MA Drafting Requests

Request #1

-1911

Direct the Department of Health and Family Services to require a physical health risk assessment upon enrollment in Medicaid and BadgerCare to identify health risks. Also require DHFS to develop aggressive disease management programs ~~to address those conditions~~, using the protocols established under the Marshfield Clinic Demonstration Project.

performance

Dr. Bob Phillips 715-387-5134 (direct no. 387-5853)

I know you can't include, "using protocols established under the Marshfield Clinic Demonstration Project" in the draft. I am not sure of the best way to reference those protocols. If you have thoughts about this, possibly we can link up with someone from Marshfield Clinic.

Request #2

-1912

Direct DHFS to apply for a federal waiver or state plan amendment (whichever would be necessary) for development of a pilot program for Medicaid that does the following:

- Offers as an option a Health Savings Account high deductible plan.
- Creates monetary incentives for participation in wellness programs.
- Provides bonus payments to providers who demonstrate health outcomes.
- Provides a health risk assessment (physical exam) upon enrollment in MA and BadgerCare to identify health risks and develop disease management programs to address those conditions, using the protocols of the Marshfield Clinic demonstration project.

Dr. Ted Paxel

→ Note that this duplicate part 3 -1911

Request #3

-1913

Direct DHFS to pursue a federal waiver or state plan amendment (whichever is necessary) for development of a Medicaid pilot program, patterned

SECTION 3
DEMONSTRATION PARTICIPATION AND STRATEGY

3.1 Reason(s) for Participation

Marshfield Clinic is interested in the use of medical informatics to improve care management and population health. The Clinic's strategy is to standardize best practices, apply best practice models of cost-effective high quality care to all its patient populations and to generate a paradigm shift to disease prevention. The Clinic's prior experience with its Security Health Plan HMO has helped foster this perspective. The PGP demonstration fits very well with these goals. Additionally, the PGP demonstration aligns incentives for Marshfield Clinic and allows for the reimbursement of previously non-reimbursed initiatives that reduce Medicare costs (e.g., anticoagulation program). The Clinic also thought that participating in the demonstration would buttress its reputation for being on the leading edge of medical care innovation, and maintain its long history of public health service.

Marshfield Clinic also recognized that the share of Medicare beneficiaries in its service area was growing. Medicare payments are a big discount on charges. With Medicare accounting for 20 percent of its revenue stream it was clear to Marshfield Clinic that they needed to "wring costs out" of Medicare so that discounts were not shifted to private payers. Keeping costs under control and cutting edge services affordable to its patient population is of particular importance to Marshfield Clinic. It is viewed as "not inexpensive" in its service area, so cost reduction is a priority.

The PGP demonstration is one of the most significant projects currently being undertaken by Marshfield Clinic. Although it has been projected that Marshfield Clinic will break even financially under the demonstration, a considerable amount of uncertainty persists and participation remains an "article of faith." Marshfield Clinic does not expect any savings due to improvements in quality measures under the PGP demonstration. This is mainly due to the short time-frame of the demonstration.

Although the Clinic ultimately decided to participate in the demonstration, decisions made in the pre-demonstration period establishing the 2 percent threshold for earning a bonus and the 5 percent cap on bonuses almost derailed the demonstration at Marshfield Clinic.

3.2 Demonstration Strategy

To accomplish the goals of the PGP demonstration Marshfield Clinic has developed and followed the following basic strategies. First, Marshfield Clinic has used informatics to improve the delivery of healthcare by introducing patient dashboards that summarize a patient's health status and provide prevention reminders (e.g., vaccinations, cancer screenings). Second, Marshfield Clinic has begun educating providers on process improvement by introducing the Process Improvement (PI) Charter and by developing Best Practice Models (BPMs). The BPMs are used to level the playing field for providers, they are developed to fill any gaps and they provide specifications on how to manage clinical practice. Third, Marshfield Clinic has improved and expanded care management programs for Medicare FFS beneficiaries. Care management programs assist in the standardization of best practices, patient education, expert systems (e.g.,

provider support and education, decision support, consult service agreements) and information (e.g., reminders, process and control measures, reporting, care audits and care planning). Care management is possible through nurse telephone lines, BPMs, case management and the development of automated systems. Marshfield Clinic is also focused on aligning incentives and providing value. Provider compensation under the Clinic's existing, traditional system is based on relative value units and the market. This type of system is aligned with FFS. Marshfield Clinic is discussing introducing three domains that would help establish a new system aligned with value: (1) clinical quality, (2) practice management and (3) cost-of-care. Finally, Marshfield Clinic believes that success under the PGP demonstration will involve an organizational transformation that will require the support of the Marshfield Clinic leadership and staff.

Marshfield Clinic's main efficiency focus for the PGP demonstration is on chronic conditions that provide the greatest potential for cost savings due to reduced hospital admissions. The two patient care interventions that occurred specifically in response to the demonstration were the telephonic heart failure program and the development and implementation of BPMs, or Best Practice Models. The Clinic is actively working to reduce congestive heart failure hospital admissions and hypertension complications. Also, the Clinic is working with local hospitals to increase the use of observation status versus hospital admission where clinically appropriate. In other areas, Marshfield Clinic views the PGP demonstration as a catalyst for interventions that the clinic would have otherwise provided. The demonstration caused some Marshfield Clinic projects to be reprioritized, accelerated, or expanded, but did not result in any entirely new interventions other than the heart failure program and Best Practice models.

The Clinic has prioritized improving quality measures that would provide the greatest enhancement in patient care.

3.3 Relationship to Group Practice Strategy

The overall plan at Marshfield is to implement evidence-based medicine. In doing so, the Clinic hopes to acquire real-time data. Marshfield's leaders also see the benefit of automating their care processes. If the PGP demonstration pays dividend, then they may be able to convince others payers (e.g., commercial) that quality improvement initiatives should be pursued. Moreover, Marshfield Clinic plans to use knowledge gained from its Health Plan experience for the PGP demonstration. Simultaneously, PGP demonstration interventions are being applied to commercial populations. In fact, a number of personnel repeated that Marshfield Clinic does not manage care differently for the different payor populations. Thus, spillovers from the demonstration and care processes for other populations occur both ways.

3.4 Leadership and Implementation Team

Marshfield Clinic's senior leadership team is involved in and supportive of the PGP demonstration as it is one of the four key priority projects for the Clinic. The demonstration is being run out of the Clinic's Quality Improvement and Care Management Department. The Clinic's Project Directors are the Medical Director and Administrator of this department. Regional Medical Directors are devoting 20 percent of their time to the demonstration. Three Clinical Nurse Specialists have been assigned to the demonstration, comprising two new full-time-equivalent (FTE) positions. The Division Medical Directors are responsible for the

operationalization of the demonstration in each of the Clinic's Divisions. Financially, a new 'costing center' has been set up to account for costs incurred through the PGP demonstration.

3.5 Implementation and Operational Challenges

Marshfield Clinic staff who were interviewed cited certain downsides to participating in the PGP demonstration. First, the demonstration is a lot of work, including the need to take responsibility for reducing avoidable Medicare Part A costs, and it competes with other projects for organizational resources. Second, the demonstration must be launched in a short period of time, and it is uncertain if it will last long enough to determine if it is successful. Third, the PGP demonstration requires a substantial upfront investment with no immediate or guaranteed return. There is no upfront money from CMS to assist in developing infrastructure. The Clinic is concerned about what will follow the 2-year demonstration period. If the demonstration is not extended the Clinic will have to dismantle programs and eliminate staff.

The fact that Marshfield Clinic is a freestanding group practice has created some challenges in developing inpatient-oriented patient care interventions. The Clinic reports that hospitals have no motivation to help it with care management of the beneficiaries assigned to it under the demonstration. Marshfield has had difficulty in identifying hospitalized patients in real time, gaining access to inpatient financial data, and in developing interventions such as end of life care, discharge instructions, and discharge medication review. The Clinic is in the process of exploring how the transition period between hospitalization and home could be bridged for their high risk beneficiaries. Initially there were HIPAA concerns. With the help of its Legal Department, the Clinic was able to resolve those concerns.

Marshfield has not met with local hospitals to discuss the demonstration per se, but they are aware of it through Marshfield's publicity releases and general administrative communication. Local hospitals are aware that the Clinic is trying to reduce Medicare admissions under the demonstration and they are concerned about loss of business. None of the hospitals that Marshfield providers admit to are supportive of reducing admissions under the demonstration in order to free up beds for other uses. There is not a hospital bed shortage in Marshfield's service area. A new hospital has opened during the time the demonstration project has been occurring. In fact, hospital census is down in the Clinic's service area.

BY 3/12 (MONDAY), please

State of Wisconsin
2007 - 2008 LEGISLATURE

LRB-1911/P1
DAK:...:...
lmk

D-NOTE

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

LRS: PLS fix request sheet

GenCat

AN ACT ...; **relating to:** requiring a disease management program and health risk assessments. ✓

Analysis by the Legislative Reference Bureau

This bill draft is in preliminary form. An analysis will be provided on a subsequent version. ✓

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 49.45 (55) of the statutes is created to read:

49.45 **(55)** DISEASE MANAGEMENT PROGRAM. The department shall develop and implement, for medical assistance recipients, disease management programs that are similar to that developed and followed by the Marshfield Clinic in this state under the physician group practice demonstration program authorized under 42 USC 1315 (e) and (f). These programs shall have at least the following characteristics:

(1) The use of information science to improve health care delivery by summarizing a patient's health status and providing reminders for preventive measures.

(2) Educating health care providers on health care process improvement by developing best practice models.

(3) The improvement and expansion of care management programs to assist in standardization of best practices, patient education, support systems, and information gathering.

(4) Establishment of a system of provider compensation that is aligned with clinical quality, practice management, and cost of care.

(5) Focus on patient care interventions for certain chronic conditions, to reduce hospital admissions.

SECTION 2. 49.45 (56) of the statutes is created to read:

49.45 **(56)** PHYSICAL HEALTH RISK ASSESSMENT. For each individual who is determined to be eligible for medical assistance, the department shall cause to be performed a physical health risk assessment.

SECTION 3. 49.665 (4g) of the statutes is created to read:

49.665 **(4g)** DISEASE MANAGEMENT PROGRAM. The department shall develop and implement, for individuals who are eligible under sub. (4), disease management programs that are similar to that developed and followed by the Marshfield Clinic in this state under the physician group practice demonstration program authorized under 42 USC 1315 (e) and (f). These programs shall have at least the following characteristics:

(a) **(1)** The use of information science to improve health care delivery by summarizing a patient's health status and providing reminders for preventive measures.

(b) **(2)** Educating health care providers on health care process improvement by developing best practice models.

(c) **(3)** The improvement and expansion of care management programs to assist in standardization of best practices, patient education, support systems, and information gathering.

(d) **(4)** Establishment of a system of provider compensation that is aligned with clinical quality, practice management, and cost of care.

(e) **(5)** Focus on patient care interventions for certain chronic conditions, to reduce hospital admissions.

SECTION 4. 49.665 (4m) of the statutes is created to read:

49.665 **(4m)** HEALTH RISK ASSESSMENT REQUIRED. For each individual who is determined to be eligible under sub. (4), the department shall cause to be performed a physical health risk assessment.

(END)

D-NOTE

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-1911/1dn P1
DAK:...:...
lmk

(date)

requirements under 55.49.45(5s) and 49.665(4g)

to

To Senator Roessler:

This bill is in preliminary form, because the following several issues arose in drafting:

1. I used as the model for creating the disease management program language from the Marshfield Clinic Physician Group Practice Demonstration Site Visit Final Report, Section 3.2 Demonstration Strategy (July 2006) that was provided me by Dr. Robert Phillips. Please check carefully to see if this language conforms to your intent.

2. By what date would you want DHFS to be required to develop and implement the disease management program?

3. Do you want health risk assessments to be performed for all current Medical Assistance and Badger Care recipients or those that are determined eligible after a certain date? If the latter, what would the date be? Do you want language about how the assessments should be used (and by whom) after they are performed?

Please let me know if I can further assist you with this bill draft.

Debora A. Kennedy
Managing Attorney
Phone: (608) 266-0137
E-mail: debora.kennedy@legis.wisconsin.gov

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-1911/P1dn
DAK:lmk:rs

March 8, 2007

To Senator Roessler:

This bill is in preliminary form, because the following issues arose in drafting:

1. I used as the model for creating the disease management program requirements under ss. 49.45 (55) and 49.665 (4g) language from the Marshfield Clinic Physician Group Practice Demonstration Site Visit Final Report, Section 3.2 Demonstration Strategy (July 2006) that was provided to me by Dr. Robert Phillips. Please check carefully to see if this language conforms to your intent.

2. By what date would you want DHFS to be required to develop and implement the disease management program?

3. Do you want health risk assessments to be performed for all current Medical Assistance and Badger Care recipients or those that are determined eligible after a certain date? If the latter, what would the date be? Do you want language about how the assessments should be used (and by whom) after they are performed?

Please let me know if I can further assist you with this bill draft.

Debora A. Kennedy
Managing Attorney
Phone: (608) 266-0137
E-mail: debora.kennedy@legis.wisconsin.gov

Kennedy, Debora

From: Stegall, Jennifer
Sent: Wednesday, March 21, 2007 2:23 PM
To: Kennedy, Debora
Cc: Volz, David
Subject: LRB 1911

Attachments: Stegall, Jennifer.vcf

Hi Debora,

I have another one for you...LRB 1911 regarding health risk assessments and disease management.

The draft should link the HRA's and the disease management protocols together. The HRA's should be used to identify health risks and disease management programs should be developed to address those identified health conditions.

Carol would like the HRA's to be performed for all current MA and Badger Care participants. The DHFS should be required to develop and implement the disease management program 6 mos. after passage of the bill.

Let me know if you need more information from me regarding changes to the draft.

Thanks!

Jennifer Stegall
Office of Senator Carol Roessler
608-266-5300/1-888-736-8720
Jennifer.Stegall@legis.state.wi.us

Stegall,
Jennifer.vcf (4 KB)

SOON - 2n edit 3/22

State of Wisconsin
2007 - 2008 LEGISLATURE

LRB-1911/P1 1
DAK:lmk:rs
STAYS

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

RECEIVED √t

AN ACT *to create* 49.45 (55), 49.45 (56), 49.665 (4g) and 49.665 (4m) of the statutes; **relating to:** requiring a disease management program and health risk assessments.

Analysis by the Legislative Reference Bureau

This bill draft is in preliminary form. An analysis will be provided on a subsequent version.

INSERT A

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 49.45 (55) of the statutes is created to read:

49.45 **(55)** DISEASE MANAGEMENT PROGRAM. The department shall develop and implement, for Medical Assistance recipients, disease management programs that are similar to that developed and followed by the Marshfield Clinic in this state under the Physician Group Practice Demonstration Program authorized under 42 USC 1315 (e) and (f). These programs shall have at least the following characteristics:

Based on the health conditions identified by the physical health risk assessments required to be performed under sub. (56)^3

(a) The use of information science to improve health care delivery by summarizing a patient's health status and providing reminders for preventive measures.

(b) Educating health care providers on health care process improvement by developing best practice models.

(c) The improvement and expansion of care management programs to assist in standardization of best practices, patient education, support systems, and information gathering.

(d) Establishment of a system of provider compensation that is aligned with clinical quality, practice management, and cost of care.

(e) Focus on patient care interventions for certain chronic conditions, to reduce hospital admissions.

SECTION 2. 49.45 (56) of the statutes is created to read:

49.45 **(56)** PHYSICAL HEALTH RISK ASSESSMENT. For each individual who is determined to be eligible for Medical Assistance, the department shall cause to be performed a physical health risk assessment.

SECTION 3. 49.665 (4g) of the statutes is created to read:

49.665 **(4g)** DISEASE MANAGEMENT PROGRAM. The department shall develop and implement, for individuals who are eligible under sub. (4), disease management programs that are similar to that developed and followed by the Marshfield Clinic in this state under the Physician Group Practice Demonstration Program authorized under 42 USC 1315 (e) and (f). These programs shall have at least the following characteristics:

Based on the health conditions identified by the physical health risk assessments required to be performed under sub. (4m)?

(a) The use of information science to improve health care delivery by summarizing a patient's health status and providing reminders for preventive measures.

(b) Educating health care providers on health care process improvement by developing best practice models.

(c) The improvement and expansion of care management programs to assist in standardization of best practices, patient education, support systems, and information gathering.

(d) Establishment of a system of provider compensation that is aligned with clinical quality, practice management, and cost of care.

(e) Focus on patient care interventions for certain chronic conditions, to reduce hospital admissions.

SECTION 4. 49.665 (4m) of the statutes is created to read:

49.665 **(4m)** HEALTH RISK ASSESSMENT REQUIRED. For each individual who is determined to be eligible under sub. (4), the department shall cause to be performed a physical health risk assessment.

(END)

INSERT 3-16

INSERT A

Currently, the Department of Health and Family Services (DHFS) administers the Medical Assistance (MA) program and the Badger Care health care program, which provide health care benefits for eligible individuals (generally, pregnant women, certain children, and elderly or disabled individuals, all of whom must meet specific low-income or low asset requirements). Families, children who do not reside with their parents, and unborn children whose mothers are not eligible for MA or Badger Care may be eligible for Badger Care if their incomes do not exceed 185 percent of the federal poverty line and they meet certain nonfinancial criteria.

This bill requires that a physical health risk assessment be performed for every individual who is eligible for MA or for Badger Care. Based on the health conditions identified by the health risk assessments, DHFS must develop and implement, for MA and Badger Care recipients, disease management programs. These programs must use information science to improve health care delivery; educate health care providers on health care process improvement by developing best practice models; improve and expand care management programs; establish a system of provider compensation that is aligned with clinical quality, practice management, and care cost; and focus on patient care interventions for certain chronic conditions.

INSERT 3-16

SECTION #. Effective dates. This act takes effect on the day after publication, except as follows:

(1) DISEASE MANAGEMENT PROGRAMS. The treatment of sections 49.45 (55) and 49.665 (4) of the statutes takes effect on the first day of the 7th month beginning after publication.

Duerst, Christina

From: Stegall, Jennifer
Sent: Thursday, March 29, 2007 2:46 PM
To: LRB.Legal
Subject: Draft Review: LRB 07-1911/1 Topic: Require DHFS to require physical health risk assessments for MA and BadgerCare enrollees and develop disease management programs

Please Jacket LRB 07-1911/1 for the SENATE.