Virginia Medicaid *Healthy Returns*[SM] Disease Management Program

2006 Report to Senate Finance and House Appropriations Committees
and
The Virginia Department of Planning and Budget

Virginia Department of Medical Assistance Services
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Introduction

According to Johns Hopkins University, people with chronic conditions account for 88 percent of all prescriptions filled, 72 percent of all physician visits, and 76 percent of all inpatient stays. The incidence of co-morbidities is escalating, causing treatment plans to become increasingly complex. Patients find it difficult to accurately follow through on a physician's directions, which often results in missed or inappropriate dosages of medications, failure to heed to warning signs, and overlooked appointments. This can lead to extensive emergency room use particularly in the case of uncontrolled asthma, and exacerbate expensive conditions, such as kidney failure and amputations, in the case of uncontrolled diabetes.

Health insurers and companies are developing disease management (DM) programs in an effort to alleviate individuals and society of the physical, psychological, social, and economic pressures associated with chronic conditions and diseases. DM programs attempt to both improve the quality of patient care and slow the growth of healthcare costs. DM programs were once considered experimental in the early 1990s, but their success in helping to improve quality of care has led to unprecedented growth in this industry. Many health insurance plans and most Medicaid programs now offer some form of DM services. DM programs are operated by managed care plans, provider groups, state agencies, and specialized DM companies.

Disease management targets chronic illness/conditions (e.g. asthma, diabetes, congestive heart failure, coronary artery disease, HIV/AIDS, etc.) by:

- Empowering the patient (with professional resources) to *manage* the condition, rather than forcing the healthcare system to treat acute episodes;
- Improving a patient's quality of care through promotion of evidence-based treatment; and

Beyond health status improvements, DM has the potential to contain the costs of healthcare by focusing on prevention and therefore, avoidance of acute care services.

DM programs offer a range of activities to address the shortcomings of the current healthcare system. Well-designed DM programs typically include the following activities: the targeting of high-risk patient populations; the promotion of evidence-based treatment plans with primary care physicians; patient self-management and education programs; patient monitoring and provider feedback; and, a rigorous system of evaluation.

Programs can be patient-centric, provider-centric, or a hybrid of both designs. Patient-centric programs typically utilize a nurse care manager to conduct assessments, monitor treatment, and support patients, often from a remote

location (usually telephonically). The main goals of patient-centric programs are to educate patients about their condition and promote self-care. In the patient-centric design, provider participation is ideal, but not essential. Conversely, for provider-centric programs provider participation is essential to the program's success. In a provider-centric program, the primary care provider (e.g. physician, nurse practitioner, physician assistant) conducts an assessment and develops a treatment plan in accordance with national evidence-based standards. Provider-centric programs operate a team approach to healthcare, where the primary care provider acts as the coordinator of the participant's healthcare. An additional incentive or compensation structure (often referred to as "pay-for-performance") is often essential for the success of a provider-centric program. Recently, DM programs began to offer blended or hybrid program designs that focus efforts on both the patient and the provider. Healthcare delivery is more effective and efficient if patients take an active role in their care and providers are supported with necessary resources and expertise to better assist patients in managing illness. Virginia's DM programs operate as patient-centric programs that focus on empowering the patient to take an active role in their heath care.

I. Overview of Disease Management in Virginia Medicaid

Disease Management in Virginia's Medicaid Managed Care Program

Virginia's Medicaid program offers two general models of care delivery: managed care for a specific subset of recipients (primarily children and non-institutionalized adults) and fee-for-service for everyone else. For several years now, Virginia has offered asthma, diabetes and other DM services to participants enrolled in Virginia's Medicaid Managed Care Organizations (MCOs). The plans are required to submit HEDIS data results[1] and are benchmarked against each other and other national plans. In 2005, 431,529 Medicaid recipients received services through five Medicaid MCOs. DMAS worked with the MCOs to ensure that each MCO will offer DM for asthma, congestive heart failure, coronary artery disease, and diabetes by 2007.

[1] HEDIS measures are standardized performance measures designed to reliably compare the performance of managed health care plans.

Disease Management Programs Offered to Medicaid MCO Participants (July 2006)

Health Plan I	Asthma, Congestive Heart Failure (CHF), Diabetes, Depression, High-risk Pregnancy, Lower Back Pain Adding Coronary Artery Disease (CAD) in 2007
Health Plan II	Asthma, CHF, Diabetes, Depression, High-risk Pregnancy, Lower Back Pain Adding CAD in 2007
Health Plan III	Asthma, Diabetes, Prenatal Adding CAD and CHF in 2007
Health Plan IV	Asthma, CAD, CHF, Diabetes, Prenatal
Health Plan V	Asthma, CAD, Chronic Obstructive Pulmonary Disorder, CHF, Depression, Diabetes, HIV/AIDS, Schizophrenia

Virginia's Fee-for-Service Disease Management Initiatives

In contrast to Medicaid managed care, the Medicaid and FAMIS fee-for-service populations have not had consistent access to DM services. Virginia first piloted the concept of disease management for this population in 1993, when beneficiaries who were enrolled in the MEDALLION PCCM program were targeted. Known as the Virginia Health Outcomes Partnership (VHOP) program, this program focused primarily on educating primary care physicians in the MEDALLION program who were treating beneficiaries with asthma. The outcomes reported for the program were favorable; however, the administrative cost to operate the demonstration was significant. One estimate of return indicated a $3.00 return for every $1.00 spent, but the methods used to estimate the return on investment for this pilot program were not considered reliable.

In 1997, the DM program was revised and a new vendor ACS (formally Heritage, Inc.) was contracted to administer the program. The Hertiage DM program was expanded to operate statewide and focused on pharmacy management and utilization. The program model was changed to de-emphasize direct patient care and substantially increased the number of disease states for the project. An evaluation of that program conducted by an outside consultant estimated a rate of return of $1.75 for every dollar spent.

Under the direction of the 2002-2004 Appropriation Act, DMAS pursued the development of a statewide DM program by issuing a Request for Proposal (RFP) in 2002. The proposed program included management of 12 disease

states and had a projected cost of $1.4 million with assumed savings of $22 million – a rate of return of $16 for every dollar spent. By industry standards this rate of return was unreasonable, therefore, DMAS was unable to find a vendor to operate a DM program for $1.4 million, and was subsequently forced to withdraw the RFP for this program in the spring of 2003.

Despite the withdrawal of the RFP, DMAS continued to explore the feasibility of developing a FFS DM program by conducting research of other state programs and by attending DM conferences. DMAS even contracted with an outside evaluator to determine if it was feasible to develop an in-house program, or continue with the initial strategy to contract the service to an outside vendor. DMAS subsequently learned that some states, such as Florida and Washington, which were currently operating DM programs, were not realizing significant, "guaranteed" cost savings that were listed in the contracts with the DM vendor. This occurred for several reasons:

1. Cost savings for some chronic conditions are realized over long-term (three-four years) rather than short-term periods of time (one-two years). States that are looking for "quick" cost savings or high returns on investment are encountering this situation and are not realizing the cost savings originally anticipated.
2. Evaluating the effectiveness of a DM program is difficult. Several of the strategies currently used by DM vendors to determine health outcomes and develop cost savings methodologies and are considered flawed because they are difficult to evaluate.
3. The development of DM programs has only recently occurred over the past decade, and several States, such as Florida and Washington, are just learning how to truly develop a program that will improve the health of program participants and realize a modest cost-savings.

Despite these issues, health insurers and States believe that DM programs do provide a valued service in improving health outcomes of participants with chronic conditions. This background of information, along with discussions with several DM vendors and States, provided DMAS with valuable insight as to the benefits, as well as pitfalls, when developing a new FFS DM program.

Healthy Returns^{SM} Pilot Disease Management Program

In 2004, Health Management Corporation proposed a pilot of the *Healthy Returns*^{SM} DM program to DMAS. *Healthy Returns*^{SM} ran from June 2004 through June 2005 and offered DM services for Virginia Medicaid fee-for-service participants with congestive heart failure and/or coronary artery disease at no cost to the Commonwealth. The *Healthy Returns*^{SM} pilot produced successful results and high levels of participant satisfaction based on data analysis provided by Health Management Corporation.

II. Virginia's Expanded *Healthy Returns*[SM] Disease Management Program

Disease Management Procurement Process

In accordance with the provisions of Item 326 #11c of the 2005 Appropriation Act, DMAS issued a Request for Proposals (RFP) on May 25, 2005, to obtain a vendor for the new DM program. This RFP requested proposals for implementing a program to provide DM services to eligible individuals who have one or more of the following conditions: asthma, congestive heart failure, coronary artery disease, or diabetes. By June 27, 2005, DMAS received a total of four proposals. The DMAS evaluation team evaluated and scored each proposal. DMAS' Division of Budget and Contract Management, with consultation from PriceWaterhouseCoopers, separately evaluated and scored the cost estimate for each proposal.

On September 22, 2005, DMAS posted the Notice of Intent to Award (NOIA), indicating award of the contract to Health Management Corporation (HMC), a wholly owned subsidiary of Anthem. The contract became official on October 24, 2005. *Healthy Returns*[SM] kicked-off on November 15, 2005, and was implemented on January 13, 2006.

The initial contract with HMC is for three years, with provisions for two twelve-month extensions. The program began as an "opt-in" program (participants must actively enroll in the program) with the anticipation of converting to an "opt-out" program (participants will be automatically enrolled in the program and must proactively chose to not participate) upon approval from the Centers for Medicare and Medicaid Services (CMS).

Program Components

Healthy Returns[SM] focuses on preventative care, promotion of self-management, and appropriate use of medical services in the fee-for-service system. *Healthy Returns*[SM] provides DM services to Medicaid and FAMIS fee-for-service recipients with asthma (adults and children), congestive heart failure (adults), coronary artery disease (adults), and diabetes (adults and children).

Healthy Returns[SM] is designed to help patients better understand and manage their condition(s) through prevention, education, lifestyle changes, and adherence to prescribed plans of care (POCs). The purpose of the program is not to offer medical advice, but rather to support provider staff in reinforcing patients' POCs.

Healthy Returns[SM] is offered to all fee-for-service Medicaid and FAMIS enrollees identified as having any of the covered chronic conditions with the exception of individuals enrolled in Medicaid/FAMIS managed care organizations (MCOs); individuals enrolled in Medicare (dual eligibles); individuals who live in institutional settings (such as nursing facilities); and individuals who have third party insurance.

Healthy Returns[SM] fosters improved health of its members by better coordinating pharmacy utilization, physician services, and patient self-care. It also emphasizes increased adherence to behaviors associated with optimal health. Key *Healthy Returns*[SM] components include patient assessment, routine patient contact, an inbound call service, and patient mailings. Specifically, the program objectives are to:

- Improve Health Quality Outcomes - reflected in patients having the appropriate tests performed in compliance with recommended guidelines;
- Improve Health Status Outcomes- reflected in patients having improved clinical test levels and fewer days of lost activity;
- Optimize Utilization- reflected by increased use of preventative services to reduce the use of more expensive medical services, such as inpatient admissions and emergency room visits; and
- Control Healthcare Costs- reflected through decreased costs for expensive, but often-preventable hospital stays and procedures.

Healthy Returns[SM] participation for the first six months of implementation:

***Healthy Returns*[SM] Participation**
1/13/06 – 9/30/06

Condition	Medicaid	FAMIS
Asthma	9,432	530
Coronary Artery Disease	1,110	0
Congestive Heart Failure	877	0
Diabetes	4,607	43
TOTAL	16,026	573

Healthy Returns[SM], interventions are focused on the patient and include:

- Participant Care Management
  - Baseline health status assessment;
  - Routine monitoring;
  - Education on health needs and self-management;
  - Monitoring of participant compliance with self-management protocols; and
  - Facilitation of contact with providers and community agencies.
- Nurse Line Call Line
  - Available to participants 24 hours per day, 7 days per week through a centralized toll-free number; and
  - Provides clinical support to answer questions for DM program participants and assist participants with referrals.
- Evidence-Based Treatment
  - Utilization of national evidence-based guidelines for the specialized conditions.

Healthy Returns[SM] provides two levels of DM services: standard and high-intensity. Individuals are placed into a service level based on factors including recent emergency room utilization and progression of the condition.

- Standard Program: The majority of individuals eligible for DM are enrolled in the standard program. Standard program interventions include an initial phone call to enroll the individual, a welcome kit including detailed information on his or her condition, and quarterly educational newsletters. Standard enrollees may also contact the 24-Hour Call Line which is available to participants seven days a week through a centralized toll-free number. Licensed medical professionals staff the call line to answer basic medical questions and facilitate referrals to HMC's licensed pharmacists and nutritionists.

- High-intensity Program: Generally, 20 percent of members participate in the high- intensity program. In addition to services that are provided in the standard program, these individuals receive scheduled phone calls from a HMC nurse. The HMC nurse reviews the patient's prescribed plan of care (as provided to HMC by the patient's physician) or if the prescribed plan of care is not available, the nurse will utilize nationally recognized evidence-based guidelines to assist the patient in better managing his or her condition.

Member Engagement

Members receive a general notification of the program, a condition specific welcome kit (targeted towards high or standard patient intensity), a patient goals letter, scheduled and unscheduled nurse follow-up calls (high intensity), a quarterly newsletter with disease specific information, condition specific non-compliance letters (if appropriate), outbound call messages, and a satisfaction survey**.** All materials are available in both English and Spanish and a medical translation service is available on-demand for participants who speak languages other than English.

Provider Engagement

HMC engages providers though several strategies. Providers receive an introductory letter and brochure, new participant report, physician action guide, evidence based guidelines, action guides, and prescription and emergent reports.

To improve upon the program, DMAS and Health Management Corporation are working with the Virginia Chapter of the American Academy of Pediatrics (VAAAP) to ensure that *Healthy Returns*[SM] meets the needs of the pediatric members. Through this effort, HMC implemented several suggestions of the VAAAP including disseminating the key care recommendations included in the HMC practice guidelines; convening a council to improve collaboration among HMC and academic medical center staff; and providing information about *Healthy Returns*[SM] through the professional societies so that physicians will be well

informed about the program. In addition, VAAAP members were invited to participate on HMC's Medical Advisory Board to further encourage collaboration and ultimately improve the care of children in Virginia.

Transition from "Opt-in" to "Opt-out" Program Design

Healthy Returns[SM], is currently an "opt-in" program where recipients identified with one of the four chronic conditions voluntarily choose to participate in the program. Eligible participants are identified through claims analysis or provider referral, and invited to participate through initial outreach by the program administrator. DMAS is pursuing a transition from "opt-in" to "opt-out" status with CMS. Under an "opt-out" program, individuals with an eligible chronic condition are automatically enrolled and receive program materials. Individuals who are automatically enrolled, however, may disenroll from the program at any time.

Virginia Innovations in Disease Management: Home and Community-based Waiver Participants

Virginia is the first state to offer DM to participants receiving long-term care services though one of seven home and community-based waivers. Virginia's home and community-based waivers provide specialized services that allow participants to receive services in a community setting of their choice as an alternative to an institution. DMAS currently offers the following home and community-based waivers: Elderly and Disabled with Consumer Direction, HIV/AIDS, Mental Retardation (MR), Day Support, Developmental Disabilities, Technology Assisted, and Alzheimer's. Special protocols were developed with key stakeholder input to optimize DM resources for home and community-based waiver participants – particularly for the MR waiver participants.

DMAS worked with several advocacy organizations and local agencies to develop the protocols for working with individuals with MR. Since some MR wavier clients are not in the position to make unassisted healthcare decisions, DMAS found that it is often more appropriate for the participant's case manager, guardian, family member, or residential provider to be the direct contact for HMC. DMAS, therefore, requested that HMC contact the MR Director of the appropriate community services board to identify the appropriate contact for the individual.

Virginia Innovations in Disease Management: Agency for Healthcare Research and Quality Learning Network

Virginia was one of six states initially selected to participate in the national Agency for Healthcare Research and Quality (AHRQ) Medicaid Case Management Learning Network. Virginia's *Healthy Returns*[SM] program is being evaluated by AHRQ for best practices in design, implementation, satisfaction, and outcomes. AHRQ Learning Network also provides Virginia the opportunity to learn about initiatives and innovations in other states and obtain technical assistance from experts in the field.

Staff from the AHRQ Learning Network provided consultation and technical assistance on program evaluation, provider involvement, and the waiver approval process. DMAS staff provided AHRQ a quarterly log detailing the development, implementation, and progress of *Healthy Returns*[SM]. DMAS staff worked with AHRQ staff through workshops, site visits, and conference calls.

Healthy Returns*[SM] *Preliminary Validation and Evaluation Plans

DMAS contracted with MPRO, a Michigan-based external quality review organization, to develop a validation strategy for *Healthy Returns*[SM]. MPRO is a recognized leader in healthcare quality improvement and patient safety initiatives with extensive experience in Medicare and Medicaid programs, managed care operations, research methodologies and data analysis. MPRO will work directly with HMC to validate *Healthy Returns*[SM] program processes, procedures, and outputs.

In addition to validating the program information provided by Health Management Corporation, DMAS is in the process of identifying an external evaluator to examine the clinical and financial impact of *Healthy Returns*[SM] through a thorough evaluation strategy. Evaluating a DM program is very important but extremely challenging. DM is still a relatively new initiative and best practices in evaluation design are still in development. The most difficult part of evaluating DM lies in projecting what health consequences and expenses might have been had the DM services not been provided. DMAS is receiving technical assistance from the Agency on Healthcare Research and Quality on the evaluation design and initial program results are expected in the fall of 2007.

Overall, DMAS hopes to see an increased quality of care including fewer gaps in medications, better control of chronic conditions, improved compliance with prescribed medications, increased utilization of the primary care system, decreased inappropriate use of the emergent care system, increased adherence to the physician's prescribed plan of care, and most importantly, improved health outcomes and better overall health.

DMAS' contract with HMC requires that it report on the following measures:

- Condition specific outcome measures (Appendix A) at baseline and every 6 months;
- The health and functional status of participants based on a standardized tool at baseline and every 6 months;
- The utilization of medical services to include:
    - The number of hospital admissions and readmissions,
    - The number of emergency room visits,
    - The number of ambulatory visits, and
    - HEDIS-like measures.
- The level of participant satisfaction with the program (conducted annually by a third party); and

- Documentation of participant's experience with and access to HMC's services.

In addition, when the "opt-out" version of the program is implemented, HMC will report on the return of DMAS' financial investment in *Healthy Returns*[SM]. HMC will develop a predictive model of expected expenditures and will compare this to the actual expenditures less the cost of the program. HMC's proposed return on investment methodology will be approved by DMAS prior to analysis. Expected healthcare expenditures will include, but will not be limited to inpatient hospital, outpatient hospital, physician, pharmacy, lab, and x-ray expenditures.

In addition to evaluating *Healthy Returns*[SM], DMAS worked with each MCO to ensure that all five plans will offer DM services for individuals with asthma, congestive heart failure and diabetes by 2007. These four conditions are covered in the *Healthy Returns*[SM] program for fee-for-service participants. This will allow DMAS to compare the results of the MCO DM programs with the results of *Healthy Returns*[SM], thus enabling DMAS to identify strengths are areas for improvement in Virginia Medicaid DM programs.

III. Conclusion

The Department of Medical Assistance Services worked diligently to successfully implement *Healthy Returns*[SM] for more than 16,000 Medicaid fee-for-service participants. Through *Healthy Returns*[SM] individuals with complex chronic conditions are now receiving the support and assistance that they need to handle the difficult challenge of managing a chronic illness. DMAS is working with experts to develop an evaluation strategy to ensure that *Healthy Returns*[SM] is providing the best possible DM services in the most cost-effective manner possible. DMAS looks forward to enhancing DM services and using them to better meet the needs of Medicaid participants in the upcoming years.

Appendix

Appendix A

2006-2008 Appropriations Act, Item 302. GG. 2. The department shall report on its efforts to contract for and implement disease state management programs in the Medicaid program by November 1 of each year of the biennium, to the Chairmen of the Senate Finance and House Appropriations Committees and the Department of Planning and Budget. The report shall include estimates of savings that may result from such programs.

Appendix B
Condition Specific Clinical Outcome Measures

A. Clinical Outcome Measures for Coronary Artery Disease (CAD)
Variables to be Measured
Percent of participants post-MI taking beta-blockers
Percent of all participants taking an aspirin or antiplatelet drug
Percent of participants with a CAD diagnosis who had fasting lipid panel assessed within the measurement year per ATP-III
Percent of all participants who received a flu vaccination within the last 12 months.
Percent of all participants who have ever received a pneumococcal vaccine
Hospital admissions for MI within the measurement period
Percent of all participants who had a depression screening
Percent of participants with BP<130/85

B. Clinical Outcome Measures for Congestive Heart Failure (CHF)
Variables to be Measured
The percent of participants taking aspirin, other antiplatelet medication or anticoagulant
Percent of all CHF participants who received a flu vaccination within the last 12 months
Percent of all CHF participants who have ever received a pneumococcal vaccine
<u>Participant Education</u> Percent of CHF participants who comply with daily weights Percent of CHF participants who comply with sodium restriction Percent of CMF participants who comply with medication regimen
Percent of CMF participants readmitted to the hospital with a primary diagnosis of heart failure within 30 days of hospital discharge for heart failure
Rate of emergency department visits with heart failure primary diagnosis or for pulmonary edema
Rate of hospital admissions for CHF
Percent of all CHF participants who had a depression screening

C. Clinical Outcome Measures for Diabetes
Variables to be Measured
Percent of diabetes participants with a cholesterol test in the past year
Percent of diabetes participants with BP <130/80
Percent of participants with diabetes who had one microalbumin screening test in the measurement year or receiving treatment for existing nephropathy
Percent of participants with diabetes who had at least two A1C tests in the measurement year
Percent of all diabetes participants who received a flu vaccination within the last 12 months
Percent of all diabetes participants who have ever received a pneumococcal vaccine
Percent of all diabetes participants who had a depression screening

D. Clinical Outcome Measures for Asthma
Variables to be Measured
Rate of hospital admissions for asthma
Percent of all asthma participants who received a flu vaccination within the last 12 months
Percent of participants with spirometry testing within the past 12 months
Percent of asthma participants with an emergency department admission for asthma in the past 12 months
Percent of asthma participants with personal action plan for managing their asthma

HEDIS-like 2005 Measures
Effectiveness of Care
Controlling High Blood Pressure
Beta-Blocker Treatment After a Heart Attack
Persistence of Beta-Blocker Treatment After a Heart Attack
Cholesterol Management After Acute Cardiovascular Event
Comprehensive Diabetes Care
Use of Appropriate Medications for People with Asthma
Access/Availability of Care
Adult's Access to Preventative/Ambulatory Health Services
Satisfaction With the Experience of Care
CAHPS ® 4.0 or the most recent version of the Adult Survey
Use of Service
Inpatient Utilization-General Hospital/Acute Care
Ambulatory Care
Inpatient Utilization-Nonacute Care
Outpatient Drug Utilization