

EVALUATING COORDINATION OF CARE IN MED-ICAID: IMPROVING QUALITY AND CLINICAL OUTCOMES

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EVALUATING COORDINATION OF CARE IN MEDICAID: IMPROVING QUALITY AND CLINICAL OUTCOMES

WEDNESDAY, OCTOBER 15, 2003

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2123, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Wilson, Brown, and Green.

Staff present: Patrick Morrissey, deputy staff director, Chuck Clapton, majority counsel; Jeremy Allen, health policy coordinator; Eugenia Edwards, legislative clerk; David Nelson, minority counsel; Bridgett Taylor, minority professional staff member; Purvee Kempf, minority professional staff member; and Jessica McNiece, minority staff assistant.

Mr. BILIRAKIS. Good morning. I call this hearing of the Health Subcommittee to order. If you are wondering what we were just discussing up here, the very significant issue of the Cubs game last night, and to the couple of young people there who tried to catch that foul ball and probably will be ostracized the rest of their lives from Chicago. I would have to move if I lived there.

Anyhow, I would like to thank our witness for taking the time to join us and provide their perspectives of strategies for improving the health of Medicaid patients to enhance care and coordination activities.

As I pointed out during last week's subcommittee hearing on challenges facing the Medicaid program in the 21st century, a comprehensive review of Medicaid should reveal a number of opportunities underlined for improving this program. In my opinion, learning more about the innovative strategies States are adopting to improve patient care is one of those opportunities. I feel that this is an especially critical area, because as we discussed last week, Medicaid payments for elderly, blind, and disabled beneficiaries who represent 27 percent of the total Medicaid population account for 73 percent of total payments.

Obviously, these beneficiaries who are more likely to suffer from one or more chronic illnesses have the most to gain from effective coordination of care programs. Additionally, the Medicaid program itself could realize substantial savings as well. As we will discuss

today, States have used a number of different strategies, most notably disease management to meet this goal. My own State of Florida, for example, has partnered with several entities to better manage the chronic conditions that we know make up such a large part of Medicare spending—of Medicaid spending, and I am pleased that Dr. Rhonda Medows, the Secretary of Florida's Agency for Health Care Administration, was able to join us this morning.

Welcome, Doctor, and I know that we are all looking forward to hearing more about Florida successes. Many States are also beginning to enroll more of their Medicaid beneficiaries in managed care plans. There is evidence that beneficiary outcomes are improving under the managed care model which emphasizes coordinating care, preventive benefits, disease management services for chronically ill patients and improving patient outcomes. We will find out from you hopefully whether that is the case.

And finally today, we will explore what kind of programs States have adopted through their traditional fee-for-service structure to help improve patient outcomes. Primary care, case management programs have been implemented in a number of States. We have a couple of State representatives with us today to talk a little more about their ideas and how they have worked at the State level. It is my hope that this survey of coordination of care programs will help members of the subcommittee learn more about what types of care coordination strategies work best and how we can apply these lessons as we continue to think about how we can get the most out of our Federal investment and Medicaid.

I would like to, again, thank all of our witnesses for joining us today, and we all look forward to your testimony and am pleased now to yield to my friend from Ohio now, Mr. Brown, for an opening statement.

Mr. BROWN. Thank you, Mr. Chairman.

Thank you all, to all the witnesses who are joining us this morning. I would like to start by commending Ms. Wilson, my friend from New Mexico who has worked on behalf of the committee to determine whether there are ways to maximize our return from investment on Medicaid and especially appreciate the work she has done.

To the extent that we can use information and coordination and outreach to reduce the burden of disease we enhance Medicaid's role in the public health system and potentially squeeze more value out of the dollars we invest. It makes sense to pursue these goals.

Looking at my own State of Ohio, disease management is one of several tools the State's Medicaid program is using to improve health and health care in that State; for example, Medicaid—Ohio Medicaid—has initiated a large physician profiling demonstration to learn more about variations in clinical practice and make use of that information to refine clinical outcomes.

Ohio's Medicaid's also working with the public health and provider community to make sure children receive age-appropriate immunizations and increase the number of high risk children who receive screening for lead poisoning.

Ohio has also initiated several demonstration projects aimed at improving the quality and cost effectiveness of care for the aged, the aged, the blind, and disabled.

Public health outreach, disease management, and other tools would be worthwhile, even if they didn't save money, but there is every reason to believe that they can and they will, but I have reservations about relying on Medicaid HMO's and private disease management companies as a primary vehicle for integrating coordination of care into Medicaid. Effective disease management, like effective health care, hinges on continuity. HMO's undoubtedly do some things well but providing continuity of care is not one of them.

Some 2.4 million senior and disabled Americans have been dumped from Medicare+Choice HMO's over the last 4 years. It would be difficult to find a population more in need of care coordination of continuity of care than Medicaid beneficiaries, but disappearing coverage and disease management just simply do not mix very well.

Over the last 4 years, three Ohio HMO's, for instance, contracting with the Medicaid program, were shut down by the Department of Insurance, leaving both beneficiaries and providers in the lurch. To put those three failures into context, there were currently six HMO's currently serving Medicaid patients in my State. Three HMO failures is not a minor problem. Medicaid and pullouts are certainly not unique to Ohio, so continuity of care is an issue everywhere.

I also question whether we are actually setting the stage for increased spending by paying private plans, whether they are private HMO's or private disease management companies to do what the Medicaid program itself could do.

To return to Medicaid plus Medicare+Choice, for example for a moment, Medicare was supposed to save the program money. No such luck.

Medicare+Choice plans have managed to inflate Federal spending while deserting beneficiaries left and right. You cannot begrudge HMO's their desire to maximize profits but you can prevent them from earning those profits at the expense of Medicare and the expense of Medicaid beneficiaries and American taxpayers. That is not to say that partnering with private companies is always a bad idea. It is just to say that privatization is not invariably a good idea.

In the case of Medicare and Medicaid, if we overestimate the ability of these companies to achieve efficiencies and underestimate the length to come, they will go to maximize profits. We will have no one but ourselves to blame when disease management savings simply fail to materialize.

In the case of Medicare+Choice HMO's, we not only overestimated their ability to achieve efficiencies, we allow these plans to compromise core principles, like universality, continuity, reliability. All this and higher Medicare expenditures too, not exactly a bargain for beneficiaries or for taxpayers.

When its profitability versus the public good, profitability is going to win out, and when the choice is to return the maximum number of dollars to State Medicaid programs or return the maximum number of dollars to shareholders, the shareholders are going to win in a private system.

We should consider all reasonable options when it comes to making the most of the dollars we spend on Medicaid, but if history is any guide, we should be aware of private sector solutions that promises big gains at a small cost. As a woman once wiser than I said, the nice thing about hitting your head against the wall is it feels really good when you stop.

Thank you.

Mr. BILIRAKIS. The Chair thanks the gentleman, and I appreciate Mr. Brown commenting on the work, task force work, that Mrs. Wilson is undergoing on this issue, and I certainly join in that accolade, and I will recognize her for an opening statement.

Mrs. WILSON. Thank you, Mr. Chairman, and thank you for holding this hearing today. It is the third in a series that your subcommittee has held on Medicaid and ways that we can—I hope it lays the foundation for looking at ways that we can improve Medicaid for the people who depend upon it most.

In the first hearing that we had, we talked about consumer-directed care, and the reality is under Medicaid, beneficiaries have far fewer choices than most of the rest of us who have health insurance provided by employers or private health insurance. In giving people choices and the ability and the knowledge to be able to manage their own care improves satisfaction and improves people's health.

We also heard last week in testimony that Medicaid doesn't do a very good job of collecting data on whether people's health improves or not. Seems, though, we have all kinds of information on how much money we spend, but almost no information on whether anybody's life is better because we spent it.

We lack the evidence to show what we can do to improve people's health, and the reality is that Medicaid was really set up for acute care. It was set up to pay claims and not to prevent disease or to improve the quality of people's health who have disease. It doesn't reward physicians for coordinating care for people with chronic illness.

There are some States, about 21 of them, where beginning to experiment with ways to manage chronic disease, because chronic diseases represent about 60 percent of the cost of health care in this country. Diseases like diabetes, heart disease, asthma among children, depression and cancer, drive up health care costs, and if we can manage those diseases to improve the quality of health for those who are facing those diseases, we will be much better off and much healthier as a country. But Medicaid doesn't—is not set up to address those problems. It shouldn't require a waiver from the rules to do what is right in the first place, and we need to change Medicaid so that it is not about following the payment slip and it is about improving the health of those who depend upon it.

There are some tools we are going to hear about today that I think are interesting and exciting, some States that decided they were going to break the mold and ask for a waiver and beg CMS to approve all of their paperwork, so that you can do some innovative things to improve the health of the people who depend on Medicaid. I am looking forward to hearing about the results that you are seeing, but you shouldn't be the exception. You should be the rule, and you shouldn't have to say, "Mother, may I," to get there.

I am particularly pleased to welcome Chris Selecky from the LifeMasters here today. LifeMasters does some good work in the State of New Mexico, and I look forward to hearing your testimony and the testimony of all the witnesses we have here today.

Thank you Mr. Chairman.

Mr. BILIRAKIS. I thank the gentlelady.

Mr. Green for an opening statement.

Mr. GREEN. Thank you, Mr. Chairman, and like my colleague, I appreciate you holding these continued hearings on the Medicare program, but particularly today with the care coordination. It is an important issue, and I am glad we have the opportunity to learn more about it.

Approximately 125 million Americans live with some form of chronic disease, the most costly and preventable of all health problems. According to the CDC, chronic diseases account for 75 percent of the \$1 trillion spent on health care each year in our country. They have an impact on almost every American family for the premature death, long-term illness and disability, loss of income and costly out-of-pocket expenses.

Chronic diseases are among the most prevalent costly and preventable of health problems. By the year 2020, health care expenditures for the chronic disease will actually reach \$1 trillion, or 80 percent of health care costs. This is especially problematic in the Medicaid program, as 30 percent of Medicaid population suffers from these chronic diseases, such as diabetes, hypertension, chronic obstructive pulmonary disease, or cardiovascular disease.

The cost of treating chronic diseases account for 80 percent of the total Medicaid expenditures. Because Medicaid patients often lack a primary care physician or rely on emergency room for the treatment of these diseases, these patients often lack access to the kind of preventative measures that can help better control their chronic diseases, so investigating ways to improve chronic disease management is such an important topic, care coordination, disease management, and primary case management and other programs have all sought to improve outcomes for individuals as chronic diseases throughout the same time reduces the cost in the program.

These programs aspire to improve day-to-day care for conditions like diabetes and asthma, so that we can reduce the number of hospital visits and acute episodes that often come with these diseases are untreated. These programs not only make financial sense but they also improve quality of life for the beneficiaries who rely on them to improve their health.

I would much rather spend money preventing kidney failure than have countless individuals with diabetes go on dialysis each year, and I see that in my own district, but like every other issue this committee considers, there is a disagreement over different groups about how best to provide these services. Some feel strongly that the private sector models are the best route.

I would argue that the savings generated by real disease management should be reinvested in the program, rather than used to pay a percentage of corporate profits, and I think these are fair questions and States are suffering some of their worst budgeted crises in years, and Medicare dollars are scarce. And again, I know from my own experience in Texas we are having problems not only

with Medicaid scarce dollars, but also with our children's health care, where we lost almost 200,000 children for the budget short-falls.

We should certainly do all we can to ensure that our limited dollars are wisely spent, and Mr. Chairman, I look forward to the testimony of our witnesses and I yield back my time.

Mr. BILIRAKIS. I thank the gentleman.

[Additional statement submitted for the record follows:]

PREPARED STATEMENT OF HON. W.J. "BILLY" TAUZIN, CHAIRMAN, COMMITTEE ON ENERGY AND COMMERCE

Thank you, Chairman Bilirakis, for holding this important hearing today. I also want to thank all of our witnesses for their testimony, which will provide valuable perspectives on current efforts to better coordinate care for Medicaid beneficiaries.

As we heard in last week's hearing, Medicaid is a critically important program that provides health care services for the poorest and sickest Americans. However, Medicaid also faces a number of challenges—including the perverse incentives it provides for states to improperly obtain additional federal funding and how restrictive federal statutory mandates limit states' ability to best address beneficiary needs with flexible benefit packages.

The need to better coordinate care is another challenge that confronts the Medicaid program. While this challenge is not unique to Medicaid, it is particularly relevant to the program, given the large number of chronically ill patients who are Medicaid beneficiaries. Traditional fee-for-service Medicaid programs have been singularly ineffective in managing the health care needs of these patients. This has contributed to rapidly increasing health care costs and unsatisfactory clinical outcomes.

Clinical data shows just how poorly traditional Medicaid does at treating many beneficiaries with chronic conditions. For example, data from one large Florida hospital revealed that 90 percent of Medicaid patients with diabetic symptoms were admitted through the emergency room. This is deeply disturbing—diabetes is an eminently manageable disease, which can be controlled through a regimen of physician monitoring, diet, exercise and regular testing of blood insulin. It is unacceptable that, in some cases, 90 percent of diabetic Medicaid patients are seeking hospital admissions through the emergency room, rather than obtaining their treatments under the direction and care of a primary care physician.

Unfortunately, this situation is not limited to the treatment of diabetes. The same hospital I referenced earlier also reported similarly high emergency room admission rates for Medicaid patients with hypertension and congestive heart failure. Medicaid's failure to adequately coordinate the care of these patients leads to increased utilization of expensive inpatient hospital services, increased costs for the program, and worse clinical outcomes for patients.

These types of failures have prompted several states to affirmatively act to better coordinate Medicaid beneficiaries' care. These efforts have included contracting with disease management organizations, managed care plans and a variety of other innovative state-sponsored initiatives to promote improved clinical outcomes. All of these programs share several characteristics—including an emphasis on better coordination of medical services and pharmaceutical benefits, increased patient education, and efforts to ensure greater adherence to clinical treatment guidelines.

States using these programs have experienced some dramatic successes, including significant reductions in the number of necessary hospitalizations and emergency room visits. In addition, managed care initiatives have produced significant program savings by reducing the amounts spent on pharmaceuticals, durable medical equipment and certain acute care services.

We can learn from some of these successes, as we consider ideas to reform Medicaid. While the coordination of care for Medicaid beneficiaries creates significant opportunities to improve patients' quality of care, it also raises significant concerns. To date, efforts to implement effective coordination of care initiatives have been hampered by a lack of adequate performance measures and analysis of clinical outcomes that can demonstrate whether these programs deliver the benefits they promised. Several recent reports have criticized the overall cost-effectiveness of certain coordination of care programs. Moreover, some efforts that have been described as coordination of care reforms, instead have simply replicated existing flawed Medicaid structures.

I believe we owe it to Medicaid's beneficiaries to provide them with better care. Improved coordination of care holds the potential to produce significant Medicaid savings, but more importantly, to also dramatically increase the quality of care that beneficiaries receive. I look forward to hearing the testimony of the witnesses, who will hopefully help us identify how we can achieve these important goals.

Mr. BILIRAKIS. We will go right into the panel. Your written statements are part of the record and I hope what you would do would be to supplement those statements. We will set the clock for 5 minutes for each of you.

Obviously, if you are on a roll and 5 minutes is up, I am certainly not going to cut you off, but we would appreciate if you could stay as close to it as you can, because we will be asking questions, and you will have an opportunity to supplement some of your statements that way.

The panel consists of Ms. Chris Selecky, the chief executive officer of LifeMasters Support SelfCare, Inc. She is testifying on behalf of the Disease Management Association of America; Mr. Dan Hilferty, president and CEO of the Keystone Mercy Health Plan of Philadelphia, testifying on behalf of the American Association of Health Plans; Dr. Rhonda Medows, Secretary of the Florida Agency for Health Care Administration, Tallahassee, Florida, testifying on behalf of the State of Florida; Mr. Jeffrey Simms, assistant director of North Carolina Division of Medical Assistance, testifying on behalf of North Carolina, so to speak; and Ms. Melanie Bella, Assistant Secretary, Office of Medicaid Policy and Planning, on behalf of Indiana.

Welcome, again.

Thank you so very much for taking time to be up here, and we will start off with Ms. Selecky.

Please proceed.

STATEMENTS OF CHRISTOBEL E. SELECKY, CHIEF EXECUTIVE OFFICER, LIFEMASTERS SUPPORT SELFCARE, INC., ON BEHALF OF THE DISEASE MANAGEMENT ASSOCIATION OF AMERICA; DANIEL J. HILFERTY, PRESIDENT AND CEO, KEYSTONE MERCY HEALTH PLAN OF PHILADELPHIA, ON BEHALF OF THE AMERICAN ASSOCIATION OF HEALTH PLANS; RHONDA MEDOWS, SECRETARY, FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, ON BEHALF OF STATE OF FLORIDA; JEFFREY SIMMS, ASSISTANT DIRECTOR, NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE; AND MELANIE M. BELLA, ASSISTANT SECRETARY, OFFICE OF MEDICAID POLICY AND PLANNING, STATE OF INDIANA

Ms. SELECKY. Good morning.

Thank you, Mr. Chairman and Representative Wilson, for inviting me to speak before the committee today.

My name is Christobel Selecky, and I am the-president elect of the Disease Management Association of America, which is a non-profit interdisciplinary association dedicated to the advancement of health improvement for people with chronic conditions.

I am also the CEO of LifeMasters Supported SelfCare, a privately held disease management organization that provides coaching, education, and support to more than 300,000 people nationwide.

We are fully accredited by the National Committee for Quality Assurance to provide disease management services to people with asthma, congestive heart failure, coronary artery disease, COPD, and diabetes, and manage the other conditions that go along with these diseases like depression and high blood pressure.

Our company was founded by a physician, almost 10 years ago, for the sole purpose of providing disease management services. We have provided these services to thousands of Medicaid beneficiaries for several years and currently work with several thousands of beneficiaries in Florida and New Mexico.

We were one of the first disease management organizations to be selected by Florida to provide services to their fee-for-service beneficiaries and we are pleased to be continuing with that relationship.

In the first 2 years of that program, we were able to provide the State almost \$4.5 million in real bottom line cost savings on an average population of just 2,500 beneficiaries with congestive heart failures. This represented a 5.6 percent net reduction in health care costs. These savings were the result of significant reductions in health care service utilization; for example, emergency hospitalizations went down by almost 40 percent.

In addition, beneficiaries received increased levels of evidence based care from their physicians, such as the 78 percent increase in annual cholesterol screenings. These programs work equally well in fee-for-service and managed care plans. In New Mexico, nurses in our Albuquerque call center provide our program to Medicaid beneficiaries with diabetes and coronary artery disease who are members of the Presbyterian health plan.

Disease management is one of those very rare win-win opportunities in health care, in which the beneficiaries win because they get a better quality of life. The physicians win because they have the opportunity to manage their patients more efficiently and the patients win because utilization and health care costs are reduced. The beneficiaries we serve often have multiple conditions, are taking several prescription drugs, see many different physicians, and often experience complications leading to expensive emergency hospitalizations. These complications are caused by things like drug interactions, the impact of lifestyle choices or the failure to correctly follow the treatment plan prescribed by the physician.

Medicaid beneficiaries face additional challenges, such as low levels of literacy, language barriers, frequent changes in eligibility, problems with gaining access to primary care, transients and other life issues making health care a secondary concern and higher levels of mental-health issues than the general population. Disease management programs identify and work proactively with people to educate and support them in making necessary lifestyle and behavior changes, to monitor their condition in between office visits and to alert their physicians to any changes in their patient's condition.

In Medicaid population, disease management organizations have learned to make special efforts, such as finding beneficiaries a medical home, coordinating transportation, providing home assessments and training, adapting programs to assess language, literacy and cultural issues and coordinating with local mental health and social-service resources.

It has been our experience in several States that Medicaid beneficiaries are hungry for the support and enhanced access to care that disease management programs provide, and that they participate in these programs at equal or higher levels than our commercial populations.

It is critical that our country begin to address the needs of our chronically ill Medicaid beneficiaries, now. In spite of best efforts, the Medicaid fee-for-service program is not set up to facilitate the program of optimal care for beneficiaries. We believe the solution is to integrate fully integrated fully accredited disease management programs into fee-for-service and manage Medicaid according to the following principles. There should be no discrimination against beneficiaries who currently lack access to the benefits of disease management. These programs should be made available to all Medicaid and duly eligible beneficiaries, regardless of whether they were in managed care or fee-for-service.

Medicaid fee-for-service programs should consider directly contracting with accountable disease management organizations which can ramp up quickly to immediately begin delivering the benefits of these services on a population wide basis with financial arrangement that would result at a minimum budget neutrality.

Results of disease management efforts should be measured and reported objectively, using consistent standardized methods, and disease management providers should be selected based on demonstrated and documented ability to deliver positive financial and quality outcomes.

Based on the results from several States, we believe that a comprehensive disease management strategy could deliver cost savings to the Medicaid population into the billion dollars annually while concurrently improving access to care, quality of life, and health outcomes.

I appreciate the opportunity to share my views of experience in disease management with you and look forward to trying to answer some of your questions.

[The prepared statement of Christobel E. Selecky follows:]

PREPARED STATEMENT OF CHRISTOBEL E. SELECKY, PRESIDENT-ELECT, DISEASE MANAGEMENT ASSOCIATION OF AMERICA, CHIEF EXECUTIVE OFFICER, LIFE MASTERS SUPPORTED SELF CARE, INC.

The Disease Management Association of America (DMAA) is a non-profit, voluntary membership organization, founded in March of 1999, which represents all aspects of the disease management community.

Creation of the association was in response to the continued growth of disease management in the United States. The increasing number of stakeholders dependent on the "promise" of disease management for cost effective, quality healthcare in this new millennium has created a need for a single voice and a more scientific approach to the measurement of the success of disease management programs.

DMAA has established an industry-standard definition of qualified DM programs and entities. The DMAA definition, established in consultation with primary care and specialty physicians and representing private practice, health plan, and institutional perspectives, is as follows:

- Disease management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant, supporting the physician/patient relationship and their plan of care;
- Emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies; and

- Evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.
- Disease management services provided to an individual must include:
 - Population identification processes;
 - Evidence-based practice guidelines
 - Collaborative practice models to include physician and support-service providers;
 - Patient self-management education (e.g. primary prevention, behavior modification programs, and compliance/surveillance);
 - Process and outcomes measurement, evaluation and management, and routine reporting; and
 - Feedback loop (e.g. communication with patient, physician, health plan, and ancillary providers and practice profiling)

The Disease Management Organization which I am privileged to lead, LifeMasters[®] Supported SelfCareSM, Inc., has extensive experience in and NCQA accreditation for providing disease management programs to patients with CHF, COPD, CAD, Diabetes, and Asthma and has demonstrated that a multi-disciplinary Disease Management program including patient education, interactive vital sign and symptom monitoring, nurse support and physician intervention can significantly reduce unnecessary utilization and improve quality of care. The company was founded by a physician in 1994 and currently provides services to more than 300,000 individuals nationwide through its contracts with healthplans, employers, and government agencies. The LifeMasters[®] service model has served as the basis for five major published outcomes papers.

States are experiencing unprecedented budget deficits as a result of the economic recession and its resultant impact on tax revenues. Following more than a decade of economic expansion, state tax revenues are falling for the third year in a row and most states have already dipped into their “rainy day” funds to make ends meet in the previous 2 years. This year’s budget balancing promises to be the most difficult in recent times.

State Medicaid agencies are having an exceptionally difficult time making ends meet as the result of rising health care costs and increasing enrollments over the past several years.

Most states are contemplating Medicaid program reductions in the form of: 1. Reduced benefits; 2. Tightened eligibility requirements; 3. Lower health care provider rates; and 4. Moving Medicaid fee-for-service beneficiaries to managed care.

For most poor people, low-income children, the frail elderly, and the blind and disabled, Medicaid is often the only source of health care coverage available to them. Reducing eligibility and access to care for these groups may offer short-term savings by shifting costs from the state to the safety net providers and the community. But the economic hardship placed on safety net providers today, however, will likely have to be swallowed by the state in subsequent years. To stop this cycle, we must explore alternative strategies that do more than shift costs.

To identify successful cost-cutting strategies for Medicaid it makes sense to begin with an understanding of what drives health care costs in this population. A report by the Centers for Disease Control and Prevention’s Chronic Disease Center estimates that 70% of the nation’s medical costs are attributable to the treatment of people with chronic disease(s). In addition, 75% of the nation’s deaths result from complications associated with chronic disease. In a recent report in California, where LifeMasters is headquartered, the Legislative Analyst’s Office (LAO) estimated that more than 25% of adult beneficiaries, or over 700,000 people, enrolled in Medi-Cal have at least one chronic condition. The greatest concentration of chronic disease is among the aged, blind and disabled (ABD) population where the California LAO estimated that 440,000 ABD beneficiaries cost the state \$5.3 billion in 2001, an average annual cost of \$12,000 per beneficiary. On a national basis, the elderly and disabled constitute 25% of Medicaid beneficiaries but account for two thirds of the healthcare costs.

Nationally, the direct cost of treating people with chronic disease(s) is estimated to be at least \$510 billion this year and will soar to \$1.07 trillion by the year 2020. Three diseases, diabetes, congestive heart failure (CHF) and coronary artery disease (CAD), account for \$250 billion or more in annual direct costs, and \$429.2 billion in total costs (including lost productivity, wages, etc.). Many of these expenditures are related to preventable repeated hospitalizations and emergency room visits. During the next 30 years, as the U.S. population ages, the number of individuals and estimated cost of care for people with chronic disease is expected to grow dramatically. The time for the states and the federal government to devise proactive cost reduction and quality improvement strategies is now.

Further compounding problems for states are the health care challenges caused by disparities of race, class, culture and ethnicity facing the nation's elderly and disabled poor. Barriers of education and language directly impact a patient's ability to access care. These patients may not seek care, or may rely solely on emergency room visits, and may be non-compliant with follow-up. These factors contribute to the high cost of care, and relatively poor outcomes, for Medicaid eligible patients. The chart displays the disproportionate burden of diabetes facing non-whites.

Cardiovascular disease is a leading cause of morbidity and mortality for all racial and ethnic groups, but as with diabetes, non-whites disproportionately experience all risk factors (excepting tobacco use) and rates of complications. Hispanics are also more likely to have high blood pressure and elevated cholesterol, major risk factors for cardiovascular disease. In addition, African Americans and other minorities experience death rates from diabetes and heart disease that are 50-100% higher than their Caucasian counterparts.

As Congress and the states ponder solutions to this problem, we urge you to consider implementing an innovative approach to managing health called disease management (DM). DM has taken shape over the past several years and is showing great promise to deliver better care at lower cost. These results have been achieved while simultaneously increasing beneficiary access to care, enhancing patient satisfaction with their healthcare providers, and improving clinical outcomes. Although there is no singular solution to cure the complex problems facing Medicaid today, DM is one option that can immediately begin to reduce costs while improving health outcomes. Based on experience managing similar populations, it is estimated that DM could save the states many millions of dollars.

Nearly 25 states have initiated disease management efforts, at least at a pilot project level, and eight have initiated comprehensive programs similar to the ones described below. Furthermore, the U. S. Department of Health and Human Services (HHS) and Centers for Medicare and Medicaid Services (CMS) have gained Congressional approval to begin larger scale demonstration projects with Medicare and Medicare/Medicaid dual eligible populations with chronic disease. Several large awards were made late in 2002 and several other DM demonstrations are expected to be awarded and implemented in 2003 and 2004.

DESCRIPTION OF THE PROBLEM

When Medicaid was created in 1965 (Title XIX), the intent was to improve the medical care being delivered under the public assistance programs. Beneficiaries were expected to enter the program for a period of time while they needed public assistance and then move back into the private sector. Consequently, most Medicaid programs were originally rooted in the provision of acute care under a medical treatment model that largely ignored prevention, self-management, peer support, and management of complex, co-morbid conditions.

Most people receiving public assistance, however, stay on service longer than expected. Coupled with advances in the pharmaceutical and clinical management of chronic conditions, people now have substantially longer life expectancies, extending the period of eligibility for a larger percentage of the population than was envisioned in 1965. This added longevity has contributed greatly to the steadily growing number of beneficiaries dually eligible for Medicaid and Medicare. The U.S. Census Bureau indicates that life expectancy rates have increased steadily since 1965, as follows:

Year	Life expectancy at birth, both sexes, all races (years)
1965	70.2
1970	70.8
1975	72.6
1980	73.7
1985	74.7
1990	75.4
1995	75.8
2000 Projections	76.4
2010 Projections	77.4

As a result, chronic diseases, such as arthritis, asthma, cancer, chronic obstructive pulmonary disease, CHF, depression, and diabetes account for 60 percent of medical costs in the United States. Cardiovascular disease (principally high blood pressure, heart disease, and stroke) is the leading cause of death among both men and women and across all racial and ethnic groups. About 58 million Americans live with some

form of the disease. In 1999 alone, cardiovascular disease cost the nation an estimated \$287 billion in health care expenditures and lost productivity, and this burden is growing as the population ages.

Medicare has recognized that an acute care system is no longer appropriate where the major killers and cost drivers of our era are chronic conditions. Moreover, it has reacted by exploring high-tech, innovative delivery systems, such as DM. Medicare has thus far lacked the legislative authority, however, to implement its demonstrations on a beneficiary-wide scale to provide fair access to all fee for service beneficiaries. On the state level, in the past two years, legislation has been passed in several states to fund DM. As many as two dozen states considered DM legislation in their recent legislative sessions.

Those states undertaking DM have elected not to cover dually eligible beneficiaries in their DM projects since the state would be primarily responsible for paying the cost of the DM program, most savings achieved through DM, however, would accrue to CMS (this is the result of Medicare being the primary payor and states are generally being at risk for only pharmacy, Medicare co-payments and transportation costs for this population). In fact, many beneficiaries enrolled in DM programs in FFS Medicaid lose this benefit when they become eligible for Medicare. Former CMS Deputy Administrator Ruben King-Shaw made it clear that CMS is willing to approve waivers that would allow states to share in any savings achieved through DM efforts with dually eligible beneficiaries. CMS is also reviewing "unsolicited" demonstration projects for the management of dual eligibles with chronic disease, whereby CMS would fund the DM project.

Like the ABD population, dual eligibles have chronic disease prevalence rates much higher than the overall Medicaid population. For example, CHF prevalence in the dual eligible population may approach 10% while the prevalence in the general population is less than 1%. The average monthly cost for dual eligibles with CHF is approximately \$1,500 to \$2,000 compared to a \$200 to \$300 monthly cost for the overall Medicaid population. Whether or not the states elect to offer DM services for this population will likely depend on the ability of the states to negotiate shared cost savings with CMS or on having CMS fund DM services as part of a CMS demonstration project.

Historically, a small proportion of Medicaid beneficiaries have accounted for a major proportion of Medicaid expenditures. In the fee-for-service environment, health care for individuals with chronic illness has often been fragmented and poorly coordinated across multiple health care providers and multiple sites of care. Evidence-based practice guidelines have not always been followed, nor have patients always been taught how best to care for themselves. These shortcomings are particularly true for patients served under reimbursement systems in which providers lack incentives for controlling the frequency, mix, and intensity of services, and in which providers have limited accountability for the outcomes of care, such as fee for service Medicaid.

In its current form, the health care system is not equipped to educate, monitor or support these very sick patients on a longitudinal basis to ensure proper coordination of care and compliance with complex treatment regimens. For fee for service Medicaid beneficiaries, this problem is exacerbated by the lack of any medical management or quality improvement infrastructure. The infrastructure offered by DM programs fills these gaps resulting in better human and financial outcomes.

Disease managers provide a safety net for seriously and chronically ill patients in between their physician visits, and are frequently credited with helping patients with chronic disease avoid unnecessary hospitalizations, unnecessary emergency room (ER) visits, surgery, and other more invasive care. Instead of relying solely on the physician-based care system (which, under managed care, and even in fee for service, has suffered serious and often irrational restraints from formularies, utilization review, and incentives to reduce doctor-patient consultation time), DM programs typically provide access to health care professionals on a 24-hour per day/ 7-day per week basis. Although disease managers are typically nurses, dietitians, health educators, social workers, and others who do not take the place of the primary care physician, they bridge the care management gap that often exists for patients between physician office visits. Given the propensity by many Medicaid beneficiaries to use the ER for primary care, DM can act as a means of educating patients on the proper use of the health care system, thus directing patients to primary care, as well as coordinating a patient's care across a variety of care settings, i.e., ER, specialist, PCP, etc.

Disease managers also improve physicians' effectiveness by providing real-time patient data and timely information on disease-specific best practices protocols. Without a DM program, it is unlikely that physicians can monitor patients effec-

tively between (and even during) visits, due to constraints on their time and office staff.

Given the few Medicaid Managed Care plans available to Medicaid beneficiaries in rural settings, DM could serve to fill the access to care and quality gap now being experienced in these areas and greatly reduce overall costs. Since most DM services can be fully implemented telephonically or via the Internet, rural patients in DM programs enjoy significantly improved access to care. In addition, to the extent that the DM programs succeed as expected, rural patients should not need as many visits to hospitals or specialty facilities, which may be distant from their homes and therefore avoided. Finally, on-line and telephonic DM programs frequently offer patient self-management and informational tools without cost, which improves access to services by the uninsured and poor.

DM programs address issues raised by the Institute of Medicine (IOM) regarding medical errors and quality of care. The IOM reports on medical errors and the deteriorating quality of healthcare in America¹ argue that DM is not only integral to preventing medical errors, but also to protecting and improving overall health care quality, especially for the chronically ill. In the reports, the IOM Committee on Quality of Health Care in America cites extensive evidence that “the nation’s health care industry has foundered in its ability to provide safe, high-quality care consistently to all Americans. Reorganization and reform are urgently needed to fix what is now a disjointed and inefficient system.”

The IOM quality of care report properly stresses the issues posed by chronic conditions, and concludes that:

“clinicians, health care organizations, and purchasers—companies or groups that compensate health care providers for delivering services to patients—should focus on improving care for common, chronic conditions such as heart disease, diabetes, and asthma that are now the leading causes of illness in the United States and consume a substantial portion of health care resources. These ailments typically require care involving a variety of clinicians and health care settings, over extended periods of time.”

To address these issues, the IOM suggests that private and public purchasers, health care organizations, clinicians, and patients should work together to redesign health care processes in accordance with the following rules:

- **Care based on continuous healing relationships.** Patients should receive care whenever they need it and in many forms, not just face-to-face visits.
- **Customization based on patient needs and values.** The system of care should be designed to meet the most common types of needs, but have the capability to respond to individual patient choices and preferences.
- **The patient as the source of control.** Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them.
- **Shared knowledge and the free flow of information.** Patients should have unfettered access to their own medical information and to clinical knowledge.
- **Evidence-based decision-making.** Patients should receive care based on the best available scientific knowledge.
- **Safety as a system property.** Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.
- **The need for transparency.** The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or when choosing among alternative treatments.
- **Anticipation of needs.** The health care system should anticipate patient needs, rather than simply reacting to events.
- **Continuous decrease in waste.** The health care system should not waste resources or patient time.
- **Cooperation among clinicians.** Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.”

With regard to medical errors, the IOM emphasized that one of the chief culprits in medical errors is the lack of care management and coordination, resulting from the decentralized and fragmented nature of the health care delivery system, and the multitude of unaffiliated providers practicing in different settings without access to complete medical record information or coordination.

¹*Crossing the Quality Chasm: A New Health System for the 21st Century*, Committee on Quality of Health Care in America, Institute of Medicine, National Academy Press, Washington, D.C. (2001).

The IOM reports are, in all respects, a call to action for, and a validation of, the critical need to support and promote DM as a solution to many of the problems besetting the health care system, both public and private, managed care and fee-for-service. High-quality DM programs focus directly on the chronic conditions that the IOM reports consider most costly and ripe for new models of intervention, and improve clinical and financial outcomes in every one of the areas considered most problematic by the IOM.

ENHANCING CARE COORDINATION—DISEASE MANAGEMENT

The central premise behind DM is elegant in its simplicity. Simply stated, the value proposition for DM is that “healthier people cost less.” Put another way, if we can improve the health of the population, we will reduce their demands on the health care system and that reduced demand translates into lower costs. Chronic illness is a major driver of health care costs. One reason for this is that many chronically ill individuals experience acute episodes that require expensive (and often traumatic) treatment in institutional settings. The incidence of such episodes can be reduced or entirely avoided through proper management of chronic conditions, as can the progressive worsening of chronic conditions that leads to complications and co-morbidities. Thus, if health care payors can efficiently deliver interventions that result in improved management of their chronic condition to those beneficiaries, quality improvement and cost savings will result.

Candidates for DM services are typically identified through review of their health insurance and available medical data by health insurers and disease management organizations (DMOs), or by their primary care providers. Disease managers then reach out to these individuals and, in concert with their physicians, enroll them in DM programs.

Many of the interventions that can be provided to individuals with these chronic illnesses are often relatively simple. For example, great progress can be made by promoting smoking cessation, improvements in diet and exercise, and teaching patients to better self-manage many aspects of their condition like blood glucose level self-monitoring and adherence with prescription drug regimens. These interventions are supported by regularized, ongoing communication between beneficiaries, care providers and disease managers through a variety of media including phone, mail and electronic, and, when warranted, in-home visits, that serves to promote adherence, monitor clinical status, ensure a continuum of care, and to proactively identify and address situations that could lead to avoidable acute events. Most DMOs have proven adept at addressing populations with multiple conditions, which is significant because a high percentage of individuals with chronic disease have more than one condition (co-morbidity).

One challenge in delivering effective DM services lies with the fact that the beneficiary population can be a difficult one to impact. Often, the harmful behaviors and habits that DM programs seek to address have become highly ingrained over decades. In other cases, beneficiaries are depressed as a consequence of their condition, have grown skeptical of health care interventions, and may have developed hostility toward the health care system. DM programs have developed techniques for successfully reaching these populations and are able to uncover and motivate the underlying desire of most chronically ill individuals for improved quality of life.

Another important feature of disease management is the integration with the beneficiary’s personal physician. Many DM programs assist the physician as well as the patient by helping to provide evidence-based practice guidelines specific to their patients and their conditions. DM programs develop programs and techniques for reaching out to physicians and have generally been successful in achieving positive physician satisfaction and participation.

DM works. Peer reviewed studies show that DM can have a significant impact on both the cost and quality of care and health outcomes.

OUTCOMES

The state of Florida was one of the first states to offer disease management services to beneficiaries eligible for Medicaid fee for service and Primary Care Case Management (PCCM). In LifeMasters® program for Florida Medicaid beneficiaries with Congestive Heart Failure, we were able to reduce healthcare expenditures over a two-year period by 16.3%, resulting in a net savings to the state (after paying for program costs) of \$4.4 million for an average of just 2,500 beneficiaries. Other states have launched their own DM initiatives including Washington, Colorado, Texas, Oregon, Mississippi, Ohio, Kansas, Idaho, Missouri and Arkansas to name just a few. There are several DM Organizations that have extensive experience meeting the distinct needs of Medicaid populations.

Florida Medicaid Results (Population-based CHF Program)

Indicator	Baseline Year	Intervention Period (Two Years)	Percent Change/Comment
Total Medical Claims/Year	\$77,727,365 (Projected two year costs).	\$65,065,548 (Two year actual costs).	-16.3%
Hospital days/Year	8,859 per 1000 members	5,431 per 1000 members	-38.7%
Percent of beneficiaries on ACE inhibitor/angiotensin receptor blocker therapy.	58.1%	76.5%	32%
Percent of beneficiaries on beta blockers.	30.2%	44.1%	46%
Percent of beneficiaries receiving an annual cholesterol screening.	30.3%	53.8%	78%
Percent of patients reporting abstaining from smoking.	N/A	69%	N/A
Percent of patients compliant with drug treatment plan.	N/A	98%	N/A
Percent of patients compliant with dietary restrictions.	N/A	77-85%	Depends on risk category and month measured
Compliant with drug treatment plan.	N/A	98%	N/A

LifeMasters also provides services to managed care Medicaid beneficiaries through a relationship with Presbyterian Health Plan in New Mexico. Presbyterian has 133,000 Medicaid beneficiaries. Of this number, there are 2,100 beneficiaries with Coronary Artery Disease (CAD) and Diabetes enrolled in the disease management program. While it is too early in the program to have clinical, cost, and quality data available, we have found the same level of receptivity to the program as we experienced with fee for service Medicaid beneficiaries in Florida. One of our disease management nurses said of one of her program participants: "When I first started calling [the participant] in May, she was stressed and depressed and frustrated with her foot pain. Since that time, she has started walking a few miles 4 times a week and lifting weights. She has lost 10+ lbs and her energy and spirits are higher than ever. After a trip to her podiatrist, her feet are feeling better. She often thanks me for calling her and holding her accountable to keep on top of her DM and exercising. Without the program she doesn't think she would be doing so well."

LifeMasters has also provided services to managed care Medicaid beneficiaries through a relationship with Fallon Community Health Plan, which has been ranked the number one HMO in America four times over the past several years: twice by *Newsweek* (1999, 1996) and twice by *U.S. News and World Report* (1998, 1996). Beginning in 1999, Fallon's members with diabetes were enrolled in the LifeMasters diabetes management program. According to Val Slayton, MD, Fallon's former Chief Medical Officer, the cost savings achieved with the Medicare (9.2%) and Medicaid (42.9% for a relatively small population) populations have been larger than those in the Commercial group (4.7%) for patients with diabetes in the first year on a per member, per month (pmpm) basis compared with baseline figures (see below). Diabetic claims cost on a PMPM basis fell from \$691 to \$632.

Fallon Community Health Plan Results (Diabetes) Program Results after 1 Year

Indicator	Baseline Year	Intervention Period	Percent Change/Comment
Total Medical Claims/Year	\$717.80	\$486.93	-42.9%
Hospital days/Year	1,536 per 1000	1,173 per 1000	-23.6%
Cardiac (CHF+CAD) Days/Year	284 per 1000	69 per 1000	-75.6%
Average HbA1c Value (entire population)	8.2%	7.5%	-8.5%

Other Disease Management Organizations have had success in deploying DM interventions in Medicaid populations.

McKesson Corporation has extensive expertise providing disease and demand management experience through direct contracting with State Medicaid programs including contracts with the Washington State Medical Assistance Administration (MAA), the Oregon Medical Assistance Program, Florida's Agency for Health Care Administration (AHCA), the Mississippi Division of Medicaid, and Colorado's Division of Health Care Policy and Administration. Furthermore, the states of New Hampshire and Montana have selected McKesson to provide disease management for their Medicaid fee-for-service population.

Initial results for Washington MAA (asthma, diabetes and heart failure) have demonstrated significant clinical and economic improvement. The state of Washington recently released their first year estimated net savings from their disease management programs. The results from the state show greater than \$1.5 million of first year savings for the 18,000 Medicaid recipients eligible for the service. Savings of \$900,000 were noted in the diabetes population, \$375,000 for heart failure, and \$250,000 for asthma.

Columbia United Providers, a Medicaid managed care provider based in Vancouver, Washington has had significant success in implementing behavior changes among members enrolled in an asthma DM program. At the time the plan's members first enrolled in the asthma program approximately 8% had an action plan; at six months, nearly 46% had such a plan—an increase of 450%. Members taking asthma medication every day to control symptoms increased to 33% at six months from 29% at enrollment. The analysis of medical and pharmacy claims (using a matched cohort design) for this Medicaid Program was quite positive and resulted in a very positive financial return to the client (\$2.25 ROI).

A second managed Medicaid program in the Northeast completed an asthma program for its identified members, showing highly significant reductions in inpatient, emergency room and outpatient symptomatic office visits utilization when compared to a matched cohort of non-participating asthmatics ($p < .01$ for all comparisons), resulting in a very favorable financial return (\$1.61 ROI).

In addition to these Medicaid-specific analyses, McKesson has completed 9 medical claims analyses for commercial asthma programs; 13 completed studies for commercial diabetes programs; and 10 completed studies for commercial heart failure programs. The results of these studies demonstrate improvements in health status and net reductions in claims costs resulting in favorable ROI.

The experience of McKesson' Care Support Programs demonstrates their efficacy and relevance to Medicaid populations. These studies strongly suggest that structured DM programs can create positive clinical and financial outcomes while promoting enhanced self-management through continued support, education, and patient involvement.

LifeMasters and McKesson are not unique in achieving results such as those described above. As the industry matures, other companies are also demonstrating the economic and qualitative value of DM services in the commercial, Medicare+Choice, and Medicaid arenas

DM PROGRAMS ARE BUDGET NEUTRAL IN THE FIRST YEAR OF IMPLEMENTATION

Most DM programs expect to generate net savings during the first contract year (defined as savings greater than the cost of the DM program), with the greatest program impact being realized in the second half of the year, once the majority of program prospects are enrolled. Further savings are expected in years two and beyond as the program staff has more time to interact with program participants and their physicians. Savings are generally calculated by comparing per member per month healthcare costs for the year(s) in which the program was in effect with a per member per month baseline which is adjusted for medical inflation. In some cases, a control group methodology is employed which compares the cost of people who had access to the program with a group of similar people who did not. This is particularly useful because chronic disease is progressive in nature and costs can be expected to increase in the absence of a program. However, there are ethical concerns about denying a program to people who could benefit from it. The table below illustrates this ability of a CHF disease management program to reduce cost trend as well as actual cost.

Which disease(s) the states elect to focus their immediate attention on will depend largely on the prevalence and cost of disease(s) in the Medicaid population and the states' specific goals. For example, if the state's immediate goal is to maximize return on investment and savings in the first year, the likely choice is to manage beneficiaries with diabetes, CHF and CAD. People with these conditions are costly, the diseases are closely related (many people with diabetes are co-morbid with CHF or CAD) and a significant reduction in hospitalizations and ER visits can happen

very quickly. If the state decides to move in that direction, it is recommended that the state contract with one organization to manage these conditions in a specific geography. This approach leads to much better coordination of care and less confusion among patients and their physicians.

RECOMMENDATIONS

DMAA believes that comprehensive disease management, if fully employed in Medicaid, can:

- Achieve the objective of better addressing preventive care and chronic illness under Medicaid
- Improve the safety and quality of care by adhering to evidence-based treatment guidelines and outcomes data, and by providing patients with a safety net between physician and hospital visits, thereby reducing drug and treatment errors and improving care coordination
- Improve access to care by around the clock nursing and high-tech contacts, and by assisting rural caregivers and their patients who do not have the benefit of easy entrée to in-person care
- Improve patient self-management of, and responsibility for, preventing and treating their conditions by its innovations in patient-centered and collaborative education
- Improve financial cost containment without sacrificing quality or patient satisfaction by serving as an alternative to the increasingly unacceptable cost-containment techniques of managed care, such as utilization review, gatekeeper restrictions, referral limitations, and drug restrictions
- Enhance efforts in the public health arena by providing health improvement programs on a population basis; creating financial incentives to promote and deliver preventive interventions on a large scale using advanced outreach technologies, especially secondary preventive measures; and encouraging those segments of the private sector that have not yet embraced DM to do so.

DMAA supports the integration of fully accredited DM programs into fee for service and managed Medicaid according to the following principles endorsed by DMAA:

- There should be no discrimination against beneficiaries who currently lack access to the benefits of DM programs available to some managed care and fee for service Medicaid enrollees
- Medicaid fee for service programs should directly contract with DM organizations to offer such benefits on a population basis.

Congress and the states should focus their initial DM efforts on managing beneficiaries with the highest cost, highest prevalence conditions where evidence exists that changes in lifestyle, monitoring and early intervention reduce costs and improve health outcomes.

With these criteria in mind, the first priority should be to disease manage aged, blind and disabled beneficiaries with diabetes, congestive heart failure (CHF), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD) or asthma. A secondary emphasis should focus on managing all fee for service beneficiaries and dual eligibles with these same chronic illnesses. States should focus their efforts on beneficiaries with these diseases for a number of reasons including:

- Diabetes, CHF, CAD, COPD and asthma affect more than 20% of the entire Medicaid aged, blind, disabled and dual eligible populations while accounting for as much as 75% or more of total costs.
- Incidence of these diseases continues to grow at a significant rate—costs will continue to increase over time.
- These debilitating diseases greatly diminish an individual's quality of life and have a high rate of morbidity and premature mortality.
- Non-whites are disproportionately affected by these chronic diseases, experiencing much higher morbidity and mortality rates than their white counterparts. Focusing on managing people with these diseases helps to minimize the impact of the racial and ethnic disparities experienced in health care.
- Diabetes, CHF and CAD are closely related, with a great percentage of people with diabetes developing CHF and/or CAD as a result of the cardiovascular damage caused by their diabetes. People with diabetes are frequently co-morbid with these conditions.
- Typically, investing in DM for these groups delivers a return on investment of 150% to 250% in the first year.
- Asthma prevalence rates among low-income children and adults make it a high public health priority. First year ROI experienced managing people with asthma is break even or slightly positive.

- Much of the human and economic cost associated with these diseases can be positively impacted through longitudinal health management, lifestyle modification, disease-specific vital signs and symptoms monitoring, and early intervention. These efforts have been shown to reduce or delay health complications while lowering overall costs.

CONCLUSION

Based on documented cost reductions and quality improvements from Medicaid DM programs in selected states, it is likely that a comprehensive DM strategy covering beneficiaries with diabetes, CHF, CAD, COPD, asthma and ESRD could deliver cost savings to the Medicaid program into the billions of dollars annually while concurrently improving access to care, beneficiary quality of life and health outcomes.

The most innovative states along with Medicare+Choice and private sector organizations have benefited from high quality DM, and these organizations now have irrefutable evidence that these programs have not only improved the delivery of healthcare services, but have also achieved impressive clinical quality improvements and cost savings. Based on the demonstrated evidence of successful clinical and financial outcomes of disease management programs, DMAA and LifeMasters believe that our nation should move to offer disease management services to all Medicaid beneficiaries with chronic disease.

Mr. BILIRAKIS. Thank you very much, Ms. Selecky.
Mr. Hilferty?

STATEMENT OF DANIEL J. HILFERTY

Mr. HILFERTY. Mr. Chairman and members of the subcommittee, my name is Daniel Hilferty. I am president and CEO of AmeriHealth Mercy/Keystone Mercy Health Plan. AmeriHealth Mercy and its family of health plans serve over 1.3 million Medicaid beneficiaries in six States, Pennsylvania, New Jersey, Kentucky, South Carolina, Virginia, and California.

As a mission-driven organization, AmeriHealth Mercy specializes in managing the delivery of health care services and providing health care management services for organizations serving enrollees in Medicaid managed care programs and State children's health insurance programs.

I appreciate this opportunity to testify about the value of the private sector health plans bring to the Medicaid program. AmeriHealth Mercy/Keystone Mercy has played a leading role in improving health care quality for Medicaid beneficiaries.

I am also testifying today on behalf of the American Association of Health Plans.

Today, I will focus on strategies Medicaid's managed care plans are implementing to improve the health care system for Medicaid enrollees. My testimony will also emphasize the importance of ensuring that State Medicaid managed care programs are funded at levels that support the participation of Medicaid managed care plans and their providers.

At the same time, I will discuss the important role that plans are playing in delivering cost-effective health coverage and ensuring that State Medicaid programs receive maximum value for their limited resources at a time when State budgets are severely restrained.

First I would like to talk about coordination of care. Health plans participating in State Medicaid-managed care programs have developed systems of coordinating care for ensuring that Medicaid beneficiaries receive all medically appropriate health care services.

Covered under the State Medicaid managed-care program on a timely basis.

As a result, physicians services, hospital care, prescription drugs, and other health care services are integrated and delivered through an organized system whose overriding purpose is to prevent illness, improve health status, and employ the best practices to swiftly treat medical conditions that occur. This approach is far superior to a system of uncoordinated care, in which patients are forced to navigate a fragmented health care system on their own.

AmeriHealth Mercy serves a high percentage of non-traditional Medicaid recipients, the sickest of the sick, those accounting for the highest cost, the aged, blind, and disabled. AmeriHealth Mercy is at risk for the total health care of the patient/member.

Therefore, we have designed a population-based approach to care management, which has enhanced the quality of life for our members and produced significant annual savings for these high cost members. In terms of preventive health care services, instead of focusing solely on treating beneficiaries when they are sick or injured, Medicare-managed care plans place a strong emphasis on preventive health care services to keep beneficiaries healthy, detect diseases at an early stage, and avoid preventable illnesses.

Passport health plan owned by University Health Care in Kentucky and managed by our organization has improved adolescent immunizations by over 160 percent, from 1997 to 2002 and increased well child visits in the first 15 months of life by 216 percent.

Over 90 percent of our pregnant members receive prenatal care, meeting the standards of the National Committee for Quality Assurance for whom passport has earned the highest level of accreditation, excellent in all categories; in fact, each of our entities has achieved NCQA status of outstanding or excellent.

In terms of disease management services, Medicaid management care plans have also introduced the concept of disease management programs to Medicaid. Improving quality of care for beneficiaries with chronic conditions by focusing on the comprehensive care of patients over time, rather than individual episodes of care.

AmeriHealth Mercy's disease management programs have improved health outcomes and significantly lowered the cost of care for the highest cost patients. These programs have improved patient care and achieved major savings for small but very ill population groups; for example, our hemophilia case management program has reduced hospitalizations by 40 percent for 60 members, thus saving \$2 million annually in the cost of blood factor and overall medical care.

In terms of innovations by Medicaid health plans, Medicaid-managed care plans have developed a wide range of innovative programs to improve the health status of Medicaid beneficiaries; for example, our plan in Pennsylvania, Keystone Mercy, is promoting preventive health care for Medicaid through a health ministry program for women.

This program links church groups with other medical and social services in their communities. Using a team of specially trained nurses, this program provides women with health assessments to identify diseases for which they may be at risk. This assessment

is followed by a second session in which women learn about preventive measures they can take to avoid these conditions, and at the same time, learn about nutrition, exercise, and stress management techniques.

In order for these programs to continue, there must be an adequate funding of Medicaid health plans. While Medicaid-managed care plans are focused intensely on improving health care for Medicaid enrollees, our efforts are complicated by the steps States have been taking to limit funding for Medicaid benefits in recent years.

The American Association of Health Plans and its member plans are pleased that the centers for Medicare/Medicaid services has issued regulations upholding the fundamental principle that Medicaid managed-care plan rates must be actuarially sound. We believe it is critically important for CMS to proactively work with the States to be sure these are implemented in a way that will promote fair and adequate payments.

We also urge the subcommittee to closely monitor this issue and ensure that payments to Medicare plans are actuarially sound.

There is a value to Medicaid-managed care. While payment adequacy is a major concern for Medicaid-managed care plans, it is also important for Congress to recognize that plans are working hard to ensure that State, Medicare-managed programs receive the highest possible value for the dollars they spend on health care. Passport, our plan in Kentucky, has saved the Commonwealth \$92.4 million on 100,000 lives in just 4 years, and our health choices program in Pennsylvania has saved the Department of Public Welfare hundreds of millions of dollars since its inception in 1997.

At the same time, enrollees in these programs benefit from improved continuity of care and are highly satisfied with their care.

In conclusion, I want to emphasize that AmeriHealth Mercy and its family of health plans, along with other American Association of Health Plan member plans, is strongly committed to our mission of providing high quality affordable patient-centered care, patient centered health coverage to low income Americans and persons with disabilities.

We are proud of the success we have demonstrated in improving the health that is available under Medicaid programs to many of our Nation's most vulnerable citizens.

In conclusion, I would just like to say thank you for this opportunity.

[The prepared statement of Daniel J. Hilferty follows:]

PREPARED STATEMENT OF DANIEL J. HILFERTY, PRESIDENT AND CEO, AMERIHEALTH MERCY/KEYSTONE MERCY HEALTH PLAN ON BEHALF OF THE AMERICAN ASSOCIATION OF HEALTH PLANS

Mr. Chairman and members of the subcommittee, my name is Daniel J. Hilferty. I am President and CEO of the AmeriHealth Mercy/Keystone Mercy Health Plan. AmeriHealth Mercy and its family of health plans serve over 1.3 million Medicaid beneficiaries in six states, Pennsylvania, New Jersey, Kentucky, South Carolina, Virginia and California. As a mission-driven organization, AmeriHealth Mercy specializes in managing the delivery of health care services and providing health plan management services for organizations serving enrollees in Medicaid managed care programs and State Children's Health Insurance Programs (SCHIP).

I appreciate this opportunity to testify about the value that private sector health plans bring to the Medicaid program. AmeriHealth Mercy/Keystone Mercy has played a leading role in improving health care quality for Medicaid beneficiaries. We

do this by coordinating care, placing a strong emphasis on preventive health care services, providing disease management services for chronically ill patients, and offering innovative programs to promote the health and well being of our Medicaid enrollees. We are strongly committed to ensuring that Medicaid enrollees have access to high quality, affordable, patient-centered health coverage.

I am also testifying today on behalf of the American Association of Health Plans (AAHP), of which AmeriHealth Mercy/Keystone Mercy Health Plan is a member through our parent, Independence Blue Cross of Pennsylvania. AAHP and its member plans have a longstanding commitment to Medicaid and its mission of meeting the health care needs of low-income Americans and persons with disabilities. AAHP's membership includes approximately 100 health plans participating in Medicaid managed care programs. In my testimony, I will refer to such plans as Medicaid managed care plans. Collectively, AAHP members serve more than half of the 15.5 million Americans who are covered under Medicaid managed care plans.

Today, I will focus on the strategies Medicaid managed care plans are implementing to improve the health care system for Medicaid enrollees. I will begin by reviewing the importance of coordinated care and why this approach is producing better health outcomes and higher satisfaction among Medicaid beneficiaries than Medicaid fee-for-service programs. Next, I will focus on preventive health care services and disease management programs offered by Medicaid managed care. I will also highlight several specific examples of the dozens of innovative programs that plans have developed to meet the needs of their Medicaid enrollees.

My testimony will also emphasize the importance of ensuring that state Medicaid managed care programs are funded at levels that support the participation of Medicaid managed care plans and their providers. At the same time, I will discuss the important role that plans are playing in delivering cost-effective health coverage and ensuring that state Medicaid programs receive maximum value for their limited resources at a time when state budgets are severely strained.

COORDINATION OF CARE

Medicaid managed care plans have developed systems of coordinated care for ensuring that Medicaid beneficiaries receive all medically appropriate health care services, covered under the state Medicaid managed care program, on a timely basis in a challenging environment in which an individual's Medicaid eligibility may change during the year. In general, each Medicaid beneficiary is encouraged to establish a relationship with a primary care physician who helps make arrangements for specialty visits, hospital care, home health care, or other care he or she may need. The primary care physician ensures that each patient receives the best available care in the most appropriate setting, and oversees all of a patient's treatments and medications.

Moreover, coordinated care systems provide for the seamless delivery of health care services across the continuum of care. In other words, physician services, hospital care, prescription drugs, and other health care services are integrated and delivered through an organized system whose overriding purpose is to prevent illness, improve health status, and employ best practices to swiftly treat medical conditions that occur.

This approach is far superior to a system of uncoordinated care in which patients are forced to navigate a fragmented health care system on their own. Coordinated care provides the opportunity to reduce emergency room visits for routine care, and to ensure prompt access to primary care physicians and specialists when care is needed. It also promotes communication between treating physicians about various treatments and medications a patient receives. This is very important because the interaction of multiple medications prescribed by multiple physicians can result in high risk to the patient and death in some instances.

Coordinated care creates an intense focus on health care quality because health care services are well integrated and a single physician oversees each patient's care. AmeriHealth Mercy serves a high percentage of non-traditional Medicaid recipients, the "sickest of the sick," those accounting for the highest costs (aged, blind and disabled). AmeriHealth Mercy is at risk for the total cost of care for the patient/member. Therefore, we have designed a population-based approach which links traditional medical care management with pharmacy care management to promote comprehensive, cost effective, quality care. The results are striking. Our case management programs for high cost populations have enhanced the quality of life for our members and produced an annual savings of \$740,000 for just 190 high cost members.

Research findings indicate that systems of coordinated care are highly successful in improving access to health care for Medicaid enrollees. For example, a study pub-

lished in the March 2001 issue of the *American Journal of Public Health* found that, in New York City, Medicaid managed care enrollees are more likely than Medicaid fee-for-service enrollees to have a regular source of health care and also more likely to obtain care from a doctor's office or a clinic. The same study found that Medicaid managed care enrollees are less likely than Medicaid fee-for-service enrollees to obtain care from a hospital emergency room or an outpatient hospital clinic, which are not optimal settings for receiving routine care.

PREVENTIVE HEALTH CARE SERVICES

Instead of focusing solely on treating beneficiaries when they are sick or injured, Medicaid managed care plans place a strong emphasis on preventive health care services that help to keep beneficiaries healthy, detect diseases at an early stage, and avoid preventable illnesses.

According to AAHP's 2001 and 2002 Industry Surveys, Medicaid managed care plans routinely provide coverage for diabetes screening, colorectal cancer screening, prostate cancer screening, mammograms for women age 40 and older, hearing tests for newborns, and osteoporosis screening. In addition, a large percentage of Medicaid managed care plans contact enrollees on a regular basis with reminders about child immunizations, mammograms, cervical cancer screening, or other preventive services. By actively encouraging enrollees to receive these services, plans are empowering them to take proactive steps to enhance their health and well-being.

AAHP's surveys also found that almost all Medicaid managed care plans offer various types of counseling programs. Many programs focus on prenatal care, nutrition, or exercise counseling, while others address issues such as smoking cessation or alcohol dependency. These programs help enrollees address behavioral or lifestyle issues in ways that can significantly improve their health and the quality of their lives.

Medicaid managed care plans also typically exceed the core objectives of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program by placing a strong emphasis on primary care for children. The EPSDT programs of Medicaid managed care plans typically include aggressive education and outreach components in order to ensure that children receive complete physical examinations, hearing and vision checkups, dental care, immunizations, and other health care services they need to stay healthy. One Medicaid managed care plan in Connecticut has implemented a program that, by using specially trained staff to place "welcome" calls to Medicaid enrollees, was successful in increasing EPSDT participation rates from 52 percent to 75 percent in just one year. The delivery of these crucial primary care services is an important factor in promoting good health among children and adolescents in the Medicaid program.

Passport Health Plan, owned by University Health Care in Kentucky and managed by our organization, has improved adolescent immunizations by over 160 percent from 1997 to 2002, and increased well-child visits in the first 15 months of life by 216 percent. Over 90 percent of our pregnant members receive prenatal care meeting the standards of the National Committee for Quality Assurance from whom Passport has earned the highest level of accreditation, Excellent in all categories.

DISEASE MANAGEMENT SERVICES

Medicaid managed care plans have also introduced the concept of disease management programs to Medicaid—improving quality of care for beneficiaries with chronic conditions by focusing on the comprehensive care of patients over time, rather than individual episodes of care. Because of their prevalence, asthma and diabetes are the two illnesses that are targeted most frequently for disease management services by Medicaid managed care plans. AAHP's surveys found that the top three benefits of these services are: (1) reduced morbidity and mortality; (2) lower health care costs; and (3) improved patient satisfaction.

The success of these programs is demonstrated by research findings which show that asthmatic children covered by Medicaid managed care plans are less likely to experience serious asthmatic attacks that require them to be hospitalized, relative to asthmatic children who have fee-for-service Medicaid coverage. According to a 2002 report by the Wisconsin Department of Health and Family Services, 11.7 percent of asthmatic children in the Medicaid fee-for-service program had asthma-related hospital admissions, compared to only 8.6 percent of asthmatic children in Medicaid HMOs.

AmeriHealth Mercy's disease management programs have improved health outcomes and significantly lowered the cost of care for the highest cost patients. These programs have achieved major savings and improved patient care for small, but very ill populations groups. For example, our Hemophilia Case Management pro-

gram has reduced hospitalizations by 40 percent for 60 members, thus saving \$2 million annually in the cost of blood factor and medical care. Our Dialysis Case Management program saves \$2 million annually by improving patient care for 300 members. Finally, our Sickle Cell Case management program has reduced hospitalizations by 23 percent and emergency room visits by 24 percent. The savings from high quality Medicaid managed care are indisputable and the value to members is high.

INNOVATIONS BY MEDICAID HEALTH PLANS

Last year, AAHP published a report highlighting more than 60 initiatives Medicaid managed care plans have undertaken to improve the health status of Medicaid beneficiaries. This report provides practical guidance to policymakers and health care professionals on effective strategies for addressing the needs of Medicaid beneficiaries.

For example, our plan in Pennsylvania, Keystone Mercy, is promoting preventive health care for its Medicaid enrollees through a Health Ministry Program for Women. This program links church groups with other medical and social services in their communities. Using a team of specially trained nurses, this program provides women with health assessments to identify diseases for which they may be at risk. This assessment is followed by a second session in which women learn about preventive measures they can take to avoid these conditions and, at the same time, learn about nutrition, exercise, and stress management techniques.

Another AAHP member plan, Humana, has implemented a program in both Florida and Illinois to improve patient care for pregnant Medicaid enrollees. Under this program, the health plan first takes steps to identify women who are at risk of experiencing complications during their pregnancies. Obstetrical case managers then perform ongoing assessments of these women and coordinate the care they receive from their primary care physicians and other health care professionals. Educational materials, including a pregnancy-related guidebook, are a key component of this program. A survey found that 99 percent of participants were satisfied with this program.

Another excellent example is an asthma program that an AAHP member plan, UCare Minnesota, implemented in Minnesota in 2000. This program provides Medicaid beneficiaries who have asthma with an "action plan"—developed by their primary care physicians—with specific directions on steps to take when a patient's asthma reaches certain levels of severity. In addition, this program makes arrangements for respiratory nurses to conduct home health visits during which they educate patients about the proper use of their inhalers and peak flow meters. Patients can also reach respiratory nurses through a telephone hotline that is open 24 hours a day, seven days a week. A survey of patients participating in this program found that 97.1 percent were satisfied with their action plan and 98.8 percent were satisfied with their nurses.

The Medicaid populations we serve are unique. Our PerformRx program, an insourced pharmacy management program, has applied our 20 years of experience in Medicaid care management to achieve an 8.8 percent average annual pharmacy trend, versus the national trend of 20 percent. Remember, this is for the sickest, most disadvantaged citizens!

ADEQUACY OF MEDICAID HEALTH PLAN PAYMENTS

While Medicaid managed care plans are focused intensely on improving health care for Medicaid enrollees all across the nation, our efforts are complicated by the steps states have been taking, in response to budget crises, to limit funding for Medicaid benefits in recent years. According to a September 2003 report by the Kaiser Family Foundation, 21 states either reduced or froze Medicaid managed care payments in fiscal year 2003, and 19 states are targeting Medicaid managed care for similar payment cuts or freezes in fiscal year 2004. These cost containment measures are seriously challenging the viability of Medicaid managed care program participation for plans that are demonstrating their strong commitment to providing Medicaid beneficiaries with the high quality health coverage they need and deserve.

AAHP and its member plans have strongly encouraged the Centers for Medicare and Medicaid Services (CMS) to take appropriate steps to ensure that state Medicaid agencies provide adequate funding for plans serving Medicaid enrollees and their providers. We are pleased that the agency has issued regulations and related guidance upholding the fundamental principle that Medicaid managed care payment rates must be actuarially sound.

We believe it is critically important for CMS to proactively work with the states to ensure that these regulations are implemented in a way that promotes fair pay-

ments to support the continued viability of Medicaid managed care programs. We also urge the subcommittee to closely monitor this issue and take any steps that may be needed to ensure that payments to Medicaid managed care plans are actuarially sound.

VALUE OF MEDICAID MANAGED CARE

While payment adequacy is a major concern for Medicaid managed care plans and their enrollees and providers, it is also important for Congress to recognize that plans are working hard to ensure that state Medicaid managed care programs receive the highest possible value for the dollars they spend on health care. In addition to delivering high quality health coverage, health plans also bring value to the Medicaid program by providing coverage that is much more cost-effective than fee-for-service Medicaid coverage.

One recent study, conducted by the Lewin Group, found that pharmacy benefits are 10 to 15 percent less costly under Medicaid managed care programs, compared to Medicaid fee-for-service programs. This is a highly significant finding, considering that rapidly rising prescription drug costs are a major factor contributing to medical inflation throughout the health care system.

Another study, conducted by Milliman USA, Inc., estimated that Medicaid managed care plans saved the Wisconsin Medicaid and BadgerCare programs a total of \$35 million in 2001 and \$56 million in 2002. This study indicated that health plans did a better job, relative to the Medicaid fee-for-service system, of reducing the inappropriate use of emergency rooms and unnecessary inpatient hospital stays. Moreover, this study found that Medicaid health plan enrollees in Wisconsin are more highly satisfied than Medicaid fee-for-service enrollees.

Yet another study, conducted by Schaller Anderson, found that managed care plans in Oklahoma's Medicaid program achieved savings of four percent in the total medical and administrative costs associated with health care for persons with chronic disabilities. This same study found that 61 percent of Medicaid managed care enrollees with chronic disabilities said their care was better than under the Medicaid fee-for-service program; another 32 percent said their care was about the same. Fully 60 percent of these beneficiaries said it was easier to get prescription drugs through their health plan than through the fee-for-service program.

Passport, our plan in Kentucky, has saved the Commonwealth \$92.4 million on 100,000 lives in just four years and our HealthChoices program in Pennsylvania has saved the Department of Public Welfare hundreds of millions of dollars since its inception in 1997. At the same time, enrollees in these programs benefit from improved continuity of care and are highly satisfied with their care.

CONCLUSION

In conclusion, I want to emphasize that AmeriHealth Mercy and its family of health plans, along with other AAHP member plans, is strongly committed to our mission of providing high quality, affordable, patient-centered health coverage to low-income Americans and persons with disabilities. We are proud of the success we have demonstrated in improving the health care that is available under Medicaid programs to many of our nation's most vulnerable citizens.

By coordinating care, by emphasizing prevention, by offering disease management services to the chronically ill, and by developing innovative programs to meet the unique needs and circumstances of our Medicaid enrollees, we have established ourselves as a model for Congress to consider as you address the challenges in Medicaid—including the current funding crisis—and undertake future efforts to expand coverage to the uninsured.

Mr. BILIRAKIS. Thank you so very much, sir.
Dr. Medows, you are on.

STATEMENT OF RHONDA MEDOWS

Ms. MEDOWS. Good morning, Chairman Bilirakis, Representative Brown, Representative Wilson, Representative Green.

I want to thank you for the opportunity to address with you today the role of disease management in Medicaid programs, as well as improving clinical outcomes. I am Dr. Rhonda Medows, I am a family physician, and also the Secretary of Florida's Agency for Health Care Administration. That is the State's agency that ad-

ministers the Medicaid program as well as regulates health-care facilities and HMO's.

Today I would like to share with you some highlights of our innovative programs that are in the State of Florida, as well as some lessons learned as we have trudged through implementing disease management programs over the years.

By way of history, you may recall that Governor Bush, in his recent testimony, stated that Florida is the fourth in the Nation, in terms of the size of its Medicaid program. We serve 2.2 million people and have a \$12.7 billion budget.

On further review of the health care expenditures that are covered in that budget, we noted that 50 percent of our health care expenditures were associated with only 5 percent of our population. On further review, we noted that 5 percent of the population had in common several chronic illnesses. Disease management has allowed us to address those chronic disease States, as well as those in need of beneficiaries more directly. So since 1997, Florida became one of the first States in the Nation to implement disease measured programs as a way of addressing those needs. To date, we have disease-measured programs for individuals with diabetes, hypertension, congestive heart failure, asthma, all the immune diseases, HIV AIDS, hemophilia and depression.

The goals for disease management for us include four major categories. One is that we want to be able to change the behavior of the beneficiary, and by changing the behavior, I mean, to increase their compliance with their treatment regimen, to get them to understand what their disease consists of and how they can best control it.

We encourage medication compliance, lifestyle changes, such as correct diet, weight loss, smoking cessation, home monitoring of blood pressures, and also glucose monitoring for those with diabetes.

The second goal is to improve the quality of care that is delivered, and this is best noted when we see that we through disease management actually coordinate their care better, coordination between the patient and physician, as well as between the primary-care physicians and specialists and other health-care professionals.

We also, through disease management, have the opportunity to share best practices and use those across the State.

Third goal would be to improve health outcomes. Well, if one and two happen, then our third bullet actually comes to play, but in addition to improving the quality of care and changing behaviors, we also want to make sure we empower the beneficiary to assume the ability to make their wise health care decisions, so therefore, we invest in their education, the resources they need, and support their need to make those correct health care decisions; and our fourth goal is to lower health care expenditures. This comes about when they are able to make again the correct health care decisions. We note that this occurs when they are taught about the appropriateness of ER visits, the use of hospitals for care.

We teach them how to do preventive care, how to do maintenance care, instead of focusing on crisis care or acute care, which have been the previous model.

We also look at the expenditures in terms of not just the dollar amount saved by looking at claims, but also in terms of the quality of life and quality of health that they develop with these changes.

We use measures that are evaluated by independent evaluators to try and keep this as scientifically sound as possible.

I would like to share with you some lessons learned, and there is probably a whole book that we could probably go through, but I will try to condense it down to maybe five basic ones. No. 1, disease management is an investment in people. The return on this investment is not one that you should think is going to be immediate. We are talking about a long-term investment that takes years to develop.

In the short-term, what happens is we enjoy the benefit of people making lifestyle changes. We enjoy watching the improvements in clinical outcomes as they develop. We enjoy the benefit of having emergency room visits decline and hospitalizations decline as people learn to take better care of themselves and invest in themselves up front.

Second, we have learned the value of public private partnerships. At a time when our State budgets are very well constrained, we have learned to look outward into the community and into the private sector to partner with us in the development of these programs.

Our third lesson learned that I would share with you is that we have learned to look at the whole person, and when I say this, I mean that our first disease management program focuses primarily on a specific disease state that an individual had and providing them with specific services to address that one disease. In reality, though, many of our beneficiaries actually have multiple diseases. They have co-morbidities.

To be more realistic in our approach to try and improve their health outcomes, we had to address their multiple co-morbidities. It is difficult to treat someone with asthma, prescribe medication and not take into account that they also have diabetes as well, that the medication we prescribe for asthma does not affect their diabetes. It does. It needs to be taken into account, and on that note I can say that one of our prime examples of being able to address the person as a whole and to look at co-morbidities is the Florida Healthy State program. This is the program that we have developed in partnership with Pfizer, so this is our public private partnership.

In it, we address the needs of people who have asthma, hypertension, diabetes and congestive heart failure. Pfizer provided a grant for the disease management program for its development and for its operations. The Agency for Health Care Administration used this money and funding to contract with 10 of our high-volume safety net hospitals scattered about the State.

In addition, I should note that it is not just a partnership with the hospital, but it is with the medical community that is associated with that hospital.

In addition, we also had contracted with the call center to provide additional support services. This created a community-based network of care statewide.

The components of the Florida Healthy State program include the following: No. 1, 60 care managers. These are nurses who are individually assigned to individual beneficiaries, usually those who are higher at risk for any of the four diseases that I have described to you and we have 13,000 individuals who are assigned to a particular nurse who is available to them, not just on phone. I do not want to shock you, but occasionally home visits do occur.

No. 2, there is a 24/7 call center that is available to all participants in this program. At the call center there are medical professionals and health-care professionals available, whether they be nurses, nutritionists, et cetera . They are able to provide education, and let's just say gentle encouragement to the individual to take care of themselves, complete their compliance as required.

Mr. BILIRAKIS. Please try to summarize, Doctor.

Ms. MEDOWS. I am going to try to wrap this up real quick. The program also consists with providing them with the home health care supplies they need to manage their disease. It provides health literacy. It is both culturally and linguistically appropriate, as well as a different literacy levels, as well as product donation. The program has reached 113,000 individuals. The fourth and final lesson that I will go over with you today is that the disease management program we believe needs to be community-based. We believe that the services should be delivered where the beneficiary lives. Through a partnership with Bristol Myers Pharmaceutical Company, we have a program that is community-based. It utilizes the 27 fully health care qualified centers in the State and seven counties, and what it does is it incorporates the value of lay health care leaders who are already in the communities, some of which are faith-based, and it is primarily directed toward minority communities, Hispanics, African Americans, et cetera, and what we do is pair them up with health-care professionals, who can take the information back into the community for education support, particularly on issues such as diabetes and depression. Those would probably be the major lessons learned.

In conclusion, I would like to say that we are seeing through our programs, both the ones that I mentioned and the many other others that we have, that there is improved lifestyle changes, there is improved behavior in terms of making correct health care decisions. There is a decline in the use of ER visits, as well as inpatient hospitalizations.

We believe that disease management is a potentially powerful tool in managing health, as well as health care costs.

Thank you. I appreciate the time.

[The prepared statement of Rhonda Medows follows:]

PREPARED STATEMENT OF RHONDA MEDOWS, SECRETARY, FLORIDA AGENCY FOR
HEALTH CARE ADMINISTRATION

Good Morning, Chairman Bilirakis, Representative Brown, and Members of the Committee. Thank you for this opportunity to address the Committee on improving quality and clinical outcomes through disease management in the Medicaid program. I am Dr. Rhonda Medows, Secretary for Florida's Agency for Health Care Administration (AHCA)—the state agency that directly oversees the Medicaid program. Today, I will briefly highlight a number of innovative Medicaid disease management programs in Florida.

As you learned from the testimony of Governor Bush earlier this year, Florida's Medicaid program is the nation's fourth largest. We serve more than two million people and manage a \$12.7 billion budget.

Disease management in Florida is a pioneering effort to coordinate treatment efforts and improve health outcomes. We established a number of unique programs that are financed through innovative strategies—including pharmaceutical investments, and other state partnerships. They focus on chronic diseases, the area that accounts for one of the largest portions of Medicaid spending. We spend 50 percent of our Medicaid budget on 5 percent of our beneficiaries.

In 1997, Florida Medicaid was one of the first state Medicaid programs to establish a disease management program, and may, today, have the largest Medicaid initiative in the U.S. We have learned a great deal about what works and what does not. Time is needed to realize the full benefits of disease management, but early outcomes are positive and worth noting.

This is what we know(disease management works. It saves dollars. For a three-year period starting in July 2000, it is estimated that through program savings and manufacturer guarantees, federal and state Medicaid program spending has been reduced by nearly \$90 million. And, more importantly it has led to changes in health behaviors, better health outcomes, and improved quality of care and life. We have seen individuals lose weight, start exercising, and check their blood pressure and blood sugar on a daily basis. Many have returned to more active lifestyles, allowing some to return to work.

In Florida, we started with a demonstration project and have now implemented disease management programs for asthma, autoimmune disorders, congestive heart failure, diabetes, hemophilia, HIV/AIDS, hypertension, and depression.

Our goals have been to educate consumers, promote best practices, improve health outcomes and care coordination, and reduce both emergency room visits and inpatient hospitalizations. Our first efforts were segmented. That is, we assigned beneficiaries to specific interventions targeted for specific diseases. We quickly found that significant numbers of beneficiaries had more than one chronic condition. This led us to change the program to address patients with multiple diseases. We adjusted our focus to caring for the total patient, not just the diseases.

DISEASE MANAGEMENT PROGRAMS

Beneficiary education and consultation has been a primary focus of the GlaxoSmithKline program as they have provided funding through a medication error demonstration project. AstraZeneca has funded outreach to physicians through regional pharmacists.

The first effort to serve patients with multiple diseases was through our partnership with Pfizer, Inc., to serve people with asthma, congestive heart failure, diabetes, and hypertension. Pfizer provided a grant for disease management services, and the Agency contracted with 10 high-volume hospital systems and one call center. Patients are matched with 60 nurse care managers to provide one-on-one beneficiary education and to support change in health behavior. The program expanded—doubling from the original 50,000 targeted population—to more than 113,000 beneficiaries enrolled in this disease management program.

Participants work individually with their nurse care managers who assess their physical, mental and environmental status, provide education about their diseases, support healthy behavior changes, coordinate care with primary care providers and specialists, and help with access to other needed services. The process empowers people. It helps them make better health care choices and navigate the health care system more efficiently. It provides help with managing the conditions at home by offering glucometers and lancets for diabetics, pillow covers and peak flow meters for asthmatics and weight scales and blood pressure cuffs for heart failure patients at no charge to either the beneficiary or Medicaid.

With Bristol-Myers Squibb we launched a second partnership to provide disease management services through a contract with Federally Qualified Health Centers in seven counties. For the first time we employed a faith based outreach model using Promotoras (lay health workers) with health professionals, and social workers to provide education and support for a minority population with diabetes and depression. More than 2,100 minority beneficiaries have been enrolled.

These partnerships offer a new funding model financed by pharmaceutical manufacturers through a combination of investments and guaranteed savings. Service delivery is focused in the communities where beneficiaries live and requires daily involvement by participants toward a goal of improving both their overall health and their quality of life.

Let me provide an example. Cora Stewart is a 62-year-old Miami woman with diabetes, hypertension, congestive heart failure and emphysema. Before enrolling in disease management under the Pfizer grant, she was insulin dependent, had high cholesterol and could not walk a block or climb stairs. Working with her nurse care manager, Cora lost 45 pounds in six months. She began monitoring her blood pressure at home. She recently attended her daughter's wedding—without the walker she has relied on for years. She has taken control of illnesses that previously controlled her life.

These disease management programs have reduced inpatient hospitalizations and the number of emergency room visits, brought a new level of coordination to every participant's total health care, and improved their quality of life immeasurably. And as if those outcomes were not enough, we have realized substantial cost savings.

Disease management is a powerful tool both in managing health and in containing Medicaid costs. This common sense approach is emerging as the next important chapter in health care.

Thank you. I will be happy to answer any questions you may have.

Mr. BILIRAKIS. Thank you, Doctor.

Mr. Simms.

STATEMENT OF JEFFREY SIMMS

Mr. SIMMS. Good morning, Mr. Chairman, and other members of the subcommittee.

I am Jeffrey Simms, one of the assistant directors of the State Medicaid program for North Carolina, and thanks for the opportunity to share our experience with you.

Over the last 10 years, the North Carolina Department of Health and Human Services, through its two agencies, the Division of Medical Assistance and the Office of Research Demonstrations and Rural Health Development, has worked diligently to link Medicaid recipients with the primary care provider and create medical homes across the State.

This link with the provider has enabled us to really establish a system where we can have the infrastructure to build upon to improve the health care for the Medicaid patients in North Carolina.

As of October 1, 2003, we have more than 700,000 Medicaid recipients linked with the primary provider and in the medical home across the State. 417,000 of those 700,000 recipients are enrolled with providers who are participating in what we call community care of North Carolina, where we are able to have disease management and other quality improvement conditions in place for them.

The Community Care of North Carolina program has established a structure that allows the local, State coalition of county, which includes primary care providers, health departments, hospitals and departments of Social Services to partner together and create a local health care delivery system for the Medicaid patients receiving care.

The local CCM networks identify costly patient services and then develop strategies which will improve utilization and cost management.

The local community care networks collaborate at the State level through statewide clinical directors groups, which select targeted disease and care management processes which will be implemented systematically in all networks. They also review evidence-based practice guidelines and establish program measures.

Disease management in North Carolina has been implemented for diseases specific to asthma and diabetes, and these initiatives include process measures like chart audits, whereby the State and

local networks can measure the providers performance and offer feedback regarding this process measure.

Since the implementation of the asthma initiative over the last 4 years, we have seen a continual increase in the number of individuals who suffer from asthma who are appropriately staged or documented for staging, given the appropriate prescription for corticosteroids and accurate asthma action plans in their medical records.

Improvement can also be seen in the areas of hospitalizations and emergency room utilization for children who suffer from asthma.

For the period of April 2000 through December 2002, the rate of inpatient hospitalizations for children who were linked with the CCNC doctor is 5.3 per 1,000 member months in comparison to 8.2 per 1,000 member months for individuals who were not linked with CCNC providers.

Overall cost data shows that for calendar year 2000, the average asthma episode cost is was \$687 for children who were linked with the CCNC provider and the cost for children not linked with the CCNC provider was \$857 for the episode.

Through the CCNC program, we are able to identify patients who use the emergency room frequently for what would be classified as routine primary care and the care managers follow up with the patients on the telephone, reminding him of primary telephone care office hours, after hours telephone numbers, and they also do home visits as well.

We are seeing the benefits of these efforts, but we are limited in the steps that can be taken to control the inappropriate use of the emergency room because of certain regulations.

During the period of July 1, 2001 to June 30, 2002 we were able to show somewhere in the neighborhood of a 6 percent difference in emergency room utilization for the individuals and children linked with CCNC providers.

The CCNC infrastructure at the local level affords us the opportunity to work with the local hospitals to devise strategies to reinforce the medical home concept and to also provide the patient's primary care providers with real time emergency room encounter sheets.

That is where the local partnership with the local hospital helps us and is able to come to the table to work with us.

We are also exploring reimbursement options for the emergency room as well. The providers who are participating in community care of North Carolina have seen this, as the opportunity to really work together and identify ways and strategies to improve care, but not only improve care and quality, but also figure out ways to address some of the budget issues we are facing with our North Carolina Medicaid program. They identify strategies that would give us quick return.

One of those is by looking at prescribing patterns for the providers participating in the community care of North Carolina. As a result, the providers have come together and they have developed a voluntary provider list where they are able to go in and look at prescribed drugs that evaluate the relative cost of medicines prescribed to key therapeutic categories.

They identify the top 100 drugs by Medicaid expenditures in North Carolina, and then arrange those compounds in a tiered fashion, whereas the providers are now able to see where the actual costs are.

As a result of this voluntary provider-driven effort, preliminary findings show that a post-rollout period of February through March of 2003 has shown 22 percent lower expenditures compared to pre-rollout period of September through October of 2002.

Additionally, the Community Care of North Carolina infrastructure has allowed us to develop and implement strategies that are not necessarily included in the traditional PCCN program. We have looked at a nursing home polypharmacy initiative that creates pharmacist and physician teams that review drug profiles and medical records and care coordination for Medicaid patients and nursing homes.

They determine if a drug therapy problem exists and recommend a change and perform follow-up. Approximately 9,200 nursing home residents had greater than 18 drugs used within a ninety-day period. The criteria used to identify individuals included inappropriate drugs for the elderly, known as Beers drugs, drugs used beyond usual time limits, drug use warning and precautions and potential therapy duplications.

We have been able to see some results of that initiative in the UNC School of Pharmacy, is completing an extensive evaluation of this initiative.

In my conclusion, the Community Care of North Carolina program provides the infrastructure for the Department of Health and Human Services and the Medicare program of North Carolina to set priorities that can be implemented at the local level. We will continue to identify additional disease management initiatives and other opportunities for coordination, which will allow us to collaborate with public providers—public and private providers at the local level.

We have learned that the success of this program is contingent on community ownership, partnership, appropriately aligned incentives, behavior change and the ability to measure change and patients.

Thank you.

[The prepared statement of Jeffrey Simms follows:]

PREPARED STATEMENT OF JEFFREY SIMMS, ASSISTANT DIRECTOR, NORTH CAROLINA
DIVISION OF MEDICAL ASSISTANCE

Over the last ten years, the North Carolina Department of Health and Human Services through two of its agencies—the Division of Medical Assistance and the Office of Research Demonstrations and Rural Health Development, has worked diligently to link Medicaid recipients with a primary care provider in their local community, creating a medical home and addressing the access to medical services issue commonly known to Medicaid recipients. This link with the provider has established the basic infrastructure of the Community Care of North Carolina Program, also known as Carolina ACCESS I, II & III, a statewide primary care case management program. Community Care of North Carolina provides a system wherein the health care for the Medicaid population can be managed through a fee for service reimbursement environment.

As of October 1, 2003 more than 700,000 Medicaid recipients across the state have medical homes with providers through this PCCM program and approximately 417,000 of these recipients are linked with one of the 2,000 providers who participate in a Community Care Provider Network that focuses on improved quality, utili-

zation and cost effectiveness for the Medicaid program. Included in the supporting information is a map showing the distribution of the current thirteen CCNC networks across North Carolina. We are in the process of expanding the CCNC networks statewide by June 30, 2005.

The Community Care of NC Program has established a structure that allows the local stakeholders in a county, which includes primary care providers, health departments, hospitals, and Departments of Social Services, to partner together and create a local health care delivery system for the Medicaid recipients receiving care in their community. The local CCNC networks identify costly Medicaid patients and services and then develop strategies that will improve utilization and cost management. This local collaboration also assists in the elimination of the fragmentation of care between public and private providers.

The local Community Care Networks collaborate at the state level through the statewide clinical directors group, which selects targeted disease and care management processes that will be implemented systematically in all networks; reviews evidenced-based practice guidelines; and establishes program measures. At the present time these targeted disease and care management processes include: asthma, diabetes, pharmacy management, high risk/high cost management, and emergency room utilization.

Any of the disease management initiatives implemented in Community Care of NC involves the clinical directors group setting performance standards; each network obtaining local provider buy-in; standardized physician toolkits; local and state level technical assistance; and practice level quality improvement system processes.

The asthma and diabetes disease management initiatives include chart audits as a process measure whereby the state and networks can measure the providers' performance and offer feedback regarding this process measure. Since the implementation of the asthma initiative over the last four years we have seen a continual increase in the number of individuals who suffer from asthma who had documentation of staging, appropriately prescribed corticosteroids and accurate asthma action plans in the medical record. A bar graph is included in the packet showing this trend. Also included is a graph showing the chart audits for diabetes, which also shows improvements in the way providers are treating individuals who suffer from diabetes.

Improvement can also be seen in the area of hospitalizations and emergency room utilization for children who suffer from asthma. For the period of April 2000-December 2002, the rate of inpatient hospitalizations for children linked with a CCNC provider was 5.3 per 1000 member months, whereas those children linked with providers who were not participating in CCNC was 8.2 per 1000 member months.

For that same period, April 2000 through December 2002, the pediatric asthma emergency room utilization rate was 158 per 1000 member months for children linked with a CCNC provider, whereas for children linked with providers who were not participating in CCNC, the rate was 242 per 1000 member months.

Overall cost data shows that for calendar year 2000, the average asthma episode cost was \$687 for children under 18 years of age linked with a CCNC provider and the cost for those children linked with a provider who was not participating in CCNC was \$857. We are in the process of pulling more recent cost data related to the treatment of asthma.

CCNC has enabled the North Carolina Medicaid program to establish medical homes for the Medicaid population across the state. However, we still struggle with the inappropriate use of the emergency room. Through the CCNC program we are able to identify patients who use the emergency room for what would be classified as routine primary care and the care managers follow up with those patients on the telephone, reminding them of their primary care provider's office hours and after hours telephone number. We are seeing the benefits of these efforts, but we are limited in the steps that can be taken to control the inappropriate use of the emergency room. During the period of July 1, 2001 through June 30, 2002, we were able to show a 6% difference in the number of children linked with a CCNC provider who received services in the emergency room when compared to the children linked with a provider who was not participating in CCNC. The CCNC infrastructure at the local level affords us the opportunity to work with the local hospitals to devise strategies to re-enforce the medical home concept and to also provide the patient's primary care providers with real time emergency room encounter sheets. We are also exploring reimbursement options for the emergency room.

The physicians who participate in Community Care of North Carolina felt the need to encourage providers to take an informed look at their prescribing habits for their Medicaid patients. The providers felt the need to evaluate the relative costs of medicines prescribed in key therapeutic categories. They identified the top 100 drugs by Medicaid expenditures in North Carolina and then arranged those compounds in a tiered fashion by average wholesale price (AWP), where Tier 1 drugs

offer the greatest potential cost savings to the Medicaid program. The tiered list is shared with providers throughout the CCNC network via posters, pocket-sized reference cards and an electronic drug reference entitled ePocrates. As a result of this voluntary, provider driven effort, preliminary findings show that a post-rollout period of February-March 2003 has a 22% lower expenditures compared to a pre-rollout period of September 2002-October 2002. The actual savings equals approximately \$640,000.

Additionally, the CCNC infrastructure has allowed us to develop and implement a nursing home poly-pharmacy initiative that creates pharmacist and physician teams that review drug profiles and medical records for Medicaid patients in nursing homes. They determine if a drug therapy problem exists and then recommend a change and perform follow-up. Approximately, 9,208 nursing home residents had greater than 18 drugs used within a 90 day period. The criteria used to identify the individuals included: inappropriate drugs for the elderly known as "Beers drugs"; drugs used beyond usual time limit; drug use warnings and precautions; the prescription advantage list; and potential therapeutic duplication. Of the 9,208 patients, recommendations were made on 8,559 of them and 74% or 6,359 had recommendations implemented. This initiative has proven that the pharmacist and physician team approach reduces costs and improves quality. The UNC School of Pharmacy is completing the evaluation of this initiative. Potential expansion options include all nursing home and assisted living patients, including adult care home patients in North Carolina.

In my conclusion the Community Care of North Carolina program provides the infrastructure for the NC Department of Health and Human Services to set priorities that can be implemented at the local level. We will continue to identify disease management initiatives and other opportunities to collaborate with public providers at the local level. We have learned that the success of this program is contingent upon community ownership, partnership, appropriately aligned incentives, behavior change, the ability to measure change and patience.

Mr. BILIRAKIS. Thank you very much, Mr. Simms.

Ms. Bella, you are on.

STATEMENT OF MELANIE M. BELLA

Ms. BELLA. Good morning, Mr. Chairman, Representative Brown, Representative Wilson and Representative Green.

My name is Melanie Bella. I am the Medicaid director for the State of Indiana, and I appreciate the opportunity to come talk to you a little bit about what we are doing.

Under the leadership of our Governor, Joe Kernan, and in partnership with our State Department of Health and the Health Commissioner, Dr. Wilson, we have developed what we call the Indiana Chronic Disease Management program. It is a program that is designed to change the way care is delivered statewide, not just within the Medicaid population, because the problems that we see plaguing our programs in the area of chronic disease are the same ones that our Medicare beneficiaries are facing, our employers are facing, and the rest of the public health community providers in Indiana are facing, so it is critical that we have the partnership of the Department of Health in building this community effort that we have put together.

Right now, we started our program in July and we have a program in place for recipients place for diabetes and recipients with congestive heart failure and we will be adding asthma, stroke, hypertension, HIV AIDS within the next 6-month period, so we are excited about the initial results we are seeing, and I want to talk to you a little bit about how we got to where we are.

We started out looking at using commercial disease management vendors and changed the course to really do what we call assemble the pieces in a locally based infrastructure across the State that

utilizes our existing public health infrastructure and puts together a program that works for the State, regardless of payer source, regardless of disease state, to create true sustainable long-term value for the State of Indiana.

Henceforth, our focus has been on developing infrastructure that we need to promote permanent, long-term, sustainable change, so if I could just direct you to that picture over there for a few minutes and hopefully keep me on time here.

I want to talk to you about the main pieces that are part of our program and how they work together, and there are five main principles that we have used in putting together this infrastructure, those being what we promote as evidence-based guidelines, protocols for our providers. We believe strongly that this program must have the involvement of patients and we have a strong patient self-management program, we use the Stanford self-management approach.

We would not be able to do this program without extensive involvement by the primary care providers in the Indiana community.

Fourth, this program must be cost effective for us. As you all know, the pressures that Medicare and payers everywhere are facing, and last it is very important that we use our existing public health infrastructure. If we are going to spend resources on attacking the problems of chronic illness, we wanted to spend those in-state and infuse them into the local public health infrastructure, rather than spend them quite honestly with a commercial vendor, so let me talk to you about those pieces.

If you start at the top, that is where Medicaid and the Department of Health are working together and using community resources, and that feeds really into the heart of our program, which is the patient and the provider.

The goal of this program is to keep the patient engaged with their medical home, knowing if we are going to have long-term sustainable success the patient has to be engaged with their primary-care provider. We provide a support system, but that is just short-term, dead-end work with our high-needs patients and put them back in touch with their primary-care system to promote the medical home concept.

On the left-hand side is where we bring in the patient, and we are teaching them self-management, how to better interact with their primary care providers and make healthy choices and decisions affecting their health care.

On the right-hand side are the materials and tools that we give to our providers. We were fortunate enough to be kind of adopted by the McCall Institute and use the chronic care model and the institute for Health Care Improvement to help us take evidence-based guidelines, work with our physician, community, and commercial payers within the State to modify them for Indiana's use and put together guidelines and protocols that have been endorsed by payers and providers to spread across the State so that everyone in Indiana is using the same evidence-based guidelines for these disease states, so it is those resources that we feed into our providers.

I brought a copy today. We have a provider tool kit and a nurse care manager book, very simple, straightforward guidelines, flow sheets. I would be happy to share this with anyone.

In addition, we have all of this on CD that we have provided to all of our providers who are interested across the State and who are also willing to share with any other State Medicaid programs or public health entities, because this has been developed in the public domain and we want to maximize the public investment for everyone.

Mr. BILIRAKIS. Would you provide those to the committee?

Ms. BELLA. Certainly. I will be happy to do that.

Mr. BILIRAKIS. Without objection, that will be the case and that will be made part of the record.

Ms. BELLA. Okay.

Thank you very much.

Again focusing on the heart of the patient and provider, the question was what supports do we give to promote the medical home concept, so we have a care management component that has two pieces: One is a call center and one is a network of care managers.

Our call center is managing about 80 percent of our patients, although they touch everyone in our program and our call center functionality is provided with our existing partner who provides call center services to Medicaid. That helps us, because they already know our population and they have credibility with our provider base.

We have a nurse care manager network that those functions are provided to us by Indiana Minority Health Coalition and our primary health care association; again, resources already located in the community who know how to deal with our patient population.

And last and most importantly, we have a Web-based patient registry that we developed in conjunction with one of the Medicare quality improvement organizations to support the exchange of data and the ability to measure outcomes, and we—I know I am running out of time, but I would be remiss not to let you know that we have a very strong measurement and evaluation component in place that is being provided to us by the Regenstrief Institute of the Indiana University School of Medicine. They will be doing a statewide study of our program, as well as a randomized controlled trial, so that we can truly isolate the impact of these interventions and see if what we are doing is successful or not, so I would very much appreciate the opportunity to talk to you today and would love to share information with anyone who is interested in how to change the way care is delivered across their State.

Thank you very much.

[The prepared statement of Melanie M. Bella follows:]

PREPARED STATEMENT OF MELANIE M. BELLA, ASSISTANT SECRETARY, INDIANA
FAMILY AND SOCIAL SERVICES ADMINISTRATION

INTRODUCTION

Chairman Bilirakis, Ranking Member Brown, distinguished Subcommittee members, thank you for this opportunity to share with you an initiative designed to improve quality and clinical outcomes for Medicaid recipients in Indiana. My name is Melanie Bella, and I am the Assistant Secretary of the Indiana Family and Social Services Administration, and the Director of the Office of Medicaid Policy and Plan-

ning (OMPP). In partnership with the Indiana State Department of Health and the State Health Commissioner, Greg Wilson, M.D., we have developed and implemented a comprehensive initiative, the Indiana Chronic Disease Management Program (ICDMP), designed to change the way health care is delivered across the state of Indiana.

The goal of the ICDMP is to build a comprehensive, locally based infrastructure that: 1.) is sustainable; 2.) strengthens the existing public health infrastructure; and 3.) helps improve the quality of health care for all populations, not just Medicaid recipients. We hope that the ICDMP infrastructure will be an asset not only for patients but also for healthcare providers. We also hope the ICDMP can serve as a model for other states that may be interested in building integrated, locally based infrastructures for their Medicaid program and state as a whole. Strengthening public health systems and care delivery networks designed to decrease the prevalence of chronic illness and increase the use of primary care ensures that states are maximizing the public investment in achieving quality health outcomes.

MEDICAID CHALLENGE

The Medicaid program in Indiana covers approximately 765,000 recipients at a cost of \$4.3 billion today. Like most states, enrollment and demand for Medicaid services continues to increase. By the end of State Fiscal Year 2005, Indiana expects to spend \$4.8 billion to cover over 825,000 recipients. Even with continued cost containment efforts, the rates of growth in Medicaid expenditures will continue to be unsustainable for states unless they develop new strategies for managing Medicaid costs. The new strategies must address the primary drivers of Medicaid expenditures: utilization and poor quality. It is critical that Medicaid programs focus on controlling utilization and improving health care quality for recipients with chronic illness. By making strategic system investments, states can develop the infrastructure necessary to improve care delivery and quality outcomes, which will help chronically ill patients lead more productive lives, slow the rate of growth in the short term and, ultimately, reduce costs in the long term.

BACKGROUND

In 2000, approximately 125 million people in the United States had some type of chronic illness and by 2020 it is estimated to grow to 157 million. By 2010, 17% of our GDP will be spent on health care, and 78% of these costs will result from chronic diseases, including almost 80% of total Medicaid expenditures, and this is increasing as our population ages. Numerous surveys and audits have documented gaps between well-established guidelines for the clinical aspects of care and how practitioners are actually delivering care. Providers feel resource constrained and too rushed to meet the clinical, educational, and psychological needs of chronically ill patients and their caregivers. Patients often experience care that is uncoordinated, impersonal and unsupportive, which may leave them feeling incapable of meeting the day-to-day needs of managing their chronic condition.

In Indiana, national, state, and local partners are working together to implement a model of care for people with chronic conditions. Indiana's five major objectives for its chronic disease management program are as follows:

- Provide consistently high quality care to Medicaid recipients that improves health status, enhances quality of life and teaches self-management skills.
- Provide support to primary care providers and integrate primary care with case management.
- Utilize and strengthen the public health infrastructure.
- Reduce the overall cost of providing health care to Medicaid patients suffering from chronic diseases.
- Achieve long term results by changing the way primary care is delivered across the state, not just for Medicaid.

The key themes underlying the objectives are: patient self management, involvement of primary care providers, utilization of public health infrastructure and cost effectiveness. Most importantly, Indiana's program eventually aims to change the way care is delivered statewide—regardless of payer source and regardless of illness.

We are initially targeting recipients with diabetes and congestive heart failure (CHF) and are quickly expanding to include asthma, stroke, hypertension and HIV/AIDS. Other chronic diseases will be added as appropriate and necessary. The clinical priorities of each condition are based on currently available scientific evidence. The principles used to improve care for the chronic conditions include:

- Implementation of the Chronic Care Model in the primary care settings.

- Creation of a care management network to provide support to primary care practices.

This will begin through a series of “Collaborative” learning sessions, which will serve as the foundation for spreading the Chronic Care Model statewide. The Break-through Series Collaboratives were developed by the Institute for Healthcare Improvement (IHI) in the mid 90’s to facilitate health system change. Participants in the Collaborative will learn and implement an organizational approach to caring for people with chronic disease that utilizes and supports a comprehensive, sustainable locally based care network. The Collaborative model will be implemented statewide in a phased approach over a twelve-month period by sharing the best available scientific knowledge on the care for people with these conditions, and by learning and applying methods for change in the delivery of primary care.

STATE OPTIONS FOR MANAGING CHRONIC DISEASE

In the 2001 legislative session, the Indiana General Assembly mandated that the Office of Medicaid Policy and Planning (OMPP) contract with a commercial vendor to provide disease management to recipients with diabetes, congestive heart failure, asthma, HIV/AIDs and to provide case management for recipients with the top 10% of costs. OMPP issued a request for proposal (RFP), received bids from four vendors, selected one and began negotiations. Eleven months later, OMPP canceled the procurement. In the 2002 legislative session, the General Assembly removed the requirement that OMPP contract with a commercial vendor.

We learned that there are options other than the commercial vendor approach, and it is important for other states to know that alternative options exist. Many people assume there are just two choices: “make” or “buy”. “Make” usually implies starting from scratch and states are legitimately concerned about the time, resources and potential duplication of effort of that approach. The “buy” option is attractive because states can hold a vendor accountable and augment scarce state resources. The question is what is the state left with when the contract ends. Luckily, there is a third option: “assemble”. The assemble approach is basically a hybrid of the make or buy models that allows states to assemble the best pieces together into a locally based infrastructure that supports and enhances the existing state public health infrastructure. Indiana chose the assemble approach, but it is important to note the pros and cons of each option.

There are two major options in the “Buy Model”: outsourcing completely to a commercial vendor or utilizing commercial chronic illness software. Based on our analysis, we identified some of the major pros and cons of each to be as follows.

Buy: Commercial Vendor Approach

Pros	Cons
One stop shopping	Little or no local input or involvement of providers or community
Access to resources (products and people)	Jobs & revenue associated with running the program go out of state
Financial risk accepted by vendor	Risk negotiation difficult for Medicaid populations No sustainable investment in infrastructure

Buy: Chronic Illness Software

Pros	Cons
Off the shelf program, already developed	No local physician or delivery system input or involvement Limited/no flexibility with survey tool Telephonic case management only System does not always interact with claims systems, makes reporting duplicative

Assemble: Chronic Care Model

Pros	Cons
Evidence based interventions with proven results	Requires significant state resources
Allows for local input and experience in developing program components.	State retains financial risk
Promotes patient self management	In the short term, may take longer to develop and implement (note: this was not the case in Indiana)

Pros	Cons
Carries over to improve care for all patients in a practice Keeps revenues and jobs in state Provides on site as well as telephonic case management Creates a comprehensive, sustainable locally based infrastructure with effective case management in place to support primary care providers and Medicaid members.	

INDIANA'S CHOICE: CHRONIC DISEASE MANAGEMENT PROGRAM (ICDMP)

During the period of negotiations with the commercial vendor, Indiana was chosen to participate in a Policy Academy on Chronic Disease Management and Prevention sponsored by the National Governors Association. A team of state policymakers, legislators and community stakeholders attended a planning session and developed a strategic action plan. As part of that process, we became introduced to experts in the field of chronic disease management and began to question if what we had asked for in the RFP and were in the process of negotiating was in the long-term best interests of the State. As we learned more and the negotiations narrowed to debates over guaranteed cost savings as opposed to interventions, protocols and quality improvement, we concluded that the commercial vendor approach we had originally envisioned was no longer the model we wanted to pursue. We enlisted the support of Dr. Ed Wagner, Director of the MacColl Institute for Healthcare Innovation, Center for Health Studies, Group Health Cooperative, and his team in developing a program grounded in the principles of the Chronic Care Model. The Chronic Care Model was developed through Improving Chronic Illness Care (ICIC), a national program supported by the Robert Wood Johnson Foundation. The Chronic Care Model focuses on improving care delivery and promoting system change through the use of evidence based care practices, strong patient self-management and extensive involvement of primary care providers and practices. The Chronic Care Model reinforces all the elements necessary for creating a sustainable, comprehensive, locally based infrastructure:

- Evidence based guidelines
- Tools to support and assist providers
- Strong patient self management and involvement in health care decisions
- Investment in public health infrastructure
- Creation of sustainable infrastructure in a locally based manner that benefits state as a whole and leaves the state better off than when it started
- Long term focus on improving quality vs. short term focus on “guaranteed” savings

The Chronic Care Model changes the approach of medical care from reactive, acute care for illness to a preventive, coordinated care model for health that will decrease complications and eventually reduce costs. As mentioned earlier, we will be spreading the Chronic Care Model through a series of Collaborative learning sessions developed by the Institute for Healthcare Improvement (IHI). IHI has been a valuable partner in teaching us how to test change concepts and develop and implement quality improvement initiatives in the medical care environment.

ASSEMBLING THE INFRASTRUCTURE

Using the assemble approach, the first step is to identify the best components and partners available to build and strengthen the existing public health infrastructure and that will facilitate the interaction between primary care and chronic disease case management statewide.

The ICDMP has the following major components and partners:

- Program Management. Medicaid and the Department of Health are jointly responsible for the program including policy development, contracting and monitoring performance.
- Primary Care. The focal point of patient care is the primary care physician. Key elements of the ICDMP are designed to provide information and resources to support the physician. The Medicaid provider community is our partner in this component, and we are working with them to ensure our reimbursement is aligned with the outcomes we hope to achieve.
- Care Management. Care management is comprised of:
 - A Call Center that monitors patient status and follow-up based on the established protocols. We partnered with the existing Medicaid call center vendor to provide these services to take advantage of the relationships, credibility

and knowledge they already have with our recipients and providers. The call center services are available for all ICDMP patients.

- A Nurse Care Manager network whose nurses provide more intense follow up and support to a smaller group of high-risk patients. We partnered with the Indiana Minority Health Coalition and the Indiana Primary Health Care Association to hire nurses and deploy them statewide, according to physician practice and geographic area. These organizations are natural partners in that they have established relationships and credibility across the state and are fairly evenly split between urban and rural areas, which prevent overlap or duplication.
- Patient Data Registry. An electronic data registry is available to physicians and can be used for all patients. For Medicaid patients, it will be populated with claims data and case management data. We partnered with Mountain Pacific Quality Health Foundation, the Medicare Quality Improvement Organization for Montana, in the development of the Chronic Disease Management System (CDMS). CDMS contains the ICDMP care protocols and clinical guidelines, patient education materials, Medicaid claims data, reminder and recall functions and other clinical data entered by the call center, providers or nurse care managers.
- Measurement & Evaluation. Measures of program performance are being established using both claims history data and individual health outcomes indicators for both an intervention and control group. We partnered with the Regenstrief Institute, of the Indiana University School of Medicine, to perform a statewide evaluation as well as a randomized controlled clinical study within Marion County (Central Indiana region). We are committed to a rigorous evaluation of this program that will measure total costs (not just savings from reduced hospitalizations) and identify which components are effective as well as those that are not achieving the intended outcome and need to be changed. For an evaluation to be meaningful, it must be clearly structured to measure total program effectiveness. As such, when evaluating chronic disease management programs, it is critical to examine all costs for all patients during the intervention. Looking only at selected costs or only at the most expensive groups of patients can be deceiving.

In closing, I'd like to thank the Members of the Subcommittee for the opportunity to discuss this important issue with you. The Indiana Chronic Disease Management Program was assembled with the help of many experts in this field to solve a public health problem that reaches far beyond the Medicaid program alone. We would be more than happy to share any of our materials (clinical protocols, consensus guidelines, patient education materials, call center scripts, patient identification criteria, etc) with any state that is interested in assembling their own chronic disease management program. Thank you again for your time, and I would be happy to answer any questions you may have.

Mr. BILIRAKIS. Thank you, Ms. Bella, and I would ask all of you to feel free—we would welcome any additional information you might have to furnish to us, such as the information that you have talked about becomes a part of the record. So please basically help us to come up with whatever changes need to be made and any need to be made, improvement and that sort of thing.

Well, Dr. Medows, I guess it is no surprise that I am going to start with you. I am just pleased that you and others spoke with great emphasis on benefits to the patient, the patient, slash, beneficiaries, slash, patient. You know, when you talk about savings, and they are very significant obviously, because there is only so much there, and we want to be sure that the dollars are best used and in the best way possible. But I think the bottom line is the benefit to the patient. And so you have talked about improving quality of care, improve health outcomes, et cetera. I want you to feel free to submit to us in more detail, if you can, some of your experiences in that regard, you know, and what you have learned.

You talked about the four areas that Florida has learned. I find that very significant. And so if you can go into details there and in writing to us, and also, the Promotora program, because, again,

as your written statement indicates, a lot of the chronic diseases have disproportionate impact on many minority populations, and apparently a Promotora program is being very helpful in that regard in conjunction with working with Bristol-Myers. So please expand upon that, give us more details so we can learn more about it. And the reason is because we can only go into so many things here orally, but it could be very helpful.

The question that I would have is something that you haven't mentioned regarding the Florida Legislature's Office of Program Policy there, their study and their analysis, which recently released a report that was very critical of the funding, and I say very critical. Maybe very is wrong, but, in any case, critical of the funding mechanism used to pay for your disease management program. It indicated that the State could have received more money through supplemental drug manufacturer rebates rather than having the manufacturers pay for a disease management program.

So the questions regarding that are do you believe that Florida negotiated a fair deal in its negotiations from the drug manufacturers? Does the analysis account for future year savings that can be achieved through improved beneficiary health as against if you have got the dollars and use them toward that end; and what assumptions did the report make, if you know, about all the manufacturers participating in the value-added programs converting to supplemental rebate?

Now those are basically the questions. If you can take maybe the rest of the time to respond to that, I would appreciate it.

Ms. MEDOWS. Okay. Thank you, Mr. Chairman.

I do believe that the negotiations were done fairly. In 2001, the Florida Healthy State contract was signed with Pfizer, and at that time we believed that the rebate value with us, with the State of Florida and Pfizer, would have been \$33 million. Instead of that what we chose to do was take this in terms of value-added funding for the disease management program.

I would have to disagree with APAGA's conclusion that it would be better to simply take that one-time savings and rebate that would be non reoccurring as opposed to continuing the program that was already serving over 100,000 individuals.

Mr. BILIRAKIS. Can you evaluate the dollars of the program in terms of the Pfizer's—the drug manufacturers' part in it as against the \$33 million? Is that it, or are Florida beneficiaries receiving more in terms of benefits?

Ms. MEDOWS. I believe that they certainly are.

Mr. BILIRAKIS. Okay. Please continue.

Ms. MEDOWS. I believe that because if we simply had done a rebate, it would have been a nonreoccurring. We believe that several assumptions were made that would not necessarily be true: First, that if we took a rebate, that the money that would be saved for that particular year would automatically be sent back to the Medicaid program in terms of disease management. We don't know that that necessarily would be true. In fact, given budget crunch and budget shortfalls, I am not so sure that it would have made it back to them, okay.

No. 2, this was an assumption that was made that the pharmaceutical manufacturers would have agreed to a rebate if value-

added programs were not an option. The pharmaceutical manufacturers do not have to do that. They do have a third and fourth option. One is not to participate in our program at all. And two is to have us to do a prior authorization-type program which would be costly and a little bit prohibitive in terms of resources and staff. They made an additional assumption, and that assumption was not valuing what the benefits would be to the individuals being served in that program and looking in the long haul over the decreased health care expenditure because of the improved health outcomes that we expect.

Mr. BILIRAKIS. My time is up. But, again, I would ask you to expand as you may wish to your answer in that regard, because that is certainly a significant point in our deliberations.

And I now yield to Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

I would like to start by asking unanimous consent to enter into the record the Office of Program Policy analysis of the Government Accountability Office of the Florida Legislature, if I could, which discusses and illuminates some of Dr. Medows' comments and contentions. If I could enter that.

Mr. BILIRAKIS. Without objection.

Mr. BROWN. Ms. Bella, I would like to ask you and Mr. Simms each a question. I first want to mention a comment my friend from New Mexico Ms. Wilson made in her opening comments about needing more data—and, yes, the hearing last week on Medicaid showed we really don't get enough data. And I would ask the committee at some point to help us get more information from those—from those carriers, private, HMOs, both in Medicare and Medicaid that don't collect data, frankly, as well as fee-for-service, because they don't give us data on individual claims. So I hope that we can work together and be able to get more information and be able to understand both Medicare and Medicaid better in the future.

Ms. Bella, you spoke generally of some of the reasons why Indiana decided that the private vendor approach wouldn't lead to the long-term sustainable and effective case management model that you were seeking. Could you elaborate on how the private disease management organization was interested in being reimbursed, and can you approximate how much of the savings earned by Indiana would have actually gone to them?

Ms. BELLA. Sure. Thank you.

Briefly, they were—proposed to us a funding on a per-member/per-month basis. At different points in the negotiation, it was unclear whether you would be paying on eligible members, enrolled members or engaged members. And so there was a lot of variation there in terms of how you know if someone is truly being touched and affected in order to generate a payment on a monthly basis. They proposed to put a percentage of their fees at risk, and that is one of the main problems that we had, quite honestly, is that we spent a lot of time negotiating over a guaranteed savings and not a lot of time discussing the substance of the interventions. We ran into problems about how to count savings for the Medicare dual-eligibles, for example, and how to take into account the fluidity of the recipients as they go on and off the Medicaid program.

Mr. BROWN. Thank you.

Mr. Simms, it appears that because disease management is new to a number of States, that monitoring and reporting and benchmarks can be critical to creating future success, obviously. What kinds of monitoring tools—if you would share with us the monitoring tools, the reporting requirements that North Carolina implemented through its—all its ACCESS I, II and III program.

Mr. SIMMS. We have really made a lot of effort at getting the process measures in place and looking at the chart audits, those sorts of things, and that can be provided. Some of the results of those chart audits can be provided to the subcommittee.

Some other things that we have been looking at are some practice profiles for the providers. We are looking at doing an in-house sort of practice profiles that can be risk-adjusted to give to the providers. We are learning that the feedback to the docs are what really enables them to really begin looking and working more aggressively to get things in place. But I can give the subcommittee examples of those practice profiles as well and what we are putting in place.

Over the last couple of years we have also done some things with quality in relation to our patient population, looking at the CAP survey, patient satisfaction, making sure that the patients are feeling that the health care delivery system is something that is meeting their needs as well.

Mr. BROWN. Thank you.

And, Ms. Bella, one more question for you in the last minute or so. Could you just describe to us how you—more about the integration of the Department of Health, the physicians, other providers, community resources and patients when you develop the program that it seems to be more sustainable in the long run? How critical is that integration to creating a more effective and long-lasting program?

Ms. BELLA. Thank you. That is a very important question, Representative Brown. We convened a Chronic Disease Policy Advisory Council that consisted of all the major insurers in the State of Indiana, the medical associations and other health plans as well as physician groups. They came to the table and worked with us, so we got their buy-in and involvement early on, which we believe helps engage them in the implementation of our program.

In addition, we identified local resources across the State who already have relationships with recipients and the provider community as well as the public health infrastructure, and the reason we believe that makes that more sustainable is because they are invested in these decisions, and they are already part of that health care system. And we are creating the infrastructure with them, and we believe that that will make them more active participants in that and vested in the success and the long-term viability.

Mr. BROWN. Thank you.

Mr. BILIRAKIS. Mrs. Wilson to inquire.

Mrs. WILSON. Thank you, Mr. Chairman.

I wanted to ask a question of Chris and also of the three State representatives as well. In order to embark on these programs, and in your case, Chris, with the States that you work with, did the States require a waiver from CMS to try this?

Ms. SELECKY. Yes. In the case of Florida, we did have to get a waiver, and it took about a year to go through that process, which was unfortunate. It delayed the start of the program. In New Mexico we are working with the managed care organizations, so no waiver is required.

Mrs. WILSON. So the only waiver was the one that they had to apply for to do managed care under Medicaid.

Ms. SELECKY. Yes.

Mrs. WILSON. What about in the other States? Did you require waivers, and how long did it take you? Dr. Medows, do you want to—

Ms. MEDOWS. It is actually variable in terms of the length. There are some programs—we have had programs going on since 1997, so there are different people working in CMS at different times, different emphasis on getting waivers through the system.

And then you have to take into account that some of our programs like the Pfizer Healthy State program was quite new and complicated. I think we may have built some new laws just around it, new rules. It took quite a bit of work.

Mrs. WILSON. Mr. Simms, did North Carolina require a waiver in order to do what you wanted to?

Mr. SIMMS. Initially with our Primary Care Case Management program, when we started in the early 1990's, yes, it was a 1915(b) freedom of choice waiver. But most recently, with the BBA managed care regs, they allow you to do a lot of the enrollment and linkage with primary care providers through the State plan amendment process, and that is what we have been able to do with the bulk of this population. It does not allow you to mandatorily link the vulnerable or the special needs population. You have to make sure that they recognize it is a voluntary program for them. But for the bulk of the population we were able to still mandatorily link them through the State plan amendment process.

Mrs. WILSON. How about Indiana?

Ms. BELLA. Indiana also has a 1915(b) waiver for our managed care program, and we were able to add this. Basically it is an amendment to that waiver to allow us to provide these services.

Mrs. WILSON. With respect to Indiana, you mentioned that there is a—I think you said Indiana University is doing a study on measurement and evaluation. But aside from the kind of studies where someone goes in and takes a snapshot look, what kind of information systems do you have in place linking all of these to know whether you are improving the health status of the members?

Ms. BELLA. We have what is on there referred to as the Web-based patient registry, CDMS's chronic disease management system, developed by the quality improvement organization for Montana. And we have worked with them to—it is an electronic patient registry that contains claims data, clinical data, guidelines, reminder recall, anything that anybody that touches that patient wants to put in there. So we use that.

In addition, we have softer measures that we obtained through assessments that our call center is doing. We have process measures that we look at; simply, is the person getting their recommended eye exam. And then we have outcome measures, mostly through the Regenstrief Institute.

And one point to note that IU is doing for us, they are doing a statewide evaluation that will be a pre- and postsnapshot look, as you refer to. But we do have a randomized control trial going on as well that will provide an even more rigorous evaluation, and our focus is on both process and outcomes.

Mrs. WILSON. Chris, how does LifeMasters use information systems to give you—what kinds of data systems do you have on telling whether people are healthy or not?

Ms. SELECKY. We have developed a very sophisticated data base management system which brings in data from a variety of sources, Medical Claims Administration demographic data, lab information, pharmacy benefit information, and consolidates all that information into an individual profile of every single program participant with whom we work.

Mrs. WILSON. And then can you aggregate that data?

Ms. SELECKY. Yes. So we have an individual profile, and then we have an aggregated profile of the entire population. We track over time improvements in clinical status and reductions in utilization. And then we usually have that information pre the program so that we know what the baseline is. We measure what is going on during the program year, and then we do a pre-postanalysis. We also do randomized control trials as well and have third parties validate the outcomes.

Mrs. WILSON. One final question, if we can do it quickly, and that is everyone—or several folks mentioned mobility on and off of Medicaid eligibility. And I don't know whether you know that off the top of your head what your mobility rates are in Florida, North Carolina and Indiana, but if you do, what are they? I mean, what percentage of your population is there at the end of the year that you started with at the first of the year or however you measure your mobility? Dr. Medows, do you know, or should I just leave that one for the record?

Ms. MEDOWS. I would rather actually get you something that is much more definite. I can tell you that it is an issue of people losing their eligibility coming back in, because that disrupts care. And we try to make it so that if they—if we can get them back on board within 90 days, that they are just resuming instead of starting from scratch. But I can't tell you an exact number right now.

Mrs. WILSON. Maybe if we could leave that question for the record, and I would also ask to reserve the right to submit additional statements for the record.

But getting at this issue of mobility is, I think, one of the keys to addressing some of the problems we face with Medicaid.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. Thank you, Mrs. Wilson.

By the way, without objection, the opening statements of all members of the subcommittee will be made a part of the record.

Oh, Mr. Green is back.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. BILIRAKIS. You are recognized.

Mr. GREEN. Thank you. I have a number of questions.

First, Ms. Selecky and Ms. Bella, in your testimony both of you indicate that minority health is a component of disease management programs, and as is representative, I have a 60 percent plus

Hispanic district. I am especially interested in the lessons you have learned on how to treat the population; and as you point out, and we know in my own district, higher incidence for diabetes and heart disease and certain cancers, and in some cases less cancers with Hispanic women in one particular area, and a host of other chronic illnesses.

Have you designed your programs, particularly in California, but also in Indiana, to the unique needs of the Hispanic community? I guess the overall minority community, because some of these same indicators are in Hispanic communities and African American communities.

Ms. SELECKY. Yes, Congressman Green. We employ nurses who speak Spanish so we can provide multilingual services over the telephone and in person with our program participants. We provide program materials in Spanish and Chinese actually, because we have a very large Chinese population in the Bay area. And we also adapt the content of our program to cultural issues. There are definitely different issues around the way that people interact with their physician, the way that their families support them, the kinds of diet that they eat. And so we have gone through, and, again, because we have got a computer system that can adjust our program to each individual that we work with and that guides our nurses through the interaction with people, we very definitely customize the program to language and cultural and other kinds of issues.

Mr. GREEN. Ms. Bella.

Ms. BELLA. Our materials are also available in Spanish, and our nurse care managers in our call centers employ bilingual workers as well.

I would say the way we have been most successful in that is partnering with our Minority Health Coalition, who represents—who has Hispanic affiliates across the State, and they have helped us tailor those interventions to understand that the involvement of the community or involvement of the family may be different given the different cultural need. And so through our partnership with them we have been successful at tailoring our interventions in a way that we couldn't have done. We wouldn't have had that knowledge base on our own. So, yes.

Mr. GREEN. Ms. Bella, I will ask you if this committee enacted the Healthy Communities Access Program modeled after the successful CAP, the administration project and CAP provides grants to help agencies coordinate preventative and primary care for 44 million Americans without insurance. And I know that Indiana has received several CAP grants, one in Marion County, central Indiana and South Bend. And I think the objective of the CAP program, to improve coordination of health care for uninsured Americans, is similar to the Indiana Chronic Disease Management Program.

Can you tell me whether your program works with the CAP Program or the—is there cross-pollination, I guess, between the two?

Ms. BELLA. There is. That has given us a unique opportunity. With the most recent funding that we received, we were doing a survey and health assessment of the uninsured in Indiana, and we included specific questions related to chronic illness to try to understand the prevalence across the State, again, knowing that we see a lot of overlap between the uninsured and Medicaid and other

payer sources. And so our goal is to include and develop a system that covers everyone.

So it is very closely integrated with the efforts through our CAP grant and looking at how to address chronic needs across the State of Indiana. We appreciate those funds.

Mr. GREEN. Thank you.

Mr. Simms, according to your testimony, North Carolina Primary Care Case Management Program creates a physician provider network that includes nurse care managers to implement the disease management program, which is similar to the diagram here in Indiana. Can you explain the motives for physicians and providers to join together in implementing that disease management program?

Mr. SIMMS. Yes. They are very committed to having control and the opportunity to direct the local health care delivery system for the patient population there in their local communities, so they see this as the opportunity to continue and to build upon that. The providers in North Carolina have been very committed to serving Medicaid populations, especially the pediatric providers, and so they have really worked very closely with the Medicaid program with the implementation of this and see this as their opportunity to really help get the health care delivery system at a local level in place that they can continue to maintain the level of quality of care that they have been providing.

The other thing is that they also see it as the opportunity to be able to show our legislature that we can implement a local infrastructure that can contain costs, improve quality, and therefore prevent them from having to have their rates reduced as well.

Mr. GREEN. Okay. Thank you, Mr. Chairman.

I know I have a little time left. It is interesting last Friday morning in Houston, I actually met with the chief of neurosurgery at the University of Texas Health Science Center in Houston, and one of his concerns is the lack of—he sees what happens because they have a trauma care unit at Memorial Herman Hospital, but the concern about utilizing case management and nurses more into the process, and the program he talked around about was similar to what we are hearing about today.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

Without objection, there is a statement by Sandata Technologies that they wanted to submit to the record, and without objection, that will be made part of the record.

[The information referred to follows:]

PREPARED STATEMENT OF SANDATA TECHNOLOGIES, INC.

Chairman Bilirakis, Ranking Member Brown and members of the Subcommittee: We appreciate the opportunity to offer this statement on behalf of Sandata Technologies, Inc. in connection with the Subcommittee's consideration of Medicaid reform and today's hearing on "Evaluating Coordination of Care in Medicaid: Improving Quality and Clinical Outcomes."

As you know, the Medicaid-funded health care system is under great pressure to deliver quality health care to eligible beneficiaries while controlling Medicaid expenditures. Policy-makers have begun to rethink ways to deliver quality health care services in the most cost efficient manner possible while preventing the loss of limited health care dollars due to waste, fraud and abuse. We commend the Subcommittee's efforts to advance a thoughtful discussion of these important policy objectives.

Today's hearing appropriately focuses on the quality of patient care within the Medicaid system. To improve patient outcomes, we believe it is critical to ensure that the individual patient's plan of care is followed. It is important, therefore, for providers to be able to leverage easy-to-use, proven technology to accomplish that objective.

More and more of our Medicaid-funded health care will be delivered in home- and community-based settings. To meet the growing needs of patients, home care providers can rely on cost efficient, proven technology to deliver efficient, appropriate, high quality home health care throughout the United States. This technology—known as “telephony for home care”—enables providers to deploy a capable management and information technology infrastructure to prevent fraud and abuse and ensure monies are not squandered as necessary services are delivered to achieve positive health outcomes.

Telephony for home care delivers concrete benefits to State Medicaid programs and to Medicaid contracting home care providers, as described below. Equally important, it helps ensure that eligible Medicaid recipients receive the quality of care defined in their individual plan of care for the appropriate cost.

Currently, the City of New York's Human Resources Administration as well as the Nassau County Department of Social Services in New York State, the Visiting Nurse Service of New York and select visiting nurse associations in other jurisdictions mandate that their contracting and sub-contracting home health care providers use telephony for home care as a condition of contracting with Medicaid to deliver home health services.

The use of telephony for home health care by Medicaid programs delivers many benefits directly to State Medicaid home care programs, for example:

- *It reduces Medicaid expenditures* without cutting benefits to Medicaid beneficiaries.
- It ensures payment is limited to the actual hours of service performed by providers for the Medicaid home care program instead of what might be written on a paper timesheet (e.g., the City of New York Human Resource Administration's Medicaid-funded home care program *saves 5.5%* of expenditures from the difference between authorized hours and actual hours of service provided),
- It verifies patient coverage and provides payment *only* for visits that actually occur in the patient's home or other approved location.
- *It improves the quality of care delivered* by tracking tasks accomplished and matching them against the patient's plan of care.
- It reduces the time and costs of audits by providing a permanent, *comprehensive audit trail* via telephony.
- It provides important aggregate oversight data at the county, state and national level.

Equally important, telephony delivers important concrete benefits to Medicaid contracting home care agencies, for example:

- *It cuts administrative costs* by collecting all home care visit data from the patient's home electronically, eliminating manual data entry of time and attendance, tasks accomplished, etc., for billing and for payroll.
- *It ensures the delivery of quality care* in accordance with the patient's plan of care—eliminating missed visits and verifying that “the right worker was at the right place, at the right time, performing the right tasks.”
- *It improves management* visibility over field operations—i.e., telephony collects visit data in real time from the patient's home, making it available to the supervisor in real time, so they know exactly what is going on in the field.
- *There are no upfront hardware or software costs*, enabling providers to “pay as they go.”
- Likewise, providers benefit from the *permanent, comprehensive* audit trail.

A recent review of Medicaid home and community-based waivers by the U.S. General Accounting Office (GAO) concluded that the Centers for Medicare and Medicaid Services (CMS) does not adequately monitor state Medicaid and Medicaid waiver programs and the quality of beneficiary care.¹ According to GAO, the most common problems included “failure to provide necessary services, weaknesses in plans of care, and inadequate case management.”²

Telephony, with its accurate real time data collection capability and management data presentation, can play a significant role in addressing these concerns by enabling improved “visibility” into field operations and improved government oversight.

¹ *Long-Term Care: Federal Oversight of Growing Medicaid Home and Community-Based Waivers Should Be Strengthened*, GAO-03-576 (June 20, 2003).

² *Id.*

In addition, this service is available wherever telephone service is available, even under crisis conditions. During the recent blackout, for example, the service continued to collect data, so Medicaid programs and home care providers had assurance and confirmation that patients were being served.

In closing, the use of telephony for home care can provide concrete benefits to State Medicaid programs, to home health care and other social service providers, and to eligible Medicaid beneficiaries. We look forward to working in partnership with you as the Subcommittee considers ways to strengthen the Medicaid program and to ensure the continued viability of this important safety net for our nation's most vulnerable patients.

Thank you for your consideration of our views.

Mr. BILIRAKIS. I wanted to do something different just for the next few minutes.

The bottom line is quality of care, and we all agree, some States have chosen to do it themselves without the private/public, if you will, and other States have chosen to go the other way for whatever reasons. I wonder, could we take a few minutes, and I will control the time, where you all might feel free to ask each other questions? I mean, Dr. Medows, are you not curious as to how well Indiana is doing their way, and Mr. Simms, and vice versa and that? Well, if you are, raise questions.

Mr. Hilferty.

Mr. HILFERTY. Mr. Chairman, I am sorry, if I may, from our vantage point we truly believe there are situations where States, much like this Indiana program, can do it on their own. What we have come to realize is there are opportunities where States and private entities can partner and collaboratively work to get the data that is needed to do the health outcomes analysis, to really work in partnership to improve quality, improve access and, most importantly, reduce cost. So from the private perspective we are not saying it should be all private, but we are saying that there are situations.

Mr. BILIRAKIS. So you are impressed with the way Indiana is doing it, but you say that there is a possibility that there could be some improvement in there.

Mr. HILFERTY. Well, I think time will tell. I mean, we were one of the bidders on the—with LifeMasters on the business in Indiana. Time will tell, and I think the importance of collecting the data, analyzing the data and seeing if the outcomes are there—we will see if it works.

Mr. BILIRAKIS. Go ahead, please.

Mr. BROWN. Ms. Bella, if they had won—if Mr. Hilferty and Ms. Selecky had won the bid, how would it have been different in Indiana from what happened, from what you have been able to do?

Ms. BELLA. In my opinion, we would have had much less involvement in the development of the interventions. We would not be involving the community as much. The focus that we found for that approach was more on the patient management, the particular patient as opposed to managing and developing a system and an infrastructure. And so we are really stepping back and putting together a system for the State as opposed to focusing on a recipient with congestive heart failure because we want long-term system change. And so I think that that would have been the biggest difference.

Mr. BILIRAKIS. Any response, Mr. Hilferty?

Mr. HILFERTY. Well, I think that is accurate, an accurate portrayal. I think that the importance that we bring and the data bases, whether it be LifeMasters or AmeriHealth Mercy bring to the table, is we are able to analyze by disease state and to categorize folks. Yes, there is the importance of the community contact, but categorize folks by a disease state and develop programs to truly monitor their health status and improve that status.

Mr. BILIRAKIS. Dr. Medows.

Ms. MEDOWS. Yes, sir. I think I have kind of the best of both worlds because I actually have contracts with a private entity who is providing us with the funding, and providing us with some software, and providing us with some of their expertise, but at the same time, make no bones about it, the patient is still being cared for by their primary care physician. They are in their communities with their community hospital, with their community clinics. It is not a new third party just coming in and providing care. They are being treated in their home with people that they know. And then they are getting, on top of that, extra attention, extra support, and they are getting things that they weren't able to get before. It is not just a matter of a nurse calling and finding out if you have gone to the doctor.

But, like you say, we have put that personal touch. It is, why didn't you make it? Was it a transportation issue? Was there an issue with you paying your copay for your pharmaceutical? Was it that you didn't understand what you were supposed to do?

So I don't know that we would have to go all State or all private. I think, you know, I feel much more comfortable with the way that we have it compiled, that it is a combination of both. But again, as long as the focus is on improving the actual care that is being delivered to the patient and their improved health outcome, I think any of the options would be fine as long as that is the focus.

Ms. SELECKY. Mr. Chairman, might I weigh in on this?

Mr. BILIRAKIS. Sure.

Ms. SELECKY. Because I—you know, I commend all of the States for all of their efforts. And disease management is a relatively new phenomenon. It is a very difficult thing to do well. There are a lot of moving parts, and health care is about delivering quality care from physicians to their patients. And, in my opinion, disease management is really a platform to deliver evidence-based medicine and enable physicians to deliver better care to their patients. And we provide the technology and communication platform and some of the support services that help offload physicians who are very busy and who don't have time to provide educational and coaching services to their patients.

We believe very strongly in supporting the doctor/patient relationship. When we work in a community, we work equally with the doctors and the patients. We send the physicians exception reports about how their patients are doing in between office visits. We send them relevant information about how they might deliver better care to their patients. And I think that there is definitely room for very close collaboration between public entities and private entities. We do it with our commercial employer and health plan customers all the time. We wrap our programs into their existing ef-

forts, and I believe that there is room for all of the different, you know, very dedicated players in this.

Ms. BELLA. If I could add one thing. I want to echo what Dr. Medows said. I am afraid that sometimes States feel like there are just two choices. It is make or buy. And as I indicated in the testimony, we have chosen what we call the assemble approach. We are still buying some of our services, but the difference is we are in control of designing the program, and it is a system focus.

So if I think—again, if I had to answer your question again about what is different, it is that at the end of the day in the program we have put together, the resources remain in the public health infrastructure in the State of Indiana because we have made an investment there. And what we were concerned with with another program with a little different focus is that the resources leave the State, and we don't retain that expertise or that knowledge base or that critical infrastructure.

But it is not—you know, the two are not mutually exclusive. You can have a hybrid, but I think it is very important for States to understand that they with their public health system can do this themselves. And as—what is not to be minimized is the technical assistance, and best practices that were shared with us by the McCall Institute, the Institute for Healthcare Improvement, and improving chronic illness care are available to all States, and that is really the meat of what you need. What is on this little CD is the key to intervening with your providers and your patients, and those things are available in the public domain, and that helps us all maximize our investment. And so—

Mr. BROWN. If I could pursue that, Mr. Chairman, for a moment.

Mr. BILIRAKIS. By all means.

Mr. BROWN. Ms. Bella and then Mr. Hilferty, you talk about the public resources thing and the public domain, and I guess that is dollars and health care resources. In terms of information, we talked about that earlier a little bit. You—I assume that you have information how much each patient costs, how much goes to overhead, all of that. Do we get that, Mr. Hilferty, from you? Can we get that for what every patient costs?

Mr. HILFERTY. Yes.

Mr. BROWN. That is made available to Medicaid.

Mr. HILFERTY. Yes. Yes, it is, Congressman Brown. If you take Pennsylvania, for example, Pennsylvania has implemented a risk adjustment rating program where the way the plans are, it is analyzed what rate you will get in the coming year is partially done by your case mix and the data you provide to the State. And it is done through practice profiling and encounter data, and it is incumbent upon the private plan to supply that data, and then the State goes through the calculations to figure out the risk adjuster and provide the rates for the private plan.

Any—the key point is that any Medicaid managed care program that works, that includes the private sector, has to be done collaboratively. It can't be all one or all the other, all private, all public. But it is incumbent upon the private entity to provide the data, but not only to provide it, but to verify the data so that the States know that the outcomes are there, and that they can come up with a pricing strategy for those services.

Mr. BROWN. And the data coming from you, from others in the private sector, from the private contractors is every bit as comprehensive and detailed as the information that Ms. Bella would get from her public program.

Mr. HILFERTY. The difference there is that our data is—we can't confirm that it is—or our issue is related to being able to access the local provider and get them to fill out encounter data on time. An issue that we struggle with, quite frankly, is the timeliness of getting that data.

Ms. Bella, when she goes through a program, there is that individual claims data that you referenced earlier that is there on a retroactive basis. But as we have gotten better at getting the data from our private physicians, from our private hospitals, yes, we are providing the same timely information. And I would be more than happy to provide that to the committee from the States in which we do business.

Mr. BILIRAKIS. Would you do that, please.

Mrs. WILSON. Mr. Chairman.

Mr. BILIRAKIS. Mrs. Wilson.

Mrs. WILSON. If I could follow up on this a little. The data, claims data, is one thing, but that is about what we paid out. And I think one of the problems with Medicaid is that it is set up to pay claims. Does Indiana—has Indiana invested, or North Carolina or Florida invested, in the information systems to give you any information about the health status of—you know, can you tell me the improvement in A1-C for diabetics dependent on Medicare—I am sorry, Medicaid; or reduction in asthma admissions in emergency rooms?

Ms. BELLA. We have our patient registry set up to collect that information now. It is dependent on the provider practices entering that information. And so our job then—

Mrs. WILSON. So we have the same problem that Dan has.

Ms. BELLA. Well, except that we provide a migration from their system to dump into our system and make it very easy on them. If we need to send someone in there to do chart pulls and medical reviews to get us that data, we will do that because it is that critical. In addition, we can also get the data entered by the care managers or the call center, so it can come from a variety of sources, and we just work to figure out how to best get that.

But you are right. I mean, you need lab values. You need the richer clinical data to support the administrative data. But a large successful component of ours is also the pharmacy data. That can tell you an awful lot. In our system—I mean, in everybody's Medicaid system, that is real time-instantaneous data. And so much of the compliance is driven by their pharmacy, that you can use that again because it is real time as opposed to your standard medical claims to really provide you with that indicator you need to get in and manage that care quickly.

Mr. HILFERTY. I think the point you make, Congresswoman, around asthma is a good one. If you look at west Philadelphia, for example, juvenile asthma is growing at alarming rates, as it is nationwide. Well, what we are able to do is by engaging the member, the member's parents in education and from everything to what meds they should be taking to ways to relieve stress to work when

there is an emergent situation, what we have found is that we are able to take the data from their well visits, their physicians, their emergency room encounters and also the use of pharmaceuticals and really receive the improvement and the care to this membership. And that is something that disease management and case management provides that frankly is proactive in really analyzing if care is improved and if health status is improved.

Mrs. WILSON. Mr. Simms.

Mr. SIMMS. Yes. I think one of the things, and I agree with Ms. Bella, that we are having to look at ways to do the process measure, for example, the chart audit, of really getting folks in to be able to provide feedback to the docs immediately, showing them, okay, this is what you are doing with your process measures and specific to asthma.

Some other things that we are looking at doing in North Carolina is working with the school systems as well to begin looking at has there been a reduction in number of days missed by the children, by the Medicaid children, and comparing it to ways that we should see improvement in that area because of the asthma disease management initiatives. So—and then combining that with the data that we are able to pull from the claims data that will give us the ability to provide the practice profiles back to the doctors and let them know what is happening.

But, again, that is a challenge that the Medicaid programs face in that if you are really building it only upon claims data, then you have got a great challenge there. But we as well have a Web-based management system where the care managers have to enter the data in there. And so we are encouraging and continuing to stay on the care manager and the networks to make sure that information gets entered as timely as possible.

Ms. MEDOWS. I would just say ditto, but we do the same thing. I mean, just using claims data like you said just gives you the financial picture, and what we are looking at is the actual patient picture: Are we improving the quality of care; are we improving the quality of their health. And what we do is pretty much the same. We get that information from the patient themselves, we get it from their physician, from the care manager, who reaches them through the call center nurses and health care professionals that they reach that way as well and take a look at that, and look at markers that we know are associated as benchmarks for each disease state. Is it hemoglobin A1-C for diabetes?

But there is also did they get their eye exam this year? Did they have their retina examination for diabetic retinopathy? Did the asthmatic people—did they report that they are actually using those peak flow meters that we gave them? People with CHF, are they actually weighing themselves? Are they telling us the truth when they give us their weight? Are they actually taking the medication, and if not, why? And do they notice themselves an improvement in their health and in their well-being?

And I think it is important to ask them to give us that input as well, and we take that all into account. That is actually, I think, a truer measure of our success.

Mr. BILIRAKIS. Wonderful.

Well, there will be, as per usual, a series of questions which will be presented to you, and we would appreciate a timely response to them.

I would also ask maybe can you also furnish us a typical case, you know, the step-by-step process of how you handle a typical case in every one of your areas? I think that would be—could be very helpful.

And your just being here is so very, very helpful. I think we have had a good hearing. Not many members here, but, you know, we have no votes until after 6:30, and that happens on a day like that where many members are not here yet. But there is great interest in the Medicaid program on this committee. Thank you so very much for your help.

The hearing is adjourned.

[Whereupon, at 11:40 a.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

PREPARED STATEMENT OF AMERICAN DENTAL ASSOCIATION

The American Dental Association (ADA) is pleased to submit testimony for the record as the committee examines the challenges facing the Medicaid program and how to evaluate coordination of care within the program.

On behalf of the dental profession, the ADA wants to make clear that dentists find it unacceptable that in 21st century America there are children who are eligible for public assistance who cannot sleep or eat properly and cannot pay attention in school because they're suffering from untreated dental disease—a disease that can be easily prevented. As a nation, we must recognize how critical oral health is to overall health—especially to the healthy development of a child—and find the political will to do a better job of caring for the next generation of children. The dental community is committed to working with Congress, the federal agencies and the states to address and remedy this fixable problem.

The oral health community has come a long way these last few years in working to address issues affecting access to oral health care. Dental providers have joined with governors, state legislators, Medicaid officials and many others to tackle barriers impeding children's access to care present in the Medicaid program. In response, some states have worked to make oral health a priority, but as a result of serious state budget cutbacks, many more have lost ground.

In the absence of effective public health financing programs, many state dental societies have sponsored voluntary programs to deliver free or discount oral health care to underserved children. Private dentists and community organizations are working to do what is necessary to reach out to these children; however, charity alone is not a permanent system. Congress and the states must work with dentists to establish an improved health care system for the delivery of oral health care under Medicaid to our most needy and vulnerable citizens.

Because of devastating budget deficits, states have been forced to make difficult spending decisions, and dentistry has taken a serious hit. States are eliminating or severely reducing optional dental benefits under the Medicaid program for adults. These are adults who will not be able to gain employment in public focused jobs due to the affect poor oral health has on appearance, or be able to function properly due to chronic oral pain. Not having access to needed oral health care, many will end up in an emergency room. The resulting cost of emergency room treatment for patients and taxpayers far exceeds the cost of preventive dental care. In addition, emergency room care is only limited to pain management, so these individuals will still go without necessary treatment to end their suffering.

THE CURRENT SITUATION

Oral health care for the nation's poor is a patchwork of chronically underfunded, poorly administered programs. Many state Medicaid programs shortchange dental care, providing payments that fall far short of the cost needed to deliver care. This results in an insufficient number of dentists who can participate in the program. The result—underserved children and families often do not have access to necessary oral health care.

A recent ADA analysis of dental Medicaid programs across the country shows that only one in four children eligible for Medicaid receives access to needed dental serv-

ices. This is true despite the fact that federal law requires states to cover dental services for Medicaid-eligible children through the Early, Preventive, Screening, Diagnostic, and Treatment program (EPSDT). It is critical for policymakers at the federal and state level to acknowledge that oral health is integral to general health and well-being and that we work together to improve the Medicaid program to increase the participation of providers, improve the delivery of services and enhance access to care for those most in need.

As an optional benefit under Medicaid, adult dental care is often a poor stepsister to medical care, facing restrictions or elimination during tough economic times and often not reinstated when times improve. Some states simply do not cover dental care for adult Medicaid beneficiaries, and many others are cutting back. The result—underserved and vulnerable adult populations, including the frail elderly do not have access to necessary oral health care, which can be even be life threatening since we now know that oral disease is associated with systemic diseases such as diabetes and heart disease.

With the current state budget deficits, dental benefits have been severely reduced across the country both within Medicaid and the State Children's Health Insurance Programs (SCHIP):

- Georgia recently passed a state budget proposal to eliminate dental coverage for SCHIP children (an optional benefit) and also eliminate adult dental benefits.
- Michigan eliminated adult dental coverage earlier this year, eliminating care for over 600,000 adults.
- Texas eliminated dental SCHIP coverage earlier this year.

Facing tough budget decisions, many other states have frozen enrollment or reduce eligibility in their SCHIP or Medicaid programs. Others are considering how to seek federal assistance to reduce federal mandates to provide access to dental services through the EPSDT program. All of this devastates access to needed oral health care for our country's most vulnerable.

NEEDED FEDERAL SUPPORT AND RESPONSE—EXAMINE STATE MODELS

Dentists seek to work with members of Congress, the Centers for Medicare and Medicaid Services (CMS) and states to improve the Medicaid program in terms of financing and administration in order to increase dentist participation. Several problems affecting provider participation have been identified—these problems include Medicaid reimbursement rates at less than what it costs dentists to provide care, concern with the dental administrative structure, excessive paperwork and other billing and administrative complexities, and lack of case management and other social barriers that result in a high rate of broken appointments.

There are several ways to address these recognized problems. One of the most critical strategies is for states to be able to raise Medicaid rates to more closely mirror the marketplace, rather than allow dentists to be reimbursed for care at significantly less than what it costs them to provide it. Without federal support, this may not be possible, given the economic situation. In some states, inadequate fee increases set a standard in the state—sometimes for as many as 15 or 20 years. In many states it is not uncommon to find that Medicaid reimbursement rates for dental care have not been adjusted since the 1980's—not even for cost-of-living adjustments. How can dentists effectively provide care to patients if the system will not afford that care?

Recent state budget cutbacks have escalated the problem of inadequate reimbursement rates. Dentists who have signed up to participate in the program are often punished as their legislature targets provider reimbursement rates as a means to reduce state Medicaid expenditures. In 2000, for example, the Iowa legislature increased reimbursement rates from 60 to 70 percent of a dentist's usual charges—only to cut these rates to half that amount in 2002. It is impossible to achieve increased and consistent dental participation in such an inconsistent system.

The good news is that there are success stories. The bad news is that state budget deficits threaten these success stories. A recent study conducted by the ADA, *State Innovations to Improve Access to Oral Health Care for Low-Income Children: A Compendium*, shows how some states have succeeded in recent years in increasing and stabilizing Medicaid reimbursement rates at marketplace levels—such as Michigan, South Carolina and Delaware. The state of Michigan, for example, in addition to addressing reimbursement concerns, also worked to creatively improve the delivery of the dental Medicaid program. With the support of the dental community, the state contracted with Delta Dental to administer its Medicaid program within 37 counties, naming it the "Healthy Kids Dental" program. The result—a Medicaid program that functions like a private program, with each Medicaid-eligible individual bearing a Delta Dental coverage card. The program offers reimbursement rates at market

levels, has eliminated administrative complexities and functions like a private insurance benefit. Since this partnership, the number of Michigan Medicaid kids seen by a dentist has increased from 18 percent to 45 percent. Undoubtedly, this public-private model is a success story, and there are others. As Congress contemplates Medicaid reform, the ADA encourages efforts to closely examine models like the Michigan model, which seek to stabilize a public insurance program to ensure access to care.

Where state fiscal situations impede increases in provider reimbursement, state dental societies are working to encourage improvements in the administration of the Medicaid program. Some examples are improved case management, transportation services to assist patients with scheduled appointments and public education on the importance of oral health. Many dentists have faced years of frustration with the Medicaid program, resulting in a great deal of mistrust. Too often the ADA and other dental organizations have heard their members outline the administrative hassles they face within these programs. Medicaid bureaucracy through lengthy provider applications, prior authorization requirements, and complex claims forms deter provider participation. Congress should ensure that the appropriate federal agencies work with states to help address this bureaucracy and improve the system.

Examining the problem, the ADA recommends that Congress consider the following when addressing Medicaid reform and improving the coordination of care delivered to those served by the program:

- Maintain an EPSDT benefit to ensure state requirements to provide oral health services to mandatory beneficiaries;
- Increase the federal match and/or other funding support for oral health services;
- Encourage and support states in developing and implementing a dental care delivery system for their Medicaid eligible population that mirrors the private sector indemnity benefit system.

CONCLUSION

Concerned about the future of the Medicaid program, the ADA is convening a Symposium in December 2003 to address opportunities for systemic improvements to the dental Medicaid program. Our goal is to offer recommendations to Congress and the Administration on dental Medicaid reform.

Dentists are justifiably proud of the overall state of the nation's oral health, which, for most Americans, is excellent. But we cannot forget the fact that millions of people in this country—particularly low-income children and adults—aren't getting even basic preventive and restorative dental care. These children and their parents are out there suffering. There are many dentists out there who want to end that suffering. Working with Congress and the states, together we must find the will to break down the barriers that separate them.

PREPARED STATEMENT OF LAWRENCE A. McANDREWS, PRESIDENT AND CEO, NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS

The National Association of Children's Hospitals (N.A.C.H.) is a not-for-profit trade association, representing more than 120 children's hospitals across the country. Its members include independent acute care children's hospitals, acute care children's hospitals organized within larger medical centers, and independent children's specialty and rehabilitation hospitals. As the Committee discusses the challenges facing Medicaid, we appreciate the opportunity to submit this statement for the record describing the critical role Medicaid plays in the lives of our nation's children and the ability of children's hospitals to care for them.

Medicaid is the largest health coverage program for children. It is important to recognize that Medicaid is the largest single source of health coverage for children, covering nearly one in four children. Children comprise more than half of the nation's 50.8 million Medicaid beneficiaries. As such, the future of Medicaid is of special concern to children's health, and therefore to the nation's children's hospitals as well. As hospitals devoted exclusively to the health and well-being of all children, children's hospitals are integral to the pediatric health care safety net, providing both inpatient and outpatient care to a disproportionate share of children enrolled in Medicaid. Although only 3% of all hospitals, children's hospitals provide nearly 40% of the hospital care required by the 25.5 million children assisted by Medicaid.

Medicaid coverage for children is low-cost. Children are a relatively inexpensive group to cover. In FY 2000, children under 19 (including SSI disabled children) accounted for only 21% of Medicaid spending. Children's coverage is not fueling the growth in Medicaid spending. In fact, Medicaid spending for children accounts for

only 10% of the annual growth in total Medicaid spending. In addition, more than 50% of children in Medicaid are already enrolled in managed care plans, and Medicaid per capita spending for children is comparable to private coverage.

Medicaid coverage works effectively for children. During the recent economic downturn, Medicaid has been an important safety net for children whose parents have lost employer-sponsored coverage. Recently released U.S. Census Bureau data on the uninsured indicates that the number and percentage of children (under 18 years of age) without health insurance did not change in 2002, remaining at 8.5 million or 11.6%. The Census Bureau's report, *Health Insurance Coverage in The United States: 2002*, states that a decline in employment-based health insurance coverage of children was offset by an increase in coverage by Medicaid and the State Children's Health Insurance Program. The result suggests that the program—the financing structure of which is designed to accommodate fluctuations in the economy—is working as intended.

Medicaid's benefits are essential to meet children's unique health care needs. Medicaid's benefits structure, unlike any other health insurance program, is designed specifically to meet children's unique health care needs, including children with special health care needs. The health care needs of all children are special and distinct from those of adults, but the term "children with special health care needs" (CSHCN) refers to a group of children who require specialized health care, habilitation and rehabilitation services. Frequently children with special health care needs are limited, or have potential limitations, in their ability to function because of a chronic or congenital illness, a major trauma, a developmental disability, or exposure to a serious or life-threatening condition.

For CSHCN, simply having access to health insurance may not be adequate for their healthcare needs because health insurance policies, like children, come in all sizes and shapes. Private insurance often lacks the comprehensive benefits needed by this population, such as physical and speech therapy, durable medical equipment, behavioral health services, home health care and some medications. Private insurance benefits may require that an individual be improving, a definition that doesn't fit for a child with cerebral palsy who may need a service to maintain function or a child with a congenital condition who may need a service to maximize their developmental potential.

Preservation of the Medicaid program's federal guarantee of accountability for children's health insurance needs under the Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) benefit package is an essential part of sustaining the health care safety net for children. EPSDT requires that, for children only, states cover all Medicaid services that are determined to be medically necessary by their physician during a regularly scheduled EPSDT screening visit. These can include preventative services, developmental/habilitation services for very young children, eyeglasses and hearing aids to ensure that children may learn, as well as prostheses, orthotics and wheelchairs that can be provided and changed as children grow.

Medicaid affects the ability of children's hospitals to serve all children. Medicaid is not only the single largest program of public assistance for children's health care, it is the single largest payer of care delivered by children's hospitals—paying, on average for nearly half of the inpatient care provided at children's hospitals. Children's hospitals also provide the vast majority of inpatient care required by children with serious illnesses and conditions. For example, children's hospitals perform 99% of organ transplants and 88% of cardiac surgeries, and provide 88% of the inpatient care for children with cystic fibrosis. In some regions, they are the *only* source of pediatric specialty care, which makes children's hospitals essential not only to the children in their own communities but to all children across the country.

Medicaid generally falls far short of reimbursing children's hospitals for the cost of providing these essential services. As a consequence, Medicaid disproportionate share hospital (DSH) payments, which average more than \$6 million per children's hospital, are extremely important to the financial health of these institutions. In hospital FY 2001, Medicaid, including DSH payments, on average reimbursed only 84% of the costs of care in children's hospitals, a percentage that fell to 76% without DSH payments. This crucial source of funding for children's hospitals aids in their ability to serve all children.

The specialty and critical care and trauma services that children's hospitals maintain, including staffing and equipment, carry costs that are not completely covered. But this "stand by" capacity assures that these services will be there when any child needs them. Because Medicaid is a vital revenue stream for children's hospitals, any single reduction in funding presents financial difficulties, which in turn can lead to

curtailing or elimination of programs—programs relied upon not only by Medicaid-dependent children, but *all* children.

All children benefit from the work carried out at children's hospitals—regardless of whether they ever step foot inside their doors. The nation's children's hospitals serve all children by fulfilling a variety of critical public needs—training most of our nation's doctors devoted to children, providing continuing advancements in children's care, performing some of the most important, cutting-edge pediatric research and serving as centers of excellence for the sickest children in the country. Medicaid is a partner in fulfilling those public needs, and a partner in fulfilling children's hospitals' mission of providing quality care to all children.

Children should be central to any consideration of the future of Medicaid. Medicaid plays a special role in not only providing health insurance for low income Americans but by filling in gaps in other coverage, whether for Medicare or private insurance. In this capacity, it is a major payer for long term and home and community-based care, as well as for mental health services, among others. Any consideration of Medicaid's future must recognize its many important roles, including its absolutely critical role in the financing of health care for children.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF CHAIN DRUG STORES

The National Association of Chain Drug Stores (NACDS) appreciates the opportunity to submit a statement for the record on "Evaluating Coordination of Care in Medicaid: Improving Quality and Clinical Outcomes" and community pharmacy's role in disease management programs. NACDS membership consists of 217 retail chain community pharmacy companies that operate approximately 20,500 traditional chain drug stores, 15,100 supermarket pharmacies and 6,300 mass merchant pharmacies. Chain operated community pharmacies fill over 70 percent of the more than 3 billion prescriptions dispensed in the United States.

COMMUNITY PHARMACY HELPS TO ENHANCE DISEASE STATE MANAGEMENT

Pharmacy and medication therapy services are among the most commonly used and cost-effective medical interventions in the health care system. In 2002, over 3 billion prescriptions will be dispensed to patients by retail pharmacies, with the goal of improving an individual's health and quality of life.

Pharmacists have a critical role in ensuring the appropriate use of medications and the management of chronic illness. Pharmacists are most familiar with a patient's condition and drug regimen, as they often maintain the only complete and up-to-date record of medication used for all of a patient's medical conditions. As Congress considers ways to improve quality and clinical outcomes in Medicaid, it is important for Medicaid recipients to have access to community pharmacy services, as well as important disease management services provided by the pharmacy of their choice.

Many Medicaid recipients could benefit from pharmacy-provided medication and disease management programs. That is because Medicaid recipients tend to have more chronic medical conditions requiring multiple medications, and may lack a medical home. It is crucial to ensure that disease management programs are accessible and a consistent part of the patient's routine. The natural choice to consider as the best manager of disease management programs is the pharmacy. Many Medicaid recipients may have multiple physicians, but may use the same pharmacy. The consistent use of the same pharmacy will allow the pharmacist to track the status of the patient more closely than other providers or systems.

DEVELOP DISEASE MANAGEMENT PROGRAMS

Medications are safe and effective when used appropriately for the condition for which they are prescribed. An estimated \$177 billion is spent in health care on hospitalizations and other unnecessary medical costs such as emergency room visits for non-life threatening circumstances. These unnecessary medical costs are routinely from inappropriate or incorrect medication use, including noncompliance of medication regimen. It is important for Medicaid recipients who rely on multiple medications for various conditions to understand how to take their medications to optimize therapy tailored to their particular condition or disease state.

Those enrolled in Medicaid should have access to a benefit that includes comprehensive pharmacy services, not just prescription drugs. Patients with chronic conditions should be guaranteed continuous coordinated care between each of their health care providers.

A meaningful pharmacy benefit should include important components such as medication therapy management programs for chronic medical conditions, refill reminders, extended pharmacist counseling, and outcomes monitoring and evaluation.

Disease management programs are an essential element of therapeutic care plans and can help to reduce emergency room visits and hospital admissions. Preventative measures associated with disease management can improve the quality of life for patients with chronic conditions and improve their overall health care outcomes. These programs may be structured so that those patients most at risk for certain disease states can be identified and their therapy managed by a pharmacist in conjunction with their health care providers in an integrated approach to patient care. Through standardization of definitions, program components and outcome measures, patients would be assured a minimum level of clinically accepted services to treat a specific disease state.

Essential components of a disease management program should include:

- Setting goals for outcomes with the patient;
- Improved communication mechanisms between the physician, patient, pharmacist and other providers;
- Documentation and feedback for evaluation of patient progress and compliance;
- Self-management tools and educational materials to aid patients with behavior modification, compliance, self-monitoring measures and other preventative measures;
- Overall improved access to necessary prescription drugs and other disease specific services.

PHARMACIST ROLE IN DISEASE MANAGEMENT

Community pharmacies can help increase the pool of health care providers that will be needed to satisfy the demand for disease management and treatment programs for Medicaid recipients with chronic conditions

Pharmacists are familiar with a patient's conditions and drug regimens due to the pharmacy serving as a frequent point of contact for many patients. Pharmacies also maintain up-to-date and accurate patient records, in addition to the readily accessible educational and disease management tools at the local pharmacy that enhance the patient's self-management techniques. In fact, many local pharmacies already offer a variety of disease management services including diabetes self-management services, asthma and anticoagulation care training.

There are over 50,000 community pharmacies in the country, and many of them already provide comprehensive pharmacy services that demonstrate pharmacy's role in improving the quality of life of the patients they serve. Community pharmacies are therefore a logical place for disease management to occur.

Through its Medicaid Medication and Disease Management Programs Pharmacies can:

1. Identify duplicate drug therapies, potential drug-drug and drug-allergy interactions, and out-of-range dosing, timing, and routes of administration to avoid serious and costly complications.
2. Provide comprehensive written information and verbal counseling to consumers for educational and comprehension purposes to ensure optimal outcomes.
3. Remind patients to refill their medications when the refill is due to reduce the incidence of non-compliance with medication therapy, thus reducing repeated primary care provider office and emergency room visits.
4. Assist the patient in identifying other activities, such as diet and exercise, to help manage their condition(s).

In some instances, pharmacy-based disease management services has gained acceptance in public and private insurance programs. For example:

- Some states reimburse pharmacists for medication therapy and drug regimen compliance for diabetes, asthma, anticoagulation or high cholesterol, HIV/AIDS, mental health disorders, and hypertension.
- Some states require health insurance plans to provide some level of disease management to beneficiaries, and pharmacists may provide services under these programs. At least six state statutes specifically reference pharmacists as providers.
- Some managed care plans serving Medicaid recipients also privately contract with community pharmacies to provide diabetes self-management benefits.

The National Institute for Standards in Pharmacist Credentialing (NISPC) was established in 1998 to create a consolidated, nationally recognized, credential for pharmacists seeking certification in a variety of disease states. Over 1,500 pharmacists have received this nationally recognized credential in disease specific management. After having demonstrated the level of clinical competence necessary,

pharmacists develop and supervise successful disease management programs that offer a wide range of patient and disease specific services for diabetes, asthma, anticoagulation, or high cholesterol.

The competencies and credentialing standards are based on national standards developed by experts representing the National Association of Chain Drug Stores, the National Community Pharmacists Association, the American Pharmaceutical Association, the National Association of Boards of Pharmacy and other pharmacy organizations.

Evidence of the value of pharmacists has been published in key studies that demonstrate the broad range of pharmacist—provided patient care interventions. These studies have resulted in improved disease state and drug therapy management, greater patient satisfaction, improved quality of life and economic savings. For instance, the Asheville Project began in March 1997 as an effort of the City of Asheville, a self-insured employer to reduce unnecessary health care costs. As documented in four articles of the Journal of the American Pharmaceutical Association, the project resulted in a system in which pharmacists developed thriving patient care services in their community pharmacies, with employees, retirees, and dependents with diabetes experiencing improved A1c levels, lower total health care costs, fewer days of missed work, and increased satisfaction with pharmacist's services.

IMPROVING THE CURRENT DISEASE MANAGEMENT SYSTEM

The provision of disease management services and accompanying payment for these services are as important as providing the drug product itself. In order to provide continuous quality service to patients with chronic illnesses, pharmacies must be properly compensated to cover the costs of providing disease management products and services. For disease management programs to be effective in the Medicaid population, pharmacists must be able to be compensated by Medicaid as other providers do.

Pharmacies continue to seek payment as providers while providing disease management services to Medicaid recipients. The methods employed by pharmacists to improve outcomes serve to decrease chronic illness related health care expenditures.

CONCLUSION

Community pharmacists are the most accessible health care professionals in many areas of the country. Medicaid beneficiaries should be able to receive necessary disease state management services provided by community pharmacists. Any Medicaid disease management program should provide coverage for such care and allow for the participation of qualified pharmacists. The program should also allow beneficiaries to have access to valuable pharmacy-based disease management and medication therapy management services in addition to prescription drug products.

We appreciate the opportunity to submit these comments for the record, and ask that the committee members direct any questions to us about this statement. Thank you.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

The National Association of Community Health Centers (NACHC) appreciates the opportunity to submit the following statement for the record on the unique role of health centers and related health center initiatives to effect positive health outcomes for beneficiaries under the Medicaid program. NACHC is the advocate voice for our nation's over 1000 Community, Migrant, and Homeless Health Centers and Public Housing Primary Care Centers, and the patients and communities they serve.

As the Committee gathered from prior NACHC testimony, community health centers are one of the most important assets we have in providing high quality, cost-effective, primary and preventive health care to millions of people living in medically underserved communities regardless of their ability to pay.

Community health centers play a critical role in building bridges to better care, and they are an intricate part of the health care safety net, in place to catch those who fall through the cracks. Health centers today serve as the family doctor and health care home for 14 million Americans in over 3,400 urban and rural communities across the country.

One in nine Medicaid recipients, one in six low-income children, one in eight uninsured individuals, and one in ten rural Americans benefit from health centers

(known in Medicaid law as Federal Qualified Health Centers, or FQHCs). Among the millions of people served by health centers:

- 40% depend on coverage through Medicaid or SCHIP, the State Children's Health Insurance program;
- 40% lack health insurance coverage; and
- 86% are living in families with incomes at or below 200% of the Federal Poverty Level (FPL).

Moreover, health centers are at the center of a multi-year initiative to strengthen the health care safety net. Both the Bush Administration and a bipartisan majority in Congress, led by Chairman Bilirakis and Ranking Member Brown in the House of Representatives, are committed to expanding the ability of health centers to reach even more patients; a combined effort that to date has enabled health centers to provide care to more than 3 million new people, and that will eventually increase health center access points by 1,200 over five years and double the number of people served.

Time and time again, these centers have demonstrated their ability to provide effective care—reducing infant mortality, decreasing hospital admissions and lengths of stay. However, as the health care needs of low-income individuals continue to grow, so do the challenges to health centers in sustaining their ability to provide quality care to Medicaid beneficiaries and other patients. Current budget shortfalls threaten state and local financial support of health centers, even though their cost of care is among the lowest of all providers. Reductions in Medicaid eligibility, benefits, and other areas potentially jeopardize the ability of health centers to continue to provide care to all patients, including Medicaid patients. Undoubtedly, for the community health center program to sustain its efforts at improving the health of the millions of Medicaid beneficiaries and others it serves, Congress must preserve the program's unique interrelationship with Medicaid and seek to expand upon the successes of health centers to effect positive health outcomes.

IMPROVING HEALTH OUTCOMES THROUGH COLLABORATION

A major reason for the success of health centers in improving care for Medicaid beneficiaries and other individuals is found in the growing number of health centers participating in a federally-supported effort called the **Health Disparities Collaboratives**, aimed at improving health outcomes for chronic conditions among the medically vulnerable. Developed by the Health Resource Service Administration (HRSA) Bureau of Primary Health Care (BPHC), the initiative is structured around the chronic care model, defined as "a population-based module that relies on knowing which patients need care, assuring that they receive knowledge-based care and actively aids them to participate in their own care." The Collaboratives were designed to cover all chronic illnesses and, ultimately, prevention as well. Currently, participating health centers focus on diabetes, cardiovascular disease, asthma, depression, prevention, cancer, and/or HIV.

Background

The Health Disparities Collaboratives initiative was developed to change the way health care is delivered—from a provider-oriented to a patient-, family- and community-oriented system. Patients and clinicians want a holistic, unified approach that works for both of them. Since 1998, more than 450 health centers have begun to participate in the program, and by the end of 2003 the number will exceed 600, or two-thirds of all health centers—marking significant progress toward meeting the federal goal of having all BPHC-supported health centers enrolled in these Collaboratives by 2005.

Purpose

The Collaboratives seek to *transform* care through a systems model that identifies and tracks which patients need care for each health condition, *apply* the most current clinical knowledge and practice guidelines to the care that is provided, and actively *involve* patients in their own care by educating them on their condition and encouraging them to set their own health improvement goals. To achieve this last objective, Collaboratives stress planned individual and group visits to help patients track their improvement and to continue meeting their goals. Self-management education has been shown to be more effective than simply providing information to patients in improving clinical outcomes, and it possibly reduces costs associated with caring for the chronic condition.

Vital to the success of the Collaboratives also are patient registries that improve clinicians' ability to track the course of each patient's treatment and progress. In a recent case study of five health centers in various locations throughout the U.S.,

interviewed center staff consistently considered these registries as critical in reaching significant improvements in patient health.

Operation

Health centers operating Collaboratives participate in intensive, year-long learning and improvement activities. Multi-disciplinary health center teams attend three learning sessions conducted by the Institute for Healthcare Improvement under contract to HRSA that use a performance-based method of learning that supports teams from several health centers to apply, adapt, share, and generate knowledge about best practices, and to spread these best practices to other health centers. By design, the Collaboratives are to be implemented in care delivery systems quickly and efficiently. In the years following their intensive learning experience, health center clinical teams disseminate best practices to other health centers and continue to report progress on nationally shared measures.

Substantial health center resources are necessary to implement this model that successfully changes the delivery of chronic care and improves patient outcomes. Health centers must devote a multi-disciplinary team of three to five staff members—including a technical expert knowledgeable in both the subject area and the process of care and a team leader that oversees the day-to-day operation—ensures that the program is implemented, and oversees data collection. Data collection is a critical component of the Collaboratives and requires extensive development on the part of the health center.

Besides these resources, health centers must also devote valuable time to implement and administer the initiative. For example, the health center must allocate at least three to four hours a week in its already busy schedule for the team to work on the Collaboratives. Additionally, the team must take time away from the health center to participate in several learning sessions. These time and resources requirements fall on already financially strapped health centers seeing a growing number of patients.

Achievement

Today, almost 25 percent of all health center medical visits are for chronic conditions—most notably diabetes, hypertension, asthma and other respiratory illnesses, and heart conditions—or for mental health problems, and nearly 30 percent of medical encounters are for prenatal care or for key preventive services, like breast and cervical cancer screenings, immunizations, and HIV testing. Thus, the ability of the Collaboratives to improve the health of center patients will undoubtedly assist in closing the health gaps for the medically vulnerable in the U.S., and in elevating the quality of care provided through the centers because:

- The health centers are infused with the latest evidenced-based research and treatment protocols related to each of these diseases;
- Their clinicians are now able to more closely monitor our patients and provide care that is culturally-competent; and
- Their patients are more energized to be even more involved in their treatment and management of their conditions.

Whether measured in terms of individual health center patients or large populations, the Collaboratives demonstrate that it is possible to transform the health care system from one of *sickness care* to one that is truly about *health care*. Collaboratives are powerful drivers for positive change, through generating improved outcomes faster than traditional models of training or individual patient-doctor consultation, and efficiently and effectively translating research into practice. For example, only two months after the results of a clinical diabetes prevention trial were reported in the medical literature, health centers were busy learning how to put the knowledge gained from the trial into practice.

As a result of the work of the Collaboratives, the Institute of Medicine commended health centers in a recent report, *Fostering Rapid Advances in Health Care: Learning From System Demonstrations*, saying that their “strong record in chronic care management, electronic patient registries and performance measurement... contribute to providing care that is at least as good as, and in many cases superior to, the overall health system in terms of better quality and lower costs,” and recommended health centers as models for reforming the delivery of primary health care. The General Accounting Office also recently recognized the Collaboratives as a promising federal program targeting health disparities that should be expanded.

IMPROVING HEALTH OUTCOMES THROUGH PERFORMANCE MEASURES

The Collaboratives are only the latest advance in a long history of quality health care delivery by health centers. Numerous studies over the years have documented

that health centers deliver effective, high quality health care, using both objective and comparative measures of performance. For example, a recent article in a peer-reviewed journal examined various health policy studies and reports documenting the success of health centers in reducing and eliminating health disparities. Some highlights from the article include the following important findings:

- Medicaid beneficiaries who sought care at health centers were 22 percent less likely to be hospitalized for potentially avoidable conditions (Ambulatory Care Sensitive Conditions, or ACSCs) than beneficiaries who obtain care elsewhere, and were 16 percent more likely to have outpatient visits for ACSC-associated conditions. As a result, health centers have demonstrated reductions in Medicaid costs of 30 percent to 34 percent, compared with patients receiving care elsewhere.
- Prevention and screening services provided at health centers have been instrumental in reducing disparities. For mammograms, clinical breast examinations, and up-to-date Pap smears, health center women far exceed the national rate for comparable women, and meet or exceed the Healthy People 2010 goals for those categories.
- Even though health center women are more likely to be at greater risk for adverse pregnancy outcomes, their infant mortality and low birth weight rates are at or below the national averages for all women.
- Health center practices meet or significantly exceed literature-based standards for treatment of the most common conditions of hypertension, acute otitis media, diabetes, and asthma on over 80 percent of the care elements. For example, health center diabetics were twice as likely to have their glycohemoglobin tested as scheduled than the national population.
- Health center uninsured adults are more likely to receive counseling on lifestyle issues (such as diet and eating habits, physical activity, smoking, drinking, and drug use) than uninsured adults who seek care elsewhere.

REDUCING DISPARITIES IN CARE FOR MEDICAID BENEFICIARIES

A study conducted recently by researchers at the George Washington University Medical Center's School of Public Health and Health Services found that higher penetration of health centers into states' medically underserved communities is associated with significant reductions in minority health disparities. As the number of health centers serving medically underserved patients grows, this health disparity gap narrows in such key health indicators as infant mortality, prenatal care, tuberculosis case rates, and age-adjusted death rates. Significantly, the study found that comprehensive Medicaid coverage, coupled with the clinically customized and supported health care provided by health centers, "may yield the most effective medical care strategy" for reducing disparities in health care for beneficiaries of Medicaid.

The findings from this study add significantly to the already large and still-growing body of evidence that health centers are doing a remarkably effective job at providing the right kind of care for everyone they serve, regardless of race, income, insurance coverage, location, or primary language.

IMPROVING HEALTH OUTCOMES THROUGH PATIENT NAVIGATION

Community health centers have learned a lot of lessons over the last forty years of providing health care, one of the important of which is that it is not enough to open your doors and offer care, but that you must also reach out to individuals and help them get that care. To be certain, deeply rooted obstacles to accessing care exist even when health services and programs, like Medicaid, are theoretically available and affordable. Poverty, geographic isolation, cultural and ethnic differences, lack of transportation, low literacy, lack of knowledge regarding the need for or availability of health services are all barriers to health and social services for millions of unserved and underserved Americans. Availability does not equal utilization.

People who are local, indigenous members and residents of underserved communities are uniquely knowledgeable about their population's needs. Where such individuals are already serving as natural helpers, they communicate to health providers the needs of community members, provide quality health promotion and disease prevention information to community members and serve as a crucial link between their communities and providers to increase utilization of available preventive health services and to use existing health services appropriately.

As voices from within the health care system, the job of these individuals, otherwise known as Patient Navigators, is to bridge gaps and eliminate disparities in a fragmented system that is often a challenge too great to overcome—especially

among rural, urban, minority, and medically underserved communities. By guiding patients through the maze of what can be a sometimes-confusing healthcare system, especially in the case of Medicaid, patient navigation serves an effective way to increase access to care and improve health outcomes.

By their very nature, Patient Navigators are familiar with Medicaid eligibility requirements, community housing, prescription drug access, and other programs that might be available to help patients pay for their treatment, and they would also know whether local community-based organizations offer ride services in that area for medically underserved patients to get to their medical appointments.

To be sure, many federal and state programs, like Medicaid, have been created to aid poor and underserved communities, yet obstacles in the health care system are still an impediment to care for many Americans. Patient Navigation can increase efficiency and access—not by creating new healthcare programs, but by increasing access to health care and programs that already exist.

For example, the National Breast and Cervical Cancer Early Detection Program and the National Breast and Cervical Cancer Treatment Act—programs funded by the federal government and operated in large part through health centers—enable underserved women to be screened and treated for breast and cervical cancers. Patient Navigator programs work within the community health care system to bolster community outreach and support for these types of programs and to ensure that eligible women are educated, enrolled, and informed about their coverage options if diagnosed.

By breaking down barriers associated with accessing the health care system, Patient Navigator programs can serve as a cornerstone for federal and state health care initiatives and can improve health outcomes. As such, Patient Navigators help ensure that the health resources Congress and State Legislatures have already put into communities are used effectively.

All told, Patient Navigation programs work to build community education and trust, but they are also plugged into the community health care system. This combination allows Patient Navigators to serve as liaisons for patients between a complex care system and the ultimate goal—access to quality care and the improvement of health outcomes.

Congress has an opportunity to implement and expand the use of Patient Navigation in Medicaid and other areas by passing the bipartisan **Patient Navigator, Outreach and Chronic Disease Prevention Act (S.453/H.R. 918)**. This legislation would allow communities across the country to establish community-based patient navigator programs aimed at improving the health and quality of care received by individuals, including those under Medicaid.

DELIVERING MEDICAID SAVINGS THROUGH QUALITY CARE

The provision of high-quality health care, with a special, community-driven focus on the unique health needs—not to mention the special linguistic and cultural needs—of the populations they serve, has enabled health centers to deliver savings to all payers, but especially to Medicaid. According to one recent study, preventable hospitalizations in communities served by health centers were lower than in other medically underserved communities not serviced by health centers. Patients in underserved areas served by these centers had 5.8 fewer preventable hospitalizations per 1,000 people over three years than those in underserved areas not served by a health center. Several other studies have found that health centers save the Medicaid program more than 30 percent in annual spending per beneficiary due to reduced specialty care referrals and fewer hospital admissions. Based on that data, it is estimated that health centers already save almost \$3 billion annually in combined federal and state Medicaid expenditures. Of those savings:

- \$1.8 billion is in reduced federal Medicaid spending, an amount that exceeds the *total* of all Medicaid payments to all health centers last year; and
- Over \$1.2 billion is in reduced state spending, an amount that is more than four times the current national total of direct state funding to health centers across the country.

CONCLUSION

It is clear that health centers could be the foundation for reforming how states provide health care to the poor, especially in tough economic times. Time and again, health centers have demonstrated their ability to generate significant cost savings for Medicaid and other parts of the health care system, even as they improve the well-being of their patients and communities. As Congress moves forward on considering ways in which to reform Medicaid, it is critical that it keep in mind these health center efforts and successes, and seek to expand the excellent ability of these

centers to effect positive health outcomes for Medicaid and other medically vulnerable patients.

PREPARED STATEMENT OF SANDEEP WADHWA, MD, MBA, VICE PRESIDENT, MEDICAL MANAGEMENT SERVICES, MCKESSON HEALTH SOLUTIONS, MCKESSON CORPORATION

I am pleased to submit this statement on behalf of McKesson Corporation to the Subcommittee on Health of the House Committee on Energy and Commerce, subsequent to the October 15, 2003 hearing on Evaluating Coordination of Care in Medicaid: Improving Quality and Clinical Outcomes.

As the world's largest healthcare services company, McKesson is the industry leader in the provision of disease management services for state Medicaid programs. As such, we are uniquely positioned to provide Congress with information on the use of disease management programs to improve quality and clinical outcomes in the Medicaid population while decreasing health care costs.

Our disease management clients cover a broad host of purchasers of health care, including:

- *State contracts for the Fee-for-Service Medicaid* populations in Mississippi, Washington, Oregon, Colorado, Florida, New Hampshire, and Montana
- *Managed Medicaid plans* such as Columbia United Providers, Triple-C (Puerto Rico) and the Santa Clara Family Health Plan
- *Individual high risk insurance pools* like CoverColorado and the Oklahoma Health Insurance High Risk Pool
- *Commercial health plans* such as Blue Cross Blue Shield Federal Employees Program and Blue Cross Blue Shield of Texas
- *Medicare+Choice plans* such as Order of Saint Francis and Group Health Insurance

McKesson is the industry leader in care management services and software and also has market leadership positions in demand management and utilization criteria. Furthermore, we are leading providers of physician and quality profiling software and case management workflow software. As an early provider of these programs, we have been delivering disease management services since 1996. McKesson's disease management programs leverage our experience with patient services, pharmacy management, and health care quality improvement activities. Many of these programs and services reflect the capabilities and expertise of our 170 year old company, one of the largest nationwide distributors of pharmaceuticals and health care products and the largest health information technology company in the world.

Over the past two years, many states have turned to disease management to help address their Medicaid crisis. In particular, the costs for state Medicaid fee-for-service (FFS) programs are rising dramatically. The FFS population does not have many of the quality improvement and cost-control measures available to those enrolled in Medicaid managed care. The FFS population also has a disproportionate share of the Supplemental Security Income disabled population. Although the disabled population is only 17% of the Medicaid population, it accounts for nearly 40% of its costs.¹ Care coordination efforts with a particular focus on the disabled population provide a major opportunity to improve access to care, empower patients to control their conditions, enhance the quality of care, and reduce avoidable Medicaid costs.

QUALITY IMPROVEMENT

The care coordination process begins with a comprehensive effort to identify patients with a chronic illness. Patients are identified primarily through historical medical claims analysis. This process is highly efficient and accurate and allows for a comprehensive population-based identification method rather than relying on costly and more fallible chart reviews at physicians' offices. Initially, the physicians of those patients who have been identified are contacted. Direct mailings then go out to the patients informing them of the chronic care management program's design and goals. Community based awareness campaigns also help to raise awareness among patients and physicians.

Once patients have been identified, enrollment campaigns ensue. Initial enrollment and assessment takes place telephonically or through face-to-face meetings with patients. Participation in the programs is voluntary. In our experience, fewer than 5% of eligible patients have opted-out of these programs, and the highest rates

¹ Rosenbaum S. "Medicaid." *New England Journal of Medicine*. 346(8): 635-640. 2002.

of participation are among those who are the sickest, the frailest and the most vulnerable.

Most patients in Medicaid FFS see multiple physicians without one serving as the primary coordinator of care. The absence of a physician “quarterback” contributes to excessive testing, medication errors, and miscommunications. A key dimension of disease management interventions is assisting the patient in voluntarily identifying a “medical home”, which is a physician or a clinic primarily responsible for treating and managing the patient’s chronic condition. Once a medical home is established, the disease management nurse cements the relationship by serving as an advocate for the patient and informing the physician of symptoms, self management practices, and gaps with nationally accepted clinical guidelines. The quality of the patient/physician interaction is enhanced through patient education and nurse advocacy.

In Mississippi, McKesson has partnered with the University of Mississippi Medical Center (UMC) and with the Mississippi Primary Health Care Association, the trade organization of community health centers, to educate providers and beneficiaries about the disease management initiative. The Mississippi disease management program is targeted to more than 35,000 Medicaid patients with diabetes, asthma or high-risk hypertension. Twenty thousand patients are targeted in the asthma program which is predominately for children whose average age is 12. Approximately 15,000 patients, with an average age of 44, were identified for the diabetes and high-risk hypertension program. This partnership, which was launched in the spring of 2003, has been extremely successful in generating a high level of participation. Ninety-seven percent of all patients who were contacted for enrollment agreed to participate in the program.

Another aspect of disease management is addressing the slow adoption of national clinical practice guidelines in the Medicaid population. The poor and disabled are more apt to be undertreated than commercially insured populations. Patients are educated on the guideline recommendations and encouraged to discuss the appropriateness of the recommendations with their physicians. McKesson presents reports to providers on the gaps that exist between practice and guideline recommendations. Through clinical decision support tools and patient empowerment, disease management programs are designed to reduce errors of omission and improve the quality of care. In Mississippi, UMC physicians reviewed and customized McKesson’s protocols to make sure they were appropriate for Mississippi beneficiaries. For example, UMC physicians ensured that the terminology and images in the printed materials were easily understood and culturally appropriate, and that the program objectives were aligned with the state’s standards of care.

CLINICAL OUTCOMES

Improving care coordination, guideline adherence, and patient education results in improvements in clinical outcomes. This has been particularly evident in Washington State where McKesson has been providing disease management services for 21,500 Medicaid beneficiaries with asthma, diabetes or heart failure since April, 2002.

In just over one year, the program has documented clinical outcome improvements as well as financial savings to the state. In the asthma program, which serves 9,500 patients, the flu vaccination rate increased 28% in one year. The flu vaccine not only prevents asthma exacerbations, but also reduces costly hospitalizations. Regular use of anti-inflammatory drugs, which are a key intervention in controlling the symptoms of asthma patients, increased 14% over the year. Additionally, the number of patients who used an asthma action plan more than doubled, from 11% at enrollment to 25% at the end of one year. An asthma action plan is an important patient guide to self management and symptom monitoring and can reduce the morbidity associated with asthma.

Heart failure is largely the consequence of hypertension or heart damage sustained from heart attacks and is especially prevalent in the Medicaid disabled population. In the Washington Medicaid heart failure program, which serves 2,300 patients, the number of patients monitoring their weight daily increased by 74% in one year. By tracking their weight on a daily basis, patients with heart failure detect insidious weight gain, which indicates fluid build-up, and can notify their doctors before the condition becomes so severe as to threaten breathing or life. Over the year, hospitalizations in this population have decreased by over 25%.

The diabetes epidemic linked to increased rates of obesity affects both disabled adults and overweight children. Adults with diabetes typically have several related conditions such as high blood pressure, cholesterol problems, and obesity. The goal of disease management programs is to improve control of patients’ blood sugar levels

and also better manage their other risk factors. In the Washington diabetes program, which serves 9,600 patients, there was a 33% increase in the number of patients who knew their hemoglobin A1c level. The hemoglobin A1c is a key measure of long term sugar control. By teaching the patient the importance of this number, nurses have encouraged patients to participate more actively in their care and understand the physician's treatment goal. There was also a 48% increase in regular aspirin use in this population of diabetics. Aspirin use has been shown to dramatically reduce the risk of heart attacks in patients with diabetes.

These clinical improvements reflect the intense efforts of nurses to provide patients with the information, strategies, and skills to gain control of their chronic conditions and to work with their physicians to reinforce treatment recommendations. Disease management programs not only provide vulnerable Medicaid populations with nurse coaching and advocacy support; they also empower patients through skills and education to be more active participants in their care. In many instances, McKesson directs the intervention to the caregivers of the Medicaid patient. The caregiver is often the mother or guardian of a child with asthma or the spouse or daughter of a Medicaid disabled patient. These caregivers endure tremendous stress in caring for a patient, and the disease management nurses provide them with training, reassurance, support and knowledge to sustain them as effective caregivers.

BUDGET IMPACT

Perhaps the central barrier to chronic care management in Medicaid is overcoming the initial costs associated with implementing and providing these services. While these programs have demonstrated net cost savings through reductions in avoidable utilization, there are clearly costs associated with their provision.

Most states are including provisions for guaranteed financial savings in their Medicaid disease management contracts to ensure that they are either budget negative or budget neutral, a practice that has facilitated rapid adoption. If net savings to the state are not achieved, the disease management program must refund a certain amount of the fees paid by the state. Third party auditors or evaluation firms are usually hired by states to verify or conduct their reconciliation analysis.

The state of Washington program guarantees over \$2 million in savings in the first year of operations, and current estimates from the state indicate this will be exceeded. Savings from this program largely arise from reduced hospitalizations and emergency room visits due to improved disease control. The savings estimate include costs for implementation and program costs. McKesson and the state of Washington were recently recognized by the Disease Management Association of America as the leading Medicaid disease management program, based on the its evidence of quality improvement and public/private partnership.

RECOMMENDATIONS

Based on McKesson's experience with Medicaid FFS disease management programs, we would like to offer the following recommendation to the committee.

1) Federal regulatory barriers impede the ability of states to utilize disease management services. While managed care innovations are generally able to be implemented with a 1932(a) amendment to a state's Medicaid plan, most states have to seek a Medicaid 1915(b) waiver in order to offer disease management services to that population group. CMS categorizes disease management as a prepaid ambulatory health plan (PAHP); however, the 1932(a) exemption does not apply to PAHPs. Congress can play an important role in expanding the use of disease management services by addressing the regulatory hurdle to their adoption in Medicaid.

2) Ambiguity surrounding the payment for disease management services for those eligible for both Medicaid and Medicare coverage (e.g. dual eligibles) prevents many states from offering programs that would benefit this particularly vulnerable and costly population. Clarification of policies by Congress and CMS would enable states to provide these needed services to improve care and treatment outcomes and appropriately reduce costs.

CONCLUSION

McKesson's experience with Medicaid FFS disease management programs indicates that effective disease management programs lead to improved quality and clinical outcomes while reducing Medicaid expenditures. The outcomes-focused, evidence-based interventions provided in disease management programs improve coordination of care and adherence to guidelines and empower patients with appropriate knowledge and resources.

As Congress grapples with improving the quality and delivery of health care, we support the greater utilization of disease management programs as a vital way to enhance clinical outcomes for Medicaid beneficiaries, while concurrently reducing the cost of delivering better care. We look forward to working with you and members of this Subcommittee as you address these important concerns.

FOLLOW-UP TO THE WRITTEN TESTIMONY OF RHONDA M. MEDOWS, M.D., SECRETARY
OF THE AGENCY FOR HEALTH CARE ADMINISTRATION

BENEFITS TO BENEFICIARIES

The Florida Medicaid disease management program provides additional health education and supportive services to beneficiaries living with chronic disease including diabetes, asthma, heart failure, hypertension, hemophilia and HIV/AIDS. Each disease state program provides individualized health education materials, supplemental medical aids such as blood pressure cuffs and weight scales and nursing support to the specific population served. At the core of each program are nurse care managers who work with beneficiaries on a one-on-one basis, telephonically or face-to-face, to empower participants to improve their health through behavior and lifestyle changes. The nurse care managers coordinate care with the beneficiary, the family, the primary care physician and other community support organizations involved in the health of the individual. In addition, each program offers 24/7 access to a nurse, via a toll free number, to every beneficiary that is eligible for disease management.

The Florida: A Healthy State program (FAHS), part of an innovative public-private partnership between the Agency for Health Care Administration and Pfizer Inc. was the first disease management program to manage multiple disease states. It's community-based program with 60 nurse care managers in 10 hospital systems is also the largest, with over 115,000 beneficiaries living with diabetes, asthma, hypertension and heart failure enrolled. The program, now beginning a second term, has demonstrated success in improved clinical results, lower utilization of high cost inpatient services and emergency department visits, which lead to overall cost savings. The table below illustrates the program impact on utilization at the end of the first year.

	Overall	Hypertension	Asthma	Diabetes	Heart Failure
Inpatient Days	↓12.6%	↓15.0%	↓0.7%	↓13.7%	↓6.0%
Emergency Room Visits	↓1.0%	↓0.7%	↓4.0%	↓1.8%	↓1.3%
Sample Size	N=3,947	2,014	733	1,003	197

This analysis compared the number of emergency department visits and inpatient days in two groups, a) care managed and b) non-care managed. Claims data from July 2001 to December 2002 was analyzed. To be eligible for inclusion, both groups had enrollees that were Medicaid eligible continuously from July 2001 to December 2002, and were matched for eligibility category (SSI vs. TANF), disease state, prior utilization and length of time in the program.

In addition, population level improvements demonstrate that the program has successfully educated patients about their disease and health care, increased their abilities to self-manage, and changed health-related behaviors. The measurement of these health behaviors is indicative of the beneficiary's self-management skills, lifestyle indicators, and perceived quality of life. This data is self-reported by the beneficiary to the nurse care manager, using nationally recognized and validated instruments for data collection. A more detailed description of the instruments is attached, please reference the attachment "Self-Management Outcome Measures".

Health Behaviors	Program Impact
Non-Smokers (n=949)	↑3.7%
In Process of Quitting Smoking (n=949)	↑35.4%
Following a Special Diet (n=1,720)	↑14.0%
Regular Physical Activity (n=982)	↑13.9%
Medication Compliance ² (n=969)	↑39.0%
General Health Status ³	
Physical Health (n=1,834)	↑3.4%
Mental Health (n=1,834)	↑4.9%

¹ N is the number of beneficiaries with an initial health risk assessment for which a follow-up assessment has been completed. A response to the question related to the measure at both initial and follow-up, with a minimum thirty-day period between them, is required. A total of 12,365 beneficiaries have completed an initial assessment.

² Medication Compliance is measured on a 12-point scale (0=very compliant, 12=very non-compliant).

³ General health status is based on the SF12, a validated measure of general health status. A higher value indicates better health.

Clinical markers are reported specifically for each disease state based on nationally recognized clinical treatment guidelines and standards of care. Examples are:

- Asthma
 - Asthma severity classification (NHLBI Classification)
 - Peak Flow Meter use
- CHF
 - NYHA Classification (New York Heart Association)
 - Weight Monitoring
 - Cholesterol values
 - Blood Pressure
- Diabetes
 - HbA1c values
 - Cholesterol values
 - Blood Glucose
 - Self foot exams
 - BMI (Body Mass Index)
 - Blood Pressure
- HTN
 - Alcohol use
 - Global Risk score (calculated using CMS data system)
 - Aspirin use
 - BMI (Body Mass Index)
 - Cholesterol values
 - Blood Pressure Data

A complete report on program impact and outcome measures is attached. Please reference the documents “Florida: A Healthy State of the Program, Summer 2003” and “Florida: A Healthy State A Florida First Health Care Initiative, Program Update, June 2003”.

DATA ANALYSIS

Data management capabilities are one of the most important components of a quality DM program, and leads to more robust outcome measurements. In the disease management programs, information is captured throughout the program to assess improvement processes across several general domains, including health behaviors, patient self-management skills, clinical indicators, psychosocial outcomes, and health care utilization and revolves around three key areas: 1) medical record information, including laboratory test values, 2) claims data for inpatient hospitalizations and ED visits and 3) self reported data from participants. Every effort is made to insure that complete information is collected from the program participants to insure adequate statistical power to analyze the relationships between various intervention components and associated program outcomes.

Health Behaviors—Information about current health behaviors, including diet, exercise, and smoking status, are captured and stored in the disease management data system at baseline, at all relevant follow-up contacts with care managers, and summarized in regular reports.

Patient Self-Management Skills—To determine whether the program is positively impacting patients’ self-management skills, relevant information regarding self-monitoring is collected as well. This includes, but is not limited to self-monitoring of weight for patients with heart failure, home self-monitoring of blood glucose and daily foot exams for patients with diabetes, and home blood pressure monitoring for patients with chronic heart disease. Medication adherence is also measured at least annually using a 9-item validated self-report medication compliance scale (Morisky DE, Green LW, Levine DM. *Med Care* 1986. Jan;24(1):67-74.).

Clinical Indicators—To determine whether the program has had a positive impact on patients’ health status, a number of clinical measures are also captured during regular nurse care manager contacts with program participants including results of laboratory tests, vital signs, and symptoms. This data is retrieved using a variety of methods, from patient self-reports, to manual review of the medical record, to a pilot of home self-testing by beneficiaries, scheduled to begin this month.

Psychosocial Outcomes—We define psychosocial outcomes as outcomes that represent influences on patient health-related perceptions and beliefs. Several indicators of psychosocial improvement are used throughout the course of the programs including health status, self-efficacy, and patient satisfaction. The SF-12, a commonly used and validated instrument to assess health status across all conditions is administered annually. Self-efficacy regarding self-management for each disease

is also measured via the SF12 to assess patients' confidence in their ability to do what is necessary to manage their condition. This kind of efficacy is a powerful measure of patient empowerment, and a strong predictor of actual health behaviors.

To determine the level of patient and provider satisfaction with the disease management program, both patient and provider satisfaction are measured. Included in the measure of patient satisfaction are questions regarding overall satisfaction with the program, satisfaction with program staff, usefulness of information received, satisfaction with assistance with adherence to treatment and self-management plan, and whether patients would recommend the program to family or friends. An independent third party consultant was utilized to conduct a telephonic patient satisfaction survey for the FAHS program. Results are expected within the next quarter from the University of Florida.

Service Utilization—Claims data is used to collect and analyze information on service utilization to assess whether the program is influencing appropriate hospital admissions, number of days in the hospital, and reducing unnecessary or inappropriate medication and emergency room use.

POSSIBILITIES FOR IMPROVEMENT OF OUTCOMES MEASUREMENT

There are a number of ways that the Disease Management (DM) industry can improve our ability to demonstrate the value of DM programs. Obviously, conducting tightly controlled studies of disease management would be ideal, but this is not always possible, and almost always impractical in applied settings. Short of conducting randomized controlled trials, however, there are approaches that can be used to better demonstrate the effectiveness of DM programs. The industry is beginning to see value in sophisticated analytic techniques like time series analysis, or regression discontinuity designs to evaluate the savings associated with a program.

Use of the most sensitive and appropriate measures of program success is critical to accurate outcome reporting. While there have been a number of recent efforts in the DM industry to develop a standard set of outcomes measures and metrics for DM programs, to date there has not been a widely accepted version. Of primary importance is choosing measures that are sensitive to the change that the program is hypothesized to effect. These measures include care management processes and health care delivery processes defined below.

Care Management Processes are specific to the duties performed by the care managers and include information about patient engagement, services and assessments performed during all patient contacts, ongoing monitoring of additional intervention components including patient support and education, and any other related fulfillment activities associated with the program.

Health Care Delivery Processes include the actual clinical care received by the patient including preventive screening and services, appropriate medication prescribing, and other appropriate medical procedures and treatments.

ENROLLMENT AND DISENROLLMENT

Patient attrition presents an enormous challenge for the disease management programs. The mobility of the Medicaid population creates difficulties in continuity of care and accurate measurement of long term care management. The two main categories of Medicaid eligibility for the disease management program are disability (Supplemental Security Income, SSI) and low income (Temporary Aid for Needy Families, TANF). The TANF population had approximately 35% of beneficiaries remaining continuously eligible for the 12-month period of FY 2001-20002. The SSI population presents a more stable pattern of eligibility with approximately 71% remaining eligible for the same 12-month period.

The transient nature of the patient population's residence status presents large challenges for acquiring and maintaining communication with patients as well. Approximately 40% of beneficiary contact information is incorrect, creating a challenge for the disease management program to find beneficiaries and to actively engage them. Medicaid is working on system enhancements to improve the contact information. The disease management programs have added resources to increase the number of beneficiaries contacted, including on the ground personnel to literally go house to house to share program information, software packages that enable the program to gain correct phone number information, and radio and print media designed to increase awareness of the program.

Beneficiaries identified through claims data as being eligible for disease management due to disease state condition are automatically enrolled in the program and may opt-out at any point they desire. They may re-enroll at any time as well. Beneficiaries who lose Medicaid eligibility are disenrolled, and re-enrolled when eligibility is regained. Due to this high volume churn of eligibility, the disease manage-

ment programs now leave beneficiaries on the census list for 60 days after loss of eligibility, at no charge to the Agency, to improve continuity of care as many will re-gain eligibility and return to the program. In the FAHS program, care managed patients have been in the program an average of 445 days. Disenrolled patients were enrolled for an average of 329 days.

	Total Beneficiaries	Average Days in Program
Current FAHS Enrollees	89,061	445
Beneficiaries Disenrolled	40,477	329

Note: Based on beneficiaries enrolled as of November 5, 2003

An example of enrollment and disenrollment statistics for the FAHS program is outlined in the table below.

	2001Q4	2002Q1	2002Q2	2002Q3	2002Q4	2003Q1	2003Q2	2003Q3
New Enrollments	35,774	24,882	32	27,537	9,763	9,286	15,384	6,844
Re-enrollments	1	31	5,208	6,004	1,276	2,586	10,509	12,257
Disenrollments	5	126	12,430	13,408	6,891	9,883	16,507	18,840
Cumulative (end of quarter) ..	35,770	60,557	53,367	73,500	77,648	79,637	89,023	89,284

Enrollment, disenrollment, re-enrollment and cumulative enrollment statistics by quarter extracted from Pfizer Health Solutions' Clinical Management System (CMS) software.

Note: Patients disenrolled can be re-enrolled within the same quarter, even on the same day; these numbers do not represent mutually exclusive individuals.

ADDRESSING CULTURAL AND HEALTH LITERACY NEEDS

Each Florida Medicaid DM program strives to provide low literacy, culturally competent educational materials in English, Spanish and Haitian-Creole. Each vendor utilizes a universal telephonic translation line and has bi-lingual nurse care managers who interact with beneficiaries in their native language when possible.

In addition, a second initiative of the Pfizer-Florida Medicaid partnership is a comprehensive health literacy study and intervention. The study was conducted in association with the University of South Florida (USF) and 27 Federally Qualified Health Centers. Health Literacy is the ability to read, understand, and effectively use health care information and follow instructions from health professionals. The Florida Health Literacy Study investigates the direct effects of the health literacy interventions on patient disease knowledge, self-care behaviors and the management of their Type 2 diabetes and/or hypertension. The study will also estimate the indirect effects of these interventions on disease complications and, ultimately, health care costs. The study is the first of its magnitude on health literacy and is detailed below:

- **27 Federally Qualified Health Centers (FQHC) are Participating:** 14 are intervention sites, 13 are control sites. 14 Health Educators were hired and trained to provide group and one-on-one educational sessions using diabetes and hypertension materials in English and Spanish. Educational materials were available free of charge to Medicaid beneficiaries with Type 2 diabetes or hypertension at 60 community health center sites, 33 of which are non-study sites.
- **Enrollment (as of February 2003):** 679 at the intervention sites; 325 at the control sites
- **Status:** The study ended in May 2003 with a 6-month follow-up to occur in November 2003 and results are expected from the University of South Florida in first quarter 2004.

Pfizer Health Solutions underwrote two key market research projects that marked the beginning of the Florida: A Healthy State program and provided important information about the health care delivery in Florida and the patterns of utilization of the MediPass population. These include:

- The Physician Market Research (2002)
- Patient Market Research (2002)

The physician market research provided an interesting perspective on the issues and challenges faced by practitioners caring for chronically ill Medicaid patients. This feedback helped FAHS understand the intricate relationship between the social, economic, linguistic and cultural problems affecting these patients and their overall health status.

The patient market research followed in an attempt to better understand the needs of the patients served by Florida: A Healthy State. The project targeted Medicaid beneficiaries representing all races and ethnic groups. These included: Whites,

African Americans, Hispanics, and Haitians. The purpose of this project was to assess:

- Experiences with the health care system
- Effective/culturally appropriate channels of communications to disseminate information about the program and encourage patients to enroll.

Through this research it was learned that some ethnic groups value health differently and that cultural relevancy is extremely important when communicating information about health choices and personal care. These findings led to modification of all program materials to conform to the needs of the patients enrolled in FAHS:

This included:

1. *Re-designing* patients materials for cultural relevancy, language and literacy level: Bilingual program letters; Bilingual patient brochures; and Awareness campaigns (free flu shots coupons, magnetic calendars . . .)
2. *Re-designing* care management protocols: Spanish-speaking care managers available on triage line; Bilingual care managers working extended hours (Spanish, English, Haitian/Creole); AT&T translators; and Hospital staff translators
3. *Ongoing efforts include:* Developing bilingual patient education materials that meet Health Literacy principles and are written at 4th grade level. Assessing the educational needs of the patients and making health information available in various formats and different venues.
4. *Dissminating program information* through culturally appropriate trusted sources: Medicaid Offices—e.g., health fairs; Department of Children and Families—e.g., services for low-income and disadvantaged populations; Community based organizations—e.g., groups like Little Havana Nutrition Education Center, Community Voices Miami (coalition of health and social services organizations), federally qualified community health centers, child care agencies, area health education centers; Advocacy Groups—e.g., (American Heart Association, American Lung Association, American Diabetes Association), LULAC; Faith-Based Organizations/Churches—e.g., Diabetes Sundays, Lectures, Radio Shows, Church Bulletins; Government agencies—e.g., Department of Health and county health clinics, Department of Elder Affairs; Municipalities—e.g., City of Hialeah centers (large Hispanic population), City of Miami and others; Schools—e.g., County School Boards, Pediatric Asthma Programs
5. *Developing a Statewide Community Resource Directory* with relevant health and social information for nurse care managers, Medicaid Area Office staff use.

The Health Choice Network program represents an innovative Bristol-Myers Squibb funded program of faith based, culturally competent care for Medicaid beneficiaries with diabetes and depression. This community based care management program entitled Diabetik SMART is active in 8 Federally Qualified Health Centers and 50 community sites, with the faith-based outreach component involving 9 predominantly African-American and Hispanic Churches. This unique program utilizes Promotoras, or culturally appropriate lay health workers, to enhance disease management services to beneficiaries. The Promotoras, trained and supervised by registered nurses, interact with the beneficiaries, lead educational sessions and provide educational materials to actively engaged beneficiaries. Over 1,741 beneficiaries were identified as eligible, with 494 actively engaged in the program in its first year of operation. Evaluation of the program will be conducted by the University of Florida and will measure the relationship of improved health behavior, as indicated by a lower Hemoglobin A1c, to direct health care costs. The program has not been fully operational for the time necessary to accurately measure changes in health behavior, and results are expected in 2004.

Complementing these other disease management initiatives, the **Medicaid Area Office** staff organized a series of quarterly outreach campaigns partnering with the faith based community and interfaced with a Medicaid newsletter in an effort to educate and empower Medicaid beneficiaries to make better health care choices. The newsletters are printed in English, Spanish and Haitian-Creole and distributed to various local community agencies and other state agencies to raise awareness of health care issues. Each quarter has a designated theme such as “Diabetes Sunday”, during which Area Office staff worked with local pastors to hold health fairs and screening after Sunday services at predominantly African-American and Hispanic Churches in an effort to raise awareness of diabetes and the importance of screening and treatment. “A Child Primer” focused on back-to-school issues, such as immunizations and child health check-ups; “Healthy Aging” focused on elders and health care. “Managing Chronic Illnesses” is the current quarter’s theme in which Area Office staff partner with the local faith based community and provide health information and outreach activities in churches on illnesses such as diabetes, breast cancer, hypertension, heart failure and even AIDS. Up next is “Healthy Bodies, Healthy

Minds” with a focus on managing stress, mental health, healthy eating habits, physical fitness and well health exams. Copies of the newsletters are attached.

The Area Office staff have also been involved with a number of other efforts including outreach activities sponsored by the Agency Community Resource Office, the Minority Health Awareness Committee and most recently partnering with The Center for Medicare/Medicaid via First Coast Service Options, Inc. to reach individuals in communities challenged by low income, low literacy and location. Medicare and Medicaid information was provided to these individuals in Spanish, Creole and English.

Area Office staff have completed more than 2,000 education/outreach activities reaching a total of more than 200,000 individuals. Of this total more than 300 education outreach activities were completed beyond normal working hours. Education and outreach efforts are also a part of interaction with Medicaid beneficiaries as staff assists them in navigating the health care system. Publications are sent directly to beneficiaries when responding to correspondence and as a result of telephone calls received. The Medicaid Area Offices are actively, thoroughly and willingly involved with the community to reach culturally diverse groups of beneficiaries and individuals.

Outside the scope of the disease management program, the Agency has contracted with Florida A&M University’s Institute of Public Health College of Pharmacy and Pharmaceutical Sciences to conduct an objective demographic study of Florida’s Medicaid population in the interest of facilitating the development of improved service delivery models, health promotion activities and improved communication between beneficiaries and the Agency. This study will utilize (1) the analysis of existing Medicaid data and reports and (2) the collection of primary data to supplement existing knowledge including telephonic surveys. Completion of the study is expected in early 2004.

In closing, Florida Medicaid’s disease management programs have demonstrated successes in improving the health of beneficiaries enrolled by empowering them to make better health behavior choices leading to clinical improvement of their existing chronic illness and in turn, reducing health care costs. We look forward to a continued reporting of favorable outcome measures and positive impact on the lives of Medicaid beneficiaries statewide.

