SUBJECT: Creating disease management programs for certain Medicaid recipients

COMMITTEE: State Health Care Expenditures, Select — committee substitute recommended

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

0 nays

1 absent — Uresti

WITNESSES: For — Lawrence Harkless, DPM

Against — None

On — Phyllis Coombes, Rand Harris, Texas Comptroller's office

BACKGROUND: Medicaid has two types of care models — traditional and managed care. Medicaid managed care operates much like a health maintenance organization or a preferred provider organization in that generally it seeks to improve patient health and reduce costs associated with chronic conditions through disease management programs. A disease management program is a coordinated system of healthcare interventions and communications that helps patients with chronic conditions care for themselves better and improve their overall prognoses.

Unlike a managed care network, traditional Medicaid does not have a systematic way to coordinate patient care and thus does not offer disease management services. Currently, recipients of Medicaid who have chronic diseases, but are not eligible for Medicaid managed care coverage, have no other state-funded resource for disease management services.

DIGEST: CSHB 727 would make disease management services available to Medicaid recipients who were not covered by managed care plans.

It would add sec. 32.059 to the Human Resources Code, requiring the Health and Human Services Commission (HHSC) to request contract proposals from

providers of disease management programs to provide services to Medicaid recipients with chronic conditions — including heart disease, diabetes, respiratory illness, end-stage renal disease, HIV infection, and AIDS — who currently are not eligible to receive these services under a Medicaid managed care plan. HHSC could contract with public or private entities to write the requests for proposals, determine how savings would be measured, identify populations in need of disease management, develop appropriate contracts, and assist in developing the content and obtaining funding of disease management programs.

Providers would have to meet requirements set by HHSC, including the use of evidence-supported approaches based on minimum standards of care and an assurance that the recipient's primary care physician personally would be involved in the care. All contracts entered into by HHSC would have to contain written guarantees of state savings on expenditures for recipients covered by the program.

CSHB 727 would require that HHSC conduct a study to determine the conditions in Texas that resulted in the highest medical expenditures and showed the greatest promise for savings through disease management programs. HHSC would have to complete this study by December 31, 2003, and provide a report of the findings to the governor, lieutenant governor, speaker of the House, and standing committees of the Senate and House of Representatives over health and human services issues. HHSC also would have to consider these findings when requesting proposals or awarding contracts.

The bill would allow a state agency to request waivers or authorization from the federal government if it determined that such action would be necessary before implementing any provision of this bill.

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:

Disease management programs provide a means of reducing health costs over the long run. Stressing preventive care, they educate patients with chronic illnesses about how to better manage their conditions and their lives, thus

delaying or avoiding complications that are costly both in human and financial terms.

Diabetes provides an excellent example of the effect of disease management programs. According to the American Diabetes Association, 17 million people in the U.S. had diabetes in 2000, and the prevalence of this disease is growing. Not only is diabetes a leading cause of death, it is associated with a number of dangerous and costly complications, such as renal failure, amputation, and blindness. The total cost of diabetes in the U.S. in 2000 was $132 billion.

Disease management programs for diabetes can help reduce the human and financial costs associated with the disease. For example, such a program would permit children with type II diabetes to learn how to control their diets and blood sugar levels, greatly reducing the risk that they would end up with renal failure, nervous system damage, or other tragic and expensive complications later in life. Thus, money spent for prevention services now would render savings in future treatment.

The same principle applies to other conditions that CSHB 727 would include for disease management programs under Medicaid, including heart disease, asthma, and AIDS. Patients in such programs would receive the necessary information and care they needed to better manage their illnesses, including access to diet and nutrition services and a phone bank run by trained nurses that they could call with healthcare questions. Programs in other states have shown an overall reduction in healthcare costs and in lost work days for patients. There is every reason to believe that this bill would confer similar benefits to Texas.

Although the state has implemented programs in the past for managed care of specific diseases such as diabetes and asthma, these programs have not been as successful as hoped. They were assigned as additional duties to overworked agencies who had neither the experience nor the established networks to deal with disease management. CSHB 727 would improve on this model by allowing HHSC to contract with entities that were experienced in disease management programs and who already had the proper networks in place.

Another past problem has been the lack of savings. The bill would address this problem by requiring that contractors issue a written guarantee of savings to the state, and agree to pay HHSC the difference if the savings were not achieved. The Legislative Budget Board reports that CSHB 727 would have a positive fiscal impact of more than $8.5 million in general revenue through 2004-05.

CSHB 727 would allow the HHSC to determine which areas of the state most needed disease management services and to provide them there. By so doing, it would ensure that the most needy Texans were able to receive high quality care, improving the overall health of the state. It is estimated that the program would serve more than 25,000 of the sickest Medicaid patients who were not covered by managed care.

In addition, disease management programs would reduce the number of emergency room visits by patients seeking basic care for their illnesses. Routine care for patients with chronic conditions more often would be provided in the more appropriate, less costly setting of the physician's office.

OPPONENTS SAY:

Disease management programs are a waste of resources because Medicaid managed care already provides these services. They would be especially wasteful considering that managed care would become the default care model for Medicaid recipients under CSHB 1 by Heflin, the general appropriations bill for fiscal 2004-05, meaning that the state would end up paying twice for the same service. In this time of tight budgets, it makes no sense to fund a program that is duplicated through existing services.

The state has implemented similar programs in the past for specific diseases — asthma and diabetes. Both programs were managed poorly and failed to render savings to the state. Based on the past performance of state-run disease management programs, it is unlikely that this new program would save the state money.

Although disease management is an attractive idea, it is not a viable solution to the state's problems. Rather than managing asthma from the patient perspective, the state should be working on improving air quality both to prevent asthma in our children and to improve the condition of those who already have it.

This bill would not prevent low-income patients from frequenting the emergency room for basic care. They go there for convenience and for the best healthcare available, often at no cost to them and with no need to make an appointment. For some patients, such as night shift workers, emergency room doctors are the only ones that are available when they get off of work. Disease management programs would not solve this problem in our health care system.

NOTES:

The committee substitute differs from the bill as introduced by removing a requirement that the HHSC request proposals to provide disease management services specific to children and pregnant women in the Rio Grande Valley who receive medical assistance and treatment for asthma-related health conditions and are not eligible to receive those services under a Medicaid managed care plan. It would allow HHSC to contract with public or private entities to write the requests for proposals and other services and would require providers to use evidence-supported approaches based on minimum standards of care and to assure that the recipient's primary care physician personally would be involved in the care. Finally, it would require HHSC to report its study findings by December 31, 2003.

The companion bill, SB 327 by Janek, passed the Senate on the Local and Uncontested Calendar on March 13 and was referred to the House Select Committee on State Health Care Expenditures on March 18.

The proposal in CSHB 727 was part of the comptroller's E-Texas Report, *Limited Government, Unlimited Opportunity*. The comptroller's office estimates that the establishment of disease management programs would save more than $8.5 million in general revenue through fiscal 2004-05, with an increase to over $11.4 million in fiscal 2006-07. Projected lower savings in fiscal 2004-05 are attributed to the time it would take to implement the programs.