☞ **05hr_SSC-HCR_Misc_pt32**

☞ Details: Medicaid and Health Care Reform. Hearing held in Madison, Wisconsin on August 28, 2006.

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2005-06
(session year)

Senate
(Assembly, Senate or Joint)

Select Committee on Health Care Reform...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (August 2012)

- 2%

6.9

(Committee Chair Notes)

105% to 200%

- Eliminate Prior Approval for Dentists

Folks -

Low Birthwt.

Ronald Mc Donald C.

Farmers Capitol Depreciation

Changing way depreciation is used — change calculation help them buy in.

Reward Hlthy's ; Quit Smoking

INDIVIDUALS

Bonus's -

+ Incentives -

- Access to Dental care,
Pay for performance Inc
5 yrs dental service in
1 yr.
Manage Care.

Dental P Health ; PH Strategies.

Donated Dental 3co's Register

BegUP Comm Opp's Proposals

Carol Roessler
Committe Chair
Notes

Wrap around primary

? ?'s 70% HMO's

+- Health Record ?

NCO's — 1 HMO —

Program Participation

CAPS

$ 2M Incentive Payments

amts to 7.00 > Capitation rate.

Relationship to quality

High value providers

SChips other States

Schip = Badger Care

more concentration
Hospital - others 80% = ?
no risk - more fixed
pricing 2 large
Wheaton - Franciscan
Aurora
medicaid
= base of m/cd
2 other system.

Revenue - sharing - 400
don't need.
more moving to

5% Medicaid use up to

when for profit
exempt under WI law

concerns.
WEA tax exempt
now you were agreed to pay taxes

Senior Care

RISK levels
treat differently
FRODERT.
70%
on the 5

gives employers
gives govt. huge incentive to manage h.c costs.

Waiver
Redesign Badger.

$ million
New York
not a big mandatory
Marry it disease mgmt.
could make a small dent for sm

0-17 2001-2004 73-74-75%
Must Have Employer Cover
Kids to 64 -

$4000 grand save go to DEATH

2004 - 0-17 74%
18-44 73%
45-64 80%

having ins

Rebecca

FREE TRANSPO abused

Large claims steer to ...

REVISED

Senate

PUBLIC HEARING

Select Committee on Health Care Reform

The committee will hold a public hearing on the following items at the time specified below:

Monday, August 28, 2006
10:00 AM
411 South
State Capitol

The Committee will hear from invited speakers only to present on Medicaid and Health Care Reform:

BadgerCare Plus:
Helene Nelson, Secretary of DHFS
Jason Helgerson, Executive Assistant DHFS

The Role of an Academic Health Center in Health Care Reform:
Dr. Robert Golden, Dean of UW School of Medicine and Public Health
Dr. Jeff Grossman, President and CEO UW Medical Foundation
Donna Sollenberger, President and CEO UW Hospital and Clinics

Medicaid Reform Task Force Report:
~~Dr. Glen Loomis, M.D.~~ Dr. Ken Schellhase
Dr. Alan David, M.D.
Steve Wilhide, Representative from American Academy of Family Physicians

Health Care 2006: Can We Afford It? :
Dr. Mike Shattuck, Private Practice, Wautoma, WI

Crisis in the Emergency Room:
Dr. Christine Duranceau, former EMS Director for Platteville EMS
Dr. Howard Croft, Governmental Affairs Chair

Special Medical Transportation Brokering:
Ron Hermes, Legislative Liaison for DHFS

HIRSP:
Amie Goldman, CEO of HIRSP Authority

Chronic Disease Management:
Dr. Ted Praxel, Medical Director, Quality Improvement, and Care Management, Marshfield Clinic

Senator Alberta Darling
Co-Chair

Senator Carol Roessler
Co-Chair


FORWARD

Can't Cure - living with
50 90 dm

Testimony to the Senate Select Committee on Health Care Costs

Chronic Care Management

Theodore A. Praxel, MD, MMM, FACP
Medical Director Quality Improvement and Care Management
Marshfield Clinic
August 28, 2006

Objectives

- Review the current realities.
- Definitions
- Review the Physician Group Practice (PGP) demonstration project
- Value driven interventions
  - Anticoagulation services
  - Diabetes mellitus
- Care coordination objectives

Marshfield Clinic

- Founded 1916
- > 700 physician providers
- 41 Regional Centers
- >350,000 unique patients in 2004
- ~ 1.8 million patient encounters in 2004
- Security Health Plan (Clinic's HMO)
- Marshfield Clinic Research Foundation
- Education programs – Internal Medicine, Surgery, Pediatrics, Med/peds, Transitional, Dermatology

Fundamental Truth

Every system is designed perfectly for the results it achieves.

- Paul Bataldan, IHI

Current System Characteristics

- Fee-for-service
- Regardless of service value
- Disproportionately pays for the wrong things.
- Geographically adjusted

Current Situation

- > 100 million Americans have more than one chronic illness.
- > 50% of patients don't get appropriate evidence based care – Rand Corporation.
- Best practices could avoid 41million sick days and >$11 billion in lost productivity.
- Patients and family are increasingly recognizing defects in their care.

2004 Wagner

Medicare Beneficiaries

- Chronically ill consume > 95% of Medicare dollars.
- > 25% have 4+ chronic illnesses.
- The group with 4+ chronic illnesses consumes ~ 2/3rds of Medicare dollars.
- Can no longer think in individual disease state management strategies given increasing numbers of patients with multiple chronic illnesses.
- >70% of Medicaid dollars in Wisconsin are used by Seniors and people with disabilities.

Quality Measures

- Process measures – tell a team whether a specific process change has been accomplished and whether it is having the intended effect – e.g.- are the appropriate labs for a given condition being obtained (Taking a blood pressure).
- Outcomes/management measures -tell a team whether the changes it is making are actually leading to improvement – e.g.- is the therapy leading to the desired clinical outcome (Getting the blood pressure to goal < 140/90).

EFFECTIVE CARE

Medically necessary care on the basis of clinical outcome evidence, preferably from randomized clinical trials.

- ACEI/R in heart failure patients
- Warfarin in patients in qualified patients with atrial fibrillation
- Screening colonoscopy every 10 years after age 50

http://www.dartmouthatlas.org/

PREFERENCE-SENSITIVE CARE

Treatments that involve significant tradeoffs affecting the patient's quality and/or length life – should reflect patient's personal values because clinical outcomes are similar.

- Lumpectomy v. mastectomy in breast cancer

http://www.dartmouthatlas.org/

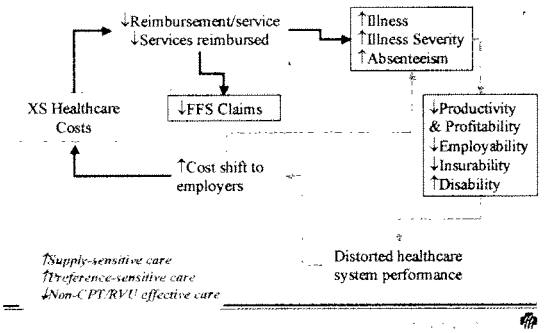
SUPPLY-SENSITIVE CARE

- 50% of all medical spending
- Chronic disease
- No evidence available
- Includes: **Office Visits, Consults, Diagnostics, Hospitalizations, ICU care**
- Determined by provider supply

http://www.dartmouthatlas.org/

Current Reality

Frequently starting with mental health and preventive services.



Health care purchasers are not getting what they want, but they *are* getting what they pay for.

Institute of Medicine Report

- Current care systems cannot do the job.
- Trying harder will not work.
- Changing care systems is the answer.

Centers for Medicare & Medicaid Services (CMS)

Physician Group Practice (PGP) Demonstration

The first 'value-based purchasing' demonstration applied to providers.

One of Ten in the Nation

- **Dartmouth-Hitchcock Clinic– Hanover, NH**
- **Deaconess Billings Clinic- Billings, MT**
- **Forsyth Medical Group– Winston-Salem, NC**
- **Geisinger Clinic– Danville, PA**
- **Integrated Resources for Middlesex Area– Middletown, CT**
- **Marshfield Clinic– Marshfield, WI**
- **Park Nicollet Health Services– St. Louis, MN**
- **St. John's Health System– Springfield, MO**
- **The Everett Clinic– Everett, WA**
- **University of Michigan Faculty Group Practice– Ann Arbor, MI**

PGP Objectives

- Align reimbursement with quality.
- Promotes using utilization and clinical data for improving quality.
- Encourage coordination of Part A (hospital) and B (outpatient) services.
- Promote efficiency in administrative structures and care processes.
- Reward for improving health outcomes.

PGP Year 1 'Q' (10 measures)

- DM-1: % DM patients (DMP) with ≥ one A1c measurement
- DM-2: % DMP A1c > 9.0
- DM-3: % DMP BP < 140/90
- DM-4: % DMP LDL Lipid Measurement
- DM-5: % DMP LDL Level < 130 mg/dl
- DM-6: % DMP ≥ 1 urine microalbumin test
- DM-7: % DMP ≥ 1 retina exam in reporting or prior year
- DM-8: % DMP ≥ 1 foot exam
- PC-7: % DMP Influenza Vaccination
- PC-8: % DMP Pneumonia Vaccination ever

PGP Year 2 'Q' (25 measures)

- HF-1: % Heart Failure Patients (HFP) LV Assess
- HF-2: % HFP hospitalized LV Ejection Fraction Testing
- HF-3: % HFP Office Visit Weight Measurement
- HF-4: % HFP Blood Pressure Measured
- HF-5: % HFP provided education on disease management
- HF-6: % HFP w/ LVSD prescribed β-blocker therapy
- HF-7: % HFP w/ LVSD prescribed ACE-I therapy
- HF-8: % HFP w/ Atrial Fibrillation prescribed Warfarin
- PC-7: % HFP Influenza Vaccination
- PC-8: % HFP Pneumonia Vaccination ever

PGP Year 2 'Q' (25 measures)

- CAD-1: % Coronary Artery Disease Patients (CADP) prescribed antiplatelet therapy
- CAD-2: % CADP prescribed lipid lowering therapy based on ATP III Guidelines
- CAD-3: % CADP w/ prior MI prescribed β-blocker therapy
- CAD-4: % CADP BP measured during last office visit
- CAD-5: % CADP ≥ 1 lipid profile during reporting year
- CAD-6: % CADP most recent LDL < 130 mg/dl
- CAD-7: % CADP and DM and/or LVSD prescribed ACE-I therapy

PGP Year 3 'Q' (33 measures)

- HTN-1: % Patient visits w/ BP recorded
- HTN-2: % Patients with last BP < 140/90
- HTN-3: % Patients w/ SBP ≥ 140 mm HG or DBP ≥ 90 mm w/ documented care plan for HTN
- PC-5: % Women, 50-69 years, mammogram in reporting or preceding year
- PC-6: % Patients screened for colorectal CA at appropriate interval
- PC-7: % Medicare patients Influenza Vaccination
- PC-8: % Medicare patients Pneumonia Vaccination ever

Process & Outcome Measures

Diabetes Mellitus	Congestive Heart Failure	Coronary Artery Disease	Hypertension & Cancer Screening
[illegible]	[illegible]	Antiplatelet Therapy	Blood Pressure Screening
HbA1c Control	[illegible]	Drug Therapy for Lowering LDL Cholesterol	Blood Pressure Control
Blood Pressure Management	[illegible]	Blood Pressure	Blood Pressure Plan of Care
[illegible]	[illegible]	[illegible]	[illegible]
LDL Cholesterol Level	Patient Education	LDL Cholesterol Level	[illegible]
[illegible]	Beta-Blocker Therapy	Ace Inhibitor Therapy	
[illegible]	Ace Inhibitor Therapy		
[illegible]	Warfarin Therapy		
Influenza Vaccination	Influenza Vaccination		
Pneumonia Vaccination	Pneumonia Vaccination		

Slice = process measures

Starting Points

- Primary Prevention: Avoid disease
- Secondary Prevention: Early detection
- Tertiary Prevention: Chronic disease

- Diabetes
- Anticoagulation
- CHF
- Hypertension
- CAD
- Dementia
- Depression
- COPD
- Frail & Elderly

HIGH COST CONDITIONS

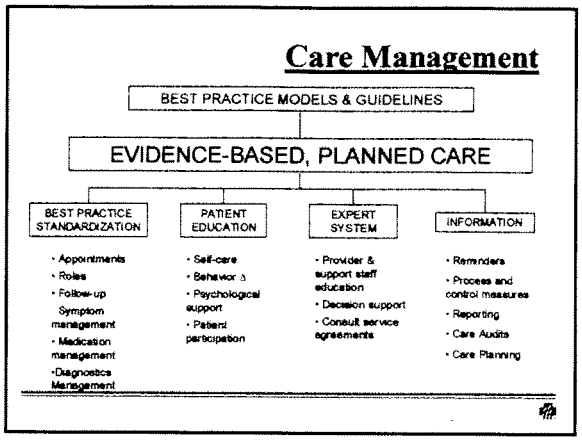
Work directly w/ each Department to …

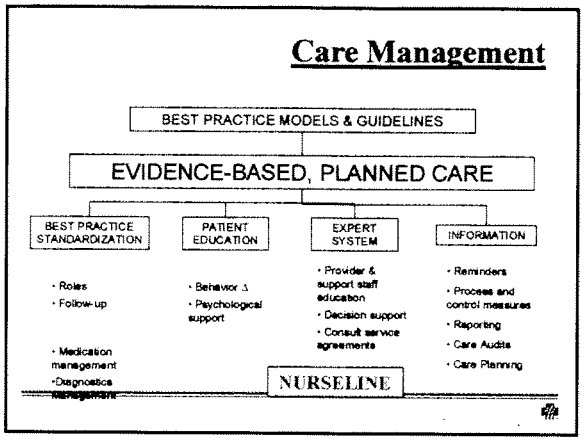
Achieve care in accordance with the Six Aims

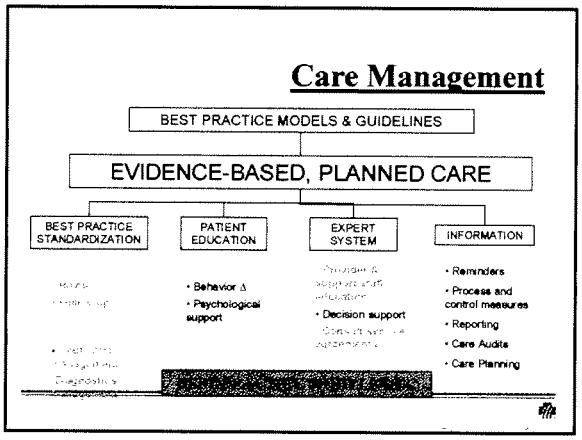
IOM Aims -

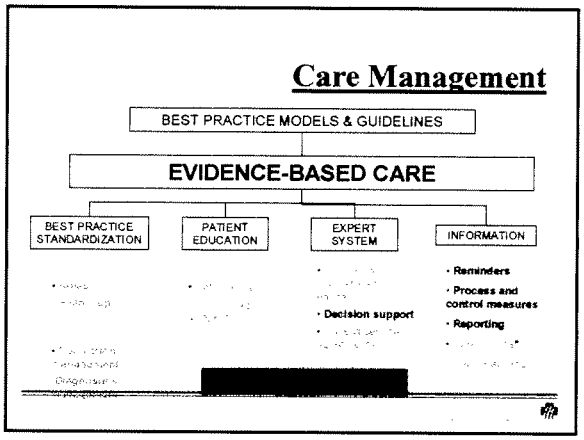
1. Safe
2. Effective
3. Patient-centered
4. Timely
5. Efficient
6. Equitable

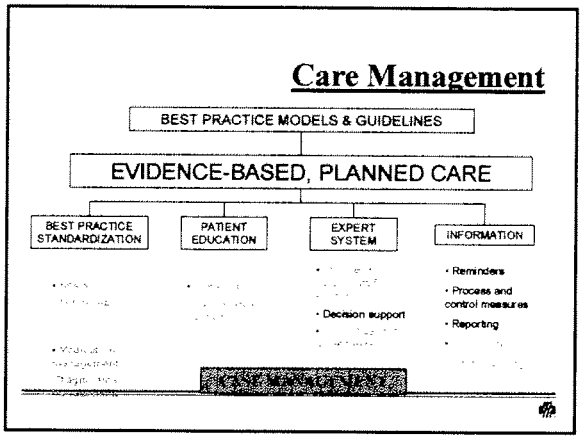
- Quality Improvement & Care Management
- Systems & Processes
- Clinic Operations

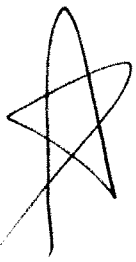












Chronic Care Management

- Anticoagulation Clinic
- Diabetes management

Rt person
Rt job
- Rt Rx
- Rt setting

Anticoagulation: An Example of Better, Less Expensive Care Made Cost-Prohibitive by Current Reimbursement Policy

	Major Adverse Events	Annual Incidence of All-Cause Hospitalizations	% Time INR Values are within Therapeutic Range
National	15%		
Clinic Control Group	6.7%	0.70	60.4%
ACS Group	2.98%	0.41	73.7%

Anticoagulation: An Example of Better, Less Expensive Care Made Cost-Prohibitive by Current Reimbursement Policy

5,000 patients/year on warfarin

- **Medicare Savings: $11.67 million**
- **Patient Savings: $2.5 million**
- **Marshfield Clinic Costs:** (~$1.4 million)
- **Reimbursement:** $0.00

Diabetes Mellitus

- Reaching Epidemic Proportions
- Services typically covered –
  - – Amputations –
  - – Dialysis -
- Services not typically covered –
  - – Diabetes protective footwear
  - – Nutrition education
- New York Times Series early 2006

Direct Medical Costs

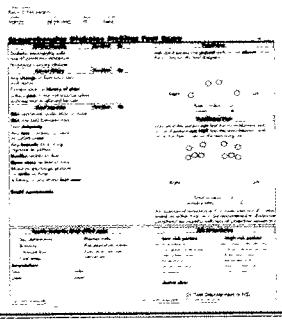
Stroke	84%	15,400 – 44,900
Acute MI	84%	15,500 – 50,000
Amputation (up to 15% of diabetic patients)	47%	23,300 – 62,200

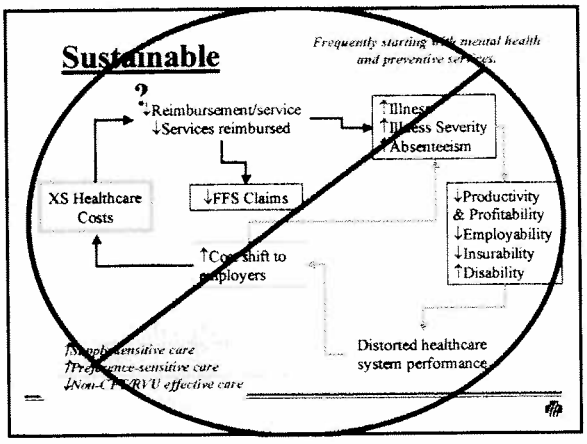
Diabetes Care 26(8), August 2003

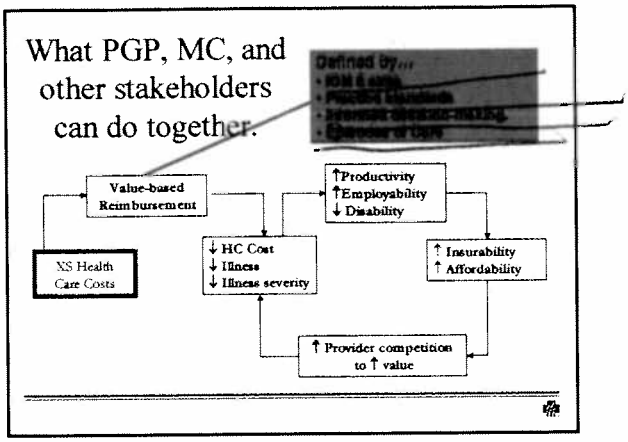
Preventing amputations

- 85% of all amputations are preceded by foot ulcers.
- Foot ulcers are preceded by loss of neuroprotective sensation.
- Early detection of loss of sensation with early intervention prevents amputations.

Diabetic Foot Exam forms







Challenges

- For patients, purchasers, and providers in the future -

$$Value = \frac{Quality}{Cost}$$

There will be a need to measure quality to prove it is high while working to continually improve quality and work to control costs to maximize value in the marketplace.

IOM vision for health care reform…

is an **economic**, as well as, **moral** imperative.

Standard Practice
Cost cuts
Value based
#2 minimize Reporting Burden
#1 definitions
WHO
Definition
Institute of Medicine
Diabetes
Starting SAT cms_pqrs pqrt_pqrs cms_pqrs for perfor Pays for Value
Having Providers Compete on Value
Value = Q / COST
Q metric for
ETF Collaborative.


FORWARD

Wisconsin Chapter
American College of
Emergency Physicians

Crisis in the Emergency Room

Select Committee on
Health Care Reform

August 28, 2006

Wisconsin Chapter
American College of Emergency Physicians

Attachments:

- Executive summary
- Committee hearing statement
- Institute of Medicine report talking points
- Articles from the *Annals of Emergency Medicine*
- Policy statement from the American College of Surgeons

Administrative Office: 10 W. Phillip Rd., Suite 120, Vernon Hills, IL 60061-1730
Phone: (800) 798-4911 ❖ *Fax:* (847) 680-1682 ❖ *Email:* WACEP@aol.com ❖ *Internet:* www.wacep.org

CRISIS IN THE EMERGENCY ROOM:
EXECUTIVE SUMMARY
AUGUST 28, 2006

The problems:

- Emergency departments provide an essential public service. We are legally required to see every patient who comes through the door, regardless of insurance status or ability to pay, and that's a good safety net. Problems from elsewhere in the health care system and society generally wind up in the emergency room – lack of access to primary care, inability to afford medicines, violence and abuse, natural and manmade disasters.
- Emergency department visits have increased **26 percent** in 10 years, but emergency departments are closing and waiting times are longer for all patients. The patchwork combination of funding for this essential public service is unraveling. While volume increases, revenues are decreasing.
- In particular, Medicaid's grossly inadequate payment rates threaten the emergency system's ability to continue providing care for all patients. For example: an emergency physician spends 3 ½ hours with a quadriplegic patient, on a ventilator, who arrived at the ER with a very serious condition requiring transfer to a tertiary care hospital for sophisticated surgery. Medicaid's payment for those 3 ½ hours is $26.99, or about $7.70 per hour.
- The problem doesn't just involve emergency physicians. We regularly call in specialists – plastic surgeons, orthopedists, and so on – to help provide optimal care to severely ill or injured patients in the ER. It's becoming harder and harder to find specialists to see patients in the ER. We may spend hours trying to locate specialists, sometimes without success; meanwhile, patients wait.

Immediate treatment:

- Set Medicaid rates for physicians' services in the emergency room at the Medi*care* level for "evaluation and management" (E/M) services – the services most closely correlated with the legal mandate of EMTALA[1] to screen and stabilize <u>all</u> patients regardless of their insurance coverage or ability to pay. By setting rates at these levels for specialists who see emergency patients as well as emergency physicians, we'll not only improve the financial viability of emergency departments, we'll alleviate the problem of finding specialists to see emergency patients.
- Make available to all emergency departments in the state an on-line information management system which allows emergency physicians to access basic medical record information about Medicaid patients' care –e.g., current medications and recent lab test results. This would speed diagnosis and treatment and reduce unnecessary duplication of expensive diagnostic tests.
- Create a referral database of specialty physicians we can use to find needed care in a timely manner.

First, do no harm: We are mindful that well-intentioned plans, such as proposals to curtail "inappropriate" emergency room visits, often have unintended consequences for patients' lives as well as for the health care system. Be careful about reducing access to this safety net in an effort to preserve it.

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[1] EMTALA = Emergency Medical Treatment and Active Labor Act, the federal law that requires emergency departments to screen and stabilize <u>all</u> patients.

Select Committee on Health Care Reform
Monday, August 28, 2006

"Crisis in the Emergency Room"

Wisconsin Chapter - American College of Emergency Physicians
Christine M. Duranceau, MD, *President*
Platteville

Howard J. Croft, MD, *Governmental Affairs Chair*
Milwaukee

Madame chair and members of the committee, my name is Dr. Christine Duranceau. I am a board certified emergency physician practicing in Platteville, and I also currently serve as the Wisconsin Chapter President of the American College of Emergency Physicians. Joining me today is Dr. Howard Croft, also board certified in emergency medicine. He practices at Columbia St. Mary's Hospital in downtown Milwaukee. On behalf of myself, Dr. Croft and all emergency physicians who take care of your constituents throughout the state, we want to thank you for inviting us to this hearing.

I want to congratulate you for taking the time and showing the interest in our state's health care system. To be sure, there are many challenges facing our citizens, especially those who need emergency medical care. In recent years, there has been an increasing focus in this aspect of the health care system, and we're hopeful that your leadership will point the State of Wisconsin on a path to success.

The Health Care Safety Net

We'd like to take just a minute to share with the committee who we are and why it has been rightly said that emergency medicine is in a state of crisis. The emergency department in your local hospital really is the first line of defense in the health care safety net.

We see it all – during a single shift an emergency physician may treat trauma victims from traffic accidents, gunshots or even a major catastrophe... patients fighting for their lives due to heart attack, diabetes or asthma... a drug overdose... alcoholics... and victims of domestic abuse, rape or other crimes. At the same time, we take care of people who accidentally cut themselves at home, who are sick with the flu, who are about to deliver a baby, or who just plain have nowhere else to turn for even the most routine health care.

You may not know it, but under federal law, those who provide trauma and emergency medical care are required to see every patient who comes through the door regardless of their insurance status or ability to pay. This is the "EMTALA" law, and we think this is a good policy. As a society, we all want to know the safety net will be there for everybody when it's needed.

An Essential Public Seri ve

But that law also puts emergency departments and the doctors who work there in a special category. Much like the fire department, we fill the role of an essential public service. Yet, unlike the fire department, we must function in a system financed through a combination of private sources, public dollars or no funding at all ... as in the case of the working poor who don't qualify for Medicaid, have no insurance and can't afford to pay for care out of pocket.

As an essential public service, we are there for everybody. Our patients are not just poor people on Medicaid, it's you, your family and your neighbors. We are open 24/7, and like

the canary in the coal mine, many of the problems in the health care system – and society itself – are first noticed in the emergency department. That includes community problems like drug and alcohol abuse. It includes the strain resulting from tight finances and insufficient staff to keep up with the demand. It includes people without insurance seeking routine care. And it even includes a big piece of homeland security through disaster preparedness and responding to bioterrorism. Emergency departments are likely the first to see victims of bioterrorism . . . they can show up anywhere as we saw with the anthrax scare a few years ago.

Challenges are Growing

The challenges facing the emergency medical system certainly are evident within the Medicaid program. But through "ripple effect," these problems ultimately affect everybody. In an overcrowded emergency department, even those with the best insurance have to wait to see a doctor. Meanwhile, cost shifting because of uncompensated, or under-compensated, care places a greater burden on those who are able to pay.

Did you know that there were nearly 114 million emergency department visits nationally in 2003? That's a 26 percent increase in 10 years. In 2002, Wisconsin reported more than 1.5 million visits. And while the volume continues to grow, emergency physician compensation is *declining* because of grossly inadequate payment rates under Medicaid, skyrocketing medical liability insurance premiums, rising overhead costs, and care that simply is never paid for. According to the American Medical Association, individual emergency physicians average $138,300 annually in lost revenue for providing EMTALA-mandated care. And we can't even deduct that as a charitable contribution!

Let me give you an example of how inadequate Medicaid fees are in this state. Recently, I had a Medicaid patient who is a quadriplegic and on a chronic ventilator who arrived with a severe headache and low blood pressure. This gentleman required a complete work-up, a CT scan, lab tests and a thorough physical. We found he had a very serious condition and needed immediate surgery. He was transferred to Madison for that treatment. I spent 3½ hours with this patient. My normal charge for this very high level of care was $281.25, but Medicaid paid the princely sum of $26.99 – or about $7.70 per hour, the same rate a junior high girl would charge for babysitting... if you're lucky. This is *not* an isolated example. You just can't keep the doors open when fees are discounted as much as 90% like this case.

"On-Call" Specialty Coverage Needs Improvement

(Dr. Croft)

Very often, a patient's medical needs are more appropriately handled by a specialist such as an orthopaedic surgeon, a cardiologist, or a plastic surgeon. In my personal experience, I've found it is becoming more difficult to get that critical "on-call" backup from specialists. While research shows there are complex reasons for this, one that stands out over and over is low Medicaid payment rates. It's very hard to overcome this reality when we're trying to call a doctor away from his home and family in the middle of the night, especially when they know their compensation will be very low, if any at all. So as a result, some doctors just don't take call period.

Here's a case I had about a year ago. A little girl had been bitten in the face by a dog. Her parents had insurance, so this was not even a Medicaid patient. She needed stitches and because of the severe injury to her face, a plastic surgeon was the best choice for her. I spent hours on the phone trying to find a surgeon that night to see this girl... with no luck. Eventually, I admitted her. She developed an infection and required much more intense treatment, not to mention the anxiety of being sick in the hospital. Plus she still needed the services of a plastic surgeon. The cost of this care was many times what it might otherwise have been if we had an adequate backup call schedule.

A couple of years ago, we were very gratified that Secretary Helene Nelson agreed to meet with

us to discuss some of these issues. The first thing she said was that she recognized emergency medical care – and Medicaid in general – is underfunded. This fact has real consequences, and you've just heard two examples. Wisconsin's emergency physicians have committed themselves to caring for our patients, and that includes working with public policy makers, like yourselves, to find solutions to these challenges.

Recommendation #1 - Medicare Rates in the ER

One recommendation we hope the committee will seriously consider is setting Medicaid rates at the Medicare level for EMTALA-services. This clearly is justified, and we believe it's essential to keep the health care safety net in your districts from unraveling. About one-third of the patients at my hospital (Columbia St. Mary's in Milwaukee) are covered by Medicaid. You just can't make up in volume what you're losing on every patient. Keeping this essential public service financially solvent is critical; letting it go will have a ripple effect throughout our communities. We already are beginning to observe symptoms from our failure to act with exceeding long waits to see a doctor, hospitals who have to divert patients elsewhere because all of their beds are filled, patients like the little girl with the dog bite who can't get proper treatment from a specialist, and even entire emergency departments being closed because of insurmountable financial pressures.

Recommendation #2 - Information Management

While adequate funding is very important, lack of access to information is a huge headache for emergency physicians. This involves both data about current and previous care received by the patient, as well as the ability to quickly find doctors for follow-up care.

I can't begin to tell you how much money simply is wasted because of tests that are repeated needlessly. Strange as it may seem, it's common for a patient to *not* reveal they just had an x-ray or a CT scan the previous week for the same complaint they have today. Who knows why... either they don't make the connection, they didn't like the answer they got from the other doctor, or they're just dysfunctional. But without that information and given certain symptoms or complaints, we are obligated to proceed with lab or imaging tests.

Lack of shared information also can affect the continuity of care when I have no idea what medications a patient might be on as a result of a previous visit to a different emergency department or doctor. And, we all have heard about the "drug shoppers" who go from ER to ER with back pain hoping to get some medicine. Believe me, they're out there.

(Dr. Duranceau)

Finally, emergency physicians are spending significant time away from patients while we call around trying to find a doctor who will provide needed follow-up care. Not long ago, I had a 32-year old man who fell off a ladder and broke his hip. I spent hours calling at least five orthopedists and five different hospitals, none of whom could or would accept the patient (who, by the way, had insurance). We ended up sending the patient to Rockford. I've also had to send patients as far as Iowa City. Now isn't that a sad state of affairs when we have to export patient to another state?

As sorry as it is to send patients far away for follow-up care, it's just as sorry that I have to spend a significant portion of my shift on the phone looking for doctors to take the patients.

These examples illustrate the urgent need for a good information management system available to all emergency departments. We already have the technology, we just need the will to make it happen. We think two steps would go a long way toward helping to ease the burden:

First, we should establish a database of doctors who will accept new patients – and especially Medicaid patients – or who will respond when called to the emergency department. At the very least, this will allow emergency physicians to direct more time to patient care. And by more effectively arranging for follow-up visits, the continuity of care will improve, as well.

Secondly, on-line medical information about Medicaid patients not only would result in better treatment, but it also would save a tremendous amount of money that's currently being wasted. We're not proposing a gold-plated electronic medical record system, which certainly would be nice but also is a huge undertaking. Something as straight-forward as a listing of previous doctor/hospital visits, recent tests, current medications and known allergies or chronic conditions would at least give us a basis upon which to make reasoned judgments about the care that's needed and justified today.

When you consider that the average cost of a CT scan is $900 to $1,400, you can see that the savings could add up very fast when these expensive tests don't need to be repeated.

The Ripple Effect - Avoid Unintended Consequences

(Dr. Croft)

As we are searching for solutions to some of these problems, it is vital to keep in mind that each action has the potential for unintended consequences. Over the past few years, there have been some studies concerning "frequent fliers" in the emergency department who appear to be over-utilizing the services there. Others are seeking routine health care in the ER when it would be more appropriately delivered in a primary care physician's office or a community health clinic. Some have suggested imposing a "co-payment" or some other financial penalty on these patients, or tightening eligibility requirements.

In the same month not long ago, I had two diabetic patients who came to me severely ill in life-threatening conditions. Neither had been taking their insulin for months because they didn't have the $35 application fee for their GAMP – general assistance – card. For lack of thirty-five bucks, both ended up needing tens of thousands of dollars in hospital care and have continuing medical problems costing the system even more money... not to mention the impact on these individuals' quality of life. This is what happens when we do things that ultimately discourage people from seeking care when they first need it. It's the ripple effect.

No Easy Solutions

As these hearings are sure to demonstrate, there are no easy solutions to the challenges facing Wisconsin citizens, and society in general. It's an incredibly complex issue. From the standpoint of emergency medicine, we sincerely hope you will keep in mind the fact that your local ER is a pillar in the health care safety net; it is an essential public service that must survive.

Addressing the issue of grossly low Medicaid rates by setting fees for EMTALA-related services to be on par with the federal Medicare system would do a lot to keep the doors open and encourage medical specialists to be there when needed. Creating an information management system would improve efficiency and save money by speeding up referrals for continuing care and eliminating unnecessary tests, not to mention improving the overall quality of care.

Wisconsin's emergency physicians are totally committed to working with you to address these challenges. Thank you for taking the time to listen to us and for considering our recommendations.

Institute of Medicine Report on Hospital-Based Emergency Care

Main Point 1: The IOM Reports are landmark studies that confirm our nation's emergency departments are fragmented and stretched to the breaking point, unable to respond to disasters.

— Underneath the surface, a national crisis in emergency care has been brewing and is now beginning to come into full view.
— Hospitals must end the practice of boarding patients in emergency departments and ambulance diversion, except in the most extreme cases, such as mass casualty events.
— An ambulance is diverted every minute in America, threatening the lives of sick and injured patients by delaying medical treatment.
— Emergency departments provide a health care safety net for everyone — the insured as well as the uninsured. The problem affects every single American.
— Emergency physicians treat 5 million more patients every year — more than 300,000 a day. 113 million came in 2003. U.S. hospitals have lost more than 198,000 beds since 1993.
— The nation's emergency physicians provide the most charity care of any medical provider — 95 percent in 2003, compared with 31 percent of all other physicians

Main Point 2: Congress must convene a hearing to address the problems facing emergency patients.

— Congress must dedicate funding to the emergency system for disaster preparedness and to reimburse hospitals that provide significant amounts of uncompensated emergency and trauma care.
— It's not enough to address the problem by asking people not to get sick.
— These results are a wakeup call to the nation to recognize emergency care as an essential community service that must be funded.
— The IOM reports confirm the results of ACEP's 2006 National Report Card on the State of Emergency Medicine — that 80 percent of states earned near-failing grades for their lack of support for emergency care systems., and the nation overall received a C-

Main Point 3: Congress must ensure that America is ready to respond to medical emergencies during a disaster and every day.

— The reports confirm that only a tiny fraction of federal funding for emergency preparedness has been spent on medical preparedness. Although emergency service providers are a crucial part of the response to any disaster, they received only 4 percent of $3.38 billion distributed by the Homeland Security Department for emergency preparedness in 2002 and 2003.
— Emergency departments are completely unsupported and unprepared for disasters, such as terrorist events, pandemic flu and hurricanes.
— Congress must recognize the role of emergency physicians and nurses in responding to disasters, and allocate funds accordingly.
— Emergency physicians are like the levies in the nation's health care system. They have a crucial role to play in disaster planning at the local, state and federal levels.

- **Main Point 4: Emergency physicians are asking the public to visit www.acep.org and send a message to Congress to convene a hearing and support of the Access to Emergency Medical Services Act** (H.R. 3875 and S. 2750).
  — This issue affects everyone. It is a national problem that requires a national solution.
  — The nation's emergency physicians are advocating for passage of the Access to Emergency Medical Services Act, which if passed, would:
    - Address the growing lack of resources in emergency care by recognizing emergency medicine as an essential community service that must be funded.
    - Address the growing physician shortage by extending limited liability. protection to physicians who care for patients in emergency departments
    - Provide financial incentives to hospitals to end the practice of "boarding" patients in the emergency department.

Who is the IOM: The Institute of Medicine serves as adviser to the nation to improve health. Established in 1970 under the charter of the National Academy of Sciences, the Institute of Medicine provides independent, objective, evidence-based advice to policymakers, health professionals, the private sector, and the public.


FORWARD
E PLURIBUS UNUM

UWHealth

Robert Golden, MD
Dean, University of Wisconsin School of Medicine and Public Health

Donna Sollenberger
President and CEO
University of Wisconsin Hospital and Clinics

Jeffrey Grossman, MD
President and CEO
University of Wisconsin Medical Foundation

UWHealth

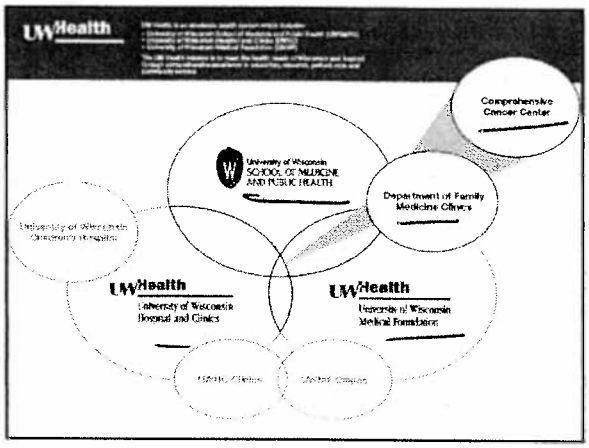
- A school of medicine and its closely affiliated educational and clinical institutions:
  - Teaching Hospital(s)
  - Faculty group practice plans
- Often includes other health professional schools - public health, nursing, pharmacy, dentistry.

UWHealth

The Academic Health Center's *social missions* – teaching, research, provision of rare and high technology services, continuous innovation in patient care, and the care of the indigent – are significant contributors to the public welfare, and *are likely to grow more important in the foreseeable future.*

Envisioning the Future of Academic Health Centers – Final Report of the Commonwealth Fund Task Force on Academic Health Centers, February 2003

UWHealth



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Advances in the biomedical and social sciences have provided us with a more complete understanding of the social and biological bases of health and disease than ever before…

Yet healthcare delivery remains "a tangled, highly fragmented web that often wastes resources by providing unnecessary services and duplicating efforts, leaving unaccountable gaps in care and failing to build on the strength of all health professionals."

The Institute of Medicine, Crossing the Quality Chasm. 2001

UWHealth

- Poor access to care and coverage for a substantial portion of our population
- Unsustainable costs
- Inadequate healthcare workforce pipeline, and problems with clinician distribution
- Translation of basic science discoveries into effective clinical care
- Concerns regarding quality/safety
- A system designed to be "reactive" rather than preventive, following conventional medical models rather than an integrated public health/medical model

Problem with existing science gap

Inadequate healthcare professionals

gap

UW Health

Serve as a "think tank" and "learning laboratory" for Wisconsin

Increase the enrollment in Wisconsin's healthcare schools, and design mechanisms to address problems in the distribution of the work force

- Wisconsin Academy of Rural Medicine
- Milwaukee Clinical Campus
- Loan forgiveness

UW Health

Role of the Academic Hospital in the Healthcare Delivery System

Donna Sollenberger
President and CEO
University of Wisconsin Hospital and Clinics

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Academic hospitals and health systems play an important role in the healthcare delivery system:

Deliver highly specialized care with state-of-the-art technology, often creating tomorrow's standard of care today

Serve as "classrooms" to educate health science professionals

Serve as "laboratories" for the translation of research from the bench to bedside

Provide a safety net for the uninsured and underinsured of the state; often the largest Medicaid providers in the area

Offer highly specialized services such as burn, trauma, organ transplant, and pediatric care for the state and the region

Deliver care not available in communities, a safety net for many areas

UW Health

- Create new treatments and methods of diagnosis and care that will be the community standard of care tomorrow
- Leaders in defining best care practices
- Lead the way in care management, particularly for the chronically ill
- Train students in evidence-based practices and innovative care models
- Identify opportunities to weed out duplication and inefficiency in current care models

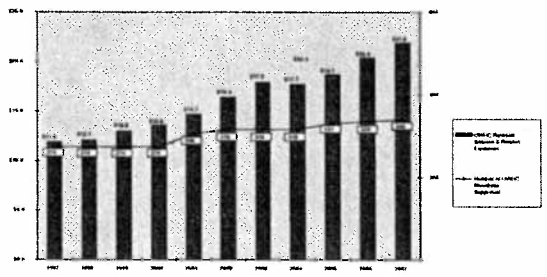
UW Health

- Support the cost of educating the next generations of physicians, nurses and healthcare workers
  - Restore the Graduate Medical Education funds cut almost four years ago

UW Health

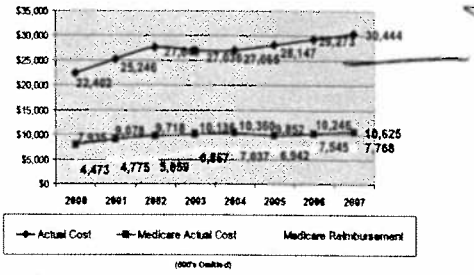
- UWHC currently trains 340.72 residents and fellows in 14 residency programs and 10 fellowship programs. In addition, another 142.28 residents and fellows in UWHC programs train at the Middleton VA, Meriter, St. Marys and other statewide locations
- On average, one-third of residents trained at UWHC stay and practice in Wisconsin

UW Health



Represents approximately 3% of UWHC's total annual operating budget in FY07

UW Health



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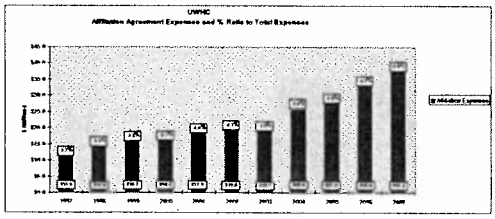
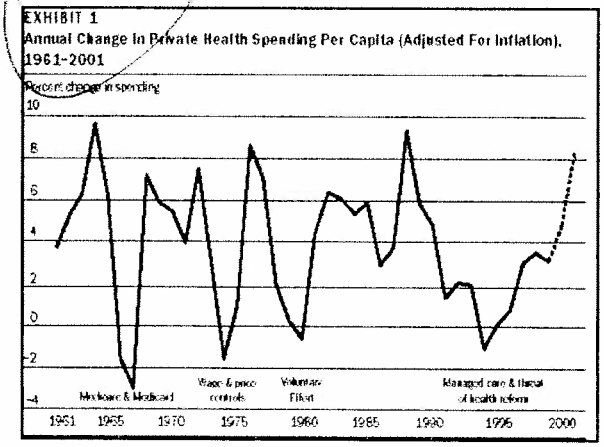


UW Health

The Role of Academic Health Centers in Creating Sustainable Reform

Jeffrey Grossman, MD
President and CEO
University of Wisconsin Medical Foundation

EXHIBIT 1
Annual Change in Private Health Spending Per Capita (Adjusted For Inflation), 1961-2001



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- Health Care Value
- Growth in Uninsured Population
- Shift from Acute to Chronic Disease
- Aging Population
- Diverse Population
- Technological Advances
- Information/Communication Technology
- Determinants of Health/Illness

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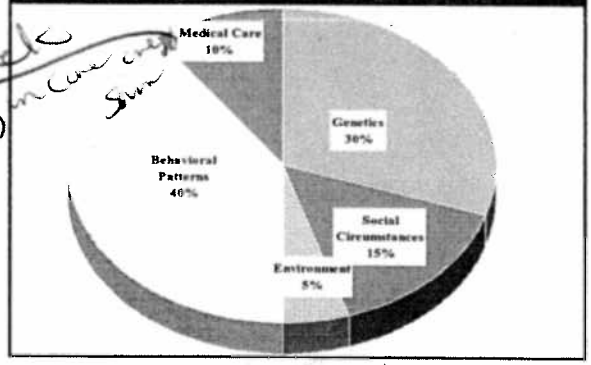

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Three key elements for sustainable reform:

1) Define our goals
2) Support the knowledge pipeline
3) Close the gap between "what we know" and "what we do"

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- Translation
- Variation
- Organization
- Education

UW Health

Clinical Procedure	Landmark Trial*	NHQR 2004
Flu Vaccine	1968	63%
Pneumococcal Vaccine	1977	54%
Diabetic Eye Exam	1981	70%
Mammography	1982	70%
Cholesterol Screening	1984	67%

* Balas EA, Boren SA., Managing Clinical Knowledge for Health Care Improvement. Yearbook of Medical Informatics 2000.

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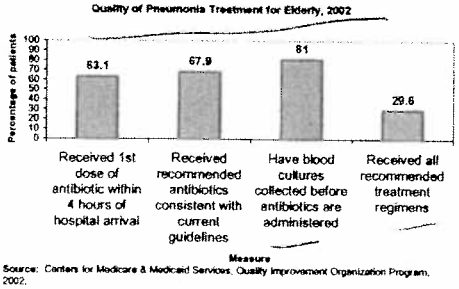

Source: Centers for Medicare & Medicaid Services, Quality Improvement Organization Program, 2002.

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"Lets be realistic: if we didn't do it with aspirin, how can we expect to do it with DNA?"

Claude Lenfant, Director NHLBI/NIH

UW Health

- Translation
- Variation – Dartmouth in New Hampshire
- Organization
- Education

UW Health

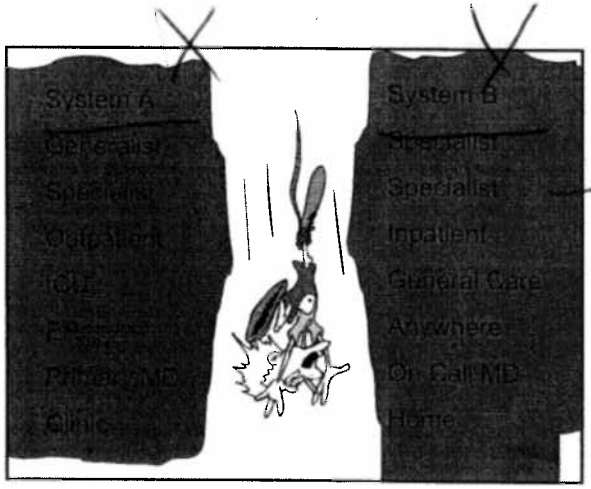
- Translation
- Variation
- Organization
- Education

Practicing same way as did 100 years ago

UW Health

"Right now we are flailing around inside 1 percent of the possible (organization of medical care) space"

- Ian Morrison, "Health Care in the New Millennium"



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We treat chronic illness in a system designed for acute care

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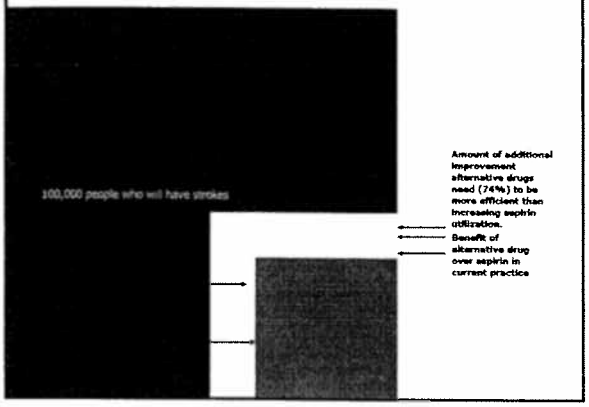
Health Care as a Commodity:

- misaligned financial incentives for services that do not cost-effectively contribute to health
- lack of incentives to provide individual or population services that promote prevention and health maintenance
- severe misdistribution of resources, correlated with race and socioeconomic status
- limitations on collaboration

Drugs to Prevent Recurring Stroke



any better drugs cheap esp. most stroke last

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- Translation
- Variation
- Organization
- Education

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Core Competencies for the 21st Century:

- Teamwork
- Grounding in Quality Improvement
- Evidence Based Practice
- Patient Centered

Policy Issues:

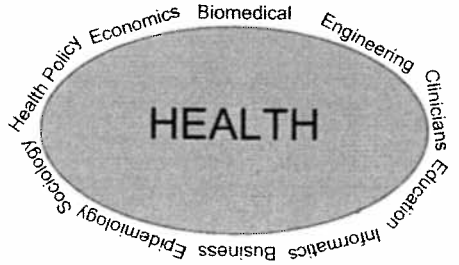
- How many health professionals do we need?
- How should they be distributed?
- What will be their roles?
- Who will share the cost for their education and training?

UW Health

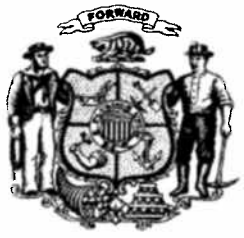
Summary Thoughts

- Think globally, act locally
- Support development and use of evidence to guide policy and practice reform
- Use reform to align goals and incentives – beware of unintended consequences
- Good health requires more than good health care
- Reform includes the cultivation of a relevant and responsive workforce
- Embrace the "Wisconsin Idea"
- UW Health and the University has a responsibility and commitment to be part of the solution

UW Health




WISCONSIN STATE LEGISLATURE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Public Hearing
Select Senate Committee on Healthcare Reform
August 28, 2006

HIRSP Authority Status Update
Presented by: Amie Goldman

Transition Update:
Effective July 1, 2006, administration of the Health Insurance Risk-Sharing Plan (HIRSP) was successfully transferred from the Wisconsin Department of Health and Family Services (DHFS) to the newly created HIRSP Authority.

The contract DHFS held with the plan's administrator, WPS Health Insurance, was also transferred to the Authority. New contracts have been established for legal services (Dewitt, Ross and Stevens) and banking services (US Bank). Options for securing benefits for Authority staff are also under consideration.

It is expected that the Authority will have 4.0 FTE: Chief Executive Officer, Operations Manager, Accounting and Finance Manager and an Executive Assistant.

Governance Structure:
The Authority is governed by a 13 member Board of Directors. The Commissioner of Insurance or his or her designee also serves as a non-voting member of the Board. Dennis Conta serves as the Board Chair and Joe Kachelski is the Vice-Chair of the Board.

Board Composition	Current Members
Wisconsin Medical Society Representative	Dr. Michele Bachhuber Marshfield Clinic
Public Member	Mr. Dennis Conta
Insurer Representative	Mr. Jay Fulkerson United Healthcare of Wisconsin, Inc Vice Chair
Health Care Plan Representative	Mr. Michael Gifford AIDS Resource Center of Wisconsin
Consumer Advocate	Ms. Diane Greenley Disability Rights of Wisconsin
Insurer Representative	Ms. Patricia Jerominski Independent Health Care Plan
Wisconsin Hospital Association Representative	Mr. Joe Kachelski Wisconsin Hospital Association, Inc.
Pharmacy Society of Wisconsin Representative	Mr. Wayne MacArdy Phillips Pharmacies
The Commissioner of Insurance, or his/her Designee	Ms. Eileen Mallow Office of the Commissioner OF Insurance
Insurer Representative	Ms. Carol Peirick Wisconsin Education Association (WEA) Insurance Corporation
Small Business Representative	Ms Deborah Severson Realityworks, Inc.
Policyholder Representative	Ms Luann Simpson
Policyholder Representative	Ms. Annette Stebbins
Insurer Representative	Mr. Larry Zanomi Group Health Cooperative-South Central Wisconsin

At it's June meeting, the Board adopted a set of by-laws, which outline the responsibilities, duties and powers of the Authority as well as the Board of Directors. Six standing committees were created in the by-laws:

Executive Committee: The Executive Committee is authorized to act on behalf of the entire board between its meetings and also services as the Board's personnel committee.

This committee is chaired by Dennis Conta.

Strategic Planning Committee: The Strategic Planning Committee is charged with developing long-range strategic plans for the Authority and conducting short-term priority planning as directed by the Board Chair.

This committee is chaired by Dennis Conta and Jay Fulkerson serves as Vice Chair.

Finance and Audit Committee: The Finance and Audit committee oversees the preparation of the annual budget and financial statements. The committee is also responsible for guiding the development of internal controls and for overseeing the annual independent audit process.

Joe Kachelski chairs this committee.

Grievance Committee: The purpose of the Grievance Committee is to establish, maintain, supervise and apply procedures for responding to grievances regarding the denial of benefit claims of HIRSP policyholders, resolve benefit claim issues and to adjudicate other grievances.

Annette Stebbins chairs this committee.

Consumer Affairs Committee: The Consumer Committee is responsible for establishing procedures and media for providing general information about HIRSP to policyholders and to the public.

Diane Greenley chairs this committee.

Legislative Committee: The Legislative Committee will monitor state and federal legislation affecting the Plan and the Authority and will supervise the preparation of the annual legislative report required by statute.

Mike Gifford chairs this committee.

Priorities:
The Authority has begun to establish a number of priorities for itself.

Infrastructure
The initial priority of the Authority's was to develop its infrastructure. Considerable progress has been made toward this goal:

- CEO hired as of July 10, 2007
- Executive Assistant hired as of July 20, 2006
- Board orientation conducted.
- By-laws drafted and adopted.
- Staffing plan approved August 21, 2006 and recruitment initiated.
- Temporary offices established and permanent office space identified.
- Secured general liability and workers compensation insurance.
- Proposal obtained for provision of benefits (health, retirement, disability) for Authority staff
- Contract signed for payroll services.
- Contract signed for website development.
- Obtained proposals for phone and voice mail system, copier/printer and office furniture.
- Executive, Grievance, and Finance and Audit committees held. Consumer and Strategic planning committees scheduled.
- Consideration of Authority investment options.
- Plan changes effective July 1, 2006 successfully implemented (residency requirement and notices of declination).
- Fiscal year 2006-07 insurer assessment process completed.
- Development and adoption of operating procedures (accounting and expense reimbursement).
- Began assessment of mental health and AODA services in preparation of December 1st report to the Joint Committee on Finance.
- Completed assessment of current disease management services under the Plan.
- Establishment of "Data Dashboard" a web-based executive information system.

Cost-Effectiveness
Improving the cost-effectiveness is also a top priority of the Authority. The Board and Authority staff have begun to lay the groundwork for this priority. The following initiatives are completed or in progress:

- *Collections.* Since the inception of the WPS contract (4/1/05), there have been 500 instances where a policyholder owed HIRSP for unpaid premiums of health care claims. Of this total, approximately one-third were eventually paid as a result of multiple mailings to the policyholder. A decision was made to send the remaining 330 to a third party collection agency.

- *Mail-Order Pharmacy.* Navitus is the pharmacy benefit manger for HIRSP. In April 2006, an initiative to utilize a mail-order pharmacy for specialty drugs was launched. Moving the purchase of these specialty drugs from a retail pharmacy to a mail-order pharmacy generally lowers the drug cost by 3% for drugs that typically cost $1,000 to $10,000 per prescription. The benefits to the policyholder are one-on-one pharmacy consultation, free home delivery and refill reminders. In order to encourage more participation in this voluntary benefit, a second

mailing was developed and will be sent to 330 policyholders using the targeted drugs and to the 120 physicians prescribing the medication.

Other Pharmacy Savings. Navitus has been asked to develop and present additional pharmacy cost-saving proposals. These will be presented to the Authority September 7, 2006.

- *Market Comparison.* WPS is currently undertaking a detailed comparison of the HIRSP policy to a standard WPS individual insurance policy to identify potential changes that could improve the cost-effectiveness of HIRSP. The results of this comparison will be presented to the Board at its October meeting.

- *Disease Management.* The Authority has inventoried the current disease management services provided through the WPS contract and has concluded that the current services are a good value to HIRSP, but are typically more like traditional care management services. The opportunity to develop and implement population based disease management programs will be considered by the strategic planning committee at its October 31, 2006 meeting.

Legislative Priorities

2005 Wisconsin Act 74 established two requirements for the Authority. The first was an assessment of the historical utilization of mental health and AODA services under HIRSP and consideration of whether the state mandated benefits for the treatment of mental health and AODA disorders would allow for evidence-based treatment of the HIRSP population. This assessment is underway and some preliminary utilization data will be presented to the Consumer Affairs Committee on August 31, 2006.

The second requirement was the development of a plan that would meet the federal definition of a health care tax credit plan. This requirement will be considered by the Strategic Planning Committee.

Other priorities

The Board is currently in the process of defining other priorities and initiatives to be considered by the Strategic Planning Committee. Two items that have been suggested to the Board by HIRSP stakeholders include development of a higher-deductible plan option and utilization of health savings accounts.

Contact Information:

HIRSP Authority
10 E. Doty St., Suite 800
Madison, WI 53703

(608) 441-5777
info@hirsp.org


FORWARD

Testimony Before the Senate Select Committee on Health Care Reform

Stephen D.Wilhide MSW,MPH
Consultant to the American Academy of Family Physicians
2021 Massachusetts Avenue
Washington, D.C. 20036

Critical Concepts and Principles for Medicaid Reform

- **Primary Care medical/healthcare home. The individual and/or family has a primary care physician who is responsible for assuring a regular source of care and leads to improved use of appropriate services and lessens inappropriate emergency room utilization**
- **Care management .Assuring patients with chronic conditions receive appropriate and necessary quality care.**
- **Care Coordination. Care is coordinated between primary care providers, specialty providers, hospitals, health departments and social service agencies.**
- **Disease management based upon best practice clinical guidelines**
- **Patient education**
- **Preventive health services and early detection of disease**
- **Pharmacy**
- **Care management information system**
- **Evidence based pharmacy formularies**

Community Care of North Carolina: A Successful Model of Medicaid Reform

Carolina Access began in five counties in 1991. Medical home concept/case management. Physicians coordinate specialty care. Physicians paid a care coordination fee above and beyond fee for service.

- **Currently over 740,000 enrollees statewide**
- **Program changed to Community Care of North Carolina in 2002 (CCNC)**
- **CCNC designed to support the development of community care systems that have the ability to develop programs and infrastructure to manage healthcare needs of the Medicaid population and improve the quality of their care through integrated community management**
- **Local non-profit networks which include, at minimum, Medicaid primary care providers and FQHC's, health department, department of social services and local hospital**
- **Each network is responsible for population management which involves identifying individuals with certain high cost or complex health conditions in need of case management, assisting the primary care physicians with disease management education, helping patients coordinate care and collecting and reporting program and patient data to the CCNC statewide office.**
- **Currently, fifteen networks including more than 3,000 physicians practicing in collaboration with health departments, hospitals, social service agencies and other community agencies managing the care of over 681,000 enrollees; about 74% of all eligible Medicaid beneficiaries in the state.**
- **Each network receives $2.50 PMPM Medicaid enhanced care management fee. Primary care providers also receive $2.50 PMPM to participate in local disease management and care coordination systems that reduce Medicaid expenditures.**
- **Primary care physicians are paid 95% of the Medicare fee schedule on a fee for service basis.**
- **Case managers hired by each network identify patients with chronic diseases and high risk conditions, assist the primary care providers in disease management and patient education, coordinate care and assure access to necessary services and collect data on process and outcome measures using the Care Management Information System.**

coord care   collect DATA
Paid with pri 6's [illegible]
[illegible]
Pat. [illegible] diagnosis
Clinical guide line [illegible]
no code [illegible]

Make sure you're at top of list in pro care.

Want [illegible]
MUST 24 HR 7 day WE on call
Paid at 95% MA fee schedule

- **Statewide clinical improvement inititatives include:**
  Asthma and Diabetes management
  Congestive heart failure
  Pharmacy initiatives addressing cost and utilization
  Emergency department utilization
  Managing those enrollees and services at highest risk and cost

PAL Physician Liaison Vs mandatory formulary

- **Networks can develop other initiatives based upon the needs of their patient population**
  -HIV/AIDS care management
  -Health disparities
  -Mental health integration
  -sickle cell anemia

Overall Medicaid Cost Savings in North Carolina from Managed Care

• Overall cost savings to Medicaid attributable to managed care in North Carolina compared to fee for service for 2004: $225 million (Mercer Consulting evaluation)

Evaluation of CCNC Disease management Initiatives

- **Initial start up program (2000-2002) evaluation of disease management:**

200,000 Patients 3 some million

Asthma
-Savings of $1,580,040. Costs included enhanced care management fees.
-Hospital utilization decreased by 23% for the CCNC enrollees under age 21
-Inpatient days decreased by 30%
-Admissions declined by 54%
-Overall emergency room utilization decreased significantly
-Number of prescriptions per enrollee decreased

Diabetes
-Savings of $2,083,824 including enhanced care management fees
-Hospital utilization decreased by 13% compared to non CNNC Medicaid patients
-Fewer emergency room visits (almost half in 2002 versus 2000)
-Prescription drug use 9% lower for CCNC patients

Behavioral Health & Primary Care = important from beginning 30% comp Both h 85%

Universal Enthusiasm for. !! in NC.

more cost effective getting care family doc treating depression at less costly rate!!

• **Access Improved for Medicaid Beneficiaries and Safety Net Providers Strengthened**

Many communities use the relationships and infrastructures developed through the networks to address other problems and populations such as the uninsured, indigent populations or nursing home residents.

Additional Benefits

- **Improved financial viability of safety net providers**

- **Medicaid beneficiaries assured a medical home and access to necessary and appropriate services**

Evidenced Based clinical Care

Asth. D.
Disease mgmt - determine to do -
$534 -
378 - participating Schep CH.
Univ NC.
3.3 m avg 2002 members
Diabetes
880 = not
859 - participated

337 - 352 days savings
288 - 319 days "

N. Carolina locally driven provider based
~~Pro.~~


FORWARD
E PLURIBUS UNUM

Marcie Malszycki Committee Clerk Notes

Senate Select Committee
8-28-06

BadgerCare Plus: Helene Nelson and Jason Helgerson

High quality and affordable health care is a pressing issue.

We don't think state government can do this alone but is apart of creating a solution.

Kids need to be on our priority list. Health insurance for children is likely to mean that they will actually receive health care. Need health start for a child to create healthy adults. Cost of health insurance is increasingly burdensome and taxing on our economy.

7% lost health insurance because employers no longer offered coverage (2003). Policy solution for kids is BadgerCare Plus which will merge existing programs under BadgerCare Plus.

Goals: all children have affordable health insurance. Improve health overall of WI residents. Lower long term care cost. Streamline administration costs.

Simplify eligibility determination with no asset test. Also want to expand eligibility. Covering women who are pregnant up to 300% of FPL. Allow parents to buy into the program. Raise income ceiling for parents to 200% of FPL. Also allow farmers and self employed individuals to buy into BadgerCare Plus. (farmers are less likely to be insured because of the nature of their business...want to change the way depreciation is determined).

Want to cut red tape and save money. Administrative cost to be cut by almost $20 million annually by streamlining program. Model the new program after SeniorCare which has a simple 1 page application form.

Want to reward HMO's that meet specific health outcome targets in ar3eas such as smoking cessation and health births.

Program pays for itself (chart).

Timeline: federal government pays for 70% now with MA waiver. Waiver runs through next March for BadgerCare. Goal is to work with Feds now to apply for new waiver for BadgerCare Plus. Want agreements created with Feds by January so that we can determine state changes in WI budget.

Are outreaching to the state through Town Hall Meetings. Also have focus groups, legislative briefings, and BadgerCare Plus advisors.

Q & A:

AD: Will be talking with you on an ongoing basis. We applaud your efforts.
We have heard a lot about access...you plan is targeted at the right group. Even when people have insurance, they can't find providers to provide the services (dental)?

HN: We ask people is this going to meet your needs in your area? People believe that this is important and smart to do. Couple things people mention: 1. Dental and 2. Mental Health Services. HMO's and medical groups are doing a great job on certain cares i.e. immunization of our children. There are many problems with dental i.e. shortage in providers who will work with MA. Fox River Valley has a new dental clinic that DHFS helped with that has dentist who volunteer to provide services.

How do we help people do the right thing...try to look at ways to beef up community based solutions.

CR: This is not a new problem regarding dental. The impact of dental problems on the rest of your body is far better understood.

LO: Are you looking at reimbursement rates?

HN: Yes, uncompensated care is burdening payers. We need to always look at a fair reimbursement. We have to look at our deficits. "Crowd Out" businesses feel that they can't provide it to their employees. Model insurance around private plan model.

This is a very healthy piece of health care reform but only a piece.

Erp: Do you have a figure of the number of no shows for dental around the state and is there a dollar number you can attach to that?

HN: Don't know but can try to find out.

CR: Full physical that gives a complete view of that person's needs and their picture of health...do we do that?

HN: Not for everyone. JH: This issue has come up. Talked about a health risk assessment. We have talked to the HMO's about this.

CR: We are very interested in seeing this be requirement. If you sign up and you receive care, you need a check up and risk assessment. 70% of state covered in HMO's. What are you doing with the other 30% that don't have HMO's or competition?

HN: We did propose in last budget to seek federal waiver regarding competition. Some of HMO's put caps on the number of individuals they will accept. We are trying to encourage them to lift their caps.
JH: There are 11 counties that have 1 HMO. We have an approved state provision right now. We did a state plan amendment that is in the process of being implemented. HMO

has to have a more expansive number of providers. They have heard from one HMO that is interested. These areas are rural.

Role of Academic health Center in health Care Reform:

Are implementing public health into the school of medicine.

Wasting resources by providing unnecessary services and duplicating efforts leaving gaps in care.

Major Challenges (slide 6). Poor access to care, unsustainable costs, concerns on quality and safety, reactive system and proactive or preventative.

How can we help?
Think tank, increase enrollment in WI healthcare schools (WI Academy of Rural Medicine and Loan Forgiveness). Loan forgiveness can persuade new grads to work in rural areas. (bill last session)

Role of the Academic Hospital in the Healthcare delivery system.

Deliver highly specialized care with state-of-the-art technology. Provide safety net for the uninsured and underinsured of the state, often the largest MA providers in the area. (slide 9)

Involved every day with those that are on clinical trials. Currently doing one on advanced stages on lung cancer (stage 4). Today with new medicines and protocols, these pt's are seeing their tumors shrink and a slow down of the spread of Cancer in their bodies.

Leaders in defining best care practices and lead the way in care management. Weed out duplication and inefficiency in current care models.

We need to support the cost of educating new generations of healthcare professionals. Need to restore the Graduate Medical Education funds cut almost 4 years ago.

It is critically important to remember the cost of training our new medical professionals. If we want to make sure we have access to healthcare, we can't forget this.

Role of Academic health Centers in Creating Sustainable Reform:

What do we do that reforms the system but also sustains it over time?

Consideration is Creating Sustainable reform: Health care value, growth in uninsured population, aging population.

Creating Enduring Reform: define our goals, support the knowledge pipeline, and close the gap between "what we know" and "what we do"

Translation: takes 17 years by the time a drug has been introduced and it gets to the pubic.

Variation: there is tremendous variation in care. Different providers treat the same problems in different ways. We have cracks in our system that pt's fall through. Electronic records could help with this.

Health Care as a commodity: lack of incentives to provide individual or population services that promote prevention and health maintenance. People do more if paid more.

Q & A:

AD: We want to talk to you in the future.

CR: Ask as homework: Think globally act globally…what are your barriers to collaboration? What do you need from us to do exactly what you want to do? Our goals are to turn this system inside out…to be proactive…need incentives. What do we need to do to align goals and incentives? Please address billing.

Erp: 20,000 people who have a stroke, you are dealing with a group of people, but are you not treating each individual differently because we are all different?

Response: There is customized care. A general way to treat an illness and then customize it to each individual if needed. We are working to combine medical with public health i.e. know how to treat but also teach good public health ex. The cold, know how to treat but also should treat good hand washing skills.

Medicaid Reform Task Force:

$30 for MA pt's vs. $80 for commercial insurance for reimbursement.

How do we provide access without going broke?

Personal Medical home: focal point through which all individuals participate in health care, promoting continuity with a MD/ clinic. Pt's receive acute, chronic and preventative medical care services that are accessible, comprehensive, integrated, and timely.

Implications: Better, cheaper care, access to primary care must be more open for MA pt's, and pt's need to learn to use the ER appropriately.

Incentivize use of the medical home: increase reimbursement, capitation fee for case management. For Pt's assured access to primary care, increased co-pays for inappropriately use ER or specialists.

Drug Program: Improved formulary put the free market to work: use competitive bidding to lower prices, and increase co-pays for non-allowed drugs.

There is a disproportionate share of payments to clinics.

Advance directives: we think all pt's should have this, MA pt's included. This reduces futile care at the end of life and it is especially important for elderly and disabled enrollees.

Q & A:

CR: Incentives to getting the POA done? Please think about that.

Steve Wilhide (background in SW):

North Carolina believes that all health care is local. Community Care of N. Carolina is their reform plan.
Care Coordination is a critical element. Fall through the cracks without coordinated care.

Also need pt education.

Case managers coordinate care and identify risky pt's. Identifies pt problems, goals, diagnosis, and interventions.

$2.50 per member per month as a cost to this program.

Participating MD's must follow clinical guidelines. Must provide 24 hour 7 days a week of availability.

Believe that MA pt's get better care with this program.

Health Care 2006: Can we Afford it?

2006-07: Average increase in rate of insurance increase cost will go from $16,000 per family to over $37,000 in the next 6 years.

Are we twice as healthy today as we were in the past despite the fact that health insurance is twice as expensive? No

Health Care is paid through a third party system (private insurance, Medicare, MA). Self pay is the exception.

Problems of a 3rd party payment system: lack of transparency for both the doctor and the pt. No competition, no incentive for providers, current system encourages spending, private insurers negotiate exclusive deals.

www.wipricepoint.org

Why does medical care cost so much?: Many reasons. Health Care is being treated as a commodity. Service industry driven by making money. See a difference in my office from 20 years ago to today. We need help with taking care of people with mental illnesses but do we see these clinics popping up anywhere? No, because they don't make any money.

What has the most impact on the way you practice medicine? Litigation fear, drug reps (largely), insurance companies, gov't regulations, financial gain, the best interests of the pt, cost of healthcare, and pt's demands.

Cost factors: advertising, Rx drug use, technology, end of life care, and under utilization of hospice care. Hospice care, we can treat you with dignity but we can't cure you.

POA's are a challenge in getting them done but we need them.

Why is primary care unavailable: P.C. MD's are undervalued (billing system of Medicare), and current payment systems encourage doing procedures.

Physician salaries after three years. Family practice and psychiatry at the lowest and cardiology, radiology, and orthopedic surgery and the highest.

Recommendations: paying for over the counter meds. Guidelines are being set up for meds and they are not being followed. Canadian drugs are cheaper so why are they illegal?

Crisis in the ER:

Many challenges facing our constituents especially in Emergency care. ER's are required to see everyone who comes through the door despite ability to pay or insurance.

We fill the role of an essential service for people. We have private sources, other funding or no funding at all.

Doctor Croft spent hours on the phone trying to find a specialist to treat a pt in the ER. Because of her delay, she developed an infection and that had to be treated before the specialist could treat.

Recommendation 1: Setting MA rates and the Medicare level for EMTALA services.

Recommendation 2: Information Management. This involves data about current and previous care received by the pt as well as the ability to quickly find MD's for follow-up care.

CR: How do we encourage them to seek treatment when they need it?

Response: they need a primary care home. We should steer them towards appropriate care. But haven't found cost effective way to do this.

CR: If we had a Case Manager, would that be the assistance that would help you?

Response: Yes

HIRSP:

Transition was successful from DHFS. WPS contract is good. 4 FTE's will be working at HIRSP.

Governed by a 13 member board.

Cost effectiveness of HIRSP. This is critical for the continued success of this program.

Collections: those who have not paid were referred to a collection agency.
Mail order Pharmacy: Navitus is the pharmacy benefit manager for HIRSP. Mail order generally lowers the cost of drugs. Savings are around 3%.
Market Comparison: WPS comparing HIRSP vs. standard WPS individual insurance policy.
Disease Management: the current services are a good value to HIRSP.

Two other priorities are: assessment of historical utilization of Mental health and AODA uses. Second is the development of a plan that would meet the federal definition of a health care tax credit plan (this is long range).

Chronic Disease Management:

Current system is fee-for-service. This is regardless of the service value.

Institute of Medicine Report: Current system cannot do the job.

Primary Prevention: Avoiding the Disease. Secondary Prevention: Early Detection. Tertiary Prevention: Chronic Disease.

CR: Gundersen Clinic was concerned about this, our ability to talk to one another, the proprietor model. What should we do?

Response: Any policy to encourage technology and the ability to talk amongst one another would be helpful. Will take awhile for Federal standards to come about.

Diabet3es is reaching epidemic proportions. There are services that are not covered such as protective footwear and nutrition education.

The challenge is: value equals quality over cost. There will be a need to measure quality to prove it is high while working to continually improve quality and work to control costs to maximize value in the marketplace.

Q & A:

Book suggested, Crossing the Quality Chasm

Specialized Medical Transportation/ brokering:

Ron Hermes and Eileen McRae

SMV transportation services $42 million annually on this. Paid for by tribal or county agencies. Covered also by publicly funded programs.

Federal government has attempted to encourage better coordination of the carious transportation program in order to eliminate duplication and improve access.

Governor's 2005-07 budget included a proposal to establish a transportation management system with an expected savings of close to $7 million.

This was eliminated by finance.

In veto message, were still required to find the savings without the brokering system. DHFS proceeded in a voluntary brokering system. The broker would have been selected through a competitive process.

DHFS did not get the mandate so had to ask counties to volunteer to participate. Several counties did not respond and only 27 indicated willingness to give up this responsibility.

DHFS still believes that this is the right idea and will streamline the process and save money. Without the appropriate mandate, this brokering system will not work.

Q & A:

CR: Unless we hear positive from our counties, we will not support. You should continue on with discussions to gain support. Incentive is best and a penalty if you don't.

RH: There was some misunderstanding among providers and counties. I think there will be greater support for this proposal should it surface again.

LO: I don't think 27 counties volunteering is minimal. 1/3 of the state is large.

RH: These counties were not contiguous together. Without counties joining together, it is hard to run a brokering system with holes in between.