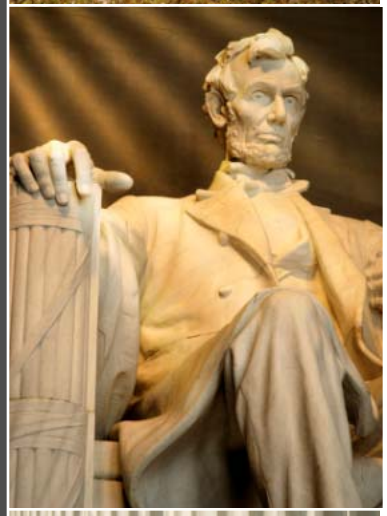
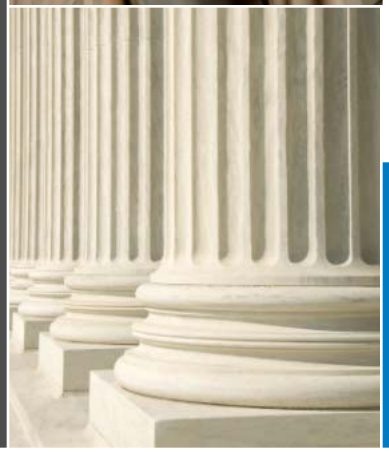




Pfizer Health Solutions

Florida: A Healthy State -
A 5-Year History of Disease Management in a Florida Medicaid Population

Scott A. Wolf, D.O., MPH, FACP
Medical Director, State Initiatives
Pfizer Health Solutions Inc

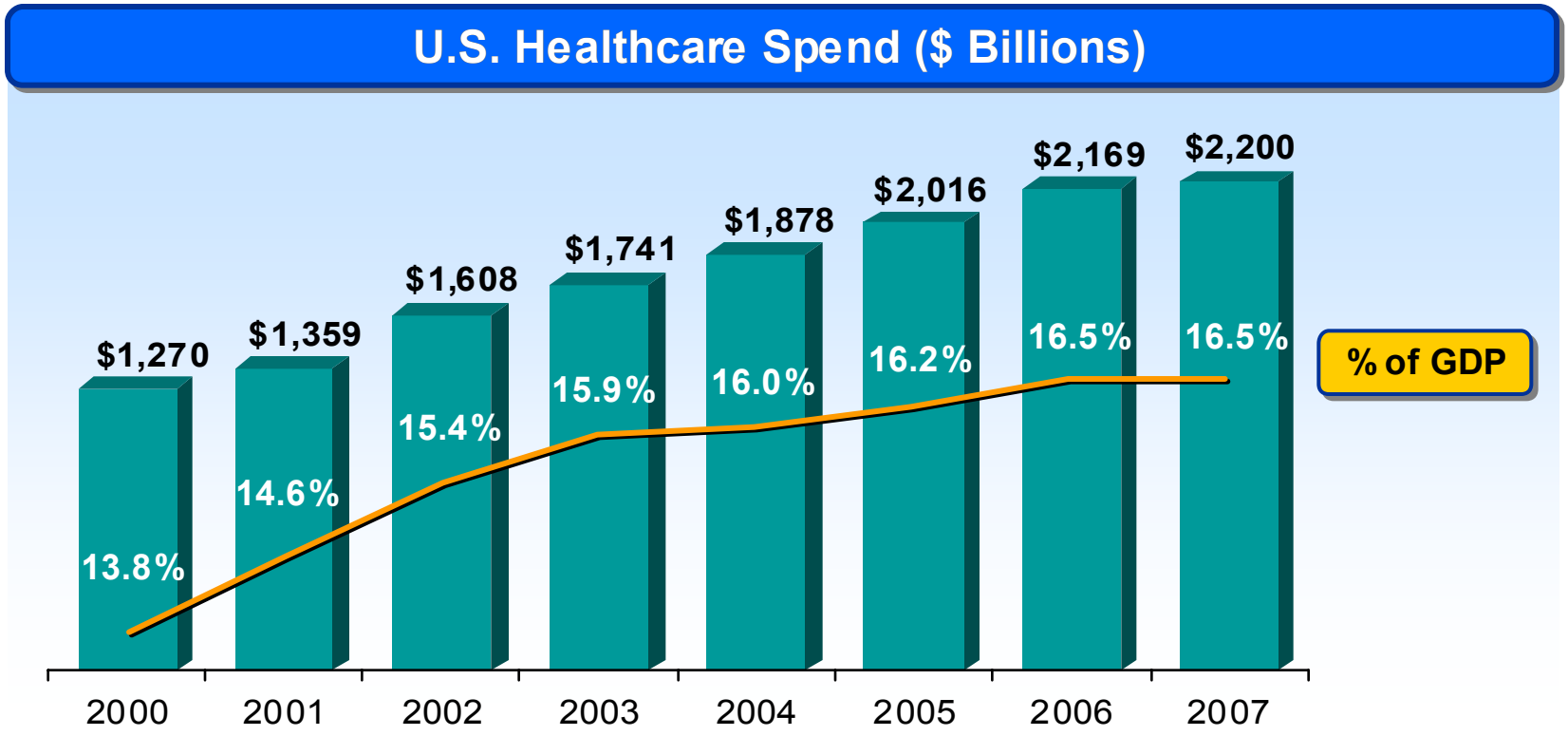
November 5, 2007

Overview

- U.S Healthcare Market Overview
- Disease Management
- The Florida Experience
- Outcomes & Evaluation
- Medicaid Reform
- Q&A

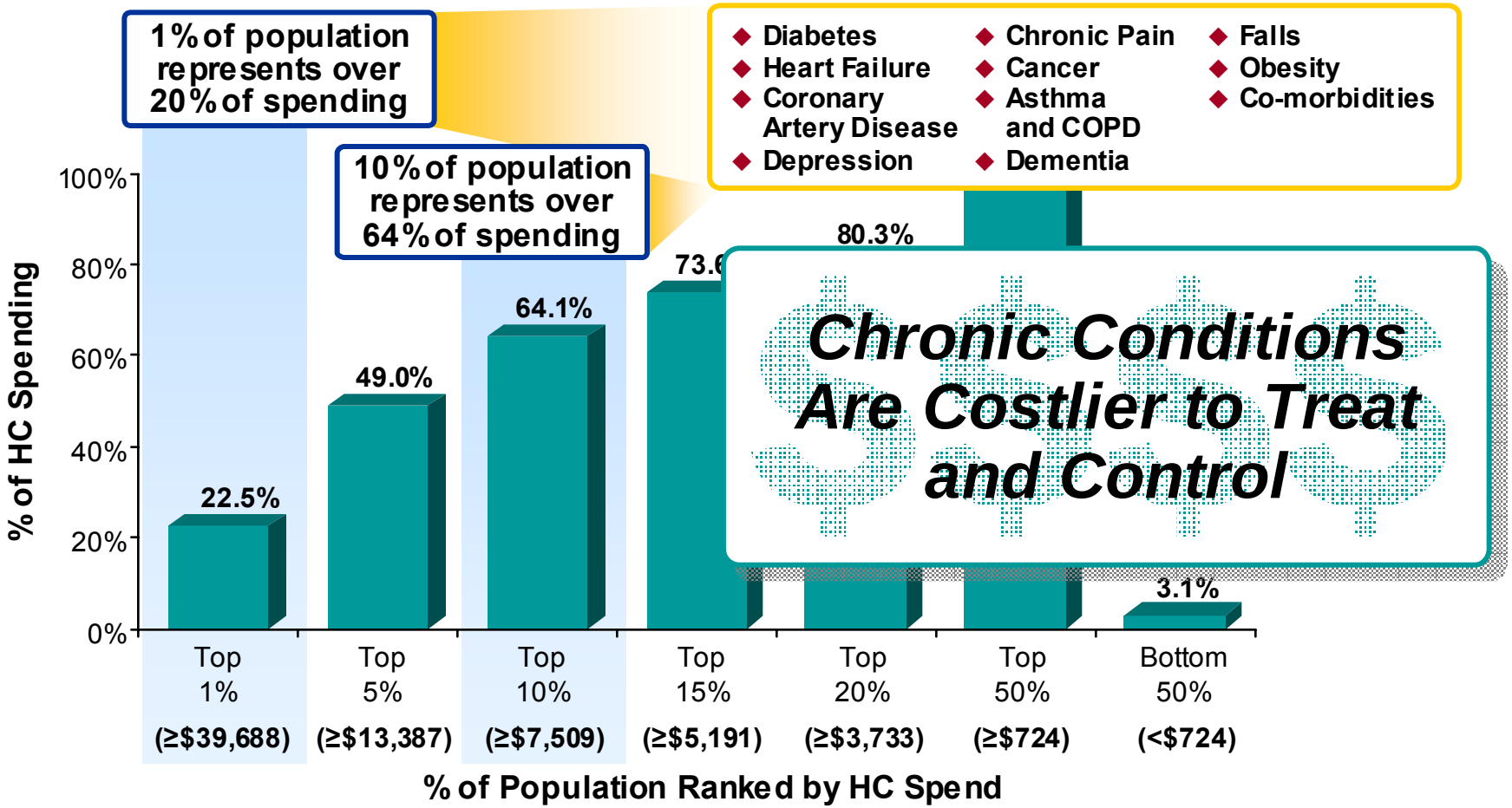
U.S. Healthcare Market

- Unrelenting spending increases
  - Approaching $2.2 trillion, 16.5% of GDP
  - Spending per person expected to increase 6% through 2012



Source: Center for Medicare and Medicaid Services, Office of Actuary

The Business of Health Care in 2007…Chronic Health Conditions Underlie the Bulk of Health Care Costs

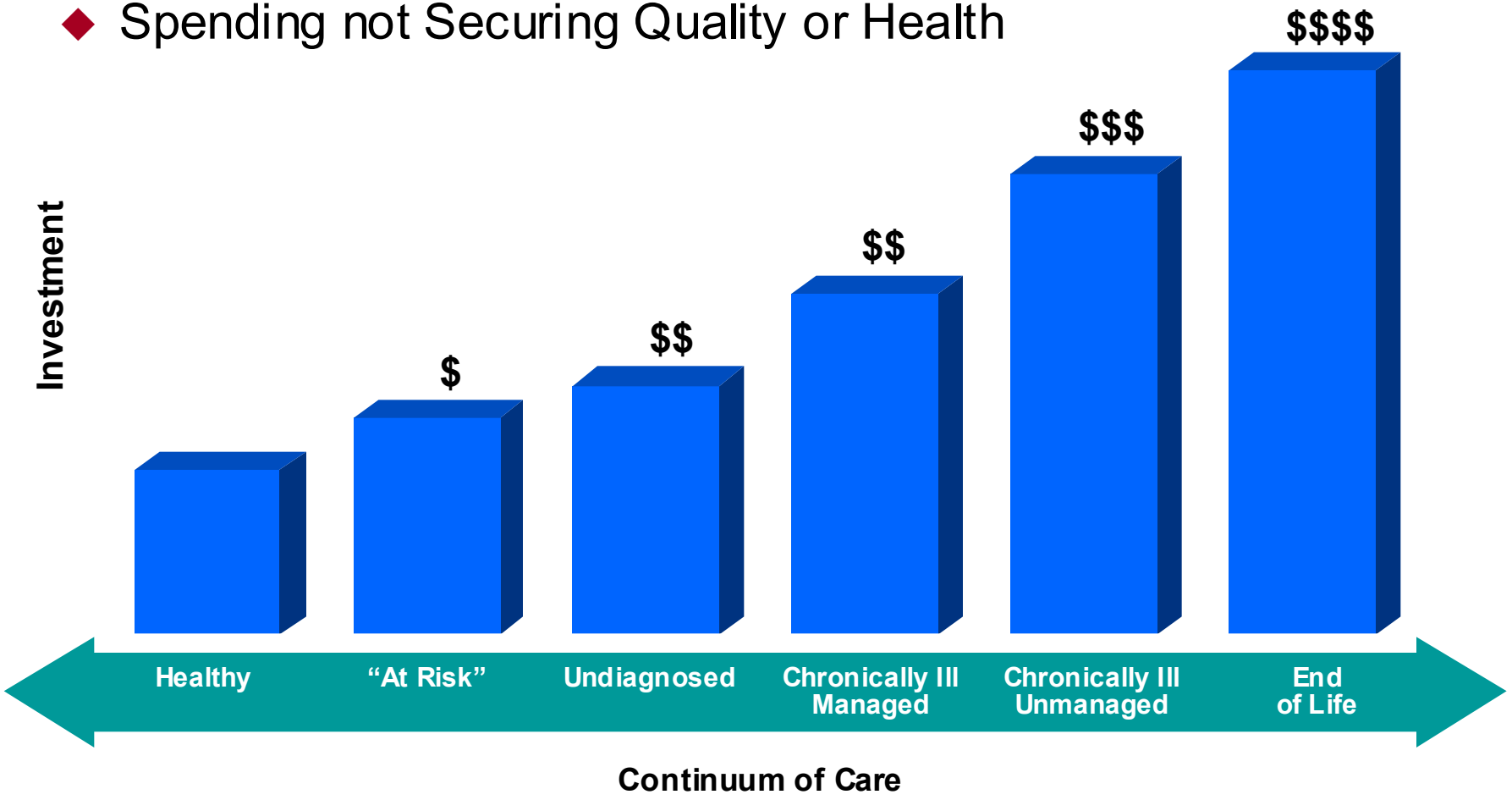


Note: Dollar amounts in parentheses are the annual expenses per person in each percentile. Population is the civilian noninstitutionalized population, including those without any health care spending. Health care spending is total payments from all sources (including direct payments from individuals, private insurance, Medicare, Medicaid, and miscellaneous other sources) to hospitals, physicians, other providers (including dental care), and pharmacies; health insurance premiums are not included.

Source: Kaiser Family Foundation calculations using data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), 2004.

Weighing the Gravity of the System

- Unrelenting Spending Increases
- Spending not Securing Quality or Health



Responding to the Changing Landscape of Health Care

The Evolution of Our Mission…

I. Indemnity

Process: MD Writes Script → Patient Receives Rx → Insurer Pays for Rx

Focus

Physician

II. Traditional Managed Care

Process: MD Writes Script → Patient Receives Rx → MCO Pays for Rx

Formulary Control

Focus

Physician

P&T Director

III. Consumerism

Process

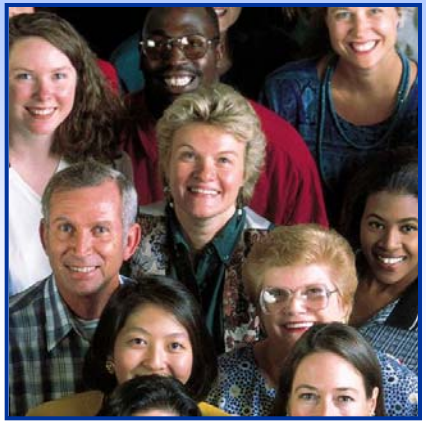
Informed and Educated Consumer

Wants Specific Medication

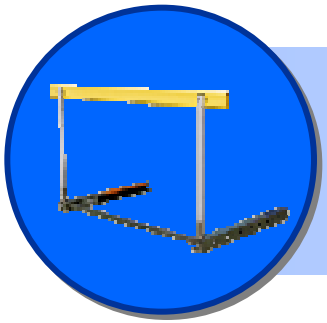
Wants MCO That Covers Service/Product

MD Writes Script → Patient Receives RX → MCO Pays for Rx

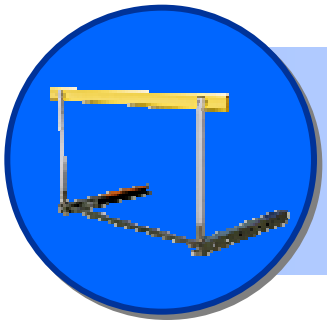
Formulary Control



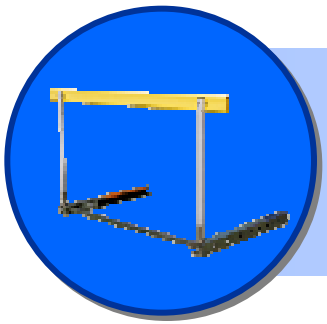
Challenges Presented by Medicaid Beneficiaries



Medicaid Beneficiaries Use Health and Health-Related Services Frequently and Often Intensively

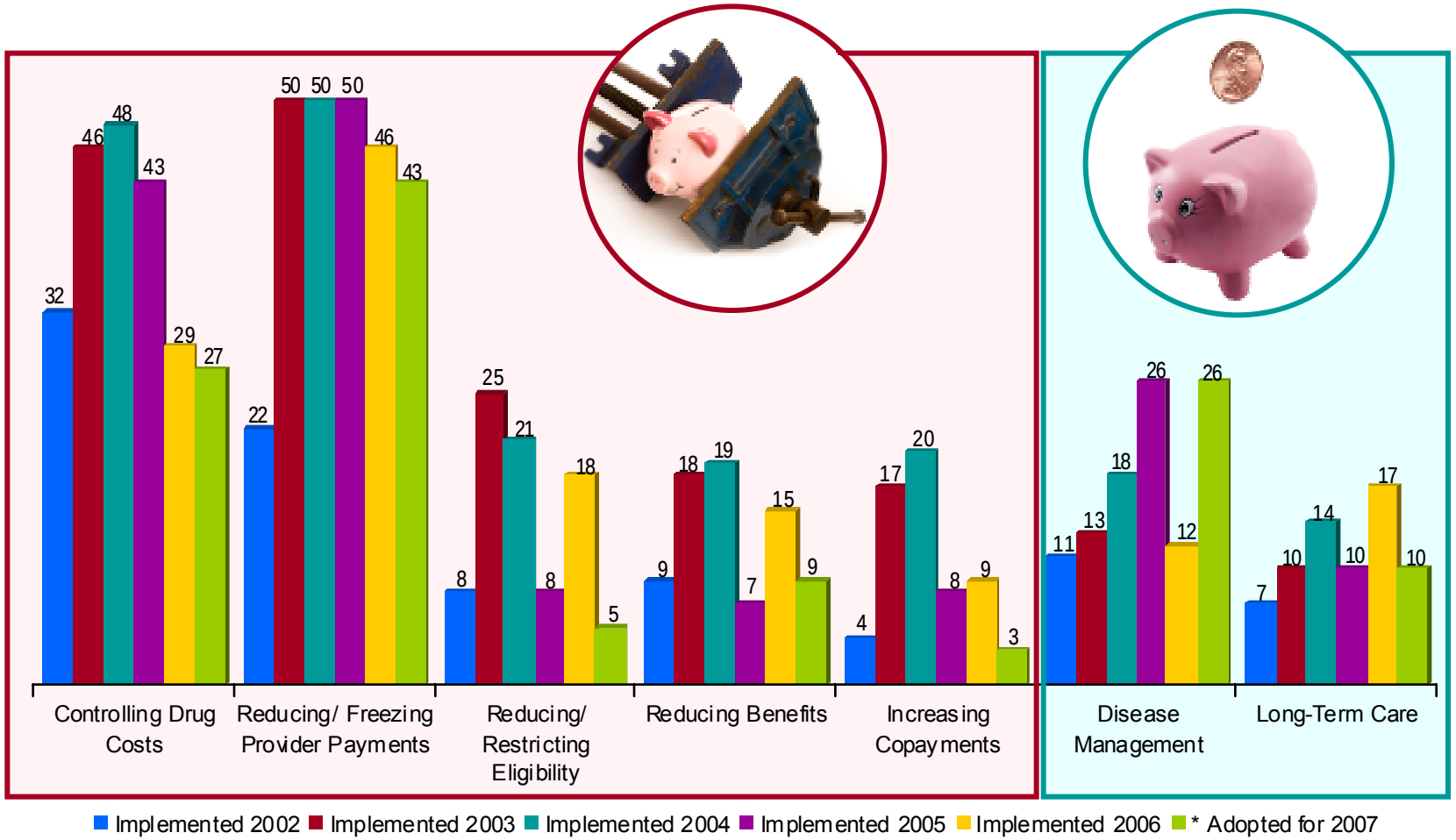


Most Have Multiple Chronic Physical and Behavioral Health Conditions Further Complicated by Difficult Socio-economic Factors



Medicaid Beneficiaries Tend to Be Mobile, Changing Addresses, Phone Numbers and Health Care Providers

States Undertaking New Medicaid Cost Containment Strategies FY 2002–2007



NOTE: Past survey results indicate not all adopted actions are implemented.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September and December 2003, October 2004, October 2005, October 2006.

Disease Management Definition

Definition

- **Disease management is a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant**

Disease Management

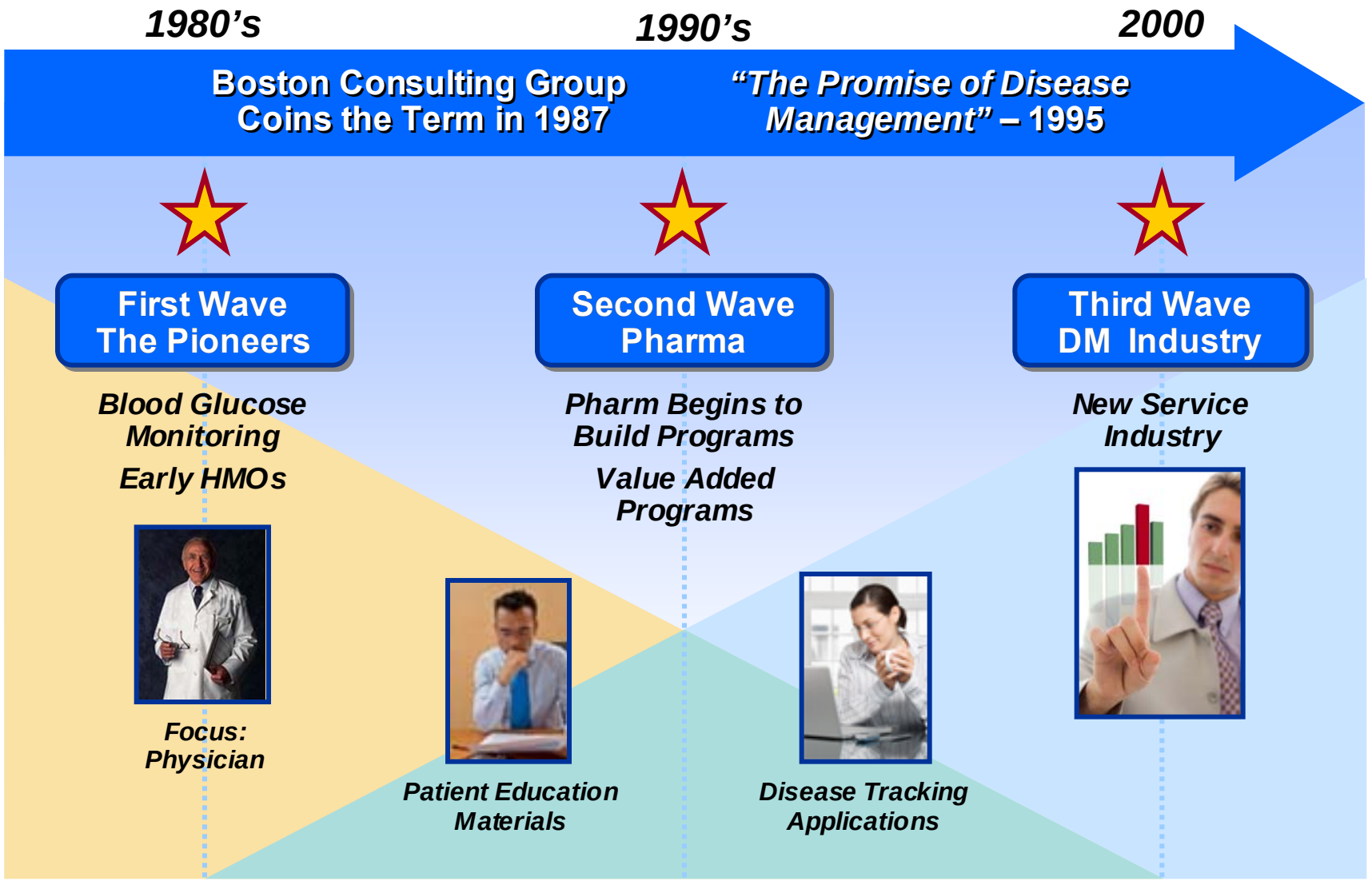
- Supports the physician or practitioner/patient relationship and plan of care;
- Emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies; and
- Evaluates clinical, humanistic, and economic outcomes on an on-going basis with the goal of improving overall health

Disease Management Components Include*

- Population identification processes;
- Evidence-based practice guidelines;
- Collaborative practice models to include physician and support-service providers;
- Patient self-management education (may include primary prevention, behavior modification programs, and compliance/ surveillance);
- Process and outcomes measurement, evaluation, and management;
- Routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling)

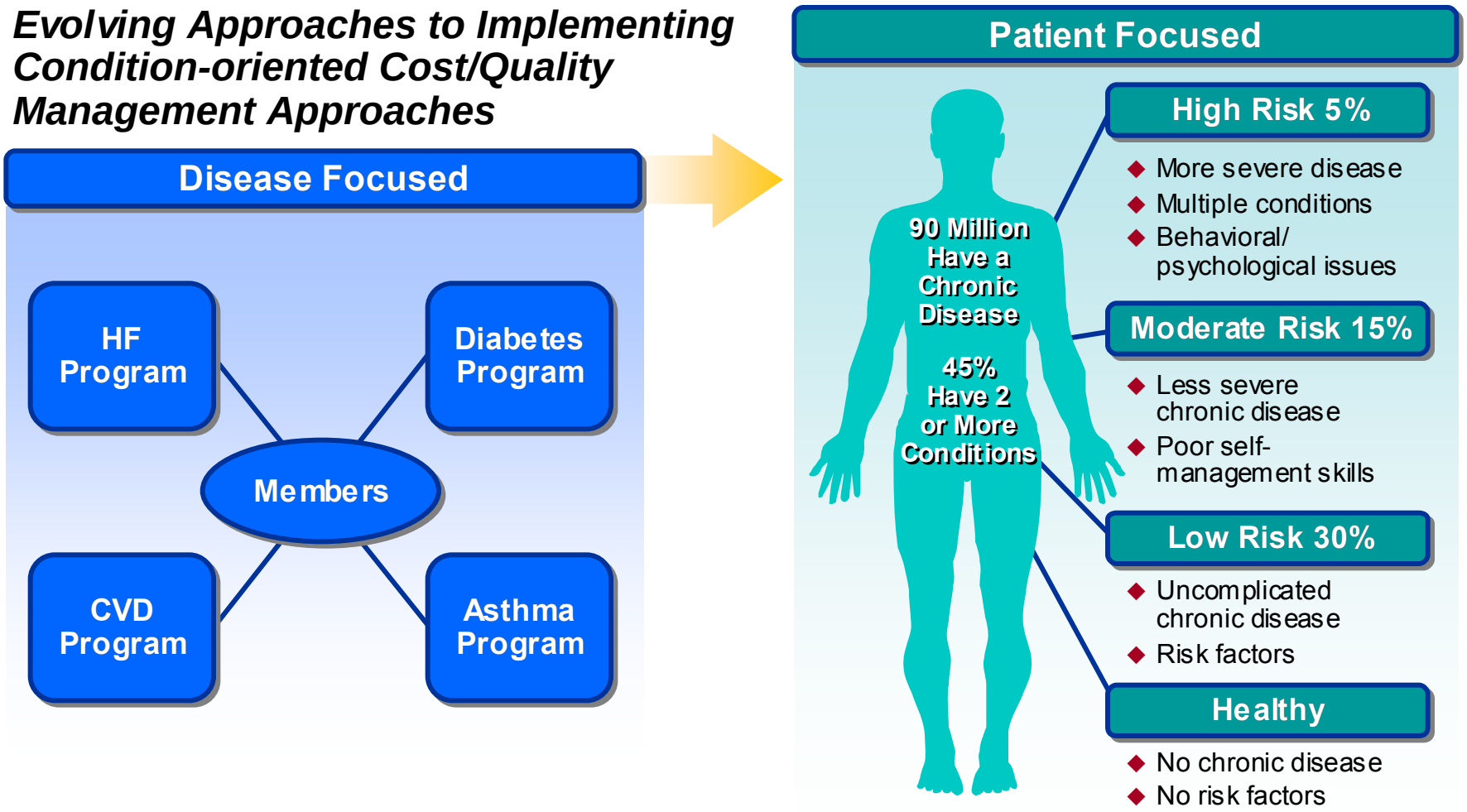
Source: Disease Management Association of America

Disease Management Landscape



Recognition of the Importance of Co-morbidities

Evolving Approaches to Implementing Condition-oriented Cost/Quality Management Approaches



Implications: Increasing Diversity of Implementation Approaches

Mission

Pfizer Health Solutions develops and implements innovative care management technologies and services through collaborations with those responsible for, or vested in, the health outcomes of patients and communities

Building a Community Care Management Program

Develop Programs

- Identify population
- Create and train network
- Engage providers and communities
- Enroll patients

Impact Patients and Healthcare

- Intervene to:
  - Change behaviors
  - Increase health literacy
  - Improve care coordination
  - Improve self-management

Measure Outcomes

- Improved clinical results
- Improved health status
- Lower health costs
- Higher patient and provider satisfaction

Disease Management Focus and Philosophy

Patient-Centered Empowerment Model

- Patient education and culturally appropriate support drives behavioral change
- Improved self-care behaviors improve clinical status and reduce utilization
- This model identifies psychosocial barriers to effective self-management

Community-Based Delivery

- Intimate community knowledge informs culturally appropriate, effective patient interaction
- Healthcare is local. Understanding the local provider and resource landscape is integral to coordinating care

Physician Alignment

- A shared commitment to evidence-based medicine supports best practices
- Physician partnership provides localized support of clinical guidelines
- Care managers facilitate care plan implementation

Transparent, Reportable Outcomes

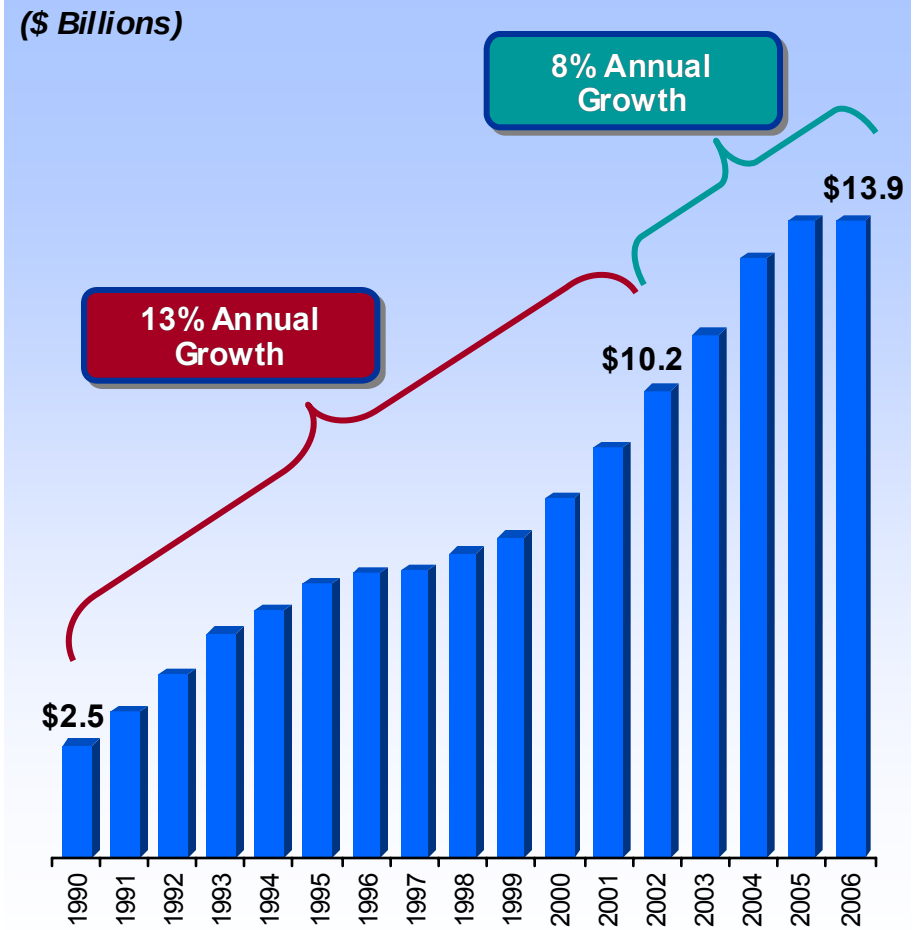
- A collaborative and transparent approach to continuous quality improvement encourages sharing of best practices
- Detailed, regular reporting allows ongoing program improvement

Florida

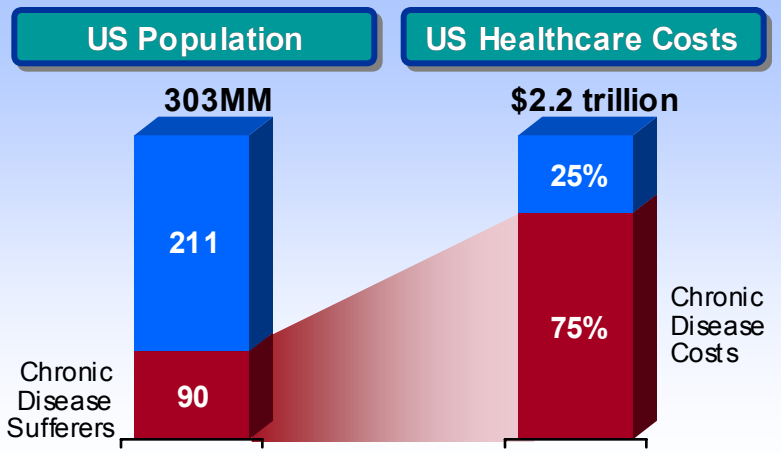
Medicaid Crisis in the State of Florida

Florida: A Healthy State
A Florida First Health Care Initiative

Annual Growth in FL Medicaid Expenditures



Chronic Disease Drives Healthcare Costs



Florida Suffers Disproportionately

Heart Disease Mortality Rates (per 100,000)

Source: State of Florida AHCA; CDC

January 2001 – Florida's Challenge

Florida Medicaid Challenge: Budgetary Crisis

"At a time when Florida was looking to be a pioneer in developing meaningful strategies to reduce the growth in costs and improve health care outcomes, Pfizer offered an innovative solution… delivering positive, measurable results well above our original objectives."

– Alan Levine
Former Secretary, FL Agency for Health Care Administration

- Reduce reimbursement to hospitals and physicians
- Implement additional utilization management and prior auth processes
- Demand supplemental rebates from pharmacy manufacturers

- New care management paradigm: Pfizer *Healthy State* Program
  - Hospital-based care management program
  - Health literacy program
  - Expanded product donation program

Public-Private Partnership

Pfizer

Florida: A Healthy State
A Florida First Health Care Initiative

and

WALL STREET JOURNAL

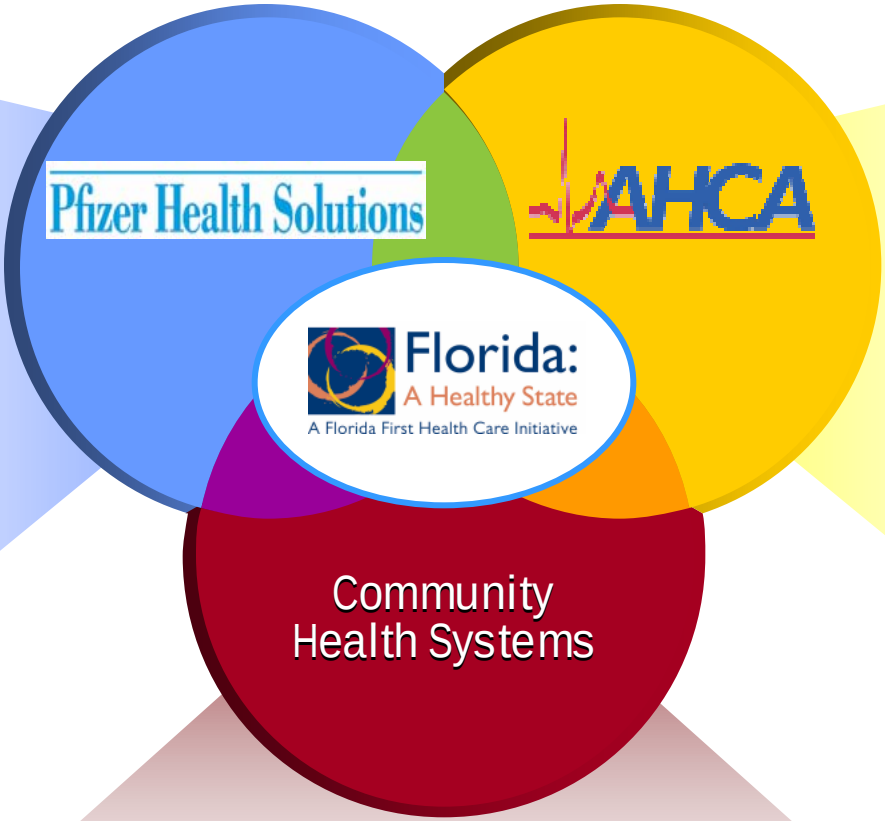
July 9, 2001

"health-policy experts say Pfizer and Florida are embarking on a grand experiment with implications well beyond one state and company."

FAHS – Partnership

Florida: A Healthy State
A Florida First Health Care Initiative

- Provider resources
- Care Management software platform
- Program content and services
- Training and support
- Patient education materials
- Analytics



- Eligibility and enrollment
- Call Center contracting
- Hospital contracting
- Provider communications
- Liaison to Governor's office
- Medicaid claims

- Local clinical oversight
- Delivery of Care Management Services
- Ancillary professional services
- Patient counseling and support

8 Priorities of Patient Centered Care

Florida: A Healthy State
A Florida First Health Care Initiative

1. Know how and when to call the doctor

2. Learn about the condition and set treatment goals

3. Take medicines correctly

4. Get recommended tests and services

5. Act to keep the condition in good control

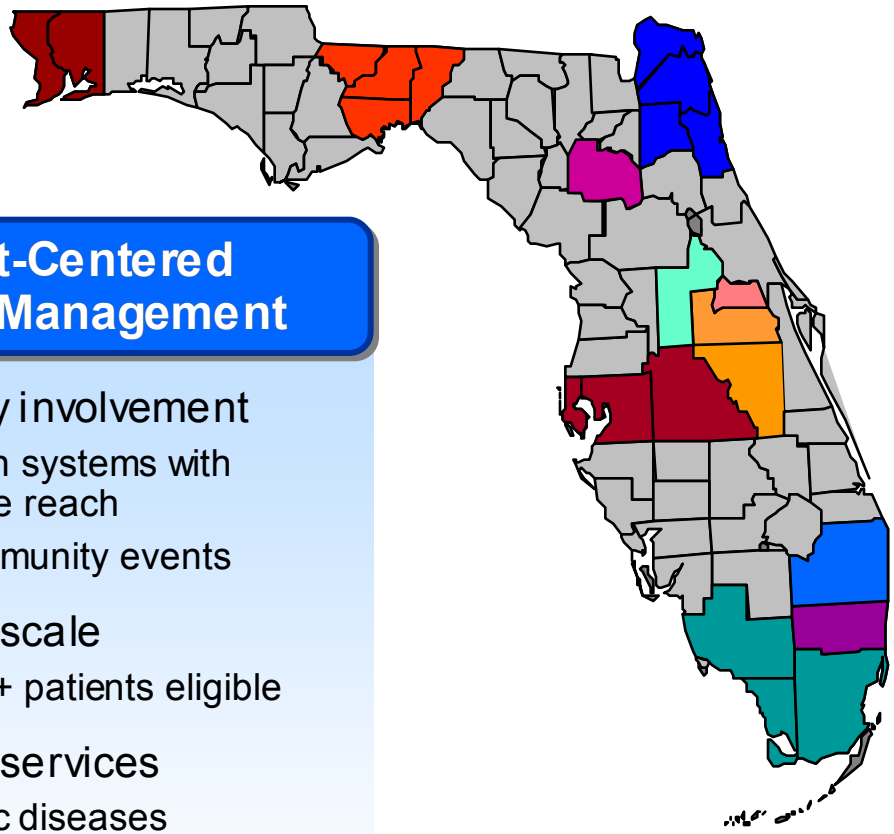
6. Make lifestyle changes and reduce risks

7. Build on strengths and overcome obstacles

8. Follow up with specialists and appointments

Program and Impact

Florida: A Healthy State
A Florida First Health Care Initiative



Patient-Centered Disease Management

- Community involvement
  - 10 health systems with statewide reach
  - 300 community events
- Significant scale
  - 190,000+ patients eligible
- Breadth of services
  - 4 chronic diseases
    - Hypertension, Asthma, Diabetes, Heart Failure
  - 24/7 triage and advice
  - Multidisciplinary care team

Behavior Changes

Clinical Changes

More Appropriate Utilization

Reduced Cost

Individual Patient Impact

"If it weren't for Nancy and Florida: A Healthy State, I wouldn't be here."

Jose G. – Heart Failure, Hypertension and Diabetes

- Reduced hospital/ ER utilization from 6 visits/year to none

- Improved asthma severity score from 4 to 1
- Reduced hospital/ ER utilization from 2 visits/year to none

"I didn't know how bad I was until I saw how life could be again."

Pierre J. . – Asthma, Hypertension and Diabetes

"I was adding sugar to everything, even to my milk. Before Florida: A Healthy State, I didn't know I had diabetes."

Jesus H. – Hypertension and Diabetes

- Reduced blood pressure from 130/70 to 112/60

- Lost nearly 40 pounds
- Reduced hospital/ER utilization from 5 visits/year to 1
- Improved BP from 143/80 to 134/78

"Before Florida: A Healthy State, nobody ever told me how to fix my diet."

Bobbie A. – Asthma, Hypertension and Diabetes

The Florida Journey

Florida: A Healthy State
A Florida First Health Care Initiative

healthier FLORIDA

Jul 2001–Jun 2003

1st Public-Private Partnership for Medicaid DM

Three Components:

1. **Disease management**
   - 4 chronic conditions
   - 122K patients eligible
   - 16K high and moderate risk patients under care management
2. **Health literacy**
   - New materials developed
   - Culturally and literacy adjusted
3. **Product donation**
   - Guarantee of $33MM
   - Savings and investment of $58.5MM

Jul 2003–Sep 2005

Extension Agreement for Disease Management

- 22% decrease in inpatient admissions
- 9% decrease in ER visits
- 4% increase in outpatient visits

Oct 2005–Dec 2006

Fee for Service Agreement

State of FL pays PHS for:

1. **Project management**
2. **InformaCare software**
   - Training
   - Upgrades
   - Maintenance
3. **Overall quality assurance**

Jan 2007–Dec 2008

PHS Wins Competitive Award for Statewide Disease Management

- 3 chronic conditions added
  - Sickle Cell
  - COPD
  - ESRD/CKD

DATA ON FILE with PHS INC

The Next Generation

Pfizer Health Solutions

McKESSON
Empowering Healthcare

Community-Based Care Team Initiative

7 DISEASE STATES
Including a Unique Component for Mental Health Care

- Asthma
- Diabetes
- Heart Failure
- Hypertension
- COPD
- ESRD
- Sickle Cell Disease

Medical Director (1)	Serve as the local program champion and liaise to PHS Medical Director
Hospital- and Community-Based Nurse Care Managers (49)	Care Management happens from within the community
Complex Care Managers (6)	Manage beneficiaries with Sickle Cell and End Stage Renal Disease
Social Workers (4)	Provide referral and linkage to community support and crisis intervention
Behavioral Health Specialists (4)	Complete in-depth Mental Health Screenings and coordinate mental health care services
Community Health Workers (10)	Culturally concordant, community-based health workers performing patient education and data collection
Registered Pharmacists (2)	Conduct in-depth medication review
Dietician (1)	Supports custom dietary plans and provides dietary counseling

Care Management Intervention

Care managers act as coaches to provide Patients with the knowledge and skills for better self-management

- Information
- Motivation
- Support
- Tools
- Planning skills

8 Priorities of Care	
1	Know How and When to Call the Doctor
2	Learn About the Condition and Set Goals
3	Take Medicines Correctly
4	Get Recommended Tests and Services
5	Act to Keep the Condition in Good Control
6	Make Lifestyle Changes and Reduce Risks
7	Build on Strengths and Overcome Obstacles
8	Follow Up with Specialists and Appointments

Credibility with Advocacy Groups and Community Resources

Florida: A Healthy State
A Florida First Health Care Initiative

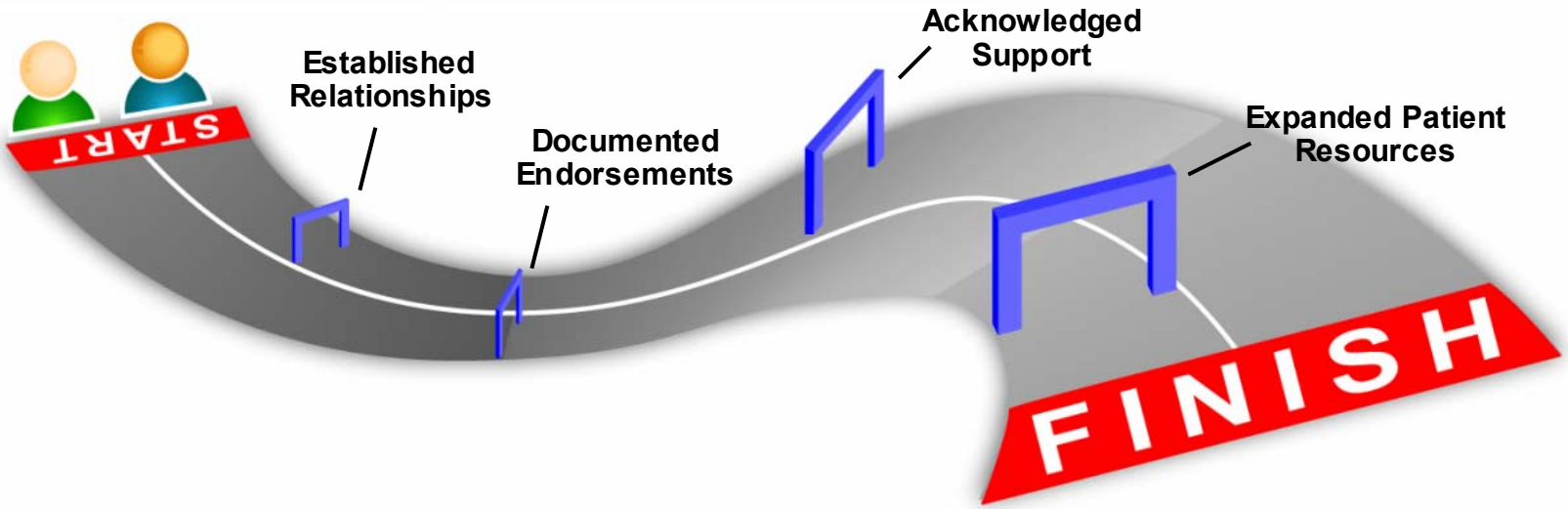
healthier FLORIDA

Advocacy Groups

- American Lung Association
- American Heart Association
- American Diabetes Association
- Asthma and Allergy Foundation of America

Community Resources

- Healthy Start (Hillsborough County Health Department)
- Children's Home Society of Florida
- Cuban American National Council, Inc.
- Little Havana Activities & Nutrition Centers of Dade County Inc.



"In short, Florida Healthy State is an innovative and beneficial program that Floridians with chronic conditions have come to rely on in order to continue to have access to needed support, medications, and reliable information that improves their quality of life."

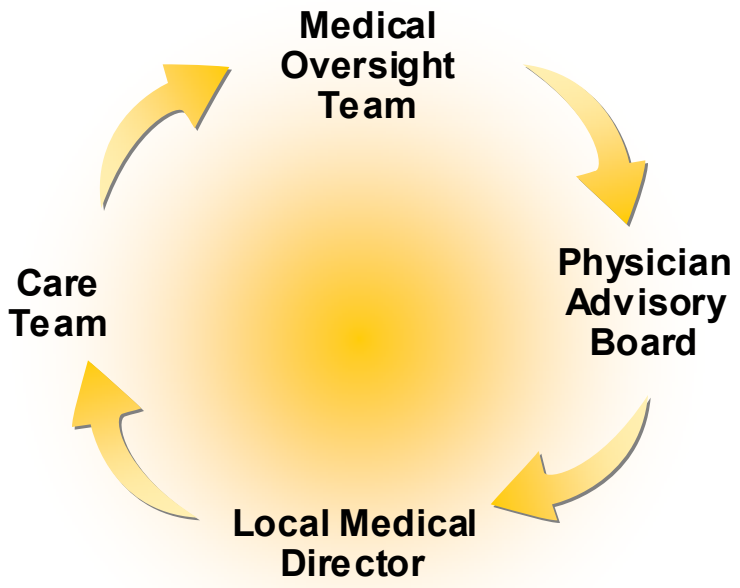
– Cheryl Small, Executive Director, Asthma & Allergy Foundation, Fl Chapter

"Congratulations! This is the greatest Disease Management Program of our time."

– Tad P. Fisher, Executive Director, Florida Academy of Family Physicians

Provider Outreach: A Team Approach

- **Medical Oversight Team:** Oversight and approval of clinical policies, quality assurance, and best practice adoption
- **Local Medical Director:** Program champion, physician liaison, peer-to-peer meetings on outliers, evidence-based guidelines and PDL adherence
- **Physician Advisory Board:** Direction, review and support guidelines



Leverage Existing Partners for Advisory Board Development

Tampa General Hospital
Tallahassee Memorial HealthCare
FACHC
Jackson Memorial Hospital
ACP American College of Physicians
NHMA National Hispanic Medical Association
SCDAA
FOMA
FLORIDA ACADEMY OF FAMILY PHYSICIANS
National Kidney Foundation of FLORIDA

Success Factors

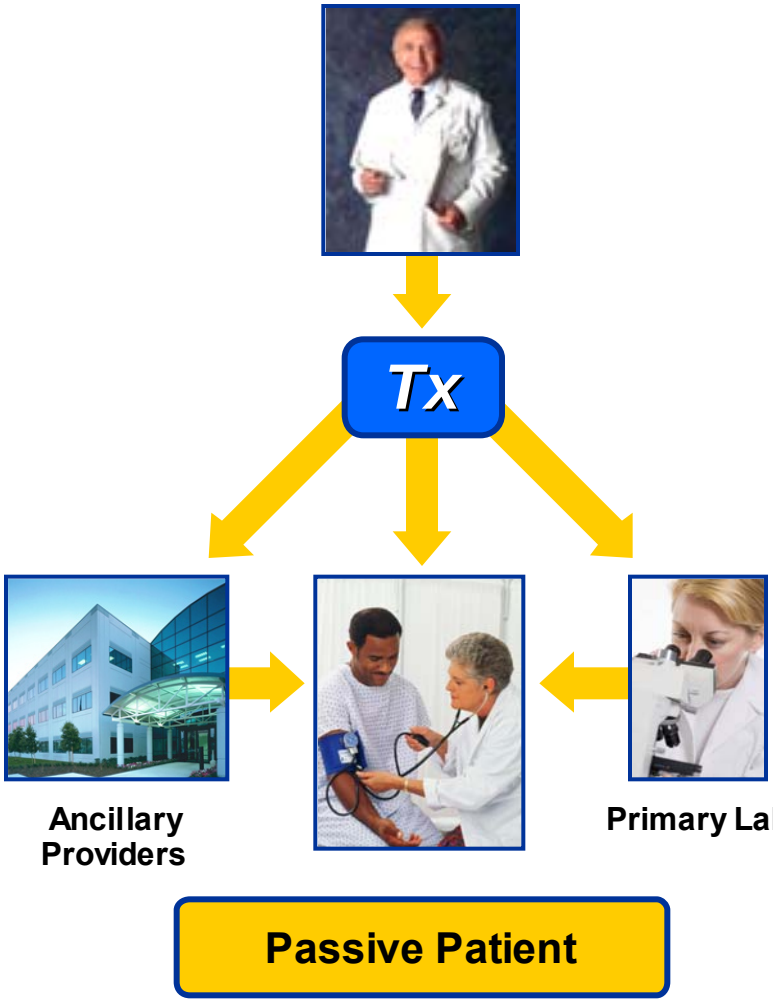
Success Factor 1 ◆ Create a long-term, adaptable approach

- Successful programs need to accommodate the changing healthcare environment. State Medicaid agencies, beneficiaries, and practicing physicians require programs that evolve with policy, coverage, reimbursement and clinical guideline changes

Success Factor 2 ◆ Build a community-based care network

Success Factor 3 ◆ Empower people to improve their own health

“Sick” Care Delivery Model



- Acute illness focused
- Reactive
- Locus of control is with the practitioner

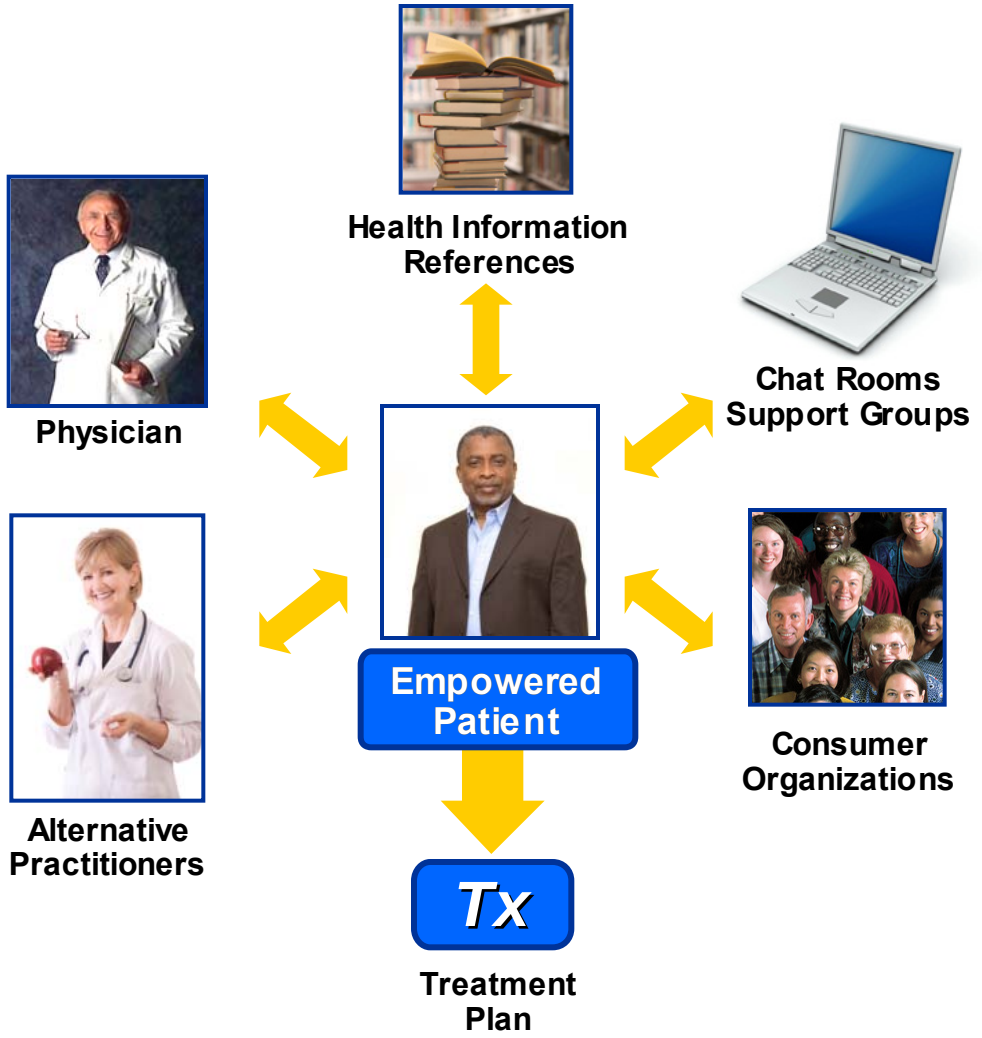
"My doctors told me this morning my blood pressure is down so low that I can start reading the newspapers."

– Ronald Reagan
40th U.S. President

Patient-Centered Care Model

"Each patient carries his own doctor inside him. We are at our best when we give the doctor who resides within each patient the chance to go to work."

– Albert Schweitzer



Source: Von Korff M et al. Collaborative management of chronic illness – essential elements. *Annals Int Med.* 1997; 127:1-97-102.

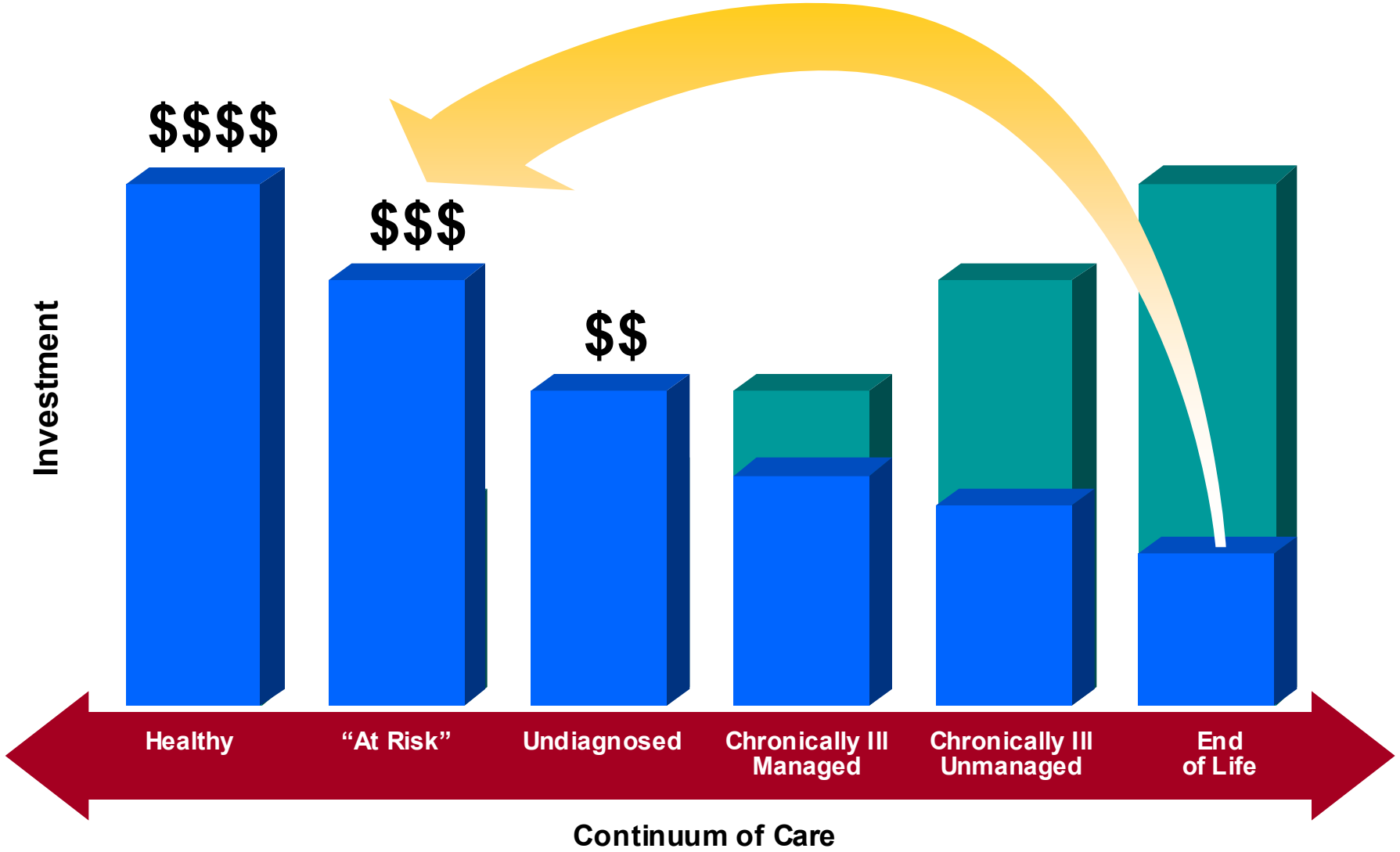
Managing Individuals → Defined Populations

Physician and Patient

Health Care Team and Population

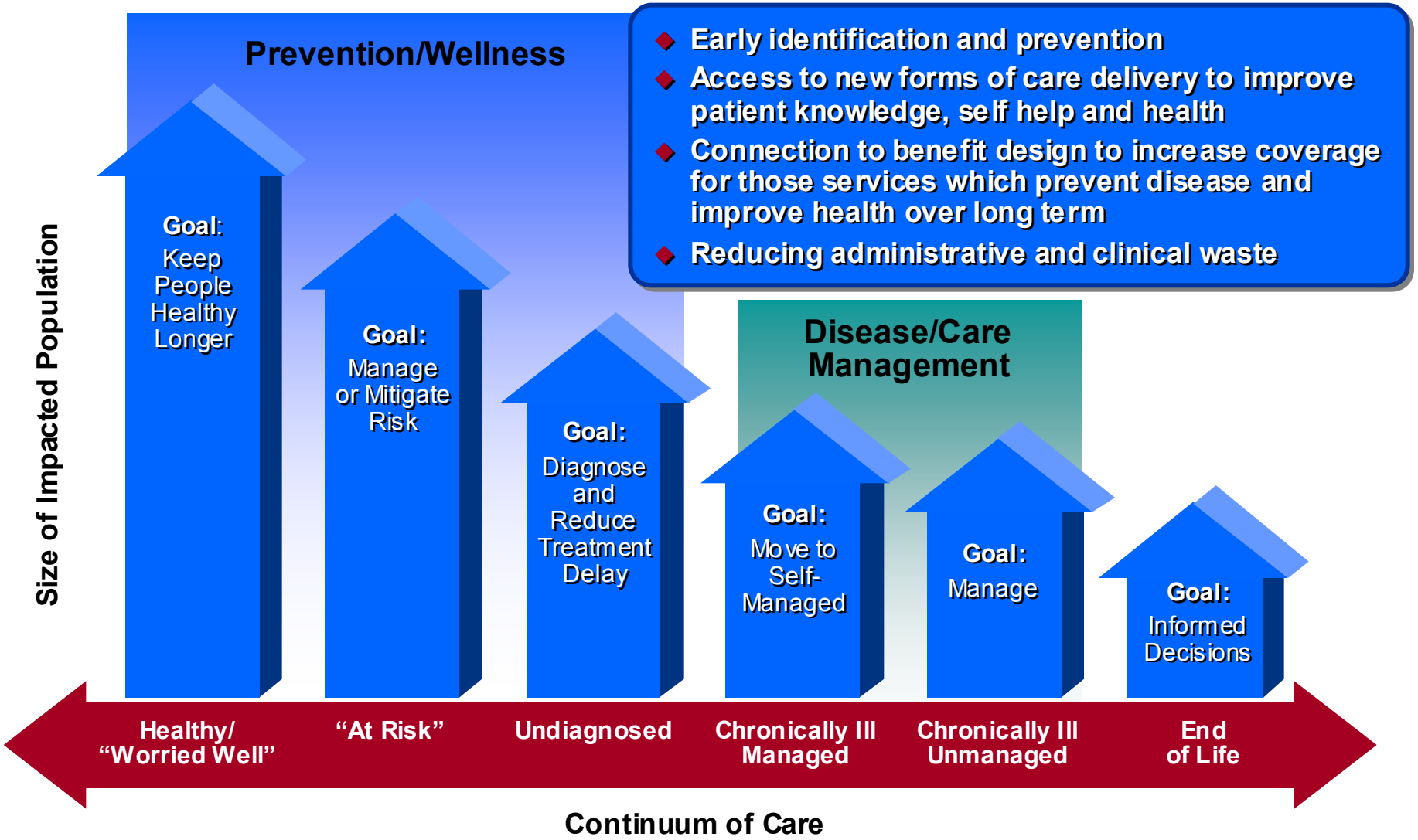
Waiting for the Big One

Shifting the Gravity of the System



The Catch

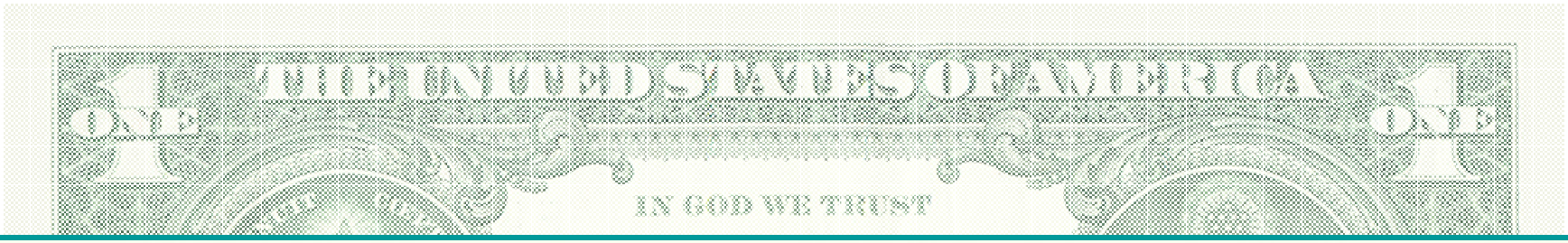
Total Health Management (THM) Framework



Conclusions/ Principles

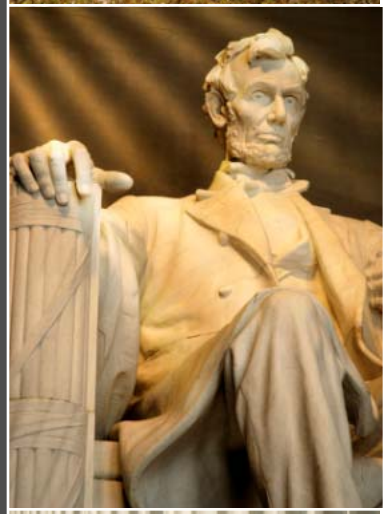
Community Based	◆ Healthcare should be local, building upon organizations that patients know and trust
Patient Centered	◆ Interventions need to be tailored to individual patients' needs, taking into account literacy level, cultural background, and lifestyle
Coordinated Across Providers	◆ Physician buy-in and coordination of care is critical to patient health and quality of care improvement, as well as total cost reduction
Driven by the Long Term	◆ Access to care and an investment in patient health drives long-term results and improvements in the healthcare system

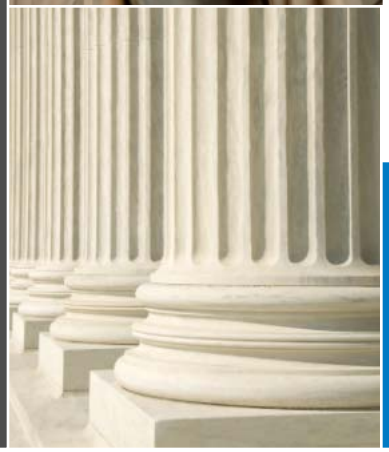
Measure of Success



IN GOD WE TRUST

Everybody Else Bring *DATA*





Pfizer Health Solutions

Disease Management Evaluation and Outcomes:
The Case of Florida: A Healthy State

David Jones
Pfizer Health Solutions Inc

November 5, 2007

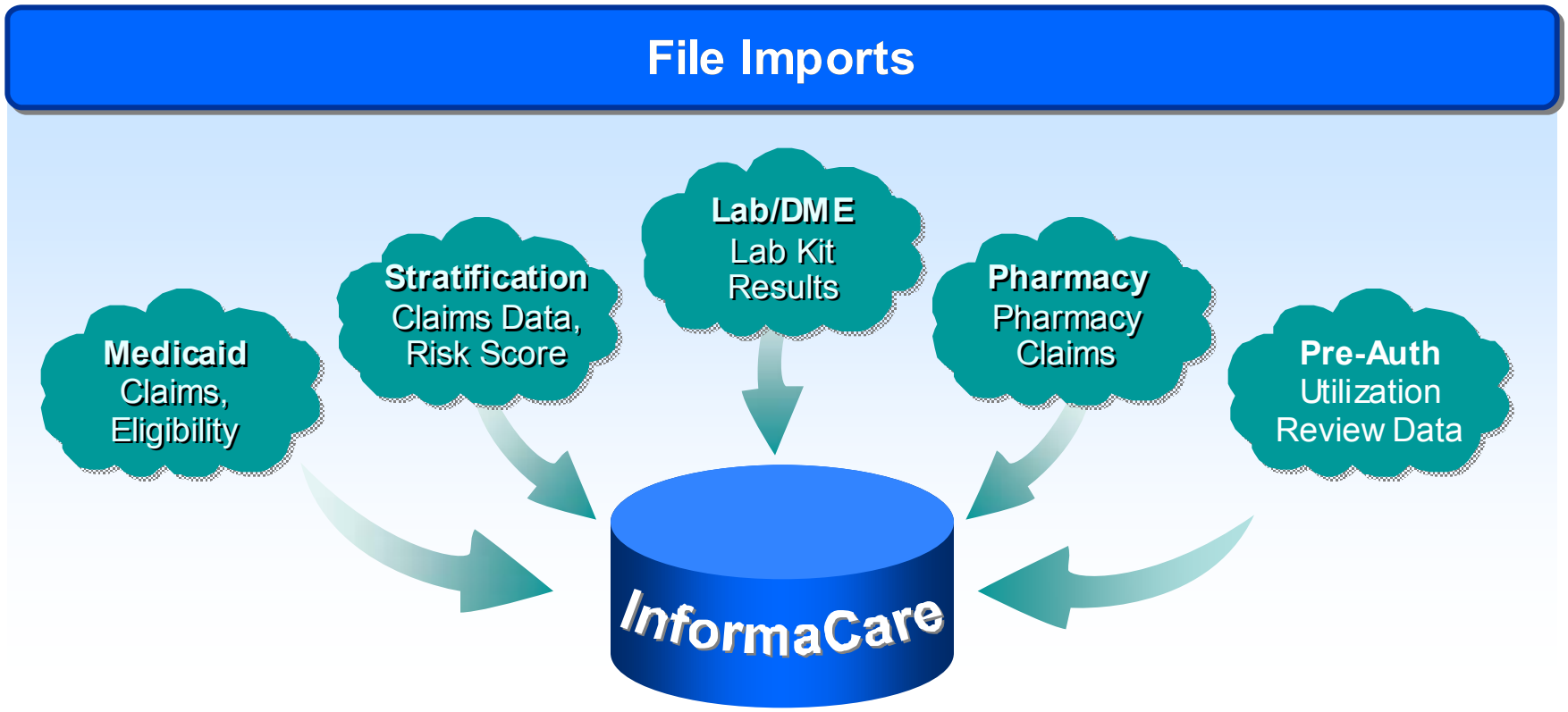
Overview

- Analytical Challenges in Medicaid DM
- Measures of Success
- The Florida Program
- Summary of Program Results
- Lessons Learned

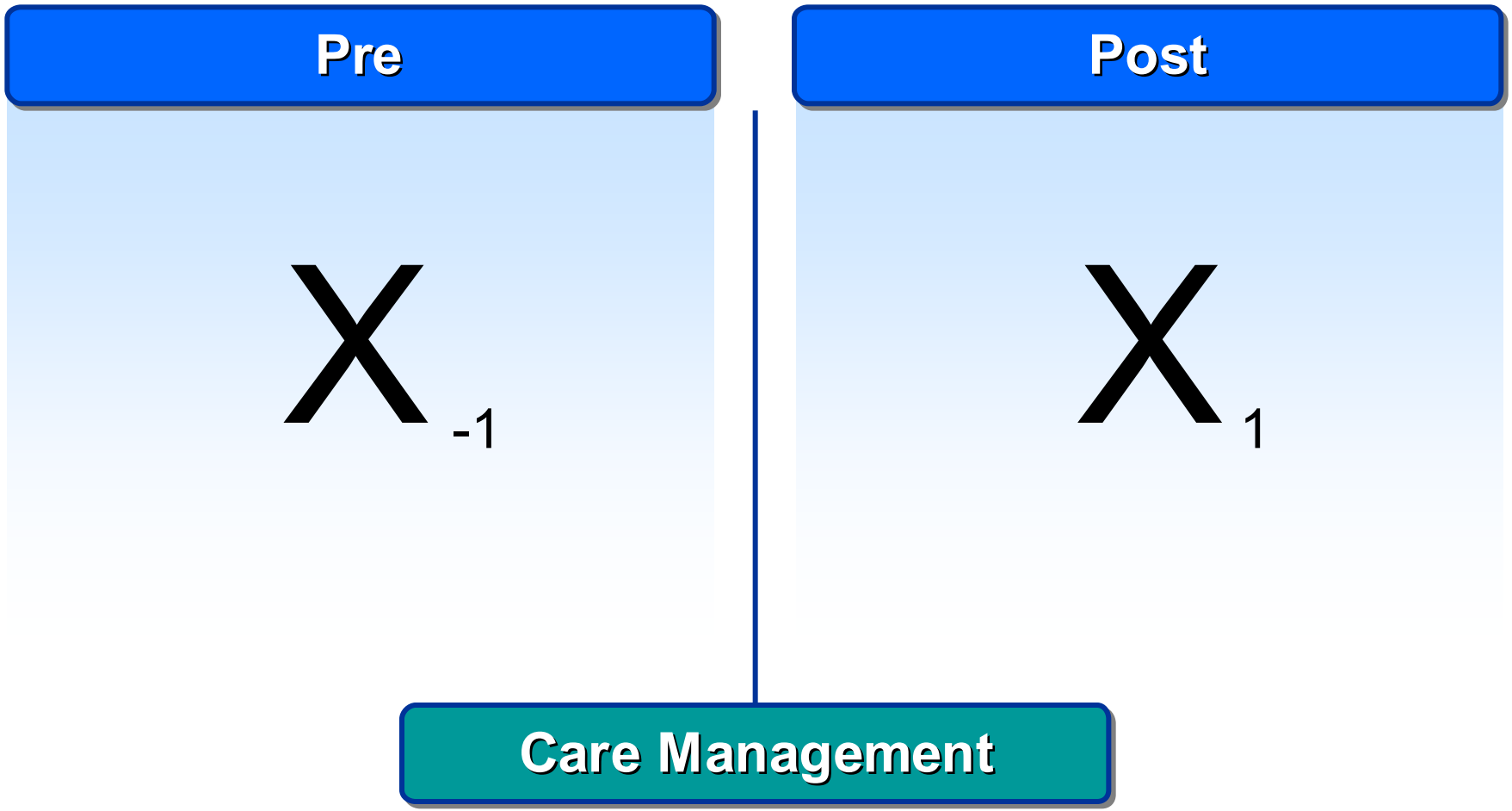
Analytical Challenges in Medicaid DM

- Lack of standards
- Disparate data sources
  - Lab data
  - Current inpatient data
  - Self-reported
  - Claims
- Overburdened providers
- Lack of real-time data flows
- High churn rate of eligible population
- Imperfect contact information

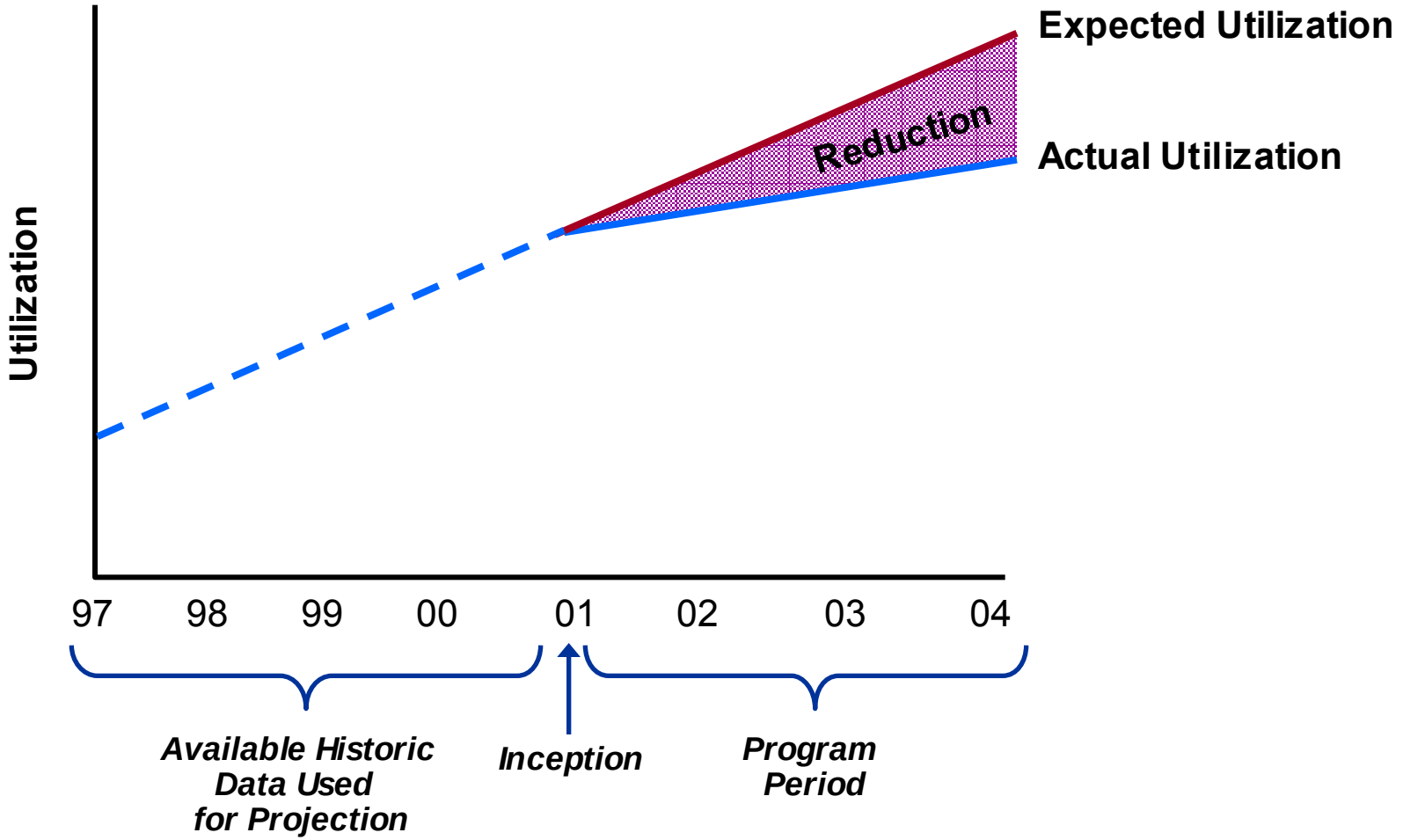
InformaCare® Data Import



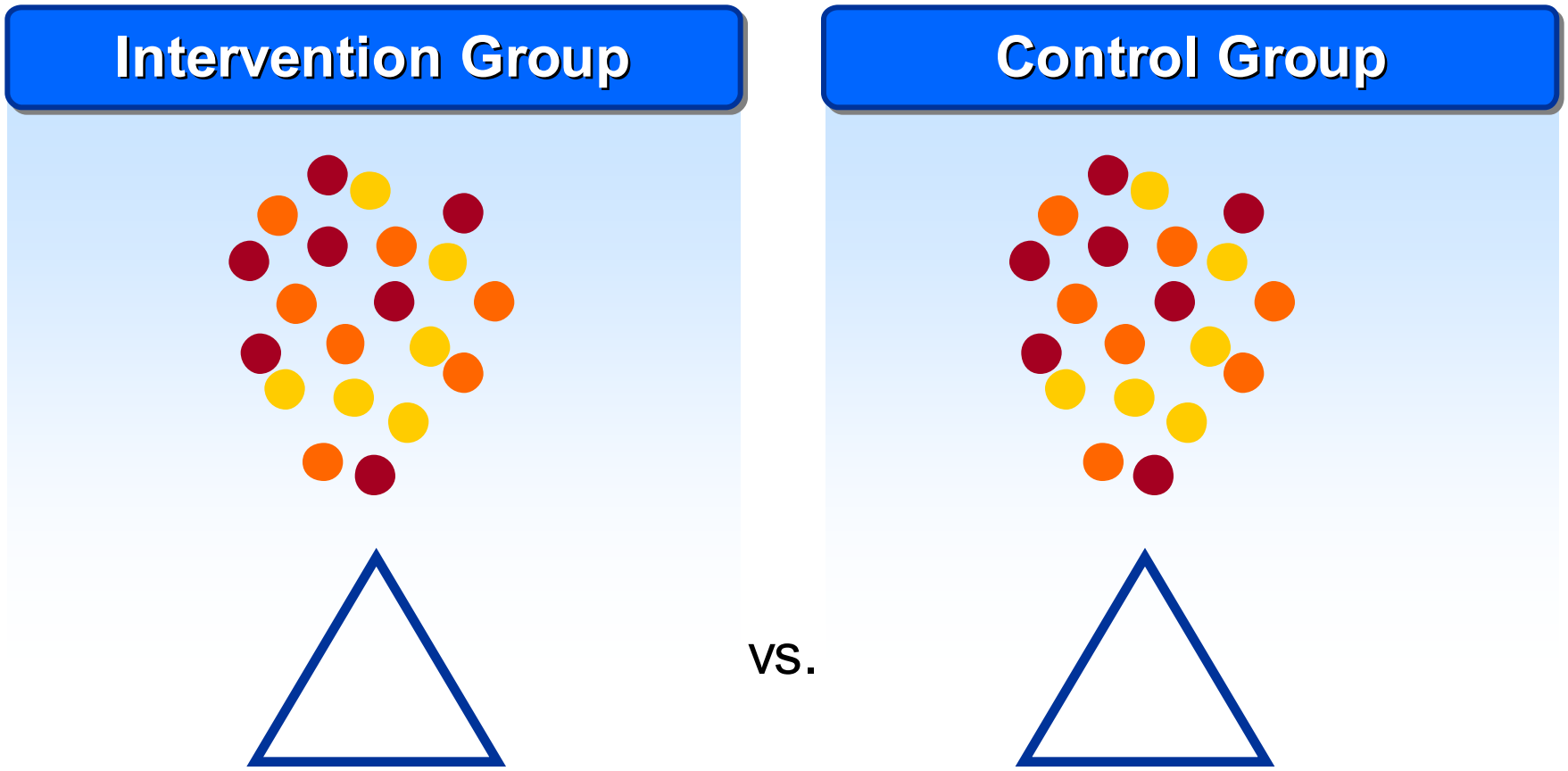
Methodology: Pre/Post



Methodology: Performance vs. Projection



Methodology: Control Group

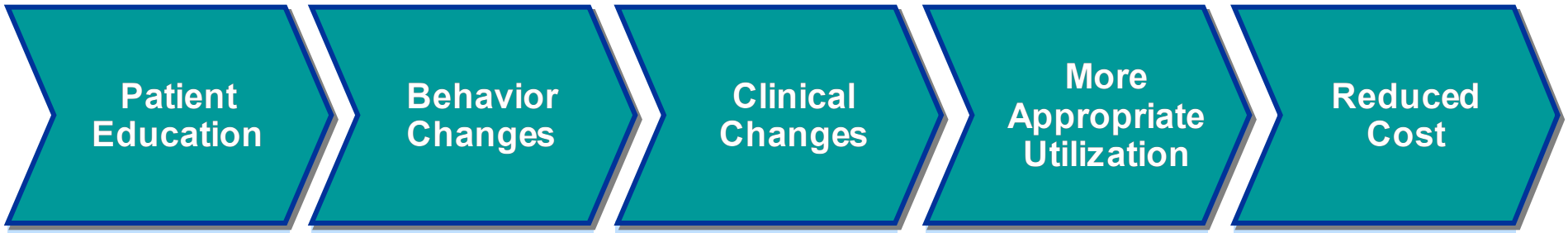


Methodology: Propensity Scores

Care Managed Patient	Propensity Score		Non-Care Managed Patient	Propensity Score
Patient A	1.0		Patient A	1.0
Patient B	1.0		Patient B	0.9
Patient C	1.0		Patient C	0.9
Patient D	0.9		Patient D	0.8
Patient E	0.9		Patient E	0.8
Patient F	0.8		Patient F	0.7

Care Managed Patients Benchmarked Against Similar Patients

Success Measurements



- Nurse contacts
- Other care team member contacts
- Mailings
- Survey completion

- Blood glucose self-monitoring
- Foot exam
- Monitoring
- Weight and blood pressure monitoring
- Smoking cessation
- Medication adherence
- Asthma self-management

- Hemoglobin A1c
- Lipid profile
- Blood pressure
- Asthma symptoms

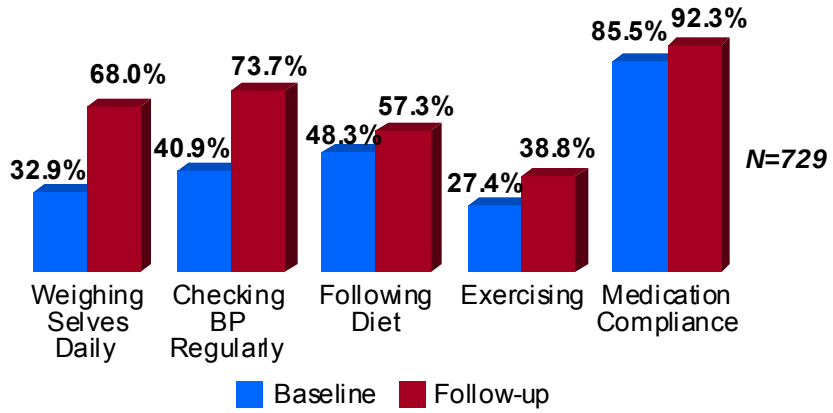
- Eye exams
- Micro albumin testing
- ACE/ARB and beta blocker use
- Antibiotic prophylaxis
- Flu shots
- Fewer inpatient visits
- More medical and outpatient visits
- Fewer ED visits
- Fewer hospital readmissions

- PMPM changes

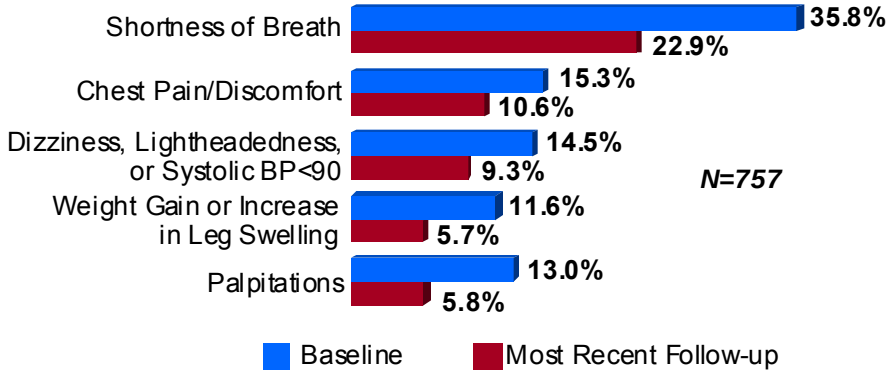
Snapshot of Success: CHF

Improved Self-Care Abilities

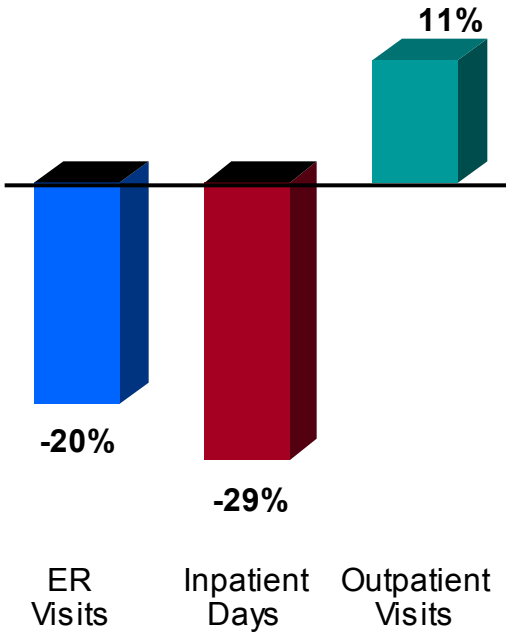
% Patients Rarely/Never Having Trouble Following a Care Plan



Reduction in Acute Symptoms



Impact on Utilization

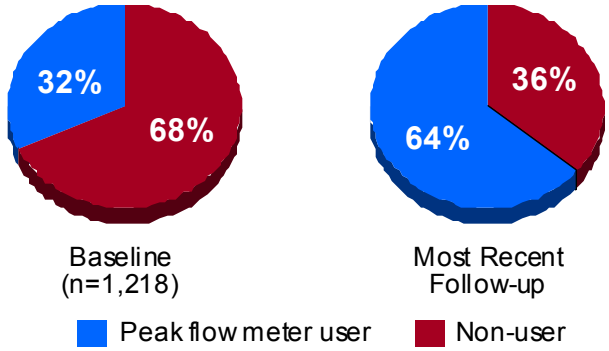


Note: Analyses show results through 12/04 (left) and through 9/05 (right) – Data on file with PHS Inc.

Behavioral Changes

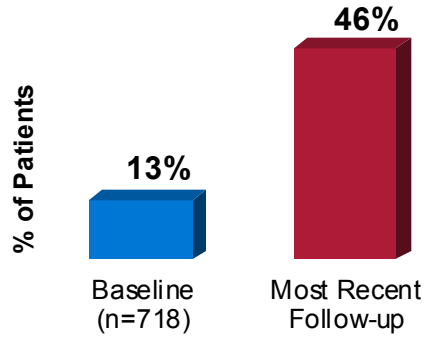
Asthma: Improved Symptom Monitoring*

Patients Using a Peak Flow Meter at Home



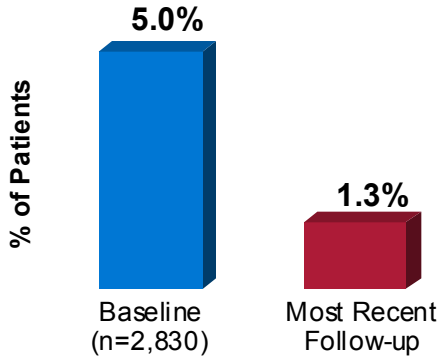
CHF: Better Weight Monitoring*

Patients Weighing Themselves Daily

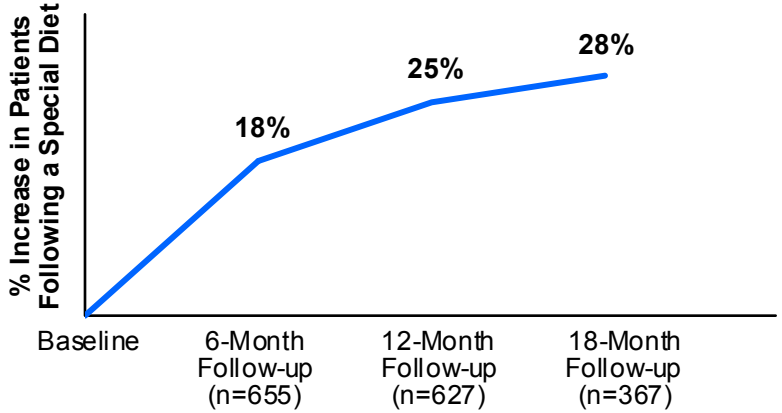


Diabetes: Improved Self-Monitoring**

Patients Not Checking Their Feet



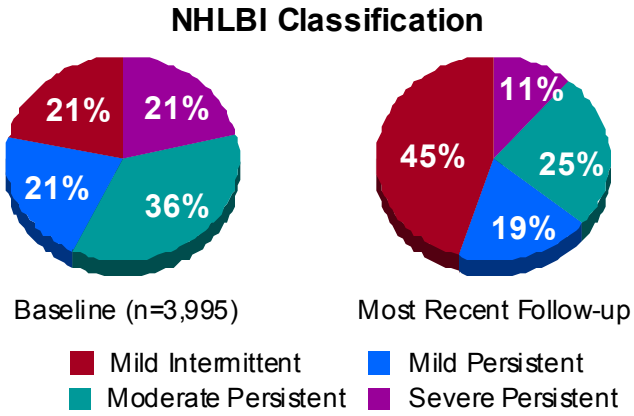
Hypertension: Special Diet Adherence**, 1



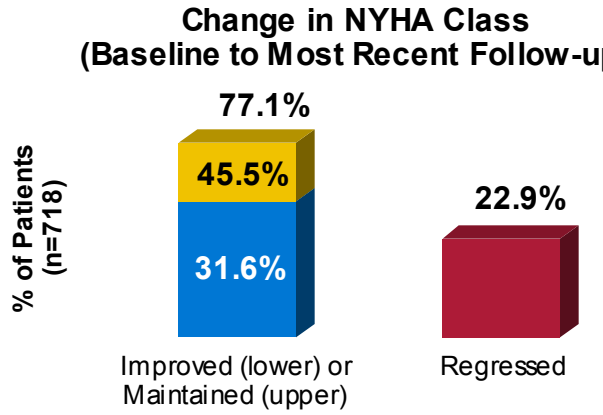
* Data collected between 11/2001 – 9/2005. Data on file with PHS Inc.
** Data did not migrate from CMS to InformaCare in 6/2004, and therefore was collected between 11/2001 – 5/2004.
[1] Populations differ across periods but have significant common membership; baseline scores for each population are similar, allowing comparison across periods.

Clinical Indicators

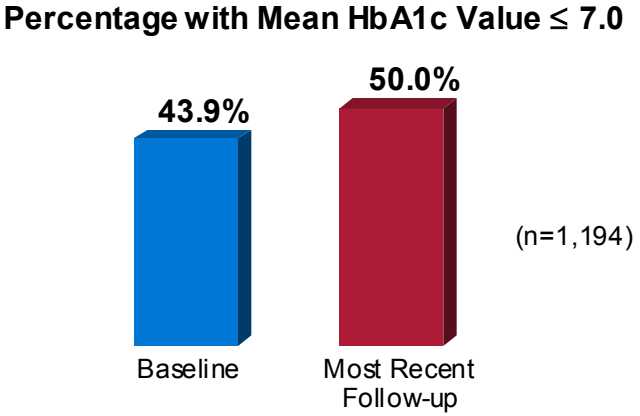
Asthma: Improvement in Symptoms*



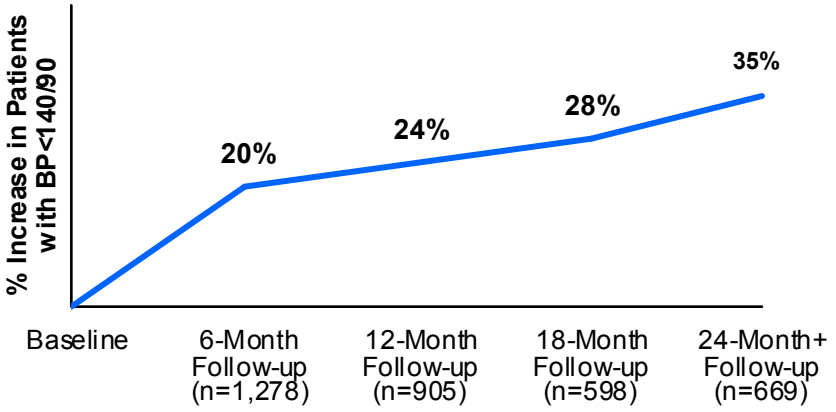
Congestive Heart Failure: Drop in Severity*



Diabetes: Lower HbA1c Values*



Hypertension: Sustained, Improved BP*1



* Data collected between 11/2001 – 9/2005. Data on file with PHS Inc.

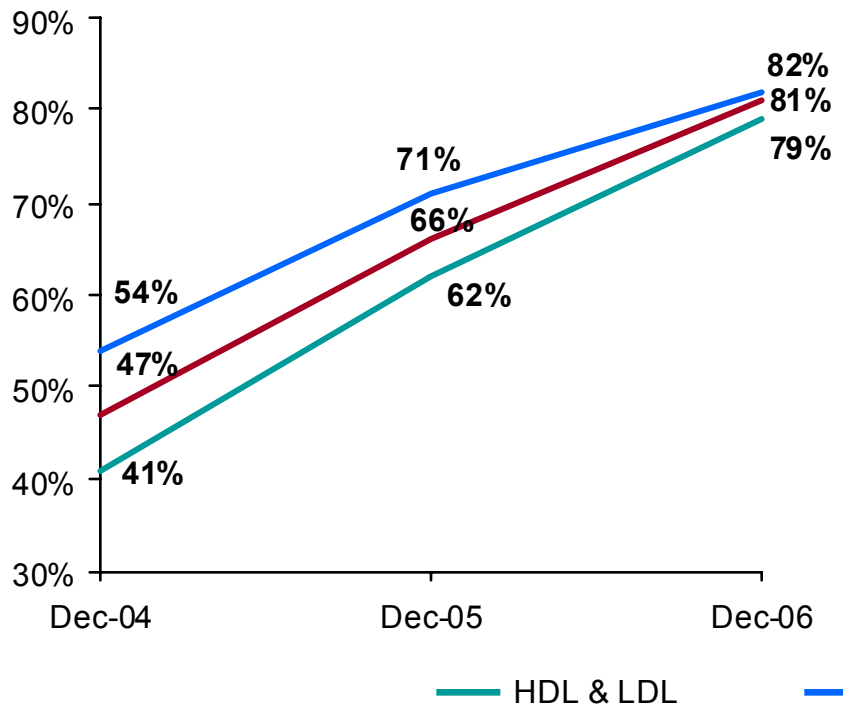
[1] Populations differ across periods but have significant common membership; baseline scores for each population are similar, allowing comparison across periods.

FAHS Quality Outcomes

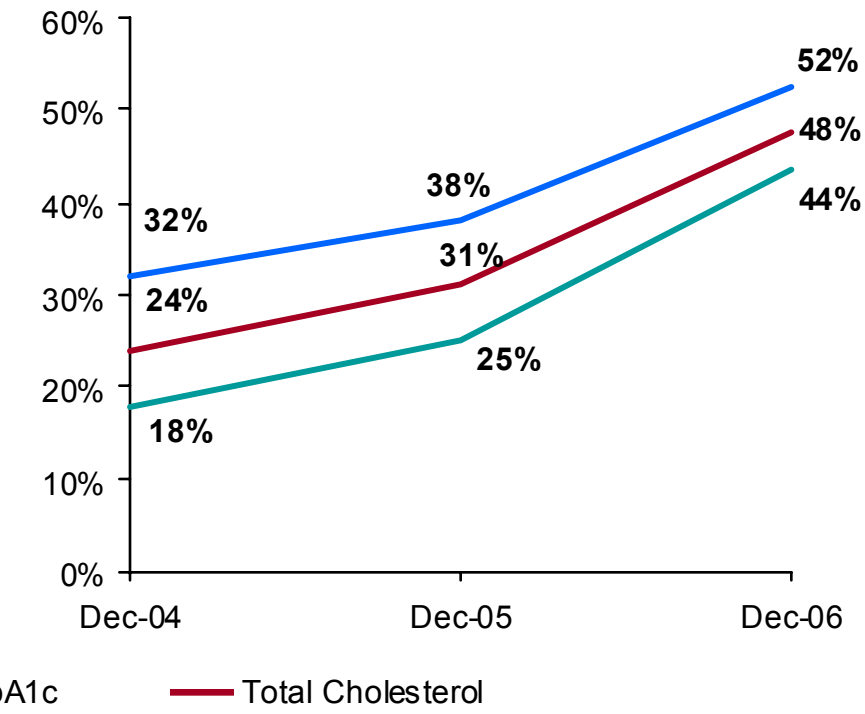
Lab Data Collection*

Enhanced Clinical Outcomes from Better Data Collection

Patients with One Or More Lab Values



Patients with Two or More Lab Values



HDL & LDL HbA1c Total Cholesterol

Source: InformaCare. Data on file with PHS Inc.
Note: Sample includes only patients who have been care managed for more than six months.
N (12/2004) = 4,086; N (12/2005) = 4,210; N(12/2006) = 3,277.

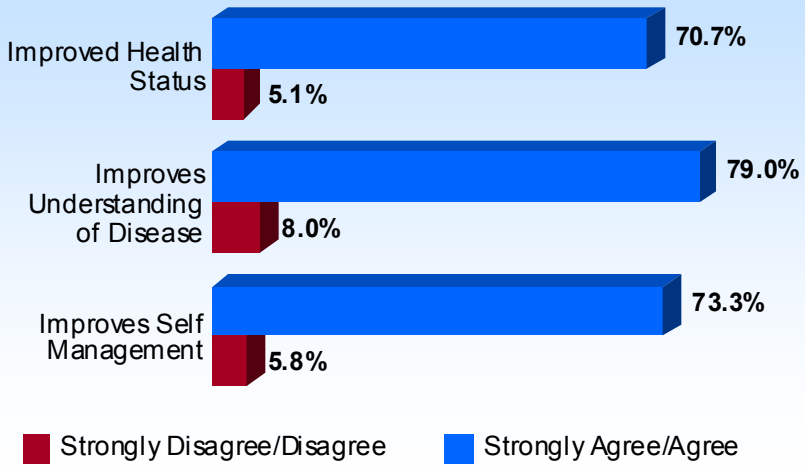
Buy-In from Physicians

Key Physician Satisfaction Indicators

Percentage of Physicians Very or Somewhat Likely to Recommend Program to…

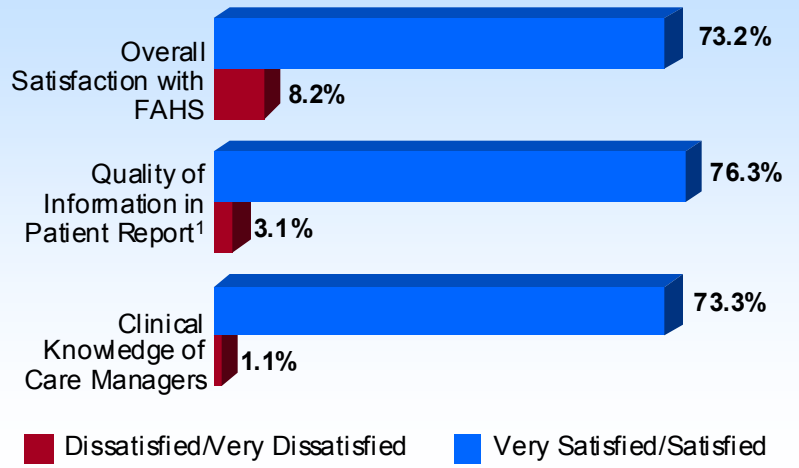
Positive Program Impact on Patients

Percentage of Physicians Agreeing or Disagreeing



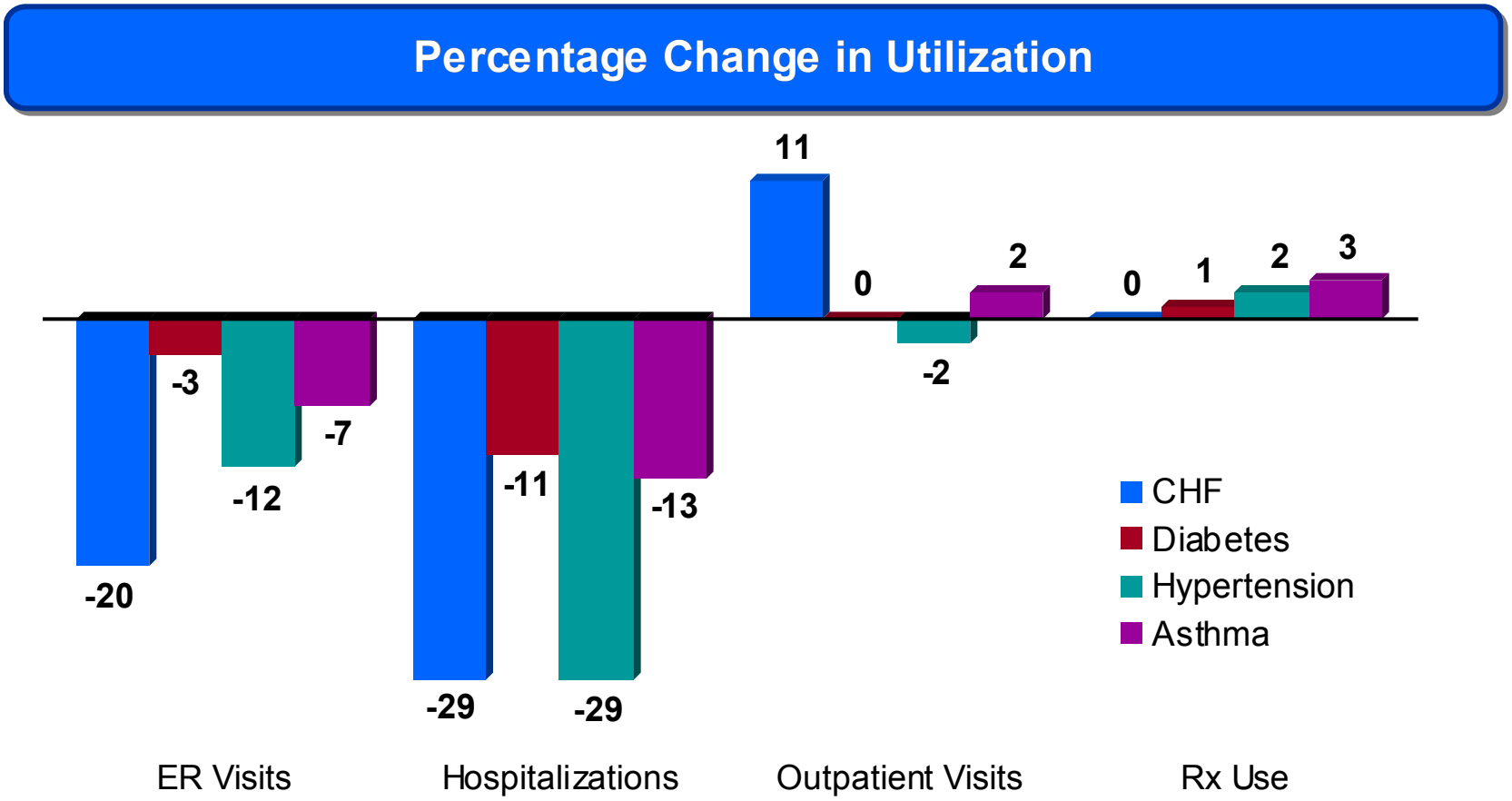
High Overall Program Satisfaction

Percentage of Physicians Expressing Satisfaction



Source: 2005 Provider Satisfaction Survey. N = 181 responding physician who had heard of FAHS. Data on file with PHS Inc.
1 Patient reports are provided to physicians and reflect either acute care issues or periodic follow-up.

Impact on Utilization*



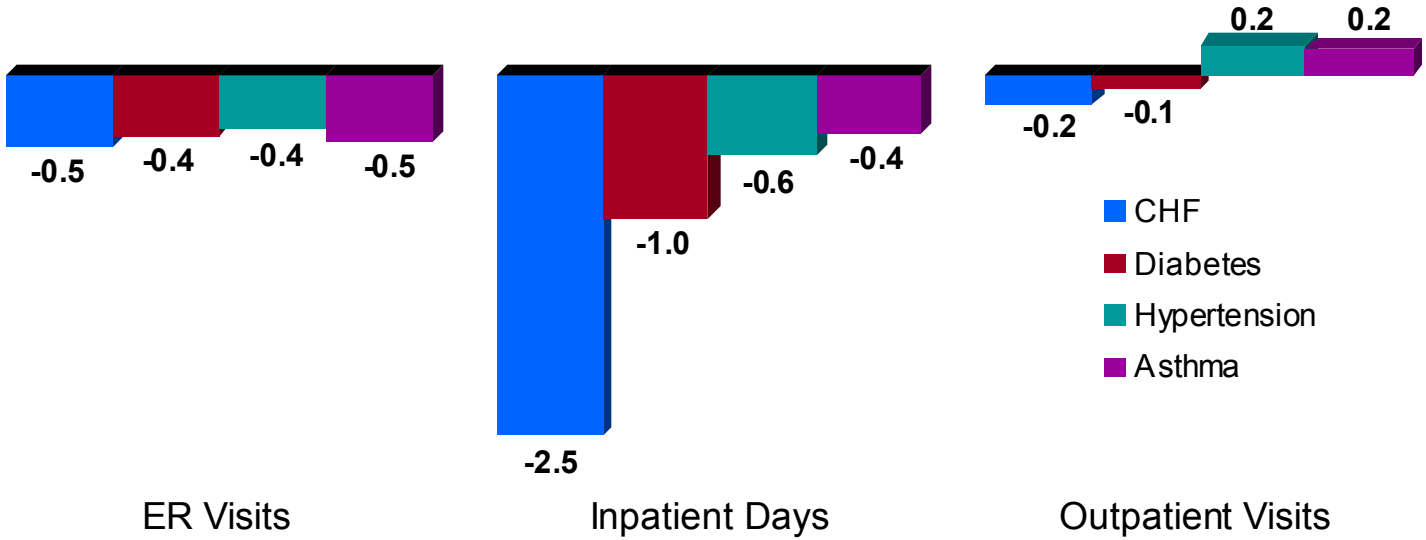
Methods: Direct-adjustment, high-risk care managed vs. high-risk non-care managed. Shows all utilization, both disease-related and non-disease-related. Shows impact after 12 months of care management.
* Data collected 11/2001 – 9/2005. Data on file with PHS Inc.

External Validation – Impact on Utilization

"[O]ur findings support the conclusion that meaningful reductions in inpatient days and ER visits can be achieved on a large-scale among Medicaid recipients in geographically diverse regions within a large state."
– Afifi, et al., *Preventive Medicine*, 2007

Utilization Change Among Care Managed Participants

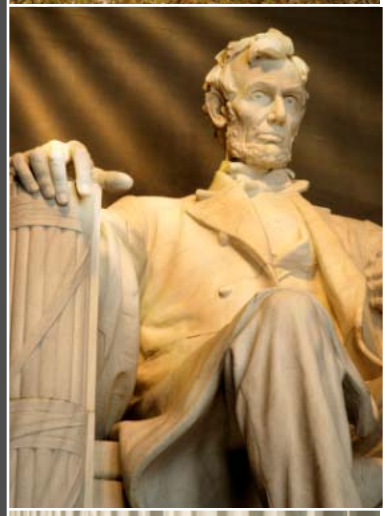
Per-participant Annual Decline in Units of Utilization in Care-Managed Patients vs. Non-Care-Managed

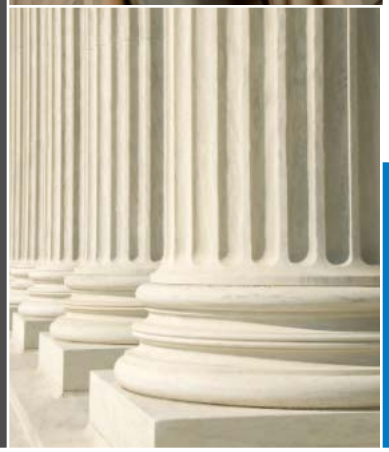


Notes: N=3,902. Analysis includes only SSI patients in the post-care-management period.
Based on data collected 11/2001 – 11/2004. Data on file with PHS Inc.
Source: Afifi, A. A., Morisky, D.E., Kominski, G.F., Kotlerman, J.B. Impact of disease management on health care utilization: Evidence from the "Florida: A Healthy State (FAHS)" Medicaid Program. *Preventive Medicine* (2007), doi:10.1016/j.ypmed.2007.02.002.

Lessons Learned

- Aggregate data as much as possible – no pain, no gain
- Focus and simplify
  - Reports
  - Findings
  - Internal and external communications
  - Resulting quality initiatives
- Strive for transparency
- Analyze across the value chain





Pfizer Health Solutions

Reform Focus:
Improving Quality and Efficiency in the Healthcare System

Mary Kay Owens, RPh., CPh.
President,
Southeastern Consultants, Inc.

November 5, 2007

Discussion Topics

- Overview of Reform Efforts
  - State Strategies
  - Basic Principles
- Improving Quality and Efficiency in the Healthcare System
  - SEC Analyses: Cost of Uncoordinated Care
  - Strategies to Improve Care Coordination and Quality
  - New Approaches for “True Reform”
- Florida Reform Plan
  - Florida Reform Plan Expansion Status

Overview of Reform Efforts

State Medicaid Strategies to Expand and Reform Health Programs

- Offer multiple benefit packages based on needed service levels
- Public/private partnerships — private plans to administer benefits
- Increased and/or sliding scale cost sharing based on income and benefit packages
- Incentives for promoting health behaviors
- Subsidize employer coverage for low-income families
- Expanding Medicaid and SCHIP programs
- Coverage for uninsured

Basic Principles of Reform

- Focus on more efficient models in coordination of care and delivery of services
- Improve the quality of care while reducing unnecessary costs
- Utilize technology to improve coordination and delivery
- Engage and reward providers and patients as active responsible participants
- Seek to improve efficiency and quality without reducing access to needed services
- Do not use cost reduction as the single measure of success
- Expansion of MCO enrollment alone is not necessarily going to achieve the reform goals

Overview and Findings of SEC Multi-State Medicaid Claims Analysis

Identifying and Quantifying the Costs of Uncoordinated Care

Goal of Analysis: Identify Uncoordinated Care

SEC Has Determined that the Vast Majority of Utilization Outliers Are Directly Correlated with:

- Excessive and/or inefficient utilization patterns such as duplicative and excessive drugs and medical services
- Uncoordinated access behaviors, which contribute to much higher than expected costs, compared to similar non-outliers with same demographic, disease, and severity profiles
  - Behaviors may include using many different prescribers and pharmacies, accessing the ER for primary care, excessive narcotic use, and others

SEC independent claims data analysis completed 2005-07.

Key Findings

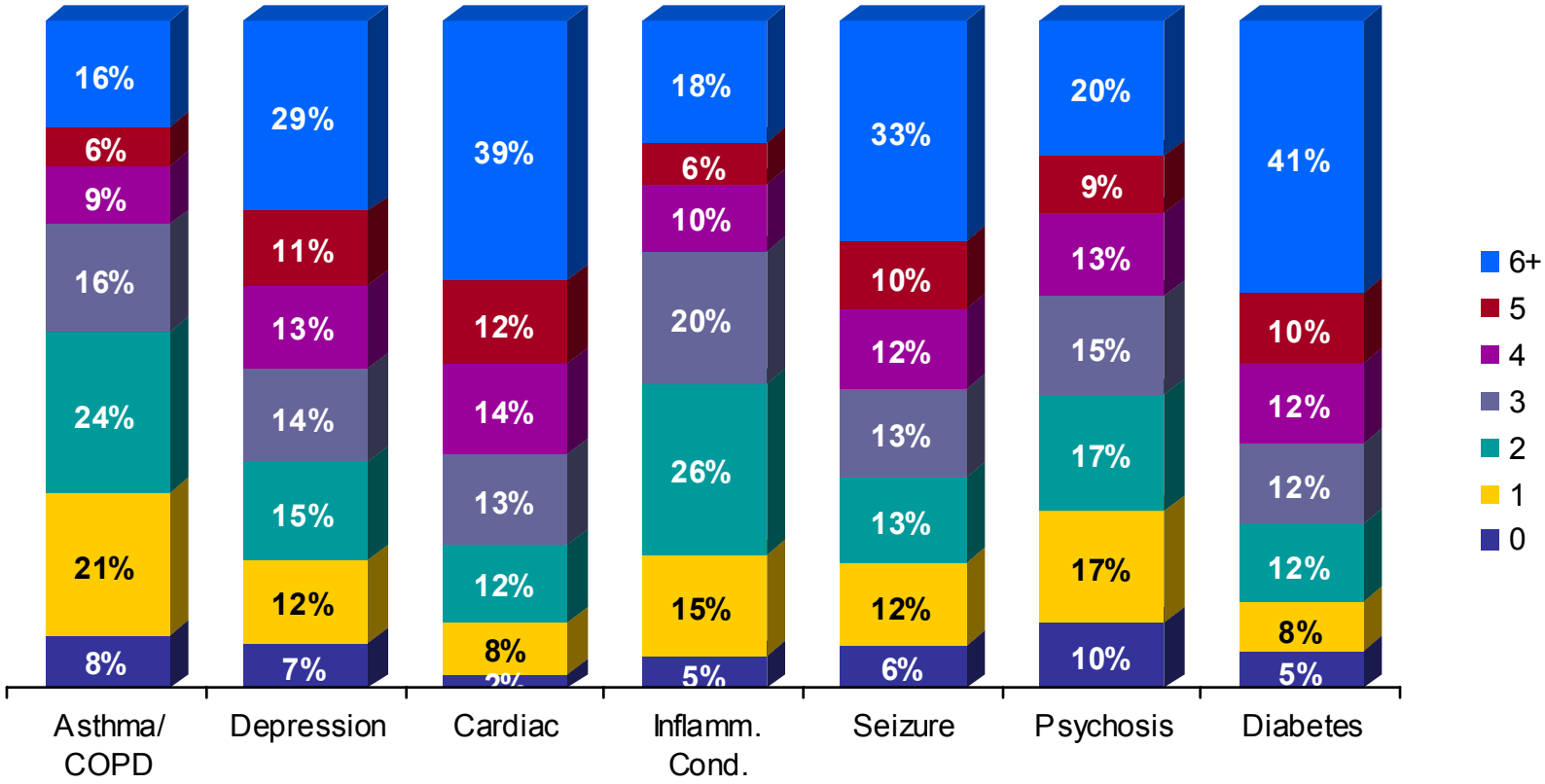
Utilization Outliers with Uncoordinated Care:

- Represent a small subset of patients (<10%)
- Account for over 30% of total spending
- Represented in:
  - All disease, co-morbidity, and severity of illness groups
  - Cost groups (very low to very high)
  - All eligibility groups (TANF and ABD)

SEC independent claims data analysis completed 2005-07.

State Example: Number of Co-Morbid Conditions for Selected Major Diseases

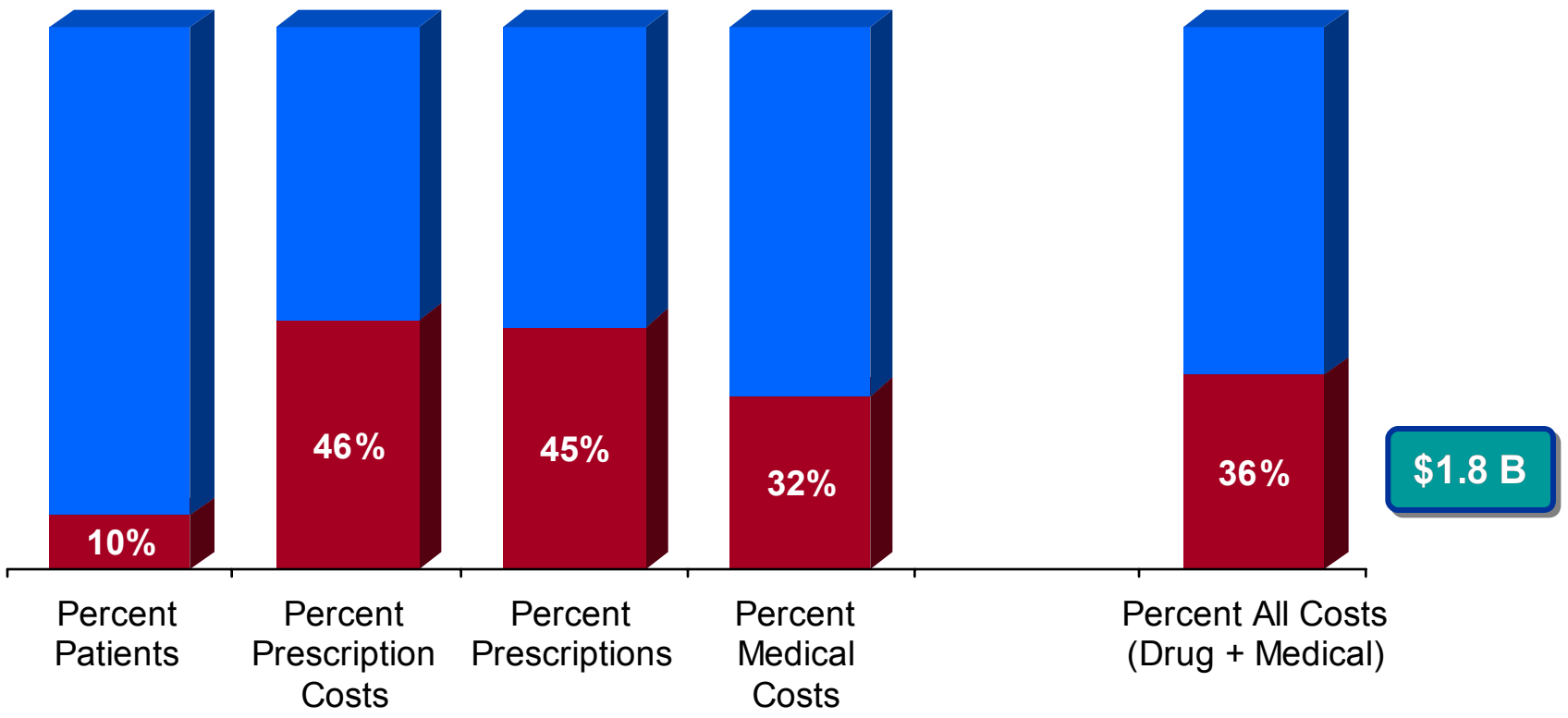
Medicaid-Only (Excludes Duals and LTC groups)



SEC independent claims data analysis completed 2005-07.

State Example: Utilization Outliers

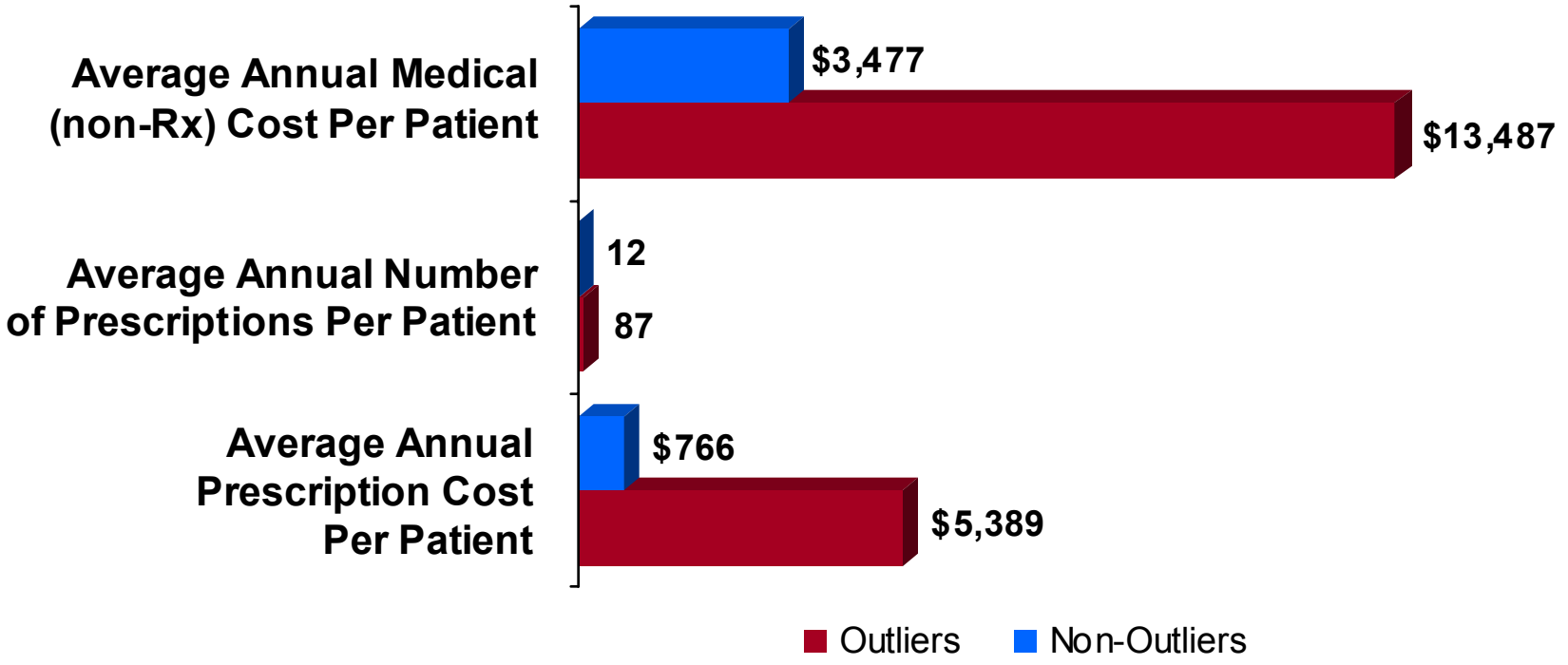
Utilization and Cost Percentages Medicaid-Only
(Excludes Duals and LTC Groups)



SEC independent claims data analysis completed 2005-07.

State Example: Outliers

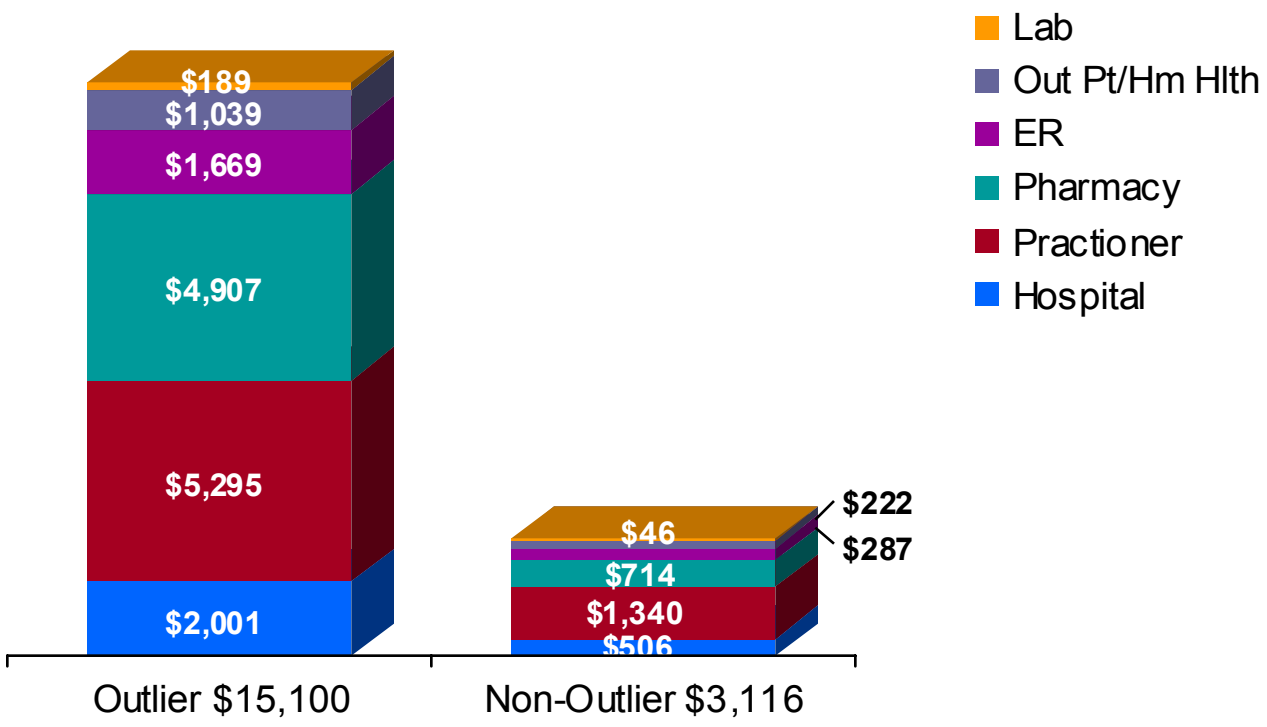
Per Patient Utilization and Cost Comparison Medicaid-Only (Excluding Duals and LTC Groups)



SEC independent claims data analysis completed 2005-07.

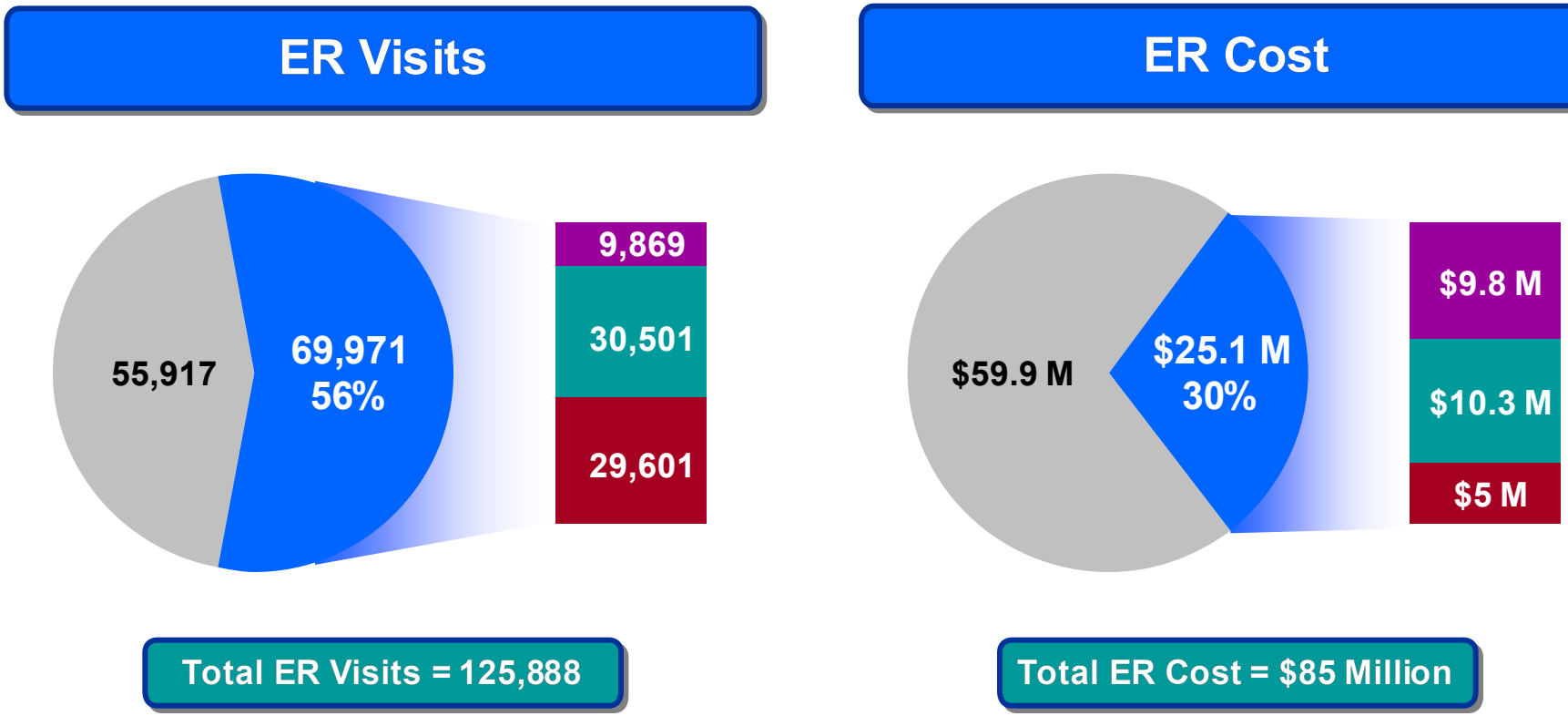
State Example:
Average Contribution of Cost Components

Outliers vs. Non-Outliers*
Medicaid-Only (Excludes Duals and LTC groups)



* This includes patients that received at least one prescription.
Note: Less than 3% of patients in either group used personal care services, and these cost are excluded.
SEC independent claims data analysis completed 2005-07.

State Example:
Avoidable Medicaid ER Visits and Cost

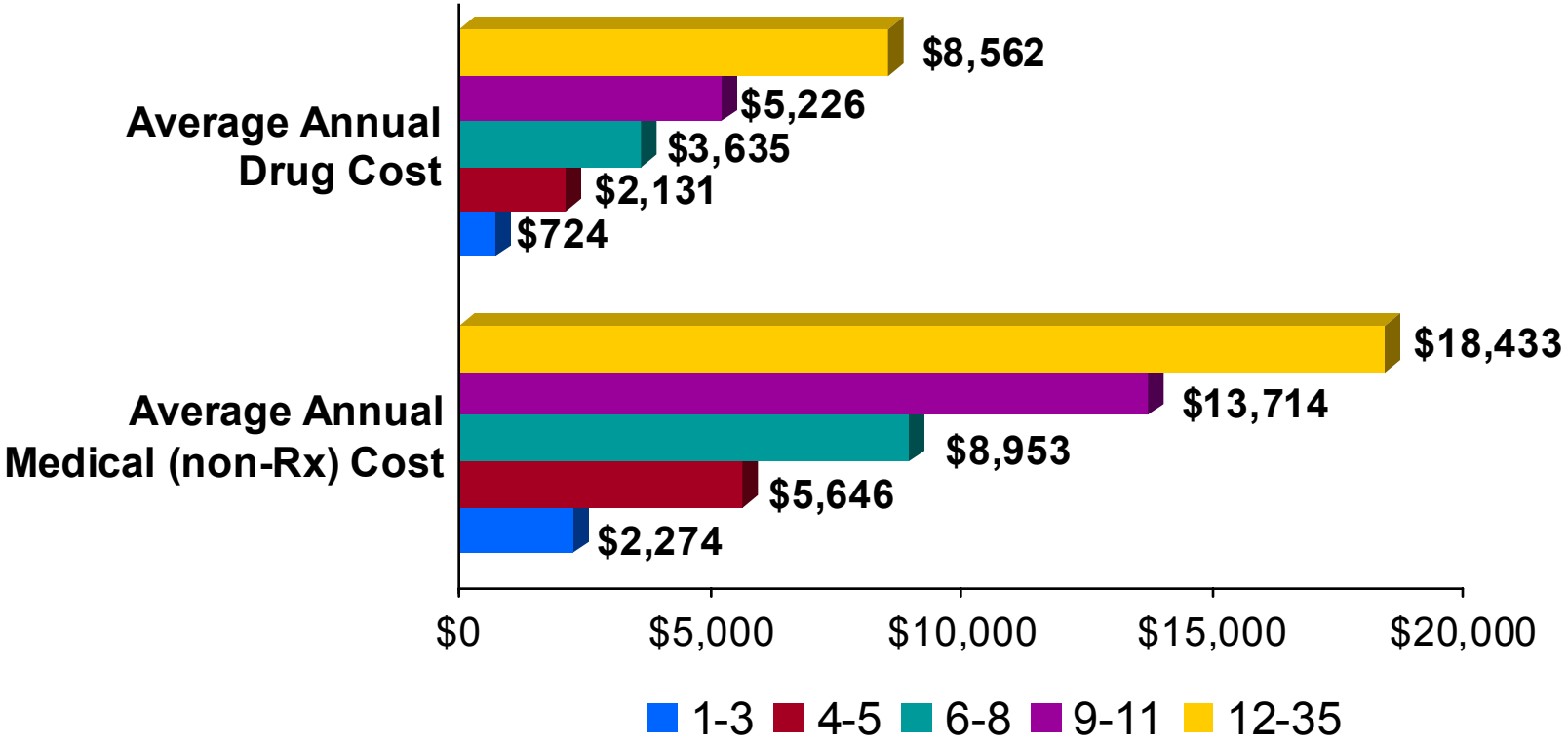


Source: The classification system is from Billings, J., et al. Emergency Department Use: The New York Story. *The Commonwealth Fund Issue Brief*, November 2000.

SEC independent claims data analysis completed 2005-07.

State Example: Outliers

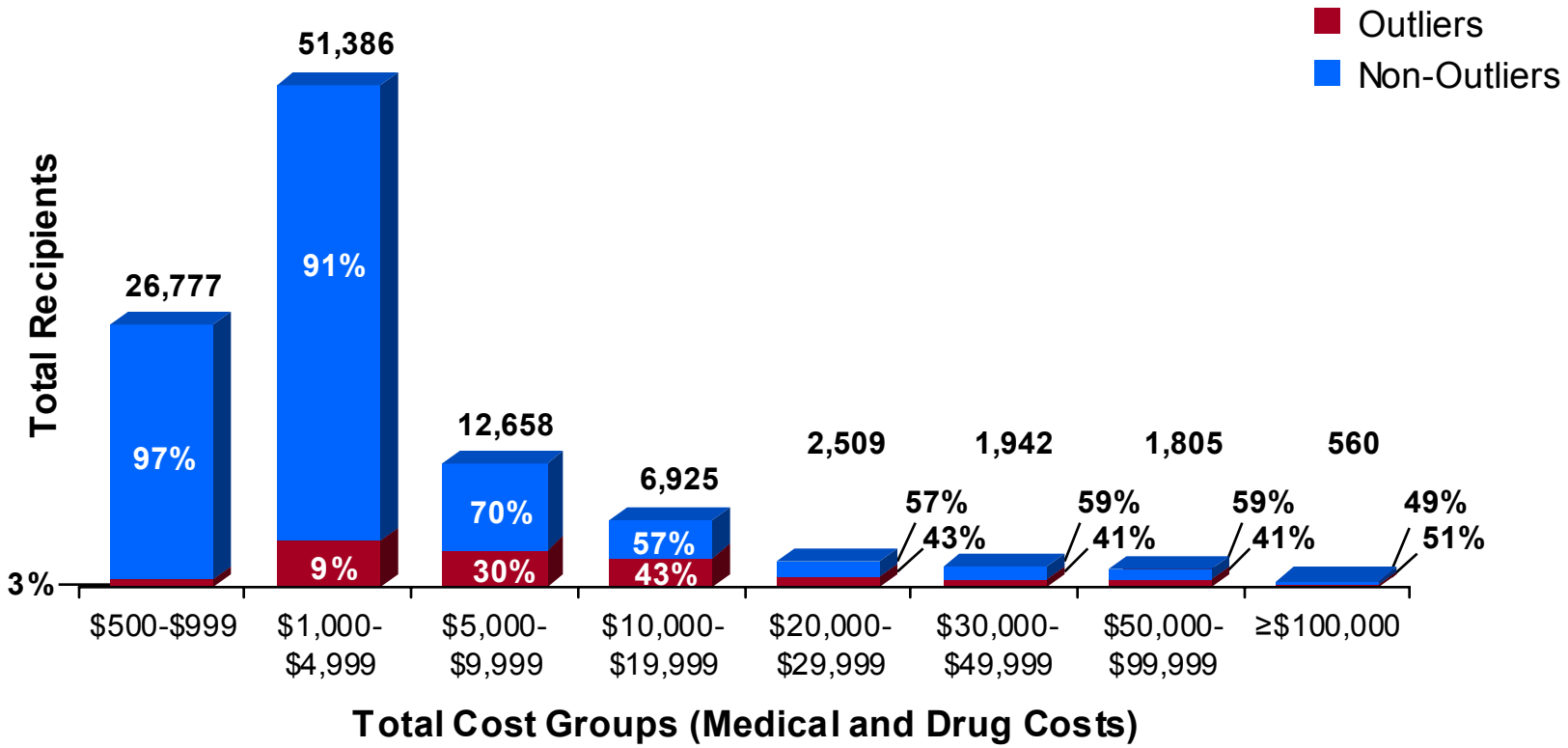
Medical and Drug Cost Data Comparison by Number of Prescribers Medicaid-Only (Excludes Duals and LTC groups)



SEC independent claims data analysis completed 2005-07.

State Example: Percent Recipients by Cost Groups

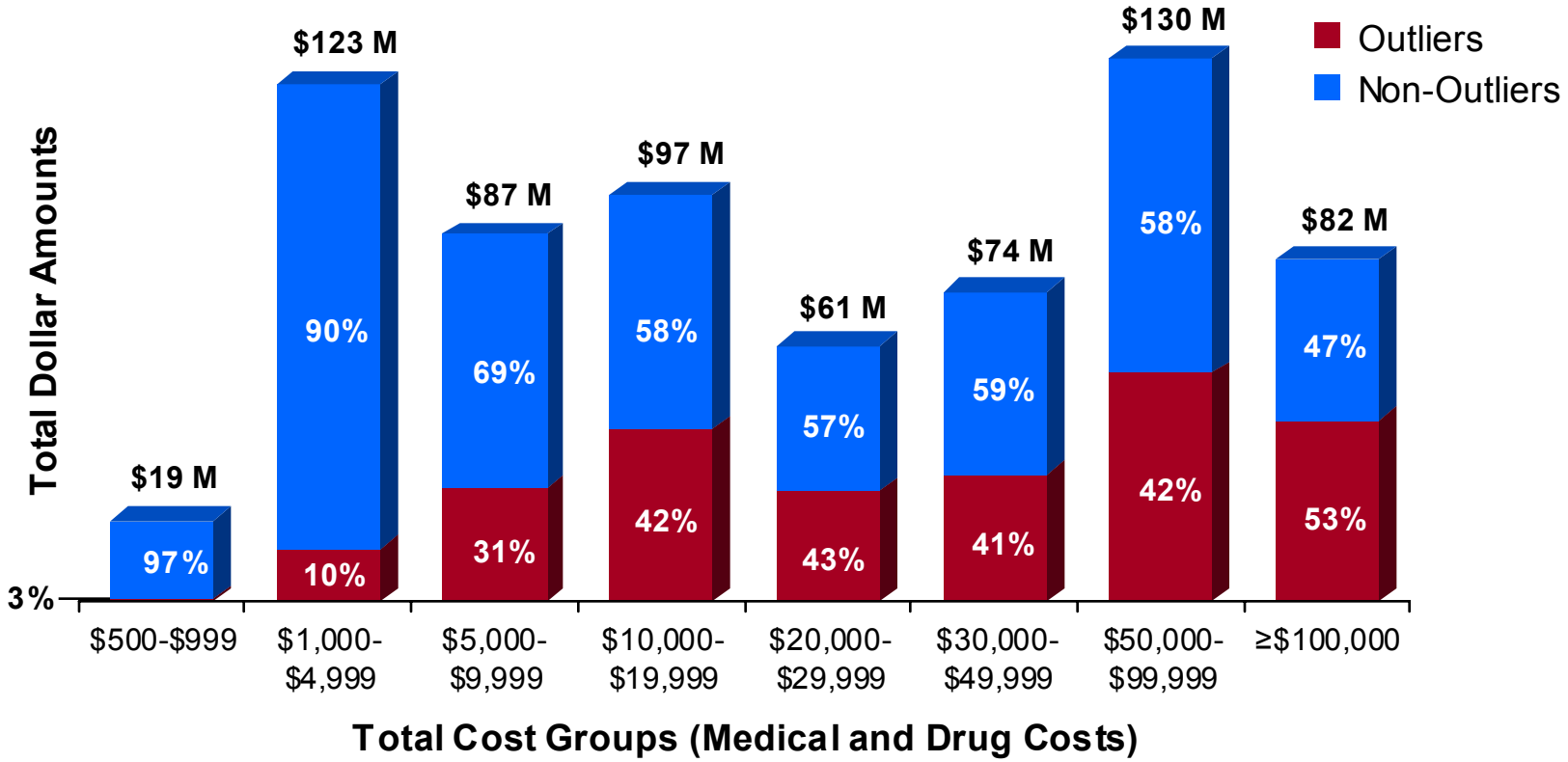
Comparison of Utilization Outliers vs. Non-Outliers by Total Cost Groups
(Percentage and Number of Recipients)



SEC independent claims data analysis completed 2005-07.

State Example:
Percent Total Dollars by Cost Groups

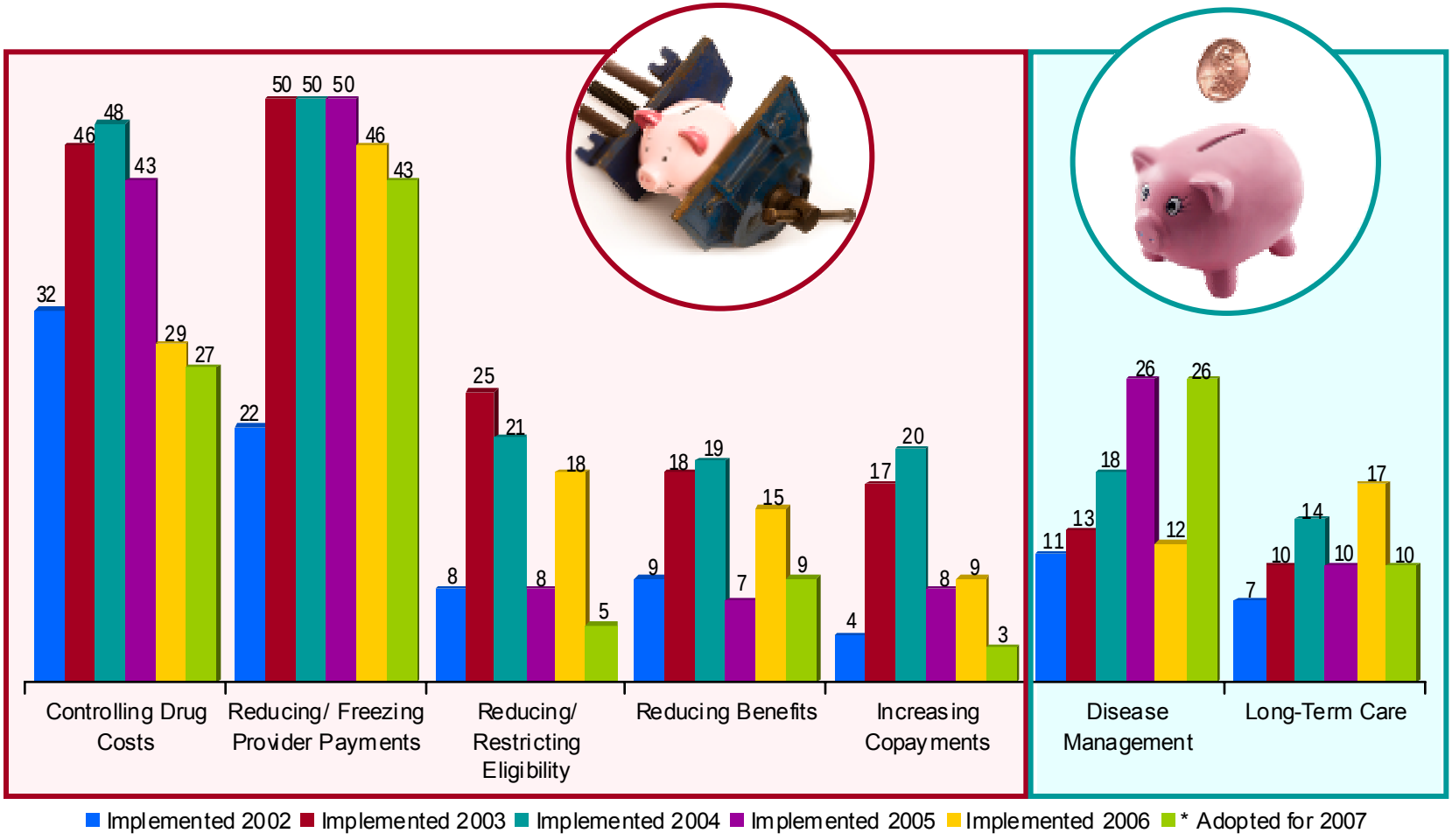
Comparison of Utilization Outliers vs. Non-Outliers by Cost Groups
(Percentage and Amount of Total Cost)



SEC independent claims data analysis completed 2005-07.

Recommended Strategies to Improve Coordination and Quality of Care in "True" Reform Efforts

States Undertaking New Medicaid Cost Containment Strategies FY 2002–2007



NOTE: Past survey results indicate not all adopted actions are implemented.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September and December 2003, October 2004, October 2005, October 2006.

New Approaches: Improve Coordination and Quality

- **Coordination of Care Via DM/CM Programs** – Address multiple conditions due to the high co morbidity profile of the Medicaid population DM/CM programs have evolved from a single disease focus to a comprehensive health focus addressing multiple diseases

- **Targeted Intervention Approach** – Due to the identified patterns among a small subset of patients who exhibit uncoordinated care (multiple providers and duplicative services) yet consume over 30% of total dollars

- **New Provider Reimbursement Models** – Recognized need to engage providers in a more active coordination of care role with appropriate financial incentives (i.e., FL Asthmatic ER Diversion Program)

New Approaches: Improve Coordination and Quality

- Patient Incentive Programs
  - Offer rewards for healthy behaviors, compliance, and active participation in treatment
- Health Information Technology Systems and Tools
  - Adopt and integrate health information technology and systems to promote care/disease management, utilization management, and compliance
- Restructure/Coordinate Utilization Review/Audit Programs
  - Drug Use Review (DUR) programs, surveillance and utilization review (SURS), and audit and investigative services need to be coordinated with each other in terms of common exception criteria applied, procedures for referrals and follow-up, and clear goals for success

“True” Reform: Implications of Coordinating Care

- Drive changes in service delivery and payment mechanisms
- Dramatically reduce unnecessary health care expenditures while maintaining existing services and access
- Ease the cost of care burden in the future
- Greatly enhance patient outcomes
- Preserve existing scope of services
- Expand access to care (i.e., to uninsured)

What Do We Need To Do?

- Encourage states and private plans to identify, quantify, and target uncoordinated care with direct provider incentive strategies and enhanced tools
- Focus their efforts on utilization reduction, intervention and monitoring for the outliers (5–10%), rather than apply access barriers to everyone in population
- Carefully monitor cost sharing and access policies to encourage appropriate utilization without denying needed care
- Support state and federal efforts that increase access and enhance continuity of care
- Consistent messaging among insurers/plans, legislative/ policy makers, providers, and patient advocates

Florida Medicaid Reform Plan

Key Elements of Florida Medicaid Reform

- Outreach Efforts with Choice Counseling
- Use Existing Delivery Systems
  - Coordinated Systems of Care
  - HMOs and Provider Service Networks (PSNs)
- New Options / Choice
  - Customized plans based on needs
  - Enhanced benefits for good patient behaviors
  - Opt-Out of Medicaid for employer coverage
- Financing
  - Premium based
  - Risk-Adjusted premiums

Florida Reform Timeline

May 2005	◆ Reform authorized by Florida Legislature in SB838
December 2005	◆ Waiver approved by Florida Legislature in HB3-B
September 2006	◆ Enrollment began for Duval and Broward counties
September 2007	◆ Enrollment began for Baker, Clay, and Nassau counties

Current Total Enrollment as of Sept 2007 is 179,903

Eligibility

- Auto assignment if plan not selected within 30 days
- Lock-in for 12 months; can change first 90 days
- Mandatory minimum benefits for children and pregnant women, for others must be actuarially equivalent to current mandated benefits

Eligibility Groups

Mandatory:	TANF, aged and disabled adults/children (SSI) groups
Voluntary:	Dual eligibles, developmentally disabled, foster children, and SOBRA groups
Excluded:	Hospice, LTC, medically needy, and breast/cervical cancer groups

Customized Plans

- Customized Benefit Packages
  - Reform health plans create benefits to meet beneficiaries' needs so they can choose package
  - Benefit packages include all federally required benefits
  - Benefit packages must have the same actuarial value as the current Medicaid benefit package

Enhanced Benefits

- Promotes self involvement in one's health care needs
- Rewards for participation in healthy behaviors with positive outcomes and improving health status
- Rewards are in form of credit dollars ($125/yr) to be used to purchase health-related products and supplies
- Over 111,000 beneficiaries have received credits for health behaviors, totaling $5,997,201 in credit dollars
- As of August 9,000 unique beneficiaries have used $260,691 in credits
- 4,475 recipients have earned the annual cap of $125

Opt-Out Program

- Employed Medicaid beneficiaries offered choice to opt-out of Medicaid and direct their Medicaid paid premium to an employer-sponsored plan
- If beneficiary chooses to opt-out, state pays up to the amount it would have paid a Medicaid plan toward the employee's share of premium
- Families can combine premiums to purchase family coverage through their employer

Risk-Adjusted Premiums

- Risk-Adjusted Rates
  - Process to predict health care expenses based on chronic diagnoses identified by drug claims data
  - Distributes capitation payments across health plans based on aggregate health risk of members enrolled in each health plan
- Risk-Adjusted Process
  - Matches payment to risk
  - Pay for risk associated with each plan's enrolled population

Evaluation of FL Pilot and Status of Expansion

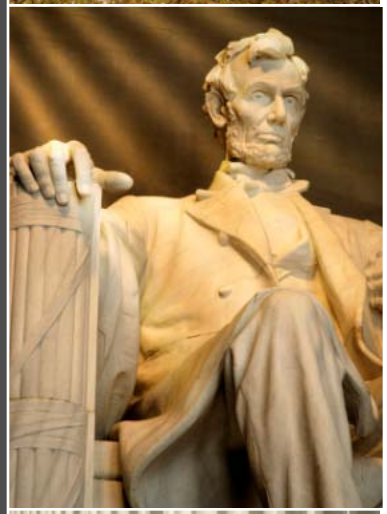
- Medicaid Inspector General released program review report Sept 2007

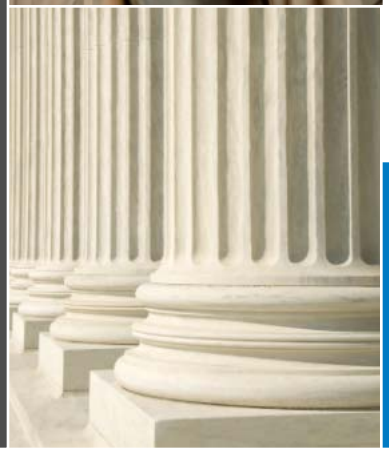
Findings

- Problems with access to needed medications and lack of information regarding HMO formulary covered drugs
- Provider networks insufficient in access to specialists and did not provide accurate data on participating PCPs during choice counseling and plan selection process
- No available encounter data from plans to evaluate performance and access to services or cost effectiveness
- No consolidated complaint system in place

Conclusion

- Reform expansion should not proceed until all issues are addressed





Pfizer Health Solutions

Mary Kay Owens, R.Ph., C.Ph.

President and Principal Consultant
Southeastern Consultants, Inc.

3019 N. Shannon Lakes Dr., Suite 202
Tallahassee, Florida 32309
(850) 668-8524 | mowens@sec-rx.com
www.sec-rx.com