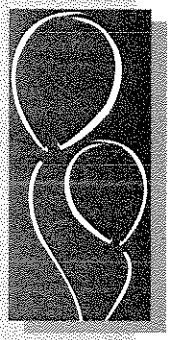

Family Services

Everyone is Family

Thomas E. Martin
President

FAMILY SERVICES OF NORTHEAST WISCONSIN SUPPORTS:

- **EXPANSION OF MEDICAID COVERAGE TO 18-21 YEAR OLD YOUTH WHO HAVE AGED OUT OF THE FOSTER CARE SYSTEM**
- **EXPANSION OF PREVENTION OF CHILD ABUSE AND NEGLECT (POCAN) HOME VISITATION FUNDS**

As you deliberate budget priorities , we respectfully request that you consider the impact of your decisions on children and families. There is no doubt that Wisconsin cares about children, and for years we have committed enormous time and resources to *fix* them. But the most recent research on child development tells us that by the time we realize they are in trouble, we are long past the window of opportunity to fix them. It is in the first two years of life that a child's future is largely decided. What we do for them and to them during this period lays the foundation for all that follows.

It's no longer enough to keep them fed and clothed. Now we know that when they are born, they really aren't quite "the finished product we thought they were" and that unless someone holds, strokes, sings, talks, smiles, reads and plays they may never be. We can not afford to ignore infants and toddlers who are born to parents who are too young, inexperienced, poor, or overwhelmed to care for their children without support. No one ever raised a healthy productive child alone, and many parents are very much alone.

For every child, with the right input at the right time, almost anything is possible. But if we miss the window of opportunity, the children and we will suffer life long effects. Unless we are willing to

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invest in prevention, we will continue to pay for jails and youth homes and mental health centers and special education.

The POCAN legislation is currently funding seven home visitation demonstration projects. I manage the largest of them: Healthy Families of Brown County. The work of Healthy Families is done by Family Support Workers who build trusting relationships with families, teach problem solving skills that promote independence, provide emotional support to parents, share information about the baby's care and development, model effective coping skills and parent-child interactions, improve the family's formal and informal support system, and link families to community resources. They ensure that children have a doctor, regular check ups and recommended immunizations. They identify or create resources, identify barriers to education and employment and provide assistance and support to overcome the barriers. They take families to community agencies, provide recreation and respite, and connect families to each other, to their neighborhoods, and to the community. They work on relationship skills, job skills, and life skills, and they provide positive reinforcement, nurturing, and approval to both parents and children. The home visits continue until the child is five years old, tapering off to quarterly as family stresses are reduced and the family becomes more connected to school and the community. It is a rare family that fails to grow and flourish in this kind of atmosphere.

In our community alone, there are 200 families and more than 300 children receiving our service. There are 300 more families who are waiting. It's not okay that there are children born in our community whose parents have neither a blanket to wrap them in nor a home to take them to.

None of us can afford to let that happen, nor can we afford to ignore the needs of youth exiting our foster care system for independent living. In many cases, these are yesterday's neglected children now grown. Studies show that this group experiences more psychological stress than others their age; forty seven percent received mental health or social service the year before they left the foster care

system. Thirty-eight percent had taken medication to alleviate emotional distress, and five percent received substance abuse treatment.

Following emancipation, fifty-one percent had no health insurance coverage. It is not all unusual for teens leaving home at 18 to return periodically for financial and emotional support. But teens leaving foster care frequently must fend for themselves, unable to provide for their continuing health care needs.

Please support the needs of vulnerable children at both ends of this spectrum.

WIC: Shaping the Health of Women, Infants and Children in Wisconsin

Wisconsin WIC Association's Suggestions for Action 2001

The Supplemental Nutrition Program for Women, Infants and Children (WIC) is the primary public health nutrition program in Wisconsin. The WIC Program serves nearly one of every two pregnant women in this state, one of every three infants born in this state, and one of every five children in Wisconsin. Basic WIC services are available in every community across the state.

WIC helps prevent children's health problems and improves their long-term health, growth and development.

WIC is a prevention program designed to influence lifetime nutrition and health behaviors. WIC provides:

- Nutrition and health education
- Breastfeeding education and support
- Health screening
- Referrals to health and community services
- Supplemental nutritious foods
- Farmers' Market Nutrition Program (in some counties)

WIC helps reduce health-care costs.

WIC is a cost-effective, sound investment. The health benefits of participation in WIC include:

- Fewer low birth weight babies
- Reduction in fetal deaths and infant mortality
- Reduced incidence of iron-deficiency anemia in children
- Improved prenatal weight gain
- Increased enrollment in health care and community services
- Improved cognitive development in children

WIC coordinates services with multiple programs.

WIC is often the gateway for parents to supportive services that enable them to better nurture and care for their infants and young children. Such services include:

- Healthy Start, Badgercare, Medical Assistance, and other health care services
- Home visitation services by public health nurses
- Head Start
- Immunization services
- Family resource centers and parenting education programs
- Family planning services
- Economic support services – housing, food stamps, child care, energy assistance
- Programs for children with special health care needs

WIC serves and supports working families.

WIC is the only nutrition program that assists low and moderate- income families in meeting the nutrition needs in the early growing years and helps participants access preventive health care. Well-nourished, healthy families translate into higher productivity and less absenteeism for Wisconsin employers.

With adequate funding, WIC provides accessible, excellent customer service for working families. WIC staff travel to rural communities, and offer early morning, lunch-hour and evening appointments to accommodate student and working parents.

Continued state funding is vital to maintain the high-quality public health services WIC provides.

Wisconsin WIC Association's Suggestions for Action 2001
WIC: Shaping the Health of Women, Infants and Children in Wisconsin

Food insecurity and hunger in the Wisconsin WIC population: In January 2001, a survey was conducted to measure the extent of food insecurity and hunger among women, infants and children served in the Wisconsin WIC Program (see *Wisconsin Food Security Survey in the WIC Population, March 2001*). Of the 1,827 families surveyed, 43% were identified as food insecure and 20% were identified as hungry. The Wisconsin WIC Association recommends the following actions be taken to address this problem:

- Expand state - wide the Farmer's Market Nutrition Program (FMNP) and increase the per-family allotment of FMNP (currently $20/family/year).
- Reinstate community hunger prevention grants under the administration of the Wisconsin Food Security Consortium to address hunger at the local community level.
- Establish a system to continually monitor food security and hunger in the WIC population and expand it to other vulnerable population groups.
- Maximize all federal resources available to Wisconsin to address food security and hunger by:
  - Increasing the number of schools offering the federal school breakfast programs.
  - Increasing the number of communities offering the federal summer food program.
  - Increasing utilization of the federal food stamp program by reducing barriers to program access and by increasing acceptability of program utilization in communities. (A study reported in The Journal of Nutrition, November 2000, demonstrated that the food stamp program is associated with food security in the WIC population in Hartford, CT).
  - Effectively utilizing federal initiatives to support local emergency food resources.

Every person in Wisconsin deserves access to nutritionally adequate and safe foods.

Breastfeeding helps make families more food secure: Infants receiving mother's milk for the first year of life are healthier and are less likely to develop chronic diseases such as diabetes, cancer, cardiovascular disease and inflammatory bowel disease. (See the *Breastfeeding Fact Sheet* from the Wisconsin Breastfeeding Coalition, November 2000). Research has shown that children who were breastfed score higher on tests of mental development than children who were formula fed. With adequate funding, WIC is successful in encouraging and supporting low-income mothers to breastfeed their infants. The Wisconsin WIC Association recommends the following actions be taken to help increase the initiation and duration of breastfeeding:

- Provide tax incentives to employers that invest in lactation programs.
- Protect the rights of women to breastfeed in those settings where they and their children have a legal right to be present.
- Require breastfeeding equipment and lactation services to be covered as medical expenses by private insurance companies, HMO's, and Medical Assistance programs.
- Work toward workplace policies that foster employers to provide flexible hours and workplace facilities to enable working mothers to continue to breastfeed.
- Increase TANF funding to enable WIC to provide breastfeeding promotion, education and support to all new mothers.

All infants deserve the best possible start in life.

Please act on the Wisconsin WIC Association's suggestions. The first years of life last forever in shaping what a child will become.

Wisconsin WIC Association

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Hello, I'm Kris Parkansky, the Economic Support Manager for Marinette County.

Thank you for this opportunity to speak today.

In June of 1999, Marinette County's entire Economic Support Unit relocated to the new Job Center. Marinette County made this tremendous commitment so we could become a core partner in Wisconsin's Job Center system and locally implement programs and provide services efficiently and comprehensively to meet the needs of our customers. I cannot express to you, how much we as employees, our customers and programs have benefited from our co-location with the partner agencies. This June, we'll be celebrating our 2nd anniversary and I can't help wonder if this will be our last.

I come before you today, to ask for your help in Job Center funding and funding allocations for the programs and services we provide to our customers.

The proposed allocation in the 2002-2003 W-2 contract for our county is at the very least, alarming. We are taking a cut of over $230,000.00 **and** we're currently running the W-2 Program at a $400,000.00+ deficit. We're not sure what to expect from our Income Maintenance Contract allocation for 2002 as it is not yet available but there's been virtually no change over the past few years. Clearly funding does not support the programs in either contract.

We **cannot** sustain any more contract cuts. We will be unable to remain co-located at the Job Center and no longer have the ability to provide a seamless delivery of services.

In 1997 AFDC ended, W-2 began and "welfare as we knew it, ended." Maybe the number of families receiving cash assistance dramatically declined, but the number of families living in poverty has not. Locally, current caseloads show we have more families receiving assistance now than prior to the implementation of W-2. The people haven't gone away . . . they're still here and they need our help.

Each time one of our contract allocations decrease, ultimately, it is our customers who suffer. Contracts continually decrease but caseloads increase.

Recently I was asked by a Job Center Partner if I've had the opportunity to observe any Job Center Team Meetings in any of the other counties. I have not. She went on to say how I should make it a point to do so just so I can see the difference between Marinette County's Job Center and some of the others. She said, "This (Marinette County's Job Center) is how I envisioned how a Job Center should operate! The collaboration among the partner agencies is outstanding."

Marinette County is looked at as a "model" for many different things. Our Job Center is considered one of the best in the State. Our Energy Assistance Program is utilized as a training model in other counties. Our Community Reinvestment Programs are viewed as extremely creative and innovative. Customer Satisfaction Surveys verify our Economic Support Unit provides outstanding service.

Please help us continue to lead in this same capacity. Thank you.

MARINETTE COUNTY
HEALTH & HUMAN SERVICES

Robert F. Jarentowski
Director

April 3, 2001

To Whom It May Concern:

I am in disagreement with Governor McCallum's plan to reduce pharmacy Medicaid reimbursement. If this reduction occurs it could potentially impact the needs of the clients I serve, the chronically mentally ill. Most of these individuals live well below the poverty level and have Medicaid as their insurance. Individuals that receive services from Community Support Programs such as the one I work for rely on caseworkers to advocate for their needs. (Community Support Programs across the state of Wisconsin were put in place in the mid 1980's when psychiatric institutions were mandated to integrate the chronically mentally ill back into society.)

One of the main services I directly provide for these individuals is medication monitoring. If the pharmacies I use to supply my client's medication were no longer willing to accept Medicaid, it would compromise their access to medication, thus their stability. Medication compliance in the chronically mentally ill population is foremost to stability and the ability to live independently in the community.

If my clients were forced to use a mail order pharmacy, this would cause difficulties with the frequent medication changes/dose changes that are common with this population of people. Where would the assistance come from the mail order company, with safety issues like what not to mix with their medicine that the face to face contact with a pharmacist provides now? How would this address acute medical illness? When medication such as antibiotics or pain medication are needed the same day medical treatment was sought?

Please on behalf of my clients, do not cut Medicaid reimbursement rates to Wisconsin Pharmacies.

Sincerely,

Sherry Millard RN

Sherry Millard, RN

SM/dls

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MARINETTE COUNTY
HEALTH & HUMAN SERVICES

Robert F. Jarentowski
Director

Memo

To: Joint Finance Committee

From: Bill Topel, Psy.D.

Subject: April 5 Public Hearing in Peshtigo, WI

Date: April 5, 2001

CC: Rep. John Gard, Co-Chairperson

Greetings, I am Dr. Bill Topel, a Psychologist and the Mental Health & Alcohol/Drug Abuse Coordinator for Marinette County Health and Human Services. I wish to testify today regarding a provision of the Governor's Budget, under the Department of Health & Family Services, regarding broadening of Medicaid Services available to Wisconsin residents.

I support legislative efforts to control GPR spending as I support local efforts to keep property taxes under control. New Medicaid programs, that the State applies for and receives permission to do, benefit citizens as well as county and state governments without impacting the tax levy. The Department of Health & Family Services until this year have encouraged counties to add Medicaid programs as a way of generating additional revenue in lieu of community aids increases. Marinette County has done this exceptionally well over the past few years. DHFS has not had to provide the State share of matching funds because counties have applied overmatch funds.

Currently, there appears to be a "hold" on starting new programs because DHFS feels that they must now come up with the "State share" and having no new GPR funds to do it with. We would like the Joint Finance Committee to establish that new Medicaid programs including the Comprehensive Community Services program and similar programs be approved by DHFS and work with the counties on implementation of other similar programs providing that no additional GPR go into them.

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Hearing

April 5, 2001

Rev. Ken Michaelis CEO, Northland Lutheran Retirement Community and Administrator, Luther Home, 161-bed skilled long term care facility in Marinette. Our program is sponsored by 18 area congregations and controlled by board members from area communities.

Thank you for coming up here to the northeastern corner of Wisconsin.

Briefly address the issue of Medicaid reimbursement for long-term nursing care for the elderly and infirm.

The need for adequate reimbursement for long-term nursing care under Medicaid is very evident.

If we as a society wish to provide adequate quality services for the lower income elderly and infirm, we have to provide adequate reimbursement for services rendered or there will be no services. Providing services through the Community Options Program, helpful for some, is not ultimately the answer. It is more economical to bundle services and deliver them in on place if the growing numbers of frail elderly are to be served.

Long-term care nursing facilities, proprietary and non-profit, are facing a crisis.

Approximately fifty proprietary facilities went bankrupt in Wisconsin last year.

Non-profits, making up losses from other sources are hanging on a bit longer, but are losing money and we are beginning to see the closure of beds. A non-profit in West Bend is closing 100 beds and a non-profit in Oconomowoc is closing 50 beds right now.

The issue is not the closure of beds or facilities. It is the loss if access to services for the poor and lower income elderly and disabled.

Luther Home suffered losses under Medicaid of approximately $350,000 in both of the past two years. We have made up much of those losses from other sources, but still haved ended up with an actual cash loss in 2000 of $75,000 from operations. We cannot continue to make up that loss from other sources as the other sources are not sufficient any longer. Our churches, having their own funding problems, cannot make up that kind of difference.

We are also faced with increasing regulation and penalties and shortages of staff. It takes more and more dollars to find the trained and compassionate staff we need to provide the care we wish to offer. Wisconsin does not have enough trained nurses and nursing assistants in the work force and long-term care cannot compete financially with hospitals for these persons.

As you plan this budget, please consider carefully adequate funding for long-term care through the Medicaid program.

Thank you.

[redacted]

Aimee Korzeniewski
Peshtigo, WI

On Feb. 25th of 2000, me and my 4 little girls came home to find my husband laying on the Floor with a gunshot wound to his head. My husband survived but substained a severe brain injury and lost his left eye. My husband was the sole provider for our Family, so not only indureing the horrbile injury to Kenny, we have struggled ~~[illegible]~~ financialy & emonitly. Kenny as gone through many surgerys and thearapies and has come along way in the past year. The front part of his brain is missing and this has greatly affected his ability to function and drasticly changed his personality, so in some sence the Kenny I Knew & loved is gone but through a Brain Injury Rehabilation Center were he currently lives he is regaining some sence of the new person he will be. This rehab center is a wonderful place ~~[illegible]~~ and was our only hope. With many years of therapy and support Kenny has the ability to reach great goals and be a productive member

[redacted]

in society. At this point of only 6 months in the rehab center the State is trying to ~~rush~~ push him out way before he's ready because of the cost, he is currently on the waiting list for the brain wavier but it could be years before they get to his name. So I asked what our options are without the brain wavier? The county's answer to me is Kenny is ready for a group home because he still needs 24hr supervison, but he has a high functioning ability, but there is no money w/o the waiver So w/o the money he will have to sit in a nursing home where he doesn't belong, then after being in the nursing home he doesn't qualify For the waiver because he's not coming from a rehab center. So why are they paying $30,000.00 a month right now For him to be rehabilated but there's no money for him to go into a group home where it's much cheapier. This past year has been alot OF hard work and many tears, we have all come along way and I'm not going to stand

buy
~~[illegible]~~ and watch Kenny go backwards, we need the funding now, these people with brain injuries can't wait, because if you've even been put in this situation it doesn't only affect the person with the injury, but the whole family unit around them.

2001-2003 Biennial Budget Recommendations - The Financial Impact on Wisconsin Pharmacies

Pharmacy Medicaid Reimbursement Rate Reduction

- Pharmacies have not been responsible for the rising cost of the MA drug program.
- Pharmacy reimbursement rates have not increased in over 12 years
- The cost of consultation, including the costs to properly educate and train Pharmacists, have increased
- The 5% change in pharmacy reimbursement will reduce gross margins dramatically as shown in the following example using the average Medicaid brand name drug cost of $60.

AWP minus 10%		AWP minus 15%
$60	**Retail Cost**	$60
$6	**AWP Discount**	$9
$54	**Discounted Amount**	$51
$4.38	**Dispensing Fee**	$4.38
$58.38	**Reimbursement Amount**	$55.38
$56.90	**Expenses** (Cost of Drug + Avg. Cost to Dispense)	$56.90
$1.48	**Gross Margin $**	($1.52)

- This decrease in margin could mean the difference between turning a small profit or losing money and going out of business for some pharmacies

Drug Assistance Programs

- The Senior Assistance Program was introduced without an identified source of funding
- The Statewide Assistance Program's requirement to limit prescription drug charges to no more than Medicaid rates will place price controls on pharmacies and inappropriately cause pharmacies to bear some of the burden for funding this program.
- The requirement for DHFS to contract for mail order delivery of prescription drugs will send jobs and business outside of the state of Wisconsin.

TESTIMONY OF ANNA SZALAGYI

AARP Appleton

Before the Joint Committee on Finance
April 5, 2001
Peshtigo, Wisconsin

Good ~~morning~~ afternoon. My name is Anna Szalagyi. I live in Appleton, and I'm a member of the Board of Directors for the AARP chapter in Appleton.

All of us who are members of AARP understand how complicated the task of putting together a fair and responsible budget must be, and we appreciate your willingness to listen to public testimony in these hearings.

For AARP members all over Wisconsin, there's no issue that's more important than establishing a prescription drug benefit for seniors.

I know you've heard from other AARP members about the tremendous expense that medication now represents for so many seniors, especially for those who can't afford to buy supplemental insurance.

What I'd like to do this morning is draw your attention to some unseen costs that Wisconsin taxpayers will end up with if this budget doesn't include a prescription drug benefit. The prescription drug benefit that AARP Wisconsin supports is Wisconsin Care, also known as Senate Bill 1 and as Assembly Bill 53.

Testimony received by AARP in Wisconsin shows that many, many seniors with serious conditions such as hypertension or Parksinson's are either going without prescribed medication altogether or just taking their medicine every other day as they try to make individual prescriptions last longer. Research demonstrates again and again that seniors who don't follow the drug regimes prescribed by their physicians get so sick that they are no longer able to look after themselves and are forced into institutional care. In other words, cutbacks on prescription drug benefits for seniors end up costing everyone much more than they appeared to have saved.

Wisconsin Care is the only prescription drug bill that recognizes the depth of the crisis that seniors find themselves in. The other plans offer only band-aid solutions. They simply won't get the job done for Wisconsin seniors.

The question I would urge you all to consider today is, "How can the state of Wisconsin ***not*** afford to approve and implement Wisconsin Care?"

Speaking on behalf of AARP Wisconsin's 734,000 members, I'd say there's only one possible answer to that question.

We urge you once again to include Wisconsin Care in the budget.

Thank you for your time.

written testimony 4/5/01

I ask that the AFCSP dollars set aside for those who suffer with Alzheimer Disease be kept seperate from "Family Care" pot. The coming epidemic of Alzheimer Disease cannot possibly be served adequately without seperate AFCSP dollars -

As an adult Day Care provider and president of the Wisconsin Adult Day Services Association I ask that the fee for Certification by the DSA is reduced to a $100 flat rate fee - By dropping the Capacity fee - This will allow Centers to afford the biennial fee - At this time the Adult Day Industry is not "fully" "niche" and the current fee is too high. Please understand that ADC have maintained participants in their homes longer saving tax payers huge dollars of nursing home expenses.

Mary Grah WADSA President
2908 Curry Lane
Green Bay, WI 54311

class families. Specifically, Senator Burke will move to maintain the AFCSP for families earning
between $20,000 and $40,000 per year.

AFCSP was created in 1985 to help people earning up to $40,000 per year and who are caregiving for
a family member with Alzheimer's disease in the home. AFCSP provides up to $4,000 per year for
respite services such as adult day care, in home help and a variety of other services. The average
grant awarded through AFCSP is only $1,500, but that's often enough to make the difference between
keeping a loved one at home and having to put a loved one into a facility.

In the last budget AFCSP was rolled into Family Care. The financial eligibility level for
Family Care is less than $20,000. Alzheimer's patients earning less than $20,000 per year can
go into Family Care for services but middle class Alzheimer's patients are left without any
assistance.

AFCSP is a small program, only $2.3 million. The program was originally funded at $1.8 million
back in 1985 when created by the Legislature. In the last budget, State Representative Marc Duff
introduced an amendment in the Republican Caucus package increasing funding for the program by
$467,000 to its current level of $2.3 million. This was the first increase to AFCSP since the
program was initiated.

When we look at the surrounding states Wisconsin is the only state cutting service to Alzheimer's
patients. Other states are recognizing the coming epidemic and are increasing funds to meet the
challenge. Ohio, for example, increased funding for its Alzheimer's respite program by 150% in the
2000-2001 budget to $7.5 million.

Representative John Gard,

I am writing to you as a constituent, in a matter that is very important to me, but has gotten me no where!

I have been in the workforce for (27) years. Eight years ago I was diagnosed with Multiple Sclerosis. During this time, I developed several severe infections in my legs, but still was able to bounce back and find transportation to work, as my right leg was too weak to drive myself.

I was in the hospital (7) days with my last episode of infection in my right leg along with (7) days in a nursing home. Because of this I can no longer walk and I use an electric wheelchair.

Asking for help was virtually impossible, I would hear:

- You have insurance.
- Your husband is employed
- Your husband has insurance.
- You can't have any insurance to qualify for several special programs.

I DO qualify for funding for the Community Options Program in Marinette County, but I am #106 on the waiting list and it might be sometime in the year 2005 that my number comes up!

Representative Gard, I could really use your help. I am only 43 years old. I might never be able to walk again, but my goal is to be as independent as I can. Currently, I am not working, but hope to again work one day as we went from a family with two incomes to a family with one. In order to do that I could really use help with the purchase of:

- A Accessible Van with a lift and hand controls -($37,000)
- A Wheelchair-Accessible Bathroom - ($13,700)

Due to the loss of my income these costs are staggering to my family and unreachable. Without these items, I have no chance to resume an independent life. These are things the COP program can help me with. **I am asking you to please support eliminating the waiting lists for the Community Options Program.** Like I said, I am number 106 on the list in Marinette County. I am one of the many that face a dependent life due to lack of funding for this important program. Funding this important program will allow people like myself the modifications and care we need to live an independent life and once again contribute to society. I have been a taxpayer for many years and I willingly gave my hard-earned money to the government. I am asking you to use my hard earned tax dollars to fully fund the COP program.

Sincerely.

Jan VanderBloemen
325 Sunset Lane
Coleman WI 54112

WISCONSIN

FOOD SECURITY SURVEY IN THE WIC POPULATION

MARINETTE COUNTY
HEALTH & HUMAN SERVICES

SHERRY STENDER, R.D.
WIC Nutritionist

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Phone (715) 732-7680
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March, 2001

Wisconsin WIC Association
and
Nutrition Section, WIC Program
Bureau of Family and Community Health
Wisconsin Division of Public Health
Department of Health and Family Services

Household Food Security Survey in the WIC Population

Introduction and Background

Healthy People 2010[1], the US Department of Health and Human Services' public health agenda for the nation, focuses national and state attention on the issue of hunger, food security, and food insecurity. It contains the following objective:

Increase food security among U.S. households and in so doing reduce hunger.

Although there is an adequate supply of food in the United States, people in some households lack access to enough food to meet their basic needs. Food security means that people have access at all times to enough foods for an active, healthy life. While most Americans are food secure and have not experienced hunger, both food insecurity and hunger remain a painful way of life for some people. Food insecurity and hunger are believed to have harmful health and behavioral impacts for pregnant women, children, elderly persons, and other nutritionally vulnerable groups.[1] The following definitions are used widely by scientists and policy makers:[1]

- **Food security**: Access by all people at all times to enough food for an active, healthy life. It includes at a minimum (1) the ready availability of nutritionally adequate and safe foods, and (2) an assured ability to acquire acceptable foods in socially acceptable ways.[1]
- **Food insecurity**: Limited or uncertain availability of nutritionally adequate and safe foods or limited and uncertain ability to acquire acceptable foods in socially acceptable ways.[1]
- **Hunger**: the mental and physical condition that comes from not eating enough food due to insufficient economic, family or community resources.[2]

Due to growing concern about food insecurity in the families served by the Supplemental Nutrition Program for Women, Infants, and Children (WIC), the Wisconsin WIC Association, an association of 36 local WIC Projects, approached the Wisconsin Division of Public Health's Nutrition Section and encouraged the collection of state and county data related to this issue. The Association, the Nutrition Section, and the Division of Health Care Financing's Bureau of Health Information (BIH) collaborated on the survey design, sample size, and how the surveys would be administered and tallied.

Survey Design

The six questions used in the survey were recommended by the Centers from Disease Control and Prevention (CDC)[3]. Extensive research was conducted to validate and standardize questions in order to accurately classify degrees of food security in the general population. The original 18-item scale, from which the six were derived, represented collaborative work between public and private institutions.[4] The University of Wisconsin Testing and Evaluation Center designed the self-administered, computer-scannable survey tool utilizing the six items. A local WIC Project translated the survey questions into Spanish.

Sample Size

The Wisconsin WIC program serves over 182,000 people per year (over 90,000 families), which represents approximately 40% of all pregnant women who give birth annually and nearly 40% of all Wisconsin children younger than five years[5]. The WIC population represents households living at or below 185% of the federal poverty level or are on Medical Assistance. The sample

size and design reflected these WIC families, the five Division of Public Health Regions based on regional program participation (Northeastern-18%, Northern-8%, Southeastern-45%, Southern-13%, and Western-16%), and all race/ethnicity groups in the Wisconsin WIC Program. Sixteen WIC Projects were selected to conduct the survey with a sample size of approximately 2,000 families.

Implementation of the Survey

The 16 WIC Projects randomly administered the survey to 1,827 WIC families (one survey per family or household) during the second and third weeks of January. Project staff transferred responses from the Spanish versions onto the UW-Testing and Evaluation Center's forms. WIC clinic translators read the survey to other non-English WIC participants and entered the responses onto the forms. The completed surveys were sent to the University for final tabulation and analysis. The Wisconsin WIC Association, the DPH Nutrition Section, and the BHI conducted further analysis of the data.

Results

The following data presents the survey responses. See Table 1 for responses by Division of Public Health Regions.

Percentages of families who were food insecure or with hunger:

- 43% of WIC families surveyed were identified as food insecure (affirmative responses to 2 or more of the survey questions).

- 20% of WIC families surveyed were identified with hunger (affirmative responses to 5 or more of the survey questions).

Percentages of families answering affirmatively for each individual question:

- 31% answered yes to the question, "In the last 12 months, did you, your family or other adults in your household ever cut the size of your meals or skip meals because their wasn't enough money to buy food?"

  Of those who answered yes to this question:
  - 18.5% stated this occurred almost every month
  - 48.5 % stated it occurred some months but not every month
  - 33% stated this occurred only 1 or 2 months in the past year

- 33% answered yes to the question, "In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money to buy food?"

- 17% answered yes to the question, "In the last 12 months, were you ever hungry, but didn't eat because you couldn't afford enough food?"

- 45% noted that the food they bought just didn't last and they didn't have money to buy more foods.

- 42% noted they couldn't afford to eat balanced meals.

Follow-Up

As a follow-up to this initial survey, the Nutrition Section and the Wisconsin WIC Association will administer the survey in the spring of 2001 to all remaining WIC Projects in the state, thus providing a representative sample from all counties across the state later in the year.

Acknowledgements

This report was prepared by staff from the Bureau of Family and Community and members of the Wisconsin WIC Association. This report was made possible by the cooperation of 16 WIC projects and 1827 survey respondents. The following WIC projects conducted the survey: Chippewa County, Columbia County, Douglas County, Family Planning Health Services (Langlade County), Grant County, Great Lakes Intertribal Council, La Crosse County, Marinette County, Outagamie County, Seeds of Health and Wee Care WIC Program (Milwaukee County) Waukesha County, Health and Nutrition Services of Racine (Racine County), Family Health Medical and Dental Clinic/La Clinica (Waushara County), Nutrition and Health Associates (Rock County), Wood County. We thank them for their contribution to making this information available.

Comments, Suggestions and Requests for Further Information

Address comments, suggestions, and requests for information to:
Patti Herrick, Wisconsin WIC Director & Nutrition Section Chief
Bureau of Family and Community Health, Division of Public Health, 608/266-3821

Linda Lee, Wisconsin WIC Association,
Nutrition and WIC Director, La County Health Department, 608785-9865

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Table 1. Household Food Security Survey by State and Region
Wisconsin WIC Program, 2001

Number of Surveys by State and Region	State Total N=1,827	Northeast N=282	Northern N=148	Southeast N=816	Southern N=244	Western N=337
Results of Survey						
WIC households/families identified as food insecure (affirmative responses to 2 or more of the survey questions)	**44%**	45%	39%	43%	39%	52%
WIC households/families identified with hunger (affirmative responses to 5 or more of the survey questions)	**20%**	22%	15%	18%	16%	27%
Summary of Survey Questions						
1. In the last 12 months, did you, your family, or other adults in your household ever cut the size of your meals or skip meals because there wasn't enough money for food?	31% yes	34% yes	24% yes	29% yes	30% yes	38% yes
2. If yes, how often did this happen…almost every month, some months but not ever month, or only in 1 or 2 months?						
Almost every month	21%	24%	14%	20%	18%	26%
Some months but not every months	49%	45%	54%	49%	44%	49%
Only 1 or 2 months	30%	31%	31%	32%	38%	26%
3. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money to buy food?	33% yes	34% yes	27% yes	32% yes	27% yes	41% yes
4. In the last 12 months, were you ever hungry but didn't eat because you couldn't afford enough food?	17% yes	22% yes	13% yes	15% yes	14% yes	24% yes
5. The food we bought just didn't last, and we didn't have money to get more. Was that often, sometimes, or never true for you in the last 12 months.	44% often/ sometimes	46% often/ sometimes	43% often/ sometimes	42% often/ sometimes	37% often/ sometimes	52% often/ sometimes
6. We couldn't afford to eat balanced meals. Was that often, sometimes, or never true for you in the last 12 months?	42% often/ sometimes	40% often/ sometimes	40% often/ sometimes	41% often/ sometimes	39% often/ sometimes	52% often/ sometimes

3/19/01

Table 2

Hunger & Food Insecurity by County In the WIC Population

	% of WIC families statewide who experience food insecurity	% of WIC families in each county who experience food insecurity	% of WIC families statewide who experience hunger	% of WIC families in each county who experience hunger
Great Lakes Inter-tribal Council (1 tribe)	43%	50%	20%	11%
Waukesha County	43%	44%	20%	20%
Waushara County	43%	44%	20%	15%
Douglas County	43%	44%	20%	21%
Outagamie County	43%	44%	20%	25%
Langlade	43%	38%	20%	15%
La Crosse County	43%	60%	20%	26%
Chippewa County	43%	49%	20%	34%
Columbia County	43%	47%	20%	25%
Seeds of Health (Milwaukee County)	43%	45%	20%	17%
Rock County	43%	39%	20%	18%
Racine County	43%	42%	20%	20%
Marinette County	43%	28%	20%	17%
Wood County	43%	36%	20%	16%
Wee Care WIC Program (Milwaukee)	43%	40%	20%	16%
Grant County	43%	28%	20%	8%

ADEQUATE FUNDING FOR SERVICES FOR THE OLDER BLIND

Older people who are blind or visually impaired should have the opportunity to maintain their independence in their homes and remain active in their communities. Inadequate state funding for the elderly blind or visually impaired causes many of these people to depend on their families and the State for costly long-term living arrangements.

Current Services and Funding

Rehabilitation Teachers employed by the State of Wisconsin, Department of Health and Family Services, Bureau for the Blind, teach older blind and visually impaired people how to maintain their independence. This includes techniques for communicating, mobility, and work in the home, such as food preparation, budgeting, and record keeping.

Fifteen Rehabilitation Teachers for the blind and visually impaired serve approximately 1,000 people statewide, with an annual budget of about $69,000 for travel and adaptive equipment. This equals $69 per client as opposed to the approximately $100 per day, or $3,000 per month that can be spent on assisted living facilities.

As of July 1, 1998, the Rehabilitation Teaching program lost approximately $80,000 of funding from the Division of Vocational Rehabilitation. With this change, client services have decreased.

Population

In 1990, approximately 90,000 Wisconsin residents were estimated to be blind or severely visually impaired. Of this number, nearly 75,000 were over the age of 55. Estimates from the Wisconsin Demographic Services Center show the population of our state will increase from about 4.9 million in 1990 to about 5.7 million in 2020. In addition, baby boomers will be entering the ranks of the elderly. Thus, it is certain that the number of people eligible to receive vision rehabilitation services will dramatically increase.

The American Foundation for the Blind 1995 data show that almost 1.1 million Wisconsin residents were over the age of 55, with the following breakdown:

Age	Visually Impaired	Severely Visually Impaired
Over 55	10 percent	2 percent
Over 65	13 percent	2 percent
Over 75	19 percent	4 percent
Over 85	29 percent	7 percent

Legislative Action Requested

The Wisconsin State Legislature should build into the base of the budget for the Bureau for the Blind $100,000 to restore lost revenue and adequately fund transportation and adaptive equipment to serve the older blind and visually impaired population in the state.

K/ofb/AARP

received 1/11/01

Sue Dachelet
Department of Health And Social Services, State of Wisconsin
200 N. Jefferson Street, Suite 311
Green Bay, WI 54301

Dear Sue,

How does one begin a letter of such profound gratitude? As you know, the decline of my vision began in April of 2000 and being 51 years old at the time, this was an unbelievable shock to my life. I found that even daily tasks had become terrifying, due to my lack of confidence, caused by my altered vision. Having been referred to you (and to Krystyna Mazur) has been the salvation of my future life. With the counseling I have received, I feel that am able to continue with a new found surety. The classes that have been made available were wonderful and helped my confidence grow again. The aids to daily living have given me back the abilities to do those things I love, as in my quilting. I marvel at the fact that someone "out there" really does care and is willing to help. Having said all this, rumors that funding may disappear or absolutely horrifies me. I feel that your program has a value that is so great, it could be impossible to calculate. After all, what is quality of life worth? In truth, I would not have died without your services, but my spirit was going quickly. Thank you from the bottom of my heart and those of my family, who also have reaped the rewards of your help to me.

Respectfully,

Patti L. Ligman, Sturgeon Bay, WI

Bureau for the Blind
Consumer Independence Survey

The Bureau for the Blind administered a consumer independence survey between March and June 2000. Upon case closure, the rehabilitation specialist gave a survey and stamped envelope to the client. The envelope was addressed to the Bureau Director. The focus of this investigation was to determine to what degree the Bureau was fulfilling its mission to enhance the independence of adults who are blind by heightening one's health and safety. This was not an evaluation of the staff of the Bureau.

One hundred and thirteen (113) usable surveys were returned. The respondents were statewide. The average age was 78, with 76 percent of the respondents being female. The data indicate that the services delivered by the Bureau have kept the majority of clients living independently. In fact, a resounding 82 percent of the respondents said they are less dependent on others since they have received services from the Bureau for the Blind. Additionally, 74 percent said that they were now in more control of making decisions that are important in their life. If they are more self-dependent, they are less likely to seek any form of assistive living services and be less dependent on their families.

One's quality of life may be correlated to their ability to move about, have a good diet, and positive leisure time. Sixty-four (64) percent said that they are able to move around better, while 28 percent said that this question did not apply to them. Clearly the services helped those it could while the others probably were non-ambulatory. Learning how to move about as a blind person ensures one's safety as it decreases the likelihood of falling. Since they received our services, 63 percent of the respondents said that they could prepare more meals. Obviously, this will help maintain good health and decrease their dependency on others. If one is able to actively participate with family, friends, and community, it can be assumed one has a positive attitude toward living. Sixty-four (64) percent of the respondents said that they are participating more actively since receiving our services. Interestingly, 20 percent said that this question did not apply, perhaps because they are very active already. Thus, a significant majority of respondents were helped in

the important wellness area of socialization. To further enhance one's health by leisure, 69 percent of respondents said that our Bureau services have helped to increase their enjoyment of reading.

Many of the people served by the Bureau maintain a household. Adults would rather do "it" themselves. This strengthens one's self-esteem. Fifty three (53) percent agreed they could better manage a household since they received services from us. Many of our clients do not have to maintain a household, which is evidenced by the 30 percent who said this question was not applicable. In addition to maintaining their home, 59 percent of respondents said they are now better able to manage their paperwork. This means the flow of mail and the paying of bills. Some people no longer do this; thus 15 percent said it was not applicable.

The majority of these respondents have increased their quality of life; they are more independent and in control of decision making. They can better manage their daily lives and are safer travelers. Because of the services received from the Bureau for the Blind, more people live independently, and fewer individuals will seek assistive living services.

Michael Nelipovich, Rh.D., Director
Bureau for the Blind
December 2000

K/ofb/clien surveydec2000

Pat Boerschinger, Chair of Statuatory Council on Blindness for Wisconsin. (920) 468-0244

(920) 437-3434 Ext 11 Tuesday & Friday

Or Call (920) 468-8869 to leave a message

For More Information concerning the Bureau

for the Blind (Older Blind Adults Housed in)
(608-266-3109
Mr. Mike Nelipovich,
Bureau Director

Proposed cuts in state budget fought

Drug, veterans funds at stake

BY SEAN SCHULTZ
Press-Gazette

Prescription drugs and veterans services topped the list of concerns presented to members of the state Senate Committee on Health, Utilities, Veterans and Military Affairs when they met Tuesday at the Brown County Central Library.

The committee, chaired by Sen. Rodney Moen, D-Whitehall, conducted a public hearing on the 2001-2003 state budget bill.

Three representatives of Northeast Pharmacies Inc., Peshtigo, spoke to the senators to urge them not to approve a reduction in the rate of Medical Assistance reimbursement for prescription drugs.

The $46.6 billion budget proposes reducing the amount of state Medical Assistance for drugs. Pharmacies now get the average wholesale price of a drug, minus 10 percent. The change would reduce the payment to the average wholesale price minus 15 percent.

Mike Clement, vice president of Northeast Pharmacies, said many pharmacies "are beginning to just say no to these outrageous contracts" that ask them to accept low reimbursements.

"Medical Assistance recipients will have to travel longer distances or use mail order to fill their prescriptions," Clement said.

William Clement, president of the company, said he has two retail pharmacies, in Peshtigo and Oconto, and a long-term-care pharmacy serving 30 nursing home facilities out of Peshtigo. Fourteen percent of his retail pharmacy prescriptions are paid by Medical Assistance, while 97 percent of the long-term-care pharmacy business is Medical Assistance.

His reimbursement rate has not been increased for 12 years, leaving his business in jeopardy as he faces increasing costs, he said.

Also Tuesday, Jerry Polus of the Brown County Veterans Service Office asked that the Department of Veterans Affairs' aid grant program remain intact with additional funding for the veterans trust fund.

The latter has been "a safety net for many aging veterans and their widows," he said. The budget proposal calls for the program to be reduced 40 percent by eliminating medical inpatient, outpatient and emergency room coverage.

Eliminating that area of the budget would mean reducing health care for many of the 20,000 veterans and 3,000 widows in Brown County alone, Polus said.

"Health care issues stand as the No. 1 issue we deal with on a day-to-day basis," he said.

Midge Pfeffer, RDH, BS
Eastern WI Area Health Education Center, Interim Executive Director
Dental Hygiene Association of WI, Professional Development Chair
2007 N. 7th St.
Sheboygan, WI 53081
920-458-4808, telephone
920-458-1645, fax
mjpf@bytehead.com

Testimony to the Legislative Council Joint Committee of Finance

I come before you today speaking for the health care underserved citizens of WI. Sitting before you are two proposals of great significance to those who are unable to afford the health care and health care benefits that you are privileged to.

One of the fiscal requests comes from WI Area Health Education Center (AHEC) asking for a modest increase in appropriations for the next biennium. You will see evidence of the worthwhile benefits of the programs provided for health care students service-learning in underserved community experiences.

This commitment to support the AHEC mission to increase access to quality, affordable health care for all citizens and to train our health care students within communities has shown success in many of your constituent communities in the past nine years. The state support for these programs is imperative to allow students to learn the value and necessity of quality health care needs for those who are not able to afford it.

The second issue I bring before you today refers to the recommendations of the Joint Legislative Council Special Committee on Dental Care Access. I was honored to be one of the participants of the committee and would like to voice my strong support for the measures included in the package. There are some who are trying to break the package apart with scare tactics that have divided the dental and dental hygiene profession in the past. There are statements being circulated that simply would not be factual as a result of passage of the recommendations. This study committee developed a total strategic plan for increasing access to dental care for the 80% of people on Medicaid and BadgerCare who are unable to find a dentist for care.

Rather than to look at each issue on its own, I ask those of you with broad vision to see that dental workforce will reach crisis proportions in the next ten years. If the only access a patient has is through the doors of a private dental practice, we can only expect that the disparity of the "haves" and "have nots" will grow. The disease rates will increase in our most needy populations—particularly children.

To ignore the reality of the dental workforce issue is to deny total systemic health to those who are not able to afford dental care. I beseech you not to make the issue a

personal mission to save dentistry and the special interests but to admit to this as a human rights issue for the underserved populations in our state.

The vision presented in the form of recommendations from the Special Committee on Dental Care Access has been a collaborative effort from many members from all interest groups involved with the dental care access issue. It is a vision that will increase oral health and provide preventive, emergency and restorative oral health care at many levels. It will produce a healthier population in those who have not seen the benefits of regular dental care. The issue is large and needs the vision of all these recommendations for fairness to the underserved populations.

2001/2003 State Budget

My name is Jason Pape. I am president of the Specialized Medical Vehicle Association of Wisconsin (SMVAW). Specialized Medical Vehicles (SMV's) provide a unique and vital service to the special needs clients of each of your districts.

The number of SMV providers in 1997 was 318. Today, there are only 174 left. With an active re-certification process now underway, more of these providers may be dropping out of the Medical Assistance program. If this happens, there does not appear to be an adequate supply of new providers coming into the system to replace those that leave.

To help boost the current number of providers, a few changes need to take place. First, the reimbursement rates need to be increased. We propose a budget of $37.5 million in the first year and $43 million in the second year of the budget. Of these overall amounts, approximately 41.7% will need to come from Wisconsin with the balance coming from the federal government as it has in the past. This will insure that SMV companies are able to upgrade vehicles and equipment to industry standards.

Second, the paperwork that is required by the Department of Health & Human Services is too complicated and cumbersome. Health professionals have a difficult time understanding the forms to adequately determine if someone qualifies for SMV services. Once the health professional has filled out the form as best they can, the SMV provider must then determine if they feel this form will pass an audit by the Department of Health & Human Services. The problem stems from a lack of interpretation from the Department.

Our association has made several attempts with the Department to obtain clarification and interpretation of the Wisconsin Administrative Code that pertains to SMV transportation. The response from the Department has only been to quote the Medical Assistance handbook and/or the Wisconsin Administrative Code, not give their interpretations. Enclosed with my testimony is a letter sent to the Department and their response. These attempts have resulted in frustration for the SMV provider, as they cannot determine until AFTER an audit if they were in compliance. We have outlined the changes necessary to allow SMV providers to do their job and remain in compliance with the Wisconsin Administrative Code.

Third, eliminate the co pay requirement for SMV services. The desired effect on the recipient of a co pay is being gained when it is collected by the clinic, or medical facility. The co pay for SMV services is unworkable for providers.

The increase in reimbursement rates, a clarification of the Wisconsin Admin. Code, and elimination of the co pay requirement will go a long way to fixing a system that is in dire need of repair.

On another note, I am the secretary of the Wisconsin Association of Taxicab Owners (WATO). Our association fully supports the efforts of the Wisconsin Urban Transit Association (WUTA) in respect to the mass transit budget. Mass transit is critical to Wisconsin and the funding will ensure services are not cut. Thank you.

Respectfully Submitted

Jason Pape
President, SMVAW
P.O. Box 209
New Richmond, WI 54017
715-246-2933

COPY

December 7, 1999

Bureau of Healthcare Financing
Fee for Service, Healthcare Benefits
P.O. Box 309
Madison, WI 53707
Attn: Kathy Gugel

Dear Ms. Gugel,

Following our fall conference for the Specialized Medical Vehicle Association of Wisconsin, there are a few questions that we as providers felt were not addressed by EDS, who was representing you at the conference. Questions arose as to the physician certification form. We would like to know if we are held in complete control of the form, as far as it's contents. For example, is the information confidential in the respect that we should only be using the pertinent information to run our business? In other words, are we held responsible for the form if the doctor decides to write, "because the sky is blue" where it asks for the description of why this form of transportation is necessary. In the real world, if we even call a doctor to verify this information, he or she does not have time to look back at the form to see what was actually written and to address our concern. In theory, this would be nice if we could call the doctor and ask to make sure this person qualifies, but when you do that, you upset the doctor because he or she says that they signed the form and because they signed the form, they shouldn't have to be second guessed. In our opinion, this form should be solely up to the doctor and however he or she fills it out should be their responsibility and if Medical Assistance has a problem with the form, to take it up with the doctor.

We would also like to know what exactly can we as providers fill in on the physician certification form? In an effort to maintain an efficient office and keep our costs low, the more that we can help the doctor do his job of certifying clients, the easier it is all around. If we would need to add a second sheet, to tell the doctor whom it's for and list the pertinent information, it simply adds to our cost and the time to put it all together. By being able to fill in some of the information to make it easier for the doctor, we can insure that the client can get timely service. An example of this is when a call comes in from a recipient in a wheelchair and we then must have the doctor sign the form, showing they qualify. If we send a blank form, and say they lose the cover letter explaining whom this is for, that will take time to fix. The recipient is the one that suffers. Now, a solution that you may come up with is to provide the service as the doctor has two weeks to complete the form. The problem with this is that once the person is seen for whatever they need to be seen for, they somehow forget about the form that we need. It then takes many phone calls to the doctor's office so they understand that the form is vital for us to stay in business.

In regards to transporting children, is it in our best interest to send a copy of the physician certification form to the state for them to verify so that we as providers are not held accountable during an audit? As I hear from other providers, the state takes a dim view on our services being provided for children. As we see it, if a doctor signs a form for a child to be transported using our service, who are we to dispute what a doctor says? Isn't the purpose of the physician certification form for just this purpose? We have this form signed by a doctor because we are NOT a doctor. Are we being asked by the state to provide a medical opinion on a recipient when we are not fully qualified to make that judgment? Are we being paid to make a medical judgment by the state or are we being paid to provide a service once a fully trained medical professional has made this determination? If someone is transported to a Medicaid covered service during the day, and we take the person home and they get into a vehicle and drive away, are we qualified to say that the person does not qualify for our services? If we then tell the recipient that we will no longer transport this recipient because we saw they can transport themselves, even though we have a properly filled our physician certification form on file, will the state back us 100% if that person files a discrimination lawsuit against us? Will we have the unlimited resources of the state at our disposal to fight this?

Another concern of ours is mismatched services. This is where a claim that we submit is not followed by a claim that a medical facility submits. For instance, say a recipient has used up all of their visits for chiropractor service. The chiropractor then says that he will accept the co-pay of $0.50 as payment in full. He still bills the state, but the claim comes back denied as the recipient has used all of their allowed services. For us as transportation providers, are we going to have to pay back that money as a mismatched service? This would be the same for a provider that bills the state but the claim is denied for any of many reasons. Are we responsible for that? If we are to call the facilities and make sure they saw the person, such as after an audit, and we are found to proven that the person was seen at that facility, will the state pay for the time and expense to prove what the state should not have questioned as we followed the rules? Even if no one bills the state other than transportation, the recipient was still transported for a Medicaid COVERED service. Who are we to think or know if the facility is going to be billing the state?

We would also like to know about providing cot or stretcher service to both MA recipients and private pay. Is there any requirement if we provide the service to private pay clients and not Medicaid recipients? As Medicaid reimbursement is no different for cots compared to wheelchair transports, yet requires much more work, and possibly two people that we may or may not be able to bill for, depending on the doctor and having a second attendant, must we provide the service to Medicaid recipients?

In regards to providing service after hours, is there any restriction to charging a facility a service fee for picking up both private pay and Medicaid clients, even if the costs are not passed onto the client? For example, if we get a call at 10 PM to transport someone back to a nursing home as they were brought in by ambulance to the emergency room, can we charge a $25 service fee as we have to send a driver out for one transport? If there are many transports, the driver is kept busy, but if they have to come out for one transport, it hardly pays to do it. If we refuse the service, the person then has to pay for the ambulance to take them back, or may have to stay overnight in the hospital.

If any of these questions are out of your expertise, please forward them to the appropriate person. There are many concerns that we as providers do have and these are just a small amount of them. We are planning on having a spring conference for the SMVAW if the bureau would be interested in attending. We, as providers, do deal in the real world, and need answers so that we can run our businesses fairly, economically, and safely. I thank you for your time in this matter and I look forward to your response.

Sincerely,

Jason Pape
President

Tommy G. Thompson
Governor

Joe Leean
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
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TTY: 608-261-7798
www.dhfs.state.wi.us

March 8, 2000

Jason Pape, President
New Richmond Transport, Inc.
P.O. Box 556
Schofield, WI 54476

Dear Mr. Pape:

Thank you for your letter with questions from your Specialized Medical Vehicle (SMV) Association fall conference.

Providers must use the information obtained from the Physician Certification Form for billing on the HCFA 1500 claim form. Wisconsin Medicaid requires the description code, which is circled by the physician, physician assistant, nurse midwife, or nurse practitioner when submitting claims. A physician, physician assistant, nurse midwife, or nurse practitioner may sign the certification form. The form must explain explicitly why the recipient may not use common carrier transportation safely, whether the disability is indefinite or temporary, and the expected length of time (for a temporary disability). See the SMV Provider Handbook, page 2Q2-003, for more complete information.

Wisconsin does not ask SMV providers to make medical judgements. Wisconsin Medicaid reimburses SMV providers for transporting only those recipients who have a documented physical or mental disability that prevents them from traveling safely in a common carrier or private motor vehicle to Medicaid-covered medical services. SMV providers must refer Medicaid recipients who do not have a documented physical disability to their county social or human service agency or their tribal agency for transportation by common carrier. See the SMV Provider Handbook, page 2Q1-004, for more complete information.

Wis. Adm. Code, HFS 104.01(2), states: No otherwise qualified handicapped individual may, solely by reason of handicap, be excluded from the participation in MA, be denied benefits of MA or be subjected to discrimination under MA. This section does not preclude SMV providers from referring those recipients who have a disability but are able to travel safely in a common carrier or private motor vehicle to the county social or human service agency or tribal agency.

The SMV Provider Handbook, page 2Q2-003, describes who must fill out and sign the Physician Certification Form. This section says it is the recipient's responsibility to get this form filled out for the SMV provider. The certification form must be in the recipient's file within 14 working days after the date it is signed and before any claim is submitted. See Wis. Adm. Code, HFS 107.23 (1) (c) 2, 3, for the rules covering the issues of documentation.

On unmatched services, the provider is given the opportunity to submit additional documentation that will support the claims that were filed. The documentation provided must support the provider's claim that the recipient actually received a Medicaid-covered service on the same date as the transport. The SMV Transportation Medical Care Verification Form, which is found in the SMV provider handbook in the Reproducible Forms section, may be submitted as documentation supporting the SMV provider's claims that were filed. Other documentation may include a statement of verification, signed by the Medicaid provider, that attests to the actual appointment and that it was a Medicaid-covered service. In the event that other insurance was the payer, the provider may submit an affidavit from the medical provider attesting to the payment for the service by the other insurance.

According to Part A of the All Provider Handbook, page A3-001: A provider is not required to accept all Medical Assistance recipients who seek services. All providers have the right to limit the percentage of Medical Assistance recipients in their practice, and nursing homes must also comply with the anti-discrimination provisions of the Omnibus Budget Reconciliation Act (OBRA). However, the provider may not discriminate (see Section IV-I of the Part A handbook). Recipients must be notified prior to the delivery of service that their Medical Assistance identification card will not be accepted so that they can choose to go elsewhere.

According to the SMV Provider Handbook, page 2Q2-005(D): As specified in HFS 107.03 and HFS 107.23, Wis. Adm. Code, Wisconsin Medicaid does not cover: extra charges for nights, weekends, or holiday services.

Sincerely,

Peggy L. Bartels
Administrator

PLB:mhy
PA02079.KG
99-12-7F

Dear Joint Finance Committee

I feel strongly that the Alzheimer's Family and Caregiver Support Program should be kept as a separate program from Family Care. With eligibility limited to an income of $20,000 per couple for Family Care, while it is $40,000 per couple for AFCSP, many middle class Alzheimer's patients will no longer be eligible if these programs are not kept separate.

Sincerely,

Anne Parkenby RN

Whispering Oaks Care Ctr
620 Harper Ave
Peshtigo, WI 54157

Dear Joint Finance Committee

I feel strongly that the Alzheimer's Family and Caregiver Support Program should be kept as a separate program from Family Care. With eligibility limited to an income of $20,000 per couple for Family Care, while it is $40,000 per couple for AFCSP, many middle class Alzheimer's patients will no longer be eligible if these programs are not kept separate.

Sincerely,

Sue Pohutzky, Corene Larson SWD, Activity Dir.

Dear Joint Finance Committee

I feel strongly that the Alzheimer's Family and Caregiver Support Program should be kept as a separate program from Family Care. With eligibility limited to an income of $20,000 per couple for Family Care, while it is $40,000 per couple for AFCSP, many middle class Alzheimer's patients will no longer be eligible if these programs are not kept separate.

Sincerely,

Simone Miller

Dear Joint Finance Committee

I feel strongly that the Alzheimer's Family and Caregiver Support Program should be kept as a separate program from Family Care. With eligibility limited to an income of $20,000 per couple for Family Care, while it is $40,000 per couple for AFCSP, many middle class Alzheimer's patients will no longer be eligible if these programs are not kept separate.

Sincerely,

Patti Nelson RN

Don Butman NAMI M&M

Talking Points for the Mental Health Budget Package
A Proposal for Legislative Budget Priorities

The following are points for use by NAMI persons who will be testifying at one of the eight Public Hearings Statewide that are planned on the Budget Bill

1. Medical Assistance Funding for Community Support Programs

- *Community Support Programs (CSP's)* are the treatment programs of the adult mental health system for persons with serious and persistent mental illness.

- CSP's have reduced inpatient hospitalization, improved lives and reduced costs by providing treatment in the community.

- Currently, counties pay the "state share" (about 40%) of the cost of this benefit. This has created a ceiling for the benefit resulting in lists of people with serious and persistent mental illness who are waiting for treatment. This is illegal under Federal Medicaid law.

- *The problem of illegal waiting lists for treatment of people with mental illness has become so serious that lawsuits are under consideration by the Wisconsin Coalition for Advocacy.*

- NAMI supports state funding for the "state share" of the Medical Assistance CSP benefit.

Cost: Current caseload – 10.7 million annually
New caseload -- $400,000 in FY 02; $1.9 million in FY 03

2. Medical Assistance Funding for Comprehensive Community Services

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

- It provides a wraparound approach for adults and children and a level of service that is between traditional outpatient care and the more intensive level of service provided by CSP.

- CCS is a service that furthers the goals of the Governors Blue Ribbon Commission on Mental Health.

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

3. **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.

4. **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.

- NAMI feels that the need for these programs far outstrips the amount of funds available. We request that $400,000 per year of new federal Mental Health Block Grant funds be earmarked for these purposes.

Cost: $400,000 per year of federal Mental Health Block Grant funds

5. **Additional Funding and Legislative Requests:**

NAMI also supports:

a. An *Independent Advocacy Program for the Managed Care Demonstration Projects.*

b. *Prescription Drug Coverage for People with Disabilities: This* is a major issue for persons with mental illness who must take costly medications in order to maintain their mental health and ability to function.

c. *Mental Health/Substance Abuse Health Insurance Parity.*

When testifying before a legislative committee it is very effective to have several persons (3 or 4) come forward to the table, and then have one person deliver the testimony. Make sure that written copies of your testimony are available to hand to the committee members and to any members of the media who may be covering the hearings.

TESTIMONY OF JENNIFER CARLETON
ONEIDA LAW OFFICE SENIOR STAFF ATTORNEY
ONEIDA NATION OF WISCONSIN
P.O. Box 109
Oneida, Wisconsin 54155
SUBMITTED FOR THE RECORD TO
STATE OF WISCONSIN JOINT FINANCE COMMITTEE
APRIL 5, 2001

On behalf of the Oneida Law Office, I would like to offer the following testimony in opposition to the reduction of the State Public Defender program's budget by $3.2 million dollars.

The proposed budget will cut funding for the State Public Defender's program by $3.2 million dollars. In Brown County alone, this will mean the elimination of two (2) full time public defender positions and create an incredible burden on the public defenders that remain. In a court system that is already over-burdened, an increase in the time it takes for criminal defendants to receive competent representation or stand trial is unacceptable.

The cost of representation of a defendant by a state public defender is approximately $20/hour. The cost of representation of the same defendant by a private attorney is $40/hour. This assumes, of course, that a private attorney can be found to provide this representation. There are currently less than twenty (20) attorneys that are willing to take such cases in Brown County. If the public defender's office cannot provide representation to a defendant, and a private attorney is unavailable, the county is responsible for providing representation at a cost of $80/hour.

Simple economics dictates that representation by State Public Defenders is preferable to privatization of the same representation. But the State Public Defender's Office is much more than a cost-effective method of providing superior legal representation to individuals who are required, by law, to that representation. The Brown County Public Defender's Office is also a professional resource that greatly benefits the Oneida Indian community.

The Oneida Indian Reservation is located within Brown and Outagamie Counties. The Brown County Public Defender's Office has indicated that approximately 1/6 of their yearly case load is Native American. Because the Brown County office has such a high volume of Native

American cases, they have developed a unique familiarity with Oneida issues, programs, services, and law that their private counterparts do not share.

For example, a Brown County Public Defender would be aware that the Oneida Tribe does not provide representation in criminal cases to any of its fifteen thousand members, while the Potawatomi and Ho Chunk Tribes do. A Brown County Public Defender who has represented a number of Oneida defendants in the past will have knowledge of Oneida A.O.D.A. programs, contacts with Oneida social service workers, and familiarity with Huber opportunities for Oneida employees. A Brown County Public Defender can refer an Oneida victim, witness, or defendant to the appropriate Tribal resource. This strong working relationship between the Oneida Tribe and the Public Defender's Office not only lessens the burden on State resources, but also provides a level of comfort to the Tribal member that they might not enjoy if they were receiving the same service from a State or County program. On the other hand, a private attorney will probably not even be aware that such a Tribal resource exists, let alone who to contact to refer a client or victim.

The Oneida Law Office has always enjoyed a cooperative and collegial working relationship with the Brown County Public Defender's Office. Eliminating even one position from this office would be extremely detrimental to its ability to offer exceptional legal representation to those who could not otherwise afford it.

Arcadian Communities, LLC

To: Joint Finance Committee, Wisconsin Legislature
From: Richard J. Ogan, Elderly Assisted Living Provider
Date: Thursday, April 5, 2001

Subject: *Statement re. Proposed 2001-2003 Biennial Budget*

Wisconsin's system for providing the elderly a community-based alternative to nursing home care is imperiled today. Last year, the Wisconsin system lost 58 assisted living residences. The toll will rise rapidly in the weeks ahead as providers face the specter of no increase in COP or COP-waiver funding for the elderly.

In Brown County, Wisconsin, where I operate 2 Residences, an estimated 1,000 elderly have applied for financial assistance which is not available to them.

Leadership must find a solution. To ignore it is to be complicit in a form of passive euthanasia. Brown County estimates 200 elderly will die while being denied life-saving assistance in the months ahead. We would not stand idle while 200 children died, we should not deny them their grandparents.

Advocacy groups suggest that $9,000,000 in state funds for the COP-waiver program during the Biennium will generate $11,000,000 in federal matching funds, effectively eliminating the waiting list for elderly assistance.

It is hypocritical of us, at best, to boast of Wisconsin's quality of life so long as we turn our backs to our parents and grandparents in their time of need.

P.O. Box 187 • DePere WI 54115-0187 • 920.983.8380 • Fax 920.983.8381