West Virginia Health Care Reform

Roadmap to Health Project: Final Recommendations to Select Committee D

(approved Dec. 18, 2008, by Executive Committee)

Kenneth E. Thorpe, PhD
Emory University

January 6, 2008

DRAFT

TABLE OF CONTENTS

TOPIC	PAGE
Health Care Reform Background	
Overview	**3**
Context	**3**
Approach	**4**
Specific Recommendations	**5**
I. Patient-Centered Medical Home	**5**
II. Reducing Administrative Costs	**11**
III. Wellness and Prevention	**13**
IV. Health Information Technology	**15**
V. Expanding Access to Care	**17**
VI. Financing	**18**
VII. Governance	**18**

DRAFT

Overview

These recommendations reflect the product of four working groups and hundreds of volunteers staffing the efforts. I have integrated these recommendations across the working groups and added some addition elements to the recommendations. The four workgroups were:

1. Administrative Simplification, headed by Carl Callison, Mountain State Blue Cross Blue Shield
2. Health Information Technology and Chronic Care, headed by Dr. Jim Comerci, Upper Ohio Valley Independent Practitioners Association
3. Health Care System Redesign, headed by Tom Susman, TSG Solutions
4. Wellness and Prevention, headed by Keri Kennedy, WVDHHR, Office of Healthy Lifestyles

Context

West Virginia spends 13 percent more per person on health care than the national average. Moreover, the growth in spending is slightly higher in West Virginia compared to the national average. Over 14 percent — some 254,000 — West Virginians were uninsured during 2007. Given the high and rising cost of health insurance, few small employers in the state offer health insurance. Nationally, 35 percent of firms with fewer than 10 workers offer health insurance compared to less than 25 percent in West Virginia.[1] Data from the U.S. Centers for Disease Control and Prevention (CDC) indicate that West Virginia has among the highest rates of childhood and adult obesity in the country. These high rates of obesity are associated with high and rising rates of diabetes, hypertension, hyperlipidemia, heart disease, pulmonary disorders and co-morbid depression.

The quality of care provided to chronically ill patients is uneven. Overall, chronically ill patients receive approximately 56 percent of the clinically recommended health care designed to manage their conditions. Much of the clinically recommended care involves self-management, persistency in filling and refilling prescriptions and regulating key metrics such as blood glucose, blood pressure and weight, among others. Research has shown that a strong presence of primary health care, often working with patients at home, is an important element of effective care.

West Virginia must act to address these issues. The high and rising cost of health insurance means lower profits and wage growth for West Virginia's businesses and workers. The high and rising rates of chronic illness not only constitute a substantial disease burden, they also represent substantial reductions in worker productivity. According to studies from the Milken Institute, every dollar spent on the medical treatment of chronic disease is associated with $4 in lost productivity. These recommendations are designed to improve the financial standing of businesses in the state, making West Virginia a more attractive business location. They also are

[1] http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2006/tiia2.pdf

designed to improve the health status and productivity of workers. Finally, they are designed to reduce wasteful administrative costs and improve access to needed health care by the uninsured.

Attacking these problems first requires a clear understanding of where the state spends its health care dollars and what is driving the rise in health care spending over time. These trends are central to the declining rate of employer-sponsored insurance in the state. I have estimated that nearly 80 percent of health care spending in the state of West Virginia is associated with chronically ill patients. A major underlying cause of chronic disease in the state is the high rate of obesity and smoking. Today, at least 30 percent of adults (according to self-reported data) are obese. This is double the rate from the 1990s.

The overarching goal of the recommendations from the Roadmap to Health Project are to improve West Virginia's ability to identify and care for chronically ill patients, thereby bringing efficiency and savings to health care spending, but this report does not limit itself just to that population. The final section of this report presents some preliminary recommendations for expanding access to health care through a universal wellness benefit and tax credits for small businesses to acquire health insurance.

Approach

The following recommendations to Select Committee D are designed to reduce the level and growth in health care spending in both the public and private sector, increase access to clinically appropriate health care services among the uninsured and improve the quality of care provided. The recommendations and design of the workgroups reflect the underlying issues driving high costs and its correlated high rate of uninsured citizens.

The current approach for paying for health care in the state and nationally was designed to pay for and treat acutely ill patients episodically. Most of the health care spending in West Virginia, however, is associated with chronically ill patients. Effective treatment of chronically ill patients requires a strong primary care base, home care to manage and prevent acute flair-ups of the condition and working with patients on care transitions (i.e. upon admission to a hospital and working with them after discharge to prevent unnecessary readmissions). This integrated care model requires information technology to track the progress of treating patients with multiple chronic conditions and a reliance on health care teams — physicians, nurse practitioners, nurses, social and mental health workers, pharmacists and other community links. Creating these teams, providing them the information technology and appropriate payments and incentives is a central challenge of reform.

At the same time, preventing disease must be at the heart of any effort to slow the rise in health care over time. This means we need to identify best practice interventions — those that reduce smoking, improve diet, exercise and nutrition. Several settings could be helpful in efforts to reduce the incidence of chronic illness, including schools, community-based interventions, the worksite and better design of health insurance benefits to encourage appropriate preventive behavior.

Specific Recommendations

Making Health Care More Affordable

We are presenting several recommendations that would reduce the growth in health care spending in public programs as well as the private sector. We start with the recommendations around modernizing the health care delivery system in the state to manage and prevent chronic illness more effectively.

I. PATIENT-CENTERED MEDICAL HOME

A. Definition

The group developed a definition of a "medical home" based on the national models, which have a physician practice leading a multi-disciplinary team. There was discussion that a West Virginia model might consider other providers in that role, but the Health System Redesign working group decided that West Virginia should not veer too far from the national model, given the current provider licensure laws, state and national standards,. If the National Committee for Quality Assurance changes its position, then the state should discuss considering this change.

The patient-centered medical home is a health care setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patients' families and communities. A patient-centered medical home integrates patients as active participants in their own health and well being. Patients are cared for by a physician or physician practice that leads a multidisciplinary health team, which may include but is not limited to nurse practitioners, nurses, physician's assistants, behavioral health providers, pharmacists, social workers, physical therapists, dental and eye care providers and dieticians to meet the needs of the patient in all aspects of preventive, acute, chronic care and end-of-life care using evidence-based medicine and technology.

Many physician groups on a national and state level have agreed to the following principles and background.

The American Academy of Pediatrics, American Association of Family Physicians, American College of Physicians and American Osteopathic Association, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the patient-centered medical home.

Principles of the Patient-Centered Medical Home[2]

Personal physician: Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician-directed medical practice: The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole-person orientation: The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life, acute care, chronic care, preventive services and end-of-life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care-planning process driven by a compassionate, robust partnership between physicians, patients and the patient's family.
- Evidence-based medicine and clinical decision-support tools guide decision making
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education and enhanced communication

1. Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate they have the capabilities to provide patient-centered services consistent with the medical home model.
2. Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician and practice staff.

---

[2] The AAP, AAFP, ACP and AOA presently are refining the language of these principles to include changes such as "physician-based" to "team-based" and "personal physician" to "care team." Until these entities formally choose to change this language, this process will live by the current principles stated above.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

1. It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
2. It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers and community resources.
3. It should support adoption and use of health information technology for quality improvement.
4. It should support provision of enhanced communication access such as secure e-mail and telephone consultation.
5. It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
6. It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
7. It should recognize case mix differences in the patient population being treated within the practice.
8. It should allow physicians to be eligible for enhanced reimbursements associated with physician-guided care management in the office settings which are realized from cost containment in other areas of the health care system, such as the reduced use of hospital emergency rooms and preventable admissions and readmissions
9. It should allow for additional payments for achieving measurable and continuous quality improvements.

B. Creating the capacity for a medical home

The major recommendation is to transform the delivery model *statewide* toward primary prevention and more proactive care management. Ideally, this new patient-centered medical home model would accommodate the capacity of small physician practices (through linking them with community health teams, or CHTs, as described below) and larger practices able to achieve full NCQA medical home certification. If effective, these new delivery models would attract the participation of Medicaid, state employees, private health plans, self-insured firms and Medicare. Smaller physician practices combined with the CHTs would have the same medical home capacity as larger physician practices.

We are proposing a phased-in transformation of the delivery model state wide through the use of several pilots described below. These recommended pilots would commence with the intent that within five years West Virginia will be able to move toward statewide implementation of the patient-centered medical home health care delivery model.

Pilots

Medical home designation is based on criteria developed by the National Committee on Quality Assurance. The NCQA imposes nine standards, including 10 must-pass elements, which can result in one of three levels of recognition. Physician practices seeking NCQA accredited medical home designation are required to establish at least five of the 10 must-have elements. They also have to complete a Web-based data collection tool and provide documentation that validates responses.

Larger group practices likely have the ability to adopt most, if not all of the key elements of an NCQA medical home. But West Virginia is a rural state with approximately 500 primary care practices with four or fewer medical providers. Many of these physician practices do not have the capacity to adopt the key minimal elements to become an NCQA medical home. For these practices, the Roadmap to Health Project recommends an alternative model than that proposed for larger group practices.

It was recognized that many individual practices might not be in a position to become an NCQA accredited Patient Centered Medical Home. In addition, it will take time for a practice to become approved. For these reasons, the Roadmap project recommends West Virginia should commence three types of pilots that would be open to all applicants and are voluntary for providers and private payers.

1) **Chronic Care Model Pilots**
Working with payers and providers, various disease states are identified and primary care providers begin to implement programs to improvement management of the agreed-upon condition of the patient.

Currently, West Virginia has a multi-payer workgroup comprised of the medical directors of the major payers, such as BCBS, The HealthPlan, Carelink and the state payers along with medical providers and others. Part of their charge is to target disease states that payers might agree to pay providers to manage and develop strategies. They are looking at childhood obesity, diabetes and asthma.

The pilots could dovetail with this current work. This would allow individual practices to work in the reform effort even if they decided not to become medical homes.

Registries might need to be developed or current ones expanded to assist those providers that do not have one.

2) **Individual Medical Homes Pilots**
The establishment of individual medical home pilots is contemplated under the patient-centered medical home concept as certified by NCQA. The system will have up-front costs associated with the transformation with the expectation that even larger savings downstream will materialize.

Those generally larger practices going for Level I certification would be granted a provisional Level I certification by virtue of certifying they are in the process of certification and currently have obtained at least 20 NCQA points. This provisional certification lasts only one year with no renewal.

Any state program must recognize NCQA and the provisional certification so long as a medical home program with enhanced provider payments is in operation.

3) **Community Centered Medical Home Pilots**

Most physician practices in the state are small. One approach that has proven effective already in other states (North Carolina) is to link primary care practices with community health teams (CHTs). The state also could build on the community health center structure it already has in federally qualified health centers as one example of a community health team. The CHTs would include social and mental health workers, nurse practitioners, care coordinators and community health workers. These personnel largely exist in community hospitals, home health agencies and other settings. The key would be to identify these resources as a separate team to collaborate with the primary care practices. The teams would focus on primary prevention (smoking cessation programs and wellness interventions) as well as working with the primary care practices to manage patients with multiple chronic conditions (for instance, the depressed diabetic patient who is not following the physicians' care plan).

In a community centered medical home, all health care agencies are connected and share resources. Citizens can enter the system of care from any point and receive the most appropriate level of care or be directed to the most appropriate care (especially with open access systems in play, shared case management and health education/self-management support services, and after-hours triage/support). NCQA currently is considering certification for such a model. Data that is collected regarding outcomes for certain indicator conditions are fed into a central repository and evaluated against a denominator (the number of citizens that are potential or real users of the health care system).

Financial incentives should involve all health care payers and could be employed to encourage the collaboration between primary care practices and the community health teams. First, the practices could receive a small, per-member per-month payment (PMPM) recognizing the additional time and responsibilities associated with developing and monitoring a care plan. To encourage the development of additional capacity (using both the CHT and the practice as the designated medical home), the PMPM payment could rise with the number of NCQA medical home "points." Second, primary care practices moving in this direction also would be eligible for financial assistance in the acquisition of an electronic health record and associated training (more detail on this is provided below in the health information technology section). Other models using capitation with shared savings could also be explored, similar to the pilot under development by the Public Employees Insurance Agency.

Target Conditions

To maximize effectiveness of the medical home models, the reform effort should prioritize chronic conditions to be targeted and resources devoted to the targets. Previous evaluations of chronic care management have shown the potential for reducing costs for several conditions, including heart failure, among homebound patients, diabetics with co-morbid conditions such as depression, hypertension and hyperlipidemia and patients with several chronic conditions. A key for physician primary care practices to manage such patients effectively is an understanding of which patients in their practice present the best opportunities for intervention, and getting the patients to participate (and be compliant) with the care plan developed by the primary care physicians.

The West Virginia Health Care Authority has data available to help identify the conditions to be targeted. While each purchaser may have his or her own needs based on demographics, it makes financial and resource sense to develop an agreed-upon list. This list is not intended to deter individual activities,

Strategies need to be developed or adopted for each targeted condition. Many of these chronic conditions already have physician agreement through published consensus panels on the appropriate clinical management of chronically ill patients (in particular for diabetes, hypertension, abnormal cholesterol and asthma). It is important that chronic disease strategies be consistent to the highest degree possible among the payers and providers. This will reduce administrative costs and will allow for easier deployment. Centralized provider training and patient material can be developed, and data analysis will be easier.

This process should not allow any single health plan to veto a disease state or a deployment strategy. It is important to get buy-in from the majority of the private purchasers. They will need to see value to pay the provider for the chronic care services. It should be noted that because of federal regulations, some state programs might not be able to participate in some of the adopted programs.

The NCQA allows a practice to determine evidence-based chronic care diseases strategies it wants to deploy; however, the key is to get the payers to pay for the program. It is hoped this process will facilitate purchaser participation.

West Virginia has a multi-payer work group in the state. This group is reviewing various chronic care strategies. We recommend this group or some version of it be assigned the responsibility of targeting disease states and coordinating the development of strategies under this proposal.

Evaluation and Goal-Setting

Any project must be evaluated; this effort is no different. The basis of what gets evaluated is an important discussion, however, and in health care, no reform will affect all of the population positively. Instead, the work we have done looks to optimize and improve our delivery system. This is a dynamic process and will evolve as we move forward.

To that end, realistic activities must be measured to determine the success or failure of a particular aspect of the program. Ultimately, the approach is designed to improve quality at lower costs, and eventually the reform must be judged in that context. The key will be to build on what we have learned. Multiple indicators will be put in place to evaluate pilot programs on practice level (How efficiently is care being provided?), system level (What can be done to improve coordination between separate entities?) and state level (Does the feedback received meet expectations set forth by the committee?).

Separate evaluations for individual applicants will ensure that NCQA guidelines are met. The evaluations also will include specifications to be met as an applicant moves from tier to tier within the NCQA PCMH model.

As a provider moves form Level I to Level II NCQA, the amount of data that can be used for evaluation will greater. As providers move to this level and receive higher reimbursement, more measures should be used for evaluation.

Measurements must be simple to understand and to collect. These should be tied to information readily available on the electronic medical record (EMR) or a claims file. EMRs must have the ability to measure case management performance and transfer the evaluation to system management outcomes. For example, if an indicator relates to colon cancer, the program could use incident data that may or may not be collected at this time. A simpler alternative might be the number of adults age 50 and above who have had a colonoscopy. If the base was 40 percent, did the program move the number to 70 percent?

If goals are set and the program moves toward those goals, it will be optimizing the health status of those participating in the program. Too often health programs get lost in a discussion of what is quality. Our definition of quality should center on meaningful measures that improve quality and reduce costs.

The most important aspect of the evaluation process is to have accurate data. Garbage in will lead to garbage out. Reasonable standards, measures and reporting methodologies must be established while working with the multi-payer group and providers.

Systems need to be built that provide immediate feedback to the practice on performance. It is not acceptable to get 12-month-old reports. We cannot manage the past; we need to manage the future.

Evaluations should be conducted at the practice level, community or network level and state level. The factors to be assessed at each level will be different and need to recognize and reflect that our current employment-based fee–for-service system largely evolved from World War II wage freezes. Any change will not occur overnight. This is a process.

II. REDUCING ADMINISTRATIVE COSTS

By some estimates, the costs of administering our health care system are 25 to 30 percent of total health care spending. Several aspects of the recommendations would reduce the costs of administering health care. One major approach — the expanded use of health information technology — is outlined below. We see two major areas for reducing administrative costs.

Practitioner Credentialing

The single most contentious subject addressed by the Administrative Simplification Work Group was credentialing of medical practitioners. The goal is to streamline and simplify the process, and in doing so, reduce some of the duplicative infrastructure. Payers and hospitals credential practitioners as part of the process of approving them as a network provider, or in the case of hospitals, allowing them practice privileges at the facility. Currently, practitioners must submit a credentialing application to each hospital where practice privileges are being requested and each payer for whom they want to be included in the payer's network. Upon receipt of the application, each hospital and payer initiates a process of verifying information contained in the application to ensure the practitioner meets their respective requirements for practice privileges and network participation. By the very nature of the process, duplication of activities are being carried out by the practitioner, the multiple hospitals for which practice privileges are being requested and the multiple payers for whom the practitioner wishes network inclusion. Although use of a West Virginia Uniform Credentialing Application mandated several years ago by the West Virginia Legislature somewhat mitigated the duplication of activities, it still exists.

To streamline the process and reduce duplicate effort across the process, the Administrative Simplification Work Group recommends legislation to establish a single statewide private entity or no more than three (3) regional entities in the state that will provide electronic access to the West Virginia Uniform Credentialing application to all practitioners. These will be the central repositories for information required by hospitals and payers as part of the credentialing process, will verify all information provided by the practitioner; including site visits to the practitioner and will make this information available electronically to hospitals and payers. The entity will also establish procedures for ensuring that practitioners' files are kept up to date by issuing quarterly reminders for updated information.

The legislation will direct the Department of Health and Human Services and the Office of the West Virginia Insurance Commissioner to solicit proposals from entities interested in performing this function. The Request for Proposal either would mandate or provide incentives for the successful bidder(s) to be located and perform functions within West Virginia. Legislation would mandate that recipients of services to be provided by the new entity be represented on the board of the entities. Legislation should provide for an initial five-year contract period for the successful bidder, and after that period, other entities could enter the market.

In recognition of the goal of reducing costs and simplifying the process associated with the credentialing process, specific timeframes and performance requirements should be placed on

both the new entity(ies) as well as the credentialing payers to ensure that the entire credentialing process is finalized within 60 days but no more than 90 days. In those cases where the process is not completed within the 90 day period, except for good cause, payers should be required to approve the application on a provisional basis. Consideration should also be given to requiring or at least allowing all practitioners of a large practice to apply for credentialing at the same time instead of at different times individually.

Prior Authorization Requirements and Processes

The Administrative Simplification Work Group discussed the requirements and processes imposed by payers in approving certain medical procedures prior to their being rendered. The work group reached a general consensus that little if any consistency exists among the different payers regarding medical procedures requiring prior authorization and procedures for obtaining the prior approval. Some work group members also provided examples where the entity rendering the service in accordance with orders from the referring physician was not paid for the procedure rendered because the referring physician had not obtained the required approval for the procedure.

Because of the varying medical procedures subject to prior authorization from different payers, the group concluded it was not possible to document and establish specific policies and procedures for obtaining prior approval for specific medical procedures or classes of procedures. The work group did conclude, however, that payers should be required to publicize specific information regarding their prior authorization policies and procedures. This information should include:

1. A listing of procedures requiring prior authorization.
2. Written documentation on how to obtain preauthorization.
3. Professionally accepted evidence-based criteria for evaluation of medical appropriateness of procedures.
4. Established timeframes for non-urgent, urgent and expedited review.
5. Identification of staff responsible for different levels of review
6. Identification of internal and external reconsideration and appeal process.

Payers should be required to make the above information available to practitioners and providers through an Internet site.

III. WELLNESS AND PREVENTION

The Wellness and Prevention Work Group identified several potential options for reducing the demand for and use of tobacco and more effective primary prevention interventions in the schools and communities designed to reduce the level and growth in obesity among children and adults. These recommendations included:

- Tobacco Cessation: Continue to promote and support efforts to decrease the number of West Virginians using tobacco products (cigarettes, cigars and assorted smokeless tobacco products).
- Nutrition and labeling: The team agreed to make a recommendation that WV pass legislation that would require chain restaurants to post calorie information at the point of purchase.
- School-based initiatives:
    - Recommend that West Virginia place a dietician in each of the regional education service area (RESA). There are 8 RESAs in the state.
    - Complete implementation of the Dance-Dance Revolution program and institute a comprehensive evaluation process for this initiative.
    - Preserve recess time (time away from instruction and not physical education time) that is allocated for physical fitness in K-12 schools. In addition, do not allow physical activity time to be withheld as a form of punishment.
    - Encourage physical activity to include sports that raise heart rates to the national threshold level required to burn calories (i.e., considered aerobic exercise).
    - Provide continuing education for school food personnel and create a job ladder structure/ hierarchy that reward food personnel for earning continuing education hours/credits.
    - Assure that school building funding guidelines account for physical activity capacity in the building of new school facilities.
    - Incorporate school-based physical activity coordinators.
- Community-based initiatives: Incentives such as tax breaks for cities and municipalities that build and maintain bike/pedestrian trails
- Use the community health teams to develop care plans for healthy children and adults designed to keep them healthy, and those at risk (pre-diabetic) to prevent their transition to full clinical diabetes, hypertension and other chronic illnesses.
- The team recommends that WV increase the percentage of federal funds (received by WV) that are dedicated for the development of trails/sidewalks.

IV. Health Information Technology

The broader use of electronic health records (E, physician decision support and e-prescribing will lower health care costs and improve the quality of care.

Health information technology, or HIT, is the key tool that will allow seamless collaboration between primary care practices and the community health teams in managing chronically ill patients. The goal of the initiative is to move toward a 60 percent adoption rate of electronic medical records in physicians' offices within the next three years. This is a bold recommendation and when combined with the community health teams would constitute major innovations and improvement in West Virginia's health care delivery system.

As stated above, the major goal of this initiative is to achieve 60 percent EMR adoption in West Virginia physician clinics in three years. This will be accomplished in four ways:

1) Recommendation for a **single common path for health information exchange t**hrough the West Virginia Health Information Network (WVHIN), affording faster adoption, health information exchange leading to option of additional health technology such as EMR, physician support tools, etc.

2) Expanding the use of HIT
   - A. Facilitation and encouragement of ongoing projects such as EMR resources in community health clinics.
   - B. Encouragement of continued development of hospital systems and deployment of hospital-supported EMR when available for hospital-based, hospital-employed and non-hospital-employed physicians.
   - C. Drive EMR adoption by financial features such as **tax incentives**, **vendor discounts**, **enhanced reimbursement** and other means to individual physician offices and clinics.

3) Recommend EMR best practices for ambulatory and hospital EMR.
   - A. Certification Commission for Healthcare Information Technology (CCHIT) certification as minimum standard
   - B. West Virginia E-Health initiative white paper on EHR /EMR adoption.

4) Recommend a funding mechanism that provides initial start-up funds and a mechanism for sustainability to include:
   - A. Funding of the network and network functions (**public/private fund)**
   - B. **IT Fund** managed by West Virginia Health Information Network. The WVHIN Board will determine direction of these funds and projects. The funds will be used for but not limited to development and sustainability of the Health Information Network, health decision support tools for health care providers and consumers, education for health informatics and health information technologists.
   - C. Bottom- level funding for EMR adoption in individual physician offices and clinical offices to include **tax incentives** and **negotiated discounts from vendors and enhanced reimbursement**. Promotion of existing and development of new ASP (application service provider) models in the state will help this level.

This approach affords an opportunity to develop a health information network systematically, deploying components in a logical model beginning with health information exchange and leading to physician support tools, electronic prescribing, connection to other networks, ASP-based EMR and others. At the same time, it offers a beginning attempt at funding EMR adoption on a grassroots level.

The public-private fund would be made up of but not limited to legislative money, grants/pilot projects and revenue generated across the health care delivery system.

V. RESEARCH AND EDUCATION

Market research

For health care reform to be effective, it is important to determine what consumers want in a health system. This is true for any entity that pays for health care coverage ─ businesses, labor unions and governmental agencies ─ as well as doctors and other providers. Reforms in the past have been structured by policymakers and health experts with little regard to what people want or value. This is not acceptable.

A series of focus groups, polls and other research should be performed to determine what the various stakeholders want and would accept. As part of this process, employers, providers and consumers should be involved in the development of survey instruments. Their questions need to be answered.

Too many times, health care reforms become an academic experiment that provides great data for journal articles yet in the long run is not workable in the real world. Data from the research should be made easily available to the public. It should aid in the development and design of health benefit programs and be used by providers to meet the needs of the market.

Education

Educational assistance is crucial. While primary care physicians and the other members of the multi-disciplinary team understand their role in the current care model, many lack the management knowledge to be an effective medical home or chronic care site. A large part of these programs consists of retooling method of care delivery. Seminars, online programs and training sessions will have to be provided. Any reform effort must determine the educational needs of the medical workforce. The effort must interface with the state's medical schools, universities and community colleges. Current curricula would need to be altered to be reflective of the roles of the members of the multi-disciplinary team under this type of delivery system. The reform process should work with state technical colleges and teaching hospitals to develop chronic care model curriculum for ancillary staff. We must work to support higher education by expanding and facilitating education for health care professionals and expanding on loan forgiveness and funding programs for health care providers (including midlevel providers) practicing in the state, particularly those in a primary care setting.

VI. Expanding Access to Care.

More than 254,000 West Virginians were uninsured in a typical month during 2007. Many of the uninsured work for small businesses, and less than 25 percent of businesses with fewer than 10 offer health care benefits today. Many of the recommendations included above are designed to lower the cost of private health insurance with the goal of increasing private health insurance.

Options for further expanding access to care and coverage could include:

A. *Wellness and health promotion benefit for the uninsured:* All uninsured in the state would be eligible for a wellness and health promotion benefit. The state could use the FQHCs and the new community health teams to provide a physical exam, health risk appraisals and age- and gender-appropriate cancer screens. Each individual would receive a care plan based on their underlying risk (i.e. good, asymptomatic at risk, diagnosed with one or more health care conditions). To realize the benefit's gains fully, those without insurance who are diagnosed with any of the six most common serious chronic medical conditions (cancers, diabetes, heart disease, hypertension, stroke and pulmonary conditions) should receive clinically appropriate medical treatment. An existing model for this approach is CDC's Breast and Cervical Cancer Treatment Program.[3] Uninsured and underinsured women at or below 250 percent of federal poverty level are eligible for cervical screening (ages 18 to 64) and breast screening (ages 40 to 64). Services include clinical breast examinations, mammograms, and Pap tests, diagnostic testing for women whose screening outcome is abnormal, surgical consultation, and referrals to treatment. This approach simply expands the current CDC program to include other chronic conditions. Under this approach, all uninsured under 250 percent of poverty with a diagnosed chronic disease would receive clinically appropriate treatment.

B. *Tax credits for small businesses that do not offer health insurance.* Small businesses with 25 or fewer workers would be eligible for a refundable tax credit of up to 50 percent of the cost of a private health insurance benefit (to be determined). To be eligible, employers must not have offered health insurance for the previous year. The program could be expanded to larger firms over time. This would make 60 percent of the uninsured eligible for a discounted insurance policy.

[3] Centers for Disease Control and Prevention, "National Breast and Cervical Cancer Early Detection Program," http://www.cdc.gov/cancer/NBCCEDP/ (accessed November 7, 2008).
In 2000, Congress passed the Breast and Cervical Cancer Prevention and Treatment Act, which gives states the option to offer women in the National Breast and Cervical Cancer Early Detection Program access to treatment through Medicaid. To date, all 50 states and the District of Columbia have approved this Medicaid option. In 2001, with passage of the Native American Breast and Cervical Cancer Treatment Technical Amendment Act, Congress explained that this option also applies to American Indians/Alaska Natives who are eligible for health services provided by the Indian Health Service or by a tribal organization.

VII. Financing

Several of the recommendations will require new funding. The two most notable are the new investment in health information technology critical for assisting in producing lower health care spending and better outcomes and providing additional health insurance for the uninsured. The workgroups identified several sources of potential funding for these initiatives. These options are outlined below.

- Increased federal matching percent under Medicaid. As part of a federal stimulus package that will pass early in 2009 the federal government may temporarily increase the Medicaid FMAP . Though the amount of new federal spending remains unclear, figures have been reported that an additional $80 Billion nationally could be available to continue to fund and/or expand health insurance coverage. .
- Increase the excise tax on tobacco products. An increase in the state excise tax from 55 cents to $1.20 per pack — the national average — with a corresponding increase in the excise tax on smokeless tobacco would raise approximately $110 million in funding.
- Health information technology fund. This fund would be used to subsidize the cost of acquiring, installing as well as training associated with adopting HIT for smaller primary care practices. Funding for this fund could come from low-interest loans, negotiated discounts from vendors, enhanced reimbursement (through evaluation and management codes), and perhaps a very small percent of total claims assessment. Even a very small assessment of 0.1 percent of claims would raise over $4 million per year for the HIT fund. This would be a temporary fund that phases out over three years.

VIII. Governance

Experience from other comprehensive state health care reform initiatives reveal that governing and coordinating these initiatives from the executive branch, with legislative overview, is critical to success. States that have been successful in implementing reforms have identified a person/office with their respective administrations responsible for and with the capacity to enact the full range of health care reform activities. This requires someone in the executive branch that can cut across all agencies and departments to execute far-reaching reforms such as the ones presented above. We would expect that the governor would identify and appoint an appropriate person to shepherd this broad-ranging portfolio of reforms through the executive branch.