# The costs of chronic illness

*State leaders look for ways to improve treatment and trim Medicaid costs*

**BY JACK PENCHOFF**

*Bruce Vladek, left, with the Mount Sinai School of Medicine in New York City and former administrator of the Health Care Financing Administration, was the keynote speaker at the State Official's Summit on Chronic Illness. Massachusetts State Rep. Dan Bosely, CSG chair, was the summit's moderator.*

The numbers tell the story. As states try to free themselves from the depths of budget deficits, Medicaid expenditures are taking a larger slice out of the state budget pie.

Between 1987 and 2002, Medicaid's portion of state budget expenditures doubled from 8 percent to 16 percent.

And with 75 percent of Medicaid spending going toward the treatment of chronic illnesses, health care experts argue that improving chronic illness care could lead to cost savings for states while at the same time improving the quality of care for patients.

To help states find ways to spend Medicaid dollars more efficiently and improve the care of the chronically ill, more than 80 state leaders and health care professionals gathered in Washington, D.C. on April 11-13 for the State Official's Summit on Chronic Illness and Disease Management.

During the summit, representatives from 35 states and two territories shared ideas on restructuring health care programs and eliminating inefficiencies in the health care system.

"We all would like to find the magic pill to control health care costs, but unfortunately there is no such remedy," said Massachusetts State Rep. Dan Bosley, CSG chairman and moderator of the summit.

## Chronic illness defined

Chronic illnesses, according to Gerard Anderson, a professor at Bloomberg School of Public Health at Johns Hopkins University, are conditions such as congestive heart failure, diabetes, hypertension and others that last a year or more, limit what a patient can do and require ongoing care.

In recent years, some 20 states have begun disease management programs to treat Medicaid patients with the more prevalent diseases.

Disease management programs treat a particular disease instead of the individual patient by identifying the population of those patients with a particular condition and establishing guidelines for treatment.

These programs have had mixed success, in part because of the basic structure of the nation's health care system.

"We do a good job of treating acute illnesses, but not so good a job with chronic illnesses," said Anderson. And most disease management programs, he said, focus on treating a single disease and not multiple conditions.

While Medicaid patients with chronic illnesses account for only 17 percent of all Medicaid patients, that group, said Anderson, is responsible for 52 percent of all Medicaid expenditures.

Anderson showed summit participants figures that demonstrate the high cost of multiple chronic conditions. In 1998, the cost of treating a Medicaid patient without a chronic illness was $737 per year. The cost of a patient with just one chronic illness was $2,307. And with each additional chronic condition the cost rose exponentially. Patients with five chronic diseases, for example, cost $12,093 to treat.

## Better coordination needed

To improve disease management, said Anderson, better coordination is needed.

A patient with multiple conditions is seeing multiple specialists. "Who's coordinating that care?" asked Anderson.

He suggested the sharing of information and better incentives to coordinate that will reduce the number of duplicate testing and the number of unnecessary hospitalizations.

This gap between acute and chronic care is of particular concern to the states, said Bosley. "In a time of limited resources and rising health care costs, we cannot afford to continue this disconnection between the system's design and the needs of real people."

The spiraling rise in Medicaid spending, and health care in general, can be attributed to the success of the health care industry in treating chronic illnesses, said Bruce Vladek, professor of health policy and geriatrics at Mount Sinai School of Medicine in New York. Vladek served as administrator of the Health Care Financing Administration in the Clinton Administration.

"We are keeping people alive who in the past would have died from acute illnesses, said Vladek. "The phenomenon of chronic illness reflects our successes."

Successes include breakthroughs in the treatment of chronic illnesses, said Vladek. Death rates from strokes and heart disease have declined dramatically. The treatment of diabetes, depression and congestive heart failure is also radically different than it was 10 or 15 years ago.

And it's those treatments, said Vladek, that are being used as models for disease management programs.

He also noted that over the past 20 years, it has been the non-elderly, disabled whose numbers have increased the most in Medicaid. In fact, the percentage of Medicaid patients in nursing homes has dropped from 51/2 percent to 4 percent over the past 20 years.

"It's not the elderly who are driving Medicaid costs, it's the younger groups," he said.

The younger, disabled Medicaid patients need services that go beyond medical care. That change is reflected in data that shows home and community-based care has grown in 20 years from a negligible percentage of Medicaid costs to 17 percent of Medicaid spending. This is nearly the same proportion as hospital spending, which is 19 percent of Medicaid expenditures.

*The moderators of breakout sessions at the Summit on Chronic Illness were, first row from left: Barbara DeBuono, Pfizer Inc. and former New York state health commissioner; Connecticut State Sen. Toni Nathaniel Harp; Maxine Hayes, state health officer with the Washington Department of Health; and Constance Pechura, senior program officer with The Robert Wood Johnson Foundation. In back are Kurt Knickrehm, director of the Arkansas Department of Human Services, left, and Trudi Matthews, CSG's chief health policy analyst.*

The single biggest challenge for Medicaid, said Vladek, is building a system of care that crosses boundaries of traditional medical care and provides patients with significant non-medical support services.

## Key roles for states

States can play two key roles in improving the quality of care for Medicaid patients, said Vladek. One is in their role as employers. States can set the standard for quality care.

States also play a central role in the training and licensure of health professions, he said.

But improved quality of care doesn't necessarily mean states will save money. "If we do a better job with the money we are now spending," said Vladek, "we can make an awful a lot of difference in an awful lot of lives."

Prevention is also a key in combating chronic illness.

Virginia Bales, director of the Adult and Community Health, Centers for Disease Control and Prevention, said poor diet and lack of exercise has led to a rise in obesity, which is a risk factor for chronic conditions such as heart disease, diabetes and strokes.

"The average annual medical cost per American is $5,000. Yet, we only spend $10 per person on prevention," she said.

The summit concluded with a final session on what states can do next. A summary of that session and the rest of the summit will be addressed in the publication *State Official's Guide to Chronic Illness*, which will be published by CSG this summer.

The summit and guide were part of Arkansas Gov. Mike Huckabee's initiative as CSG president this year.

"More than 125 million Americans - that is almost half our total population - have at least one chronic illness that requires ongoing treatment," Huckabee said last December in announcing his initiative at the CSG Annual State Trends and Leadership Forum.

*—Jack Penchoff is State Government News' senior editor.*