

State Medicaid Disease Management: Lessons Learned from Florida

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Prepared by The Health Strategies Consultancy LLC in collaboration
with Duke University.

March 2005



This paper was funded through an unrestricted educational grant from Pfizer Health Solutions to Duke University.

:: Abstract ::

Disease management (DM) has garnered significant attention as a potential method for reducing Medicaid costs and improving health outcomes. This study evaluates the *Florida: A Healthy State* program, the first DM program for low-income and disabled beneficiaries to tailor case management to Medicaid, through interviews with policy makers and other key stakeholders. The unique nature of the Medicaid population, physician buy-in, and difficulty in long-term evaluation pose obstacles to implementing successful DM approaches. These lessons may be applied by states as they implement DM programs, as well as by new Medicare Part D plans serving low-income and disabled populations.

:: Introduction ::

Over the past few years, disease management (DM) has become an increasingly popular cost-containment strategy for Medicaid programs as states face high levels of spending growth and ongoing budget challenges. Medicaid spending reached double digit growth rates in 2001, maintaining an average annual growth rate of 10.7 percent for state and federal funding from 2001 to 2004.¹ Studies find that 61 percent of adult Medicaid enrollees have chronic or disabling conditions and that these patients are 15 times as expensive to treat (\$6,672 annually) as beneficiaries without such conditions (\$432 annually).² In response, states have turned to DM with the aim of reducing the overall health care costs of patients with chronic diseases by avoiding unnecessary utilization of acute care services. Between 2002 and 2005, 42 states began or plan to begin Medicaid DM and case management programs.³ The Centers for Medicare and Medicaid Services (CMS) has recently issued guidance on DM, indicating a willingness to approve new state approaches.⁴

To date, the literature on Medicaid DM has either focused on evaluating economic results or has provided a descriptive assessment of programs. These studies generally review the trends in program goals and approaches.⁵ They also focus on the analytic difficulties in calculating program outcomes and economic results.⁶ Finally, publications by the Congressional Budget Office (CBO) and others question the ability of these programs to contain costs.⁷

Florida was one of the first states to implement Medicaid DM programs beginning in 1997. It has since experimented with programs that target different diseases, contracted with multiple types of vendors, and applied a variety of program models. After early challenges with its initial programs, Florida terminated contracts with several vendors, required stricter financial agreements, and began to consider other DM approaches. The *Florida: A Healthy State* initiative is the state's most recent attempt to refine and improve the effectiveness of DM for a Medicaid population. The initiative provides insights about conducting Medicaid DM because it is the largest and most sophisticated DM approach in Florida, building upon the state's extensive experience with previous vendors and various program models.

:: Background ::

How the *Florida: A Healthy State* program began

Florida implemented DM as part of a multi-pronged approach to Medicaid cost containment. In 2001, Florida implemented a preferred drug list (PDL) and required pharmaceutical companies to pay supplemental rebates in order for their products to receive preferred status for Medicaid coverage. In response, several companies proposed to provide additional services to the states in lieu of rebates. The state permitted three pharmaceutical companies to test the theory that better management of services and drugs would reduce costs and achieve better health outcomes through DM programs.

Under this contract agreement, Pfizer Inc. agreed to provide DM services to selected Medicaid beneficiaries without additional costs to the state. The state's Agency for Health Care Administration (AHCA) would identify beneficiaries with at least one of four diseases (asthma, diabetes, congestive heart failure or hypertension) who were high utilizers of specific medical services. The program's care managers would contact these high-risk beneficiaries by telephone or visit their homes to educate them on disease treatment and help beneficiaries establish more appropriate and consistent contact with providers. Pfizer would cover all of the administrative costs of the program including payments to the care managers as well as providing training materials and data systems. Pfizer would also provide beneficiaries with durable medical equipment, such as scales and devices to monitor changes in health conditions, and access to a 24-hour nurse hotline. Pfizer agreed to provide educational materials for other lower-risk beneficiaries with these chronic illnesses.

Pfizer guaranteed Florida \$33 million in total savings over a two year period. These savings calculations included medical cost savings and product donations offset by the costs of operating the DM program. In exchange, the state included Pfizer's products on the PDL without requiring them to pay supplemental rebates. Pfizer agreed to reimburse the state for the balance of the guaranteed amount if savings targets were not achieved.

Pfizer Health Solutions (PHS), the DM subsidiary of Pfizer Inc., began implementing the *Florida: A Healthy State* program in June 2001. This program was unique for several reasons. Unlike other DM programs, AHCA and PHS collaborated on implementation decisions. Under previous DM efforts,

vendors were exclusively responsible for designing and operating the program, whereas AHCA was involved throughout the development of the new program with PHS. The size of the program was also unique; it assumed responsibility for an estimated 50,000 beneficiaries, the largest targeted enrollment of any Florida Medicaid DM program. PHS agreed to manage four disease states rather than just one, in order to better address the needs of patients with multiple chronic diseases.

Objectives of the program

PHS and AHCA had two major goals: to achieve savings targets and improve health outcomes (although specific health targets were not established). PHS hoped to achieve these objectives by educating patients so that they could self-monitor their symptoms and alter harmful behaviors. By doing so, patients could detect problems before they progressed and avoid unnecessary hospitalizations and emergency visits. PHS and AHCA hoped these efforts would reduce costs and improve beneficiary health by reducing hospitalizations and emergency visits.

PHS also aimed to demonstrate the effectiveness of proper prescription drug utilization for improving health and decreasing medical costs. In addition to Pfizer's financial motivation to provide DM in return for preferred status for the company's drugs, one of the reasons Pfizer was willing to guarantee savings to the state was to demonstrate the company's stated commitment to the proposition that coordinated physician care, appropriate use of medical services, and prescription drugs can improve the health of high-cost beneficiaries with chronic diseases while reducing overall spending.

Florida's program evaluation

The *Florida: A Healthy State* program exceeded its target number of beneficiaries by three-fold, enrolling over 150,000 Florida Medicaid enrollees. Care managers conducted intensive case management with 19,000 high-risk beneficiaries, patients with a high number of claims related to a chronic condition. Medical Scientists, Inc., an independent third-party organization, calculated that the program saved the state \$41.9 million in medical cost savings during the first 27 months of operation, according to the savings methodology calculations agreed to by AHCA and PHS.⁸ AHCA accepted these savings calculations, but

the Office of Program Policy Analysis and Government Accountability (OPPAGA), an oversight agency that reports to the Florida legislature, criticized the methods used to calculate savings and argued that ACHA had not sufficiently assessed whether the program had improved health outcomes.⁹

In response to an OPPAGA report, AHCA defended the improvements in health status and behavior modification that resulted from the *Florida: A Healthy State* program.¹⁰ Care managers surveyed patients about their behaviors at the time of initial contact and then periodically throughout treatment. PHS measured the impact of DM by comparing beneficiary results at baseline and then at follow-up visits. ACHA reported improvement in medication compliance, regular physical activity, following a special diet, and improvement in overall physical and mental health scores among patients.¹¹

Another major goal of the program was to reduce hospitalizations and emergency department visits. PHS used claims data from high-risk beneficiary populations in care management and compared utilization rates to high-risk beneficiary populations not in care management. This approach has limitations because of potential selection bias between the two groups, as participation in *Florida: A Healthy State* was voluntary (beneficiaries were auto-enrolled, but could opt out of the program). It was also a statewide program, so there were no Florida-based natural control groups available for comparison. AHCA reported that *Florida: A Healthy State* reduced inpatient days by 12.6% and emergency department visits by 1%.¹² More recently, PHS reported that inpatient days and ED visits were reduced by 7% and 18% respectively for patients with congestive heart failure, 17% and 4.6% for patients with diabetes, 4% and 8% for patients with hypertension. Inpatient days were reduced by 4% and ED visits increased by 1% for patients with asthma.¹³

In 2004, the Florida legislature voted to discontinue the *Florida: A Healthy State* program and other so called “value-added” programs that provide DM services in lieu of supplemental rebates. AHCA is permitting these programs to operate until September 2005 for contracting reasons. AHCA plans to continue DM programs in its Medicaid program, though no longer in lieu of supplemental rebates. The state has requested vendors to bid on the DM contracts. Both ACHA representatives and PHS staff have expressed interest in the possibility of continuing the program.

:: Project Methodology ::

Given the size and extent of the Florida program and continuous interest in Medicaid DM, it is important to explore how this program was implemented on such an extensive scale, how success in enrollment was achieved, and how the program addressed the unique needs of the Medicaid population. We conducted 27 interviews with a diverse group of stakeholders who interact with the program including care managers, program administrators, medical directors, state officials, advocacy disease groups, and other community organizations. We targeted stakeholders who had a high level of involvement in the program and, therefore, were the most knowledgeable candidates for this research. The selected group of interviewees is a sample of individuals intimately involved in operating and evaluating the program who may, therefore, be more likely to support the program's model and results. However, these individuals are in the best position to accurately describe the challenges of implementing the DM program and the methods used to address these challenges.

Interviews were conducted via telephone and survey questions were provided in advance of the call. Survey questions covered topics such as objectives of the program; challenges, successes and failures of the program implementation; and methods used to evaluate the program's success. We did not conduct interviews with beneficiaries or providers, as the focus of this study is on the program development and operational lessons from Florida's experience.

Figure A describes the interviewees and their role in the *Florida: A Healthy State* program.

In addition to the interviews, the authors reviewed existing literature on Medicaid DM and publications relating to the *Florida: A Healthy State* program. This program is contracted to continue through September 2005, but our research only addresses implementation goals and program experiences through late 2004.

:: Challenges of Medicaid DM ::

Successful Medicaid DM programs must address the unique aspects of the Medicaid program, the challenging population characteristics, the relatively underdeveloped administrative capabilities, and

heightened political pressures on the program compared with commercial DM programs. The following sections discuss these challenges and evaluate the ways that PHS and AHCA addressed these issues.

Uniqueness of the Medicaid Population

PHS program operators found that Medicaid beneficiaries tend to be more mobile, be less trusting of outsiders, have lower literacy, and have poorer health than their counterparts in private health care. As a result, care managers have difficulty contacting beneficiaries and educating them about their disease. Based on our interviews, Figure B lists several factors that made implementation more difficult for this population:

Care managers indicated that another obstacle to reducing beneficiaries' inappropriate use of emergency departments was the tendency of patients to avoid clinics or primary care physicians (PCP) because of unpaid balances at their PCP's office or the likelihood that a provider will hold them accountable for failure to make behavior changes. Hospital staff indicated that patients in the program sometimes perceive that physicians ask patients why they have not lost weight or stopped smoking in degrading tones that make patients reluctant to return. Emergency facilities tend to offer health care to beneficiaries for little cost and with less behavioral accountability because they are focused on addressing acute needs rapidly and cannot refuse to serve patients. Resistance to treatment by a PCP or clinic is an added challenge for Medicaid care managers who are trying to reduce beneficiaries' use of emergency services.

Data and auto-enrollment

Unlike private plans, which have more complete and timely access to patient data, public Medicaid programs suffer from poor historical data and unreliable or missing beneficiary contact information. In Florida, the Medicaid claims data were not available until six months after treatment, hindering the identification of eligible high-risk beneficiaries and the ability to estimate baseline costs for savings projections. PHS attempted to improve program enrollment by using an auto-enrollment process, but contacting beneficiaries was a persistent problem because beneficiary contact information

from the state was often inaccurate or incomplete because of the mobility of the population. These problems with Medicaid claims data are not unique to Florida.

Mobilizing existing structure

PHS and AHCA established the *Florida: A Healthy State* initiative using the state's existing hospital structure to support the program. Care managers were placed in 10 hospitals in different geographic areas of Florida with high proportions of Medicaid beneficiaries. The care managers served patients located in a specific catchment area around each hospital. AHCA was particularly interested in operating out of the existing hospital structure to reduce the administrative burden of the program and provide care managers greater access to physicians and beneficiaries at their point-of-contact with the health care system. The program also included a 24-hour call center, located in Denver and operated by a contractor to PHS, McKesson Corporation (a commercial DM provider). The call center provided care management to high-risk beneficiaries living outside of a catchment area and was available to all beneficiaries during off-hours. Finally, PHS attempted to build upon existing services provided by community groups and disease-specific organizations, including educational resources, and support groups.

Unlike other programs in Florida's history in which the state paid a vendor to provide DM services on behalf of the state, PHS and the state of Florida collaborated to develop this program. Throughout the implementation and operation, AHCA participated in the oversight and decision making of this program and was responsible for all of the contracting within it. AHCA felt the program was more comprehensive than previous DM initiatives because it combined PHS and AHCA's resources and expertise. *Florida: A Healthy State* combined PHS' administrative capacity, program resources, and existing relationships with AHCA's previous DM experience and its credibility with hospitals.

Innovative recruiting methods

Although AHCA assigned Medicaid beneficiaries to the program, PHS was responsible for contacting them. PHS responded to the challenge of poor contact information from the state by pursuing innovative approaches to facilitate active participation. PHS found updated contact information from

community groups, physicians' offices, and clinics. PHS also utilized their extensive on-the-ground network of Pfizer staff and existing relationships with local providers to promote enrollment. The Pfizer sales representatives and physician educators distributed promotional materials to physicians with the aim of encouraging physicians to refer eligible patients to the program. Despite these efforts, PHS had difficulty engaging physicians in the enrollment process and gaining referrals for beneficiaries remained a program challenge. PHS program administrators reached out to local community organizations to educate them about the program, increase enrollment, and develop a network of support for beneficiaries. PHS also participated in AHCA's general Medicaid outreach activities.

Some interviewees commented that enrollment might have been improved if PHS approached beneficiaries at their point of contact with the health care system, when a beneficiary's health is most salient to him/her, versus calls at home when other issues may seem more pressing. Because program staff were located in the hospitals, they could have tried to meet beneficiaries in-person when they entered emergency departments or physicians' offices. However, care managers and hospital officials felt that in-person recruiting or extensive home visits for care management would be too time consuming and impractical.

PHS's Care Management Approach

PHS created a flexible care management structure that focused on a patient-centered approach and allowed care managers to respond to the individual needs of each beneficiary. Like most DM programs, care managers coached beneficiaries on medication compliance, health services utilization, and self-monitoring of health indicators. PHS care managers also addressed a wide array of lifestyle and behavioral issues with beneficiaries. Some education addressed health-related behavior changes such as smoking cessation, dietary changes, weight loss, and avoiding environmental triggers of asthma. PHS also provided beneficiaries with free durable medical equipment (e.g., blood pressure cuffs) to assist beneficiaries in monitoring their own health indicators such as weight changes, peak flow measures, and blood sugar levels.

Medicaid beneficiaries often face other life crises that direct their attention away from their health status, including food shortages, eviction, disconnected telephones, and lack of child care.

The program provided care managers the flexibility and resources to coach beneficiaries on these non-health related issues, recognizing that beneficiaries would have difficulty addressing harmful health behaviors unless other problems could be addressed. Finally, care managers were able to tailor their frequency of calls and level of intervention beyond established risk-based protocols according to the perceived need of the beneficiary.

Because of the short timeframe for program implementation, PHS wanted to purchase existing disease-specific educational materials to offer beneficiaries. However, PHS discovered that the vast majority of materials were not written appropriately for the Medicaid population because they were not low-literacy, bilingual, and culturally sensitive. Instead, PHS developed their own educational materials drawing on the expertise of existing disease advocacy groups for best practices and behavioral recommendations. The resulting brochures are written at a fourth grade reading level in both Spanish and English providing health education specifically targeted for Medicaid beneficiaries.

PHS also reached out to community organizations to help provide a network of support for their beneficiaries. Some care management sites were able to capitalize on existing resources by referring beneficiaries to other health programs in the community (e.g., asthma camps for children), and by connecting them with available resources to address their non-health related needs (e.g., food pantries). PHS compiled resource lists for beneficiaries that included contact information for local community organizations and services. These resources helped provide beneficiaries with additional support during care management and assisted with the transition once they graduated from the *Florida: A Healthy State* program. PHS attempted to coordinate with other community organizations' resources, but the program may have missed additional opportunities because of the intensive efforts required to integrate with so many other non-profit organizations.

PHS developed a new software system that assisted program operations, monitoring, and evaluation for both the care managers and the states. The database kept records of all contacts between patients and care managers and provided on-line resources for care managers with disease-specific references for abnormal laboratory values and best practice guidelines. AHCA received access to the database and was able to query the software at any time to monitor program operations and results.

Provider Buy-in

One ongoing challenge in both private and Medicaid DM programs is provider participation. Care managers and medical directors interviewed believed that providers tend to resist to external suggestions about health care practices and perceive the added administrative burden to outweigh the benefit. They also indicated that the increasing volume of DM programs makes it difficult for providers to coordinate with all programs since they implemented on a patient rather than a practice basis. Physicians who work in inpatient settings may also encounter resistance to DM from the hospital administration. According to an interviewee, for hospitals that have available beds, DM programs may reduce inpatient revenues. However, for some hospitals that are exceeding inpatient capacity, these programs help them target resources to those most in need of inpatient care.

Physician participation is particularly challenging in a Medicaid setting, where participation is voluntary and reimbursement rates are usually lower than for other insured beneficiaries. Medicaid patients are often perceived to be particularly challenging cases, and doctors in Florida are offered no additional reimbursement for participation in DM. Furthermore, the state is reluctant to specify practices that physicians must adhere to as a condition of participation in Medicaid, concerned that such requirements will reduce beneficiaries' access to providers. One interviewee believed that Florida malpractice laws have led physicians to resist serving Medicaid beneficiaries because they are perceived to be particularly high-risk patients. Finally, many physicians treat few Medicaid beneficiaries, so they may not be aware of Medicaid DM options.

Leveraging physician contacts

To improve physician buy-in, PHS paid hospital medical directors for their participation in the program, and introduced a number of novel approaches to physician recruiting. One of the primary reasons for choosing a hospital-based structure for the program was the hope that it would encourage provider buy-in and facilitate physician understanding of the program. As part of the hospital contracts, PHS paid hospital medical directors for their supervision and promotion of the program. Because medical directors are also physicians, PHS believed they would be more effective at recruiting fellow

doctors to participate. While some interviewees believed that this model helped with physician participation, many said that more buy-in from doctors would have improved the program's outcomes.

Because implementing the *Florida: A Healthy State* program was a joint responsibility between PHS and AHCA, PHS was able to use the relationships and credibility that AHCA already established with the hospitals through the Medicaid program. Thus, AHCA was responsible for all contracting with hospitals and physicians. PHS staff also visited local AHCA offices on a monthly basis to inform new Medicaid providers about the program.

Most of all, PHS attempted to convince physicians to participate by demonstrating results for their patients. One program administrator secured participation by asking a group of physicians to identify what they were unable to accomplish with Medicaid patients due to time constraints and then explained how the *Florida: A Healthy State* program could fill those gaps. Many indicated that physicians were supportive once they truly understood the program and its goals. They appreciated its ability to complement clinical care and assist beneficiaries with lifestyle changes. When PHS surveyed participating physicians, 67% indicated that the program complements their treatment, 78% say that would recommend *Florida: A Healthy State* to other providers, and 86% would recommend to patients.¹⁴ However, many interviewees still indicated that physician buy-in was one of the most significant remaining challenges for the program.

Some interviewees offered additional ways to improve physician participation. Many indicated that offering financial incentives to physicians would be one of the best ways to improve provider buy-in. Others suggested that additional feedback on patients and outcomes of the program would convince physicians that the program was effective. However, others argued this feedback simply gets overlooked in busy doctors' offices and does not actually improve buy-in. Some interviewees argued that the number of DM programs should be reduced and streamlined to ease the burden of participation. Lastly, a few respondents indicated that greater adoption of electronic medical records would enhance the care management process by reducing administrative burdens.

Political factors

Interviewees indicated that political pressures forced the program to focus on producing short-term cost savings at the expense of sustained long-term savings and improved outcomes. Medicaid DM programs are particularly pressured to demonstrate cost-containment quickly because they are publicly funded, and thus open to scrutiny from multiple stakeholders and accountable to an annual appropriation process. PHS officials suggested that longer term outcomes analyses might have been more convincing than having to demonstrate measurable savings within 12 months. This pressure to produce immediate savings also demands that DM programs focus their energy on beneficiaries who are most likely to improve their health and may ignore beneficiaries who are harder to reach, but may need more care management.

PHS faced opposition from the legislature and some of the media since the program's inception.¹⁵ A few interviewees criticized PHS' advocacy efforts as reactive to negative attention rather than proactive about building a positive public image. They suggested that additional education for state legislators about the meaningful impact of the program would have secured stronger support.

Difficulty in conducting long term evaluation

Many of the factors described above contribute to the difficulty in evaluating the ability of DM programs to reduce costs and improve health outcomes in the long term. Beneficiaries are difficult to reach, so obtaining follow-up data on compliance and laboratory results at proper intervals becomes extremely difficult. Participation in DM is voluntary which also raises the issue of selection bias on enrolled compared to non-enrolled populations making it difficult to assess program effectiveness. Data limitations contribute to the difficulty of establishing baselines levels to measure changes. Finally, political pressures to prove short term savings and continuous DM program changes contributed to the difficulty of Florida's evaluations.

:: Conclusion ::

Disease management has shown strong potential to improve the health of chronically ill patients and reduce the costs of health care delivery in the private sector. As a result, federal and state government officials are committed to testing whether DM can accomplish the same goals in the Medicaid and Medicare programs. The Medicare Modernization Act of 2003 includes several provisions to expand the availability of DM services to the Medicare beneficiaries enrolled in the traditional fee-for-service program, and 28 states have indicated they will undertake new or expanded disease/care management programs in FY 2005.

The key lesson of the Pfizer Health Solutions experience is that implementing DM programs in Medicaid requires a fundamentally different approach compared to the private sector because of the population and dynamics of the Medicaid program. Integrating beneficiaries into DM programs is complicated by the unique characteristics of Medicaid beneficiaries, such as their mobility, lower health literacy, and language barriers. Also, implementing such programs in the context of Medicaid fee-for-service is complicated by program rules governing plan members and participating providers; for legal and/or practical reasons, Medicaid cannot drop beneficiaries or providers that refuse to comply. Those who choose to operate Medicaid DM programs must also contend with data limitations and political factors that complicate program operations. As this case-study demonstrates, future DM programs will have to successfully navigate these challenges to achieve program goals.

Policy makers who assess the value of DM may need to consider process goals rather than measuring success only by savings and health outcomes targets. For example, improving the provider-patient relationship may need to be a process measure that is considered. Finally, policy makers will tightly scrutinize savings calculations and health outcomes measures in a compressed time horizon; establishing metrics that legislators, executive branch, and provider stakeholders consider valid prior to the initiation of the program is an important political component to maintaining support for disease management programs.

Figure A. Study Methods: Interview Profiles		
Interviewed Stakeholders	Role	Number of interviews
Community/Advocacy Organizations	Partner with program to provide educational materials; assist in outreach; coordinate organization’s health related activities with DM beneficiaries when possible	8
Current and former AHCA officials	Involved in program implementation; responsible for oversight and evaluation of the overall program	6
DM Vendor Staff (Pfizer Health Solutions)	Responsible for program implementation; train care managers; build partnerships with community groups; evaluate patient progress	7
Hospital Administrators/ Medical Directors	Responsible for operating hospital component of program and managing care managers; involved in securing provider participation	4
Care Managers	Primary point of contact for high-risk patients; responsible for beneficiary education and encouraging beneficiary behavior modification; perform evaluations of patients’ progress	2

Figure B. Challenges Faced by Florida DM Programs, As Identified by Interviewees

Uniqueness of Medicaid Population	Unique Challenge
More mobile, less likely to have home phone	Inhibits the state maintaining accurate contact information
Less trusting of unsolicited calls (e.g., fearful it is a bill collector, uncertain of why care manager would know about their health status)	Contacting and establishing relationship over the phone is difficult
Lower health literacy, language barriers	Makes communication more difficult, may interfere with effective telephonic coaching and educating through written materials
Inflexible work schedules (minimal ability to address personal issues during business hours)	Harder to contact during the daytime More likely to seek treatment in the emergency department
Higher rates of mental illness, more social/psychological issues	Patients may be unable to understanding health issues or have more poignant life crises to address
Poor experience with health providers in the past	Less trustful of providers
Medicaid is an entitlement program so the state cannot refuse to pay for covered services unlike the private sector	Unable to use financial incentives to alter utilization behavior
Often live in areas where environmental factors outside of their control exacerbate their health condition	More difficult to address factors contributing to illness

¹ V. Smith et al., *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005* (Washington: Kaiser Commission on Medicaid and the Uninsured, October 2004).

² S.M. Allen et al., *The Faces of Medicaid: The Complexities of Caring for People with Chronic Illnesses and Disabilities* (Princeton: The Center for Health Care Strategies, 2000); C. Williams, *Medicaid Disease Management: Issues and Promises* (Washington: Kaiser Commission on Medicaid and the Uninsured, September 2004).

³ V. Smith, *The Continuing Medicaid Budget Challenge*.

⁴ The Centers for Medicare and Medicaid Services, "Safe and Effective Approaches to Lowering State Prescription Drug Costs: Best Practices Among State Medicaid Drug Programs," 9 September 2004, <http://www.cms.hhs.gov/medicaid/drugs/strategies.pdf> (Accessed 10 September 2004).

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⁷ Congressional Budget Office, "An Analysis of the Literature on Disease Management Programs, 13 October 2004. <http://www.cbo.gov/showdoc.cfm?index=5909&sequence=0> (Accessed 15 October 2004).

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⁹ Florida Legislature, Office of Program Policy Analysis and Government Accountability, Progress Report, *Medicaid Disease Management Initiative Has Not Yet Met Cost-Savings and Health Outcomes Expectations* (Tallahassee, 2004), Report No. 04-34.

¹⁰ Agency for Health Care Administration, *Response to OPPAGA's Justification Review of the Medicaid Disease Management Initiative* (Tallahassee, 2004).

¹¹ Ibid.

¹² Ibid.

¹³ Pfizer Health Solutions, "Florida: A Healthy State Update," November 2004.
<http://www.pfizerhealthsolutions.com/pdf/ProgramOverview2.pdf> (Accessed 20 November 2004).

¹⁴ Ibid.

¹⁵ John Pain, "Pfizer Offers Controversial Program to Lower Medicaid Costs," *Associated Press*, June 16, 2003; Diane Hirth, "Pfizer, Florida Differ Over Millions," *Tallahassee Democrat*, November 10, 2004; John Dorschner, "Pfizer Savings Report Comes Under Review in Florida," *The Miami Herald*, November 10, 2004.

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