SUBJECT: Requiring state-funded health plans to offer disease management services

COMMITTEE: Select Committee on State Health Care Expenditures — committee substitute recommended

VOTE: 10 ayes — Delisi, Gutierrez, Berman, Capelo, Crownover, Deshotel, Harper-Brown, Miller, Truitt, Wohlgemuth

0 nays

1 absent — Uresti

WITNESSES: For — Carrie Coleman, Texas Association of Health Plans; Lawrence Harkless, Texas Diabetes Council

Against — None

BACKGROUND: In 2001, the 77th Legislature enacted SB 283 by Nelson, which directed the Health and Human Services Commission (HHSC) to ensure that managed-care organizations contracted under the Medicaid managed-care program develop and implement disease management programs for chronic health conditions, including asthma and diabetes. The act also directed HHSC to study the benefits and costs of disease management services in the Medicaid managed-care program.

In June 2002, HHSC and the University of Texas School of Public Health surveyed Medicaid managed-care organizations to determine the status of their disease management programs for asthma, diabetes, and high-risk prenatal care. The survey found most programs in the planning stage or early implementation. HHSC recommended modifying existing managed-care contracts to encourage the use of disease management.

State-funded health plans serve a diverse array of clients and include:

- Employees Retirement System (ERS) health insurance, the state employee health plan;
- TRS-Care and TRS-ActiveCare, health plans serving current and

retired teachers in the Teacher Retirement System;
- UT and Texas A&M health plans, for employees of those institutions;
- the Children's Health Insurance Program (CHIP) and Medicaid managed care, state-federal health plans managed by HHSC that serve low-income children and poor, elderly, or disabled people; and
- the Correctional Managed Health Care Program, which serves inmates of the Texas Department of Criminal Justice.

DIGEST:

CSHB 1735 would require certain state-funded health plans to offer disease management services. Those plans would include ERS, TRS-Care, TRS-ActiveCare, UT and Texas A&M health plans, CHIP, Medicaid managed care, and the Correctional Managed Health Care Program.

The bill would define disease management services as services that help a person manage a disease or other chronic health condition, as identified by the agency administering the program. Diseases or chronic conditions could include heart disease, diabetes, respiratory illness, end-stage renal disease, HIV, or AIDS. For plans administered by HHSC, the agency would have to select populations for which disease management would be cost-effective.

The disease management services would have to include:

- education to help patients learn to manage their condition;
- education for providers;
- models based on scientific research and minimum standards of care;
- recommended treatments and standard procedures; and
- care supervised by a physician.

Each agency required to offer disease management services would have to offer the services as soon as practicable after the bill's effective date, but no later than January 1, 2004. Each agency would have to evaluate the savings to the state and the clinical outcomes of its disease management services and would have to submit a progress report to the governor, lieutenant governor, and House speaker by December 1, 2004. Final results would be required in a final report by December 1, 2005.

The bill would take immediate effect if finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take effect September 1, 2003.

SUPPORTERS SAY:

CSHB 1735 would require state health-plan administrators to use one of the most important tools available to improve patient health and manage costs. A comprehensive disease management program teaches patients how to be alert and informed partners in the treatment of their disease and how to choose the most appropriate care. It also educates physicians and health-care providers about the best ways to help patients manage their disease. For example, a disease management program for juvenile diabetes might teach children with diabetes how to monitor their symptoms and what types of nutritional or exercise decisions might help the most. Education for physicians and health-care providers might teach them what monitoring tests should be performed and how best to communicate with their patients. This approach can result in better outcomes over the patient's lifetime and reduced costs to the payor in the form of better compliance with treatment regimens and more appropriate use of medical resources, such as emergency room visits.

The state should ensure that all state-funded health-care programs use disease management programs to maximize scarce health-care dollars. Most health-care programs already offer some disease management services, but the state could realize $3.9 million in savings in the coming biennium if all programs did. Over time, the savings should grow as patients are guided toward better decisions and chronic conditions are managed more appropriately.

CSHB 1735 would not result in a mandate for managed-care organizations because most of them are doing this in some way already. However, the programs vary considerably. Some may include patient education but not provider education. All programs should offer the key criteria established by this bill so that all plans could benefit from the services.

Each health plan should establish the disease management services that work best for its patient population. Children in CHIP have very different disease management needs from those of adult inmates in the Correctional Managed Health Care Program. No single approach is appropriate.

This bill would not exclude stakeholders from the decision-making process.

Most state agencies convene a working group or conduct informal meetings to discuss how changes may affect health plans with which they contract. There is no reason to expect that the development of disease management programs would be any different.

Physicians should supervise the development of disease management programs, as they are well equipped to evaluate research and treatment methodologies for populations of patients. Nurses and other health-care providers are integral parts of the delivery continuum and have significant contact with individual patients. CSHB 1735 would not limit their roles in any way.

Reporting is an important part of ensuring that disease management works. The agencies should have to report savings and clinical outcomes of their programs so that the 79th Legislature can evaluate initial progress.

OPPONENTS SAY:

Managed-care organizations already offer disease management programs, but CSHB 1735 would remove their flexibility in delivering the best programs for their client populations. The bill would force all providers to offer a single program, whereas regional differences might necessitate greater flexibility. For example, all CHIP providers would have to offer one asthma disease management program, but children in Houston are exposed to different environmental irritants from those that affect children in Amarillo.

Health plans should have a formal role in determining disease management programs. The state could establish working groups of health plans, physicians, and agency representatives to develop the programs. This would ensure that all groups with a stake in the outcome have a voice in the process.

OTHER OPPONENTS SAY:

CSHB 1735 should define disease management services more broadly to include other key health-care providers, such as nurses and physician assistants. Requiring care supervised by a physician as a part of the disease management program would be unrealistic, because non-physician health-care providers perform most patient education. Nurses, physician assistants, therapists, case managers, and other health-care providers have the education and training to be a leading part of a disease management program and should not be excluded.

NOTES:

The committee substitute added three elements to the bill as filed: standards for a disease management program, the test of cost-effectiveness for programs administered by HHSC, and a final report to the Legislature in 2005. It also redefined the measures by which the effectiveness of a disease management program would be evaluated.

HB 727 by Delisi is similar to HB 1735, but it concerns disease management services for non-managed care, or fee-for-service, populations in Medicaid. The Select Committee on State Health Care Expenditures reported HB 727 favorably as substituted on March 18.