

Deloitte.

Medicaid Medical Management:

A Complex Challenge for States

Produced by the
Deloitte Center
for Health Solutions

Audit • Tax • Consulting • Financial Advisory.



The Complexities of Medicaid Medical Management



State governors and legislators face tremendous challenges in managing their Medicaid programs: Enrollments are climbing, costs are soaring, enrollee health problems are more complex and providers who will agree to treat them are rapidly disappearing.

In many states, Medicaid spending is jeopardizing other important budget items – increased pay for teachers, improvements in general services, required compliance with federal mandates, and infrastructure investments to streamline government, to name just a few.

This study by the Deloitte Center for Health Solutions, part of Deloitte LLP, provides a strategic view of one critical aspect of Medicaid oversight that offers savings potential while also improving the quality of health services provided to enrollees – medical management programs.

At its most basic level, Medicaid medical management is the array of programs and services that assure delivery of the right care to the right enrollee the first time, every time. However, as this paper suggests, the design and delivery of health services to Medicaid enrollees can be particularly challenging – enrollees are often irregular users of the system; their diagnoses are frequently complicated by risk factors and social issues that render treatment plans ineffective, and in many states doctors and hospitals are simply unwilling to treat them due to liability concerns.

Effective medical management for the Medicaid population is a daunting challenge to overcome, especially if providers believe the Medicaid fee structure is unappealing. State governments will need to focus on addressing the program's cost issues while striving to provide high-quality health services for recipients.

A handwritten signature in black ink that reads "Paul H. Keckley". The signature is fluid and cursive, with a long, sweeping tail that loops back under the name.

Paul H. Keckley, Ph.D.
Executive Director
Deloitte Center for Health Solutions

Addressing an Urgent, Daunting Challenge

The effective management of their Medicaid program is a burning platform issue for state governments. Left unchecked, rising Medicaid costs will likely divert investments in education, general services, infrastructure and employee compensation. It also is a politically charged issue – policymakers understand their obligations to the program and its recipients, but identifying solutions that balance reduced cost and appropriate care is difficult.

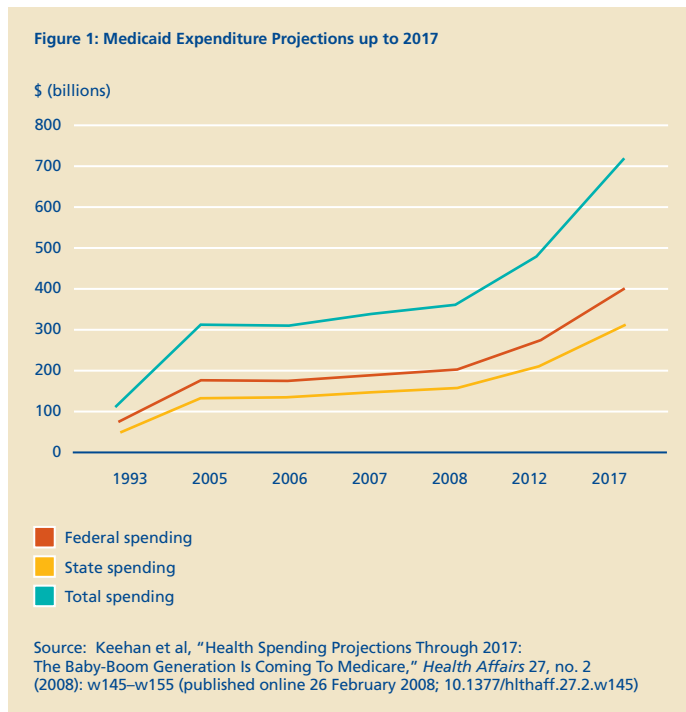


Glossary

- **Care Coordination** – For patients with a medically complex condition, care coordination is an approach to care management where proactive methods are used to help the patient optimize health outcomes and reduce risks of future complications.
- **Deficit Reduction Act (DRA) of 2005** – Permitted states to replace existing Medicaid benefits with “benchmark” coverage, including coverage for affected populations.
 - States permitted parents with disabled children to “buy-in” to Medicaid for children if family income was below 300 percent of the Federal Poverty Level (FPL).
 - Secretary can establish demonstration programs for Health Opportunity Accounts (HOAs) for up to 10 states over five years.
 - States can offer home- and community-based services for the elderly and disabled as an optional benefit instead of requiring a waiver.
- **Dual Eligible** – An enrollee who qualifies for both Medicare and Medicaid.
- **Early Periodic Screening, Diagnosis, and Treatment (EPSDT)** – All necessary medical, dental and behavioral benefits for children from birth through 20 years. There are two components: periodic screening exams and inter-periodic visits (all other health care visits).
- **Formulary Design** – A compilation of approved pharmaceuticals that reflects the current clinical judgment of the organization’s medical staff. It is used to rationalize the pharmacy benefit design so that clinically efficacious and cost-effective medications are encouraged for use by participating providers.
- **Medical Home** – Not a facility; rather, a team approach to providing health care. A medical home originates in a primary health care setting that is family-centered and compassionate. A partnership develops between the family and the primary health care practitioner. Together they access all medical and non-medical services needed by the child and family to achieve maximum potential. The medical home maintains a centralized, comprehensive record of all health-related services to promote continuity of care.
- **Medication Management Programs** – Programs to help ensure safe and proper medication use by Part D enrollees who have multiple chronic diseases (namely asthma and diabetes mellitus), take multiple Part D drugs, and are likely to incur annual costs for covered Part D drugs that exceed a predetermined level.
- **SCHIP (State Children’s Health Insurance Program)** – Enacted in 1997, SCHIP was the expansion of public health insurance coverage to more than 6.1 million children in low-income families whose income exceeds Medicaid income eligibility limits.
- **Section 1115 Waiver** – Provides a mechanism for states to use federal funds in ways that do not conform to federal standards. These waivers have been used throughout Medicaid program history to demonstrate new ways to provide coverage and deliver services to the low-income population.

Three trends suggest that urgent attention to state Medicaid programs is warranted:

- *Unsustainable Spending Patterns*
 - Medicaid, at ~22 percent, is the single largest expense category in state fiscal budgets.¹
 - Total Medicaid spending is projected to reach ~\$670 billion by 2015, doubling from 2007 levels, with states paying ~\$300 billion (Figure 1).²



- Medicaid costs are expected to continue eroding state budgets,³ with an estimated 25 percent of these budgets going toward funding the state's portion in 2010. In fiscal year 2006, the federal government's contribution to Medicaid decreased, resulting in an even larger contribution for states.⁴ Federal contributions also decreased from 2006 to 2008 (Figure 2):



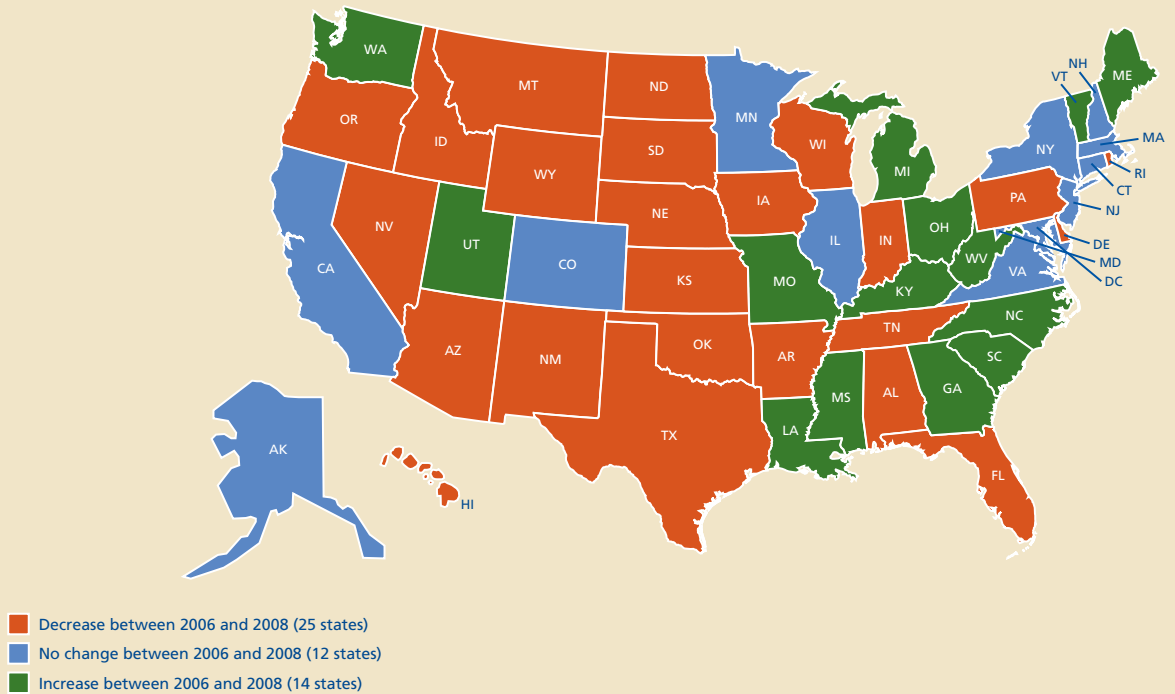
¹ <http://www.nga.org/Files/pdf/0801STIMULUSINFORMATION.PDF>

² Borger et al, "Health Spending Projections Through 2015: Changes On The Horizon," *Health Affairs* 25 (2006): w61-w73

³ National Association of State Budget Officers, *State Expenditure Reports*, 2005 and earlier reports; 2010 percentages projected by HMA.

⁴ "Why Did Medicaid Spending Decline in 2006? A Detailed Look at Program Spending and Enrollment, 2000-2006," <http://www.kff.org/medicaid/7697.cfm>

Figure 2: Half of States Experienced a Reduced Federal Medical Assistance Percentages (FMAP) from 2006 to 2008



Source: <http://aspe.06.dhhs.gov/health/fmap/htm>

- A worsening economy and depressed real estate valuations that are expected to decrease state sales tax receipts and real estate assessments will exacerbate state fiscal problems. Simultaneously, a burgeoning federal deficit will also result in fewer funds available for Medicaid. Unlike the federal government, most states are compelled by law to balance their budgets every year; Medicaid will have to compete with other state programs – particularly education – for funding. Despite its rising costs, states find that cutting Medicaid can be painful as it means losing some federal matching funds, a loss of \$1 to \$3 for every state dollar saved.
- **Growing Enrollment**
 - The number of Medicaid beneficiaries is likely to boom. The elderly and disabled populations currently contribute 76 percent of the growth in Medicaid spending,⁵ and their numbers will increase substantially with the aging of the country's Baby Boomers.
 - Medicaid temporarily bumped tens of thousands of qualified people from the program in 2006 because Congress imposed tougher proof-of-citizenship requirements. Now, the application backlog is being cleared, and Medicaid is making retroactive payments for medical costs incurred then. If the issue of illegal immigration is not addressed, expect to see Medicaid's ranks swell further.
 - Amid escalating health costs and insurance premiums, the nation is seeing continued declines in employer-sponsored health insurance and the increased inability of individuals to afford private insurance, both of which shift more consumers to Medicaid. Unfortunately, the current economic slowdown will only worsen this situation as unemployment increases and employers focus even more on cutting costs (i.e., benefits and employees).
- **Increased Concerns about Quality of Care**
 - According to a Commonwealth Fund survey, 42 percent of U.S. adults report receiving inefficient/poorly coordinated/unsafe care in the past two years. For Medicaid enrollees, the gap is even wider.⁶
 - As Figure 3 indicates, the *State of Healthcare NCQA 2007 Study* reported that Medicaid lags the commercial sector in every care effectiveness and patient satisfaction measure dating back to the study's origin in 2000. In some cases, the quality of care provided to Medicaid enrollees is as much as 30 percent below that provided to commercial enrollees.⁷

⁵ Kaiser Commission on Medicaid and the Uninsured and Urban Institute, 2007; estimates based on data from HCFA Financial Management Reports, 2006 (HCFA-64/CMS-64), MSIS and KCMU

⁶ http://www.commonwealthfund.org/newsroom/newsroom_show.htm?doc_id=394529

⁷ http://www.ncqa.org/Portals/0/Publications/Resource%20Library/SOHC/SOHC_07.pdf

Figure 3: Examples of NCQA's Comparison of Commercial and Medicaid Plans' Performance

Adolescent Immunization Status
Combination 2: Trends, 1998-2006

| Year | Commercial | Medicaid |
|------|------------|----------|
| 2006 | 57.7 | 51.2 |
| 2005 | 53.7 | 42.4 |
| 2004 | 46.9 | 38.1 |
| 2003 | 41.6 | 33.9 |
| 2002 | 31.2 | 24.8 |
| 2001 | 24.8 | 18.6 |
| 2000 | 18.4 | 13.2 |
| 1999 | 13.9 | N/A |
| 1998 | 10.5 | N/A |

Appropriate Testing for Children with Pharyngitis
Trends, 2003-2006

| Year | Commercial | Medicaid |
|------|------------|----------|
| 2006 | 72.7 | 56.0 |
| 2005 | 69.7 | 52.0 |
| 2004 | 72.6 | 54.4 |
| 2003 | 70.7 | 53.8 |

Rating of Health Care: 8, 9, or 10
Trends, 1998-2006

| Year | Commercial | Medicare | Medicaid |
|------|------------|----------|----------|
| 2006 | 73.6 | N/A | 65.6 |
| 2005 | 78.0 | N/A | 72.8 |
| 2004 | 77.6 | N/A | 72.9 |
| 2003 | 76.3 | N/A | 72.1 |
| 2002 | 75.1 | N/A | 71.6 |
| 2001 | 73.2 | N/A | 71.3 |
| 2000 | 72.0 | N/A | 70.0 |
| 1999 | 70.2 | N/A | N/A |
| 1998 | 70.3 | N/A | N/A |

Getting Needed Care: Respondents
Answering "Usually" or "Always"
Trends, 1999-2006

| Year | Commercial | Medicare | Medicaid |
|------|------------|----------|----------|
| 2006 | 84.2 | N/A | 74.2 |
| 2005 | 80.2 | N/A | 73.9 |
| 2004 | 79.4 | N/A | 74.1 |
| 2003 | 78.4 | N/A | 72.1 |
| 2002 | 76.9 | N/A | 72.4 |
| 2001 | 76.7 | N/A | 75.5 |
| 2000 | 75.4 | N/A | 74.2 |
| 1999 | 74.0 | N/A | N/A |

Source: http://www.ncqa.org/Portals/0/Publications/Resource%20Library/SOHC/SOHC_07.pdf

- The Healthcare Effectiveness Data and Information Set (HEDIS) measures captured by the National Committee for Quality Assurance for reporting health plan quality reflect a similar gap: Of the 83 measures, the quality of care provided in Medicaid plans lags all but 14. Also, the gap is wide (Figure 4).

Figure 4: Examples of NCQA's Comparison of Commercial and Medicaid Plans' HEDIS Performance

Hedis Effective of Care Measures

National Averages –2006

| Measure | Commercial | Medicare | Medicaid |
|---|------------|----------|----------|
| Adolescent Immunization Status – Hepatitis B | 74.6 | N/A | 71.1 |
| Adolescent Immunization Status – MMR | 78.8 | N/A | 75.4 |
| Adolescent Immunization Status – VZV | 63.1 | N/A | 57.4 |
| Adolescent Immunization Status – Combo 2 | 57.7 | N/A | 51.2 |
| Ann. Monitoring for Persistent Med. – Ace inhibitors/ARBs | 74.8 | 79.5 | 79.9 |
| Ann. Monitoring for Persistent Med. – Digoxin | 77.3 | 81.7 | 83.0 |
| Ann. Monitoring for Persistent Med. – Diuretics | 74.4 | 79.1 | 79.1 |
| Ann. Monitoring for Persistent Med. – Anticonvulsants | 59.4 | 59.3 | 63.6 |
| Ann. Monitoring for Persistent Med. – Combined | 74.3 | 76.4 | 77.7 |
| Antidepressant Medication Management – Contacts | 20.0 | 11.4 | 21.3 |
| Antidepressant Medication Management – Acute Phase | 61.1 | 58.2 | 42.9 |
| Antidepressant Medication Management – Continuation Phase | 45.1 | 41.0 | 27.5 |
| Appropriate Testing for Children with Pharyngitis | 72.7 | N/A | 56.0 |
| Appropriate Treatment for Children with a URI | 82.8 | N/A | 83.4 |
| Beta-Blocker Treatment After a Heart Attack | 97.7 | 93.7 | 88.4 |
| Beta-Blocker Persistence After a Heart Attack | 72.5 | 69.6 | 68.1 |
| Breast Cancer Screening | 68.9 | 69.5 | 49.1 |
| Cervical Cancer Screening | 81.0 | N/A | 65.7 |
| Childhood Immunization Status – Combo 2 | 79.8 | N/A | 73.4 |
| Childhood Immunization Status – Combo 3 | 65.6 | N/A | 60.9 |
| Childhood Immunization Status – DTaP/DT | 87.2 | N/A | 79.3 |
| Childhood Immunization Status – IPV/OPV | 91.5 | N/A | 87.9 |
| Childhood Immunization Status – MMR | 93.6 | N/A | 91.1 |
| Childhood Immunization Status – Hib | 93.5 | N/A | 89.1 |
| Childhood Immunization Status – Hepatitis B | 91.1 | N/A | 88.4 |
| Childhood Immunization Status – VZV | 90.9 | N/A | 88.9 |
| Childhood Immunization Status – Pneumococcal conjugate | 72.6 | N/A | 68.3 |
| Chlamydia Screening – 16-20 Years | 36.2 | N/A | 38.0 |
| Chlamydia Screening – 21-25 Years | 38.0 | N/A | 55.0 |
| Cholesterol Manage. for Cardiovascular Cond. – Screening | 87.5 | 88.0 | 75.5 |
| Cholesterol Manage. for Cardiovascular Cond. – Control | 56.6 | 56.0 | 35.5 |
| Colorectal Cancer Screening | 54.5 | 53.3 | N/A |
| Comprehensive Diabetes Care – HbA1c Testing | 87.5 | 87.2 | 78.0 |
| Comprehensive Diabetes Care –Poor HbA1c Control* | 29.6 | 27.3 | 48.7 |

*Lower rates are better for this measure.

Hedis Effective of Care Measures

National Averages –2006

| Measure | Commercial | Medicare | Medicaid |
|---|------------|----------|----------|
| Comprehensive Diabetes Care – Good HbA1c Control | 41.8 | 45.9 | 30.2 |
| Comprehensive Diabetes Care – Eye Exam | 54.7 | 62.3 | 51.4 |
| Comprehensive Diabetes Care – LDL-C Screening | 83.4 | 84.8 | 71.1 |
| Comprehensive Diabetes Care – LDL-C Control (<100 | 43.0 | 46.9 | 30.6 |
| Comprehensive Diabetes Care – Monitoring Nephropathy | 79.7 | 85.4 | 74.6 |
| Comprehensive Diabetes Care – Blood Pressure (<130/80) | 29.9 | 30.2 | 30.4 |
| Comprehensive Diabetes Care – Blood Pressure (<140/90) | 61.4 | 57.8 | 57.3 |
| Controlling High Blood Pressure | 59.7 | 56.8 | 53.1 |
| DMARD Therapy in Rheumatoid Arthritis | 84.8 | 68.2 | 67.6 |
| Flu Shots for Adults | 45.6 | N/A | N/A |
| Follow-up After Hospitalization for Mental Illness – 7 Days | 56.7 | 36.5 | 39.1 |
| Follow-up After Hospitalization for Mental Illness – 30 Days | 75.8 | 55.8 | 57.7 |
| Follow-up for Children w/ADHD Medication – Initiation | 33.0 | N/A | 31.8 |
| Glaucoma Screening for Older Adults | N/A | 62.2 | N/A |
| Imaging Studies for Low Back Pain | 73.9 | N/A | 78.3 |
| Inappropriate Treatment for Adults with Acute Bronchitis | 71.3 | N/A | 72.0 |
| Init./Engage Alcohol/Drug Dep. Treatment – Initiation | 43.2 | 50.3 | 43.3 |
| Init./Engage Alcohol/Drug Dep. Treatment – Engagement | 13.8 | 4.5 | 11.7 |
| Medical Assistance w/Smoking Cessation – Advising to Quit | 73.8 | N/A | 68.2 |
| Medical Assistance w/Smoking Cessation – Discuss Meds | 43.9 | N/A | 35.1 |
| Medical Assistance w/Smoking Cessation – Discuss Strategy | 43.2 | N/A | 36.7 |
| Osteoporosis Management in Women Who Had a Fracture | N/A | 21.8 | N/A |
| Potentially Harmful Drug-Disease Interactions in Elderly* Falls + Tricyclic Antidepressant, antipsychotic or sleep agents | N/A | 14.6 | N/A |
| Potentially Harmful Drug-Disease Interactions in Elderly* Dementia + Tricyclic Antidepressant, antipsychotic or sleep agents | N/A | 24.6 | N/A |
| Potentially Harmful Drug-Disease Interactions in Elderly Chronic renal failure + NSAIDS | N/A | 9.5 | N/A |
| Potentially Harmful Drug-Disease Interactions in Elderly – Total* | N/A | 19.4 | N/A |
| Prenatal and Postpartum Care – Timeliness of Prenatal Care | 90.6 | N/A | 81.2 |
| Prenatal and Postpartum Care – Postpartum Care | 79.9 | N/A | 59.1 |
| Use of Appropriate Medications for Asthma – 5-9 Years | 96.4 | N/A | 89.6 |
| Use of Appropriate Medications for Asthma – 10-17 Years | 92.9 | N/A | 87.0 |
| Use of Appropriate Medications for Asthma – 18-56 Years | 90.3 | N/A | 84.7 |
| Use of Appropriate Medications for Asthma – Combined | 91.6 | N/A | 87.1 |
| Use of High Risk Medications in the Elderly – One Drug* | N/A | 23.1 | N/A |
| Use of High Risk Medications in the Elderly – 2 or More Drugs* | N/A | 5.9 | N/A |
| Use of Spirometry in Assessment and Diagnosis of COPD | 36.1 | 26.2 | 27.3 |

*Lower rates are better for this measure.

Source: http://www.ncqa.org/Portals/0/Publications/Resource%20Library/SOHC/SOHC_07.pdf



– A study in the *Annals of Internal Medicine*⁸ reports that the quality of care provided to individuals is associated with their insurance coverage: Medicaid coverage was associated with inferior care compared to commercial coverage. According to the study, Medicaid patients with non-ST segment elevation acute coronary syndromes (NSTSE ACS) were less likely to receive evidence-based therapies and had worse outcomes (including increased mortality rates) than patients who had private insurance as their primary payor. Even after adjusting for clinical characteristics (associated illness), socioeconomic factors (education and income), and the type of center where patients received treatment, this study found that differences in care and outcomes persisted. Moreover, the data also showed that Medicaid beneficiaries face more difficulties scheduling adequate and timely follow-up care after initial treatment of an illness than those with private insurance.⁹

Other studies have documented that children with Medicaid coverage have poorer quality and timeliness of care.^{10 11 12 13} Bratton, et al,¹⁴ found that children with Medicaid had a significantly higher chance of complications related to the diagnosis and treatment of appendicitis. Newacheck, et al,^{15 16} showed that lack of insurance is associated with lack of access to timely pediatric care. Skaggs, et al,¹⁷ comparing MediCal to private-insurance scenarios, reported limited access to a timely orthopedic appointment for a hypothetical child with a broken arm. In another report, Skaggs, et al,¹⁸ identified six children with MediCal who had a delayed diagnosis of Slipped Capital Femoral Epiphysis.

Politically, Medicaid is a spotlight issue for state governors and legislators. In most cases, the tough, fiscally responsible choices that have to be made are unpopular. Perhaps the most perplexing of the three trends is the quality chasm – if a state has the fiduciary responsibility to provide appropriate care to Medicaid enrollees and persistent gaps exist, there is significant potential for liability and substantial political pressure to improve the quality of the program. This is a daunting challenge.

⁸ James E. Calvin, Matthew T. Roe, Anita Y. Chen, et al, "Insurance Coverage and Care of Patients with Non-ST Segment Elevation Acute Coronary Syndrome," *Annals of Internal Medicine*, (Nov. 21, 2006) 145 (10): 739-748

⁹ Lindsey Tanner, "Study Says Uninsured Lack Follow-Up Care," Associated Press, September 13, 2005

¹⁰ Bratton SL, Haberkern CM, Waldhausen JH. Acute appendicitis risks of complications: age and Medicaid insurance. *Pediatrics*.2000; 106 :75 –78

¹¹ Newacheck PW, Hughes DC, Hung YY, Wong S, Stoddard JJ. "The unmet health needs of America's children," *Pediatrics*.2000; 105 :989 –997

¹² Newacheck PW, Stoddard JJ, Hughes DC. "Health insurance and access to primary care for children," *N Engl J Med*.1998; 338 :513 –519

¹³ Skaggs DL, Clemens SM, Vitale MG, Femino JD, Kay, RM. "Access to orthopedic care for children with Medicaid versus private insurance in California," *Pediatrics*.2001; 107 :1405 –1408

¹⁴ Bratton SL, Haberkern CM, Waldhausen JH. "Acute appendicitis risks of complications: age and Medicaid insurance," *Pediatrics*.2000; 106 :75 –78

¹⁵ Newacheck PW, Hughes DC, Hung YY, Wong S, Stoddard JJ. "The unmet health needs of America's children," *Pediatrics*.2000; 105 :989 –997

¹⁶ Newacheck PW, Stoddard JJ, Hughes DC. "Health insurance and access to primary care for children," *N Engl J Med*.1998; 338 :513 –519

¹⁷ Skaggs DL, Clemens SM, Vitale MG, Femino JD, Kay, RM. "Access to orthopedic care for children with Medicaid versus private insurance in California," *Pediatrics*.2001; 107 :1405 –1408

¹⁸ Skaggs DL, Ashok RK, Vitale MG, Pfiefer C, Baird G, Femino D, Kay RM. "Quality of evaluation and management of children requiring timely orthopedic surgery before admission to a tertiary pediatric facility," *J Pediatr Orthop*.2002; 22 :265 –267

Medicaid: An Expanding Program¹⁹

Medicaid is a \$340 billion program that covers 62 million Americans (Figure 5).²⁰ It began as an entitlement program – Title XIX of the Social Security Act, signed into law July 30, 1965 – to provide health care services to low-income children deprived of parental support, their caretaker relatives, the elderly, the blind, and individuals with disabilities. Seniors were identified as the population group most likely to be living in poverty; about half had insurance coverage.²¹

Figure 5: Populations in Medicaid

Medicaid enrollment: Of the 62 million covered...

- 30 million are children, including 1.5 million newborns
- 16 million are adults
- 10 million are adults with diabetes
- 6 million are dual eligibles (Medicare enrollees who are poor)

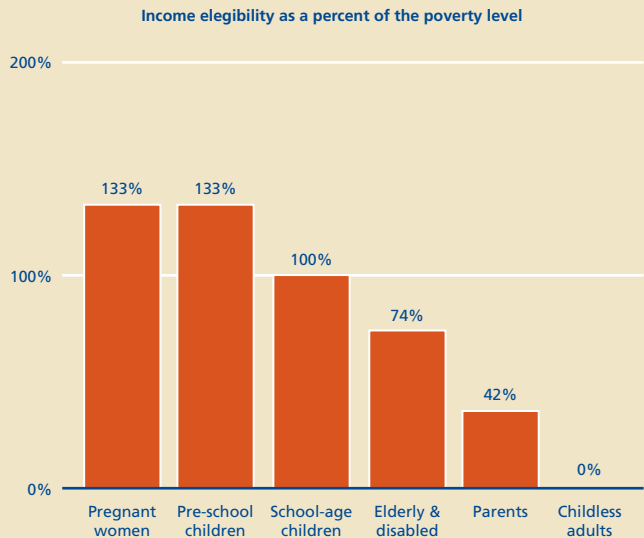
Source: NASBO, *State Expenditure Report*, Kaiser Family Foundation, 2008

Since its inception, Medicaid coverage has expanded to include:

- Mandatory services; physician, midwife and certified nurse practitioner services; laboratory and x-ray; Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services for <21 year-olds; family physician services and supplies; and rural health clinic and federally qualified health center services.
- Additionally,
 - Freedom-of-choice waivers (1915b) and home- and community-based waivers (1915c) were established; states were required to provide additional payments to hospitals treating a disproportionate share of low-income patients (i.e., DSH hospitals). The advent of waivers gave states flexibility to be creative with Medicaid benefit design to target state-specific issues among their populations.
 - Pregnant women and child care up to age 18 were established as a state option.
 - Medicaid prescription drug rebate programs were established.

- The State Children’s Health Insurance Program (SCHIP) was created, providing states with flexibility to cover children in families with incomes above Medicaid eligibility levels. (See percentages >100% in Figure 6, which indicate eligibility is higher than federally defined poverty levels.)

Figure 6: Minimum Medicaid Eligibility Levels, 2006



Source: <http://www.kff.org/medicaid/upload/7492.pdf>

- Medicaid provides unique coverage²² for dual-eligible benefits not covered by Medicare. These include long-term care (including nursing homes), dental, and vision care.
- States also have the option of covering additional services using federal matching funds. Commonly covered optional services include prescriptions, clinic services, prosthetic devices, hearing aids, dental care, and intermediate care facilities for the mentally retarded (ICF/MR). The majority of state spending on optional services goes toward elderly and disabled beneficiaries.

¹⁹ <http://www.cms.hhs.gov/History/Downloads/CMSProgramKeyMilestones.pdf>

²⁰ <http://www.medicaidforeducation.org/pdf/VSmith-NAME-26Sept2007.pdf>

²¹ <http://www.cms.hhs.gov/History/Downloads/CMSProgramKeyMilestones.pdf> ²² <http://www.kaiseredu.org/tutorials/Duals/Duals.html>

²² <http://www.kaiseredu.org/tutorials/Duals/Duals.html>

Medical Management: A New Medicaid Challenge

In commercially insured populations, health plans typically employ a cadre of medical management tools to address enrollees' health problems. The array of programs ranges from services targeting those in good health to offerings for individuals requiring significant support (Figure 7).

Figure 7: Medical Management: Representative Activities

Activities performed on behalf of sponsors and members in conjunction with providers to ensure that the appropriate people receive the highest quality of care in the appropriate setting at the right time



© 2008 Deloitte Development LLC. All rights reserved.

In Medicaid populations, however, the use of medical management programs is complicated by social and environmental factors that make routine interactions between providers and enrollees more difficult. Furthermore, the health status of both child and adult Medicaid enrollees is lower than in commercial populations, making medical management more problematic (Figure 8).

Figure 8: Medicaid Demographics, Education Levels and Ethnicities

| Cohort | Child Medicaid | Child commercial | Cohort | Adult Medicaid | Adult commercial |
|-----------------------------|----------------|------------------|-----------------------------|----------------|------------------|
| Totals | 83,752 | 53,447 | | 82,807 | 276,710 |
| Child Health | | | Adult Health | | |
| Excellent | 41% | 50% | Excellent | 13% | 18% |
| Very Good | 32% | 35% | Very Good | 22% | 40% |
| Good | 20% | 12% | Good | 30% | 32% |
| Fair | 6% | 2% | Fair | 23% | 8% |
| Poor | 1% | 0% | Poor | 9% | 1% |
| Child Age | | | | | |
| 0-3 | 32% | 21% | | N/A | N/A |
| 4-6 | 21% | 23% | | | |
| 7-13 | 40% | 54% | | | |
| Parent Age | | | Adult Age | | |
| <18 | 5% | 2% | <18 | 21% | 5% |
| 18-24 | 14% | 3% | 18-24 | 26% | 16% |
| 25-34 | 35% | 30% | 25-34 | 25% | 27% |
| 35-44 | 27% | 49% | 35-44 | 16% | 30% |
| 45-54 | 11% | 13% | 45-54 | 12% | 21% |
| 55-64 | 4% | 2% | 55-64 | | |
| Parent Education | | | Adult Education | | |
| <8th grade | 8% | 1% | <8th grade | 9% | 1% |
| high school | 34% | 21% | high school | 38% | 26% |
| some college | 27% | 36% | some college | 25% | 34% |
| College | 4% | 21% | College | 3% | 17% |
| Graduate | 2% | 18% | Graduate | 1% | 17% |
| Parent Gender | | | Adult Gender | | |
| Female | 86% | 76% | Female | 71% | 61% |
| Male | 7% | 23% | Male | 21% | 38% |
| Child Gender | | | | | |
| Girl | 47% | 47% | | N/A | |
| Boy | 50% | 50% | | | |
| Child Race/Ethnicity | | | Adult Race/Ethnicity | | |
| Caucasian | 43% | 72% | Caucasian | 45% | 76% |
| Black | 20% | 10% | Black | 20% | 8% |
| Hispanic | 27% | 9% | Hispanic | 16% | 8% |
| American Indian | 2% | 1% | American Indian | 3% | 1% |
| Asian | 3% | 5% | Asian | 8% | 4% |
| Race missing | 4% | 2% | Race missing | 8% | 3% |

Source: Minah Kang Kim; "Comparison of patient experiences in Medicaid and commercial health plans," *International Review of Public Administration*, 2006, Vol. 11, No. 1

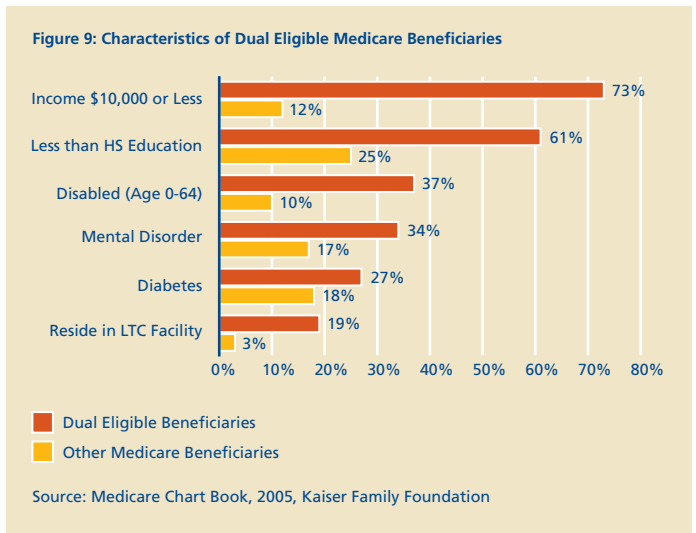
There are at least four notable characteristics of the Medicaid patient population that compound the complexity of their medical management:

- Higher incidence of complicated pregnancy
 - Deliveries account for ~50 percent of Medicaid inpatient discharges²³ and many are high-risk
 - Disproportionate costs for high-risk Medicaid births²⁴ relative to the cost for a normal full term delivery:
 - Preterm delivery at 35 weeks gestation >10x
 - Preterm delivery at 29 weeks is on average >100x.
- Higher incidence of multiple chronic conditions
 - 80 percent of Medicaid expenditures are incurred for treating chronic conditions
 - 48 percent of people with chronic conditions have more than one chronic illness²⁵
 - 70.8 percent of Medicaid enrollees report undergoing care for chronic conditions, significantly greater than for the population at large (36.2 percent) and those with commercial coverage (33.6 percent). Enrollees reported anxiety, stress and depression as the clinical problem 300 percent higher than commercial enrollee counterparts²⁶
 - 13.2 percent reported having four or more co-morbidities vs. six percent in commercial plans.²⁷ On average, an enrollee with four or more conditions receives care from five times the number of physicians compared to someone without a chronic condition.²⁸
 - Top diagnostic pairs among the most costly five percent of Medicaid enrollees:

| Co-morbid condition cluster | Prevalence |
|---------------------------------------|---------------|
| Cardiovascular-Pulmonary | 30.5 percent |
| Cardiovascular-Gastrointestinal | 24.8 percent |
| Cardiovascular-Central Nervous System | 24.8 percent |
| CNS-Pulmonary | 23.8 percent |
| Pulmonary-GI | 23.85 percent |
| Cardiovascular-Psychiatric | 22.0 percent |
| Cardiovascular-Renal | 20.8 percent |
| CNS-GI | 20.7 percent |
| Psychiatric-CNS | 20.7 percent |
| Cardiovascular-Diabetes | 19.2 percent |

Source: http://www.chcs.org/usr_doc/Full_Report_Faces_II.PDF

- Higher need for long-term care (LTC)²⁹
 - Accounts for ~35 percent of Medicaid spending (\$76.5 billion per year)
 - Substantial increase expected in future LTC requirements
 - >65 year olds, ~ 63 percent of current LTC recipients, are increasing in numbers with the aging of Baby Boomers (Note: Population 85 years and older, who almost always require LTC, is predicted to double by 2030 and quadruple by 2050)
 - Less availability of informal family care due to smaller families, higher divorce rates and higher opportunity costs of care-giving.
- High incidence of poor elderly (dual eligibles^{30 31}) (Figure 9):
 - Constitute ~14 percent of Medicaid enrollees but >40 percent of its dollar spending
 - Three times more likely to be disabled
 - 14 percent are 85 years or older
 - 33 percent have impairments in three-to-six Activities of Daily Living
 - 25 percent are institutionalized (versus three percent in non-dual eligibles)
 - Lack of proper support systems: Only a small proportion live with spouses, one-third live with family members and non-relatives while another one-third live alone.



Medical management for the Medicaid population is complex due to recipients' intertwining socio-environmental issues and medical needs. Leading private companies (Centene, Molina, AmeriGroup, and others) that manage state Medicaid programs frequently call attention to this complexity in their materials. In Figure 10 (next page), these companies describe the unique aspects of their Medicaid pregnancy support programs that illustrate how they support the socio-economic issues and risk factors of this population.

²³ Stankaitis J, et al; "Reduction in NICU admission rates in a Medicaid managed care program," 2005, 11:166- 172

²⁴ St. John EB, et al, "Cost of neonatal care according to gestational age at birth and survival status," *Am J Obstet Gynecol*, 2000, 182:170-175

²⁵ "Chronic conditions: Making the case for ongoing care," Baltimore, MD: Johns Hopkins University, Partnership for Solutions, December 2002

²⁶ *2008 Survey of Health Consumers*, Deloitte Center for Health Solutions.

²⁷ *Ibid*

²⁸ Adler R, "Health Care Unplugged: The Evolving Role of Wireless Technology," California Health Care Foundation, November 2007

²⁹ Ellen O'Brien, "Long-term care: Understanding Medicaid's role for the elderly and disabled," KCMU, November 2005

³⁰ "Dual eligibles: Medicaid's role for low-income Medicare beneficiaries," KCMU, February 2007

³¹ Dual eligible beneficiaries, Report to the Congress - New approaches in Medicare, June 2004

Figure 10: Medicaid Pregnancy Support Programs

| | |
|---|--|
| <p>Centene http://www.centene.com/corporate/whatwedo</p> | <p>“Centene Corporation (Centene) provides programs and related services to individuals receiving benefits under Medicaid, including the State Children’s Health Insurance Programs (SCHIP) and Supplemental Security Income (SSI). In addition, the Company contracts with other healthcare and commercial organizations to provide specialty services including behavioral health, health management, long-term care, managed vision, nurse triage, pharmacy benefits management and treatment compliance.”</p> <p>Example: Medical Management Program: Start Smart for Your Baby(R) (Start Smart). With this program, Centene is attempting to reduce pregnancy complications, premature deliveries, and infant disease through earlier identification of pregnant members and providing a wide range of educational materials, incentives for members, and innovative techniques to improve communication.</p> <p>A vital component of the Start Smart program is identifying pregnant members as early as possible, as well as completing an assessment of any potential health risks that these members might have. Once identified, pregnant members receive educational materials through a variety of means including mailings, phone contact and in-person visits. Communication techniques have also been initiated to appeal specifically to younger members, including text messaging, an interactive web site (www.startsmartforyourbaby.com), and MP3 players pre-programmed with educational podcasts.</p> <p>High-risk pregnant members without regular access to a telephone may also receive a special cell phone with pre-programmed phone numbers to call their doctors, Centene’s nurse triage line, and their case managers. Finally, special kits containing helpful information and gifts are provided to mothers with babies in the NICU. Centene plans to use a series of centralized and streamlined reports to track, monitor and report on outcomes for members that are enrolled in the Start Smart program.</p> |
| <p>Molina http://www.molinahealthcare.com/common/aboutus.htm</p> | <p>“Molina Healthcare, Inc. is among the most experienced managed healthcare companies serving patients who have traditionally faced barriers to quality healthcare – including individuals covered under Medicaid, the Healthy Families Program, the State Children’s Health Insurance Program (SCHIP) and other government-sponsored health insurance programs.”</p> <p>Example: Medical Management Program: The Motherhood Matters program. This program is designed to help reduce the incidence of premature and low-birth-weight deliveries, and the costly hospitalizations that result from such deliveries. Motherhood Matters is designed to do this by providing early identification of risk factors for potentially low-birth-weight infants and by giving expectant mothers early access to consistent prenatal care.</p> <p>Motherhood Matters attempts to increase healthy behaviors such as good nutrition, smoking and alcohol use cessation, safe physical activity and exercise, and to teach women to identify the signs of potential problems early in their pregnancies.</p> <p>Through a partnership with Pfizer Health Solutions (PHS), Molina’s dedicated care management staff will use PHS’ integrated care management tools and services to identify women with high-risk pregnancies as early as possible. The PHS Pregnancy Program provides Molina’s care managers with 1) an evidence-based screening questionnaire to identify women possessing indicators for a high-risk pregnancy, 2) a system for monitoring women throughout the course of their pregnancy, and 3) health information to support patient self-care and monitoring, healthy behaviors, and preparation for childbirth.</p> <p>Molina’s success is based on the fact that it has focused primarily on the Medicaid and low-income populations, and is committed to case management, member outreach and low-literacy programs.</p> |
| <p>AmeriGroup http://www.amerigroupcorp.com/about/Pages/Home.aspx</p> | <p>“AMERIGROUP Corporation improves healthcare access and quality for the financially vulnerable, seniors and people with disabilities by developing innovative managed health services for the public sector.”</p> <p>Example: Medical Management Program for Pregnancy: The Taking Care of Baby and Me program. This program identifies members via internal reports, claims data on ER visits, inpatient admissions, and office visits; self referrals; and referrals from the 24-hour Nurse Help Line. Questionnaires are administered to identify high-risk pregnancies. Care managers develop a care plan for these patients and contact them monthly to ensure they are receiving the recommended prenatal and postpartum care. The program provides education on postpartum care information and lists of health-related community services. Participants receive gift incentives such as baby care items to encourage them to keep doctor appointments.</p> <p>To maintain a member-centric view and integrate services for members across socioeconomic lines, each member has a case manager who creates a unique care plan attuned to the member’s needs. Screening tools as well as case-finding tools have been developed to help “standardize” and assess a score to each member. From there, diagnostic and social factors are evaluated, which leads to better management of members because the score has a set of issues assigned in a standardized way.</p> |

Source: Web sites indicated in the table

Building an Effective Medicaid Medical Management Program

Interviews with leading health plans and state leaders suggest that “best practices” for Medicaid medical management encompass two major categories:

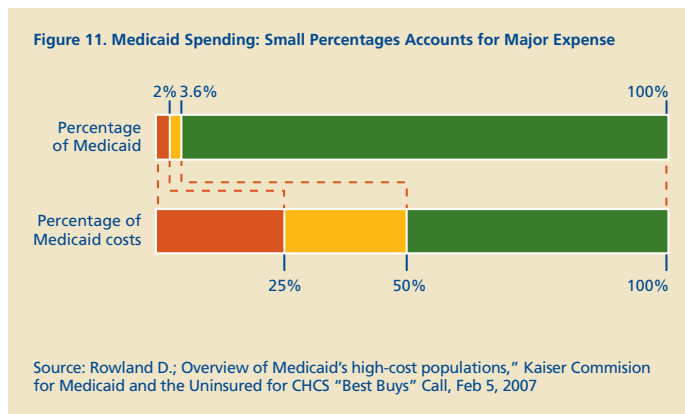
- *Clinical Population Care Management* – How health problems in the Medicaid population are diagnosed, interventions are planned and care is coordinated.
- *Administrative Medical Management* – How states and health plans operate the program to optimize enrollee patient care and satisfaction while reducing costs (i.e., policies, procedures, infrastructure, management).

Clinical Considerations: Population-based Care Management

1. Risk Stratification and Predictive Modeling

The ability to identify, evaluate and appropriately engage an enrollee is challenging, at best, for commercial plans; it can be even more complex for Medicaid enrollees. It is, nonetheless, an essential element of the medical management process.

From the point of entry into the system – whether the patient is enrolled as a result of a hospital or clinic visit or through other means – the medical management program must take inventory of the individual’s medical and social history and assign the appropriate management care team. Typically, a small number of Medicare enrollees represent a disproportionate amount of costs; risk stratification for a “normal” distribution of the state’s enrollees would result in the following breakdown (Figure 11):



The most advanced predictive modeling tools identify and stratify enrollees with a focus on their readiness to change. Common problems in Medicaid data systems are data integrity and faulty coding issues, resulting in false positives and negatives (falsely identifying recipients needing treatment and missing those who need treatment). The use of existing disease registries and decision support systems (e.g., electronic medical records) increases the likelihood that a profile is accurate and actionable by the care team.

Social characteristics of the Medicaid population complicate their profiling: Many are transient; lack transportation, telephones, or Internet access; move in and out of eligibility; may have co-morbid behavioral health issues or cognitive barriers – including difficulties in reading proficiency – making it difficult to find and track them and difficult for them to follow care plans. Some notable efforts to locate and accurately assess enrollees include:

- hiring locators to find people
- giving recipients direct-connect mobile phones
- using videos to convey information
- focusing on programs’ social risk factors:
 - Provide written materials at the third-to-fourth-grade reading level and use more visuals, pictures and larger fonts to address literacy issues and poor eyesight
 - Offer family/caregiver support
 - Address transportation/access issues: consider house calls and transportation pooling for regular check ups
 - Bridge language barriers. Amerigroup translates materials into non-English languages when five percent or more than 50 members (whichever is less) speak a primary non-English language
 - Address cultural/religious barriers
 - Identify motivational levels and readiness to change
 - Extend services temporarily after Medicaid eligibility lapses and remind recipients to renew coverage
 - Use cell phones and Internet for enrollee contact
 - Provide appointment reminder systems.

2. Preventive Health, Screenings and Education

A necessary foundation for Medicaid medical management is a comprehensive program targeting preventive health care and healthy living. Enrollee participation in such a program is particularly important for newborns and their mothers to prevent unwanted pregnancies and complications resulting from unhealthy living conditions, lack of adherence to routine screening and well-baby check-ups, and routine primary care.

³² CMS: Medicare Current Beneficiary Survey (MCBS), 2002 Access to Care File

There is widespread consensus among experts that a Medicaid preventive health program should include, at a minimum, the following:

- Early Periodic Screening, Diagnosis, and Treatment (EPSDT), immunization and preventive health reminder mailers and promotions
- Incentives (financial and non-financial) for physicians and patients. Examples include store gift cards, bus tokens, increased physician reimbursements, etc.
- Missed appointments or referrals tracking
- Collaboration with local state health departments to share information on enrollees
- Health education handouts and web sites on the importance of diet, exercise, smoking cessation, stress management, domestic violence, healthy home, etc., written at the third-to-fourth-grade reading level, different languages, and optional larger font for older populations
- Health risk assessments
- 24-hour nurse hot lines
- Telephone counseling
- Free Weight Watchers sponsorship.

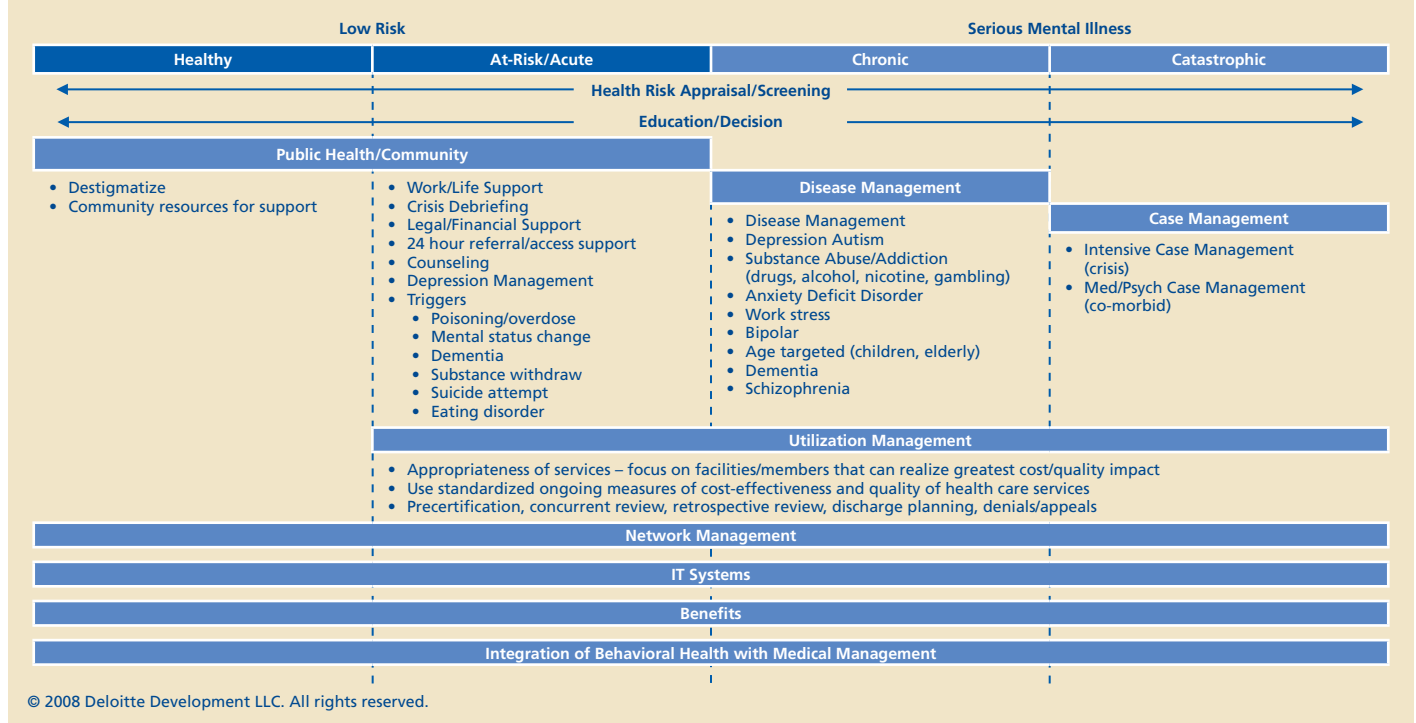
3. Chronic Care Management for Type II Diabetes, Heart Disease, Depression, COPD, Asthma and Other Conditions

Disease management is “a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant.”³³ Disease management (DM) focuses on population management of chronically ill patients, with the goal of slowing disease progression and avoiding costly hospitalizations and complications to reduce medical costs.

The primary populations served by DM programs are patients with high-prevalence/high-cost and actionable conditions such as asthma, diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disorder (COPD), coronary artery disease (CAD), etc. In most programs, a complicating factor is the prevalence of co-morbid behavioral disorders (stress, anxiety, depression, substance abuse) that limit enrollee adherence to a self-care regimen. Common efforts to engage patients in DM programs include:

- *Customized clinical algorithms (guidelines) to assist in diagnosis and treatment planning:* Leading plans develop co-morbid identification algorithms (using evidence-based guidelines) to focus care management efforts on the appropriate sequencing of interventions that will work best. Commonly occurring condition clusters like diabetes+cardiovascular+depression or asthma+COPD+depression (disease triads), are useful in helping clinicians know which condition should be treated as the primary diagnosis, and how best to address secondary diagnoses to optimize outcomes.
- *Special recognition of behavioral health issues:* Medicaid enrollees often have co-morbid conditions that include behavioral (mental health) issues. For example, substance abuse problems are more common in this population than others. Additionally, pregnant Medicaid women have smoking rates that are higher than the population at large (25 percent versus 12 percent in 2000).³⁴ Figure 12 stratifies psychosocial risk for behavioral health integration with medical management. A key strategy in managing chronic illness within the Medicaid population is integrating psychosocial assessments with physical assessments, and integrating behavioral health interventions with treatments for other medical conditions.

Figure 12: Integrated Behavioral Health Management



³³ <http://xnet.kp.org/permanentejournal/spring05/commTOC.html>

³⁴ Helpen H., et al, “Medicaid coverage for tobacco-dependence treatments,” *Health Affairs*, Vol. 5, No. 2, 2006: 550-556

Medicaid Plan in Focus: Blue Cross & Blue Shield of Tennessee

BCBS TN uses predictive modeling to help further stratify the Medicaid population by looking at an impactability index. This identifies which members have gaps in care for prioritizing outreach based on this information.

Member adherence to care plans and provider adherence to clinical guidelines is a new contractual requirement for BCBS TN. Our predictive modeling process gives us the ability to identify gaps in care, which we share with physicians in the plan. Communicating with physicians in our plan is essential.

Our predictive modeling works by looking at five key indicators to total a score:

- (1) Estimated cost for next year
- (2) Preventative gaps in care (i.e., females – pap smear, mammogram)
- (3) Chronic gaps in care (the model can pick up one or more conditions)
- (4) Is a client “impactable”? (Can something be done to help prevent rapid deterioration?)
- (5) Is a client “movable”? (If nothing is done now, will risk increase?)

In the near future, the Medicaid population will present us with more unique challenges. BCBS TN can use these scores for more than live referrals: They also ensure results that both our disease management and case management programs can use to intervene in health care.

Source: Interviews with BCBS TN

4. Case Management for the Frail Elderly, Recently Discharged and Severely Disabled

Case management focuses on the sickest one to five percent of Medicaid enrollees who drive a large portion of controllable costs. A key program element is a one-on-one, nurse-to-enrollee care management model that follows an individualized care plan. Typically, case management enrollees are identified before/after a hospital discharge; the care plan is developed by the hospital's social worker and accounts for social and environmental issues that might complicate care. Some popular features include:

- *Intense interaction via telephone and in-home:* Daily visits augmented by calls are key to program success. To address language and cultural barriers, plans use bilingual and multilingual staff, as well as staff trained for cultural competency.
- *Connected care at home:* Plans provide portable electronic/ telephonic language translation devices for home use (e.g., Cyrhone) which permit simultaneous translation into multiple languages. Additionally, the full array of bio-feedback devices for self-monitoring can be leveraged in Medicaid populations, particularly for dual-eligibles.
- *Transition coordination:* Case-managed patients move routinely through the health system's numerous settings – nursing homes, respite care, etc. Discharge planning is used to transition their care to home and outpatient settings. Standardized surveys and hospital processes are used to arrange resources for home health care following acute inpatient care.

Needed: Integrated Health and Human Services

Too often when one speaks of health and human services, what one really means is health or human services. That's because health care and human services are often funded, administered, managed and delivered separately. Yet, the health care needs of Medicaid populations are often intertwined with, and complicated by, social and environmental factors. This is especially true of high-cost Medicaid enrollees with chronic health conditions, who also frequently report high levels of stress, anxiety and depression, and who engage in such high-risk health behaviors as smoking, over-eating and drinking alcohol to excess.

Because many Medicaid enrollees have both health care and human service needs, they are often concurrently enrolled in, or at the very least interact with, both health care and human service delivery systems. Indeed, over the course of a year, a typical Medicaid enrollee may interact with a local community health clinic and a hospital emergency room, as well as a child care center, a work or education program sponsored by a state's Temporary Assistance to Needy Families (TANF) program, and a local child-support enforcement agency. Yet, the health care systems and the human services systems rarely, if ever, communicate with one another. This results in an inefficient – and ineffective – way of delivering comprehensive, coordinated care, especially to Medicaid enrollees with multiple challenges.

To “cure” this problem, the health care and human service systems must begin communicating and coordinating with each other. One means of achieving this is through health information exchanges (HIEs). Yet, few HIEs currently anticipate including human service delivery organizations, such as child care, local TANF or child support enforcement agencies, within their networks.

Two recent federal developments may spur health care and human service delivery systems to more effectively coordinate and communicate with each other. The first is a recent interim final regulation published by the Center for Medicaid and Medicare Services (CMS) within the U.S. Department of Health and Human Services (HHS). Although controversial, this regulation stipulates, in part, that Medicaid will, henceforth, pay for only a single case manager charged with the development of a coordinated case plan based on a comprehensive assessment of a recipient's health, social, emotional and psychological needs. This regulation will, in effect, force better coordination between health care and human services delivery systems by limiting the ability of both systems to separately bill Medicaid for case management services.

The second development is Medicaid Information Technology Architecture (MITA). Although still in its developmental stage, MITA holds promise for providing states with a funding mechanism for building interfaces between the health care system serving Medicaid enrollees and the human services system which often serves the same population.

Dr. Wade F. Horn, Ph.D.
Former Assistant Secretary
Department of Health and Human Services (HHS)
Director
Deloitte Consulting LLP

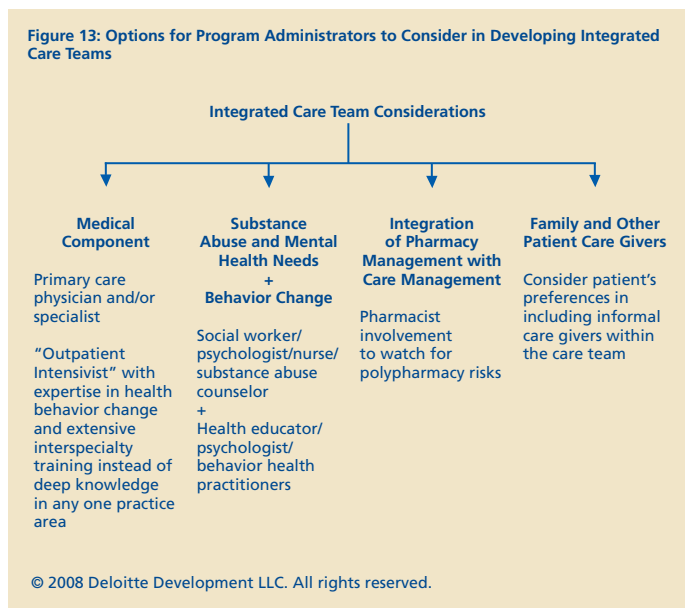
Administrative Considerations in Medicaid Medical Management

Focusing on the administrative elements of Medicaid medical management is essential to a program’s success, as they are the basis for funding requests. Typical elements include:

1. Integrated Care Team Design and Oversight

Medicaid enrollees’ complex medical and psychosocial issues require an integrated team strategy to treat patients. Care teams that include physicians, behavioral health professionals, pharmacists, and family/other patient care givers can motivate and coach participants, collaborate to share ideas, and advocate for participants to identify additional resources to help address their myriad biopsychosocial needs. As enrollees are stratified and their medical needs assessed, it is important to delegate integrated care teams that are appropriate to their health status and potential to adhere to a care plan. Some of the options program administrators must consider are highlighted in Figure 13.

Figure 13: Options for Program Administrators to Consider in Developing Integrated Care Teams



Medicaid Plan in Focus: Amerigroup

We are very “member-centric” in our approach. Each member will have a case manager who assesses their needs. Based on this analysis, different resources are brought into play and we create a unique care plan for that member.

The most efficient way to integrate services for consumers across socioeconomic lines is by examining physical and behavioral [patterns]. We desire to learn more about this; current feedback tells us that including social and support services is crucial. We understand that this will ultimately allow us to be attuned to our member’s needs.

We have developed screening tools as well as case finding tools which help us “standardize” and assess a score to our members. From there, we can look at the diagnostic and social factors. This leads to better management of members because the score has a set of issues assigned in a standardized way. We believe this is the way to manage [health] outcomes.

Source: Interview with Amerigroup

Efforts to promote integrated care team design and oversight can include:

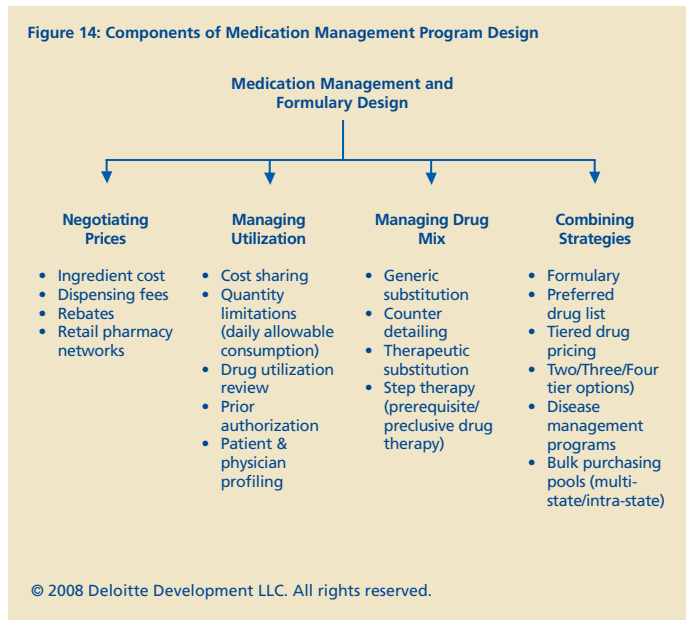
- Using retail clinics in the mix of front-line care providers
- Reporting patient outcomes and adherence by teams rather than by individual clinician
- Using the medical home model to align Medicaid enrollees with designated primary care practices whereby fees are paid for management
- Using a community-based data registry for all enrollees accessible to care teams for data input and results reporting.

2. Medication Management and Formulary Design

As Medicaid enrollees – especially those with chronic conditions – enter the health system, medical management programs focus on changing their behavior in three areas: exercise, nutrition and medication. Of the three areas, Medicaid managers have most control over medication decisions.

The fastest growing expense in most state Medicaid programs is prescription drugs. It is also the area most prone to fraud and abuse. In response, 29 states are currently implementing medication management programs; also, 17 states work with Part D medication therapy monitoring programs to oversee dual eligibles’ pharmacy utilization and clinical outcomes.

An effective medication management program typically includes the following capabilities (Figure 14):



Among specific medication management focus areas are:

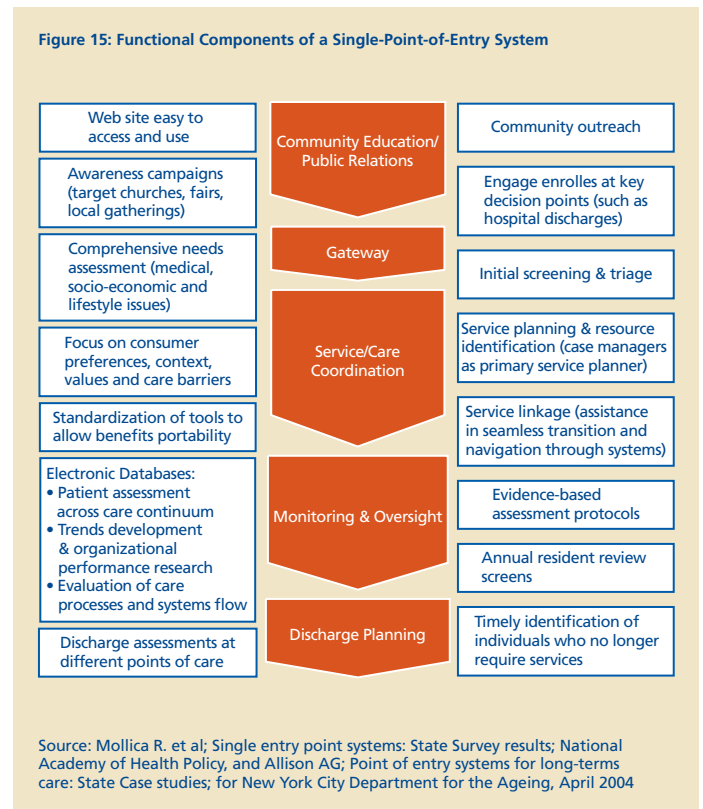
- Programs that target enrollees who have complex medication needs to address polypharmacy risks such as drug contraindications and drug-drug interactions. Such programs review the patient's medication plan and manage it with respect to their medical history and formulary exceptions, and maintain routine drug utilization reviews.
- Pay-for-performance programs and tiered value-based formularies linked to physicians and pharmacists. Formulary adherence bonuses/incentives are built into these programs.
- Home visits by nurse case managers to review the patient's medicine cabinet to ensure use of correct drug combinations and prevent under-/over-medication. Pill-pets and other innovative display technologies can help to improve patient adherence.
- Inclusion of pharmacists in integrated care teams for co-morbid and case managed populations to influence appropriate drug regimens.
- Use of medical experts and evidence-based reviews to create pharmacy policy and utilization management tools:
 - The Drug Effectiveness Review Project (DERP) at the Oregon Health and Science University's Center for Evidence-Based Policy³⁵ helps to guide development of drug comparative effectiveness reviews for specific prescriptions and therapeutic classes in policymaking initiatives.
 - In addition to comparative effectiveness reviews, other information used to develop pharmacy policies can include drug compendia, national experts, local pharmacists and prescribers, and peer-reviewed journal studies.

- E-prescribing pilots and incentives, including HIEs that focus on formulary adherence, avoidance of adverse drug events and feedback to providers about patient medication adherence.
- Alert mechanisms built from master provider and master enrollee systems to detect fraud and abuse by providers and enrollees.

3. Single Point of Entry Systems (SPOE)

The array of Medicaid service choices and funding options has grown dramatically over the years. It can be challenging for enrollees to understand the full range of available options, make informed decisions and coordinate disparate financing and delivery systems on their own, so Medicaid administrators and plans are developing Single Point of Entry Systems (SPOE) capabilities. When leveraged with the Internet, these SPOEs could enhance enrollee engagement and self-care.

A SPOE provides a centralized, trusted, one-stop portal to access all administrative program functions. It provides enrollees with a user-friendly vehicle to learn about available Medicaid services, their eligibility for specific services, and support while selecting their preferred services.³⁶ The SPOE serves as a repository for coverage information, referral and advocacy; a mechanism to learn about and apply for services; and a venue to evaluate and receive service recommendations (Figure 15).³⁷



³⁵ OHSU DERP web site, at <http://www.ohsu.edu/drugeffectiveness/description/index.htm>

³⁶ Mollica R. et al; Single entry point systems: State Survey results; National Academy of Health Policy

³⁷ Reinhard, Susan C. and Scala, Marisa. "Navigating the Long-Term Maze: New Approaches to Information and Assistance in Three States," Institute for the Future of Aging Services, Washington D.C., 2001

Several states and the District of Columbia currently offer a SPOE system for Medicaid enrollees (Figure 16):

Figure 16: Medicaid SPOE Examples

| Single Point of Entry System | Description |
|--|---|
| Wisconsin http://www.dhfs.state.wi.us/ltcare/Generalinfo/rcs.htm | Provides information and assistance regarding public benefits that may be available as well as area programs and services. |
| Oregon http://www.oregon.gov/DHS/index.shtml | Provides centralized information source for needs assessment and eligibility, pre-admission screening, case management and service plan authorization, counseling, adult protective services, and after-hours, on-call support. |
| Massachusetts http://www.mass.gov/?pageID=eohhs2homepage&L=1&LO=Home&id=Eeohhs2 | Provides centralized access, medical eligibility determination, service authorization and case management. |
| Michigan http://www.michigan.gov/mdch/0,1607,7-132-2943_4860---,00.html | Provides centralized access to eligibility determination, information, and assistance programs. |
| Maine http://www.maine.gov/dhhs/index.shtml | Provides centralized access for medical assessments of enrollees and unique issues for each patient enrollee. |
| Washington, D.C. http://www.adrc-tae.org/tiki-index.php?page=ShowCounty&map=11001 | Based on the Wisconsin model. Site streamlines eligibility determination, acts as a central point of data collection and analysis, and provides centralized information and assistance services to long-term-care enrollees. |

Source: Web sites indicated in the table

Some suggest that Medicaid enrollees don't have Internet access, which could reduce use of SPOE systems and other web-enabled medical management tools, but Deloitte's *2008 Survey of Health Care Consumers*³⁸ found that Medicaid enrollees:

- Want their providers to offer online scheduling of appointments (20.9 percent vs. 9.8 percent overall vs. 11.1 percent for commercial plans)
- Are interested in a web site on hospital quality of care (top three response at 58.9 percent vs. ~43 percent for overall and commercial populations)
- Are extremely interested in online health education (29.3 percent vs. 16.4 percent overall vs. 15.2 percent commercial plans, and 17.2 percent Medicare)
- Express similar interest as non-Medicaid enrollees in tools that monitor or manage health, provide personalized health recommendations and help to select alternatives (~30 percent for all cohorts)
- Express similar interest as non-Medicaid enrollees in online physician directories and online claim management (~20 percent for all cohorts)
- Report similar use as non-Medicaid enrollees of an electronic monitoring device (~10 percent for all cohorts), but are more likely to be currently using (25.9 percent vs. 12.8 percent overall vs. 10.2 percent for commercial plans)
- Express similar interest as non-Medicaid enrollees in self home-monitoring devices (~75 percent for all cohorts).

4. Medical Management Information System for Program Management and Quality Control

- To effectively operate their Medicaid medical management programs, medical directors and program coordinators need to know...
 - The numbers and identities of enrollees participating in each medical management program and the degree to which they are participating as directed
 - The numbers and identities of providers participating in the care management programs and the quality of their performance
 - The standards of care (evidence-based guidelines and order sets) that are the basis for the program's coverage and denial policies and procedures
 - The level of adherence of providers to the evidence-based standards of care
 - The costs associated with each encounter: direct encounters with providers, allied professionals and care teams, and indirect encounters associated with their care.

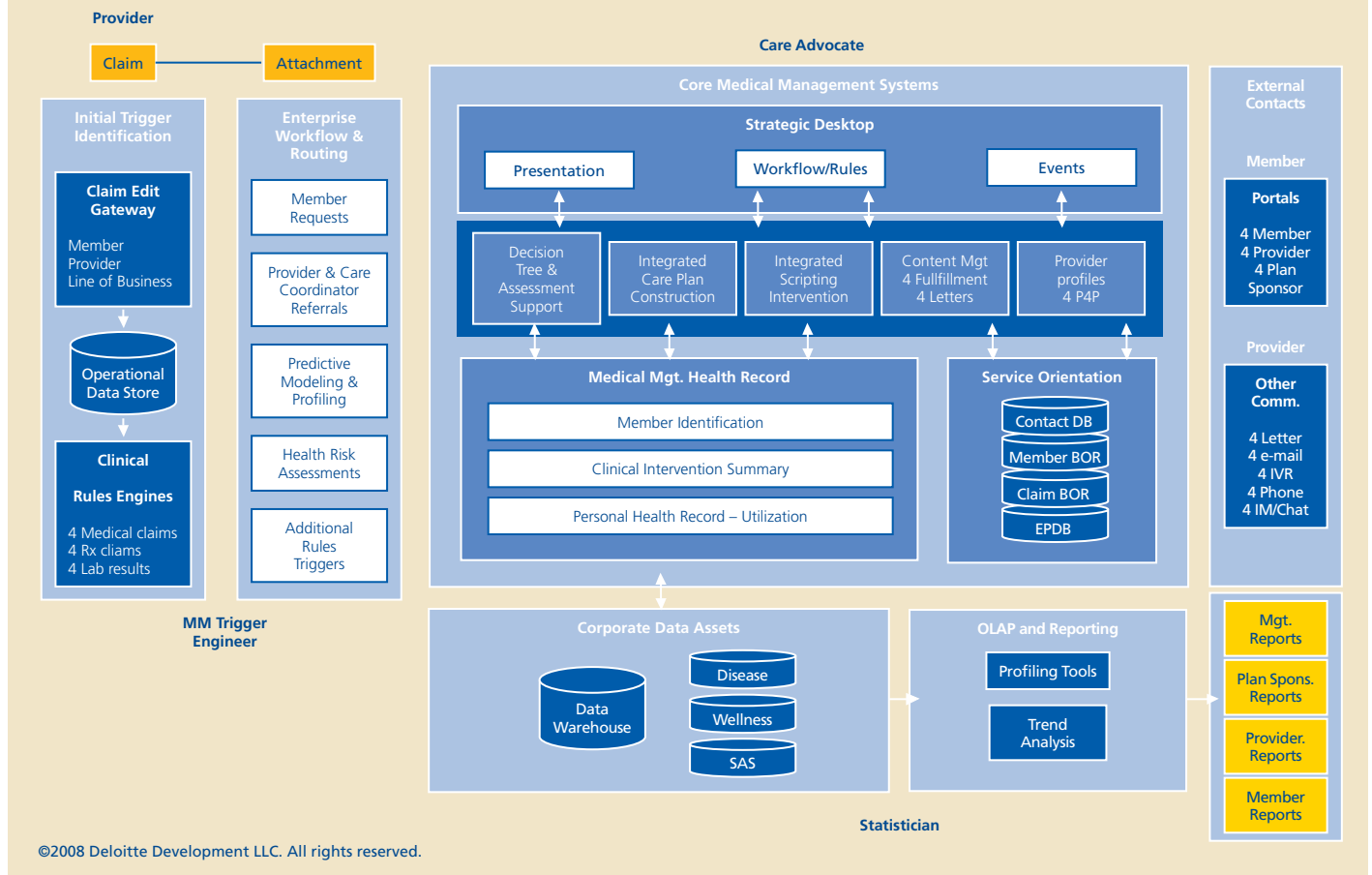
³⁸ 2008 Survey of Health Care Consumers, Deloitte Center for Health Solutions

The most significant investment a Medicaid medical management program makes is in the information technology platform (Figure 17) that permits its operators to navigate the dual challenges of cost and quality for enrollee care management.

An integrated view of all medical management functions across the numerous domains – including initial screening, facility preadmission screening, assessment of functional capacity and service needs, financial eligibility determination, care planning, service authorization, monitoring, and periodic reassessments – is needed to help Medicaid plans and administrators to deliver the medical management programs comprehensively and in an integrated fashion.³⁹

Figure 17: Medical Management Systems

The medical management application solution will be comprised of multiple application components with complex integration requirements



5. Nurse-Staffed Call Centers

Nurse-staffed call centers are essential to Medicaid medical management support operations. These call centers assist in:

- Identifying symptoms or potential concerns that patients may want to discuss with their physicians
- Developing care plans for patients
- Promoting adherence to care plans
- Locating specific resources and information helpful to patients
- Improving patient understanding of preventive health strategies
- Assisting in finding community resources to address social concerns and patient disposition
- Proactively monitoring changes in patient health status to mitigate the need for an acute care readmission or emergency department visit.

Call center staffing levels vary depending on the complexity of patient populations managed and the scope of support services provided. Nurse-staffed call centers are a significant, but necessary operating cost in Medicaid managed care.

6. Integrated Care Program for Dual Eligibles

Dual eligibles constitute the most resource-intensive enrollees in the Medicaid system. In addition, the lack of seamless coordination and responsibility-sharing between Medicare and Medicaid is a common problem. From a fiscal standpoint, this can result in payments to the wrong public program (e.g., payment to Medicaid for services for which Medicare should bear the responsibility), which exacerbates budgetary issues due to inaccurate accounting and duplicative expenditures.

It is unrealistic to expect a dual eligible with low financial means and low education level, who is often disabled, has co-morbid mental disorders and resides in a long-term facility, to navigate the complexities of Medicaid and Medicare. Therefore, more plans are integrating and coordinating their policies for the care of dual eligibles to help streamline and simplify administration. This alignment of policies occurs at several levels: program administration (program guidance, plan review, marketing, enrollment, grievances/appeals), performance evaluation, and plan and provider contracting.

Special program considerations for dual eligibles include:

- Interaction with family members or close friends upon whom the enrollee is dependent
- Understanding their home environment and their preferences for long-term and extended-care options
- Transportation, personal hygiene and nutritional support needs
- More visuals, photos and larger fonts in informational materials due to their limited reading skills and poor eyesight
- Improved communication and coordination among different levels of providers
- Assistance in obtaining durable medical equipment (e.g., wheelchairs and walkers)
- Pharmacy assistance to develop appropriate drug regimens and mitigate polypharmacy risks.

7. Evidence-based Guidelines & Process for Coverage and Denial Management

Accurate coverage and denial decisions are critical for states and Medicaid plans. Plans routinely review their coverage decisions via medical policy and pharmacy P&T committees to make sure that appropriate services are covered and that their clinical information systems reflect these coverage decisions. This coordination requires that plans review and update their coding system at least annually to reflect changes in their covered benefits and formularies. These updates can also enable fraud and abuse systems to better identify suspicious claimant and provider behavior.

Increasingly, Medicaid programs face liability challenges if the standard of care provided to their enrollees falls short of community standards afforded to commercial enrollees. Therefore, the evidence basis for coverage decisions will become increasingly important to medical management programs. It is paramount that community-based health care providers work with Medicaid program medical directors to regularly review and update their evidence-based guidelines. Among the leading sources of guidelines used by states and plans are:

- AHRQ's National Guideline Clearinghouse
- American College of Cardiology/American Heart Association and other physician specialty societies
- American College of Physicians' Clinical Efficacy Assessment Project
- American Dietetic Association
- National Heart Lung Blood Institute
- US Preventative Services Task Force
- Institute for Clinical System Improvement, Healthwise, etc.

8. Provider Services: Credentialing, Payment and Performance Reporting

Even Medicaid medical management programs that have the most advanced information technologies and clinical services can fall short in reducing costs and improving care without adequate provider participation. Doctors, hospitals, allied health professionals and specialized facilities are a critical part of the Medicaid medical management mix. However, there can be major hurdles in establishing and maintaining provider relationships:

- Credentialing providers to serve Medicaid enrollees can be a double-edged sword. Most physicians and allied professionals maintain credentials in good standing, but they also understand that the Medicaid population poses unique challenges: Enrollees require more time at office visits due to social or language issues, providers have less medical history from which to build a diagnosis or care plan, and enrollees are more inclined to sue clinicians than other patients. Most hospitals are accredited and face litigation if they deny care to anyone. Increasingly, however, providers are establishing limits on the numbers of Medicaid enrollees they will accept and, in some communities where laws allow, they have closed their practices to Medicaid altogether.

- A second challenge is payment: Medicaid programs pay clinicians and hospitals less than commercial plans and Medicare.
- Third, providers who participate in Medicaid care management programs are subject to “report cards” and transparency initiatives. In many states and communities, employers and health plans publish results of clinician performance on a myriad of metrics including patient satisfaction, adverse events, infection rates, mortality rates, etc. This can engender provider anxiety.

Medicaid program leaders must address several important questions when building their provider network:

- Since primary care – general internal medicine, pediatrics, obstetrics, gynecology, geriatrics – is central to managing preventive, chronic and long-term care populations, should the primary care network be built around community-based providers or a separate primary care system composed of community health centers, retail clinics or staff model clinics? Can primary care services be accessed adequately given the concerns of community-based clinicians about payment, liability and compliance issues for results reporting?
- Since behavioral disorders are highly prevalent in the Medicaid population and co-morbid with most chronic diagnoses, how should psychiatry and counseling be integrated effectively (mainstreamed) into the primary care setting to improve the likelihood of adherence and improved outcomes?
- Should the Medicaid program use a medical home model and pay-for-performance programs to engage providers (doctors and hospitals) in care management for Medicaid enrollees?
- Should states provide inurement protection from liability for providers who treat enrollees per the evidence-based guidelines overseen by the program? Is a medical court or other mechanism a necessary vehicle to assure providers that they will not be subjected to frivolous lawsuits based on caring for a Medicaid enrollee?
- Should the state invest in and promote use of community-wide HIEs to accelerate adoption of e-prescribing and electronic medical records by providers? Could the state tax code be used to facilitate use of information technologies that improve care, detect fraudulent activity by enrollees and reduce costs?
- Should the state issue an annual report on the quality of care provided to Medicaid enrollees and strive to achieve results paralleling commercial plan performance? How might the state direct efforts to achieve this goal by working with plans, employers and policy-makers?

Key Impact Areas: Medicaid Medical Management

| Clinical Considerations | Administrative Considerations |
|--|--|
| Risk Stratification and Predictive Modeling | Integrated Care Team Design and Oversight |
| Preventive Health, Screenings and Education | Medication Management and Formulary Design |
| Chronic Care Management for Type II Diabetes, Heart Disease, Depression, COPD, Asthma and Other Conditions | Single Point of Entry Systems |
| Case Management for the Frail Elderly, Recently Discharged and Severely Disabled | Medical Management Information System for Program Management and Quality Control |
| | Nurse-Staffed Call Center to Support Medical Management |
| | Integrated Care Program for Dual Eligibles |
| | Evidence-based Guidelines and Process for Coverage and Denial Management |
| | Provider Services: Credentialing, Payment and Performance Reporting |

© 2008 Deloitte Development LLC. All rights reserved.

A Potential Solution for State Medicaid Programs

Medical management of the Medicaid population is a tough business. Treatment approaches typically used with commercially insured populations are complicated by social issues (literacy, transportation, et al), clinical issues (risk factors, co-morbidities, et al) and provider issues (liability, payment, et al). Providers are skeptical; enrollees suspect they get inferior care compared to others; hospitals report that their emergency departments are clogged by enrollees who lack primary care; social activists complain of inequity; and all stakeholders know that the program is costly and problematic.

Successful state Medicaid medical management programs leverage information systems to identify and stratify patient health risk for population segmentation; engage and enroll patients and providers in appropriate care programs; incentivize and promote accountability; and measure results. These programs are led by visionary policy-makers who maintain clinical focus while investing in the administrative structures necessary to optimize cost-effectiveness and quality.

The provision of care drives Medicaid costs. A medical management program can potentially – and favorably – impact these costs. As Medicaid enrollments increase, state budgets tighten, and the public clamors for improved quality, medical management programs will find themselves increasingly in the spotlight.

For the majority of states, Medicaid spending is diverting funding from other worthwhile programs. Adopting technology-enabled approaches to medical management that are uniquely designed to optimize care for the Medicaid enrollee population can reduce costs and improve care. Key considerations and implications for stakeholders are detailed in Figure 18:

Figure 18: Considerations & Implications for Key Stakeholders

| Stakeholder | Key Considerations for Improving Medicaid Medical Management |
|-----------------------------------|--|
| Federal Regulators (HHS) and AHRQ | <ul style="list-style-type: none"> • HHS/AHRQ might sponsor pilot programs focused on innovation in Medicaid medical management. • Section 1115 waivers might be revisited with the inclusion of specified population-based care management outcome goals. • National standards (evidence-based guidelines) for use in states could be developed to reduce inappropriate variation and costs. This could include a national formulary (comparative effectiveness, evidence-based guidelines). • Alternative benefit packages could be developed based on the SCHIP model. This would move beyond the traditional “mandatory” and “optional” populations to: <ul style="list-style-type: none"> – Include flexibility for setting cost sharing amounts and benefit limits – Allow employer buy-in programs – Establish different benefit packages for different populations in different geographies – Eliminate retroactive eligibility periods. • Regulators could consider a medical liability waiver or medical court system to protect providers who follow evidence-based practice guidelines as a means of encouraging access to Medicare and Medicaid enrollees. • Efficacy and effectiveness of care for dual eligibles could be a special focus for innovation and best-practices funding. |
| States | <ul style="list-style-type: none"> • Policy-makers might adopt specific medical management goals and performance guarantees for the Medicaid program and tie provider incentives to outcomes for pay-for-performance programs. • States could invest in a medical management technology platform to be funded through projected long-term savings from improved care, adherence to care management efforts, etc. • States might innovate in the structuring of primary care networks that incorporate alternative models (e.g., federally qualified health centers, community mental health centers, retail clinics, et al). • States could encourage the creation of SPOE systems for enrollees • States could use tax incentives to promote local providers’ investments in and use of electronic medical record and e-prescribing. • States could promote HIEs that feature e-prescribing for use in public-private collaborative models. • States might consider outsourcing certain aspects of medical management to commercial plans that specialize in Medicaid. • States may continue to focus on changing the design of the pharmacy benefit to encourage more cost-effective utilization. Activities include: <ul style="list-style-type: none"> – requiring more drugs to have prior authorization – instituting prescription limits, – implementing or expanding preferred drug lists – instituting more supplemental rebate mechanisms. • More states could seek membership in multi-state and intra-state purchasing pools to access larger supplemental rebates. • States could create greater transparency for drug pricing. • States could consider value-based benefit design that includes lower co-payments on medications of proven clinical utility (e.g., insulin, beta blockers for asthmatics, ace inhibitors for CHF patients) to promote better adherence. Decreased medical costs could offset the investment in medications. • To comply with the DRA requirement, states could collect rebates on all physician-administered drugs: <ul style="list-style-type: none"> – This could be achieved by matching J-codes to NDCs to collect rebates on all physician-administered drugs. – Under MMA, Medicare has changed its reimbursement methodology for physician-administered drugs from a formula based on Average Wholesale Price (AWP) to one based on Average Manufacturers Price (AMP). With CMS now using an ASP-based system, Medicaid programs could consider a similar change in reimbursement methodology. – States could standardize physician-administered drug benefit design under the medical benefit or the outpatient drug benefit so that all pharmaceuticals are managed uniformly. |

(continued on p.26)

³⁹ Eiken, Steve and Heestand, Alexandra, “Promising Practices in Long Term Care Systems Reforms: Colorado’s Single Entry Point System,” December 18, 2003, Medstat Research and Policy Division, Baltimore, MD

Figure 18 (cont.): Considerations & Implications for Key Stakeholders

| | |
|---|--|
| <p>Health Plans and Employers</p> | <ul style="list-style-type: none"> • Health plans and employers could sponsor community-based HIEs that leverage information technology for enrollee fraud detection and e-prescribing. • Health plans with special capabilities in Medicaid medical management might develop risk-based contracting mechanisms with states to align incentives for program investments. • Health plans could adopt consumerism elements such as Health Savings Accounts (HSAs) to incentivize member behavior. Members with specific targeted diseases could earn rewards for adopting certain healthy behaviors. • To address data limitations, health plans could work with physicians, social services, public health facilities, and hospitals to screen and refer patients directly into appropriate programs. Health plans also could use nurse care managers for follow-up calls to validate computer-generated assessments, and adopt existing disease registry and decision support systems to input their data • To address population complexity, health plans could hire locators to find enrollees; provide appointment reminder systems; extend services temporarily after Medicaid eligibility lapses and remind recipients to renew coverage; give recipients direct-connect mobile phones, or use videos to convey information. When developing programs, plans could consider social risk factors that include: <ul style="list-style-type: none"> – Literacy levels – Family/caregiver support – Transportation/access issues (consider house calls) – Language barriers – Cultural/religious barriers – Motivational levels and readiness to change – Use of cell phones, texting, and Internet. • Health plans could partner with physicians in designing care strategies and provide incentives that resonate with them (e.g., CME) to address physician and patient participation resistance. Health plans could automatically enroll patients with an opt-out option to maximize enrollment. • Health plans could consider individual resource issues like childcare and transportation to overcome common barriers to care. • Health plans could more actively engage the community to generate program awareness/endorsement among physicians, support groups, and other organizations that service the Medicaid population to help with program recruitment and referrals. |
| <p>Providers (Physicians, Hospitals, and Allied Health Professionals)</p> | <ul style="list-style-type: none"> • Providers could consider group visits to expand options for managing chronically ill patients: <ul style="list-style-type: none"> – The majority of the visit should be spent addressing group members’ concerns and educational needs; however, physicians could include elements of a traditional patient visit, such as patient history and physical exam – The educational component of a group visit could focus on a particular disease or a broader topic, such as self-management or behavior modification – To protect confidentiality, providers could require patients to sign a release stating that they will not discuss one another’s personal information outside of the group. • Providers could promote adoption of the medical home by: <ul style="list-style-type: none"> – mobilizing community resources – forming partnerships to fill service gaps and avoid duplicating efforts – advocating for policies to improve patient care – integrating specialty and primary care. • Providers could try to better understand the target population: These patients tend to seek medical attention for acute sickness rather than for prevention. Providers, therefore, should promote health awareness and consider non-medical barriers to care. |

© 2008 Deloitte Development LLC. All rights reserved.

Medicaid Medical Management in Action

Numerous states already are operating comprehensive, innovative Medicaid medical management programs. Specific examples are highlighted in Figure 19:

Figure 19: Innovative Medicaid Medical Management Programs

| Program | Focus | Features |
|--|---|--|
| New York's Monroe Plan's Prenatal Registration http://www.monroeplan.com/ | Incentivize physician behavior | Tiered incentive program based on timely submission of the form with penalties for non-submission. Form was also standardized and streamlined (to a single page) to reduce administrative burden. Achieved a 2:1 ROI. |
| Pennsylvania's Prescription for Pennsylvania Program http://www.rxforpa.com/ | Reduce health care costs and expand access | <ul style="list-style-type: none"> • Expand coverage for the uninsured by implementing a three percent payroll tax on employers that don't offer employee health coverage, with funds going to subsidize coverage for the uninsured • Require hospitals to adopt measures to reduce infection rates • Eliminate reimbursement for extended hospital stays caused by medical errors and preventable infections • Regulate hospital expenditures for new construction and equipment • Incentivize health care providers to reduce hospitalizations for patients with chronic diseases • Expand practice scope for nurses and physician assistants to address PCP shortage • Prohibit insurers from considering pre-existing medical conditions when setting premiums • Require that at least 85 percent of health insurance premiums be spent on health care costs • Prohibit smoking in public places. |
| Florida's Partnership with Pharmaceutical Firms http://www.pfizerhealthsolutions.com/ourprojects/projectsmedicaid_florida.asp and http://www.nga.org/portal/site/nga/menuitem.9123e83a1f6786440ddcbeeb501010a0/?vgnextoid=036d5aa265b32010VgnVCM1000001a010aRCRD | Establish guaranteed savings agreements with pharmaceutical vendor partners | <ul style="list-style-type: none"> • Agreement with Pfizer Health Solutions to offer disease management services, health literacy training, and expanded drug donation programs for Medicaid enrollees • Pfizer guaranteed \$33 million savings in Medicaid costs over two years • Florida agreed to include Pfizer drugs on its preferred drug list without requiring supplemental rebates • Similar agreement with Bristol-Myers Squibb (BMS) for guaranteed savings of \$16 million. BMS will provide a health management program targeted primarily to Black and Hispanic Medicaid enrollees with diabetes and depression • Culturally competent educational interventions are an integral component of the program. |
| Centene http://www.centene.com | Various programs | <ul style="list-style-type: none"> • Progesterone steroid injections to reduce risk of premature birth and neonatal intensive care unit (NICU) admissions for pregnant women with history of premature births • Medical home model encouraged • Cell phone program for difficult-to-reach enrollees – usage lock to case manager, connections representative, PCP and nurse line • Adult day care to keep dual eligibles out of nursing homes • Expertise in cultural diversity – formal committee to comply with class standards; intranet database to capture cultural sensitivities to share with team so that if the issue occurs elsewhere, prior learnings can be leveraged • Healthy rewards saving account program to reward healthy behavior. For example, if a new member goes to the PCP for an annual exam, \$20 is deposited in account for future health care purchases • Integrated care – <i>"We're very passionate about what we do and making sure recipients get what they need. If social needs aren't met, then the quality of care for patient goes down dramatically."</i> |

(continued on p.28)

Figure 19 (cont.): Innovative Medicaid Medical Management Programs

| | | |
|---|---|---|
| <p>Keystone Mercy's Healthy Hoops Asthma Management Program⁴⁰ http://www.keystonemercy.com/community/healthyhoops/index.asp</p> | <p>Incentivize patient behavior</p> | <ul style="list-style-type: none"> • Healthy Hoops enrollment form sent to families with asthmatic children, made follow up telephone calls, encouraged enrollment, and used school nurses and community partnerships to identify asthmatic children • Professional development program for area coaches and PE teachers, health screenings and basketball camp • ER visits decreased from 40 percent to six percent; controller medication usage increased from 48 percent to 77 percent; hospital admissions decreased from 10 percent to two percent; children with sleep disturbances decreased from 36 percent to 32 percent; parental knowledge of the significance of sleep disturbances and the need for regular medical follow-up and medication adherence improved 10 percent; lung capacity improved 11 percent. |
| <p>BlueCross BlueShield of TN Caring for Kids Initiative⁴¹ http://www.bcbst.com/providers/TENnderCARE/TN_caring_for_kids.shtml</p> | <p>Increase EPSDT screening with provider and parent incentives</p> | <ul style="list-style-type: none"> • Postcards sent to parents encouraging EPSDT screening appointment • \$5 Wal-Mart gift card offered to members for undergoing EPSDT services and PCP office staff for submitting data collection form to the health plan • Collaborated with regional health departments to obtain EPSDT screening data on members. Provided health departments with member lists of those who weren't current on their EPSDT screenings, and encouraged staff to schedule and perform EPSDT screenings for any members who visited the health department for another purpose. The health departments returned member lists for those completing screening to BCBS • EPSDT screening rates increased from 54 percent to 73 percent. The incentive component for PCP office staff was more effective than the incentive program for adults. |
| <p>Amerigroup Corporation's Taking Care of Baby and Me⁴² https://www1.amerigroupcorp.com/corporate/about_us.asp</p> | <p>Education, incentives and care management</p> | <ul style="list-style-type: none"> • Identified members via internal reports, claims data on ER visits, inpatient admissions, and office visits; self-referrals; and referrals from the 24-hour Nurse Help Line • Questionnaire to identify high-risk pregnancies. Care managers develop a care plan for those patients, and contact them monthly to ensure they are receiving the recommended prenatal and postpartum care • Provides education information on postpartum care and lists of health-related community services such as childbirth education classes. Gift incentives such as baby care items are offered to encourage keeping doctor appointments • Participants had higher rates of prenatal and postpartum care and lower rates of low-birth-weight babies and NICU admissions: <ul style="list-style-type: none"> – 86 percent of participants completed > 80 percent of prenatal visits vs. 11 percent in non-participants – Four percent rate of low-birth-weight babies vs. 11 percent in non-participants – NICU admit rate of 3.5 percent vs. 12 percent for non-participants – 100 percent postpartum check-up rate vs. 49 percent for non-participants. |
| <p>Amerigroup Corporation⁴³ http://www.amerigroupcorp.com</p> | <p>Care coordination program for SSI members with asthma, diabetes, heart failure, sickle cell disease, end-stage renal disease, HIV/AIDs and substance abuse</p> | <ul style="list-style-type: none"> • Identify new SSI members' clinical needs, determine whether they have a primary care physician, and identify a need for help with issues such as transportation and housing at initial enrollment • Make welcome calls to new members and forward information collected to case management nurses and care coordinators so they can address new members' care needs • Establish a trusting, ongoing relationship with patients through regular telephone contact, hospital and home visits • Nurses develop a one-on-one clinical action plan, and refer patients to community resources to help with transportation, housing and other social service needs • Chronic illness SSI participants increased from 50 percent to 80 percent. Hospital admissions for them decreased. |

(continued on p.29)

⁴⁰ AHIP Center for Policy and Research. *Innovations in Medicaid Managed Care*, at <http://ahip.org/content/default.aspx?docid=8414>

⁴¹ Ibid

⁴² Ibid

⁴³ AHIP Center for Policy and Research. *Innovations in Medicaid Managed Care*, at <http://ahip.org/content/default.aspx?docid=8414>

| | | |
|---|--|---|
| <p>Vermont's Choice for Care http://www.aarp.org/bulletin/yourhealth/112706_vermonts_caregiving_program_spells_success.html</p> | <p>Long-term care</p> | <ul style="list-style-type: none"> • 1115 Medicaid waiver demonstration program • Services include home-based support, enhanced residential care and assisted living, nursing facility services, Cash and Counseling program, and the PACE (Program for All-Inclusive Care for the Elderly) program • The Cash and Counseling program allows people to convert their care plans for home-based services into a dollar allowance. The program also permits a small amount of the allowance to be distributed to people in cash, if that is the most effective way to maintain health and well being in their home • PACE addresses all acute, primary and long-term care needs in a health care system for frail individuals 55 years and older. Coordinated care is provided by an interdisciplinary team • Nursing home enrollees decreased by 126 (from 2,286 to 2,160); recipients receiving home- and community-based services for the highest- and high-needs groups increased by about 17 percent, while those in the moderate-needs group increased from 0 to 523. The Medicaid recipients who receive enhanced residential care services increased by 44 percent. |
| <p>Texas' Medicaid Enhanced Care Program http://www.house.state.tx.us/news/release.php?id=945</p> | <p>Medicaid disease management program focused on preventive care and physician guidelines compliance to decrease unnecessary hospital and outpatient services</p> | <ul style="list-style-type: none"> • McKesson Health Solutions' (vendor) provides: • Identification and outreach to eligible beneficiaries with health risk assessment • Education – beneficiary, provider, staff • Quality assurance • Care management • Community-based and triage services • RNs and promotoras (community health workers) to ensure that enrollee's health care is provided in a timely and culturally sensitive manner • Outcomes measurement <p>\$28.6 million savings expected and overall savings estimated at six percent of costs.</p> |
| <p>Washington, DC SPOE System⁴⁴ http://www.adrc-tae.org/tiki-index.php?page=ShowCounty&map=11001;</p> <p>Michigan Medicaid Long-term Care SPOE System⁴⁵ http://www.michigan.gov/mdch/0,1607,7-132-2943_4860---,00.html</p> | <p>Administrative simplification and efficiency for patients and providers</p> | <ul style="list-style-type: none"> • Centralized information and assistance services • Focus on long-term care services • Facilitated transfers of patients to home- and community-based services from more costly institutional setting by streamlining eligibility determination • Improved systems' analytic capability • Results: DC's breakeven period was three years with an ROI of 1.7:1 in the fourth year. MIs accrued system-wide efficiency gains of 1.7 percent, enough to fund the entire system. |
| <p>Medi-Cal⁴⁶ http://www.medi-cal.ca.gov</p> | <p>Dual eligibles and long-term care</p> | <ul style="list-style-type: none"> • Provides primary care physician and assistance for finding specialists • Physician payment increases targeted to particular specialties or geographic areas with acute access problems. Special provider payment arrangements for serving people with disabilities, including higher rate structures or bonuses • Disabled enrollees receive a provider directory that rates basic physical accessibility features of primary care physicians, and are offered a call center for assistance in finding accessible providers • Information provided in usable formats such as American Sign Language, Braille, large print, electronic, audio formats; also use auxiliary aids and services • Clinical care coordinators or case managers coordinate care among providers, serve as the key point of contact for the member, provide personalized assistance, and advocate on behalf of the member to facilitate timely access to care • Disease management programs coordinate care for certain complex diseases, such as diabetes, asthma and COPD • Case managers assess the need for appropriate equipment through routine home visits and assist the member in obtaining these devices; also provide home-based wheelchair repairs for individuals with limited mobility. |

Source: Unless footnoted, web sites indicated in the table

⁴⁴ Allison AG; Point of entry systems for long-term care: State Case studies; for New York City Department for the Ageing; April 2004

⁴⁵ Modernizing Michigan Medicaid Long-term Care: towards an integrated system of services and supports; Final Report of the Michigan Medicaid Long-term Care task force

⁴⁶ Adults with Disabilities in Medi-Cal Managed Care: Health Plan Practices and Perspectives. Prepared by the Medi-Cal Policy Institute/California HealthCare Foundation, Oakland, CA, September 2003

Authors

Paul H. Keckley, PhD
Executive Director
Deloitte Center for Health Solutions
pkeckley@deloitte.com

Howard R. Underwood, MD, FSA
Senior Manager
Deloitte Consulting LLP
Senior Fellow & MDP
Deloitte Center for Health Solutions
hunderwood@deloitte.com

Acknowledgements

Thanks to the following colleagues for their contributions and participation: Drew Beckley, Principal, Deloitte Consulting LLP; Bob Campbell, vice chairman and U.S. State Government leader, Deloitte LLP; Olivia Elee; Pamela Fromelt, Senior Lead, Deloitte Consulting LLP; Catherine Harvey, Senior Manager, Deloitte Consulting LLP; Dr. Wade F. Horn, Ph.D., Director, Deloitte Consulting LLP; Divya Paliwal; Amy Sherman, Principal, Deloitte Consulting LLP; and Chris Vojta, Director, Deloitte Consulting LLP.

Contact Information

To learn more about the Deloitte Center for Health Solutions, its projects and events, please visit www.deloitte.com/centerforhealthsolutions.

Deloitte Center for Health Solutions
555 12th Street N.W.
Washington, DC 20004
Phone 202-220-2177
Fax 202-220-2178
Toll free 888-233-6169
Email healthsolutions@deloitte.com
Web <http://www.deloitte.com/centerforhealthsolutions>

As used in this document, "Deloitte" means Deloitte LLP and its subsidiaries. Please see www.deloitte.com/us/about for a detailed description of the legal structure of Deloitte LLP and its subsidiaries.

These materials and the information contained herein are provided by Deloitte LLP and are intended to provide general information on a particular subject or subjects and are not an exhaustive treatment of such subject(s). Accordingly, the information in these materials is not intended to constitute accounting, tax, legal, investment, consulting or other professional advice or services. Before making any decision or taking any action that might affect your personal finances or business, you should consult a qualified professional advisor.

These materials and the information contained therein are provided as is, and Deloitte LLP makes no express or implied representations or warranties regarding these materials or the information contained therein. Without limiting the foregoing, Deloitte LLP does not warrant that the materials or information contained therein will be error-free or will meet any particular criteria of performance or quality. Deloitte LLP expressly disclaims all implied warranties, including, without limitation, warranties of merchantability, title, fitness for a particular purpose, noninfringement, compatibility, security and accuracy.

Your use of these materials and information contained therein is at your own risk, and you assume full responsibility and risk of loss resulting from the use thereof. Deloitte LLP will not be liable for any special, indirect, incidental, consequential, or punitive damages or any other damages whatsoever, whether in an action of contract, statute, tort (including, without limitation, negligence), or otherwise, relating to the use of these materials or the information contained therein.

If any of the foregoing is not fully enforceable for any reason, the remainder shall nonetheless continue to apply.

About Deloitte

Deloitte refers to one or more of Deloitte Touche Tohmatsu, a Swiss Verein, and its network of member firms, each of which is a legally separate and independent entity. Please see www.deloitte.com/about for a detailed description of the legal structure of Deloitte Touche Tohmatsu and its member firms. Please see www.deloitte.com/us/about for a detailed description of the legal structure of Deloitte LLP and its subsidiaries.

Copyright © 2008 Deloitte Development LLC. All rights reserved.

Deloitte. Center for Health Solutions

About the Center

The Deloitte Center for Health Solutions (the "Center"), located in Washington, D.C., is part of Deloitte LLP and was formed to further research on and develop solutions to some of our nation's most pressing health care and public health-related challenges. Please visit www.deloitte.com/centerforhealthsolutions for more information.

Copyright © 2008 Deloitte Development LLC. All rights reserved.

Member of
Deloitte Touche Tohmatsu