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☞ Details: Medicaid and Health Care Reform. Hearing held in Madison, Wisconsin on August 28, 2006.

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2005-06
(session year)

Senate
(Assembly, Senate or Joint)

Select Committee on Health Care Reform...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (August 2012)

Senate

Record of Committee Proceedings

Select Committee on Health Care Reform

Medicaid and Health Care Reform

The Committee will hear from invited speakers only to present on Medicaid and Health Care Reform:

- **BadgerCare Plus:**
  Helene Nelson, Secretary of DHFS
  Jason Helgerson, Executive Assistant DHFS

- **The Role of an Academic Health Center in Health Care Reform:**
  Dr. Robert Golden, Dean of UW School of Medicine and Public Health
  Dr. Jeff Grossman, President and CEO UW Medical Foundation
  Donna Sollenberger, President and CEO UW Hospital and Clinics

- **Medicaid Reform Task Force Report:**
  Dr. Ken Schellhase, Wisconsin Academy of Family Physicians
  Steve Wilhide, American Academy of Family Physicians

- **Health Care 2006: Can We Afford It? :**
  Dr. Mike Shattuck, Wautoma, WI

- **Crisis in the Emergency Room:**
  Dr. Christine Duranceau, American College of Emergency Physicians
  Dr. Howard Croft, Wisconsin College of Emergency Physicians

- **HIRSP:**
  Amie Goldman, HIRSP Authority

- **Chronic Disease Management**:
  Dr. Ted Praxel, Marshfield Clinic
  Dr. Robert Phillips, Marshfield Clinic

- **Special Medical Transportation Brokering:**
  Ron Hermes, Legislative Liaison for DHFS

August 28, 2006 **PUBLIC HEARING HELD**

Present: (5) Senators Roessler, Darling, Olsen, Erpenbach, and Miller

Absent: (0) None.

Appearances For

- None.

Appearances Against

- None.

Appearances for Information Only

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  Jason Helgerson, Executive Assistant DHFS

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Registrations For

- None.

Registrations Against

- None.

Marcie Malszycki
Committee Clerk


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Health insurance for all kids

Governor Doyle's Plan to Provide Health Insurance for All Kids

Governor Doyle's Health Care Vision

- Every Wisconsin resident has a right to health care access.
- State government must do what it can to ensure that residents have access to high quality, affordable health care.
- No child should ever be without health insurance.
- The rising cost of health care is bad for the Wisconsin economy. State government must work with the private sector and other stakeholders to find ways to control costs.

Governor Doyle's Health Care Policy Agenda

1. Badger Care Plus – Health Insurance for all Children
2. Healthy Wisconsin – Reinsurance for Catastrophic Care
3. Family Care Statewide
4. Access to Affordable Prescription Drugs
   - Protect SeniorCare
   - Canadian Drug Website
   - Badger Rx
5. Health Care "Dumping" Ban for Large Employers

Governor Doyle's Health Care Policy Agenda (cont.)

6. E-Health Board – Information on Quality and Cost in Health Care, Reduce Medical Errors (WHIO, POVD replacement legislation).
7. Tax Deduction for Health Insurance Premiums for Workers that Don't Have Access to Employer-sponsored Insurance.
8. Permit the Development of Health Care "Co-ops" for Farmers and Small Businesses.
9. Vital Investments in Public Health Programs.

Rising Number of Uninsured Children

- In 2003, 86,000 children (7% of total) were without health insurance for at least part of the year. In 2004, this number rose to 91,000.
- The lack of health insurance falls hardest on "near poor" families. Twelve percent (12%) of near poor children were uninsured for at least part of the year in 2004.
- Fewer and fewer businesses are offering their employees health insurance plans.
  - In 2001, 76% of Wisconsin residents had their health insurance coverage provided by their employers. That number in 2004 was 69%.
  - Over the same period of time the MA program has grown but not enough to avoid an increase in the uninsured rate.

Policy Solution = *BadgerCare Plus*

- Create a single, comprehensive health care safety net program for families that merges the "family" MA, BadgerCare and Healthy Start Programs.
- The new program would provide access to affordable health insurance for all kids as well as expand eligibility in other areas.
- The combined program would serve approximately 500,000 residents.
- This effort represents the most comprehensive reform of Wisconsin's MA program since its creation in 1965.

Program Goals

- Ensure that all children have access to affordable health insurance.
- Improve the overall health of Wisconsin residents.
- Lower the long-term cost of the MA program.
- Simplify and streamline the family MA/BadgerCare/Healthy Start programs to save millions of dollars in overhead costs and eliminate barriers to enrollment.

Key Proposal Elements

- Simplify Eligibility Determination
  - One, simple system of eligibility determination
  - No asset test
  - Eliminate the EVF process
- Expand Eligibility
  - Allow all parents to "buy-in" to BadgerCare Plus for their children.
  - Cover pregnant woman up to 300% FPL.
  - Cover adult caretakers and parents that temporarily lose custody of their children.
  - Raise income ceiling for parents to 200% FPL.
  - Allow farmers/self-employed individuals to "buy-in" to BadgerCare Plus.

Key Proposal Elements (cont.)

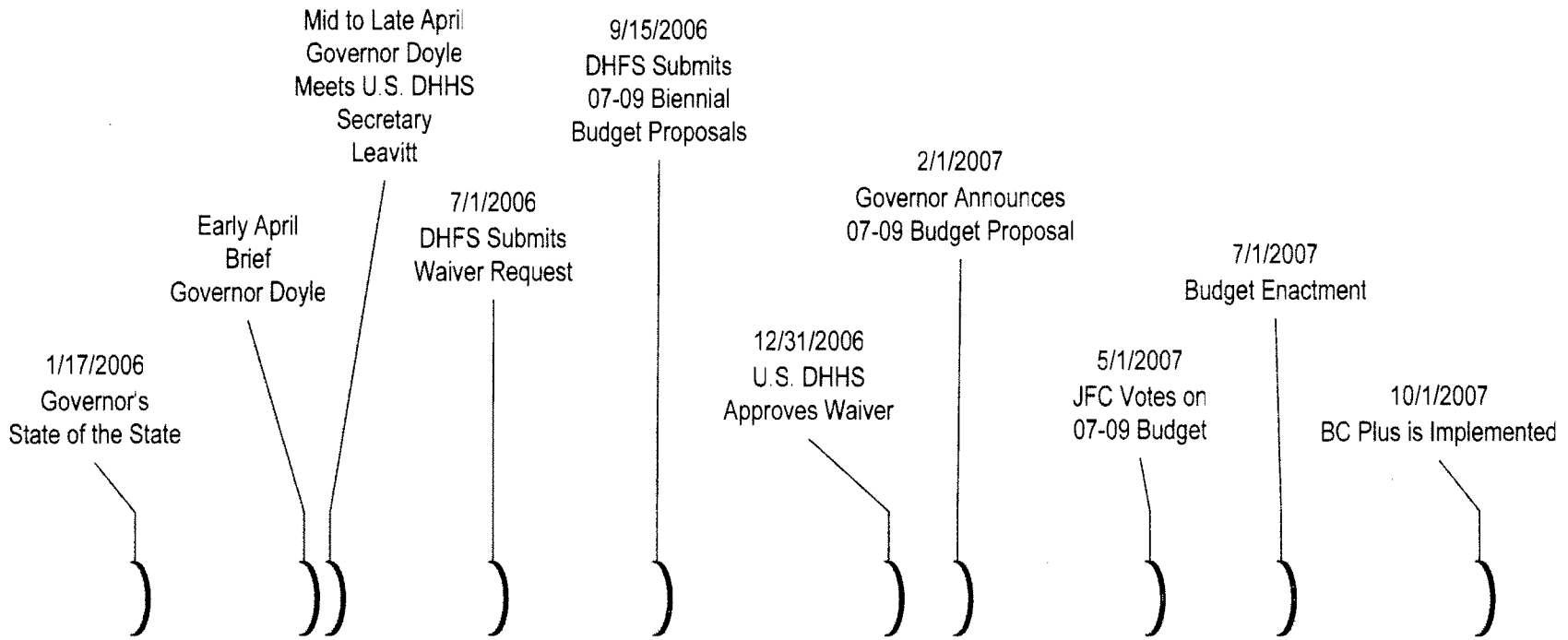
- Improve overall health of participants
  - Enroll all participants in managed care organizations to ensure access to primary physicians.
  - Reward HMO's that meet specific health outcome targets in areas such as smoking cessation and healthy births.
  - Increase access to dental services through pay for performance and/or other innovative strategies.
- Cut red tape, save money
  - Reduce administrative expenses by almost $20 million annually by streamlining program.
  - Model the new program after SeniorCare which has a simple 1 page application form.

Program Pays for Itself!

	SFY08	SFY09
Benefit Cost	$ 12.5 million	$ 23.5 million
Administrative Cost	$ 0.7 million	$ 0.8 million
Total Cost	**$ 13.2 million**	**$ 24.3 million**
HMO Expansion Savings	$ 16.8 million	$ 22.9 million
State Administrative Savings	$ 2.5 million	$ 2.5 million
Total Savings	**$ 19.3 million**	**$ 25.4 million**
NET COST OF BC PLUS	**($ 6.1 million)**	**($ 1.1 million)**

BadgerCare Plus Project Timeline

3/31/2006



Outreach

- BadgerCare Plus Advisors to meet every couple of months to provide guidance on program design.
- Focus groups of providers and program participants to identify problems with current programs and suggest improvements.
- Town Hall meetings with Governor Doyle and/or Secretary Nelson to discuss the new program and get useful input from interested parties around the state.
- Legislative briefings with interested legislators/staff as program design is finalized and input from CMS is received.

Summary

- BadgerCare Plus is a historic opportunity to reform Wisconsin's Medicaid program.
- Through reform we will be able to:
  - Cover all kids and extend the health care safety net in other important ways
  - Improve the health of participants
  - Save taxpayer money
  - Simplify and streamline government
- Over the next several months we will be seeking a lot of input from stakeholders as we design the new program.

For More Information

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http://dhfs.wisconsin.gov/badgercareplus/


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UW Health

Robert Golden, MD
Dean, University of Wisconsin School of Medicine and Public Health

Donna Sollenberger
President and CEO
University of Wisconsin Hospital and Clinics

Jeffrey Grossman, MD
President and CEO
University of Wisconsin Medical Foundation

UW Health

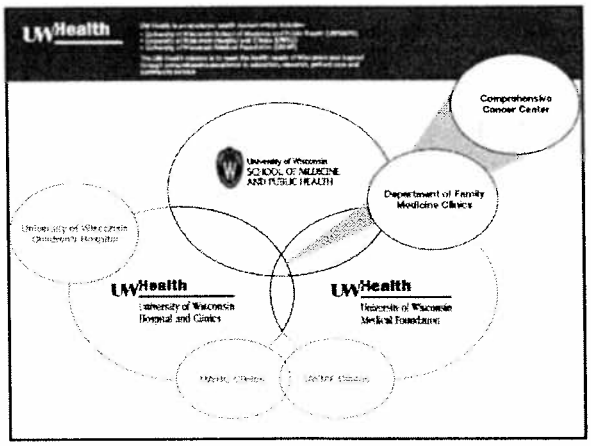
- A school of medicine and its closely affiliated educational and clinical institutions:
  - Teaching Hospital(s)
  - Faculty group practice plans
- Often includes other health professional schools - public health, nursing, pharmacy, dentistry.

UW Health

The Academic Health Center's *social missions* – teaching, research, provision of rare and high technology services, continuous innovation in patient care, and the care of the indigent – are significant contributors to the public welfare, and *are likely to grow more important in the foreseeable future.*

Envisioning the Future of Academic Health Centers – Final Report of the Commonwealth Fund Task Force on Academic Health Centers, February 2003

UW Health



UW Health

Advances in the biomedical and social sciences have provided us with a <u>more</u> complete understanding of the social and biological bases of health and disease than ever before...

Yet healthcare delivery remains "a tangled, highly fragmented web that often wastes resources by providing unnecessary services and duplicating efforts, leaving unaccountable gaps in care and failing to build on the strength of all health professionals."

The Institute of Medicine, Crossing the Quality Chasm. 2001

UW Health

- Poor access to care and coverage for a substantial portion of our population
- Unsustainable costs
- Inadequate healthcare workforce pipeline, and problems with clinician distribution
- Translation of basic science discoveries into effective clinical care
- Concerns regarding quality/safety
- A system designed to be "reactive" rather than preventive, following conventional medical models rather than an integrated public health/medical model

UW Health

Serve as a "think tank" and "learning laboratory" for Wisconsin

Increase the enrollment in Wisconsin's healthcare schools, and design mechanisms to address problems in the distribution of the work force

- Wisconsin Academy of Rural Medicine
- Milwaukee Clinical Campus
- Loan forgiveness

UW Health

Role of the Academic Hospital in the Healthcare Delivery System

Donna Sollenberger
President and CEO
University of Wisconsin Hospital and Clinics

UW Health

Academic hospitals and health systems play an important role in the healthcare delivery system:

Deliver highly specialized care with state-of-the-art technology, often creating tomorrow's standard of care today

Serve as "classrooms" to educate health science professionals

Serve as "laboratories" for the translation of research from the bench to bedside

Provide a safety net for the uninsured and underinsured of the state; often the largest Medicaid providers in the area

Offer highly specialized services such as burn, trauma, organ transplant, and pediatric care for the state and the region

Deliver care not available in communities, a safety net for many areas

UW Health

- Create new treatments and methods of diagnosis and care that will be the community standard of care tomorrow
- Leaders in defining best care practices
- Lead the way in care management, particularly for the chronically ill
- Train students in evidence-based practices and innovative care models
- Identify opportunities to weed out duplication and inefficiency in current care models

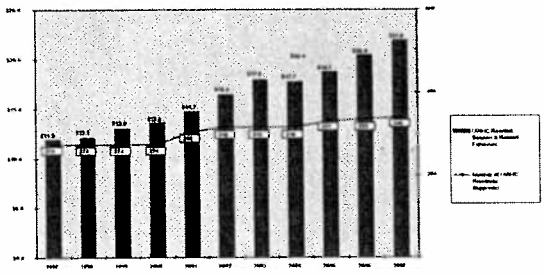
UW Health

- Support the cost of educating the next generations of physicians, nurses and healthcare workers
  - Restore the Graduate Medical Education funds cut almost four years ago

UW Health

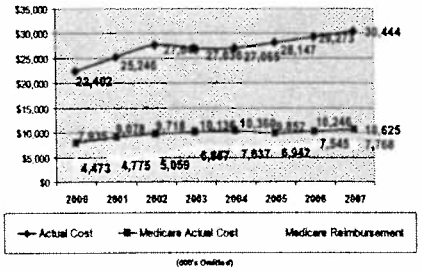
- UWHC currently trains 340.72 residents and fellows in 14 residency programs and 10 fellowship programs. In addition, another 142.28 residents and fellows in UWHC programs train at the Middleton VA, Meriter, St. Marys and other statewide locations
- On average, one-third of residents trained at UWHC stay and practice in Wisconsin

UWHealth

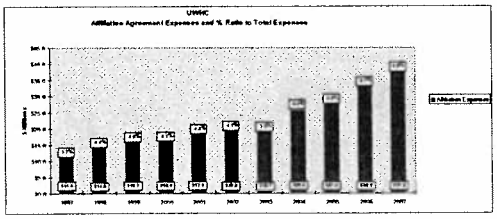


Represents approximately 3% of UWHC's total annual operating budget in FY07

UWHealth



UWHealth

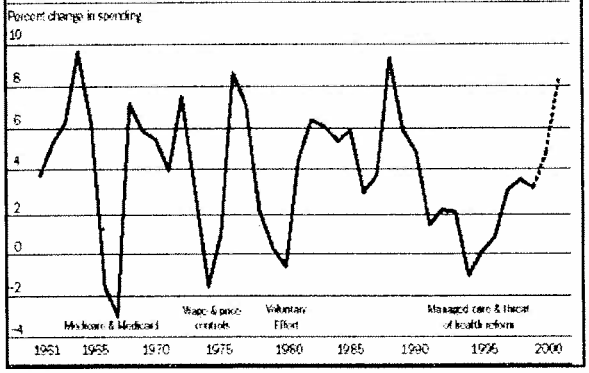


UWHealth

The Role of Academic Health Centers in Creating Sustainable Reform

Jeffrey Grossman, MD
President and CEO
University of Wisconsin Medical Foundation

EXHIBIT 1
Annual Change in Private Health Spending Per Capita (Adjusted For Inflation), 1961-2001



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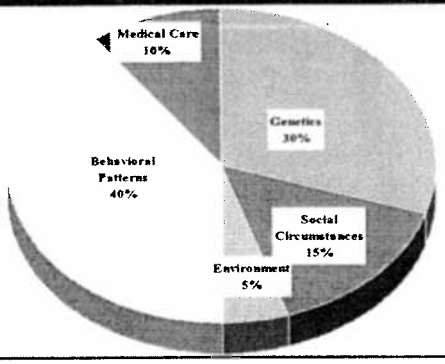
- Health Care Value
- Growth in Uninsured Population
- Shift from Acute to Chronic Disease
- Aging Population
- Diverse Population
- Technological Advances
- Information/Communication Technology
- Determinants of Health/Illness

UWHealth



UWHealth

Three key elements for sustainable reform:

1) Define our goals
2) Support the knowledge pipeline
3) Close the gap between "what we know" and "what we do"

UWHealth

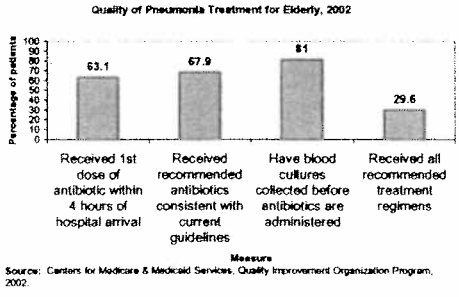
- Translation
- Variation
- Organization
- Education

UWHealth

Clinical Procedure	Landmark Trial*	NHQR 2004
Flu Vaccine	1968	63%
Pneumococcal Vaccine	1977	54%
Diabetic Eye Exam	1981	70%
Mammography	1982	70%
Cholesterol Screening	1984	67%

* Balas EA, Boren SA., Managing Clinical Knowledge for Health Care Improvement. Yearbook of Medical Informatics 2000.

UWHealth



UWHealth

"Lets be realistic: if we didn't do it with aspirin, how can we expect to do it with DNA?"

Claude Lenfant, Director NHLBI/NIH

UW Health

- Translation
- Variation
- Organization
- Education

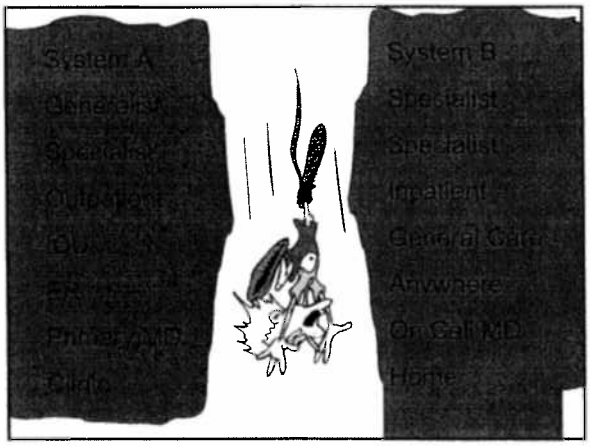
UW Health

- Translation
- Variation
- Organization
- Education

UW Health

"Right now we are flailing around inside 1 percent of the possible (organization of medical care) space"

- Ian Morrison, "Health Care in the New Millennium"



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We treat chronic illness in a system designed for acute care

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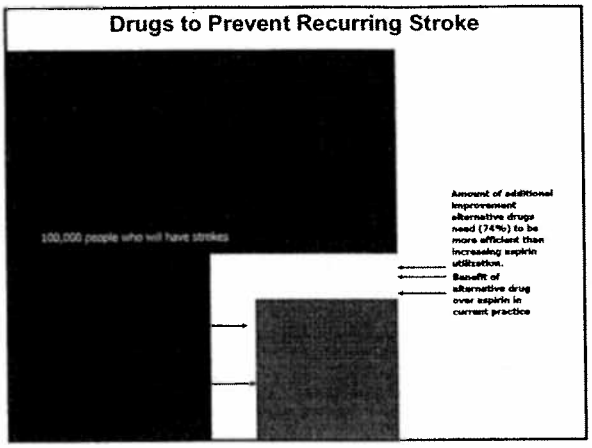
Health Care as a Commodity:

- misaligned financial incentives for services that do not cost-effectively contribute to health
- lack of incentives to provide individual or population services that promote prevention and health maintenance
- severe misdistribution of resources, correlated with race and socioeconomic status
- limitations on collaboration



UW Health

- Translation
- Variation
- Organization
- Education

UW Health

Core Competencies for the 21st Century:

- Teamwork
- Grounding in Quality Improvement
- Evidence Based Practice
- Patient Centered

Policy Issues:

- How many health professionals do we need?
- How should they be distributed?
- What will be their roles?
- Who will share the cost for their education and training?

UW Health

Summary Thoughts

- Think globally, act locally
- Support development and use of evidence to guide policy and practice reform
- Use reform to align goals and incentives – beware of unintended consequences
- Good health requires more than good health care
- Reform includes the cultivation of a relevant and responsive workforce
- Embrace the "Wisconsin Idea"
- UW Health and the University has a responsibility and commitment to be part of the solution

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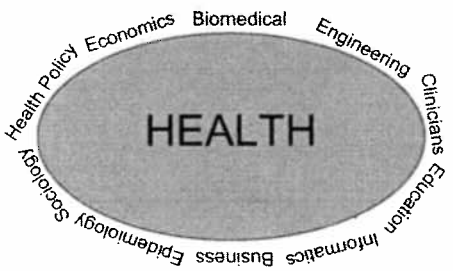


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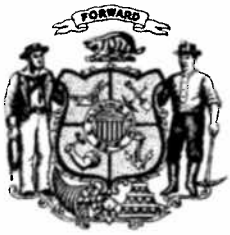
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Testimony Before the Senate Select Committee on Health Care Reform

Stephen D.Wilhide MSW,MPH
Consultant to the American Academy of Family Physicians
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Critical Concepts and Principles for Medicaid Reform

- **Primary Care medical/healthcare home. The individual and/or family has a primary care physician who is responsible for assuring a regular source of care and leads to improved use of appropriate services and lessens inappropriate emergency room utilization**
- **Care management .Assuring patients with chronic conditions receive appropriate and necessary quality care.**
- **Care Coordination. Care is coordinated between primary care providers, specialty providers, hospitals, health departments and social service agencies.**
- **Disease management based upon best practice clinical guidelines**
- **Patient education**
- **Preventive health services and early detection of disease**
- **Pharmacy**
- **Care management information system**
- **Evidence based pharmacy formularies**

Community Care of North Carolina: A Successful Model of Medicaid Reform

Carolina Access began in five counties in 1991. Medical home concept/case management. Physicians coordinate specialty care. Physicians paid a care coordination fee above and beyond fee for service.

- **Currently over 740,000 enrollees statewide**
- **Program changed to Community Care of North Carolina in 2002 (CCNC)**
- **CCNC designed to support the development of community care systems that have the ability to develop programs and infrastructure to manage healthcare needs of the Medicaid population and improve the quality of their care through integrated community management**
- **Local non-profit networks which include, at minimum, Medicaid primary care providers and FQHC's, health department, department of social services and local hospital**
- **Each network is responsible for population management which involves identifying individuals with certain high cost or complex health conditions in need of case management, assisting the primary care physicians with disease management education, helping patients coordinate care and collecting and reporting program and patient data to the CCNC statewide office.**
- **Currently, fifteen networks including more than 3,000 physicians practicing in collaboration with health departments, hospitals, social service agencies and other community agencies managing the care of over 681,000 enrollees; about 74% of all eligible Medicaid beneficiaries in the state.**
- **Each network receives $2.50 PMPM Medicaid enhanced care management fee. Primary care providers also receive $2.50 PMPM to participate in local disease management and care coordination systems that reduce Medicaid expenditures.**
- **Primary care physicians are paid 95% of the Medicare fee schedule on a fee for service basis.**
- **Case managers hired by each network identify patients with chronic diseases and high risk conditions, assist the primary care providers in disease management and patient education, coordinate care and assure access to necessary services and collect data on process and outcome measures using the Care Management Information System.**

- **Statewide clinical improvement inititatives include:** Evidence based guidelines
  Asthma and Diabetes management
  Congestive heart failure
  Pharmacy initiatives addressing cost and utilization
  Emergency department utilization
  Managing those enrollees and services at highest risk and cost

- **Networks can develop other initiatives based upon the needs of their patient population**
  -HIV/AIDS care management
  -Health disparities
  -Mental health integration
  -sickle cell anemia

Overall Medicaid Cost Savings in North Carolina from Managed Care

• Overall cost savings to Medicaid attributable to managed care in North Carolina compared to fee for service for 2004: $225 million (Mercer Consulting evaluation)

Evaluation of CCNC Disease management Initiatives

- **Initial start up program (2000-2002) evaluation of disease management:**

Asthma See monthly cost savings
-Savings of $1,580,040. Costs included enhanced care management fees.
-Hospital utilization decreased by 23% for the CCNC enrollees under age 21
-Inpatient days decreased by 30%
-Admissions declined by 54%
-Overall emergency room utilization decreased significantly
-Number of prescriptions per enrollee decreased

Diabetes
-Savings of $2,083,824 including enhanced care management fees
-Hospital utilization decreased by 13% compared to non CNNC Medicaid patients
-Fewer emergency room visits (almost half in 2002 versus 2000)
-Prescription drug use 9% lower for CCNC patients

- **Access Improved for Medicaid Beneficiaries and Safety Net Providers Strengthened**

Many communities use the relationships and infrastructures developed through the networks to address other problems and populations such as the uninsured, indigent populations or nursing home residents.

Additional Benefits

- **Improved financial viability of safety net providers**

- **Medicaid beneficiaries assured a medical home and access to necessary and appropriate services**


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Wisconsin Academy of Family Physicians

Medicaid Reform in Wisconsin: Recommendations of the Wisconsin Academy of Family Physicians

Ken Schellhase, MD MPH
for the WAFP Medicaid Task Force

Staff Physician, Waukesha Memorial Hospital
Faculty, Medical College of Wisconsin

Overview

- Background—our view of the problem
- WAFP's Response—highlighted recommendations of the Medicaid Reform Task Force

Medicaid Squeeze

- Safety net for vulnerable populations-patients who otherwise would not have access to appropriate care
  - Poor children, disabled, poor elderly, etc
- Mismatch between revenue and expenses
  - Cost containment pressure, potential for funding cuts
- Relevance for Family Physicians:
  - We are the front line of essential access to healthcare for this challenging population
  - Current reimbursement creates a strong disincentive to see Medicaid patients

Background data

- Percent of WI residents enrolled in Medicaid is rising (now 9%); 40% of all births in WI covered by Medicaid
- WAFP member survey:
  - 99% of WI Family Physicians accept Medicaid
  - At current pay levels:
    - 38% unlikely to take new Medicaid patients at current pay levels
    - 30% likely to stop seeing current patients

- My clinic loses money on every Medicaid visit:
  - Typical office visit pay at Waukesha Family Practice
    - Medicaid: $30 (vs. commercial insurance: $80)
  - Office overhead: $50/patient…*before* MD salary
- 38% of our patients are Medicaid
  - Not sustainable w/o subsidy as a teaching clinic

The problem

How do we provide access to quality medical care for these vulnerable populations without going broke?

WAFP recommendations for a sustainable solution

- To fix the Medicaid budget:
  - Don't cut benefits, eligibility, or reimbursement
- Instead, consider a integrated, proactive approach which includes:
  1. Give every patient a Personal Medical Home
  2. Incentivize patients AND physicians to use the Medical Home
  3. Overhaul prescription drug program
  4. "Disproportionate share" payments for high-volume clinic providers
  5. Require advanced directives for all patients in Medicaid

Personal Medical Home

- PMH: focal point through which all individuals participate in health care, promoting continuity with a physician/clinic
- patients receive acute, chronic and preventive medical care services that are accessible, comprehensive, integrated, and timely
- Implications:
  - Better, cheaper care (Starfield report)
  - Access to primary care must be more open for Medicaid patients
  - Patients need to learn to use ER care appropriately

Incentivize use of the Medical Home

- For physicians:
  - Increase reimbursement for Medical Home patients
  - Capitation fee (e.g., $2.50 pmpm) for case management, in exchange for assuring access to Medicaid patients in timely fashion, coordinating appropriate specialist care
  - Penalties for not providing such access coordination
- For patients:
  - Assured access to primary care on an urgent basis, where 90% of health care needs can be met
  - Increased co-pays for inappropriate ER use, specialist self-referrals

Overhaul prescription drug program

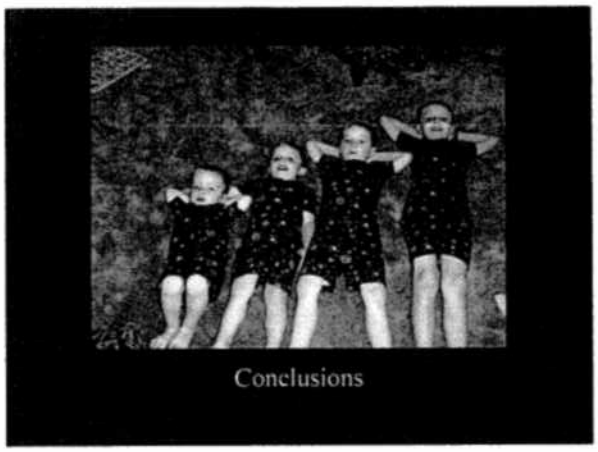
- Improved formulary
  - Need accurate info at point-of-care (web, PDA)
  - Must have reasonable range of options—one standard drug from each class (minimum)
- Put the free market to work: use competitive bidding to lower prices
  - Consider multi-state purchasing consortium
- Increase co-pays for non-allowed drugs

Disproportionate share payments to clinics

- Cost-based reimbursement (like FQHCs) for large Medicaid providers (>25% of patients)
- Consider replicating FQHC model of professional liability insurance coverage through state pool for large providers

Advance Directives

- All Medicaid patients should be required to have an Advanced Directive to help guide care if he/she is incapacitated
  - Help reduce futile care at the end of life
  - Especially important for elderly and disabled enrollees



Conclusions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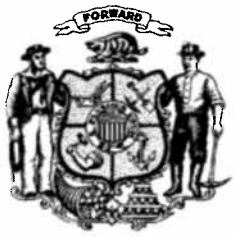
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Community Care of North Carolina

A Provider-Led Strategy for Delivering Cost-Effective Primary Care to Medicaid Beneficiaries

A Case Study by Stephen Wilhide & Tim Henderson
Consultants to the American Academy of Family Physicians

May, 2006

CCNC is a State/Local Partnership

- Networks of local essential health providers responsible for managing care for a specific Medicaid population
  Dept. Social Services, Hospital, Safety Net Providers
  Health Dept.
- Quality improvement initiatives implemented by networks
- Cost containment initiatives

History

- Began in 1991 as an expanded primary care case management program -- *Carolina Access*
  - In concert with NCAFP and NC Pediatric Society
- 1998: Nine *Carolina Access* networks agreed to participate in new statewide care management initiative -- *Community Care of North Carolina*
- CCNC joins physicians with community providers (hospitals, health departments, departments of social services)
- State legislature very supportive
  - Evidence of cost savings and quality improvement key

Goals of CCNC

- Improve quality of care for Medicaid beneficiaries
- Contain costs
- Strengthen sustainable community care systems

CCNC Today

- Fifteen local *Access* networks across the State
- More than 3,000 participating primary care physicians working collaboratively with health departments, hospitals, social services and other community providers
- Managing the care of 74% of all Medicaid beneficiaries in North Carolina

700,000 enrolled -

Care Management Strategies of CCNC

- Case Management/ Disease Management
- Best Practice Clinical Guidelines
- Care Coordination
- Patient Education

Each network responsible for population management -

Identify patients with high risk and high cost or complex health conditions in need of care management. Assist physicians with patient education Report data in Care Management Info. System

Case Management

Case managers in each network:

- identify high risk patients
- assist providers with disease management
- help coordinate care, assure access
- collect data on processes and outcome measures

Care Management Information System

- Identifies patient problems, interventions, goals and cost savings
- Identifies patient diagnosis, goals, interventions, and cost savings
- Examined to identify implementation of clinical outcomes and utilization patterns

Community Care Networks

- Not-for-profit 501(c)(3) organizations
- Receive $2.50 PMPM case management fee to hire case managers or devote resources to manage enrollees
- Networks elect physician as medical director
- Networks participate in clinical improvement initiatives

Participating Primary Care Physicians

- Follow clinical guidelines
- Help educate patients regarding managing own care and utilizing appropriate services
- Provide clinical information for information management system
- Provide '24/7' services
- Carry minimum liability insurance
- Receive $2.50 PMPM enhanced case management fee

Paid 95% of Medicare fee schedule

Current Clinical Improvement Initiatives

- Asthma and diabetes management
- Congestive heart failure
- Cost and utilization pharmacy initiatives
- Emergency department utilization
- High cost/high risk enrollees

Evaluation and Outcomes

- Asthma Management
  - Costs savings over three years: *$3.3 million*
  - 23% fewer hospitalizations
  - 28% decline in inpatient days
- Diabetes Management
  - Cost savings over three years: *$2.1 million*
  - Rate of hospitalization lowered
  - ED utilization decreased by almost half

Conclusions

Interviewed CCNC primary care physicians report:

- Medicaid patients received better care
- Added services of case managers improved outcomes
- Added PMPM case management fee *and* payment of 95% of Medicare fee schedule improved access
- Opportunity to participate in development of evidence-based clinical guidelines was important

Conclusions

CCNC/Medicaid report:

- State/networks have realized significant cost savings
- State/networks/PCPs have realized important improvements in care quality and coordination

Medicaid Cost Savings Attributable to Primary Care Management in *Carolina Access* and *Community Care of North Carolina (CCNC)*

"[CCNC/Access] is a practical solution to rising health care costs in Medicaid. The General Assembly is quite supportive of this program." Senator Bill Purcell, Co-Chair, Health Care Committee May 11, 2006.

Savings from *Carolina Access* Compared to Historical Fee-for-Service Costs:

State Fiscal Year 2004 between $230-260 million
State Fiscal Year 2003 between $195-215 million

Savings from *Carolina Access* Compared to Program Expenditures Without Any Concerted Cost Control Efforts:

State Fiscal Year 2004 between $118-130 million
State Fiscal Year 2003 between $50-70 million

State Fiscal Year 2004 Cost to operate CCNC: $10.2 million

Savings Resulting From *CCNC* Disease Management

For people with asthma:

- Average Per Member Per Month costs (2002): *CCNC-participating Access patients*: $378*
  Access-only patients: $534*
- Anticipated Savings (2000-2002) to *CCNC-participating Access patients*: $3.3 million*
- Hospitalizations Per 1,000 Members under age 21 (2000): 23% fewer for CCNC patients compared to Access-only patients.

Note: These differences between CCNC and Access-only enrollees widened in 2001 and 2002.

For people with diabetes:

- Average Per Member Per Month Costs (2002): *CCNC-participating Access patients*: $859*
  Access-only patients: $880*
- Anticipated Savings (2000-2002) to *CCNC-participating Access patients*: $2.1 million*
- Hospital Admissions (2000-2002): *CCNC-participating Access patients*: 288-318 days
  Access-only patients: 337-352 days

* These estimates include all Medicaid costs, including the physician case management fee and the additional CCNC network fee. The data were further adjusted to reflect the age-cohort differences in savings. Cost savings are associated with significant changes in utilization and other practice measures (i.e., reduction in hospital emergency room visits).

Sources:

1. "Access Cost Savings-State Fiscal Year 2003 Analysis", Letter to Jeffrey Simms from Mercer Government Human Services Consulting, June 25, 2004. "Access Cost Savings-State Fiscal Year 2004 Analysis", Letter to Jeffrey Simms from Mercer Government Human Services Consulting, March 24, 2005. CCNC program officials.
   Note: The Mercer Cost Effectiveness Analysis included AFDC only for Inpatient, Outpatient, ED, Physician Services, Pharmacy, Administrative Costs, Other.
2. T. Ricketts et al, Evaluation of Community Care of North Carolina Asthma and Diabetes Management Initiatives: January 2000-December 2002. North Carolina Rural Health Research and Policy Analysis Program, The Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill, April 15, 2004.