



Medicaid Disease Management

Update - 2004

DM Colloquium – Philadelphia; June 28, 2004

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Today's Discussion

I. CMS Advisory Letter to States

- *Update from Washington – Encouraging news for States*

II. State Medicaid Highlights in 2004

- *Update from Florida – Mixed reviews continue*
- *State Survey Results – Current and emerging models*

III. Contracting & Evaluation Challenges

- *Concerns about Guaranteed Savings*
- *State Challenges*
- *Lessons Learned*

I. CMS Advisory Letter to States



Center for Medicare & Medicaid Services

Guidance Letter to State Medicaid Directors

**“CMS Urges States to Adopt DM Programs,
Agency Will Match State Costs”**

February 26, 2004

<http://www.cms.hhs.gov/states/letters/smd022504.pdf>

I. CMS Advisory Letter to States



Federal Support Models

1. Federal Administrative Match for DMOs - 50%

- a) Will fund DMO contracting; Risk-sharing under PAHP

2. Medical Services Federal Match at 50-80%

is available for licensed professionals, with geographic, provider targeting and patient stratification permissible using:

- a) Waiver options – 1915(b)(3), 1115(a)(2), etc.
- b) State Plan Amendments 1905(a) 1932(a)
- c) 1115 Demonstrations – populations not in state plan

II. State Medicaid Highlights - 2004

A word of caution – People are watching.



Florida Legislative Progress Report, May 2004

Office of Program Policy Analysis and Government Accountability,
Office of the Florida Legislature

***“Medicaid DM Initiative Has Not Yet Met
Cost-Savings & Health Outcomes
Expectations”***

<http://www.oppaga.state.fl.us/reports/health/r04-34s.html>

Florida Legislative Report, *May 2004*

Setting Un-realistic Expectations?



“After nearly 7 years, the DM initiative

- 1. “Continues to fall short of legislative expectations and goals.**
- 2. “Continues to serve a small percentage of eligible recipients.**
- 3. “Services were available for only 5 out of 9 targeted diseases.**
- 4. “Health outcomes have not been sufficiently evaluated.**

5. “Has reportedly saved \$13.4 million, however, the agency has not finalized cost savings for several programs.

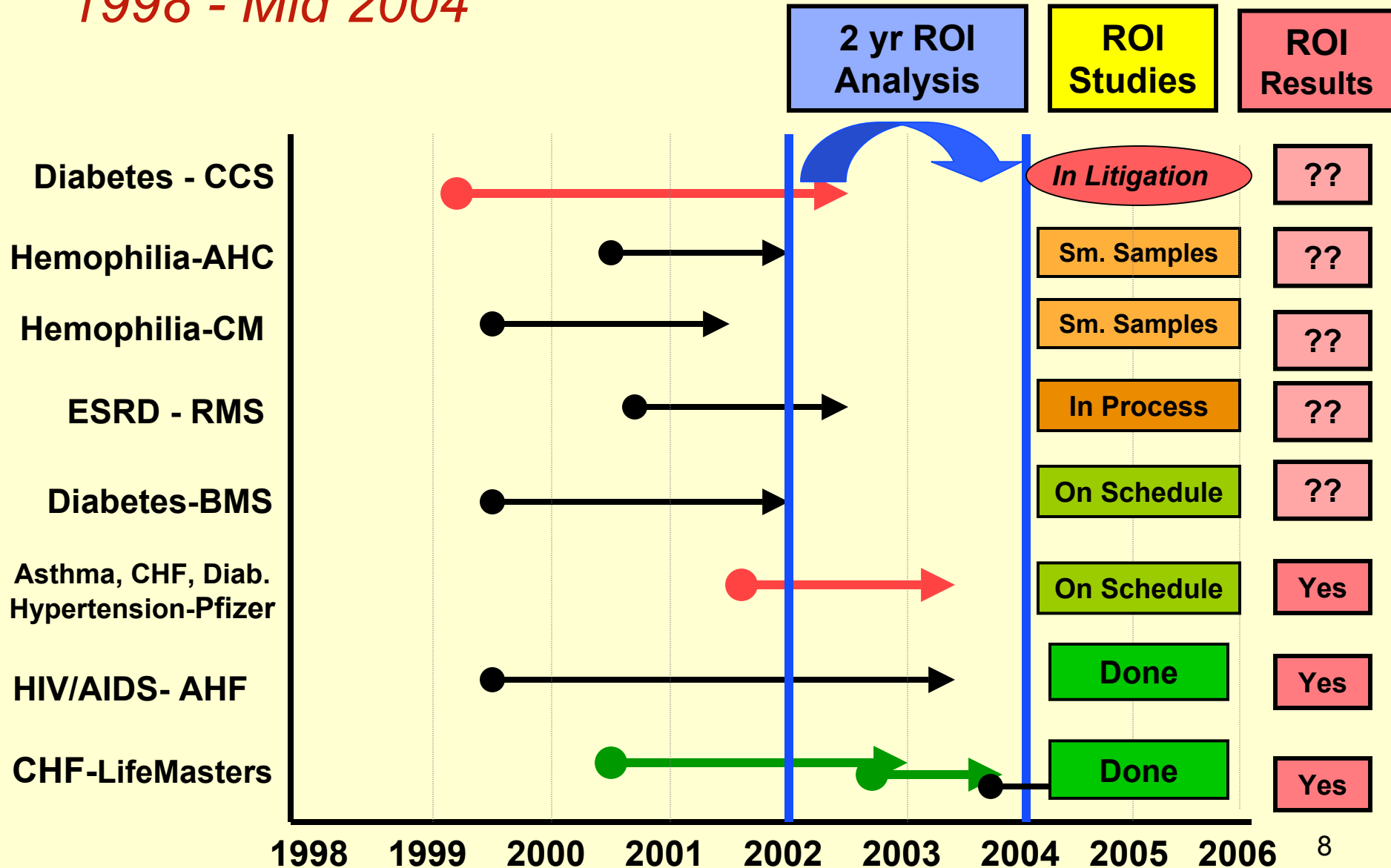
6. “Cost savings are likely overstated because of weak approaches to estimating baseline costs.

7. “Agency oversight does not ensure that:

 Recipients:
 - Receive appropriate levels of service, *or that*
 Physicians:
 - Support the initiative, and
 - Use best practice guidelines.

Florida Contract Reconciliation Status

1998 - Mid 2004



Other State Activities

DM Survey Results

Two Very Different Models in Play

1. 'Build' – *Provider-focused models*

Training in guideline use & new incentives for traditional providers to perform, coding for performing evidence-based office-based services.

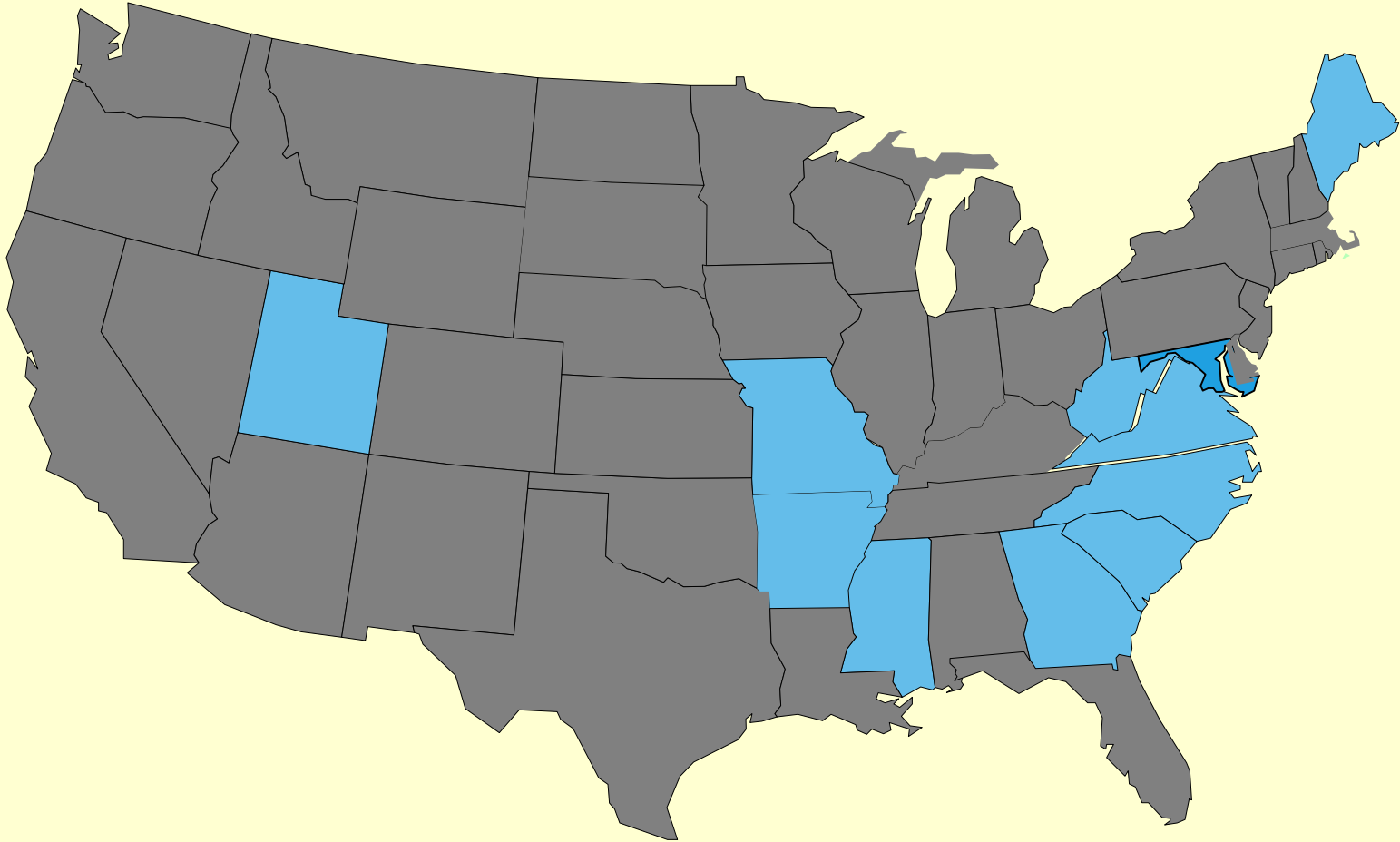
2. 'Buy' – *Patient-focused models*

Contracting with DM Vendors who contact (outreach to) patients at their homes.

Using Medical Call Centers, RN Home Visits, Home monitoring . .

‘Build’

Using Existing, Local Providers



Government Managed Solutions

‘Build’ or ‘Make’ = “We Make it up as we go . . . ”

'Build'

Advantages and Challenges

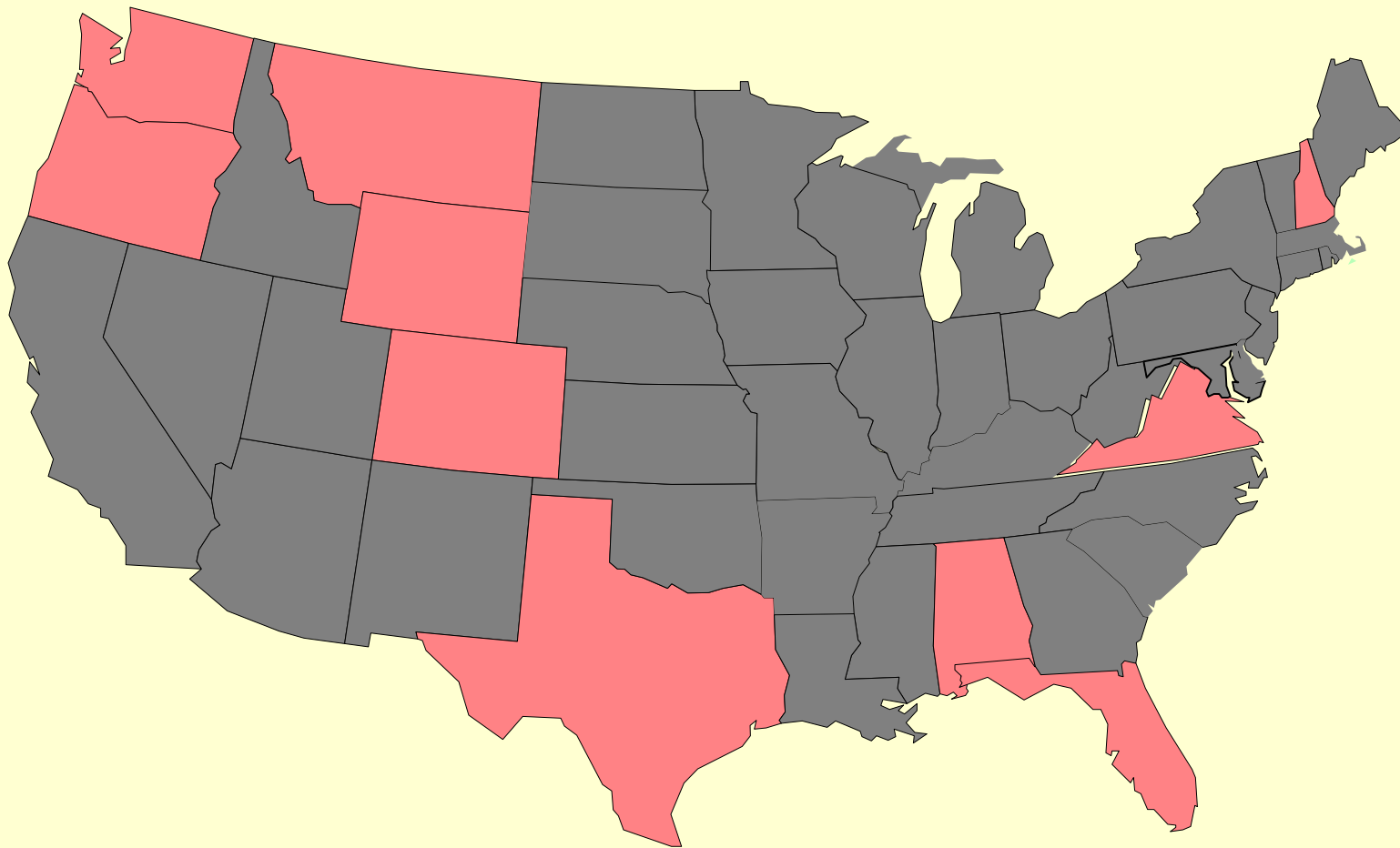
Advantages: Using Existing Providers

- **Local Providers are part of the existing fabric: Already in State networks & data systems.**
- **MDs want to provide good care - but need help.**

Challenges

- **Must train, certify, assure guideline use, reporting.**
- **Payment for extra work may not be available.**
- **Communications with MDs and program uniformity.**
- **State data capabilities to track performance.**

'Buy' – *Outsourcing with IT Solutions from Experienced DM Vendor*



Private Market Solutions
Early Adaptors

'Buy'

Advantages and Challenges

Advantages – Using DM Vendors

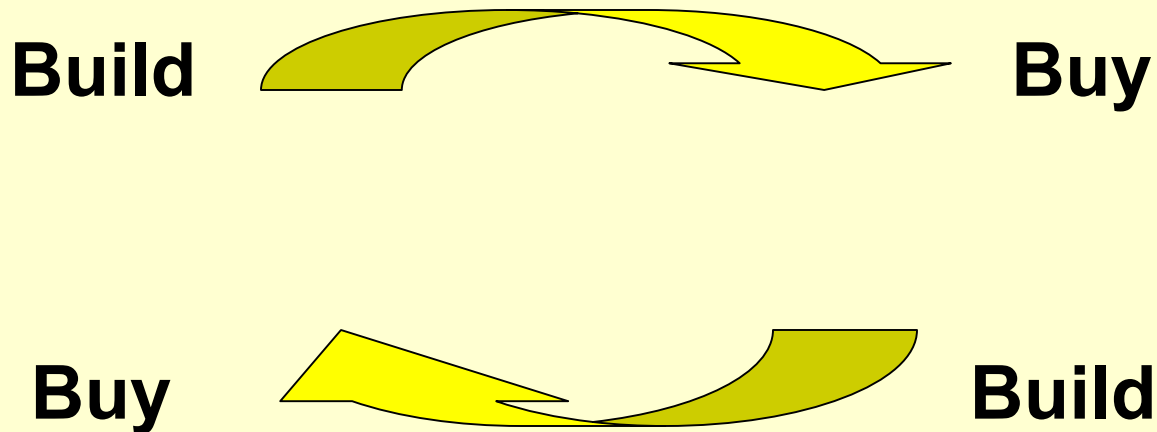
- **Quick DM start up for inexperienced states.**
- **'Prospect of guaranteed or shared savings'.**
- **Superior IT and DM experience / strategies.**

Challenges

- Monitoring and managing of vendor contracts.
- Provider buy-in & cooperation; intrusion into their practices, with their patients a major problem.
- Proving Cost Savings, quality outcomes.
- Reduction of the reconciliation hassle factor.

States starting to switch models to improve local DM capabilities & ROI results.

Model Switching Started in 2004



Emerging Approaches

2004 - 05 & beyond ----->

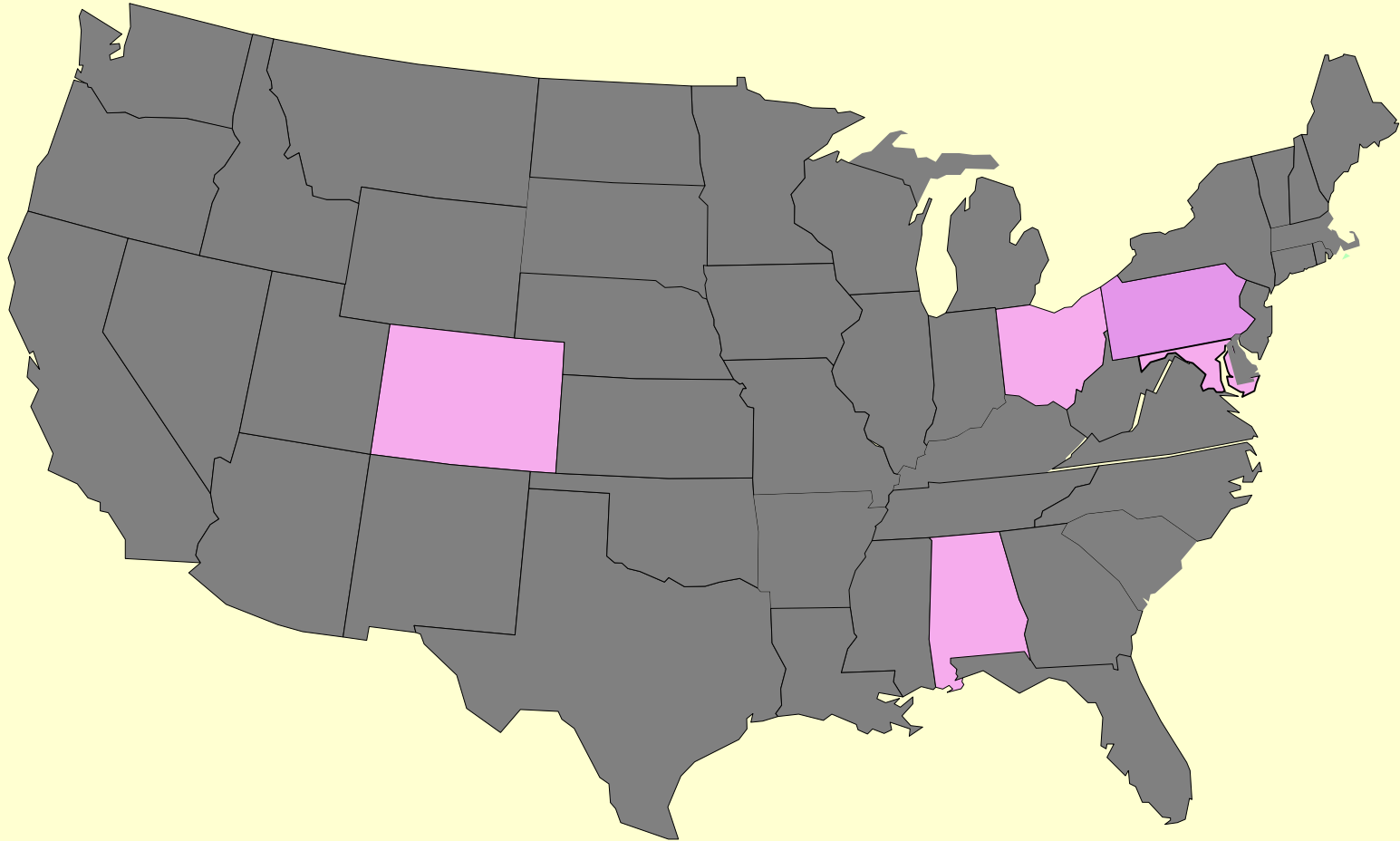
Multiple Approaches

State using both **Build** *and* **Buy** options simultaneously.

Assemble – *New DM Consortiums*

State directed or promoted collaborations between existing Medical providers *and* outsourcing of certain services to vendors (PBMs, Pharmacists, 24 x 7 call centers, etc.)

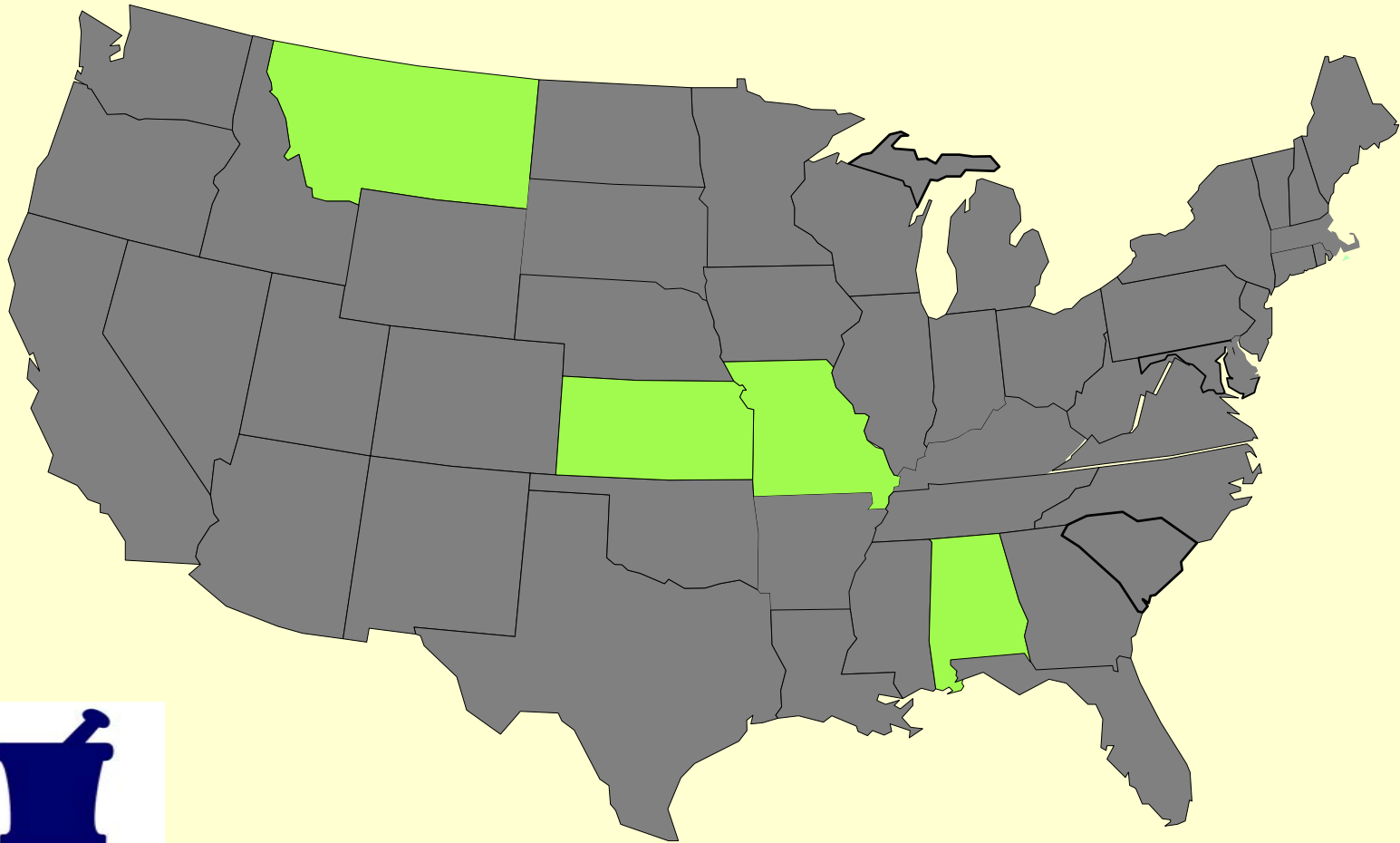
DM - Building and Buying Is On the Rise



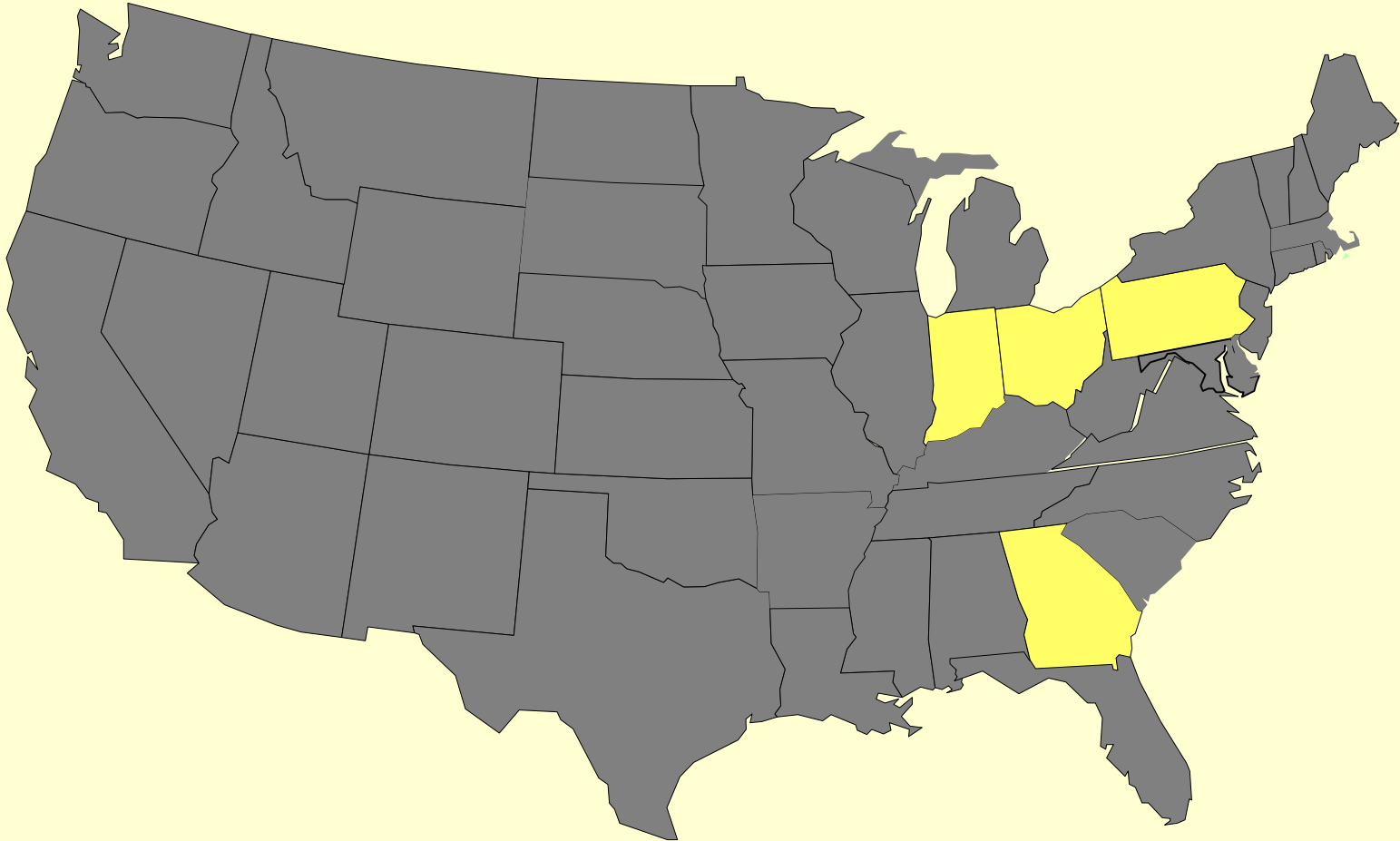
'Battle Ground States'

Enhanced DM Pharmacy Programs

Rx Counseling, MD Teaming, Home Visits



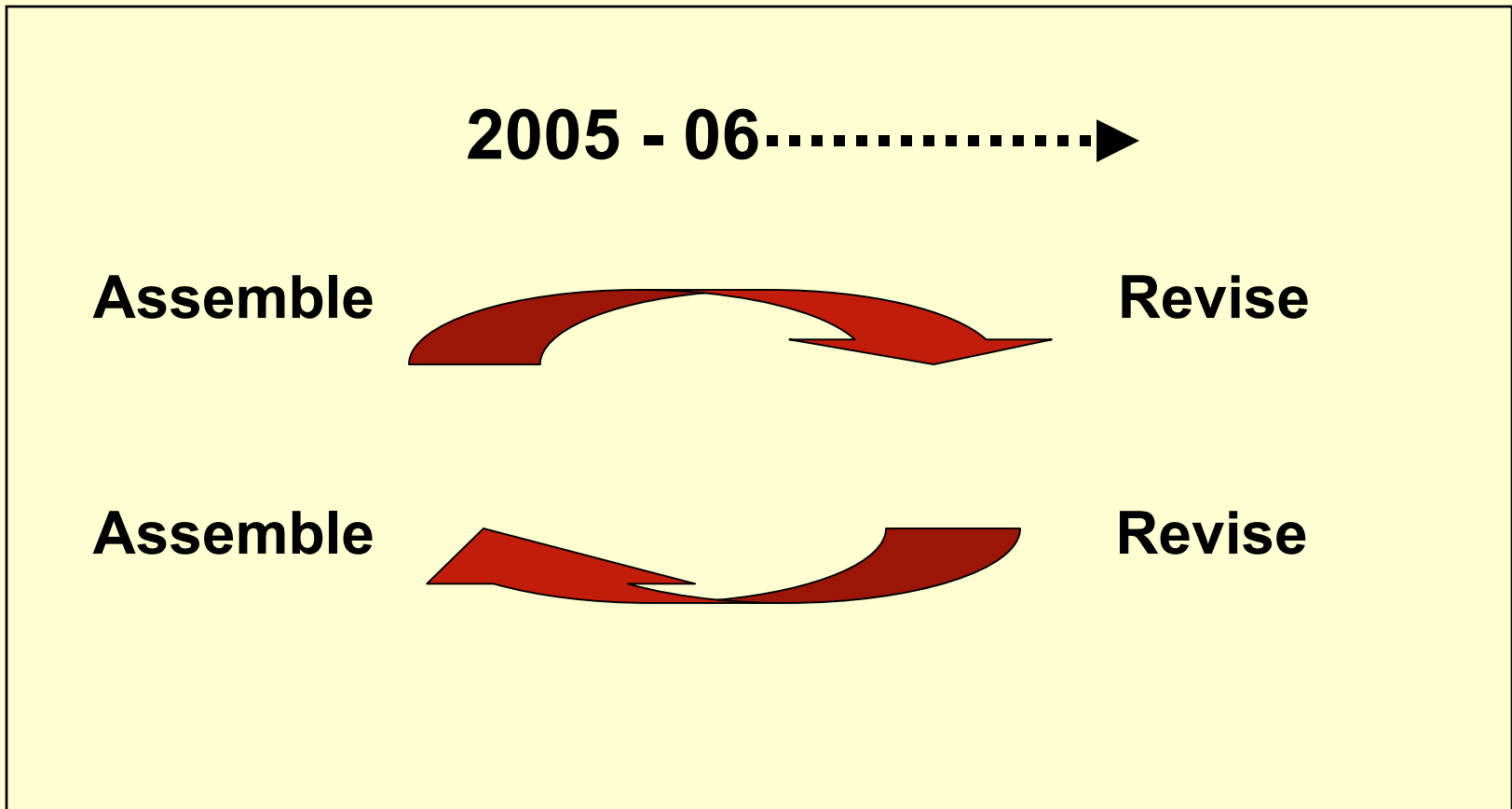
***‘Assemble’ = State directed ‘collaboratives’
among providers & vendors growing***



New Battle Ground States

Prediction

By 2005-06 States will promote Local Consortia with DMO Call Center & IT Support.



III. Contracting & Evaluation Challenges

Risk-based Contracting – *Apparent Trends*

A. Used *primarily* by states new to DM:

To save state money 'fast' - *under political pressure.*

B. Some states with early risk contracts:

1. Now re-negotiating with providers and DMOs (e.g. performance-based contracts, EBGs)
2. Enhanced PMPM and Case Rate payments.
3. Limited risk corridors (5% contract bonuses and take-backs)
4. Goal: To minimize year-long reconciliation battles with vendors.

Contracting & Evaluation Challenges

C. States pay More for Risk-based Contracts

1. Vendors must pay high re-insurance premiums.
2. Vendors can **not** book revenues until contract completion
- *which may be years down stream.*

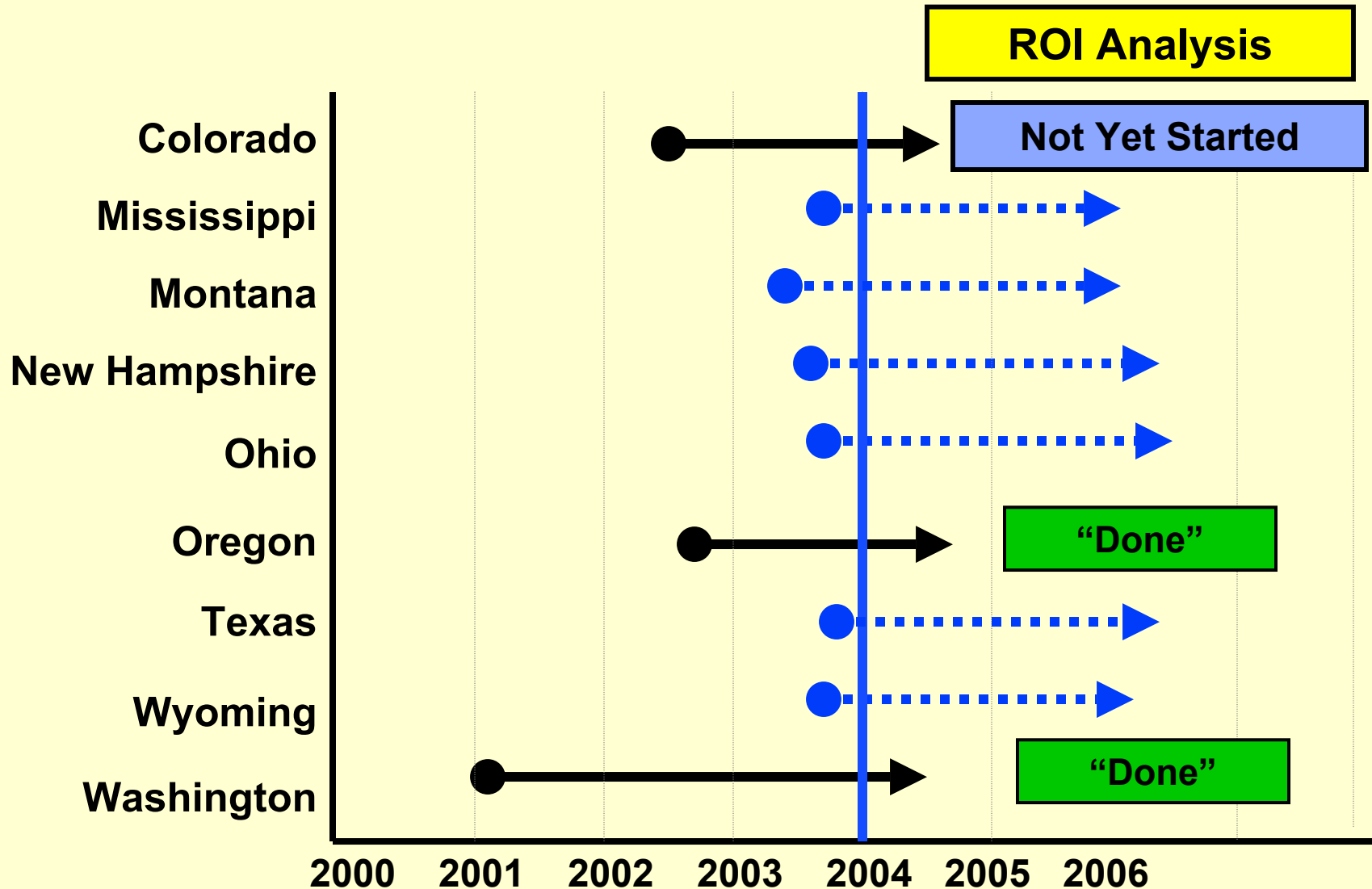
D. Questionable ROI Analysis

Some state ROI evaluations being performed largely:

1. By vendors.
2. By wholly-owned subsidiaries of vendors.
3. By contractors with close business ties to vendors.
4. By state staff and / or actuarial firms with *little to no experience* with complex DM evaluation issues.

Current Status of State Savings Analysis

2002 - 2004 – An Immature Science



Issues with Current State Efforts

Observations

1. **Shortage of DM Technical Assistance to States that is:**
 - a) Transparent & Conflict-free
 - b) Completely Vendor Independent
 - c) HIPAA compliant
2. **Need for ‘Generally Accepted’ and Standardized’ ROI / Savings Methodologies**
3. **Questions will be raised about the credibility of reported Outcome Evaluations**



Medicaid DM: *Lessons Learned*

1. **Outsourcing:** Best for 'must implement something fast' approach with fairly high chances for positive short term results.
2. **'Pilot projects:'** Help build necessary internal experience and minimize mistakes.
3. **'Build'** Takes longer to set up, but state may have more control over local stakeholders.
4. **Planning Process:** Getting started with a thorough planning process and learning from best practices of others improves program design, and chances for success.
5. **'Declaration of Independence'** Need for 'Independence' in evaluation of public domain DM savings analysis, using generally accepted guidelines and conflicted-free organizations.