



**STRETCHING STATE HEALTH CARE DOLLARS:
CARE MANAGEMENT TO ENHANCE COST-EFFECTIVENESS**

One of a Series of Reports Identifying Innovative State Efforts
to Enhance Access, Coverage, and Efficiency in Health Care Spending

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INTRODUCTION

With over three-quarters of current Medicaid spending devoted to people with chronic conditions, and the number of Americans with at least one chronic condition expected to rise more than 25 percent by 2020,¹ states are pursuing efficiencies through various types of “care management” strategies for high-cost individuals. Such efforts represent one of the few policy options that hold the promise both of containing costs and improving health outcomes for high-risk populations.

Care management is the coordination of care in order to reduce fragmentation and unnecessary use of services, prevent avoidable conditions, and promote independence and self-care. Alternatively called advanced care management (ACM), targeted case management (TCM), high-cost or high-risk case management, care coordination, disease management, and other terms, care-management programs manifest themselves in a wide variety of ways. While they vary in goals, strategies, target populations, specific services provided or emphasized, administrative practices, and assessment capabilities, all states but one make optional care-management services available to at least one Medicaid population.² These services can be provided directly or contracted out to specialized vendors. A few states, such as Colorado, Oklahoma, and Washington, are relying on care management to contain costs in their high-risk pools.

Care-management programs can be categorized in several ways, including the following:

- *Medical- vs. long-term-care-oriented.* Some programs target people with complex medical conditions, while others focus on elderly and non-elderly people with multiple needs or disabilities who are eligible for nursing-home care but who— with proper support and coordinated social and long-term care services—could be maintained within the community.
- *Targeted diagnosis.* Some programs target individuals with specific diseases. For example, 14 states provide care management for Medicaid beneficiaries with asthma, 14 states focus on those with diabetes, and 6 target patients with congestive heart failure.
- *High service use or cost.* Some programs target people with high risk of hospitalization and adverse outcomes. These individuals may, for example, have more than a certain number of chronic conditions, take more than a specified

number of prescription medications, be considered high-cost users (e.g., claims reach a designated amount or are within the top 10 percent of Medicaid cost per enrollee), or make a higher-than-average number of trips to the hospital emergency department (a.k.a. “frequent fliers).

- *Key intervention.* Some programs (generally disease-based) provide educational materials on proper care that reflect evidence-based management guidelines; others focus on pharmaceutical management (e.g., the Center for Health Care Strategies is facilitating a Medicaid clinical pharmacy-management initiative in four states);³ and others use intensive one-on-one “advanced care” interventions by nurses or other health professionals for complex cases.

One comprehensive study found that effective care-management models have the following three components in common: assessment and planning; implementation and delivery of services; and reassessment and adjustment of interventions.⁴ Nevertheless, it is very difficult to measure the full impact of care-management programs. Program planners and evaluators generally look for evidence of improved health status and functionality, reduced utilization of services, lower overall costs, and “return on investment” (ROI) based on savings minus program costs.⁵ But although ROI is a powerful indicator, most programs are relatively new and do not yet have the data or the ability to measure all forms of savings. In addition, it is not always a simple matter to quantify improved health outcomes and long-term reductions in service utilization.

Evaluations of some of the older statewide care-management programs (e.g., Florida) found improvements in care quality but mixed results in terms of net savings to the state.⁶ However, other programs—some of them pioneering new models in care management—are documenting financial savings as well as better health:

- Colorado estimates that its “advanced care management” initiative—integration of disease-management and care-management interventions for its high-risk pool enrollees—generated \$2.3 million in direct savings to the state from May 2002 to September 2003.⁷
- Community Care of North Carolina estimates that its Emergency Department (ED) initiative targeting frequent ED users resulted in \$10.4 million in savings for FY 2001–2002. Also, Community Care’s care-management programs for asthma and diabetes saved \$3.3 million and \$2.1 million, respectively, in the three-year 2000–2002 period.⁸

It will be very important to continue monitoring and evaluating these kinds of programs. Toward this end, Colorado joined with four other states to form the Advanced Care Management Task Force (ACMTF), a cooperative outcomes-research effort (described in the second state profile below) that combines and assesses high-risk pool data from participating states. The program's objectives are to obtain a reliable, even definitive, picture of high-risk pool enrollees and to document the impact of specific care-management strategies on high-risk populations.

Another goal is to develop a national database that allows state high-risk pools and other coverage programs to compare best practices for treating specific health conditions and better managing costs. Policymakers can support and build on these kinds of efforts. Along with providing evaluations of emerging Medicaid-based care-management models, the information gained can potentially help states, the federal government, and private insurance and health delivery systems manage care, effectively and efficiently, for a U.S. population increasingly burdened by chronic conditions.

Additional Resources

Arnold Chen, Randall Brown, Nancy Archibald, Sherry Aliotta, and Peter T. Fox, *Best Practices in Coordinated Care* (Princeton, N.J.: Mathematica Policy Research, Inc., 2000).

Jennifer Gillespie and Robert L. Mollica, *Coordinating Care for the Chronically Ill: How Do We Get There from Here?* (Portland, Maine: National Academy for State Health Policy, February 2003).

Disease Management: The New Tool for Cost Containment and Quality Care, issue brief (Washington, D.C.: National Governors Association Center for Best Practices, February 2003).

Ben Wheatley, *Disease Management: Findings from Leading State Programs*, State Coverage Initiatives issue brief, vol. 3, no. 3 (Washington, D.C.: State Coverage Initiatives, December 2002).

Matrix: State Activity—Advanced Care/Disease Management (DM)

State	Program Name	Type of Strategy and Implementation Date	Participation
Current Examples			
North Carolina	ACCESS II and III	Primary-Care Case Management <ul style="list-style-type: none"> Partnerships between Medicaid and 12 community networks Strategies include identifying patients, designing interventions, and improving accountability 	July 1998 Over 235,000 Medicaid beneficiaries assisted
Colorado, Arkansas, Kansas, Oklahoma, Washington	Advanced Care Management Task Force	Advanced Care Management Research Effort <ul style="list-style-type: none"> Cooperative research effort coordinated by CoverColorado (state's high-risk pool health plan) that assesses data in several states to measure the impact of care-management strategies on high-risk patients Findings allow participating states to compare and manage costs and to learn about best practices 	May 2002 5 states
Indiana	Chronic Disease Management Program	Disease Management and Intensive High-Risk Nurse Management <ul style="list-style-type: none"> Treatment plan developed and implemented by a case manager, working either in person or over the phone with diabetes, asthma, and congestive-heart-failure patients 	July 2003 Over 26,000 expected to participate by end of first year
Florida	Disease Management in Medicaid	Disease Management <ul style="list-style-type: none"> State contracts with private vendors to manage care for individuals with HIV/AIDS, hemophilia, diabetes, asthma, and other chronic conditions 	1999 Medicaid beneficiaries with chronic conditions
Texas	Texas Medication Algorithm Project/Texas Implementation of Medication Algorithms	Disease management <ul style="list-style-type: none"> Public mental-health providers trained to follow specified treatment patterns and standardize charts for patients with schizophrenia, bipolar disorder, and depression 	1996 Approx. 200,000 patients served via 41 community centers

State	Program Name	Type of Strategy and Implementation Date	Participation	
Washington	Diabetes Training Collaborative, others	Disease Management <ul style="list-style-type: none"> • Providers trained to manage care for diabetes patients • Disease management for Medicaid patients with multiple conditions. 	Piloted in 1999, expanded in 2002 (diabetes collaborative)	Approx. 27,000 patients in Medicaid disease management, with 150,000 given access to 24-hour nurse hotline
Vermont	Chronic Care Collaborative	Disease Management Curriculum Development <ul style="list-style-type: none"> • A curriculum based on Institute for Healthcare’s “Breakthrough Model for Change” is taught to providers and their staffs over 12 months • Providers report back on their success in implementing the model and the effect on outcomes for patients with diabetes and related cardiac conditions. 	October 2003	1,500 patients served.
Initiatives to Watch				
Kentucky	Medicaid Disease Management	Disease Management <ul style="list-style-type: none"> • State will hire a contractor to establish a program for Medicaid beneficiaries with high-cost conditions, and will evaluate utilization patterns in this population 	Plan announced in February 2004	No estimates yet on number of participants
New Mexico	UNM Care Program expansion	Case Management and Medical Home for Uninsured <ul style="list-style-type: none"> • State is examining feasibility of statewide expansion of UNM Care program (now operating in Bernalillo county), which provides a “medical home” (a designated site or coordinator of health care) and case management for the uninsured below 235 percent of the federal poverty level 	Evaluation results due in October 2004 to state legislature	Basic UNM Care Program now covers approximately 12,000 enrollees

STATE PROFILES

NORTH CAROLINA: COMMUNITY CARE OF NORTH CAROLINA (ACCESS II AND III)

Purpose/Goal

Community Care of North Carolina (CCNC), also known as ACCESS II and III, is a statewide program in which local networks of primary-care providers coordinate prevention, treatment, referral, and other services for Medicaid enrollees. The goals of CCNC are to increase access to care, promote community-based systems of care, enhance care management, and improve quality and cost-effectiveness in the Medicaid program.⁹ A collaboration between the state, counties, community institutions, and physicians, CCNC relies on care management, adoption of best practices, and local providers' accountability to reduce duplication and fragmentation of services. CNCC builds on Carolina ACCESS I, the statewide primary-care case-management (PCCM) program, which connects Medicaid enrollees with a "medical home" that serves as a designated site and coordinator of care.

Key Participants

Part of Medicaid, CCNC is administered by the state's Office of Research, Demonstrations and Rural Health in partnership with the Division of Medical Assistance. Each network must include the local Department of Social Services, Public Health Department, hospitals, and primary care providers. The state encourages other stakeholders (such as county governments) to participate as well, and a few community networks include area mental-health programs or school systems.

Program Description

CCNC provides "an opportunity for community health care providers to collaborate and demonstrate their ability to manage the health care needs of the Medicaid population."¹⁰ As of May 2004, more than 3,000 North Carolina physicians were serving some 530,000 Medicaid members in 13 networks, which covered nearly 75 of the 100 counties in the state and about 73 percent of the Medicaid PCCM population.

The state pays a total of \$5 per member per month (pmpm): the networks receive a \$2.50 enhanced care-management fee, and \$2.50 pmpm is paid to the primary care provider. Using care managers and medical management staff, the networks identify high-cost patients and develop plans to manage utilization and cost. Each network is required to address four quality-improvement program areas:

- Disease management (e.g., asthma, diabetes, congestive heart failure, gastroenteritis)
- High-risk high-cost patients
- Pharmacy management (Prescription Advantage List, or PAL)
- Emergency Department utilization.

The state provides guidance and resources (disease-management protocols, for example, or successful ED models), while encouraging the networks to “localize” their strategies and branch out with additional efforts. A number of pilot initiatives that focus on therapy services, low birthweight, health disparities, mental health integration, in-home care, and sickle-cell anemia are thus being pursued.¹¹ Accountability is achieved through chart audits, practice profiles, scorecards, monitoring of progress toward benchmarks, and care-management reports on high-risk and high-cost patients. Many communities also use the relationships and infrastructure developed through CCNC to address other local problems and populations, such as the uninsured indigent populations or nursing-home residents.

CCNC is based on the realization that a community-based approach is more effective than a state top-down strategy and that local systems must be developed in order to change behaviors and practices.¹² There is some alignment of incentives among participants. Because counties contribute about 4 to 5 percent of the Medicaid budget, they have an interest in reducing overall health costs. And a primary incentive for providers is that participation helps them retain control over the health care delivery system; traditionally, North Carolina has had very little HMO penetration, and physicians would prefer to help the state attain efficiencies through the CCNC model rather than to see it shift to a private HMO model.¹³

Time Frame

The North Carolina Medicaid program established its PCCM model as ACCESS I in 1990. Community Care of North Carolina (ACCESS II and III) was initiated in July 1998. Initial participation by communities was voluntary. In 2002, the North Carolina General Assembly legislated that the program become statewide by the end of 2005.

Required Legislation/Authority

CCNC was originally authorized by the Centers for Medicare and Medicaid Services (CMS) through an amendment to its Section 1915(b) managed care waiver. It was subsequently incorporated into a State Plan Amendment.

Funding Mechanisms

During state FY 2002, the CCNC portion of the Medicaid budget was \$29 million in order to finance the \$5 pmpm paid to networks and providers. Under the budget-neutrality assumption—that care-management costs would be offset by savings elsewhere in the Medicaid program (e.g., reduced emergency-room, pharmacy, and inpatient utilization)—new appropriations were not necessary. Actually, *net* savings have been achieved, as described below.

Efficiencies

Asthma and Diabetes Disease-Management Initiatives

CCNC networks use national “best practices” disease-management techniques, adopted by the CCNC Clinical Director’s Committee, for patients diagnosed with asthma or diabetes. Examples of such required measures include appropriate prescriptions for asthma patients and retinal exams for individuals who suffer from diabetes.

A study comparing the costs and utilization of Medicaid recipients with asthma or diabetes who were enrolled in CCNC or the basic PCCM program (in those regions where CCNC has not yet been developed) found lower costs and fewer emergency-room visits and hospitalizations among the CCNC-managed patients:¹⁴

- In 2001, pmpm costs for CCNC asthma patients were \$27—or 4.7 percent less than pmpm costs for PCCM patients—translating into savings of about \$1.5 million for the year.
- In 2002, there were 21 percent fewer inpatient hospital admissions per thousand individuals among asthmatic CCNC children than among asthmatic PCCM children.
- CCNC children had 37.5 percent fewer emergency-room visits for asthma-related diagnoses than did PCCM children.
- The average pmpm cost for diabetics was \$21 (about 2.4 percent) lower among CCNC patients, generating about \$300,000 in savings. Differences varied by age group, however, with cost \$19 pmpm *higher* among CCNC patients in the 21-to-44 age group.¹⁵
- The hospitalization rate among diabetic patients was 9 percent lower for CCNC than for PCCM members in 2002.

- In 2002, CCNC diabetic patients used 8.8 percent fewer prescriptions per person than did PCCM diabetic patients.

The study estimated overall CCNC savings of \$3.3 million and \$2.1 million on asthma care and diabetes care, respectively, over the three-year 2000-to-2002 period.

Emergency Department Initiative

The current ED initiative targets enrollees with at least three ED visits over a six-month period. Care managers conduct outreach and education—including an emphasis on the importance of securing a “medical home”—and then follow up with the enrollee. Total savings for FY 2001 to 2002 is estimated at \$10.4 million.

PAL Process

In the PAL process, a pharmacy committee defines drug classes and unit doses, and Medicaid calculates the relative drug cost and ranks the drugs into price tiers. Physicians are educated about the system, and they are given feedback through a PAL scorecard that indicates their prescription patterns over time. After a pilot PAL process resulted in a 22 percent decline in pharmacy expenditures, a CCNC-developed PAL was distributed to all licensed physicians in North Carolina through a partnership with the state medical society.

Initiatives That Grew Out of CCNC Infrastructure

As noted earlier, one of the accomplishments of CCNC has been the establishment of community partnerships and infrastructures that then branch out to address additional issues and populations. The resulting initiatives are now improving quality of care and saving state dollars beyond the CCNC program. A Nursing Home Polypharmacy initiative, for example, targets nursing-home residents who have taken at least 18 medications in a 90-day period. Teams of pharmacists and physicians review the medical records and drug profiles, and they then recommend changes such as eliminating duplication and applying the PAL process. Cumulative savings from this initiative over a two-year period were estimated to be \$16 million.

Another example has been a one-network pilot project funded by the Commonwealth Fund and called “Assuring Better Child Health and Development” (ABCD). The project, which involved a comprehensive child-development screening model, increased the portion of children screened for developmental delays from 3 percent to 63 percent over a three-year period. The model is being expanded to additional networks.¹⁶

Challenges and Future Plans

According to CCNC officials, the primary challenge has been in financially justifying the program to the state legislature and administration. Because state budgetary pressures make the program vulnerable to cutbacks, CNCC leaders need to repeatedly demonstrate its cost-effectiveness. As a result, they must favor network initiatives that promise short-term savings over those that may improve health outcomes over the longer term but will not likely reduce costs right away.

Other challenges have been to develop information systems that meet data needs and to promote enrollee education and responsibility. Also, the program has had to address federal regulations regarding Emergency Department rules and enrollment of Medicare/Medicaid dual-eligibles.¹⁷

With respect to future plans, the CCNC program will begin to explore options for incorporating financial incentives for physicians and it will expand its disease-management protocols beyond asthma and diabetes to other common chronic diseases. Another focus will be dual-eligibles (who may voluntarily enroll in CCNC) and other eligible populations who tend to be high-cost users. Finally, program administrators hope to promote models for successful patient education, with the goal of patients taking more responsibility for their health.

For More Information

Web site: <http://www.dhhs.state.nc.us/dma/1999report/mangcare.html#23>

Contact: Jeffrey Simms, Assistant Director of the NC Office of Research, Demonstrations, and Rural Health and of the NC Division of Medical Assistance. Phone: (919) 857-4016. E-mail: jeffrey.simms@ncmail.net.

COLORADO: COVERCOLORADO'S MULTISTATE ADVANCED CARE MANAGEMENT TASK FORCE

Purpose/Goal

Colorado incorporated “advanced care management” (the combination of specific disease-management and more generalized care management) into its high-risk health insurance program, CoverColorado. The state’s goals were to reduce costs and improve the quality of life for enrollees—a population with complex and expensive chronic medical conditions.

In addition to its CoverColorado efforts, Colorado joined with four other states to form the Advanced Care Management Task Force (ACMTF), a cooperative outcomes-research effort that combines and assesses high-risk pool data from the participating states. The objectives were to profile high-risk pool enrollees and document how they are affected by specific-disease and care-management strategies. The ACMTF collaboration has led to a national database that helps state high-risk pools and other coverage programs to compare costs and best practices for treating particular health conditions, and to better manage costs.

Key Participants

CoverColorado is a nonprofit medical-insurance program that was created by the Colorado legislature in 1990 to provide comprehensive coverage to residents unable to obtain insurance from private companies because of preexisting medical conditions. CoverColorado contracts with Health Integrated, which provides general care-management services, and with McKesson Health Solutions, which provides specific disease-management services, for high-risk enrollees.

The agencies that administer high-risk pools in Colorado, Kansas, Oklahoma, Washington, and Arkansas have joined together with Health Integrated to form the ACMTF.

Program Descriptions

CoverColorado

Colorado’s high-risk pool enrolls approximately 5,000 people who were denied private insurance because of preexisting conditions.¹⁸ This population is estimated to be 2.5 times “sicker” than the general population, with enrollees having as many as 17 comorbidities. The program contracts with RXSolutions to manage its pharmacy benefit and identify drugs associated with high-cost illnesses. The pharmacy data thus generated can also be

useful in identifying errors in utilization, such as over- or underutilization of drugs or people taking excessive numbers of drugs per month. These data, updated on a daily basis, trigger referrals of participants to Health Integrated for care-management services or to McKesson Health Solutions for disease-management services. Sophisticated technological interfaces allow the three companies to share information and confer when indicated. Such integration, the hallmark of the Advanced Care Management model, is uncommon in state high-risk pools elsewhere.

Disease-management strategies include training in the use of treatment guidelines for specific conditions such as asthma, diabetes, congestive heart failure, and coronary-artery disease. Care management encompasses nurse-counseling, pharmacy-review, utilization-management, case-management, and depression-management programs. These interventions combine high-tech tools for monitoring participants with personalized services—including negotiating with providers and medical-equipment suppliers for lower fees.

Advanced Care Management Task Force (ACMTF)

After jointly designing the high-risk pool database—using a population of 2.5 million lives to compare risk profiles (such as preexisting conditions and comorbidities), admissions, length of stay, medical claims, fees, and other data—the ACMTF-participating states submitted their data to Health Integrated. The company can now compare high-risk pool populations both across states and between states.¹⁹

Comparisons among participating states are useful because their high-risk pools employ different levels of disease and care management. Colorado and Oklahoma adopted both disease and care management, Washington uses care-management services only, and Arkansas does not use either strategy.

Time Frame

CoverColorado adopted advanced care management in May 2002.

ACMTF began in December 2002, when four participating states contracted with Health Integrated to conduct the data collection and analysis.²⁰ Each state submitted two years' worth of data, and Health Integrated presented the results of its efforts to the group in September 2003.

Required Legislation/Authority

CoverColorado did not require any special legislation to contract for disease- or care-management services or to participate in ACMTF.

Financing Mechanisms

CoverColorado pays Health Integrated on an hourly basis for care management and on a per-member-per-month basis for utilization management. The program pays McKesson on a pmpm basis as well, though the fee varies with the level of severity of the participant's condition. The cost of the two programs is typically about 26 percent of CoverColorado's total per-member administrative costs. The average total of Health Integrated's and McKesson's fees is \$13.94 per member per month.

Health Integrated conducted the ACMTF data collection and analysis free of charge.²¹ However, participating states assume that they will need to find funding sources in order to maintain their databases (e.g., update them on a regular basis) as well as to continue the analysis and dissemination of results.

Efficiencies

Colorado and the other ACMTF states expect three general types of savings from managing high-risk patients through various disease- and care-management interventions:²²

- *Direct Savings.* These savings derive from reductions in utilization, “redirecting” care toward lower-cost services, and alternative financial arrangements stemming from clinical decision support, timely management, and direct negotiations with providers.
- *Clinical-Outcome Savings.* These savings can result from patient education, pharmacy and treatment compliance, increased involvement by the patient with community and primary care givers, and overall patient empowerment. Such savings cannot easily be tracked in direct-claims costs for specific acute episodes, but studies indicate that improved clinical outcomes have a noticeable effect on reducing future chronic and acute episodes.
- *Patient Savings.* These are savings to enrollees in copayments and deductibles, and in service costs during preexisting-condition waiting periods, that result from interventions such as care coordination, redirected care, and education. Enrollees

can obtain (without cost) care- and disease-management services even while certain medical services are excluded from coverage during the waiting period for preexisting conditions. This policy helps them save their own money while paying out-of-pocket during waiting periods, encourages them to seek necessary care, and, it is hoped, may keep them healthier after they complete the waiting period. Meanwhile, the health plan also benefits—from a prolonged period before the deductible is met and claims are paid, and from reduced claims costs once the deductible is met.

Estimates indicate that CoverColorado generated \$2.3 million in direct savings associated with the care-management interventions from May 2002 to September 2003. An ACMTF analysis of CoverColorado’s performance the year before and after adopting advanced care management shows significant declines in inpatient admissions and bed days per 1,000 members, and in total claims cost per member (see table below) despite an 86 percent increase in enrollment in CoverColorado.²³ Interestingly, there was a slight (1%) *increase* in emergency-room visits per 1,000 members over this period; administrators are using this information to focus on ways to reduce preventable ER use. CoverColorado administrators maintain that advanced care management is generating a 3:1 return on investment for the program.²⁴

Selected Changes in CoverColorado Utilization and Claims Costs
After Introducing Advanced Care Management

	2001–2002	2002–2003	% Decline
Inpatient admissions/ 1,000 members	178.1	143.0	19.7
Inpatient bed days/ 1,000 members	908.5	648.4	28.6
Total claims cost per member	\$5,565	\$5,050	9.3

Source: CoverColorado, 2003.

Challenges and Future Plans

One challenge for CoverColorado is how to translate its efficiencies and cost savings into expanded access. The premiums for the high-risk pool are set at 150 percent of the average commercial insurance plan premium (with a 20 percent discount if family income is below \$36,000/year), so savings do not result in reduced premiums for enrollees. Rather, savings translate into lower assessments on insurance carriers for funding low-income subsidies. Other states that achieve efficiencies in covering high-risk patients may

be able to reallocate their savings in other ways—such as reducing premiums, covering more services, or widening eligibility criteria—that would expand access to coverage.

Challenges related to participation in ACMTF include setting parameters for measuring and documenting savings that are reliable and acceptable to each state’s Board and actuaries.

Colorado will soon receive results of a two-year ROI study by Health Integrated that includes disease-management participants. At that point, CoverColorado expects to “tweak” the programs and make adjustments as needed.

Looking forward, the states face a challenge in securing funding to maintain and build the database and to continue analysis and dissemination of findings. As of summer 2004, the task force does not have ongoing funding, but members are continuing to run data through the system with the goal of keeping the database as current as possible.

Because of the lag in obtaining valid claims data, several of the ACMTF states are just now beginning to receive data covering a sufficiently long time period so that they may use it in their management decisions. Meanwhile, the states are examining utilization and costs within their own high-risk pools, analyzing how their experience compares with that of other states, and contemplating what interventions and changes should be made to better manage their costs. As a group, they will decide whether and how to continue their collaboration on the database and analysis.

For More Information

Web site: <http://www.covercolorado.org>

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SNAPSHOTS OF ADDITIONAL ADVANCED-CARE/ DISEASE-MANAGEMENT INITIATIVES

INDIANA: CHRONIC DISEASE MANAGEMENT PROGRAM

Phased in, 2003 to 2004

In June 2003, the Centers for Medicare and Medicaid Services approved the proposal of the Indiana Office of Medicaid Policy and Planning to create the Indiana Chronic Disease Management Program (ICDM), which would provide enhanced Medicaid benefits to state residents with diabetes, congestive heart failure, and asthma. The program, operated jointly by the state's Medicaid agency and Department of Health, is rolling out in phases. As of September 2004, the program was operating statewide for diabetes, pediatric asthma, and congestive heart failure; hypertension and stroke components will be implemented shortly. Expected to help 26,000 beneficiaries, both adults and children, the program is particularly targeted to enrollees whose health care costs place them in the top 10 percent of health care expenditures.

Once enrolled in ICDM, individuals work with a nurse case-manager to develop a treatment plan to maximize control of their disease. High-risk enrollees receive intensive, one-on-one nurse care-management through a network that includes the Indiana Minority Health Coalition and the Indiana Primary Health Care Association. Those with less intensive conditions work by telephone with their case manager. The state has contracted with AmeriChoice to run a center that accepts calls from enrollees and makes its own proactive calls to patients in order to conduct medical assessments and provide education, dietary information, and other instructions on how to manage their care. The program is expected not only to save money for the state's Medicaid program but also to increase the quality of life for enrollees.

For More Information: <http://www.indianacdmprogram.com/>.

FLORIDA: DISEASE MANAGEMENT IN MEDICAID

Implemented 1999

Since 1999, Florida has provided disease-management (DM) services to individuals enrolled in MediPass, the Medicaid managed-care program that utilizes a primary-care case-management mechanism. The DM programs target MediPass patients with HIV/AIDS, hemophilia, diabetes, asthma, cancer, congestive heart failure, kidney disease, hypertension, and several other chronic conditions. The state, which estimates that

approximately 19 percent of the MediPass population qualifies for these DM services,²⁵ contracts with eight disease-management organizations²⁶ to address each high-cost illness.

Evaluations of these programs have had mixed results. In 2001, an assessment of the asthma program found that inpatient hospital costs had declined to \$70.86 per month; asthma-related outpatient costs decreased \$38.06 per month; and total Medicaid expenditures for program participants decreased by 33 percent (approximately \$3,525). Another study found that the program had reduced medical-claims costs by 38 percent for patients with hemophilia and by 40 percent for HIV/AIDS patients, relative to the previous year's expenditures. However, a comparison of DM-participating patients with those not participating showed that the cost reductions were not statistically significant.²⁷ There are also concerns that the cost savings associated with the DM program are offset by the costs of administering the program.²⁸ Nevertheless, some analysts believe that the main benefit of DM is not so much cost savings but the improvement of care by providers and administrators, which in turn has lasting effects on health outcomes.²⁹

For More Information: www.cga.state.ct.us/2003/olrdata/hs/rpt/2003-R-0097.htm.

TEXAS: TEXAS MEDICATION ALGORITHM PROJECT AND TEXAS IMPLEMENTATION OF MEDICATION ALGORITHMS

Implemented 1996

The Texas Medication Algorithm Project (TMAP) was designed to ensure consistent treatment for individuals with major depressive disorder, bipolar disorder, and schizophrenia. The impetus behind the project was the recognition that patients' health statuses were not improving because they often would see different providers who prescribed different medications and protocols.

Under Phase IV of the TMAP project—titled Texas Implementation of Medication Algorithms (TIMA)—the Texas Department of Mental Health and Mental Retardation³⁰ began to roll out the algorithms (treatment rules) for use by all of the public mental-health agency's providers. TMAP/TIMA requires physicians to follow specified treatment patterns and standardize their patients' charts so that other providers understand why the treatment protocol was chosen and, as a consequence, be more likely to follow it. Physicians are also providing patients with much more detailed information and education about the drugs they are taking so that they can be better self-advocates.

Approximately 200,000 patients are being served by TMAP, through 41 community centers. Ultimately, all Texas providers who prescribe pharmaceuticals (including psychiatrists and nurse practitioners) will be trained in the TMAP system. TMAP administrators report that an evaluation of 1,421 patients who were treated under TMAP/TIMA found evidence of improved clinical outcomes for all three disorders that the program addresses. Given its success, TMAP has inspired the adoption of similar programs in 13 other states, including Florida, Ohio, Kentucky, and Pennsylvania.

For More Information: TMAP: <http://www.bhrm.org/guidelines/tmap.pdf>;
TIMA: <http://www.dshs.state.tx.us/mhprograms/timaptintro.pdf>.

WASHINGTON: DIABETES TRAINING COLLABORATIVE AND OTHER DISEASE-MANAGEMENT PROGRAMS

Implemented 1999, expanded in 2002

In 1999, Qualis Health,³¹ the Washington State Department of Health, and the Improving Chronic Illness Care initiative (a national program of the Robert Wood Johnson Foundation) instituted two diabetes training collaboratives using the chronic-care model.³² In its first year, the state reported a 12.6 percent reduction in diabetes deaths. Given this early success, the state expanded the program in 2002 to include additional chronic conditions—asthma, congestive heart failure, kidney disease, and others. In its five years of operation, the state has trained 200 representatives of provider practices (including physicians, nurses, and administrative staff at private offices and clinics, hospital clinics, and health plans).³³

Also in 2002, the state's Department of Social and Health Services began enrolling Medicaid "aged, blind, and disabled" patients—that is, individuals with certain multiple chronic conditions—into disease-management programs.³⁴ The program has now enrolled over 27,000 disabled patients, and about 150,000 Medicaid beneficiaries have access to a 24-hour nurse hotline, which receives some 1,600 calls per month. The state is working with two disease-management vendors, McKesson Health Solutions and Renaissance Health Care. A clinical evaluation of the program is being conducted by the University of Washington, and an evaluation of cost savings is being conducted by actuarial consultants; findings are expected to be available sometime in November 2004 on the state's Department of Social and Health Services Web site: <http://www1.dshs.wa.gov>.

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VERMONT: CHRONIC CARE COLLABORATIVE

Implemented October 2003

The Vermont Department of Health, working closely with the Vermont Program for Quality in Health Care (VPQHC), began a yearlong initiative in October 2003 to promote a care-management program for individuals with diabetes and related cardiac disease. Program objectives include improving care for people with diabetes, successfully implementing and spreading the chronic-care model, and aligning payment with best practices.

Using the Institute for Healthcare Improvement's "Breakthrough Model for Change," the VPQHC developed a chronic-care curriculum and learning modules that are being presented periodically over the course of the year to 14 teams of providers, office staff, nurses, and others involved in the provision of primary care and family practice. These teams are charged with applying the model in their own caregiving environments to small subgroups of their diabetes patient pool (approximately 1,500 patients are participating altogether) and with submitting monthly progress reports to VPQHC. The teams are also working with health plans (including Medicaid) to share information and ideas about potential changes in health care financing to better accommodate care management. In October 2004, the teams and health plans will discuss their experiences at a forum targeting policymakers and health care leaders, among others.

The collaborative is funded by a combination of federal and state funds.³⁵

For More Information:

<http://www.healthyvermonters.info/hi/chronic/chroniccare.shtml>.

SNAPSHOTS OF INITIATIVES TO WATCH

KENTUCKY: DISEASE MANAGEMENT FOR HIGH-COST UTILIZERS

Under Development

In an effort to close a budget deficit of \$1.3 million over the next two fiscal years, the Kentucky Medicaid program is planning to use an outside vendor to implement a disease-management program that will reduce the costs of caring for individuals with chronic and high-cost conditions. At the same time, the state will contract with experts to review and analyze beneficiaries' utilization patterns, in an effort to identify which individuals use the emergency department rather than a doctor's office or other primary care setting. These initiatives, along with the use of a pharmacy-benefits manager to negotiate discounts for Medicaid pharmaceutical purchasing, are expected to save the state \$300 million in the fiscal year beginning July 1, 2004. While there are no estimates yet on how many individuals will be served by these disease-management programs, the state hopes that the savings thus realized will eliminate the need to cut 673,000 individuals from Medicaid.

NEW MEXICO: EXPANSION OF THE UNM CARE PROGRAM

Under Development

The University of New Mexico (UNM) Care Program provides primary care and case-management services to uninsured individuals who live in Bernalillo County—which includes the city of Albuquerque—have income below 235 percent of the federal poverty level, and are not eligible for Medicaid. As mandated by the state legislature in early 2004, the Department of Human Services (DHS) is studying the feasibility of expanding the program statewide.

The DHS study is assessing other state hospitals' ability to implement such a program, either independently or with support from the UNM Health Sciences Center. It is also examining UNM's experience regarding the costs and benefits of providing comprehensive, team-based care coordination, in hopes of identifying the financing and administrative strategies that allow the model to operate. Findings from this study will be reported to the interim legislative health and human services committee at its October 2004 meeting. In addition to studying UNM Care itself, DHS is looking into expanding Care One, a pilot project being conducted by UNM Care. Care One is a disease-management program serving the highest-risk, highest-cost indigent patients whose conditions are likely to lead to deteriorated clinical status.

NOTES

¹ Jennifer Gillespie and Robert Mollica, *Coordinated Care for the Chronically Ill: How Do We Get There from Here?* (Portland, Maine: National Academy for State Health Policy, February 2003).

² The Centers for Medicare and Medicaid Services (CMS) define care management as “services which assist an individual eligible under the plan in gaining access to needed medical, social, educational, and other services.”

³ Initiative includes the Washington Therapeutic Consultation Service, Texas Medication Algorithm Project, AmeriChoice of Pennsylvania Behavioral Pharmacy Management System, and North Carolina Nursing Home Polypharmacy Initiative.

⁴ Arnold Chen, Randall Brown, Nancy Archibald, Sherry Aliotta, and Peter T. Fox, *Best Practices in Coordinated Care* (Princeton, N.J.: Mathematica Policy Research, Inc., 2000).

⁵ See Ben Wheatley, *Disease Management: Findings from Leading State Programs*, State Coverage Initiatives issue brief, vol. 3, no. 3 (Washington, D.C.: State Coverage Initiatives, December 2002).

⁶ Saul Spigel, *Florida Disease Management Program*, OLR Research Report, January 28, 2003, 2003-R-0097, <http://www.cga.state.ct.us/2003/olrdata/hs/rpt/2003-R-0097.htm>.

⁷ Based on interviews with Barbara Brett, Executive Director, CoverColorado; see state profile.

⁸ Thomas C. Ricketts, Sandra Greene, Pam Silberman, Hilda A. Howard, and Stephanie Poley, *Evaluation of Community Care of North Carolina Asthma and Diabetes Management Initiatives: January 2000–December 2002* (Chapel Hill, N.C.: North Carolina Rural Health Research and Policy Analysis Program, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, April 2004).

⁹ Jeffrey Simms, “North Carolina’s Medicaid Managed Care Program.” Presentation at State Coverage Initiatives Conference, January 2003; and Core Community Care Presentation, NC Department of Medical Assistance, January 30, 2004.

¹⁰ Ibid.

¹¹ Core Community Care Presentation, NC Department of Medical Assistance, January 30, 2004.

¹² Ibid.

¹³ There is one small Medicaid HMO program in Charlotte, with about 12,000 enrollees.

¹⁴ Ricketts et al., *Evaluation of Community Care*, 2004.

¹⁵ A state administrator explains this disparity as follows: A significant number of the providers participating in the networks are pediatric providers, so initially pediatric populations received the bulk of the interventions. During the past year this dominance has changed, however; now all primary care providers who serve Medicaid are participating in the networks.

¹⁶ Helen Pelletier and Melinda Abrams, *ABCD: Lessons from a Four-State Consortium* (New York: The Commonwealth Fund, December 2003).

¹⁷ The Emergency Medical Treatment and Labor Act (EMTALA) regulation, published in the *Federal Register* (vol. 68, no.174, p. 53222) on September 9, 2003, and effective November 10, 2003, states that an Emergency Department must provide a medical screening exam if “a prudent layperson observer would conclude, based on the person’s appearance or behavior, that the person needs emergency examination or treatment.” Prior to September 2000, North Carolina was able to restrict payment for non-emergent conditions in the emergency room and require the primary care provider’s authorization in order for the hospital to receive payment. CMS ruled that such

denial of payment without the PCP's authorization number was not compliant with EMTALA's "prudent layperson" regulations.

¹⁸ To be eligible for CoverColorado, applicants must meet at least one of the following criteria: denied individual health insurance within the past six months; approved for private insurance within the past 60 days but unable to receive coverage for at least 6 months because of a preexisting condition; approved for insurance but at a premium rate that is higher than the cost of CoverColorado; coverage involuntarily terminated within the past 60 days; eligible under HIPAA, the Trade Act tax-credit provisions, or Pension Benefit Guarantee Fund; a dependent of an eligible person; or a diagnosis considered a "presumptive medical condition" (presumed to result in an automatic rejection by an insurance company). Further, an applicant must not be eligible for Medicaid, Medicare, or any other publicly supported health coverage program. When individuals in Colorado are denied private insurance, they are given information in the denial letter about CoverColorado, including basic eligibility criteria and enrollment instructions.

¹⁹ The group uses medical and pharmacy claims information to evaluate historical performance, assess health status (morbidity), and predict health care costs, needs, and resource use based on that health status.

²⁰ Arkansas has always been part of the five-state group and submitted data for analysis, but as of November 2003 it had not yet completed its contract with Health Integrated.

²¹ CoverColorado's actuaries have verified Health Integrated's findings.

²² *Parameters for Care Management Savings Measurement*, Health Integrated, May 2003.

²³ Enrollment for 2003 has been flat or declining slightly per month.

²⁴ CoverColorado and Health Integrated representatives report that a recently completed 12-month outcomes study, undergoing academic review at the time of this publication, indicates a 1.7-to-1 return on investment in just the utilization and case-management segments of the advanced care management integrated initiatives. Other ROI studies are under way.

²⁵ Spigel, *Florida Disease Management Program*, 2003.

²⁶ See http://www.fdhc.state.fl.us/Medicaid/Disease_Management/leg_report_dm_winter_w6.pdf.

²⁷ *Disease Management: The New Tool for Cost Containment and Quality Care*, issue brief, (Washington, D.C.: National Governors Association Center for Best Practices, February 2003).

²⁸ Spigel, *Florida Disease Management Program*, 2003.

²⁹ *Disease Management: The New Tool*, 2003.

³⁰ This department ceased operation on September 1, 2004. Community mental health services are now delivered through the Texas Department of State Health Services.

³¹ Qualis Health is a nonprofit organization dedicated to improving the quality and efficiency of health care through the provision of services such as utilization management, case management, quality assessment and improvement, and systems auditing. Its clients include consumers, employers, providers, managed care organizations, third-party administrators, insurers, and government agencies.

³² The "chronic-care model" identifies the essential elements that encourage high-quality chronic-disease care: the community, the health system, self-management support, delivery system design, decision support, and clinical information systems. The model emphasizes productive

interactions between informed patients who take an active part in their care and providers with resources and expertise (E. H. Wagner, “Chronic Disease Management: What Will It Take to Improve Care for Chronic Illness?” *Effective Clinical Practice* 1 [Aug.–Sept. 1998]: 2–4).

³³ Washington State Department of Social and Health Services *Care Coordination* newsletter, Fall 2003.

³⁴ According to the 2001-03 Operating Budget, Chapter 7, Laws of 2001 E2, Section 209 (6).

³⁵ Approximately \$100,000 is provided through a combination of grant funding from the Centers for Disease Control and Prevention’s Diabetes Control Project and the Health Resources and Services Administration’s Rural Hospital Flexibility project. At the state level, funding for an assessment of hospitals and commercial health plans is appropriated to the VPQHC as part of its annual budget. The VPQHC then directs a portion of these funds to the Chronic Care Collaborative program.

RELATED PUBLICATIONS

Publications listed below can be found on The Commonwealth Fund's website at www.cmwf.org.

[*Stretching State Health Care Dollars During Difficult Economic Times: Overview*](#) (October 2004). Sharon Silow-Carroll and Tanya Alteras, Economic and Social Research Institute. This overview report summarizes a series of four reports identifying innovative state efforts to enhance access to care, coverage, and efficiency in health care spending. Topics include: building on employer-based coverage; pooled and evidence-based pharmaceutical purchasing; targeted care management; and innovative use of uncompensated care funds.

[*Stretching State Health Care Dollars: Building on Employer-Based Coverage*](#) (October 2004). Sharon Silow-Carroll and Tanya Alteras, Economic and Social Research Institute. Whether subsidizing an existing employer plan or creating a new and more affordable program for uninsured workers, states are using their dollars, regulatory/legislative powers, and purchasing clout to leverage employer and employee contributions in order to cover more people. This is one of a series of four reports identifying innovative state efforts to enhance access to care, coverage, and efficiency in health care spending.

[*Stretching State Health Care Dollars: Pooled and Evidence-Based Pharmaceutical Purchasing*](#) (October 2004). Sharon Silow-Carroll and Tanya Alteras, Economic and Social Research Institute. Many states are implementing drug-cost-containment mechanisms that do not merely pass state expenditures on to consumers in the form of higher copayments and deductibles but instead put innovative approaches in place that reduce state costs so as to expand or maintain access. This is one of a series of four reports identifying innovative state efforts to enhance access to care, coverage, and efficiency in health care spending.

[*Stretching State Health Care Dollars: Innovative Use of Uncompensated Care Funds*](#) (October 2004). Sharon Silow-Carroll and Tanya Alteras, Economic and Social Research Institute. Experts warn that providing uncompensated care could become more difficult for hospitals in the years ahead as a result of their rising costs and lower operating margins, limited state revenues, cuts in Medicaid DSH, and a growing uninsured population. These trends have spurred strategies in several states aimed at reducing the need for expensive uncompensated services over the long term. This is one of a series of four reports identifying innovative state efforts to enhance access to care, coverage, and efficiency in health care spending.

[*Dirigo Health Reform Act: Addressing Health Care Costs, Quality, and Access in Maine*](#) (June 2004). Jill Rosenthal and Cynthia Pernice. Jointly supported by The Commonwealth Fund and The Robert Wood Johnson Foundation, this report by the National Academy for State Health Policy comments on the status of Maine's Dirigo Health Reform Act, which aims to provide affordable coverage for all of the state's uninsured—approximately 140,000—by 2009.

[*Expanding Health Insurance Coverage: Creative State Solutions for Challenging Times*](#) (January 2003). Sharon Silow-Carroll, Emily K. Waldman, Heather Sacks, and Jack A. Meyer, Economic and Social Research Institute. The authors summarize lessons from 10 states that have innovative strategies in place for health insurance expansion or have a history of successful coverage expansion. The report concludes with recommendations for federal action that could help states

maintain any gains in coverage made and possibly extend coverage to currently uninsured populations.

[*Small But Significant Steps to Help the Uninsured*](#) (January 2003). Jeanne M. Lambrew and Arthur Garson, Jr. A number of low-cost policies could ensure health coverage for at least some Americans who currently lack access to affordable insurance, this report finds. Included among the dozen proposals outlined is one that would make COBRA continuation coverage available to all workers who lose their job, including employees of small businesses that are not currently eligible under federal rules.

[*Medicaid Coverage for the Working Uninsured: The Role of State Policy*](#) (November/December 2002). Randall R. Bovbjerg, Jack Hadley, Mary Beth Pohl, and Marc Rockmore. *Health Affairs*, vol. 21, no. 6 (*In the Literature* summary). The authors conclude that insurance coverage rates for low-income workers would increase if state governments chose to do more for their uninsured workers. But states decline to tackle this issue for several reasons. Federal law requires them to cover many low-income nonworkers before they insure workers. As well, poorer states cannot afford much coverage for their low-income workers.

