STATE OF WEST VIRGINIA
COMPREHENSIVE MEDICAID REDESIGN PROPOSAL
***** DRAFT *** MAY 4, 2005 *** DRAFT *****

Introduction

The goals of the West Virginia Comprehensive Medicaid Waiver Proposal are to:

a) streamline administration;
b) tailor services to meet the needs of enrolled populations;
c) coordinate care, especially for those with chronic conditions; and
d) provide members with the opportunity and incentives to maintain and improve their health.

While the State has been successful in holding annual Medicaid growth to between 7-9% each of the last four years, well below the national average of 12.9%[1], this growth continues to be two to three times the growth rate of the State's general revenue.

Should this effort prove successful, the State intends to offer health care access via a Medicaid buy-in to low-income working adults in order to develop a healthy workforce. The recently released Statistical Abstract of the United States (published by the Census Bureau) showed that West Virginia had the lowest workforce participation rates for people over the age of 16 in the United States at 62% participation for men and 47.7% participation for women.[2] In order to build a healthy workforce and attract employers, the State believes it is essential to offer health care access to working age adults. The State may also explore public-private-employee partnerships in order to make health care insurance more widely available.

Eligibility

Currently, West Virginia Medicaid's coverage groups comply with Title XIX of the Social Security Act and regulations contained in Title 42, Section 435, of the Code of Federal Regulations. Based upon the federally-mandated criteria, the program places members into one of 29 coverage groups **(Appendix A - West Virginia Medicaid Coverage Groups)**. Rules which were designed when Medicaid served as health coverage for welfare recipients still control eligibility. The present coverage groups include:

a) families with children deprived of care for a specific reason;
b) the aged, blind and disabled adult population;
c) pregnant women with family incomes below a specified percentage of the federal poverty level; and
d) children with family incomes below a specified percentage of the federal poverty level.

As you know, states cannot cover populations outside of the regulations without a special waiver. The current categorical eligibility system does not allow appropriate populations to receive benefits, i.e., low-income childless adults, and the State believes that it is no longer applicable to the needs of its low-income citizens and families. Working age adults have the highest uninsured rates at 21.9%[3] of all age groups in West Virginia, and the State has one of the lowest per capita incomes in the United States.

Following a review of several states' waivers and processes, particularly Utah, Montana, Hawaii, and Arizona, and the eligibility categories used, West Virginia Medicaid could reduce its categories into four to five targeted groups that include children, adults, the disabled, the elderly, and the institutionalized.

Further review of current states' eligibility requirements and income guidelines shows that it is probable that West Virginia can simply eliminate categorical eligibility and allow income levels to become the basis for Medicaid eligibility. The National Academy for State Health Policy (NAHSP) has recommended this method of eligibility determination. An expert panel convened by NAHSP stated:

> "Medicaid should provide comprehensive health care coverage for the poorest Americans – all people with incomes at or below the federal poverty level – without regard to age, family structure, or health status. Current requirements to cover children and pregnant women with incomes above the poverty level should be continued. States should continue to be permitted to extend Medicaid eligibility beyond minimum federal requirements."[4]

Basing Medicaid eligibility on income levels will continue coverage for all mandatory coverage groups. In the future, this method could be used to expand eligibility to the low-income uninsured. West Virginia could implement flexible benefit packages for higher-income population groups that might not be as comprehensive as provided for those groups with lower incomes or special needs. Benefit packages can be developed dependent upon the unique needs of a member while maintaining cost neutrality. In addition, different levels of personal responsibility, incentives and contributions to healthcare can be implemented using this model.

Services

The State of West Virginia is committed to providing high quality services to its Medicaid members. However, the State recognizes that there is a more efficient and effective way of providing and offering services other than the current method as mandated by federal rules. Therefore, the State proposes major changes in the provision of services in West Virginia. As mentioned above, the State intends to develop benefit packages which

are specific to different populations or member groups.

The State intends to restrict access to some services currently mandated by federal law. For example, healthy adults may not have access to podiatry, this service would be limited to diabetics and others demonstrating medical necessity. Services will be reconfigured to reflect best medical practice and, in the case of long term care populations, to reflect the language of the *Olmstead*[5] decision which directs care to be given in the most appropriate setting for a member's needs. As with many other states, the long-term care population is West Virginia's most expensive coverage group. The implementation of case management practices by Managed Care Organizations (MCO) will eliminate duplicative and/or unnecessary services. Existing waivers and demonstration projects dealing with this small, but expensive population are underway in other states such as the Arizona Health Care Cost Containment System - Alternative Long-Term Care (AHCCC-ALTC).[6]

The addition of non-traditional services to certain segments of our client group would be phased in over the first three years of the demonstration. These may include medical screenings, weight loss assistance, nutrition counseling, addiction counseling and the continuation of smoking cessation programs. In addition, members will enter into personal responsibility agreements with the State which will focus members on health maintenance/improvement and disease prevention/maintenance (Appendix B - West Virginia Medicaid Member Personal Responsibility Agreement). Program success will be measured in decreases in diabetes diagnosis rates, diabetic complications, high cholesterol rates, high blood pressure rates, along with other disease-based health improvement measures. Increases in immunization rates will also be measured as evidence of program success.

A key to ensure the success of the redesigned Medicaid 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 penalties or incentives built into the program to ensure proper utilization of the program benefits.

As described previously, providers have historically not been reimbursed for the time that they spend providing members with such services as weight loss assistance, nutrition counseling, addiction counseling, and smoking cessation. However, as the three-year phase-in of these services takes place under the redesign, these services will be promoted to both providers and beneficiaries.

In addition, because the redesigned Medicaid Program will have tailored benefit plans for different eligibility groups, there must be a series of ongoing communication vehicles to ensure that the member is aware of the requirements of his/her benefit package, and the proper way to use the benefits in order to take advantage of any financial incentives or to avoid any penalties as a result of his/her use of the benefits. These 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.

Flexible Benefits

The flexibility states need to manage their Medicaid Programs is contingent upon being freed from the constraints imposed by current state plan requirements in the areas of state-wideness, amount, duration and scope of services, comparability, cost-sharing, freedom of choice, and EPSDT. The state must be able to offer systems, services, or coordination of care programs in certain geographic areas of the state. The state must be able to offer different benefits to different populations, which are responsive to the needs of individuals within that population, yet sensitive to the states ability to fund the services that are covered. Additionally, the state must be allowed to include benefits such as case management, health education, and non-traditional services which are not available to all beneficiaries or all groups of beneficiaries.

Benefit packages must allow the states to limit freedom of choice of providers and, specifically with regard to EPSDT, the State wishes to use the American Academy of Pediatrics standards of infant and children's regular check-ups and managed in a way that assures the individual child's health care needs are identified and met with timely quality care, rather than as a separate model, superimposed on the general healthcare system and overseen by a separate administrative structure.

Current federal rules which require that all state-covered services, both mandatory and optional, be made available to all Medicaid eligibles, results in a "one size fits all - carte blanche" approach that contributes to the cost of the system, and limits the extent to which it may be responsive to the unique needs of smaller populations, and individuals within those populations.

As mentioned above, the State of West Virginia proposes to reduce the eligibility categories to four, or possibly five, targeted groups. They include: children, adults, the disabled, the elderly, and the institutionalized/long term care. These categories would still cover all of the current mandatory populations.

West Virginia proposes to establish a flexible benefit plan for each of these populations, which would be responsive to the needs of the individuals within the group, as well as sensitive to the constraints of available funding. The risk in defining four or five benefit plans resides in the tendency to replace one large "one size fits all" benefit package with four or five "one size fits all" benefit packages serving smaller groups of eligibles. West Virginia proposes to avoid that risk by building in flexibility within each of the benefit plans.

Specific recommendations for benefit plans are as follows:

1) Children

Children's basic benefit plan should cover diagnostic, preventive, and treatment of services for both acute care medical needs as well as needed specialized treatment. The health screening needs of children, which are presently covered by the EPSDT Program, should be incorporated in the standards of practice in the medical treatment/management of children in a manner which meets or exceeds the federal requirements for such screening, but does not require the separate administrative structure currently utilized to assure that those services are performed. Coverage of specialized services required by children would include early intervention and specialized child development services, which are presently covered by Medicaid but administered under separate administrative structures.

2) Adults

West Virginia would define a basic benefit for healthy adults. That benefit would be defined to reflect the range of services generally covered in employer sponsored health plans. Such coverage could include physician services, diagnostic lab and radiology services, a limited inpatient hospital benefit as defined in the Montana 1115 waiver, entitled "Montana Basic Medicaid for Able Bodied Adults". However, the benefit package would provide for: emergency dental situations, specifically palliative treatment for relief of pain, certain emergency medical conditions of the eye, and certain medical supplies, such as diabetic supplies, as well as emergency services rendered in outpatient settings.

3) Long-Term Care/Institutional

See below.

4) Well Elderly

The benefit package for this population should include the basic benefit defined for

healthy adults, with additional services to enable them to live independently, but which do not require the level of care rendered in the institutional setting. Additionally, individuals within this population who have chronic diseases should be afforded the services available through Disease State Management Programs directed to the specific type of chronic condition, i.e. diabetes, COPD, hemophilia.

5) Disabled

Individuals within this category include those individuals currently served under the Aged/Disabled and MR/DD Home and Community Based Services Waivers. The benefit package for this category of individuals should include the basic health care benefits, lab, radiology, physician, acute-care hospital services, and inpatient mental health services as necessary. However, the benefit should also focus on providing case management/care coordination to assure that the range of specific services currently available are appropriately allocated and utilized in a manner which is both responsive to the needs of the individuals within the group and rendered in a cost effective manner, which is sensitive to the programs funding constraints.

Medicaid Health Investment Accounts

As part of the Personal Responsibility Agreement, the State is considering the use of Health Investment Accounts. In order to change human behavior, there needs to be a penalty or a reward. An employee who performs beyond expectation may receive an improved wage. However, if you drive 70 mph in a 55 mph zone you may get a ticket.

Using co-pays as a deterrent in Medicaid is very difficult. At this time, 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. If the State imposes higher co-payments, since the provider cannot refuse treatment because of a lack of ability to pay, the co-payment becomes a reduction in the provider's reimbursement. The co-payment will not change behavior.

Another alternative is to provide an incentive for preferred behavior. Reward a member for not misusing services or improving his/her health status. This principle is being used in the private sector. It is known as consumer-driven health care.

The same type approach could be used in Medicaid with certain modifications. The member would at the beginning of each quarter receive a certain amount of credit in an account. Each time the member sought care, a co-payment would be deducted from the account. If a member filled a brand drug when a generic was available, the member would

have a larger co-payment deducted. If a person was treated in an emergency room when it is determined not to be an emergency, then there would be a co-payment.

Credits would be added if the member participated in wellness or disease management programs. If a person was a non-smoker, their co-payment amounts would be lower. This account could be a leverage tool where none exists.

The bookkeeping would be done by Medicaid or a third party vendor. Reward payments would need to be mailed to the members on a quarterly basis. With these accounts the state could effectively manage utilization. It could also lead to a change in behavior. There should be some caution in deploying this system for populations that are disabled or in nursing homes. There is little they can do to control their care, and they have a limited range in which they can maintain and/or improve their health.

Electronic Health Records

Increased use of electronic record systems will assist the Bureau in tracking over- and under-utilization of services. Electronic health records will enable providers to better manage their patients' needs and reduce medical errors. Management information will also allow the Bureau 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 clients in addition to increasing the long-term costs to the program. The use of an electronic health record will facilitate implementation of Medicare Part D, electronic prescribing.

Currently, the State of West Virginia has several significant electronic health records projects including mental health agencies, hospitals and primary care centers. Two projects are based on the VISTA system. The seven state facilities (two psychiatric hospitals, one acute care hospital and four nursing homes) are modifying the VISTA system, the Veterans' Administration electronic health records software, to meet their needs.

The State will seek grants to expand the VISTA system and other existing community practices to more private providers and is willing to partner with the federal government to develop a statewide demonstration project and/or an information management system for coordinated care management which would allow individuals to safely remain in their homes and communities for longer periods of time.

The Community Health Network and its fourteen member health centers are implementing an electronic health record system. The Network is one of three pilot sites working with the Centers for Medicare and Medicaid Services, the Veteran's Administration (VA) , the Bureau of Primary Health Care and Indian Health Services to adapt the VA's

VISTA electronic health record system for use in the community health setting. This project is also being coordinated with the West Virginia Medical Institute as the Quality Improvement Organization for Medicare as part of its Doctor's Office Quality (DOQ-IT) initiative. The Network is testing the functionality of CMS' VISTA-Office EHR to determine the feasibility of using this software as an integrated disease management system.

As a preliminary step to developing an integrated disease management system that includes electronic health record functions and health information exchange capabilities for these targeted disease areas, clinical staff representatives of the Network pilot sites (Primary Care Systems, Tri-County Health Clinic, Lincoln Primary Care and Pendleton Health Care) are reviewing existing clinical protocols for disease management in targeted areas and are developing common agreed to protocols and procedures with outcome measures for these diseases. Participating clinicians include medical directors, care coordinators and other clinical providers and support personnel. This coordination is an important part of the process of establishing tools to measure outcomes and effectiveness and to permit other integration of related clinical tools.

The lead clinicians have begun participating in regular conference calls to guide the implementation of the project at each site and to coordinate the project with other clinical applications (i.e., laboratory and prescription management interface, immunization registry and other clinical reporting such as patient outcome measures). The lead clinicians will also work with the Network staff who will integrate and oversee coordination of the electronic disease management tools with the practice management software utilized as part of the Community Health Network and its member health centers.

West Virginia Medicaid Long-Term Care Services

In 2004, 122,334 elderly, blind and disabled Medicaid members–comprising approximately 33 percent of total Medicaid members–accounted for 65.16 percent of total Medicaid expenditures. This cohort has access to primary, acute, hospital and specialty care, behavioral health services, as well as nursing facility and home- and community-based long-term care through a basically fee-for-service delivery system.

Two factors show that West Virginia's need to bring effective quality health care to its low-income aging population will increase in coming years: West Virginia is the third oldest state in the nation (we have the 3rd highest percentage of residents 65+)[7] and West Virginia has the highest median age in the country at 38.9.[8]

It is proposed that West Virginia embark on a reform of its long-term care program services. The overarching purpose of this reform would be to integrate all long-term care services for all types of members needing such services into a single continuous system of care that is professionally planned, coordinated and focused on the management of the

health services needs of each individual. Such a system would be initiated through a single point of entry and would provide for care enabling the individual to live in the least restrictive setting, realizing that delay of nursing facility placement would result in savings to the state.

The member should be able to understand the full array of services available and how they will be accessed and coordinated. The program will include a prudent level of monitoring to assure the individual's appropriate participation in their health and well-being. Eligibility for participation in long-term care will be based on functional standards as well as economic circumstance that puts the individual at near-term risk for nursing facility care. Additionally, individuals with lower levels of activities of daily living (ADLs) would be eligible for community-based care, while those with higher levels of ADLs would be eligible for nursing facility care.

To facilitate this reform, West Virginia would seek CMS' approval to fold the home- and community-based services into the redesign.

To further facilitate this reform, the State would seek to be able to add home modifications, assistive technology, home-delivered meals, and other reasonable types of service that would support the individual's capacity for healthily living outside of a nursing facility.

Financing

Consistent with the State's intent to build greater flexibility into the delivery of services appropriate to redefined eligibility categories, the financing under this proposed Medicaid redesign will also need to be revamped. Each eligibility category will have a specific array of benefits covered, and the financial structure to support each benefit program must be sufficiently flexible to support the differences among these categories and changes over time.

The West Virginia Medicaid Redesign Proposal envisions that a per capita funding level will be established for each defined benefit package These per capita funding levels will need to provide for reasonable increases in medical inflation using an agreed-upon proxy, as well as accommodating changes in enrollment that will occur due to changes in the state's economic condition, demographic shifts, and technological advancements. These per capita amounts will need to take into consideration the case-mix intensity or other demographic-sensitive changes occurring within each of the defined eligibility groups over time.

The State anticipates that efficiencies in the administration of the Medicaid Program will be

achieved through:

a) the streamlined eligibility structure being proposed;

b) the promotion of healthy lifestyles through non-traditional benefits including education; and

c) enhanced care coordination.

The West Virginia Medicaid Program will be able to achieve an acceptable level of growth to ensure the long-term stability of the Medicaid Program.

Conclusion

The State of West Virginia appreciates the opportunity to offer this concept paper for comment and consideration. With or without a Medicaid redesign, the West Virginia Medicaid Program will be significantly altered in the next two years to respond to the budget constraints faced by the State. West Virginia fervently believes that unfettered from the current Medicaid regulations it could reduce Medicaid growth and maintain appropriate services for Medicaid members. As mentioned in the introduction, once this is achieved, the State would move to examining options to broadened Medicaid access to low-income working adults. The State looks forward to receiving feedback on this paper.

Endnotes

1. As determined by the Kaiser Commission on Medicaid Facts, Medicaid and the Uninsured, November 2004.

2. 2004 United States Statistical Abstract, United States Bureau of the Census.

3. West Virginia Health Care Study 2003, West Virginia University Institute for Health Care Policy and Research.

4. National Academy for State Health Policy, Making Medicaid Work for the 21st Century, Overview of Recommendations (full report available at www.nashp.org).

5. Olmstead v. L.C. ex.rel. Zimring 527 US 581 (1999)

6. Arizona waiver information can be found at the Centers for Medicare and Medicaid Services website @ www.cms.hhs.gov/medicaid/waivers/azwaiver.asp

7. Source: U.S. Census Bureau 2000, Summary File 01, Table PCT 12, U.S. Administration on Aging Information Memorandum AOA-IM-02-02-01-01.

8. Source: U.S. Census Bureau 2000, Table DP-1, Profile of General Demographic Characteristics, 05-01.