



Medicaid Reform

Bringing State Medicaid Agencies and Community Health Centers Closer Together on Disease Management

March 2009

This Issue Brief was prepared by the National Association of State Medicaid Directors (NASMD) under contract with the Health Resources and Services Administration, U.S. Department of Health and Human Services.

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Introduction

Disease management has grown significantly during the past several years in the public sector as an initiative intended to provide quality health care in a cost-effective manner to persons with chronic conditions. State Medicaid agencies, as payers, see program costs continue to escalate and look for strategies that better address the health care needs of their most expensive populations. Disease management or care management for high-risk, high-cost Medicaid enrollees, especially those with multiple chronic health needs, affords states an opportunity to meet enrollee needs and address program costs.¹ As providers serving a low-income and largely uninsured or Medicaid-eligible population, Public Health Service Section 330 funded Community Health Centers (referred to as “Health Centers” throughout the rest of this document) continually face the challenge of serving populations with disproportionate chronic care needs using limited resources.^A The growth of disease management in publicly funded programs parallels the growth of disease management in the private sector. Through the Health Resources and Services Administration (HRSA) sponsored Health Disparities Collaboratives (HDC), Health Centers have gained more than 10 years of experience implementing innovative disease management strategies and generating proven results for high-risk, high-cost Medicaid patients.

Many state Medicaid agencies see disease management as an important strategy to better address the health care needs of their most expensive populations—generally, the elderly, the disabled, or those living with chronic disabling conditions. These populations represent a minority of the total Medicaid population, but they consume a majority of program funds. In the past seven years, most states have implemented or begun to implement disease management programs as part of their Medicaid programs.² Medicaid managed care has been used primarily as a tool for improving care and lowering costs for populations of families, women, and children. In contrast, disease management is increasingly being viewed by states as the most promising program approach for improving care and lowering costs for populations with chronic conditions in their managed care and fee-for-service programs, primarily the aged, blind, and disabled.

Since 1997, Health Centers nationwide have been focused on improving the quality of care provided to patients with chronic conditions through an initiative sponsored by HRSA and called the Health Disparities Collaboratives (HDC) initiative. This initiative aims to achieve strategic system change in the delivery of evidence-based, quality driven primary care. Hundreds of HRSA-supported Health Centers have already participated in

^A Health Centers serve as one of the Federal government’s primary methods for attempting to ensure access in underserved areas. Along with Federally Qualified Health Centers – Rural Health Clinics, Disproportionate Share Hospitals and National Health Service Corp providers are other federally recognized components of America’s safety net for uninsured persons.

collaboratives focused on managing and reducing the impact of asthma, cancer, depression, diabetes, and cardiovascular disease. In addition, this initiative has spawned efforts by Health Center networks and other providers to develop and conduct collaboratives that are equivalent in their design and content. Nearly 90% of HRSA-supported Health Centers have participated in HDC or other similar quality initiatives.³

State Medicaid programs and Health Centers have always been closely linked; they have a shared or common mission helping to ensure that necessary health care is provided to low-income populations. The Medicaid program has a significant financial impact on Health Centers as the major payer for low-income populations. Nationally, between 30 percent and 40 percent of Health Center patients are Medicaid beneficiaries. Approximately one-third of the revenues that Health Centers receive nationally come from Medicaid. Health Centers receiving federal grants are required to have a Medicaid provider number and serve Medicaid patients.

At the same time, Health Centers provide value to Medicaid programs. They often take patients that no other provider is willing to serve and are a key partner in ensuring access for Medicaid beneficiaries across the Nation. For example, Health Centers care for patients in both urban and rural underserved areas. By providing Medicaid beneficiaries with preventive and primary care services, Health Centers help Medicaid avoid paying for costly alternatives, such as emergency room care or inpatient hospital stays.⁴ The cost-effectiveness of Health Center care is well documented. Several comparative effectiveness studies of Medicaid utilization show that Health Centers save Medicaid roughly 30% in annual spending per beneficiary due to fewer emergency department visits, hospitalizations, and specialty care referrals.^{5/6} In addition, Health Centers take all uninsured patients, so they can continue to serve as a medical home for the many individuals and families that move on and off Medicaid because of changes in circumstances. Moreover, in many communities where Medicaid is a key payer of health care services for low-income and vulnerable populations, Health Centers are an important provider of services. Approximately one in nine Medicaid beneficiaries receive services from Health Centers;⁷ Health Center expenditures account for only a small percentage of state Medicaid budgets.⁸

Health Centers have several attributes that make them excellent providers to implement and operate disease management programs. First, they tend to be medical homes for many of their patients; providing continuity of care over long periods of time. Second, they have a variety of clinical personnel who can provide the wrap-around services required in a disease management program. Third, Health Centers generally provide a comprehensive set of services, including outreach, translation, and case management. Lastly, Health Centers have gained invaluable experience through the HDC in implementation, performance evaluation and continuous quality improvement for disease management programs. That profile presents a unique opportunity for state Medicaid agencies to leverage Health Centers' pre-existing investments, expertise and proven success.

As stated by HRSA, the objectives of the Health Disparities Collaborative initiative are to:

- generate and document improved health outcomes for underserved populations;
- transform clinical practice through new evidence-based models;
- develop the expertise, infrastructure, and multidisciplinary leadership to improve health status; and
- build strategic partnerships.

HRSA recognizes that the health care market is changing and that pay-for-performance approaches are important in public and commercial health care systems. To compete, Health Centers will need to provide data on the cost, quality, and outcomes of care. Both HRSA and Health Center leadership from across the country believe that a quality approach to disease management is critical to Health Centers thriving in a competitive health care market.

This report examines how state Medicaid agencies and Community Health Centers have designed and implemented their disease management programs, including the extent to which state Medicaid agencies and Health Centers have worked together, the opportunities this creates, and the ongoing challenges they face in operating these programs. In addition, the report explores the role of disease management in current state Medicaid reform initiatives and how Medicaid agencies and Health Centers intend to work together on these programs.

Florida, Idaho, North Carolina, and West Virginia were selected for study because of their various experiences with disease management and because disease management is a component of Medicaid reform in three of these states. Information was collected through interviews with state Medicaid officials, state Primary Care Association (PCA) personnel, and Health Center staff in the case study states; as well through a review of the health policy and services literature.

Chronic Care and Disease Management

The growing interest in the management of chronic conditions derives, in part, from the need to contain escalating costs in the Medicaid program. Disease management programs have identifiable components and usually incorporate the Chronic Care Model (described below). Evidence-based medicine provides feedback on best practices that can guide disease management strategies and outcomes.

Prevalence and Cost of Chronic Conditions

Persons with chronic conditions are a minority of the population, but they account for the vast majority of health care spending, including Medicaid spending. This relationship holds true, regardless of the source of payment.⁹

- Over eighty percent of Medicaid spending is for the almost 40 percent of noninstitutionalized beneficiaries with one or more chronic conditions.

- Seventy-four percent of private health insurance spending is attributed to the 45 percent of privately insured people who have chronic conditions.
- Seventy-two percent of all health care spending for the uninsured is for care received by the 31 percent of the uninsured with chronic conditions.

This is why so many payers in both the private and public sectors are focused on lowering the cost of care provided to these individuals.

Disease Management Defined

The Disease Management Association of America defines disease management as “a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant.”¹⁰ Disease management:

- supports the relationship between physician or practitioner and patient as well as the plan of care;
- emphasizes the prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies; and
- evaluates clinical, humanistic, and economic outcomes, on an ongoing basis, in order to improve overall health.¹¹

Components of disease management include:

- processes for population identification;
- guidelines for evidence-based practice;
- collaborative practice models that include practicing clinicians and providers of support services;
- patient self-management education (e.g., primary prevention, behavior modification programs, and compliance and surveillance);
- measurement, evaluation, and management of processes and outcomes; and
- routine reporting and feedback (e.g., practice profiling and communication with patients, physicians, health plans, and ancillary providers).¹²

The Chronic Care Model

Virtually all disease management programs incorporate the Chronic Care Model in their design. This model was developed by Edward Wagner, MD, MPH, FACP, director of the MacColl Institute for Healthcare Innovation at the Center for Health Studies, Group Health Cooperative of Puget Sound in Seattle, Washington, and his colleagues, with support from the Robert Wood Johnson Foundation. It was developed in response to deficiencies in the management of chronic illnesses such as asthma, depression, diabetes, and heart disease. These deficiencies include rushed practitioners not following practice guidelines, a lack of care coordination, a lack of active follow-up to ensure the best outcomes, and patients inadequately trained to manage their illnesses. The model was developed drawing on available literature about promising strategies for chronic illness management as well as input from national experts. It was subsequently tested across programs nationally. The Chronic Care Model is intended to overcome the above-mentioned systems deficiencies by transforming health care from a reactive system that treats sick people to a proactive system that keeps people as healthy as possible.

The Chronic Care Model identifies essential elements that encourage high-quality chronic disease care:

- the community;
- the health system or health care organization;
- self-management support;
- delivery system design;
- decision support; and
- clinical information systems.

Evidence-based change concepts under each element together foster productive interaction between informed patients who take an active part in their care and providers backed by resources and expertise. The model can be applied to a variety of chronic illnesses, health care settings, and target populations. The intended outcomes are healthier patients, more satisfied providers, and cost savings. The Chronic Care Model can be used within the context of Medicaid disease management to support quality initiatives and improved health outcomes.

Evidence-Based Medicine

Evidence-based medicine is a key component of disease management and the Chronic Care Model. It is a methodology for evaluating the validity of research in clinical medicine and applying the results to the care of individual patients. Evidence is gathered through the systematic review of the literature and is critically appraised. The results are then integrated with physician and patient decision-making.¹³

The process of consulting best available research is an ongoing one repeated to keep the practitioner up to date on the newest information. It is part of the ongoing review process that calls for changes and adjustments. Evidence about the most effective methods of changing clinician behavior can be incorporated into disease management programs and, therefore, clinical and economic outcomes can be improved by reducing variation from optimal practice.

Health Centers' Approach to Chronic Care and Disease Management

Health Centers have widely adopted disease management through the development of chronic disease management collaboratives. Although support for these collaboratives has come from different partners, the Health Disparities Collaboratives initiative of the Health Resources and Services Administration has been the primary catalyst for Health Centers' efforts in this area.

Health Disparities Collaboratives

HRSA launched the HDC initiative in 1997 as a national effort to focus on conditions of highest importance in terms of cost, volume of patient visits, and complexity of need. The

federal agency initially selected five state-level primary care associations—organizations of Health Centers—to convene the Health Centers in their region (clusters). Diabetes was the first disease the program addressed, followed by cardiovascular disease, asthma, cancer, and depression. An important partner from the beginning has been the Institute of Healthcare Improvement which has provided much of the technical infrastructure to support the practice teams participating in the collaboratives. The Chronic Disease Care Model is at the core of this infrastructure.

HDC Approach and Model

The approach to disease management taken by the HDC initiative and similar initiatives across the nation incorporates many of the attributes of total quality management in that the operation is being assessed and adjusted on a continuous basis. The six components of HDC's Chronic Disease Care Model are the same six elements of Wagner's Chronic Care Model:

- inclusion of the community;
- focus on the health care organization;
- patient self-management support;
- decision support;
- delivery system design; and
- clinical information systems.

All six components of the model are addressed to achieve change. Teams learn about changes that can be made within each area and then test these changes at each site. Teams make small changes and learn from each change. Ultimately, these various changes leverage themselves to all parts of the provider's system and often extend to the provider's partners in local safety nets.

Experience with Disease Management Programs in the Case Study States

In 2001, only 11 state Medicaid programs had disease management programs. According to a study by the Kaiser Commission on Medicaid and the Uninsured, by 2005, 26 states had implemented disease management programs within their Medicaid programs and new and expanded programs continue to be planned.¹⁴ The increased number of such programs is, in part, due to pressure to save money during a period of economic difficulty, but it also reflects the growing recognition of disease management in the private sector.¹⁵

Similarly, chronic care management programs have spread to Health Centers throughout the nation since the late 1990s. Only with the involvement and long-term focus of a federal agency have Health Centers with limited funding been able to stay focused on an initiative that requires significant resources to get up and running. Other sources of funding, particularly the Robert Wood Johnson Foundation's Improving Chronic Illness

Care program, were also recognized for providing essential funding for similar initiatives.¹⁶

Most of the case study states also have had significant experience with disease management, both in their Medicaid program and among their Health Centers.

Florida

Both the State Medicaid agency, the Agency for Health Care Administration (AHCA), and the state primary care association, the Florida Association of Community Health Centers (FACHC), have had disease management programs in place for several years. AHCA first contracted with outside vendors to provide disease management (DM) services in 1999 using grants from pharmaceutical companies. Initially, the state hired a different vendor for each disease it was targeting. The program has now evolved into two programs: 1) *Florida: A Healthy State Program* and, 2) the *Diabetes Promotora*. This latter state disease management program uses Federally Qualified Health Centers (Health Centers).

Florida: A Healthy State Program is a partnership between the state and Pfizer and is administered by AHCA with support from a contract with Pfizer Health Solutions. Pfizer provides support with disease management program components such as proprietary disease management software, patient education materials, and community outreach programs. AHCA contracts with Pfizer for DM services through 10 health systems across the state based on geographical location and high Medicaid patient volume. This program targets asthma in children, and diabetes and hypertension in adults. Care managers coach beneficiaries on medication compliance, health service utilization, and self-monitoring of health indicators. They also address various life-style and behavioral issues.

Diabetes Promotora has been implemented by AHCA and funded by Bristol Myers Squibb. It is a community- and faith-based diabetes promotora and behavioral health disease management program. The program uses Health Centers to provide culturally appropriate community-based care for diabetics and prediabetics. Nurse care managers work on-site at the Health Centers. The Diabetes Promotora initiative trains members of the community to educate their peers. Outreach through churches, particularly in the African American community, is also part of this program.

Health Centers in Florida began participating in HRSA's HDC initiative in 1999. The Florida Association of Community Health Centers (FACHC) committed to providing support to Florida's Health Centers as they strive to reach the goals of the HDC as part of the Southeast Atlantic Cluster infrastructure. The diabetes collaborative has the longest history of implementation in the HDC, however, asthma, cancer, cardiovascular disease, and depression collaboratives have been implemented since 1999. Of the 38 Health Centers in the state, 25 have gone through the collaborative learning process and 24 continue to participate in the initiative. The initiative first focused on specific disease collaboratives. It has now progressed toward an all-inclusive planned care model of delivering services. After a Health Center has gone through the initial year focusing on one disease (phase I), it can use the principles learned to spread the planned care model to

other conditions, providers, and delivery sites. This is known as the transformation phase (or phase II). A lesson learned from participating in the collaborative, according to Southeast Atlantic Cluster staff located at FACHC, is that its goals and tasks must be fully integrated into the clinic's care management system. Rather than existing as an independent project, disease management collaboratives have to be integrated into the Health Center's overall quality improvement program.

Florida's Health Centers were sought out to participate in reform measures. FACHC has worked closely with the executive office of the governor, the state legislature, and AHCA as the reform effort evolved from a concept to a bill that was eventually passed by state lawmakers and approved by the federal Centers for Medicare and Medicaid Services. FACHC has positioned Health Centers to actively participate in this initiative. As with any state Medicaid program, there is a need to control the rapid rate of growth in program costs. Community Health Centers (CHCs) clearly fit in the strategy as a component of the overall plan. Establishing a medical home for many low-income residents will improve health outcomes as well as reduce health care costs for those same patients. Getting chronically ill patients into a disease management program will address both goals of reducing costs and improving outcomes. The 24 CHCs currently active in transforming their delivery systems through the HDC initiative are focused on spreading positive changes throughout their delivery system.

Among other reforms, Florida has transformed its Upper Payment Limit (UPL) program, which provided matching funds for hospitals to draw down through the state's Low Income Pool (LIP) program, and to provide some relief for uncompensated care and rising Medicaid costs. The state has earmarked \$8 million in LIP funds for Health Centers to help provide primary care services, including DM programs. Some of these funds will be used to improve and expand DM services.

Idaho

Among the case study states, Idaho has the least experience with disease management. However, while the state Medicaid program has had limited experience with disease management programs, it has made disease management an important part of its Medicaid reform initiatives related to prevention and wellness. Idaho Health Centers began participating in the HRSA HDC in 1999, when 3 of the state's 10 Health Centers started with the diabetes collaborative. Currently, five Health Centers participate. Each Health Center addresses at least two of three diseases - asthma, depression, and diabetes. An electronic patient registry has been created, and most of the Health Centers are now using it to collect and report data on patient outcomes. The experience that Health Centers have developed will be beneficial to the state.

North Carolina

In North Carolina, both the Medicaid agency and Health Centers have been working on disease management programs for several years. Medicaid has relied on a community-based approach using the structure of the state's Primary Care Case Management (PCCM) program. The Community Care Plan has 14 regional networks using PCCM

providers, including hospitals, local doctors, local health departments, and departments of social services. The networks hire nurse care managers to work with physicians. The state has hired experts to educate providers about evidence-based best practices and provide standardized tools to support the efforts of primary care providers. In addition, the state employs 10 staff members to support the networks. Their work includes training local networks in case management and providing support for information systems and tracking. As an incentive to participate in the program, the network and the provider are each paid \$2.50 per patient per month by Medicaid. Providers not participating in the program are only paid \$1.00 per patient per month for the case management of health services.

The North Carolina Chronic Disease Management Collaborative (NCCDMC) was established in 2003 as a state-based pilot focusing on diabetes. NCCDMC followed a very similar approach to HRSA's disease collaboratives and has been deemed equivalent by HRSA. It has received initial and ongoing support from the North Carolina Community Health Center Association (the state primary care association) and the North Carolina Division of Public Health's Diabetes Prevention and Control Program and Heart Disease and Stroke Prevention Program as well as funding from the Robert Wood Johnson Foundation. Over time, the collaborative has expanded its targets to include cardiovascular conditions, cancer screening, and prevention initiatives.

Data from Health Centers in the NCCDMC diabetes and cardiovascular collaborative registry for 2004 and 2005 reveal significant progress. The number of patients in the cardiovascular collaborative was 4,160, and 3,250 were in the diabetes program. Improvements in the process of care for the diabetic patients have occurred over time, including foot checks (35 percent to 52 percent); hemoglobin A1c testing two times per year (10 percent to 30 percent); dilated eye exam (5 percent to 20 percent); and pneumococcal vaccines (6 percent to 15 percent). Outcome data show an increase, from 26 percent to 50 percent, in the percentage of the population with blood pressure measurements below 135/85.¹⁷ Long-range goals set even higher targets.

NCCDMC is continuing to train more teams each year, with demand from the provider community exceeding its ability to train. The state Medicaid and Health Center initiatives, while having some communication with each other, have progressed separately.

West Virginia

The West Virginia Medicaid agency first implemented a disease management program in 1999. The agency targeted beneficiaries in the state's Primary Care Case Management program. It used claims data to identify the target population that would benefit from the program. PCCM providers were trained to use clinical guidelines and reimbursed for their participation in the program and compliance with the guidelines. The state Medicaid program has an ongoing diabetes education program for providers that it runs jointly with the state Diabetes Prevention and Control Program. As an incentive to participate and take the training, Medicaid providers are reimbursed for providing extended patient visits.

In 2006, WV Medicaid initiated its “roll-out” the Mountain Health Choices Program. One of the first Medicaid Waivers granted after the implementation of the Deficit Reduction Act. Targeting mothers and children, beneficiaries could opt in to more benefits if they followed through with self-management goals.

The West Virginia Community Health Centers have been an active participant in the HRSA Health Disparity Collaborative initiative. Nineteen of the 28 Federally Qualified Health Centers completed Phase I and Phase II training. Nine health centers elected to not participate in the HDC activities for a number of reasons, including the expenses associated with the “team” participation and time commitment requirements. In some cases, specific centers did not have the resources to participate. Three of the nine centers were identified by Medicaid as “pilot-sites” in the implementation of the Mountain Health Choices Program. These centers adopted an alternative approach to implementing the Care Model that included the full integration of an electronic health record. To assure that their capacities to produce desirable health outcomes in the populations they serve were comparable to those centers participating in the formal Health Disparities Collaborative program, the six remaining health centers were provided support and training through the West Virginia Primary Care Association in collaboration with the West Virginia University, Office of Health Services Research and the Diabetes Prevention and Control Program.

Characteristics of Disease Management Programs in the Case Study States

Health Centers have several attributes that make them good candidates to run disease management programs. In the case study states, however, their involvement in these programs has been somewhat limited to date. Many state Medicaid agencies outsource their disease management programs, though this pattern may be changing. State Medicaid agencies view cost savings as a critical goal of disease management programs, while community Health Centers tend to emphasize quality of care and patient outcomes. These differences in focus, however, need not be mutually exclusive.

Limited Coordination with Health Centers

Despite experience with disease management in the case study states, coordination among the Medicaid agency, the primary care association, and Health Centers on disease management initiatives has been limited. This is true even though many Medicaid beneficiaries receive their care in Health Centers.

Florida’s Medicaid agency offers its disease management program as a component of the pharmacy program. The agency has sought assistance by contracting with vendors to operate the program for Medicaid beneficiaries but has not coordinated the effort with Health Centers.

Cooperation between the North Carolina Medicaid agency and the North Carolina Community Health Center Association often occurs. Officials say the two groups communicate well even on potentially contentious issues such as prospective payment

systems. To date, however, the Health Centers in the North Carolina Chronic Disease Management Collaborative have not worked directly with the state Medicaid agency on disease management. Moreover, to date, the North Carolina Medicaid program's disease management initiative—the Community Care Plan—has not attempted to coordinate its activities with the Health Centers' collaborative. This is true despite the fact that some of the collaborative's Health Center members are located in the same communities where the North Carolina Community Care sites are located. Recently, however, officials with the North Carolina Medicaid program and the North Carolina Community Health Center Association have agreed to work together on disease management efforts.

West Virginia Community Health Centers are uniquely positioned to influence how Medicaid will effectively and efficiently address the primary care needs of its beneficiaries in the near future. West Virginia was awarded Medicaid Transformation grants in all five content areas. These grants creatively defined the “systems” infrastructure in which WV Medicaid will integrate statewide information system interconnectivity and data exchange, quality improvement and health education technical assistance, e-prescribing and medication management, and promote self-management initiatives. More recently, new synergies have been engendered between WV Medicaid and health centers. For example, the integration of the WV Medicaid e-prescribing and medication management objectives with the HRSA sponsored Patient Safety and Pharmacy Collaborative. A health center managed pharmacy network comprised of more than 20 health centers, the schools of pharmacy, and WV Medicaid have teamed up to enhance the safe delivery of medications to WV health center users. Demonstrations of this magnitude have energized providers, payers, and politicians to aggressively seek “tangible” and rapid healthcare delivery and reimbursement “change” in the state.

Finally, the Idaho Medicaid agency has not had contact with its Health Centers regarding disease management because it has not had a program. Like West Virginia, however, the state is discussing how Health Centers could participate as part of the state's Medicaid reform initiative. Despite limited interaction in the past, a trend of increasing collaboration may be emerging in Idaho.

Program Outsourcing by Medicaid Agencies

Some state Medicaid agencies have hired outside firms or collaborated with pharmaceutical companies to develop and implement disease management programs. The interviews with state officials conducted for this study suggest this pattern may be changing.

States can “buy” or outsource their DM programs through contracts with vendors, or they can “build” or develop them in-house working through the existing staff and providers in the state. A 2004 study by Kaiser found that up to that time, most states felt pressure to buy their program from vendors because of:¹⁸

- a need to implement and show some quick results in the form of savings;
- the time and effort needed to develop programs;
- a reluctance to build new government functions; and
- a lack of cash to invest up front in building new programs.

Hiring outside companies addressed many of these issues.

For example, Florida contracted with companies affiliated with pharmaceutical companies to operate its disease management programs. A major reason for using these companies was that funding for the project was provided by the pharmaceutical companies as a form of supplemental rebates under the Medicaid program. No state dollars were needed. Future financing for the program will come from agency funds, not grants from pharmaceutical companies. AHCA has contracted with Pfizer Health Solutions to operate all of the disease management programs, and implementation began January 1, 2007.

North Carolina, on the other hand, administers its disease management program internally by building a community-based approach that uses the structure of the state's Primary Care Case Management program. Leveraging the PCCM program structure has proven to be an efficient and effective way to implement chronic care management using evidence-based best practices. The state employs 10 staff members to support the networks. Their work includes training local network staff in case management and providing support for information systems and tracking.

West Virginia has administered disease management programs internally in the past and intends to do so in the future. Its pilot program (1999 through 2001) was operated by the state within the state PCCM program. Plans for care management within the Medicaid reform initiative will be developed and administered with in-house staff.

Although Idaho has not yet implemented a disease management program, it is planning such a program—developed with in-house resources—and is looking to emulate the Health Disparities Collaboratives model.

Differences and Similarities in Emphasis Between Medicaid Agencies and Health Centers

As a purchaser of health care services, most states view cost savings as an important objective of their Medicaid disease management programs. Many state legislatures are requiring their state Medicaid agency to save a prescribed amount of money, either measured in absolute dollars or as a percentage of program expenditures. These mandates are presented in the context of Medicaid programs that continually find themselves under close scrutiny because of escalating program costs and constraints in the total state budget. States often place their disease management vendor at risk to achieve such savings. For example, Florida currently requires its vendors to achieve 5 percent savings targets for all services provided to the enrolled population.

Improvements in the quality of care provided to patients and health status outcomes are the highest priority for Health Centers that have participated in chronic care collaboratives, according to Health Center and collaborative officials. Improvements in the cost-effectiveness of service delivery to patients with chronic conditions are expected by Health Centers, but measurable cost savings are not viewed as the main objective of

the program. Therefore, Health Centers tend to focus on broad practice and system changes that result in short- and long-term patient benefits and long-term cost savings.

Interestingly, the 2004 Kaiser study suggests that states that build their own programs may emphasize health outcomes as much as cost savings.¹⁹ The implication is that these states are more committed to the Chronic Care Model and believe that higher-quality care and patient involvement in care will help control costs over time. For example, North Carolina's Community Care Program objective is to improve program outcomes, not achieve short-term savings. The potential is significant where state and health center priorities come together to generate better health outcomes by providing quality care to more beneficiaries at a lower cost.

Challenges to Provider and Patient Participation

State Medicaid agency officials and PCA and Health Center staff who were interviewed agreed that ensuring provider and patient participation in a disease management program can be a challenge. PCA and Health Center staff believe provider participation maybe a challenge for some Health Centers for several reasons. First, participating in a collaborative requires significant time and resources that do not go directly to patient care. Second, some physicians view the model as interfering in their practice and the usual way they provide care. Third, physicians are skeptical of a new program's ability to produce positive results. Yet physicians have become more accepting of disease management programs as they have been implemented and matured, primarily because these programs have produced measurable positive results for patient care.

Medicaid officials said provider participation in a disease management program can be a problem. In response, Medicaid programs tend to use incentives to gain provider participation. First, as in the case of North Carolina, participation in the Medicaid PCCM program depends on participation in the Community Care program. Second, a state can provide financial incentives by paying a higher office visit rate for disease management visits when doctors conduct screening and provide counseling to the patient.

With regard to patients, a Florida Medicaid official identified several reasons why patient participation is a challenge. First, contacting beneficiaries can be difficult because some are transient and hard to locate. Second, some beneficiaries initially do not understand that the program can help them. Third, some beneficiaries see a stigma attached to some chronic diseases such as HIV/AIDS and, therefore, hesitate to be labeled as such and participate in the program. The official said these challenges can be overcome. Initially, the state provides financial incentives in the form of \$10 coupons for Wal-Mart or groceries. Over time, ongoing education and communication help beneficiaries understand the benefits of the program. Finally, personally achieved results help motivate beneficiaries to stay involved. Health center staff had similar comments.

Disease Management as Part of Medicaid Reform

Florida, Idaho, and West Virginia have each proposed making disease or care management part of their Medicaid reform plans. State officials see these programs as an important part of their efforts to redesign their Medicaid programs. Specifically, the

officials view disease management as consistent with—and an important tool in achieving—several objectives of their reform efforts, including:

- prevention and wellness;
- consumer-driven health care;
- improved quality assurance; and
- cost containment.

Florida

Florida's Medicaid reform plan emphasizes patient responsibility and empowerment. It includes an enhanced benefit account (EBA) based on consumer-driven models that have been introduced in the private sector (e.g., health savings accounts). Prevention and wellness will be encouraged, and beneficiaries will receive incentives for healthy behaviors. For example, if at-risk persons with asthma, diabetes, or heart disease participate in disease management programs, they could earn funds that would be deposited in their EBA. In addition, beneficiaries will have a choice of health plans in which to enroll, including employer-sponsored plans.²⁰ Once beneficiaries have acquired access to benefits through their EBA, they can purchase services not covered by the basic benefit package, such as over-the-counter drugs. Florida will rely on its own Medicaid disease management program and the programs contained in employer-sponsored health plans. Health Centers in the state will be providers in health plans, but they have not been given a specific disease management role in the reform initiative.

Florida's Health Centers are community-based health care providers. In calendar year 2006, they served as the medical home to 702,188 patients and handled 2,800,000 visits. Thirty-eight Health Centers are operating in the state, and these organizations currently provide high-quality health care in more than 230 service delivery sites. In 2006, 178,136 patients (25.4 percent of all patients) receiving medical services at Florida Health Centers were Medicaid recipients. State legislation requires that health management organizations within the pilot project areas include Health Centers in their provider networks.

Florida Medicaid has not directly contracted with Health Centers to provide DM services to Medicaid-eligible individuals; however, Florida Health Centers are involved in DM programs. If Medicaid-eligible individuals enrolled in a Medicaid DM program seek services at a Health Center, then the DM care manager will coordinate patient care with the Health Center. This could include managing medication, educating patients on health and life-style issues, and reinforcing the importance of making and keeping primary care appointments. Health Centers are not precluded from providing disease management services to their clients/patients, but no reimbursement is available for stand-alone DM services provided by CHCs. In Florida's Medicaid reform initiative, health plans are required to provide DM programs for enrollees with asthma, diabetes, hypertension, HIV/AIDS, and congestive heart failure, and they may offer other DM programs if they choose. The health plan may choose to provide the programs directly or to subcontract with other DM service providers. If a Health Center offers a DM program, the Center could choose to subcontract with a health plan to provide DM services to the plan's enrollees.

Idaho

Idaho officials report that prevention and wellness is the bottom line of its value-based initiative to modernize Medicaid. They believe that disease management programs provide strong underpinnings to achieve this goal. The state plans to establish personal health accounts for individuals. These accounts will have a baseline monetary value that is increased when the individual complies with recommended preventive care goals and demonstrates healthy behaviors. State officials believe disease management will help focus screening on patients most at risk for poor outcomes. Prevention and management of chronic disease, according to these officials, is the best and most efficient way to provide quality care. In addition, Idaho officials believe that involving beneficiaries in the management of their care is another positive component as the state looks to develop a consumer-driven health care model.

The Idaho Medicaid program, which to date has had limited experience with disease management programs, intends to begin implementing a significant program as part of the reform of its Medicaid program. Initially, the program will be developed in a limited geographic area with the only two physician residency programs in the state as disease management partners. The state sees the residency programs as logical entities with which to start the DM program because they are clearly defined programs with supervisory structures in place. This will enable the state to identify and resolve initial problems with the DM program, and the structured supervision will expedite training and oversight of physicians. After the initial roll-out, the state intends to quickly expand the program to the state's Health Centers. Idaho has been developing the program internally, in consultation with the residency programs and the state Primary Care Association, and it intends to administer the DM program inside the state Medicaid agency with input from the health division. Both agencies are housed in the Idaho Department of Health and Welfare. Diabetes will be the first disease in the program when it rolls out, but others will be added over time, including asthma, depression, and cardiovascular disease. The state intends to use a model of chronic care management that is similar to the Health Center's Health Disparities Collaboratives.

West Virginia

West Virginia officials see similar advantages to using a disease management model. Prevention is one of the main objectives of the state's Medicaid redesign effort. In addition, the state will establish health reward accounts (HRAs), similar to Florida's EBAs. HRAs will require beneficiaries to choose and manage their health care decisions. This includes signing a membership agreement that requires beneficiaries to keep medical appointments, participate in screenings, attend educational sessions, and comply with prescription regimens. Beneficiaries will still receive Medicaid services through the program's existing health plans. Credits will be deposited in the Health Rewards Account and can then be exchanged for items and services not covered as part of the basic service package. Beneficiaries will receive credits for actions such as seeking screening and care for asthma, diabetes, and cardiovascular disease. A disease management program that screens and monitors the health of beneficiaries and has a self-management component is consistent with West Virginia's proposed reform model.

Currently, of the 34 community health centers, there are approximately nine different EHR systems fully implemented or in development. The West Virginia Primary Care Association, through its board affiliation with the WV Health Information Network, is actively working to link all EHR systems together through a common information pathway so eventually data can be captured and analyzed in terms costs, benefits, and future health program planning.

Not unexpectedly, each health center has been engaged in adopting its own choice for an electronic health record. Many WV health centers continue to maintain an array of disease registries including diabetes, cardiovascular/hypertension, asthma, depression. To date, five WV health centers are using the VistA (Veterans Health Information Systems and Technology Architecture). Furthermore, the “Network” has been an integral partner with WV Medicaid as it develops approaches to support and encourage adoption of EHR and data exchange systems in order to meet statewide care management objectives.

West Virginia’s Mountain Health Choices is a novel approach to benefits redesign which begins with the establishment of a medical home for Medicaid members. The program has been rolled out statewide for the Aid to Families with Dependent Children-related eligibility categories. Medicaid members included in the new program will be asked to contact their medical home to develop a health care plan with their provider. Each provider also has a care manager who will work with Medicaid members to help them achieve the goals they and their provider have agreed upon. In addition, Medicaid members are asked to sign a member responsibility agreement stating that they will keep appointments for themselves and their children at their medical home, use the emergency room only for emergencies, notify their medical home of a change in address, and work toward the goals set with their provider. Care managers will play an integral part in helping members understand the agreement and achieve the goals that members have identified.

A Desire for Cost Savings

States officials assert that disease and care management programs will lead to savings over time, but their use will not bring about immediate savings as was the objective of many state Medicaid disease management programs in the past. Officials from each of the three states pursuing Medicaid reform initiatives expressed a belief that if prevention and wellness are emphasized and beneficiaries are given appropriate quality health care, beneficiaries will become healthier and, therefore, their care will be less costly to manage over time. In addition, they say, savings will accrue because of greater efficiencies in system administration.

Florida, Idaho, and West Virginia officials report that a primary goal of reform is to improve prevention and wellness services for Medicaid beneficiaries. This will be complemented by introducing personal responsibility and choice into the program and, at least in the case of Florida, introducing some competitive market forces. As new elements are introduced, such as health reward accounts, incentives meant to improve

wellness also aim to sensitize beneficiaries to the cost of services and lead to program savings.

Florida has said that a key element in its reform plan is achieving a sustainable growth rate in the program. Rather than emphasizing a quick reduction in expenditures, the state sees the longer-term benefit of patient responsibility, empowerment, and knowledge fostering a Medicaid marketplace that is more sensitive to costs and prices. State officials believe such sensitivity will lead to a moderation in cost increases.

Idaho officials believe strongly that prevention and wellness will help control costs over time, but they anticipate no specific program savings from the introduction of the disease management program. Similarly, in West Virginia, state officials believe that the collaboration with Health Centers on care management and electronic health records will bring about savings over time.

Conclusions

In this discussion of Medicaid programs and Health Centers, the focus on disease management has produced observations on similarities and differences between these payers and providers and on ways they collaborate. First, just as the use of disease management programs has grown in the private sector, state Medicaid agencies and Health Centers have also acquired substantial experience in the planning, implementation, and ongoing operation of disease management and chronic care programs.

Second, state Medicaid agencies tend not to work with Health Centers in the design and implementation of their DM program despite the experience of Health Centers with chronic care management collaboratives. This may be due, in part, to the differences in focus for state Medicaid agencies as payers and Health Centers as providers. State Medicaid agencies have placed a greater emphasis on cost savings, while Health Centers tend to emphasize improving the quality of care. State Medicaid agencies must be responsive to governors and state legislators regarding state spending. The main objective of Health Centers is to improve the health care of their patients. The gap is bridgeable; importantly, any effort to coordinate program initiatives must recognize and bring together these differing but complementary perspectives.

Third, an ongoing challenge in disease management programs is getting patients and providers to actively participate. Changing behavior patterns for both groups requires significant educational efforts and incentives. Once trained, Health Center teams are responsible for motivating patients and can best do this by engaging their patients concerning the benefits of the program. Collaboratives have found that providers not initially motivated can be encouraged to participate by focusing on the goals or outcomes of the program. After the initial training, collaborative staff follow up with communications to senior health center staff to answer questions and encourage their participation.

Fourth, Medicaid reform appears to be changing the environment and assumptions under which state Medicaid agencies introduce and operate disease management programs. Perhaps most critical, the approach and objectives of the Health Center Chronic Care Model are consistent with, and support the objectives of, state Medicaid reform proposals. Medicaid agencies are beginning to consult with Health Centers on designing and developing disease management programs. Medicaid reform is providing a context for cooperation between Medicaid agencies and Health Centers to introduce the Chronic Care Model and blend their objectives into one—providing quality health care in a cost-effective manner. Health Centers may provide a good one-stop chronic disease manager and medical home model as states move forward.

As payers—and now purchasers—state Medicaid agencies are bound to face financial pressures that could mislead them to limit commitments to long-term quality-of-care objectives, unless the cost savings to be derived from disease management programs show that quality has a positive impact on cost-effectiveness. Through their work with the health disparities collaboratives, Health Centers have proven their ability to reduce costs through quality improvement and disease management – in both short-term (ER visits, hospitalizations) and long-range indicators (reduction of lifetime risk of diabetes complications).²¹ With this knowledge, state Medicaid agencies can confidently partner with Health Centers in disease management efforts. Health Centers can play an important role in helping states achieve cost savings while improving quality and improving outcomes through disease management.

End Notes

¹ Center for Health Care Strategies, *Medicaid Best Buys for 2007: Promising Reform Strategies for Governors* (Hamilton, N.J.: Center for Health Care Strategies, December 2006).

² V. Smith et al., *Medicaid Budgets, Spending and Policy Initiatives in State Fiscal Years 2005 and 2006: Results of a 50 State Survey* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, October 2005), 34.

³ Remarks to the National Association of Community Health Centers' Policy and Issues Forum by HRSA Administrator Elizabeth M. Duke. March 19, 2007. Washington, D.C.

⁴ See M. Falik et al., “Ambulatory Care Sensitive Hospitalization and Emergency Visits: Experiences of Medicaid Patients Using Federally Qualified Health Centers,” *Medical Care*, vol. 39, no. 6 (2001): 551–61; and BC Duggar et al., *Utilization and Costs to Medicaid of AFDC Recipients in California Served and Not Served by Community Health Centers* (Washington, D.C.: Center for Health Policy Studies, The Heritage Foundation, 1994).

⁵ Proser, M. “Deserving the Spotlight: Health Centers Provide High-Quality and Cost-Effective Care,” *J Ambulatory Care Manage*, vol. 28, no. 4(2005):321-328

⁶ Falik M et al. “Comparative Effectiveness of Health Centers as Regular Sources of Care: Application of Sentinel ACSC Events as Performance Measures” *J Ambulatory Care Manage* vol. 29, no. 1,(2006): 24-35.

⁷ M. Proser, *The Safety Net on the Edge* (Bethesda, Md.: National Association of Community Health Centers, August 2005), 2.

⁸ Health center expenditures comprise from 0.5 percent to 3.0 percent of state Medicaid budgets, according to conversations with state Medicaid directors and state primary care association directors.

⁹ Partnership for Solutions, Johns Hopkins University, *Chronic Conditions: Making the Case for Ongoing Care* (Baltimore, Md.: Johns Hopkins University, Partnership for Solutions, September 2004).

¹⁰ From the Disease Management Association of America website at www.dmaa.org.

¹¹ Ibid

¹² Ibid

¹³ Visit the Evidence-based Medicine Resource Center at www.ebmny.org.

¹⁴ Smith et. al.

¹⁵ C. Williams, *Medicaid Disease Management: Issues and Promises* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, September 2004), 6.

¹⁶ Improving Chronic Illness Care (www.improvingchroniccare.org) is administered by the MacColl Institute for Healthcare Innovations at the Group Health Cooperative in Seattle, Washington.

¹⁷ Data for 2004 to 2005 supplied by the North Carolina Chronic Disease Management Collaborative staff.

¹⁸ Williams, 7

¹⁹ Williams, 10.

²⁰ States interested in consumer-directed health purchasing models have two types of models from which to choose: the insurance model and the direct services model. The insurance model, developed by Florida, allots each Medicaid beneficiary a premium amount to purchase a state-approved insurance product or insurance available through the beneficiary's employer. The direct services model, as it is applied in West Virginia, sets up the health spending account for each beneficiary, but services are still provided through traditional Medicaid primary care case management systems. For a more detailed discussion of states applying consumer-driven models to Medicaid, see C. Milligan, C. Woodcock, and A. Burton, *Turning Medicaid Beneficiaries into Purchasers of Health Care: Critical Success Factors for Medicaid Consumer-Directed Health Purchasing* (Washington, D.C.: AcademyHealth, January 2006).

²¹ Huang ES et al. "The Cost-Effectiveness of Improving Diabetes Care in U.S. Federally Qualified Community Health Centers." *Health Services Research*. 29 (2), (2007) 259-64 And Langdon BE et al. "Improving the Management of Chronic Disease at Community Health Centers". *N Engl J Med* vol 356, no. 9,(2007): 921 - 934