CHCS
Center for
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Disease Management as a Vehicle for Getting Value in Medicaid

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Health Care System Pressures

- Roughly 50% of Americans not receiving evidence-based care (Quality Chasm)
- Increasing complexity and prevalence of co-morbidities and disabilities
- Primary care and behavioral management increasingly complex
- Most consumers receiving inadequate support for self-management and health promotion
- Crowd-out/"crowd-in"
- Policymakers and purchasers tend to resort to short-term, budget driven actions

Medicaid: Chaos or Opportunity?

- Big Numbers
  - 52 M
  - $320 B
- Key Challenges
  - Disproportionate racial and ethnic participation
  - 80/20
- Increasingly Sophisticated Players
  - State Purchasers
  - Managed Care Entities (MCOs, EPCCM)

Opportunity, IF…

- Manage Care vs. Manage Costs
  - Opportunity Costs of Poor Policy Decisions
- Make the Case for Quality
  - Business Case
  - Economic Case
  - Social Case
- Front-end Investments = Long Term Gain

Importance of Long Term Solutions

- 80 percent of Medicaid resources are spent on people with chronic conditions.
- 39 percent of Medicaid enrollees have one or more chronic conditions.
- Eleven million non-institutionalized Americans with chronic conditions have only Medicaid coverage.

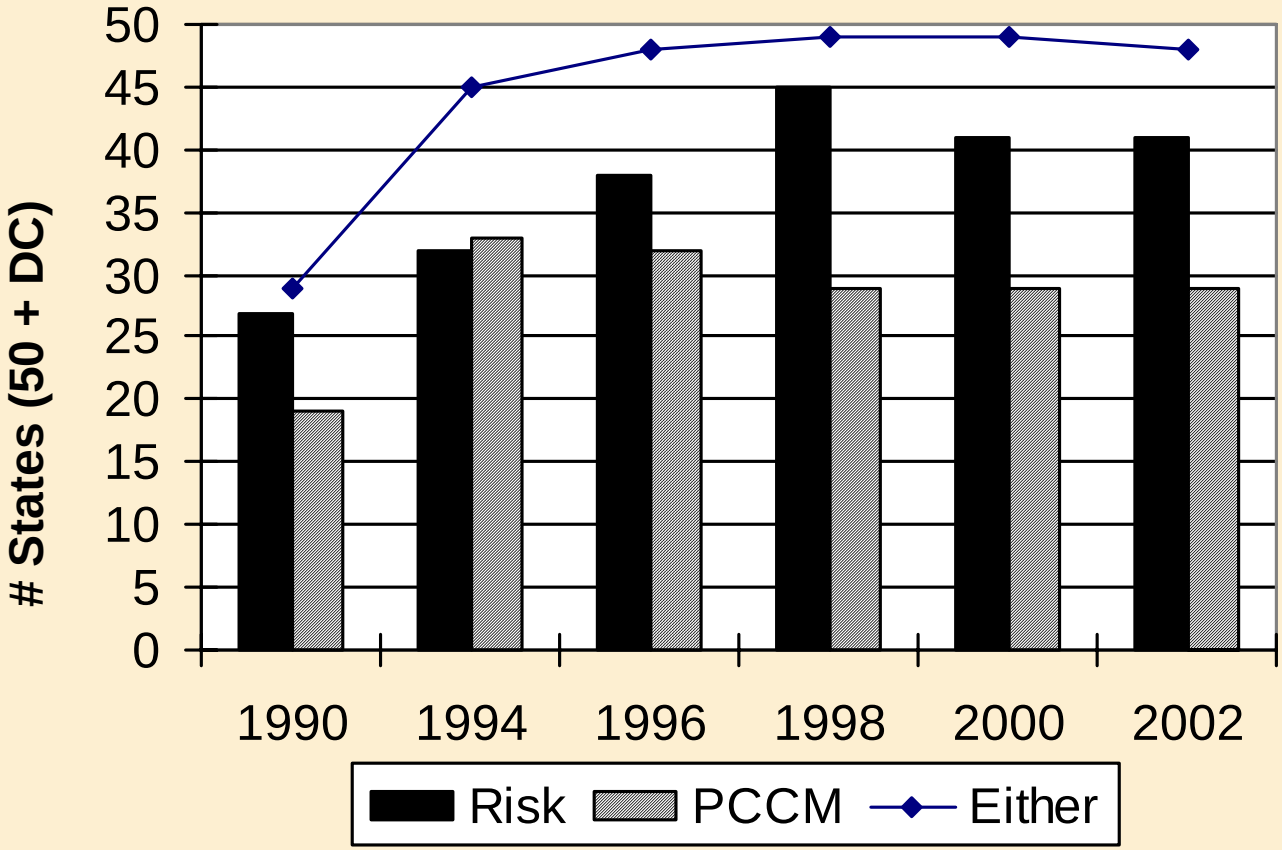
Source: http://www.partnershipforsolutions.com/dms/files/chronicbook2002.pdf

Managing Care in Medicaid

- Goals of Care Management:
  - Create medical home and coordinate care
  - Improve health outcomes
  - Control costs
- States use a variety of care models:
  - Primary Care Case Management (PCCM)
  - Enhanced Primary Care Case Management (EPCCM)
  - Risk-Based Managed Care (RBMC)
  - Disease/Care Management (DM)
  - Medicaid-Medicare Demos (Medi-Medi)

Care Management Trends: Moving Away from FFS

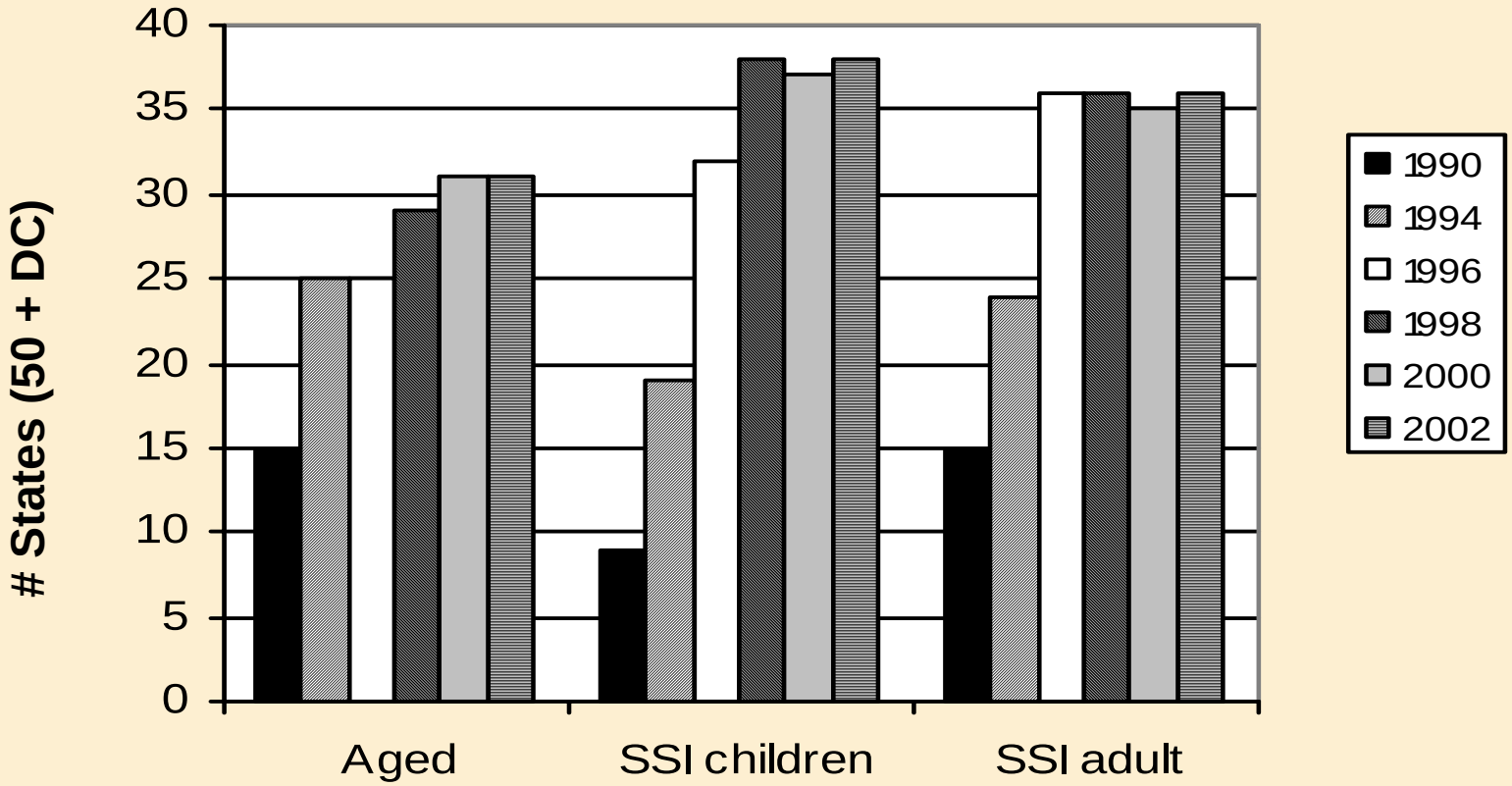
All but three states enroll their members into RBMC, PCCM, or both.*



*Trend data adapted from: Kaye, Neva . "Medicaid Managed Care Looking Forward Looking Back." 2005. National Academy for State Health Policy . 08 Jul. 2005 <NASHP.org>.

Care Management Trends: Moving Into More Complex Populations

Since 1994 over half of all states have enrolled some people with complex needs into a care management model.



*Trend data adapted from: Kaye, Neva . "Medicaid Managed Care Looking Forward Looking Back." 2005. National Academy for State Health Policy . 08 Jul. 2005 <NASHP.org>.

Care Management Trends: Moving Into More Complex Populations

Among states with managed care programs, the survey found:

- 65 percent enrolled at least some aged beneficiaries;
- 79 percent enrolled at least some SSI children; and
- 75 percent enrolled at least some SSI adults.
- Members of these groups were enrolled into both RBMC and PCCM programs.

*Trend data adapted from: Kaye, Neva . "Medicaid Managed Care Looking Forward Looking Back." 2005. National Academy for State Health Policy . 08 Jul. 2005 <NASHP.org>.

Care Management Trends: Disease/Care Management

- Over 30 states have a FFS/PCCM DM program*
- Some states contract with a commercial vendor (Florida, Washington, Mississippi)
- Some states make or assemble a program "in house" (North Carolina, Indiana)
- Considerable innovation in CM/DM is occurring in the safety net system (FQHCs, safety net hospitals)
- Single disease focused programs recognize the need to evolve to address the significant co-morbidities of Medicaid consumers

*"Disease Management in Medicaid." 2004. California Healthcare Foundation . 08 Jul. 2005 <CHCF.org>.

State Options: Make, Buy, Assemble

- Make / Assemble
  - Develop "in house", typically as part of Primary Care Case Management (PCCM) program
  - Majority use the Chronic Care Model framework
  - Examples: North Carolina, Vermont, Indiana
- Buy
  - Outsource to commercial vendor
  - According to LifeMasters Supported SelfCare, 11 states have outsourced and several more are releasing RFPs
  - Examples: Washington, Oregon, Mississippi

Other Models

- Pharmaceutical funded (Colorado, Florida, Arkansas)
- Pharmacy based (Missouri, Texas)
- Managed care organization based (multiple states)

Highlights of Best Practices

- Washington
- North Carolina
- Indiana

Washington: Program Summary

- In 2001 session, Washington's Legislature directed DSHS to implement Disease Management (DM), in order to improve outcomes and save between 5% and10% of medical expenses in current fiscal cycle
- Target Population:
  - Fee-For-Service: SSI (aged, blind or disabled) clients, not on Medicare
  - About 125,000 clients can use the Nurse Advice Line
  - Estimated 30,000 are eligible for DM because of diagnosis; 17,000 clients actively participate
- Chronic Conditions: Asthma, Diabetes, HF, COPD, ESRD, CKD
- Statewide Implementation
- Two contractors: McKesson Health Solutions and Renaissance Health Care

WA: Results of Independent Evaluations

- First Year Study by University of Washington found:
  - Significant increase in asthma action plans
  - Significant increase in eye exams and HgA1c test for diabetics
  - Increase in ER utilization for three conditions
  - Drop in high-risk asthma length-of-stay in hospital compared to controls
  - Lower hospital and ER use by ESRD clients
- Milliman USA found that, compared to baseline expenses:
  - ESRD saved $300,000 in first year, $400,000 in second year in excess of fees paid for DM services. Exceeded the contractual guarantee.
  - Asthma, CHF, and Diabetes lost money in the first year, saved $560,000 in second program year in excess of fees paid for DM services. Did not meet the contractual guarantee.

WA: Client Self-Reported Outcomes

- Asthma clients' use of daily controller medications – improved by 15%
- Annual diabetic screening exams (hgbA1c, lipid panel, foot exams) – improved by 12%
- Heart Failure clients' use of daily weight scale - improved by 30%
- AV fistula rate for ESRD – improved by 15%
  - Medicaid performs above national standard rates for ESRD
  - Medicaid ESRD standard rates are in line with the best records in commercial coverage
- Annual flu vaccine (all conditions) – improved by 17%

North Carolina: Program Summary

- Target Population: TANF, MIC, Aged, Blind, Disabled
- Chronic Conditions: Asthma, Diabetes, CHF (2006)
- Statewide Implementation via Community Networks
  - Local Network QI Infrastructure: Local Medical Director, dedicated case managers, physician buy-in, practice level system change
  - State CCNC QI Infrastructure: Clinical staff for technical assistance, QI performance reports, claims data reports, annual chart audit reviews
- Responsibilities of Networks Include:
  - Managing Medicaid members' care
  - Developing quality improvement initiatives
  - Implementing cost containment initiatives
  - Creating systems to improve care

NC: Results of Independent Evaluation

- Cecil G. Sheps Center for Health Services Research Findings (April 2004):
  - Both CCNC Asthma & Diabetes Interventions resulted in reduced ED visits and inpatient hospital admissions
  - Cost savings for diabetes care for 3 year period approximately $2.1 million
  - Cost savings for asthma for calendar year 2002 approximately $1.58 million
- Chart audit results show improvement in diabetes and asthma process measures

Indiana: Program Summary

- Target Population: Aged, Blind, Disabled Adults (including dual eligibles); Children with Asthma
- Chronic Conditions: Diabetes, Congestive Heart Failure, Asthma, Chronic Kidney Disease
- Statewide Implementation
- State-Assembled Program Components:
  - Chronic Care Provider Collaboratives: 4 Regional
  - Evidence Based Guidelines: Statewide Dissemination
  - Patient Self Management
  - Nurse Care Managers
  - Centralized Call Center
  - Electronic Patient Data Registry
  - Measurement & Evaluation: RCT & Time-Series Evaluation

IN: Results of Preliminary Independent Evaluation

- Regenstrief Institute conducting two prong evaluation:
  - Randomized Controlled Trial (RCT) – Central Indiana
  - Time-series Evaluation – Statewide
- Preliminary Evaluation Findings*
  - RCT
    - CHF: $720 PMPM net cost savings
    - Diabetes: $41 PMPM net cost increase (increased costs in high-risk, decreased costs in low-risk)
    - Overall ROI: $29 M estimated net savings annually
  - Time series
    - There may be a slowing in the rate of growth of expenditures with the advent of the program

*Presented by Regenstrief Institute 9/28/05. Prepublication findings – please do not cite, distribute, quote.

IN: Clinical Outcomes Early Data

- CHF patients are experiencing fewer and shorter hospitalizations
- Hemoglobin A1C blood test reflects average blood sugar control for the past few months
- Medical record data captured by nurse care managers showed HbA1C decreased about 0.3 percentage points
  - Clinically significant: compares to 0.25 in intensive interventional studies of lifestyle change
- Electronic clinical record data from RCT, while still substantially incomplete, showed:
  - 2%-6% more likely to have A1C<7 (excellent control)
  - 0%-5% less likely to have A1C>9 (terrible control)

*Presented by Regenstrief Institute 9/28/05. Prepublication findings – please do not cite, distribute, quote.

Happenings In Other States

- Mississippi: Reports cumulative net savings of $19.2 M after first two years of operation*
- Oregon: Reports avoided costs of $6 M after first year of operation*
- Florida: Reports improved patient self management (e.g. reduction in smoking, improvements in dietary compliance) and clinical process measures (e.g. % on ACE Inhibitors/ARBs, LDL and HbA1c testing)**
- Vermont: Investing $100 M in HIT over 5 years
- Massachusetts: Contracting for health coaches/buddies
- Missouri: Pairing primary care providers and pharmacists

*Contracting with McKesson Health Solutions
**Contracting with LifeMasters Supported SelfCare

Sampling of Other DM/Quality Improvement Investments

- Behavioral Health Integration: CareSouth Community Health Center
- Care Team Redesign: Commonwealth Care Alliance, Cambridge Health Alliance
- Health Coaches: Partners Healthcare System
- Consumer Direction: Whatcom County (www.sharedcareplan.org)
- HIT: Health plans (e.g. Sentara) and provider practices (e.g. Greenhouse Internists, 4 physician Medicaid practice)
- Remote Monitoring: John Hopkins HealthCare
- Financial Incentives: CareOregon, Partnership Health Plan

Back Where We Started: Turning Challenges into Opportunities

- Managing Co-morbidities
- Consumer Self Direction
- Special Needs Plans (SNPs)
- Medicare Chronic Care Demonstrations
- State and Federal Reform Efforts
- "Scoreable" Savings

Score-ability and the Long-term Business Case

- OMB/CBO methods for scoring need to be changed. For example…maintaining electronic medical records, "would save the Feds billions and save lives as well"… however federal scorers only count the costs of launching the technologies and not the amount that would be saved over time.

Newt Gingrich and Peter Ferrara
Wall Street Journal
September 26, 2005

How Do We Get There… Medicaid Quality Building Blocks

The next step is to get more states (and those considering reform at the federal level) to focus on the Building Blocks for Quality

1. Evidence-Based Practices
2. Measures/Outcomes
3. Information Technology
4. Continuous Quality Improvement
5. Pay for Performance
6. Care Management
7. Integrated Care
8. Consumer Direction

Medicaid Quality Solutions

BUILDING BLOCK	EXAMPLE
1. Evidence-Based Practice	New York State is implementing standardized asthma guidelines. Indiana is adopting standardized consensus guidelines for select chronic conditions.
2. Measures/Outcomes	Virginia developed a Managed Care Performance Report to guide improvement efforts. California designed the "Dashboard" report for an "at-a-glance" view of targeted performance measures.
3. Information Technology	Indiana Medicaid developed an electronic patient data registry for the state's chronic disease management program. Numerous health plans developed asthma registries.
4. Continuous Quality Improvement	More than 150 managed care entities have participated in CHCS' Best Clinical and Administrative Practices (BCAP) initiative to improve care for targeted groups of consumers. Many states, e.g. Wisconsin and California, are working with health plans to implement and track CQI.
5. Pay for Performance	New York is distributing up to $13 million to plans through its incentive program. Seven plans in California are paying a provider bonus to improve HEDIS well-visit rates for babies and teens. Many states, e.g., Michigan, New Mexico, are using auto-assignment to reward high-performing plans.
6. Care Management	North Carolina's PCCM program assigns nurse care managers to local practices to assist with chronically ill, high-risk patients. Oklahoma, Oregon, Washington, and Pennsylvania have developed requirements for special/exceptional needs coordinators based at the state or health plan level.
7. Integrated Care	Commonwealth Care Alliance, a specialized plan for dual eligibles in Massachusetts, uses a comprehensive care coordination approach to address members' physical, behavioral and social needs. Massachusetts, Minnesota and Wisconsin have established comprehensive integrated care programs
8. Consumer Direction	Cash and counseling demonstration programs, e.g., in Arkansas, Florida, and New Jersey, offer preliminary evidence for how consumers might manage their own care. West Virginia Medicaid and other states seek to create health investment accounts that will reward consumers for healthy choices.

Questions??