State Health Watch

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THOMSON AMERICAN HEALTH CONSULTANTS

In This Issue

Newest batch of reports show the states' budget pressures are easing

New data indicate that the continuous deterioration that plagued state finances for the past several years appears to be easing.

The reports come from the National Governors Association (NGA), National Association of State Budget Officers, and the National Conference of State Legislatures (NCSL).

"Fewer states are reporting budget gaps in the early months of fiscal year 2004," according to an NCSL report. "The rate and extent of the financial improvement, however, is uneven and has failed to reach many states. But for wary policy-makers, the lack of more bad news is good news."

NCSL president Marty Stephens, speaker of the Utah House of Representatives, said, "It's too early to pull out the sunglasses, but the fiscal storm we've endured may be breaking up."

NCSL executive director Bill Pound said the fiscal situation in the last few years "presented state legislators with new challenges and difficult choices. There is now reason for optimism."

*See **States' budgets** on page 2*

Washington state disease management stakes a claim for controlling costs, improving care

Recognition of Washington state's Medicaid disease management program as Best Disease Management Program — Medicaid by the Disease Management Association of America is helping focus attention on the value of such programs for controlling costs and improving health care in Medicaid.

Fiscal Fitness: How States Cope

Washington's program, most of which is operated under contract by McKesson Health Solutions, focuses on high-risk clients diagnosed with one of four chronic conditions — congestive heart failure, diabetes, asthma, and kidney disease. Officials say the program, which started in April 2002, has saved more than $2 million in its first year. **(See related story about program philosophy and case studies, p. 6.)**

The officials say the key to success in disease management is to center on patients with chronic conditions who can be stabilized or improved by more intensive management. That means adding nurse

*See **Fiscal Fitness** on page 5*

State Health Watch
The Newsletter on State Health Care Reform

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States' budgets

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NCSL said that state lawmakers were very cautious in preparing their FY 2004 budgets in hopes of avoiding the midyear budget cuts and other adjustments that have created problems in recent years. Nationally, FY 2004 appropriations are slightly below FY 2003 spending levels.

According to the group's November budget update survey of states:

- 10 states reported that a budget gap had appeared since the fiscal year began, down from 31 states with gaps a year earlier.
- The cumulative budget gap was $2.8 billion, down from $17.5 billion last year.
- FY 2004 budget gaps range from less than 1% in Connecticut and Rhode Island to 14% in Alaska (where officials say the amount still is smaller than originally projected).
- Several states reported that while a gap had not opened, there were factors that could lead to one.
- State revenue performance for FY 2004 is uneven across the states.
- 21 states reported that revenues were performing above the original forecast, with revenues on target in 13 other states and 16 states reporting that collections are below estimates. Last year, three states had revenues above projections, 10 on target, and 37 below expectations.

NGA's December 2003 *Fiscal Survey of States* found that while the economy has begun to show some signs of improvement, states continue to grapple with short-term cyclical and long-term structural problems.

"Budget gaps are lingering as spending pressures persist, particularly from Medicaid and other health care, and as revenues remain sluggish," the report noted, "although in some states, recently they have shown signs of resuscitation. As in previous years, states are confronting these challenges by enacting negative growth budgets, increasing taxes and fees, reorganizing programs, and drawing from reserves."

Costs continue to strive budgets

Looking specifically at health care, NGA said that the rise in Medicaid spending, coupled with the downturn in state revenue collections, continues to strain state budgets severely. Medicaid spending increased by 9.3% in FY 2003 after going up by 12.8% in FY 2002. This growth rate of about 23% in two years compares to an actual decline of 0.3% in state revenue growth during the same time period.

"States appropriated an increase of 4.6% for fiscal 2004, an amount that most likely will prove to be too low," the NGA explained. "In fact, 32 states already assume they will have a shortfall in their fiscal 2004 Medicaid budgets. The trends in Medicaid are consistent with the rise in private insurance costs, though Medicaid growth rates, in fact, are lower. States have been able to maintain a growth rate below private insurance levels due to the aggressive cost-containment efforts used by all 50 states."

Over the past three fiscal years, according to the NGA, 50 states have reduced or frozen provider payments; 50 states have implemented policies to control prescription drug costs, such as prior authorization and preferred drug lists; 34 states have reduced or restricted eligibility; 35 states have reduced benefits; and 32 states have

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NCSL wants Medicaid flexibility, federal support

A Medicaid reform proposal released by the National Conference of State Legislatures (NCSL) is driven by two factors — the increasing need for the Medicaid program and the program's increasingly unaffordable cost to states. A partial solution envisioned by NCSL involves facilitating more state experiments to meet the needs of those who are uninsured and underinsured, allowing states to cut costs with minimal loss of services, and reducing long-term care costs.

"NCSL does not expect to be able to stop increases in Medicaid costs due to rising health care costs and the aging of the population," the organization says. "These will continue, and we expect to pay our share. We do hope to get more for our dollar and to slow the growth in costs." NCSL federal affairs counsel Joy Johnson Wilson tells *State Health Watch* that because the proposal was released just before the 2003 Christmas holiday, there was no time to shop it with members of Congress and their staffs. "But we have received a fair amount of response from other stakeholders and interested parties who want to pursue parts of it."

NCSL proposals include:

1. Allowing states to modify existing programs by plan amendment rather than waivers in many areas. Areas where this could be applied include establishing and setting the size of programs for home- and community-based care as an alternative to nursing homes; setting minimum work requirements for recipients with incomes above the minimum federal requirement for program eligibility; prescription-drug-only options with enhanced eligibility for the option and copayments and deductibles; basing eligibility for families and individuals on their low income even if they do not fit categorical eligibility; imposing enhanced deductibles and copayments on program recipients with incomes above minimum federal requirements for eligibility; and flexibility to modify priority service lists.
2. Modifying the prescription drug plan option to provide for regular compliance audits of the rebate program; public disclosure of prices that states pay for individual drugs and rebates received to reveal net prices; continuation of prior authorization procedures; and permitting a prescription drug-only option with enhanced eligibility and enhanced income-based deductibles and copayments.
3. Making permanent a provision for fiscal relief to states for Medicaid during hard economic times through a formula that would automatically provide additional relief in bad economic times and revert to the normal federal cost sharing in good economic times. NCSL suggests that the federal cost share for Medicaid be increased by 1% for every 0.25 of a percentage point that the national unemployment rate is above 4.5%. The organization suggests that for each federal fiscal year, the government use the average of the unemployment rates for the 12 months ending on the July 1 preceding the start of the federal fiscal year. NCSL says it recognizes that other formulas are possible and is prepared to work with Congress and the administration on alternatives that could achieve the desired result.
4. Providing additional flexibility to states in the Early and Periodic Screening, Diagnosis, and Treatment program, the Medicaid eligibility process, an expedited waiver process, and elimination of the current cost-neutrality requirement for many classes of waivers, especially for waivers with prior legislative approval.
5. Reforming the Medicaid nursing home program to provide for physical, psychological, and social needs of clients; preserve the right of self-determination, dignity, and independence; provide access to services for diagnosis and treatment of mental illness; provide incentives for provision of restorative and rehabilitative services; and recognize the important role nonmedical personal care and social services play in maintaining a person's independence. NCSL also asks for relief from prescriptive nursing home reform requirements included in the 1987 Omnibus Budget Reconciliation Act.

Ms. Wilson says the top priority in the proposal is the section that may take many by surprise — the notion of an institutionalized automatic federal payment increase to states for Medicaid during hard economic times.

"We really had to beg for the fiscal relief that we needed and got in the last session," Ms. Wilson tells *State Health Watch*. "There should be something in the law that is triggered when the economy hits a specific point. The proposal we've made [to tie such increases to levels of unemployment above a defined

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percentage] is just to get the discussion started. We want to work with an economist to flesh out our recommendations. I just think it's needed because we worked so hard and still barely got some fiscal relief."

Another key priority is the reform of nursing home payments and requirements because, according to Ms. Wilson, states realize that long-term care is a "growth area" in terms of state budget problems.

"There aren't a lot of options for fixing it," she says, "although the partnership may help."

A third area she stresses is the need for greater flexibility.

[Download a summary of the Medicaid reform proposal from www.ncsl.org. For more information, contact Joy Johnson Wilson at (202) 624-8689.] ■

increased copayments. (**See related article, p. 3.**)

Not only are states limiting spending, the NGA said, but approximately half of them also are planning to generate additional revenue for Medicaid through fees or taxes on health care providers, reallocating tobacco settlement funds, and increasing cigarette taxes.

The NGA survey found that escalating Medicaid costs continue to place the program in the forefront of state budget issues. While the Jobs and Growth Reconciliation Act has helped states by providing a temporary increase in the federal Medicaid matching rate, which should bring states $10 billion in fiscal relief in FY 2003 and FY 2004, as states plan for FY 2005, they find that the drop-off of the federal relief will force another round of difficult decisions in Medicaid.

Over the next decade, Medicaid spending is projected to grow at an average annual rate of 8.5%, according to the Congressional Budget Office, a rate that would far exceed state revenue growth even after a full economic recovery is under way.

Signaling the difficulty states still have with health care spending, a four-month study conducted by the Gannett News Service found that children across the country are being cut off from doctors because states are rolling back health insurance for the working poor. The new service's study found that 22 states have restricted children's health insurance programs over the last 18 months.

"We will certainly have sicker kids because of this," said Leighton Ku, a researcher with the Center of Budget and Policy Priorities, in regard to the survey. "This will cause problems for their parents, too, because if the kids are home sick, the parents are going to miss work.

The Gannett survey found that some 270,000 children of low-income working parents have been barred from health insurance programs in the nine states where estimates are available, Texas and Florida lead the country in the number of low-income children shut out of state health insurance programs, and changes to state programs are expected to hurt immigrant children, especially Hispanics.

Schools could feel the impact

Studies have shown that children without health insurance miss more school than insured children and that their classroom performance is impaired. The researchers said that could mean trouble for schools that face new federal mandates to improve the performance of all students. Parents of sick, uninsured children are likely to seek medical care through hospital emergency departments and public clinics, even though they can't pay for it. An increase in uncompensated care will translate into high prices for families with health insurance, according to health professionals.

NCSL pushing Medicaid reform

The health committee of the NCSL has adopted a Medicaid reform proposal that calls for increasing state flexibility to allow greater innovation in meeting needs of uninsured and underinsured residents. The committee also is proposing a funding formula that would automatically provide additional relief in bad economic times and revert to the normal federal-state cost-sharing in normal economic times.

NCSL also proposes increased accountability and openness in prescription drug purchases to facilitate free market competition and slow the growth of drug costs.

Meanwhile, a study released in December 2003 by the Center for Studying Health System Change found that health care spending per privately insured American slowed in the first half of 2003, increasing 8.5%, down from the 10% increase in the second half of 2002.

Despite the fact that the 1.5% decline in health care spending growth was the largest six-month drop since the early 1990s, health care spending in the first six months of 2003 still grew nearly three times faster than growth in the overall economy, as measured by a 2.9% growth in per-capita gross domestic product during the same period.

"Increased patient cost sharing is probably an important factor in the slowing of cost trends, but few experts expect this tool to substantially lower cost trends over the long

term," said center president Paul Ginsburg, a co-author of the study. "Without more effective cost-control measures, the rising cost of health insurance will make coverage unaffordable to more and more Americans."

While other research shows employer-sponsored health insurance premium increases reached a 13-year high in 2003, rising an average 13.9%, the significant slowing of underlying health cost trends in 2003 could prompt the first slowdown in premium growth since the mid-1990s.

Spending growth has slowed

The slowing of the overall cost trend reflected slower growth in all four categories of health care spending analyzed — inpatient and outpatient hospital care, physician services, and prescription drugs. Prescription drug spending slowed the most, rising only 8.5% in the first half of 2003, considerably less than the 13.4% increase in the second half of 2002.

The first half of 2003 was the first time since the mid-1990s that the cost of prescription drugs did not grow at a double-digit rate.

Spending on hospital inpatient care grew 7.6% during the first half of 2003, down from an 8.3% increase in the last six months of 2002. Spending on outpatient care increased 12.9% in the first half of 2003, down from 14.1% in the second half of 2002.

Outpatient care remains the fastest growing category of health care spending.

Spending on physician services increased 6.1% in the first half of 2003 and was the slowest growing category of health care spending.

[Additional information is available from www.nga.org and www.ncsl.org.] ■

Fiscal Fitness

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managers who can assess and educate clients as well as help providers sidestep the complications and other problems that otherwise might further erode clients' conditions and add significant cost to their care.

Doug Porter, assistant secretary for Medical Assistance administration in the Washington Department of Social and Health Services in Olympia, tells *State Health Watch* the state tried several programs in the past, which were unsuccessful, but kept looking for a way to address needs of the 30% of the Medicaid caseload, the disabled and the elderly, who take 50% of the dollars.

Mr. Porter says McKesson originally projected savings of $1.3 million, but the contractor and state agency were pleased to see that the savings were outstripping the projections. (**See article on measuring return on investment in DM programs, p. 7.**)

He said the program is voluntary for clients, but very few of those who have been targeted decline to participate. Anecdotal information from clients, their families, and providers indicate that the effort is being very well-received.

For example, according to Mr. Porter, congestive heart failure patients tend to be overweight, and it is known that rapid weight gain can signal fluid retention. Without the focused disease management program, there would be no one to remind patients to weigh themselves or to provide a special scale for use in monitoring their weight. There also has been success in getting people to comply with a medication regimen. Program nurse consultants keep in touch with the high-risk patients, Mr. Porter tells *State Health Watch*, and "it must be a breath of fresh air to have someone check up on you to make sure you're OK."

Incentives for vendors, patients

He tells *State Health Watch* that lessons learned from the first year of experience include fine-tuning incentives for vendors to deliver significant savings and for clients to participate in the program.

According to Mr. Porter, Washington started with a flat rate for the vendor and a commitment to evaluate the savings. At this point, he says, they are willing to structure the next contract so that savings can be shared. He says they don't want to charge blindly into a capitation arrangement because they want to be sure how the savings are being generated and confident that people still can get the care they need. But capitation definitely should be explored, he says, because that's where the money is.

Care Coordination Section manager Alice Lind tells *State Health Watch* they have learned the importance of working with providers and ensuring that any disease management contractor wants to work closely with providers. It also has been important, she says, for the vendors to have an in-state presence that can facilitate participation in on-site training and problem-solving activities.

"Very few providers initially were predisposed to be receptive," Ms. Lind cautions. "They didn't like what they saw as interference in their practice or that they would be judged by an outside entity. Also, some providers have been working on their own on chronic care and didn't see what they would learn from our vendor. But we've managed to win over even the most resistant doctors, and they now see that our nurse case managers are there to help them."

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Washington case studies show DM programs work

According to the Washington State Department of Social and Health Services in Olympia, studies have shown clearly that a relatively small number of beneficiaries with certain chronic illnesses account for a disproportionate share of Medicaid services.

Because their care is complicated and demanding, those same patients tend to receive fragmented care involving multiple providers and multiple sites of care, including frequent hospitalizations.

Since Medicaid is having financial resource problems in most states, this type of patient population is a natural target for increased scrutiny. The department said it should be noted that the complexity-of-care and quality-of-care issues involved have persuaded many providers that a different system of managed care may be needed.

One reason for urgency in developing a better system of care is that the nation's patient population is aging and the number of chronically ill beneficiaries in Medicaid can be expected to grow dramatically in the next few years. The department explained that the increased costs inherent in such a trend have very serious implications for the entire Medicaid spectrum.

Part of the challenge Washington state has set for itself is to demonstrate that the kinds of disease management efforts that have been undertaken in the private sector to better coordinate health services and control costs will operate effectively with Medicaid.

"There is ample reason to be hopeful that such practices will reduce unnecessary hospitalizations and emergency department visits, while encouraging regular office visits and thereby helping to reduce health care costs as well as improving health status," the department added.

Materials distributed by the agency include four examples of disease management success stories:

- A homeless dialysis patient lived in a temporary shelter that was closing. He ate his meals at a local mission and at churches. Because of past drug and alcohol problems as well as several incidents of time spent in jail, he had difficulty getting into permanent housing. Getting to dialysis regularly was a problem, in part, because of the unresolved housing issues. The care manager worked with the patient's social worker and parole officer to find a housing situation with meals, and the patient now goes to dialysis regularly.
- A man struggled with a weight-loss plan and hypoglycemia, but his symptoms did not make sense to him. When he entered the state's diabetes management program, he was frustrated. The program nurse learned that his blood sugars were being monitored every three months and he was not doing any home monitoring. As a result, he was having hypoglycemia when he followed his diet and couldn't understand why. After discussions with the care nurse, he was able to begin daily self-glucose monitoring and tracking the results. He switched to a new physician who was very supportive of the program and encouraged him to stay in regular touch with the program nurse. After six months in the program, the client is adjusting his diet according to his blood sugar levels and says he feels better and understands why.
- A 50-year-old woman in the diabetes management program encountered neuropathy following back surgery and was ignoring her former physician's advice to begin taking insulin. She was in pain and poor health and had concluded that it would be impossible for her to deal with her diabetes. Officials say her attitude began to change after just one visit with a program nurse. She said that contact inspired her to make positive changes — she started monitoring her blood sugar, controlling her diet, and exercising every day. She got a flu vaccination in the winter, checks her blood sugar twice daily, and hopes to stall the need for total dependence on her wheelchair. "It's nice to know I have someone to help me," she has told state officials. "This program has turned my life around."
- A woman who had a morbid fear of needles would feel faint whenever she received a numbing shot before insertion of the larger dialysis needles. Over time, she grew more accustomed to the needles, but still dreaded that part of the procedure. The care manager talked with the clinical manager and proposed that the patient receive an anesthetic cream that numbs the skin. The nephrologist agreed, and today the patient no longer has needles anxiety because her dialysis has become pain-free. ■

Ms. Lind says the response from patients has been "fabulous" because they appreciate the support and service and express surprise that Medicaid would develop such a program to help them.

From the contractor's perspective, McKesson vice president of medical management services Sandeep Wadhwa tells *State Health Watch* they have identified two key success factors. First, he says, there has been a good working partnership with the state Medicaid staff. The state officials have helped their McKesson counterparts navigate the Medicaid bureaucracy and have been an invaluable partner in introducing McKesson and the program to doctors and to the community. The second key success factor Mr. Wadhwa cites is the involvement of community stakeholders. He says they have worked with many state groups to encourage them to view the program as a resource rather than as a threat.

It has been important, he says, that services initially have been offered to fee-for-service Medicaid patients and that McKesson has done a thorough analysis of the populations to be covered to assess the potential for financial and clinical improvement. It also matters, according to Mr. Wadhwa, whether the state decides to fund the program through a waiver or an amendment since different types of funding can give a different flavor to the initiative.

McKesson doesn't have a preferred financing mechanism, according to Mr. Wadhwa.

"We've learned to be nimble and to work with states in whatever way they want to work with the Centers for Medicare & Medicaid Services," he says. "It's probably cleanest with a waiver, and the state has more ability to shape the program. Amendments can be easier, but there can be configuration issues to be sure that all conditions are met. If waivers were easier, we'd enthusiastically support them."

Improved outcomes during the first year have included: 1) an increase in the rate of asthma clients receiving flu shots from 45% to 59%; 2) an increase in the percentage of congestive heart failure patients who weigh themselves daily from 28% to 67%; and 3) an increase in the percentage of diabetics who take aspirin daily from 41% to 57%.

Other accomplishments claimed for the program include: 1) more than 150,000 clients have access to a 24-hour nurse hotline operated by McKesson with calls averaging 1,600 per month, including 900 requests for guidance for symptoms of illness; 2) care coordination includes referrals to other state agencies and local community groups, assistance with access to medical providers, and referrals to the tobacco quit line; and 3) disease management education for more than 200 physicians, reinforcing the importance of standards-based medicine and improving quality and delivery of care.

[Contact Mr. Porter at (360) 725-1915; Ms. Lind at (360) 725-1629; and Mr. Wadhwa through McKesson public relations manager Jordan Gruener at (303) 664-6410.] ■

Measuring return on investment for DM isn't easy

Because disease management programs do not provide instantaneous savings, the decision to invest in them represents a belief that savings will occur down the line as a result of the programs' effectiveness. A November 2003 Academy Health issue brief, *Evaluating ROI in State Disease Management Programs*, says the challenge for policy-makers is to prove that disease management both improves health and yields an economic return. The brief was published by the State Coverage Initiatives of the Robert Wood Johnson Institute in Washington, DC.

Thomas Wilson, an epidemiologist and principal with Wilson Research of Loveland, OH, says if the fees that states pay to develop their own disease management programs or to contract with a vendor are less than the money they save from decreases in use of impatient and outpatient care, prescription drugs, and other services, then states have earned a positive return on investment (ROI).

Measuring the financial return associated with disease management programs is difficult because changes in health care costs over time cannot be assumed to be due only to the disease management intervention in the population that received the disease management services. Other external factors also could have played a role, Mr. Wilson says. For example, costs could have dropped in the disease management population because that group recently had been exposed to a heavily promoted new drug, or because they experienced a change in benefit design, or any of a number of other external factors.

According to Mr. Wilson, there are two general approaches to calculating ROI — direct and indirect. A direct assessment of ROI uses primary data only. It must include at least one outcome metric that is

available in both the intervention and reference populations. Mr. Wilson says that to substantiate an ROI estimate, it is strongly recommended that measurement for at least one proximate outcome metric be taken in both groups as well. Assuming the clinical metrics change in the same direction as the financial metric, it will provide some assurance that the financial impact was paralleled by a change in a clinical metric.

Using secondary data

An indirect ROI assessment, according to Mr. Wilson, is one that uses secondary data, such as that found in a benchmark-type design. Such an analysis should include at least one proximate outcome metric; the ultimate outcome is inferred. An example of an indirect assessment would be the imputed savings of lowering blood pressure over a five-year period, based on an acceptable formula for calculating savings. Mr. Wilson says it should be noted that ROI assessments are easily biased by both nonequivalence and lack of comparability.

ROI is always an estimate, he. says, and there are many biases that can influence it.

"For any study," Mr. Wilson says, "pure objectivity and independence is a myth. Therefore, one should still assess the extent to which potential conflicts of interest might compromise the results. Ideally, the evaluator: 1) is qualified; 2) has little or no conflict of interest bias prior to the study; and 3) is not subject to any pressure, whether direct or indirect, from the client during the study."

Given the uncertainty associated with disease management analyses, he cautions, it probably is not possible to prove that disease management positively affects ROI by the legal standard of "beyond a reasonable doubt." A more reasonable goal, he says, is to aim for a "preponderance of evidence," which means that ROI assessments should not be based on a single study. Rather, evidence should be refreshed constantly with new data, which will assure those who pay the health care bills that the investments they made months or years earlier were intelligent ones.

Along the same lines, a Center for Studying Health System Change issue brief, *Disease Management: A Leap of Faith to Lower-Cost, Higher-Quality Health Care,* said that disease management programs are difficult to evaluate systematically because they are rarely implemented consistently across health plans and vendors and often evolve over time. Several studies have demonstrated that specific disease management programs can improve patient care and reduce service utilization, the report says, but the evidence varies widely across health conditions and types of interventions.

The authors noted that most health plans are interested in programs that can produce relatively short-term reductions in health care utilization and costs, because high membership turnover makes it difficult for plans to capture long-term savings. But employers may value longer-term results beyond those of interest to health plans, such as reductions in absenteeism and work-related injuries and improvements in worker productivity and satisfaction.

The center's survey of several markets seems to indicate that disease management programs are achieving desired results in some, but not all, health plan settings. The report noted that a Seattle plan that dropped most of its programs in 2002 found that only a prenatal care program for high-risk pregnancies produced a positive return on investment and improved patient outcomes. The plan's other programs reportedly were expensive to administer and served only limited numbers of members.

Other plans in Seattle; Greenville, SC; and Miami reported that some disease management programs can improve clinical performance or patient outcomes, although some still lack clear evidence of economic return on investment.

Insurer sees value

One insurer, convinced in the cost-effectiveness, has been offering lower premiums to fully insured employers that include disease and/or case management programs in their health plans.

Like health plans, the survey report said, employers have difficulty evaluating disease management effectiveness. A few large employers operating disease management programs independently of health plans have found evidence of program achievements. The center reported that one employer that offered an evidence-based program to manage workers' serious medical conditions found that one in 16 patients was misdiagnosed, creating meaningful opportunities to improve care. That employer also reported saving more than $2 in health care costs for every $1 spent on disease management.

Overall, however, relatively few employers have been able to assess the performance of disease management programs for their specific employee populations, the report explained. In part, this is because health plans often do not have enough participants from any single employer to support employer-specific assessments, and many employers have not attempted to model systematically the health or economic effects of disease management activities on their work force.

"Lack of consistent evidence of improved quality and reduced costs has prevented more rapid acceptance of disease management programs, according to some employers," the report concluded.

Economic viability in DM

Finally, what the American Association of Health Plans/Health Insurance Association of America (AAHP/HIAA) described as groundbreaking research announced at a Washington, DC, briefing Nov. 6, 2003, purports to overcome limitations in previous research and show that some disease management programs are economically viable. The associations said some studies in peer-reviewed literature used well-designed methodologies to find significant cost savings in disease management but were based on the experiences of a single health plan and the extent to which such results can be generalized is uncertain.

Likewise, other studies did not adequately address important methodological issues such as the statistical phenomenon known as "regression to the mean," something that occurs when, for example, a disease management program enrolls patients who had particularly high utilization of health care services in the year before the program started. Costs for such patients would be expected to fall — to regress to the mean — in later periods of time, regardless of whether the patients participated in a disease management program. Failure to control for regression to the mean could result in the effects of the disease management program being overstated.

The AAHP/HIAA survey looked at 10 health plans that operate 25 different disease management programs for congestive heart failure, coronary artery disease, congestive obstructive pulmonary disease, low back pain, and end state renal disease. Researchers said the 10 plans represent a variety of model types, geographic regions, and enrolled members. Included were Medicare and Medicaid beneficiaries, enrollees in commercial HMOs and preferred provider organizations, and members of self-funded employer plans.

The AAHP/HIAA said the disease management programs had similar elements that could be replicated in other health plan settings, including patient education materials such as information on self-care management, telephone-based nurse case management, distribution of information to physicians about clinical practice guidelines and utilization patterns, and home visits.

Each plan was asked if it had evaluated the effects of its disease management programs on utilization or cost and, if so, what methodology was used to conduct the evaluation.

"As expected," the researchers added, "no evaluation met the 'gold standard' of a randomized, controlled study — health plans face enormous barriers to randomly assigning patients to treatment and control groups in a pure experimental design. But all the plans used valid, nonexperimental methods in an effort to rule out plausible, alternative explanations [such as regression to the mean] for any decreases in utilization or cost among disease management enrollees."

The report concentrated on eight of the 25 evaluations that were particularly thorough in ruling out plausible alternative explanations. The researchers said that most eliminated the potential for selection bias, which would occur if those selected for disease management were systematically different from those not selected, by enrolling all people with a particular condition in the program for that condition, rather than enrolling only an advantageous subset of people with the particular condition.

All the evaluations tracked utilization and costs for several time periods before the disease management program began, and for several time periods after the one-year point. Some evaluations achieved a form of randomization by gradually phasing in the disease management enrollment across geographic areas, simulating the effect of a randomized, controlled study.

According to the report, while quality of care was not the main focus of the survey, all of the disease management programs showed improvements in clinical outcomes consistent with published literature. "It appears clear," according to the

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

researchers, "that when a chronic condition such as asthma or diabetes is managed appropriately on a continuing basis, patients enjoy a better quality of life and avoid many medical crises."

Key points made by the researchers included:

- Asthma disease management programs reduce total health care costs and show a strong return on investment.
- Disease management programs for congestive heart failure reduce emergency department visits and inpatient admissions by one-third.
- Disease management programs for low back pain provide a strong return on investment.
- Diabetes disease management programs reduce per-member, per-month costs, inpatient days, inpatient costs, and total costs.
- Disease management programs for multiple chronic conditions provide a major ROI.

The researchers explained the eight evaluations they reported on "break new ground in overcoming the limitations of previous research on disease management. Unlike some earlier studies, these evaluations are valid because they address important methodological issues, such as the statistical phenomenon known as regression to the mean. And these evaluations are generalizable because they cover multiple health plans, different areas of the country, and a diverse range of people of various ages from different socioeconomic backgrounds."

[Contact Mr. Wilson at (513) 289-3743. E-mail: twilson@wilsonresearch-llc.com. For the Center for Studying Health System Change report, go to: www.hschange.org. Phone: (202) 484-5261. For the AAHP/HIAA report, go to: www.aahp.org.] ■

Youth smoking down despite weak programs

While states are coming under fire for not spending as much tobacco settlement money on smoking cessation programs for youth as they should, the American Legacy Foundation's 2002 National Youth Tobacco Survey indicates that the prevalence of current smoking among high-school students declined about 18%, from 28% in 2000 to 22.9% in 2002. But the survey found no significant decrease in prevalence of smoking among middle-school youth in the same period.

The Washington, DC-based American Legacy Foundation was created as a result of the tobacco settlement agreement in 1998, and develops programs that address the health effects of tobacco use through grants, technical assistance and training, youth activism, strategic partnerships, counter-marketing and grass-roots marketing campaigns, public relations, and outreach to populations disproportionately affected by tobacco use.

Poll results were included in the Nov. 14, 2003, *Morbidity and Mortality Weekly Report*, published by the Centers for Disease Control and Prevention (CDC). The National Youth Tobacco Survey is the only comprehensive national survey that measures use of cigarettes, cigars, smokeless tobacco, pipes, bidis (leaf wrapped, flavored cigarettes from India), and kreteks (clove cigarettes) among middle school and high school students in the United States.

Researchers found that each day in the United States, some 4,400 youths ages 12 to 17 try their first cigarette, and an estimated one-third are expected to die from a smoking-related disease.

In 2002, 13.3% of middle-school students reported current use of any tobacco product, with cigarettes the most commonly used product. There were no significant differences in usages by sex. Cigars were the second most commonly used product, followed by smokeless tobacco, pipes, bidis, and kreteks. Males were more likely than females to use all tobacco products except for cigarettes. There were no significant differences found for any type of tobacco use when the data were cut by race or ethnicity.

Among high-school students, 28.4% report current use of any tobacco product, with no difference by sex, although white students were more likely to use cigarettes than blacks, Hispanics, or Asian students. Cigars were the second most common tobacco product, followed by smokeless tobacco, pipes, kreteks, and bidis. Males were more likely than females to use all tobacco products except for cigarettes. Asian students were less likely to use cigars, and white students were more likely to use smokeless tobacco than students in other racial or ethnic groups.

The researchers said the lack of progress in reducing smoking among middle-school students suggests that health officials should improve implementation of proven anti-smoking strategies and develop new strategies to promote continued declines in youth smoking. They also noted that the declines in cigarette smoking and overall tobacco use among high-school students reflect downward national trends since 1997, and the declining use of cigars, bidis, and kreteks, and the unchanged use of smokeless tobacco and pipes among high-school students suggested that students are not substituting other tobacco products for cigarettes, and efforts to reduce

cigarette smoking might be reducing use of all tobacco products.

"Why middle-school and high-school students appear to be responding differently to the current anti-smoking environment is not clear," the report said. "Factors expected to discourage youth from smoking include increases in cigarette prices; implementation of smoke-free laws and policies; restrictions on tobacco advertising; and governmental anti-tobacco campaigns. However, spending on tobacco industry marketing doubled during 1997-2001, and tobacco industry-sponsored media campaigns have been determined to reduce the impact of public health campaigns."

According to the researchers, the survey data suggest that further refinements in evidence-based strategies will be needed to cut tobacco use among middle-school students. Efforts that might be successful could focus on devising more targeted and effective media campaigns; reducing depictions of tobacco use in entertainment media; starting campaigns to discourage family and friends from providing cigarettes to youth; promoting smoke-free homes; starting comprehensive school-based programs and policies in conjunction with supportive community activities; and reducing the number of adult smokers so that youths see more non-smoking role models.

Meanwhile, a report presented to Congress by a number of anti-smoking groups charged that states are spending less on smoking prevention programs than the amount recommended by the CDC. According to the report, only Arkansas, Delaware, Maine, and Mississippi spend the levels recommended by the CDC to fund tobacco prevention programs. And five states and the District of Columbia reportedly have not dedicated any tobacco settlement money to prevention programs.

One reason for the decrease in prevention spending, analysts suggested, is state budget problems, since 16 states have used tobacco settlement money to secure bonds that lawmakers used to reduce state budget deficits.

At a Nov. 12, 2003, hearing sponsored by the U.S. Senate Committee on Commerce, Science, and Transportation at which the report was released, committee chairman John McCain (R-AZ) suggested that an ounce of prevention might be worth more than a pound of cure.

"From both a long-term economic perspective and a moral perspective, I would like to understand why states are, to a large degree, ignoring the problem of youth smoking," the senator said. "The surgeon general testified in 2000 before this committee that smoking prevention programs work, and that proper funding of these programs could cut smoking rates in half by 2010. I believe the tobacco settlement revenues may be our best chance to dramatically reduce smoking rates, especially among our children."

Presenting the report on prevention activities, Campaign for Tobacco-Free Kids president Matthew Myers said the failure of states to do as they had promised "will have tragic consequences for the health of our nation's children and the amount taxpayers are forced to pay in the future to cover the costs of tobacco-related Medicaid expenditures. . . . Every state that has implemented a well-funded tobacco prevention program in accordance with the guidelines issued by the CDC has experienced a significant reduction in tobacco use. These programs work."

Mr. Myers reported that states have a clear source of revenue to address the problem because, despite their recent budget shortfalls, states are actually collecting more tobacco-generated revenue than ever before from the tobacco settlement and tobacco taxes. That is because 32 states and the District of Columbia have increased tobacco taxes since Jan. 1, 2002. Altogether, he said, states in 2003 will collect $19.5 billion in tobacco-generated revenue, and it would take just 8.2% or $1.6 billion for every state to fund prevention programs at the minimum level recommended by the CDC.

"That leaves plenty of tobacco revenue to balance budgets and meet other needs," he said. "But the states are barely spending a third of what the CDC recommends."

National Governors Association executive director Ray Scheppach said that the "most important issue facing states today is the dismal fiscal situation. States are enduring the worst fiscal stress since World War II, and although the national economy is beginning to recover (**see cover story**), state revenue growth has not responded, and historically has lagged federal recoveries by upward of 18 months.

American Legacy Foundation president Cheryl Healton issued four challenges to the Senate committee:
1. The nation must reinforce and

renew its commitment, and the commitment in individual states, to youth tobacco prevention.
2. Attention must be given to the 47 million Americans who are smokers and especially the large percentage of them who want to quit.
3. Encouragement is needed for new and expanded public-private partnerships between business, unions, communities, states, and the federal government that will help expand the life-saving benefits of prevention programs and smoke-free workplaces.
4. Congress should continue its oversight responsibilities, tracking the progress of the tobacco settlement and encouraging the federal government to find appropriate avenues to become a more direct partner in tobacco prevention programs on the national level.

(To find out more about the survey, contact the American Legacy Foundation. Web: www.americanlegacy.org.) ■

Clip files / Local news from the states

This column features selected short items about state health care policy.

Medicaid plan would restrict nursing homes to truly poor

ALBANY, NY—Leaders of the New York State Senate have proposed far-reaching revisions of Medicaid, the health plan for the poor that has become a crippling burden on New York's state and local governments.

They recommended, among other things, the diversion of people from nursing homes and restrictions on access to some prescription drugs. The Senate Republicans said their plan would both improve care and save $2.5 billion over five years, claims that were made difficult to gauge by a lack of detail in their report.

Democrats and a variety of liberal groups quickly disputed such predictions, but some of the Senate's usual critics, particularly advocates for the disabled, held out cautious hope that this time, the Republicans were on to something valuable.

Majority Leader Joseph L. Bruno and his colleagues are taking on the $40 billion-a-year program because of the strain it puts on state finances, and discontent at the local level that many state lawmakers fear could grow into a political backlash against them.

The counties and New York City pay a share of the program's cost, an expense that has expanded even as their budgets have contracted, prompting local officials to complain that Medicaid has forced them to cut other programs and raise taxes.

—*New York Times*, Dec. 23, 2003

Nebraska unveils mental health plan

LINCOLN, NE—Hastings and Norfolk officials say they're uneasy about the newly unveiled proposal for a state mental health facility in Omaha. It's not that they dispute Omaha's crying need for more crisis care and intermediate care. But they fear that the Omaha facility is the reason that the state mental hospitals in their communities have been targeted for closure. "I'd like them to have a good facility there, one that's functional, accessible, and meets the needs of patients," said Kevin Piske, a psychologist at the Norfolk Regional Center.

"I don't want to see them cannibalize Norfolk and Hastings for a facility that really isn't going to do anything different," he said.

Gov. Mike Johanns and officials at the University of Nebraska Medical Center and Creighton University Medical Center presented a document describing a *Nebraska Center of Excellence in Behavior Health* they envision for Omaha.

The two medical centers would provide staff for the facility. Construction and start-up costs would be paid through private donations, Mr. Johanns said.

Ongoing operational costs would come from government coffers. It is the latest piece of the state's mental health overhaul — proposed by the governor and state Sen. Jim Jensen of Omaha — that calls for the closure of regional centers in Norfolk and Hastings in 2005 to free up and bring in money for community-based mental health services.

—*Omaha World-Herald*, Dec. 16, 2003