38K

Position Paper

Pharmacy Medicaid Reimbursement Rate Reduction Included in the State Budget Bill

Background

Federal law allows states the discretion to determine how to estimate the cost of a drug and to set the dispensing fee. In Wisconsin, the Department has set that rate based on the Average Wholesale Price (AWP) minus 10 percent. The Department of Health and Family Services had submitted a budget request to change the rate to AWP minus 15 percent. Governor McCallum included that budget request in his proposed budget that he submitted to the legislature and it is now included in Senate Bill 55 (SB55) and Assembly Bill 144 (AB144)

Program Principles

Pharmacies do not have control over the factors that contribute to AWP or the overall increasing Medicaid drug expenditures. The Medicaid reimbursement rate for most brand name drugs is based on the average wholesale price (AWP). The AWP is assigned to a drug by its manufacturer and is widely available in one of three publications: the Red Book, Medispan, or the Blue Book. To the extent that manufacturers increase the AWP for a drug, Medicaid payments for the drug also increase. The health status of the Medicaid population and physician prescribing patterns also affect the utilization of prescription drugs by Medicaid recipients.

The AWP does not reflect the actual cost of acquiring the drug. As a result, most states that use the AWP as the basis for MA drug reimbursement discount the AWP by a specified amount. The most common discount rate among state Medicaid programs is 10%. Although some pharmacies may purchase brand name prescription drugs at a cost less than AWP – 10%, the net difference accounts for additional costs associated with the acquisition of drug products (wholesale charges, returns, inventory costs, etc.). Some Medicaid programs, such as that in lace in Alabama, reimburse pharmacies using a mark-up of the Wholesale Acquisition Cost (WAC) to account for the additional costs associated with acquiring the drug product.

History of Governor McCallum's Proposal

DHFS, in its 1999—2001 budget request attempted to reduce these rates by AWP minus 18 percent. This proposal was based in part by a study done by the federal Office of Inspector General (OIG) published in April 1997. The OIG analysis was based on data collected from a random sample of 10 states and the District of Columbia. The study concluded that the national average acquisition cost for drugs was 18.3 percent below the AWP. The study, however, was flawed because it did not consider other costs incurred by pharmacists.

The Legislative Fiscal Bureau wrote the following in a paper on June 1, 1999 to the Legislature's Joint Committee on Finance. *"A limitation of the OIG and other studies is that the manufacturer invoice price of a drug may not capture all the costs by a pharmacy for the acquisition of the drug. For example, the invoice price does not include shipping and other wholesale costs that pharmacies incur."*

The Fiscal Bureau paper noted that the authors of the OIG report identified a number of other limitations with its own study. The review was limited to ingredient acquisition costs and did not address the following areas: (1) the effect of Medicaid business as a condition to other store sales; (2) the cost to provide professional services other than dispensing a prescription, such as therapeutic interventions, patient education and physician consultation; and (3) the cost of dispensing which includes costs of computers, multi-part labels, containers, technical staff, transaction fees, Medicaid-specific administrative costs and general overhead.

Pharmacy Society of Wisconsin 701 Heartland Trail Madison, WI 53717
608-827-9200 fax 608-827-92092 tome@pswi.org www.pswi.org

WALGREENS WILL REDUCE PHARMACY HOURS IN 30 ILLINOIS STORES DUE TO CUTS IN STATE MEDICAID PAYMENTS

DEERFIELD, Ill., March 29, 2001 – Walgreens today announced that as of Monday, April 2, it will discontinue prescription service evenings and Sundays in 30 Illinois stores due to recent cuts in State Medicaid payments. These stores will remain open their usual hours for non-pharmacy business, but prescription hours will be only 9 a.m. to 5 p.m., Monday through Saturday.

The company also announced it has put future new store development in heavy Medicaid neighborhoods on hold pending reinstatement of adequate reimbursement.

"These are difficult decisions," said CEO L. Daniel Jorndt, "because they hurt our patients in inner city neighborhoods that we have served for decades. But under the significantly lower rates mandated by the State Dec. I5, most of these stores are losing money and the rest are just barely breaking even. In order to keep them open at all, we must reduce our costs by reducing hours."

The CEO added that Walgreens will continue to work with Illinois legislators to restore Medicaid fees and find ways to achieve overall savings in the State's drug program, including efforts to increase federal matching funds. "We hope this can be achieved and our regular store hours reinstated," said Jorndt. "Meanwhile, affected stores will direct patients to alternate sources, including 24-hour Walgreens, that will continue to fill prescriptions around the clock."

Walgreens fills nearly 30 percent of all retail Medicaid prescriptions in the state, three times as many as the next provider. Since its founding on the South Side of Chicago 100 years ago this June, Walgreens has built a strong – and growing – presence in inner city communities throughout Illinois. For example, the company recently broke ground for a store at the corner of Madison Street and Western Avenue in Chicago, which will be the first new retail establishment built in that neighborhood in more than 30 years. In 1999, a new Walgreens was the first construction in downtown East St. Louis in a quarter century.

The State's December action cut the rate paid community pharmacies by an average of $2.50 per prescription. That means many pharmacies which were marginally profitable are now losing money. The cuts reduced both the fee paid to the pharmacy (covering salaries, computers, rent, utilities, etc.) **and** the reimbursement for medication which drugstores buy from pharmaceutical manufacturers. Illinois, which had below average rates before the cut, now ranks 39th in Medicaid reimbursement among the 43 states in which Walgreens operates. It also has the worst payment cycle, ranking 43rd out of 43 states in the time it takes to pay pharmacies after billing.

"This situation threatens the existence of 'mom & pop' and chain pharmacies in low-income neighborhoods and rural communities throughout the state," said Jorndt. "Without adequate reimbursement, many of these stores will close, severely reducing access to prescription service, eliminating jobs and sapping economic vitality from places that need it the most."

"We are well aware of the pressures the State faces as its prescription costs rise," added the Walgreens CEO. "But this increase is due to an aging population that needs more medication, an increase in the number of eligible patients and the introduction of many new, expensive, but life-saving and life-improving drugs. The State's drug expenditures are *not* rising because community pharmacies are making more money. To the contrary, the profit margin community pharmacies earn on prescription drugs they dispense has declined nearly 30 percent in the past decade."

Even before the State's December action, the Walgreen stores where hours will be reduced yielded a profit in the lower third of all Illinois stores. Stores with the highest Medicaid business returned **less than 20 percent** the profit of stores with the lowest number of Medicaid prescriptions. This is due to higher store operating costs and lower non-prescription purchases per customer, as well as administrative costs associated with filling Medicaid prescriptions.

"Despite low profitability, our commitment to Illinois Medicaid and inner city retailing has been firm,"

explained Jorndt. "We started in the inner city, we know how to serve these communities, and we are proud of the convenience, healthcare, jobs and neighborhood stability our stores offer. We are one of very few national chains with a strong, lasting presence in inner city America.

"But just as we have pulled out of private insurance plans with unacceptable reimbursement rates, we must address public plan reductions. We deeply regret the problems our reduced hours will cause loyal patients in areas including Chicago, Peoria, East St. Louis, Springfield and Kankakee."

Walgreens, headquartered in Deerfield, Ill., operates 409 stores in Illinois as well as a data center in Mt. Prospect; distribution centers in Mt. Vernon and Berkeley; and an accounting office in Danville. The company employs 20,400 Illinoisans. Over the past five years, Walgreens has invested approximately $700 million in new store construction in Illinois and has added more than 5,300 jobs in the state.

The following stores will now fill prescriptions ONLY from 9 a.m. to 5 p.m., Monday through Saturday. Hours for the rest of the store will not change:

540 25th Ave., Bellwood	5401 S. Wentworth Ave., Chicago
7410 N. Clark St., Chicago	5036 S. Cottage Grove Ave., Chicago
1606 N. Mobile Ave., Chicago	6330 S. Martin Luther King Drive, Chicago
5346 S. Ashland Ave., Chicago	12635 S. Halsted St., Chicago
5518 Chicago Ave., Chicago	1401 Western Ave., Chicago Heights
1200 W. 87th St., Chicago	1201 E. Wood St., Decatur
2041 W. 79th St., Chicago	2510 State St., East St. Louis
2649 E. 79th St., Chicago	15901 S. Wood St., Harvey
9511 S. Jeffrey Ave., Chicago	14700 S. Halsted St., Harvey
1546 N. Central Ave., Chicago	1700 E. Court St., Kankakee
5018 S. Cicero Ave., Chicago	3148 W. 159th St., Markham
3401 W. Roosevelt Road, Chicago	100 Lake St., Maywood
4700 S. Halsted St., Chicago	1109 W. Main St., Peoria
6200 S. Western Ave., Chicago	600 S. Western Ave., Peoria
1628 E. 87th St., Chicago	1310 S. 5th St., Springfield

Email comments to: Michael Polzin

Corporate Communications Home

WALGREENS ANNOUNCES 30-DAY DELAY IN REDUCTION OF PHARMACY HOURS; CONTINUES WORK TO RESTORE MEDICAID FEES

DEERFIELD, Ill., March 31, 2001 -- Walgreens announced tonight that it will delay its planned reduction of pharmacy hours in 30 Illinois stores for one month. The chain had previously announced that due to recent cuts in State Medicaid payments it would discontinue prescription service evenings and Sundays in 30 Illinois stores starting Monday, April 2.

CEO L. Daniel Jorndt made the announcement at the Saturday evening service at Salem Baptist Church on the city's South Side. "We had a constructive meeting this morning with your pastor, Reverend James Meeks, as well as Reverend Jesse Jackson of PUSH, State Representative Mary Flowers and Congressman Jesse Jackson, Jr.," Jorndt told the congregation. "We agreed to honor their request for a delay of our plans to give us all time to work together with Governor Ryan and the legislature to find a way to resolve this situation and reinstate Medicaid funding. We're very grateful for the support voiced for our stores this morning and for the time these leaders gave to share their views. Like us, their goal is to assure convenient, neighborhood access to prescription service."

The decision to reduce hours in 30 stores was very difficult, said Jorndt. "Our problem is not with these communities, which we've served for decades," he explained. "It's with the heavy cuts the State made last December, dropping Illinois' Medicaid reimbursement rate to 39th lowest among the 43 states in which we operate. Under the new reimbursement, virtually all these stores are losing money. In order to keep them open at all, we must reduce costs by reducing hours. We will delay that move until May 1, but will continue working very hard to inform the public and our State legislators of the seriousness of this problem.

"This is not a Walgreen problem," added the CEO. "It's a community pharmacy problem, threatening the existence of 'mom & pop' and chain pharmacies in city and rural communities across the state."

Jorndt appealed to Salem Baptist Church members to contact their state legislators and urge them to restore Medicaid funding. "Community pharmacies need your voice to be heard in Springfield," he said. "No store -- not a Walgreens, not an independent drugstore, not another chain store -- can stay in business long when it's losing money. Walgreens is leading this fight for neighborhood prescription rights ... I respectfully invite you to join us and the community leadership represented here this evening."

Email comments to: Michael Polzin

Corporate Communications Home

IndependenceFirst
The Resource For People With Disabilities

4/20/01
Joint Finance Committee
Washington High School Public Hearing

Michael Hineberg
Independence*First*
600 W. Virginia Ave.
Milwaukee, WI 53204

Dear Joint Finance Committee

My name is Michael Hineberg. I am employed at **Independence***First*, where I coordinate the Attendant Referral Program. I help people with disabilities find Personal Care Attendants to come into the home and help with personal cares, cooking and shopping. Consumers pay attendant wages with money from COP or out of pocket. The vast majority pay through COP. Depending on what his or her disability is, a person must wait any where from 3 to 15 years for COP funding. Often, people either die or move to a nursing home before money is available. No one will dispute the difference in quality of life when you compare a nursing home to living in your own home. Living in your own home is less expensive and provides more independence, more choice.
I sincerely ask you to increase funding to create more slots for COP and reduce the waiting list. Thank you for your consideration.

Sincerely,
Michael Hineberg
Michael Hineberg

Managed
Health
Services

1205 So. 70th Street, Suite 500 • West Allis, WI 53214-3167 • 414-345-4600 • Fax 414-345-4624

April 20, 2001

Senator Brian Burke
Room 316 South, State Capitol
Madison, WI 53702

Representative John Gard
Room 315 North, State Capitol
Madison, WI 53702

Dear Senator Burke and Representative Gard:

As you know, Managed Health Services is a 16 year-old HMO that serves more than 95,000 Medicaid and BadgerCare members in 19 counties from Green Bay to Kenosha. We consider it a privilege to participate with the State of Wisconsin to provide managed care services for children and adults, many of whom are working, low income, taxpaying citizens, without health insurance for their children or themselves.

From my experience, the Medicaid/BadgerCare program has proven to be a blessing to the poor and uninsured families who had been living in fear that a serious injury or illness could destroy their often fragile financial stability. Managed Health Services has been able to provide quality care to both our Medicaid and BadgerCare members because we are fortunate to have over 3,6000 caring physicians in our network, in addition to hospital systems like Aurora, Children's Hospital and Covenant in the Milwaukee area and Affinity in the Green Bay area.

The continued success of this program is the reason I am writing to you today. I ask that you support the Budget as submitted by Governor McCallum; however, there are four issues that I would like to bring to your attention:

- Continued funding for the Medicaid and BadgerCare Managed Care Program. The current budget provides for increases of 3.5% for FY2002 and 3.9% for FY2003. These are the minimum increases that would enable these programs to remain viable.

- Increases in hospital rates (and, indeed, all provider rates) need to be tied to increases in premiums for Medicaid/BadgerCare Managed Care companies. As currently outlined in the budget, there are significant increases proposed in the Medicaid reimbursement rates for hospitals. To remain competitive, the HMO Program must have similar increases.

- HIRSP Funding. The present budget makes up reductions in State support of HIRSP by increasing the "tax" on insurance/HMO entities. The current budget would add to the administrative costs of the Medicaid Managed Care Program by increasing the HMO assessment. This additional cost was not factored in to the proposed baseline HMO rate increase.

- Contract restrictions on HMOs may make them non-competitive. The proposed elimination of the HMO exemption, which presently allows HMOs to operate under management contracts, would significantly increase administrative costs to the HMOs, by eliminating our ability to achieve the efficiencies of scale which such agreements bring. At a time when increasing administrative requirements are placed on HMOs, especially those participating in government programs, this widens the gap between available premium and operational costs.

These issues are of great concern to us, as continued resources and funding are needed to keep the Medicaid/BadgerCare program alive and operating as a model program for America's working poor. Thank you in advance for your support.

Sincerely,

Sandra Tunis

Sandra Tunis
Senior Vice President, Program Performance & Regulatory Affairs

cc: Kathleen Crampton, President and CEO

G:\Gov_Prog\SHARE\LEGISLAT\Joint Finance Letter April 20.doc

H.O.S.E.A.
Hope Offered through Shared Ecumenical Action

3767 East Underwood Avenue • Cudahy, Wisconsin 53110 • Phone: (414) 486-1718 • Fax: (414) 486-1712

HOSEA statement for the Wisconsin Joint Finance Committee – April 20, 2001
HOSEA calls for a Wisconsin Works (W-2) program that Works

Hello my name is Colleen Hagen and I am the Chair of the HOSEA W-2 Committee. HOSEA's belief has always been that W-2 should ultimately be about reducing poverty. However, we have yet to see conclusive evidence that W-2 has delivered.

The most recent Legislative Audit Bureau's audit of the W-2 program addresses W-2 effectiveness by stating and I quote, "W-2's success in ensuring the economic self-sufficiency of former participants has not yet been established". Based on our experience we believe this to be a most truthful assessment.

Even as we speak the next round of W-2 contracts are being written including the new performance standards. HOSEA believes that each of you, as members of this committee have an opportunity to make a significant impact on these new W-2 performance standards.

HOSEA and our partner MICAH are calling on the Joint Finance committee members to seize this opportunity and take a stand against waste and inefficiency. It is time to make sure that families who are struggling to climb out of poverty have a fighting chance to do so.

Therefore, HOSEA calls on the members of this Committee to embrace, and advance the following principles and policies to improve W-2 effectiveness.
Reduce the number of W-2 agencies. With less than 6,000 clients in Milwaukee County, why do we still need 5 agencies to administer the program?

HOSEA believes that ineffective agencies such as Maximus and Employment Solutions are still doing business because of a clause in the state statutes known as the "Right of First Selection". Our experience confirms that the Right of First selection combined with weak performance standards basically guarantees agencies the next contract regardless of prior performance.
We call on the Joint Finance Committee to introduce legislation to remove the Right of First Selection statute.

Furthermore, success of W-2 must no longer be determined simply by how many people can be removed from employment support services. The success of W-2 must be measured instead by the percentage of W-2 clients that actually rise out of poverty. A second criterion for success needs to be the percentage of people eligible for W-2 services that are actually enrolled in the program.

Although currently proposed performance standards include several improvements, overall they remain inadequate. For example, the tracking of clients leaving W-2 remains at 6 months. The

HOSEA calls for a Wisconsin Works (W-2) program that Works

HOSEA calls upon Governor Scott McCallum and the Department of Workforce Development (DWD) to improve the W-2 performance and accountability by adopting the following principles and policies:

1. Redefine the standards by which the success of the W-2 program is measured
The success of W-2 must no longer be determined simply by how many people are removed from employment support services. **The success of W-2 must instead be determined by:**

- **the percentage of W-2 clients who move out of poverty by reaching full employment**
- **the percentage of people eligible for W-2 services that become enrolled in W-2**

To accomplish these goals DWD must:

-Abandon light touch and increase W-2 client enrollment. W-2 agencies must inform all clients of available support services, if clients ask for them or not.
-Apply sufficient resources to implement outreach programs that enroll all eligible families with unmet needs, including the reenrollment of eligible W-2 clients who have left W-2.
-Move the "Moving out of poverty" indicator from the Information Only section into the Required Criteria section.

2. *Extend client tracking period to a minimum of 18 months DWD only requires agencies to track W-2 clients who have moved to employment for 180 days. Extended client tracking will provide verifiable evidence as to whether W-2 clients are finding and keeping sustainable employment. Many people who return to the workforce remain in need of, and eligible for, W-2 support services. Even while employed many families still need childcare, transportation, housing assistance, foodstamps just to name a few available services.

3. Remove the "Right of First Selection" clause from W-2 contracts. Maximus and Employment Solutions have demonstrated that this "guarantee" of winning another W-2 contract contributes to inefficiency and mismanagement.

4. Reduce the number of W-2 agencies The massive caseload reduction calls for a similar reduction in the number of W-2 agencies. At a minimum remove Maximus, and any other agency that has created serious credibility problems by flagrantly abusing clients and taxpayer money. Reducing the number of W-2 agencies is fiscally responsible as it reduces unnecessary overhead, especially administrative costs.

5. Place W-2 contracts with local public or non-profit entities. Local entities can be held more accountable. In addition, public entities do not receive millions of taxpayer dollars in profits. More funds will be available to assist families struggling to reach self-sufficiency.

6. *Financial Management – Do not remove the proposed language, however the Department needs to define a specific standard for the word "significant".

7. *W-2 agency staff meet training requirements – Do not remove the proposed 9 benchmarks.

8. *W-2 agency service meets or exceeds expectations for consumer satisfaction – Do not remove the proposed language.

9. *Earnings Gains – In addition to the proposed language, establish a measurable criterion that sets a Base Wage Rate standard. A Base Wage Rate must at least be set at, or above, a living wage rate.

*2,6,7,8,9 reference language contained in the DWD Performance Standards for the 2002-2003 and related Programs Contract

Community Advocates
Twenty Years of Opening Doors for a Better Milwaukee
4906 W. Fond du Lac Ave., Milwaukee Wisconsin 53216 (414) 449- 4777

MEMORANDUM

TO: Members, Joint Committee on Finance

FROM: Public Policy Committee
Child Abuse Prevention Network

DATE: April 20, 2001

RE: Day Care for Special Needs Children

There are a number of W-2 and low income parents in Wisconsin who are caring for a child with a disability, and, as a result, are unable to perform work functions. The children are often "medically fragile" with serious medical conditions that require a trained caretaker to administer medical treatment and services (such as tracheas, g-tube feeding, etc.). It is important to note that this problem affects a fairly small and manageable group of W-2 participants and low income parents. However, those that are affected face the unfair dilemma of trying to adhere to W-2 rules that require substantial time spent outside the home in an employment activity and making sure their children's medical needs are adequately and skillfully attended to. The challenge of any legislation is to make sure that these exceptions are adequately addressed without losing sight to the need for inclusionary language as outlined in federal law.

Recommendation:Create options for low income and working parents that includes remaining at home to care for a medically fragile child and being adequately compensated. Legislation needs to address those parents who are the exception to the rule and need to remain at home. The W-2T grant does not adequately compensate them. Parents on W-2T need more than a two year limit since a child may need care until age 21. The federal five year limit does not address this issue. These families could be part of the 20% of TANF caseload exempted from the W-2 time limit.

Recommendation:Expand the Medicaid benefit to provide nurses, aides and/or personal care attendants for medically fragile children in the child care setting. Explore having HMOs cover skilled nursing care. Explore increasing the fee scale for medically fragile children to help cover costs. Many day care providers cannot meet their costs when the staff coverage requires almost one on one coverage.

Thank you for the opportunity to present these public policy issues.

Testimony to the Joint Committee on Finance April 20, 2001

My wife and I live in Wauwatosa. Our daughter, who has suffered from serious mental illness for 22 years, lives in Milwaukee. We are members of the **(National Alliance for the Mentally ill (NAMI).** I have served on the NAMI Wisconsin Board and am now on the Legislative Committee. Experience with our daughter, NAMI and a Family Support Group keeps us aware of the many unmet needs of people who suffer from mental illness.

I will briefly cover three topics :

1. Four managed care demonstration sites for mental health and substance abuse have been started. The involved counties need additional funding for information systems and other quality improvement activities. We request **$125,000 per site in 2002** and **$75,000 per site in 2003.** Existing Mental Health Block Grant funds of **$262,000/year,** designated for system change activities, can be used for this purpose. Earmarking of new MHBG funds of **$238,000 in 2002** and **$38,000 in 2003** is also requested.

An adequate outcome evaluation will require and additional **$50,000 in 2002 and $100,000 in 2003**.

2. Prescription Drug Coverage for People with Disabilities is needed. The Governor's budget contains a prescription drug benefit for low income seniors. Persons with disabilities who are on **Medicare and not receiving Medical Assistance benefits (about 50,000 individuals**) have a similar need for drug coverage. In fact most of these individuals **have very low incomes** and face great hardships in paying for prescription drugs. This is a **major issue** for persons with **mental illness** who must take very costly medications to maintain their mental health and ability to function.

3. Persons with Mental Health and Addiction problems face discrimination in health insurance coverage. They receive much lower coverage for their illnesses than persons with other illnesses. We request legislation requiring health insurance policies to provide parity for mental health/AODA coverage. A parity bill, to be introduced this session, is the same as last sessions bill. The fiscal estimate for increased health insurance cost for state employees was **$350,000 per year.** This amounts to and **increase in premiums of about one tenth of one per cent**. A Wisconsin coalition consisting of over 80 groups representing over 2 million people statewide, has formed for the passage of parity legislation.

We request you also review the hand out sheets on NAMI topics. We have much evidence to show that these changes will reduce the high cost of untreated mental illness.

Gene Duncan
11026 W. Derby Ave.
Wauwatosa, WI 53225

Medical Assistance Funding for Community Support Programs and Comprehensive Community Services

Community Support Programs (CSP)

Request:

- We are requesting that the State pay the state share of Medicaid CSP reimbursement for all individuals. According to estimates by the Department of Health and Family Services the cost for the current caseload is approximately $10.7 million annually and the cost for the new caseload is estimated to be $400,000 in FY 02 and $1.9 million in FY 03.

Rationale:

- Community Support Programs provide effective treatment for persons with serious mental illness. Community Support Programs are the cornerstone of the adult mental health system, providing community treatment for adults with serious mental illness. They have been proven to reduce inpatient costs and have the potential to help keep individuals with mental illness out of the corrections system.

- The Wisconsin Medicaid program currently reimburses counties the federal share only of the rate for CSP services. Counties must pay the state share from available funds (primarily community aids and county tax levy). As a result many counties have formal or informal waiting lists for services. The DHFS estimates that approximately 700 people are in need of CSP services and are not receiving them. *Waiting lists for Medicaid services violate federal requirements that individuals be served with reasonable promptness.*

  - Unless action is taken during this budget session there will be litigation on the waiting list issue. It is more sensible and cost effective to solve the waiting list problem through legislation than through the courts.

Comprehensive Community Services (CCS)

Request:

- We are requesting that the state pay the state share of the Comprehensive Community Services benefit. Cost estimates are currently being developed.

Rationale:

- Comprehensive Community Services is a Medical Assistance benefit that was adopted by the Legislature in the last biennium, but has not yet been implemented by the Department of Health and Family Services.

- CCS is a recovery oriented benefit that furthers the goals of the Governor's Blue Ribbon Commission on Mental Health. It will provide services for many individuals who are currently falling through the gaps, such as persons who are homeless, have histories of trauma, or are in jail.

- Like CSP the counties are required to pay the "state share" of the CCS Medical Assistance benefit.

Community Based Mental Health Services for Children with Serious Mental Illness

- Currently approximately 28 Wisconsin counties receive state funding for integrated services projects for children with serious mental illness. Additional counties have received federal funding for such services.

- These programs have been effective in reducing the need for inpatient care and juvenile justice placements.

- However 40 counties do not have such programs.

- Early treatment and diagnosis will minimize the disabling effect of mental illness, leading to better functioning and futures for young people.

- NAMI requests that at least half of the new federal Mental Health Block Grant funds be earmarked for children's community based mental health treatment and that additional GPR be provided to expand integrated services projects statewide.

Staff within the Bureau of Community Mental Health is also needed to ensure that programs are implemented. We are requesting 1.5 FTE staff positions, with at least .5 FTE of these positions being a parent of a child with a severe emotional disturbance.

Proper funding of the above-described services will also achieve goals which NAMI Wisconsin feels are of paramount importance in two areas:

a. *The County Jail System:* Proper treatment will enable counties to address the serious problem of the growing number of people with mental illness in the jail system by diverting people appropriately from the "front end" of the system. These people with mental illness will be able to receive treatment rather than incarceration. Proper funding will enable counties to deliver appropriate mental health services to persons coming out of the jail system who have been identified as having serious mental illness, thereby helping with the "revolving door" problem.

b. *The Transitioning of the Youth from the Juvenile Mental Health System to the Adult System:* Improved systems will be able to place youths into effective treatment programs as they age out of juvenile programs. This transition situation has been identified as a major problem by advocacy groups and by the Bureau of Community Mental Health.

Consumer and Family Support Services:

- The DHFS has provided Mental Health Block Grant funds for consumer operated services and for family support and advocacy programs for several years. These programs run drop-in centers, consumer education and employment services, and family information and peer support services.

Funding to support the mental health/alcohol and other drug abuse (MH/AODA) managed care demonstration projects.

Request: $500,000 (FY02): $262,000 FED (existing mental health block grant (MHBG) system change grant funds) and $238,000 FED (new MHBG funds).

$300,000 (FY03): $262,000 FED (existing MHBG system change grant funds) and $38,000 FED (new MHBG funds).

Rationale:

- We are requesting $125,000 per site in FY02 and $75,000 per site in FY03 to increase funding closer to the amount needed to ensure successful implementation of these projects.
  - This money will be utilized to develop information system capabilities that will ensure that the State gets the type of comprehensive and accurate information required to evaluate and further develop this initiative. Sites will also use these funds to support network development, formulate quality improvement processes, support internal organizational changes (e.g., project management) to support taking on the additional requirements of a managed care contract, and to involve consumers and family members in their planning process.
- In the 1999-2001 biennial budget the Legislature authorized the DHFS to select up to four demonstration sites and allocated $160,000 per site (payable in two installments of $80,000 each) for planning and development funds (the second installment of funding for two of these sites was deferred to the 2001-2003 biennial budget and is included in the Governor's budget request).
  - However, the DHFS estimates based on its experience with Family Care, that the cost to bring up a care management organization is $688,000, of which counties are expected to pay one-third. Therefore the state contribution is estimated at $458,000. This is "one-time only" funding; that is, these are funds necessary to the development of the project but which do not need to be continued once the project has become operational.

Additional funds requested:

1. The initial $160,000 provided to support the demonstration sites was a combination for GPR and Medicaid FFP. The Governor funded the remaining $160,000 deferred to this budget period from the MHBG. We request that this $160,000 be funded from GPR and FFP similar to the other initial development funds.
2. We request the addition of one full-time staff position in DHFS to support evaluation and implementation of the demonstrations, as requested by DHFS. The Legislature approved three full-time staff for the MH/AODA managed care demonstrations in the 1999-2001 budget. However, Family Care, which must accomplish many of the same tasks has many more staff. The inadequacy of staffing for the MH/AODA managed

care project is jeopardizing the DHFS' ability to accomplish the number of complex tasks required for this initiative.

3. An adequate project evaluation will require additional funds for conducting consumer surveys and additional data analysis activities. During the planning for this project considerable time and resources were expended to develop an evaluation instrument. We are requesting $100,000 in FY02 and $200,000 in FY03 for the DHFS to contract with an independent entity to conduct consumer outcome surveys and other activities to support the project evaluation. These funds should be eligible for federal Medicaid matching funds making the GPR request $50,000 in FY02 and $100,000 in FY03.

Prescription Drug Coverage

Request:

We are requesting that any prescription drug package that is developed cover non-elderly individuals with disabilities who are on Medicare and who need prescription drug coverage.

Rationale:

- The Governor's budget calls for the development of a prescription drug assistance plan for low income seniors. This plan does not cover people with disabilities who are on Medicare and who do not have any prescription drug coverage.

- There are approximately 80,000 people with disabilities in Wisconsin on SSDI who receive Medicare. Approximately one third of these individuals also receive SSI and Medical Assistance and another 1600 have a Medicare supplement policy through the HIRSP program. This leaves approximately 56,000 Wisconsin citizens with disabilities who may not have prescription drug coverage.

- A national study has found that of persons who are under 65 and on Medicare:

  - ✓ 77% report incomes below 200% of poverty as compared to 50% of those 65-84 and 66% of persons 85 and older
  - ✓ 47% report difficulty in accessing or paying for medical care, compared to 22% of those 65-84 and 18% of persons 85 and older
  - ✓ 30% report spending all their savings for or having difficulty paying medical bills, compared to 12% of those 65-84 and 10% of persons 85 and older.

- ✓ Thus, people with disabilities on Medicare are poor and need assistance with their medical costs, as much if not more than individuals who are elderly. This is especially a problem for persons with mental illness, many of whom must take expensive medications in order to control symptoms and function on a daily basis.

Health insurance parity for mental health and substance abuse treatment.

Request:

- Change the statutes to require that if group commercial health insurance plans offered in the state of Wisconsin provide coverage for mental health and substance abuse treatment that this coverage be no more restrictive than coverage for other disorders.

- The fiscal estimate for an identical bill introduced in the last session indicated that the cost to the State for health insurance for state employees would be less than $350,000 per year. This amounts to an increase in premiums of about one tenth of one percent.

- This item is not currently in the budget bill but it is possible that part of it could be included in the budget because of the impact on coverage for state employees.

Rationale:

- Currently, state statutes require that if commercial group insurance plans offer coverage for mental health and substance abuse treatment, they must provide a minimum level of benefits, which is described in statutes. In fact, most plans have used this minimum as the maximum benefits offered.

  - As a result, employees who require mental health or substance abuse treatment for themselves or for covered family members are often required to incur large debts for treatment that would be covered for other disorders, receive services from the public sector (which increases costs for taxpayers) or go without treatment.

- Mental illness and alcohol and other drug abuse disorders are treatable.

  - Treatment effectiveness for depression is 80-90%, compared with effectiveness rates of less than 50% for cardiovascular disease.
  - When compared to other chronic illnesses like diabetes and asthma, relapse rates are lower for alcohol/drug abuse disorders and treatment compliance rates are higher.

- Parity costs little and can save a lot.

  - Results from other states and numerous studies suggest that parity increases insurance premiums may be less than 1%.
  - Implementation of parity does not restrict the ability of insurers from appropriately managing care so individuals are receiving only medically necessary services for established disorders.
  - Additionally, there is evidence that provision of treatment for mental health and substance abuse disorders can yield savings through reduced use of primary and acute care, improved productivity at work and few sick days.

- Finally, the current limitations on coverage of mental illness and substance abuse disorders are discriminatory and unfair.

ADAPT
Southeastern Wisconsin April 20, 2001

Good Morning

Mr. Tyler and I are here representing ADAPT of Southeast Wisconsin. ADAPT is an organization of Americans with Disabilities supporting our right to live in our communities alongside our brothers and sisters without disabilities. Members of ADAPT range in age from childhood through retirement age. We come in both sexes and all national origins. We have many types of disabilities. We come together to ask you to support services that allow us to remain in or return to our homes as a priority.

We join the Survival Coalition of Disability Organizations in our support for the "Waiting List Initiative" and CIP1A / CIP2 improvements. The "Waiting List Initiative" is a program by the major disability organizations to eliminate waiting lists for home and community-based services.

We would like you to add $6 Million in new funds to Community Integration Program (CIP) IB, $2 Million to Community Options Program (COP) Waiver, $2.5 Million to the Family Support Program (FSP), $2 Million for Birth to 3 (B-3) programs, and $450,000 for Community Support Programs (CSPs) for a total increase in year 1 of $13 Million. We also ask you to add $32 Million to CIP-IB, $6 Million to COP Waiver, $5 Million for FSP, $2 Million for B-3, and $1.5 Million for CSPs for a total increase for the second year of $46.5 Million. The "additional" funds actually save the state money because community services are cheaper to provide than the same services from residential service providers as shown in the attached chart for the Department of Health and Family Services. You can decrease the MA budget for institutional care to realize these savings.

Intermediate Care Facilities for the Mentally Retarded (ICF-MRs) are nursing homes for people with developmental disabilities. They provide "active treatment" in addition to standard nursing home services. CIP-IA and CIP-IB are programs that fund home- or community-based services for people leaving ICF-MRs. These "slots" are created when an ICF-MR closes a bed and a slot is budgeted. Generally one slot serves one person. CIP-IA provides funds for people leaving state centers for people with developmental disabilities (state-run ICF-MRs). CIP-IB provides funds for people leaving other ICF-MRs in the state.

We pay $00/day to keep each person in a DD center bed. Increasing the CIP-IA rate to $300/day for people leaving developmental disabilities centers during the biennium and increasing the rate for those who left or will leave before July 1, 2001 to $160/day will allow the centers to be down-sized or closed.

The State should save money by closing institutions that are no longer necessary. The facilities at the centers can be used for other purposes such as the woman's prison in Union Grove and the geriatric prison to be built on the grounds of the northern center. We support the Survival Coalition goal of closing two of the three DD centers within five years.

We also believe that the CIP-II rate should be increased and artificial limits on the number of "slots" should be removed. CIP-II funds services for people leaving regular nursing homes. CIP-II slots are created when a nursing home closes a bed and the state has budgeted the slot. COP-W is also for people (elderly and those with physical disabilities) who meet a nursing home "level of care." When a bed is closed behind a person leaving a nursing home, the MA cost of $100/day is replaced by an average cost of about $40/day. The Department of Health and Family Services should continue to use CIP-II to allow people with mental illness living in nursing homes to return to community settings, where possible.

We believe that the governor's proposal to spend Intergovernmental Transfer funds to increase payments to the Nursing Home industry is ill-advised and should only be allowed if the funds can be used for long term care services of the consumer's choice. State Medical Assistance budgeting policies should be changed so that funds may follow a person from an institution to the community. Community-based services are required under the ADA and allow a flexible response to the increasing number of nursing homes closing. Increasing CIP slots when beds close does not increase state spending and therefore should not require legislative approval. We also support funding the Family Care Alternative Model to simplify funding of community care.

The Family Support Program funds respite care and other services for families of people with developmental disabilities. The Birth to Three programs fund enrichment and other services for children from birth to three with severe disabilities.

Community Support Programs are Medical Assistance programs which provide services for people with mental illness in the community. Historically, counties have paid the share of MA funds not paid by the federal government. Some counties have not fully funded the programs denying some people services to which they are entitled.

We also support the "Families are Worth It" Children and Families Package. This package includes a proposal to provide new funding to begin piloting the Children's Long Term Support (LTC) Redesign to serve 20% of the state's eligible children. This would require $1.3 million in year 1 and and $3.3 million in the second year. It also includes $1.575 for "lifespan respite" projects for each year and increased funding for special education.

While the governor's proposal would decrease the state special education reimbursement rate from 35.7% to 33.2% Survival and the Quality Education Coalition would like the rate increased to 50%. "Families are Worth It" also includes increased reimbursement for children who are extraordinarily expensive to serve, $5 Million Year 1 and $10 Million Year 2 increases for alternative education programs, $4 million to expand "integrated services"/wraparound programs to serve children with emotional disturbances, and changes to the medical assistance reimbursement formula that would return local special education funds to the local districts.

We believe that the long-term care system in the state is too complex. Many people

require advocacy in order to access services that are safe, healthy, less expensive and recognize the potential of the person. The state should provide advocacy for residents of care institutions and those who need community services. We support full funding of the long term care Ombudsman program and the Survival proposals to fund Family Care Independent Advocacy ($550,000 each year) and MH Advocacy, including advocacy on assisting transition services.

We support delivery of consumer-controlled Mental Health services. We endorse the Survival Mental Health Package. Recovery of people with mental illness can be increased by increasing funding of consumer and family support programs by $250,000 in year 1 and $500,000 in year 2 and increasing the consumer relations coordinator position in the Bureau of Community Mental Health to full time ($24,000). In addition to these components and the ISP/wraparound services referred to above, the flexible wraparound services provided by the comprehensive community service benefit should be funded. In addition, $160,000 for year 1 and $928,000 for services in each year of the biennium should be provided for the Blue Ribbon Commission demonstration projects. These projects are intended to provide more consumer and family directed, managed mental health care.

$1 million per year in new DVR funding & reforms are necessary to ensure that people with disabilities can gain real employment opportunities.

Special transportation is necessary for many people with disabilities to go shopping, go to the doctor or a job. Urban areas with mass transit systems are required to provide paratransit service for those unable to ride the bus due to their disability. Because of inadequate state support for this service, many systems provide inadequate services or rely upon county property tax levies. Other areas of the state lack any significant transportation service for people with disabilities. We support the Survival proposal to increase "85.21" funding by $7.5 Million in each year of the biennium.

Assistive Technology (AT) helps many people with disabilities to live in the community. Federal funding for resources, technical assistance and advocacy related to AT has decreased in recent years while the need has increased. We support the Independent Living Assistive Technology Initiative for $800,000 in each year.

The proposed prescription drug benefit should be expanded to people with disabilities.

Thank you for your attention. Please Free Our People!

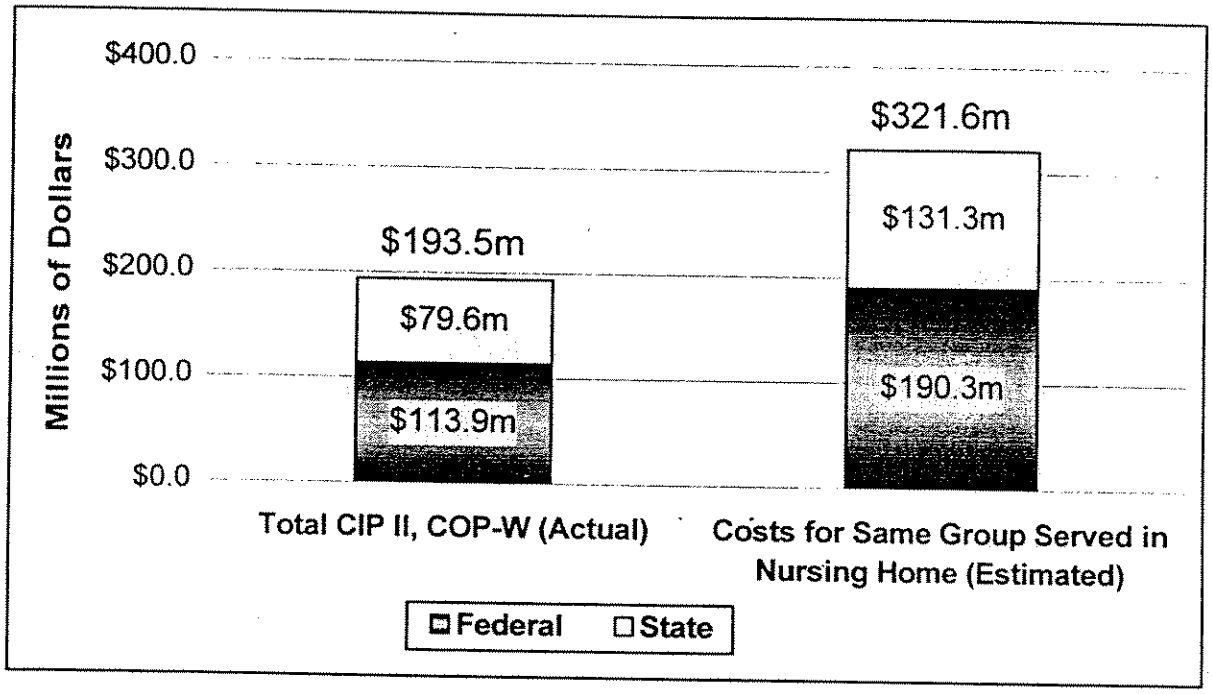
On behalf of ADAPT - SE Wisconsin

Mike Bachhuber
1240 E. Chambers St.
Milwaukee, WI 53212
bachuber@execpc.com
(414) 372-8609

Tobie Tyler
N17 W26860 E. Fieldhack Dr. A
Pewaukee, WI 53072
tobielaw@aol.com
(262) 695-9428

Comparing COP-Waiver Participants' Costs to their Costs if They Would Have Received Nursing Home Care

This graph illustrates the costs for participants served in the COP-Waiver and compares those costs for these same participants if they would have been served in a nursing home. If COP-Waiver participants at the same level of care were served in a nursing home the total state and federal costs are compared below.



Catharine Krieps
1042 S. 7th Avenue
West Bend, WI 53095
(262) 338-8537
ckrieps@attglobal.net

Testimony on Behalf of the Birth to Three Program,
Joint Finance Hearing, April 20, 2001

Hello. My name is Catharine Krieps, and this is my son, Benjamin Newell. We came from West Bend today to speak with you about the Birth to Three program. I represent Birth to Three Lasts a Lifetime, so I'm speaking for other parents all around the state who care very much about this program.

When he was born 4 ½ years ago, Benjamin had a very difficult delivery, and was deprived of oxygen. He spent his first three weeks in the hospital's intensive care nursery. For a week and a half, I couldn't even pick him up. When it was time for us to bring him home, my husband Jim and I had no idea what to do with Benjamin. We were first-time parents, but we also had to feed him through a tube in his nose. It was overwhelming to try to take care of all his medical needs.

Thankfully, someone from the hospital contacted the local Birth to Three program. Our therapists were our lifeline, especially that first year. They came to our house, and showed us how to help Benjamin play and develop. They helped our family, too, by giving us information and ideas, and putting us in contact with other parents of special needs children. They guided us through some of the hardest times any family can face. Above all, they helped us to begin our relationship with Benjamin as our child, and not as a complicated set of medical problems.

Birth to Three has made a real difference for us, and for many other families like ours. A month ago, we held a legislative breakfast, and gave you our Birth to Three stories on teddy bears and in binders like the one I have here, which has dozens of stories from all over the state. All these families are asking you to support Birth to Three by fully funding it, which would cost an additional $2 million a year.

Right now, the program is stretched to the breaking point. There has been no state funding increase since 1996, but 21% more children are receiving services. For some time, counties have struggled with this increase. Some have threatened to shut down their programs. In many counties children are not getting the services they need. One proposed "solution" is to cut back on the number of children eligible for Birth to Three. That would just send children with more delays and greater needs into the schools, and into our state's institutions. No one can call that a solution.

All children deserve a good start in life. With the help of the Birth to Three program, every child in Wisconsin can have it. Please support full funding for Birth to Three in this budget, for our children's sake. Thank you.

One final note: I have received more Birth to Three stories from families since our legislative breakfast, so I have brought those along to share with you today.

LEGISLATOR PARTICIPATION AT BREAKFAST March 13, 2001

LEGISLATORS PRESENT

Senator James Baumgart
Sen. Richard Grobschmidt
Senator Dave Hansen
Sen. Joanne Huelsman
Senator Rodney Moen

Rep. Terese Berceau
Rep. Spencer Black
Rep. Glenn Grothman
Rep. Scott Jensen
Rep. Steve Kestell
Rep. Judy Krawczyk
Rep. John La Fave
Rep. Michael Lehman
Rep. MaryAnn Lippert
Rep. Mark Miller
Rep. Joe Plouff
Rep. Kitty Rhoades
Rep. John Ryba
Rep. Jennifer Shilling
Rep. Jeff Stone
Rep. Steven Wieckert

LEGISLATORS WHO SENT STAFF

Governor Scott McCallum

Senator Chuck Chvala
Senator Jon Erpenbach
Senator Mary Lazich
Senator Mary Panzer
Senator Judy Robson
Senator Carol Roessler
Senator Robert Wirch

Rep. Larry Balow
Rep. Peter Bock
Rep. David Cullen
Rep. Marc Duff
Rep. Steven Foti
Rep. Don Friske
Rep. John Gard
Rep. Scott Gunderson
Rep. Timothy Hoven
Rep. Suzanne Jeskewitz
Rep. Jim Kreuser
Rep. John Lehman
Rep. Lee Meyerhofer
Rep. Mark Pettis
Rep. Tom Sykora
Rep. John Townsend
Rep. David Travis
Rep. Robert Turner
Rep. Gregg Underheim
Rep. Daniel Vrakas
Rep. Bob Ziegelbauer

Milwaukee Journal Sentinel

final edition

Plush push: Fund effort uses bears

By JESSICA HANSEN
of the Journal Sentinel staff

Families of children with special needs will gather in Madison next month to wage a teddy bear war they hope will persuade lawmakers to increase funding for the Birth to Three program.

The program, federally mandated but implemented by states and counties, offers therapy for developmentally disabled or delayed children up to age 3, and provides education and support for their families.

Since 1996, federal and local funding for the program has increased, but state funding has not, shifting more of the financial burden to Wisconsin counties. Teddy bear campaign organizers and at least one state legislator say that burden is becoming nearly impossible to meet.

On March 13, members of Parents as Leaders, or PALS — a statewide network of parents of children with special needs — will meet in Madison to distribute the bears to Gov. Scott McCallum and all of the state's legislators. Each bear will carry the photo and story of a disabled child who has been helped by Birth to Three.

Legislators then will meet one-on-one with the children and their families at a legislative breakfast.

"We think it's time our legislators meet our children and step up to the plate on this issue," said Anne Eggenberg, a member of PALS and an organizer for the teddy bear campaign. "We cannot take the risk that some children will not receive the services they need."

Eggenberg's 13-month-old son, Adam, will be among those children represented at the gathering.

Born nine weeks premature, Adam suffered brain damage because of a lack of oxygen during delivery. Doctors enrolled him in the Birth to Three program shortly after he was born.

"The therapy Adam receives has really made a difference in his development," Eggenberg said. "He is making slow, but steady, progress."

While Eggenberg says her son has been helped by the program, "drastic underfunding" is forcing some children to go without services. According to PALS, many counties have cut the number of services they offer and some counties have started making parents pay for therapies that are offered.

The federal government requires states to have Birth to Three, which offers physical, speech and occupational therapies to children with special needs. States and local governments must administer the program and find whatever funding the federal government does not provide.

In Wisconsin, federal and state aid pays for 53% of Birth to Three, according to data compiled by PALS, which is part of the Wisconsin Personnel Development Project. The project gets its money from the Wisconsin Department of Health and Family Services.

Wisconsin counties pay the other 47%.

Since 1996, federal funding of Birth to Three has increased 9.8%; county funding has increased 34%. However, in that time, Wisconsin has not increased state funding of the program at all, the data shows.

State Rep. Mark Miller (D-Monona) said the state's refusal to increase funding, thus forcing counties to pick up the tab, is "killing" the program in Wisconsin.

"I know the impact on those counties," he said. "It's one thing to say we require it by law, and another thing to fund it. To me, it's just unconscionable that we require counties to have this and not give them the funding to do that. This is a big issue for counties."

Miller said he is working closely with fellow Rep. Terese Berceau (D-Madison) "to make a concerted effort to put this on the state budget."

For Angela and Jim Mirr and their 2-year-old son, Auden, such relief cannot come too soon.

Since Auden was 3 months old, the Mirrs have driven from their home in Markesan in Green Lake County to Oshkosh, a two-hour round trip, for Auden's various therapy appointments.

Auden, who has Down syndrome, gets speech, physical and occupational therapies.

Oshkosh was the closest therapy available, Mirr said. It is paid through state disability benefits, not Birth to Three.

"Right now, it's down to twice a week but there was a time frame where I was going (to Oshkosh) four times a week," Angela said. "It's hard. It was disruptive to his sleep patterns. It was disruptive to his schedule running him four days a week. It was a financial burden with the gas."

Angela Mirr said her family — including eldest daughter Danielle, 10 — plans to help hand out bears next month and will attend the legislative breakfast.

Until then, Angela Mirr will continue her own part of the campaign: contacting families, pediatricians, nurses and teachers who work with children with special needs. So far, she says, she has sent out close to 100 invitations.

"We have to contact as many of them as we can, so those people in Madison see it's not just a bunch of emotional parents," she said. "It's also professionals and teachers who have strong opinions about this, too."

CONTACT

For more information about the PALS teddy bear campaign and legislative breakfast, contact:

- Angela Mirr at (800) 865-2103, Ext. 03
- Catharine Krieps at ckrieps@attglobal.net or (262) 338-8537.

Submit Birth to Three family stories to:

- Catharine Krieps, 1042 S. 7th Ave., West Bend WI 53095. Include your name, address, story and child's photos. Include three copies of each submission (one each to be distributed to the governor, your senator and your representative).

Milwaukee County
Long Term Care Council

Testimony Before the Joint Committee on Finance
Friday, April 20, 2001

Good Morning, my name is Josephine Henderson and I am Secretary to the Milwaukee County Long Term Care Council. I am speaking in behalf of that Council which represents the interests of older adults and people with physical and developmental disabilities.

I am here today to share the concerns of the Council regarding funding for Long Term Support Services in the proposed State budget.

As you know the Milwaukee County Department on Aging is a pilot site for Family Care, a program you unanimously supported in the previous State budget. In the 9 months that Family Care has been operating in our county:

* We have seen the wait list for service decrease from 3,435 people in July of 2000 to 1,966 people today. That wait list will end by August of this year.

* We have seen 53 institutionalized elders return to the community using Family Care funds and

* We have responded to over 40,000 requests from older adults and those who care for them for information about programs and benefits to assist them.

We know that Family Care is working for older adults in our county! Given this preliminary success, we are puzzled as to why the proposed budget slows down the momentum for this important program. Funds to bring Kenosha into the Family Care fold are imperative to forward movement. With other counties eager to share our success, we urge you to restore funds that will help them plan to bring Family Care to their citizens as well.

We understand the need to review such a new and radical benefit carefully. Our Long Term Care Council shares that oversite function with you locally. But while Family Care is being tested, we cannot stand by and ignore the 11,000 or more people waiting for help in non-family care counties. The Community Options Program is the Lifeline for elderly and disabled people in the 67 non-family care counties. You must give them hope and assistance too while Family Care is piloted. We urge you to allocate resources to address the needs of those who are waiting throughout the State.

We know that keeping people healthy will ultimately prevent or delay their need for public assistance. Yet this budget pays lip service to a benefit that is key to wellness efforts – that is prescription drug coverage. It seems penny wise and pound foolish to address the care needs of the frail and disabled without assuring that people have the medication they need to prevent their reliance on the Long Term Care system. We urge you to include a meaningful prescription drug benefit in the upcoming budget.

Finally, we ask you to reconsider the elimination of consumer and independent oversite of Family Care. Our local Long Term Care Council has benefited from the expertise of those who actually participate in the day-to-day operations of the long term care system. Those who receive services and those who provide services are in a unique position to assure that Wisconsin's Long Term Care programs remain national and international models. We cannot afford to design and operate such life-sustaining programs in a vacuum. We urge you to restore the dollars that would support both the statewide Long Term Care Council as well as the independent advocates.

I want to conclude my remarks with a story, which I hope, will illustrate the reason for my appearance before you today.

As you know, Long Term Support programs in Wisconsin are about choice. They are about receiving the right amount of service, in the right place and at the right time. This was certainly the case for Joanne and James. Joanne had lived in a nursing home in Milwaukee for 5 years. In January, she learned that that nursing home was closing. Instead of contemplating more time in institutional care, Joanne and her friend James decided that they would test the promise of "choice" and "dollars following the person" that Family Care promised. They asked their care manager to investigate the possibility of public housing for them. Despite their need for help with housekeeping, baths and transportation – despite the years they had lived in the nursing home they decided to take a chance. When the nursing home tempted them with placement in another facility, they asked for help from the independent advocate. With everyone acting as a team and with the easily available Family Care dollars, Joanne and James will move into their new apartment on May 1st.

This is one of hundred's of success stories possible because together as a State, we decided we could make a bold statement through our Long Term Support Program's.

Please do not weaken in your resolve now. We are so very close to success.....

April 20, 2001

TO: Members of the Wisconsin State Legislature, Joint Committee on Finance

FROM: Darryl D. Pendleton D.M.D., Executive Director
Milwaukee Area Health Education Center (AHEC)

RE: Wisconsin AHEC System request for $1.5 million annual appropriation for the 2001-03 biennium

Thank you for supporting the Wisconsin AHEC.

The attached information will serve as my written testimony to support the Wisconsin AHEC's request for an increase of $341,800 over the governor's proposal, for a total annual appropriation of $1.5 million for the 2001-03 biennium.

Please feel free to call me at (414) 226-2432 if you have questions.

One again, thank you for your support.

Milwaukee Area Health Education Center, Inc. (MAHEC)
2220 East North Avenue
Milwaukee, WI 53202
(414) 226-2432 • FAX: (414) 226-2433

UW Medical School-WI AHEC System, Inc.
1300 University Ave./203 Bradley Memorial
Madison, WI 53706
(608) 263-1712 • FAX (608) 263-5995

AREA HEALTH EDUCATION CENTER SYSTEM

WISCONSIN

March 19, 2001

TO: Members of the Wisconsin State Legislature, Joint Committee on Finance

FROM: Wisconsin Area Health Education Center (AHEC) System

RE: Wisconsin AHEC System request for $1.5 million annual appropriation for the 2001-03 biennium

In the last biennial budget cycle (1999-2001) the legislature approved an annual appropriation of $1.5 million for the operation of the Area Health Education Center System in Wisconsin. We were most gratified to receive this vote of confidence from the legislature for our programs. Unfortunately, Governor Thompson used his line item veto to reduce the amount by $350,000, to $1,154,000 annually. Governor McCallum's budget proposes an annual appropriation for AHEC of $1,158,200 for the 2001-03 biennium. AHEC is requesting an increase of $341,800 over the governor's proposal, for a total annual appropriation of $1.5 million for the 2001-03 biennium.

AHEC's federal funding for core programming ($2.26 million at its peak in FY97) ended on September 30, 1999. The federal AHEC program expects the states to maintain their AHECs after federal core funding ends, but Wisconsin AHEC did not expect state funding to completely replace the federal dollars. We did expect a base level of state funding that would enable us to

- maintain our statewide program office and four regional centers,
- retain staff adequate to ensure a minimal level of continuing programming in each region,
- provide support for several targeted statewide initiatives, and
- provide an organizational base adequate for seeking additional public and private grant funds targeted at new projects to improve the delivery of health care in Wisconsin's communities.

Milwaukee Area Health Education Center, Inc. (MAHEC)
2220 East North Avenue
Milwaukee, WI 53202
(414)226-2432 • FAX: (414) 226-2433

UW Medical School-WI AHEC System, Inc.
1300 University Ave./203 Bradley Memorial
Madison, WI 53706
(608)263-1712 • FAX (608) 263-5995

The AHEC System Board calculated that an annual appropriation of $1.5 million was the minimum amount needed in continuing state support to be able to meet these goals. With a lower appropriation, we feared that we would have to close one of the regional Centers. However, because we had the final three months of federal core support remaining in state fiscal year 2000, we were able to maintain all four Centers in FY00 and initiate some new statewide programs even with the $350,000 reduction resulting from the Governor's line item veto. In FY01, however, we have had to eliminate some of our statewide project funding, reduce regional programming and hold key staff positions vacant in order to cover a full twelve months of operating costs for our Centers. If the AHEC appropriation remains at the current level, we will have to revisit the question of either closing a Center or eliminating statewide projects. To enable the AHEC System to continue to address, on a regional level and through statewide initiatives, the problems of access to quality health care in our underserved communities, we are looking to the legislature to restore the full $1.5 million annual appropriation requested by AHEC.

The Wisconsin AHEC System works to improve the supply, distribution and quality of health care professionals in Wisconsin, thereby improving access to health care in the state's rural and underserved areas. During the 1999-01 biennium, regional programming has focused on four key program areas:

1. Enhancing the learning experience for all health professions students at community-based sites, with an emphasis on interdisciplinary programs, developing cultural competence and technology support.

2. Supporting health careers recruitment programs in underserved rural and urban areas, to assist high school and college students from underrepresented populations prepare for entry into health professions schools.

3. Supporting faculty mentors and preceptors at community-based training sites with continuing education, technology support and other services to enhance the practice environment and maximize the ability of health professionals in underserved communities to provide high quality health care.

4. Partnering with local organizations for outreach activities to improve the health of the community.

In each of these program areas, the regional Centers provide the network to bring together the resources of our academic, community and employer partners in a collaborative effort to improve access and quality of health care in Wisconsin's communities. Overall, during the first year of the current biennium (July 1999-June 2000), AHEC Centers supported or enhanced community-based training opportunities at 239 community-based sites for over 1500 health

professions students (including medical students and medical residents, and students in dentistry, nursing and nurse practitioner, pharmacy, physician assistant, allied health, social work and dental hygiene programs). Health careers programming included large group informational sessions to K-12 audiences reaching approximately 4600 students, 425 K-12 staff and 42 high schools, including 36 high schools in underserved areas. In addition, Centers provided support, encouragement and enrichment programming for 143 college students, 177 high school students and 354 elementary and middle school students from minority or underserved populations who are interested in health careers. Centers also sponsored continuing education programs reaching over 2000 providers. Eight of these programs were offered via distance technology. Approximately 1500 people attended AHEC-sponsored conferences and health education programs for the general public. The attached pages provide additional detail about the activities of each Center in 1999-2000 and the communities affected in each region.

In December 1999, the AHEC Board identified four areas for statewide initiatives. These are areas where the Board determined that AHEC was uniquely able to bring together partners and resources to focus attention statewide on several areas of need:

- Oral Health/Access to Dental Care
- Telecommunications Access Initiatives
- Innovative Partnerships with Local Health Departments
- Health Care Workforce Development

The **Oral Health Initiative** addresses Wisconsin's problems providing adequate access to dental care for all its residents. Through this initiative, AHEC has worked to facilitate training more dental students at sites in underserved areas through site development and a tele-dentistry program. The program also includes a symposium to introduce students to Medicaid programs and development of an outreach plan to address the barriers Medicaid recipients face in accessing dental care. In addition, an oral health website is being developed for use by K-12 students. A variety of regional initiatives also address Wisconsin's dental care crisis.

The **Telecommunications Access Initiative** seeks to expand Internet access and videoconferencing capability at various training sites to enable programs to continue to place students in community sites while assuring consistency in the educational program for all students. The broad goal of the initiative is to create a community of learning that overcomes barriers of distance and allows core curriculum and teacher/learner consultation to be available at

community-based clinical training sites everywhere in Wisconsin.

Work began on the **Innovative Partnerships with Local Health Departments Initiative** following a joint conference with local health departments and the Division of Public Health in October 1999, as we began to pursue several areas of collaboration. One of the most exciting outcomes was the initiation of the *Community Health Internship Program*, a summer program matching students with county health departments for service-learning projects. The first program was developed in summer 2000 by Milwaukee AHEC in partnership with the UW Medical School- Milwaukee Clinical Campus and the City of Milwaukee Health Department. Students participated in field work, clinical shadowing opportunities, lectures and presentations by medical personnel. This program provided the health department with assistance in several important projects while students gained valuable experience. Plans for 2000-2001 projects with local health departments focus on building on the success of the Milwaukee summer intern program by providing continuing support for that program and facilitating development of similar programs in other regions.

The Wisconsin AHEC system has traditionally focused its activities on development of Wisconsin's primary care physician, physician assistant, pharmacist, dentist and advanced practice nursing workforce. The **Health Care Workforce Development Initiative** was designed to take a broader focus on emerging needs for bachelors-prepared nurses, personal care and long term care workers, and public health and allied health professionals. Our goal is to develop Wisconsin's healthcare workforce at all levels so that it

- is sufficient in number and training to provide high quality care in all areas of the state
- is distributed so that it meets the needs of individual communities, institutional settings, and larger geographic areas that are currently underserved,
- reflects the diversity of the state's population, and
- is skilled at meeting the needs of patients from various cultural backgrounds.

AHEC's October 2000 conference *Developing Wisconsin's Health Care Workforce* provided participants with an overview of Wisconsin's current health care workforce, health status indicators and emerging health needs; current workforce planning effort and innovative strategies for addressing recruitment, retention, diversity and distribution of the health care workforce. To begin to address these issues, AHEC embarked on several new programs, including organization of the *Health Careers Consortium*, a group of health careers professionals who work to develop better outreach programs to the schools; and co-sponsorship of the *Health Care Workforce Coalition* which works with various government, employer and professional groups, including the Wisconsin Hospital Association, the Wisconsin Nurses Association, the Department of Workforce Development, the Governor's Work-Based Learning

Board and the Department of Public Instruction to develop broader support for health professions programming in the schools, articulation of career opportunities for health care workers, and a forum for discussion of policy issues affecting development of an adequate health care workforce for Wisconsin. The activities of these groups are outlined in more detail in the attached materials.

There is still much work to be done in all these areas. With a full budget of $1.5 million, we plan to continue our commitment to new programming focused on these four initiatives. Without it, AHEC's ability to continue to develop innovative programs to improve the distribution, supply, quality, utilization and efficiency of health personnel in underserved communities will be seriously compromised.

Attachments:
- Wisconsin AHEC Contacts
- Map of Wisconsin AHEC Regions
- Wisconsin AHEC System Board of Directors
- Wisconsin AHEC Organizational Chart
- 1999-2000 Program Year Summary of Accomplishments

cc: Members of the Legislature
Dept. of Administration Budget Office staff
Legislative Fiscal Bureau staff

AREA
HEALTH
EDUCATION
CENTER
SYSTEM

Wisconsin AHEC System

The **Area Health Education Center** (AHEC) program is a national program, begun in 1970, for improving the accessibility and quality of primary health care. The program was designed to encourage universities and educators to look beyond the institutions to partnerships that meet community health needs, working toward the goal of decentralizing health professions training and linking communities with academic health centers in partnerships that promote cooperative solutions to local health problems.

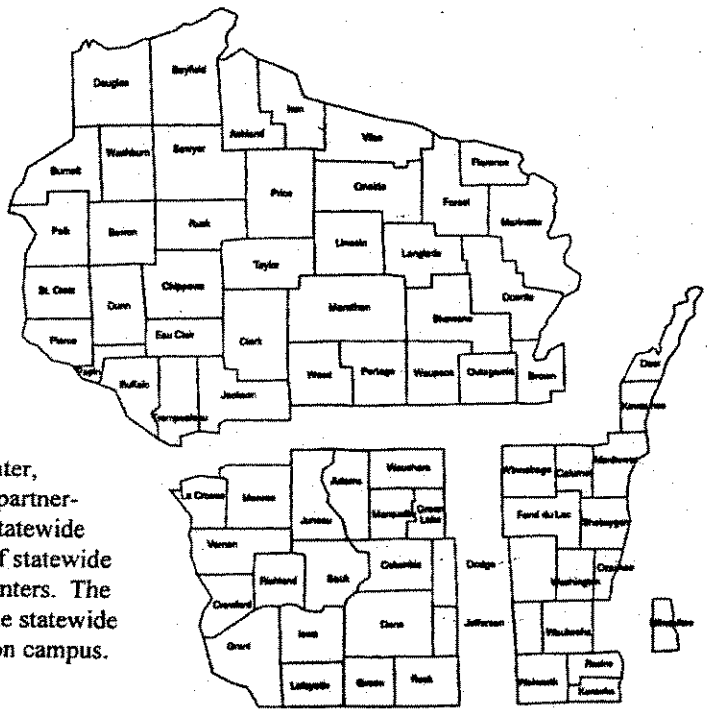
Development of the AHEC program in Wisconsin started with a small state grant in 1990. The program received federal core AHEC funding from 1991-1999. It is now supported through an allocation in the State of Wisconsin budget, smaller federal and private foundation grants and membership and services fees, as well as the substantial contributions of its academic and community partners in developing and maintaining community sites.

The **Wisconsin AHEC System** works to improve the supply, distribution and quality of health care professionals in Wisconsin, thereby improving access to health care in the state's rural and urban underserved areas. Program areas include the following:

- Enhancing the learning experience for all health professions students at community-based sites, with an emphasis on interdisciplinary programs, developing cultural competence, and technology support
- Supporting health careers recruitment programs in underserved rural and urban areas, to assist high school and college students from underrepresented populations prepare for entry into health professions schools
- Supporting faculty mentors and preceptors at community-based training sites with continuing education, technology support and other services to enhance the practice environment and maximize the ability of health professionals in underserved communities to provide high quality health care
- Partnering with local organizations in a variety of outreach activities to improve the health of the community.

The **Wisconsin AHEC System** has established four regional, private, not-for-profit AHEC corporations to insure community representation in decision-making regarding AHEC programs. The community boards of these regional corporations allow the **AHEC System** to be cognizant of and responsive to community needs.

Each of the four regional centers is an independent not-for-profit corporation, separate from the medical school, and has a designated geographic area. The four regional centers cover the entire geographic area of Wisconsin. Each regional center has a center director working at least 75 percent time. In addition to the Executive Director, each AHEC employs a support staff, usually including an education coordinator. To insure community representation in decision-making regarding AHEC programs, each center has a community board comprised of health professionals, community representatives, and consumers in the regions served by the community-based AHECs. Board representation and input allows Centers to respond to community identified needs. The boards meet quarterly and keep minutes of all proceedings. In 1998 the four regional centers approved by-laws to create a statewide organization, with representation from each center, the academic partners and state and community organizations. In partnership with the UW Medical School, the Board of Directors of this statewide organization, Wisconsin AHEC System, Inc., provides oversight of statewide AHEC activities, including distribution of funds to the regional centers. The UW Medical School provides space and administrative staff for the statewide program office at the Medical School facilities on the UW-Madison campus.



(over)

Each AHEC conducts programs in conjunction with various health professions schools. Centers not only partner with schools within their geographic region, but also draw on the disciplines of health care professionals best suited to meet the health care needs of the communities the centers are serving. In conjunction with each of these schools, centers have created or supported over 50 AHEC sites where health professions students are trained. These sites include migrant and community health centers, health care for the homeless projects, rural health clinics, managed care organizations, as well as other public and private community-based clinics, and hospitals that serve rural and urban underserved populations. Many of these sites allow students to participate in other settings such as an AIDS support network, an Alzheimer's center, a WIC program, or an immunization clinic, among others.

In addition to developing these opportunities for community-based training for health professions students, Wisconsin AHEC has also developed health careers programs to assist high school and college students from underrepresented populations prepare for entry in health professions schools, facilitated continuing education programs for health care providers to maximize the ability of health professionals in underserved communities to provide high quality health care, provided programs to improve access to computer-based health information resources, and developed other programs to enhance the practice environment in underserved areas.

Wisconsin AHEC System Program Office
Nancy A. Sugden, Director
1300 University Ave./203 Bradley
Madison, WI 53706
(608) 263-1712
(608) 265-5995 FAX
nasugden@facstaff.wisc.edu

Northern Wisconsin AHEC
Suzanne Matthew, Director
719 N. 3rd Ave.
Wausau, WI 54401
(715) 675-7899
(715) 675-3441 FAX
smatthew@dwave.net

Eastern Wisconsin AHEC
Midge Pfeffer, Interim Director
900 Wood Rd.
P.O. Box 2000
Kenosha, WI 43141
(262) 595-2135/(920) 458-4808
(262) 595-2513 FAX
mjpf@bytehead.com

Southwest Wisconsin AHEC
Joel Davidson, Director
1300 University Ave./ 214 Bradley
Madison, WI 53706
(608) 265-9510
(608 265-0639 FAX
cardioma@itis.com

Milwaukee AHEC
Darryl Pendleton, Director
2220 East North Ave.
Milwaukee, WI 53202
(414) 226-2432
(414) 226-2433 FAX
milahecp@aol.com

Wisconsin AHEC System

Summary of Accomplishments

1999-2000 Program Year

Program Area	Accomplishments
1. **Enhancing the learning experience for all health professions students at community-based sites, with an emphasis on interdisciplinary programs, developing cultural competence and technology support**	<u>Development of Community-Based Training Sites and Curricula</u> • total of 239 community-based training sites now active, serving over 1500 health professions students <u>Interdisciplinary training experiences</u> • new curriculum developed at two sites in Milwaukee area • updated interdisciplinary program offered to 16 students at 10 sites in northwestern Wisconsin • rural health care delivery course developed for pre-professionals in southwest Wisconsin region • explored possibilities with three potential partners in northeast Wisconsin. • developed interdisciplinary potential of dental hygiene program in school-based clinics in Green Bay <u>Programs extending student's competence in providing care to diverse populations</u> • new curriculum developed at 2 sites in Milwaukee area • 60 community cultural rounds presentations • one conference on health care in the urban setting with 260 attendees • site development and design of 3 year community curriculum for family practice residents in Elkhorn • two-day cultural immersion experience with Native American and Hmong communities for 35 health professionals in the Northern region • new training opportunity for residents at a Migrant Health Center in the Southwest region • the *Wisconsin Express* program provided summer experience for 25 students at sites throughout the state • AHEC's academic calendar for health professions students provided expanded health data and information on Wisconsin's underserved communities <u>Services for access to Internet, telehealth and distance education resources</u> • three new web-based courses/information sites developed • developed teledental resources for use by 260 dental students • Internet health information search skills workshops provided to over 350 providers and staff • developed infrastructure for distance education case conferences for rural residency training programs • developed WATF grant proposal for funding additional equipment. • funded development of 7 courses for nurse practitioner distance education program

2. **Supporting health careers recruitment programs in underserved rural and urban areas, to assist high school and college students from underrepresented populations prepare for entry into health professions schools**	Outreach efforts to recruit minority students and students from underserved communities • increased health careers activities, continuing education for minority providers and community-based training in the Milwaukee region • increased capacity for recruitment and retention statewide by providing support for health professions student organizations • provided staff and organizational support for the WisTREC program, which provides training opportunities for health professionals in underserved communities who wish to pursue nurse practitioner, physician assistant or nurse midwife training while maintaining their current employment Intensive programs for pre-college and college students, including summer programs • summer programs in Milwaukee, Kenosha, Madison and Wausau provided opportunities for approximately 50 minority students • test prep (GRE, DAT, MCAT and SAT/ACT) courses provided for 43 students Health career awareness activities • health careers programming reached 200 grade school students, 1750 high school students and 500 college students statewide • see Healthcare Workforce Development initiative (5d.) below for more information
3. **Supporting faculty mentors and preceptors at community-based training sites with continuing education, technology support and other services to enhance the practice environment and maximize the ability of health professionals in underserved communities to provide high quality health care**	Regional faculty development workshops • Milwaukee: Community Cultural Rounds (2000 participants), urban health conference (260 participants), dental preceptor training, physical therapy preceptor training (37 participants). • Northern: seven workshops on building information search skills conducted for 77 providers. • Southwest: training program for 53 providers on health care issues in agricultural populations. • Eastern: funding provided for development of medical student, resident and physician assistant preceptors in Door County • Statewide: workshops on mentoring for cultural competence; preceptor development workshops for family medicine and physician assistant community faculty Telecommunications and library resources support for rural providers • training in accessing health information via the Internet provided for 45 public health nurses in the Eastern region • three train-the-trainer workshops presented in three different communities in the Northern region to teach health information Internet searching skills • Internet health information search training to 12 sites and 285 individuals in the Southwest region. Innovative faculty and student projects to develop interdisciplinary and cultural competence curricula and experiences and web-based distance learning projects • nine new projects Wisconsin Rural Training Track Study Group • held two statewide WRTTSG meetings, developed RTT website for more effective student recruitment and supported travel for faculty to national meetings.

4. Partnering with local organizations for outreach activities to improve the health of the community	Eastern: • prenatal care program for uninsured women in Kenosha county • presentations by medical residents to Fox Valley community groups and schools • development of school-based health services in Fond du Lac, Two Rivers and Green Bay • community outreach health clinic in Menomonee Falls • health education at diabetes clinic in Calumet County • development of Women's Area Health Connection in Ripon • Sexual Assualt Nurse Examiner training program in southeast Wisconsin • health education program for Hilbert area families and community members Milwaukee: • Community Cultural Rounds presentations • oral health promotion • minority health promotion and publicity campaign • community health summer internship program • Internet resources for diet and nutrition • tobacco prevention activities • urban health conference • physical therapy preceptor training • dental preceptor training Northern: • "Telehealth Network Support Group" project provided 8 group meetings via distance for 77 facilitators and community members • two day cultural immersion experience with Native American and Hmong communities for 35 providers • assisted with downlink of APHA annual conference at 6 sites for 31 providers maintained Northern AHEC listserv and continuing education web page, providing notices for 163 training and education programs • SSDI/AHEC "Building Skills" workshops provided for 250 health providers • organized two Women's Health Conferences attended by over 650 women Southwest: • training in assessment and management of adolescents who abuse alcohol, tobacco, and other drugs provided to 36 medical residents • funding provided to develop a nursing care delivery model for health promotion and prevention presented to 230 practicing health professionals and preceptors • a new, student-run clinic was started at a community-based site for homeless adolescents • funding was provided to a program providing 18 medical students with leadership training and support to carry out innovative community service projects • funding provided to develop a nursing care delivery model for health promotion and prevention presented to 230 practicing health professionals • a training program was held for 53 providers in a three-county agricultural area around agriculture-related health needs • provided on-site and hands-on Internet health information search training at 12 sites to 285 participants.

5a. **Special Statewide Initiatives:** **Oral Health**	AHEC's Dental Initiative has been developed and implemented primarily by Milwaukee AHEC in partnership with Marquette Dental School. Components of this statewide program include: • A Medicaid Symposium is scheduled for the spring of 2001; the symposium will introduce students to Medicaid programs. • An Oral Health Website is being developed with the Wisconsin Teachers Association. • Externship Preceptor Conference – a training workshop for dentists interested in serving as preceptors • Tele-Dentistry Initiative – currently 3 sites are being established. Additional state and federal support will be sought to expand the project to include additional sights • DHFS Medicaid Mandate – the DHFS has been directed to develop an education and outreach plan addressing the educational barriers Medicaid recipients face in accessing dental care • National Health Service Corps (NHSC) Scholarship – one students has been accepted for the scholarship, and will serve as an ambassador to help recruit future students for the NHSC scholarship Other initiatives in the AHEC regions include: • a proposal for a new dental residency program in an underserved area in southwest WI • a proposal for a new dental clinic where an estimated 24 dental hygienist students per year will provide care for Medicaid and other underserved patients in southwest WI. • addition of a dental hygiene preceptor supervising students in two Family Resource Centers in the Green Bay school system.

5b. **Special Statewide Initiatives:** **Telecommunication Access for Training Sites**	Under this initiative, funding was provided for enhanced Internet access for students and residents at family medicine training sites throughout Wisconsin. Computers and network hardware, as well as support for a dial-in modem pool were provided at a variety of clinic sites (including Belleville, Verona, Wausau, Eau Claire, Richland Center, Monroe, Baraboo and Appleton) enhancing existing resources and enabling residents and students dial-in access for email, web and library resources. New routers purchased for DFM clinics in Belleville, Verona, Wausau and Eau Claire will allow Family Medicine to upgrade their network connections to frame relay T1 speeds (12 times faster than current connections). This will also enable them to deploy video over the network as part of the soon to begin WATF grant written by DFM, AHEC and UW Med School Academic Affairs. The WATF grant will use the DFM statewide digital network to conduct medical education and training via video, the web and email. Targeted users include medical students, medical residents, and faculty. The broad goals of the project are to create a community of learning that overcomes the barriers of distance and allows core curriculum and teacher/learner consultation to be available everywhere in Wisconsin. The intent is to serve as a model for distance learning that can be used by other health professions such as nursing and pharmacy, and that will be of on-going use for continuing education of health professionals. The project's technology core consists of a new video technology from Cicso called IP-TV which uses standard Internet protocols to broadcast video to use PC's, the use of personal videoconferencing products such as Microsoft NetMeeting to connect individual teachers and learners, and a dial-in modem pool with a 1-800 number for statewide access to the electronic resources of the UW-Madison regardless of user location. See also Teledental project, in (5a), above.

5c. **Special Statewide Initiatives:** **Innovative Partnerships with Local Health Departments**	Work on this initiative began with the *October 1999 Wisconsin AHEC annual conference, "Promoting Healthier Communities in Wisconsin,"* a joint meeting with Wisconsin Division of Public Health attended by 150 people. A number of formal and informal partnerships developed from this meeting. A follow-up meeting was held in February 2000 at which participants agreed on several areas where AHEC/DPH collaborations would be most fruitful: • Conference facilitation, • Development of community service learning experiences for health careers students, in partnership with local public health agencies, • Continuing education for health care professionals, including public health workforce in the areas of cultural competence, population health, epidemiology and evidence-based practice, • Expansion of distance education opportunities for practicing professionals, and • Recruitment of young people and adults into the health professions workforce. AHEC supported a variety of projects under this initiative, solicited through a call for proposals, including: *Community Health Internship Program* This summer program matches students with county health departments for service-learning projects. The first program was developed in summer 2000 by Milwaukee AHEC in partnership with the UW Medical School- Milwaukee Clinical Campus and the City of Milwaukee Health Dept. Students participated in field work, clinical shadowing opportunities, lectures and presentations by medical personnel. Funding provided stipends to the student interns and supplies necessary for their projects. Twelve students did projects mentored by 6 health department personnel and health professions faculty. *Community Health Internship* projects included: • EMPACT Beach Health Water Project • Internet Intervention for Low Fat Diet & Physical Activity in Middle School Students • Data Compilation for Healthiest Milwaukee Data Indicators Set • Attitudes of Dental Providers and Dental Care Toward HIV/AIDS Patients • High Risk Diabetic Patients: Assisting with the Monitoring and Education of High Risk Diabetic Patients • Sexuality Transmitted Disease in HIV Positive Women: Establishing a Patient Education Module • Issues in Geriatric Medicine: Monitoring Falls in an Elderly Population • Investigating Women's Health Issues: The Workings of a Nurse Midwifery Center in an Urban Setting • Investigating the Different E. Coli Bacteria Strains in the Milwaukee Area Water *Rural Health and Aging: Expansion of Health Care Services to Underserved Older Adults in Waushara County* This project is a collaboration between the Waushara County Health Department and UW-Oshkosh College of Nursing. The immediate objectives are (1) to provide intensive experience for senior nursing students in a rural setting, (2) to respond to the health needs of rural, isolated elderly persons, residing in low-income or trailer housing, and (3) to initiate recruitment efforts to educate and help attract future health professionals to practice in rural areas. Successful completion of the project will result in casefinding and continuity of health service to low income, socially isolated and medically underserved rural elderly.

5c. (continued) Special Statewide Initiatives: Innovative Partnerships with Local Health Departments	*Extension of Health Services to Underserved Communities by Senior Nursing Students* This project is a partnership with Winnebago and Waushara County Health Departments to provide 2 UW Oshkosh nursing students with an 8-week summer externship and to establish clinical projects for 50-60 nursing students/semester during the academic year. Students will participate in assessment and prevention services by going into schools, clinics, homes, neighborhood groups, homeless shelters and numerous other community sites where they would work directly with community members. The implementation of the projects by nursing students will extend the resources of the health department to better meet the health care needs of underserved populations. *Caring, Inc.: A Partnership for Public Health* This project is a partnership between the LaCrosse County Health Department and Viterbo College School of Nursing. It is based on a community-building model, working with the people of a community to build their capacity. The purpose of the project is to 1) strengthen the public health nursing practice component of the nursing curriculum; 2) provide accessible health promotion/education services to a medically underserved population; and 3) establish an ongoing partnership between the School of Nursing, the La Crosse County Health Department and the Salvation Army. It will result in an innovative learning experience for student nurses; a Health Resource Center where clients can receive health education, screening, follow-up and referral; and an academic-community partnership with multiple formal and informal linkages within the community. This project will establish a new clinical site and provide all senior nursing students at Viterbo (70-80 students) with the opportunity to rotate through the Salvation Army Health Resource Center. Students will have a public health nurse preceptor and work collaboratively to provide health promotion and health education services to a vulnerable population. *Collaborative Interdisciplinary Discussion Groups on Hmong Culture* The focus of this project, a partnership between the UW Eau Claire, the Hmong Mutual Assistance Association and the Eau Claire City/County Health Department, is on improving the health of Hmong clients through increasing the knowledge of health providers . Health professions involved included physicians, nurses, counselors, social workers, psychologists, dietitians, health educators and others. Leaders will be recruited from the first group to lead collaborative research discussion groups in another larger, managed health care agency. This pilot project provided the foundation for a grant proposal to the Agency for Health Care Policy Research to provide for continued funding.

5d. Special Statewide Initiatives: Healthcare Workforce Development	The Wisconsin AHEC system has traditionally focused its activities on development of Wisconsin's primary care physician, physician assistant, pharmacist, dentist and advanced practice nursing workforce (see item #2, above). This initiative was designed to take a broader focus on emerging needs for bachelors-prepared nurses, personal care and long term care workers, and public health and allied health professionals at all levels. Our goal is to develop Wisconsin's healthcare workforce at all levels so that it • is sufficient in number and training to provide high quality care in all areas of the state • is distributed so that it meets the needs of individual communities, institutional settings and larger geographic areas that are currently underserved • reflects the diversity of the state's population • is skilled at meeting the needs of patients from various cultural backgrounds AHEC's *October 2000 annual conference "Developing Wisconsin's Health Care Workforce,"* provided 150 participants with an overview of Wisconsin's current health care workforce, health status indicators and emerging health needs; current workforce planning efforts and innovative strategies for addressing recruitment, retention, diversity and distribution of the health care workforce.

5d. (continued) Special Statewide Initiatives: **Healthcare Workforce Development**	The *Health Careers Consortium* (facilitated by Northern AHEC) , is a statewide organization of over 80 health careers professionals from high school, technical college university and provider organizations who meet regularly to develop programs to provide better outreach to schools. Projects include production of a quarterly newsletter, a display board, career information sheets and other materials for distribution to students, as well as development of a web page (www.wihealthcareers.org) to provide better information to students in an attractive format. *Wisconsin Health Careers* , a booklet with information on over 70 health care fields. intended for use by high school and college students, was revised and updated for distribution in the spring of 2001. It will also be available on the AHEC web page (www.ahec.wisc.edu) *Workforce Planning for Northern Wisconsin Health Care* This focus of this project was to gather factual, direct and focused data from healthcare workers in northern Wisconsin to use as a base for strategic workforce planning. A one-day strategic-planning session was developed in partnership with Northern AHEC for all health career consortium partners. The outcome of the project was a workforce-planning document specific to northern Wisconsin. *Health Care Workforce Coalition* Southwest AHEC and the Wisconsin Health and Hospital Association (WHA) are co-chairing a statewide Healthcare Workforce Coalition focused on • identifying critical healthcare workforce needs • promoting health care career opportunities to middle-and high school age students and others • working with the state Department of Public Instruction and Wisconsin Technical College System to bring more attention to health career opportunities and to better understand the articulation of healthcare courses, degrees, and certification • working with the Wisconsin legislature to educate our representatives about the critical health care workforce needs facing the state and to gain their support for initiatives to make it easier to enter the health care workforce. The coalition has, with support from AHEC, WHA, Wisconsin Nurses Association, and the RWHC, produced a six-minute recruitment video that gives students and parents a look at the career opportunities in health care and a 30-second TV spot that will air statewide with information about how to get more details on health career educational opportunities in Wisconsin. Additionally, a brochure about health careers has been developed that will be distributed to schools. The brochure has a tear-off card that can be sent back to the AHEC office for more information about health careers. A toll-free number to call will also be provided. AHEC staff will call back, if requested, and provide more in-depth information and direct students to educational institutions with their specific health care career interests. A liaison list is being developed for all technical college campuses and 4-yr. campuses in Wisconsin with healthcare programs. The liaisons will be contacted by AHEC so that they can follow up with potential students and/or their parents. The coalition is also drafting material to conduct a legislative briefing during state budget deliberations this spring. Focus will be on the healthcare worker shortage and what initiatives could be initiated to help increase the number of students going into health careers. Recently, coalition members have been meeting with representatives from the Department of Public Instruction to better understand the health occupations and health education courses that are offered in Wisconsin's schools, the certifications required to teach these courses, the barriers to articulating courses from high school to technical college and within the technical college system itself, and have been discussing options to increase students' exposure to health occupations and utilizing health care professionals in the schools to help teach these courses under the guidance of a certified teacher.

WISCONSIN
STATE COUNCIL

SEIU

Stronger Together

SERVICE EMPLOYEES
INTERNATIONAL UNION
AFL-CIO, CLC

8021 W. Tower Avenue
Milwaukee, WI 53223-3215
414.357.8160
Fax: 414.357.8166

Testimony of Dr. Robert Kraig,
Political Director, SEIU Wisconsin State Council,
On Nursing Home Staffing and the 2001-2003 Biennial Budget,
Joint Finance Committee, Washington High School, Milwaukee,
April 20, 2001

There is no longer any doubt that there is a major crisis in the quality of care in Wisconsin's nursing homes. Recent press reports have made clear what those who actually deliver the care have known for sometime: that Wisconsin nursing homes are not adequately staffed, and that short staffing is a grave risk to the well being of our most fragile and vulnerable citizens.

As a health care union that represents over 4,000 nursing home workers in Wisconsin, and over 100,000 nationally, we are deeply concerned that the Governor's budget contains a large increase in nursing home Medicaid reimbursement rates, but does not tie this increase to improved staffing.

We are also concerned that the proposed run-up in nursing home rates is based on a flawed and slanted financial analysis paid for by the nursing home industry itself.

In addition, we are concerned that a large long term care structural deficit will be created by this rate increase that will hamper future efforts to bring Wisconsin nursing home staffing standards into line with the latest research on what is necessary to provide quality care.

I The Nursing Home Staffing Crisis

Beneath the recent press reports of dangerous conditions in many Wisconsin nursing homes is a deeper crisis in the delivery of nursing home care.[1]

Over the last decade, the acuity (relative illness) of nursing home residents has skyrocketed, but staffing has not kept pace. Seniors who used to reside in nursing homes increasingly turn to community-based programs as an alternative to institutionalization. In addition, hospitals are discharging patients into nursing homes sooner and sicker than ever before.

---

1. See, for example, *Milwaukee Journal Sentinel*, April 8, 2001, April 10, 2001, April 11, 2001; *Waukesha Freeman*, January 17, 2001; *Wisconsin State Journal*, April 8, 2001; *Milwaukee Labor Press*, February 22, 2001, *Union Labor News*, March 2001; WTMJ TV 4 Milwaukee, January 15, 2001; WISN TV 12 Milwaukee, January 15, 2001, WDJT TV-58 Milwaukee, January 15, 2001; Wisconsin Radio Network, October 18, 2000, January 14, 2001, March 16, 2001; Wisconsin Public Radio, April 16, 2001; *Capital Times*, October 19, 2000, WMT-TV 15 Madison, October 18, 2000; WKOW -TV 27 Madison, October 18, 2000.

work the third most dangerous job in America–more dangerous than construction or mining.[5] Second, recent research indicates that frustration over short staffing is the number one reason CNAs leave the profession. There is not a shortage of people willing to take CNA positions, but a retention crisis. Turnover rates in Wisconsin's proprietary nursing homes are over 94% per year.[6] These turnover rates also waste an immense amount of resources. It is estimated that it costs $2,000 dollars to hire a new worker, and train them to become a CNA.

Nursing home operators say that they will use Medicaid increases to improve staffing, but there is overwhelming evidence that the only way to assure better staffing is to require specific staffing ratios. Many nursing homes, especially for-profit facilities, deliberately short staff in order to squeeze more money out of their operations. A comprehensive federal study, the HCFA Report to Congress, concluded that "*There is virtually no link between what an individual facility spends and the rate it receives. . . . higher rates might be taken in as profit or spent on capital improvement rather than on staffing.*"[7] The experience with the wage pass through in the last budget should be enough to show that many Wisconsin nursing homes cannot be trusted to do the right thing with state money, unless they are specifically required to do so.[8]

Current Wisconsin staffing standards are not only too low, they are also very difficult to enforce. Our members tell us that the only time the standards are faithfully followed is the day that state surveyors are actually in the facility. There is an overwhelming national consensus that the only way to assure decent nursing home staffing levels is to convert to a ratio system. A ratio system, unlike the current Wisconsin hours per resident day system, requires a specific number of CNAs to residents and nurses to resident for each shift.

The SEIU proposal is for CNA to resident ratio of 1 to 5 on day shift, 1 to 10 on evening shift, and 1 to 15 on night shift, and a nurse staffing ratio of 1 to 15, 1 to 25, and 1 to 35. This proposal was editorially endorsed by the *Milwaukee Journal Sentinel* last week, which concluded that the proposal "makes sense" and that "lawmakers should make that proposed change a priority."[9]

---

[5] SEIU Fact Sheet, "Nursing Home Workers: Caring 'Til it Hurts," November 2, 2001.

[6] Iowa Caregivers Association, "*Certified Nursing Assistant Recruitment and Retention Pilot Project Phase I: Survey Results" (1998)*; Bureau of Health Information, Department of Health and Family Services, *Wisconsin Nursing Homes and Facilities for the Developmentally Disabled, 1999* (November, 2000)

[7] HCFA, "Report to Congress" (2000).

[8] "Audit: Nusing Homes Didn't Pass Along Wage Increases," Milwaukee *Business Journal*, February 2, 2001; Robert Kraig, "Nursing Home Industry Needs Protection from Itself," Op Ed, Milwaukee *Business Journal*, February 16, 2001.

[9] "The Nursing Home Crisis," Editorial, *Milwaukee Journal Sentinel*, April 11, 2001.

skewed the cost projections in the report high and the rate projections low.

Second, the industry report makes a number of misleading assertions which confound the relationship between federal Medicare and the state Medicaid formula.

The report claims both that a rise in the acuity of nursing home residents and the shift to a prospective payment system in federal Medicare have financially burdened the industry. They also blame increased admissions, and resultant patient turnover, for increasing the nursing home industry's Medicaid resident costs.

The report fails to mention that nursing homes have aggressively pursued higher acuity residents to capture more Medicare money. They have continued to do this because Medicare business is still lucrative, despite federal cutbacks designed to curtail profiteering by the large nursing home chains. In fact, Medicare payments increased by over a billion dollars each of the last two years. In addition, the report fails to mention that this pursuit of Medicare money, when it is not accompanied by the increased staffing needed to care for a sicker resident population, has exasperated the quality of care and staffing crisis in Wisconsin nursing homes. Perhaps this is why there has been such a shocking increase in serious jeopardy violations.

The report also asserts an erroneous link between bankruptcies and the Wisconsin Medicaid reimbursement rate. The report notes that Wisconsin's bankruptcy rate is higher than that of other midwestern states, but fails to clarify that this is a function of federal Medicare policy, not state Medicaid rates. In point of fact, Wisconsin happens to have a higher percentage of for-profit chains that were involved in Medicare speculation, and where hit hard by federal Medicare reform. These chains went bankrupt because they loaded up on bank debt to expand into the lucrative Medicare business. Now, the financial prospects for the major chains are looking brighter. Because of the Medicare increases approved by Congress in the Fall of 2000, investment bankers are again investing in nursing homes. As a result, many of the major nursing home chains will come out of bankruptcy this summer.[11] In addition, according to their own report, for-profit nursing homes are doing much better in the state Medicaid formula than not-for profit and government facilities. Given the track record of these chains, and their need to free up capital to make up for their own financial miscalculations, it is predictable that an overgenerous Medicaid rate increase will be used for purposes other than increased staffing, wages, or improvements in the quality of care.

It is disturbing that a very flawed and slanted industry audit report is serving as a basis for a very large run-up in the Medicaid reimbursement rate. Amazingly, the Governor's budget actually includes more money than the nursing home industry's own report requests. The industry report asks for an extra $79 million per year, and includes the county homes in its calculations. The Governor's budget includes a $115 million increase in the first year and $157 million in the second year of the biennium. Since the release of the Governor's budget, industry officials have begun asserting that this is the actual amount they need.[12]

---

[11] "The Refurbishing Begins: With Medicare Reimbursements Back, Health Care Services Taps Capital Markets," *Investment Dealers Digest*, April 16, 2001.

[12] See *Milwaukee Journal Sentinel*, April 8, 2001.

April 20, 2001

Public Forum on Wisconsin's Budjet

Hello, and thank you very much for your time and attention. My name is Laurie Casey

6433 Powell Place
Wauwatosa, WI 53213
414-453-7850

I represent my family, which includes a 9 year old, Michael, who was born with Spina Bifida, and my son David who has Autism. I also ~~represent~~ here as a member of the Wisconsin Survival Coalition.

I am here to ask you to increase funding in the budjet for the programs that help our family survive. Many of these programs haven't had any increases in over 6 years. Many families are on long waiting lists for services. These programs have guidelines which means that all those on the waiting lists truly are eligible and have <u>real</u> <u>needs</u>.

There are many things that our extended families and churches are unable to do or are uncomfortable doing for our family, such as respite, help with many medical expenses, transportation and community living services. Most of these services are better provided by proffessionals and others who welcome a calling or carreer in these kinds of services. These people have training and skills which can help our children become more independent and help our family stay together by modeling good parenting skills for children with disabilities and by helping mitigate the stress of chronic illness or disability

Fully funding these programs creates jobs, and supports families and helps create a future for our children, which we hope will lead to ~~dependency~~ rather than more.

OVER

I am particularly interested in seeing the waiting list for the Family Support program eliminated and the funding amount per family increased. Currently there are more eligible families waiting than are being served. This program has had no increase in its funding amount since 15 years ago. The families eligible for this funding all love and support in their own homes children who years ago would have been institutionalized. It costs over $40,000.00 to $60,000.00 to keep a child in an institution. If we all put our children in a State run institution, the state would need to raise 100 million to support them.

When my son was born, I chose to keep him home with his family and I gave up my job as a computer installer and trainer for a major bank, to care for him. We now make do with one income and a small amount of Family Support funding. This barely pays a tenth of the extra costs of keeping our son home with us - even though we have good insurance.

Please don't forget families like Ours. Disability can happen to anyone. It can happen to your family on the way home tonight. These programs are the saftey net that is there for everyone who may need it, not as an entitlement, but as an assurance that when tragedy strikes, there will be trained, caring proffessionals to help you get back onyour feet as quickly as possible with the ability, knowledge and equipment to face whatever obstacles remain. Tradgedy can, ~~become~~ with help, become an opportunity to learn more about the human spirit and human adaptability, and ~~to become~~ an opportunity to learn compassion and tolerance and unconditional love, by allowing families to stay together, and communities to remain whole -

Sincerely, Jennie Casey

Waiting List Package

ISSUE: Across Wisconsin people with disabilities and family members are struggling because they receive inadequate or no services to assist them to live and work in the community. At times this has forced people to needlessly enter an institution or struggle to live in the community. Others rely on family members or may be at home without supports or daytime programming.

Community Integrated Program:

- Medicaid Waiver program that allows the use of Medicaid funds for long-term support services in community settings.
- About 4,000-5,000 adults with developmental disabilities are waiting for critical services.
- The average waiting period is four years.

Community Options Program:

- The Community Options Program (COP) is a state-funded program to provide assessments, case plans and community services as an alternative to nursing home placements for all disability groups as well as the frail elderly.
- About 2,200 people with physical disabilities are waiting for support to live in the community through the Community Options Program.

Family Support:

- Assists families with children with severe disabilities to stay intact and prevent out-of-home placements by providing flexible funding for needed services, support and information.
- 2,333 families are currently on the waiting list for Family Support.
- 540 families are reported by the counties to be underserved. Although a family can receive $3,000 for each eligible child, the 1999 average amount given for an eligible child is $1,612.
- 3,032 families are estimated to be eligible but have not applied for the Family Support Program.

Birth to Three Program:

- Both federal law and state rules require that early intervention services be provided to the maximum extent possible in the child's natural environment, a setting that is natural or normal for the child's age peers who have no disabilities.
- Services in Wisconsin are underfunded, even though this program is a federal entitlement.
- The last two state biennial budgets provided a 0% funding increase.
- Counties have been forced to provide fewer services or have had to increase county funding that was then not available to fund people on the waiting list for other needed community services.

Direct Service Workforce Shortage:

- Chronic underfunding of personal care, the Community Integration Program, and Community Options Program has created a crisis in the current support system for people with disabilities.

POSITION: The ultimate funding goal is an allocation of $55 million in state funds on an annual basis. This funding increase virtually eliminates the known disability waiting list and begins to address workforce and labor market issues. The Council supports phasing-in a total increase of $57.5 million in state funds over the 2001-2003 biennium:

LEGISLATIVE INITIATIVE:

- Increase in state funds for the Medicaid Waiver programs serving people with developmental disabilities and brain injuries will generate a match of federal funds. The funding will also increase wages and benefits for support workers.

First Year:	$6 million, GPR $15 million, FFP	**Second Year:**	$32 million, GPR $50 million, FFP

- Increase in state funds for the Community Options Program will generate a match of federal funds to begin to address the physical disabilities waiting list.

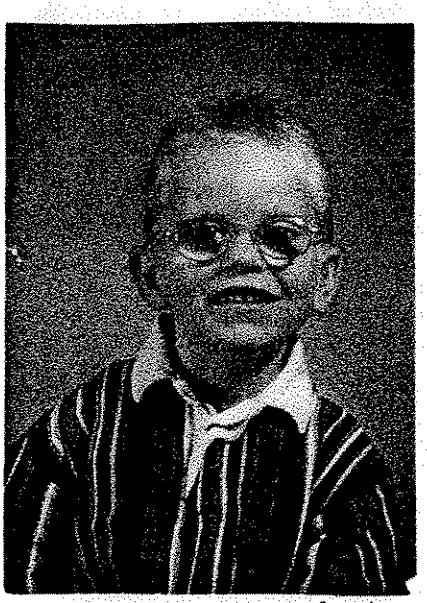
First Year:	$2 million, GPR $5 million, FFP	**Second Year:**	$6 million, GPR $10 million, FFP

- Increase in state funds for the Family Support Program to begin to address the waiting list.

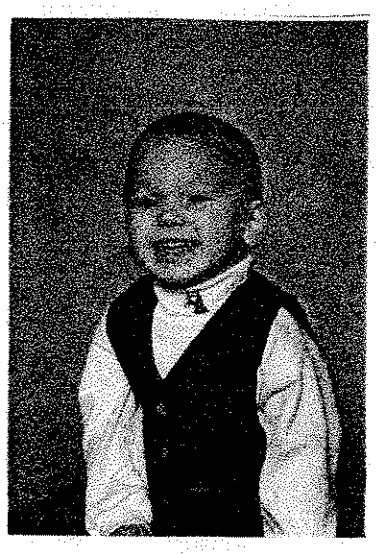
First Year:	$2.5 million, GPR	**Second Year:**	$5 million, GPR

- Increase in state funds for the Birth to Three Program to cover increased costs of the program.

First Year:	$2 million, GPR	**Second Year:**	$2 million, GPR



Collin 4yrs old



Casey 2yrs old

Riley 2months old

Brent + Brenda Mueller
122 E. Tweedy St.
Hustisford, WI 53034
920-349-3514

Brenda, Member of Dodge County Birthtothree advisory board

We are the proud parents of four boys, three of whom are profoundly deaf. Collin has completed the birth to three program. Casey is currently in the program and Riley is just entering the program.

Birth to three has been a God send. Providing us with services and equipment denied to us by our insurance. The birth to three staff are always finding new ways to educate and help our family. Without this program our children and family would not be where it is today and our future would not look as promising.

April 20, 2001

Joint Committee on Finance

RE: Public Hearing at Washington High School

Dear Sirs,

My name is Julie Alexander and I am a person with a disability who also works for Independence*First* as a Lead Coordinator in the Independent Living Skills Program. I would like to present the following testimony for your consideration.

First, I would like to express my support for the 2001–2003 Budget Proposals for Disability Services from the Survival Coalition of Wisconsin. I am including these proposals for your review. As a person with a disability working in the human service field, I find it disgraceful that there is a three to fifteen year wait list for people with disabilities to receive support services, so that they can live independently in the community. Most people who have disabilities that I have talked to prefer to live in the community rather than living in a nursing home. It is less costly for people with disabilities to live in the community with quality care. They can choose people whom they wish to invite in their home to provide for their care needs. I would advocate for a reduction in the proposed funding of nursing homes ($115,000,000 for nursing home increases in Year 1 and $157,160,800 in Year 2 through the Intergovernmental Transfer Program). Use of these funds for community services would clear up the waiting list.

Second, I am in support of closing the state institutions and integrating more people with development disabilities into community support programming. I believe that the same funding used to support state institutions could provide a quality support program for people with developmental disabilities in the community.

Third, I am in support of providing more funds for the Birth to Three Program, so this program can assist families in dealing with disability issues at an earlier age. When these issues are dealt with earlier many children do not need special education services when they go to school.

Finally, I am concerned about the training that emergency personal have in dealing with people with disabilities involved in traffic accidents. Through my conversations with an organization called Safe Extraction, Incorporated, I have learned that emergency personal have very little training in how to deal with people with disabilities and assistive technology in emergency situations. I would support additional funding for this issue.

Please review the information I have provided and take steps to provide funds so people with disabilities can make choices on how and where they want to live and receive support.

Sincerely,

Julie Alexander

Julie Alexander