

Partnership for Medicaid Partnership for Medicaid

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Improving Care Management for Chronic and Other Conditions*

Care management strategies are increasingly used in the private sector to improve patient outcomes and help control health care costs. Medicaid enrollees are especially likely to benefit from aggressive care management strategies because they are often sicker than other populations, frequently experience multiple co-morbidities, and face socioeconomic barriers that complicate their care. In addition to potential cost savings, better care management for these populations will improve overall quality of care and will ultimately lead to better health outcomes.

To extend the benefits of care management more broadly, new strategies are needed to better align financial incentives in ways that will promote care management for Medicaid recipients. A variety of care management strategies and reimbursement mechanisms should be promoted to help reduce Medicaid spending while improving overall health care quality.

*The ideas and opinions expressed in this document reflect the contributions of individual members of the Partnership. While every effort has been made to achieve consensus among all members, the ideas expressed in this document are not necessarily those of, nor are they endorsed by, any particular member organization(s) of the Partnership.

BACKGROUND

Care management strategies are increasingly used in the private sector to improve patient outcomes and help control health care costs. Care management involves addressing patient needs comprehensively and working with patients to maintain their health status, applying the most current clinical knowledge and practice guidelines to the care that is provided for a patient's condition. It also actively involves the patients in their own care, helping them to learn about their condition and to set goals for their own health improvement, using planned individual and group visits to help them track their improvement and to stay the course. It can often involve not only physicians and nurses but also other health care professionals, social workers, or case managers. Strategies such as assigning patients to a "health care home" to facilitate the delivery of coordinated, preventive care and engaging in comprehensive discharge planning can help eliminate inefficiencies, reduce improper utilization of services and maximize health care quality in a cost-effective manner. These innovative efforts are literally transforming the way health care is delivered – strengthening the provider-patient relationship.

Care management is particularly important in the case of individuals with chronic illnesses, especially diabetes, asthma, hypertension and other cardiovascular diseases, cancer, and HIV. **One hundred thirty-three million people in the U.S. have at least one chronic condition, and the number with two or more is on the rise.**¹ Care for patients with chronic conditions is contributing to the rapid increase in health care costs. This trend is especially significant in the Medicaid program where care for elderly and disabled beneficiaries, many of whom have multiple chronic conditions, consumes 72 percent of total Medicaid spending. There is also a need for better care coordination for healthier populations as well, however, and broad implementation of care management strategies holds the promise of substantial Medicaid savings.

Medicaid enrollees are especially likely to benefit from aggressive care management strategies because they are often sicker than other populations, frequently experience multiple comorbidities, and face socioeconomic barriers that complicate their care. In addition to potential cost savings, better care management for these populations will improve overall quality of care and will ultimately lead to better health outcomes. For example, studies have shown that oral health care can be an essential factor in the medical management of diabetes, as there are several oral health complications and diseases associated with diabetes. Ensuring oral and general health care is coordinated helps to improve the success of the patient's health care management.

Care management is also a valuable tool for preventing illness and reducing medical complications for pregnant women. **Perinatal care management has been shown to provide improved health outcomes for mothers and infants and yield a substantial cost-savings.**² Perinatal care management can help to identify problems early, better manage developing and existing health problems and complications, and reduce risky behaviors like substance abuse and poor nutrition. It can also quickly detect dozens of potentially costly or even fatal genetic disorders, and promote normal growth and development. The costs of prevention pale by comparison to the costs of treating pregnant women who receive late or no prenatal care and infants who are not screened at birth. Four of the ten most expensive inpatient hospital charges are attributable to inadequate perinatal care.³

¹ Partnership for solutions. *Chronic Conditions: Making the Case for Ongoing Care*. Baltimore, MD: Johns Hopkins University, Robert Wood Johnson Foundation, 2004. <http://www.partnershipforsolutions.com/DMS/files/chronicbook2004.pdf>

² Anne F. Carman et al. 2004. Evaluation of Perinatal Care Management Programs: An Integrated Review. *Care Management Journals*. 5(1): 19 – 24.

³ Lisa Potetz and Brad Wright. *Maternal, Infant, and Child Health in the United States, 2005*. Washington DC: March of Dimes.

Traditional managed care organizations have already made great strides in promoting care management, and states are increasingly utilizing care management strategies for their Medicaid populations enrolled in managed care. However, many Medicaid recipients have yet to benefit from care management interventions. For example, the elderly and disabled are frequently excluded from Medicaid managed care and have not benefited from care management, even though they are especially likely to benefit from such strategies.

POTENTIAL SOLUTIONS

To extend the benefits of care management more broadly, new strategies are needed to better align financial incentives in ways that will promote care management for Medicaid recipients. Currently, incentives for savings exist only at the state level, and the Medicaid reimbursement system does not reward providers for effectively managing care. Instead, the system is skewed toward inpatient care, providing significantly reduced reimbursement in the outpatient setting. Further, many of the services necessary to properly manage care, such as case management, care planning, and interpretation services, receive limited reimbursement or are not reimbursed at all. **A variety of care management strategies and reimbursement mechanisms should be promoted to help reduce Medicaid spending while improving overall health care quality.** For example:

- ***Health Disparities Collaboratives*** – Most federally-supported community health centers are participating in the Collaboratives, which focus on improving care and outcomes for their predominantly low-income, minority, and either uninsured or Medicaid/Medicare covered patient populations. Begun in 1998, these Collaboratives focus on the chronic conditions most commonly exhibited by health center patients, but also encompass the delivery of preventive health care. Several cost-impact studies of this care model have already demonstrated its significant potential for improving health care quality and health outcomes and reducing health care costs, especially for Medicaid patients. The most significant study to date was conducted by the state of South Carolina, which found that Medicaid realized **an overall savings of 25 percent or more in the total health care costs of Medicaid patients with diabetes being treated through the Collaborative.** Lower costs were effectively driven by substantial reductions in hospital admissions and lengths of stay, as well as lower hospital emergency room use, among the health center patients. However, for the Collaboratives to operate successfully, Medicaid policy must change to: recognize group health education activities furnished to multiple patients; the roles of allied health professionals (such as health educators) in collaboration with primary care providers; and the fact that a single planned patient visit may involve more than one encounter (for example, medical and podiatric care for a diabetic patient). Moreover, payment policy must also recognize the increased costs of establishing and maintaining patient registries so important for tracking the care of patients in such systems.
- ***Medicaid Provider Service Networks (PSNs)*** – One way to institute care management, and simultaneously achieve Medicaid savings, is to facilitate the establishment of Medicaid Provider Service Networks (PSNs) by creating a new category of managed care entity under Section 1932 of the Medicaid statute. A PSN is a network of affiliated providers including, at a minimum, primary care providers, specialty care providers and hospitals that can provide coordinated care to their patients. The PSN would contract directly with the Medicaid agency to provide a defined set of benefits, and are paid on a fee-for-service, non-risk basis. It would further be permitted to share in savings with the state achieved through reductions in utilization, creating a win-win-win situation for patients, providers and the state/federal Medicaid program. The private sector has begun developing this kind of model (e.g., in MN

some employers contract directly with provider-based systems). And in the Medicaid context, the state of Florida has very successfully developed a PSN model – the South Florida Community Care Network – that has **achieved savings (\$30 million over three years) and some quality improvement for its patients.**

- **Medicaid Managed Care** – Another way to improve care and achieve savings is for states to enroll SSI populations into managed care systems whose provider network is particularly skilled in working with people with disabilities. Currently 28 states voluntarily serve some SSI children in managed care, up from 9 in 1990; and 27 states serve adult SSI recipients, up from 10. When the unique care needs of people with disabilities are addressed in the organization and financing of their care, Medicaid managed care has the potential to substantially improve their care. States have substantive experience with managed care for SSI populations, and many studies have shown cost savings and improvements in satisfaction and quality among SSI recipients. For example, a recent study in Oklahoma compared costs, quality of care and member satisfaction levels among SSI beneficiaries with special needs before managed care enrollment and one year after. In addition to administrative and cost of care savings, the study found that 61 percent of enrollees thought their care was better in the health plan, and 60 percent said it was easier to get a prescription filled. **In Texas, an evaluation of a Medicaid SSI managed care plan found that it had achieved a 17 percent reduction in Medicaid costs for plan enrollees.**
- **Medicaid Fee-For-Service Programs** – Several fee-for-service programs also work to improve care coordination and achieve savings by contracting with outside vendors to provide patient assistance in managing their care. For example, the state of Alabama created a care/case management program in dentistry to assist patients in scheduling and maintaining oral health appointments and receiving needed follow up care. **As a result, appropriate patient utilization improved as did dentists' satisfaction with the program.**
- **Medicaid Disease Management** – Another way to improve care is to expand Medicaid disease management programs. CMS defines disease management as, “a set of interventions designed to improve the health of individuals by working directly with patients and their physicians on treatment plans regarding diet, adherence to medicine schedules and other self-management techniques.” Typically, DM focuses on such chronic conditions as diabetes, hypertension, asthma and congestive heart failure. States operating DM pilots include Colorado, Illinois, Texas, Florida, Massachusetts, Wyoming, Montana, Pennsylvania, Puerto Rico and Hawaii. For the Colorado schizophrenia pilot, registered nurses in a 24 hour-call center are used to recruit, assess, provide education, care coordination and outcomes monitoring for the schizophrenia/physical disease DM program participants, using evidenced-based protocols when available. The program deploys the registered nurse care managers to work as field operatives, visiting with patients and clinicians to provide home counseling visits, referrals and to promote the use of clinical guidelines to ensure the treatment recommendations are followed. **Studies suggest that long-term savings flow from reduced pharmacy costs, fewer emergency room visits and lower inpatient hospital utilization.**

- RECOMMENDATIONS -

A variety of care management strategies and reimbursement mechanisms should be promoted to help reduce Medicaid spending while improving overall health care quality. These strategies include: **Health Disparities Collaboratives, Medicaid Provider Service Networks, Medicaid Managed Care, Medicaid Fee-For-Service Programs, and Medicaid Disease Management**