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Briefing: NCSL 2004 Annual Conference
Facing Medicaid Challenges: Tools for the Future
July 21, 2004

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JAMES EVANS: Okay. We'll go ahead and begin. First I'd like to just thank the Kaiser Family Foundation for web casting this session. And those of you who would like to see the session on the internet you can go to www.kff.org. I'm James Evans, the Senator here in Salt Lake City, Utah, from district one. And I chair the Health and Human Services Committee for the state of Utah, Utah State Senate.

I'm going to introduce the panelist on here. I'm going to ask each to stand as I introduce them so you can get a face with the name and then we can begin the presentations.

First, we have Representative Tom Birch [misspelled?]. He's the chairman of the House, Health and Welfare Committee for the commonwealth of Kentucky. He has served as a member of the state legislature for 30 years. Representative Birch is also very active in NCSL and has served as chairman of the Health Committee. Representative Birch works diligently for family and children's issues and was instrumental in passage of the early childhood development legislation. It's Representative Birch to my immediate right.

Then we have three other speakers which I will introduce now. We have Jill Joseph-Bell who is vice president of public affairs for Passport Health Plan, the region's Kentucky Medicaid management care plan. She's responsible for legislative, community and media affairs for the 130,000 member

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health plan. Her duties include communications, outreach and education to members in the 16 county service area.

To her right we have Brian, at the end

[Laughter]

We have Brian Burwell who is vice president and director of chronic care and disability within the research and policy division of MedStat, a healthcare information technology company. During his 20 year tenure with the company, Mr. Burwell has directed over 30 studies for federal and state agencies on Medicaid and long-term services.

We have Miss Brown-Woofter, is a registered nurse and currently serves as program administrator for the Agency for Health Care Administration for Florida Medicaid Bureau of Health System Development. She oversees the entire Medicaid disease management initiative and has acted a contract manager for health, a contract manager for each of the eight traditional Florida Medicaid disease programs, coordinating all elements of the program.

And I believe I just introduced everyone. Did I not? I lost track.

So with that we'll start with Representative Birch and then proceed as outlined.

TOM BIRCH: Thank you. My presentation is going to be very short because Jill is the brains behind this here, but. Back in 1990 in Kentucky we realized we had a problem with

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Medicaid which hadn't really realized we had a problem back as far as 1974. And I had the brilliant idea of just taking the money we had in Medicaid and just buy everybody a health insurance policy and we'd be done with that problem. But evidently it was a great idea that came too early in the process. But we did come up. The Secretary for Health Services called me over in 1990 and asked me if I'd work on a plan for Kentucky. We divided the state up into eight districts and we were going to assign so many counties to each one of these districts and see that each Medicaid person had a provider assigned to them. When we first started out building up to network, my staff and I and the people at the University of Louisville and the University Hospital in Louisville, worked together to build that network. The idea was that then to go another district to another district in order to finally get everybody under a managed care program. The one in Louisville after we'd worked for a couple years finally came under passport and has worked very well for us. Our Medicaid costs are down. Our drug costs are down. And all of our costs, I can be quite honest with you if it was not for passport, operating in about 13 to 14 counties around Louisville, our Medicaid costs would be further out of sight than they are now. We did try to set up a district in Lexington which is the Fayette County area which is another center of population. And it got off the ground for a while but the emphasis was not

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strong enough there. Each district is set up. They had to set up a fund in order to protect each other and usually it was about between $5 and $10 million. They had to put upfront money. And then eventually they would get that back after the program got off the ground. It seemed like other places out in the state liked the fee for services better and consequently we could not build a consensus out in those rural areas in order to do managed care. I brag on this all the time. And fast forward is module that you can pick up and put anywhere in any state where you've got enough providers and the will to do it. And I think Jill will give you more of the nuts and bolts about what we've done in Jefferson County and the surrounding 13 or 17 counties that we have. But it was not an easy job. We had to bring a lot of providers in screaming and kicking and squealing. In order to do this we had problems with the dental element of it because we did not really fund it enough in that area. We had to bring that up. We had some doctors who felt that they were not reimbursed enough. For over about a year or two we did finally resolve those problems to where I was getting calls every day. I hardly ever get a call. In fact I don't get a call, I'm fast forwarding, from my district or anywhere around the state where it's used. That's where we started at in. I'll let Jill go ahead and do the fine tuning.

JILL BELL: Thank you Representative Birch. I'm honestly, this gentleman has really been the key to keeping

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this managed care plan going in Kentucky. We've been very fortunate. I was not there at the onset. Believe me there were a lot of advocates. There were a lot of providers who were not happy about managed care coming to the Commonwealth of Kentucky and the Medicaid program. So, believe me the slides I'm going to go through to show you what we've been able to do over the past six years are truly attributable to the courage of people like Representative Birch. And as there are members of our state legislature who I know are here, they may not be in the audience. If you are, thank you. But it really is due to their courage and their ongoing support of this program that allows us to be successful.

And as Representative Birch said this plan was created by the legislature with two goals in mind. One to stabilize the rising cost in the Medicaid program and two to improve quality care. And I think we'll be able to show you that we've done both.

Some quick statistics. We began operations in 1997. We're a 130,000 member health plan now. In 1997 we started up with 95,000 members. We have an extensive provider network. We have over 3,000 providers. We are a 501(c)3 non-profit HMO. We operate as a sole source contract under 1115b Waiver of the federal government. And I think that's really been a key part of our success. We do not have competitors in our market. When an individual is deemed eligible for Medicaid, they are

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our members. So for the past six or so years we've had these members with us and we've been able to track their improvement.

This is what our membership looks like. As with most Medicaid programs, most of our members are children or under age 21. Thirty two percent are our what we call our moms and babies in the sober category. Twenty nine percent in AFCC [inaudible]. We do have SSI without Medicare and those of you who were in this previous session we also manage the dual eligibles. We have [inaudible] ship program. If you're taking children's health insurance program and our foster care kids.

This slide, I've attempted to give you an overview as to what our structure looks like. We actually operate under a three party contract with the Commonwealth of Kentucky. The Commonwealth of Kentucky has a contract with University Healthcare and we say this is our traditional historic safety net provider. The University of Louisville as Representative Birch mentioned, the University Medical School Practice Association, U of L Hospital, Jewish Hospital, the Norton Healthcare System, all the hospitals in our community, the public health departments and the federally qualified health centers, that's the group that the Commonwealth of Kentucky went to ask them to start this plan in our region. And that's the group that put up the initial investment. Another part of the contract in the third-party contract is our Partnership Council. That's a provider organization. We have over 29

providers that are on that council, representing all areas. We have pharmacists. We have hospital representatives. We have primary care physicians. We have specialists that are on that group. They meet on a bi-monthly basis. They're charged with all quality improvement programs, setting policy for quality improvement. There's a number of committees that actually report up to the Partnership Council including a medical management committee, a pharmaceutical and therapeutics committee and a quality member access committee. This is another real key to our success. And the contract with the state of Kentucky does require the signature of the chairman of the Partnership Council along with the signature of the chairman of the University Healthcare Board.

Now in the middle you see this arrow that says AMHP Turnkey Management. I am actually an employee of AmeriHealth Mercy Health Plan. AmeriHealth Mercy was hired by University Healthcare to manage the day to day operations of this health plan. AmeriHealth Mercy has several years of experience in Medicaid only health plan management. We have over one million members in five states. We are actually owned by independents Blue Cross and Blue Shield and the Sisters of Mercy. We're a very mission driven organization with a tradition of caring for the poor. So I think this structure is really the key to the success of this organization.

We've also been successful because we lock arms with

our community. All stakeholders involved in caring for the members are involved in this health plan one way or another. Again we work very closely with our government leaders. We work with the community health agencies, social service agencies. I mentioned our Partnership Council. The number of providers that are involved. And we also work with our health departments and have extensive outreach and education to members.

We like to think of our program as successful because we have balance, much like a three legged stool is balanced. I mentioned that the legislature had two goals in mind which was to improve quality and to also contain rising costs. But as Representative Birch mentioned, when we started this plan, when they started this plan, there was a lot of member advocates and providers who weren't so happy about this. Early on we realized that is was going to be very important to get the member advocates and the providers on board. And so we believe we're successful because we have all three things in place.

So first I'd like to talk about the first leg of the stool which is cost avoidance or reduction in healthcare cost trends. Milliman [misspelled?] USA actually did a report that showed what the state of Kentucky had projected to spend in our 16 counties versus what we came in at over those five years. There was a gap of $110 million. So we were able to save the Commonwealth of Kentucky $110 million through primarily

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utilization management techniques, pharmacy management, all the traditional managed care techniques that you would think of. Our administrative costs are very low. Again I mentioned that we are a sole source contract. That means that we're not spending marketing dollars. We're not doing big advertising. If you're a Medicaid member in our 16 counties, you're our member. So our monies go to member education, member materials, and things like that, a lot of outreach and extensive education efforts.

Now the next leg of our stool is quality. And again we always say you can't have cost savings without improved quality. We believe they go hand in hand. We are accredited by the National Committee for Quality Assurance. We received an excellent accreditation. For a very young health plan we were very proud of that. And as you can see we earned top grades in all the categories that are measured. So how do we improve a quality and access? We have a lot of programs that are operating. The Mommy and Me perinatal [misspelled?] care program. We have a 24/7 nurse advice line. We have disease management programs for COPD, diabetes, asthma, HIV/AIDS, sickle cell and obesity. We do have nurse case managers on staff. And we have intensive case management programs. Again I mentioned our outreach and member education.

Okay, here's the best part. I'm going to show a series of graphs here that really are I think what all of you are

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looking for, which is okay show me the results. EPSDT is the Early Periodic Screening and Diagnosis Treatment program. It's really the well child care . . . well child care program for members under age 21. When we took over in '97 there was statewide compliance rate of 17%. We just reported at 83% and the national goal, best CMS is 80%. Now you'll see a blip there in 2002 and that was because CMS changed their methodology. It had to do with reporting office visits and what month they used to report the age of the child. So that is why you see that big jump there, but we're very proud of this. And that, this chart shows lots of intensive efforts in working with the providers providing them with information about when there panel were due screens. Us having our own outreach department. Phone outreach, postcards, etc. working with the health department to get these types of numbers.

Okay these are some more Hedith [misspelled?] measures. As you can see in our well child visits in first 15 months of life, the red line there is the national average for Medicaid health plans, for Medicaid in general. And we score quite far above the national average in this measurement as well as several others. And I need to say that in many of the categories that we're measuring right now through Hedith we're actually scoring in the 90th percentile. We're very, very proud of that. Well child visits in third, fourth, fifth and sixth year of life. Adolescent well care visits which are always a

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challenge for health plans. Again we are scoring above the national average. And adolescent immunizations. Again above the national average. We're quite proud of that. As you can see we improve year to year to year. So. We've learned over the years. We've kept this membership. We can continue to educate them through mailings, through outreach and education events, and working closely with our providers which is really the key. Use of appropriate medications for people with asthma, and this is ages 5 to age 56. So sometimes people think of asthma as only a childhood a disease. It's definitely in our adult population as well and in our dual eligibles. And again we're scoring above the national average in all these categories. Comprehensive diabetes care. For those who were at the previous the session, you know again the dual eligibles primarily are sicker. They do have more chronic conditions. We are working closely with this group of people. We have about 12,000 dual eligibles in our population. And as you can see those with an LDL less than 130 is considered controlled. We do score above the national average in that category. And also in terms of the percent who are monitored for kidney disease. Perinatal care. Again an area we're very proud of. And we do have a lot of expectant moms. I think we had 6,000 deliveries in 2003. In terms of the percent of members receiving prenatal care visit in the first trimester or within 40 days of enrollment, we're scoring at 90.4%, above the

national average. Frequency of ongoing prenatal care which you know is so important to deliver those healthy babies and also save on the cost, tremendously above the national average. It's kind of sad to see the national average at 39.22%. We're scoring at 86%. And also in post-partum care. Again through intensive outreach and education and we have a focus department that are working specifically in the Mommy and Me area.

The third leg of our stool talks about member satisfaction and provider satisfaction. I've got some charts here through CAP that show we are scoring above the national average in terms of member satisfaction both in the adult population and those members with children.

Okay, someone mentioned earlier in an earlier session about a holistic approach, taking care of these members and because they have such intensive needs. We do that. We believe all of our programs, disease management, case management, pharmacy management, SCTU [misspelled?] utilization management. All of these programs are successful because we're focused on the member.

I just want to quickly go over the key success factors. We are a sole source and provider sponsored. I think mentioned that in great detail but that is a real key to our success. And as Representative Birch said it is a program that could be replicated through the country. We have an extensive provider network. The partnership model with our providers involved

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with all the committees that report up through that Partnership Council is really a key to our success. All the state coders are at the table. I think I mentioned I detail AmeriHealth Mercy Health Plan. We are operating in five states but there was tremendous amount of experience in working with this population. And that thought was very, was really very interesting to the University Healthcare Board. They were providers. They took care of people but they really didn't have the health plan management background so we've had a good marriage. We have local management that knows the community and works closely in the community. So while AmeriHealth Mercy's headquarters is in Philadelphia and our backroom operations like claims processing, information technology, those types of services are in Philadelphia. All the high touch services like member services. I mean all of the individuals have their own car just like commercial plans. They call in member services. We work with them to meet their needs. All provider relations are there in Louisville, Kentucky. Just about any high touch service you can think of is right there in Louisville.

We have a good working relationship with our state legislatures and the administration. And we work very closely with them to keep them apprised of what we're doing and answer any questions they have. And we have appeared before their committees on several occasions. We have the case management

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programs, the disease programs. We also do utilization review.

We do sub-contract or vision and dental services. And that's been very successful. We are; we do have the responsibility for oversight; however, we have sub-contracted. And as a matter of fact AmeriHealth Mercy was just awarded the contract for pharmacy benefit management services for Passport as well. They have a rehab. A pharmacy benefit management company called Perform Rx. So we really now have the pharmacy benefit management truly in house. Vision and dental is still sub-contracted.

We do have pharmacy cost controls in place. We send targeted letters to participating providers regarding patient over utilization. We promote increased generic utilization and use of prior authorization.

Again we have a strong emphasis on preventive care. We work closely with our members and member advocates so we have high satisfaction levels and their involvement. And we do collaborate and lock arms with the caring community, community agencies and health departments.

So just to wrap up these remarks. We believe that to reduce costs and improve healthcare which is what were charged with with this program. All programs must be integrated and all stakeholders must have a sense of ownership. Passport Health Plan has been custom created for the specific requirements of the Medicaid membership. And again only by

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being strong in each of these areas, quality cost savings in member and provider satisfaction, have we been able to be successful.

Thank you.

[APPLAUSE]

JAMES EVANS: I just had one quick announcement I wanted to make. And that was that we will not be covering the issue of Medicaid pharmaceuticals during this session. And if you're interested in this important topic, please attend the session tomorrow. And that session is entitled "Affordable Pharmaceuticals: the States in Medicare." And that will be in this room, Ballroom H, from 8:30 am to 10:30 am tomorrow.

[PAUSE]

MELANIE BROWN-WOOFTER: Hi. My name is Melanie. I'm from Florida Medicaid and it's a pleasure to be here with you this afternoon. I'd like to thank the NCSL for the opportunity to share with you Florida Medicaid's disease management experience.

We. I'd like to begin by giving you an overview of the Medicaid program in Florida and then talk about the history of our disease management initiative and talk about success, opportunities and challenges that we've encountered along the way.

The Florida Medicaid program has approximately 2.1 million eligible beneficiaries. We have a budget this year of

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$14 billion. We've experienced double digit increases in budget over the last several years. We rank, we're the fourth largest Medicaid population in the nation and we're the third largest in Medicaid spending. And you can see that we have a managed care segment and a primary care case management segment. And we have mandated that about 60% of the population will be enrolled in managed care and about 39-40% in our primary care case management with 1% going to our provider service network.

Disease management has been around for quite some time before the Medicaid. In 1997 the governor appointed a task force on Medicaid reform. One of the recommendations from that task force was disease management. We then received proviso language and statutory authority from our legislature to institute disease management programs. The first four were HIV/AIDS, asthma, diabetes and hemophilia. In the following year we received authorization to bring up end stage renal disease, heart failure, sickle cell anemia and cancer and hypertension. And over the next year issued procurement in the method of an invitation to negotiate an ITN and then we came to contract for diabetes, HIV and AIDS. In 2000 we came to contract for ESRD and heart failure.

Now this, these were our traditionally modeled dm programs in terms of we had one vendor or sometimes two vendors come in to do one program for us. And then in 2001 our

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legislature authorized that we could value added. And that in lieu of supplemental rebates, cash supplemental rebates, we could use disease management programs. And that's when our Firestore Agreement was signed and also our agreement with Mr. Mars Squibb to do disease management for asthma, diabetes, hypertension and heart failure. And our Bristol Meyers Squibb program is also a diabetes and a depression program, but it's mulled a little bit differently. We'll go to that in a minute. We also brought up the Autoimmune Center and we are the first center of its kind in the nation. The Autoimmune Center is actually a medical management model for targeted disease states in that we are doing research-based evidence guidelines for autoimmune disorders. And what you see at the bottom here is our HIV/AIDS contract. Our dm program was statewide except for the Miami-Dade area and the Ft. Lauderdale area and then in 2001 we were able to come to contract with a vendor to serve those two areas as well.

Okay. Along with the authorization to bring up these programs, we also encountered budget reductions in anticipation of savings for programs that were not even operational. So our disease management program was under the gun from the very beginning to reduce costs and show outcomes in relation to budget reductions. And I have to add that in 2000, 2001, we saw budget restoration of almost $40 million, realizing that savings would not happen overnight and it takes a year or two

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for us to be able to show outcomes. This is a statutory authorization that was behind it. And the main goals on it were to reduce overall cost and to increase more appropriate utilization of resources.

Okay. So what have we actually done? In the first phase of our program we came to an agreement with ITG to do an [inaudible] program statewide. We then fund contracts with Cordian [misspelled?] Care Solution, the AIDS healthcare foundation to do diabetes and HIV/AIDS. Both of those were statewide with the exception of Dade and Brower [misspelled?] Counties as I've mentioned. And we also brought up our hemophilia program. And we used two vendors, one in the north part of the state, which was Caramark [misspelled?], and one in the south part of the state which was Accordive [misspelled?]. Now it's interesting to note with hemophilia that there are only about 200 folks with hemophilia in Medicaid. About 120 of those are actually in the Medipass program that we serve, but yet they were about the third highest spend for a disease category in all Medicaid. So that's why we wanted to target one of those programs early on. Within signed contracts for ESRD and chronic kidney disease and congestive heart failure. Now these programs are all our traditional model of disease management. We contracted with one vendor or two vendors to come into the state, establish a presence, do provider outreach, do beneficiary outreach and show savings immediately

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which was a very daunting task but we have found several vendors who were up to that opportunity and who have done very well for us.

Our next phase we looked at COPD and we did a very interesting tele-medicine pilot project utilizing about 25 people in Medicaid. And we established, we gave them a computer and a dedicated ISDN line and they had access to a nurse 24/7 and they were completely monitored via tele-medicine. And then of course we brought up our autoimmune program as well.

Now in our most recent stage in our value added agreement with Pfizer and Bristol Meyers Squibb, we modeled this a little bit differently in that in the Pfizer program, Pfizer has given us a grant to disease management. Medicaid then contracted with our 10 largest hospital partners in the state, geographically statewide, to actually implement disease management services so that we're actually changed disease management into a model at the provider level rather than at a vendor level coming in, having to establish provider relationships or physician relationships.

The Bristol Meyers Squibb initiative is unique in that we utilized SQHC's or federally qualified health clinics in order to be able to do the disease management. This program is designed too around a [inaudible] model in that we use lay healthcare workers who are trained and supervised by an RN to

actually provide the disease management services. So these are culturally appropriate people from the community working with others who have the disease in order to help educate them and to change their behavior in their lifestyle to one that's into a more health approach toward their diabetes.

We also have just recently actually in 2004 had a contract with Core Solutions to do an evaluation of the total initiative from the very first ITN to the last contract that we have going and we expect those results to be finalized too within the next few weeks.

I'd like to add here too that it's not on the slide, but we're also looking at . . . we've noticed with our rare disease states such as hepatitis and hemophilia, that these diseases tend to be managed better with a pharmacy overlay. These people are medically indigent but they're not educationally indigent as compared to someone with diabetes or CHS who may not know about the disease process and may not understand what's going on. So we are issuing ITN's for both disease states tied to one vendor to distribute product statewide with a disease management overlay. So that we'll negotiate one price per factor for hemophilia and one price for hepatitis treatment medications and then bound to that price will be disease management services. So it's sort of a unique look at where we are.

Now you may ask why do we target these seven or these

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nine disease states. And it's mainly due to cost. If you'll look, you'll see the number of beneficiaries that have been identified just in Medipass with this disease process, total claims, total spend there and then a per member per month is the last column. So for these 11 disease states that are identified the total spend is 15% of the population in terms of numbers but it's over 50% of the spend for Medicaid. Now when you see no chronic conditions that means that these people have not been identified as having a chronic illness by claims data alone. And they account for $1.2 billion of spend and the other 11 conditions account for over a billion dollars of spend. So that's where we are.

Okay. What have we found in our disease management program? There are several areas that we recommend to other states or to other programs who'd like to do this to target. One is solicit your resources and target those appropriately. One is to look at engaging or enrolling patients because that is very difficult to get these folks involved. And once they've been reached by a nurse and been touched, they're very anxious to be in the program and they actively participate. But finding them is a great deal, it's very difficult. Also data. Your data people, the data capabilities of the programs that you have are ver . . . are just critical to success. I cannot say enough or emphasize enough how important that new ability to actually data mined and not just data gather is to

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the success of these program. You also want to look at the services that are going to be provided in the program and using partners instead of multiple vendors, i.e., if you have one vendor that can do many disease states and use different partners, hospital partners, clinic partners, individual physician groups or individual physicians, you'll see a much great success with your program. And then too a new let's say contracting, look at guaranteed results, performance based contracts, more so than risk based or just financial based contracts.

Now initially we want to look at different models of disease management so that's why went with several different vendors. And we want to look at improved care and improved outcomes. If you notice on here we looked at reducing inpatient and reducing ER. We expected pharmacy to increase because people were gonna become adherent to their medication regimen but we expected the ER and inpatient to decrease and the ratio to be one in that all costs would go down.

Initially we identified people who were eligible to be in disease management in our primary care case management program which is our PCCM also known as Medipass. And we excluded those who were in HMO's, any other advantage care plan, MCO, Minority Physician Network, Provider Service Network. Any of those groups were excluded as well as children who were in children's medical services. That group is

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excluded also. And so we came up with a hierarchy of mutually exclusive disease states. So if someone had HIV/AIDS and asthma they would be in the HIV program. They couldn't be in two programs at one time. Now there's difficulty with that because a majority of our beneficiaries will have more than one chronic condition. You'll see somebody here has CHS, diabetes and hypertension. So if you can have a program that manages all those disease states you can manage the individual not just the disease. It makes a great deal of difference.

This is an actually busy slide. It talks about all the things that we wanted from our DM program. So these were all of the components that we wanted whenever we started the program up. Patient education, distribution of best practice guidelines, provider intervention, home visits, case management care coordination, sort of all it together.

We also looked at it identifying the folks from a population based approach in that people were who enrolled. Meaning that people who were identified by claims data on the [inaudible] census. And we sent it out to the vendors. They were in the program. We paid an administrative fee for all the folks that were on that list whether they were touched or not but the vendor was held at risk for everybody on that list whether they touched them or not. So they were charged with lowering total costs on all of those folks whether there had been intervention or not. It's very difficult. Engaging the

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beneficiaries are difficult because they move frequently, they have wrong phone numbers, the phone has been disconnected. Up to 40% of our contact information that we have in our Medicaid database is not current. So the vendors are already at behind the eight ball if you will because they can't reach about 40% of the population. So we've got to come to some terms with being able to do that. We also allowed the beneficiary to opt out at any time. So they could come in and come out of the program at will and they could come in as many times as they wanted. And so we that had to do with federal regulations, around our 1915b [misspelled?] Waiver to our managed care plan in order to operate the disease management programs. Again initially we contracted with an ITN, we looked at administrative fees, shared savings, we held all of our vendors at risk. They had to save 6.5% off total cost per year in the program in order to be able to share in any savings over that. If they did not meet 6.5% then they had to return the administrative fees that had been advanced for the program.

Okay. In terms of actually how the programs operate. DM programs are expensive and so one of the things that we're looking at going forward is to integrating the infamous stand alone approach to one that involves managed care or maybe other large physician groups to sort of integrate that service into models of care that already exist. Again analytics and data. Cost projections are very, very difficult. We've had a great

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deal of trouble with establishing baselines. We've brought in an actuary to help us with that and being able to project costs in order to actually demonstrate the savings has proved more difficult than we thought it would. And then claims-based identification is not perfect. Just because there's a claim for a certain disease state, ICD 9 code or lab test that's been done doesn't mean that the patient has the disease. There are also folks out there who have the disease. We don't have a claim for service and so it's not been recognized.

In order to reach critical mass you have to be able to engage and actually serve a large number of participants in order to achieve maximum return on investment. And so again enrollment is not engagement. We're looking at moving from a disease state approach to a population based approach so that we serve the entire population perhaps in a geographic area rather than serving individuals just with CHS or just with diabetes.

Turnover. Our Medicaid turn every month there's 100,000 new names, 100,000 names off. So the turn is great. On average our Medicaid beneficiaries stay in Medicaid about 7 months out of the year. And that's less with [inaudible] than it is with our SSI and disabled population. Again the folks are hard to contact and then the patient distribution. So we thought that well if we can't find the beneficiaries we'll just work with the individual physicians and all the patients that

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that physician sees that's eligible for disease management we'll just engage those folks. Well most of our primary care physicians only have one or two or maybe 10 beneficiaries that are eligible for disease management. So in order to do that you have to have a large amount of resources to target samples of providers rather than just to be able to target maybe 100 or 150.

In terms of outcomes, we do have [inaudible] outcomes. Some of them have shown great improvement but we've been limited in end sizes with our date because Medicaid is a payer plan. We don't have a way to receive electronically lab results and other health indicators so that there's a great deal of resources that have to be expended to actually go the physician's office and manually go through charts and pull those values. The other thing that we can do is actually beneficiary on the phone and use self-reported data which is not optimal but it's just something that we can do. Other approaches that we've used include home health, home testing kits so that we actually mail home testing kits to beneficiaries and get a return. And we've seen about a 20% response right on that pilot project and we anticipated less than 10% so we've been very please with that. The other thing to consider is [inaudible] that are present and so that you would, do you have one beneficiary that reports on outcomes on several different disease states. And then coverage

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limitations simply because Medicaid cannot provide every service that might be needed and there are some limits to what we can do. Again in order to enhance programs, data is critical. The ability to manage the data and to comb through Medicaid's claims data is just invaluable. Again target your resources. You want to . . . we risk stratified our beneficiaries so that those with low risk or high risk based on disease state severity. Those at high risk got intensive interventions, a call from a nurse every week, a home visit, some sort of tele-medicine, any sort of home health aid that we could provide at no cost as well. And then folks who are at lower risk with a lower severity of illness got patient education materials, maybe a quarterly contact with a nurse, they had access to the 24/7 nurse advice line that was there. And so these were lower cost interventions. One thing too when you look at your resources is health literacy. It's very, very important. Most of our med, our materials have to go out at a third grade reading level and that's across the board for Medicaid. It's very difficult to find culturally appropriate health materials for education that are at a, that are culturally appropriate and that are at a third grade reading level. So a lot of that we've had to develop on our own. And then too the integration of services. And so that if you have a single program rather than having to manage multiple programs you'll see efficiencies there. Again [inaudible] with control

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over desired outcomes just like the performance based contracting rather than just risk based contracting. And to create opportunities for engagement with patients at different levels. Have a nurse in the ER. Have a somebody at the clinic. Have someone in the physician's office so that when the patient goes in at different points of care, they have access to the disease management program.

What I'd like to talk about too and I don't have a slide for it. We don't always get to talk about this so I'm just going to do it today. What the hell.

Okay. For diabetes, we are still in litigation over our reconciliation process. I'll tell you it's been very difficult with the early contracts to look at baselines that were accurate and then look at savings that were involved. For our HIV program we saw $5.7 billion in savings over 4,000 folks in the first year. We saw $7.6 million in saving the second year. We saw another $7 million in savings the third year and projected to be at over $6 million in our fourth year. And then for our south Florida contract, Miami-Dade County, we're projecting a little over $5 million in savings in the first two of that program as well. And that again is over 4,000 folks statewide and then another 2,000 folks that are in Dade or Brower County.

For our hemophilia programs our program that was in the south part of the state showed about $112,000 in savings, over

60 people for one year. And then the program that was geographically in the north part of the state showed $800,000 in savings over 60 folks in just one year. We're not quite sure why the disparity in savings was for both of those programs except to say with an end size of 60 there's very little that you can actually save on these programs.

For our instate [inaudible] program we're in final stages with that but the projected savings is going to be between $5 and $7 million for the first year and that was over 3,000 folks. For our congestive heart failure program which served again about 3,000 folks only in Medicaid areas one through seven which is geographically the north part of our state we showed $7 billion in saving the first year and a little over $5 million in savings the second year. And for our third year we're projecting to be right at $6 million. So there are, you know, there are savings there to be gained.

And for our tele-medicine project there were savings in that program however, they did not cover the cost of the technology. And that was due to a limited size, 25 folks, and also to not be to the cost of the technology at that time was greater than what it is today. So if we implemented this program today we probably would be able to show savings. We did see significant reductions in ER visits with that program however.

Now with our Pfizer Florida Healthy State program, the

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first year alone we saw $7.5 million in savings, 15,000 people had been actively care managed. That 7.5 million was measured over 7 months of program. The first three months were allowed a start-up. We did not measure cost for savings for that period of time. So that program realized us a little over a million dollars a month in Medicaid savings off total cost not just disease specific.

And we're still in evaluation with our Bristol Meyers Squibb program. That evaluation is going to be a little unique because we are going to look at hemoglobin A1C's [misspelled?] actual lab values and tie that to a financial outcome so that we can actually draw the line and show the difference between when you actually have improved health that you can lower costs. So we're very excited about that.

In addition I have some utilization measurements as well. For our Florida Health State Program, we reduced inpatient base overall by 12.6% and we reduced emergency room visits by 1%. And that was measuring two groups, people that came into the program at the same time those who were intensively care managed and those who did not receive care management services. So the difference in those two groups showed a reduction in hospitalization and inpatient and ER visits. And then by disease state our hypertension program showed 15% reduction inpatient days. Asthma was about 1%. Diabetes were down 14% and heart failure was down 6%. So by

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disease state and overall program we did see savings and saw changes in utilization patterns towards more appropriate utilization which we were very pleased with. In our other congestive heart failure program we saw a reduction of about 25% in inpatient days so we were very, very pleased with that program as well.

Some of the other successes that we've seen is that beneficiaries have shown increased changes in behavior. The only tools that we've given our disease management programs are patient education and behavior change models. There's been no utilization management given to them. So these changes have actually occurred in these cost savings without UM which we think we can enhance savings if we use a pharmacy overlay or some sort of prior authorization overlay as well. So those are things to consider too. And when you empower a beneficiary and educated them they'll show a great deal of change. These are Medicaid folks who have had no one on their side. There have been, there's been no one behind them, no one to help them and without being able to read and write very well and to understand your disease's process it's very difficult to make good health decisions. And so just the act of a nurse calling and so that they know that someone cares and someone is interested in them helps to change their behavior. So disease management works for those it touches. We just have to find a way to touch everybody in the program.

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Thank you.

[APPLAUSE]

[PAUSE]

JAMES EVANS: I just wanted to give you a quick note on Melanie's presentation. We do not have copies of the slides so if you're in the back looking for them we don't have copies of those slides. They will be on our health program website within two weeks which is at www.ncsl.org/programs/health/health.htm .

BRIAN BURWELL: Good afternoon. My name is Brian Burwell. I'm going to switch gears a little bit with you here and talk about Medicaid and long-term care and opportunities for cost containment on long-term care services.

When we talk about Medicaid and long-term care I think it's important to think of two major populations. One is the aged and disabled population. The other is the MRDD population which as you well know also consumes a lot of Medicaid resources. Today I'm going to focus on the aged and disabled population.

There are about 3.1 million aged and disabled persons receiving Medicaid financed long-term care services in the year 2003. About 1.7 million of those 3.1 million were being, receiving services in a nursing home setting. About 1.4 million in home and community based settings.

This is a very expensive population. The aged and

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disabled alone account for about a third of all Medicaid expenditures. That includes about $54 billion in long-term care expenditures alone, just long-term care services. But as you know people with long-term care needs also use other Medicaid coverage services particularly prescription drugs and I estimate there's about another $30 billion in Medicaid expenditures for other Medicaid covered services for long-term care recipients.

In addition most of these people are dual eligibles as you know and they cost a lot to the Medicare program as well. I estimate that that's another around $49 billion in annual expenditures and this is from just the Medicaid aged and disabled population. So altogether this population of about 3.1 million people incur about $132 billion in total Medicaid and Medicare expenditures. That comes out to about $43,000 per person per year.

For the aged and the disabled population, although there's been a lot of growth in home and community based services about three quarters of Medicaid spending for home and community based waivers is for MRDD services not for the aged and disabled. About 83% of total expenditures for this population is still attributable to the cost of nursing homecare, about 17% on home and community based services.

There's a lot of variety across states in the level of spending for long-term care. This statistic that I'm showing

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you here is just total Medicaid long-term care expenditures in a state and these numbers do include MRDD expenditures divided by state population. So at the top of the list is New York, Connecticut, Washington. New York's spending about $800 per state resident on Medicaid long-term care services. The United States average is around $288 and at the bottom are Georgia, Utah and Nevada. So you can see about oh eight, eight-fold, eight, nine fold difference between the top and bottom states. So the amount of money that states spend on long-term care is highly variable from state to state.

Okay. I'm going to talk a little bit about some of the potential policy levers for containing long-term care costs. And if you were at the last session, you'll know that there was a lot of discussion about transfer of assets and Medicaid planning which is one thing that states will do is trying to control the leakage around Medicaid eligibility and people transferring [inaudible] to get in on Medicaid. This is not easy to do and I think a lot of states tend to throw up their hands or say that it's a federal problem. I disagree with that personally. I think it's very difficult work in order to contain the leakage. It really gets down to the day to day work of your Medicaid eligibility workers but there are things that can be done to control Medicaid planning. I believe that the biggest loophole in Medicaid eligibility for long-term care is what's called the penalty for the transfer of assets

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provision and elder law attorneys are very well aware of this loophole. It has to do with when the penalty period starts for an illegal transfer of assets and the penalty period begins on the date of the transfer. So. You know if I was an elder law attorney, thinking of the easiest Medicaid planning devices if mom or dad go into a nursing home the best advice is okay transfer all, half your assets right away as soon as they go in the nursing home. By the time the remaining half are spent the penalty period is over and the person is eligible for Medicaid without a penalty. So that's why it's called half a loaf. And so the real asset limit for Medicaid for long-term isn't really $2000 for a single individual, it's half of what you have. And that's only the countable assets. That doesn't even include the exempt assets. There are a number of states before I leave that topic. I believe that there are four states that have submitted applications to CMS to close some of the federal some of the loopholes around Medicaid planning. Those applications are still pending but they are available on websites. Connecticut and Minnesota, Massachusetts I know are three of the states. And those you can see what changes those states are seeking.

Another cost containment opportunity has to do with the state recovery programs. The state recovery programs were mandated and opened in 1993. Up till that time they were optional, so all states must have and implement a state

recovery program. Even though this mandate started 10 years ago, I would still characterize the state recovery programs as relatively new. Again these programs are not easy to do. They have to do with the arcania [misspelled?] of Medicaid eligibility policy and you know it's one of those policy issues in which the devil is in the details. The main opportunity here obviously is the state recovery from the recipient's primary residence, the home. That's the main non-countable asset that can be kept by the beneficiary and still qualify for Medicaid. And if the primary residence is still in the person's estate when they die, that's a potential source of recovery. There are no statistics on this but I'd be willing to bet over 90% of all recoveries come from beneficiaries' homes. Obviously there's a lot of politics around taking away the family home from a deceased Medicaid recipient. I think a lot of it also revolves around states not implementing their state recovery programs very well. You hear stories on the news all the time of families having mother or father die in a nursing home and all of a sudden getting a letter from the state saying you owe us $40,000, $50,000 with no education before that. It's the worst thing that a state can do.

I think the model program for state recovery is the state of Oregon. They've been doing it for a long time. They have a long history of doing it. They have a lot of . . . they have an excellent program. They have an excellent education

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program in terms of setting expectations about what it means when you go on Medicaid, that the state does have an estate recovery program. They do it in a very progressive fashion. Also when a beneficiary dies and there is a family home and the family heirs want to keep the home, the state is willing to negotiate with the family regarding keeping the family home. It's willing to delay payment and is willing to essentially take a mortgage on that home and have the family pay back in installments. Oregon recovers about 5% every year of what they spend annually on Medicaid and nursing homes. Now 5% may not sound like a lot of money but when states are spending billions of dollars on Medicaid and nursing home care, that's a significant amount of money. The average nationwide is less than 1%. There's a large variation in the effectiveness in state programs and we really lack information on the amount of home equity owned by the Medicaid long-term care population.

I'm currently working on a study jointly sponsored by the Department of Health and Human Services and AARP in which we're collecting updated information on what each state is doing in regard to their state recovery programs. That study ought to be available some time next year.

Managed long-term care programs. We heard today a lot about managed long-term care programs for the non-long-term care population. There has been very little of activity in regard to contracting for long-term services using managed care

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models. And there are a lot of reasons for doing that but I believe that there is revived interest among states now in using managed long-term, managed care models for purchasing long-term care services. And states are doing this as they do it for all managed care initiatives is the value proposition of getting more for their money by using a managed care approach than a fee for service approach on long-term care.

The only state now that has a statewide managed long-term care program is Arizona. As you probably know Arizona never had a fee for service program, only came into the Medicaid program using a managed care model under a Section 1115 waiver. Initially they did not include long-term care at all in their access program but in 1989 they implemented a long-term care program that uses the same model. They state contracts with of what they call program contractors in each of its counties to manage the long-term care population. And in Maricopa [misspelled?] County which is Phoenix, they contract with three different health plans which all compete for members in that county. And it's a very interesting model.

There is significant limitations on the supply side if states want to do managed long-term care. There are really are a lack of vendors who are doing this on any kind of national scale. There are a lot of pace programs which you may have heard about. Pace programs are relatively small. They're relatively local organizations that have no aspirations of

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doing this entrepreneurially. And a state that really wants to do managed long-term care will have difficulty finding vendors. The only company doing this on a national basis is Evercare [misspelled?]. But I think there is going to be growing interest on this as states increase their activity in this area. I would characterize this market as still in the very early stages of development. Basically there's two ways that the companies are getting into this. One is either long-term care organizations who understand what it is to provide services to long-term care recipients, kind of developing managed care expertise, knowing how to provide services on a risk basis. The other way it's developing you know as care organizations who serve maybe Medicaid populations or commercial populations are getting into managed long-term care and developing expertise in the long-term care business. Today I've seen a lot, there's been a lot more of the former than the latter. It's been; the development of the market has largely come from organizations that provide long-term care services and are trying to develop the managed care component.

[Inaudible] still nationwide only less than 3% of Medicaid recipients receiving long-term services are receiving them under managed care approaches. The vast majority remain in fee for service.

States are interested in further expansions and home and community based services although growth rates in the

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Medicaid home and community based care waiver program have been slowing in recent years. It's now a very large program. I believe it's up to around $17 billion. Nursing home rates are continuing to decline nationwide. They are now I believe somewhere in the low 80's and they continue to go down every year. That is an industry that is struggling. I think states are wondering at this point how much more savings are achievable through further home and community based care expansions.

I just want to talk a little bit about some of the changing paradigms that I see in Medicaid and long-term care services. These are definitely kind of shifts in how people are conceiving long-term care. And there is definitely kind of a change in language, change in thinking around long-term care. One is changing the term long-term care to long-term supportive services. This definitely comes; a lot of these changing paradigms are coming from the disability community. Disability community does not like the word care, it's too passive. And for first to talk about long-term care in regard to long-term supports, supports providing services to allow people to obviously remain in the community. Also instead of talking about quality of care in terms of monitoring the system, a lot more people are talking about quality of life at the end of life. And thinking about quality assurance activities from a quality of life perspective. Not that quality of care is not

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important but quality of life measure and quality of life thinking is coming into state thinking a lot more. Shifting from provider driven care to self-directed care. There's a lot of interest in a self-directed care models. Some of you may have heard of the Cash in Counseling Demonstration program in which people actually it's not quite a voucher but get a individual budgets that they can use to then buy their own long-term care services. They can use the budget any way they want. They can hire and fire their own providers. The Cash in Counseling Demonstration is showing very positive findings in regards to its evaluation is now moving into phase two and CMS is working actively to incorporate more self-directed care, concepts and models into the mainstream Medicaid program.

We're moving from process quality measures to outcome measures in terms of thinking about what we are actually trying to achieve when we buy long-term care services. And instead of paying for individual services and silos and monitoring those separately and managing those separately, there's a lot more thinking around paying for people. That obviously fits in well with the kind of the managed care concept.

In the end I just wanted to say a little bit about what I think is the as states look to the future of Medicaid and long-term care what states are thinking about and what the message is from state governments to citizens around this issue. And I see an emerging message from states is we can't

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sustain this into the future. We cannot sustain the current level of funding in Medicaid for long-term care. Over 60% of all people in nursing homes at any one point in time are on Medicaid. It's a you know, a very significant part of the state Medicaid budget and as people look to the future and the aging of the baby boom population it's only going to get worse and worse. I think states are saying to people our benefits are going to be more restrictive rather than less restrictive. It's going to be more difficult to get Medicaid and if you get on Medicaid it's not going to be as generous as it is currently. And the message obviously to the baby boom population is don't count on Medicaid being there when you may need. You have to think about your own, pre-financing of your own future long-term care needs and you better start now. I see a lot of states have a growing interest in sponsoring kind of long-term care education campaigns to get that message across to try to increase the amount of savings that people make for their own future long-term care needs to not how I promote the long-term care insurance but to promote individual planning for future long-term care needs in the void, in order to avoid this. The alternative of being on Medicaid. So. I see this as, as, you can see this in the NGA documents that were recently issued around the annual NGA Meeting. I think governors are particularly starting to convey this message and I think you're going to see more and more of this kind of

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messaging from states in the future.

Thank you very much.

[APPLAUSE]

[PAUSE]

JAMES EVANS: So I want extend a thank you to our panelist for their insightful information today. We do have some time available until 3 o'clock and if any of the members or attendees would like to ask any questions I just ask that you come down to the mike, state your name and who you represent and address you question to any of the panelists.

SCOTT DIBIAZZIA [misspelled?]: Thank you very much. I'm Scott DiBiazzia with the Plasma Protein Therapeutics Association and we represent the manufacturers of blood clotting factor therapies that are used to treat hemophilia. And this question is directed at Ms. Brown-Woofter. And you talked a little bit about the pharmacy overlay for the treatment of hemophilia, and I was hoping really a two-part question. First if you could comment on the status on the status the implementation of that pharmacy overlay. And also if you could comment on you talked a little bit about contracting with a single vendor for the provision of factor therapies to medicate beneficiaries in Florida. You also talked a little bit about the assignment of a single reimbursement rate for factor therapies. I was wondering if you could comment a little bit about whether OCCA [misspelled?] has

thought about potential implications on access to those therapies if the state were to go into a single source contract with the assignment of a single reimbursement rate.

MELANIE BROWN-WOOFTER: I'll be happy to. Thank you for the question. Our hemophilia procurement was actually issued and we did award . . .the right to contract with one vendor that was protested and we expect an administrative decision to be out probably within the next two weeks and we'll reissue on the procurement again most likely. We did look at the issue of access medications that's why we chose one distributor so that all factory products are on the list. They're excluded from our PDL and they are available but they'll be one price for a factory product that we distribute. And then of course the disease management overlay will be with that. So that. And there also will be a QA committee if you will that any beneficiary and Medicaid can access that committee to either protest or have a fair hearing to say I'd like to use a different product or I think this is the best one for me. We also look at outliers and then have a profession, have the committee made up of professionals, physicians, nurses, and others and pharmacists to look at it and make recommendations in terms of treatment. So that the product will not be, there will not be limited access to product. We're looking appropriate utilization so that the appropriate product is used in the appropriate [inaudible] for these

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individuals.

SCOTT DIBIAZZIA: But you're saying that there could potentially be some so-called speed bumps if a patient in wanted to use a different product.

MELANIE BROWN-WOOFTER: Yes. There could be, but there shouldn't be in theory. But there could be yes in reality.

SCOTT DIBIAZZIA: And have you considered whether or not the assignment of a single reimbursement rate whether that could result in increased utilization of lower priced therapies and less utilization of higher priced therapies and restricted access to higher priced therapies and things of that nature. I'm wondering, you know, what you've thought about in terms of whether or not there is gonna be potential access issues.

MELANIE BROWN-WOOFTER: Well we encouraged each of the vendors who submitted a bid to be very creative in their financial AWP aspect of that. The minimum was AWP minus 39% so they could go back and forth with whatever percentage they wanted. And if they wanted to use [inaudible] pricing or whatever they could do that as well. So like I said they AWP was the pricing just in the procurement instrument itself. So that that would allow it to be a little bit more open.

But the reason that we did that with hemophilia is that 9% of the cost of hemophilia is around factor product. And only 10% were related to hospitalization around patient visits so we had to find a way, a mechanism, to control the pharmacy

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costs of that in order to be able to provide services to as many people as we could. And that was the methodology that we used. But like I said the [inaudible] thing the pricing was up to the bidder and then we just went to the [inaudible] procurement process and that's how we'll select.

SCOTT DIBIAZZIA: Great. Thank you.

PATRICK COLLINS: Yes good afternoon. My name is Patrick Collins and I'm ZLB Bearing. We're a manufacturer of hemophilia clotting factor and I also previously worked for the National Hemophilia Foundation. And not to gang up on Miss Brown-Woofter, but I do also have a question with regard to the Florida contract and why the specific reliance on average wholesale price as a means for reimbursement? As I'm sure you're aware and many of the legislators here in the room and other Medicaid programs, average wholesale price has been a figure where it is jokingly referred to as "Ain't What's Paid." Several reports have come out from the General Account Office State and Medicaid for a control units, the Inspector General of HHS that average wholesale price is not reflective of the actual price of the therapy. Obviously hence the deep the discount off of AWP. My question would be why not base reimbursement on more of the market price for the therapy, whether it be an average manufacturer's price, an average sales price, something that a company would submit to CMS that is audited periodically and something other entities are moving

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forward to? The Congress for example has moved toward an average selling price. California has moved toward an average selling price. And I raise this for two reasons. One the concern is that with an AWP minus 39 in Florida, the contracted entity really has an incentive to steer patients toward the product that has the greatest spread. That means one particular product for a particular disease state. With hemophilia that could lead to if you're using that one particular product the potential for greater inhibitive development, the potential for greater allergic reaction, the potential for less or more time for hemostasis [misspelled?]. So I guess my question is why did you use AWP and not an alternative market based option.

MELANIE BROWN-WOOFTER: The decision to use AWP really came out of our pharmacy unit and that was just a pricing that they wanted to go with. And that was given as an example in their procurement as a minimum that we would accept. And that we challenged anyone who wanted to submit a bid to use any price [inaudible] that they would see fit. And so that the distributor, actually the PBM, and they have to negotiate a price with the manufacturer. We could use any manufacturer. We can use any product that is out there that the beneficiary can show medical evidence that they need to use will be open, but we'll just negotiate that one 5% effort to control the costs like I said for Medicaid. Because right now all of our

factor products depending on where the consumer goes which pharmacy they use is a different price that comes in so this an attempt to make that cost be consistent across the board rather than having individual pricing.

PATRICK COLLINS: I would just conclude by saying that a more market based price would lead to competition based on the price of the therapy work, a Medicaid or a patient or whomever could choose, could pick and choose based on a price as well as on the efficacy of the product whereas the reliance on the AWP leads to a reliance on the spread between what the provider paid for the product, what they're being reimbursed for the product. And any good business person would try to streamline as many people as possible to that particular product that provides the greatest profit for them. So I would [inaudible] with that.

MELANIE BROWN-WOOFTER: I agree with you but we really want to look efficacy of the products and let the right product be used for the right individual. And that's why we're looking at the oversight with the QA committee to make sure that folks don't fall through the crack and that they're not just streamlined towards the lower cost product.

SCOTT LOWACO [misspelled?]: My name is Scott Lowaco with First Health Services and I want to applaud the state of Florida for many very creative and innovative management techniques. I do have one question though about the value the

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status of the value added programs in Florida. It's my understanding that Florida allowed the acceptance of value added disease state management guarantees from some drug companies in lieu of paying cash supplemental rebates to the state Medicaid program through a supplemental rebate. And that the drug companies had to guarantee a certain amount of savings and so I'd like you to first comment on whether or not those savings guarantees were achieved. And the second question is the Florida independent legislative evaluation committee of PAGA [misspelled?] I believe did a report that concluded that Florida missed out on an additional $64 million worth of savings if they had required cash supplemental rebates rather than these disease state management programs and that that led to Florida legislature actually terminating the value added programs in the current Florida state budget. I just don't know if that is in fact correct or not and I was hoping you could clarify both points for me.

MELANIE BROWN-WOOFTER: Again thank you for the opportunity to clear this up.

Yes, in 2001 the legislature did authorize us to use disease management programs as in lieu of supplemental rebates. And in this past legislative session they did mandate as of July 1 we could no longer use value added. We had to negotiate cash supplemental rebates. What that means is that the supplemental rebate issue is separate from our disease

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management program. Our disease management program is continuing. We will honor the contracts with our hospital partners through the end of the term and they'll just be change in the structure of the funding mechanism with that. So the value added or the supplemental rebate has ended but the disease management program will continue under a different financing model.

In terms of the PAGA report, PAGA did actually two reports. One of them was on disease management and one of them was on the pharmacy utilization piece or the supplemental rebate. And that report did show or did state that the . . . that the state could have [inaudible] a large cash amount around $60 million had we gone with a cash rebate rather than using the value added programs. The agency has taken the position that we did not agree with the methodology that was used in that report and so we haven't, we have contested its results. It may have played a part in the legislature this year. I'm not quite sure why the legislature mandated that the supplemental, that the value added would end, but they did. Now they do allow one value added in the behavioral health so we do have one manufacturer who is negotiating contracts now for behavioral health services in order to keep their medications on the PBL

SCOTT LOWACO: I see.

MELANIE BROWN-WOOFTER: Yeah.

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SCOTT LOWACO: Thank you very much.

JOHN HEDEN [misspelled?]: I'm John Heden from New Mexico. Again I want to thank the panel not picking on Florida but Melanie maybe you could, I get very confused when I look at a multitude of contractors for all the different diseases. And I'm wondering if you've done some analysis that would demonstrate if you had one contractor that was dealing with the patient for all their conditions. It seems to me that there is some additional effectiveness from that kind of an approach and what the confusion is in having multiple contractors. Could you go into some explanation of that?

MELANIE BROWN-WOOFTER: Sure.

JOHN HEDEN: Speak slowly. Speak a little so we can und . . .

MELANIE BROWN-WOOFTER: [Laughter] Oh yes. Okay I'll try to slow down a little bit. There's so much to say in so little time.

[Laughter]

We haven't done a formal evaluation of the contracting but it did appear to us at once we contracted under the value added program with Florida Healthy State that to be able to manage multiple disease states was an advantage to us with one vendor. We also have had outside evaluations come in mainly from core solutions and from a couple other [inaudible] as well who have recommended that we reduce our administrative burden

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had we been able to contract with just one entity rather than contract with multiple entities. And we've advised some other Medicaid's to do that as well and we've success in other state Medicaid programs you know if they've used that approach. We also think it would help too in the evaluation of outcomes and so that this consistency in reporting because in our disease management initiative we allowed the initial models to use whatever reporting mechanisms they wanted. We told them this is the outcome that we want and you can use whatever numerator or denominator you want in order to report it. And that was in order for us to be able to take a look at what would be the best mechanism because we didn't know. And now we're at the point of having to take a look and go back with our vendors and saying this is, we want to be consistent. This is the methodology that we want to use. So if you had one vendor all along you would have consistent reporting results across time and you would be able to look at year one to year two more a little more effectively than what we can now.

JAMES EVANS: Were there any other questions from the audience. Sounds like Representative Birch may be needing to take a visit to Florida. [Laughter] Now it just sounds like you maybe you ought to visit Florida and explain your Passport program.

Were there any other closing comments? Jane.

So with that I would like to thank those that had

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presented today for our Facing Medicaid Challenges: Tools for the Future. We had Representative Birch, Jill Joseph-Bell, Brian Burwell, and Melanie Brown-Woofter. On behalf of the state of Utah as a state Senator I'd also like to thank you all for attending Salt Lake City for the convention. We are a very friendly and hospitable city and we enjoy visitors, especially those that spend a lot of money.

[Laughter]

So with that I think the session is concluded. Thank you.

[APPLAUSE]

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