Virginia Managed Care Performance Report 2004 - 2005

December 2005

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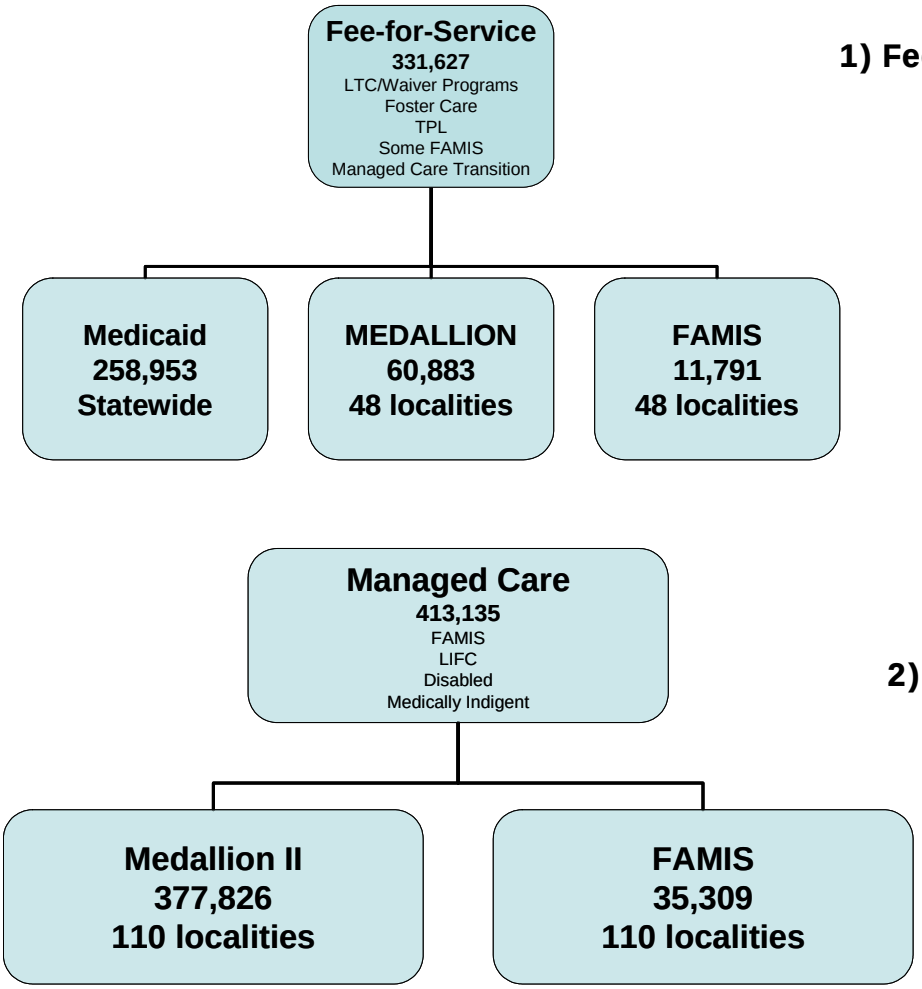
Introduction to Virginia's Managed Care Programs

This is the fourth installment in a series of annual managed care performance reports which summarizes highlights in Managed Care and the Division of Health Care Services during State Fiscal Year 2005 (July 1, 2004 through June 30, 2005).

Description of Programs: The Virginia Department of Medical Assistance Services (DMAS) primarily serves the low income population of the Commonwealth through two delivery programs based on the population and the locality of enrollees: (Program enrollments and locality counts are as of December 2005)



1) Fee-for-Service (FFS)

- **Title XIX** (Standard Medicaid program)
- **MEDALLION**, a Primary Care Case Management (PCCM) program utilizing contracted primary care providers in certain localities
- **FAMIS,** (Family Access to Medical Insurance Security Plan)
  - Title XXI-State Child Health Insurance Plan (SCHIP)

2) Managed Care Organizations

- **Medallion II**, a program utilizing contracted managed care organizations (MCO)
- **FAMIS**, (Family Access to Medical Insurance Security Plan)
  - Title XXI-State Child Health Insurance Plan (SCHIP)

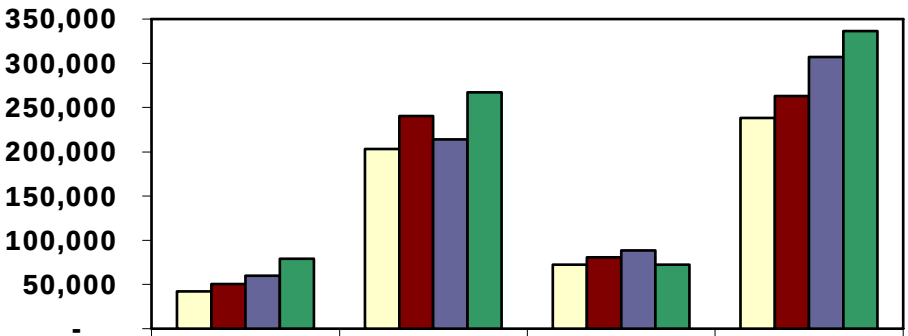
Acronyms:
Long Term Care (LTC)
Third-party liability (TPL)
Low income families with children (LIFC)

Virginia has a combination SCHIP program that consists of a separate FAMIS program and a Medicaid Expansion. SCHIP and Medicaid Expansion enrollment is reported under Medicaid FFS and Managed Care in the charts above.

DMAS Mission: To provide a system of high quality, comprehensive health services to qualifying Virginians and their families.

The two delivery systems are structured to manage the ever-growing enrollee population. The first chart illustrates the number of enrollees per program over the last four years. In the second chart, the enrollment is displayed by aid category: Aged, Blind and Disabled (ABD) and Low Income Families with Children (LIFC)*.

Figure 1. Enrollment and Expenditures**



	FAMIS	Fee-for-Service	MEDALLION	Medallion II
July 1, 2002	42,251	203,439	72,435	238,131
July 1, 2003	50,680	240,242	80,796	262,961
July 1, 2004	60,070	213,750	88,742	306,959
July 1, 2005	79,315	266,873	72,379	336,272

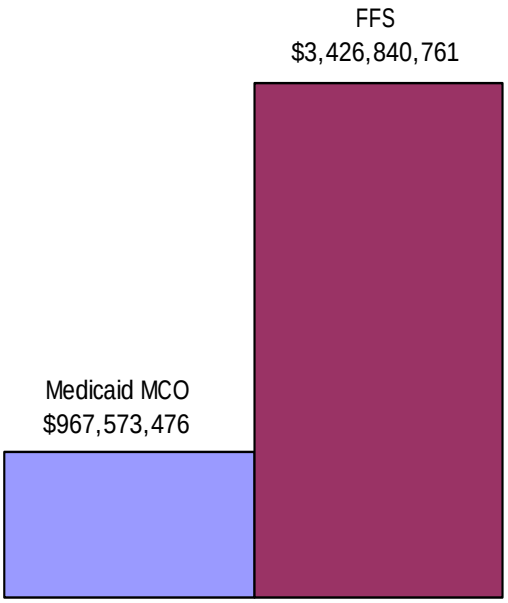
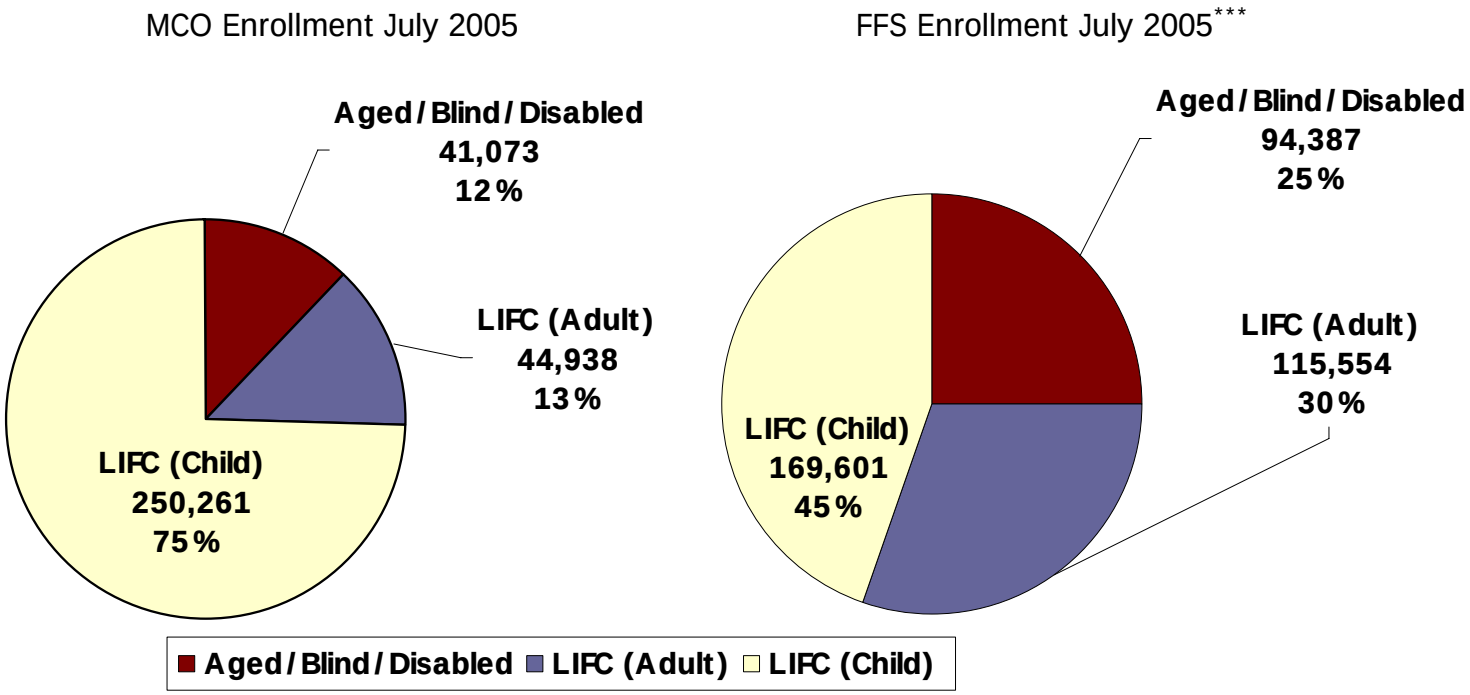


Figure 2. Medicaid Enrollment by Aid Category



* Formerly Temporary Assistance to Needy Families (TANF)

** FAMIS enrollment includes both FAMIS and SCHIP Medicaid Expansion program
Expenditures are for FY 2005. Medicaid MCO does not include SCHIP Medicaid Expansion or other programs. FFS inclues MEDALLION

*** MEDALLION and FFS are combined in FFS figures

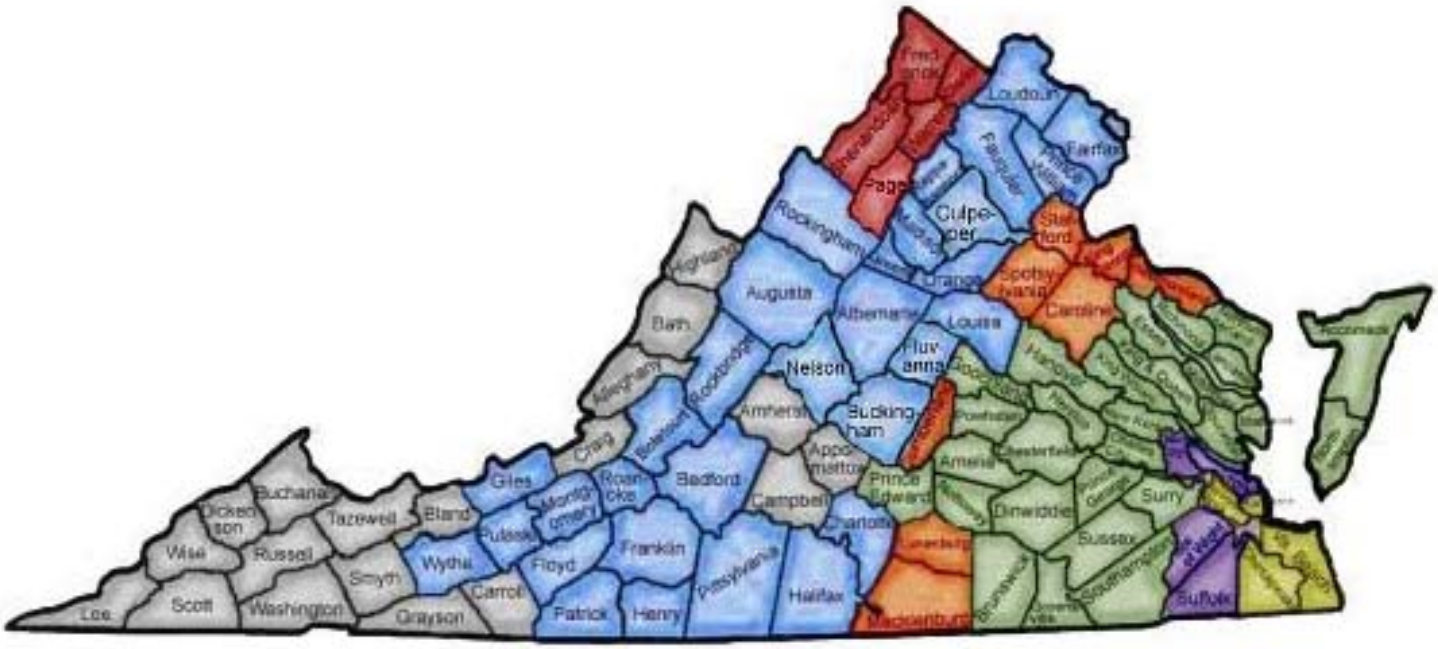
In 1996, DMAS began a partnership with MCOs to serve the Low Income Families with Children and the Aged, Blind and Disabled population; this was expanded to implement the FAMIS program in 2001. The goal of the partnership is to improve health outcomes, manage utilization, enhance provider networks and reduce expenditures; this is accomplished through converting fee-for-service lives to managed care. The program, now in its 10th year, has demonstrated that the managed care model for low-income populations produces consistent results. **As of December of 2005, 377,826 Medicaid and 35,309 FAMIS enrollees are being served by six (6) MCOs in 110 localities.**

Figure 3. Managed Care Conversions

- January 1996 – 7 cities/counties
- November 1997 – 6 cities/counties

} 80,000 Lives Added

- April 1999 – 33 cities/counties - 70,000 Lives Added
- October 2000 – 9 cities/counties – 10,000 Lives Added
- December 2001 – 48 cities/counties – 103,000 Lives Added*
- December 2005 – 8 cities/counties – 40,600 Lives Added**



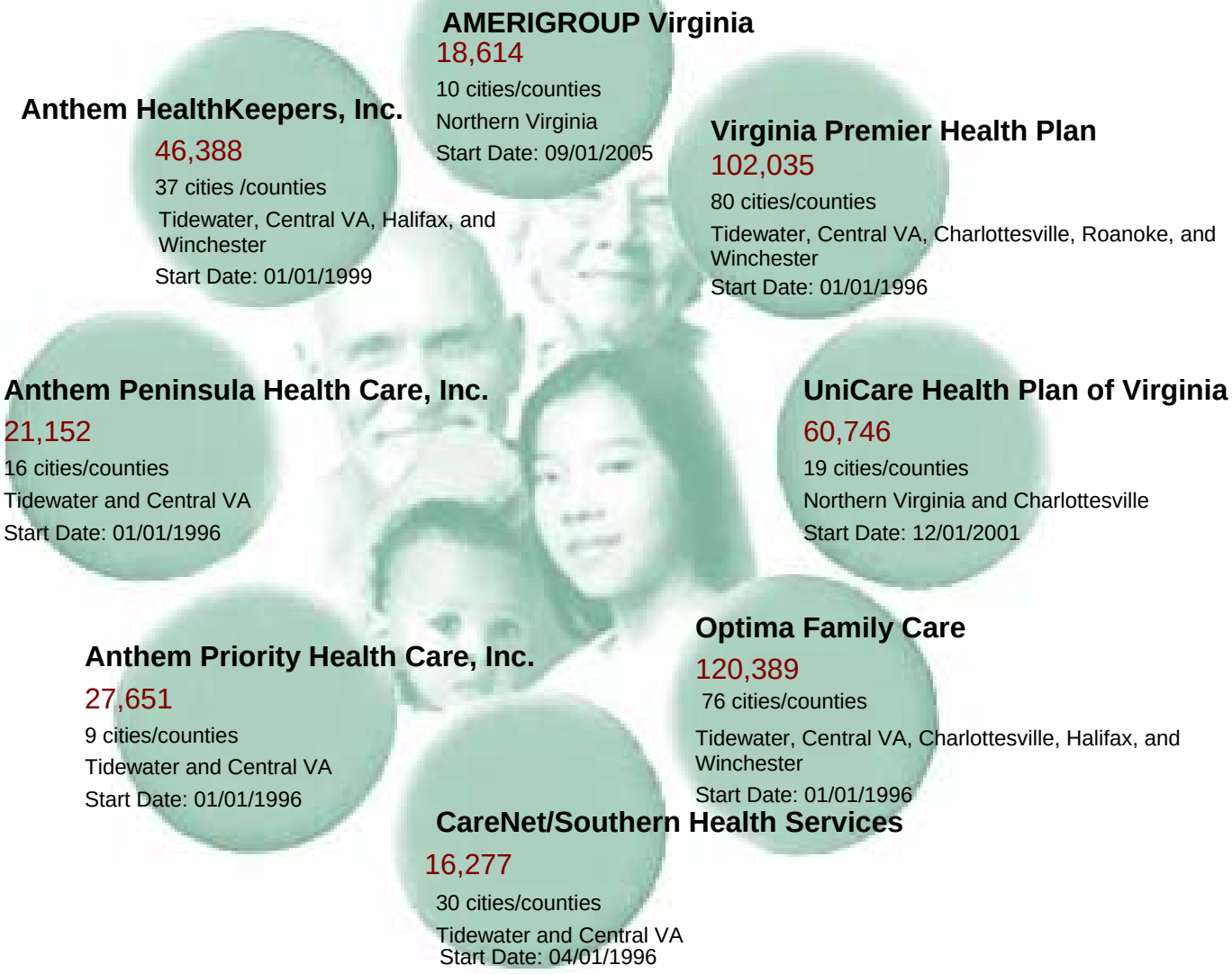
* After 2001 FAMIS enrollees were added in areas where MCOs were already located

** This number includes the addition of AMERIGROUP effective September 1, 2005 in Northern Virginia.

History of Health Plans:

Over the past 10 years, Virginia has maintained MCO partnerships with commercial plans, provider sponsored plans, and Medicaid only plans. Throughout the history only one plan, Optima Choice has left Virginia. The latest plan to join DMAS was AMERIGROUP in September 2005 to serve enrollees in Northern Virginia. In 2001 UniCare Health Plan of Virginia, Inc. joined to cover Northern Virginia, presently, UniCare Health Plan of Virginia, Inc. is merging with Anthem on January 1, 2006.

The participating plans, their enrollment, localities and start date are illustrated below: (Enrollment includes FAMIS)



MCO Information

- Enrollees as of December 2005
- Localities, Regions & Start Date

Collaborative Partnerships

DMAS collaborates with health plans to improve its operations in three main areas: national accreditation, financial workgroup, and monitoring.

Accreditation:

In addition to state licensure, the plans must be accredited by The National Committee for Quality Assurance (NCQA). The health plans are also required to provide Health Plan Employer Data and Information Set (HEDIS) reports, which have standardized credentialing, increased a focus on quality, and enabled the Department to benchmark health outcomes.

Two of Virginia Medicaid MCOs ranked 10th (Anthem) and 23rd (Optima) among the top 25 Medicaid health plans in the country. The Accreditation Standards score is a complex methodology used to develop the national rankings and is based on the following four measures: access to care, overall member satisfaction, prevention, and treatment. Virginia is the second state, after Tennessee, to require NCQA Accreditation for all Medicaid managed care plans.

Financial Collaborations:

Rate setting within financial workgroup: In addition to using the Chronic Illness and Disability Payment System (CDPS) model for rate setting, DMAS approaches rate setting in a fashion that fosters a stable relationship with the MCOs. Like other states, rates are set based on claims data, encounter data, and actuarial judgment. However, the Virginia Medicaid process is a collaborative approach with formal input from contracting managed care organizations. The Virginia Medicaid rate setting process involves meetings with health plans and Price Waterhouse Coopers, the contracted auditing firm, to review and discuss all aspects of the rate calculations. The comments of the participating health plans are considered before the rates are finalized. This allows DMAS and the MCOs to have a level of confidence that rates will be set in a predictable, rational way and ensures MCOs that their input is valuable to the rate setting process.

Optima Family Care received an A+ rating based on 2004 fourth quarter data from the prestigious Weiss Ratings Agency. This award, granted to only twelve health plans in the nation, recognizes an insurance company's financial solvency.

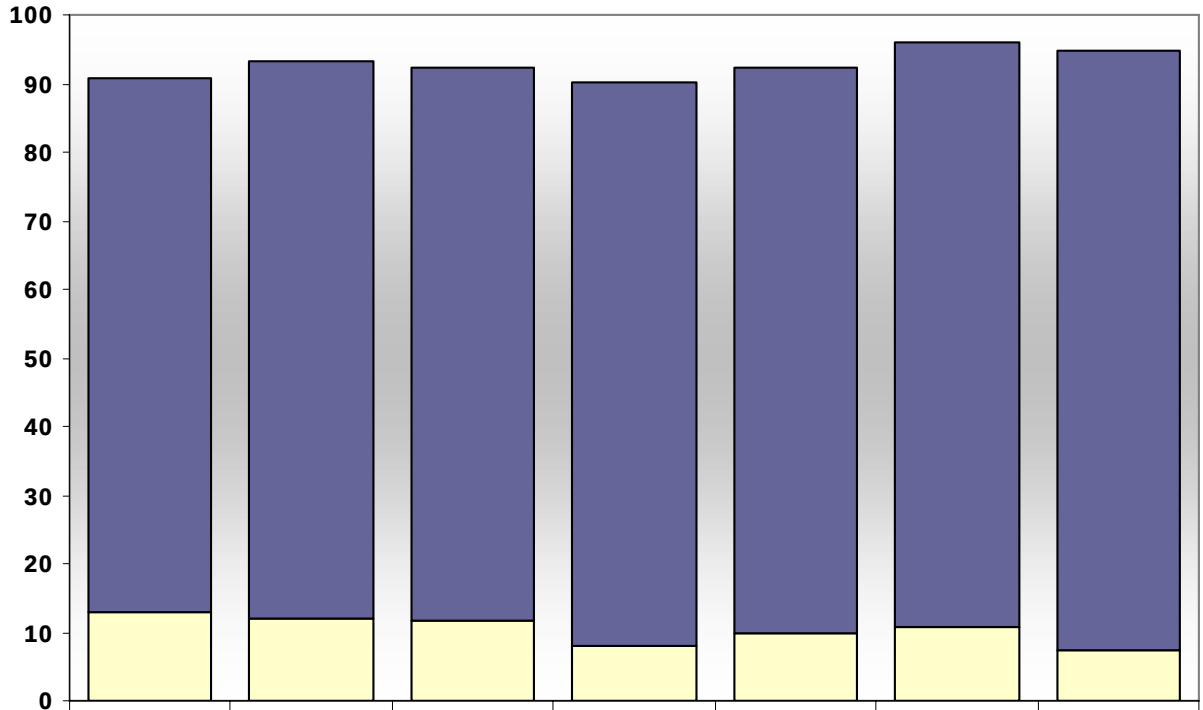
Financial Collaborations:

Solvency: The Virginia Bureau of Insurance licenses MCOs operating within Virginia. The licensing process ensures financial solvency. For the purpose of this report, DMAS focuses on two measures of financial solvency: administrative and medical cost ratios.

- The Administrative Cost Ratio is the percentage of each dollar paid to the MCO that is spent on administration (e.g., salaries, offices, rent).
- The Medical Cost Ratio is the percentage of each dollar paid to the MCO that is spent on medical care.

Based on the annual 2004 financial reports provided by the MCOs to the Provider and Reimbursement Division, the Medicaid MCOs appear to manage their debt well and appear financially sound, profitable, and solvent. There has been improvement in the administrative cost ratios for various MCOs in 2003. The ratios below reflect filings for all business segments of the MCOs, both commercial and Medicaid. Individual financial information on the contracted managed care organizations is available on the Virginia State Corporation Commission Bureau of Insurance web site. This information can be accessed at: http://www.state.va.us/scc/division/boi/webpages/boifaq2c.htm.

Figure 4. MCOs' Administrative and Medical Cost Ratios – 2004



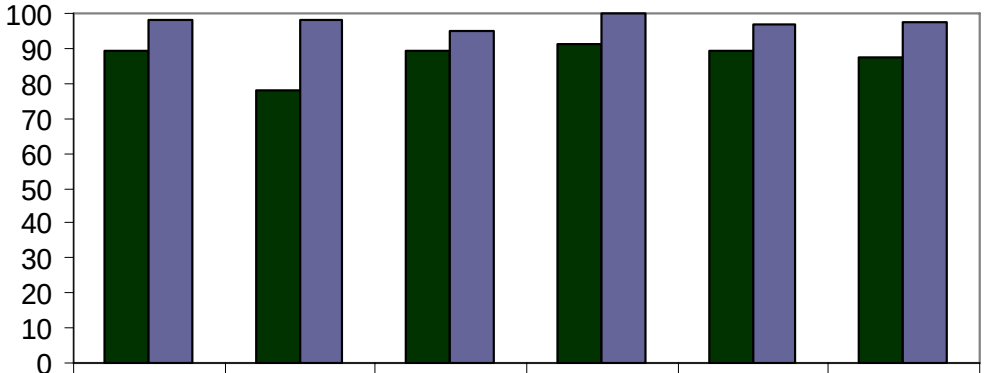
	MCO A	MCO B	MCO C	MCO D	MCO E	MCO F	MCO G
Medical Ratio	77.74	81.17	80.39	82.03	82.46	85.15	87.26
Administrative Ratio	13.07	12.12	11.82	8.11	9.83	10.74	7.43

Monitoring:

Encounter Data: As of November 2005, MCOs managed the health care of 397,064 (54%) of all Virginia Medicaid and FAMIS enrollees, in addition, the Commonwealth of Virginia spends over $950 million dollars (2005) for Medicaid managed care services. (This number does not include SCHIP Medicaid Expansion enrollees and MEDALLION enrollees). For these reasons, accurate health care claims and encounter data are necessary for the most effective use of Virginia's resources. Health care claims and encounter data are used as part of rate setting, performance management, and quality improvement processes. This year DMAS focused on improving encounter data due to issues with the submission, validity, verification, and management of encounter data. In addition, the Centers for Medicare and Medicaid Services (CMS) now requires actuarially-sound managed care rate setting based on accurate and complete encounter data. Also, there has been increased interest in performance management of managed care by legislative committees and staff. The Commonwealth recognized that external assistance was required to resolve the encounter data processes and contracted with MEDSTAT to conduct an encounter data validation study. MEDSTAT, part of The Thomson Corporation, provides market intelligence and benchmark databases, decision support solutions, and research services for managing health care costs and quality. DMAS also hired analysts to provide oversight to all encounter activities. DMAS and MEDSTAT developed and implemented an encounter data validation study in phases that identified key performance improvement needs. The study is still in progress and continues to assist in improving performance management processes and the reliability of encounter data.

Operational Systems Review: The contracted external quality review organization, Delmarva Foundation for Medical Care, conducted an Operational Systems Review of each MCO's policies, procedures, and services in three main areas: Enrollee Rights and Protections, Quality Assessment and Performance Improvement, and Grievance Systems. This annual evaluation was conducted during January 1, 2004 through December 31, 2004 to monitor and validate the overall quality performance of the MCOs. The compliance scale ranged from 0-100.

Figure 5. Aggregate Operational Systems Review - Overall Compliance Scores
(Source: Operational Systems Review – SFY 2004)



	Anthem	CareNet	Optima	UniCare	VA Premier	Average
2003	89	78	89	91	89	87
2004	98	98	95	100	97	98

The full External Quality Review Report can be found at:
www.dmas.virginia.gov/mc-external_qualtiy_reviews.htm

Healthy Virginia Initiatives

The partnership with MCOs this year produced three notable results:

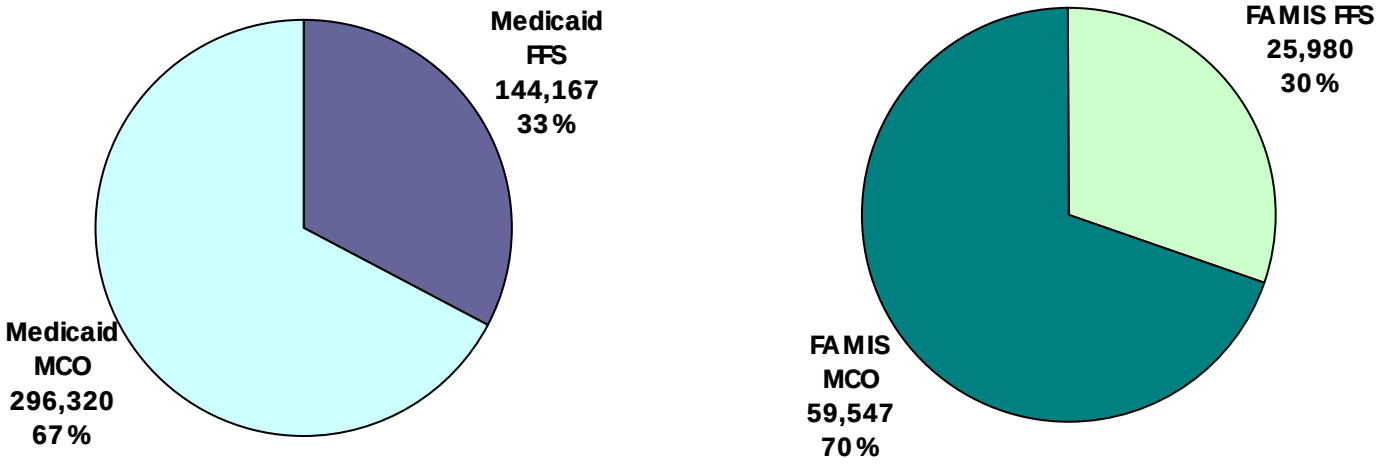
1) Programs were developed to support Governor Warner's Healthy Virginians Initiatives,
2) Chronic Care and Disease Management Programs produced positive HEDIS outcomes, and
3) Managed Care Organizations activities were replicated in the fee-for-service program.

Governor Warner's Healthy Virginians Initiatives focused on the health of children and women. The Healthy Virginian's Initiatives created programs that improved access, eligibility, and data outcomes. Results of Governor Warner's Healthy Virginians Initiatives include: increased child enrollment, ***Smiles for Children*** (dental program), improved immunization rates, increased access to obstetrical care, the FAMIS MOMS program, and improved prenatal care.

Increased Child Enrollment:

Since last year, 12,950 lives were added to the Virginia Managed Care population. Of that population, the majority of enrollees are children. As of December 1, 2005 98% of all eligible children are now enrolled in Medicaid/FAMIS.

Figure 6. Enrollment of Children as of December 2005



There are several successful new strategies focused on increasing child enrollment. One strategy involved creating a new FAMIS application process. Following the February 1, 2005 availability of e-applications, 30% of new applications were received via Internet. This on-line application was demonstrated in May 2005 via a Web broadcast during "Cover the Insured Week". Eighty-eight percent (88%) of new enrollees rated the application process as easy or very easy. Another enrollment approach was a media campaign using a FAMIS recipient's parent as the spokesperson. Anthem led this effort through an unprecedented partnership including DMAS, other Medicaid MCOs, health care providers, and private organizations. **As a result of Governor Warner's directives and DMAS collaborations, over 420,000 children are now enrolled in either FAMIS or Medicaid.**

Dental:

In FY 2003, only 28.9% of children enrolled in Medicaid/FAMIS received dental services. In addition to low enrollee utilization, only 17% of practicing dentists participated. Dentists cited several issues as reasons for the low participation in the Medicaid and FAMIS programs: low reimbursement, administrative "hassles", patient no-shows, and provider concerns regarding MCOs (i.e. varying coverage policies/procedures among MCOs and FFS, administrative requirements, and Medicaid clients transitioning between MCOs and FFS).

DMAS worked with the Virginia Department of Health (VDH), the Virginia Dental Association (VDA), the Old Dominion Dental Society (ODDS), the Dental Advisory Committee (DAC), and the dental community to design, develop, and implement a new dental program initiative that focuses primarily on increasing provider participation, access, and pediatric dental utilization. As part of Governor Warner's Healthy Virginians Initiatives, ***Smiles for Children*** was created.

In addition to the support received from the dental community, the health plans also shared the goal of improving pediatric dental care and access by consolidating FFS and managed care dental services into a single program. The MCOs supported and participated in the program's creation despite the fact that pediatric dental services were carved out of the health plan benefit and managed by a single vendor (Doral Dental USA, LLC).

Smiles For Children™
Improving Dental Care Across Virginia

Smiles for Children includes many changes and improvements for both providers and patients. The most significant changes include:

- A 30% overall increase in funding for dental fees;
- Allowed the dental community to participate in the design;
- Dental services for all children are coordinated by a single dental benefits administrator;
- A dedicated call center for providers and patients; and,
- Industry standard program administration including flexible billing methods, prompt payment, streamlined authorization requirements, and a simplified credentialing process.

The program was implemented on July 1, 2005. First quarter data indicates an increase in provider participation of 108 newly enrolled providers. Part of the program's implementation includes an outreach and education effort to begin in the first quarter of 2006. This effort is expected to increase enrollee utilization of dental services.

Dental Grant Participation:

DMAS was one of 15 states selected to participate in the Center for Health Care Strategies Purchasing Institute's 'Best Practices for Oral Health Access' grant program. The program took place September 28, 2005 in Philadelphia, Pennsylvania and was funded in part by The Robert Wood Johnson Foundation. The Institute convened teams from 13 states for the three-day interactive workshop filled with practical information and successful examples from the field. The institute provided DMAS and its community dental partners with tools to develop a strategic action plan and improved the quality of and access to oral health services for beneficiaries of Medicaid and FAMIS. As part of the grant, DMAS will focus on case management, increasing utilization for young pregnant women, and expanding community care.

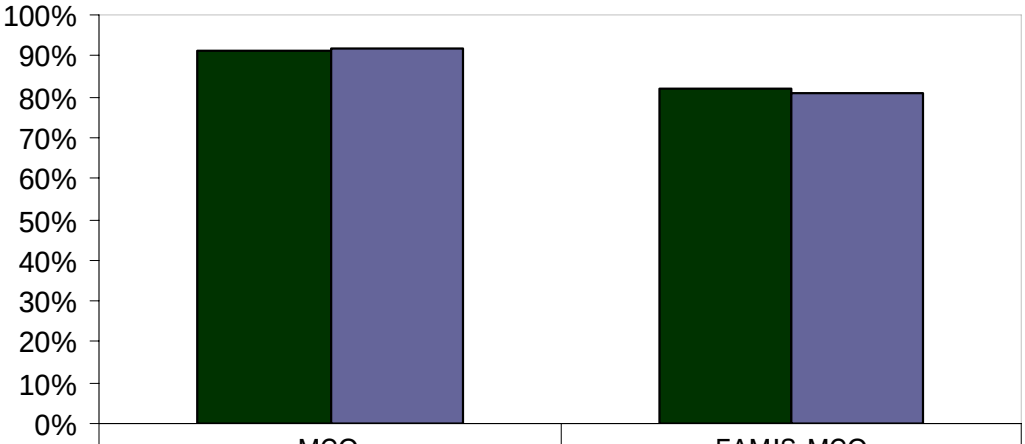
Tammy Driscoll, former Dental Manager, and Steve Riggs, DDS received Recognition Awards on September 18, 2005 for 'Dedicated Services and Efforts in the Development of the *Smiles for Children* Program' at the House of Delegates Business Session of the Virginia Dental Association's Annual Meeting.

Child Health Outcomes-Immunizations:

In conjunction with Governor Warner's focus on child health, DMAS evaluates immunization compliance as a key performance indicator. Delmarva Foundation for Medical Care, Inc. (DMAS' external quality review organization) reported the MCOs' immunization compliance for the 4:3:1 series for children at 24 months was 92%. Based on the Medicaid aggregate rate, Virginia Medicaid has exceeded its 4:3:1 immunization target of 85% for the second time. The rate for the FAMIS MCO population was 81%.

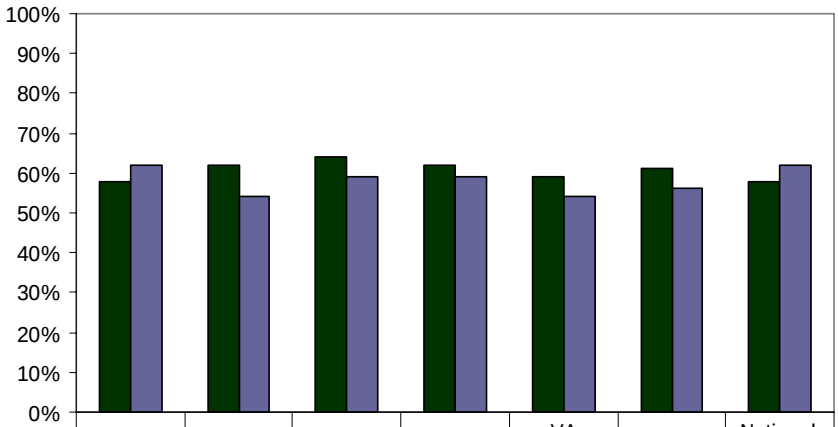
According to *plan-level* HEDIS audits, two MCOs (Optima and UniCare Health Plan of Virginia, Inc.) met the benchmark and one plan (Anthem) performs above the national average in immunizing two-year-olds for Combo One (DTaP, OPV/IPV, MMR, Hib, Hep B) in 2005.

Figure 7. MCO Level 4:3:1 (Diphtheria, tetanus, pertussis, polio and measles, mumps, rubella)*
(Source: Immunization Study at 24-Months – SFY 2004)



	MCO	FAMIS MCO
SFY2003	91%	82%
SFY2004	92%	81%

Figure 8. Plan–Level Combo One (DTaP, OPV/IPV, MMR, Hib, Hep B)
(Source: NCQA HEDIS Data Submission Tool 2005)



	Anthem	CareNet	Optima	UniCare	VA Premier	Average	National Medicaid
2004	58%	62%	64%	62%	59%	61%	58%
2005	62%	54%	59%	59%	54%	56%	62%

* National Medicaid data not available for the 4:3:1 measure.

Improving Prenatal Care:

Medicaid is the primary payer for obstetrical services and on average pays for about 30% or approximately 30,000 births each year in the Commonwealth. Last year, Governor Mark Warner signed the Executive Directive 2 (ED2) which created a Rural Obstetrical Services Work Group. This workgroup focused on three needs: reimbursement, access, and malpractice. The Governor and DMAS focused on prenatal care and along with the Virginia Department of Health (VDH) have created programs and enhancements in support of improving prenatal care in the Commonwealth.

For the complete Executive Directive 2 report, go to:
http://www.vdh.virginia.gov/COMMISH/OBFinal_Report.pdf

Access to Obstetrical Care:

Governor Warner authorized a significant and unprecedented emergency increase in reimbursement for obstetrical services effective September 1, 2004. Since September 2004, there has been a net increase of 62 Medicaid obstetrical providers. The obstetrical providers added to the network since 9/1/04 are distributed throughout the Commonwealth including Central Virginia, Hampton Roads, Northern Virginia, and Western/Southwestern Virginia.

FAMIS MOMS:

FAMIS MOMS is Virginia's new health insurance program providing prenatal and delivery services for uninsured pregnant women who do not qualify for the current Medicaid pregnant women services. This program is offered to women who fall between 133% Federal Poverty Limits (FPL) through 150% FPL. This program was implemented on August 1, 2005. DMAS anticipates that 400 women will enroll in the program by SFY2006. **As of December 1, 2005, 156 pregnant women are enrolled in FAMIS MOMS**.

FAMIS MOMS
Covering Pregnant Women With Affordable Health Insurance

For more information on the FAMIS MOMS program, go to:
http://www.famis.org/moms.cfm?lang=English

For more information of the FAMIS program, go to:
http://www.famis.org/

Obstetrical Care Outcomes-Prenatal Care Timeliness:

It is a priority for MCOs to monitor access to early prenatal care as most women, many from high-risk groups, have enrolled in Medicaid as a result of their pregnancy. The HEDIS definition for timeliness of prenatal care is as follows: the percentage of women enrolled in an MCO that received a prenatal care visit during the first trimester within 42 days of enrollment.

Four of the five plans had *plan-level* HEDIS rates above the National HEDIS Medicaid rate of 76 %, with average rate at 83%. In the *aggregate* Delmarva Foundation prenatal care clinical study, findings indicate a higher quality of prenatal care access for Virginia MCO enrollees (aggregate) than national Medicaid enrollees (77% -78% vs. 71%-76%).

Figure 9. Prenatal Care Initiated in the First Trimester
(Source: Prenatal Care Study – SFY 2004)

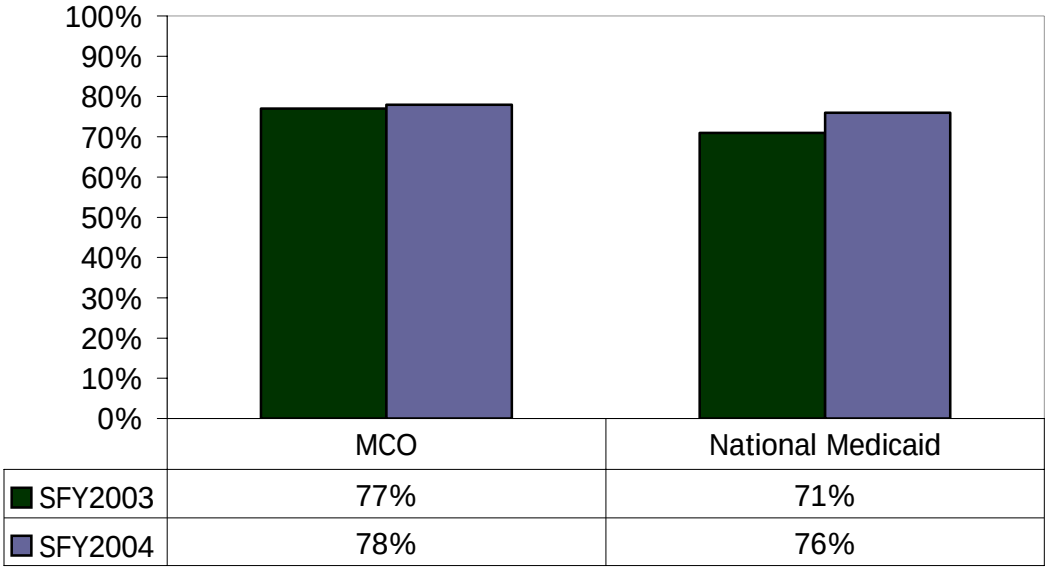
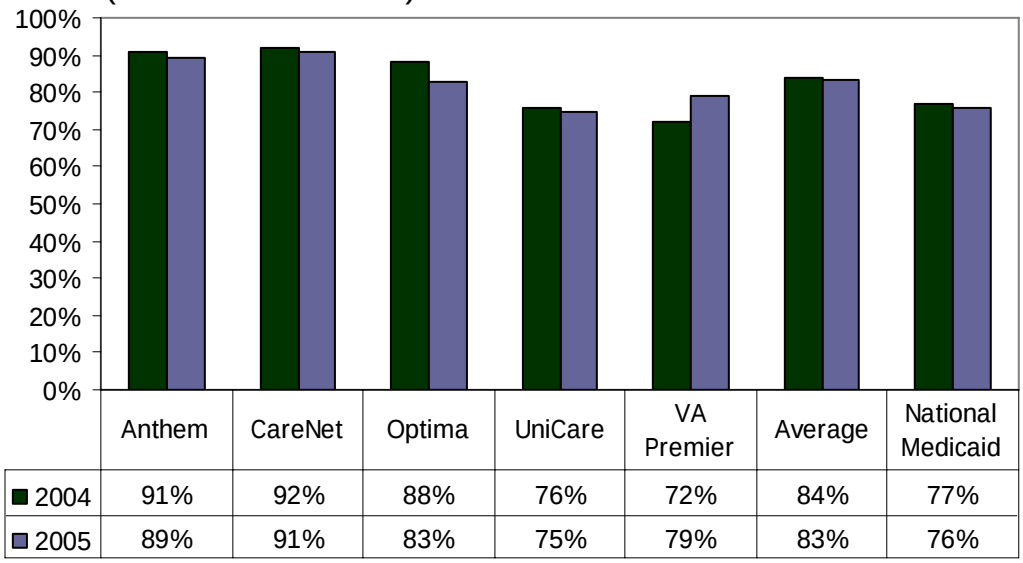


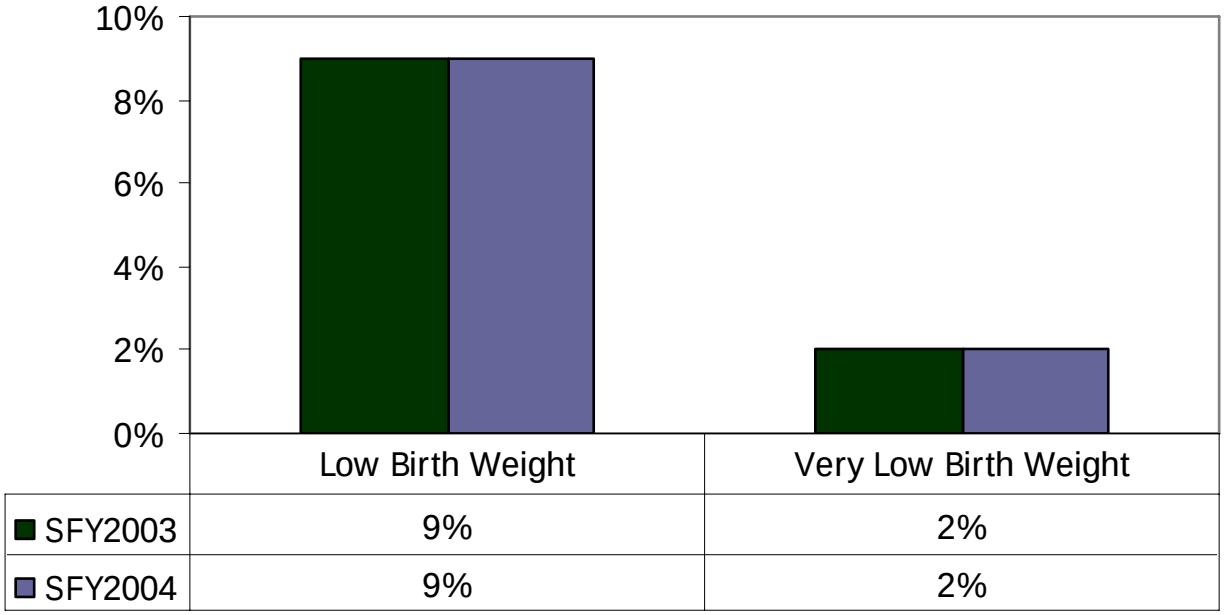
Figure 10. Prenatal Care Timeliness
(Source: HEDIS 2005)



Obstetrical Care Outcomes-Birth Weight:

Beginning prenatal care within the first trimester and obtaining the recommended numbers of prenatal care visits are essential to reducing the likelihood of maternal complications and premature deliveries. Complications and premature births can result in long-term health problems for the child and add an enormous expense to the health care system.

Figure 11. Low and Very Low Birth Rates*
(Source: Prenatal Care Study – SFY 2004)



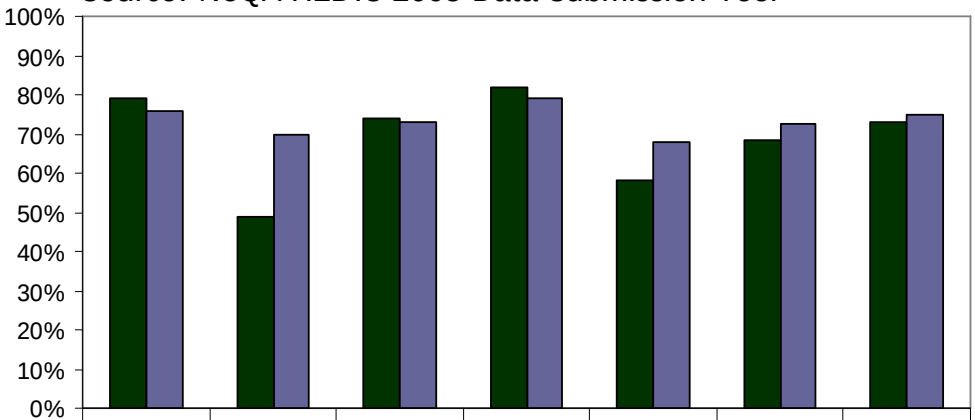
* National Medicaid data not available for the low and very low birth weight rate measures.
Low birth weight = 1,501 to 2,500 grams, Very low birth weight = 1,500 grams or less.

Chronic Care Management:

All MCOs have delivered high quality disease management programs to enrollees. Annually, DMAS and the MCOs select a number of HEDIS measures to evaluate their continued progress of reducing the burden of disease among enrollees. Two conditions selected for review in SFY 2004 were diabetes and asthma. Next year, the focus conditions will include: Diabetes, Asthma, Coronary Artery Disease (CAD), and Chronic Heart Failure (CHF).

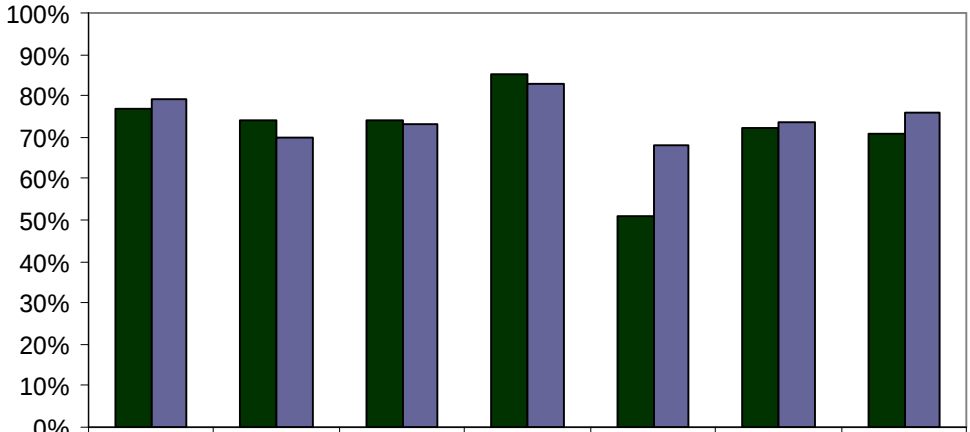
Diabetes: Diabetes management is an important measure within the Medicaid population. According to studies cited by the American Diabetes Association, a 50% - 70% reduction of diabetes complication can be realized with control interventions. In 2005, all MCOs submitted the required diabetes-related HEDIS measure outcomes and two MCOs executed performance improvement projects to monitor utilization patterns and control. Two MCOs outcomes indicate a successful improvement intervention; their rates exceeded the national benchmarks in both A1c testing and LDL-C screenings (79% vs. 75% and 83% vs. 76%, respectively).

Figure 12. Diabetes Measures: Rating of A1c Testing
Source: NCQA HEDIS 2005 Data Submission Tool



	Anthem	CareNet	Optima	UniCare	VA Premier	Average	National Medicaid
2004	79%	49%	74%	82%	58%	68%	73%
2005	76%	70%	73%	79%	68%	73%	75%

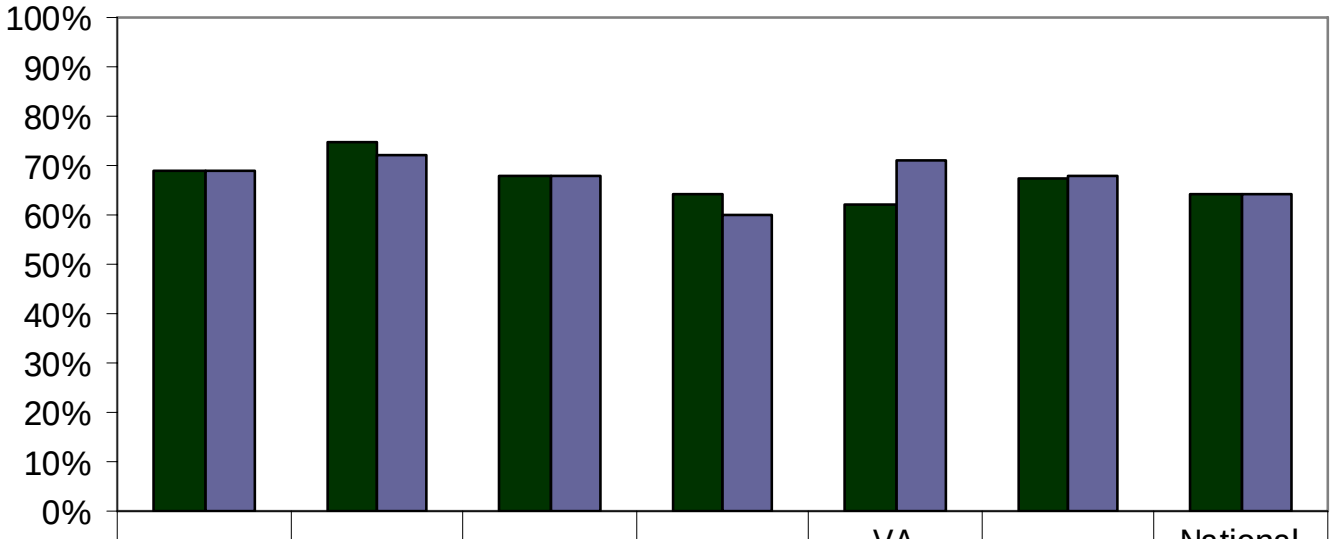
Figure 13. Diabetes Measures: Rating of LDL-C Level Screening
Source: NCQA HEDIS 2005 Data Submission Tool



	Anthem	CareNet	Optima	Unicare	VA Premier	Average	National Medicaid
2004	77%	74%	74%	85%	51%	72%	71%
2005	79%	70%	73%	83%	68%	74%	76%

Asthma: According to the Virginia Department of Health's 2003 Behavior Risk Factor Surveillance System, the prevalence of asthma in Virginia is highest among low income individuals than those with a higher socioeconomic status (12% vs. 6%). The HEDIS measure 'use of appropriate asthma medications' enables the health plans to evaluate their success in one area of asthma disease management. HEDIS rates for the use of appropriate medications for people with asthma were above the national average for all MCOs except one.

Figure 14. Use of Appropriate Asthma Medications
Source: NCQA HEDIS 2005 Data Submission Tool



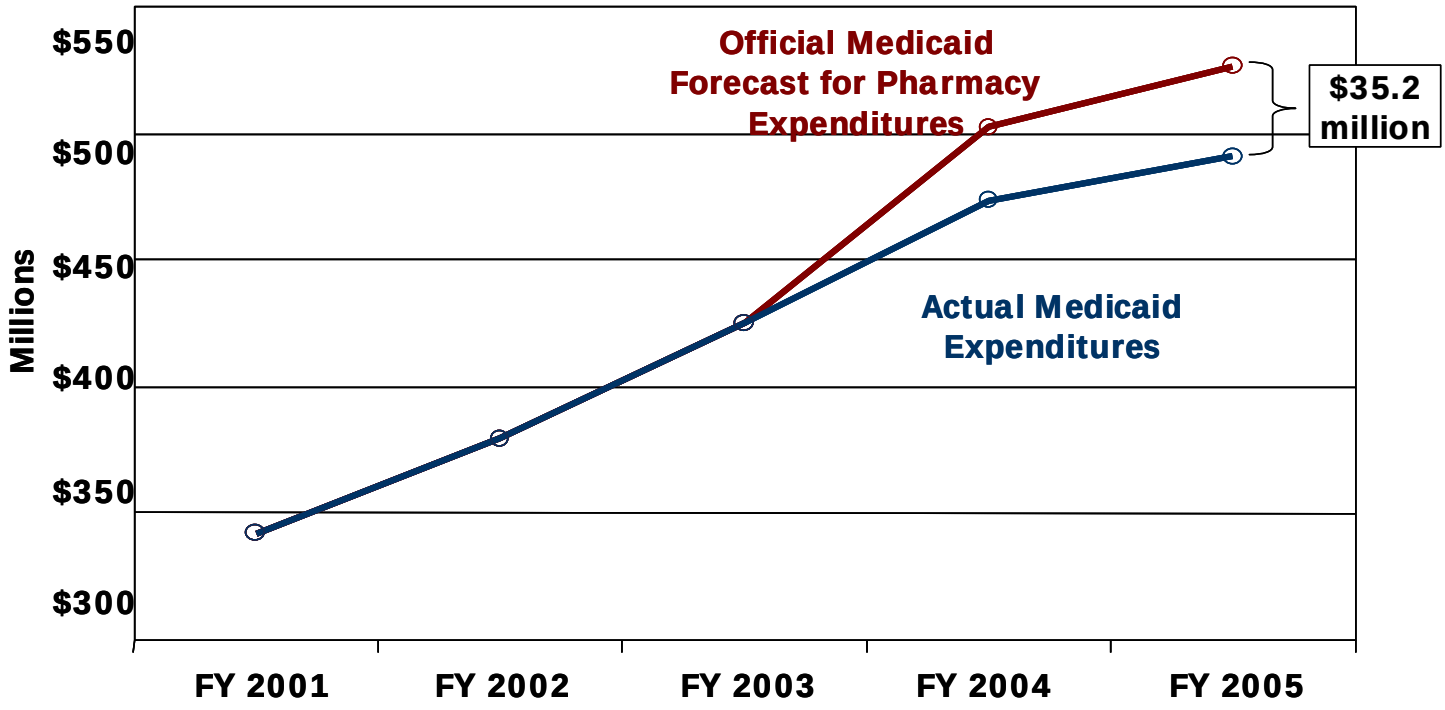
	Anthem	CareNet	Optima	UniCare	VA Premier	Average	National Medicaid
2004	69%	75%	68%	64%	62%	68%	64%
2005	69%	72%	68%	60%	71%	68%	64%

Replication of Managed Care Practices within Fee-For-Service:

DMAS values the MCOs willingness to share lessons learned and best practices gained. The commercial community often implements quality and cost savings programs that DMAS can use to improve the way it delivers health care to its enrollees. From the commercial sector, DMAS adopted best practices that contributed to improving the way it operates the Pharmacy program and created a Disease State Management program.

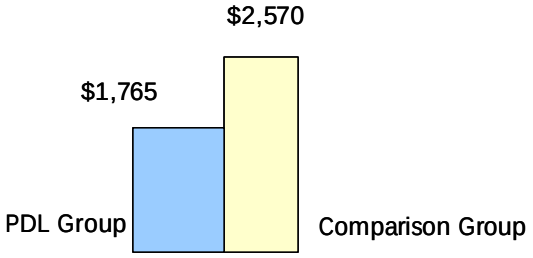
Pharmacy: DMAS anticipates a significant savings through the implementation of the Preferred Drug List (PDL) program, Maximum Allowable Costs (MAC) program, supplemental rebate programs, and enhanced fraud and abuse controls.

Figure 15: Estimated Savings in the Pharmacy Program since the Implementation of the PDL (October 2003 - May 2005)



The implementation of the PDL program has proven to decrease spending levels compared to recipients who use non-preferred drugs. Total Medicaid spending for the typical person on preferred drugs is actually less than the amount observed for persons on non-preferred drugs.

Figure 16: Annualized Medicaid Spending Levels per Recipient (October 2003 - May 2005)



An evaluation of Virginia's preferred drug list was conducted and shows the following:

- DMAS has successfully designed and implemented a PDL program that has produced a high compliance rate without denying recipients access to drugs.
- Nearly seven of ten prescriptions that were written for non-preferred drugs prior to the implementation of the PDL were switched to preferred drugs once the program started.
- When persons who were switched to drugs on the PDL are considered along with others whose initial prescriptions were written for drugs on the PDL, the overall program compliance rate is 93 percent. This exceeds the 85 percent rate needed by DMAS to meet the legislatively established savings target for the program.
- The vendor for the PDL program operates an efficient call center, handling more than 61,400 requests without denying any patients access to drugs.
- Since the PDL program was implemented in January 2004, the estimated savings in the overall Medicaid pharmacy program total more than $35 million.
- Though more research is needed, this study found no adverse health impacts for persons who were switched to drugs on the PDL compared to those who were allowed to remain on non-preferred drugs.

For the complete 'Evaluation of Virginia's Preferred Drug List' report go to:
http://www.dmas.virginia.gov/downloads/pharm-DL_Health_Impact_Briefing_8-31-05.ppt

MCO partnerships with DMAS are exemplified in the Pharmacy and Therapeutics (P&T) Committee and the Maximum Allowable Costs (MAC) Program. The Chair and Vice Chair of the P&T committee are affiliated with two Medicaid MCOs and the MAC program is administered by a Medicaid MCO.

Disease State Management (Fee-for-Service): Disease Management is viewed by DMAS as an effort to lessen the physical, psychological, social, and economic pressures associated with chronic disease. DMAS began a focus on DM for the fee-for-service population in 1993. DMAS internally launched a total of two programs that focused on DM and in 2002 solicited a Request for Proposal (RFP) but was unable to find a vendor that could design a program for the proposed cost or who could guarantee the required savings. As a result, DMAS withdrew the RFP. In the spring of 2004, Anthem offered to provide a pilot DM program at no cost to the Commonwealth. DMAS agreed to the pilot and Anthem's subsidiary - Health Management Corporation Inc. (HMC) - implemented this program. Key components of the program, entitled "Healthy Returns," included:

- Patient contact and assessment,
- Patient counseling, on-going assessment, and the development of a treatment plan,
- Inbound call service, and
- Patient mailings.

The preliminary results for the "Healthy Returns" program reported ten months of data which showed clinical improvements of the health outcomes of program participants, as well as a gross cost savings of $618,998 in health care expenditures. (However, the cost savings did not take into account the administrative expenses for operating the program). The success of the pilot program led DMAS to solicit another RFP for disease state management within the FFS population.

DMAS issued a Request for Proposal on May 25, 2005 and awarded the contract to Health Management Corporation, which will administer the "Healthy Returns" DM program to begin implementation on January 13, 2006. Key goals will include the delivery of preventative care, promotion of self-management and appropriate use of medical services in the fee-for-service system. The DM program will provide services to Medicaid/FAMIS fee-for-service recipients with the following conditions:

- Asthma,
- Diabetes,
- Congestive Heart Failure, and
- Coronary Artery Disease.

Disease State Management
DMAS

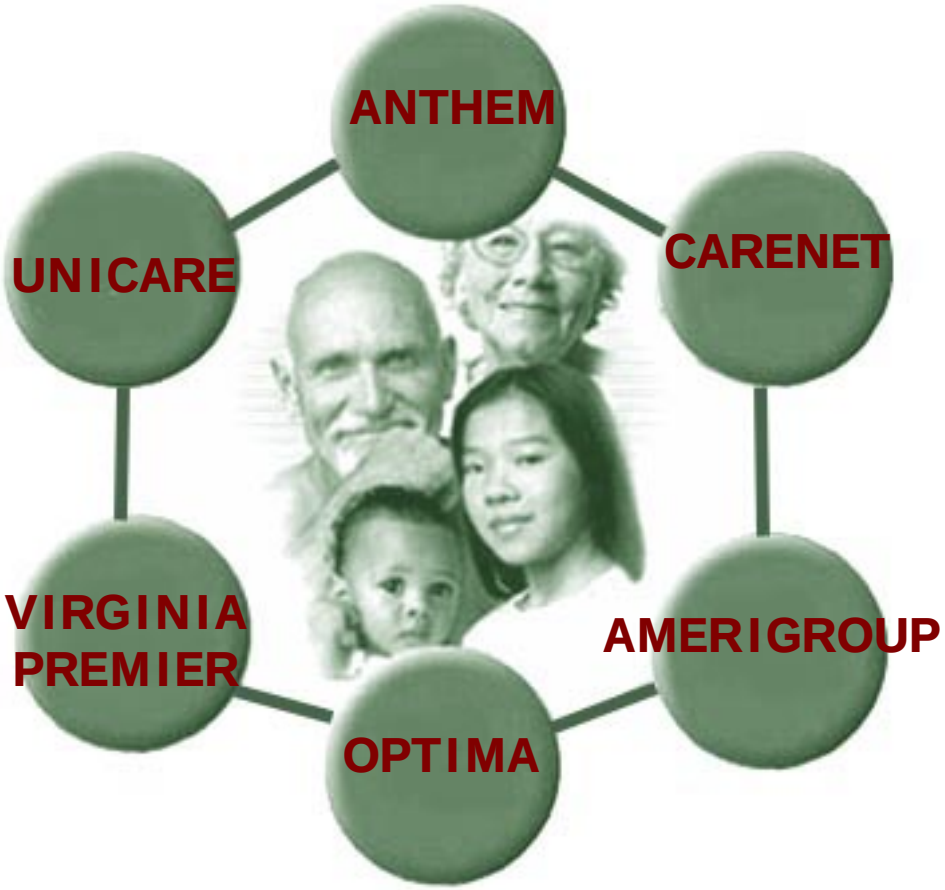
The program will begin as a voluntary program. DMAS is seeking a waiver in order to make the program an opt-out program, whereby those eligible are automatically enrolled and must opt out of participation. In addition, Virginia's DM program is unique to other DM programs by including those enrolled in the home and community based waiver.

In 2004, Virginia was asked by the Agency for Health Care Research and Quality (AHRQ) to participate in the Learning Network on care management which focuses on disease management evaluation.

Celebrating 10 Years of Conversions with Managed Care Organizations

The 1996 MCO pilot project has grown from 80,000 to 360,000 enrollees in the last ten years. The goal of the program was to provide Medicaid and FAMIS enrollees with an integrated, comprehensive healthcare delivery system. In 2005, this managed care mission, a collaborative effort of the Commonwealth of Virginia, DMAS staff and contracted MCOs, has not only achieved this goal but has contributed many other improvements to Virginia Medicaid. These improvements include providing managed enrollees with nationally ranked quality healthcare and sharing best practices to support the growth of non-managed Medicaid ventures such as pharmacy, dental, and FFS disease management programs.

DMAS' decision to convert more areas to managed care is based on a proven record of achievement displayed by cost savings, positive health outcomes, and national recognition. This report gives us the opportunity to thank our MCOs for a productive past as we look to a more successful future.



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