

**The Council of State Governments
2007 Innovations Awards Program**

**State of West Virginia
Department of Health and Human Resources
APPLICATION**

**ID # 07-S-51WVMOUNTAINHEALTH
State: West Virginia**

Assign Program Category: Health Services

1. **Program Name:**
Mountain Health Choices
2. **Administering Agency:**
Department of Health and Human Resources
Bureau for Medical Services
3. **Contact Person (Name and Title):**
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9. **Please provide a two-sentence description of the program:**
Mountain Health Choices is a new Medicaid program in West Virginia. It will contain the long-term growth of the program by providing Medicaid members with the tools they need to improve their health and by providing incentives for healthy choices.

10. **How long has this program been operational (month and year)? Note: the program must be between 9 months and 5 years old on April 2, 2007, to be considered.** Planning for the redesigned program began in April 2005 and is described more fully in item 12 below. However, the first phase of Mountain Health Choices commenced on July 1, 2006, when all eligible members were assigned medical homes (the place where you receive your health care and where your medical records are kept). The change in benefits and the available choice between a basic and enhanced plan went into effect on March 1, 2007 when all eligible members were transferred from the traditional benefit package into Mountain Health Choices. A basic plan covers all healthcare services which are mandated by federal and state laws. The enhanced plan offers extra benefits that are not included in the basic plan. Benefit descriptions of both the basic and enhanced plans are attached. The first phase of the program will be introduced in all West Virginia counties by the end of 2007.
11. **Why was the program created? What problem[s] or issue[s] was it designed to address?** It was created to improve the health of the Medicaid population. Mountain Health Choices seeks to contain future costs of the Medicaid Program by partnering with our members to develop healthier lifestyles. It arose from the need to provide the right care at the right place at the right time for the Medicaid population. West Virginia has higher rates of disability than the national average.
12. **Describe the specific activities and operations of the program in chronological order.**

April 2005: A Medicaid Redesign Committee, which was made up of a broad spectrum of providers, advocates, consumers and Department of Health and Human Resources (DHHR) staff, met to craft the conceptual framework for Medicaid Redesign. The committee used the following mission statement as a guide:

To support an enhanced quality of life for Medicaid beneficiaries by facilitating access to appropriate, high quality, cost effective services; to provide these services in a user friendly manner to both consumers and providers; to use the state's purchasing power to foster excellence in health care quality, efficiency and service; to work collaboratively with other partners in the health care community to promote comprehensive health care; and to focus on the future by providing preventative care and health awareness education.

The Committee split into five subcommittees: Eligibility; Benefits; Electric Health Records/Quality Outcomes; Member Agreement; and Healthy Rewards Accounts. These subcommittees, working through the Medicaid Redesign

Committee, helped DHHR shape the concept of redesigning Medicaid in West Virginia.

May 2005: DHHR submitted an initial concept paper to the Centers for Medicare and Medicaid Services (CMS) in May 2005. The concept, to promote healthier lifestyles for Medicaid recipients is based on two fundamental tenets. First, Medicaid recipients bear the primary responsibility for their health by incorporating good health care practices and decision making into daily life and by pursuing a healthier lifestyle. This tenet asserts that the individual generally determines not to smoke, to maintain a healthy weight, abstain from substance abuse, exercise and stay physically active, obtain screening examinations and comply with disease management guidelines.

The second fundamental tenet stresses that medical homes bear responsibility:

- to promote and educate consumers about good health care practices;
- to incorporate good health care practices into the delivery of care;
- to monitor patients to ensure they implement good health care practices; and
- to measure the resulting patient's health status indicators and outcomes.

November 2005: CMS approved the DHHR's initial concept paper and requested additional details. DHHR, with the assistance of the committee, submitted an expanded concept paper to CMS. CMS accepted this concept and DHHR staff began work on a waiver. Subsequently, the passage of the 2005 Deficit Reduction Act enabled West Virginia to change its benefit plans through the less administratively cumbersome State Plan Amendment process.

May 2006: The State Plan Amendment, which was approved by CMS is attached.

With the guidance of the mission statement, DHHR took (and will take) the following actions:

- Simplified the eligibility groups in order to tailor benefits to specific populations.
- Ensure that our members get the right care at the right place at the right time by the right provider.

We will accomplish the above action by allowing members to choose a medical home. This reflects a team approach to providing health care and care management, which includes the development of a plan of care and the determination of the outcomes desired. The patient is not a passive participant but a full, active member of the team. This represents a shift to an active role in the management of one's own health.

Medicaid members sign their member agreements in the medical home with the assistance and guidance of a medical professional. The agreement outlines the members' rights and responsibilities and sets achievable expectations for member behavior. In many ways, it is also an educational tool.

Members must sign the member agreement to be eligible for the enhanced plan under Mountain Health Choices.

Adult members who do not sign the member agreement, for themselves and/or their children will not be eligible for rewards and benefits. They will receive services available under the basic plan. Children whose parents choose not to sign up for the enhanced plan on their behalf will be placed in the basic plan. Copies of the plans are attached.

13. **Why is the program a new and creative approach or method?** The Medicaid reform plan allows West Virginia members to continue to receive health care services or to access enhanced benefits and wellness services by signing a member agreement with their medical home. A copy of the member agreement is attached.

The hallmarks of Mountain Health Choices are:

- 1) Encouraging healthy behavior and discouraging inappropriate use of medical services through Healthy Rewards Accounts;
- 2) Outlining the rights and responsibilities of members and/or members' parents and/or guardians in a member agreement;
- 3) Streamlining eligibility categories from 29 to 5;
- 4) Adjusting benefit packages to reflect private sector benefits and tailoring benefits to the eligibility category as opposed to the current "one size fits all"; and
- 5) Using outcome measures and electronic health records to monitor the performance of health care providers and the progress of members toward meeting health goals.

Mountain Health Choices marks a shift for the Medicaid program from a program that simply pays for medical services to one that functions as a full partner with members and providers in order to improve the health of the population. By providing Medicaid members with the tools and supports they need to reach optimal health, we believe we will be able to reduce the long term growth of the Medicaid program.

14. **What were the program's start-up costs? (Provide details about specific purchases for this program, staffing needs and other financial expenditures, as well as existing materials, technology and staff already in place.)** DHHR developed Mountain Health Choices primarily with existing staff and resources. The planning efforts that preceded establishment and

implementation of Mountain Health Choices was entirely voluntary and involved over 100 individuals. Market research was conducted to determine what incentives appealed to Medicaid consumers. This research is being used to develop Healthy Reward Accounts.

The redesign of the program required MMIS (Medicaid Management Information System) reconfiguration, which cost \$358,968.75.

15. **What are the program's annual operational costs?** In West Virginia, Medicaid's operating costs are approximately \$2.5 billion annually.
16. **How is the program funded?** The Medicaid program is jointly financed by the federal and state governments.
17. **Did this program require the passage of legislation, executive order or regulations? If YES, please indicate the citation number.** Yes, Mountain Health Choices required a State Plan Amendment, which was approved by CMS on May 3, 2006. A copy of the State Plan Amendment is attached.
18. **What equipment, technology and software are used to operate and administer this program?** The West Virginia MMIS uses re-determination date, county, and rate codes to determine those members eligible to be enrolled in the Basic Benefit Plan of Medicaid Redesign. MMIS transmits a file of members weekly to Automated Health Services (AHS). These members are then notified by AHS to select a medical home. If they have a medical home they are to make an appointment in order to complete the member agreement. Through the agreement, the member can then be upgraded to the Enhanced Benefit Plan. AHS then records the member upgrade in their system and sends an interface to the MMIS indicating those members who have completed the form and indicators of the types of services they have agreed to complete. The MMIS sends a file to the HMOs monthly to inform them of the plan in which their members need to be enrolled.

West Virginia was also awarded five transformation grants by CMS to build a more innovative, efficient Medicaid program. These grants will allow West Virginia to create a web portal which will allow those providers with prescription authority and pharmacists to view medical and pharmacy claims and will alert providers to pharmacy management issues which could negatively impact the health of the member.

19. **To the best of your knowledge, did this program originate in your state? If YES, please indicate the innovator's name, present address, telephone number and e-mail address.** While Medicaid reform is ongoing in most states, West Virginia was one of the first to use the flexibility allowed in the 2005 Deficit Reduction Act to create multiple benefit plans. The program originated from a

group of stakeholders, DHHR staff and clinical professionals, led by the vision of Governor Joe Manchin and Secretary Martha Walker.

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20. **Are you aware of similar programs in other states? If YES, which ones and how does this program differ?** The member agreement and the Healthy Rewards Account are unique to West Virginia's Mountain Health Choices. By signing the member agreement, members agree to take responsibility for making good decisions regarding their and their families' health. The Healthy Rewards Account will be the mechanism with which the state recognizes consistent, healthy decision-making.
21. **Has the program been fully implemented? If NO, what actions remain to be taken?** Mountain Health Choices has not been fully implemented. The pilot is currently underway in three counties. The program will expand to additional counties in June 2007 and will be statewide by the end of 2007. DHHR staff is currently working with CMS to develop the criteria for Healthy Rewards Accounts.
22. **Briefly evaluate (pro and con) the program's effectiveness in addressing the defined problem[s] or issue[s]. Provide tangible examples.** As of April 10, 2007, 92% of Medicaid members who have made the choice between the Basic and Enhanced Benefit Plans have chosen the Enhanced Benefit Plan. This rate of participation exceeded the Committee's expectations and is seen as an early indicator of success.

By encouraging members to make an appointment for a well visit and discuss health improvement goals for the coming year, Medicaid members are able to partner with their healthcare provider and payer. The program sets expectations and members are motivated to meet those expectations. Not only does Mountain Health Choices encourage a healthier lifestyle, it also gives Medicaid members a sense of control and builds their self-esteem.

Medical providers have expressed their appreciation of the program because it gives them tools with which to hold their patients accountable and work with them to improve their health. The technology developed as part of the program allows Medicaid staff to review goals set by members and their providers, which can be used to monitor standards of care. This technology and collaboration among members, providers and the Medicaid program is a first step toward pay-for-

performance to reward providers who give quality care. Not only does this benefit the Medicaid program, but will result in improving the quality of care for all West Virginians.

An empiric evaluation of the program's effectiveness will not be possible until longitudinal data is available. DHHR wants to demonstrate that appropriate care and services can improve the health of Medicaid members by reducing the number of hospitalizations, emergency room visits and catastrophic illnesses in this population.

23. **How has the program grown and/or changed since its inception?** While we are still in the initial stages of the program, we are committed to maintaining the ideals set forth by our advisory committee for the transformation of the state's Medicaid program. Our mission remains the same: to improve the health of Medicaid members. We are collecting suggestions and problems most frequently encountered by both members and providers, in order to improve upon our program.
24. **What limitations or obstacles might other states expect to encounter if they attempt to adopt this program?** The flexibility made available to states in the Deficit Reduction Act is a recognition by the federal government of the fact that one size does not fit all in the Medicaid program. By simply paying for medical services, the program may have not improved health outcomes for members in its forty-year history. States now have the ability to adjust the program to fit the needs of their populations.

West Virginia is proud to partner with our partners at CMS to design a system that offers meaningful incentives to Medicaid members wishing to take responsibility for their own and their children's health.

The changes occurring in West Virginia's program have drawn criticism from some who perceive that Mountain Health Choices punishes members for not making good choices. This is a criticism we disagree with. The administration, as well as the original committee, rejected any and all measures that would deny medically necessary care to our members.

Mountain Health Choices begins the process of changing the way members and providers interact with Medicaid. It is a program that is evolving from one that simply pays for medical services to one which functions more like a true health insurance plan. This change in mindset is a critical first step if the growth of the Medicaid program is to be contained in the long term on both the state and federal level.