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Florida Medicaid Disease Management: Challenges, Successes and Lessons for the Future

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Third National Disease Management Summit
Baltimore, Maryland
May 13, 2003

Florida Medicaid: Challenges, Successes and Lessons for the Future

Objective

Review issues related to implementing a Disease Management program for a State Medicaid Program.

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Presentation Outline

- Medicaid Challenges
- Successes – Solutions
- Lessons Learned

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Program Overview

- In 1998, LifeMasters was selected through rigorous RFP process to provide CHF disease management in North Florida
- Urban/rural population mix
- Several thousand beneficiaries targeted for program enrollment
- Population-based program (all severity levels)
- Included co-morbidity management – 1/3 of CHF patients also had Diabetes
- 100% Fee Risk – 6.5% net savings guarantee
- Program started in September 2000

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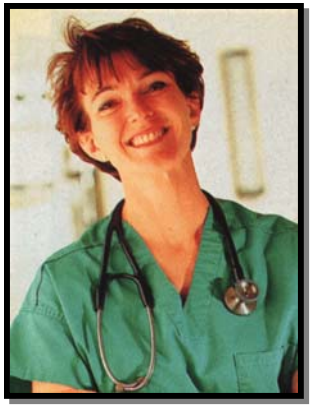
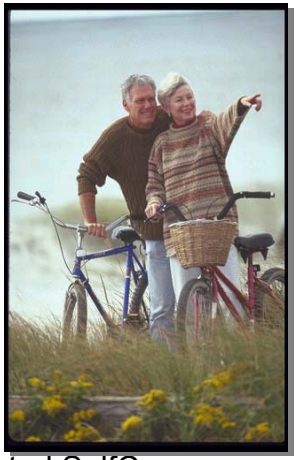
Medicaid Programs Present Unique Challenges

- Beneficiaries
- Providers
- Contracting

Our Founding Principles



- Clinical Decision Support for Physicians



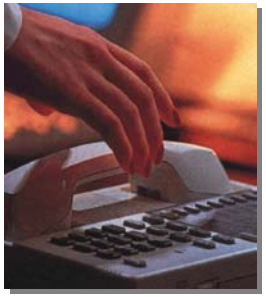
- Supported SelfCare for their Patients

Physician Decision Support

Self-Monitoring

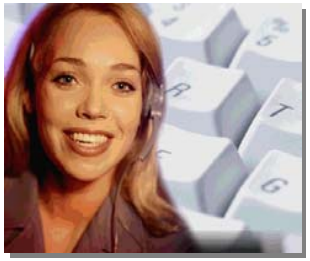
- Participant Self-Monitoring
  - Vital Signs
  - Symptoms

Data Capture & Analysis



- Choice of easy to use methods
  - IVR, Web, Connected device
- Customized for co-morbidities
- Alert Generation

Alert Generation & Data Verification



- MD-set thresholds
- Verified and triaged by LifeMasters nurse
- Provides feedback to support coaching

MD Exception Reports

- Actionable information
- Best Practice Support
- Early intervention
- Improved efficiency

Supported SelfCare

- Individual assessment and orientation
  - Self care concepts
  - Disease-specific information
  - Self-monitoring instruction and equipment
  - Placement in individualized care program

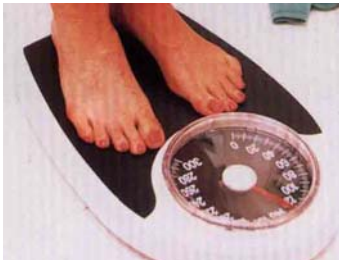
Coaching

- Use of data to constantly customize program
  - Coaching by LM nurse
  - Dynamic risk stratification
  - Behavioral change support

Education

- Regular health education calls
- Educational materials
  - Video series
  - Living Well Magazine
  - Disease specific literature
  - LifeMasters OnLine

Self-Monitoring



- Routine self monitoring of vital signs and symptoms
- Easy to use data entry
- Provision of regular feedback

Medicaid-Specific Challenges: Beneficiaries

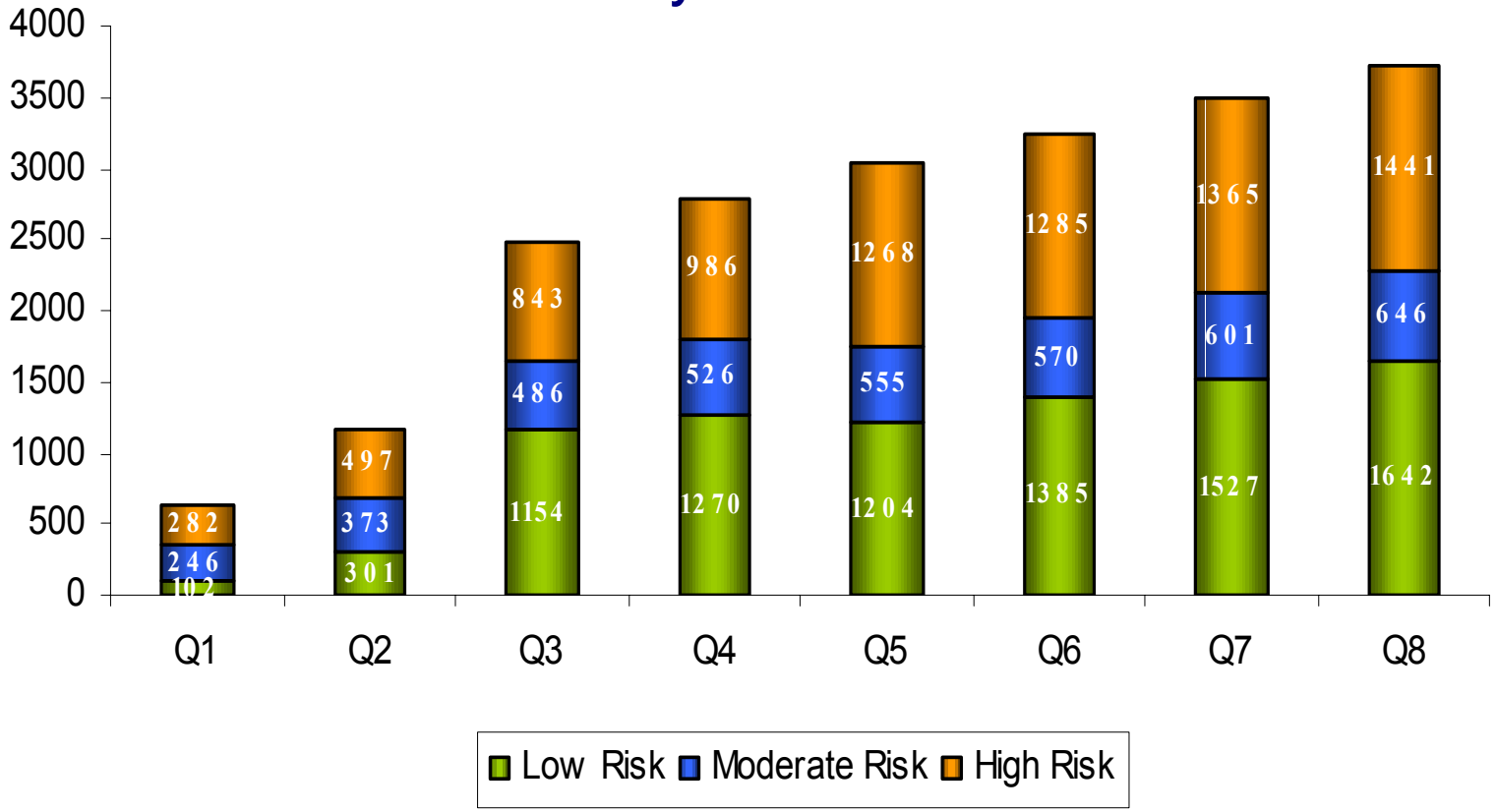
- Communication
  - Telephones, language, cognitive
- Education Level
  - Reading proficiency
  - Understanding of health issues
- Life Priorities
  - Basic needs such as housing & food are higher priorities than healthcare
- Transience
  - Difficult to find and retain
- In and out of eligibility
  - Difficult to provide continuity of care

Medicaid-Specific Challenges: Beneficiaries

- Access to care
  - Transportation
  - Fewer Physicians to choose from
  - Use of ED for primary care
  - Dispersed and rural population
- Sicker population
  - High prevalence of obesity, smoking, co-morbidities

Population Skewed More Toward High Risk Than Typically Experienced*

Beneficiary Enrollment by Severity Level by Quarter



***nearly twice as many high/mods as average**

Unique Population Needs can be Met by Adapting Outreach Efforts

- Finding the Individual (Moved or Incorrect Address)
  - Hired “Local Locators” to find individuals
  - Provided information back to AHCA
  - Ongoing patient recruitment efforts at AHCA area offices and health departments, hospital case mgrs and PCP’s
- Individuals Without Phone Service
  - Installed phones in Beneficiaries’ homes
  - Provided Direct Connect Mobile Phones
- High % of Individuals Who Missed Initial Training
  - Reminders
  - Coordinated transportation
  - In-Home training (57% - much higher than usual 10%)

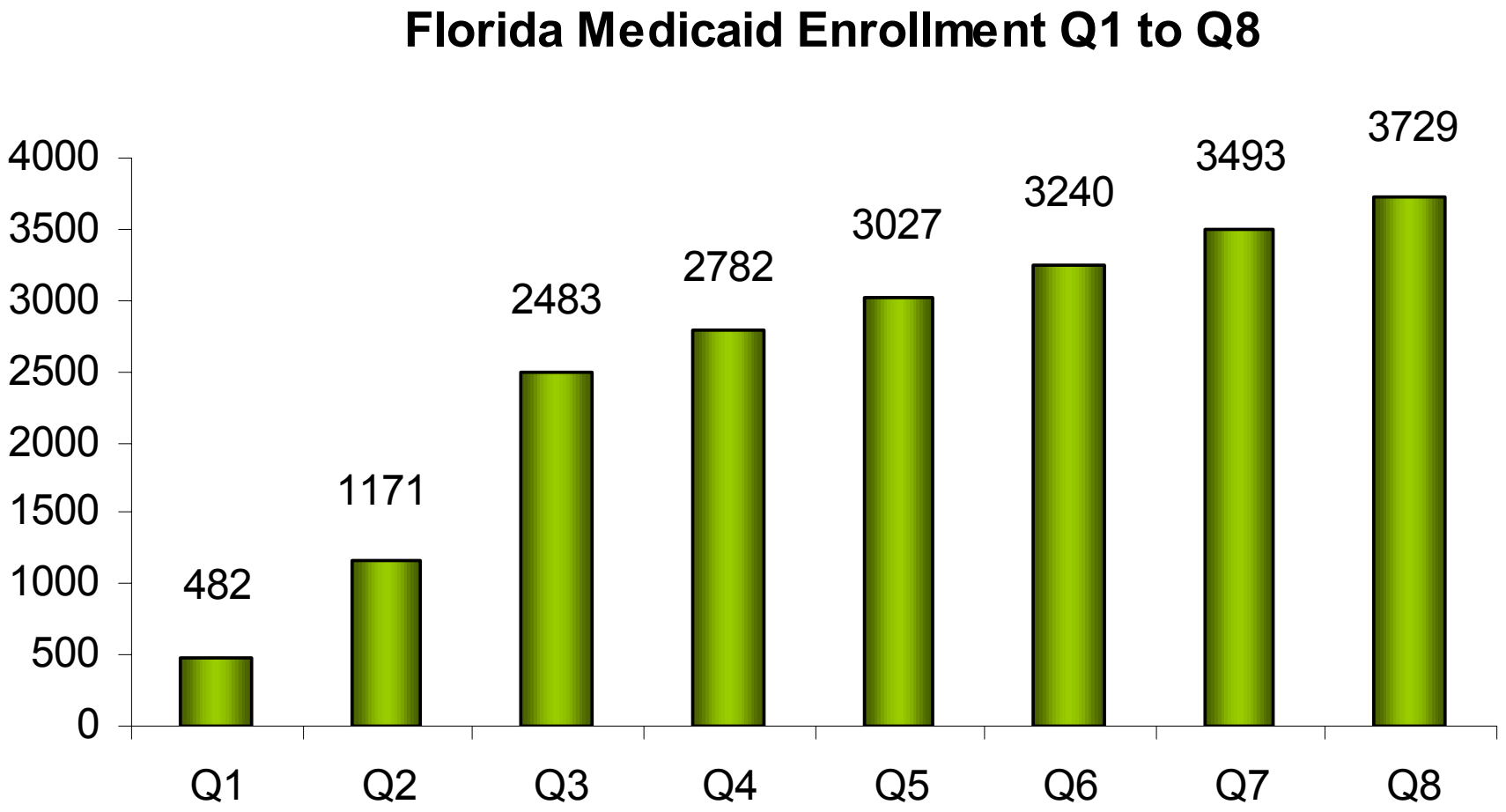
Unique Population Needs can be Met by Adapting Outreach Efforts

- Individuals In-and-Out of Coverage
  - Continued support for 90 days or until verification that they weren't eligible (with no reimbursement from AHCA)
  - Reminders to extend Medicaid coverage prior to expiration of benefits
- Engaging the Individual
  - Allayed concerns over losing Medicaid benefits
  - Focused on building trust with disease manager
  - Negotiated with patient to determine minimum acceptable level of participation
  - Positioned service as increasing access to healthcare
- Reading Challenges
  - Created 3rd/4th grade reading materials (versus 8th)
  - Developed videos – More beneficiaries (97%) have VCRs than phones (90%)

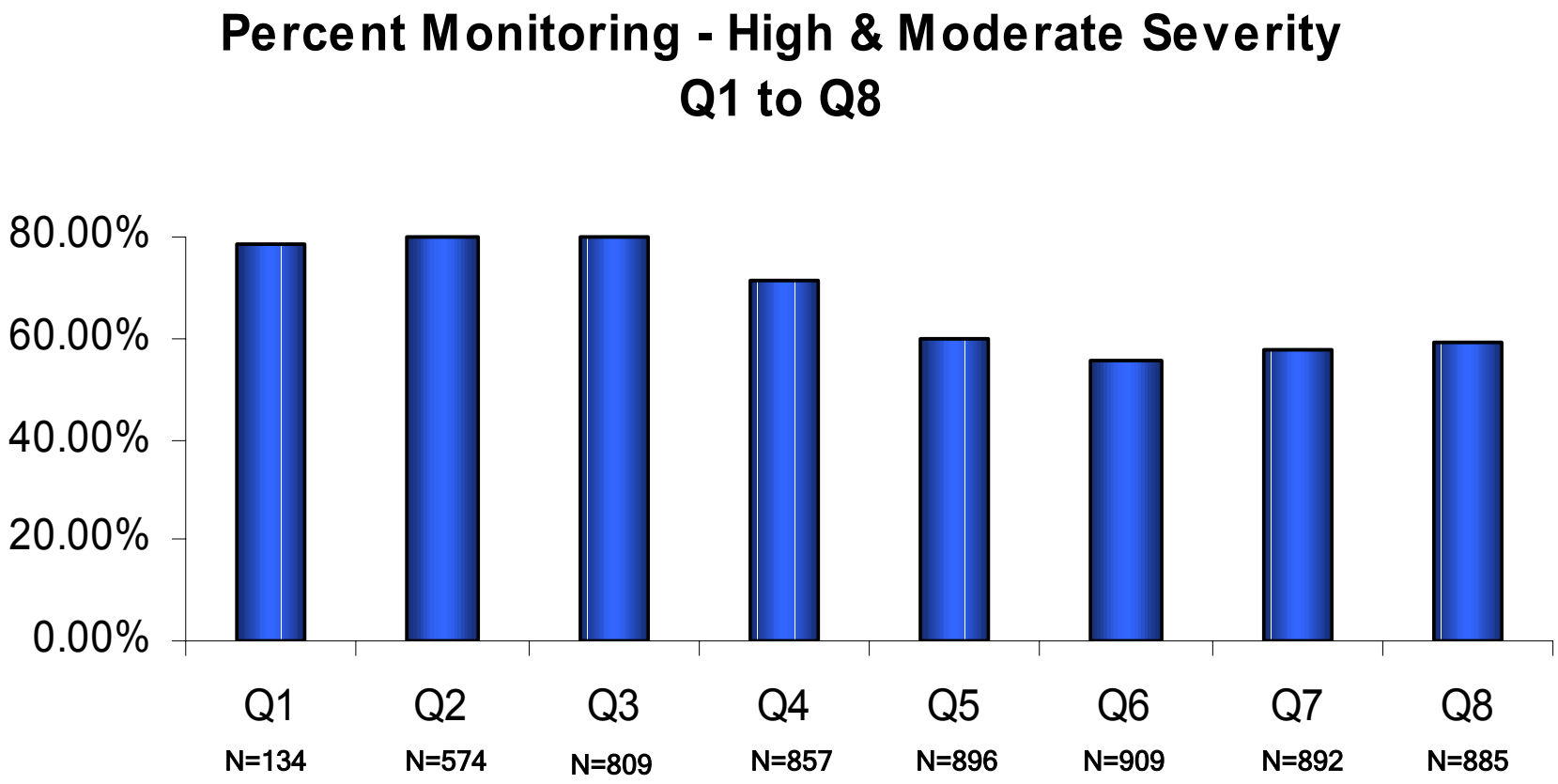
Unique Population Needs can be Met by Adapting Outreach Efforts

- Unique Needs
  - Provided higher frequency and level of support
  - Depression and mental illness screening and referral
  - Language barriers – materials in Spanish, Chinese, and English; used Spanish speaking disease managers
  - Dealt with mental and physical disabilities
  - Needed to coordinate transportation

Customization Resulted in High Success in Finding and Enrolling Beneficiaries

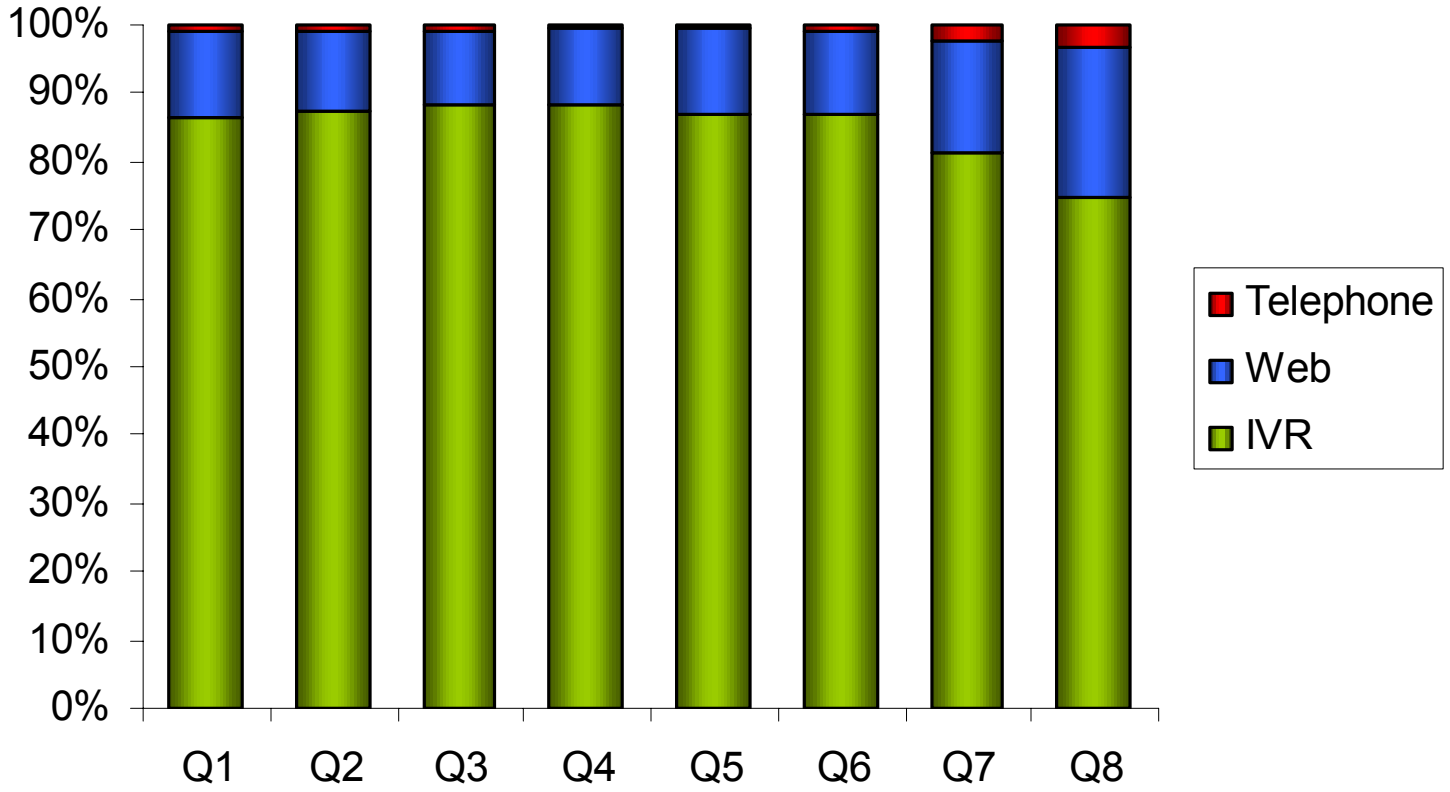


Beneficiaries Actively Participated in the Program by Entering their Vital Signs



As Expected, Web Use was Not High but Alternative Methods are Always Available

Method of Data Entry by Beneficiary by Quarter



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High Success in Changing Beneficiary Behavior

- 63.8% of smokers reported compliance with decreasing or abstaining from smoking
- 98% of recipients reported compliance with prescription drug therapy
- 92.5% of recipients reported compliance with dietary restrictions related to CHF

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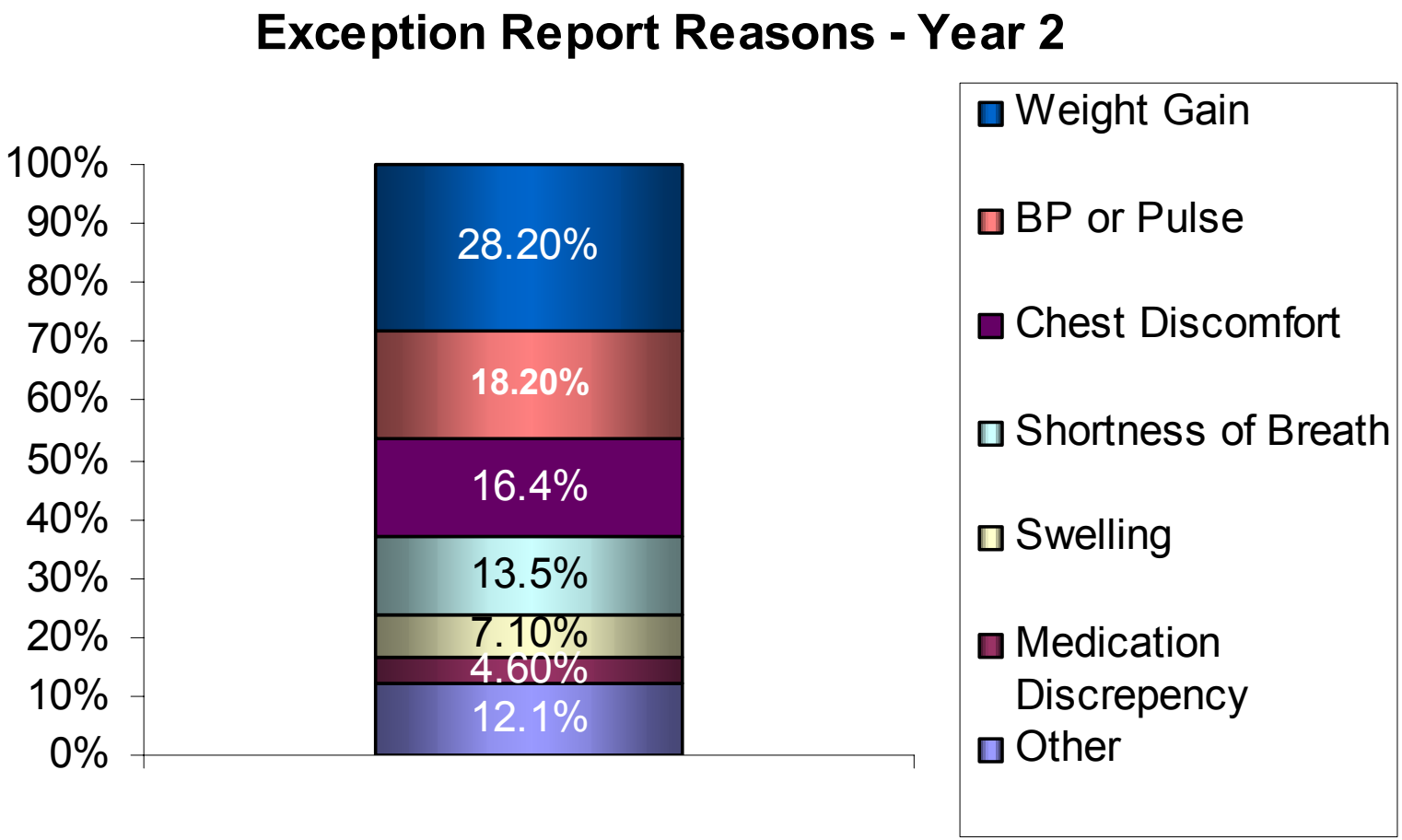
Medicaid-specific Challenges: Providers

- Lack of experience with DM programs
- Fewer physicians accept Medicaid
  - Lower reimbursement rates
  - Challenging population
- Little coordination of care
  - Lack of traditional relationship with PCP
  - ER often used as overflow mechanism
- Few rural physicians
  - Beneficiaries with unmet health needs
- Lower adherence to best practices
  - No incentives or oversight

Provider Objections Can Be Overcome by Adapting Outreach Efforts

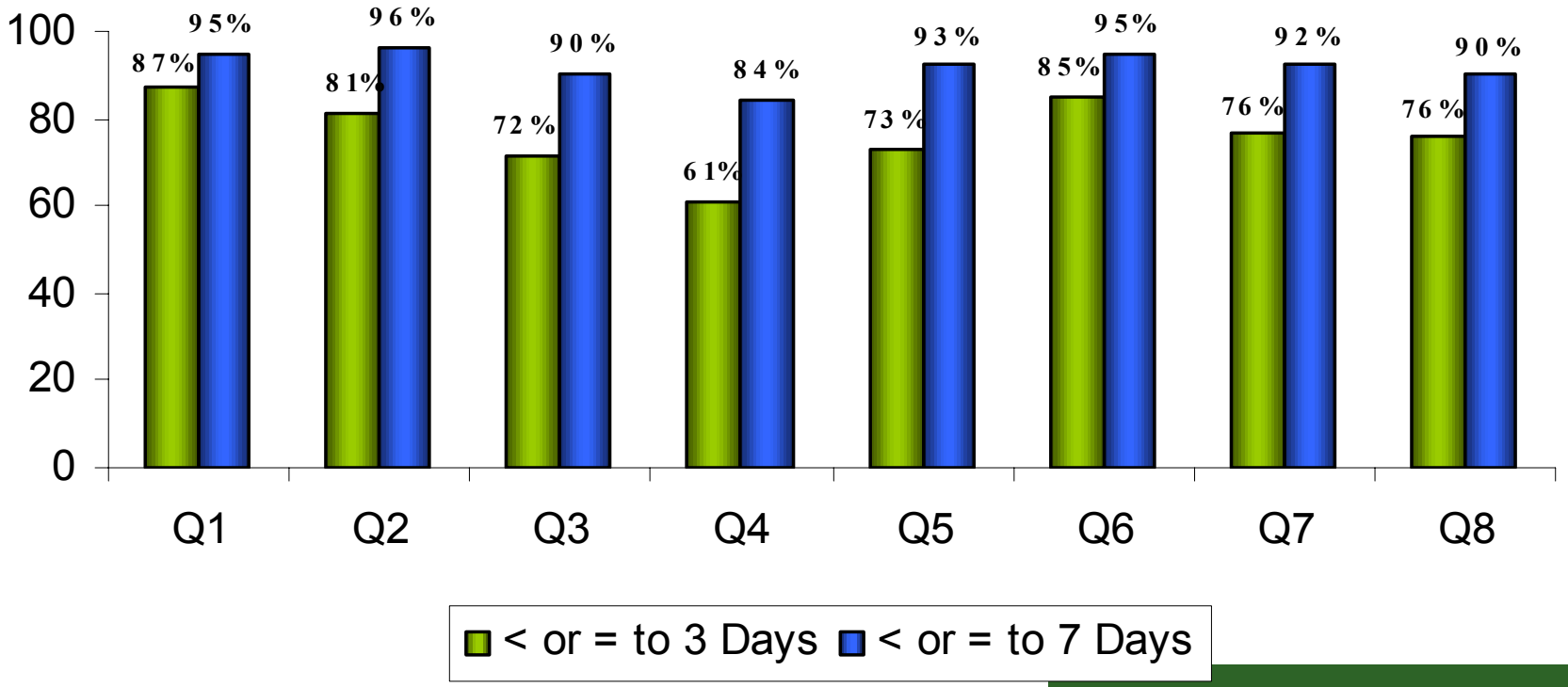
- Improving DM experience and acceptance
  - Detailed high volume physicians and clinics
  - AHCA letters to providers encouraging their participation
  - Sponsored Grand Rounds at Medicaid-dense hospitals
- Supporting best practice adherence
  - Initiated incentive study to determine effectiveness of incentives to drive best practices, ACE Inhibitor usage, etc.
- Enhancing coordination of care
  - Reports to physicians on quarterly basis and when patient experiences validated out of bounds clinical event (exception reporting)

Valuable Information was Given to Providers about their Patients

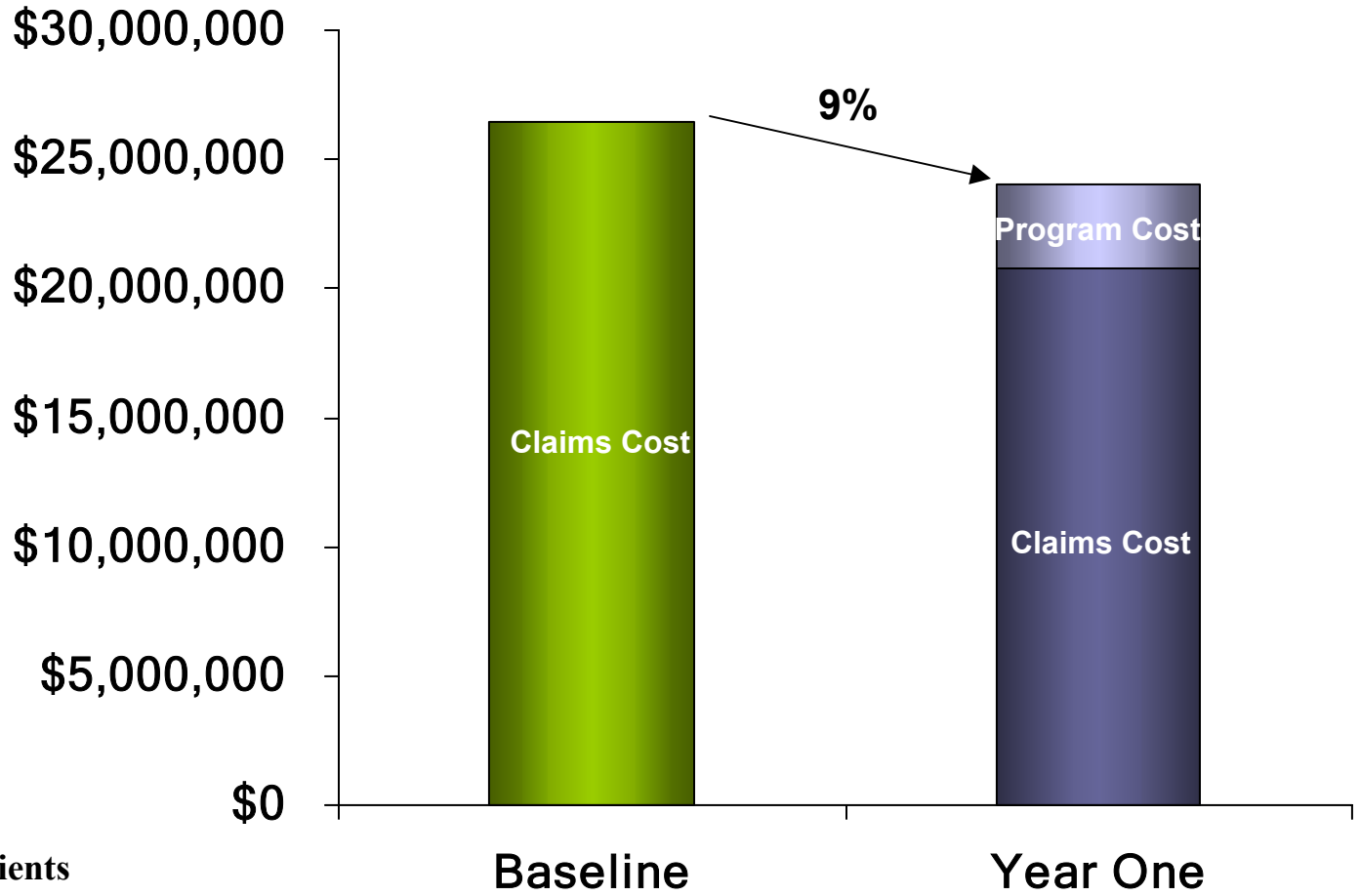


Providers Participated Actively in the Program by Responding to the Reports

Provider Response Time to Exception Reports by Quarter



First year Results on a Total CHF Population – Florida Medicaid*



3,000 Patients
Baseline year = 7/1/98 to 6/30/99 (adjusted for Medicaid Budget increases and North Florida expense)
Measurement year = 9/1/00 to 8/31/01

***Preliminary results pending final AHCA approval**

Medicaid-Specific Challenges: Contracting and Implementation

- Baseline & measurement methodology
  - Establishing financial and quality metrics that accurately measure program performance
  - Adjusting for changes in population demographics, disease prevalence & severity, inflation
  - Identifying excluded services & members
  - Dealing with eligibility issues
- Data exchange
  - AHCA driven identification process
  - No data in advance to perform stratification
  - Retroactivity and eligibility issues in quarterly data refreshes
  - Incomplete beneficiary and provider data

Medicaid-Specific Challenges: Contracting and Implementation

- Timing
  - Very early DM program with little precedent - negotiation took a year
  - CMS (HCFA) waiver approval took 18 months
- Politics
  - Aggressive Savings Guarantees & Fee Risk (Legislature had proactively reduced AHCA budget anticipating DM savings)
  - OPPAGA Audit right when LM program was beginning

Lessons Learned

- Identify and codify program design, expected outcomes, baseline, and data exchange up front
- Employ a proactive vs. reactive approach with Beneficiaries and Providers
- Monitoring is essential as early warning of clinical exacerbation for severe CHF patients
- Manage the entire person including life issues
- Co-morbidities must be managed and population programs work best (no more “disease of the month”)
- Enrollment must be fast & creative to achieve optimal outcomes
- Combined telephonic/local approach works best
- Identify & solve communication issues early – use methods best suited to population/individual

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