Virginia Medicaid *Healthy Returns*[SM]
Disease Management and Chronic Care Management Programs

Virginia Department of Medical Assistance Services
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I. BACKGROUND

According to the Centers for Disease Control and Prevention (CDC), chronic diseases are the leading causes of death and disability in the United States. They account for seven out of ten deaths. Furthermore, the medical costs associated with people with chronic diseases account for more than 75 percent of the $1.4 trillion spent on health care in the United States.[1]

In contrast to Medicaid managed care in Virginia, the Medicaid and FAMIS fee-for-service populations have not had consistent access to disease management (DM) services. However, in 2004, Health Management Corporation (HMC), a wholly owned subsidiary of Anthem, approached DMAS and proposed a pilot disease management (DM) program at no cost to the Commonwealth. The pilot was successful, and in 2005, Virginia issued a Request for Proposals (RFP) to expand its DM initiatives.[2] HMC was awarded the contract and the expanded DM program was implemented on January 13, 2006. *Healthy Returns*^{SM} focuses on preventive 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, chronic obstructive pulmonary disease (COPD)[3], congestive heart failure (CHF), coronary artery disease (CAD), and diabetes.

The *Healthy Returns*^{SM} program continues to be fully operational, in accordance with Item 306 Z.1 of the 2008 Appropriations Act (Attachment A). Item 306.Z.2 of the 2008 Appropriations Act requires that DMAS provide annual reports to the General Assembly on the status of the DM and CCM programs (Attachment A). DMAS has submitted annual reports to the General Assembly since the inception of the DM program. However, this year's report differs from previous reports because:

- It includes claims-based DM health outcomes data in addition to self-reported data.
- The report includes an additional year's worth of data which enables DMAS to assess how well the DM program is meeting its goals and objectives. Last year, data was not available since the program was still new and baseline data was under development.
- This is the first year DMAS has reported on the CCM program.

II. DISEASE MANAGEMENT IN VIRGINIA'S MEDICAID MANAGED CARE PROGRAM

Virginia's Medicaid program currently 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. As of August 2008, 468,187 Medicaid and FAMIS recipients were receiving services through five Medicaid MCOs. For several years now, Virginia has offered asthma, diabetes and other DM services to participants enrolled in Virginia's Medicaid Managed

[1] 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.
[2] In accordance with the provisions of Item 326 #11c of the 2005 Appropriations Act.
[3] In accordance with the provisions of Item 302 FFF of the 2006 Appropriations Act, DMAS added chronic obstructive pulmonary disease to the *Healthy Returns*^{SM} disease management program on May 1, 2007.

Care Organizations (MCOs). Each MCO is required to submit Healthcare Effectiveness Data and Information Set (HEDIS) data[4] annually. The MCOs are benchmarked against each other and HEDIS national Medicaid averages. DMAS has worked with the MCOs to ensure that, at a minimum, each MCO offers DM programs for asthma, COPD, CHF, CAD, and diabetes (see Table I).

Table I: Disease Management Programs Offered to Medicaid MCO Participants

Plan	Disease Management Programs
CareNet	Asthma, Coronary Artery Disease (CAD), Heart Failure (HF), COPD, Diabetes, Depression, Maternity Management Program including High-Risk Pregnancy, Obesity Program (for children)
Virginia Premier	Asthma, Diabetes, Prenatal, COPD, Heart Disease, Obesity
Anthem	Asthma, CAD, CHF, COPD, Diabetes, Maternity Management Program, Renal Care Management Program
Optima- Sentara	Asthma, Cardio Vascular Disease (CVD), COPD, Diabetes, Prenatal, End Stage Renal Disease, sickle cell disease, high complexity case management
Amerigroup	Asthma, CAD, CHF, COPD, Depression, Diabetes HIV/AIDS, Schizophrenia, Obesity ages 6-21

III. VIRGINIA'S FEE-FOR-SERVICE DISEASE MANAGEMENT & CHRONIC CARE MANGEMENT INITIATIVES

A. Overview of the DM Program

Similar to the DM programs provided by the MCOs, all fee-for-service Medicaid and FAMIS enrollees are potentially eligible to receive DM services, but through the *Healthy Returns*^{SM} program. *Healthy Returns*^{SM} is designed to help patients in the fee-for-service environment 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.

As mentioned, *Healthy Returns*^{SM} provides DM services to Medicaid and FAMIS fee-for-service recipients with asthma (all individuals), COPD (individuals 18 years and older), CHF (individuals 18 years and older), CAD (individuals 18 years and older), and diabetes (all individuals).

Healthy Returns^{SM} is offered to fee-for-service Medicaid and FAMIS enrollees identified as having any of the covered chronic conditions with the exception of (1) individuals enrolled in an MCO; (2) dual eligibles (individuals enrolled in Medicare and Medicaid); (3) individuals who live in institutional settings (such as nursing facilities); and, (4) individuals who have third party insurance.

Healthy Returns^{SM} operates as a voluntary "opt-in" program (participants must actively enroll in the program). Virginia obtained approval for this initiative through the Medicaid State Plan, under the Deficit Reduction Act of 2005, State Flexibility in Benefits Packages.[5] Under this

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

[5] This option provides states with the opportunity to offer an alternative benefits package to beneficiaries without regard to comparability and certain other traditional Medicaid requirements.

authority, *Healthy Returns*[SM] has to be an "opt-in" program. The Centers for Medicare & Medicaid Services (CMS) approved Virginia's State Plan Amendment in October 2006.

B. Key Components of the Disease Management Program

Key *Healthy Returns*[SM] components include patient assessment, routine patient contact, an inbound call service, and patient mailings. Program interventions focus 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
  - Staffed by licensed medical professionals and 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 three levels of DM services: standard, moderate (as of June 2008), and high-intensity. Individuals are placed into a service level based on factors including, but not limited to, recent emergency room utilization and progression of the condition.

Regardless of intensity level, individuals eligible for the DM program receive an initial phone call to ask if they would like to voluntarily enroll in the program, a welcome kit including detailed information on his/her condition(s), and quarterly educational newsletters. In the moderate and high intensity programs, individuals receive condition specific non-compliance letters (if appropriate), outbound call messages, and scheduled phone calls from a HMC nurse. The HMC nurse develops the patient's plan of care based on self-reported and claims-reported outcomes, and if possible, feedback from the patient's physicians. HMC's program's goals are all based on nationally recognized evidence-based guidelines. Although standard enrollees do not receive outbound phone calls, they may contact the 24-Hour Call Line.

C. Provider and Stakeholder Engagement

HMC also 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 the program, DMAS and HMC are working with the American Academy of Pediatrics (AAP) to ensure that *Healthy Returns*[SM] meets the needs of the pediatric members. AAP nominated a member that currently serves on HMC's External Expert Physician Panel. The AAP representative provides input into the clinical content and program components for HMC's programs and specifically addresses issues brought forth by all chapters of the AAP, including the Virginia Chapter. Through this effort, HMC has 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 are well informed about the program.

D. Inclusion of Home-and-Community Based Waiver Participants in the Disease Management Program

Virginia was the first state to offer DM to participants receiving long-term care services through 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 or Disabled with Consumer Direction, HIV/AIDS, Mental Retardation/Intellectual Disabilities (MR/ID), Day Support, Developmental Disabilities, Technology Assisted, and Alzheimer's.

Special protocols were developed based on input from key stakeholders 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 always 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.

IV. OUTCOMES: *HEALTHY RETURNS*^{SM} PRELIMINARY YEAR TWO RESULTS

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

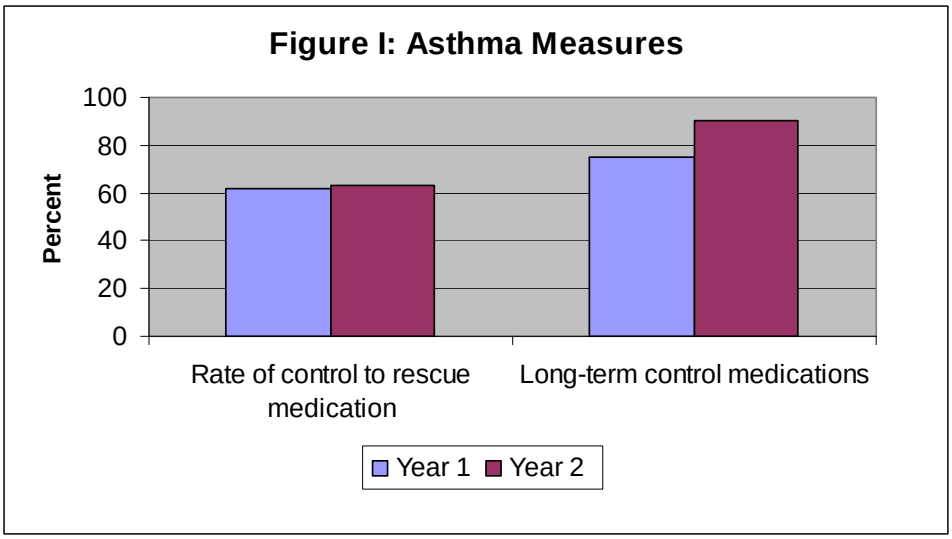
- Condition specific outcome measures (Appendix B);
- The health and functional status of participants based on a standardized tool;
- The utilization of medical services to include:
    - The number of hospital admissions and readmissions,
    - The number of emergency room visits,
    - The number 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.

As mentioned previously, the majority of this year's report includes claims-based DM health outcomes data. Only a small portion of the report discusses self-reported data. Based on a preliminary Year Two outcomes report submitted by HMC, improvements were observed on the majority of claims-based data. Claims-based condition-specific outcomes are highlighted below.

<u>Asthma</u>

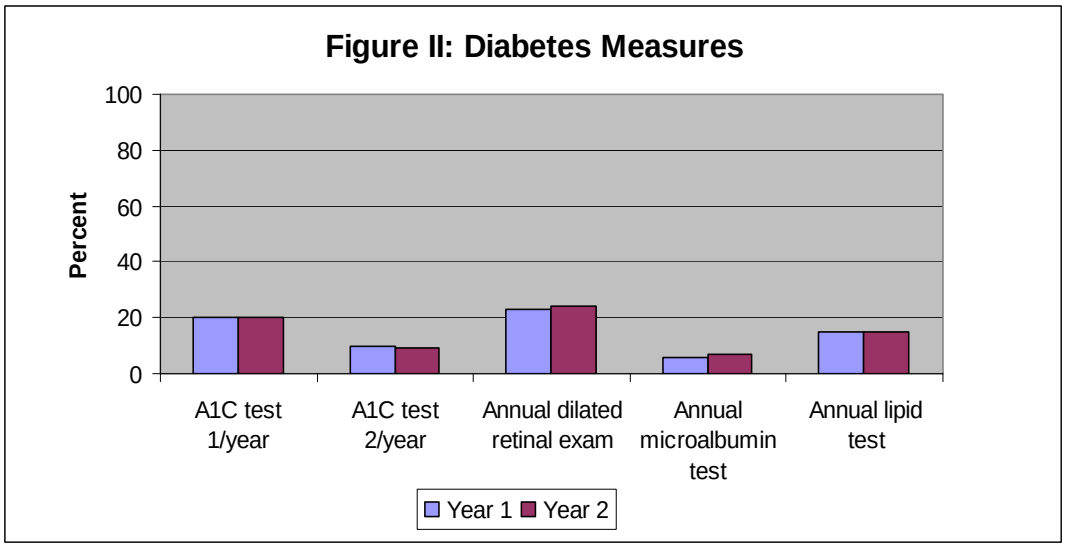
Based on claims-based outcomes data, 90 percent (up from 75 percent the previous year) of members are being prescribed long-term control medicines (see Figure I). This is positive because, in many people with asthma, long-term control medicines are prescribed to be taken

every day, usually over long periods of time, to control chronic symptoms and to prevent asthma attacks. Furthermore, the ratio of control to rescue medications is relatively high at sixty-three percent (one percentage point higher than last year). Rescue medicines are part of a group of medicines called "quick relief medicines", which provide rapid, short-term treatment and are taken when worsening asthma symptoms occur. In many people with asthma, ongoing asthma treatment per the provider's care plan includes consistent usage of control medications, and this may lead to a reduction in the need for quick relief medicines.



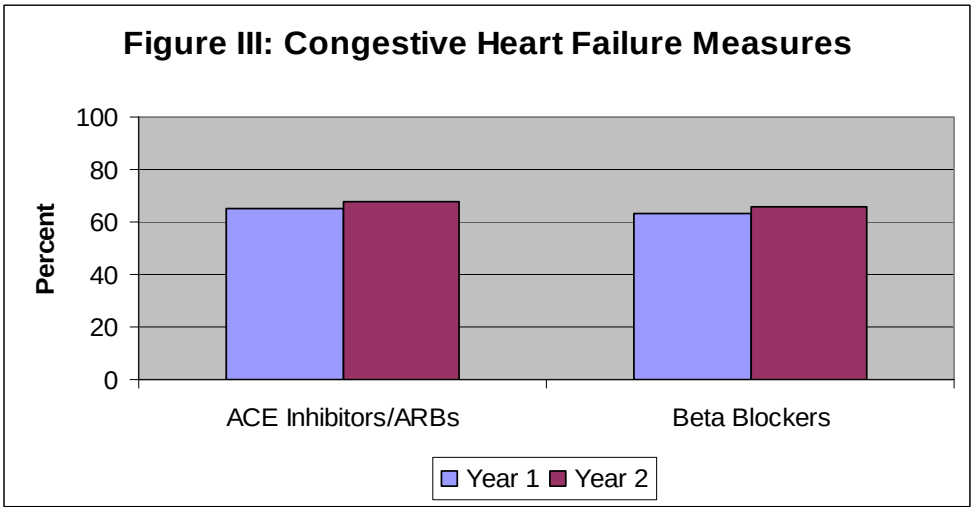
Diabetes

Claims-based diabetes data remained relatively stable from the previous year. Twenty percent of program participants had one HbA1c test in the year, the same percentage as the previous year, and nine percent had two HbA1c tests, down one percentage point from the previous year. Twenty-four percent of participants received their annual dilated retinal exam, seven percent received their annual microalbumin test, and 15 percent received their annual lipid test. These percentages either remained the same from the previous year or increased by a percentage point. Overall, the percent of patients receiving these annul tests is not as high as the Department would like to see; therefore, these represent several areas for improvement. Improvements on these measures (1) enable members to better manage their conditions; and, (2) put them at decreased risk for major complications associated with diabetes.



Congestive Heart Failure

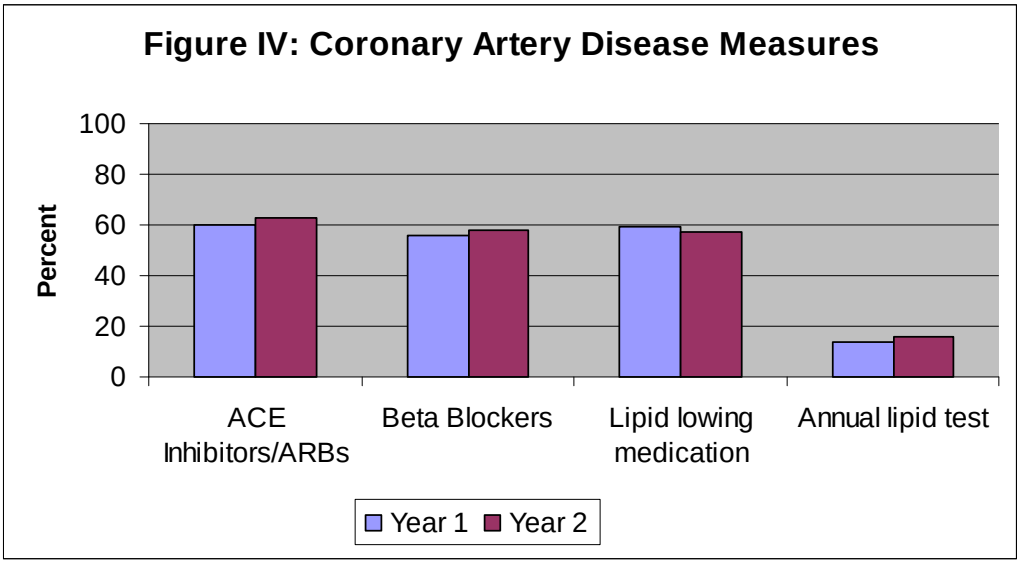
According to Figure III, the percent of members prescribed ACE inhibitors/ARBs and Beta blockers both increased by three percentage points from last year. Specially, 68 percent of members were prescribed ACE inhibitors/ARBs, up from 65 percent the previous year. ACE inhibitors/ARBs are medications that lower blood pressure and reduce the strain on the heart. They are often recommended for persons with CHF to reduce the risk of cardiovascular complications. Similarly, 66 percent of members were prescribed Beta blockers, up from 63 percent the previous year. As with ACE inhibitors/ARBs, Beta blockers slow the heart rate and lower blood pressure to decrease the workload on the heart and help to decrease the risk of cardiovascular complications.



Coronary Artery Disease

There were slight increases in both claims-based outcomes for ACE inhibitors/ARBs and Beta blockers among CAD members. Specifically, 63 percent of members were prescribed ACE inhibitors/ARBs, compared to 60 percent the previous year. Fifty-eight percent were prescribed Beta blockers, up slightly from 56 percent the previous year. ACE inhibitors/ARBs and Beta

blockers are shown to help control blood pressure and prevent further heart damage. There was also an increase in the claims-based outcome for those members receiving an annual lipid test. It is important for members to check their cholesterol levels and keep them at healthy levels to maintain optimal heart health. The percent of members being prescribed lipid lowering medications decreased to 57 percent from 59 percent the previous year, illustrating an area for improvement.

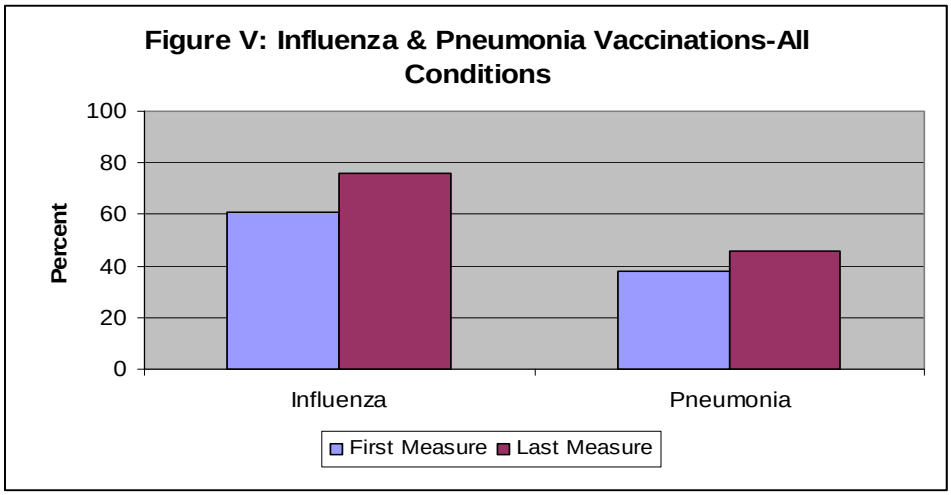


Chronic Obstructive Pulmonary Disease

As mentioned previously, COPD was added to the disease management program in May 2007. The claims-based measure for prescribed bronchodilator medication was 73 percent, but there are not any comparison data at this time. However, since last year was the first year, it was included in the disease management program. Bronchodilators are medications that dilate or open the airways and are used in the treatment of COPD. HMC and DMAS will continue to monitor the change associated with this measure in coming years.

Influenza and Pneumonia Vaccinations

Members with chronic conditions are advised to receive flu and pneumonia vaccinations to avoid medical complications. Flu vaccines are recommended yearly and the pneumonia vaccine is recommended every five years. There was a substantial increase in flu and pneumonia vaccines among managed members. Specifically, influenza vaccines increased from 61 percent to 76 percent and pneumonia vaccines increased from 38 percent to 46 percent.



Participant Satisfaction and Physical and Mental Status

In addition to the claims-based outcomes highlighted above, the *Healthy Returns*^{SM} program received high satisfaction marks from high intensity members based on satisfaction surveys. Specifically, 71 percent of high intensity members reported that they had better control over their health/condition as a result of being in the program, 89 percent rated the program as "Excellent" or "Very Good", and 98 percent indicated that they would recommend the program to others. Importantly, participants reported they have made improvements in both physical and mental status since participating in the program. These improvements are paramount to the success of disease management programs, including *Healthy Returns*^{SM}.

V. THE CHRONIC CARE MANAGEMENT PROGRAM

As mentioned, DMAS has been developing a Chronic Care Management (CCM) Program in accordance with Item 306 Z.1 of the 2008 Appropriations Act (Attachment A). As designed, the CCM Program focuses on Medicaid and FAMIS fee-for-service recipients who are at highest risk for high utilization of services and cost of services. These individuals need comprehensive care management services with a particular focus on cost reduction.

DMAS released a RFP on July 16, 2008, to solicit proposals from private companies that have experience providing chronic care management. When selected, the contractor will serve as a central broker for eligibility determination and care management. At a minimum, the contractor will be expected to produce a cost neutral program.

DMAS is seeking federal approval for the CCM program through the Medicaid State Plan, under the Deficit Reduction Act of 2005, State Flexibility in Benefits Packages. Consequently, as with the DM program, enrollment in the CCM program will be voluntary (opt-in).

DMAS submitted its State Plan Amendment to CMS on April 14, 2008, and the Department continues to clarify and resolve program requirements with CMS. DMAS is still working with CMS to obtain approval of the program; therefore it will not select a vendor until approval is granted. DMAS has temporarily postponed implementation of the CCM program until approval is granted and federal matching funds are guaranteed.

VI. 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. There are now 17 states participating in the Learning Network. Staff from the AHRQ Learning Network provide consultation and technical assistance on program design, implementation, and evaluation.

For example, staff from the AHRQ Learning Network reviewed DMAS' CCM RFP and provided invaluable comments, suggestions, and technical assistance in areas such as, care management program coordination; guaranteed savings; predictive modeling methodology; comprehensive assessment tools; treatment plans; and, program evaluation. The technical assistance enabled DMAS to develop a more focused program and to strengthen our RFP requirements.

The 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. DMAS staff continues to provide AHRQ periodic updates on the progress of the DM program during regularly scheduled conference calls.

The DM program has gained national attention as illustrated in DMAS being invited to speak at various conferences. For example, staff presented the program at the COPD Summit in November 2007 in Richmond, Virginia, and the National Governor's Association in March 2008, in Washington, DC. The DM program was discussed during a presentation at the 13th Annual Health Management Congress in July 2008 in Lake Buena Vista, Florida. The DM program will be presented at the National Academy for State Health Policy pre-conference in October 2008 in Tampa, Florida, and at the AHRQ Learning Network meeting in December 2009, in Bethesda, Maryland.

VII. CONCLUSIONS

The Department worked successfully to implement the *Healthy Returns*^{SM} DM program for Medicaid and FAMIS fee-for-service participants. Now that the DM program has been fully operational for two years, DMAS has more health outcomes to gauge the effectiveness of the program. Specifically, with the inclusion of claims-based data, DMAS can gain a better sense of the impacts the DM program is having on participants' health outcomes. Highlights from this year's program include:

- Improved rates of Influenza and Pneumonia Vaccinations: There was a substantial increase in flu and pneumonia vaccines among managed members. Specifically, influenza vaccines increased from 61 percent to 76 percent and pneumonia vaccines increased from 38 percent to 46 percent. Annual vaccinations help members with chronic conditions avoid unnecessary medical complications resulting from Influenza and Pneumonia.

- High participant satisfaction: Seventy-one percent of high intensity members reported that they had better control over their health/condition as a result of being in the program, 89 percent rated the program as "Excellent" or "Very Good", and 98 percent indicated that they would recommend the program to others. Participant satisfaction is especially important in a program where participation is voluntary.

- Chronic Obstructive Pulmonary Disease: DM services are now available for members with COPD. The addition of COPD as a covered condition under DM enables Medicaid participants to receive the support they need to properly manage this condition.

Going forward, DMAS is working with HMC to intensify operational aspects of the program to better identify and manage high intensity members, those participants who could benefit the most from the DM program.

As a result of the Department's concentrated efforts on managing chronic illnesses, many individuals are now receiving the support and assistance that they need to handle the difficult challenge of managing a chronic illness. DMAS looks forward to further enhancing disease management services and using them to better meet the needs of Medicaid participants in the coming years.

For additional program on the DM program, please go to http://www.dmas.virginia.gov/dsm.htm,

APPENDIX A

2008 Appropriations Act, Items 306. Z.1. & Z.2

Z.1. The Director, Department of Planning and Budget is authorized to transfer amounts, as needed, from Medicaid Program Services (program 45600) to Administrative and Support Services (program 49900) to fund administrative expenditures associated with contracts between the Department of Medical Assistance Services and companies providing disease state and chronic care management programs services for Medicaid recipients. The department shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

Z.2. The department shall report on its efforts to contract for and implement disease state and chronic care 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

DISEASE MANGEMENT: 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
Participant Education 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

E. Clinical Outcome Measures for Chronic Obstructive Pulmonary Disease
Variables to be Measured
Percent of COPD participants prescribed bronchodilator medications
Percent of COPD participants adherent with COPD-related medications
Percent of COPD participants currently not smoking
Percent of COPD participants with annual influenza vaccination

HEDIS-Like 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