Introduction

In 2003, the California state legislature directed the Department of Health Services to apply for a federal waiver to test the efficacy of providing a disease management (DM) benefit to fee-for-service Medi-Cal beneficiaries with specific chronic diseases. This presentation provides an overview of disease management, examines states’ experiences with disease management in Medicaid including case studies of four leading states, and examines the lessons learned from these experiences. While policymakers and experts continue to debate the effectiveness of these programs, this presentation identifies the potential opportunities for improving chronic disease care for Medicaid beneficiaries with disease management, discusses the challenges to developing a successful program, and provides practical lessons for both policy makers and program officials.

Disease Management in Medicaid was compiled by the Health Strategies Consultancy (HSC), a health care consulting firm that specializes in the area of Medicare and Medicaid policy. More information on the authors can be found on the final page of the presentation.

Document Navigation

The contents sidebar serves as a navigational tool. Click on a category to access that page.
What is Disease Management (DM)?

Disease management describes a coordinated and proactive approach to managing care and support for patients with chronic illnesses.

DM Programs Employ These Strategies

- Improved disease and treatment information to providers and consumers
- Improved disease monitoring
- Improved compliance with proven "best practices" for managing a disease
- Improved coordination and communication among caregivers and patients

To Accomplish These Goals

- Reduced direct and indirect costs
- Higher quality of life
- Clinical improvements
Disease vs. Case Management

These terms are often used interchangeably; most states refer to their programs as disease management programs.

<table>
<thead>
<tr>
<th>Disease Management</th>
<th>Case Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programs are focused on treating patients with specific diseases.</td>
<td>Programs are usually focused on the care of the patient as a whole, enrolling patients with complex combinations of medical conditions.</td>
</tr>
</tbody>
</table>
Why Disease Management?

- Chronic diseases account for 78 percent of the nation’s medical costs.
- People with chronic conditions use more health care services than others.

![Graph showing the percentage of health care services used by people with chronic conditions and others.]

- The number of Americans suffering from at least one chronic condition is expected to rise over the next two decades.

  **2003:** 125 million  
  **2020:** 157 million (estimate)

# Prevalence and Cost of Disease in the U.S.

<table>
<thead>
<tr>
<th>Disease</th>
<th>Approximate Annual Prevalence (millions)</th>
<th>Approximate Economic Cost† (billions)</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
<td>61</td>
<td>$368</td>
<td>2004‡</td>
</tr>
<tr>
<td>Cancer</td>
<td>10</td>
<td>175</td>
<td>2002</td>
</tr>
<tr>
<td>Diabetes</td>
<td>18</td>
<td>132</td>
<td>2002</td>
</tr>
<tr>
<td>Alzheimer’s</td>
<td>5</td>
<td>100</td>
<td>1994</td>
</tr>
<tr>
<td>Arthritis</td>
<td>70</td>
<td>82</td>
<td>1995</td>
</tr>
<tr>
<td>Stroke</td>
<td>5</td>
<td>54</td>
<td>2004‡</td>
</tr>
<tr>
<td>Depression</td>
<td>19</td>
<td>53</td>
<td>1999</td>
</tr>
<tr>
<td>Osteoporosis*</td>
<td>10</td>
<td>17</td>
<td>2001</td>
</tr>
</tbody>
</table>

* Sums for osteoporosis include only direct expenditures such as hospital and nursing home costs.
† Includes direct cost of caring for individuals, such as expenditures for medical care, and indirect cost such as lost work days, lost productivity, and mortality.
‡ These figures are estimates.

Sources: American Heart Association; Centers for Disease Control and Prevention; American Diabetes Association; Alzheimer’s Association; National Institute of Mental Health; and National Osteoporosis Foundation.
Snapshot of the DM Industry

- An estimated 97 percent of health plans are currently pursuing some type of disease management effort.
- 71 percent of employers that provide health insurance either have or are considering offering DM services.
- DM industry revenues are expected to rise dramatically by the end of the decade.

## DM Program Activities Can Vary

<table>
<thead>
<tr>
<th>Low Engagement</th>
<th>High Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Tech (Emerging)</strong></td>
<td><strong>Low Engagement</strong></td>
</tr>
</tbody>
</table>
| ● Risk Screening  
  Stratify patients for different program interventions based on medical criteria. | ● Remote Monitoring  
  Use new information technology devices to monitor patients at home. |
| **High Engagement** | **High Engagement** |
| ● Remote Monitoring  
  Use new information technology devices to monitor patients at home. | ● Remote Monitoring  
  Use new information technology devices to monitor patients at home. |
| **Low Tech (Traditional)** | **Low Tech (Traditional)** |
| ● Population Screening  
  Target patients by disease and age group. | ● Outreach/Case Management  
  Case managers call patients to monitor progress. |
| ● Patient Education  
  Distribute brochures on how to manage chronic disease, etc. | ● Team-based Care  
  Providers coordinate patients’ care. |
| ● Performance Feedback  
  Inform providers of progress in patients’ health. | ● Guidelines/Support  
  Promote best practices among providers. |
Managed Care Organizations Are Pioneers in Bringing DM to Medicaid

- Medicaid Managed Care Organizations (MCOs), operating in 47 states, have a long history of applying DM services. However, Medicaid MCOs generally enroll healthier populations and use tools that may not be effective for more vulnerable populations.

- Medicaid MCO DM programs and tools have kept pace with the private sector. They offer coordinated services and continuity of care that emphasize preventative services and focus on diabetes and asthma care as well as improving maternal and child health.

- Some Medicaid MCOs outsource DM programs, paying vendors based on performance metrics. For example, a disease management diabetes program is required to lower hemoglobin A1C levels by a certain percentage; DM asthma program is required to reduce hospitalizations by a set percentage.

- MCOs’ belief in the return on investment for DM (in terms of cost and quality) fuels Medicaid Fee-for-Service (FFS) programs’ interest in DM strategies. However, MCOs have ability to conduct sophisticated evaluations due to availability of coordinated medical and pharmacy claims data.
MCOs Cover a Different Population from Those Enrolled in FFS

States are beginning to design disease management options for vulnerable populations in fee-for-service.

Community Clinics Offer Chance to Facilitate Medicaid DM

Statistics

More than 700 Community Health Centers (CHCs) at 2,000 U.S. clinics are:
- Charged with providing “primary and preventive care to medically underserved populations.”
- Served more than 8.3 million people in 2002.

Services

Many clinics already provide DM services to Medicaid beneficiaries.
- Federally Qualified Health Center (FQHC) clinics are expected to participate in DM initiatives.
- While the overwhelming majority of Community Health Clinics are not paid for DM services, Medicaid does reimburse some preventive services although reimbursement does vary by state.

Many DM and preventive services target:
- Maternal/early childhood health (prenatal education, childhood immunizations, etc.)
- Diabetes; including diagnosis, regular disease monitoring, and patient education
- Asthma

Community Clinics Offer Chance to Facilitate Medicaid DM (cont’d)

Funding

CHC funding comes from federal grants, Medicaid, private insurance, and patient fees. Clinics, however, are increasingly dependent on Medicaid funding.

- In 15 years, Medicaid’s share of CHC revenues more than doubled, rising from 15 percent to 34 percent.
- Only 25 percent of Community Health Centers participated in Medicaid managed care in 1994. By 1998, 65 percent were taking part.

Quality

Several studies cite CHCs’ success in improving quality of patient care.

- Diabetic patients who use CHCs are twice as likely to have glycohemoglobin tested on schedule.
- CHC Medicaid patients are 22 percent less likely to have preventable hospitalizations.

As the marketplace changes, CHCs face significant challenges, including cuts in Medicaid, growth in managed care and a rising number of uninsured.

Community Clinics Can Integrate DM into Medi-Cal

Many Medi-Cal patients have established relationships with primary care providers in community clinics (CHCs).

- Under California’s Medi-Cal plan, about 900,000 patients visit 720 community health clinics several times each year, for a total of about 3 million patient visits annually.
- Primary care providers are familiar with their patients’ language and culture.

Considerable momentum building to provide DM services at CHCs.

- Approximately 40 percent of CHCs are participating in a chronic care model initiative for at least one disease, such as diabetes, resulting in changed practices and the provision of standard key measures.
- Growing support from CHC leadership for DM development and adoption.

CHC proponents advocate provision of, and reimbursement for, disease management services in the primary care setting, typically the Community Health Centers, as opposed to carving-out services to commercial DM vendors.

Community Clinics Face Hurdles in Facilitating Medi-Cal DM

Lack of Reimbursement

Most CHCs:

- Depend on foundation and private donations to maintain disease management services
- Are not positioned to take on financial risk associated with a modified DM initiative, whereas private vendors may be willing to do so.

Medicaid DM Programs for FFS Implemented in Over 30 States

Note: Map does not highlight states with "targeted case management" programs for Medicaid populations.
Conditions Most Commonly Targeted by DM Programs

Private Sector
- Cancer
- Maternal/Neonatal
- Rare Diseases
- End-Stage Renal Disease (ESRD)

Both
- Cardiovascular Disease/Congestive Heart Failure (CHF)
- Respiratory Illness/Asthma
- Diabetes

Medicaid
- Depression
- Anxiety
- Psychosis
- Hypertension

“Examining Costs of Chronic Conditions in a Medicaid Population.” Managed Care, August 2002.
CMS Encourages Use of DM for FFS Populations

“We encourage states to take advantage of the opportunities DM programs offer to provide coordinated, cost-effective care that improves the health of Medicaid beneficiaries.”

— Dennis Smith, Director, Center of Medicaid and State Operations

- A letter to state Medicaid directors outlines several models states may use to gain federal funds for DM programs in Medicaid. It defines which DM programs qualify for medical services versus administrative matching costs.

- Outside funding for disease management from pharmaceutical manufacturers is counted as a supplemental rebate; the state must share a portion of that funding with the federal government, based on the federal match rate.

States Implement DM Programs Under Varying Authority

DM can be implemented as a benefit under a state plan amendment (SPA) under these circumstances:

1905 (a)  
- Included as a Medicaid service
- Must be provided to everyone who meets particular requirements
- Must be statewide; geography cannot be limited
- Provider choice cannot be restricted
- Enrollment is voluntary

1915 (a)  
- Managed care
- Must be statewide
- Provider choice cannot be limited
- Enrollment is voluntary

1932 (a)  
- Loosens 1915 (a) to allow states to require some beneficiaries to enroll in Primary Care Case Management or managed care
- Provider choice and geography can also be limited (i.e., not statewide)
- Certain groups (including dual eligible beneficiaries) are excluded
States Implement DM Programs Under Varying Authority (cont’d)

DM can also be implemented under an SPA with administrative dollars if no direct health services, such as outreach and educational materials, are provided.

- The 50 percent match rate for most administrative services is usually lower than the match rate for medical services, which averages 57 percent nationally.
- Match rates are the same for CA.

DM can be implemented with waivers under these circumstances:

1915 (b)
- Can mandate enrollment (including dual eligible beneficiaries)
- Can limit geography and provider choice
- Provide services to beneficiaries enrolled in the waiver

1915(c)
- Beneficiaries meet institutional level of care
- Can limit geography and enrollment
- Services provided to beneficiaries enrolled in the waiver
### Selected Examples of DM in Medicaid FFS

<table>
<thead>
<tr>
<th>State</th>
<th>DM Program Focus</th>
<th>Years in Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florida</td>
<td>Asthma, CHF, HIV/AIDS, Hemophilia, ESRD, Diabetes, Hypertension, Depression</td>
<td>1998 – Present</td>
</tr>
<tr>
<td>Mississippi</td>
<td>Asthma, Diabetes, Hyperlipidemia, Coagulation Disorders</td>
<td>1998 – Present</td>
</tr>
<tr>
<td>North Carolina</td>
<td>Asthma, Diabetes, Long-term Care Polypharmacy</td>
<td>1998 – Present</td>
</tr>
<tr>
<td>Washington</td>
<td>Asthma, CHF, Diabetes, ESRD, Other High-cost Patient Populations</td>
<td>2002 – Present</td>
</tr>
</tbody>
</table>

**Note:** CHF: Congestive Heart Failure; COPD: Chronic Obstructive Pulmonary Disease; ESRD: End-Stage Renal Disease; GERD: Gastroesophageal Reflux Disease
Highlights of DM Programs in Selected States

Florida
- Leader in implementing disease management in Medicaid

Washington
- Experiments in risk-based contracts

North Carolina
- Innovations in pharmacy management in the long-term care setting

Mississippi
- Community-based DM approach in Jackson
Florida Has Experimented with DM for Several Years

1997–8
- State obtains waiver to start DM programs.
- First diseases targeted—asthma, diabetes, HIV/AIDS, and hemophilia.

1998–9
- Initial diseases continued.
- CHF, ESRD, hypertension, cancer, and sickle cell anemia begin.

1998–2000
- State ends contracts for ESRD and CHF.
- New and more stringent financial requirements imposed on vendors.

2000
- Given implementation challenges, state looks for new approaches to manage chronic conditions.
- COPD added.

2001–2
- Pharmaceutical industry sponsored DM programs accepted in lieu of supplemental rebates in conjunction with Preferred Drug List.
- State agencies recognized savings but state legislative budget office criticized program savings.
- State decided, in 2004, to end these programs in September 2005.
Florida’s Experience

- Many comprehensive programs focus on individual diseases, which incorporate a range of services such as patient education and nurse case management.

- Legislature granted DM authority and reduced the Medicaid budget in anticipation of DM savings.

- Challenges emerged over time related to enrollment, interruptions in Medicaid eligibility, provider involvement, staffing costs, and data limitations when trying to calculate savings.

- Program adjustments have included efforts to:
  - Target enrollment and engage beneficiaries;
  - Move from multiple vendors to a partnership of vendors, providers, beneficiaries, and manufacturers;
  - Emphasize improved health outcomes, not just savings.
Florida Evaluation Results Vary Depending on Point of View

Florida Agency

- All non-manufacturer sponsored DM programs have produced savings of $13.3 million since implementation; projected savings of $19.3 million between 2002 and 2004.
- Manufacturer sponsored programs* produced savings of $64.7 million since implementation in 2002.
- Manufacturer sponsored DM programs have reduced inpatient days and ER visits; hospital admissions have decreased by 36 percent; other programs have experienced similar results.

Florida Assembly’s Budget Office (OPPAGA)

- DM programs have only saved $13.4 million compared to anticipated savings of $112.7 million from 1997 to 2001.
- Manufacturer-sponsored programs saved less than cash only rebates.
- Criticized state’s methodology and insufficient assessment of whether health outcomes have improved.

*DM programs operated by drug manufacturers in lieu of supplemental rebates; savings include manufacturer contributions to develop and run programs.

## Washington’s DM Programs

<table>
<thead>
<tr>
<th>Patient Populations</th>
<th>Vendor</th>
<th>Patient Identification</th>
<th>Program Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>McKesson</td>
<td>Medical claims data identify patients</td>
<td>Nurses maintain regular contact with patients via telephone</td>
</tr>
<tr>
<td>CHF</td>
<td></td>
<td>Vendor stratifies patients by risk level</td>
<td>Higher risk patients receive in-person visits</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ESRD</td>
<td>Renaissance</td>
<td>Beneficiaries identified during dialysis sessions</td>
<td>Nurses make in-person visits during dialysis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not stratified by risk</td>
<td>Follow up visits focus on education and self management</td>
</tr>
</tbody>
</table>

Note: University of Washington will perform evaluation and use baseline per-person costs to determine program savings.
Unique Attributes of Washington’s DM Programs

- Vendors must assume full risk in contracts

- Financial and clinical goals are clearly expressed in the contracts.
  - Cost goals include vendors producing at least 5 percent cost savings through reductions in hospitalizations and unnecessary use of ERs
  - Clinical qualify goals are developed on a disease-specific basis.
    About 55 percent of asthma enrollees must have an annual flu shot; Diabetes enrollees must have improved HgA1c values and increased use of aspirin; 80 percent of ESRD enrollees should have Albumin 3.5 or greater, URR 65 or greater, Hematocrit 30 or greater, and Calcium X Phosphate 70 or less.

- Methodology for evaluation established prior to program implementation.

- State limited vendor selection to McKesson and Renaissance.

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Preliminary Results for Washington’s DM Programs

- Programs report an estimated $2 million in savings during first full year in operation (2002 to 2003).
  Full public evaluation of cost data not yet available.

- 150,000 Medicaid FFS beneficiaries identified; 15,500 actively participating in DM program.
  Active participants include: 5,500 asthma; 1,700 congestive heart failure; 8,000 diabetes; and 150–300 end-stage renal disease.

- Quality improvements include:

  ![Bar Chart]

  Source: "Washington Medicaid and its Contractor, McKesson, Get National Award for Best Disease Management Program."
North Carolina’s Pharmacy Management Initiative

- The governor and legislature directed the health department to address rising Medicaid Rx costs.

  2001 Figures:
  - Expenditures: $1.1 billion
    (Elderly accounted for 34 percent)
  - Growth rate: 16 percent

- Nursing home polypharmacy issues identified—pilot to address this area implemented as part of broader Rx reform.
Long-Term Care (LTC) Polypharmacy Initiative

Team
LTC Pharmacists and Physicians

Drug Regimen Review
- LTC Patients Taking 8+ Rx
- Inappropriate Rx Use
- Rx Warnings/Precautions
- Therapeutic Duplication

Quality and Cost Outcomes

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First Year Results for North Carolina’s Pilot Polypharmacy Initiative

North Carolina decided to expand the polypharmacy program statewide after its pilot year.

**Quality Results**
- 19 percent decline in use of unnecessary Rx drugs
- 7 percent decline in use of the wrong dose
- 9 percent decline in use of Rx drugs with potential adverse effects
- Added new Rx to drug regimens in 3 percent of cases

**Cost Results**
- $16 million in annual savings reported
- 4.2 percent savings per patient
- 13:1 savings to costs ratio
Mississippi’s Community-based Approach to Disease Management

Jackson, MS clinic affiliated with University of Mississippi

- Pharmacy management programs provided in CHCs for Medicaid beneficiaries with asthma, diabetes, and coagulation disorders
- Patients identified based on medical diagnosis.
- Over 40 percent of patients enrolled in the program have coverage through Medicaid FFS.
- Pharmacists manage patient drug regimens, promote self monitoring, patient education.
- Pharmacists reimbursed for DM consultation services; no additional payment for performance measures.
- Participating clinics report $100K in savings associated with prevented hospitalizations.
Lessons Learned from Early Medicaid DM Programs

Observations focus on the following areas:

- Selecting conditions
- Outsourcing DM services
- Identifying/enrolling beneficiaries
- Securing provider buy-in
- Measuring outcomes
Selecting Conditions

Factors to Consider
Success in selecting a specific disease depends on:
- Large number of beneficiaries having the condition, resulting in costly acute events, such as ER visits;
- Consensus surrounding treatment pathways;
- Measurable quality and cost outcomes.

Result
Asthma, diabetes, and CHF are most often targeted by states.

Future Trends
Holistic approaches to patient (or case) management that focus on the patient, and not only disease.
Outsourcing DM Services

Factors to Consider

- High upfront costs if programs administered internally; however, may result in long-term savings and meaningful program change.
- Low upfront costs if outsourced, as states can leverage vendor infrastructure and experience (vendors also often assume financial risk).
- Different vendors for different diseases may complicate care for beneficiaries with multiple conditions.

Result

- Many states are outsourcing in the current budget climate.

Future Trends

- Continued interest in outsourcing.
- Experimentation with new partnerships, such as with pharmaceutical companies, to secure funding and expertise.
Identifying Eligible Beneficiaries

Factors to Consider

● Limitations in Medicaid data systems
● Miscoded diagnoses on claims forms

Result

● In absence of alternatives, medical and/or pharmacy claims data still used to identify patients

Future Trends

● Integrated use of data files; supplementing data files with additional patient information not recorded electronically
Enrolling Beneficiaries

Factors to Consider

- Issues with consistency in enrollment
- Lack of continuity of care due to frequent use of ERs and lack of consistent communication among providers

Result

- Fluctuating enrollment causes patient drop off and modest program uptake.

Future Trends

- Temporary extension of DM program enrollment
- States move toward automatic DM enrollment with an opt-out option
Securing Provider Buy-In

Factors to Consider

- Some providers view programs as administratively burdensome;
- Many providers receive very little communication on program effects;
- Many programs provide little incentive for physicians to participate.

Result

- Modest provider participation

Future Trends

- Compensating providers for disease management services;
- Including providers in program design;
- Increasing provider receptiveness by allowing them to identify methods that best suit their needs;
- Giving physicians feedback on program effects through quarterly summaries of patients’ progress.
Non-Monetary Strategies to Secure Provider Buy-In

- Integrating physicians into program design
  Physicians are more likely to participate in programs developed by their peers, as opposed to vendors, insurers, or policymakers.

- Developing program with clinical goals as primary focus
  Physicians often do not participate in DM programs because the emphasis of the program is on financial goals rather than clinical goals.

- Providing physicians with feedback on quality effects of program
  Physicians express frustration at being far-removed from the program and not knowing the impact the program has on patient care.

- Profiling of DM and preventive services to establish medical practice standards
  DM vendors and insurers have found that physicians sometimes respond to periodic reports of how they compare to their peers, such as diagnostic test usage and patient compliance in taking certain medications.
Evaluating DM Programs

Factors to Consider

- Difficulties in establishing budget baseline data
- Effects of program may be realized in the future beyond evaluation timeframe
- Challenges associated with tracking Medicaid patients

Result

- Savings calculations and health outcome results often questioned
- Difficult to clearly prove DM results because methodology is often criticized

Future Trends

- States establishing quantifiable goals in advance of program implementation
- Third-party validation of data
Discussion of DM Evaluation Methodologies

Limitations of State Data

- Lag between time when medical services are rendered and cost data are submitted
- Sometimes separate systems for physician, ER visits, and clinical outcomes data
- Difficulty in demonstrating causal link between calculated savings and clinical data

Methodological Challenges

- Difficulty of establishing a true control group
- Regression to the mean — if beneficiaries have particularly high costs during one time period, their costs would be expected to fall regardless of their participation in DM
- Hard to isolate other factors that contribute to improved health outcomes or decreased costs
- Hard to account for higher short-term costs from enrolling patients who were underutilizing and neglecting needed services
Challenges with DM in Medicaid

Multiple and inherently complex needs of Medicaid patients
- Many patients suffer from more than one chronic condition
- Many beneficiaries see multiple providers
- Inconsistent patient follow up

Measuring savings is particularly difficult in the Medicaid environment
- Incomplete data and unique population challenges make it more difficult than measuring the impact in the private sector

Federal approval for programs viewed by some as barriers to implementation
- State Medicaid Director letter indicates administration may be more receptive than in the past
Promise of DM in Medicaid

- DM programs can improve care quality and patient satisfaction. Beneficiaries report improved health and higher satisfaction with the health care system.

- Medicaid DM activity is growing as states confront budget crises. States hope that DM will help to achieve cost savings without compromising quality.

- Key stakeholders show interest in successful state experiences and future DM trends. States are watching the experience of the forerunners as they implement their own programs.
Despite Questions About Outcomes, State Interest in DM Persists

“The DM industry has developed programs that claim to improve the quality of health care services and reduce their costs, but… it is not yet clear whether those programs can improve health outcomes, much less produce long-term savings.”

— CONGRESSIONAL BUDGET OFFICE SEPTEMBER 2002

“DM provides a strategy for states to improve patient health outcomes and limit health care spending…”

— NATIONAL GOVERNORS ASSOCIATION FEBRUARY 2003

“We encourage states to take advantage of the opportunities DM programs offer to provide coordinated, cost-effective care that improves the health of Medicaid beneficiaries.”

— CENTERS FOR MEDICARE AND MEDICAID SERVICES FEBRUARY 2004

About the Foundation
The California HealthCare Foundation, based in Oakland, is an independent philanthropy committed to improving California’s healthcare delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality healthcare.

For more information about CHCF, visit us online at www.chcf.org.

About HSC
The Health Strategies Consultancy is a health care consulting firm that specializes in health policy issues in the areas of Medicare and Medicaid policy, health information technology, reimbursement for pharmaceuticals and medical devices, and post-acute care. The firm serves a diverse client base, including Fortune 500 health care technology companies, Federal government agencies, and major health care foundations. The firm’s activities in the area of Medicaid policy focus on the implications of current and future Medicaid program changes on beneficiary care, state budgets, and product commercialization; Medicaid disease management programs; and the impacts of the Medicare prescription drug benefit on state Medicaid programs and dual eligible beneficiaries.

More information about the firm can be found at www.healthstrategies.net.