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FEDERAL AND STATE INITIATIVES ON CHRONIC DISEASE MANAGEMENT

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You asked for information on federal and state chronic disease management initiatives.

SUMMARY

"Chronic disease management," also called "disease management," seeks to improve patient care and outcomes and reduce health care costs by concentrating services on people with chronic diseases. These people tend to use a greater share of medical services, typically from multiple medical providers and often without care coordination. Disease management programs often work directly with these patients and their physicians on treatment plans, diet, keeping to medicine schedules, and other self-management techniques.

Many private insurance companies have used disease management techniques for some time. A number of private companies known as disease management organizations sell their specialized services to insurance companies, employers, managed care organizations and, more recently, state Medicaid programs. Pharmaceutical companies also often engage in disease management services. And pharmacy benefit management organizations (PBMs) also use disease management activities to reduce their clients' drug costs.

The federal government has approved Medicaid waivers and plan amendments for states to create Medicaid disease management programs. Federal legislation in 2003 also creates several Medicare chronic care and disease management pilots. And a 2004 federal letter to state Medicaid directors urges them to create Medicaid fee-for-service disease management programs.

At least 40 states currently have or are planning some sort of disease management programs for some portions of their Medicaid populations, either under managed care, fee-for-service, or both, but they vary considerably in their target populations and target diseases. Some states contract for Medicaid managed care for children and families with private managed care organizations that apply various disease management methods. A number of states recently authorized disease management programs, expanded them to more diseases or to cover Medicaid fee-for-service populations (elderly and disabled people), or decided to study establishing them.

Connecticut has used disease management procedures as part of its Medicaid managed care (HUSKY) program for a number of years, and is now preparing to request proposals for a disease management program for its Medicaid fee-for-service populations.

States that apply disease management to Medicaid fee-for-service populations approach the service in several ways. Some create their own Medicaid disease management programs; others contract with disease management organizations or, in some cases, pharmaceutical companies, PBMs, or pharmacists, to provide the services. Still others use a combination of these methods. Programs vary in the number of diseases targeted, the populations targeted, contract terms, amount of risk the companies take, and the level of savings they may guarantee the state.

States hope to use these programs to improve health outcomes and save money for their Medicaid programs. Existing research shows some improved outcomes, although most studies are limited in that they are, so far, short-term. Some studies find the limited research on cost savings promising, but others we have found caution that the cost-savings evidence is so far insufficient because it is too short-term and not scientifically rigorous enough to conclusively prove large savings for the programs.

CHRONIC DISEASE MANAGEMENT

Chronic disease management is a recent approach that seeks to improve patient care and outcomes and reduce health care costs by concentrating services on people with chronic conditions such as diabetes, asthma, heart disease, and HIV/AIDS. Such people, especially the elderly, often have several chronic conditions and receive medical care from a number of providers that is not always coordinated. People with chronic conditions often do not follow treatment and medication regimens, have a high rate of preventable complications, and have a high use of costly services, such as emergency room visits and hospitalizations. Disease management programs help such high-cost patients follow appropriate treatments, use less costly outpatient interventions, and learn how to self-monitor their conditions.

Disease management offers an integrated approach that features case management, patient and physician education, and patient monitoring. The programs typically focus on:

- identifying patients with diseases appropriate for management;
- identifying medical practices that research shows to be most effective (evidence-based practice guidelines);
- supporting adherence to these practices by providing treatment guidelines to medical providers, reviewing patients' compliance with the guidelines, and helping physicians monitor patients;
- educating patients in self-management and adherence to treatment plans and engaging them more in their own treatment; and
- collecting and analyzing process and outcome measures.

Private health insurance companies and managed care plans have routinely used disease management programs for a number of years. Many states have routinely used the procedures in their Medicaid managed care programs for a number of years and a growing number are beginning to use them in their Medicaid fee-for-service programs, which are most likely to cover elderly and disabled people, groups that are more likely to have multiple chronic conditions.

In the future, it is likely that more of the U.S. population will have chronic conditions as people live longer and the elderly population increases. The proliferation of chronic disease management programs in both private health insurance, managed care, Medicare, and Medicaid fee-for-service programs could have significant long-term implications for the well-being of this aging population and their long-term care needs. The programs have the potential to improve people's health, reduce their acute episodes of sickness, and perhaps reduce the proportion of people who eventually need long-term care by delaying or shortening the time for which they need it. And positive outcomes of disease management in these populations could, in turn, lead to changes in public health programs for the general population.

FEDERAL INITIATIVES: MEDICARE AND MEDICAID

Medicare

In late 2003, the Medicare Modernization law (P.L. 108-173), which also established Medicare prescription benefits, required the federal Center for Medicare and Medicaid Services (CMS) to undertake a number of demonstrations to improve Medicare chronic care for seniors and disabled people in both Medicare fee-for-service and managed care programs (§§ 721 and 722). A recent OLR report, 2004-R- 0520, discusses these and other new Medicare initiatives.

Other information on the Medicare chronic care improvement pilots, including the request for proposals, is available at:
http://www.bhtinfo.com/06_07_04.htm
http://www.nhpf.org/pdfs_ib/IB797_ChronicCare.pdf
http://www.itaa.org/isec/docs/choniccare.pdf
http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.342v1.pdf

The Congressional Budget Office's (CBO) recent study "An Analysis of the Literature on Disease Management Programs" (October 13, 2004), reviews numerous existing studies and concludes that, while they show improved care processes and health measures, up to now there is "insufficient evidence" to conclude that these programs can generally reduce the cost of health care services. CBO judges that the few studies that show cost savings do so only for a small, controlled population and do not take all health care costs into account, including the costs of the

program itself. The report finds little existing research that directly addresses these issues for older, sicker Medicare beneficiaries. It states that CBO will continue to monitor the research, specially the results of the new pilot programs being established under the Medicare Modernization Act. The study is available at: http://www.cbo.gov/ftpdocs/59xx/doc5909/10-13-DiseaseMngmnt.pdf

Medicaid

CMS has previously authorized several disease management demonstrations in connection with states' Medicaid waivers. Earlier this year, CMS sent a letter to state Medicaid officials encouraging states to adopt Medicaid chronic disease management programs and promising to match state costs for running them. The letter suggests several models that would be eligible for a federal match. States could (1) contract with a disease management organization to manage the patient's overall care (but not restrict access to other Medicaid services) and pay the organization a capped amount per patient, (2) establish a primary care case management program where the state works with providers to enhance care for patients with chronic conditions, or (3) contract with individual providers to provide management services.

In order to be eligible for Medicaid matching funds, the programs must include direct services to patients such as medical assessments, disease and dietary education, instruction in self-management, and medical monitoring. These services must be provided by licensed practitioners such as doctors, nurses, or pharmacists. A program limited to administrative activities only by the state or its contractors could not qualify as providing direct services, but could qualify for federal matching for state plan administration.

According to the CMS letter, states can develop such programs under either a Medicaid waiver or a Medicaid state plan amendment. Pharmaceutical manufacturers can fund such programs for states, but the states must consider such funding a supplemental rebate on prescription drugs and report it as an offset in the amount of federal Medicaid funds the state claims. If states enroll people who are dually eligible for Medicaid and Medicare in these programs, they must ensure that Medicare is the primary payer for covered diabetes self-management training sessions and for services under the newly authorized Medicare demonstrations. States can request CMS technical assistance in developing the programs. The letter and a CMS press release can be found at: http://www.cms.hhs.gov/states/letters/smd022504.pdf
http://www.cms.hhs.gov/media/press/release.asp?Counter=967

CONNECTICUT PLANNED DISEASE MANAGEMENT INITIATIVE

Legislation in 2003 requires the Department of Social Services commissioner to design and implement a case enhancement and disease management initiative for an integrated and systematic approach for managing health care needs of high cost Medicaid recipients. It allows DSS to do this by contracting with an entity that has an established and demonstrated capability in disease management initiative design and implementation (PA 03-3, § 51, June 30 Special Session). DSS is in the process of creating the RFP for the new program, and it is not yet known when it might be released. Its plan apparently is to provide coordinated case management to high-cost patients with chronic diseases in the fee-for service program (elderly and disabled people), rather than to concentrate on individual diseases. DSS's Medicaid managed care program (HUSKY) already provides some disease management services to its enrollees.

In addition, SA 03-14, while not directly disease management, addresses prevention of two chronic diseases. It requires the Department of Public Health (DPH) to develop a comprehensive heart disease and stroke prevention plan. The plan must include public health policy strategies effective in preventing and controlling risks for strokes, based on available research, and methods to increase stroke symptom awareness. It requires the DPH commissioner to report on the plan to the Public Health Committee by January 1, 2005.

STATE DISEASE MANAGEMENT INITIATIVES

Locations and Design

At least 40 states either have or are planning some type of disease management program for at least part of their Medicaid populations. These states are Arizona, Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Louisiana, Maryland, Maine, Massachusetts, Michigan, Minnesota, Missouri, Mississippi, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, and Wyoming.

We compiled this list from several sources, including:

1. a National Conference of State legislatures (NCSL) document, "State Disease Management Program Descriptions," (enclosed), which briefly describes 21 Medicaid disease management programs actually operating in 2003 (Alabama, Arkansas, Colorado, Florida, Georgia, Illinois, Indiana, Maryland, Maine, Minnesota, Missouri, Mississippi, North Carolina, New Jersey, Oregon, South Carolina, Tennessee, Texas, Utah, Washington, and West Virginia), as well as several new program authorizations, available at : http://www.ncsl.org/programs/health/StateDiseasemgmt1.htm;

2. An April 2004 NCSL 50-state summary of recent disease management legislation that includes new programs of some type, many of which are pilots, changes and additions that states with existing programs made, new task forces, and any related legislation, available at: http://www.ncsl.org/programs/health/diseasemgtleg04.htm; and

3. the Kaiser Commission on Medicaid and the Uninsured's *The Continuing Budget Challenge: State Medicaid spending Growth and Cost Containment in Fiscal years 2004 and 2005: Results from a 50-State Survey* (October 2004), Appendix K and J, p. 72 and 73, which lists more recent actions states have taken on disease management, available at: http://kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=48004

These state programs' target populations vary considerably. Some aim at Medicaid managed care, Medicaid fee-for service, or both and some aim at private providers. Their administrative structure also varies. Some are state-operated and some are contracted to private disease management organizations. Their financial arrangements have varying levels of risk, and some have specific guaranteed minimum savings to the state in the contract.

Program Effects

By now, most experts agree that the programs improve patients' quality of care and life, but, even though states have reported some promising results, it is still not clear to what extent they save money for

state Medicaid programs, according to a June 2004 article in NCSL's publication, *State Legislatures*, "Conquering Chronic Diseases," enclosed and available at:
http://www.ncsl.org/programs/pubs/SLmag/SLWeeklyJun28_Disease.htm
http://www.ncsl.org/legis/pubs/slmag/2004/04SLJun_Disease.pdf

A September 2004 Kaiser Commission on Medicaid and the Uninsured report, "Medicaid Disease Management: Issues and Promise," looks at disease management programs in nine selected states: Colorado, Florida, Indiana, Maryland, Missouri, New York, North Carolina, Oregon, and Washington. The report concludes that, if carefully designed, disease management programs can address many health system issues affecting the disabled and chronically ill, but that program savings and improved quality of care are more difficult to demonstrate. Overall, it finds that "preliminary indications appear promising."

The report points out that a small portion of the Medicaid population is responsible for a large portion of its costs and cites recent research showing that 4% of Medicaid enrollees are responsible for 53% of program costs. It also concludes that states have tried a variety of approaches and, over time, some programs have gone from concentrating on single diseases to addressing multiple chronic conditions and have evolved from a primarily pharmaceutical-focused approach to a more enrollee-focused approach (where nurse care managers help patients work on behaviors and self-management). The report, which discusses issues and problems in developing these programs, is available at:
http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=46784

Related OLR reports on various states' chronic disease management programs, which we have enclosed, include:

OLR Report 2003-R-0268, Medicaid Disease Management, describes Medicaid disease management programs in other states.

OLR Report 2003-R-0097, Florida Disease Management Program, describes Florida's programs in detail. Florida was among the first states to establish disease management programs in the 1990s and currently has a number of programs. However, an August 5, 2004 *Health Law Reporter*, p. 1152 reports that the state is planning to end its disease management contracts with three drug makers when they expire in 2005

(Pfizer, Bristol-Myers Squibb, and GlaxoSmith-Kline, concluding the programs failed to generate enough savings. Other information on Florida's programs can be found at:
http://www.ncsl.org/programs/health/florida/
http://www.fdhc.state.fl.us/Medicaid/Disease_Management/index.shtml

OTHER RESOURCES

NCSL Resources on Disease Management
http://www.ncsl.org/programs/health/dmres.htm

"Chronic Disease Management Programs? Improving Health while Reducing Costs," a January 4, 2004 Issue Brief from the Center on an Aging Society at Georgetown University discusses the characteristics and potential savings of disease management programs. It is available at:
http://ihcrp.georgetown.edu/agingsociety/pdfs/management.pdf

The National Pharmaceutical Council has brief state-by-state synopses of state disease management programs available at:
http://www.dmnow.org/state_activities/. The site also links to a CMS snapshot of state disease management programs that have received Medicaid waivers:

http://www.dmnow.org/state_activities/CMS_Snapshot_of_FFS_Medicaid_DM_Programs.pdf

Mathematica's Issue Brief, April 2004, discusses disease management options and issues for states to consider:

http://www.mathematica-mpr.com/publications/PDFs/diseaseman.pdf

Other resources that may be of interest include:

State Coverage Initiatives Issue Brief, "Disease Management Findings from Leading State Programs" (December 2002):

http://www.statecoverage.net/pdf/issuebrief1202.pdf

State Coverage Initiatives Issue Brief: "Medicaid Disease Management: Seeking to Reduce Spending by Promoting Health" (August 2001):

http://statecoverage.net/pdf/issuebrief0801.pdf

American College of Physicians Online: "What Will It Take to Improve Chronic Care?"

http://www.acponline.org/journals/ecp/augsep98/cdm.htm

National Governors' Association reports:

http://www.nga.org/center/topics/1,1188,D_3877,00.html
http://www.nga.org/center/divisions/1,1188,C_ISSUE_BRIEF^D_5177,00.html
http://www.nga.org/cda/files/031403DISEASEMGMT.pdf
http://www.subnet.nga.org/ci/1-aging.html

Robert Wood Johnson Foundation reports:

www.improvingchroniccare.org
http://www.rwjf.org/publications/publicationsPdfs/Advances2_2004.pdf

Agency for Health Care Research and Quality reports:

http://www.ahcpr.gov/research/elderdis.pdf

CDC chronic disease prevention materials:

http://www.cdc.gov/nccdphp/bb_aging/index.htm
http://www.cdc.gov/pcd/

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