CHCS
Center for
Health Care Strategies, Inc.

Value Driven Solutions in Medicaid

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State Coverage Initiatives National Meeting
February 24, 2006

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)

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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.

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

Beware Of Short Term Fixes

	Focus	Examples
Step 5	Value-Driven Approaches	•Chronic disease management •Outcome based pay for performance •Integrating Medicare & Medicaid acute care
Step 4	$$-Driven Desperate Measures	•TBD as states are figuring out that just cutting is not slowing the rate of growth….
Step 3	Eligibility	•Increasing premiums (e.g., CHIP kids) •Capping enrollment / eliminating optional groups
Step 2	Services	•Capping benefits/visits (e.g., 4 Rx limit) •Eliminating optional services (e.g. dental)
Step 1	Reimbursement	•Across the board rate cuts •Eliminating inflationary adjustments

HIGH
Level of Difficulty
LOW

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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)

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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

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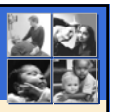
*"Disease Management in Medicaid." 2004. California Healthcare Foundation . 08 Jul. 2005 <CHCF.org>.

Highlights of Best Practices



- Washington
- North Carolina
- Indiana

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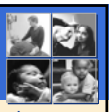
Washington: Program Summary



- 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

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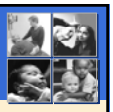
WA: Results of Independent Evaluations



- 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.

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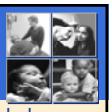
North Carolina: Program Summary



- 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

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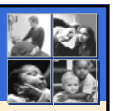
NC: Results of Independent Evaluation



- 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

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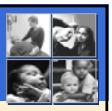
Indiana: Program Summary



- 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

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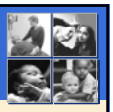
IN: Results of Preliminary Independent Evaluation



- 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

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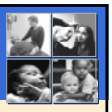
*Presented by Regenstrief Institute 9/28/05. Prepublication findings – please do not cite, distribute, quote.

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

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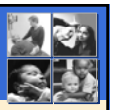
Sampling of Other DM/Quality Improvement Investments



- 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

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Getting to Value… 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

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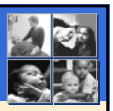
Value-Driven Solutions



BUILDING BLOCK	STATE EXAMPLES
1. Evidence-Based Practice	Indiana, New York
2. Measures/Outcomes	California, Virginia
3. Information Technology	Rhode Island, Tennessee, New York, Indiana (development phases)
4. Continuous Quality Improvement	California, New York, Wisconsin
5. Pay for Performance	Michigan, New Mexico, New York
6. Care Management	North Carolina, Oklahoma, Pennsylvania, Washington
7. Integrated Care	Massachusetts, Minnesota and Wisconsin
8. Consumer Direction	Arkansas, Florida, New Jersey (Cash & Counseling programs)

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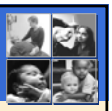
Score-ability and the Long-term Business Case



- 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

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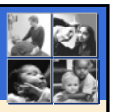
Closing Thoughts: Keys to Success



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

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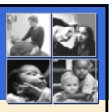
Questions??



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