

STATE OF WEST VIRGINIA

Medicaid Redesign Proposal

Joe Manchin III, Governor

November 7, 2005



*West Virginia Department of
Health and Human Resources*

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Introduction

The goals of the West Virginia comprehensive Medicaid Redesign proposal are to:

- streamline administration;
- tailor services to meet the needs of enrolled populations;
- coordinate care, especially for members with chronic conditions; and
- provide members with opportunity and incentives to be responsible for maintaining and improving their health and their family's health.

Prevention, personal responsibility and disease management are hallmarks of the redesign. In the prevention arena, non-traditional services such as nutrition counseling and weight loss programs will be added to the benefits package. West Virginia will introduce Healthy Rewards Accounts, which provide the incentive for members to make healthy decisions and use health care services appropriately. The Redesign will also focus upon establishing a medical home for all members.

Members will be allotted credits each quarter that they can use for things like co-pays and non-emergent emergency services. Members could use account balances for uncovered services.

Under the direction of Governor Joe Manchin III and West Virginia Department of Health and Human Resources Secretary, Martha Yeager Walker, the West Virginia Medicaid Redesign Team was formed. This team includes DHHR staff, staff from other state agencies, representatives from professional associations, providers, members and advocates. Beginning in August 2005, the team met every two weeks with subcommittees meeting weekly. This expanded concept paper is the result of those efforts to fulfill the following charge:

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 emphasizing personal responsibility, promoting preventative care and health awareness education.

West Virginia Medicaid's Mentally Retarded and Developmentally Disabled (MR/DD) Waiver and its Aged and Disabled (AD) Waiver will continue to operate according to the recently approved federal waiver renewals. These Waivers will not be incorporated into the Redesign Proposal.

Eligibility

West Virginia proposes significant changes in existing eligibility categories. Currently, 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. The West Virginia Medicaid Redesign Team recommends simplifying these coverage groups from the current 29 categories to four. These four categories are further illustrated in Attachment A.

The proposed categories collapse the current 29 into four and include:

- children;
- adults 65 and over;
- those with special needs; and
- adults with children.

Children

The Medicaid children's coverage groups will not change. Children have to meet an income test. They will have no asset test and will continue to receive Medicaid for a continuous 12-month period once determined eligible. West Virginia serves children at the following levels with relation to the federal poverty level:

Age	Federal Poverty Level
Less than 1	150% FPL
1 to 6	133% FPL
6 to 19	100% FPL

When a child's income exceeds the Medicaid Federal poverty level a determination for West Virginia's State Children's Health Insurance Program (SCHIP) is automatically completed. For children, WV SCHIP eligibility is up to 200% of the federal poverty level.

Adults 65 and Over

Individuals in this age group are currently eligible under the Qualified Medicaid Beneficiaries (QMB), Specified Low-Income Medicaid Beneficiaries (SLIMB), and Qualified Individuals (QI) eligible criteria as a single individual or as a couple. Individuals must be eligible for and enrolled in Medicare. QMBs are only eligible for limited Medicaid coverage that includes payment of Medicare Parts A and B premium amounts and payment of all Medicare co-insurance and deductibles,

including those related to nursing facility services. SLIMBs and QI coverage is limited to payment of the Medicare Part B premium. West Virginia covers 4,764 QMBs; 3,585 SLIMBs and; 2,475 QIs.

Special Needs Groups

The Special Needs Group eligibility category includes:

- those who are institutionalized (includes NH and ICF/MR);
- people with disabilities; and
- other limited coverage groups.

Because almost one third of the WV Medicaid population (78,000) are SSI recipients, the state must improve the health care status of this group while controlling the increasing demand for health care and its associated costs. For this population, the state plans to improve cost-effectiveness and quality through value-added delivery systems, financing, and management initiatives, which includes programs that manage the care across the continuum.

West Virginia's Aged and Disabled (AD) Waiver and its Mentally Retarded/Developmentally Disabled (MR/DD) Waiver will continue to operate according to the recently approved waiver renewals. These waivers will not be incorporated into the Redesign.

Adults with Children

This coverage group is currently eligible for the West Virginia Medicaid program when their circumstances fall within the State's Aid to Dependent Children (AFDC) eligibility criteria. To receive AFDC Medicaid, the income for a family of three can be no more than \$243/month. This group also has a \$1,000 asset test.

Currently, West Virginia serves 16,055 members in this category. This group may be considered for expansion when the Redesign demonstrates sufficient savings.

Pregnant women are currently covered at 150% FPL. West Virginia Medicaid currently covers 55% of all births.

Benefit Packages and Services

The attached spreadsheet (see Attachment B) provides eligibility categories and benefits. The Redesign benefits packages were crafted following a comparison with private and public insurers.

The categories of benefits are broad, but provide the information necessary to understand the coverage for each eligibility category. Any constraints on specific benefits are clearly identified. Actuarial review is necessary to determine if benefits and constraints will meet cost neutrality mandates. Attachment B provides a general view of the eligibility groups' proposed coverage.

Healthy Rewards Accounts

Two of the expected outcomes of the West Virginia Medicaid Redesign includes improving the health of Medicaid members and more efficient use of state and federal resources. A tool to assist in that effort is a new West Virginia-designed concept known as *Healthy Rewards Accounts*. The premise of these accounts is based on Consumer Directed Health (CDH) now used in the private sector.

In the private sector, employers establish high deductible employee benefit plans. Along with these plans are health reimbursement accounts funded by the employer. These accounts are used to finance a portion of out-of-pocket medical expenses incurred by employees. If a person spends wisely or has no claims, the ending balance may be carried year-to-year.

While a high deductible account would not be applicable for the Medicaid program, the idea of incentives or disincentives for member behavior is appropriate. Unlike private insurance, Medicaid does not allow large meaningful or enforceable co-payments. Under this concept, if a certain class of pharmaceuticals has two equal choices, and 'A' will cost the state \$1.00 and 'B' will cost the state \$50.00; it would be in the best interest of the state and the member to share the savings if the member chooses 'A'; the least expensive option. Currently, if the member and his or her health care provider want 'B', the person will get 'B', with no consequence for the member or the provider. This is a situation that must be changed.

Certain private employer health plans provide an incentive for members to participate in various disease management and wellness programs. In exchange they receive an incentive or premium discount for improving their health status. The West Virginia Public Employees' smoker-surcharge is a relevant example. Smokers pay \$360 more per year for health insurance than non-smokers.

The impact of Private Sector Consumer Directed Health (CDH) is well documented. Companies that employ this strategy experience better results than traditional plans. The City of Hurricane, West Virginia, uses a CDH strategy. For the 2005 plan year, their net increase in health cost was 6.05%. This is compared to a greater than 10% trend projected for the West Virginia Public Employee Insurance Agency (PEIA) for state fiscal year 2005.

A large provider of CDH in West Virginia reports their average trend among the company's total book of business is 7%. This is far below the national trend for standard packages of 9.2% as reported in the 2005 Kaiser Family Foundation Employer Benefits survey.

West Virginia intends to establish a Healthy Rewards Account for all Medicaid members who have the ability and capability to partner in their personal health decisions and this will be the first target population.

The account will receive a deposit of credits in accordance with a predetermined formula. The credits will carry forward and the member will be eligible to convert those credits to a list of items or services which may not be available through the West Virginia Medicaid program.

In the beginning, the accounts will be used for a limited number of incentives or disincentives. As the program is refined over time, Healthy Rewards can be expanded and become more comprehensive.

Disincentives:

Some examples of member behavior West Virginia Medicaid intends to target with disincentives are:

- non-emergent use of emergency services;
- missed medical appointments;
- non-compliance with the preferred drug list; and
- smoking

Medicaid programs across the country, as well as all payors, experience problems with inappropriate use of emergency services. Instead of using the primary care system, many members seek primary and urgent care from an emergency room. According to statistics provided by the West Virginia Hospital Association, there were 1.1 million emergency room visits in 2004 in the state of West Virginia. There were 585 visits per 1,000 state residents for the general population. For West Virginia Medicaid there were 790 visits per 1000 Medicaid members.

For those with Healthy Rewards Accounts, a significant portion of credits would be used to pay a co-payment for non-emergent use of emergency services. Some may question how this might be accomplished. PEIA and other private insurers charge significant co-payments to members who use emergency services inappropriately. Medicaid can use this process.

There is a perception in the provider community that West Virginia Medicaid members have a high no-show rate. This leads to two concerns. First, providers become frustrated and refuse to treat Medicaid members. Secondly and more importantly, many medical conditions require compliance checks and follow-up visits. If a patient does not follow up, the result can be negative health outcomes or hospitalization leading to higher costs. After missing a predetermined number of visits, a certain amount of credit will be deducted from the Healthy Rewards Account.

The final disincentive in the first phase would be for failure to choose from the preferred drug list. Medicaid will move to a multi-tiered co-payment structure with

non-preferred drugs having higher co-payments deducted from the Healthy Rewards Accounts. In fiscal year 2004 the average cost for a generic drug for West Virginia Medicaid was \$22.31, compared to \$96.73 for a brand. The generic dispensing rate was only 50.12% for WV Medicaid. (The West Virginia Public Employee Insurance Agency (PEIA) generic dispensing rate for fiscal year 2005 was 55.5%. The difference can be attributed to PEIA's ability to impose a meaningful co-payment differential on generics.)

Incentives:

The first phase incentive programs would be limited to the following care management or wellness initiatives: prenatal care, well-child checkups and vaccinations, cardiovascular, asthma and diabetes care as well as tobacco cessation. As the program develops, additional disease states may be included.

Studies show that proper prenatal care will reduce the chance of a negative outcome at birth. Currently, West Virginia Medicaid pays for over 50% of the births in the state. The West Virginia Health Statistics Center indicates 41% of pregnant Medicaid members use tobacco products. West Virginia shall initiate a plan offering incentives to members for participation in tobacco cessation programs. The cost for a baby born prematurely can easily exceed \$200,000 in medical claims to the Medicaid program.

Pharmacy expenditures for West Virginia Medicaid amplify the need for management of the above listed disease/health states. For calendar year 2004, the program spent 9% of drug expenditures (\$34,004,407) on cardiovascular medications; the plan expended \$21,822,877 on anti-asthmatic medications and \$20,950,033 on diabetic related medications and supplies.

As individuals comply or adhere to the programs, additional credits will be added to their account. Simplicity must be the key with this aspect of the program. The financial details in terms of the size of the monthly account deposits and the amount of credits will depend on further review of available data. Medicaid program goals will also play a large part in determining the size of incentives and disincentives.

Healthy Rewards Accounts provide a tool to offer meaningful incentives or disincentives. Currently, there are few ways for West Virginia Medicaid to influence the behavior of its members. The program is limited to a \$3.00 co-payment on medical services and products. Providers cannot deny services if participants do not pay. The current situation in West Virginia Medicaid is that there are no cost-sharing mechanisms, only provider payment reductions which do not impact member behavior in a healthy or positive way.

By bringing members into partnership with their health care providers, West Virginia Medicaid hopes to foster more active member participation in their health

care. Not only will they become better informed, they will be become involved in programs that will improve quality of life for themselves and their families.

Electronic Health Information

A key component to the proposed West Virginia Medicaid Redesign is to identify quality outcomes and reward both providers and members for achieving performance expectations. The ability to gather timely health information is essential to providing quality health outcomes. Electronic access to data will be a vital part of the process. West Virginia will design and implement a health information system that will allow a common framework for and of the following components:

- Electronic medical records;
- Medicaid claims;
- Medicare claims;
- Commercial insurance claims;
- Public health data;
- Nursing Home MDS data; and
- Mental Health data.

The State will also survey health organizations to identify what data is currently collected electronically, whether that data can be made available for State use and the specific data elements included. The State will also attempt to identify the number of providers currently using various types of electronic record keeping, such as electronic appointment or paperless record keeping systems.

The systems currently in use, as well as products available commercially and governmentally, will be assessed to ascertain which products meet the State's data collection needs. Systems will be reviewed for ease of implementation, staff training needs, maintenance, accessibility and special features (i.e. intelligence which suggests additional tests that might be necessary based on symptomatology, or which flags medications that may be contraindicated or appear to be a dosage concern).

Currently, the State of West Virginia is developing and is currently involved in several significant public health informatics projects which will promote harmonization of local and national standards. These include projects at mental health agencies, hospitals and primary care centers. The seven state facilities (two psychiatric hospitals, one acute care hospital and four nursing homes) are modifying the Veterans' Administration's Veterans Health Information Systems and Technology Architecture (VISTA) electronic health records system to meet their specific needs.

In addition to the above activities, the information gathered from health records can be combined with claims payment data. This will facilitate the development of baseline information on the health care utilization practices of individual members, providers, specific population groups, and build the foundation of data that will allow West Virginia Medicaid to meet its goal of providing appropriate

health care, in the correct quantity, quality and duration to meet needs of all members. Through assessment, policy and assurance this data will allow the State to examine over - and under - utilization of services, the use of preventive versus emergency services, and measure the improvement in the quality of members' health.

Lastly, data from electronic health records will be part of the on-going disease management activities already underway in the State. Currently, clinical staff are reviewing existing clinical protocols for disease management in targeted areas and are developing common protocols and procedures with outcome measures for these diseases.

The State will seek grants to expand the electronic capabilities of providers and is willing to partner with the federal government and/or private entities in the development of the statewide health information demonstration project.

Long-Term Care

The primary goal for long-term care services in West Virginia's Medicaid Redesign is to provide access to the most integrated setting that provides coordination of care to improve and maintain health status, while being mindful of member preference and within the state budget allowance.

Entry into Medicaid for those with long-term care needs should be a single entry process. The vehicle for entry into the system is the individual needs assessment. Needs assessment should be provided by independent, resource management professionals, qualified through training and experience, certified by the state, and not attached to or associated with any provider of service. Moreover, these resource managers should be qualified to assist in the development of and, as needed, advocate for and support the member's own development and management of her or his resource management contract.

The needs assessment should be proactive in prevention and identification of needs and preferences. It should allow for a maximum level of choice, independence, and integration within state budget constraints and reduce the need for prior authorizations and additional forms and administrative processes. The goal of the needs assessment is to allow the member full participation in the management of services and care.

Once the resource manager completes the initial assessment of the member, a Resource Management Contract (RMC) will be developed. The guiding principles of the RMC are that it is self-directed, person-centered, mutually accountable, enforceable and monitored for quality of outcome. The RMC has three goals:

- to provide a roadmap of the member's long-term care support needs and desires;
- to document an agreement between the member and the Medicaid program for Medicaid delivered services and supports identified in the needs assessment; and
- to encourage active participation in determining and managing the use of resources provided by the contract.

The independent resource manager will oversee the RMC and its implementation, providing assurances that the member maintains an optimal level of direction over the process.

Integrating social supports and services for individuals receiving long-term care is an essential component of the West Virginia Redesign.

Planning of long-term care services for the future must take into consideration the historical barriers to a wide range of long-term care services and supports. These barriers have included:

- lack of access to the full range of services in many rural areas of the state;
- lack of appropriate education and training programs for those interested in working in long term care services;
- lack of adequate compensation;
- emphasis on institutional care rather than on the professionals providing habilitation, rehabilitation and other home and community based services;
- diminishing numbers of workers available to provide needed long term care services;
- provider driven services rather than consumer driven services;
- management of care that emphasized “service limiting” processes rather than service enabling.

Each of these barriers and others which may arise must be addressed in terms of system facilitation, provider education, career development programs, provider reimbursement, recruitment and retention initiatives and other ways to attract, train and keep quality professionals in our long-term care system.

Quality Outcomes and Outcome Measurements

The use of performance measurement is a key component of West Virginia's Redesign Initiative. Quality Outcome measures shall reflect efficiency, effectiveness and responsiveness in assuring access to health care services as well as the timeliness of those services to West Virginia Medicaid members.

In developing outcome measurements, West Virginia shall use pre-existing indicators that are evidence-based, well-tested, accepted by providers and incorporate multiple dimensions of care. Benchmarks will be established in order to:

- identify areas needing improvement and on-going monitoring;
- set performance goals and;
- assess progress towards meeting established goals in key areas of importance.

The use of a measurement matrix will allow West Virginia to construct reports for consumers, advocacy groups and members of the public to demonstrate the success of the redesign program. A measurement matrix will also enable West Virginia to make sound management decisions in its Medicaid program.

As a component of its measurement matrix, West Virginia will develop incentives to encourage and reinforce the delivery of evidence based practices and health care delivery system transformation that promote better outcomes as efficiently as possible. Employing a comprehensive set of performance measures combining elements from existing quality assurance and quality improvement monitoring activities with newly developed elements will result in a quality monitoring strategy that is commonly referred to as a value-based purchasing (VBP) program.

Attachment C is West Virginia's proposal for a comprehensive Quality Plan.

West Virginia Medicaid Member Agreement

The Medicaid Member Agreement is a component unique to the proposed West Virginia Medicaid Redesign. Medicaid members, guardians of children and possibly other populations would sign the agreement upon enrollment and re-determination. The agreement outlines the rights and responsibilities of individuals who become Medicaid members. The responsibilities include the expectation that Medicaid members keep their medical appointments, take their medications as directed, notify their healthcare provider if they are not feeling well and ask questions if they do not understand their medical providers' instructions.

In addition, each member agreement will have an attached addendum which describes the recommended check-ups and exams for healthy children, healthy men, healthy women and healthy diabetics. This range of addendums will be expanded as the program is further developed. Members who comply with the agreement and those who comply and improve their health status may be eligible for special benefits and/or bonus credits to their Healthy Rewards Account. Members may have credits deducted from their account if they consistently do not show up for their medical appointments, do not adhere to medical direction resulting in a reduced health status, or if they use emergency services inappropriately.

The Medicaid Member Agreement gives responsibility to members, sets expectations for behavior and rewards success. The addendum to West Virginia's member agreement is based upon the American Academy of Family Practice Clinical Preventive Guidelines, the Agency for Healthcare Research and Quality's (AHRQ) Guide to Clinical Preventive Services, recommendations of the U.S. Preventive Services Task Force (USPSTF), and the American Academy of Pediatrics Clinical Guidelines.

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 and federal government. 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 examine options to broaden Medicaid access to low-income working adults. The State of West Virginia looks forward to working with its federal partners to improve and refine its Medicaid program.

Attachment A
Proposed Eligibility Groups

MEDICAID REDESIGN ELIGIBILITY GROUPS

CHILDREN'S COVERAGE GROUP

Eligibility	Changes	State Plan Changes	Waiver Required	FPL Current	FPL New
Income Based on child Income Test	None			Less than 1 – 150% Continuously eligible newborns 12,279 (CEN) 1 to 6 – 133% 6 to 19 – 100% Members (133,569)	No changes
Asset Test - None Can Have Other Insurance Coverage	None				
12 Month Continuous Eligibility	None				

MEDICAID REDESIGN ELIGIBILITY GROUPS

ADULTS 65 AND OVER COVERAGE GROUP

Current Eligibility	Changes	State Plan Changes	Waiver Required	FPL Current	FPL New
<p>QMB Include NHC Single \$798/mo. Couple \$ 1070/mo.</p> <p>SLIMB Single \$799 – \$957/mo. Couple \$1,071 – \$1,283/mo.</p> <p>QI-1 Single \$958 – \$1,077/mo. Couple \$1,284 - \$1,444/mo.</p> <p>Asset Levels Single \$3,030 Couple \$6,000</p>	<p>65 and over</p>		<p>No</p>	<p>100% FPL QMB – 4,764 Between 101% - 120% SLIMB – 3,585 Between 121% - 134% QI-1 – 2,475</p>	

MEDICAID REDESIGN ELIGIBILITY GROUPS

SPECIAL NEEDS COVERAGE GROUP

Program	Changes	State Plan Changes	Waiver Required	FPL Current	FPL New
Nursing Home Service	None			225% 4,468	No Change
ICF/MR	None			225% 210	No Change
HCB Waiver Categorically Needy Optional				225% Members 1,270	No Change
MR/DD				225% Members 648	No Change
Children with Disabilities	None			225% 648	No Change
Deemed SSI DAC, MPD, SGA, MPG, MSS, MPC, PAC, MPW, MPT, MPR				SSA Standards 1,847	No Change
Breast & Cervical Cancer Diagnosis No other insurance	No Change			N/A 535	
Ryan White Special Funding Not Medicaid	No Change			Members 295	
Illegal Aliens	No Change			1	

MEDICAID REDESIGN ELIGIBILITY GROUPS

ADULTS WITH CHILDREN COVERAGE GROUP

Eligibility	Change	State Plan Changes	Waiver Required	FPL Current
Income Income Test No deeming	None			July 16, 1996 AFDC payment levels
Asset Test	None			Asset Test - \$1,000 1 - \$149 2 - 201 3 - \$253 4 - \$312 Members 5/05 (16,055)
Pregnant Women No Asset Test				150% FPL Members 5/05 (8,785)
Transitional Medicaid (Up to 12 Months)	None			Members 3,212 Loses Medicaid due to earnings
Extended Medicaid Child Support (4 Months)	None			Members 294 Ineligible due to Child Support amount received

Attachment B

Proposed Benefit Packages

DEPARTMENT OF HEALTH AND HUMAN RESOURCES
 BUREAU FOR MEDICAL SERVICES
 MEDICAID REDESIGN
 BENEFITS PACKAGES/SERVICES

Potentially Capped Population

Benefit Description	Children	Adult w/o Children*	Well Elderly		Adult w/Children		Special Needs/Long Term Care	
			w/Medicare	w/o Medicare	Preg. Women	Adults	Children	Adults
Inpatient Hospital Services	X	X-cap \$ level		X	X	X	X	X
Outpatient Services	X	X-limit \$2,500/yr.		X	X	X	X	X
Emergency Room Services	X	X		X	X	X	X	X
Physicians/NP Surgery/Medical	X	X-\$5 co-pay/visit		X	X	X	X	X
Lab/X-Ray/Diagnostic Radiology	X	X-limit \$250/yr.		X	X	X	X	X
Preventive Services:	X	X		X	X	Per Preventive guidelines	X	
Cardio-Vascular risk: nutritional counseling; exercise program	X				X	X	X	
Diabetes: nutritional counseling; diabetic supplies; exercise program; podiatry	X				X	X	X	
Hypertension	X				X	X	X	
Asthma	X				X	X	X	
Cystic Fibrosis	X				X	X	X	
Metabolic Disorders							X	
Prenatal Services					X			
Right from the Start Program					X		X	
Birth to Three							X	
Tobacco Cessation Program					X	X		
Immunizations	X				X	X	X	X
Pharmacy	X	X-Generic-\$3.00; PDL-\$10.00; Brand--\$25.00**		X	X	X	X	X
Emergency Ambulance Services	X			X	X	X	X	X
Dental	X				Basic Benefit w/cap \$	Basic Benefit- \$ Cap w/copayment	X	Limited \$ cap
Vision/Glasses	X						X	
Mental Health	X				X	X-limited pkg	X	X
Chronically Mentally Ill	X						X	X
Case management	X				X		X	X
Clinic and Rehab Services	X				X		X	X
Therapy Services	X				X		X	X
Hearing	X				X		X	X
Family Planning (older children 12-18 years)	X				X	X	X	X
Non-emergent transportation					X		X	X
Catastrophic Benefit w/premium		X						
Durable Medical Equipment				X			X	X
Home Health				X			X	X
Home & Community Based Services				X			needs based	needs based
Personal Care Services				X			needs based	needs based
MR/DD Services							needs based	needs based
Facility				X			X	X
Nursing Home				X			X	X
ICF/MR							X	X

* Potential premium for catastrophic coverage

**If person chooses a brand when generic is available and there is no documentation that the generic cannot be taken, the member would be responsible for the entire cost of the drug.

Attachment C

Quality Plan Proposal

West Virginia Quality Plan

Domain	Indicators	Data Sources
<p>Access Definition: Obtaining services in a timely manner.</p> <p>For example: network capability, waitlists, # kept appointments</p>	<p>Examples:</p> <p>Structure: Number of facilities/clinicians to treat specific problems. Process: Ease of contacting provider and getting an appointment in timely manner. Outcome: Average number of days from appointment requested to appointment.</p>	
<p>Service Utilization Definition: Amount and types of services provided to a patient.</p> <p>For example: Prevention visits, inpatient utilization, LOS, under and over utilization by service/diagnosis</p>	<p>Examples:</p> <p>Structure: Provider has established clinically based data collection process at intake. Process: Process includes appointments scheduled, consumers prompted, intake conducted and service levels determined. Outcome: Compared to total population, percent of patients by clinical presentation receiving care.</p>	
<p>Effectiveness of Care Definition: Appropriate care for presentation.</p> <p>For example: Provider credentials, clinical outcomes, management of specific diseases, prevention</p>	<p>Examples:</p> <p>Structure: Identify outcome indicators specific to clinical presentation. Process: Design system to track indicators specific to clinical presentation. Outcome: Of the total number of children completing TX Protocol, X% showed significant improvement as measured by the CAFAS.</p>	
<p>Patient Experience Definition: Rights, responsibilities, service satisfaction and complaints</p> <p>For example: Education of rights/responsibilities, Personal Responsibility Contacts, Satisfaction w/services and system, and number/types of complaints</p>	<p>Examples:</p> <p>Structure: Survey/questionnaire to report quality of a service or patient experience during the health care process Process: Patient will report or respond to questionnaire re: degree of satisfaction with the service received or with process of accessing care Outcome: "Mean" score or percentage or respondents who report "XYZ"</p>	
<p>Safety Definition: Relates to potential and/or bodily/emotional harm.</p> <p>For example: Number of medical errors, infection control, incident reporting</p>	<p>Examples:</p> <p>Structure: Provider or facility must have a safety plan. Process: Procedures are established for tracking and reporting Medical errors. Outcome: With baseline established, medical errors will decrease X% each year.</p>	
<p>Administrative Definition: Relates financial accounting and information technology.</p> <p>For example: cost of care, "pay for performance", electronic record capability</p>	<p>Examples:</p> <p>Structure: Design data collection system to capture true cost of care by diagnosis and clinical condition. Process: Analyze true cost of care, including prevention measures, acute and chronic TX protocols, emergency care, etc., of specific clinical conditions. Outcome: Identify cost-effective treatment strategies and areas where prevention should be funded to decrease total cost of care.</p>	

Attachment D
Medicaid Member Agreement

WEST VIRGINIA MEDICAID MEMBER AGREEMENT

MEMBER RIGHTS

1. **I understand** that the information I provide is confidential and the Medicaid Program and my health plan only will release the information for purposes related to the administration of the Medicaid Program.
2. **I understand** that I have a right to be in charge of my health care. I understand that I have a right to see my medical records. I will be a part of all decisions about my health care. I can talk freely and honestly with my health care provider and ask him or her any questions I have about my or my children's illness and treatment.
3. **I understand** that I will be treated fairly and with respect. I will get the care and treatment I need as soon as possible. I understand that I cannot be treated differently because I am in the Medicaid Program or because of my age, sex, race, national origin, illness or health condition.
4. **I understand** that I have a right to know about all laws, regulations, rules and requirements about the Medicaid Program and my health plan.
5. **I understand** that I can call or write to my health plan about any questions or tell them about problems I am having by calling (304) 558-XXXX or writing to XXXX.
6. **I understand** that as a Medicaid member that that I have a Right to appeal any decision and to receive a prompt Fair Hearing before the Department of Health and Human Resources, Board of Review. I can request a fair hearing by calling (304) 558-XXXX or writing to XXX.

MEMBER RESPONSIBILITIES

1. **I understand** that it is my responsibility to follow the rules and requirements of the West Virginia Medicaid program and my health plan. I understand that it is my responsibility to take the best care of myself and my children.
2. **I will cooperate** with the Medicaid Program and my health plan and provide them with accurate and timely information about myself and my family members. I will notify the Medicaid Program of any changes in my life situation. Changes may include, but are not limited to:
 - a. a change in address or phone number;
 - b. someone moving in or out of my home;

- c. getting or losing a job;
 - d. any changes in earnings, income or assets; and
 - e. any changes in health status such as becoming pregnant, being diagnosed with a disease or achieving my health improvement goals.
3. **I understand** that it is my responsibility to do what is necessary to stay healthy. I understand that smoking, using drugs illegally, drinking too much alcohol, and being overweight are bad for my health. I promise to try not to do these things. I will go to the special programs as my health care provider advises in order to improve and maintain my health including exercise and nutrition programs.
 4. **I promise** to examine the booklets and materials my health care provider gives me about how to be a healthy person or have them explained to me by my health care provider. I will ask my health care provider questions if I do not understand his or her instructions or if I do not understand the material I have read.
 5. **I understand** that it is my responsibility to select a medical home. If I do not select a medical home in 45 days, one will be selected for me. I understand it is my responsibility to go to that medical home when I or any of my family members get sick. I understand that I should go to my health care provider at least once a year for a check up, and to take my children more often when the health care provider advises me to. I will listen to the health care provider when I or my children are sick, and do what the health care provider tells me to do; including taking the medications he/she gives me. I will show up on time when I or my children have an appointment to see the health care provider. If I must cancel when I have an appointment, I will call to tell my health care provider I cannot come. I will only do this when there is a very good reason. If I miss three consecutive appointments, I understand I will be assessed a penalty.
 6. If I hold up my part of this agreement and I meet the health improvement goals set by my doctor, I understand that I may receive an award or have to pay less for my medical appointments and my medicines.
 7. If I do not hold up my part of this agreement, I understand that I may be excluded from the special benefit programs and may be excluded from incentive programs.
 8. **I will** go to the hospital emergency room only when I feel it is a medical emergency. Whenever, I am sick I will call my doctor first and go see him or her. If I cannot talk to my doctor or some one in the doctor's office and it is an emergency, then I will go to the hospital.

WEST VIRGINIA MEDICAID RESPONSIBILITIES AND ACKNOWLEDGMENT

1. **DHHR will** work with you and your health care provider to develop a health improvement plan and make any changes that may be needed.
2. **DHHR will** support your health improvement plan by providing information, guidance and services.
3. **DHHR will** encourage you to take the lead in determining the plan to achieve your health improvement goals.
4. **DHHR will** give you timely notice before anything negative happens to your benefits and will provide the opportunity for a Fair Hearing on any issue related to your benefits or to your health improvement plan.
5. **As a representative of DHHR,** I have carefully explained the above information and acknowledge the responsibilities of the Department

Income Maintenance Worker Signature

Date

MEMBER ACKNOWLEDGMENT

I understand the information contained in this document and agree to follow this, my West Virginia Medicaid Member Agreement.

West Virginia Medicaid Member Signature

Date

MEMBER AGREEMENT

In order to be a **responsible parent** I agree to...

1. NOT smoke
2. take my children to all of their check-ups
3. make sure my children get all of their shots
4. take my children to the dentist
5. follow all of the safety guidelines recommended by my health care provider

In order to be a **healthy woman** I must...

1. see my health care provider every year for a check-up
2. see the dentist every 6 months
3. have advanced directives on my medical records so that it is clear what my wishes are if I get hurt and cannot state my wishes
4. get all of my shots
5. have a female pap test and breast exam every year starting at age 18 (or when I first become sexually active)
6. have a mammogram regularly, as instructed by my health care provider, starting at age 40
7. have colorectal cancer screening starting at age 50 (age 40 if colon cancer runs in my family)
8. have my cholesterol checked starting at age 25
9. make sure I have a complete skin exam by my health care provider at my check-up
10. NOT smoke or use alcohol in excess
11. maintain a healthy weight (body mass index less than 25)
12. take control of my health and know my health status
13. know my family health history because it can affect my health

In order to be a **healthy man** I must...

1. see my health care provider every year for a check-up
2. see the dentist every 6 months
3. have advanced directives on my medical records so that it is clear what my wishes are in case I get hurt and cannot state my wishes
4. have colorectal cancer screening completed every year starting at age 50 (age 40 if colon cancer runs in my family)
5. talk to my provider about screening for prostate cancer starting at age 50 (age 40 if prostate cancer runs in my family)
6. have my cholesterol checked starting at age 25
7. make sure I have a complete skin exam by my health care provider at my check-ups
8. NOT smoke or use alcohol in excess
9. maintain a healthy weight (body mass index less than 25)
10. take control of my health and know my health status
11. know my family health history because it could affect my health

If I have **diabetes** (“sugar”) I must...

1. know what a Hemoglobin A1C is (average sugar over 3 months)
2. know my Hemoglobin A1C (a number from 4-15)
3. know my goal for my Hemoglobin A1C (less than 7)
4. get my blood checked regularly (about every three months)
5. know my blood pressure and my blood pressure goals (less than 130/80)
6. know my cholesterol and what my goals are (total less than 200, LDL less than 70, HDL more than 40)
7. follow a diabetic (low sugar) diet
8. take all of my medicines
9. exercise at least three times a week for about an hour
10. see my provider every three months (unless they instruct me otherwise)
11. see a diabetic instructor twice a year
12. get a complete foot check every year
13. make sure I understand the effects diabetes has on my heart, kidneys, eyes, legs
14. see the eye doctor every year
15. get all of my shots

TO BE A HEALTHY PERSON - KNOW YOUR NUMBERS!

Body Mass Index (BMI)--an accurate way to know if I am a healthy weight
Cholesterol (total, LDL, HDL, triglycerides)
Blood Pressure
Hemoglobin A1C (HgA1C) if you are a diabetic