Table 8

Nonelderly Population Living in Consolidated Metropolitan Statistical Areas (CMSAs) With Selected Sources of Health Insurance, by CMSA,[a] 1999

CMSA	Total	Employment-Based Coverage			Individually Purchased	Public		Uninsured
		Total	Own name	Dependent		Total	Medicaid	
	(millions)							
Total	95.8	63.4	32.5	31.0	5.6	11.8	9.3	18.1
Boston-Worcester-Lawrence, MA-NH-ME-CT	5.0	3.6	1.8	1.8	0.2	0.8	0.6	0.6
Chicago-Gary-Kenosha, IL-IN-WI	7.9	5.6	2.8	2.8	0.3	0.7	0.6	1.4
Cincinnati-Hamilton, OH-KY-IN	1.6	1.2	0.6	0.7	0.1	0.2	0.1	0.2
Cleveland-Akron, OH	2.7	2.0	1.0	1.0	0.1	0.3	0.3	0.3
Dallas-Fort Worth, TX	4.9	3.2	1.7	1.5	0.3	0.5	0.4	1.1
Denver-Boulder-Greeley, CO	2.4	1.7	0.9	0.8	0.1	0.2	0.1	0.5
Detroit-Ann Arbor-Flint, MI	5.2	3.7	1.8	2.0	0.3	0.7	0.6	0.6
Houston-Galveston-Brazoria, TX	4.2	2.5	1.3	1.2	0.2	0.4	0.2	1.2
Los Angeles-Riverside-Orange County, CA	14.3	7.8	4.0	3.9	0.9	2.0	1.7	3.9
Miami-Fort Lauderdale, FL	3.4	1.8	0.9	0.8	0.3	0.4	0.3	1.0
Milwaukee-Racine, WI	1.8	1.3	0.6	0.7	0.1	0.1	0.1	0.2
New York-Northern New Jersey-Long Island, NY-NJ-CT-PA	17.9	11.6	5.9	5.7	0.9	2.6	2.2	3.4
Philadelphia-Wilmington-Atlantic City, PA-NJ-DE-MD	5.2	3.7	1.8	1.9	0.4	0.7	0.6	0.7
Portland-Salem, OR-WA	2.2	1.4	0.8	0.7	0.2	0.3	0.2	0.3
Sacramento-Yolo, CA	1.6	1.0	0.5	0.5	0.1	0.2	0.2	0.2
San Francisco-Oakland-San Jose, CA	6.3	4.5	2.5	2.0	0.4	0.6	0.4	1.0
Seattle-Tacoma-Bremerton, WA	3.0	2.1	1.2	0.9	0.2	0.4	0.2	0.5
Washington-Baltimore, DC-MD-VA-WV	6.2	4.6	2.4	2.2	0.3	0.7	0.3	0.9
	(percentage within CMSA category)							
Total	100.0%	66.2%	33.9%	32.3%	5.8%	12.3%	9.7%	18.9%
Boston-Worcester-Lawrence, MA-NH-ME-CT	100.0	72.1	36.1	36.0	4.9	15.8	12.3	11.7
Chicago-Gary-Kenosha, IL-IN-WI	100.0	71.4	35.6	35.8	4.2	9.4	7.1	17.4
Cincinnati-Hamilton, OH-KY-IN	100.0	75.6	35.5	40.1	4.4	10.9	7.9	11.8
Cleveland-Akron, OH	100.0	73.5	37.8	35.7	5.5	11.0	9.5	12.2
Dallas-FortWorth, TX	100.0	65.0	33.8	31.2	5.7	9.9	7.2	22.3
Denver-Boulder-Greeley, CO	100.0	69.9	37.8	32.1	5.1	8.8	5.4	19.7
Detroit-Ann Arbor-Flint, MI	100.0	72.2	33.8	38.4	6.1	13.1	10.9	11.8
Houston-Galveston-Brazoria, TX	100.0	59.2	30.5	28.7	4.8	8.5	5.4	29.5
Los Angeles-Riverside-Orange County, CA	100.0	54.7	27.6	27.1	6.4	14.0	12.0	27.2
Miami-Fort Lauderdale, FL	100.0	53.0	28.1	24.8	8.4	11.8	9.8	29.4
Milwaukee-Racine, WI	100.0	75.3	34.2	41.1	5.4	7.4	6.4	13.6
New York-Northern New Jersey-Long Island, NY-NJ-CT-PA	100.0	64.5	33.0	31.5	5.1	14.3	12.4	19.0
Philadelphia-Wilmington-Atlantic City, PA-NJ-DE-MD	100.0	70.8	34.5	36.3	7.7	13.7	11.7	12.5
Portland-Salem, OR-WA	100.0	66.4	36.1	30.3	8.5	11.9	10.0	16.0
Sacramento-Yolo, CA	100.0	66.8	34.6	32.3	7.2	15.3	13.9	15.3
San Francisco-Oakland-San Jose, CA	100.0	71.0	39.6	31.4	7.0	9.7	6.9	16.4
Seattle-Tacoma-Bremerton, WA	100.0	68.5	39.8	28.6	5.8	14.7	7.9	15.7
Washington-Baltimore, DC-MD-VA-WV	100.0	74.6	38.9	35.6	5.1	11.2	5.3	14.7

Source: Employee Benefit Research Institute estimates of the March 2000 Current Population Survey.

Note: Details may not add to totals because individuals may receive coverage from more than one source.

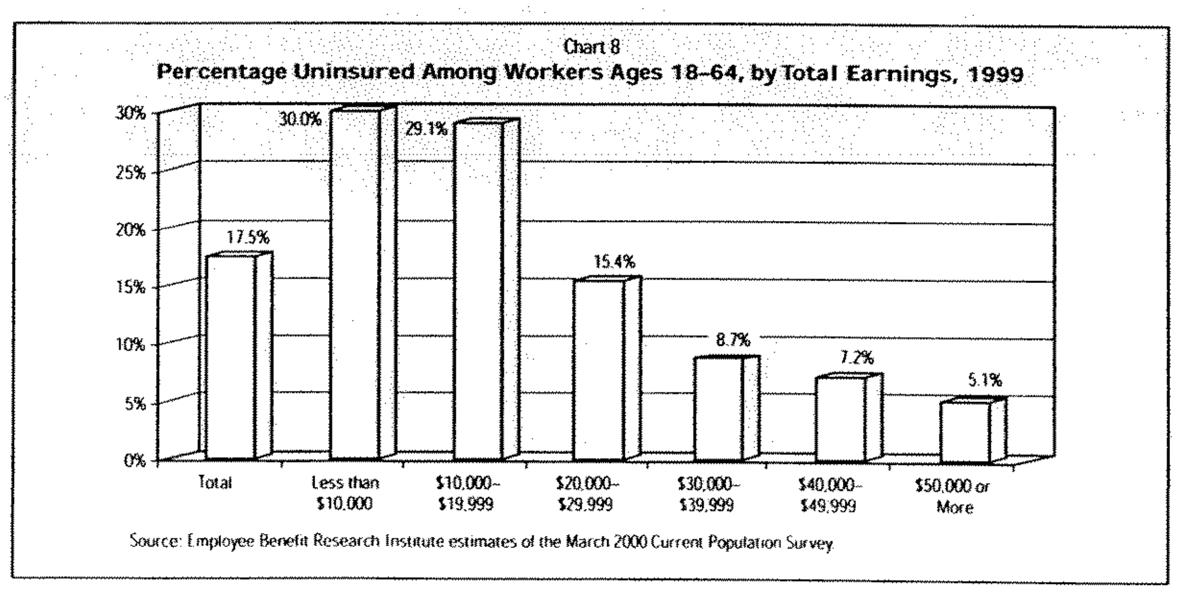
[a]The specific metropolitan identifiers on this file are based on the Office of Management and Budget's June 30, 1993, definitions.

Table 9
Nonelderly Population With and Without Health Insurance, by Region, State, and Citizenship, 1999 In Regions and States With 75,000 or More Noncitizens Where the Percentage of Noncitizens is Greater than 5 Percent

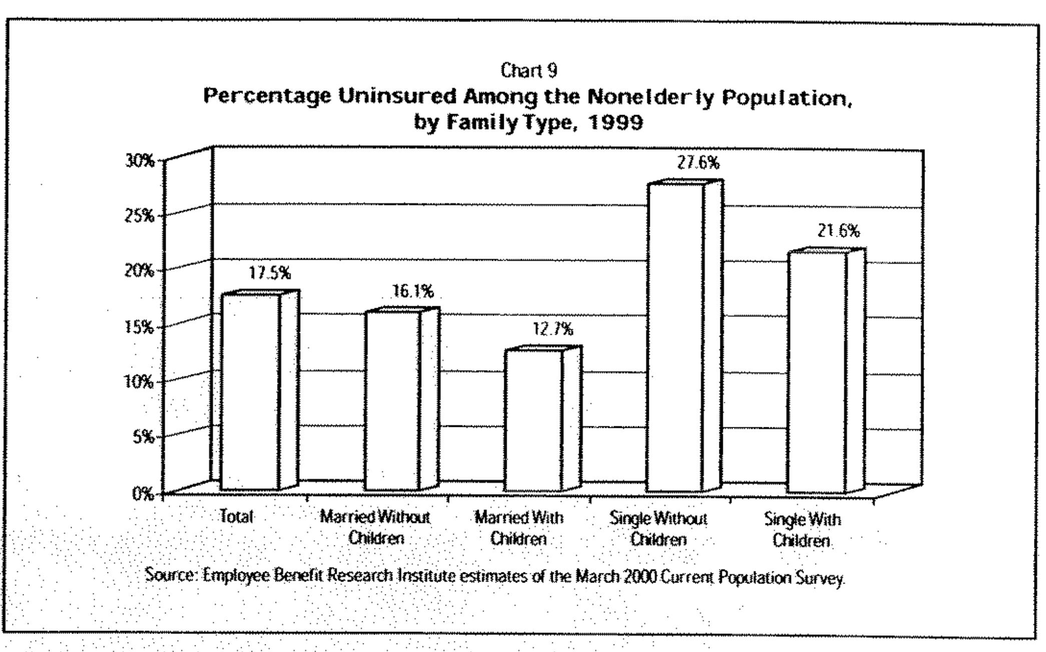
			Insured			Uninsured			Percentage Uninsured	
Region and State	Total Population	Percentage Noncitizens	Total	Citizen	Noncitizen	Total	Citizen	Noncitizen	Citizen	Noncitizen
	(millions)	(percentage)			(millions)				(percentage)	
Total	240.7	7.0%	198.5	189.2	9.4	42.1	34.7	7.4	15.5%	44.1%
New England	11.9	6.0	10.5	10.0	0.5	1.4	1.2	0.2	10.6	27.5
Massachusetts	5.4	8.6	4.8	4.4	0.3	0.6	0.5	0.1	10.1	29.6
Connecticut	2.9	5.3	2.5	2.4	0.1	0.3	0.3	0.0	10.9	19.0
Middle Atlantic	33.3	8.4	28.1	26.5	1.6	5.2	4.0	1.2	13.1	42.1
New York	16.2	12.5	13.2	12.1	1.1	3.0	2.1	0.9	14.7	45.3
New Jersey	7.1	9.3	6.0	5.6	0.4	1.1	0.8	0.2	12.8	36.4
East North Central	39.7	3.3	34.4	33.6	0.9	5.3	4.8	0.5	12.6	33.9
Illinois	10.9	6.4	9.2	8.7	0.4	1.7	1.5	0.2	14.4	35.8
South Atlantic	42.2	6.3	34.3	32.7	1.5	7.9	6.8	1.1	17.2	42.0
Maryland	4.3	5.7	3.8	3.6	0.2	0.6	0.5	0.1	12.0	38.6
Virginia	6.0	5.1	5.0	4.8	0.2	1.0	0.9	0.1	15.4	27.4
Florida	12.4	12.4	9.6	8.8	0.8	2.8	2.1	0.7	19.6	46.3
West South Central	26.8	6.5	20.2	19.4	0.8	6.5	5.6	1.0	22.3	54.9
Texas	18.0	9.0	13.3	12.6	0.7	4.6	3.7	0.9	22.7	56.9
Mountain	15.7	6.9	12.3	11.8	0.5	3.4	2.8	0.6	19.1	54.3
Colorado	3.8	7.5	3.1	3.0	0.1	0.7	0.6	0.2	15.7	52.3
Arizona	4.3	9.8	3.2	3.1	0.2	1.0	0.8	0.2	20.7	57.4
Nevada	1.7	10.6	1.3	1.2	0.1	0.4	0.3	0.1	19.9	47.5
Pacific	40.2	14.5	31.7	28.6	3.1	8.5	5.8	2.7	16.8	46.0
Washington	5.1	5.3	4.2	4.0	0.2	0.9	0.8	0.1	16.6	36.0
Oregon	3.0	5.1	2.5	2.5	0.1	0.5	0.4	0.1	14.3	56.2
California	30.4	17.4	23.6	20.8	2.8	6.8	4.3	2.5	17.3	46.7
Hawaii	1.1	9.6	0.9	0.8	0.1	0.1	0.1	0.0	11.1	25.4

Source: Employee Benefit Research Institute estimates of the March 2000 Current Population Survey.
*Fewer than 50,000 respondents (weighted) in this category.

Chart 8
Percentage Uninsured Among Workers Ages 18–64, by Total Earnings, 1999



Source: Employee Benefit Research Institute estimates of the March 2000 Current Population Survey.



Family Type

Single individuals and individuals in single parent families were more likely to be uninsured than married couples either with or without children (chart 9). Among the reasons for this are that married couples and two-parent families may have higher income levels, and both adults may be employed, increasing their chances of receiving employment-based coverage.

Age

Individuals ages 45–54 were less likely to be uninsured (13.4 percent), and individuals ages 21–24 were more likely to be uninsured (33.4 percent), than those in all other age groups in 1999 (table 10). The high proportion of young adults without health insurance may occur because they are no longer covered by a family policy and may not have established themselves as permanent members of the work force. Some young adults may also have lost access to Medicaid, which covered them up through age 18 in some states. Many in this group may think that they do not need health insurance because their probability of encountering a high-cost medical event is very low.[8] In addition, young workers may be ineligible for an employment-based plan because of waiting periods imposed prior to eligibility.

Children

Nearly 14 percent of all children—or 10 million children—were not covered by employment-based health insurance or privately purchased health insurance and were either ineligible or did not receive publicly financed medical assistance in 1999 (table 11). Sixty-three percent of all uninsured children were in families with incomes below 200 percent of the poverty level. More than 26 percent of children whose family head did not work were uninsured (chart 10). Most uninsured children were in families whose head was employed year-round, either full-time or part-time, with no unemployment (71.2 percent) (chart 11). However, children in families headed by full-year, full-time workers were much less likely to be uninsured than those whose family head worked part-time or experienced some unemployment (chart 10).

Policy Implications

Americans without health insurance are a concern for a number of reasons. First, individuals without health insurance are less likely to receive basic health care services than insured individuals. The uninsured report having fewer ambulatory visits than individuals with

[8] Both Fronstin (1999a) and Cooper and Schone (1997) found that young workers are less likely than older workers to be covered by employment-based health insurance even when a plan is offered to them.

Table 10

Persons Ages 18–64 With Selected Sources of Health Insurance, by Gender and Age, 1999

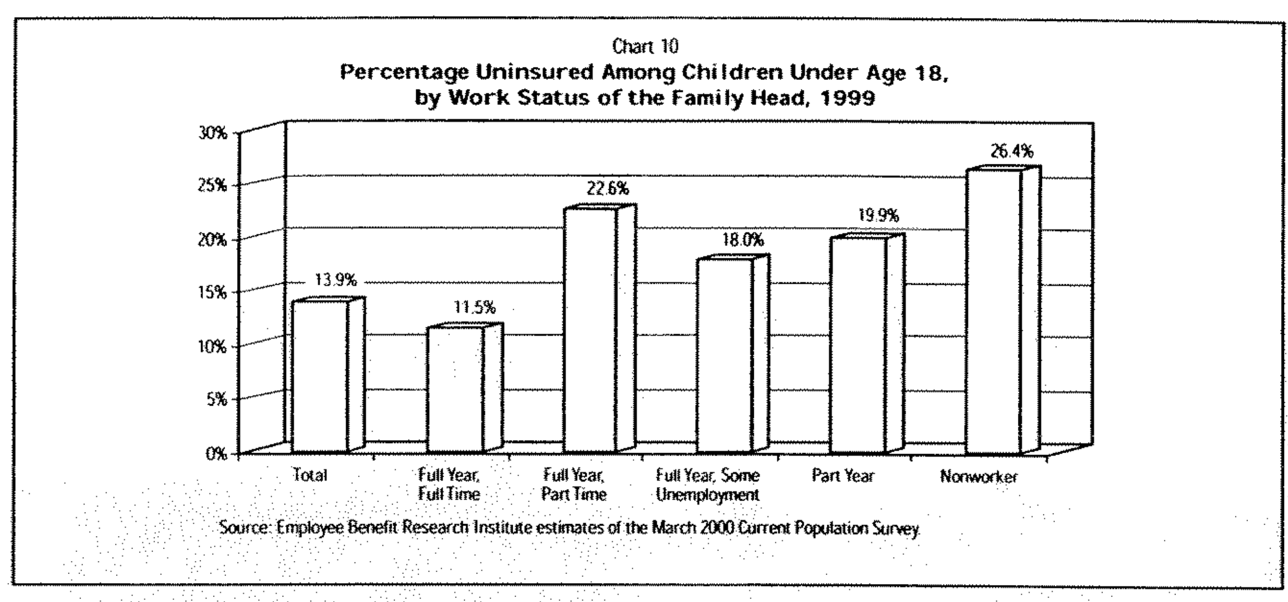
Gender and Age	Total	Employment-Based Coverage			Individually Purchased	Public		Uninsured
		Total	Own name	Dependent		Total	Medicaid	
					(millions)			
Total	168.4	113.9	80.1	33.8	10.4	17.5	10.5	32.1
Ages 18–20	12.0	6.5	1.2	5.3	1.5	1.7	1.4	2.9
Ages 21–24	14.4	7.0	4.3	2.7	1.4	1.6	1.3	4.8
Ages 25–34	37.5	25.0	19.2	5.9	1.4	3.1	2.3	8.8
Ages 35–44	44.5	32.3	23.2	9.1	2.2	3.7	2.3	7.4
Ages 45–54	36.6	27.5	20.5	7.0	2.0	3.5	1.7	4.9
Ages 55–64	23.4	15.7	11.7	4.0	2.0	3.9	1.5	3.4
Males	82.3	56.2	45.5	10.7	4.8	7.0	3.6	16.8
Ages 18–20	6.0	3.4	0.7	2.8	0.7	0.7	0.5	1.5
Ages 21–24	7.1	3.4	2.3	1.2	0.7	0.4	0.3	2.7
Ages 25–34	18.3	12.2	10.9	1.3	0.6	0.9	0.6	4.9
Ages 35–44	21.9	15.8	13.6	2.1	1.0	1.5	0.9	4.0
Ages 45–54	17.8	13.5	11.4	2.1	0.9	1.7	0.7	2.3
Ages 55–64	11.1	7.9	6.7	1.2	0.8	1.8	0.6	1.4
Females	86.0	57.7	34.6	23.1	5.7	10.5	6.8	15.3
Ages 18–20	5.9	3.1	0.6	2.5	0.8	1.0	0.8	1.3
Ages 21–24	7.3	3.5	2.1	1.5	0.7	1.2	1.0	2.1
Ages 25–34	19.2	12.9	8.3	4.6	0.8	2.2	1.7	3.9
Ages 35–44	22.6	16.5	9.5	7.0	1.2	2.2	1.4	3.4
Ages 45–54	18.7	14.0	9.1	4.9	1.0	1.8	1.0	2.6
Ages 55–64	12.3	7.7	5.0	2.7	1.2	2.1	0.9	2.0
				(percentage within gender and age categories)				
Total	100.0%	67.6%	47.5%	20.1%	6.2%	10.4%	6.2%	19.1%
Ages 18–20	100.0	54.2	10.3	44.0	12.3	14.2	11.4	24.0
Ages 21–24	100.0	48.4	29.9	18.5	9.9	11.2	8.9	33.4
Ages 25–34	100.0	66.7	51.1	15.6	3.8	8.4	6.3	23.3
Ages 35–44	100.0	72.5	52.0	20.4	4.9	8.3	5.3	16.6
Ages 45–54	100.0	75.1	56.1	19.0	5.3	9.5	4.6	13.4
Ages 55–64	100.0	67.0	49.9	17.0	8.5	16.5	6.3	14.5
Males	100.0	68.2	55.2	13.0	5.8	8.5	4.4	20.4
Ages 18–20	100.0	57.0	11.0	46.0	11.0	10.9	8.6	25.3
Ages 21–24	100.0	48.3	31.6	16.7	10.2	6.2	4.2	37.7
Ages 25–34	100.0	66.4	59.4	7.0	3.5	5.0	3.4	26.5
Ages 35–44	100.0	72.1	62.3	9.7	4.7	6.8	4.2	18.3
Ages 45–54	100.0	75.5	63.8	11.7	5.2	9.6	4.0	13.1
Ages 55–64	100.0	71.1	59.9	11.2	7.0	15.8	5.1	12.9
Females	100.0	67.1	40.2	26.9	6.6	12.2	7.9	17.8
Ages 18–20	100.0	51.5	9.5	41.9	13.5	17.5	14.2	22.7
Ages 21–24	100.0	48.6	28.3	20.3	9.6	16.0	13.4	29.2
Ages 25–34	100.0	67.0	43.2	23.9	4.0	11.6	8.9	20.3
Ages 35–44	100.0	72.9	42.1	30.8	5.1	9.8	6.3	14.9
Ages 45–54	100.0	74.7	48.7	26.0	5.5	9.5	5.2	13.7
Ages 55–64	100.0	63.2	40.9	22.4	9.9	17.2	7.4	16.0

Source: Employee Benefit Research Institute estimates of the March 2000 Current Population Survey.
Note: Details may not add to totals because individuals may receive coverage from more than one source.

Table 11
Children With Selected Sources of Health Insurance, by Poverty Level and Age, 1999

Poverty Level and Age	Total	Employment-Based Coverage	Individually Purchased	Public: Total	Public: Medicaid	Uninsured
			(millions)			
Total	72.3	44.5	5.3	16.6	14.5	10.0
Under age 6	23.6	14.1	1.3	6.3	5.7	3.3
Ages 6–12	28.7	17.7	2.3	6.6	5.7	3.8
Ages 13–17	20.0	12.7	1.8	3.7	3.1	2.9
0–99% of Poverty	12.7	1.9	1.0	7.5	7.3	3.1
Under age 6	4.5	0.6	0.3	2.9	2.9	1.0
Ages 6–12	5.2	0.8	0.4	3.1	3.0	1.2
Ages 13–17	3.0	0.5	0.3	1.5	1.5	0.8
100%–149% of Poverty	8.1	3.1	0.7	3.2	2.9	1.8
Under age 6	2.7	1.1	0.2	1.2	1.1	0.5
Ages 6–12	3.4	1.3	0.3	1.3	1.2	0.7
Ages 13–17	2.0	0.7	0.2	0.7	0.6	0.5
150%–199% of Poverty	7.6	4.1	0.6	1.9	1.6	1.5
Under age 6	2.6	1.4	0.1	0.8	0.7	0.5
Ages 6–12	3.0	1.7	0.3	0.7	0.6	0.5
Ages 13–17	2.0	1.0	0.2	0.4	0.4	0.5
200% or More of Poverty	43.9	35.3	3.0	3.9	2.6	3.7
Under age 6	13.7	11.0	0.7	1.4	1.0	1.3
Ages 6–12	17.2	13.8	1.2	1.4	0.9	1.4
Ages 13–17	13.1	10.5	1.1	1.1	0.6	1.1
			(percentage within age and poverty categories)			
Total	100.0%	61.5%	7.4%	22.9%	20.0%	13.9%
Under age 6	100.0	59.9	5.4	26.9	24.0	13.9
Ages 6–12	100.0	61.5	7.8	22.8	20.0	13.4
Ages 13–17	100.0	63.4	9.1	18.4	15.3	14.5
0–99% of Poverty	100.0	15.2	8.0	59.2	57.7	24.2
Under age 6	100.0	13.8	6.6	64.6	63.3	22.2
Ages 6–12	100.0	15.9	7.5	59.2	57.8	23.9
Ages 13–17	100.0	16.3	10.8	51.2	49.2	27.5
100%–149% of Poverty	100.0	38.4	9.0	39.3	36.2	21.6
Under age 6	100.0	39.3	5.8	44.5	40.7	19.2
Ages 6–12	100.0	39.6	10.0	38.6	35.8	20.4
Ages 13–17	100.0	35.1	11.8	33.4	30.5	26.9
150%–199% of Poverty	100.0	54.3	8.2	25.7	21.5	19.4
Under age 6	100.0	54.6	5.7	30.3	25.1	17.9
Ages 6–12	100.0	55.9	9.1	24.4	20.4	18.3
Ages 13–17	100.0	51.6	10.4	21.5	18.4	23.2
200% or More of Poverty	100.0	80.4	6.7	8.9	5.9	8.5
Under age 6	100.0	80.2	4.8	10.2	7.5	9.3
Ages 6–12	100.0	80.7	7.3	8.4	5.4	7.9
Ages 13–17	100.0	80.3	8.1	8.1	4.8	8.4

Source: Employee Benefit Research Institute estimates of the March 2000 Current Population Survey.
Note: Details may not add to totals because individuals may receive coverage from more than one source.



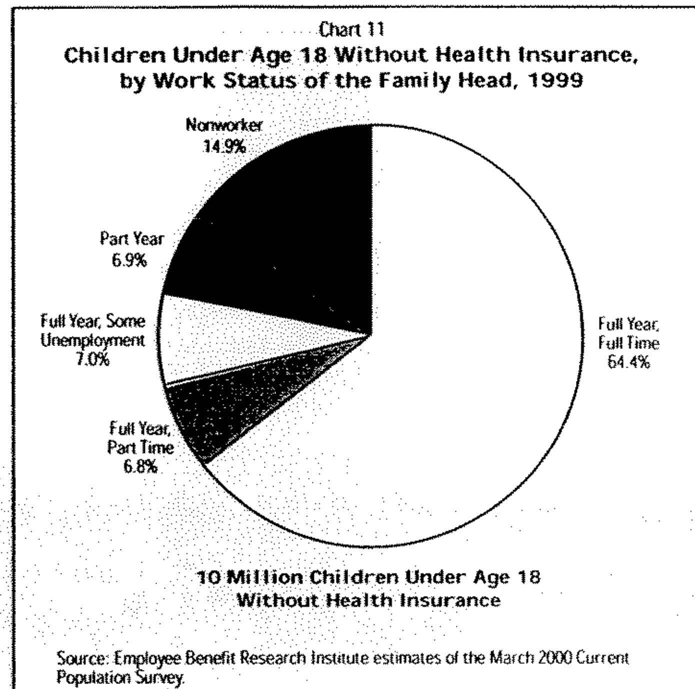
private or public health insurance, in part because of the greater difficulty in obtaining access to care, and, as a result, are more likely to seek care in a more costly emergency room setting.[9] Hence, the population's overall health status may be lower, and individuals' overall productivity may be lower (Fronstin and Holtmann, 2000). Second, providers of health care, especially hospitals but also physicians, are often uncompensated for the care that they provide to uninsured individuals, and may seek to shift the cost of that care to other private and public payers.[10] However, the movement toward a more competitive health care market and the use of alternative forms of third-party reimbursement arrangements, such as capitation, fee schedules, and discounting, have made it more difficult for health care providers to shift these costs to other payers of health care (Morrisey, 1996). As a result, the nature of cost shifting may be changing. For example, Cunningham et al. (1999) found that physicians involved with managed care plans and those who practice in areas of high managed care penetration tend to provide less uncompensated care to the uninsured.

The combination of a growing economy and the lowest unemployment rates in more than 25 years is finally having an impact on the uninsured. Between 1998 and 1999, the uninsured declined from 18.4 percent to 17.5 percent of the nonelderly population. Furthermore, the number of nonelderly Americans without health insurance coverage declined from 43.9 million to 42.1 million, even though the size of the population increased by 2.1 million persons.

While the percentage of Americans who are uninsured has stopped growing, and is even declining, the uninsured will continue to be an important public policy issue for a number of reasons. The expansion in employment-based health insurance and the decline in the uninsured have occurred at a time when health insurance costs are rising. When health care costs increase, health insurance coverage would be expected to decline, with employers shifting the cost of coverage onto workers, or even dropping coverage completely. But as shown in this paper, more workers and their dependents were covered by employment-based health insurance coverage in 1999 than in 1998, and employers have not been shifting the premium onto workers. An annual survey by William M. Mercer indicates that the worker share of the premium has been unchanged since 1993 (William M. Mercer, 2000), while an annual survey by the Kaiser Family Foundation and the Health Research and Educational Trust found that there was a slight *reduction* between 1996 and 2000 in the percentage of the premium workers were required to pay (Gabel et al., 2000). Employers have, however, recently made changes

[9] Krauss et al. (1999) found that 55.7 percent of the uninsured had at least one ambulatory medical care visit in 1996, compared with 76.2 percent of individuals with only public insurance and 77.2 percent of individuals with any private insurance. They also found that among persons with at least one visit, the uninsured had an average of 5.1 visits, compared with 8.7 visits by persons with only public insurance and 6.5 visits by those with any private insurance. Another study found that among persons visiting a health care provider, 17 percent of the uninsured received health care in an emergency room, compared with 9 percent of the privately insured (Cunningham and Whitmore, 1998). Furthermore, Fronstin (1998 and 2000a) found that 22 percent of the uninsured were in a family where someone had difficulty obtaining needed care, compared with 10–11 percent of the insured population, mainly because they could not afford health care.

[10] Traditionally, cost shifting occurs when a health care provider raises its prices to one set of payers because it lowered them to another set (Morrisey, 1996).

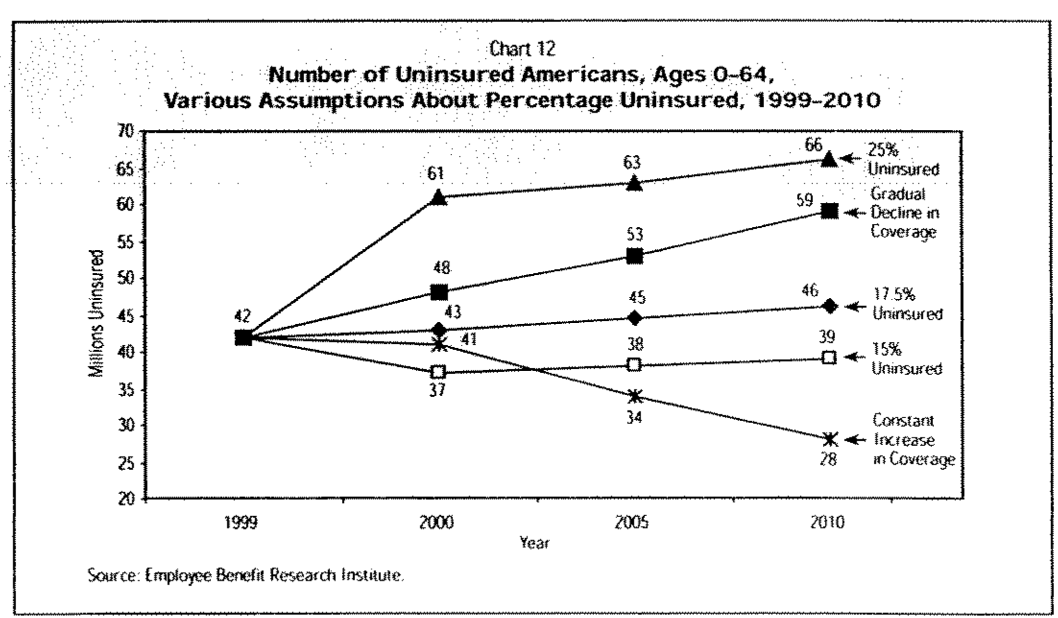


to prescription drug benefits in response to rising prescription drug costs (Copeland, 2000).

Even though the number and percentage of uninsured declined substantially between 1998 and 1999, more than 42 million Americans remain uninsured. As long as the economy is strong and unemployment is low, employment-based health insurance coverage will expand and the uninsured will decline gradually. However, even if the United States experiences five more years of declines in the uninsured similar to that in 1999, 34 million Americans would still be uninsured in 2005. If the economy continues to soften or comes close to a recession (for instance, because of rising energy costs), the number of uninsured would easily and quickly start to increase again as unemployment rises. Should a severe downturn in the economy occur, causing the uninsured to represent 25 percent of the nonelderly population, 63 million Americans would be uninsured (chart 12).

Ultimately, the challenge is how to continue to substantially reduce the number and percentage of uninsured. A number of proposals to reduce the number of Americans without health insurance coverage have been offered.[11] While they often recognize that the bulk of uninsured Americans are either children or workers employed by small firms, the proposed

[11] *See Fronstin (2000a) for an analysis of the proposals put forth by the recent presidential candidates.*



strategies to deal with these populations are incremental, and are unlikely to have a substantial impact on the number of uninsured Americans.

Conclusion

This *Issue Brief* has provided a summary of the characteristics of people with and without health insurance, and the sources of the health insurance, from the March 2000 CPS. It finds that many factors affect the likelihood of an individual having health insurance and the source of that coverage. These factors include both demographics and employment characteristics and often vary by location. For example, work status and income play a dominant role in determining an individual's likelihood of having health insurance. In addition, age, gender, firm size, hours of work, and industry are all important determinants of an individual's likelihood of having coverage; however, these variables are also closely linked to employment status and income. Variations by race, ethnicity, and citizenship also are closely linked to employment status and income.

Recent trends in coverage have also been presented. The data indicate that while the percentage of Americans who are uninsured has stopped growing, and is in fact declining, there are still 42 million Americans without health insurance coverage. While an increasing percentage of Americans are being covered by employment-based health plans, this trend may not continue because of the re-emergence of health care cost inflation, especially if the economy goes into a recession. Research illustrates the advantages to consumers of having health insurance and the benefits to employers of offering it. In general, the availability of health insurance allows consumers to avoid unnecessary pain and suffering and improves the quality of life, and employers offering benefits report that it has a positive impact on worker recruitment, retention, health status, and productivity (Fronstin and Helman, 2000). Ultimately, the challenge is how to substantially reduce the number and percentage of the uninsured.

Appendix

The data presented in this *Issue Brief* come from the March Current Population Survey (CPS), conducted annually by the U.S. Census Bureau. The March CPS provides answers to questions on labor-force participation, unemployment, work experience, family income, demographics, and health insurance coverage. The CPS is the most widely used source of data on unemployment rates, poverty, and income in the United States.

The CPS has undergone a number of changes over the years that affect the comparability of data in the time series. In the March 1988 CPS, the questionnaire was substantially changed. Among the changes that were made, questions were added that inevitably picked up more people with health insurance coverage and reduced the number of uninsured in the survey (Moyer, 1989; and Swartz and Purcell, 1989). Prior to the March 1988 CPS, only employed persons were asked about employment-based health insurance. Starting with the March 1988 CPS, all persons ages 15 and older were asked about employment-based coverage. This change resulted in the identification of coverage for persons (and their families) covered by former employers through either retiree health benefits or COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985). Another major change affected the health insurance coverage of children. Questions were added about coverage from sources outside the household. Imputation methods for children's coverage were also revised to collect more accurate information about coverage type and policyholder. An additional set of questions was added to get more accurate information about children on Medicaid and those covered by a plan purchased directly from an insurer. Finally, weighting, program-

ming, and processing improvements were made to the survey (Levit et al., 1992).

Starting with the March 1995 CPS, the questionnaire was revised again. The Census Bureau utilized a more detailed set of health insurance questions designed to take advantage of computer-assisted survey interviewing collection (CASIC) technology. The order of the questions was changed, and the wording in some of the questions was changed. In addition, the sampling frame was changed, potentially complicating comparability of the estimates prior to March 1995 with those starting in or after March 1995. The new questions appear to have affected responses regarding the total number of respondents covered by employment-based health insurance coverage, individually purchased coverage, Tricare (formerly known as CHAMPUS), and CHAMPVA. Questions on Medicare and Medicaid were also revised, but because estimates of Medicare and Medicaid from the CPS do not vary much from year to year even when the survey is unchanged, it is difficult to know how much the estimates were affected by changes to the survey and how much represents true changes. The longer-term trends in coverage are likely to be representative of the true change, because the estimates do not change much from year to year. Swartz (1997) documents these data issues in greater detail.

Recently, the Census Bureau made another change in the CPS that had a very small effect on the health insurance trend data. Starting with the March 1998 CPS, the Census Bureau modified its definition of the population with Medicaid coverage. Previously, an individual reporting coverage from the Indian Health Service (IHS) only was counted as part of the Medicaid population. Beginning with the data in the March 1998 CPS, individuals covered solely by IHS are counted as uninsured. This methodological change affected roughly 300,000 individuals. If this change had not taken place, the Medicaid population would have fallen by 0.9 percentage points between 1996 and 1997, instead of by 1.1 percentage points, and the uninsured would have increased to only 18.1 percent instead of 18.3 percent.

A number of changes can be expected in the CPS over the next few years. First, in March 2000, a question was added to the CPS that directly asks respondents whether they were uninsured in the previous year. This question is designed to pick up individuals who fail to report health insurance coverage when first asked. Findings from this question are expected to be released at a later date. Second, the sample size of many small states will be doubled, and in some cases even tripled over the next few years. However, some states may continue to have a small sample of uninsured individuals even after the sample size is tripled.

In order to compare the March 1995 CPS and later years with earlier years in this paper, data from the March 1988 CPS through March 1994 CPS have been adjusted to reflect two changes that occurred with the change between the March 1994 CPS and March 1995 CPS. First, the data analyzed prior to March 1995 have been re-weighted to reflect the revised sampling framework that occurred in the mid-1990s. Second, the data on employment-based health insurance coverage and individually purchased coverage have been adjusted in response to what appears to be a reallocation of coverage from individually purchased coverage to employment-based coverage between the March 1994 CPS and the March 1995 CPS.

Duration of Coverage

Data from the March CPS do not allow researchers to determine the length of time that an individual is insured or uninsured. The Survey of Income and Program Participation (SIPP), another survey conducted by the Census Bureau, allows longitudinal analysis of the uninsured. Copeland (1998) found that 37 percent of the uninsured population was uninsured for one to four months, 22 percent was uninsured for five to eight months, 9 percent was uninsured for nine to 11 months, and 33 percent was uninsured for 12 months or longer. Similarly, Bennefield (1998) found that 29 percent of all uninsured spells lasted 5.3 months or longer. These data

would seem to indicate that even though many individuals may lose health insurance during any given month, the majority remain uninsured for a short time, and may even be eligible for coverage under COBRA or various state continuation-of-coverage laws.

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POINTS FOR TESTIMONY
APRIL 10, 2001

INTRODUCTORY POINTS:

- 2001-2003 biennial budget is definitely one of the leanest budgets in recent years
- Unfortunately, funding for health related items in the budget was also paired down
- At a time when the state's uninsured rate is in double digits (11%), and enrollment is rapidly growing in state health programs, the choice to under-fund these important health programs will likely cause a crisis in the health care of Wisconsin's citizens
- There is a funding source available for assisting in the health care needs of our citizens. The tobacco settlement monies are an appropriate and legitimate source for making whole programs such as HIRSP and Medicaid.

HIRSP

-there has never been a worse time to reduce state funding for the HIRSP program
-enrollment has sky-rocketed over the past year, increasing 32% since Dec. 99; subsequently, the growing population has driven up HIRSP program costs
-not only does the reduced GPR subsidy raise insurer and provider assessments by $800,000 each, annually, but the brunt of this cut will be felt by HIRSP policyholders who will pay over $2.2 million in higher premium charges
-draw parallel between insurance policy cancellations last fall and growth in HIRSP applications
-the $3.8 million GPR reduction for HIRSP should be funded with tobacco monies in the same amount

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MEDICAID ADMINISTRATION:

- it is worth noting that the Governor's budget also fell short in funding the Medicaid Contract administration budget by $7.1 million over the biennium
- tobacco monies are a logical mechanism for filling this budget hole

PRESCRIPTION DRUG COVERAGE FOR SENIORS:

(NOTE: the budget did not allocate any money for funding a prescription drug benefit. GOP and Dem proposals range from $15 million to over $70 million a year.)

TOTAL BUDGET HOLE: $11 MILLION

Wisconsin Personal Services Alternatives, Inc.

WPSA is a state coalition of personal care providers and represents the majority of agencies, organizations and counties that provide personal care services to Medical Assistance recipients in Wisconsin. Each organization varies in size, from providers that employ 20 personal care workers annually to providers that employ 850 personal care workers on a yearly basis. 56% of the 72 WPSA Members responded to this survey.

The questions and results of that survey are as follows:

1. What was your PCW starting Rate of Pay before 7/1/00?
Average = $6.98/hour

2. What was your PCW wage range before 7/1/00?
The PCW wage range before 7/1/00 was $5.25/hour up to $10.50/hour (the average rate of pay was $7.55/hour).

3. What was your PCW starting rate of pay after 7/1/00?
Average = $8.34/hour (representing 20% of the 29% reimbursement increase)

4. What is your current PCW wage range?
The PCW wage range currently is $6.37/hour to $12.00/hour (the average rate of pay as of 7/1/00 was $8.70/hour).

5. Before 7/1/00 did you provide additional benefits to PCW's and if so what type of benefits?
70% responded yes and the benefits varied (e.g., sick time, vacation time, retirement, medical, weekend differential pay) –50% of the agencies provided some type of health insurance/medical care benefit.

6. After 7/1/00 did you provide benefits to PCW's and if so what type of benefits?
22% of the respondents added benefits or would be adding benefits for the PCW's which included vacation time, sick time, medical insurance and life insurance. 63% of the respondents were struggling with keeping current benefits due to ever-increasing costs of benefits, particularly medical insurance costs. Many respondents were waiting to see what future increases there would be in the MAPC rate and they mentioned their fear of another seven year freeze in the rates (similar to the 0% increase from 1990 through June 1997).

7. What is your Actual Cost per Hour of Personal Care?
Average = $16.84/hour

8. Are you planning to continue to provide Personal Care Services?
95% responded yes

9. Are you planning to raise PCW wages within the next 12 months?
76% responded yes but another 14% of the providers were waiting to see of there would be regular increases in the reimbursement rate. Several providers were waiting to see the rate increase projections in the next biennial state budget.

10. Are you planning to provide or enhance benefits to PCW's?
29% responded yes, 19% were not sure

11. Have you given regular yearly raises and other benefits to PCW's before 7/1/00?
76% responded yes

12. Did the new PCW reimbursement rate keep your agency from going out of business?
76% responded yes

13. What percentage of your business is funded by MA Personal Care?
Average = 55%

Summary of WPSA Personal Care Worker Wage and Benefit Survey:

As of 7/1/00, beginning wages for personal care workers increased 20%, from $6.98 to $8.34 per hour, with over 76% of the providers planning on giving personal care workers additional raises within a 12 month period. Before the rate increase in July, 70% of the providers already provided benefits to personal care workers including vacation time, retirement, medical, sick time, differential pay for weekends, etc. 22% of the providers will be adding benefits for the PCW's and an additional 63% of the providers are considering other benefits if future funding increases are a reality for this program. The current average cost per hour to provide personal care services is $16.84/hour, which is already 9% over the reimbursement rate of $15.50 per hour. Even before the MAPC rate increase was enacted, 76% of provider organizations gave regular annual raises to personal care workers. The MAPC rate increase of 7/1/00 prevented 70% of the providers that responded to this survey from going out of business. On the average, 55% of the funding to provide services by the providers is received from Medical Assistance Personal Care.

3/15/2001

Completed by: ***WPSA Legislative Committee***

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WISCONSIN PERSONAL SERVICES ALTERNATIVES, INC.

What is Wisconsin Personal Services Association (*WPSA*) All About?

WPSA is a state coalition of Personal Assistance Providers that represents the majority of agencies, organizations and counties that provide Personal Assistance Services to consumer recipients in Wisconsin. Each organization varies in size, from providers that employ 20 personal care workers annually to providers that employ 850 personal care workers on a yearly basis. *WPSA* Membership numbers over 65 members.

The purpose of *WPSA* shall be to:

Provide, promote and advocate for consumer-oriented, consumer-focused, quality personal assistance for persons of all ages.

The goals of *WPSA* Inc. shall be to:

1. Unite agencies and consumers who have an interest in personal services
2. Educate agencies and consumers about personal service regulatory issues
3. Develop a practice stance about regulatory issues
4. Expand consumer choices
5. Promote quality services based upon consumer preferences and satisfaction of the service
6. Advocate for policies on the local, state and federal levels that promote the mission statement
7. Integrate the model into the consumer-directed model in the delivery of services, when necessary

What Does *WPSA* Have to Offer?

- ✓ A gathering of professionals, employees, and consumers all striving to understand and improve the quality of homecare in the state
- ✓ Access to information on workshops and seminars related to home and personal cares.
- ✓ Legislative updates on related issues.
- ✓ Viewpoints, ideas, forms, policies and procedures used in established agencies throughout the state.

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Web Site: http://wpsa.homestead.com/WPSA.html

"For these are all our children . . .
we will all profit by, or pay for,
whatever they become." James Baldwin

Child Welfare
Hard Times For Troubled Kids

Recommendation: Expand Medicaid coverage to 18-21 year old youth who have aged out of the foster care system and pull down federal dollars to implement this program. Begin the program on July 1, 2001.

Background

Governor McCallum's 2001-2003 Biennial budget fails to include a request by the Department of Health and Family Services (DHFS) for $47,500 GPR in 2003 to begin phasing in a program extending Medicaid coverage to youth ages 18-21 who have been in the foster care system. This request reflects a recent federal policy change in the Medical Assistance program that allows states an option to insure foster care youth who "age out" of the foster care system.

Recognizing the unique problems faced by youth who are transitioning from foster care to independent living, Congress passed the John H. Chafee Foster Care Independence Act. President Clinton signed it into law on December 14, 1999. In addition to the MA option, the Chafee Foster Care Independence Program (as it is more commonly known) provides flexible funding for states to implement programs aimed at meeting educational, vocational, financial, emotional, social, medical, and housing needs imperative to self-sufficiency for foster care youth. Federal funding for the program was increased from $70 million to $140 million as a capped entitlement.

If the program starts on July 1, 2001, the cost for the first year is estimated to be $177,500 in General Purpose Revenue (GPR). This would draw down $245,100 in federal funding (FED). Second year implementation costs are estimated at $505,200 GPR and $697,600 FED for a total of $1,202,800. When fully implemented the cost is $1.6 million to cover 1,100 youth including those leaving out-of-home placement in groups homes, residential care or juvenile facilities. These estimates may be high since they are based on the assumption that all eligible youth would participate. However, some youth may move out of state; others may access health insurance through jobs or not apply.

The Problem

Teens leaving home at age 18 or 19 years is a common experience in our society, but it is usually expected that they may return home for financial and emotional support from time to time. Teens leaving foster care when they are declared independent at age 18 face different challenges

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than many youth. They have no source of financial support. Foster parents have no obligation to continue a relationship with them, although some do continue to help. Fortunately, the Chaffee program has new provisions that alleviate some of these problems. And the Medicaid option was one of the most important.

Rationale to Restore the MA Option

Research has shown that youth who age out of the system have continuing health care needs, as do most teens and young adults. While other young adults may have the option of staying on their parents' insurance policy, foster care youth are cut off and expected to fend for themselves.

Funding the DHFS proposal would allow more youth to access MA services, particularly the mental health services for a longer period of time. This may lead to better employment opportunities with an increased probability for access to employee-based health care.

A recent study by Mark E. Courtney and Irving Piliavin followed Wisconsin foster care youth prior to exiting out-of-home care and 12 to 18 months after again after exiting. Their findings highlight the urgency of this issue:

- Wisconsin foster care youth experience more psychological stress than other youth their age as evidenced by scores on the Mental Health Inventory. These scores remained high, 12 to 18 months later.

- Forty-seven percent of these youth received some form of mental health or social service the year before they left the foster care system. The most common service received was individual counseling or therapy followed by group counseling or therapy. Thirty-eight percent of youth had taken medication to alleviate emotional distress. Five percent of youth had received substance abuse treatment. Only twenty-one percent of these youth received mental health or social services following their emancipation.

- Fifty-one percent of youth had no health insurance coverage at follow-up.

- The general health of Caucasian foster youth in Wisconsin is significantly poorer than other Caucasian youth of the same age group in the general population, as denoted by scores on the General Health Rating Index.

- Obtaining medical care was the greatest problem reported by youth attempting to acquire independence. Forty-four percent said they had a problem finding medical care most or all of the time.

- Only 11 percent of youth interviewed reported receiving concrete assistance in obtaining health insurance before discharge from the system.

Other states in our region have all chosen to participate in the Medicaid option.

Legislative Initiatives Regarding the Department of Health & Family Services (DHFS) Medicaid Prior Authorization Process for Therapies for Children with Special Health Care Needs

I am Lynn Steffes- a Pediatric Physical Therapist for 21 years, a representative of the WPTA Pediatric Practice Committee, the Medicaid Committee and the Legislative Action Committee. Today I am here as the Project Coordinator for the SURVIVAL COALITION Medicaid Group. The Survival Coalition represents the efforts of over 25 advocacy organizations throughout Wisconsin.

I would first like to extend my appreciation and admiration for the Senate Health Committee for requesting an audit of the DHFS process when auditing Medicaid Providers. The Legislative Audit Bureau is also engaged in an audit of the Prior Authorization process as requested by the Survival Coalition and the many families & providers they represent. That audit was initiated in the fall of 2000. With the consistent communications between the LAB and our organization, I am confident that the problems will be diagnosed & resolutions will be forwarded. We all know that it is incumbent on both the State Legislature & the Governor's office to insure that the Audit findings result in real solutions that translate into improved access to medically necessary services for children & families in Wisconsin's Medicaid Program.

In order to be poised for a proactive response, the Coalition has sought to recommend positive changes in the process and have shared these recommendations with both the Audit Bureau and key legislators.

<u>Please consider the following Legislative Initiatives to enhance the Medicaid Card Services:</u>

Problem: The current definition of "Medical Necessity" is subject to ongoing reinterpretation with DHFS in administering Medicaid Card services. A definition that is contemporary and includes a clear understanding of the ongoing needs of children & adults with life-long disabilities is available and should be considered for Medicaid recipients in WI.

Administrative Rules that clearly define "Medical Necessity" should be established with careful consideration of children with long term health and rehabilitative needs.

Problem: Currently the aggressive prior authorization process in place in the WI Medicaid program is based on a management model appropriate for managing short term acute rehabilitative services. Ongoing prior authorization on an 8-12 week basis for the long-term *habilitative* needs of children & adults with disabilities is costly for providers and the state. It results in needless repetitive paperwork, delays in services and stress on families within the system.

A separate process should be established that enables the long term rehabilitative and care management of children & adults with special health care needs to be approved annually for an appropriate level of ongoing service. Perhaps a correlating this process with the potential Pediatric Long-Term Care waiver program would offer a better long-term care management solution. Limiting the aggressive Prior Authorization process to managing episodic needs for service such as defined in a traditional medical utilization review model.

Problem: Families and providers wishing to consider and prepare appeals for modified or denied PA's have little information stated in the original denial/modification upon which to base their decision. They must currently initiate an actual formal appeal to receive a written explanation regarding the basis for denial/modification.

DHFS should be required to provide more specific information regarding the reason for modification/denial of PA's immediately upon modification/denial.

Problem: Families & providers navigating the Prior Authorization process and issues surrounding both community and school-based services are hindered by the complexity of the system. With increasing challenges and time required to administer services for Medicaid recipients, providers are less willing to offer the additional time and resources needed to prepare for and participate in the formal appeals process. Without Provider participation, most families find it intimidating and difficult to present their child's case to the hearing officer.

An independent ombuds program should be established to assist families in navigating this process for the PA process including issues of access to therapies, DME, home & personal care.

Problem: Substantial cost increases in administering services to WI Medicaid recipients have been noted by providers over the past 5 years. This increase has been the result of the costly prior authorization process and its ongoing demand for volumes of repetitive paperwork. It has resulted in a disincentive to provide needed services to children & adults with disabilities in WI. On the other hand, WI school districts involved in billing the WI Medicaid Program for school-based services are surveyed regularly and experience rate increases and administrative compensation related to the cost of providing Medicaid services and performing outreach activities. A similar study of community-based providers would enable the Department to capture information about the rapidly growing costs of providing services and accessing Medicaid reimbursement for this population.

A mandatory cost study should be conducted every 3-5 years with community-based Medicaid Providers to capture the related costs to the delivery of service including the costly Prior Authorization process.

Problem: Currently the WI Medicaid program demonstrates a preference for school-based services for children with special needs, despite the clearly defined role of school-based services in their of meeting the "educational" needs of children. This preference may be fueled by the fact that the School-Based Services benefit in WI currently funnels 40% of Federal revenues received into the state general fund.

In addition, there is no related legislation to the school-based service benefit that describes that revenues received by a district should be used to enhance special education or related services. Therefore, when a school district provides and bills for school-based therapy services, the state makes money on these services whether or not the student's medical needs for therapy are met. There have been few if any increases or changes in the level of therapy services available in school districts related to the increased revenues. Yet there have been increasing denials related to "duplication of services" issues for medically based community services. This results in a net decrease in the services available to children in our state despite the obvious increase in federal dollars.

There should be a substantial reduction in the amount of Federal Medicaid dollars flowing to the WI General Fund for School-Based Services. The current system creates improper incentives for service to be delivered through the schools in lieu of community-based services despite the significant differences in delivery models.

Problem: Providers have experienced Medicaid audits and recoupments based on unclear, unpublished guidelines for documentation and delivery of Medicaid Services. Since ongoing provider education & standards are often unclear, the Bureau of Health Care Integrity should consider for recoupment only those billed services that are provided in clear violation of written policy in force at the time of the services in question. Infractions that cannot be so substantiated with specific provider publications should be given an "educational audit" and follow up. The Federal Health Care Finance Administration has recently stated their support for educational audits in cases where true fraud and abuse could not be substantiated.

Regulations should be established insuring that Provider Audits have an educational option when non-criminal intent is noted for minor violations in regulations. Regulations should be established that limit DHFS' ability to implement tighter standards for audit than what are clearly published and provided to Medicaid Providers of Service.

3/10/01 Respectfully Submitted by Lynn Steffes, PT
Survival Coalition, Medicaid Project Leader (414) 587-0374

Position Paper

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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.

The Pharmacy Society of Wisconsin strongly opposes the Governor's proposal and recommends its elimination from SB55 and AB144, the biennial budget bills.

- Wisconsin Medicaid pharmacy providers have borne the brunt of cost containment initiatives for the MA prescription drug program. In fact, pharmacy reimbursement has not increased in over 12 years.
- The State of Wisconsin has an obligation to assure its policies do not reduce the availability of important and necessary health care services. Reduction in pharmacy reimbursement will result in dramatic reductions in the quantity and quality of services provided to MA recipients.
- The State of Wisconsin must pursue and expand the provider reimbursement policies, which encourage the optimal use of prescription drugs by the citizens of the state. The Governor's proposal would create the opposite effect.

The Governor's Proposal and its Impact on Wisconsin Pharmacies

Under current law, participating Wisconsin pharmacies are reimbursed at AWP minus 10% plus a $4.38 dispensing fee. The Governor's proposal would change the AWP to minus 15% plus a $4.38 dispensing fee. To further illustrate this, the following example has been prepared based on an average Medicaid brand name drug cost of $60.

Under current law of AWP minus 10% the following calculation would apply:

$60 minus $6 plus $4.38

Under the Governor's budget proposal of AWP minus 15% the following calculation would apply:

$60 minus $9 plus $4.38

The additional $3 reduction from a pharmacy's average gross profit of approximately $7.50 per prescription would result in a 40% cut in a pharmacy's realized reimbursement.

Position Paper

State-Based Prescription Drug Benefits Provisions Included in the State Budget Bill

Background

The Pharmacy Society of Wisconsin (PSW) represents over 2,000 pharmacists and pharmacy technicians—all of whom take a great deal of pride in the quality of care they offer to patients. PSW supports comprehensive Medicare reforms that bring about the inclusion of Rx drugs as a covered benefit. Until Congress acts, however, PSW members support the establishment of a state-based prescription drug program for Wisconsin's low-income senior citizens. Such a program will help to ensure that low-income seniors will have the ability to purchase valuable, often life-saving, medicines.

On February 20, 2001 before a joint session of the Wisconsin Legislature, Governor Scott McCallum introduced his 2001 – 2003 biennial budget recommendations. The recommendations have been introduced simultaneously to both the State Senate and Assembly as Senate Bill 55 (SB55) and Assembly Bill 144 (AB144). The Governor's budget contains provisions to create a drug benefit for seniors and a statewide assistance program.

Prescription Drug Assistance for Seniors

The Governor recommends requiring the Department of Health and Family Services (DHFS) to seek a federal waiver to expand the MA prescription drug coverage to low-income seniors over 65 who lack drug coverage. Participants would pay an enrollment fee, deductibles that vary by income, and co-payments for brand-name and generic drugs. The Department of Administration is also directed to contract with a private entity to operate a state-sponsored discount program open to residents regardless of income or age. In addition, both departments are directed to promote existing drug discount programs offered by drug manufacturers and private companies. Other activities that will expand the availability of discount drugs include bulk purchasing of maintenance drugs for persons with chronic conditions; developing a multi-state purchasing pool; and assisting federally-qualified health centers to participate in federal drug discount programs. These are all advocated in the budget.

The Governor's recommendation for this section is unfunded. As recommended by his office, it is estimated to cost $14 million annually and provide prescription drug coverage for an estimated 62,000 seniors; however, the Governor did not provide funds for the program, but, rather, he intends on using unidentified savings from DHFS.

The program requires participants to pay an annual enrollment fee of $25. In addition to the fee, participants would have to pay co-payments of $10 for generics and $20 for brand name drugs after annual deductibles are paid. The deductibles are as follows:

- An individual with an annual household income at or below 110% of the federal poverty level would not have to pay a deductible.
- An individual with an annual household income that exceeds 130%, but does not exceed 155%, of the federal poverty level shall pay a deductible of $600.
- An individual with an annual household income that exceeds 155%, but does not exceed 185%, of the federal poverty level shall pay a deductible for each prescription drug that equals the Medicaid rate.

Statewide Assistance Program

In addition to a seniors program, the Governor wants to implement a second prescription assistance

program that would be made available to any Wisconsin resident regardless of age or income. Participants would pay an annual enrollment fee [not specified in his budget] to the state that would allow them to receive prescription drug discounts that are set at the state's Medicaid rate. The program calls for discounts for pharmacy providers that are the same or greater than the pharmacy discounts required by the Medicaid program.

The Governor's plan would also direct the Department of Health and Family Services and the Department of Administration to contract with a private entity for the bulk purchase and mail order delivery of prescriptions for MA recipients.

Criteria

PSW is committed to working with members of the Legislature, the Governor and his administration to advance the enactment of legislation to create a well-designed, adequately-funded and efficiently-administered prescription drug program for Wisconsin's neediest seniors.

PSW is opposed to and recommends the elimination of the Governor's proposal to create a prescription drug benefit for Wisconsin seniors along with a state-wide discount benefit. This position has been taken because these proposals do not meet the criteria established by the PSW Board of Directors.

Principles for Program

In an effort to assist with the development of an effective benefit program for Wisconsin seniors, PSW recommends the following:

A well-designed program will benefit enrollees and providers. Wisconsin pharmacists should not be burdened with layers of government bureaucracy as a condition of participation. In order to guarantee that seniors have access to pharmacy services, pharmacies should given the choice to participate in the prescription program. Participation should be voluntary. Pharmacies should not be required to participate in the program as a condition of enrolling as a Medicaid provider.

Establish a dedicated source of funding. Wisconsin needs to appropriate adequate funds necessary to provide prescription drug benefits to low-income seniors. Funds could be obtained through a combined use of general purpose revenues (GPR), program revenues (PR) and rebates from participating pharmaceutical manufacturers. A Wisconsin-based plan should also make use of federal block grants if they become available.

Wisconsin's reimbursement rate should not be tied to Medicaid rates. Rates based on charges such as the Wholesale Acquisition Cost (WAC) provide for a better reflection of a pharmacy's drug purchases.

Wisconsin should not adopt programs that impose price controls on retail community pharmacies. Community pharmacies operate in an extremely competitive marketplace, resulting in very low profit margins. State-administered price controls will only distort this competitive marketplace. Instead, marketplace competition should dictate the retail price for medications.

Establish medication therapy management programs. Providing the elderly with increased access to medications without also supporting an effective system for their rational and safe use is not a wise policy. As part of the prescription drug program, a medication therapy management program should also be developed for seniors most at risk for potential medication problems or adverse reactions. This would help assure that positive outcomes are achieved from the use of prescription medications. These pharmacy-based services would include disease management, case management, education, counseling and medication compliance programs.

Studies have documented the effectiveness of therapy management programs in helping to assure the safe, effective and cost-conscious use of medications.

Located in the Krohn Clinic

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State Senator Rod Moen and other distinguished members of the Senate Health Committee. I would like to welcome you to Black River Falls and thank you for allowing me to appear this morning in order to address Senate Bill 55 and Assembly Bill 144 as it pertains to my profession.

My name is John Hogden and I am a Registered Pharmacist. I live in Black River Falls and I have owned and operated the Black River Falls Clinic Pharmacy, located in the Krohn Clinic, for twenty-eight years. I grew up in Galesville, went to the University of Wisconsin and also own the Galesville Pharmacy and the Blair Pharmacy. Our pharmacies provide pharmaceutical care to these communities along with five skilled care nursing facilities representing over 500 residents and several community based residential facilities.

I appear here today in opposition to Governor Scott McCallum's pharmacy medical reimbursement rate reduction and to comment on the proposed state-based prescription drug benefits provision. The governor's proposals to reduce the Medicaid reimbursement rate and his prescription drug discount plan will have a devastating impact on Wisconsin pharmacies and pharmacists.

My opposition to a reduction in the Medicaid reimbursement rate is simple. Small rural pharmacies serving local skilled nursing care centers and other residential facilities have a very high proportion of Medicaid recipients. Along with the regular community based Medicaid patients, about 30 to 50 % of our business is Medicaid! The proposed change reduces pharmacy reimbursement by $30 million state-wide and results in a 40% reduction to a pharmacy's gross margin. Wisconsin would rank dead last in Pharmacy Medicaid reimbursement nationwide. This would put many pharmacies out of business! What are the health care centers going to do when 90% of their residents are Medicaid and don't have pharmaceutical service because pharmacies either can't afford to provide it or they have gone out of business?

Pharmacists are not the cause of the escalating Medical Assistance Drug Budget in fact; pharmacy reimbursement has not increased in over twelve years! The increase in the cost of medication comes from drug companies who have literally no cost controls placed on what they charge. Believe me, it is no fun to be on the front lines and have to tell your patients that their prescriptions have gone up in price again! Please note that pharmacies don't benefit financially with the increasing costs of prescriptions. We receive a fee for providing the medication and consultation, therefore, as the cost of medication goes up our gross margin goes down! You can imagine the impact that this has had on pharmacies over the past decade.

2001- 2003 BIENNIAL BUDGET – MEDICAID REIMBURSEMENT
Retain Governor's Proposed Increases in Provider Reimbursement

The Governor's budget includes potentially significant increases in Medicaid reimbursement for all provider services, including physician services. This rate increase is contingent on Wisconsin receiving several hundred million dollars in "Intergovernmental Transfer" (IGT) funds. Under the Governor's proposal, a sum of money equal to the amount necessary to increase Medicaid reimbursement for all providers' services by 5% in each year of the budget will be devoted to increasing provider reimbursement. From that total sum of money, all providers would automatically receive a 2.5% increase in each year of the budget, and providers who are currently reimbursed at a ratio lower than "50% billed-to-paid" would be eligible for additional increases to be determined by DHFS.

SMS urges an amendment to restore the original budget language which:

- Proposes to capture IGT funds;
- Recommends Medicaid provider reimbursement increases.

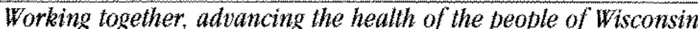
Medicaid – as well as BadgerCare which is administered and reimbursed following Medicaid guidelines – now provides health insurance to nearly a half million low income Wisconsin residents, representing an increase of almost 100,000 since BadgerCare's inception just a couple years ago. The combination of already low reimbursement rates consistently outpaced by inflation, and the nearly 20% growth of the program is a cause of great concern for medical clinics across the state. Medicaid reimbursement for physician services does not cover the actual cost of delivering the service and is not used to cover physician salaries. Many clinics are losing substantial amounts of money by seeing Medicaid patients and may need to scale back the number of patients in the future.

A recent State Medical Society (SMS) survey of clinics of all sizes from throughout Wisconsin revealed the following information:

- Clinic overhead expenses (not including any physician salary or benefits) average approximately 61% of the amount billed for physician services;
- Medicaid reimbursement to clinics for physician services averages 42% of the amount billed for physician services, or less.**

These results mean that, on average, clinics lose about 50% of their overhead expenses on every Medicaid patient. Cuts in staff, equipment, supplies or services are the inevitable result if this trend is not reversed, and these will impact the quality and availability of medical services for all patients in Wisconsin.

** The SMS survey collected information for the six physician visits (out of over 20,000 possibilities) most commonly billed in Medicaid, accounting for 13% of the Medicaid fee-for-service budget for physician service reimbursement, according to DHFS. The survey results found reimbursement levels between 22 and 42%.

State Medical Society of Wisconsin

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2001-2003 BIENNIAL BUDGET – HEALTH INSURANCE RISK SHARING POOL (HIRSP)
Restore GPR Funding

The Governor proposes a modification of the Health Insurance Risk Sharing Pool (HIRSP) by eliminating $1.9 million per year in current GPR funding. The Governor's proposal replaces GPR funds with increases in health insurer assessments, increases in premiums paid by enrollees and by further reductions in reimbursements to providers. Dramatic increases in administrative costs are also included in the budget without explanation.

Support an amendment to Governer's budget bill which would:

- Restore $3.8 million in General Purpose Review (GPR) cut from the HIRSP program. That cut would raise premiums for the enrollees, whose premiums pay for 60% of the program, by almost $2.3 million. This is too great a burden for patients who already pay high deductibles and premiums.

- Keep premuims for patients affordable.
  Maintain the premium and deductible subsidies for those with incomes below $25,000.

- Keep health care for HIRSP patients accessible.
  The proposed $3.8 million cut in the HIRSP program will reduce reimbursements for hospital and physician services. Both groups already accept deeply discounted reimbursement rates in the HIRSP program. Further cuts in reimbursement rates may negatively impact care for all patients, and may lead to potential access problems for HIRSP enrollees.

- Review administrative cost increase.
  The substantial increase in HIRSP administrative costs - $3.8 million or 67% - appears unwarranted by projected enrollment increases. These costs should be scrutinized, and if appropriate scaled back.

The Budget proposes reducing State support for HIRSP at a time when HIRSP enrollment is rising and at a time when the HIRSP safety net is needed more than ever. HIRSP must remain a viable option for citizens who cannot find private insurance due to high-risk medical conditions. Changes such as those proposed in this budget may make this option prohibitive for patients as well as providers who would have face deeper cuts in reimbursement rates.

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2001-2003 BIENNIAL BUDGET – BADGERCARE
Remove Request For Waiver Creating New Delays For BadgerCare Enrollment

Governor McCallum is seeking a federal waiver from US HHS Secretary Tommy Thompson to permit DHFS to extend the time-period an applicant must be without access to health insurance before becoming eligible for BadgerCare from 3 to 6 months. The waiver also changes some of the current exceptions that permit immediate enrollment. Finally, the waiver would allow the department to delay enrollment, potentially for several months or more, until it verifies whether a family or child has or had access to employer-subsidized health care.

SMS urges your support for:

- Restoring the current "Good Cause" reasons that are listed as exceptions to the three-month look-back in the rules.
- Retaining the current insurance access evaluation process which occurs after a recipient is enrolled in BadgerCare.

The Governor's proposal makes the following changes in the Good Cause exceptions to the Look-Back Rule:

- Currently there is no required look-back period if a person loses his/her coverage due to loss of employment unless he or she voluntarily quits. In the Governor's proposal, there would be three-month look-back for these persons (in other words, a new three-month waiting period for BadgerCare coverage). If the family or child lost coverage without losing the job providing the coverage, then the look-back period in the Governor's proposal is 45-days, as long as the loss of coverage was not the family or child's fault.
- Currently, there is no waiting period if a person was covered by a group health insurance plan provided by the employer and the person changed to an employer not offering family coverage. The Governor's proposal cancels this exemption. Likewise, if a person had health insurance provided through an employer and the employer discontinues the health care coverage for all employees, BadgerCare coverage is immediate. This exemption is also lost in the Governor's plan.
- If a person's COBRA continuation coverage is exhausted (after 18 months), there currently is no look-back period. The Governor's proposal would create a three-month look-back period.

Delete the budget language which extends the "no insurance" eligibility requirement from 3 to 6 months. We understand this is intended to address concerns that employers may drop health insurance coverage and instead encourage employees to apply for BadgerCare, however, SMS is unaware of any evidence documenting this phenomenon. Similarly, there is no documentation of a problem with the current employer health care eligibility-verification process. Changing the process to create delays of this magnitude is unjustified. The SMS believes that these proposed modifications would decrease access to needed health insurance coverage thereby increasing emergency department use and decrease access to essential medical care.

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2001-2003 BIENNIAL BUDGET – TOBACCO FUNDING/EXPENDITURES
Meet WTCB Requests for Funding and Securitization Policy

The Governor proposes that $33.2 million be provided to the Wisconsin Tobacco Control Board (WTCB) for tobacco reduction and control activities. This is $2 million short of the WTCB's own request, but supporters of the WTCB (including members of the TRUST campaign which is composed of the Lung Association, Heart Association, Cancer Society, Smokefree WI and State Medical Society, among others) are pleased to see the Governor's commitment to the WTCB's activities.

The Governor also moved funding for the Thomas T. Melvin Youth Prevention and Education Program from General Purpose Revenue (GPR) to the WTCB, meaning the WTCB must spend $1.5 million of its resources to keep the program funded.

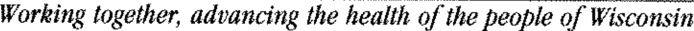
The Governor recently unveiled a proposal to "securitize" the tobacco settlement, which would sell the state's rights to future tobacco settlement payments for a one-time lump sum payment now. The plan, as put forward, means that instead of receiving approximately $160 million per year from the tobacco companies for the next 20-25 years, the state would receive a lump sum of $1.3 billion immediately.

The Governor's plan:

- Takes $350 million of the one-time lump sum payment to fix the 2001-2003 state budget shortfall;
- Puts $570 million into an endowment (no specific purpose for the endowment is in the budget); and,
- Uses $337 million to pay for financing fees and debt service.

SMS requests your support for the following components of any tobacco settlement plan:

- At a minimum, amend the budget to clearly establish an endowment or trust for the sole benefit of the WTCB or its successor. The endowment should be sufficiently large so annual earnings can fund the WTCB's activities at an appropriate level.
- Create an endowment or trust for the benefit of other health care related items or programs such as Medicaid, BadgerCare, community health clinics, health care organizations and providers who work with populations adversely affected by tobacco use by adding specific language to the budget bill.
- Avoid one-time use of funds derived from securitization.
- Oppose an endowment or trust fund created with tobacco settlement funds from being invested directly in tobacco.

State Medical Society of Wisconsin

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2001-2003 BIENNIAL BUDGET – IMMUNIZATION REGISTRY
Reinstate GPR Funding for Wisconsin Immunization Registry (WIR)

Wisconsin will lose $875,000 in federal funding this biennium because Governor McCallum did not provide GPR funding in his budget for the Wisconsin Immunization Registry.

DHFS has already developed a statewide Internet based registry with start up funding from the federal government. It was launched statewide in May 2000 and currently over 140 active immunization providers are using the registry. These providers account for 6.8 million immunizations given to 1.4 million patients. The registry allows health care professionals, public health departments, schools and parents to accurately track the immunizations for all Wisconsin children. This will:

- Increase immunization rates, which decreases preventable illnesses and saves health care dollars.

- Decrease unnecessary duplication of immunizations, which saves money for public and private health plans.

In order to receive federal matching funds from the Federal Health Care Financing Administration (HCFA), the state must commit: $228,000 in 2002 and $366,000 in 2003. **With this $594,000 GPR funding, the state will receive close to $875,000 from HCFA.**

SMS urges your support for:

- **Restoring the GPR funding of $594,000 ($228,000 in 2002 and $366,000 in 2003) in order to run the Wisconsin Immunization Registry.**

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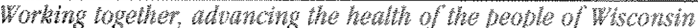

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2001- 2003 BIENNIAL BUDGET – MEDICAID FRAUD & ABUSE
Remove Governor's Proposals on Medicaid Provider Fraud & Abuse

Governor McCallum's budget contains several "Medicaid fraud and abuse" provisions that are unnecessary and unfair to physicians and other Medicaid providers. Similar provisions were proposed in the 1999-2001 Biennial Budget but they were ultimately removed. The Department of Health and Family Services then attempted to do an emergency rule. Fiscal estimates project these draconian provisions will save the Medicaid program – a program with a total budget in excess of $3,000,000,000 – a mere $80,000.

We ask your support for:

- Deletion of fraud and abuse provisions in the budget affecting physicians and other health care professionals from the budget bill.

Illustrations of Fraud and Abuse Language in the Budget Which Cause Concern:

- Due Process Rights Removed

  Providers' due process rights will be removed when a dispute arises over a "recoupment" of Medicaid funds (recovery of funds allegedly paid in error). Instead of the current right to hearing before a neutral fact finder, providers will only be permitted an informal meeting with DHFS staff to discuss the disagreement. Further, if providers are unsuccessful in convincing DHFS staff of their position in the recoupment dispute, they will be charged 1% interest per month if they do not pay the entire amount by the state-imposed deadline. This penalty is retroactive to the date the overpayment was made, even if the alleged overpayment was many years ago.

  This runs contrary to concepts of due process, and is akin to not providing criminal suspects a judicial hearing, but simply an informal meeting with police and prosecutors to argue their innocence before penalties are imposed.

- Infringements on Patient Confidentiality

  DHFS gains the right to audit, investigate and have access to "any" needed patient health care records. We believe that records in excess of those applicable to the subject of the audit should not be so broadly accessible.

We believe that Medicaid providers who abuse or commit fraud against the program should be investigated and prosecuted when appropriate – however, they should be accorded due process rights. We are unaware of any effort by DHFS to express their concerns, seek input, or work cooperatively with the State Medical Society, or any other physician organization regarding service problems, toward resolution of the issues these provisions are apparently designed to address. In concert with very low reimbursement rates and other administrative difficulties, program changes like these which impugn physician character in a very negative manner act as yet another disincentive for providers' participation in Medicaid.

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Summary of Medicaid reimbursement media stories

- January 17, 2001, *"It takes a walking saint to do this"*, Waukesha Freeman
- January 18, 2001, *"Nursing home closing to affect 185 residents"*, Milwaukee Journal Sentinel
- January 13, 2001, *"Nursing homes struggle financially"*, Wausau Daily Herald
- January 10, 2001, *"Nursing homes change planned"*, The Capital Times
- January 9, 2001, *"Nursing home struggles detailed"*, Eau Claire Leader Telegram
- December 22, 2000, *"We're running out of miracles"*, Waukesha Freeman
- December 22, 2000, *"Nursing homes ask legislature for attention"*, Waukesha Freeman
- December 15, 2000, *"Care homes warn of crisis"*, Wisconsin State Journal
- November
- November 1, 2000, *"Villa Marina receives positive support"*, Superior Daily Telegram
- October 12, 2000, *"Care center rises above the rest"*, Wausau Daily Herald
- October 10, 2000, *"County officials question Leean's motives on aid to nursing homes"*, Sheboygan Press
- October 5, 2000, *"Showing they care: Those with stakes in nursing homes tell officials about industry's dire needs"*, Eau Claire Leader Telegram
- October 2, 2000, *"Squeeze on nursing homes prompts calling of summit"*, Eau Claire Leader Telegram
- September 23, 2000, *"The high cost of living – and dying"*, Waukesha Freeman
- September 23, 2000, *"Nursing homes' financial distress hits home"*, Waukesha Freeman
- September 23, 2000, *"By the Numbers/Report on the Financial Condition of Nursing Homes in Wisconsin"*, Waukesha Freeman
- September 23, 2000, *"Tough Choices"*, Waukesha Freeman
- September 21-22, 2000, *"Nursing homes fight for fairness"*, Chippewa Herald
- September 19, 2000, *"Medicaid blamed for nursing homes woes"*, The Daily Press, Ashland, WI
- September 19, 2000, *"Audit: System fails nursing homes"*, Eau Claire Leader Telegram
- September 19, 2000, *"Nursing home industry seeks $80 million"*, Milwaukee Journal Sentinel
- September 18, 2000, *"State nursing homes face financial crisis"*, Wausau Daily Herald

- September 18, 2000 *"Nursing homes in distress over Medicaid repayments"*, Chippewa Herald
- September 18, 2000, *"Nursing homes in poor financial health"*, The Janesville Gazette
- September 18, 2000, *"Nursing home leaders blast state system"*, Milwaukee Journal Sentinel.
- September 18, 2000, *"It's a crisis, nursing homes say,"* Wisconsin State Journal
- August 20, 2000, *"Health chief wants to ease nursing home regulations"*, Milwaukee Journal Sentinel
- July 23, 2000, *"Nursing homes understaffed, patients in danger, report said"*, Milwaukee Journal Sentinel
- September 20, 2000, *"System abuse hurts residents who pay"*, Milwaukee Journal Sentinel
- September 19, 2000, *"State nursing home workers meet here"*, Wisconsin Rapids Daily Tribune

Mike's files/WHCA/media summary 1-17-01

Waukesha Freeman 1/17/01

'It takes a walking saint to do this'

Legislator addresses nursing home worker shortage, salaries

Todd Ponath/Freeman Staff

Happiness Kammerzelt, a nursing assistant at the Waters of Westmoreland, talks to one of the residents while feeding her at the nursing home Tuesday.

Industry officials say idea is not realistic

By ANNE E. SCHWARTZ
Freeman Staff

Liveroa Gillespie doesn't just make a living, she makes a difference.

As a certified nursing assistant at the Waters of Westmoreland nursing home, 1810 Kensington Drive in Waukesha, Gillespie said her job isn't about the money. At about $9 an hour, it can't be.

A profession in crisis

"It's not all about the money for me," Gillespie said. "I'm making a difference. I like caring for the residents and treating them how I'd want someone to treat me or my family."

At 24, Gillespie has been a CNA for seven years - an anomaly in a profession that is in crisis to retain and attract workers.

Debra Taylor, a certified nursing assistant at the Waters of Westmoreland nursing home, helps feed a resident Tuesday afternoon.

CNAs are at the heart of a new debate in Wisconsin on nursing home care. State Rep. Peggy Krusick, a Milwaukee Democrat, announced Tuesday she will introduce legislation in the next two weeks that would require nursing home facilities to provide higher staffing levels.

"With hospitals discharging patients more quickly, many nursing homes just don't have enough nurses and aides to attend to the increasingly complex medical needs of the population they serve," Krusick said.

Krusick has the support of the Service Employees International Union, the state's largest organization of nursing home health care workers, including

See ASSISTANTS, Back Page

FOR MORE INFORMATION

The following Web site will provide a guide to various Wisconsin Department of Health and Family Services programs and services.

Included at this site is information on choosing a nursing home and staffing reports on nursing homes, which can be searched by facility.

The site is http://www.dhfs.state.wi.us/programs.htm

Assistants

From Page 1A

CNAs.

"The staffing levels have dropped so low in many facilities that it's a physical danger to residents," the union's political director, Robert Kraig, said. "We have members saying they can't provide care at these current staffing levels."

The issue not only is the dearth of workers, but their compensation.

"We give McDonald's-level pay for extremely demanding work," Kraig said. "The level of injury for nursing home workers rivals that of construction workers or miners."

The state requires 2.5 hours of direct care per resident per day. Krusick said that is too low, and said she will include language in the bill that specifies ratios instead – one direct-care staff person to every five residents during the day. The number of staff people would be slightly lower during the afternoon and evening shifts.

But the leaders of the state's two nursing home associations touted the idea as "feel-good legislation." The associations have been lobbying the legislature to increase Medicaid reimbursement levels.

"We can't just talk about passing a law to raise minimum staffing," John Sauer, executive director of the Wisconsin Association of Homes and Services for the Aging, said. "At its core is the problem of underfunding. It's not realistic to ask nursing home facilities which already are operating at a deficit to further increase their expenditures. We can't pass feel-good legislation without dealing with the root causes."

And those who run the state's nursing homes said the idea does not address the problems inherent in the profession.

A shallow employment pool

"It's simplistic to throw more people at a situation," Catherine Hackney, administrator of the Waters of Westmoreland, said. "Where will these people come from? Those individuals who come out of school with many opportunities ahead of them want to be dressed up and work with computers. They don't want to work with body fluids. It takes a walking saint to do this."

CNAs do the unenviable tasks that come with caring for the elderly and frail. They change soiled diapers and bedding, bathe and feed residents, and often must deal with the behavioral problems that come with deteriorating health – verbal abuse, combative behavior and depressed residents.

Currently, 16 percent of the available CNA jobs are vacant. To recruit more workers, the industry has tried youth apprenticeship programs, lobbying to change immigration laws so more people can get into the country to provide health care services, and promoting the industry as a place to make a difference.

The labor pool from which Krusick wants to cull simply isn't out there, Tom Moore, executive director of the Wisconsin Health Care Association, said.

"The bill we should be looking at is a bill to increase the Medicaid reimbursements for these facilities – to keep them open," Moore said. "We need money to pay the staff we have now. (Krusick) is on a collision course with reality."

Krusick countered that she is all for increased Medicaid reimbursements to the facilities, but she'd like to see the funds earmarked for increasing staffing levels and salaries.

"Care givers have told me they are frustrated and stressed," Krusick said. "This bill will go a long way in giving care givers the care they want to provide and will provide the quality of care we want for our loved ones."

(Anne E. Schwartz can be reached at aschwartz@conleynet.com)

Wisconsin
B
THURSDAY, JANUARY 18, 2001 MILWAUKEE JOURNAL SENTINEL

Nursing home closing to affect 185 residents

Glendale center cites finances, vows to help with relocation

By DAVID UMHOEFER
and GRETCHEN SCHULDT
of the Journal Sentinel staff

A big Glendale nursing home that just six months ago took in 66 patients from the troubled Audubon HealthCare Center is closing in June, state and corporate officials said Wednesday.

The voluntary shutdown of Shores Health and Rehabilitation Center, announced by Atlanta-based Mariner Post-Acute Network, will force the move of 185 residents, many with chronic mental illnesses along with physical ailments.

Mariner, which is in Chapter 11 bankruptcy, blamed inadequate Medicaid and Medicare reimbursements and the saturation of nursing home beds in the Milwaukee area for the closing.

Mariner also owned the sprawling Audubon facility in Bayside. Audubon closed last June after state and federal health regulators acted to close the home for poor care. The Shores closing is voluntary and will take place over six months, in contrast to the rushed shutdown of Audubon, which drew protests from resident advocates.

Audubon and Shores were two of a rapidly dwindling number of nursing homes locally that accepted significant numbers of residents of all ages suffering from chronic mental illness.

State health regulators are concerned about how former Audubon residents, in particular, will handle their second move in less than a year. Many Shore residents have bounced betwee mental hospitals, apartment and nursing homes in recer years.

"It's awful, just awful," Su Schroeder, director of the state' nursing home regulatory agenc said of the plight of the forme Audubon residents. "No on should have to go through it."

Schroeder said the state an Mariner would work closely wit residents, families and goverr ment agencies to find appropr

Please see NURSING HOME, 7

185 residents will lose their home

NURSING HOME, From 1B

ate placements for Shores residents.

Claudia Stine, an official with the state Board on Aging and Long-term Care, which advocates for nursing home residents, said the shortage of housing either in the community or in nursing homes would make the relocation difficult.

"We have really grave concerns about these folks and whether appropriate placements can be found," she said. "Our heart really goes out to these residents and their families."

Both Schroeder and Mariner spokeswoman Melody Chatelle promised a team effort to ensure a smooth relocation by June 30. Mariner, which is consolidating its nursing home holdings, felt it couldn't sustain an adequate level of care at Shores given the financial situation, Chatelle said.

Mariner informed residents Tuesday of its plan.

Next Thursday, the Board on Aging will hold an informational meeting for residents and families who want to know what alternative housing options are available, Stine said.

The facility will work closely with residents one-on-one to help them find appropriate housing, Chatelle said.

Meanwhile Wednesday, Magistrate Judge William E. Callahan Jr. issued a preliminary injunction compelling Mariner Post-Acute Network to make available to the Wisconsin Coalition for Advocacy Inc. all documents related to the deaths of a 62-year-old man at Audubon HealthCare Center and a 53-year-old man at Shores Health and Rehabilitation Center.

"This is pretty much a 100 percent win as far as I'm concerned," said coalition attorney Michael Bachhuber. "The issue is people are dying there, and from looking at the medical examiner's record, they shouldn't have been dying."

The importance of Callahan's decision goes beyond those two facilities, Bachhuber said. The number of reports of possible abuse or neglect in nursing homes around the state is increasing, and "this decision will allow us to get in there faster and conduct an investigation," he said.

Callahan said in his decision, dated Tuesday, that both men died when they choked on food. Their full identities are not given.

WAUSAU DAILY HERALD 1/13/01

Nursing homes struggle financially

By Andy Napgezek
Wausau Daily Herald
anapgaze@wdhprint.com

Residents at Mount View Care Center in Wausau appreciate the emotional and physical help they get from nursing home staff. The trouble is, there aren't enough workers to go around.

That's because nursing homes across the state are losing money and have had to make cuts in wages, benefits and services, said Tim Steller, chief executive officer for North Central Health Care, the county-run care facility that houses Mount View. Nursing homes have had trouble recruiting and keeping enough good help.

"Quite simply put, (the issue) deals with money," Steller said. "We have a critical funding shortage."

He said Mount View expects to lose $3.2 million during 2001, mostly because of the insufficient Medicaid reimbursement rate.

Steller welcomed four area lawmakers Friday morning to the first stop on a bus tour of six area nursing homes. State Reps. Jerry Petrowski, R-Stettin, and Greg Huber, D-Wausau, and Sens. Roger Breske, D-Eland and Russ Decker, D-village of Weston, participated in the half-day program designed to illustrate the conditions and challenges at care facilities in central Wisconsin.

Laura Glassford, 59, of Marathon has been a Mount View resident for 16 months.

"The nurses are just wonderful," she said. "But there is such a shortage, especially at nights."

Overnight, she said there are two aides for her 59-bed wing. Not only could this cause problems in an emergency, it affects such mundane tasks as visiting the rest room.

Many residents need assistance getting to the toilet then back to bed. Glassford said she often has had to wait 30 to 45 minutes on the toilet before an aide could help her off.

"They do a wonderful job for how shorthanded they are," she said.

But it all comes back to money — something Wisconsin nursing homes don't have. And money is the reason lawmakers were asked to tour the care facilities Friday, so they could see how needy the industry has become. The main reason for their plight is the low reimbursement rate of Medicaid.

Medicaid is a federal program for low-income people, 40 percent of which is paid for with state money, the rest with federal funds. "How it is spent is in the purview of the state government," Steller said.

He offered the following reasons that more of that money should be pumped into nursing homes, based on results of a survey of 328 Wisconsin care facilities performed last year by BDO Seidman, a national accounting and management consulting firm.

■ Medicaid pays the care

See NURSING/2A

Local

Nursing

From Page 1A

costs for 70 percent of Wisconsin's nursing home residents.

■ The average nursing home loses $11 per day on every Medicaid patient in its care. That means a nursing home with 100 beds would lose $300,000 on its Medicaid patients.

■ Statewide, 10 percent of the nursing homes are bankrupt. That's twice the percentage of surrounding Midwestern states.

■ Low Medicaid payments hurt nursing homes' ability to pay higher worker wages and retain valuable staff. Last May, 14 percent of all long-term care worker positions were vacant.

Lori Knauf, Mount View social worker, worries that there is no economic wiggle room left.

"You can start at Burger King and make more money than (some workers) do here," she said. "I don't think we can make any more cuts."

Mount View employees continue to provide care and emotional assistance, but they have to pay bills and buy food.

Deb Freitag, Mount View pharmacist, teared up when she talked about the workers who care for her father and mother-in-law — both of whom are residents.

"Sometimes when they don't notice me, I see people bending down and hugging my dad and I get weepy," she said. "I pray this care can continue."

During a brief period for questions and comments, one resident spoke plainly to the lawmakers.

"It's a matter of priorities," he said. "These are our parents, our brothers and sisters. Don't you think these people deserve priority over a highway project or a park?"

Peter Wynhoff, 59, president of the Mount View resident council said a healthy nursing home network benefits everyone.

"You don't know, you might be in here someday," said Wynhoff, who suffers from multiple sclerosis, a disease that affects the central nervous system and causes the loss of muscular functions.

"We didn't plan on it," he said.

Rob Orcutt/Wausau Daily Herald

State Sen. Russ Decker explains the strains on nursing home funding to residents of Wausau Manor and nursing home owners and administrators during a Nursing Home Association tour of homes for lawmakers Friday.

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Nursing home change planned

Madison, 1-10-01

By Chris Murphy
The Capital Times

A plan to phase out some uncertified workers at Wisconsin's nursing homes could lead to admissions cuts, says an industry representative, but a union lobbyist called the move the right one.

The federal government ordered the state last year to draft a plan to phase out "single-task workers" often used to feed or transport nursing home residents. The state Department of Health and Family Services submitted a plan on Dec. 29 to phase out the workers over the course of a year.

The federal Health Care Financing Administration ruled that the Social Security Act prohibits single-task workers, and Service Employees International Union political director Robert Kraig said there was good reason for the interpretation.

Seniors entering nursing homes now are much more frail than those entering homes just a few years ago, Kraig said, because they now tend to stay in their own homes longer. Although it may sound relatively simple to help feed someone or push a wheelchair, Kraig said that "with very fragile residents, there are a lot of things that can go wrong if they're given care by people who are not well-trained."

To be licensed, Wisconsin certified nursing assistants must receive 75 hours of training. Kraig said the training gives them enough understanding of a patient's overall condition to prevent mistakes. The Service Employees International Union represents many nursing home employees, including single-task workers.

Brian Purtell, legal services director for the Wisconsin Health Care Association, agreed that some patients, such as those with swallowing problems, require more attention than single-task workers can give, but he added that many more patients safely benefit from them.

The reason they are necessary, said John Sauer, director of the Wisconsin Association of Homes and Services for the Aging, is because the state has a severe labor shortage. Single-task workers aren't the final answer, he added, because they don't count against mandated staffing requirements, but they are a valuable supplement.

Without the help, Sauer said Wisconsin nursing homes may have to start cutting back on the number of patients they take in to make sure they can safely care for the ones they have. He added that nursing home officials hoped for a friendlier interpretation of federal law from the incoming Bush administration.

Assuming Senate confirmation, the new head of the Department of Health and Human Services will be Wisconsin Gov. Tommy Thompson, whose administration has embraced single-task workers in the state.

But despite Thompson's expected arrival, Purtell said the best bet for a reprieve was through legislation. U.S. Rep. Paul Ryan, R-Janesville, for example, offered a bill last year that would have legalized single-task workers and another that would have established a pilot project for their use in up to five states.

Neither bill passed, but Ryan said last week that he would continue his efforts this year.

"We have a problem, and our problem is a great labor shortage in our nursing homes," Ryan said.

But Kraig said the main reason nursing homes have a shortage of workers was because they pay "McDonald's level wages" for very demanding work. He added that inadequate staffing at homes made for poor working conditions and therefore higher turnover.

Purtell agreed that wages for nursing home workers should be higher, but he laid the blame for that problem on the federal government. He called the reimbursement rates for Medicare and Medicaid patients much too low.

Using single-task workers indirectly helps to fill vacant positions for certified staff because they serve as a recruitment pool, Sauer said. High school students, for example, sometimes work part-time as single-task workers and later become certified nursing assistants once they see what it's like to work in a nursing home, he said.

To Brian P from John Sauer

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Nursing home struggles detailed

Speakers tell of need for more funding

By Jennifer Schmidt
Leader-Telegram staff

PEPIN — With tears in his eyes, Bill Mountin spoke from his heart about watching his wife, Thora, slip away from his care and into the trust of a nursing home.

"I just couldn't take care of her anymore," said Mountin of Pepin, whose wife is battling Alzheimer's disease.

Mountin bowed his head before the 300 or more people at a heath care rally in Pepin and wept quietly before continuing. "But she sure is getting good care at the Manor," he said.

"The Manor" refers to the Pepin Manor nursing home, one of many long-term care facilities struggling to remain financially viable, provide fair wages for its staff and maintain the standards of care that government regulations demand.

Several people spoke at the long-term care summit Monday night at the Pepin High School gymnasium on behalf of local nursing homes.

Joining Mountin were elected officials, nursing home representatives and concerned residents.

The summit was held to build support for change in the state's Medicaid system. Similar meetings recently were held in Eau Claire and Rice Lake.

"Funding in the last couple years has just been going down and down," said Dale Anderson, Pepin Manor administrator, who helped organize the summit. "We're just barely making it."

Eleven percent of Wisconsin's 440 nursing homes have filed bankruptcy in the last year, Anderson said, and he fears that the numbers soon will increase.

"Someone needs to stand up, and I'm not a public speaker, but I'm going to give my statement today," he said. "We all want quality care, but we need the funding to do it. The wages we pay people in health care are not respective wages."

Maxine Johnson, 75, of Pepin was one area resident in attendance who recognizes the daily struggles area nursing homes encounter.

"I've had enough people involved in nursing homes, and I know it's a problem," said Johnson, whose mother lived in a nursing home for three years. "I especially noticed that there's an awful big turnover of employees at our local one, and I think it's because they can't compete with the jobs. They can get jobs other places."

Anderson said he's had employees work for him for 15 or 20 years who don't make more than $8 an hour.

"It's kind of sad," he said. "Aren't our priorities mixed up?"

Anderson's hopes are that the state and federal government can develop a plan to increase nursing home funding.

Sen. Dave Zien, R-Eau Claire, didn't need much convincing.

"We're going to be out there fighting for you," he said enthusiastically. "You care about this whole issue, and that's what it takes. Keep up the great work."

The Pepin nursing home has 51 residents. Anderson estimated about 73 percent of them to be on Medicaid.

U.S. Rep. Ron Kind told the crowd he hopes to make nursing home funding more of a priority in Washington, D.C.

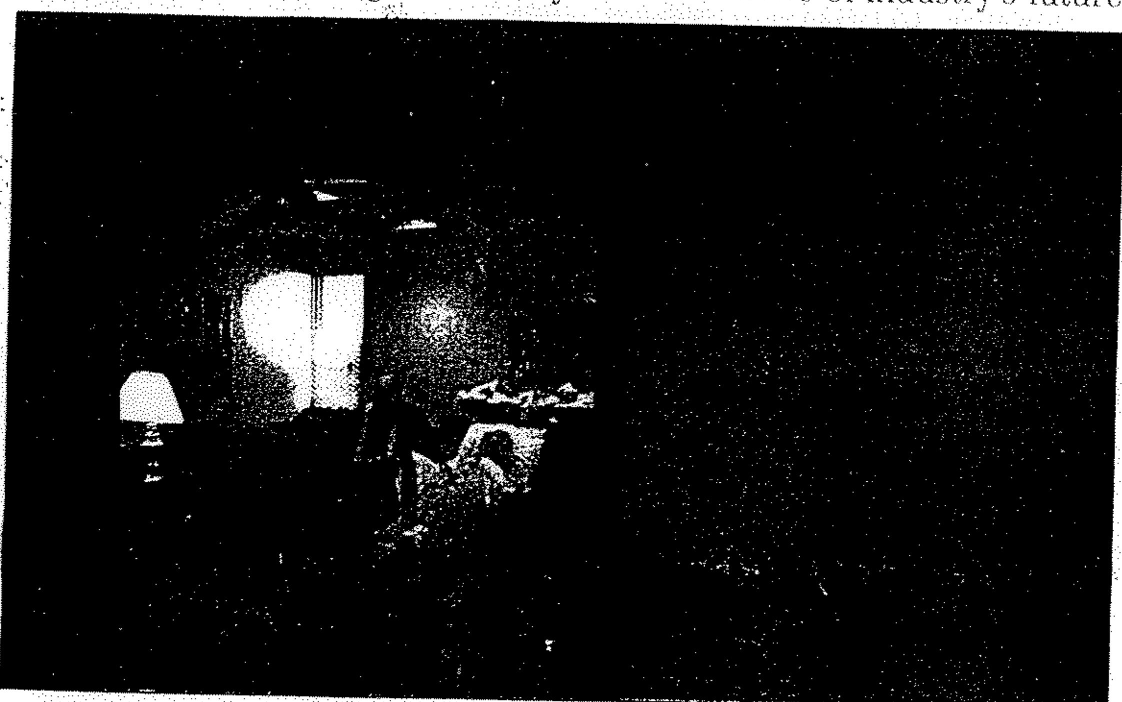
"This initiative is important to all of us," Kind said. "It's an issue of growing prominence across the nation. I'll continue the efforts in Congress and try to elevate these issues."

Schmidt can be reached at 830-5840, (800) 236-7077 or jennifer.schmidt@ecpc.com.

Waukesha Freeman 12-22-00

'We're running out of miracles'

State's nursing homes greet holiday with dire news of industry's future



Todd Ponath/Freeman Staff

Waters of Westmoreland resident Al Kaye talks with his wife, Leone, in one of the sitting rooms at the facility decorated for the upcoming Christmas holiday

By ANNE E. SCHWARTZ
Freeman Staff

WAUKESHA - Al Kaye's hand shook slightly as he cradled the hand of his ailing wife, Leone. No one knows if she hears or sees what is going on around her.

And illness has stolen the voice Al always used to reassure her of his love. It is a small miracle Al can laugh with visitors and greet his wife with a smile each day in the room they share at the Waters of Westmoreland health care center.

As Catherine Hackney, executive director of the Waters, looked on, she too could use a miracle.

But there are precious few miracles in the state's nursing homes this Christmas.

Dire news

"I'm concerned for my facility and for the industry at large," Hackney said as she padded through the nursing home at 1810 Kensington Drive in Waukesha, where festive holiday decorations sprung from every corner in odd contrast to the conversation. "If the reimbursement doesn't change, if we don't offer people viable salaries ... it scares me to death."

Hackney and other long-term care facility administrators were greeted this holiday season with dire news on their industry's future. Two of the state's nursing home associations projected losses this year will exceed $300,000 per home on resi-

See HOMES, Page 2A

Nursing home study facts

A survey of 441 nursing homes around the state was conducted during the first week of December by the Wisconsin Health Care Association and the Wisconsin Association of Homes and Services for the Aging, and 245 homes responded.

- The average nursing home in Wisconsin is at 90 percent capacity.
- Homes average 68 percent Medicaid residents.
- While some have vacancies, one-third of the members reporting said they have now suspended new admissions or are restricting them.
- One-third also have denied or delayed admissions already, with 1,423 people denied a nursing home bed in December.
- The percentage of unfilled nursing home jobs remains high. Statewide, 16 percent of certified nursing assistant jobs, 14 percent of licensed practical nurse jobs, and 14 percent of registered nurse jobs were unfilled in the month of December.

(Source: Wisconsin Health Care Association, Wisconsin Association of Homes and Services for the Aging)

Nursing homes ask legislature for attention

By ANNE E. SCHWARTZ
Freeman Staff

At the height of the season of giving, the nursing home industry could use a little Christmas.

Results of a survey conducted by two of the state's nursing home associations revealed what those on the front lines of long-term care already knew: nursing homes are running out of miracles.

Losses this year in Wisconsin are expected to exceed $300,000 per home on residents served by Medicaid, the federal insurance program for the poor.

"These losses are catastrophic," Tom Moore, executive director of the Wisconsin Health Care Association, which represents 250 homes, said. "If the trend continues, a lot of members of our profession aren't going to be around very long."

Moore said the industry has

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Anita Hoth helps a fellow Waters of Westmoreland resident with his Christmas lights attached to the back of his wheelchair

State

From Page 1A

become one of "women in poverty taking care of women in poverty.

"Because 80 to 90 percent of nursing home residents are women, the wage the workers derive is such that they are at the poverty line," Moore said. "Those women are taking care of women who outlive their savings. This is a huge women's issue."

What Moore and his colleagues want to see is a commitment by the state Legislature to realign its funding priorities.

"We're looking for honesty in the whole budget process," John Sauer, executive director of the Wisconsin Association of Homes and Services for the Aging, said.

The state contributes 40 percent of the money to nursing homes for Medicaid patients, and the federal government, 60 percent. Advocates are seeking $115 million in state taxpayer dollars over the next two years.

The low government reimbursement rates have created a deficit of $100 million, both men said. It is private-pay patients who then are left holding the bag, they admitted.

"Private-pay individuals are having to pay substantially more for long-term care," Sauer said. "It's a hidden subsidy."

Those people can pay as much as $1,500 more to compensate for the state's underpayments, he said.

Failure of the state's nursing homes is an unfortunate inevitability and a potential taxpayer burden, the advocates said. Hospitals routinely charge $500 to $800 a day for care, and in-home nursing care can range from $20 to $70 an hour, figures supplied by the associations revealed.

"If our profession fails, where will these people go?" Sauer said. "In many cases, they have no other options."

State Rep. John Gard, a Peshtigo Republican and co-chair of the Joint Finance Committee, told the Freeman the nursing homes can expect to see an adjustment in the Medicaid reimbursement formula, but "not as much as they're asking for, I suspect," Gard said.

"There is a real problem in the state's nursing homes," Gard said. "We know that we need to find some answer to it, especially when we see some (of the state's nursing homes) in receivership. Some of it has to do with Medicaid reimbursement and some has to do with questionable management. We've got to do what we can for these people."

Gard added "it would be nice" if the federal government would help out, "but maybe with a Health and Human Services secretary like Gov. Tommy Thompson, we might get some help."

Thompson is expected to present his budget to the legislature at the end of January. After debate, the final version is expected to pass in June.

(Anne E. Schwartz can be reached at [illegible])

Waters of Westmoreland Executive Director Catherine Hackney jokes with Al Kaye, a resident at the facility.

Todd Ponath/Freeman Staff

Homes

From Page 1A

[illegible] served by Medicaid, a federal assistance program for the poor, according to a report released Thursday.

The problem, in the eyes of the associations, is low Medicaid reimbursement rates by the state. The pinch has resulted in difficulties hiring staff for low wages, and the onus of the resulting deficit rests on private pay patients.

"Our people are extremely dedicated, and they're working miracles trying to maintain quality care," John Sauer, executive director of the Wisconsin Association of Homes and Services for the Aging said. "But with (Medicaid) payments so low, we're having trouble recruiting and retaining workers.

"We're running out of miracles."

But administrators like Hackney are determined to continue [illegible]

Anita Hoth laughs as she talks with another Waters of Westmoreland resident near a Christmas tree.

"You can sit in your room and mope and be alone, but that's not a life."

– Anita Hoth, nursing home resident

[illegible]

Christmas in a new home

[illegible]

not everyone has forgotten.

"Hey! You lost your shoe," [illegible] called out to a man inching [illegible] way down the hallway in a wheelchair sporting one stocking foot. "You have to look out for each other. That's what we do here. You can sit in your room and mope and be alone, but that's not a life."

Some area parishes adopt a grandparent, and school groups often visit during the holidays. There are sing-a-longs in the lounge where residents, energized by the season, belt out carols. Some sit idly in their chairs, seemingly unaware of the world around them.

"It's sad sometimes," Hoth said as she watched a woman roll by, slumped forward in her wheelchair, pushed by an aide. "She doesn't even talk to me anymore. You become attached to people and then ... But I guess that's life."

Hackney snagged a chair beneath the Christmas tree next to where Hoth was seated.

"Merry Christmas, Anita!" she said with seemingly endless enthusiasm for each resident she saw.

At the end of the day, Hackney headed home, and after all [illegible] done at the Waters, she hauled the boxes from the closet and decorated her own tree.

[illegible]

Wisconsin State Journal
FRIDAY, DECEMBER 15, 2000 MADISON, WISCONSIN

Care homes warn of crisis

The average loss per nursing home in Wisconsin this year is projected at $300,000.

By Patricia Simms
Health reporter

Wisconsin nursing homes are racing toward catastrophe, advocates said Thursday, with projected losses this year of more than $300,000 per home.

"We can't continue to perform miracles," said John Sauer, executive director of the Wisconsin Association of Homes and Services for the Aging. "If the situation doesn't improve, people will get out of the business.

"There will be chaos in the long-term care system."

A year ago, two state nursing home associations commissioned an audit of Wisconsin's 440 homes.

> **'We can't continue to perform miracles. If the situation doesn't improve, people will get out of the business. There will be chaos in the long-term care system.'**
>
> John Sauer
> executive director, Wisconsin Association of Homes and Services for the Aging

The study found Medicaid reimbursement rates, as a percentage of actual costs, were among the lowest in the nation.

Medicaid pays for almost 70 percent of Wisconsin's nursing home residents. Medicare and private payments cover most of the rest.

In addition, the audit said, the average nursing home in Wisconsin with 100 beds and 70 percent Medicaid patients lost $250,000 in 1999.

An update done by the associations last week boosted projections to $300,000 in losses per home this year.

"These losses are catastrophic," said Tom Moore, executive director of the Wisconsin Health Care Association, Thursday.

The update also reported:

◆ While some nursing homes have vacancies, one-third of those responding

Please see NURSING, Page A13

Nursing

Continued from Page A1

said they have now suspended or are restricting admissions.

◆ The average nursing home in Wisconsin is at 90 percent capacity.

◆ Residents who are paying for nursing home care themselves are increasingly being hit with higher rates to offset shortfalls for Medicaid residents.

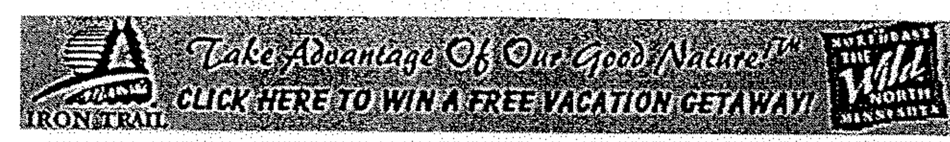
Without legislative action, Moore said, more nursing homes will go out of business. Advocates are seeking $115 million in state taxpayer dollars over the next two years.

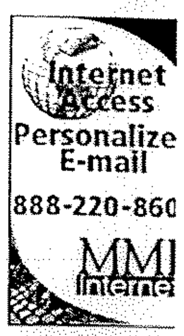
Joe Leean, secretary of the state Department of Health and Family Services, has argued the nursing home industry is over-built.

Leean also said Wisconsin nursing homes have received greater increases in Medicaid reimbursement than other health care providers.

Medicaid is a federal insurance program for the poor. The state contributes 40 percent of the dollars, the federal government 60 percent. The state generally decides how the money is spent.

Medicare is a federal insurance program for the elderly.





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Villa Marina receives positive report

But overall financial picture for nursing homes looks bleak

Maria Lockwood
Lori Randa-Foley, administrator of Villa-Marina Health & Rehabilitation Center, smiles in the lobby of the center. Foley and her staff are proud of the recent deficiency-free survey Villa Marina received from the state of Wisconsin.

Susan Anderson
The Daily Telegram

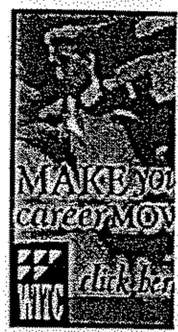
Lori Randa-Foley, administrator of Villa Marina Health and Rehabilitation in Superior is proud of the recent deficiency-free survey from the state of Wisconsin. For a long-term care facility anywhere, the survey results are commendable. But for a nursing home in Wisconsin, the rating is heroic.

With nearly 70 percent of the cost of running a long-term care facility being labor, and with the Wisconsin Medicaid payment system among the worst in the country, Randa-Foley believes the system of extended care as we know it is near collapse.

Candy Kending, regional personnel director for the Avanti Health Systems, said good care is dependent on caregivers.

So far, Kending said she is able to staff in excess of the minimum that the state requires. The minimum required by the state is 2.5 nursing service hours per day, per intermediate care resident. For those considered to need highly skilled care, the state maintains there has to be a minimum of 2.7 hours given. But Kending said residents need more than the minimum.

"You'll never get through a survey if that's what you're basing your numbers on," Kending said.



But who will pay for even minimum care hours? Kending said an average of 70 percent of the residents of nursing homes across the state have their care paid by Medicaid, or medical assistance.

And medical assistance does not provide the reimbursement needed to care for the people in nursing homes. Nursing homes are losing about $11 per day for each of their residents, Kending said, for an average of $250,000 per home.

"If they plan to stay in business, they're going to have to turn away medical assistance," Kending said. "Sooner or later it becomes a class warfare issue."

A study released this month by BDO Seidman, a national accounting and business firm, done for, but independent of, the Wisconsin Health Care Association (WHCA), documents the crisis. Their findings include the following.

* Wisconsin's nursing homes operate in the red. The average operating margin for all state nursing homes in 1999-2000 was a negative 4.79 percent.

Inadequate Medicaid payments had the single greatest impact on the deterioration of the financial and operational conditions of Wisconsin's nursing homes.

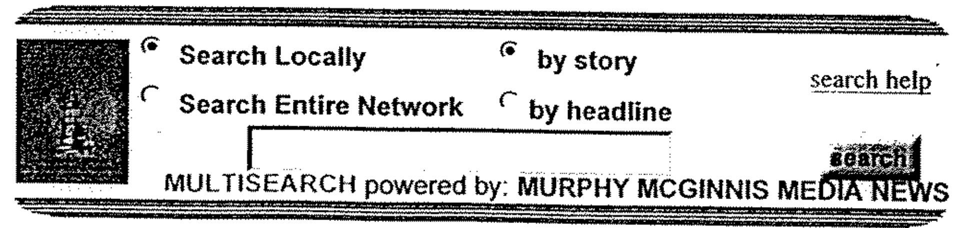
* Wisconsin's 2000-2001 Medicaid payment ceilings measured as a percentage of nursing facility costs paid, are the lowest in the United States.

Tom Moore, executive director of AHCA, in a telephone interview on Monday, said there was indeed a crisis.

"It's time for elected officials to recognize we have a growing population of elderly with growing needs and it costs money to do the job."

Moore said though Medicaid is a federal program, the state sets the costs with the federal government contributing 60 percent.

"It's a question of priorities and they seem to be prisons, stadiums and tax refunds," Moore said.

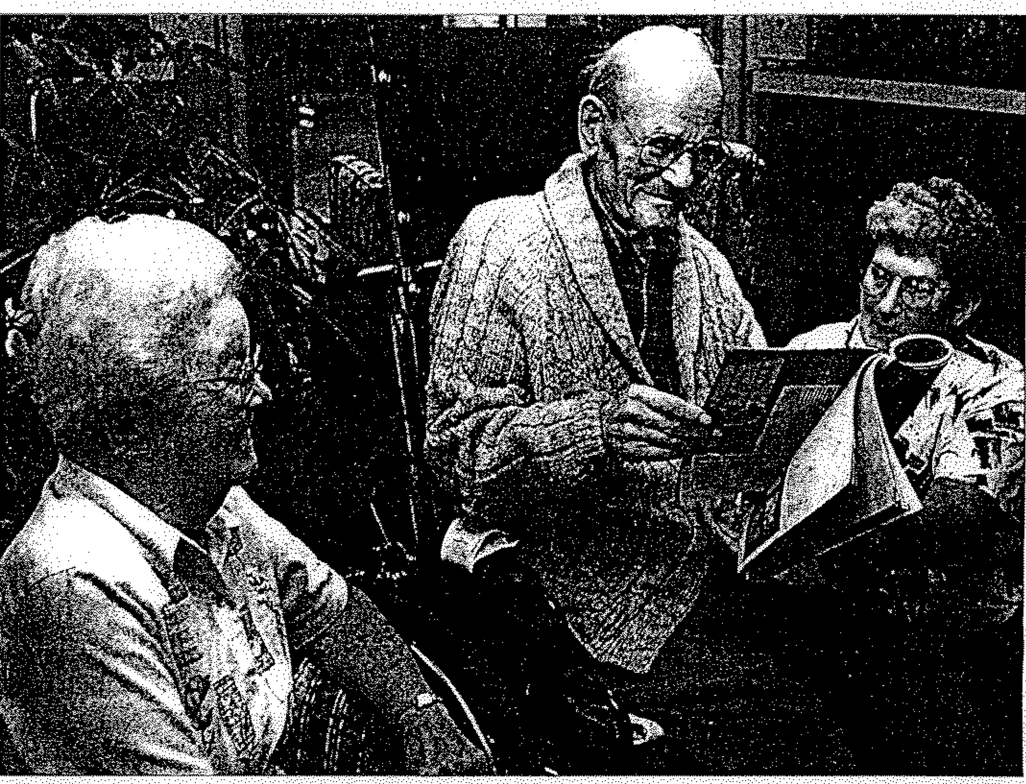


Wausau Daily Herald — WISCONSIN'S BEST NURSING HOME — Thurs Oct 12, 2000

Care center rises above the rest

Residents, families happy with care at Colonial Manor

By Nikki Kallio
Wausau Daily Herald



Rob Orcutt/Wausau Daily Herald

Certified nursing assistant Sandy Little (right) helps Martin Siik, 92, with a magazine Tuesday while Edna Drewitz, 86, listens to the conversation at Colonial Manor Medical and Rehabilitation Center, Wausau.

Mercer resident Gigi Shukes can't say enough about the attentive care Wausau's Colonial Manor Medical and Rehabilitation Center provides her mother and mother-in-law.

The fact that the nursing home was ranked as Wisconsin's best by the state's largest nursing home association doesn't seem to surprise her.

"That is very proper," Shukes said. "Because I tell you in the past 12 years my mother's been there and the two (years) that my mother-in-law's been there, I couldn't have asked for better help from family and friends."

Colonial Manor, 1010 E. Wausau Ave., was named facility of the year at Wisconsin Health Care Association's annual meeting in Green Bay.

Volunteers, officials and residents' family members say the dedicated staff makes Colonial Manor rise above the rest, even at a time when Vencor, the chain that owns the facility, is in the midst of bankruptcy proceedings.

Vencor, which also owns Kennedy Park Medical and Rehabilitation Center, and about 10 percent of the state's nursing facilities during the last year filed for bankruptcy protection to get their finances in order.

Vast cuts in Medicare and Medicaid have partially contributed to the industry's financial woes.

But the dedication of Colonial Manor's 171 employees never let that stand in the way of providing a superior level of service to their residents, said administrator Jean Burgener.

"Their commitment is to the patients that we serve, and it's just because they care so very much," Burgener said. "They go the extra mile all the time. That's what it's all about. This award is theirs, not mine."

The Wisconsin Health Care Association also cited the facility for perfect scores from state regulators and for the facility's involvement in the community.

Barb Amsrud, director and teacher at Good Shepherd Lutheran Church preschool, began volunteering at Colonial Manor about three years ago after her class visited the facility for an art and music program.

"Because of that, I saw how nice Colonial Manor was, and that's what got me involved," Amsrud said.

When she visits, she said she sees well-cared-for residents, a dedicated staff and a comfortable atmosphere.

Amsrud said the staff should be recognized for maintaining a high level of care when the industry is suffering.

"I think that is commendable," she said.

Sandy Little has worked as a certified nursing assistant for a year and a half and said the best part of her job is working with the residents.

"I like to interact with them," she said. "It's just nice working here. ...The residents come first."

Gigi Shukes said the staff works extra hard to help her with any questions or concerns. Shukes' mother, "Cede" Raseni, speaks only Italian, but the staff took time to teach her a few key words in English to help avoid any problems, she said.

"Too often there's unfortunate, not pleasing stories in the media," she said. "Once in a while, when we have a chance to do a little bit of bragging, we should."

Public celebration

The public is invited to attend a celebration to honor Colonial Manor Medical and Rehabilitation Center as the state's facility of the year. The celebration is from 1 p.m. to 2:30 p.m. Friday, Oct. 20, at the center, 1010 E. Wausau Ave.

The event includes keynote speakers, awards and music. RSVP at 842-2028.

MISSPOKEN

'lubs, fuzzy math and fake facts get attention in ampaign's final weeks/A5

FOOD FOLKLORE

Sheboygan meat market draws mention in a new book on Wisconsin cuisine/A9

ROLE MODEL

Random Lake's Ben Hagel leads both on the soccer field and off/B1

The Sheboygan Press

shebpress.com

: Sections, 20 Pages — Tuesday, October 10, 2000 — 50 Cents

County officials question Leean's motives on aid to nursing homes

By Kurt Rentmeester
of The Press Staff

Some Sheboygan County leaders want to know if limits placed on state and federal aids for nursing homes could be part of an effort by state Department of Health and Family Services Secretary Joe Leean to eliminate county-run facilities.

"I think Joe Leean has a responsibility to us, as elected officials, to really address this issue," Sheboygan County Supervisor John Van Der Male told attendees Monday morning at a legislative breakfast.

He wants Leean to meet with county administrators in the state as soon as possible to study the matter.

Private for-profit, non-profit and county-run homes will be short this year between $80 and $100 million in reimbursements, according to state Rep. Jim Baumgart, D-Sheboygan

Private for-profit, non-profit and county-run homes will be short this year between $80 and $100 million in reimbursements, state Rep. Jim Baumgart, D-Sheboygan predicted.

Changes in both Medicaid and Medicare funding should be reconciled with staff needs at nursing facilities, Van Der Male said.

Cuts in Intergovernmental Transfer Program funds could leave taxpayers shouldering more costs. The Sheboygan County Health Care Centers received between $2 and $3 million in ITP funds this year, county Finance Director Tim Finch had said.

"Sheboygan County (nursing homes), according to Finance Director Tim Finch, "has a (an annual) deficit of over $2 million. If it was a private business, we would go under Chapter 11,"

Turn to AIDS/A6

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The Sheboygan Press
A GANNETT NEWSPAPER

St. Nicholas Hospital presents

A New Baby's Coming to My House:

New Class: Monday, Oct. 30, 6:30 p.m. - 7:30 p.m.

at the Family Resource Center • 3149 Saemann Avenue • Sheboygan

Siblings-to-be prepare for the arrival of a new baby through interactive, age-appropriate activities with Family Resource Center staff. Parents prepare for the upcoming changes in a session with a staff from Lakeshore Mental Health. Children will make a gift for their new sibling.

Fee: $10

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1601 North Taylor Drive • Sheboygan, WI 53081

An Affiliate of Hospital Sisters Health System • www.stnicholashospital.org

Get a great deal in the Classifieds

Monday extends the amount of time the city has to buy the parcel from one year to 18 months, Graf said. That gives the city time to buy the property and pay the money back if the peninsula isn't purchased.

"In the event the City Council the taxes.

"What the Friends say is 'If you buy the (Reiss) property, it's a gift and it becomes part of the whole package,'" Muth said. If the city doesn't buy the peninsula, the Friends will extend the funds as a loan with a low inter-

service facility, keeping the property on the tax roll.

City Development Director Jackie Jarvis said the reason the new city proposal was brought

Friends of Sheboygan vide funds to develop Center, require only majority votes that nigh

Aids/Leean questioned

Continued from A1

Van Der Male said. "I don't want our residents to suffer in Sheboygan County. We have a moral obligation. But as elected officials, we also have a responsibility to our constituents."

Federal leaders announced last week that new ITP rules will change how states can calculate their funding, said Craig Thompson, legislative director for the Wisconsin Counties Association.

Other states, such as New York and Pennsylvania, also are losing funds, he said. There are differences in funding phase-ins so that every nursing home is treated differently.

The state is receiving more reimbursement dollars than originally planned, he said. But not enough is going to nursing homes.

Originally, it was believed nursing homes would keep about $1 of that amount, while the state gets the remainder, Thompson said. However, the state gets about $1 while nursing homes receive the remainder.

The Sheboygan County Health Care Centers are currently going through a $9 million overhaul.

Plans involve the closing of the Comprehensive Health Center at the end of 2002. Both the mentally ill and developmentally disabled will be moved to an expanded Rocky Knoll Health Care Facility in Plymouth; Sunny Ridge Nursing Home in Sheboygan will remain a skilled nursing facility.

The downsizing in Sheboygan County is part of a trend being seen elsewhere..

The Rock County Board of supervisors recently decided to reduce the number of beds at its nursing facilities from 325 to 180, Thompson said.

They also decided out-of-county residents no longer will be cared for, resulting in the discharge of 42 patients to their home counties. State officials have said they don't know where those people will be placed.

Manitowoc County voters will decide in November whether to keep running its county nursing home.

NOTICE OF REFERENDUM ELECTI

NOVEMBER 7, 2000

NOTICE IS HEREBY GIVEN, that at an electior held in the several towns, villages, wards, anc tion districts of the State of Wisconsin, on Tu November 7, 2000, the following question submitted to a vote of the people pursuant tc

"Shall sections 68 and 70 of 1999 Wiscor Act 182, which extend the right to vote in f eral elections in this state to the adult c dren of U.S. citizens who resided in this s prior to establishing residency abrc become effective on January 1, 2001?"

This referendum is a result of 1999 Wiscon 182 (1999 Assembly Bill 700). A copy c Wisconsin Act 182 (1999 Assembly Bill 700) viewed or downloaded from the State E Board's website at **http://elections.state.v** copy also can be obtained from the office county clerk, or the Legislative Documents F 1 East Main Street, Madison, Wisconsin.

DONE in the City of Sheboygan
This 10th day of October, 2000

Julie Glancey
Sheboygan County Clerk

Skate/ Teens' idea gets backer

Continued from A1

said, regarding the skate park plans. "Certainly the kids are smart enough to understand that as well."

But wrap up the confidence of the four 15-year-olds and you feel an air of certainty that the wheels won't stop spinning until their dreams are a reality.

"He said we could all get together, plan the park and work out details," said Below.

"He has a lot of space and said he would do all the fundraising," Payne said.

"He's very flexible about what we'd put in the park,"

Hungry for a change?

Starting next week we'll be changing our daily section lineup so our informative **Food** section now will be published inside Monday's paper.

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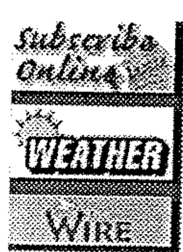

Thursday, October 5, 2000

Internet Account Access from

Showing they care

Those with stakes in nursing homes tell officials about industry's dire needs

By Traci Gerharz Klein
Leader-Telegram staff

Retired nurse Berniece Wagner captured the attention of state legislators and nursing home employees as she worried out loud Wednesday night about the present and future of Wisconsin's nursing homes.

"It's not the best time to be in a nursing home," said Wagner, 76, who placed her 85-year-old sister, Esther, in Dove Healthcare Nursing & Rehabilitation this summer after Esther had a stroke.

Wagner told the 100 or so people in attendance at a long-term care summit in Eau Claire that she is tired of troubles in the industry. The latest problems were highlighted in a study that found Wisconsin's nursing homes lost $100 million last year providing care for Medicaid patients because of shortfalls in state reimbursement.

That September study prompted the summit, part of a statewide campaign started by the Wisconsin Health Care Association to inform legislators and ask for their help in saving nursing homes.

Indeed, it's that serious, said Jim Deignan, administrator of Dove, 1405 Truax Blvd., who organized the summit with state Rep. Rob Kreibich, R-Eau Claire.

Deignan said Dove has 67 percent of its residents on Medicaid. "I don't want to scare anyone, but we're struggling payroll to payroll, month to month, just like everyone else."

In fact about 50 of the state's nursing homes, or about 11 percent, have filed for bankruptcy because of a shortfall in Medicaid reimbursement, he said. He points to the recent study done by BDO Seidman, a national accounting firm, that says it costs a nursing home $117 a day to care for a Medicaid resident, and the state pays