

## Medicaid Transformation Grant Application

The West Virginia Bureau for Medical Services is pleased to submit the West Virginia Medicaid Transformation Proposal which includes the following five concepts:

1. Healthier Medicaid Members through Personal Responsibility
2. Healthier Medicaid Members through Health System Improvement;
3. Healthier Medicaid Members through Applied Technology;
4. Healthier Medicaid Members through a Stronger Medicaid Program; and
5. Healthier Medicaid Members through Enhanced Medication Management.

If you should have any questions regarding any part of the proposal please contact:

Nancy V. Atkins, MSN, RNC, NP  
Commissioner  
West Virginia Bureau for Medical Services  
350 Capitol Street, Room 251  
Charleston, WV 25301  
Phone: (304) 558-1700  
Fax: (304) 558-1451  
E-mail: [nancyadkins@wvdhhr.org](mailto:nancyadkins@wvdhhr.org)

or

Cynthia Beane, MSW, LCSW  
Program Manager  
West Virginia Bureau for Medical Services  
350 Capitol Street, Room 251  
Charleston, WV 25301  
Phone: (304) 558-1700  
Fax: (304) 558-1509  
E-mail: [cynthiabeane@wvdhhr.org](mailto:cynthiabeane@wvdhhr.org)

## Abstract

### **West Virginia's Medicaid Transformation Initiative- Healthier Medicaid Members through Personal Responsibility**

The West Virginia Medicaid transformation initiative assures that each Medicaid member receives quality care, in a timely manner, in the right health care setting. The transformation initiative consists of the following five components:

- 1. Healthier Medicaid Members through Personal Responsibility**
2. Healthier Medicaid Members through Health System Improvement;
3. Healthier Medicaid Members through Applied Technology;
4. Healthier Medicaid Members through a Stronger Medicaid Program; and
5. Healthier Medicaid Members through Enhanced Medication Management.

West Virginia is one of the first in the nation to redesign its Medicaid program under the authority granted by the Deficit Reduction Act of 2005 to improve the health of enrolled members through enhanced access to preventive and disease management services, defined personal health management goals and responsibilities and rewards for healthy behavior. Political and state agency leaders are committed to creating an efficient system focused on prevention, disease management, and incentives to improve or maintain health. With this systems change wellness and prevention are sought as rigorously as treatment. West Virginia is well positioned to move to the next level of systems transformation and build on the state's initial steps towards redesign.

***Healthier Medicaid Members through Personal Responsibility*** will be achieved through member agreement, member education, healthy rewards, and personalized health care. The State Medicaid program has established an innovative approach to encourage Medicaid members to take a greater role in managing their health in collaboration with a team of community health providers to create a new model for health maintenance and chronic disease self-management.

The West Virginia Bureau for Medical Services is requesting \$1,937,110 from the Centers for Medicare & Medicaid Services (CMS) to support the *Healthier Medicaid Members through Personal Responsibility Initiative*. The redesign of the West Virginia Medicaid program is focused on creating a more effective and efficient program over the long-term. Each participating Medicaid member will have a Medical Home and a personal health plan based upon the individual's health conditions and readiness to make needed behavior modifications to attain or maintain good health. The Medicaid Health Transformation Initiative will modernize the Medicaid system by placing the responsibility, accountability and the opportunity for health improvement in the hands of its members.

## *State of West Virginia Medicaid Transformation Initiative*

### *Part 1 - Healthier Medicaid Members through Personal Responsibility*

**Statement of Project/Need** The State of West Virginia is one of the first in the nation to redesign its Medicaid program under the authority granted by the Deficit Reduction Act of 2005 (DRA 2005) to improve the health of enrolled members through enhanced access to preventive and disease management services, defined personal health management goals and responsibilities and rewards for healthy behavior. The State Medicaid program has established an innovative approach to encourage Medicaid members to take a greater role in managing their health in collaboration with a team of community health providers to create a new model for health maintenance and chronic disease self-management.

West Virginia has a population of approximately 1.8 million. Medicaid is a \$2.2 billion a year program with an enrollment of approximately 360,000 (20% of the State's population). The costs of the Medicaid program are growing faster than the State's economy and these escalating costs cannot be sustained with other competing budget needs.

CMS approved WV's State Plan Amendment on May 3, 2006. Unlike other states that sought waivers for the redesign of their respective Medicaid programs, West Virginia was uniquely poised to take advantage of the provisions in the DRA 2005. The West Virginia Medicaid program has been working with a group of health care providers, members, advocates and interested parties on Medicaid improvement initiatives since Governor Joe Manchin took office in 2005. The State's Medicaid Redesign program, designated as **Mountain Health Choices**, incorporates the recommendations of these program participants and emphasizes personal empowerment and responsibility. At the heart of **Mountain Health Choices** are:

- **Healthy lifestyle and a healthy start, emphasizing the Health in health care;**

- Electronic health records and networking providers;
- Accountability for personal choices and a change in attitudes;
- Responsibility – fiscal and personal – **R**espect and **R**ewards; and
- Teamwork – the member, the medical home and a team of providers and Medicaid working together.

The West Virginia Medicaid transformation initiative assures that each Medicaid member gets quality care, in a timely manner, in the right health care setting and consists of the following five components:

1. Healthier Medicaid Members through Personal Responsibility (as described in this document);
2. Healthier Medicaid Members through Health System Improvement;
3. Healthier Medicaid Members through Applied Technology;
4. Healthier Medicaid Members through a Stronger Medicaid Program; and
5. Healthier Medicaid Members through Enhanced Medication Management.

**Member agreements and expectations:** One of the cornerstones of the Medicaid Redesign project involves execution of a formal member agreement that **outlines member rights and responsibilities and sets achievable expectations for member behavior.** This was a key requirement added to balance personal responsibility with access to advanced health care support. The agreement will be signed in conjunction with the assignment of a member’s medical home with the assistance and guidance of a health care professional. Members will be expected to take their medications, keep their appointments or, more importantly, cancel them if they can’t keep them, use the emergency room only for emergencies, and to participate in health improvement programs. Thus, members will be better informed and have more choices.

The agreement also serves as an **educational tool**. By creating formal expectations as a mutual agreement of the program and participant, the Medicaid program is attempting to change attitudes and encourage a healthier lifestyle. The agreement also provides that an active, participatory approach to managing health on a daily basis (and that of participating family members) has rewards. Access to enhanced services requires an investment of time and effort on the part of the member and an active partnership with the member's health care team. These healthy rewards are an incentive for those who help themselves by following their personal health plan, keeping medical appointments and using health care services in a coordinated, appropriate fashion.

**The need for self-management and personal responsibility:** Most studies in West Virginia and in other states reflect that, of the two-thirds of the Medicaid participants that are not aged or disabled, the prevalence of disease (and associated costs) mirrors the rates for society as a whole. In West Virginia, studies have shown that, of the 60,000 adult (non-elderly or disabled) Medicaid members:

- ◆ 64% (38,400) are obese or overweight;
- ◆ 32.4% (almost 20,000) have high blood pressure (with another 28% (16,800) at-risk with pre-hypertension);
- ◆ 37.5% (22,500) have high cholesterol;
- ◆ 28.2% (nearly 17,000) are current smokers;
- ◆ Nearly 10 % are diabetic (6,000) and 40% (24,000) are pre-diabetic; and
- ◆ 85% (51,000) have one or more risk factors for chronic disease.

Similar studies have shown that living with a chronic condition can be managed and many of the complications of these diseases can be avoided through regular contact with health care providers, patient education and self-management, with regular physical activity:

- Improved blood sugar control leading to a 1% reduction in blood sugar levels reduces the risk of developing certain diabetic complications (eye, kidney, and nerve disease) by 40%. **Estimated hospitalization cost for complications of diabetes in West Virginia \$400 million. Medicaid cost: \$36 million.**

- Regular eye exams and timely treatment could prevent up to 90% of diabetes related blindness and regular foot examinations and patient education could prevent up to 85% of diabetes-related amputations. **Estimated hospitalization cost: \$16.6 million. Estimated Medicaid cost: \$2.0 million.**

- Pre-diabetic patients (with elevated risk factors) who walk an average of 30 minutes a day, 5 days a week and lower their intake of fat and calories can reduce their risk of diabetes by 58%. This means avoiding the suffering from diabetes and the associated **average lifetime medical cost of this disease estimated at \$250,000. The annual cost of care for a diabetic is 4 times that of an individual without diabetes.**

- Treatment to control blood pressure can reduce heart disease and stroke by 33 to 50% and diabetes-related kidney failure by 33%. **Estimated hospitalization cost for heart disease and cardiovascular complications: \$1.8 billion. Medicaid cost: \$250 million.**

- About 90% of middle-aged West Virginians will develop high blood pressure in their lifetime, and nearly 70% of those who have it now do not have it under control. Lowering blood pressure levels reduces risk of death from coronary heart disease, stroke, and total cardiovascular disease. **A recent study places the lifetime cost of each new case of cardiovascular disease at almost \$500,000.**

**Member education:** A key to the success of the Medicaid Redesign program will be member education. Education will take place in two different ways:

a) provider education of members, designed to promote healthy lifestyles and disease prevention; and,

b) a comprehensive educational program to ensure that members understand their new benefit packages, and personal financial responsibility under the program, including any financial rewards or disincentives built into the program to ensure proper utilization of the program benefits. Part of the requested grant funds will be used for the design and development of this member education program. The member education portion of this program complements the **Mountain Health Choices Health Improvement Institute** portion of the provider training program that is a component of the overall program and for which a separate proposal (Part 2) was submitted. Training will also be enhanced by the ongoing partnership with the Offices of Community Health Systems and Epidemiology and Health Promotions within the Department of Health and Human Resources. These education tools will not only need to be made available prior to a Medicaid member's enrollment, but on an ongoing basis, as members' eligibility for different benefit structures may change throughout the length of their Medicaid enrollment, given changes in their personal situations or health status.

**Healthy Rewards:** As part of the Personal Responsibility Agreement, the State will implement "Healthy Rewards" for Medicaid members to encourage compliance with individual responsibilities and the adoption of healthy lifestyles. Using co-pays as a deterrent in Medicaid is very difficult. Under the present Medicaid structure, co-payments are only used for pharmacy benefits. Co-payments are so small they do not influence behavior. In addition, a provider cannot refuse service to a member that cannot pay or refuses to pay the co-payment.

The concept of healthy rewards for individual members is consistent with the “pay for performance” incentive for health care providers that is being incorporated into the realignment of the delivery system that is covered in the accompanying proposal. This consumer-driven health care is also consistent with the Institute of Medicine’s recommendations for reform of the health care delivery system.

Participating Medicaid members will receive a Healthy Reward account that will be used to track utilization of appropriate health care services. Members who keep appointments and participate in preventive and appropriate utilization of care services under the member responsibility requirements will qualify for healthy rewards. Members who fill a brand drug when a generic is available (and not medically contra-indicated) or utilize emergency room services inappropriately may have amounts deducted from their Healthy Rewards accounts. This account will be tracked using the technology discussed in the accompanying technology proposal. Amounts accumulated in these Healthy Rewards accounts can be utilized for additional health care services, such as wellness program participation or dental or vision screening services. As a result Medicaid beneficiaries will become cost-conscious consumers with expanded choices of plans and treatment.

**Targeted populations and health conditions:** The targeted group for implementation of the Medicaid health improvement and personal responsibility initiative includes Medicaid-covered TANF children and covered adults with children. According to the most recent enrollment figures, there are approximately 60,000 adults and 191,000 children covered by Medicaid, representing approximately 70% of covered Medicaid members and approximately 14% of the total population of the State.

**Meeting personal responsibility with personalized health care:** This project builds upon many of the recommendations of national groups such as the American Academy of

Physicians and the American College of Physicians for a new model of more effective, patient-centered health care. The personal responsibility and accountability aspects of the program must be complemented by a patient-centered approach to health care delivery. The accompanying proposal for realignment of the health care delivery system is an integral part of helping Medicaid members meet the personal responsibility expectations. Some of the innovative aspects of this project include:

- Each participating Medicaid member will receive appropriate screening, medical education and an appropriate action plan to address chronic conditions and health risk factors.
- The member's health care team works with the member to assure that comprehensive care, age appropriate prevention, acute care, chronic illness care and health management coordination are incorporated into a personal health plan based upon the individual health status of the member, the readiness to make lifestyle changes and the educational and social background of the individual member.
- Each member will have a personal health improvement and management plan that is based upon evidence-based, best practices in self-management and assessments of the member's readiness for behavioral change.
- An electronic information system will be utilized that provides access to important health information for the member and web-enabled interoperable technology will assure portability of information. Participating providers will be able to report on designated outcome measures and clinical indicators electronically from coordinated electronic health information systems and have access to the central data warehouse to coordinate the care of a member who seeks care from multiple health care sources.

- Each member will have 24/7 access to medical advice and health coaching to ensure achievement of self-management health objectives and proper utilization of medical services.
- Health information systems will support remote monitoring of high-risk patients and other advanced technology applications to offer a continuum of care to avoid complications and hospitalizations of chronically-ill members.
- Members with multiple chronic conditions or a history of poor life-style choice or non-adherence will receive intensive health management services to encourage active participation in their own care, also involving family members as appropriate and agreed by the member.

***Project Justification:*** The redesign of the West Virginia Medicaid program is focused on creating a more effective and efficient program over the long-term and not for the purpose of immediate cost containment. With this systems change wellness and prevention are sought as rigorously as treatment. Although the leaders of this program believe it can slow the growth of the program, the focus of the program is to achieve these objectives through appropriate use of the health care delivery system by members, through realignment of the delivery system itself by implementation of the Chronic Care Model and electronic health information technology and by partnering with the members to improve their long-term health. The Mountain Health Choices program meets a number of the Medicaid Transformation objectives:

- **It streamlines administration** by consolidating 29 eligibility groups into 4;
- **It tailors the benefits to the needs of each population** – traditional Medicaid provides all services to all members, a one size fits all approach. Under the new program, each group will have its own set of benefits.

- **Care is coordinated, especially for members with chronic conditions.** A care manager will make sure members receive the screenings and treatment for long-term health rather than just treating acute or emergency conditions.
- **Members are afforded the opportunity and incentives to maintain and improve their health.** If members partner with their medical home to maintain and improve their health, they will be rewarded. In the demonstration phase of our project, one primary care center has offered visits to the fitness center as a healthy reward and the response has been very positive. This program emphasizes the HEALTH in healthcare.
- **It focuses on prevention.** In the first phase of the program, the clinical focus is on healthy adults and children. As noted above West Virginia has extremely high rates of obesity, diabetes and heart disease. One of the objectives of the program is to prevent these problems from developing in this population and/or delay the onset of the complications that arise from them.
- **Personal responsibility is built into the care system.** Medicaid members will be expected to keep appointments, follow the plan of care, make sure their children receive regular care and be responsible for their choices.
- **Care management is an integral part of the plan.** Health care will be managed in the medical home and with electronic health records and personal care managers; each member will have personal and coordinated care.
- **Care is delivered and coordinated by a medical home and/or in an Advanced Medical Home, if available.** Every Medicaid member will be assigned a medical home and may have access to an Advanced Medical Home. The Medical Home will utilize a team approach to providing health care and care management. Whether involving a primary care provider, specialist, mental health specialist, or sub-specialist, the Medical

Home will facilitate the development of a plan of care, the determination of the outcomes desired, facilitation and navigation of the health care system, and provision of follow-up and support for achieving the identified outcomes. In addition, an Advanced Medical Home will also maintain a centralized comprehensive record of all health-related services needed to provide continuity of care.

***Project Goals and Outcomes*** The Medicaid Health Improvement project will transform the Medicaid system by placing the responsibility, accountability and the opportunity for health improvement in the hands of its members. Each participating Medicaid member will have a Medical Home and a personal health plan based upon the individual's health conditions and readiness to make needed behavior modifications to attain or maintain good health. Integrated and electronically-connected health care teams will use integrated clinical reminders, patient education and risk stratification tools to help Medicaid members meet personal responsibility guidelines and health self-management goals.

As the system evolves, regional primary care Advanced Medical Homes will be connected to the Medicaid agency's data warehouse so that complete health information can be exchanged to permit both the regional systems and the Medicaid agency to engage in population-based health management and predictive modeling to evaluate the clinical and cost effectiveness of these programs and to identify the need for additional training of health care providers or Medicaid members to achieve the program objectives.

The project will utilize nationally-accepted clinical outcome measures for the targeted disease states, such as those established by the American Medical Association, to determine clinical effectiveness of the program. An anticipated outcome is significant improvement in the clinical indicators of the targeted Medicaid population, an increase in the number of Medicaid members achieving control of chronic conditions, a reduction in the number of

hospitalizations for the targeted population for avoidable complications of the chronic conditions and a corresponding reduction in the cost of institutional or emergency care for these conditions and containment in medication costs due to effective management of the underlying conditions. As a condition for certification as an Advanced Medical Home, participating providers must demonstrate that an electronic health information system utilized meets all HIPAA and interoperability standards and can electronically report to Medicaid clinical outcome data.

***Estimate of Impact to Beneficiaries*** The project implementation schedule contemplates that up to 10% of the targeted Medicaid members will be enrolled in the demonstration project within the first 18 months of the project and another 15% of the targeted Medicaid members will be enrolled within the first 24 to 36 months of the program. While the targeted Medicaid population will be enrolled in the project on a phased-basis, the number assigned to Advanced Medical Homes will be contingent upon the development of this network of qualified providers and the rate at which these providers can be certified. It is the intent of the program to phase this health improvement initiative to all Medicaid members over a four year period.

***Description of Magnitude of the Transformation/System Change*** The magnitude of the project involves the training of 251,000 participating Medicaid members on healthy lifestyles, health status and risk, disease self-management and proper use of available health resources. The project will transform the current Medicaid system from a fragmented, disjointed system to a member-managed, integrated, pro-active system that provides Medicaid members (and other patients) with the information and tools needed to more effectively self-manage chronic conditions and avoid the costly complications that consume disproportionate health care resources. It is anticipated that the multi-faceted

approach to health system reform with member responsibility can be replicated in other states and many of the tools developed with these transformation grants can be shared as part of an on-line learning community under the Mountain Health Choices Health Improvement Institute.

***Description of Sustainability of the Project*** The State intends to re-invest any cost savings into expansion and maintenance of the program after the grant funds have been exhausted. The grant funds are being used for infrastructure development and program planning and implementation and once the member training programs have been developed, they can be sustained on an ongoing basis through coordination with regular Medicaid program administration. The managed care organizations will also sustain these efforts as part of the plan for coordination of care with the provider community.

***Evaluation Plan*** The State intends to evaluate the effectiveness of the program using internal Medicaid agency resources and the data warehouse to be developed as part of this project. Specific outcomes at every level of the service delivery system will be evaluated for continuous improvement. The clinical outcomes will also be independently evaluated using a number of existing resources, including contractual relationships the State has with quality improvement organizations and academic health research and policy organizations. The Medicaid agency intends to utilize its managed care organizations under contract to survey Medicaid members to assess the impact the personal responsibility provisions have on member satisfaction, access to and utilization of health care and attitudes toward prevention and healthier lifestyles. The state intends to select measures from CMS' *The Guide to Performance Measures: A Compendium* that will support established quality goals of the overall Medicaid agency's Quality Assurance plan.

**Description of Project Implementation Readiness** Under the project plan, Medicaid participants will begin the process of enrollment in the new program starting November 1, 2006. The program design calls for the assignment of a medical home within 30 to 45 days of enrollment and a health care assessment by the medical home within 90 days of enrollment for determination of the needs of the member for health counseling, education or the disease management programs of the managed care organization and/or an Advanced Medical Home. It is during these interactions that a Personal Health Management Plan will be developed.

**Healthier Medicaid Members through Personal Responsibility - Timeline**

<b>Action Step</b>	<b>Time Line</b>
WV Health Information Network	July 2005
WV e-Health Initiative	July 2005
Data Warehouse Development	March 2006
Electronic Health Rec. Implemented by Pilot Clinics	April 2006
State Plan Amendment Approval of the Medicaid Redesign	May 2006
Presentation of Medicaid Redesign to multiple stakeholders for potential collaboration and outreach	May 2006- on-going
Members establish a medical home	July 2006- on-going
Outreach Brochure finalized and distributed	July 2006
Education and outreach to providers	July 2006 – on-going
CHCS Pay for performance Institute participation	October 2006
MMIS eligibility process	October 2006
Internal restructure of BMS to shift focus to quality and health assurance	October 2006
Education and outreach to members with member agreements, and rights and responsibilities	November 2006-on-going
Enrollment broker begins accepting member agreements	November 2006- on-going
Pay for Performance Development	November 2006
Health Improvement Institute	November 2006
Healthy Rewards Development	December 2006
Automated Pharmacy Prior Authorization(PA) System Algorithm Development	December 2006
Benefit Changes Effective in Pilot counties	January 2007
Enhance Data Warehouse Foundation for interoperability	January 2007
MITA Expansion Planning	January 2007

<b>Action Step</b>	<b>Time Line</b>
Advanced Medical Home Certification	March 2007
Automated Pharmacy PA Implementation	April 2007
Web Portal for Pharmacy Claims Implementation	June 2007
Quality outcome and measurements established- Data analysis and remediation	June 2007
Provider Technology Incentives	July 2007
MITA Expansion Implementation	October 2007 – on-going
Healthy Rewards Implementation	January 2008
Pay-for-Performance Implementation	January 2008
Development of treatment guidelines for chronic disease care management coordination	March 2008
Training and credentialing of pharmacists for use of treatment guidelines	June 2008
Implementation of Point of Sale clinical rules engine to identify gaps in therapy in management and prevention of chronic disease.	November 2008

**Budget:**

BUREAU FOR MEDICAL SERVICES TRANSFORMATION GRANT BUDGET PROPOSAL Healthier Medicaid Members through Personal Responsibility		
<b>DESCRIPTION</b>	<b>YEAR 1</b>	<b>YEAR 2</b>
2.0 Full-Time Equivalents	84,000.00	85,680.00
Fringe Benefits	24,660.00	24,970.00
Total Personnel & Fringe Benefits	108,660.00	110,650.00
Contractual Services - Member Education	600,000.00	700,000.00
Contractual Services - Healthy Rewards	200,000.00	200,000.00
Supplies	1,200.00	1,200.00
Equipment	0.00	0.00
Other Expenses		
Travel	4,500.00	4,500.00
IT Support	3,200.00	3,200.00
<b>TOTALS</b>	<b>917,560.00</b>	<b>1,019,550.00</b>

## **Budget Description**

**Personnel:** Program Manager and support staff will be assigned to the project for a two (2) year period.

**Fringe Benefits:** 18.5% for variable cost; fixed \$359 for monthly health insurance; \$250 annual Civil Service charge.

**Member Education:** Development and implementation of member education through outreach workers, printed materials, educational forums and audio visual materials.

**Healthy Rewards:** Healthy Rewards program development, research and analysis of data to individualize member rewards.

**Supplies:** General office supplies for Medicaid personnel working with the project.

**Travel:** Conference/meetings both in-state and out-of-state for Medicaid personnel working with the project.

**IT Support:** Desktop and network support for each employees workstation for Medicaid personnel working with the project.

## Abstract

### **West Virginia's Medicaid Transformation Initiative- Healthier Medicaid Members through Health Systems Improvement**

The West Virginia Medicaid transformation initiative assures that each Medicaid member receives quality care, in a timely manner, in the right health care setting. The transformation initiative consists of the following five components:

1. Healthier Medicaid Members through Personal Responsibility
- 2. Healthier Medicaid Members through Health Systems Improvement;**
3. Healthier Medicaid Members through Applied Technology;
4. Healthier Medicaid Members through a Stronger Medicaid Program; and
5. Healthier Medicaid Members through Enhanced Medication Management.

West Virginia is one of the first in the nation to redesign its Medicaid program under the authority granted by the Deficit Reduction Act of 2005 to improve the health of enrolled members through enhanced access to preventive and disease management services, defined personal health management goals and responsibilities, and rewards for healthy behavior. Political and state agency leaders are committed to creating an efficient system focused on prevention, care management, and incentives to maintain or improve health. With this systems change wellness and prevention are sought as rigorously as treatment. West Virginia is well positioned to move to the next level of systems transformation and build on the state's initial steps towards redesign.

***Healthier Medicaid Members through Health System Improvement*** will transform the primary care delivery system into a network of connected Advanced Medical Homes. The Advanced Medical Homes will apply the Chronic Care Model to provide pro-active patient-centered preventive and chronic disease care. Advanced Medical Homes will utilize an interactive electronic health management system with integrated clinical reminders, patient education and risk stratification tools to help Medicaid members meet personal responsibility guidelines and health self-management goals. Ultimately, the regional Advanced Medical Homes will be connected to the Medicaid data warehouse which will enable the system to engage in population-based health management and predictive modeling. The system will be able to evaluate the clinical and cost effectiveness of programs and will identify the need for additional training of health care providers or Medicaid members to achieve program objectives.

The West Virginia Bureau for Medical Services is requesting \$3,895,730 from the Centers for Medicare & Medicaid Services (CMS) to support *Healthier Medicaid Members through Health System Improvement*. This improvement will transform the current health delivery system from an acute-focused, fragmented, reactive system to a patient-centered, integrated, pro-active system that provides Medicaid members with the information and tools needed to more effectively self-manage chronic care conditions and avoid costly complications that consume disproportionate health care resources.

## *State of West Virginia - Medicaid Transformation Initiative*

### *Part 2 - Healthier Medicaid Members through Health System Improvement*

**Statement of Project/Need** The State of West Virginia is one of the first in the nation to redesign its Medicaid program under the authority granted by the Deficit Reduction Act of 2005 (DRA 2005) to improve the health of enrolled members through enhanced access to preventive and disease management services, defined personal health management goals and responsibilities and rewards for healthy behavior. The State Medicaid program has established an innovative collaboration with leading community health care providers to create a new model for health service delivery and coordination.

West Virginia has a population of approximately 1.8 million. Medicaid is a \$2.2 billion a year program with an enrollment of approximately 360,000 (20% of the State's population). The costs of the Medicaid program are growing faster than the State's economy and these escalating costs cannot be sustained with other competing budget needs.

CMS approved WV's State Plan Amendment on May 3, 2006. Unlike other states that sought waivers for the redesign of their respective Medicaid programs, West Virginia was uniquely poised to take advantage of the provisions in the DRA 2005. The West Virginia Medicaid program has been working with a group of health care providers, members, advocates and interested parties on Medicaid improvement initiatives since Governor Joe Manchin took office in 2005. The State's Medicaid Redesign program, designated as **Mountain Health Choices**, incorporates the recommendations of these program participants and emphasizes personal empowerment and responsibility. At the heart of **Mountain Health Choices** are:

- **Healthy lifestyle and a healthy start, emphasizing the Health in health care;**
- **Electronic health records and networking providers;**

- **A**ccountability for personal choices and a change in attitudes;
- **R**esponsibility – fiscal and personal – **R**espect and **R**ewards; and
- **T**eamwork – the member, the medical home and a team of providers and Medicaid working together.

The West Virginia Medicaid transformation initiative assures that each Medicaid member gets quality care, in a timely manner, in the right health care setting and consists of the following five components:

1. Healthier Medicaid Members through Personal Responsibility;
2. Healthier Medicaid Members through Health System Improvement (as described in this document);
3. Healthier Medicaid Members through Applied Technology;
4. Healthier Medicaid Members through a Stronger Medicaid Program; and
5. Healthier Medicaid Members through Enhanced Medication Management.

The objective of Medicaid Redesign and Mountain Health Choices is to improve the future of West Virginia by investing in the health of its citizens and empowering them to make healthy choices.

**The at-risk segment of the Medicaid population:** Most studies in West Virginia and in other states reflect that, of the two-thirds of the Medicaid participants that are not aged or disabled, the prevalence of disease (and associated costs) mirrors the rates for society as a whole. In West Virginia, studies have shown that, of the adult population:

- ◆ 64% are obese or overweight;
- ◆ 32.4% have high blood pressure (with another 28% at-risk with pre- hypertension);
- ◆ 37.5% have high cholesterol;
- ◆ 28.2% are current smokers;

- ◆ 8.8% have diabetes (and another 3% are undiagnosed diabetics);
- ◆ 40% are pre-diabetic; and
- ◆ 85% have one or more risk factors for chronic disease.

**The costs of chronic conditions:** Nationally, these chronic diseases account for roughly 78 percent of health care costs annually. More than 800,000 (over 40%) West Virginians have one or more chronic conditions. These conditions account for:

- 70 % of hospital admissions and 80% of all days spent in a hospital;
- 72% of physician visits and 88% of prescriptions filled;
- nearly 60% of emergency room visits; and
- 70 cents of every dollar spent for health insurance by employers and workers.

(Source: Robert Wood Johnson, *Partnership for Prevention, Health Affairs*)

According to the Robert Wood Johnson study, 83% of Medicaid spending is for the almost 40% of non-institutionalized beneficiaries that have chronic conditions. Similar studies in West Virginia have shown there is a strong correlation among chronic disease, utilization of health care and risks of complications:

- One in every five dollars billed for hospital care in West Virginia is related to diabetes. Eight of every ten hospital discharges are related to cardiovascular disease.
- Medicaid and the State's employee insurance program (Public Employee Insurance Agency or PEIA) had over \$200 million in obesity-related expenditures in 2001. There is a strong correlation (67%) between an unhealthy weight and diabetes, high blood pressure, hypertension, heart disease, asthma and/or cancer).
- Alarmingly, nearly 85,000 of West Virginia students are overweight or at risk of being overweight. Overweight adolescents have a 70% chance of becoming overweight or obese adults. Obese individuals spend 36% more on health services

and 77% more on medications than individuals that maintain a healthy weight. According to a recent study, obesity is responsible for 61% of type 2 diabetes in this country. Obese individuals have a 27 times higher risk of developing diabetes than individuals that maintain a healthy weight. (Source: WV Bureau for Public Health)

**Targeted populations and health conditions:** The first group selected for implementation of the project is Medicaid-covered TANF children and adults with children. The project will be phased-in over a four year period for this group. During this implementation phase, those not enrolled in **Mountain Health Choices** will continue to receive traditional Medicaid services. According to the most recent enrollment figures, there are approximately 60,000 adults and 191,000 children covered by Medicaid, representing approximately 70% of covered Medicaid members and approximately 14% of the total population of the State.

According to national studies, it is projected that 55% of the adult Medicaid population will have no current chronic conditions, but that nearly half of this group will have some elevated risk (pre-diabetes, pre-hypertension, overweight, family history, etc.) for developing a chronic condition. It is projected that 24% will have one chronic condition, while 21% will have two or more chronic conditions (see Robert Wood Johnson study). These studies also indicate that nearly 85% of the adult Medicaid patients in the target group have or are at-risk for one or more chronic conditions. Accordingly, the focus areas for health improvement for adults will be on lifestyle modification (weight management, exercise, tobacco cessation, stress management) and chronic conditions (diabetes, cardiovascular disease, depression, asthma).

As for the targeted Medicaid children members, the most common chronic condition is respiratory illness and according to WV DHHR statistics, the prevalence of

asthma for Medicaid beneficiaries is 11.8%. Each asthmatic averages 9.3 prescription claims at a cost of \$457 annually. The average total cost for each Medicaid patient with asthma is nearly \$700 annually. Nearly four percent of this population will be hospitalized at some time during the year for asthma complications. The focus areas of the Medicaid health improvement initiative for children will be on asthma, weight management, diabetes, and immunizations.

**Innovative aspects of this project:** This project builds upon many of the recommendations of national groups such as the American Academy of Physicians and the American College of Physicians for a new model of more effective, patient-centered health care. Some of the innovative aspects of this project include:

- Each participating Medicaid member will receive appropriate screening, medical education and an appropriate action plan to address chronic conditions and health risk factors.
- Care is planned: the care team works with the member to assure comprehensive care, age appropriate prevention, acute care, chronic care and health management coordination at the point of service.
- Each member will have a personal health improvement and management plan that is based upon evidence-based, best practices in self-management and assessments of the member's readiness for behavioral change.
- An electronic information system will be utilized that provides access to important health information for the care team when it is critically needed and web-enabled interoperable technology will assure portability of information. Participating providers will be able to report on designated outcome measures and clinical indicators electronically from a central electronic health information system.

- Each member will have 24/7 access to medical advice and health coaching to ensure achievement of self-management health objectives and proper utilization of medical services.
- Health information systems will support remote monitoring of high-risk patients and other advanced technology applications to offer a continuum of care to avoid complications and hospitalizations of chronically-ill members.
- Complex patients with issues such as behavioral health issues, multiple chronic conditions or a history of poor life-style choice or non-adherence will receive intensive health management services to encourage active participation in their own care, also involving family members as appropriate and agreed by the member.

**Improving the health care delivery system:** To meet the health improvement objectives of the Medicaid Redesign program and foster healthier Medicaid members, it is essential to create a more effective network of health care providers utilizing the care concepts outlined above. As part of this member health improvement initiative, training will be provided through this unique public-private partnership among the Medicaid agency, the Offices of Community Health Systems and Epidemiology and Health Promotion within the Department of Health and Human Resources, the Healthy Lifestyles Coalition and provider organizations such as the Community Health Network of West Virginia, the West Virginia State Medical Association Foundation, the West Virginia Academy of Family Physicians and the West Virginia Chapter of the American Academy of Pediatrics.

These organizations have created the **Mountain Health Choices Health Improvement Institute** to prepare community health care providers to qualify as “Advanced Medical Homes” for Medicaid members and to participate in performance-based health outcome incentives under the “Pay for Performance” demonstration concepts. The

qualified providers will be certified as Advanced Medical Homes by the Office of Community Health Systems for the Medicaid program. In addition, the Medicaid program recently received grant funding to participate in the national P4P Institute to coordinate lessons learned in other programs that may be integrated into the Medicaid transformation initiative to reward health care providers who are meeting the disease management and health outcome objectives of **Mountain Health Choices**.

***Project Justification*** The redesign of the West Virginia Medicaid program is focused on creating a more effective and efficient program over the long-term and not for the purpose of immediate cost containment. Although the leaders of this program believe it can slow the growth of the program, the focus of the program is to achieve these objectives through appropriate use of the health care delivery system by members, through realignment of the delivery system itself by implementation of the Chronic Care Model and electronic health information technology and by partnering with the members to improve their long-term health. In this system wellness and prevention are sought as rigorously as treatment. The Mountain Health Choices program meets a number of the West Virginia Medicaid Transformation objectives:

- **It streamlines administration** by consolidating 29 eligibility groups into 4;
- **It tailors the benefits to the needs of each population** – traditional Medicaid provides all services to all members, a one size fits all approach. Under the new program, each group will have its own set of benefits.
- **Care is coordinated, especially for members with chronic conditions.** A care manager will make sure members receive the screenings and treatment for long-term health rather than just treating acute or emergency conditions.

- **Members are afforded the opportunity and incentives to maintain and improve their health.** If members partner with their medical home to maintain and improve their health, they will be rewarded. In the demonstration phase of our project, one primary care center has offered visits to the fitness center as a healthy reward and the response has been very positive. This program emphasizes the HEALTH in healthcare.
- **It focuses on prevention.** In the first phase of the program, the clinical focus is on healthy adults and children. As noted above West Virginia has extremely high rates of obesity, diabetes and heart disease. One of the objectives of the program is to prevent these problems from developing in this population and/or delay the onset of the complications that arise from them.
- **Personal responsibility is built into the care system.** Medicaid members will be expected to keep appointments, follow the plan of care, make sure their children receive regular care and be responsible for their choices.
- **Care management is an integral part of the plan.** Health care will be managed in the medical home and with electronic health records and personal care managers; each member will have personal and coordinated care.
- **Care is delivered and coordinated by a medical home and/or an Advanced Medical Home, if available.** Every Medicaid member will be assigned a medical home and may have access to an Advanced Medical Home. The Medical Home will utilize a team approach to providing health care and care management. Whether involving a primary care provider, specialist, mental health specialist, or sub-specialist, the Medical Home will facilitate the development of a plan of care, the determination of the outcomes desired, facilitation and navigation of the health care system, and provision of follow-up and support for achieving the identified outcomes. In addition, an Advanced

Medical Home will also maintain a centralized comprehensive record of all health-related services needed to provide continuity of care.

***Project Goals and Outcomes*** The Medicaid Health Improvement project will transform the primary care delivery system of the State into a network of connected medical homes and Advanced Medical Homes that utilize the Chronic Care Model to provide patient-centered preventive and chronic disease care in a pro-active fashion. Financial incentives and training will be made available to encourage providers to become certified and operate as Advanced Medical Homes. Each participating Medicaid member will have a Medical Home and a personal health plan based upon the individual's health conditions and readiness to make needed behavior modifications to attain or maintain good health. The Network of Advanced Medical Homes will utilize an interactive electronic health management system with integrated clinical reminders, patient education and risk stratification tools to help Medicaid members meet personal responsibility guidelines and health self-management goals. These Networks are expected to function regionally to coordinate care of Medicaid members and to arrange referrals and access to specialty care in concert with the member's medical home.

As the system evolves, these regional networks of Advanced Medical Homes will be connected to the Medicaid agency's data warehouse so that complete health information can be exchanged to permit both the regional systems and the Medicaid agency to engage in population-based health management and predictive modeling to evaluate the clinical and cost effectiveness of these programs and to identify the need for additional training of health care providers or Medicaid members to achieve the program objectives.

The project will utilize nationally-accepted clinical outcome measures for the targeted disease states, such as those established by the American Medical Association, to determine

clinical effectiveness of the program. An anticipated outcome is significant improvement in the clinical indicators of the targeted Medicaid population, an increase in the number of Medicaid members achieving control of chronic conditions, a reduction in the number of hospitalizations for the targeted population for avoidable complications of the chronic conditions and a corresponding reduction in the cost of institutional or emergency care for these conditions and cost containment in medication costs due to effective management of the underlying conditions.

One example of the technology being used as part of this project is the MedLynks electronic health information and disease management system which is being implemented by Community Health Network of West Virginia and was developed under a collaborative agreement with Indian Health Service. As a condition for certification as an Advanced Medical Home, participating providers must demonstrate that an electronic health information system utilized meets all HIPAA and interoperability standards and can electronically report to Medicaid clinical outcome data.

***Estimate of Impact to Beneficiaries*** The project implementation schedule contemplates that up to 10% of the Medicaid members of the target group will be enrolled in the demonstration project with Advanced Medical Homes within the first 18 months of the project and another 15% of the Medicaid members within the target group will be enrolled with these qualified providers within the first 24 to 36 months of the program. While the targeted Medicaid population will be enrolled in the project on a phased-basis, the number participating with Advanced Medical Homes will be contingent upon the development of this network of qualified providers and the rate at which these providers can be certified. It is the intent of the program to phase this health improvement initiative to all Medicaid members over a four year period. The intent of the program is to integrate this

network of Advanced Medical Homes with the designation of a primary medical home in concert with the disease management programs of the managed care organizations already operating with the Medicaid program to provide an integrated, patient-centered system of care and support to achieve the desired outcomes.

***Magnitude of the Transformation/System Change*** The magnitude of the project involves the retraining and certification of a network of primary care providers that are currently providing care for the 251,000 targeted Medicaid members. The project will transform the current health care delivery system from an acute-focused, fragmented, reactive system to a patient-centered, integrated, pro-active system that provides Medicaid members (and other patients) with the information and tools needed to more effectively self-manage chronic conditions and avoid the costly complications that consume disproportionate health care resources. In this system wellness and prevention are sought as rigorously as treatment. It is anticipated that the multi-faceted approach to health system reform with member responsibility can be replicated in other states and many of the tools developed with these transformation grants can be shared as part of an on-line learning community under the Mountain Health Choices Health Improvement Institute.

***Description of Sustainability of the Project*** The State intends to re-invest any cost savings into expansion and maintenance of the program after the grant funds have been exhausted. The grant funds are being used for infrastructure development and program planning and implementation and once the training programs have been developed, they can be sustained on an ongoing basis through coordination with other state programs (i.e., State health promotion programs) and funding from participating professional organizations as part of on-going continuing education activities. The managed care organizations will also

sustain these efforts as part of the plan for coordination of care with the provider community.

***Evaluation Plan*** The State intends to evaluate the effectiveness of the program using internal Medicaid agency resources and the data warehouse to be developed as part of this project. Specific outcomes at every level of the service delivery system will be evaluated for continuous improvement. The clinical outcomes will also be independently evaluated using a number of existing resources, including contractual relationships the State has with quality improvement organizations and academic health research and policy organizations. The Medicaid agency will assure the effective and efficient provision of services and supports through systematic data collection and analysis. The state intends to select measures from CMS' *The Guide to Performance Measures: A Compendium* that will support established quality goals of the overall Medicaid agency's Quality Assurance plan.

***Description of Project Implementation Readiness*** Under the project plan, Medicaid participants will begin the process of enrollment in the new program starting November 1, 2006. The program design requires the assignment of a medical home within 30 to 45 days of enrollment and a health care assessment by the medical home within 90 days of enrollment for determination of the needs of the member for health counseling, education or the disease management programs of the managed care organization and/or an Advanced Medical Home. It is during these interactions that a Personal Health Management Plan will be developed.

The Medicaid program has pre-certified three community health centers that have been involved in a demonstration project to implement this care model over the past year. The Medicaid program will convene the provider groups and intends to establish the Mountain Health Choices Health Improvement Institute within 60 days of securing the

requested grant funding. Using many of the existing resources of the Offices of Community Health Systems and Epidemiology and Health Promotion within the Department of Health and Human Resources and the Healthy Lifestyles Coalition, the development of additional certified Advanced Medical Homes will begin within 90 days of award of the grant funding.

### **Healthier Medicaid Members through Health Systems Improvement- Timeline**

<b>Action Step</b>	<b>Time Line</b>
WV Health Information Network	July 2005
WV e-Health Initiative	July 2005
Data Warehouse Development	March 2006
Electronic Health Rec. Implemented by Pilot Clinics	April 2006
State Plan Amendment Approval of the Medicaid Redesign	May 2006
Presentation of Medicaid Redesign to multiple stakeholders for potential collaboration and outreach	May 2006- on-going
Members establish a medical home	July 2006- on-going
Outreach Brochure finalized and distributed	July 2006
Education and outreach to providers	July 2006 – on-going
CHCS Pay for performance Institute participation	October 2006
MMIS eligibility process	October 2006
Internal restructure of BMS to shift focus to quality and health assurance	October 2006
Education and outreach to members with member agreements, and rights and responsibilities	November 2006-on-going
Enrollment broker begins accepting member agreements	November 2006- on-going
Pay for Performance Development	November 2006
Health Improvement Institute	November 2006
Healthy Rewards Development	December 2006
Automated Pharmacy Prior Authorization(PA) System Algorithm Development	December 2006
Benefit Changes Effective in Pilot counties	January 2007
Enhance Data Warehouse Foundation for interoperability	January 2007
MITA Expansion Planning	January 2007
Web Portal for Pharmacy Claims Development	January 2007
Advanced Medical Home Certification	March 2007
Automated Pharmacy PA Implementation	April 2007
Web Portal for Pharmacy Claims Implementation	June 2007
Quality outcome and measurements established- Data analysis and remediation	June 2007
Provider Technology Incentives	July 2007
MITA Expansion Implementation	October 2007 – on-going
Healthy Rewards Implementation	January 2008

Action Steps	Time Line
Pay-for-Performance Implementation	January 2008
Development of treatment guidelines for chronic disease care management coordination	March 2008
Training and credentialing of pharmacists for use of treatment guidelines	June 2008
Implementation of Point of Sale clinical rules engine to identify gaps in therapy in management and prevention of chronic disease.	November 2008

**Budget:**

BUREAU FOR MEDICAL SERVICES TRANSFORMATION GRANT BUDGET PROPOSAL Healthier Medicaid Members through Health Systems Improvement		
<u>DESCRIPTION</u>	<u>YEAR 1</u>	<u>YEAR 2</u>
2.5 Full-Time Equivalentents	105,000.00	107,100.00
Fringe Benefits	30,820.00	31,210.00
Total Personnel & Fringe Benefits	135,820.00	138,310.00
Contractual Services - Health Improvement Institute	950,000.00	950,000.00
Contractual Services - Pay for Performance	850,000.00	850,000.00
Supplies	1,500.00	1,500.00
Equipment	0.00	0.00
Other Expenses		
Travel	4,500.00	4,500.00
IT Support	4,800.00	4,800.00
TOTALS	<u>1,946,620.00</u>	<u>1,949,110.00</u>

**Budget Description**

**Personnel:** Program Manager and support staff will be assigned to the project for a two (2) year period.

**Fringe Benefits:** 18.5% for variable cost; fixed \$359 for monthly health insurance; \$250 annual Civil Service charge.

**Health Improvement Institute:** The development and implementation of steering groups and sub groups for clinical parameters of health improvement. Education of providers on quality initiatives and the chronic care model which will be instrumental in the establishment of the advanced medical home.

**Pay-for-Performance:** The development of Pay-for-Performance methodology, criteria and rates. Education of providers, implementation and data analysis.

**Supplies:** General office supplies for Medicaid personnel working with the project.

**Travel:** Conference/meetings both in-state and out-of-state for Medicaid personnel working with the project.

**IT Support:** Desktop and network support for each employees workstation for Medicaid personnel working with the project.

## Abstract

### **West Virginia's Medicaid Transformation Initiative- Healthier Medicaid Members through Applied Technology**

The West Virginia Medicaid transformation initiative assures that each Medicaid member receives quality care, in a timely manner, in the right health care setting. The transformation initiative consists of the following five components:

1. Healthier Medicaid Members through Personal Responsibility
2. Healthier Medicaid Members through Health System Improvement;
- 3. Healthier Medicaid Members through Applied Technology;**
4. Healthier Medicaid Members through a Stronger Medicaid Program; and
5. Healthier Medicaid Members through Enhanced Medication Management.

West Virginia is one of the first in the nation to redesign its Medicaid program under the authority granted by the Deficit Reduction Act of 2005 to improve the health of enrolled members through enhanced access to preventive and disease management services, defined personal health management goals and responsibilities, and rewards for healthy behavior. Political and state agency leaders are committed to creating an efficient system focused on prevention, care management, and incentives to improve or maintain health. With this systems change wellness and prevention are sought as rigorously as treatment. West Virginia is well positioned to move to the next level of systems transformation and build on the state's initial steps towards redesign.

***Healthier Medicaid Members through Applied Technology*** will transform the current fragmented, disjointed system to a member-managed, integrated, pro-active system. The initiative will transition the health records of 251,000 Medicaid members from paper to electronic format including the integration of information on healthy lifestyles, health status and risk, disease self-management, and proper use of available health resources. Health records will be linked through an interoperable system that protects privacy as it connects patients, providers, and payers, resulting in fewer medical mistakes, less hassle, lower costs, and better health. Integrated and electronically connected health care teams will use integrated clinical reminders, patient education and risk stratification tools to help Medicaid members meet personal responsibility guidelines and health self-management goals. Utilization of electronic health management will assist in tracking over and under utilization of health care services and permit a more thorough and timely evaluation of health outcomes.

The West Virginia Bureau for Medical Services is requesting \$1,766,280 from the Centers for Medicare & Medicaid Services (CMS) to support *Healthier Medicaid Members through Applied Technology*. This initiative will build on the current electronic health management efforts to advance the broad adoption of electronic health information technology. The use of electronic information technology will integrate the current health delivery system and will improve the quality of care while reducing cost.

## *State of West Virginia Medicaid Transformation Initiative*

### *Part 3 - Healthier Medicaid Members through Applied Technology*

**Statement of Project/Need** The State of West Virginia is one of the first in the nation to redesign its Medicaid program under the authority granted by the Deficit Reduction Act of 2005 (DRA 2005) to improve the health of enrolled members through enhanced access to preventive and disease management services, defined personal health management goals and responsibilities and rewards for healthy behavior. The State Medicaid program has established an innovative approach to facilitate healthier Medicaid members through empowered members and health care providers using health information and clinical technology.

West Virginia has a population of approximately 1.8 million. Medicaid is a \$2.2 billion a year program with an enrollment of approximately 360,000 (20% of the State's population). The costs of the Medicaid program are growing faster than the State's economy and these escalating costs cannot be sustained with other competing budget needs.

CMS approved WV's State Plan Amendment on May 3, 2006. Unlike other states that sought waivers for the redesign of their respective Medicaid programs, West Virginia was uniquely poised to take advantage of the provisions in the 2005 DRA. The West Virginia Medicaid program has been working with a group of health care providers, members, advocates and interested parties on Medicaid improvement initiatives since Governor Joe Manchin took office in 2005. The State's Medicaid Redesign program, designated as **Mountain Health Choices**, incorporates the recommendations of these program participants and emphasizes personal empowerment and responsibility. At the heart of **Mountain Health Choices** are:

- **Healthy lifestyle and a healthy start, emphasizing the Health in health care;**

- **E**lectronic health records and networking providers;
- **A**ccountability for personal choices and a change in attitudes;
- **R**esponsibility – fiscal and personal – **R**espect and **R**ewards; and
- **T**eamwork – the member, the medical home and a team of providers and Medicaid working together.

The West Virginia Medicaid transformation initiative assures that each Medicaid member gets quality care, in a timely manner, in the right health care setting and consists of the following five components:

1. Healthier Medicaid Members through Personal Responsibility;
2. Healthier Medicaid Members through Health System Improvement;
3. Healthier Medicaid Members through Applied Technology (as described in this document);
4. Healthier Medicaid Members through a Stronger Medicaid Program; and
5. Healthier Medicaid Members through Enhanced Medication Management.

**Use of electronic health information:** Increased use of electronic health information systems will assist the Medicaid program in tracking over- and under-utilization of health care services and permit a more thorough and timely evaluation of health outcomes. By encouraging more rapid adoption of electronic health information technology, the Medicaid program will work with participating providers to better manage the health needs of Medicaid members and reduce medical errors. Utilization of electronic health management systems will also allow the Medicaid program to spot trends indicating fraud, doctor shopping for prescription medication and failure to keep appointments with specialists, all of which adversely impact the health of members and increase the costs of the program.

Under this initiative, the Medicaid program will provide enhanced reimbursement with a portion of the proceeds of this grant, as a demonstration project in preparation for “pay for performance” for those participating providers that are able to report designated clinical information to Medicaid’s clinical data warehouse. This initiative builds upon several significant electronic health records projects already underway in West Virginia by state-run facilities, mental health agencies, hospitals and primary care centers. Two significant projects are based on the award-winning VISTA system, the electronic health information system used by the Veteran’s Administration. Seven state-owned and operated facilities (two psychiatric hospitals, one acute care hospital and four nursing homes) are modifying the VISTA system to meet the health care needs of the individuals served by these facilities.

The Community Health Network of West Virginia (“Network”) is implementing a health information system based upon a version of VISTA used by Indian Health Services. To meet the health improvement objectives of the Medicaid project, the Network is working with its member health centers to implement this system known as “MedLynks”. The system is integrated with the Network’s centralized practice management system and with a common reference laboratory (LabCorp). It will also be integrated with the West Virginia Telehealth Network (WVTHN), a telehealth system being implemented by the Network and its participating members to link with specialty care and for sharing of disease management services such as nutrition and exercise counseling.

The Medicaid transformation initiative for technology also leverages concurrent efforts to expand adoption of health information technology that are already underway in West Virginia. The State of West Virginia recently enacted legislation creating the West Virginia Health Information Network (WVHIN). Senate Bill 170 created WVHIN to promote the design, implementation, operation and maintenance of a fully interoperable

statewide network to facilitate public and private use of health care information in the state. WVHIN will support a variety of electronic clinical transactions, including disease management, preventive medicine alerts, and prescription drug tracking. WVHIN will be managed and operated by a 17-member Board of Directors representing the state's medical schools, medical associations and other health care providers.

The West Virginia eHealth Initiative (WVeHI) is a collaboration of doctors and hospitals and their professional associations, the collaboration was established in 2005 to work with health care providers, health insurers, business and government to facilitate the use of health information technology. The coalition is encouraging broad adoption of electronic health information technology, including e-prescribing and computerized physician order entry (CPOE), both of which are intended to reduce medication errors.

**Portability of health information:** Participating providers using certified health information technology meeting the expectations and system capabilities outlined above will be able to create a continuity of care record for high risk patients that can be shared with local and regional health providers who are also providing care to the Medicaid members. Telehealth networks such as MDTV operated by West Virginia University or WVTHN operated by the Network will be used to coordinate consultations for high risk patients. A continuity of care record based upon the standards recommended by the American Academy of Family Physicians will be created through web-enabled interoperable technology by participating providers or regional networks that will give other health care providers much needed information about a participating Medicaid member's medications, allergies, problem-list, recent treatments and lab tests. These systems are being designed to also accommodate Medicaid's "personal healthy rewards accounts" contemplated in conjunction with personal responsibility agreements for enrolled Medicaid members.

**Personal health plans:** As part of the overall Medicaid health improvement program, it is contemplated that each patient will have a personal health management plan, with individualized goals, responsibilities for diet and physical activity and a customized education program based upon health risk status that will serve as the coordination tool for health management coordinators working with care teams and managed care organizations on behalf of each Medicaid member. These personalized health plans will be tracked through the certified electronic health information systems contemplated as part of this initiative.

**Access to specialty care:** To achieve the health care objectives of the program, it is important to create comprehensive access to care for the Medicaid members. It is contemplated that many Medicaid members may have access to specialty care in rural areas through increased utilization of telehealth services. The utilization of telehealth programs have proven effective in disease management programs for disadvantaged Medicaid patients for whom transportation is an issue. Some of these resources will be shared and accessed on a regional basis through the use of existing or new telehealth networks using the latest in digital technology. It is also contemplated that as part of this initiative, a portion of the grant proceeds will be used to encourage the development and utilization of remote, in-home monitoring of high risk patients by health care providers. Part of the grant proceeds will be used to provide incentives to providers demonstrating the benefits of this remote monitoring as part of this health improvement initiative.

Much of the training of health care providers described under Part 2 of the proposal provided through the Mountain Health Choices Health Improvement Institute will utilize state of the art web-enabled technology to distribute the training through desk-top

connection to the Internet so that the clinical practice of the health care providers is not unduly interrupted and access to care in many rural areas of the state is maintained.

**The need for self-management and personal responsibility:** Most studies in West Virginia and in other states reflect that, of the two-thirds of the Medicaid participants that are not aged or disabled, the prevalence of disease (and associated costs) mirrors the rates for society as a whole. In West Virginia, studies have shown that, of the 60,000 adult (non-elderly or disabled) Medicaid members:

- ◆ 64% (38,400) are obese or overweight;
- ◆ 32.4% (almost 20,000) have high blood pressure (with another 28% (16,800) at-risk with pre-hypertension);
- ◆ 37.5% (22,500) have high cholesterol;
- ◆ 28.2% (nearly 17,000) are current smokers;
- ◆ Nearly 10 % are diabetic (6,000) and 40% (24,000) are pre-diabetic; and
- ◆ 85% (51,000) have one or more risk factors for chronic disease.

It is the intent of the program to more effectively manage the care and conditions of Medicaid members to reduce the prevalence of these chronic conditions or the complications that lead to loss of life, a reduction in the quality of life and greater utilization of health care resources by Medicaid members. The technology initiative outlined in this proposal is one aspect of the overall Medicaid health improvement initiative aimed at creating a healthier Medicaid population.

**Impact on Quality and Cost:** The Medicaid transformation component focused on health technology is based upon several national studies and reports confirming the important role that technology can play in improving the quality of care and reducing the cost of care for the Medicaid population. A White House information technology advisory

committee says one in five medical lab tests are needlessly repeated, and one out of seven hospitalizations takes place only because prior test results were not available. Senate Majority Leader Bill Frist, R-Tenn., who is a heart surgeon, says 7,000 Americans die each year because handwritten prescriptions are misread at pharmacies. According to a report by the Senate Committee on Health, Education, Labor and Pensions, “healthcare is one of the least efficient industries in America. Settling a single transaction in health care can cost as much as \$12 to \$25, whereas banks have cut their costs to less than a penny per transaction by using modern information technology. “A new [study](#) from RAND, published in the prestigious healthcare journal *Health Affairs*, finds that adoption of interoperable electronic medical records (EMRs) could yield efficiency and safety savings totaling about \$81 billion annually for the U.S. healthcare industry.

The effort needed to transform the health care delivery system is daunting. According to a [2003 National Ambulatory Medical Care Survey](#), 83% of office-based physicians in the US continue to use paper based medical records. In concert with the efforts of Medicaid to encourage a robust network of Advanced Medical Homes under this transformation initiative, the deployment of health information technology by primary care providers is essential to the overall objectives of the Medicaid health improvement program. The incentives and demonstration projects that are part of this initiative are critical components of technology infrastructure development in the state.

**Healthy Rewards:** As part of the Personal Responsibility Agreement being implemented as an integral part of the Medicaid Redesign program, the State will implement “Healthy Rewards” for Medicaid members to encourage compliance with individual responsibilities and the adoption of healthy lifestyles. The concept of healthy rewards for individual members is consistent with the “pay for performance” incentive for health care

providers that are being incorporated into the realignment of the delivery system that is covered in the accompanying proposal. This consumer-driven health care is also consistent with the Institute of Medicine's recommendations for reform of the health care delivery system.

Participating Medicaid members will receive credits in a healthy reward account on a regular basis. Members that meet program expectations for self-management, keeping appointments and utilizing health care appropriately will be rewarded and conversely, those who do not will lose credits in the healthy reward account. This account will be tracked in a variety of ways, including the use of web-enabled interoperable technology as discussed in the accompanying provider proposal (Part 2). The program contemplates that these Healthy Rewards credits can be utilized by members for additional health care services, such as wellness services or dental or vision services.

**Targeted populations and health conditions:** The targeted group for implementation of the Medicaid health improvement and personal responsibility initiative includes Medicaid-covered TANF children and covered adults with children. According to the most recent enrollment figures, there are approximately 60,000 adults and 191,000 children covered by Medicaid, representing approximately 70% of covered Medicaid members and approximately 14% of the total population of the State.

**Meeting personal responsibility with personalized health care:** This project builds upon many of the recommendations of national groups such as the American Academy of Physicians and the American College of Physicians for a new model of more effective, patient-centered health care. The personal responsibility and accountability aspects of the program (as described more fully in Part 1 of the proposal) must be complemented by a patient-centered approach to health care delivery (as described more fully in Part 2 of the

proposal). As noted above, to meet the health improvement objectives of the program, it is essential to expand the use of electronic information systems by providers to provide access to important health information for the members. As part of the demonstration initiative, web-enabled interoperable technology will be used for at-risk members to provide portability of information. Participating providers will be able to report on designated outcome measures and clinical indicators electronically from coordinated electronic health information systems and have access to the central data warehouse to coordinate the care of a member that seeks care from multiple health care sources. Electronic health information systems will support remote monitoring of high-risk patients and other advanced technology applications to offer a continuum of care to avoid complications and hospitalizations of chronically-ill members.

**Project Justification** The redesign of the West Virginia Medicaid program is focused on creating a more effective and efficient program over the long-term and not for the purpose of immediate cost containment. Although the leaders of this program believe it can slow the growth of the program, the focus of the program is to achieve these objectives through appropriate use of the health care delivery system by members, through realignment of the delivery system itself by implementation of the Chronic Care Model and electronic health information technology and by partnering with the members to improve their long-term health. The Mountain Health Choices program meets a number of the Medicaid Transformation objectives:

- **It streamlines administration** by consolidating 29 eligibility groups into 4;
- **It tailors the benefits to the needs of each population** – traditional Medicaid provides all services to all members, a one size fits all approach. Now, each group will have its own set of benefits.

- **Care is coordinated, especially for members with chronic conditions.** A care manager will make sure members receive the screenings and treatment for long-term health rather than just treating acute or emergency conditions.
- **Members are afforded the opportunity and incentives to maintain and improve their health and there is a focus on prevention.** As noted above West Virginia has extremely high rates of obesity, diabetes and heart disease. One of the objectives of the program is to prevent these problems from developing in this population and/or delay the onset of the complications that arise from them.
- **Personal responsibility is built into the care system.** Medicaid members will be expected to keep appointments, follow the plan of care, make sure their children receive regular care and be responsible for their choices.
- **Care management is an integral part of the plan.** Health care will be managed in the medical home and with electronic health records and personal care managers; each member will have personal and coordinated care.

***Project Goals and Outcomes:*** The Medicaid Health Improvement project will transform the Medicaid system by placing the responsibility, accountability and the opportunity for health improvement in the hands of its members. Each participating Medicaid member will have a personal health plan based upon the individual's health conditions and readiness to make needed behavior modifications to attain or maintain good health. Integrated and electronically-connected health care teams will use integrated clinical reminders, patient education and risk stratification tools to help Medicaid members meet personal responsibility guidelines and health self-management goals.

As the system evolves, medical homes and regional networks of Advanced Medical Homes will be connected to the Medicaid agency's data warehouse so that complete health

information can be exchanged to permit both the regional systems and the Medicaid agency to engage in population-based health management and predictive modeling to evaluate the clinical and cost effectiveness of these programs and to identify the need for additional training of health care providers or Medicaid members to achieve the program objectives.

The project will utilize nationally accepted clinical outcome measures for the targeted disease states, such as those established by the American Medical Association, to determine clinical effectiveness of the program. An anticipated outcome is significant improvement in the clinical indicators of the targeted Medicaid population, an increase in the number of Medicaid members achieving control of chronic conditions, a reduction in the number of hospitalizations for the targeted population for avoidable complications of the chronic conditions and a corresponding reduction in the cost of institutional or emergency care for these conditions and cost containment in medication costs due to effective management of the underlying conditions.

As a condition for certification as an Advanced Medical Home, participating providers must demonstrate that an electronic health information system utilized meets all HIPAA and interoperability standards and can electronically report to the Medicaid data warehouse all designated clinical outcome data.

***Estimate of Impact to Beneficiaries*** The project implementation schedule contemplates that up to 10% of the targeted Medicaid members will be enrolled in the demonstration project within the first 18 months of the project and another 15% of the targeted Medicaid members will be enrolled within the first 24 to 36 months of the program. While the targeted Medicaid population will be enrolled in the project on a phased-basis, the number of health care providers participating in the technology and data warehouse portions of this initiative will depend upon the effectiveness of the incentives of the demonstration

project and the other initiatives that are concurrent to this project. It is the goal of the program to phase this health improvement initiative to all Medicaid members over a four year period.

***Description of Magnitude of the Transformation/System Change*** The magnitude of the project involves the transition of the health records of 251,000 from paper to electronic format and the integration of information on healthy lifestyles, health status and risk, disease self-management and proper use of available health resources into an integrated electronic health management system. Nearly all health records will be linked through an interoperable system that protects privacy as it connects members, providers, and payers, resulting in fewer medical mistakes, less hassle, lower costs and better health. The project will transform the current Medicaid system from a fragmented, disjointed system to a member-managed, integrated, pro-active system that provides Medicaid members (and other patients) with the information and tools needed to more effectively self-manage chronic conditions and avoid the costly complications that consume disproportionate health care resources. In this system wellness and prevention are sought as rigorously as treatment. It is anticipated that the multi-faceted approach to health system reform with member responsibility can be replicated in other states and many of the tools developed with these transformation grants can be shared as part of an on-line learning community under the Mountain Health Choices Health Improvement Institute.

***Description of Sustainability of the Project*** The State intends to re-invest any cost savings into expansion and maintenance of the program after the grant funds have been exhausted. The grant funds are being used for initial incentives to providers to adopt electronic health information technology will be sustained on an ongoing basis through coordination with regular Medicaid program administration. The managed care

organizations will also sustain these efforts as part of the plan for coordination of care with the provider community and integration of electronic health information technology into program administration.

***Evaluation Plan*** The State intends to evaluate the effectiveness of the program using internal Medicaid agency resources and the data warehouse to be developed as part of this project. Specific outcomes at every level of the service delivery system will be evaluated for continuous improvement. The clinical outcomes will also be independently evaluated using a number of existing resources, including contractual relationships the State has with quality improvement organizations and academic health research and policy organizations. The Medicaid agency will assure the effective and efficient provision of services and supports through systematic data collection and analysis. The state intends to select measures from CMS' *The Guide to Performance Measures: A Compendium* that will support established quality goals of the overall Medicaid agency's Quality Assurance plan.

***Description of Project Implementation Readiness*** Under the project plan, Medicaid participants will begin the process of enrollment in the new program starting November 1, 2006. The program design calls for the assignment of a medical home within 30 to 45 days of enrollment and a health care assessment by the medical home within 90 days of enrollment for determination of the needs of the member for health counseling, education or the disease management programs. It is during these interactions that a Personal Health Management Plan will be developed.

**Healthier Medicaid Members through Applied Technology – Timeline**

<b>Action Step</b>	<b>Time Line</b>
WV Health Information Network	July 2005
WV e-Health Initiative	July 2005
Data Warehouse Development	March 2006
Electronic Health Rec. Implemented by Pilot Clinics	April 2006

<b>Action Steps</b>	<b>Time Line</b>
State Plan Amendment Approval of the Medicaid Redesign	May 2006
Presentation of Medicaid Redesign to multiple stakeholders for potential collaboration and outreach	May 2006- on-going
Members establish a medical home	July 2006- on-going
Outreach Brochure finalized and distributed	July 2006
Education and outreach to providers	July 2006 – on-going
CHCS Pay for performance Institute participation	October 2006
MMIS eligibility process	October 2006
Internal restructure of BMS to shift focus to quality and health assurance	October 2006
Education and outreach to members with member agreements, and rights and responsibilities	November 2006-on-going
Enrollment broker begins accepting member agreements	November 2006- on-going
Pay for Performance Development	November 2006
Health Improvement Institute	November 2006
Healthy Rewards Development	December 2006
Automated Pharmacy Prior Authorization(PA) System Algorithm Development	December 2006
Benefit Changes Effective in Pilot counties	January 2007
Enhance Data Warehouse Foundation for interoperability	January 2007
MITA Expansion Planning	January 2007
Web Portal for Pharmacy Claims Development	January 2007
Advanced Medical Home Certification	March 2007
Automated Pharmacy PA Implementation	April 2007
Web Portal for Pharmacy Claims Implementation	June 2007
Quality outcome and measurements established- Data analysis and remediation	June 2007
Provider Technology Incentives	July 2007
MITA Expansion Implementation	October 2007 – on-going
Healthy Rewards Implementation	January 2008
Pay-for-Performance Implementation	January 2008
Development of treatment guidelines for chronic disease care management coordination	March 2008
Training and credentialing of pharmacists for use of treatment guidelines	June 2008
Implementation of Point of Sale clinical rules engine to identify gaps in therapy in management and prevention of chronic disease.	November 2008

### **Budget Description**

**Personnel:** Program Manager and support staff will be assigned to the project for a two (2) year period.

**Fringe Benefits:** 18.5% for variable cost; fixed \$359 for monthly health insurance; \$250 annual Civil Service charge.

**IT Integration/Health Information Interoperability:** Design of roadmap for data integration and health information systems interoperability.

**Provider Technology Incentives:** Incentives for providers to develop electronic health records to qualify for advanced medical homes.

**Supplies:** General office supplies for Medicaid personnel working with the project.

**Travel:** Conference/meetings both in-state and out-of-state for Medicaid personnel working with the project.

**IT Support:** Desktop and network support for each employees workstation for Medicaid personnel working with the project.

**Budget:**

BUREAU FOR MEDICAL SERVICES TRANSFORMATION GRANT BUDGET PROPOSAL Healthier Medicaid Members through Applied Technology		
<u>DESCRIPTION</u>	<u>YEAR 1</u>	<u>YEAR 2</u>
1.5 Full-Time Equivalents	63,000.00	64,260.00
Fringe Benefits	18,490.00	18,730.00
Total Personnel & Fringe Benefits	81,490.00	82,990.00
Contractual Services - IT Integration & Health Systems Interoperability	750,000.00	850,000.00
Supplies	900.00	900.00
Equipment	0.00	0.00
Other Expenses		
Provider Technology Incentives	500,000.00	500,000.00
Travel	4,500.00	4,500.00
IT Support	3,200.00	3,200.00
<b>TOTALS</b>	<b>832,390.00</b>	<b>933,890.00</b>

## Abstract

### **West Virginia's Medicaid Transformation Initiative- Healthier Medicaid Members through a Stronger Medicaid Program**

The West Virginia Medicaid transformation initiative assures that each Medicaid member receives quality care, in a timely manner, in the right health care setting. The transformation initiative consists of the following five components:

1. Healthier Medicaid Members through Personal Responsibility
2. Healthier Medicaid Members through Health System Improvement;
3. Healthier Medicaid Members through Applied Technology;
- 4. Healthier Medicaid Members through a Stronger Medicaid Program; and**
5. Healthier Medicaid Members through Enhanced Medication Management.

West Virginia is one of the first in the nation to redesign its Medicaid program under the authority granted by the Deficit Reduction Act of 2005 to improve the health of enrolled members through enhanced access to preventive and disease management services, defined personal health management goals and responsibilities, and rewards for healthy behavior. Political and state agency leaders are committed to creating an efficient system focused on prevention, care management, and incentives to improve or maintain health. With this systems change wellness and prevention are sought as rigorously as treatment. West Virginia is well positioned to move to the next level of systems transformation and build on the state's initial steps towards redesign.

***Healthier Medicaid Members through a Stronger Medicaid Program*** will enable Medicaid to become a more pro-active program that is focused on member health rather than simply enrollment and claims processing. By creating a clinical claims data warehouse, the Medicaid program will build a foundation that will improve the health of Medicaid members. This transformation will create a sophisticated integrated health assurance organization that uses health information and clinical data, risk stratification, disease management and predictive modeling approaches to prevent disease and detect strategies to improve health and member lives.

The West Virginia Bureau for Medical Services is requesting \$1,731,680 from the Centers for Medicare & Medicaid Services (CMS) to support *Healthier Medicaid Members through a Stronger Medicaid Program*. This initiative will transform the current fragmented, disjointed system to a member-managed, integrated, pro-active system that provides Medicaid members with the information and tools needed to more effectively self-manage chronic conditions and avoid costly complications that consume disproportionate health care resources.

## *State of West Virginia - Medicaid Transformation Initiative*

### *Part 4 - Healthier Medicaid Members through a Stronger Medicaid Program*

**Statement of Project/Need** The State of West Virginia is one of the first in the nation to redesign its Medicaid program under the authority granted by the Deficit Reduction Act of 2005 (DRA 2005) to improve the health of enrolled members through enhanced access to preventive and disease management services, defined personal health management goals and responsibilities and rewards for healthy behavior. The State Medicaid program has established an innovative approach to facilitate healthier Medicaid members through empowered members and health care providers using health information and clinical technology and through a transformed Medicaid program operating as a health assurance program rather than a claims-processing focused entitlement program.

West Virginia has a population of approximately 1.8 million. Medicaid is a \$2.2 billion a year program with an enrollment of approximately 360,000 (20% of the State's population). The costs of the Medicaid program are growing faster than the State's economy and these escalating costs cannot be sustained with other competing budget needs.

CMS approved WV's State Plan Amendment on May 3, 2006. Unlike other states that sought waivers for the redesign of their respective Medicaid programs, West Virginia was uniquely poised to take advantage of the provisions in the DRA 2005. The West Virginia Medicaid program has been working with a group of health care providers, members, advocates and interested parties on Medicaid improvement initiatives since Governor Joe Manchin took office in 2005. The State's Medicaid Redesign program, designated as **Mountain Health Choices**, incorporates the recommendations of these program participants and emphasizes personal empowerment and responsibility. At the heart of **Mountain Health Choices** are:

- **H**ealthy lifestyle and a healthy start, emphasizing the Health in health care;
- **E**lectronic health records and networking providers;
- **A**ccountability for personal choices and a change in attitudes;
- **R**esponsibility – fiscal and personal – **R**espect and **R**ewards; and
- **T**eamwork – the member, the medical home and a team of providers and Medicaid working together.

The West Virginia Medicaid transformation initiative assures that each Medicaid member gets quality care, in a timely manner, in the right health care setting and consists of the following five components:

1. Healthier Medicaid Members through Personal Responsibility;
2. Healthier Medicaid Members through Health System Improvement;
3. Healthier Medicaid Members through Applied Technology;
4. Healthier Medicaid Members through a Stronger Medicaid Program (as described in this document); and
5. Healthier Medicaid Members through Enhanced Medication Management.

The objective of Medicaid Redesign and Mountain Health Choices is to improve the future of West Virginia by investing in the health of its citizens and empowering them to make healthy choices.

**Transformation of the Medicaid System:** The objectives of the Medicaid redesign program include: 1. streamlining administration; 2. tailoring services to meet the needs of enrolled populations; 3. coordination of care, especially for those with chronic conditions; and 4. providing members with the opportunity and incentives to maintain and improve their health. One of the central administrative objectives of the Medicaid transformation is to better use health outcome information from members to evaluate education and training

programs, the effectiveness of healthy rewards and pay for performance incentives, the patterns of health care utilization, opportunities for predictive modeling using the Medicaid data warehouse and better coordination with other state health programs. Utilization of electronic health management systems will also allow Medicaid to spot trends indicating fraud, doctor shopping for prescription medication and failure to keep appointments with specialists, all of which adversely impact the health of members and drive up the costs of the program. The use of the electronic health management system will also accelerate discoveries that will define an individual's risk of disease, response to treatment and likelihood of side effects.

The West Virginia efforts complement and track national efforts to transform Medicaid. In a study conducted in late 2005 for the Agency for Healthcare Research and Quality (AHRQ), Avalere Health found that of 101 health information exchanges under way in 35 states, only 19 mentioned Medicaid as a stakeholder. The University of Massachusetts is conducting an AHRQ-funded study of how Medicaid can help advance health IT. Mike Leavitt, Secretary of the Department of Health and Human Services, has stated his desire to reform Medicaid and the other major federal health insurance program, Medicare, so that they "are viewed as leaders in the collaborative development and use of health information technology, quality measurement and pay for performance."

**Coordination with MITA:** The Centers for Medicare & Medicaid Services (CMS) has acknowledged that the changing health care landscape has drastically affected the architecture of the Medicaid Management Information System (MMIS) that supported Medicaid programs such as West Virginia's. Starting in 2003, CMS recognized the need to create a new technical framework for the MMIS of the future and awarded a contract to the Computer Sciences Corporation (CSC) to develop the Medicaid Information Technology

Architecture, referred to as “MITA.” According to an article appearing in *Government Health IT* (August 14, 2006), Rick Friedman, director of state systems for CMS’ Medicaid division, has stated that the goal of MITA is to provide ways for Medicaid to link up with a larger health IT system and incorporate clinical information, thereby giving providers a holistic view of each patient’s health and care needs. Part of Friedman’s vision for MITA includes connecting to regional health information organizations (RHIOs) or other data repositories. He described state Medicaid systems as future nodes on a nationwide health information network.

As noted in the separate transformation proposal on applied technology (part 3), the West Virginia Medicaid transformation initiative leverages concurrent efforts to expand adoption of health information technology that are already underway in West Virginia. The creation of the West Virginia Health Information Network (WVHIN) to promote the design, implementation, operation and maintenance of a fully interoperable statewide network to facilitate public and private use of health care information is consistent with the establishment of the Medicaid data warehouse described above that would permit Medicaid to participate in one or more RHIOs consistent with MITA. WVHIN will support a variety of electronic clinical transactions, including disease management, preventive medicine alerts, and prescription drug tracking. The West Virginia eHealth Initiative (WVeHI), a collaboration of doctors and hospitals and their professional associations, is also encouraging broad adoption of electronic health information technology, including e-prescribing and computerized physician order entry (CPOE), both of which are intended to reduce medication errors. These initiatives are the private complement to the State’s objectives to transform internally the Medicaid program consistent with the MITA objectives for technology application.

Through the West Virginia Medicaid transformation efforts and coordination with the Medicaid data warehouse, continuity of care information based upon the standards recommended by the American Academy of Family Physicians can be accessed by participating providers or regional networks that will give other health care providers much needed information about a participating member's medications, allergies, problem-list, recent treatments and lab tests. These systems are being designed to also accommodate Medicaid's "healthy rewards accounts" contemplated in conjunction with personal responsibility agreements for enrolled Medicaid members.

**The need for a shift in focus from claim processing to health management:** The West Virginia Medicaid program, during the past year, processed nearly 20.4 million claims for its 360,000 members. However, under the current system, most of the claim information is based upon coding of health care services that does not afford access to health indicators conducive to outcome measures. In West Virginia, studies have shown that, of the 60,000 adult (non-elderly or disabled) Medicaid members:

- ◆ 64% (38,400) are obese or overweight;
- ◆ 32.4% (almost 20,000) have high blood pressure (with another 28% (16,800) at-risk with pre-hypertension);
- ◆ 37.5% (22,500) have high cholesterol;
- ◆ 28.2% (nearly 17,000) are current smokers;
- ◆ Nearly 10 % are diabetic (6,000) and 40% (24,000) are pre-diabetic; and
- ◆ 85% (51,000) have one or more risk factors for chronic disease.

Nationally, these chronic diseases account for roughly 78 percent of health care costs annually. More than 800,000 (over 40%) West Virginians have one or more chronic conditions. These conditions account for:

- 70 % of hospital admissions and 80% of all days spent in a hospital;
- 72% of physician visits and 88% of prescriptions filled;
- nearly 60% of emergency room visits; and
- 70 cents of every dollar spent for health insurance by employers and workers.

(Source: Robert Wood Johnson, *Partnership for Prevention, Health Affairs*)

According to the Robert Wood Johnson study, 83% of Medicaid spending is for the almost 40% of non-institutionalized beneficiaries that have chronic conditions. Similar studies in West Virginia have shown there is a strong correlation among chronic disease, utilization of health care and risks of complications. These studies reveal that one in every five dollars billed for hospital care in West Virginia is related to diabetes. Eight of every ten hospital discharges are related to cardiovascular disease. Medicaid and the State's employee insurance program (Public Employee Insurance Agency "PEIA") had over \$200 million in obesity-related expenditures in 2001.

It is the intent of the program to more effectively manage the care and conditions of Medicaid members to reduce the prevalence of these chronic conditions or the complications that lead to loss of life, a reduction in the quality of life and greater utilization of health care resources by Medicaid members. The internal Medicaid technology and realignment initiatives outlined in this proposal is one aspect of the overall Medicaid health improvement initiative aimed at creating a healthier Medicaid population.

**Healthy Rewards:** As part of the Personal Responsibility Agreement being implemented as an integral part of the Medicaid Redesign program, the State will implement "Healthy Rewards" for Medicaid members to encourage compliance with individual responsibilities and the adoption of healthy lifestyles. The concept of healthy rewards for individual members is consistent with the "pay for performance" incentive for health care

providers being incorporated into the realignment of the delivery system that is covered in the accompanying proposal (Part 2). Training will be enhanced through the partnership with the Offices of Community Health Systems and Epidemiology and Health Promotions within the Department of Health and Human Resources. This consumer-driven health care is also consistent with the Institute of Medicine recommendations for reform of the health care delivery system. The Medicaid program will work with its managed care contractors and internal health improvement staff to evaluate the effectiveness of these programs and to make appropriate adjustments in training, member education, benefit alignment and incentives. This is another example of a more pro-active Medicaid program that is focused on member health rather than merely enrollment and claims management.

***Project Justification*** The redesign of the West Virginia Medicaid program is focused on creating a more effective and efficient program over the long-term and not for the immediate purpose of cost containment. Although the leaders of this program believe it can slow the growth of the program, the focus of the program is to achieve objectives through appropriate use of the health care delivery system by members, through realignment of the delivery system itself by implementation of the Chronic Care Model and electronic health information technology and by partnering with the members to improve their long-term health. The Mountain Health Choices program meets a number of the West Virginia Medicaid Transformation objectives:

- **It streamlines administration** by consolidating 29 eligibility groups into 4;
- **It tailors the benefits to the needs of each population** – traditional Medicaid provides all services to all members, a one size fits all approach. Now, each group will have its own set of benefits.

- **Care is coordinated, especially for members with chronic conditions.** A care manager will make sure members receive the screenings and treatment for long-term health rather than just treating acute or emergency conditions.
- **Members are afforded the opportunity and incentives to maintain and improve their health.** This program emphasizes the HEALTH in healthcare.
- **It focuses on prevention.** As noted above West Virginia has extremely high rates of obesity, diabetes and heart disease. One of the objectives of the program is to prevent these problems from developing in this population and/or delay the onset of the complications that arise from them.
- **Personal responsibility is built into the care system.** Medicaid members will be expected to keep appointments, follow the plan of care, make sure their children receive regular care and be responsible for their choices.
- **Care management is an integral part of the plan.** Health care will be managed in the medical home and with electronic health records and personal care managers; each member will have personal and coordinated care.

***Project Goals and Outcomes*** The Medicaid Health Improvement project will transform the Medicaid system by transforming the focus on the administration of the program within Medicaid from merely claims processing to health assurance. By creating a clinical claims data warehouse, the Medicaid program can shift its focus from provider payment to improving the health of its members. As a result of this effort, it is anticipated that regional networks of providers (medical homes and networks of Advanced Medical Homes) will be connected to the Medicaid agency's data warehouse so that complete health information can be exchanged to permit both the regional systems and the Medicaid agency to engage in population-based health management and predictive modeling to evaluate the

clinical and cost effectiveness of these programs and to identify the need for additional training of health care providers or Medicaid members to achieve the program objectives.

The project will utilize nationally-accepted clinical outcome measures for the targeted disease states, such as those established by the American Medical Association, to determine clinical effectiveness of the program. An anticipated outcome is significant improvement in the clinical indicators of the targeted Medicaid population, an increase in the number of Medicaid members achieving control of chronic conditions, a reduction in the number of hospitalizations for the targeted population for avoidable complications of the chronic conditions and a corresponding reduction in the cost of institutional or emergency care for these conditions and containment of medication costs due to effective management of the underlying conditions.

All of the electronic health information and telehealth applications must be HIPAA compliant to be certified for use in the Advanced Medical Home and must meet current standards and expectations for interoperability for health information exchange and reporting to the Medicaid data warehouse.

***Estimate of Impact to Beneficiaries*** The transformation of the Medicaid agency from one focused on provider payment to an integrated organization focused on member health, will have an enormous impact on the lives of beneficiaries. The first group selected for implementation of the project is Medicaid-covered TANF children and adults with children. According to the most recent enrollment figures, there are approximately 60,000 adults and 191,000 children covered by Medicaid, representing approximately 70% of covered Medicaid members and approximately 14% of the total population of the State. According to national studies, nearly 85% of the adult Medicaid patients in the target group have or are at-risk for one or more chronic conditions.

Under the current health care delivery system and Medicaid operating environment, nearly 85,000 of West Virginia students (approximately 39% Medicaid members) are overweight or at risk of being overweight. The realignment of the Medicaid program not only has the potential to stabilize costs within the program through the reduction of the number of Medicaid members utilizing high cost services (ie. hospitalizations, multiple medication, etc.) but substantially improving the quality of life for its members. Studies show that many of the chronic conditions afflicting West Virginians can be avoided or the conditions can be managed more effectively to preclude complications. By focusing on more effective diabetic care, reducing the toll of cardiovascular disease and better managing asthma, nearly one-third of the Medicaid population can be spared the projected burden of living with complications of a chronic disease.

***Description of Magnitude of the Transformation/System Change*** The magnitude of the project involves the transition of a program that has historically been focused on enrollment of eligible members based upon categorization of an individual's health and economic status to a sophisticated integrated health assurance organization that uses health information and clinical data, risk stratification, disease management and predictive modeling tools to keep 360,000 Medicaid members healthy. The project will transform the current Medicaid system from a fragmented, disjointed system to a member-managed, integrated, pro-active system that provides Medicaid members (and other patients) with the information and tools needed to more effectively self-manage chronic conditions and avoid the costly complications that consume disproportionate health care resources. In this system wellness and prevention are sought as rigorously as treatment. It will require a redevelopment of the technology infrastructure of the Medicaid agency and a retraining and reallocation of personnel to meet these new program objectives. It is anticipated that the

multi-faceted approach to reformation of Medicaid and the corresponding health system accompanying newly defined member responsibilities can be replicated in other states and many of the tools developed with these transformation grants can be shared as part of an on-line learning community under the Mountain Health Choices Health Improvement Institute.

***Description of Sustainability of the Project*** The State intends to re-invest any cost savings into expansion and maintenance of the program after the grant funds have been exhausted. The grant funds being used for initial incentives to providers to adopt electronic health information technology will be sustained on an ongoing basis through coordination with regular Medicaid program administration. The managed care organizations will also sustain these efforts as part of the plan for coordination of care with the provider community and integration of electronic health information technology into program administration.

***Evaluation Plan*** The State intends to evaluate the effectiveness of the program using internal Medicaid agency resources and the data warehouse to be developed as part of this project. Specific outcomes at every level of the service delivery system will be evaluated for continuous improvement. The clinical outcomes will also be independently evaluated using a number of existing resources, including contractual relationships the State has with quality improvement organizations and academic health research and policy organizations. The Medicaid agency also intends to utilize its managed care organizations under contract to survey Medicaid members to assess the impact the personal responsibility provisions have on member satisfaction, access to and utilization of health care and attitudes toward prevention and healthier lifestyles. The impact of the internal changes in Medicaid will be assessed and evaluated by both the administration and legislature as part of the on-going

program review for budget and management effectiveness and by CMS as part of its oversight of the federal participation in the program. The state intends to select measures from CMS' *The Guide to Performance Measures: A Compendium* that will support established quality goals of the overall Medicaid agency's Quality Assurance plan.

***Description of Project Implementation Readiness*** Under the project plan, Medicaid participants will begin the process of enrollment in the new program starting November 1, 2006.

<b>Action Step</b>	<b>Time Line</b>
WV Health Information Network	July 2005
WV e-Health Initiative	July 2005
Data Warehouse Development	March 2006
Electronic Health Rec. Implemented by Pilot Clinics	April 2006
State Plan Amendment Approval of the Medicaid Redesign	May 2006
Presentation of Medicaid Redesign to multiple stakeholders for potential collaboration and outreach	May 2006- on-going
Members establish a medical home	July 2006- on-going
Outreach Brochure finalized and distributed	July 2006
Education and outreach to providers	July 2006 – on-going
CHCS Pay for performance Institute participation	October 2006
MMIS eligibility process	October 2006
Internal restructure of BMS to shift focus to quality and health assurance	October 2006
Education and outreach to members with member agreements, and rights and responsibilities	November 2006-on-going
Enrollment broker begins accepting member agreements	November 2006- on-going
Pay for Performance Development	November 2006
Health Improvement Institute	November 2006
Healthy Rewards Development	December 2006
Automated Pharmacy Prior Authorization(PA) System Algorithm Development	December 2006
Benefit Changes Effective in Pilot counties	January 2007
Enhance Data Warehouse Foundation for interoperability	January 2007
MITA Expansion Planning	January 2007
Web Portal for Pharmacy Claims Development	January 2007
Advanced Medical Home Certification	March 2007
Automated Pharmacy PA Implementation	April 2007

<b>Action Steps</b>	<b>Time Line</b>
Web Portal for Pharmacy Claims Implementation	June 2007
Quality outcome and measurements established- Data analysis and remediation	June 2007
Provider Technology Incentives	July 2007
MITA Expansion Implementation	October 2007 – on-going
Healthy Rewards Implementation	January 2008
Pay-for-Performance Implementation	January 2008
Development of treatment guidelines for chronic disease care management coordination	March 2008
Training and credentialing of pharmacists for use of treatment guidelines	June 2008
Implementation of Point of Sale clinical rules engine to identify gaps in therapy in management and prevention of chronic disease.	November 2008

**Budget:**

BUREAU FOR MEDICAL SERVICES TRANSFORMATION GRANT BUDGET PROPOSAL Healthier Medicaid Members through a Stronger Medicaid Program		
<b>DESCRIPTION</b>	<b>YEAR 1</b>	<b>YEAR 2</b>
1.5 Full-Time Equivalents	63,000.00	64,260.00
Fringe Benefits	18,490.00	18,730.00
Total Personnel & Fringe Benefits	81,490.00	82,990.00
Contractual Services - MITA Expansion/Electronic Health Records	650,000.00	900,000.00
Supplies	900.00	900.00
Equipment	0.00	0.00
Other Expenses		
Travel	4,500.00	4,500.00
IT Support	3,200.00	3,200.00
<b>TOTALS</b>	<b>740,090.00</b>	<b>991,590.00</b>

## **Budget Description**

**Personnel:** Program Manager and support staff will be assigned to the project for a two (2) year period.

**Fringe Benefits:** 18.5% for variable cost; fixed \$359 for monthly health insurance; \$250 annual Civil Service charge.

**MITA Expansion/Electronic Health Records:** To develop the roadmap for the redevelopment of the technological infrastructure of the Medicaid Agency to manage the quality and cost of the Medicaid Program utilizing clinical data values.

**Supplies:** General office supplies for Medicaid personnel working with the project.

**Travel:** Conference/meetings both in-state and out-of-state for Medicaid personnel working with the project.

**IT Support:** Desktop and network support for each employees workstation for Medicaid personnel working with the project.

## Abstract

### **West Virginia's Medicaid Transformation Initiative- Healthier Medicaid Members through Enhanced Medication Management**

The West Virginia Medicaid transformation initiative assures that each Medicaid member receives quality care, in a timely manner, in the right health care setting. The transformation initiative consists of the following five components:

1. Healthier Medicaid Members through Personal Responsibility
2. Healthier Medicaid Members through Health System Improvement;
3. Healthier Medicaid Members through Applied Technology;
4. Healthier Medicaid Members through a Stronger Medicaid Program; and
- 5. Healthier Medicaid Members through Enhanced Medication Management.**

West Virginia is one of the first in the nation to redesign its Medicaid program under the authority granted by the Deficit Reduction Act of 2005 to improve the health of enrolled members through enhanced access to preventive and disease management services, defined personal health management goals and responsibilities, and rewards for healthy behavior. Political and state agency leaders are committed to creating an efficient system focused on prevention, care management, and incentives to maintain or improve health. With this systems change wellness and prevention are sought as rigorously as treatment. West Virginia is well positioned to move to the next level of systems transformation and build on the state's initial steps towards redesign.

***Healthier Medicaid Members through Enhanced Medication Management*** will establish an automated prior authorization system which allows the pharmacist to submit claims through a Point of Sale System and significantly reduce cost. This system will encourage more appropriate prescribing; enhance provider relations, and free pharmacists in the Rational Drug Therapy Program to have time for meaningful discussions and skilled clinical review. A web portal will be added to allow prescribers and pharmacists to view medical and pharmacy claims as they are submitted. A clinical rules engine will alert prescribers of clinical expectations and pharmacy management issues.

The West Virginia Bureau for Medical Services is requesting \$4,287,110 from the Centers for Medicare & Medicaid Services (CMS) to support ***Healthier Medicaid Members through Enhanced Medication Management***. This initiative will enable pharmacist to complete patient profiles, allow for the identification of chronic disease that is not being treated according to evidenced-based guidelines, as well as preventing the progression of chronic disease. The pharmacist will be integrated into the care team of the Medicaid member and will provide point of sale assistance to the member in preventing and managing the care of chronic disease.

## *State of West Virginia - Medicaid Transformation Initiative*

### *Part 5 - Healthier Medicaid Members through Enhanced Medication Management*

**Statement of Project/Need** The State of West Virginia is one of the first in the nation to redesign its Medicaid program under the authority granted by the Deficit Reduction Act of 2005 (DRA 2005) to improve the health of enrolled members through enhanced access to preventive and disease management services, defined personal health management goals and responsibilities and rewards for healthy behavior. The State Medicaid program has established an innovative approach to encourage Medicaid members to take a greater role in managing their health in collaboration with a team of community health providers to create a new model for health maintenance and chronic disease self-management. Part of this initiative involves enhanced medication management capabilities for the system.

The West Virginia Medicaid transformation initiative assures that each Medicaid member gets quality care, in a timely manner, in the right health care setting and consists of the following five components:

1. Healthier Medicaid Members through Personal Responsibility;
2. Healthier Medicaid Members through Health System Improvement;
3. Healthier Medicaid Members through Applied Technology;
4. Healthier Medicaid Members through a Stronger Medicaid Program; and
5. Healthier Medicaid Members through Enhanced Medication Management (as described in this document);

West Virginia has a population of approximately 1.8 million. Medicaid is a \$2.2 billion a year program with an enrollment of approximately 360,000 (20% of the State's population). The costs of the Medicaid program are growing faster than the State's economy and these escalating costs cannot be sustained with other competing budget needs. The

budget for the Medicaid pharmacy program is \$390 million annually and is the second largest line item in the Medicaid budget. The Medicaid program paid for 6.7 million prescriptions in 2005.

The Medicaid pharmacy program has sought to contain costs with the establishment of a Preferred Drug List and with an extensive prior authorization (PA) program. The Preferred Drug List covers 64 therapeutic categories and requests for non-preferred drugs require a call to the help desk of the Rational Drug Therapy Program, located within the West Virginia University School of Pharmacy and staffed by seven clinical pharmacists. Many of these calls could be approved routinely with an automated prior authorization (PA) system, which would eliminate waiting time for prescribers, pharmacists and Medicaid members.

As part of this proposal, the Medicaid program plans to evaluate and implement an automated PA system that would allow the pharmacist to submit claims through the Point-of-Sale system and significantly reduce the amount of money spent on PA administration, as well as interruptions in the clinical practices of health care professionals involved. This system will check the claims database for pre-determined PA criteria, approve the claim if appropriate, or send a denial message and advise the pharmacist to call the help desk if criteria is not met. At that point, the pharmacists at the help desk of the Rational Drug Therapy Program will review the claim, the patient's history and make any necessary requests for further information. They will be able to work with either the prescriber or pharmacist to make sure that the member receives the appropriate medication.

By automating pre-determined clinical algorithms, routine prior authorizations can be issued through the Point-of-Sale (POS) system. The clinical expertise of the pharmacists employed by the Rational Drug Therapy Program will be reserved for prescriptions requiring

case-by-case review. This technology will support enhanced POS processing and aid in Preferred Drug List maintenance and support, screen for inappropriate quantities of medications prescribed, early refills of medications, patterns of fraud and abuse, and will support the Pharmacy Lock-In Program.

It is anticipated that this system will significantly lower costs by eliminating the expenditure of valuable resources on routine approvals, encourage more appropriate prescribing, enhance provider relations by reducing the administrative burden for obtaining PA's, and free the pharmacists working in the Rational Drug Therapy Program to utilize their expertise for requests requiring skilled clinical reviews. It is estimated that 60-80% of the calls that are now routed to the RDTP program are for routine matters and can be more effectively handled by an automated prior authorization system, resulting in significant administrative savings, more appropriate prescribing from providers and better tools for improved management and reporting capabilities for the pharmacy program

According to national studies, it is projected that 55% of the Medicaid population will have no current chronic conditions, but that nearly half of this group will have some elevated risk (pre-diabetes, pre-hypertension, overweight, family history, etc.) for developing a chronic condition. It is projected that 24% will have one chronic condition, while 21% will have two or more chronic conditions (Source: Robert Wood Johnson, *Partnership for Prevention, Health Affairs*)

The most common condition found in children who are Medicaid members is respiratory illness. According to DHHR statistics, the prevalence of asthma for Medicaid beneficiaries is 118.7 per 1,000. Each asthmatic averages 9.3 prescription claims annually at a cost of \$457 and comprises 6.3% of the annual pharmacy budget. The average annual total cost for each Medicaid patient with asthma is nearly \$700. Nearly four percent of this

population will be hospitalized at some time during the year for asthma complications. The focus areas of the Medicaid health improvement initiative for children will be on asthma, weight management, prevention of Type II diabetes, and immunizations.

**Impact on the at-risk segment of the Medicaid population** West Virginia Medicaid is uniquely poised to take advantage of the features of the Deficit Reduction Act of 2005 (DRA 2005). Redesign efforts are well underway and the pharmacists, along with innovative tools for providing care management for their patients, could be one of the most influential members of the health care team in promoting the mission of Medicaid Redesign in West Virginia. The purpose of Redesign is to promote wellness and prevent the occurrence or progression of chronic diseases.

Most studies in West Virginia and in other states reflect that, of the two-thirds of the Medicaid participants that are not aged or disabled, the prevalence of disease (and associated costs) mirrors the rates for society as a whole. In West Virginia, studies have shown that, of the adult population:

- ◆ 64% are obese or overweight;
- ◆ 32.4% have high blood pressure (with another 28% at-risk with pre-hypertension);
- ◆ 37.5% have high cholesterol;
- ◆ 28.2% are current smokers;
- ◆ 8.8% have diabetes (and another 3% are undiagnosed diabetics);
- ◆ 40% are pre-diabetic; and
- ◆ 85% have one or more risk factors for chronic disease.

**The costs of chronic conditions:** Nationally, these chronic diseases account for roughly 78 percent of health care costs annually. More than 800,000 (over 40%) West Virginians have one or more chronic conditions. These conditions account for:

- 70 % of hospital admissions and 80% of all days spent in a hospital;
- 72% of physician visits and 88% of prescriptions filled;
- nearly 60% of emergency room visits; and
- 70 cents of every dollar spent for health insurance by employers and workers.

(Source: Robert Wood Johnson, *Partnership for Prevention, Health Affairs*)

- According to the Robert Wood Johnson study, 83% of Medicaid spending is for the almost 40% of non-institutionalized beneficiaries that have chronic conditions.

**Improving the health care delivery system:** The redesign of the West Virginia Medicaid program is focused on creating a more effective and efficient program over the long-term and not for the purpose of immediate cost containment. Although the leaders of this program believe it can slow the growth,, the focus of redesign is to achieve these objectives through appropriate use of the health care delivery system by members, through realignment of the delivery system itself by implementation of the Chronic Care Model and electronic health information technology and by partnering with the members to improve their long-term health. The Mountain Health Choices program meets a number of the Medicaid Transformation objectives:

- **It streamlines administration** by consolidating 29 eligibility groups into 4;
- **It tailors the benefits to the needs of each population** – traditional Medicaid provides all services to all members, a one size fits all approach. Under the new program, each group will have its own set of benefits.
- **Care is coordinated, especially for members with chronic conditions.** A care manager will make sure members receive the screenings and treatment for long-term health rather than just providing episodic care.

- **Members are afforded the opportunity and incentives to maintain and improve their health.** If members collaborate with their medical home to maintain and improve their health, they will be rewarded. In the demonstration phase of our project, one primary care center has offered visits to the fitness center as a healthy reward and the response has been very positive. This program emphasizes the HEALTH in healthcare.
- **It focuses on prevention.** In the first phase of the program, the clinical focus is on healthy adults and children. As noted above West Virginia has extremely high rates of obesity, diabetes and heart disease. One of the objectives of the program is to prevent these problems from developing in this population and/or delay the onset of the complications that arise from them.
- **Personal responsibility is built into the care system.** Medicaid members will be expected to keep appointments, follow a plan of care, make sure their children receive regular care and be responsible for their choices.
- **Care management is an integral part of the plan.** Health care will be managed in the medical home and with electronic health records and personal care managers; each member will have personal and coordinated care. Pharmacists could be more effectively included in care management with the tools to aid them in counseling patients regarding their drug therapy, the importance of compliance with laboratory tests and screenings ordered by their physicians, and working with prescribers to prevent access to drugs that can be used fraudulently by members.
- **Care is delivered and coordinated by a Medical Home and/or an Advanced Medical Home, if available.** Every Medicaid member will be assigned a Medical Home or an Advanced Medical Home, if available. The Medical Home will utilize a

team approach to providing health care and care management. Whether involving a primary care provider, specialist, mental health specialist, or sub-specialist, the Advanced Medical Home will facilitate the development of a plan of care, the determination of the outcomes desired, facilitation and navigation of the health care system, the provision of follow-up and support for achieving the identified outcomes. The Advanced Medical Home will also maintain a centralized comprehensive record of all health-related services needed to provide continuity of care. Web-based access by pharmacists and prescribers to all claims submitted for Medicaid members will be a valuable adjunct to the information stored at the Advanced Medical Home of the member.

***Project Goals and Outcomes*** The West Virginia Medicaid program is currently utilizing the only Windows-based commercial off-the-shelf unified relational database, software application, and claims processing system in the nation. This system offers a web portal for providers to view the status of claims that have been submitted for payment. With this proposal, we will add an additional portal which to allow prescribers and pharmacists to view medical and pharmacy claims as they are submitted, enabling Medicaid providers to view their patient's medical and pharmacy profiles. Prescribers will have the capability of viewing and downloading claims data submitted for their patients (drug claims, diagnosis codes, CPT codes, etc.) over a period of 24 months.

With a clinical rules engine added, prescribers can be alerted regarding clinical exceptions and management issues for the patients. They will also be able to examine specific formulary issues, along with prior authorization criteria. Suggested prescribing alternatives and best practice information will be included in this clinical rules module. The same web portal access will be provided to pharmacists who will be able to review claims

and clinical history. This real-time access will prevent fraud and abuse that occurs when patients are drug seekers and visit many providers, as well as emergency rooms, in order to obtain controlled substances. This tool will protect Medicaid members from receiving drugs that are inappropriate for their conditions, from adverse drug-drug interactions, from duplicate therapies and support prescribers by furnishing real time information regarding patient drug and medical history. In addition to web portal access for pharmacists and prescribers, care for members can also be delivered at the pharmacy point of service. Medicaid members make an average of 9-10 visits per year to a pharmacy, making the pharmacist the healthcare professional they see most consistently. An enhancement will be made at the Point of Service that will fit into the pharmacists' workflow process, utilizing widely accepted transmission protocols for real-time transactions. This enhancement will identify any patient with a chronic condition, highlight any deviation from the standard of care for that condition, and attach an intervention notification to the pharmacy via the NCPDP 5.1 transaction. A follow-up fax with detailed intervention information, documentation and reference will be sent to the pharmacy in time for the pharmacist to consult with the patient regarding the information generated. Surveillance algorithms can be developed to ensure that recommended interventions are performed, including data records for evidence of recommended provider visits, lab tests, and drug refills

Since pharmacists, prescribers, and patients each hold information essential to coordinating care and bringing patients care in line with established treatment standards, this tool is the key that brings all of the elements together that are necessary for truly coordinated care management. This tool will also aid in profiling prescribers who employ evidence-based treatment protocols and are eligible for enhanced reimbursement, based on their

standard of care. Prescribers who do not engage in current standards will be identified and targeted for educational interventions.

Most prescribers lack time with patients to discuss and reinforce standards of care, With this tool the pharmacist will be able to review the complete patient profile, integrate both medical and pharmacy information into the review, and capitalize upon the relationship that patients have established with them. An incentive will be provided to pharmacists for their cognitive services. Many chronic conditions, such as asthma, hypertension, heart failure, coronary artery disease, depression, migraines, chronic obstructive pulmonary disease, osteoporosis, gastrointestinal disease, and substance abuse, will be addressed with this tool. Recent studies have shown that many of the psychotropic agents cause weight gain and contribute to the development of diabetes and other associated chronic conditions. The addition of a clinical rules engine and the capability of alerting the pharmacist of a need for care coordination at the Point-of-Sale will enhance care management for Medicaid members and their providers. Credentialed pharmacists will be engaged to deliver interventions at the point of service with members, which will aid in identifying patients with chronic diseases.

***Estimate of Impact to Beneficiaries*** As noted above, the Medicaid program paid for 6.7 million prescriptions last year. The benefits to the Medicaid members in reduced medication errors, identifying and eliminating gaps in therapy and better medication adherence have been outlined above. A recent study published in the Journal of the American Medical Association notes that automated prescription systems, when used with electronic health systems for prescribing and order entry can reduce medication errors by up to 81%. Senate Majority Leader Bill Frist, R-Tenn., who is a heart surgeon, says 7,000 Americans die each year because handwritten prescriptions are misread at pharmacies.

***Description of Magnitude of the Transformation/System Change*** The magnitude of the project involves providing access for every prescriber and pharmacy provider in the state to medical and pharmacy claims data through a secure web portal. It will also require training pharmacists to use tools provided at the point-of-sale to identify gaps in therapy for the treatment of chronic diseases. Pharmacists are currently successfully involved in the management of diabetes through the Public Employees Insurance Program. Current estimates are a reduction of \$1200 annually per member for those enrolled in the Face-to Face Diabetes Management Program. Integration of the pharmacist into the care team for Medicaid members will also have a significant impact on the care of patients with other insurance coverage, in addition to those participating as members of Medicaid. The level of care provided by pharmacists will be elevated statewide with the implementation and support of the tools described in this project. These tools will also help to curb the ascertainment of controlled substances for fraudulent use and improve the level of drug abuse prevention throughout the state. It is anticipated that the multi-faceted approach to medication management can be replicated in other states and many of the tools developed with these transformation grants can be shared as part of an on-line learning community under the Mountain Health Choices Health Improvement Institute.

***Description of Sustainability of the Project*** Savings generated in reduced administrative costs by an automated prior authorization program, by increased compliance with the Preferred Drug List, with the elimination of gaps in therapy in the treatment of chronic diseases, the elimination of duplication of medications and reductions in fraud will be used to sustain the project.

***Evaluation Plan*** The State intends to evaluate the effectiveness of the program using internal Medicaid agency resources including comparisons of medication utilization

and physician prescribing patterns. The clinical outcomes will also be independently evaluated using a number of existing resources, including contractual relationships the State has with quality improvement organizations and academic health research and policy organizations. In addition, the state intends to select measures from CMS' *The Guide to Performance Measures: A Compendium* that will support established quality goals of the overall Medicaid agency's Quality Assurance plan.

***Description of Project Implementation Readiness*** The Medicaid claims processing system, which is Windows-based, has recently undergone CMS certification and can be easily adapted to the addition of any of the technological modules described. This project as proposed will be implemented in three phases statewide:

1. Implementation of an automated prior authorization system
2. Addition of a web portal to allow access to prescribers and pharmacists the ability to view patient profiles
3. Addition of a search engine, enhanced with clinical algorithms developed to promote evidence based guidelines for the treatment and prevention of chronic diseases to the POS System.

**Healthier Medicaid Members through Enhanced Medication Management**

<b>Action Step</b>	<b>Time Line</b>
WV Health Information Network	July 2005
WV e-Health Initiative	July 2005
Data Warehouse Development	March 2006
Electronic Health Rec. Implemented by Pilot Clinics	April 2006
State Plan Amendment Approval of the Medicaid Redesign	May 2006
Presentation of Medicaid Redesign to multiple stakeholders for potential collaboration and outreach	May 2006- on-going
Members establish a medical home	July 2006- on-going
Outreach Brochure finalized and distributed	July 2006
Education and outreach to providers	July 2006 – on-going
CHCS Pay for performance Institute participation	October 2006

<b>Action Step</b>	<b>Time Line</b>
MMIS eligibility process	October 2006
Internal restructure of BMS to shift focus to quality and health assurance	October 2006
Education and outreach to members with member agreements, and rights and responsibilities	November 2006-on-going
Enrollment broker begins accepting member agreements	November 2006- on-going
Pay for Performance Development	November 2006
Health Improvement Institute	November 2006
Healthy Rewards Development	December 2006
Automated Pharmacy Prior Authorization(PA) System Algorithm Development	December 2006
Benefit Changes Effective in Pilot counties	January 2007
Enhance Data Warehouse Foundation for interoperability	January 2007
MITA Expansion Planning	January 2007
Web Portal for Pharmacy Claims Development	January 2007
Advanced Medical Home Certification	March 2007
Automated Pharmacy PA Implementation	April 2007
Web Portal for Pharmacy Claims Implementation	June 2007
Quality outcome and measurements established- Data analysis and remediation	June 2007
Provider Technology Incentives	July 2007
MITA Expansion Implementation	October 2007 – on-going
Healthy Rewards Implementation	January 2008
Pay-for-Performance Implementation	January 2008
Development of treatment guidelines for chronic disease care management coordination	March 2008
Training and credentialing of pharmacists for use of treatment guidelines	June 2008
Implementation of Point of Sale clinical rules engine to identify gaps in therapy in management and prevention of chronic disease.	November 2008

**Budget:**

BUREAU FOR MEDICAL SERVICES TRANSFORMATION GRANT BUDGET PROPOSAL Healthier Medicaid Members through Enhanced Medication Management		
<b>DESCRIPTION</b>	<b>YEAR 1</b>	<b>YEAR 2</b>
2.0 Full-Time Equivalents	84,000.00	85,680.00
Fringe Benefits	24,660.00	24,970.00
Total Personnel & Fringe Benefits	108,660.00	110,650.00
Contractual Services - Pharmacy Web Portal, Automated Drug Prior Authorization System, & Clinical Rules Engine	2,000,000.00	2,050,000.00
Supplies	1,200.00	1,200.00
Equipment	0.00	0.00
Other Expenses		
Travel	4,500.00	4,500.00
IT Support	3,200.00	3,200.00
<b>TOTALS</b>	<b>2,117,560.00</b>	<b>2,169,550.00</b>

**Budget Description**

**Personnel:** Program Manager and support staff will be assigned to the project for a two (2) year period.

**Fringe Benefits:** 18.5% for variable cost; fixed \$359 for monthly health insurance; \$250 annual Civil Service charge.

**Medication Web Portal/Automated Prior Authorization System/Clinical Rules**

**Engine:** Design, development and implementation of medical history and medication real-time web portal to allow transparency to providers for improvement in quality of care. The development and implementation of an automated prior authorization point of sale system

and clinical rules engine to engage the pharmacists in overall care management, and to link pharmacists with health care providers in comprehensive care management.

**Supplies:** General office supplies for Medicaid personnel working with the project.

**Travel:** Conference/meetings both in-state and out-of-state for Medicaid personnel working with the project.

**IT Support:** Desktop and network support for each employees workstation for Medicaid personnel working with the project.