of having some 'skin in the game.' A reasonable cost-sharing for MA enrollees is appropriate and needed to begin to create more educated healthcare consumers with some 'skin in the game', too. When I hear that Wisconsin continues to create more ways to spend MA dollars because it will garner more Federal matching dollars, I become even more concerned. The incentive is to spend more and more, but in reality neither the State of Wisconsin nor the Federal government has money to pay for this. We are both BROKE! Finally, I would strongly support full state control of the MA program without Federal mandates or need for waivers. This can be accomplished if the Federal government moves toward block grants for states, relinquishing all control over that money once it is granted. If I know I only have \$100 in my bank account, I am not going to buy a \$150 dress. Likewise, if the state has a set amount of money to spend on MA programs, the most important and necessary programs should get funding first and when the money runs out, the funding ends. Or, move more toward managed benefits programs where once again, consumers become more accountable for their healthcare consumption. Tough love, yes, but business reality. The State of Wisconsin has had a heart of gold with respect to the MA programs over the past years and now the pot of gold is running dry. It is time to recognize what we can and cannot afford to pay for in this state.

Greg

You are looking at a more expensive way of doing business, a system that is facing federal Food Share sanctions, a higher error rate than the counties and a system that will likely lead to increased fraud. Please consider keeping some local presence, i.e. county staff.

Linda

I am writing on behalf of my 2 year old grandson and my husband. My grandson was born premature and weight only 2 pounds at birth. Due to his premature birth he has ongoing respiratory problems that have landed him in the hospital on several occasions in his short life. My husband is presently on Medicare and SeniorCare. If these programs are taken away or cuts are made to them, my grandson will no longer be able to get the care he needs and my husband will have to pay for higher prescription drug coverage than we can afford. The biggest issue is that my grandson be able to get the coverage he needs. If he loses this coverage and can not get the medical help he needs in the future he could die! That is very scary and devastating to our family.

Danielle

ACCESS.WI.GOV has proved extremely efficient and helpful for applicants and those renewing their coverage. Difficulties arise when individuals have specific questions and/or need personal communication with an enrollment specialist. The phone triage system keeps members on hold for way too long, using up their limited time, money and patience. Would it be possible to have an electronic Q and A application added to ACCESS? This would be practical, cost-efficient and limit hiring additional specialists to staff the phone lines.

Adams

You need to fix the wait time on the phone. It makes it impossible for people to get changes through- including reporting that they are able to decline services because they have health insurance. It would save a lot of money if you were able to get changes into the system quickly. I am sure many people just give up after an hour of being on hold.

Teresa

The Department of Health Services could improve services by keeping the eligibility determination at the county level and keeping the county offices open with experienced county workers. People in our communities need to have a place they can go to get their questions answered in a timely fashion and to have their benefits determined timely and accurately. To not have these ESS/income maintenance departments in the counties would be a huge mistake and disservice to our customers. The ESC is a huge example and should have taught a lesson as to how NOT to do something.

Michael

Support the creation of peer-run respite centers by funding their development and by making these services reimbursable under Medicaid.

Anna

Preserve funds for Medicaid recipients (level of service). Decrease pre-authorizations, paperwork necessary to receive aid. Do not allow governor's appointed person to have unilateral decision making.

Beverly

IRIS to ensure that the consumer or person in this program is not being financially abused by the IRIS providers. The population that I work with are very vulnerable due to trauma and other disabilities from abuse throughout their lives. A DD victim since birth, gets SSI and others come into life and there is abuse oversight in IRIS process.

Patricia

Review application process, some people apply 3-4 times, not efficient. Read a negative or positive notice, they are difficult to understand.

Pamela

Capping Family Care enrollment is a direct recant on promises made by Governors in both political parties to serve our most vulnerable citizens.

Peg

Improve IRIS infrastructure, info is inconsistent to providers/consumers causing lag time potentially leading to decreased service delivery and decreased quality of life. Be sensitive to the other budget pressures that effect transition age youth and young adults with disabilities. Other budgets effecting these citizens are public special education and county related services.

Jean

These programs should not be cut. They are vital to the health and well-being of WI citizens.

Steve

Fulling funding the FY 11 MA budget without enrollment or payment cuts; preserving the MA safety net for our most vulnerable populations; preserving the integrity of the hospital assesment; minimizing cost-shifting to employers and employees from unreimbursed MA costs and uncompensated care.

Trisha

Ensuring customers get quality service when applying for assistance. Currently the centralized enrollment process has a higher rate of errors and poor timliness when processing applications when compared to county agencies. Counties are receiving many calls from these individuals asking for help as they cant get through to the ESC. This all costs the state money. County agencies are typically a go to for our customers to get the help they need, whether it be applying for assistance programs or getting resources and referrals to other programs.

Christine

1)Repair, update, complete: CARES/CWW fixes - system issues seriously hinder effciencies. 2)Application process - they amount of information online & paper is overwhelming, especially for EBD. 3)Staff training.

Jeannie

Centralization of IM functions is not the answer to raise families out of poverty. This approach has failed in other states and the initial attempt at this in WI has also failed. Centralization will decrease the numbers of families receiving services, will lead to increased fraud, and likely will result in more CPS activity.

Herb

Gradually become a self directed system bypassing the middleman like HMO's. Raise the eligibility for Badgercare. Authorize the purchase of gloves (barrier for ventilator patients). Allow frail and disabled to make money without jeopardizing their Medicaid eligibility.

Marjean

Raise the Asset limit for EDB, LTC MA, SSI. It has been \$2000 forever and this is not enough money for people to save for their property taxes, vehicle, unexpected expenses, etc. It honestly would not make more people eligible because the income limits are low. I think \$5,000 - \$10,000 would be a better solution.

Susan

Reduce spending costs for transportation of qualified medicaid/medicare recipients. I currently work for one of the managed care organizations and our company alone spends 2.8 million dollars of Wisconsin tax payor money to provide valet, door-to-door cab service for members to receive medical care. Please don't misunderstand, while I believe some individuals truly benefit and need cab and wheelchair transportation services, there are several individuals who are capable of taking the bus, a large transit system already in place in Milwaukee. Then, there are member's who commit fraud and believe transportation is a right and not a benefit. In addition, why is this program only offered in Milwaukee, what about all of the outlying area's of this state. Our company spends \$1,600 in bus tickets versus 2.8 million in cab fare - what a dishonor to the tax payors of a state over 5 billion dollars in debt.

Julie

Obviously the ESC. Need I say more. The stats tell the story.

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.

Jay

I propose a more simplistic system of direct contracting with the state. The state DHS has in the past initiated direct contracts to individuals, small or large corporations. Removing the costly middle man (Family Care). Guarantee service to all in need, with focus on individual quality service.

Kitty

Simplify application process and remove barriers to application. Collaborate with consumers, providers, case managers and advocates.

Richard

Current primary and preventive health care methods are necessary but not sufficient. Most effective are consumer-level interventions and health promotions, and environmental change. Health promotions should target high-need populations.

Kathleen

1) Inviting input from free and community clinics would help identify areas which need the most attention. 2) Increase reimbursement to a level which covers the Providers' overhead. This would increase Provider participation both for primary and specialist care. I realize this is counter-intuitive to the current economic situation, however, with improved access and more timely care, medical conditions will respond to more economic treatments and prevent more catastrophic care needs into the future. 3) Health care literacy: patients who come to our free clinic are given hope about access and are empowered to take an active role in their physical well being. Knowledge helps them be compliant to most treatment plans. 4) Persons being released from Prison should receive Medicaid before leaving incarceration. Many have chronic and serious conditions, and will usually not be employed or have the resources to pay for healthcare for at least 6 months. 5) Persons who qualify and are approved for disability would benefit greatly from Medicare enrollment immediately. If I understand it correctly, they are required to wait 2 years for Medicare. They lose their jobs because of health issues; they cannot afford Cobra on disability payments; it would make more sense to give them insurance earlier in their disability than later -- perhaps treatment would improve their situations enough that they could get off Medicare and Disability with reviews. 6) Food Share provides recipients with nutritional needs, however, very unhealthy foods are often purchased with these dollars. Obesity is a serious public health issue and perhaps the Food Share program could be limited to support only the purchase of healthy foods in the dairy, meat, vegetable, and fruit categories. Power drinks, sodas, chips, etc could be non-covered items like soap, laundry and paper products.

Self direct but still have infrastructure of business.

Sarah

An easier form of access to Primary care and Dental Care for families. More education of children and families so they can better determine what necessitates trips to the Emergency Department.

Chrissy

Improve care coordination - there should be a coordinator that stays with kids once they are eligible for waived services no matter where they end up. Health ins for foster parents should be an option. We must improve knowledge of how the plan of care works in coordination with multiple entities or somehow get better integrating services.

Will

I have seen a disturbing trend for family members, friends, and providers targeting vulnerable individuals and persuading them to join IRIS as a means to financially exploit these individuals. There must be some sort of screening or management to avoid this type of exploitation.

Susan

Use of Medical Nutrition therapy (MNT) provided by registered dietitians as a tool to reduce Medicaid costs while providing the best care for WI residents.

Curtis

1) Eliminate cost reporting system & duplications of paperwork. 2) Eliminate the control functions that only serve to hurt providers. 3) Licensure regulation has become excessive. 4) Change the focus of survey process. 5) Use the resources at hand. 6) Shift our focus back to care not administration. 7) The competitive model is not working, change it. 8) Permanent clients.

Marge

We are experiencing a 3% decrease to our budget in a group home setting. The needs of the people I serve have increased. There are no options for more help. Our salaries for care staff income are \$9-\$10/hr. Medicare & Medicaid cuts only give us more back breaking hard work.

Donna

Reimbursement rates for services needed for high needs developmental disability population or we will be pushed back into larger institutional sized residents.

Damian

Why did Ms. Rhoades object to Health WI? Was there anything worthwhile in it? What will Gov. Walker do to improve access and affordability over and beyond making cuts?

Tom

I am opposed to seniors on SeniorCare having to enroll in a commercial drug plan in addition to SeniorCare.

Mike

Stop the implementation of the transportation brokerage until the department, consumers, and the provider community can look at additional ways of containing cost.

Steven

We don't know enough about how you and your providers do business to adequately answer this question.

Michael

Access to health care for non-custodial males. Especially those coming out of institutions.

Jennifer

Increase preventative nutrition counseling availability to young children and families. Most young children who are overweight become overweight as adults if it is not addressed early. Early nutrition education is an integral piece in attaining healthy habits early thus preventing diseases such as cancer, hypertension, diabetes and heart disease that are attributed to obesity.

Robert

As providers, we feel state government in general is buffeting providers constantly with new regulations, standards and new initiatives while at the same time reducing our funding as expenses for food, health insurance and energy are rising. Case in point, reduction in support for pre-vocational employment and move to community employment. In the long run, this is a good thing, but currently pre-vocational services is being put under a microscope and undervalued and the costs associated with supported employment is high. Who will fund this in the short term until savings from increased employment for those with disabilities is realized? What about providers that invested in facilities that 3 years ago were supported by state staff. At the same time, residential facilities are taking huge cuts or re-organizing homes into larger facilities pushing our independently living movement back 15 years. As we take on new initiatives with additional work and expansion, we do this at a time when staffing has been reduced to save costs. How can less people do increased work and still support individuals properly? Residential providers can tell you about 15% cuts from MCOs and at the same time mandated staff training and regulations multiply to include sprinkling group homes.

Kimberly

I don't see any necessary changes

Kari

The waiting lists and closed enrollment are a huge problem and lead to the worsening of health conditions and overuse of emergency rooms which costs far more in the long run.

Leona

Funding free clinics is very economical. here we serve the uninsured. We provide all services and medication needed to our clients. We have the three major health care providers in the area donate services on a quarterly basis for labs, basic diagnostic services like x-rays and MRI's.

Kristi

DHS should require full-time employment for those receiving BadgerCare and BadgerCare+. I know several people receiving these benefits who only work part-time because if they worked full-time they would not qualify to receive the benefits. There is no reason they cannot work full-time. This angers me as I am someone who worked hard, went to college to make something of myself, am employed full-time and continuing to pay my student loans as well as the taxes that fund programs for those who think the government should provide for them. DHS also could improve all programs by providing the services of a registered dietitian. Registered dietitians complete a minimum of a 4-year degree in nutrition. Their skills are beneficial in the prevention and treatment of many diseases including obesity, heart disease, diabetes, hypertension, kidney disease, celiac disease and many others.

Marcia

Reduction of duplication of eligibility determination, look at screening already done rather than repeating the process.

Lori

Family Care MCOs do not have uniform contracting standards and lack common infrastructure to support program operations in an integral manner.

Mary

The Department has had legislative oversight and public input on any proposed changes to Medicaid. My son, who was diagnosed with Schizoaffective Disorder in 1995, now lives independently, works part time, and has achieved a good quality of life. If there would be changes to Medicaid which would affect his health benefits, especially his medications, he would relapse. He has not been hospitalized for the symptoms of his illness since 2000. Wisconsin has been providing good care, and I so want this to continue.

Lazarus

Overall I think the system is a good system.

edward

DO NOT go to a voucher system, it would destroy the present mental health care system and in the long run cost far more to implement a system that would not effectively solve the problem of how the community can care for its citizens with mental illness and still meet its own needs

Dave

Prior to increasing IRIS funded services, DHS needs to restructure Family Care so that MCO members receive needed services. Rescind the revised prevocational services definition. Revise procedures to ensure that ADRC's are the only entity that administer the LTC functional screen to reduce personnel costs at MCO's. Allow for larger caseload sizes in Family Care. Return IDT's to their full membership. Eliminate positions paid by MCO's previously funded by Pathways grant. Standardize salary and benefits at MCO's. Do not require MCO's to match the experience of the 5 pilot counties. Require all MCO's to maintain no more than 15% case mgmt & admin expenses.

Amy

Help keep Gov. Walker from shredding our budget in all of the areas that people need assistance most. These are people, including me, who cannot always take care of themselves and I'd like to know what Walker will do with all of the homelessness and rise in mental health diagnoses (because people, without Badger Care, can't get their meds), and ultimately (and most sadly) the new population of criminals.

Danita

The Department could improve the quality of services by making sure that the consumer knows who their contact person is at the local level. Taking that away by consolidating income maintenance or economic support will turn people away and leave them with nothing. It will impersonalize a very delicate and personal subject for some elderly, disabled or mentally handicapped individuals. It will complicate the process, require additional staff to supervise the contracted providers and will create more inefficiencies. Honestly, The Department of Health Services could improve by seeking out new leadership - starting with the Governor and working it's way down.

Sylvan

The Department should take a very cautious approach to expanding the IRIS program. It is not possible to assume that elderly and often infirm individuals have the capacity to self manage their care, knowing when medications might interfere with each other, knowing the right and correct amounts of food to eat and how important it is to communicate with loved ones to avoid isolation. The IRIS program's rule that family members can become care givers without going through proper training, be paid exorbitant amounts for providing care, with little or no verification that care is actually being provided, along with the elimination of the Department's former requirement that family members who provide care go through a licensed agency is a prescription for fraud, particularly since there are no unannounced visits to the home or apartment by state oversight staff. While self directed care may well be appropriate for those younger individuals who have the capacity to understand regulations, who have active and involved parents and who understand the various roles of local and private agencies, many older individuals who are poor, with limited schooling are not that sophisticated and often are preyed upon by their relatives. This is a special problem in the limited English speaking population. I have reviewed the application for IRIS and am astounded that anyone thinks that the forms can be understood by most of the elderly and many of the disabled clients who financially and physically qualify for Family care. The current system in Milwaukee County with Nurses and Case Managers visiting and talking with Family Care members on a regular basis, assign detailed questions about their health, and changes of their health, eating habits, sleep patterns, ability to get out of the home has worked extremely well and should not be replaced.

Carol

Please keep funding for Family Care and Badgercare. Our daughter with Down Syndrome has benefitted greatly from these services and would be lost without Easter Seals and medical care. I know cuts have to be made but these are our most vulnerable citizens who cannot speak for themselves.

Gina

My agency provides services to older adult clients. In one program we serve the individuals who aren't eligible for Family care because they still have some limited assets. Once they run out of money we have always been able to enroll them in Family care and continue to serve them so that they can stay out of nursing homes. Without Family care these clients would end up in nursing homes. A major concern that I have is where will we be able to find enough nursing homes beds for the people who will not be able to enroll in Family care. In WI (Milwaukee) we have closed so many nursing homes as a result of Family Care allowing people to remain at home or in a least restrictive setting that it is now difficult to find nursing homes for our clients who take T-19.

Susan

I am very concerned about funding the needs of our most vulnerable citizens: individuals with special needs. Rehab therapies (which consume approximately 1% of the Medicaid budget) -PT, OT, SLP- offer the best opportunities for a person to become independent, able to care for themselves, or actively participate in (and direct) their own care. The current PA process is cumbersome, arbitrary, and costly to the provider/health care system AND the State and results in delays in needed services. Prior statistical analysis has shown that the PA process is akin to putting a \$500 lock on a \$200 bike.

Mark

The Department has spent a lot of time implementing peer specialists into our service system for mental health. We also need to have recovery coaches also implemented to our service system to help people with SUD. Recovery coaches are not sponsors, they are NOT COUNSELORS they are people that have lived life experience in addiction, that have found recovery and want to help them as they transition out of treatment, jail, and prison. These people need the help and just volunteer models aren't enough. I am prepared to help implement a wonderful model that is also supervised by a clinician, which makes it billable to Medicare. This would help recidivism, cut down on wait lists, and help the people of Wisconsin become tax paying productive members of society. I'm already working on the infrastructure and ready to implement this model, all I need is help from the department.

William

The Department should gain greater knowledge and awareness of recent long-term mental health outcome findings for schizophrenia, depression, anxiety and bipolar disorders. These long-term studies are now available in Robert Whitaker's latest book Anatomy of an Epidemic, Part III, Outcome Studies and Findings

Stephanie

Community based treatment, use of certified peer specialists.

Jordon

Get serious about IRIS program, there is a duplication of services in MCO's.

Chris

Fire Scott Walker.

Ed

Talk to consumers.

Ronald

Any change that will restrict access to face to face eligibility services, require additional travel and expense, or require use of telephone or computer technology will adversely affect individuals that seek to apply for MA.

Erin

DHS should stop centralization. Services for income maintenance services are delivered more efficiently and cost effectively than doing these services by an enrollment service center. Cost by counties \$283/case, cost by ESC \$291/case.

Rick

Coverage for home health services as a cheaper alternative to nursing home expenses.

Lynn

Disabled and elderly need this more than the women going out and getting pregnant who are able to work, and the illegal aliens we support.

Mark

Revisit the 2009 downsizing agreement at Sout Wisconsin Center and use the savings to fund other long term support systems for people with intellectual and developmental disabilities in the community.

Linda

Assisting the educational institutions for dental hygiene education establish mid-level providers.

Jane

Allow more flexibility for Children's Long Term Redesign Waiver

Hilary

Make the online application match up with what the workers actually need. Allow people to check a box as to what program they want to apply for. Train the ESC staff on ALL programs so the consumer does not need to be transferred multiple times before getting help.

Ardyth

Don't cut, innovate.

Gail

Ensure participants have access to preventative services, delayed access to care increases cost.

Ruth

Establish consumer to consumer & parent to parent supports at the local level (at least regional). Strengthen the relationship between DHS & DPI. Adequetly fund long term care, end waiting lists. Allow the programs to refine & stabilize. Emphasis on integrated care for acute & primary care.

Charlene

Expand ADRC's to cover remaining 15% of Wisconsin residents in 13 counties and 3 tribes.

Joanne

Instead of cutting funding for programs, streamline the whole program (i.e. BadgerCare, Core, Medicaid) into one Medical Core for all, eliminate any insurance company involvement.

Arnold

Peer support as evidence based practice. Revisit Peer Link Model. Wants mandate for county to hire peer specialist at a living wage with benefits.

David

Expand Family Care, do not cap enrollment.

Erika

Maintain SeniorCare, it is cost effective for the state and for seniors.

Marianne

Expand reimbursement for Registered Dietitians to provide medical nutrition therapy.

Natasha

Making healthcare more accessible to those who need it. School based clinics are a must to provide point of service care where it is needed most in the inner city schools. Sometimes the school nurse is the healthcare person the student sees. Parents have to take off work or will not seek healthcare for their child at all because they cannot afford to miss work. This forces them to send a sick child to school and hope they make it through the day. Also programs to help curtail marijuana use among our children.

Mary

Providing services to workers in need can help keep them productive and can keep them from long-term dependence

Tami

Streamline prior authorization process for different therapies (physical, occupational, speech).

Jim

BC policy forces people to decline increased income due to ineffective (too abrupt) phase-out. New Veteran's Home in Chippewa falls may be ARRA funded, but it's not needed

John

Concerned about cuts to institutional settings.

Amy

Open enrollment back up to people who need access to these services.

James

MCO's - why teams of 2?

Mary

Adequately fund capitated rates for FamilyCare, IRIS. Decrease utilization of RNs to realistic, needed levels. Also too many social workers for population. A ration of 200:1 patients to workers used to work fine. MCOs are top-heavy.

Deborah

Stop taking funding away from our most vulnerable citizens: elderly, disabled, poor, working poor and children.

Nancy

Better training for IRIS Consultants. Increase hiring qualifications provide sick time and vacation.

Barbara

I feel very strongly that the Department of Health Services should keep BadgerCare+, as it is vital to the health and wellness of so many people in the community. Without this coverage, people will end up going to the emergency room and will frequently be admitted, which is far more costly in the long run than preventative health care and access to ongoing health maintenance and treatment by one's primary care physician.

Linda

Making help more accessible for those whose need is only to have occupational therapy or other types of therapy. Our son doesn't have health issues with his autism he just needs some help in areas of social interaction which require therapy.

Elizabeth

I have a 9 year old son with CP (cerebral palsy). He has also had a valve replacement. He is a bright, fun child who is in a regular classroom at school, keeping up with his peers, and pulled out only for Math. His CP does not allow him to walk for very long distances, he uses a walker for short household/school walks and uses a power wheelchair for keeping up with his peers and getting around. We have him in a stander daily along with stretches and exercising. My frustrations in dealing with Medicaid include the following:1. Paperwork - each year I fill out the same LONG forms. My sons CP will not change. Every other year we have a visit from the KB representative. Why? I have been told that I could fill out a form to elongate the time between visits but have to obtain this form and to then meet with a social worker through the department of Health. This does not seem to be a cost effective solution. Why can't I do this on my own? We do not need to be on more list, meet with more state paid employees, and require more costs to our government to take care of our child. Streamlining this system, decreasing paperwork, making websites straightforward and decreasing all of the middlemen/woman is what we should be doing.2. Again Paperwork related. To obtain outside therapy for our son (with CP periodic physical therapy is needed), prior authorizations(PA) are required. These PA's take hours of non-reimbursed time for the physical therapist (PT) to complete. We have never had a PA that has then not asked for more information ...again more non-reimbursable hours for the PT and they are typically asking for information that was included in the original PA. The PA requirement has had a DIRECT impact into the cost of obtaining outside therapy for everyone. The hospitals and clinics have increased the bottom line cost of therapy to pay for these non-reimbursable requirements by Medicaid. As a parent of a special needs child, over the years I have paid out of pocket to make sure that my child receives the care that he needs when we have been denied services. When he was 2,3,and 4 the average cost of an hour of therapy was around \$120. This past summer we were quoted over \$400. I can't afford that...thankfully we appealed our denial by Medicaid and the judge ruled in our favor and my son was able to obtain therapy. Other consequences of paperwork/requirements on everyone's healthcare ... our town hospital eliminated their pediatric therapy department and we now must travel to the next town to obtain outside therapy. No longer will many hospitals and clinics want to play the ever losing game with Medicaid...they can't afford to do this. In the end our children's healthcare loses out.3. It is frustrating having an administrative law judge decide the healthcare of my child. I prefer having a licensed professional in the health arena that has actually touched and seen my child decide what his needs should be! Our therapists and doctor's are licensed by the state. We must trust them to know when children need or do not need therapy or services.4. The school system is reimbursed by Medicaid for providing medical services. This has GREATLY impacted our ability to obtain outside therapy for our children. My son is in a regular educational room. His SCHOOL therapy needs are very different than his medical therapy needs. We can not blur these differences or needs and that is what is happening - in the end children are not being taken care of in our state. I do not feel that the schools should be charging Medicaid for services. They are eliminating our ability to care for our children. A school therapist does not have the time or resources to provide medical therapy to children with motor issues such as mine. She has her hands full just making sure that my child is functioning and keeping up with his peers in his classroom which is her job.5. We must work with local dentists to improve their reimbursement rates. Building new/large clinics and bringing in more infrastructure is NOT the answer - this is just costing tax payers more money. We have dental chairs but must be able to at least cover costs for local dentists. If Medicaid does not have the money for this then they need to eliminate dental coverage or give a one time voucher for each recipient to find a dentist to help with their care. 6. Go over every piece of paper that must be filled out and ask: Does this paperwork requirement increase the cost of healthcare? Does this actually streamline services? Does this improve the quality of this program and allow tax dollars to actually help families and children or does it just produce a job for someone in government? Does this eliminate fraud and waste or are there better, more efficient ways to do this?

Dennis

By not concerning changing the current Senior Care system. Don't fix what isn't broken. It's affordable and it is income based so those you receive more pay more, etc. etc.

Mel

Don't cut county mental health, human services, education or any other programs. the biennial budget will decimate those programs, resulting in untold misery and more people being put in jail and dying early.

Edna

I feel having two CMO in Milwaukee County for the sake of competition is a waste of funding. Milwaukee County is fiscally responsible and can handle the elderly and developmentally disabled. In addition, it is confusing to consumers to having the two options. My recommendation is one CMO run by Milwaukee County.

Prunckle

I'm very please with the level of care that is provided through my Badger Care Plus Core Plan. It would be nice if a larger variety of prescriptions were offered, but largely the care received is excellent. It is unfortunate that DHS services may be cut by the current legislators. I implore the lawmakers of Wisconsin to not cut services offered by DHS.

Martha

I am paralyzed from my neck down, totally dependent on others to assist me at the same time have been working as a Resource Specialist for 14 years. DHS needs to continue what they are doing for individuals. If possible, individuals who are making significantly more money than others should pay more taxes. And/or within DHS reduce some of the positions that aren't as hands on with participants of the services.

Jane

Since my son has transitioned to Family Care (Community Care), he has lost a vital community integration service due to funding issues. He also lost 2 days of work due to the economy. He is now unable to receive the supports he needs (individualized community integration to build skills needed in the community, and supports to find additional appropriate employment due to his loss of hours). The end result has been that he is regressing and is isolating himself at home. We are losing all gains that he has made in the past. Also, please monitor licensed residential facilities more closely. We have had many issues and there is not enough monitoring of staff or enforcement of choice. It is our word against theirs, so the onus should not be placed upon families/guardians to monitor. Surveillance should be implemented.

Thomas

Family Care Program

Scott

BadgerCare, is very important to farmer families, especially young new farmers. Farmers and rural eligible populations: don't have internet, have hard to figure income, have fluctuating income. 1. In 72 counties, fewer than 40% of farms have high-speed internet. 2. Some farmers have been denied because eligibility workers have a hard time learning to deal with self-employed, losing experienced workers could create problems. 3. Income fluctuations should not mean spotty coverage; they'd rather pay higher premiums during boom times

Ben

Medical assistance prior approval for durable medical equipment.

Tim

Centralizing may not actually be cost-effective. Budget document language seems contradictory, and without a specific timetable, could create "a woodwork effect". Short-term savings by cutting folks might mean that by the time people are eligible, they are expensive. This may also be a Civil Rights violation to the extent that it will cut transit by eliminating authority of regional transit authorities.

Jeff

Expand program to include everyone so businesses do not have to provide ins. State ins only, no private health care.

Craig

Caretaker concerned about policy changes to IRIS.

Sarah

Cost effectiveness needs to improve within programs. All these Medical Assistance programs are designed to be cost-effective. I know DHS continues to perform audits of Care Management Organizations and Case Management units and this is probably the best way to determine areas where money may be going toward wants, rather than needs, and where improvements could be made in each program. I work for Family Care, and my department continues to have ongoing trainings relating to the best way to meet our member's needs while remaining cost effective. Trainings on things like the Long Term Care Functional Screen and the RAD Method I believe are beneficial because it ensures there is a standard throughout each program. Everyone has the same training, and everyone knows what is expected of them. So I guess the best thing for DHS is to see where organizations are not complying with those standards and provide resources needed for those organizations to improve. Rather than looking at if Family Care or IRIS or Senior Care, etc. is cost effective overall, it would be best to use audits to look at areas or care management organizations which are lowering the cost effectiveness of the program, and eliminate areas which are not able to meet the cost-effective intentions of the programs.

Doree

Please keep CSP funding levels current