COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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October 20, 2009

MEMORANDUM

TO: The Honorable Charles J. Colgan
Chairman, Senate Finance Committee

The Honorable Lacey E. Putney
Chairman, House Appropriations Committee

Daniel S Timberlake
Director, Virginia Department of Planning and Budget

FROM: Patrick W. Finnerty
Director, Department of Medical Assistance Services

SUBJECT: Report on the Virginia Department of Medical Assistance Services *Healthy Returns*[SM] Disease Management Program

Item 306 (Z)(2) of the 2009 Appropriations Act requires the Department to report on its efforts to contract for and implement disease management and chronic care management programs in the Medicaid program by November 1 of each year, to the Chairmen of the Senate Finance and House Appropriations Committees and the Department of Planning and Budget.

This program has assisted many Medicaid enrollees manage their chronic disease. However, due to continuing severe budget shortfalls and the need to make difficult program and funding decisions, the funding for this program was eliminated in the Governor's September cost savings initiatives.

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

PWF/mal

Enclosure

Cc: The Honorable Marilyn B. Tavenner, Secretary of Health and Human Resources

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

Virginia Department of Medical Assistance Services
November 1, 2009

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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, chronic illnesses account for more than 75 percent of total U.S. health care spending.

In contrast to Medicaid managed care in Virginia, the Medicaid and FAMIS fee-for-service populations have not historically had consistent access to disease management (DM) services. However, in 2004, Health Management Corporation (HMC), a wholly owned subsidiary of Anthem, approached the Department of Medical Assistance Services (DMAS) and proposed a pilot 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. 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), heart failure (HF), coronary artery disease (CAD), and diabetes.

The *Healthy Returns*^{SM} program continues to be fully operational, in accordance with Item 306 Z of the 2009 Appropriations Act (Attachment A). Item 306 Z requires that DMAS provide annual reports to the General Assembly on the status of the DM program. 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:

- Utilization data in addition to claims-based health outcomes and self-reported data;
- An additional year's worth of data which enables DMAS to assess how well the DM program is meeting its goals and objectives; and,
- A description of DMAS' care coordination efforts for Virginia's Elderly or Disabled with Consumer Direction (EDCD) long-term care waiver participants.

On September 8, 2009, Governor Kaine announced his cost savings actions to reduce spending in Fiscal Year 2010. As part of his plan, the contract for the Healthy Returns disease management program, which is up for renewal in November 2009, will not be renewed (Attachment B). Consequently, the program will no longer be available effective October 31, 2009. Therefore, this report summarizes data from the last complete year that the DM program will operate.

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 June 2009, 515,364 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 Care Organizations (MCOs). Each MCO is required to submit Healthcare Effectiveness Data and

Information Set (HEDIS) data annually [1]. The MCOs are then 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, HF, CAD, and diabetes (see Table I).

Table I: Disease Management Programs Offered to Medicaid MCO Participants

Plan	Disease Management Programs
Amerigroup	Asthma, CAD, CHF, COPD, Depression, Diabetes, HIV/AIDS, Obesity ages 6-21, Schizophrenia
Anthem	Asthma, CAD, CHF, COPD, Diabetes, Maternity Management Program, Renal Care Management Program
CareNet	Asthma, COPD, CAD, Depression, Diabetes, Heart Failure (HF), Maternity Management Program including High-Risk Pregnancy, Obesity Program (for children)
Optima- Sentara	Asthma, Cardio Vascular Disease (CVD), COPD, Diabetes, End Stage Renal Disease, High Complexity Case Management, Prenatal, Sickle Cell Disease
Virginia Premier	Asthma, COPD, Diabetes, Heart Disease, Obesity, Prenatal

III. VIRGINIA'S FEE-FOR-SERVICE DISEASE MANAGEMENT PROGRAM

A. Overview of the Disease Management 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), HF (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) dual eligibles (individuals enrolled in Medicare and Medicaid); (2) individuals who live in institutional settings (such as nursing facilities); and, (3) 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 the DM program through the Medicaid State Plan, under the Deficit Reduction Act of 2005, State Flexibility in Benefits Packages.[2] Under this 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.

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

[2] 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.

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. Specific program interventions focus on the patient and include:

- Participant Care Management, including baseline health status assessments; 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;

- A Nurse Call Line staffed by licensed medical professionals who provide clinical support and referrals. The Nurse Call Line is available to participants 24 hours per day, 7 days per week through a centralized toll-free number; and,

- The use of national evidence-based guidelines for the specialized conditions.

Healthy Returns[SM] provides three levels of DM services: standard, moderate, 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 Nurse Call Line.

C. Provider and Stakeholder Engagement

HMC also engages providers through 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 THREE RESULTS

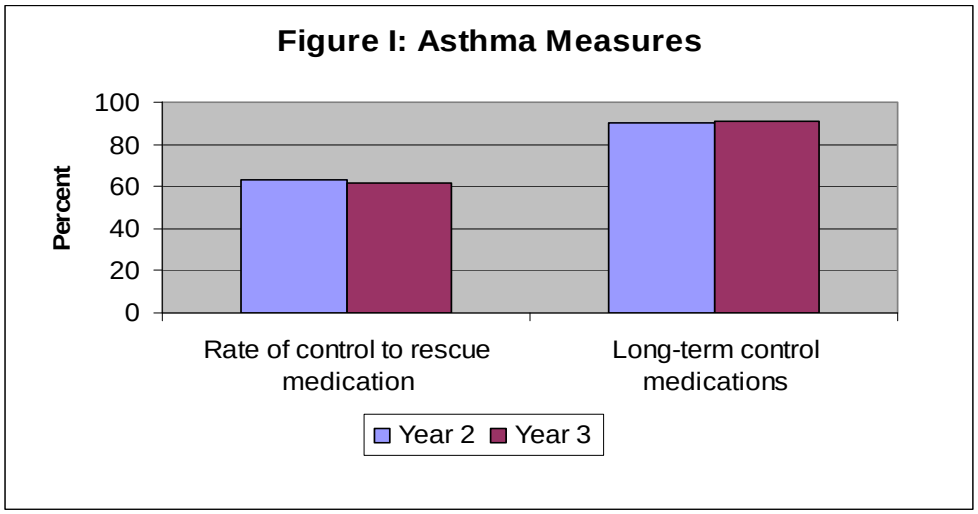
DMAS' contract with HMC requires that HMC report on the following measures:

- Condition specific outcome measures (Attachment C);
- Health and functional status of participants based on a standardized tool;
- Participant satisfaction with the DM program; and,
- Utilization of medical services, including:
    - Emergency department visits;
    - Inpatient admissions;
    - Inpatient days;
    - Outpatient facility visits;
    - Outpatient professional visits; and,
    - Pharmacy use.

Specific outcome data are highlighted below:

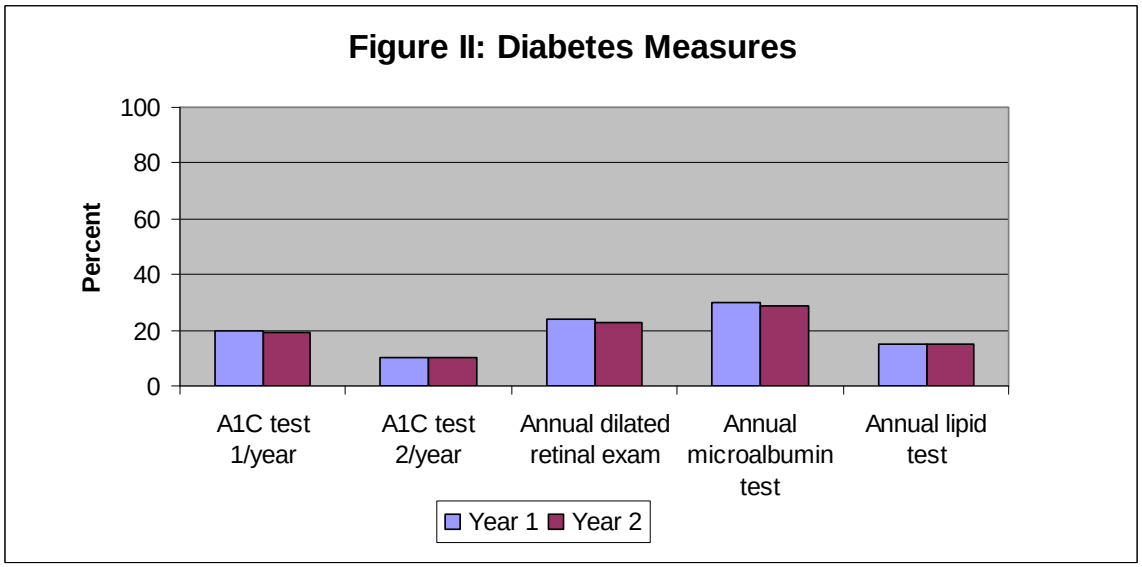
<u>Asthma</u>

Based on claims-based outcomes data, 92 percent of members had their long-term control medications filled (see Figure I), up slightly from 90 percent the previous year. 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 62 percent (one percentage point lower 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.



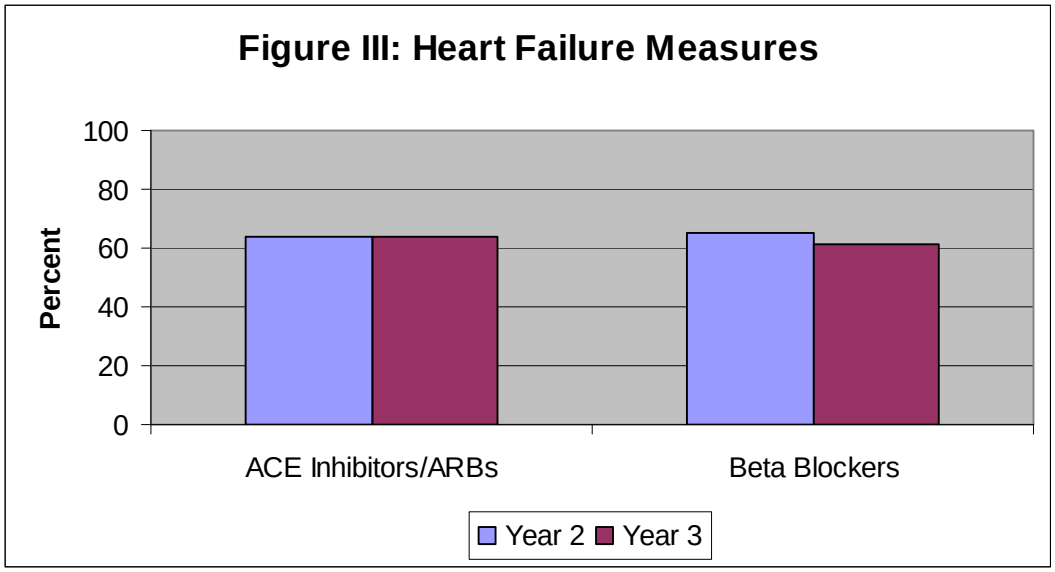
Diabetes

Claims-based diabetes data remained relatively stable from the previous year (see Figure II). Nineteen percent of program participants had one HbA1c test in the year, down one percentage point from the previous year, and 10 percent had two HbA1c tests, the same from the previous year. Twenty-three percent of participants received their annual dilated retinal exam, 29 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 decreased by a percentage point. Overall, the percent of patients receiving these annual tests is not as high as the Department would like to see; therefore, these represent several areas for improvement. Improvements on these measures would (1) enable members to better manage their conditions; and, (2) put members with diabetes at decreased risk for major complications.



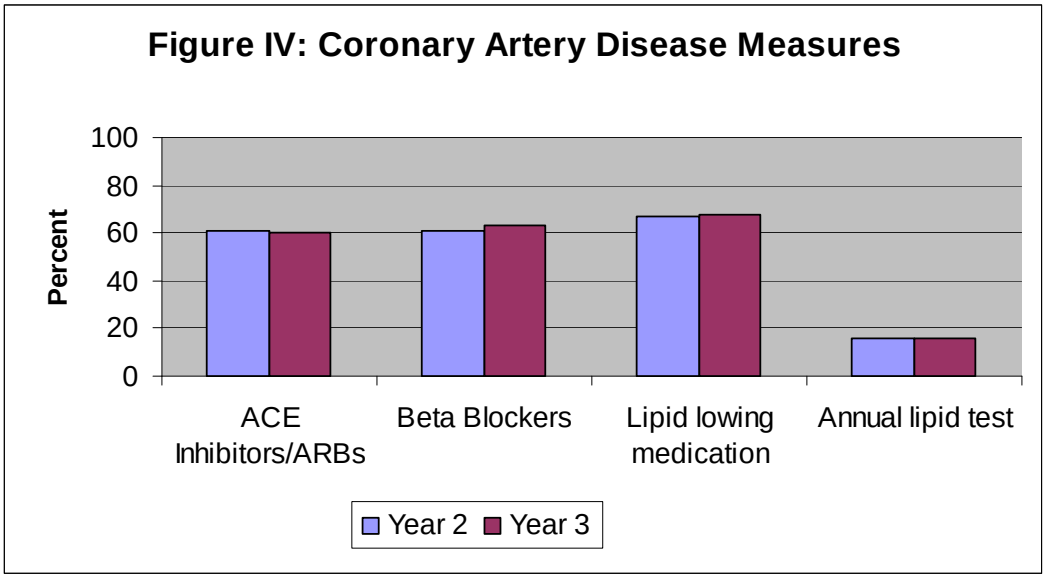
Heart Failure

According to Figure III, the percent of members who had ACE inhibitors/ARB prescriptions filled remained the same and the percent of members who had Beta Blocker prescriptions filled decreased slightly from last year. Specially, 64 percent of members had ACE inhibitors/ARB prescriptions filled, the same as 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 heart failure to reduce the risk of cardiovascular complications. Similarly, 61 percent of members had Beta Blocker prescriptions filled, down from 64 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.



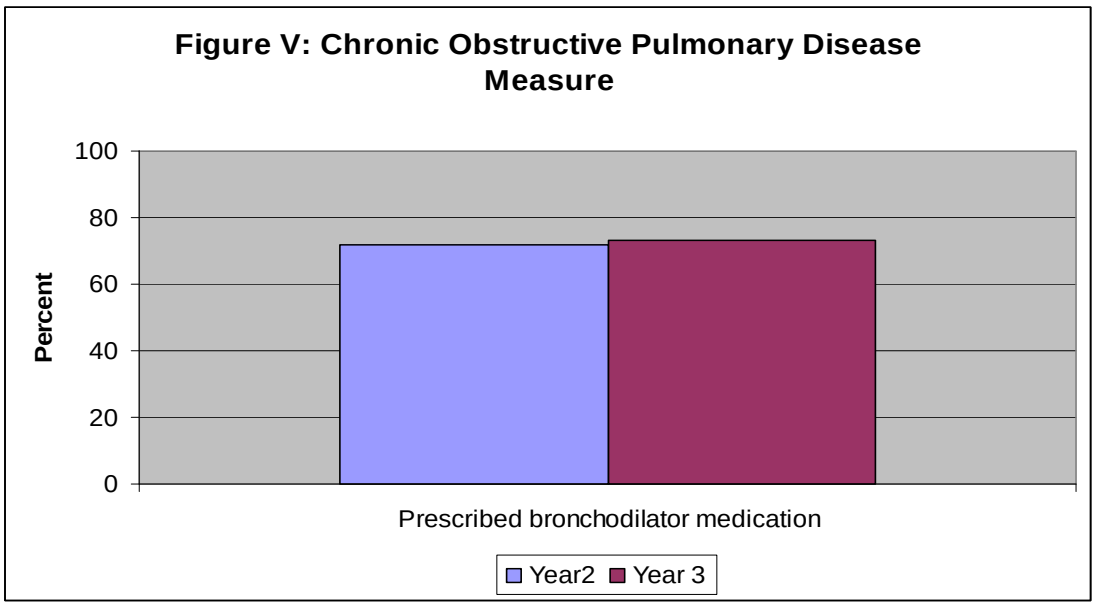
Coronary Artery Disease

As shown in Figure IV, there were slight increases in both claims-based outcomes for Beta Blockers and lipid lowering medications among CAD members. Specifically, 63 percent of members had their Beta Blocker prescriptions filled, up slightly from 61 percent the previous year. Beta Blockers are shown to help control blood pressure and prevent further heart damage. There was also a slight increase in lipid lowering prescriptions being filled (68 percent compared to 67 percent the previous year). The percent of ACE Inhibitors/ARB prescriptions filled decreased to 60 percent from 61 percent the previous year. Claims-based outcomes for those members receiving an annual lipid test remained constant from the previous year (at only 16 percent). It is important for members to check their cholesterol levels and keep them at healthy levels to maintain optimal heart health, so this indicates an area for improvement.



Chronic Obstructive Pulmonary Disease

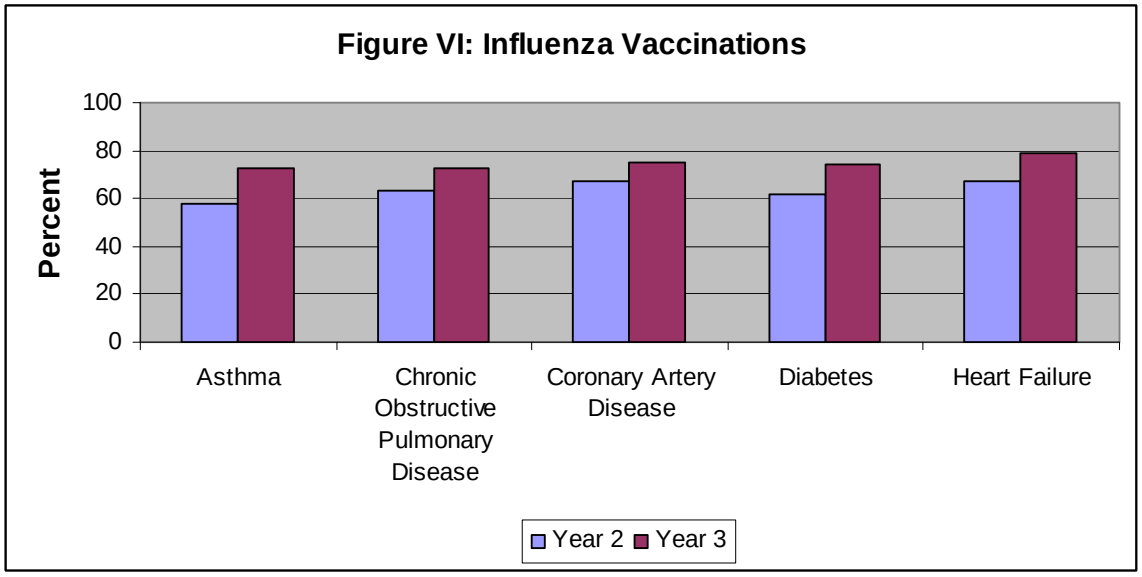
As shown in Figure V, the claims-based measure for bronchodilator medication prescriptions being filled was 73 percent, up slightly from 72 percent the previous year. Bronchodilators are medications that dilate or open the airways and are used in the treatment of COPD.



Influenza Vaccinations

It is recommended that members with chronic conditions receive yearly flu vaccinations to avoid medical complications. There was a substantial increase in flu vaccines among managed members, ranging from an 8 percentage point increase for members with CAD to a 15 percentage point increase for members with asthma. Specifically, as shown in Figure VI, influenza vaccines increased from 58 percent to 73 percent for asthma, 63 percent to 73 percent for COPD, 67

percent to 75 percent for CAD, 62 percent to 74 percent for diabetes, and 67 percent to 79 percent for members with heart failure.



Self-Reported Satisfaction with Disease Management Program

In addition to the claims-based outcomes highlighted above, the *Healthy Returns*^{SM} program received high satisfaction marks from high and moderate intensity members based on satisfaction surveys. Of the high and moderate intensity members who responded to the satisfaction survey, 89 percent rated the program as "Excellent" or "Very Good", and 99 percent indicated that they would recommend the program to others. Importantly, 98 percent of survey respondents reported they had better control over their health/condition as a result of being in the program. Lastly, 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 such as *Healthy Returns*^{SM}.

Utilization

One goal of the *Healthy Returns*^{SM} disease management program is to minimize acute care episodes and reduce hospital admissions and emergency department (ED) visits. As shown in Table 2, condition-related utilization results varied depending on the setting. More specifically, inpatient admissions and inpatient days decreased from the previous year, down 5 percent and approximately 13 percent, respectively. Outpatient facility visits and outpatient professional visits increased, perhaps indicating that DM members are seeking outpatient care versus going to inpatient settings. Emergency department use showed an 18 percent increase from the previous year, indicating a possible area for improvement. Pharmacy utilization decreased about 5 percent from the previous year. It is important to note that the results contained in HMC's preliminary report have not been independently verified.

Table 2: Condition-Related Utilization per 1,000 Diagnosed Members (per 100 members for office, outpatient professional, and pharmacy)

	Inpatient Admissions	Inpatient Days	Emergency Department Visits	Outpatient Facility Visits	Outpatient Professional Visits	Pharmacy
Change From Previous Year	-5.0%	-12.8%	18.1%	3.1%	1.7%	-4.6%

V. 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. By the end of 2008, 15 states were participating. In 2008, grant funding for the Learning Network ended and the last face-to-face meeting was held in December 2008, in Bethesda, Maryland.

During the grant period, Virginia benefited greatly from the AHRQ Learning Network. Specifically, staff from the AHRQ Learning Network provided consultation and technical assistance on program design, implementation, and evaluation. The AHRQ Learning Network also provided Virginia the opportunity to learn about initiatives and innovations in other states and obtain technical assistance from experts in the field. During regularly scheduled conference calls, DMAS staff provided AHRQ periodic updates on the progress of the DM program.

VI. DMAS' CARE COORDINATION EFFORTS

In addition to the DM program, the Department is exploring the feasibility of developing a care coordination program for individuals enrolled in Virginia's Elderly or Disabled with Consumer Direction (EDCD) long-term care waiver.

Virginia planned to launch the Virginia Acute and Long-Term Care (VALTC) integration program in July 2009. VALTC was to offer a coordinated health and long-term care delivery system for individuals enrolled in the EDCD waiver and for individuals who were dually eligible for both Medicaid and Medicare. In December 2008, however, the Department determined that it was not feasible to pursue VALTC given the uncertain costs, the current economic climate, and the inability of interested MCOs to take on the additional financial risk of a new program at that time. DMAS still intends to pursue integrated care and is now exploring the feasibility of developing a care coordination program as a next step toward integrated care for adult EDCD waiver participants.

In July 2009, DMAS issued a Request for Information (RFI) for organizations interested in providing input into the design of a care coordination program for participants of Virginia's EDCD waiver. This program would support adult EDCD waiver participants with establishing, arranging, and monitoring long-term care services. The RFI provided interested organizations the opportunity to comment on the program design and provide cost estimates for operating the program. Seventeen organizations submitted responses to the RFI. The Department is reviewing the responses and determining the feasibility of and next steps for the program.

VII. SUMMARY

The Department worked successfully to implement the *Healthy Returns*^{SM} DM program for Medicaid and FAMIS fee-for-service participants. The program has provided assistance and support to many persons with chronic health conditions, and program participants have indicated satisfaction with the DM program and services. However, given the continuing budget shortfalls and the need to make very difficult program and funding decisions, the DM program will no longer be available effective October 31, 2009. DMAS is working closely with HMC to notify providers and participants and to minimize disruption in members' chronic care management. DMAS will also continue to examine other ways to assist enrollees in managing their chronic diseases.

ATTACHMENT A

2009 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.

ATTACHMENT B

LANGUAGE FROM GOVERNOR KAINE'S FY 2010 BUDGET REDUCTION PLAN

	GF Reduction	Revenue/Transfers
GF Savings/Resources	($1,235,099)	$0

Eliminate disease management contract

Eliminates the disease management program (Healthy Returns) in the Medicaid program. The contract for the program is up for renewal in November 2009, and the contract will not be renewed.

ATTACHMENT C

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