State Health Watch

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THOMSON
AMERICAN HEALTH CONSULTANTS

In This Issue

States in a box: Nothing to do but reduce their payments and benefits

Accelerating health care spending. A steep and lengthy drop in revenues. These twin evils are at the heart of the states' ongoing fiscal crisis, says the National Governors Association (NGA).

Commenting on the latest *Fiscal Survey of the States*, released at the end of June by NGA and the National Association of State Budget Officers, NGA executive director Raymond Scheppach noted that health care represents about 30% of state budgets, and Medicaid accounts for about 20%. While Medicaid growth was high in the early 1990s, the rate of growth fell to just 3.3% by 1996. But it then increased dramatically to an average of 9% in 2000 and jumped again to 13.1% in 2002.

"Unfortunately," Mr. Scheppach says, "this explosion took place at the same time that revenues were collapsing. States have limited ability to control the cost of Medicaid or other health care costs such as the cost of drugs or increased copayments. Double-digit cost increases are a national problem affecting all health care purchasers — the private sector, the federal government, and nonprofit organizations. All states can do is reduce

*See **States in a box** on page 2*

New training, technical assistance, and grants help six states manage pharmacy strategies

"The Medicaid program in Washington implemented a three-part program designed to promote appropriate and cost-effective use of prescription drugs and improve quality of care. An initial review of the Therapeutic Consultation Service, a program run by Affiliated Computer Services that targets high-volume utilizers and prescribers, has demonstrated savings of $5.13 million in the first five months following implementation."

Fiscal Fitness: How States Cope

Statements such as this, taken from a report prepared by the Lawrenceville, NJ-based Center for Health Care Strategies (CHCS) on the impact of clinical pharmacy management programs, are encouraging state officials to take a close look at such programs as they attempt to restrain pharmacy costs in Medicaid and other state programs. State efforts in this area will be helped by an initiative to support new training, technical assistance, and grant-making for up to six states interested in developing

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State Health Watch
The Newsletter on State Health Care Reform

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States in a box

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provider payments, restrict eligibility, or reduce benefits."

As a percentage of state budgets, Medicaid ranges from a low of 8.7% to a high of 30%. NGA says the far western and northeastern states are facing the worst budget problems, with both the deepest drop in revenues and a high percentage of their budgets devoted to Medicaid spending.

The fiscal survey report indicates that Medicaid cost increases stem primarily from increased costs for pharmaceuticals and enrollment increases. As their costs have increased, state Medicaid expenditures have exceeded the amounts originally budgeted for the program. Some 25 states experienced Medicaid shortfalls in fiscal year 2002, and 28 states are expecting shortfalls in the coming fiscal year, according to the report. State shortfalls as a percentage of the total Medicaid program in FY 2002 ranged from less than 1% to 23% of program costs, with an average of 5.5%. The combined amount of the shortfalls in FY 2002 and 2003 totals more than $6 billion.

The reality of what states are facing in health care costs is seen in a report on a study by the Center for Studying Health System Change (HSC), which found that although the rate of growth in health care spending eased slightly in 2002 compared with 2001 (a 9.6% increase rather than 10%), it still is extremely high by historical standards and represents a much steeper increase than that seen in the overall economy, which went up 2.7% in 2002 as measured by per capita growth in gross domestic product.

The study was published on the Internet as a special *Health Affairs* article, and quotes HSC president Paul Ginsburg, a co-author of the study, as saying that "the good news is that health care spending growth slowed for the first time in five years, but the bad news is that health care spending continues to increase rapidly. Unless underlying health care cost trends slow significantly, health insurance premiums will continue to rise rapidly, and the number of uninsured Americans will increase."

Despite the slight decrease in 2002 spending growth, employer-based health insurance premiums rose again in 2003 by an average of 15%, the largest jump in at least 10 years. There are indications that the premium increases would have been even higher, perhaps 18%, if not for increased consumer cost-sharing through higher deductibles, copayments, and coinsurance.

More than half the overall spending increase was attributed to rapid growth in hospital spending per privately insured person for the second straight year. Of special concern to analysts: Hospital cost increases are driven increasingly by inflation, not by increased use of services.

Spending on inpatient hospital care increased 6.8% in 2002, accounting for 14% of total spending growth. Spending on outpatient hospital care grew 14.6% in 2002, surpassing prescription drugs as the fastest-growing spending component and accounting for 37% of overall spending growth.

After going up 8% in 2001, the increase in hospital utilization slowed to 5.7% in 2002, likely as a result of increased patient cost-sharing and completion of the transition to a looser form of managed care.

Hospital prices increased 5.1% in 2002, the largest one-year jump since at least 1994. As a result of higher prices and the slowing trend of increased utilization, price inflation

accounted for almost half the increase in hospital spending in 2002, compared with about a third of the increase in hospital spending in 2001.

For the third year in a row, according to the HSC study, prescription drug spending increased at a slower pace, growing 13.2% in 2002 and accounting for 22% of overall spending growth. Factors affecting the slowdown in prescription drug prices include increased use of three-tier copayment structures, a reduction in new drugs coming to market, and a greater availability of generic drugs.

HSC says spending on physician services increased 6.5% in 2002, which was 27% of the total spending increase. Both higher prices and increased use of physician services played a role, but growing utilization was the more important factor.

Mr. Ginsburg says that even with the mixed results, it is an important development in spending trends that 2002 was the first year in five years that a one-year increase in spending did not exceed the preceding year's increase.

Consumers can expect a second round of sizable increases to cost-sharing requirements in 2003, according to Mr. Ginsburg's report. He says employers' ability to pass along sizable increases in cost-sharing to their employees is likely a reflection of the continuing softness of the U.S. economy and rising unemployment that has led to a loosening of labor markets.

"While employers raised cost-sharing requirements to control rising premiums," says the study, "they made little change to the proportion of the total premium that employees are required to pay … . The fact that employers targeted cost sharing rather than employees' share of premium to control costs reflects a clear strategy. Employees can avoid some or all of the increase in cost sharing and reduce their out-of-pocket spending by responding to the incentive and using fewer services."

Mr. Ginsburg says the outlook for the future is as mixed as the 2002 results he reported. A number of forces could lead to further deceleration of the health care cost trend, he says, but some developments might drive the cost trend upward again.

Two forces that could contribute to deceleration are growth in consumer cost-sharing and the sluggish U.S. economy. Forces that could exert an upward pressure include cuts in Medicaid provider payments that could lead providers to seek higher payments from private payers. Also, the federal government could further constrain provider payment rates for Medicare patients, which could lead to additional shifting of costs to private payers.

"Despite the uncertainty about future cost trends," Mr. Ginsburg writes, "conditions do seem ripe for the underwriting cycle to turn soon — and slow the premium trend — if the cost trend does not increase in 2003. The health insurance industry is now experiencing strong profitability in general. This will eventually set off a new round of price competition as plans begin to enter new markets and shift their strategic focus from improving profitability to growing market share … . A turn in the underwriting cycle will not, however, bring about a major slowdown in premium increases; this can only be accomplished by a major slowdown in underlying cost trends. Until this happens, employers and employees will continue to face the many negative consequences of high cost growth, and uninsurance will likely continue to rise."

Meanwhile, Commonwealth Fund president Karen Davis told a U.S. Senate Appropriations Committee subcommittee that bold steps need to be taken on the supply side of the health care equation if costs are to be brought under control.

"The U.S. has relied on a mixed public-private system of insurance, managed care, and market competition to shape the health care system," Ms. Davis said. "Yet the U.S. has the highest health care spending per capita in the world, and during the 1990s health spending in the U.S. rose faster than in other industrialized nations. The key to containing costs — as well as getting higher value for what we spend — may well lie in fundamental changes to the supply side of the market. We need to shift our attention to reducing errors, eliminating waste and duplication in clinical care, modernizing and streamlining administration, promoting transparency and accountability for performance, and aligning financial incentives for physicians, hospitals, and other health care providers to reward high-quality and efficient care."

After reviewing many of the all-too-familiar statistics on health care costs, Ms. Davis pointed out that health care spending in this country is higher than elsewhere because we pay higher prices for the same services, have higher administrative costs, and perform more complex specialized procedures.

Sick adults in the U.S. report higher rates of medical errors, she said, are more likely to go for duplicate tests, and are less likely to have their medical records available when they go for care compared with similar adults in other major English-speaking countries. In addition, ours is the only major industrialized nation not to provide health coverage for all.

Ms. Davis testified that steps that could be taken on the supply side include:

• public reporting of cost and quality data on physicians, hospitals,

nursing homes, other health care providers, and health plans;

• broad-scale demonstrations of new approaches to health insurance coverage, science-based benefits, use of modern information technology, and high-quality care;

• investment in health information technology;

• development and promulgation of clinical guidelines and quality standards;

• payment for high performance in delivery of health services under Medicare, Medicaid, and private insurance; and

• investment in research to gain evidence of what works to improve care, eliminate waste and ineffective care, and promote greater efficiency, including use of modern information technology, teamwork, and improved processes of care.

"What we all want from our health care system is not necessarily cheaper care," Ms. Davis declared, "but assurances that resources are being invested wisely to buy higher-quality, more patient-responsive care that achieves better outcomes. We should aspire to a high-performance health system — one that is high-quality, efficient, and accessible to all Americans."

She said that in the past, those seeking to control costs have focused primarily on the demand side of the market. In other industries, she said, the path to lower costs lies in greater production efficiency, and financial rewards accrue to those firms that succeed in producing a high-quality product more efficiently. "But in health care we rarely reward or insist on either greater efficiency or higher quality. In the future, we should shift our attention to reducing errors, eliminating waste and duplication in critical care, modernizing and streamlining administration, promoting transparency and accountability for performance, and aligning financial incentives for physicians, hospitals, and other health care providers to reward high-quality and efficient care."

Ms. Davis told the hearing that if the United States has the world's most costly health system but still fails to give everyone access to care and falls far short of providing the safe, high-quality care that it is possible to provide, the conclusion that there is room for improvement is inescapable.

[The NGA fiscal survey is available at www.nga.org. Contact Mr. Scheppach at (202) 624-5300. The HSC study is available at www.healthaffairs.org/WebExclusives/Strunk_Web_Excl_061103. Contact Mr. Ginsburg at (202) 484-5261 or go to www.hschange.org. Contact Ms. Davis at (212) 606-3800 or by e-mail at kd@cmwf.org.] ■

The cost of uninsurance: $65 billion to $130 billion

In a ground-breaking analysis, the Institute of Medicine (IOM) has calculated what the United States loses each year due to poorer health and early deaths among the 41 million uninsured people in the United States. The Institute says the loss, estimated between $65 billion and $130 billion, is a hidden cost that could be recouped by extending health coverage to all.

The group did not project the cost of a health insurance plan to cover everyone. The report did say the estimated aggregate value of improved health if everyone had coverage exceeds the cost — estimated at $34 billion to $69 billion — of providing the uninsured the additional health services they would use if they gained coverage and used the same amount and kinds of services as the insured.

In releasing the report, Mary Sue Coleman, president of the University of Michigan and co-chair of the Institute of Medicine Committee on the Consequences of Uninsurance, said the society-wide costs of leaving 41 million Americans uninsured each year are not primarily due to the expense of providing free health services to those without coverage. Rather, she said, most of the cost of uninsurance reflects the poorer health and shorter lives of uninsured individuals who frequently receive too little health care and receive it too late. Societal costs, as documented in previous IOM reports, include:

• Uninsured children lose the opportunity for normal development and educational achievement when preventable health conditions go untreated. Likewise, uninsured adults with chronic health conditions are less likely to receive routine care.

• Families lose peace of mind because they live with uncertainty and anxiety about the medical and financial consequences of a serious illness or injury.

• Communities with high rates of uninsurance can face reductions in primary care and hospital services. They also often have to divert resources from public health activities to pay for care for the uninsured, adversely affecting everyone, not just the uninsured.

• The economic vitality of the country is diminished by productivity lost as a result of poorer health, disabilities, and premature deaths among uninsured workers.

• Medicare, Social Security Disability Insurance, and the

criminal justice system probably cost taxpayers more than they would if everyone had health insurance up to age 65 and if the chronic and disabling conditions of those who now lack coverage were better treated.

To arrive at its estimate of a health loss worth between $1,600 and $3,300 for each individual without insurance each year (aggregating to between $65 billion and $130 billion), the IOM committee relied on the concept of "health capital." In her statement, Ms. Coleman said health "is like other investments. It gives us a stream of future returns in the form of enjoyment of life, productivity, and developmental potential. Individuals in better health obtain higher returns. Those who die prematurely lose all returns. The dividends from higher levels of health capital include higher expected lifetime earnings, the value we individually place on being alive and healthy, and improved educational and developmental outcomes in children."

The committee cautions that its analysis is for benefits that could be realized if extensions of coverage reduced the morbidity and mortality of uninsured Americans to the levels for individuals who are comparable on measured characteristics and who have private health insurance. The estimate does not include spillover losses to society as a whole of the poorer health of the uninsured population. It accounts for the value only to those experiencing poorer health and subsumes the losses to productivity that accrue to uninsured individuals themselves.

The committee's approach to analysis relies on strategies used by federal agencies such as the U.S. Environmental Protection Agency, the Food and Drug Administration, and the Department of Transportation in calculating the costs and benefits of regulatory interventions.

"When these agencies regulate health and safety risks, for example, by setting fuel emissions standards and requiring seat belts and air bags in cars, they estimate the value of these interventions in terms of improved health and extended lives throughout society," Ms. Coleman said. "Similarly, the lack of health insurance across the United States can be thought of as imposing a risk to the health and longevity of the American population. As many as 60 million Americans lack coverage for at least a month over a year's time, and the number who experience a gap without coverage during a two-year period is about 80 million. Many more of us are at risk of being uninsured at some point in our lives than we tend to think."

Ms. Coleman says the committee's estimate of the health capital lost by the American population because of uninsurance is based on conservative assumptions, and the losses could be even greater.

The committee's report differs from many others in that it does not focus on uncompensated care or expensive hospitalizations because of delayed treatment as the majority of the costs due to being uninsured. Rather, it concentrates on the costs that result from poorer health outcomes of uninsured individuals.

Families with uninsured members, the report says, bear costs resulting from the financial burdens and risks of out-of-pocket health care spending. Because children's receipt of health care depends on their parents' coverage status, children in families with uninsured parents are less likely to receive adequate services. The spillover costs of uninsurance experienced within communities result from both the poorer health of uninsured populations and the demands made on local public budgets and providers to support care for those without coverage.

In its analysis of the costs of health care now used by those who lack health coverage, the committee determined that:

- Uninsured children and adults are less likely to incur any health care expenses in a year and, on average, incur health care costs well below half of average spending for services by all those under age 65.
- People who lack health insurance for an entire year have out-of-pocket expenditures comparable, in absolute dollar amounts, to those of people with private coverage. Uninsured individuals pay for a higher proportion of the total costs of care rendered to them out of pocket, however, compared to insured individuals under age 65 (35% compared to 20%). They also have much lower family incomes. Out-of-pocket spending for health care by the uninsured is more likely to consume a substantial portion of family income than out-of-pocket spending by those with any kind of insurance coverage.
- The total cost of health care services used by individuals who are uninsured for all or part of a year was estimated to be $98.9 billion for 2001.
- The best available estimate of the value of uncompensated health care services provided to people who lack health insurance for some or all of a year is roughly $35 billion annually, about 2.8% of total national spending for personal health care services.

The committee also notes a quality-of-life and security issue for those who are uninsured, saying they bear the burden of increased financial risk and uncertainty. "Although the estimated monetary value of the potential financial losses that those without coverage bear is relatively small (compared to the full cost of their services) because of uncompensated care, the psychological and behavioral implications of

living with financial and health risks and uncertainty may be significant," the report says.

In her statement, Ms. Coleman said that compared to the annual growth in national health spending, about $100 billion between 2000 and 2001, the cost of additional services for the uninsured is about half of that one-year increase.

She said the committee examined the "ethical costs of leaving 15% of the nation uninsured." In the absence of action to expand coverage, she said, "we can expect the existing gap in health outcomes between insured and uninsured Americans to widen. As health care interventions become ever more effective in improving health and extending life, the disparity in access to effective health care will become more inequitable and socially divisive.

"Today our health care system has resources it lacked a generation ago to detect disease earlier and ameliorate the effects of chronic conditions such as hypertension, diabetes, asthma, and depression. Deeply ingrained American cultural and political values of equality of opportunity, mutual concern, and equal respect among members of our national community are betrayed when we afford some members — but not everyone — the ability to achieve a longer, more productive and healthier life through public support of health insurance."

Ms. Collins said the committee concluded that (1) as a society we would be better off if the uninsured had health coverage, (2) we would gain peace of mind if no one lacked or was at risk of losing coverage, and (3) insuring everyone would strengthen health care services for all.

[Access information about the report at www.nationalacademies. org.] ■

Behavioral managed care: Don't dismiss it, because changes are coming

State purchasers, policy-makers, plan executives, and consumers should not dismiss public sector managed care or assume it has arrived at the end of its cycle. That's the conclusion of a working paper published by the Lawrenceville, NJ-based Center for Health Care Strategies on what lies ahead for Medicaid behavioral managed care.

"Overall, managed care is viewed as bringing added value to the field," writes Dr. Sandra Forquer, "especially in the area of controlling costs and implementing policies that would have been difficult for the purchaser to put in place without the strong arm of for-profit behavioral managed care companies. While there also is consensus that there had been some very serious design and financing flaws in some early attempts, there was general agreement that the lessons learned from those debacles will make it possible to avoid repeating them."

Ms. Forquer tells *State Health Watch* there is concern because managed behavioral health care companies are pulling out of what they see as an unprofitable business. Also, the number of requests for proposals and other opportunities for managed behavioral care are decreasing.

"We wanted to look at what opinion leaders thought the movement away from behavioral managed care means to the future of Medicaid managed behavioral health care," she says.

Her interview respondents indicated that public-sector managed care will be designed differently in the future, with three areas targeted as priorities for further examination by states, health plans, providers, and consumers: risk arrangements, the role of safety-net providers, and administrative services only (ASO) contracting.

Adoption of capitation as a funding strategy seems greatly diminished moving forward, according to Ms. Forquer. Respondents indicated that capitation creates incentives for undertreatment and can contribute to for-profits making their margins, however slim they may have become, on care dollars. Opinion leaders suggested that states consider moving to ASO contracts or look to increasing the role of safety-net providers and ensuring their continued participation in the program.

Ms. Forquer says a second practical implication of the survey for its target audiences is that there is definite agreement that integrated care is the preferred model for delivery of mental health, substance abuse, and primary health care services. The report says, "Policymakers and purchasers must address five critical areas if movement in this direction is to be achieved: structural issues, provision of support services, disease management strategies for special needs populations, protection of the behavioral health dollar from being moved to physical health cost centers, and stigma and discrimination in the primary care setting."

For providers, a critical structural issue is time, i.e., the 15-minute visit vs. the 60-minute session. People with serious and persistent mental illness are not seen as treatable in the context of a 15-minute visit. Ms. Forquer says development of evidence-based disease management protocols to address that question should be a high priority. Provision of wraparound services — support and outreach services that go beyond general case management — is another relevant issue for both

providers and plans to consider.

The report says behavioral health consumers face a high degree of stigma and discrimination in primary care settings. If such patients don't feel respected and treated with dignity, or if they feel their needs are not being met in the primary care environment, they won't enter its doors.

"We could find ourselves back in an era where one waits until one is very ill before seeking help, and hospitalization becomes the only option available," Ms. Forquer says. "Policymakers, purchasers, plans, and consumers should elevate this issue in their integration discussions. The recommendation of numerous opinion leaders that the psychiatrist should serve as the primary care physician for [behavioral care patients] should actively be explored and piloted."

The report also noted the importance of consumer and family involvement to the quality of behavioral health programs. Children and adolescents have been identified as the population most at risk for the near future, the report says.

Key conclusions reached by the 33 experts Ms. Forquer interviewed were:

• Public-sector managed behavioral health care is an improvement on the previous models of fee for service and grants, but implementation has varied from excellent to unsatisfactory. While well-executed behavioral managed care programs can integrate fragmented funding streams, improve clinical and financial outcomes, and take controversial actions that would be difficult for a public agency, poorly executed programs can disrupt care, worsen clinical outcomes, degrade local safety nets, and heighten conflict.

• Future contracts will emphasize shared risk arrangements, a stronger role for safety-net providers, and selective purchase of administrative services.

• Integration of physical care, mental health care, and substance abuse care is desirable, but there are very few successful models, and most interviewees doubt that it can be accomplished in the near future.

• Well-structured and -supported consumer participation leads to better programs and policies.

• Children and adolescents are viewed as the population most at risk for the next few years.

A decade of experience with Medicaid managed behavioral care suggests that success requires full participation from four key stakeholder groups: state leadership, managed behavioral health care organizations, providers, and consumers/families.

Ms. Forquer tells *State Health Watch* she was interested to find that, almost without exception, the experts she interviewed agreed that an integrated system is preferable to carve-outs, with treatment time being the key issue.

"One respondent said the behavioral health setting is time-sensitive, unlike primary care offices, where 15 minutes is all a patient can get," she says.

Ms. Forquer finds behavioral health care and primary care at an important crossroads.

"Behavioral health managed care as a system for controlling costs and managing outcomes continues to be a management strategy of choice in many states," she writes. "The future may reveal a shift from capitation to shared risk arrangements with safety net providers. And administrative services only arrangements may become the preferred option with for-profit behavioral managed care companies."

[Download the report from www.chcs.org/publications/purchasing.html. Contact Ms. Forquer at (719) 538-9922.] ■

Fiscal Fitness

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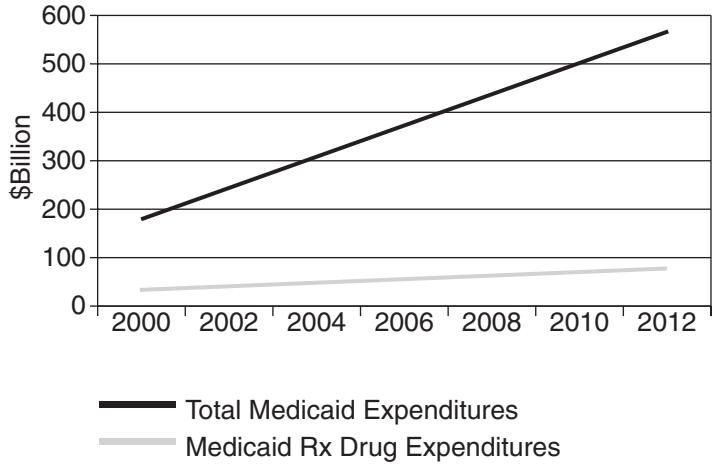
quality-focused pharmacy management strategies. The goal of the initiative, which will start this fall, is to find feasible solutions that improve quality, reduce costs, and are amendable to all stakeholders. Primary focus areas for technical assistance include pharmacy case management and physician and patient profiling and education activities.

Controlling pharmacy costs has been a major effort in many states in recent years, given the increasing fiscal pressure on state officials. Prescription drug spending is the most rapidly growing component of the total Medicaid budget, and has become a specific target for states' cost-containment strategies. (**See graph, p. 8.**) In fiscal year 2001, Medicaid fee-for-service prescription drug costs were $24.7 billion (combined federal and state). The Centers for Medicare & Medicaid Services has projected costs to grow by approximately 24% in 2003, to $32.5 billion. Most state officials attribute this growth to a combination of factors, including increased utilization and price of prescription drugs, an increased number of products on the market, and the mix of drugs taken by beneficiaries.

The CHCS report says drug spending is a separately appropriated item in most states, which fuels an environment in which drugs are seen as separate from overall medical costs. While increased use of drugs may improve quality of care or even reduce costs, states are focused on increases in drug spending.

CHCS state purchasing programs director Anna Fallieras says many states hope to manage rising prescription drug costs through preferred drug lists and limitations on the quantity of drugs beneficiaries

Medicaid Prescription Drug Expenditures Compared with Total Medicaid Expenditures



Source: Center for Health Care Strategies, Lawrenceville, NJ.

may receive each month.

But, Ms. Fallieras says, restricting benefits without a plan to ensure quality is not compromised may increase hospitalizations, emergency room visits, and ultimately costs over the long term, especially when the benefits in question relate to prescription drugs.

"Unfortunately," she says in the report, "the effects of these programs on quality are generally not being studied. Key stakeholders groups are thus concerned about the potential effect of state programs on quality."

The report says state Medicaid programs can mitigate prescription drug costs by exerting influence on price, utilization, and drug mix.

"Clinical pharmacy management initiatives focus on influencing utilization and mix to enhance the quality of care provided to beneficiaries and reduce prescription drug and other program costs," Ms. Fallieras says. "Through education, nurse-patient case management, provider detailing, and other activities, clinical pharmacy management programs generally seek to eliminate inappropriate drugs from patients' regimens, reduce the risk of harmful and expensive drug interactions, and boost compliance. These initiatives also attempt to influence the mix of drugs taken by beneficiaries by promoting best practice guidelines that providers recognize, and by monitoring patients with a history of taking expensive medications. Often making small changes first to improve the drug regimens of the sickest, most expensive beneficiaries can lead to meaningful cost savings. Early data from some programs [such as the one in the state of Washington, quoted at the beginning of this article] support the claim that states' immediate focus on quality can promote cost reduction in the short and long term."

Ms. Fallieras says the potential for cost savings isn't the only reason why states should consider alternatives that promote clinical quality. Such programs are more politically palatable, she says, which gives states an opportunity to save money without denying access to services or limiting eligibility. Also, such initiatives typically focus on some of the most vulnerable beneficiaries in the Medicaid program to ensure their complex clinical care needs are met.

In general, according to the report, clinical pharmacy management programs establish systems or processes to monitor and intervene in the treatment of patients taking prescriptions. The monitoring and intervention may be episodic, occurring at various points in time, or may be an ongoing activity that affects patients over a period of months or years.

A CHCS framework suggests that the structure of existing clinical pharmacy management programs includes identification/stratification of patients or providers for interventions; establishment of clinical goals to guide development of interventions; outreach/interventions to enroll and maintain patients in a program that produces change in their care plans; and monitoring/evaluation to measure effectiveness of a program and continually improve it. (**See graph, p. 9.**)

Clinical pharmacy management activities often are divided into two broad categories: pharmacy case management and physician profiling. Pharmacy case management is seen as a system or program in which Medicaid or private insurers identify and manage beneficiaries meeting one or more criteria such as generating high prescription drug costs, taking a high number of prescription drugs, or having a specific disease. Case management typically is triggered when a patient reaches a set drug limit, generates claims above an established level, or is diagnosed with a particular disease.

Physician profiling is a technique used to identify providers who prescribe outside of accepted guidelines. Such programs typically are triggered through drug utilization reviews, which generate data on physician prescribing histories and compare these data to expected prescribing patterns within drug categories.

Depending on the degree of variation, interventions might rely on general educational materials on prescribing protocols or a pharmacist consultation to review specific patient medication issues.

Many more states have undertaken pharmacy case management than have entered into physician profiling, although many private insurers make good use of the latter technique.

The CHCS report contains case studies from Maryland, North Carolina, Texas, and Washington, representing a variety of plan types and approaches to incorporating pharmacy case management or physician profiling programs into a pharmacy benefit.

For instance, in 2000, Maryland Physicians Care implemented a disease-driven case management program for diabetes patients enrolled in the Maryland Medicaid managed care plan. The program gives physicians comprehensive information, tools, and counseling to support treatment of beneficiaries with diabetes through an integrated approach. Ms. Fallieras says implementation of this program has resulted in improved beneficiary health, reduced medical service utilization, and a net decrease in direct medical costs.

Schaller Anderson consultant Neil West, who worked with Maryland officials on the project, tells *State Heath Watch* the state is collecting lab values and pharmacy information and matching those data to physician groups so they can get a perspective on all the patients involved.

The program uses the hemoglobin A1c test, which measures blood sugar, to gauge success of the efforts. When they first started giving information to plan medical directors, 36% of patients had A1c readings higher than 9.5. After a few months in the program, only 20% of the same patients had readings higher than 9.5.

Mr. West says the results led to physicians getting an A1c testing machine for their clinic to better track the patients. They also are doing diabetic retinopathy screenings. Another project has opened in western Maryland with 150 patients with paired data, and they're hoping to be able to apply it to a larger geographic area so they can evaluate the impact of people moving among health plans.

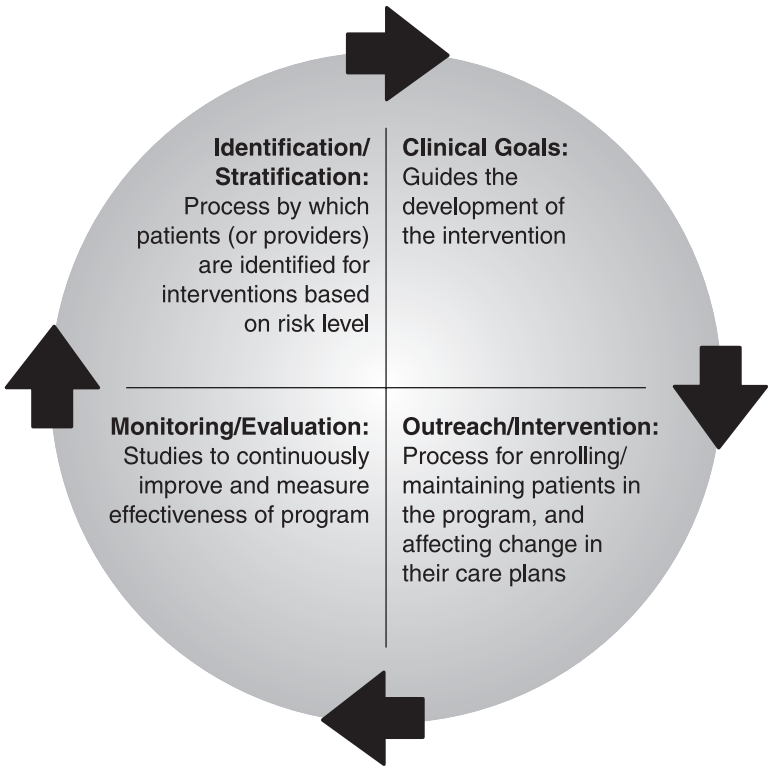
Mr. West and Schaller Anderson also have been working in Missouri with a university-owned health plan and an asthma program. In studying hospital, emergency room, and pharmacy costs for this project, they have seen an increase of about $1 per person per month in pharmacy costs because of an increase in the use of controller medications. But that has been accompanied by a 50% reduction in hospitalizations.

"The net effect has been a significant savings," Mr. West tells *State Health Watch*. "It's probably worth $200,000 a year to the health plan's bottom line."

The program works by monitoring patient drug records for instances when patients have prescriptions for rescue medications but not for controller medications. "It's only a small percentage of patients," Mr. West says, "but they are the ones who get into trouble. We can flag the charts and talk to people to find out what's going on."

[Contact Ms. Fallieras or obtain copies of the full report at (609) 895-8101. Contact Mr. West at (602) 659-2060 or by e-mail at neilw@schalleranderson.com.] ■

Structure of Existing Clinical Pharmacy Management Programs



Source: Center for Health Care Strategies, Lawrenceville, NJ.

Quality-of-life assessments view patients as partners in care

A by-product of efforts to increase patient empowerment and involvement in their own care is the use of quality-of-life assessments in evaluations of state Medicaid programs. Frank Funderburk, an analytic scientist with the Delmarva Foundation, which has been involved in quality improvement activities for more than 25 years, tells *State Health Watch* that the use of quality-of-life assessment builds on the work of Avedis Donabedian at the University of Michigan in looking at health care in terms of structure, process, and outcomes.

"It takes a patient-centered point of view that is consistent with patient empowerment and reflects the cumulative effect on an individual of various levels of observable effects of interactions within the health care system," says Mr. Funderburk.

The addition of quality-of-life assessments to overall evaluations allows health care system performance to be fine-tuned and encourages cost-effective performance, he says. It also allows system executives to target improvements that can cut costs.

"There is emerging literature that shows that both mortality and morbidity can be predicted from assessments of quality of life," Mr. Funderburk tells *State Health Watch*. "When you focus on quality of life, you can engage people in promoting their own health. This work is especially relevant to chronic diseases such as diabetes and HIV."

Some of the initial assessment work was done with people who have developmental disabilities. Outcomes indicators measure such data elements as physical well-being, mental well-being, safety, self-determination, and independence, looking at both the patient's perspective and the organizational supports that are in place.

"We can model how well people ought to be doing and target the interventions that are the most appropriate," Mr. Funderburk says. "We're heading toward using quality of life for health care improvement at the system level."

Lengthy interviews precede assessment tool development

Delmarva Foundation vice president Cindy Weinmann tells *State Health Watch* of an additional assessment tool developed through one-on-one interviews that lasted several hours each, looking at 25 measures of key domains.

"We want to go beyond a person's reported quality of life and assess the extent to which supports are present and whether other supports are needed," she says.

The various quality-of-life scales being developed look at more than patient satisfaction and the absence of disease, according to Mr. Funderburk. In addition, cultural context is important to achievement of a good measurement.

As the field develops, there are barriers to state use of quality-of-life assessments. Although physicians and other health care providers are trained to provide objective clinical evaluations of patient health status, many feel less comfortable when assessing the emotional and perceptual aspects of patient well-being referred to as quality of life.

The Delmarva team says if health-related quality-of-life assessments are to reach their full potential as a rational guide to health care delivery, experience has shown they must demonstrate their relevance to various constituencies in the health policy arena.

Don't fall into trap of seeing assessment as a frill

Acceptance of health-related quality-of-life assessment would be enhanced by an understanding of the information needs of patients, providers, researchers, administrators, and policy analysts. Communication among researchers, administrators, and practitioners is essential if health care quality-of-life assessment is to become a useful tool in state health policy evaluations, Mr. Funderburk says. Too often, he says, people drop this sort of evaluation as a frill rather than seeing it as the ultimate quality issue and using it within budget constraints to allocate resources.

Mr. Funderburk gives one example of how quality-of-life assessments could be used for patients who have a chronic disease, such as hypertension. Patients who have chronic diseases often don't take the medications that have been prescribed for them. In a quality-of-life assessment, researchers can ask what there is about a specific medication that causes people not to comply with their medication regimen. A key question on this assessment could be, "How can we help the consumer adjust to and manage lifestyle changes?" Through such questions, one can learn how patients' goals often drive noncompliance with medication requirements. For instance, a patient who wants to be alert may not continue taking a medication that slows him or her down.

[Contact Mr. Funderburk and Ms. Weinmann at (410) 763-6275.] ■

Use SCHIP tactics to attract Medicare patients to Medicaid

While states' budget problems are limiting interest in attracting new people to the Medicaid program, that situation will surely change at some point, and then states will be looking for ways to reach out to those eligible for Medicare. A study by Mathematica Policy Research senior health researcher Suzanne Felt-Lisk says one model that states can use to improve outreach to Medicare beneficiaries is the SCHIP program and its intense focus on enrolling all who are eligible for it.

Even with the state budget constraints, Ms. Felt-Lisk tells *State Health Watch* she has been "pleasantly surprised that the Centers for Medicare & Medicaid Services [CMS] has been involved in outreach and encouraging states" to reach out to Medicare beneficiaries.

Ms. Felt-Lisk says barriers to enrollment of Medicare beneficiaries are similar to those for SCHIP. First, people often don't know enough about Medicaid to recognize that they may be eligible. Next, there is a stigma attached to Medicaid, although Kaiser Family Foundation focus groups have suggested that the stigma issue recedes if officials are able to talk with those who are eligible. A third concern is with the Medicaid eligibility rules and the reliance on an assets test.

This issue of *State Health Watch* brings you news from these states:

It can be important for Medicare beneficiaries to participate in Medicaid, she says, because Medicaid can cover some or all of the out-of-pocket expenses that remain after Medicare coverage for low-income elderly or disabled people. But, at best, only about 60% of the elderly who are eligible for Medicaid are enrolled in it.

In an Operational Insights paper written for Mathematica, Ms. Felt-Lisk looks at the barriers and at steps that can be taken to overcome them. She writes that many of those who are dual-eligible Medicare beneficiaries don't recognize themselves as low-income people and are used to getting by on their own.

CMS has several programs under way to promote Medicaid enrollment for eligible Medicare beneficiaries, she says. These include mailing notices to prospective enrollees, distributing pamphlets about the program, advertising in the media, developing a three-page model application form for states to adapt or adopt, and developing a section on the Medicaid program in the *Medicare & You* handbook CMS distributes to beneficiaries.

Also, the National Medicare Education Program, designed to educate beneficiaries about their benefits, includes several components that can link beneficiaries to information and assistance about Medicaid eligibility and enrollment, including a toll-free telephone help line and beneficiary counseling and other services from State Health Insurance Assistance Programs.

CMS (when it was known as HCFA) wrote to state Medicaid directors in October 1998 suggesting they develop outreach and enrollment strategies modeled on those used for SCHIP. Regional training sessions were held in 1999, and several grants were awarded in 2000 to encourage states to build partnerships for innovative ways to do outreach.

Ms. Felt-Lisk says implementation of SCHIP led to an unprecedented focus by policy-makers, advocates, and others on how to reach a population that needs financial assistance with health care costs but does not necessarily seek it out. The following strategies have emerged from their experience:

1. Developing partnerships. To improve access to insurance coverage under SCHIP, states have recognized the importance of partnerships with other public- and private-sector organizations. Many states work with community-based organizations, advocacy groups, and other relevant units within their state. The organizations interact with the target population of children, allowing the state to leverage existing community resources and relationships for more effective outreach.

Within that structure, Ms. Felt-Lisk points to a number of SCHIP efforts that should be useful in enrolling dual-eligibles. First is the need to project an appealing image of the program. She reports that attractive and compelling ad campaigns promoting the message that SCHIP provides affordable health coverage for uninsured children in working families help reduce the stigma of public programs and encourage enrollment. Some states also use the media effectively, with some reporting that radio was particularly effective in rural areas. Many have found that advertising on foreign-language radio and TV stations is a good way to reach minority populations. Creative approaches include persuading the business community to stuff promotional cards in retail bags at discount

department stores, pharmacies, and retail outlets; distributing program information with employee paychecks; placing program information and a toll-free hotline number on grocery store bags and milk cartons; and developing bus and subway cards. Providers often help with outreach, and the National Governors Association has suggested developing a promotional video to play in physician offices and at sites where SCHIP eligibility is determined.

2. Simplifying enrollment. Most states have streamlined their SCHIP application and renewal policies and forms. Application and renewal processes also have been made more user-friendly. About 40 states now accept mail-in applications for SCHIP, often even including postage-paid return envelopes. Many states also have eligibility staff working in communities.

3. Reaching adult caregivers. SCHIP's outreach efforts focus directly on adult caregivers, including parents and grandparents.

4. Creative initiatives to promote SCHIP. Once enrolling uninsured children became a national priority, according to Ms. Felt-Lisk, financial and non-financial assistance began to come from many disparate sources. The federal government increased the match rate for SCHIP, while foundations funded outreach efforts.

The researcher reports that while most states use pamphlets and posters, and many have used direct mail to advertise the dual-eligibles program, they have not partnered, translated materials into other languages, or market-tested the materials as extensively as they have for SCHIP. "Ad campaigns similar to those used for SCHIP could reduce stigma where it is a barrier to enrollment and help low-income elderly become aware that they might be eligible for assistance," she says. "Another idea that showed promise in a demonstration is to send letters to likely eligible Medicare beneficiaries. States could do more to build relevant partnerships, even using some of the same relationships built for SCHIP."

Ms. Felt-Lisk says researchers have found that education beyond a single-phrase message is critical. More than for the SCHIP population, dual-eligibles prefer learning from other people face to face.

Addressing the application issue, she says that in contrast to SCHIP enrollment processes, the process for enrolling low-income elderly people in Medicaid typically remains cumbersome, due in large part to the assets test. She says states have flexibility under section 1902(r)(2) of the Medicaid law to eliminate the assets test or loosen or eliminate verification requirements to streamline the process. Alternatively, federal policy-makers could decide to eliminate or lessen requirements for the assets test as a way to expand access to care. But, she says, Medicaid still has a long way to go to become more consumer-friendly in its application process for dual-eligibles.

Ms. Felt-Lisk says states that want to do a better job of reaching out to dual-eligibles can use some of the SCHIP creative strategies, such as creative partnering, without changes in state policy or processes. Other changes, such as streamlining and simplifying the application process, require a concerted effort by state Medicaid agencies, which may not come until the budget crisis eases.

"Thoughtful translation of some of the strategies and lessons from the SCHIP experience should help boost the health of low-income older and disabled Medicare beneficiaries for whom enrolling in Medicaid is now either an unknown option or too formidable a process," she says. But she says she does not yet know of any state that is doing particularly good work in this regard, which leaves a lot of room for improvement.

[Download CMS information from www.cms.gov. Contact Ms. Felt-Lisk at (202) 484-4519.] ■