TMH, Rural Hospitals Prepare for 10 Percent Cut in State Medicaid Reimbursement

Tomah Memorial Hospital (TMH), along with other Critical Access Hospitals (CAHs) across the state, will see a 10 percent reduction in Wisconsin Medicaid reimbursements beginning January 1, as part of a state budget provision aimed at filling a $600 million gap in the state’s Medicaid program.

Officials from Tomah Memorial Hospital; Tri-County Memorial Hospital and Nursing Home, Whitehall; and Black River Memorial Hospital, Black River Falls;—all CAHs—met Tuesday, November 17 with 31st Senate District Rep. Kathleen Vinehout (D-Alma) to discuss the impact of the state’s 2009-2011 budget provision that calls for the Wisconsin Department of Health Services to cut Medicaid payments to CAHs by $18 million—or 10 percent across the board.

“These would be devastating cuts,” Vinehout said. “They (cuts) would mean we’d end up laying people off, it means services wouldn’t be available when they need to be available or difficult to provide them. We want to make sure that the local hospitals have the money to provide services that the people need,” she added.

For Tomah Memorial, a Critical Access Hospital since 2001, the cut would mean a $250,000 decrease in Medicaid reimbursements, which CEO Phil Stuart said could result in fewer local services.

“A quarter million dollars is the same as being able to hire six people,” Stuart explained. “It could mean reduction in services on a local level, and it could mean we need to change our hospital rates and charge more to those that have insurance, which is that whole cost shifting thing that we don’t want to do; so it is a very difficult situation.”

Merged Senate Health Care Reform Legislation Introduced

Cost pegged at $849 billion, Healthcare Quality Coalition language included

This week U.S. Senate Majority Leader Harry Reid introduced the Senate’s merged version of health care reform legislation, The Patient Protection and Affordable Care Act.

The Congressional Budget Office (CBO) estimates that the legislation will provide coverage to some 94 percent of Americans legally residing in the U.S. (31 million more individuals) and come in at a cost of $849 billion. The insurance coverage expansions would cost $599 billion, primarily due to Medicaid expansions and subsidies provided through the Exchange.

Senator Reid stayed true to his earlier comments that he would include an opt-out public plan option in the Senate merged bill. The public plan would be based on negotiated rates and would need to charge premiums that fully cover costs. The CBO estimates roughly one-third of the states would opt-out of the public plan. The legislation also allows for the establishment of new nonprofit cooperatives.

Medicare and Medicaid payments are reduced under the legislation by roughly $106 billion, primarily through market basket and productivity adjustments. Additionally, Disproportionate Share payments, both on the Medicare and Medicaid side, are reduced by $43 billion.

(continued on page 3)
State Considers New Program for BadgerCare Plus Core Plan Wait List

After upwards of 80,000 people signed up for the BadgerCare Plus Core Plan, a Medicaid program designed to provide access to health care services for 52,000 uninsured childless adults, the Wisconsin Department of Health Services this week proposed a new state benefit for the people who are on the Core Plan waiting list. The proposed program, BadgerCare Plus Basic, would provide very limited benefits to childless adults who have incomes below 200 percent of the federal poverty level. Adults with income below 200 percent of the poverty level who have minor children are eligible for other Medicaid programs.

DHS presented its proposal at a joint legislative hearing of the Senate and Assembly health committees and then to a group of stakeholders that included health care providers, insurers, and advocates. While presenting the plan at the legislative hearing, Jason Helgerson, administrator of the State’s Medicaid program, explained that DHS designed the Basic plan to be a bridge to the Core plan or to coverage that becomes available through the federal health care reform efforts. According to DHS, 38 percent of the Core Plan enrollees are between 19 and 30 years old. Over half, 53 percent, reported no physical conditions while 6.4 percent reported three or more (conditions such as asthma, depression, diabetes, hearing problems, cancer, and COPD). Helgerson proposed three benefit-design alternatives for the Basic plan, one that includes no hospital benefit and two others with minimal hospital benefits.

Helgerson said, “Our challenge is designing a plan that people will buy. We thought a premium of around $100 per month would be about right.” Helgerson continued, “We need to avoid adverse selection. People who cost less than $100 a month will need to subsidize those people who cost more than $100 per month. Given the State’s budget situation, there can be no state subsidy of the premiums.”

Health care providers who deliver services to the Basic plan enrollees would be paid Medicaid rates after enrollees meet potentially prohibitive deductibles. In earlier discussions, DHS said that the Basic

Federal Health Reform Fails to Address Payment, Quality Disparities

Turkal: “Payment system in Wisconsin doesn’t match the value and quality of our care.”

Four health care experts shared their views on the impact federal health reform would have on Wisconsin at a forum hosted by WisPolitics.com/WisBusiness.com November 17 in Madison. Moderated by Jeff Mayers, WisPolitics.com, panelists included: Nick Turkal, MD, president/CEO, Aurora Health Care; Sen. Alberta Darling, (R-River Hills); Larry Schreiber, president, Anthem Blue Cross/Blue Shield; and, Karen Timberlake, secretary, Department of Health Services.

With so much of the health reform debate centered on health insurance coverage, Turkal said his concern is for the patient.

“What happens to the patient? The patient has to be at the center of the debate,” according to Turkal. Patients are looking for value, and value, according to Turkal, is measured by the quality, cost and service they receive. “We won’t be successful if we don’t base reimbursement on value,” he said.

Experts agree that simply expanding coverage will not address the cost of health care. Reforming the way providers are paid by realigning incentives to reward quality and good outcomes, and focusing on personal responsibility and inappropriate/preventable utilization, are key to slowing cost growth.

If providers are rewarded based on quality, they will become more efficient, outcomes will improve and patients will receive better care, according to Turkal. Wisconsin has one of the most highly integrated health systems in the country, which leads to better patient outcomes, less duplication, and higher quality patient care.

“Every time you improve quality in health care...cost goes down,” he said. “It’s been proven over and over again.”
President’s Column
Two New Reports Forecast Gloomy Future

Two reports released last week portend difficult times ahead for Wisconsin policy makers, health care providers and Medicare beneficiaries.

The Pew Research Foundation (a foundation and “think tank” of non-partisan leanings) says that Wisconsin’s fiscal outlook is in bad shape and that the 2011-13 state budget will start with a structural deficit of at least $2 billion. The Pew Center on the States report, “Beyond California: States in Fiscal Peril,” gives Wisconsin a “Top Ten” ranking in a group of states that includes CA, MI and IL.

Predictable partisan sniping followed release of the report with Wisconsin Department of Administration Secretary Mike Morgan defending the state’s fiscal position as “holding our own” in a difficult economy and Senator Alberta Darling (R-River Hills) calling the state’s level of spending “unsustainable.”

Among the more interesting commentary was that of former Democratic State Senator Mordecai Lee, now Professor of Government Affairs at UW-Milwaukee. Lee gave significant credibility to the Pew study, noting that “structurally, we are around the corner of becoming like California.” That state began issuing IOUs to service providers and vendors earlier this year and Illinois—a state that is also on the Top Ten list—is notorious in its chronically-late Medicaid payments to hospitals, nursing homes and clinics.

The other report was prepared for Congress by CMS and throws cold water on claims by Democrat leaders that $500 billion in Medicare cuts will “improve” coverage for seniors. In fact, the government study says that the spending reductions will likely reduce benefits (Medicare Advantage), reduce the number of providers (lousy Medicare payment) willing to see Medicare patients, and “could jeopardize access to care for millions.”

The report also underscored an issue that Congressional leaders have consistently ignored—inadequate physician workforce—by stating “the additional demand for services will be difficult to meet....and could be a shock to the system.”

The CMS study, in addition to adding credibility to detractors of the most current reform proposals, is bad news politically for legislative champions. The most politically active and engaged voting block when it comes to health care is seniors. And the CMS study is pretty unequivocal in saying that their benefits and access to care are likely to worsen over time.

Steve Brenton,
President

Continued from page 1 . . . Merged Senate Health Care Reform Legislation Introduced

Language advocated for by the multi-state Healthcare Quality Coalition (HQC, www.qualitycoalition.net) related to geographic variation and value were included in the legislation as well. The Wisconsin Hospital Association and other Wisconsin providers and organizations are members of the HQC.

Among many others provisions are:

- Payment reductions for readmissions – estimated to save $7.1 billion (over 10 years)
- Financial penalties for hospital acquired conditions – estimated to save $1.2 billion (over 10 years)
- One-year physician payment fix to the Sustainable Growth Rate
- Creation of Independent Medicare Advisory Board (I-MAC) but excludes hospitals from their recommendations through 2019
- Redistribution of 65 percent of unused residency slots
- Extends for one year multiple rural provisions
- Extends the Recovery Audit Contractor (RAC) program to Medicaid
Independent CMS Report Highlights Serious Problems with House-Passed Reform Bill

Reduced access, higher prices possible

This week a new report highlights what some already fear with the House-approved health care reform bill—it would increase national health care expenditures, would do little to moderate health care costs and could exacerbate access problems.

The independent Office of the Actuary of the Centers for Medicare & Medicaid Services released its analysis of the financial and coverage impacts of the non-tax provisions under health care reform legislation, HR 3962. HR 3962 was approved by the U.S. House of Representatives on a 220-215 vote. The analysis does not include implications of tax provisions, such as the income tax surcharge on high-income taxpayers, included under the legislation.

Coverage Expansions Cost $935 Billion

The bright spot of reform legislation will be ways to provide health coverage to those in need; however, cost and access issues associated with such expansions continue to be one of the issues plaguing health care reform. This rings true with HR 3962 as well.

The CMS report estimates that 34 million U.S. citizens and legal residents would be provided essential-benefits coverage under HR 3962, equaling 93 percent coverage in the nation. Of the 34 million, 21 million would gain coverage under Medicaid and another 10 million through the newly created Exchange. However, it is this very expansion and accompanying cost that cause some of the more troubling implications long-term.

It is estimated that coverage expansions will net out costing $935 billion, of which $512 billion can be attributed to the expansion of Medicaid. The rest of the $935 billion price tag is due to affordability credits for low-income individuals ($592 billion) and credits for small employers who offer coverage ($11 billion). Deducting the $180 billion in penalties individual and employers will pay for not having or offering coverage equals the $935 billion cost.

Medicare Savings Equal Cuts To Providers

The report finds that net Medicare savings will total $571 billion under HR 3962. Reductions to Parts A and B will total $282 billion coming largely from market-basket payment updates and productivity adjustments. The Report specifically calls attention to its view that Medicare productivity adjustments may be “unrealistic,” further cautioning:

“HR 3962 would introduce permanent annual productivity adjustments...using a 10-year moving average of economy-wide productivity gains...it is doubtful that many [providers] could improve their own productivity to the degree achieved by the economy at large. Over time, a sustained reduction in payment updates, based on productivity expectations that are difficult to attain, would cause Medicare payment rates to grow more slowly than, and in a way that was unrelated to, the providers’ costs of furnishing services to beneficiaries. Thus, providers for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and might end their participation in the program (possibly jeopardizing access to care for beneficiaries).”

(continued on page 7)
Memorial Medical Center in Neillsville Hosts Sen. Kreitlow

Memorial Medical Center’s Board, staff, and community health council hosted State Senator Pat Kreitlow on October 19. After a facility tour, Senator Kreitlow participated in Q&A sessions, discussing multiple health-related issues such as electronic medical records, health care reform, and insurance coverage.

Memorial’s physicians and staff underscored both the unique value of rural health care, such as access and shorter wait times as well as the challenges faced, including difficulties recruiting medical providers. The group also made sure to discuss serious concerns regarding legislation banning the use of mandatory overtime.

“This is an uncertain time in health care. It’s imperative we clearly communicate with legislators to ensure that quality, accessible care continues while hospitals get reimbursed what it costs to efficiently provide that care,” remarked Scott Polenz, Memorial’s CEO.

WHA Workforce Council Told “Retirements Will Hit Hospitals Within the Decade”

A survey just completed by the La Crosse Medical Health Science Consortium found more than 50 percent of the members of four major hospital employee groups plan to retire within the next 10 years. They include nurse aides, phlebotomists, medical assistants and emergency medical technicians/paramedics. Consistent with WHA workforce surveys, the La Crosse survey found as a group, laboratory workers are the oldest, while health information staff and physicians were close behind.

The survey confirms findings included in WHA’s recently released 2009 workforce report. According to Judy Warmuth, WHA’s vice president of workforce development, “Wisconsin hospitals are acutely aware of and deeply concerned that the aging of the workforce and the general population together will create unprecedented challenges to the health care workforce.”

Speaking at the WHA Workforce Council meeting November 29, Joanne Sandvick from the La Crosse Consortium, said among all groups, the deciding factor across all 4,000 health care workers that completed the survey on when they will retire is financial security. Nearly 32 percent of the workers indicated they plan to gradually reduce hours as

(continued on page 8)
Hospitals Encouraged to Share Flu Immunization Clinic Info with 2-1-1

Hospitals and health systems that have public immunization clinics scheduled over the duration of the flu season are encouraged to share the information with their local 2-1-1 call center. 2-1-1 developed a “flu clinic finder” (www.wisconsinfluclinic.info) to make this information available to the public. Individuals seeking an immunization can call 2-1-1 or use the flu clinic finder at 211wisconsin.org to identify the nearest location.

2-1-1 is a valuable community service that can help ease calls and inquiries to hospitals and clinics from individuals looking for information related to flu clinics. The flu clinic finder has attracted more than 140,000 searches for immunization clinics; the majority were for H1N1.
DHS Publicizes H1N1 Provider Network for Uninsured

The Department of Health publicly announced the availability of the provider network established to provide care for uninsured individuals that are experiencing influenza-like symptoms. Uninsured individuals can receive an outpatient visit for evaluation and treatment at no cost.

The Wisconsin Hospital Association worked closely with DHS and member hospitals and health systems to establish the provider network. In response to a DHS request, hospitals and health care systems identified more than 300 sites, including hospitals and outpatient clinics, which will perform medical exams, give immunizations and treat individuals that are uninsured.

“Hospitals are committed to serving the health care needs of their communities. Whether a person has insurance or not does not determine if they will receive care,” according to WHA President Steve Brenton. “However, by establishing this network it helps direct the uninsured to clinic settings for non-emergent care, which helps reduce costs and could also reduce the wait time for patients seeking care for influenza-like illnesses.”

In a November 16 news release, DHS said uninsured individuals experiencing influenza-like symptoms wishing to receive a visit for flu-related care can call 2-1-1 or their local public health agency to locate a provider within the network. The purpose of the network is to serve uninsured individuals in need of treatment for influenza. Non-flu related services provided during the visit and follow-up visits are not covered and payment for non-flu related services will remain the individual’s responsibility.

DHS urged individuals to call ahead before going to a provider in the network as appointments may be necessary. The news release also pointed out that visits to hospital emergency departments should be reserved only for people that require emergency care.

The provider network has been established for uninsured individuals only. People who have health insurance should contact their regular health care provider if they need care.

“We have found that not everyone needs to receive health care for the H1N1 virus, but for persons who are at high-risk of complications from influenza, early diagnosis and treatment of this virus is especially important no matter what a person’s insurance status may be,” said Dr. Seth Foldy, State Health Officer.

For information about H1N1 influenza, visit, http://pandemic.wisconsin.gov.

Continued from page 4 . . . Independent CMS Report Highlights Serious Problems with House-Passed Reform Bill

National Health Expenditures Would Rise

The Report also details that over the next 10 years national health expenditures will increase by $289 billion, primarily due to the increased coverage expansions, and would typically result in a “fairly substantial” increase in the utilization of health care services. It also warns lawmakers that “supply constraints might interfere with providing the services desired by the additional 34 million insured persons.”

CMS further finds that “providers might tend to accept more patients who have private insurance and fewer Medicaid patients, exacerbating existing access problems....” and that “it is reasonable to expect that a significant portion of the increased demand for Medicaid would not be realized.”

In concluding, CMS foreshadows significant trouble for the providers and patients, “The additional demand for health services could be difficult to meet initially with existing health provider resources and could lead to price increase, cost-shifting, and/or changes in providers’ willingness to treat patients with low-reimbursement health coverage.”
Member News: Beloit Memorial Hospital and Beloit Clinic Form New Integrated Health System

Beloit Memorial Hospital and Beloit Clinic have joined to create the Beloit Health System—an integrated health care provider—officially starting at the beginning of the new year. The new, combined health system will have about 1,500 employees.

Greg Britton, president/CEO, Beloit Memorial Hospital, said the health care industry is being challenged throughout the nation, and this new affiliation is hoped to put the hospital and clinic in the best position to meet future challenges.

“For many years, the clinic and the hospital have been closely aligned for the best interests of the community,” explains Britton. “We have an opportunity to bring our health care services into a new era of health to sustain ourselves long into the future. Our goal is to better position our hospital for future health care reform and cost containment.”

“The winner of this partnership is definitely the community at large,” emphasizes Dr. Leo Egbujiobi, cardiologist and chair of the clinic integration committee. “Beloit Clinic has been here for 62 years and this is the biggest step we’ve taken to improve physician recruiting, advance our technology and ensure health care stability in our area. This is huge.”

Continued from page 5 . . . WHA Workforce Council Told “Retirements Will Hit Hospitals Within the Decade”

they near retirement and 31 percent hope to return to the workplace as contract or casual employees after retirement.

According to Sandvick, the goal of the survey (which mirrors one done in the Fox Valley and Central/Southwestern Wisconsin) was to develop a statewide picture of which health care professionals will retire when to guide academic institutions as they make decisions on current and future program capacity. All results have been shared with health care providers, community leaders, and educational institutions.

“We know that health care workforce planning is most successful when it is approached on a regional basis and all players are at the table,” according to Warmuth. “The La Crosse consortium is one of four in Wisconsin that will make a real difference in whether we will meet the demand for health care workers in the future.”

Anesthesia assistants (AAs) are currently pursuing licensure in Wisconsin. Bob Stupi, board member of the Wisconsin Academy of Anesthesiologist Assistants, and Jay Mesrobian, MD, past president of the Wisconsin Society of Anesthesiologists presented an overview of the AA role, including education and certification. There are currently 15 AAs practicing in two Wisconsin locations. They practice only under the direct supervision of an anesthesiologist and do not practice in settings that do not have anesthesiologists. Warmuth raised the long-standing issues with the Department of Regulation and Licensing regarding time to obtain a Wisconsin license and time to investigate complaints. While progress has been made, creating more licensed groups and additional workload to the department threatens current success and future progress.

Also at the meeting, Council members worked to find common definitions for vacancy and turnover that would best reflect the way hospitals currently collect data. Hospitals now use many different means to calculate and report these variables. There was agreement on some components, but more work is needed to find definitions that appropriately describe how these terms apply in all hospitals.
Continued from page 2 . . . Federal Health Reform Fails to Address Payment, Quality Disparities

“Aurora Sinai serves a heavy Medicaid population and has some of the top quality scores in the county,” Turkal said. “The way we are paid does not match the strategy of providing incentives to improve quality. If you standardize care and improve quality, you get a more affordable option.”

Medicare and Medicaid provider payment rates lag far behind what it costs hospitals to provide care. If that continues, according to Turkal, hospitals will be unable to sustain high quality care and will be unable to deliver value to patients.

“We’re at a real disadvantage in Wisconsin,” according to Turkal. “The fact is other states get a lot more money for Medicaid. The payment system in Wisconsin doesn’t match the value and quality of our care.”

Darling fears the proposal for a public option alternative will “drive people to government programs.” She predicted the House health reform bill would do nothing to stem cost-shifting onto private insurance holders and would create new tax burdens for small businesses.

Timberlake said nearly one in eight persons—or 721,000 people—is enrolled in the BadgerCare program. Wisconsin was recently recognized nationally as being on the “leading edge” in terms of Medicaid expansions, even as the recession ripped through the economy.

All panelists could agree on one point: individuals must take more responsibility for their own health.

“Fifty percent of the dollars Anthem spends in the market place are because of situations where people made the decision to eat the wrong things...not exercise...smoke,” according to Larry Schreiber, president of Anthem Blue Cross/Blue Shield. “Whatever we discuss, we have to build in individual responsibility.”

Unhealthy behaviors and end-of-life care were both mentioned as major contributors to health care costs.

“Until we get our arms around these issues, we’ll never address costs,” Turkal said.

The adult obesity rate in Wisconsin is staggering. According to Timberlake, two thirds of adults living in Wisconsin are overweight and obese. Wisconsin’s obesity rate in 1980 was 11 percent; in 2008 it climbed to 26 percent.

“If we could take the obesity rate back to the 1980 level,” according to Timberlake, “We’d take $1 billion out of the cost of health care in Wisconsin.”

Reform Could Bring Steep Rise in Health Insurance Premiums

The subject of health reform has led to “good, healthy debate,” according to Schreiber, but what has been proposed so far “will not be good for Wisconsin.”

Schreiber said Anthem has run extensive actuarial studies on the House bill’s impact on Wisconsin. The studies showed individual premiums would increase 200 percent for young, healthy adults, rise 122 percent for those of average age and health, and drop 11 percent for the elderly. Small business owners that offer health insurance would see premiums increase 53 percent.

“We’re for comprehensive reforms done right, but the House bill does nothing to address cost and quality, which are the biggest health care cost drivers across the country,” Schreiber said.

Stories From Our Hospitals

Aurora BayCare Medical Center, Green Bay
WIAA sports physicals included free heart screening

For the start of the 2009 school year, student athletes participating in Wisconsin Interscholastic Athletic Association (WIAA) sports were able to register for sports physical assessments and heart assessment at Green Bay’s Aurora BayCare Orthopedic & Sports Medicine Center. The sports physicals meet school and WIAA requirements. Components included:

- A full health screening by a physician
- An evaluation of any muscle/skeletal issues by an orthopedic surgeon, if needed
- A vision exam
- A variety of interactive stations to measure flexibility and strength
- A functional assessment
- A video-based program to diagnose students who may be at risk for ACL injuries

A new component of the sports assessment in 2009 was the free cardiomyopathy screening to test athletes’ heart-health. Although the total value of the sports physical is $350, students were charged a $30 fee that was donated back to the student’s athletic club or school’s athletic department.

Students were advised to dress in shorts and gym shoes, bring their sports card and be accompanied by their parent or guardian to sign a parental consent form.

Columbus Community Hospital, Columbus
Community Care

At six years old, Danielle S. shouldn’t have to worry about whether or not her physical therapy sessions are covered by medical insurance.

Danielle was diagnosed with Moyamoya at age 3. The condition, only affecting one in two million children in the United States, causes strokes in Danielle due to the narrowing of blood vessels, which carry blood to the brain. In 2006 Danielle underwent surgery to move the blood vessels and began occupational and physical therapy sessions at Columbus Community Hospital. The therapy assisted Danielle in regaining movement in her right side, which was nearly paralyzed from her original strokes. While the therapy was successful, insurance coverage for the sessions was maxed out for the year by the fall of 2008. In November 2008, Danielle suffered three strokes and additional occupational and physical therapy was needed.

Without insurance to cover the bill and three other children at home under the age of 10, Danielle’s parents applied for community care at Columbus Community Hospital. The hospital covered over $2,500 in physical therapy costs. In 2009, due to the intensified need for occupational and physical therapy, the coverage was maxed out by May, and Columbus Community Hospital once again covered over $2,500 in physical therapy costs so Danielle could continue her sessions.

(continued on page 11)
Continued from page 10 . . . Community Benefits: Stories From Our Hospitals

“We are thankful to know that our family can continue to focus on Danielle’s recovery rather than just paying the bills,” said Danielle’s mother. “We appreciate the fact that (Columbus Community Hospital) has payment options available for patients and their families.”

Submit hospital community benefit stories to Mary Kay Grasmick, editor, at mgrasmick@wha.org.

Continued from page 1 . . . TMH, Rural Hospitals Prepare for 10 Percent Cut in State Medicaid Reimbursement

The cut would also equate to a loss of about $250,000 for Black River Memorial and a $100,000 - $125,000 cut at Tri-County Memorial.

A total of seven CAHs are located in Vinehout’s Senate District, including: Tomah Memorial, Franciscan Skemp, Arcadia; Franciscan Skemp, Sparta; Black River Memorial Hospital, Black River Falls; Chippewa Valley Hospital, Durand; Tri-County Memorial, Whitehall; and Luther Midelfort Oakridge, Osseo. There are 59 CAHs in Wisconsin.

The Critical Access Hospital program was created by the 1997 federal Balanced Budget Act as a safety net device, to ensure Medicare beneficiaries access to health care services in rural areas. It was designed to allow more flexible staffing options relative to community need, simplify billing methods and create incentives to develop local integrated health delivery systems, including acute, primary, emergency and long-term care.

“One of the things I can do is take the information from the rural hospitals and use that to gather the legislative support among my colleagues,” Vinehout said. “We are looking at alternatives to figure out how to bring more federal money into this state.”

Vinehout said Wisconsin ranks “relatively low” among all other states in terms of bringing in federal money. “We’ve got to be smarter about how we run our Medicaid program so that we can look at options on how to bring in more federal money,” she said. “I think it’s a little bit odd the way the federal government system works, but that’s the system that we’re working with now, and if that’s what we need to do to bring in more money to keep our hospitals doing well and serving our local people—that’s what we need to do.”

Vinehout also urged local residents to show their support for local hospitals. “They (residents) can talk to their elected officials and say, ‘we need to help our Critical Access Hospitals; we need to help our rural hospitals get more federal dollars,’” she added.

Stuart, who also sits on the Wisconsin Hospital Association (WHA) Board of Directors and helped organize Tuesday’s meeting, said he’s pleased Vinehout is willing to work with hospital officials to prevent the devastating cuts.

“I think it will be a win situation for Critical Access Hospitals and a win for the state and the budget process,” Stuart said.

He said plans are also underway to meet with 92nd District Rep. Mark Radcliffe (D-Black River Falls) to discuss the issue, although no date has been finalized.
Plan would not reimburse Critical Access Hospitals or Federally Qualified Health Centers for the cost of providing services to the enrollees; they would be paid at fee-for-service rates to the extent their services are covered at all.

Senator Jon Erpenbach, chair of the Senate health committee, asked Helgerson how the premiums compared to those in the private insurance market. Helgerson said that premiums for an individual with group health coverage cost about $4,500 per year. Senator Erpenbach asked, “But with such a limited benefit, high deductibles, and Medicaid reimbursement rates, shouldn’t the price be substantially lower than the private rates?”

Comparing commercial insurance premiums, which must include all mandated benefits, with premiums for the new Basic plan, which includes very few or substantially pared down mandated benefits, is not an apples-to-apples comparison. Some have suggested commercial insurers be allowed to craft a similarly slimmed down benefit package that could be offered to those on the waiting list. For years, small businesses, insurers and others have been calling on the state to allow commercial insurers to sell “mandate-lite” insurance plans.

Representative John Richards, chair of the Assembly health committee, asked whether the Core and Basic Plans were supplanting private insurance. For example, would some of the 19 – 30-year-olds (who comprise nearly 40 percent of those enrolled in the Core Plan) be eligible for coverage under their parents’ health plans given the new mandated coverage for children up to age 27? Helgerson said DHS would not make applicants in this age range ineligible if they do not pursue coverage under their parents’ plans. People who actually elect COBRA coverage, which the federal government currently subsidizes at 65 percent of the cost, are not eligible under the Core Plan and would not be eligible under Basic. Those who decline COBRA are eligible for coverage under the Core Plan and would be eligible under the Basic Plan. Helgerson explained that DHS would encourage people to look into other available options before enrolling in the program, but stopped short of saying applicants would be required to exhaust other options first. Some legislators encouraged DHS to expand eligibility to more people and to provide an expanded benefit package. Others sought assurances the Legislature would be involved in the development process.

Later at the meeting of stakeholders, Helgerson reiterated the need to have the right mix of lower-cost enrollees to offset the higher-cost enrollees. Helgerson said that that might be accomplished by providing catastrophic hospital coverage; for example, DHS’ proposal that includes a $7,500 deductible at Medicaid rates for hospital coverage or another proposal that provides for two inpatient stays. Joy Tapper, Milwaukee Health Care Partnership, asked for DHS to define the target population and suggested that DHS convene a work group to design a benefit plan for that population. Helgerson explained that time was of the essence.

Helgerson promised draft legislation soon that could be considered quickly by the Legislature.