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WEST VIRGINIA'S MEDICAID CHANGES UNLIKELY TO REDUCE STATE COSTS OR IMPROVE BENEFICIARIES' HEALTH

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The federal Deficit Reduction Act of 2005 (DRA), signed into law in February 2006, gives states new options to scale back health-care benefits for children and parents enrolled in Medicaid.[1] On May 3, 2006, West Virginia received federal approval to provide a scaled-back basic benefit package for most children and parents in its Medicaid program, while giving them access to an "enhanced" benefit package if they sign and conform to an agreement with the state.[2] This change, made through an amendment to West Virginia's state Medicaid plan, was approved by the federal Centers for Medicare and Medicaid Services (CMS) less than two weeks after it was submitted for review. West Virginia provided no opportunity for public comment before submitting the state-plan amendment to CMS.

West Virginia intends to implement the plan in three rural counties (Clay, Lincoln, and Upshur) beginning on July 1 and to phase in implementation statewide over four years.

About three-quarters of the beneficiaries who will be affected by the plan are children. In 2002 (the most recent year for which data are available), 183,000 children and just under 60,000 parents were enrolled in West Virginia's Medicaid program; about two-thirds of these parents are women.[3] Only parents in families with income below 37 percent of the poverty line ($6,142 per year for a family of three in 2006) are eligible for Medicaid in West Virginia, while children can be covered at somewhat higher income levels.[4] Thus, the two groups affected by the plan will be low-income children and very-low-income parents.

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[1] Section 6044 of the Deficit Reduction Act of 2005, Pub. L. 109-171, added a new section 1937 to the Social Security Act. The Centers for Medicare and Medicaid Services provided guidance on implementation of the new section state Medicaid programs on March 31, 2006. Letter to State Medicaid Directors, SMDL #06-008.

[2] The state plan amendment is at http://www.wvdhhr.org/bms/oAdministration/bms_admin_WV_SPA06-02_20060503.pdf.

[3] The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from MSIS reports from CMS for FY2002 available at www.kff.org.

[4] West Virginia covers children under age one with family income below 150 percent of the poverty line, children between the ages of one and six with income below 133 percent of poverty, and children from six to nineteen with income below 100 percent of the poverty line. In 2006, the poverty line for a family of three is $16,600 per year.

According to Governor Manchin, the state's plan will "help bring down program costs while helping to prevent disease."[5] Close examination shows, however, that the plan is unlikely to lower the amount that West Virginia spends on Medicaid, largely because the affected groups account for *less than one-quarter* of the state's Medicaid costs, or to improve beneficiaries' health.

Scaled-Back Basic Benefits Package for Children and Parents Will Offer Fewer Services

The DRA allows states to provide alternative packages of Medicaid benefits to most children and parents enrolled in Medicaid.[6] (Seniors, adults and children with disabilities, children in foster care, and most pregnant women must continue to receive Medicaid coverage under pre-DRA rules.) Under West Virginia's plan, the basic benefit package for parents and children who enroll in Medicaid will have fewer benefits than the state's Medicaid program now offers.

For children, the basic benefit package will limit them to four prescription drugs a month and impose new limits on dental, hearing, and vision services. In addition, it will *eliminate* coverage for skilled nursing care, orthotics, prosthetics, tobacco cessation programs, nutrition education, diabetes care, and chemical dependency and mental health services.

Under the DRA, a state that chooses to provide an alternative benefit package to children under age 19 must provide additional "wraparound" coverage so children continue to receive the full array of services provided through Medicaid's Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) program. Congress added the EPSDT benefit to Medicaid in 1967 — and strengthened it in subsequent years — in recognition of the critical role Medicaid plays in promoting the health and development of low-income children.[7] Under EPSDT, states must ensure that all children enrolled in Medicaid receive regular check-ups — including vision, dental, and hearing exams — as well as necessary immunizations. States also must ensure that children are covered for all necessary follow-up diagnostic and treatment services that can be covered under federal Medicaid rules.[8]

The West Virginia plan includes EPSDT in the list of services covered under the basic package for children. However, it *excludes* certain services that EPSDT covers, and it limits other such services. There is a basic inconsistency here, since under EPSDT, children who need them are supposed to be entitled to the very services that are contained in West Virginia's *current* benefit package but are being eliminated or scaled back under the state's new plan.

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[5] Scott Finn, "Medicaid changes approved," *The Charleston Gazette*, May 4, 2006.

[6] Under the DRA, states can provide different benefit packages to children and parents living in different parts of a state, and states can vary benefits for different groups based on their health care needs or other factors. In designing benefit packages under the DRA, states can choose among several "benchmark" benefit packages, which are modeled on, or are equivalent to, benefits offered to state and federal employees or benefits provided by the state's largest HMO. States also have the option of offering "Secretary-approved coverage," which is defined as any coverage found appropriate by the U.S. Secretary of Health and Human Services. West Virginia has chosen this last option.

[7] Sara Rosenbaum, D. Richard Mauer, Peter Shinn, and Julia Hidalgo, "National Security and U.S. Child Health Policy: The Origins and Continuing Role of Medicaid and EPSDT," George Washington University School of Public Health and Health Services, April 2005.

[8] Section 1905(r) of the Social Security Act; 42 CFR §§440.40; 441.50-441.62.

This inconsistency is explained by the fact that West Virginia has redefined ESPDT to include only the screening exams and some dental, vision, and hearing services that are part of the EPSDT benefit. The definition the state has adopted fails to include the follow-up diagnostic and treatment services that a health-care provider prescribes for a child, on the basis of the child's screening examination.[9] Under West Virginia's definition of EPSDT, services such as diabetes care and mental health services thus would not be covered for children under the basic benefit package. This definition of EPSDT is contrary to federal law.

For parents as well, the basic benefit package will cover fewer health care services than the current Medicaid program does.[10] For example, parents will no longer have coverage under the basic benefit package for emergency dental services, diabetes care, physical or occupational therapy, or mental health services. Moreover, the basic benefit package will limit parents to four prescription drugs a month (down from the current ten) and to transportation for five non-emergency trips a year. (There is no current limit on necessary medical transportation.)[11]

"Enhanced" Benefits Available for Those Who Sign Agreement with the State

All children and parents affected by the plan will receive the new basic benefit package until they (or their parents on behalf of the children) sign a "Medicaid Member Agreement" entitling them to an enhanced benefit package. The agreement must be signed at the office or clinic of the beneficiary's health-care provider. In the agreement, the beneficiary agrees to "do my best to stay healthy," to "go to health improvement programs as directed by my medical home [health care provider]," and "to go to my medical home when I am sick."

According to West Virginia's state plan amendment, when a beneficiary "does not fulfill the responsibilities" listed in the agreement, his or her Medicaid coverage will revert to the basic benefit package.

Health care providers will be expected to monitor and report on their patients' compliance with their member agreements. In the first year of implementation, providers will be asked to monitor whether beneficiaries receive health screening exams, follow health improvement programs, show up for scheduled appointments, and take their medication as directed. Beneficiaries who fail to meet

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[9] The definition of EPSDT in the provider manual is "a comprehensive and preventative child health program for Medicaid eligible individuals under the age of 21. EPSDT includes periodic screening, vision, dental and hearing services." West Virginia Department of Health and Human Resources, Chapter 200-13, September 1, 2003. This definition includes the services set out in the first four parts of the definition of EPSDT in the federal Medicaid statute, which describes the physical and mental health screening exams, vision, hearing and dental screening exams, and some vision, hearing and dental services that are part of the EPSDT benefit. The West Virginia definition does not, however, include coverage for diagnostic and treatment services that are necessary to address "physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan" as described in the last part of the federal definition of EPSDT. Section 1905(r)(5) of the Social Security Act

[10] Benefits by State: West Virginia (October 2004) The Kaiser Commission on Medicaid and the Uninsured Medicaid Benefits Online Database at www.kff.org/medicaid/benefits.

[11] Parents currently pay co-payments of up to $3 per prescription **for** prescription drugs. The new plan does not make any changes in the rules for cost-sharing.

these requirements could be moved back into the basic benefit package.[12] The state plan amendment suggests that beneficiaries who go back to the basic benefit package can reapply for enhanced benefits after 12 months or when their Medicaid coverage is renewed.

For children, the enhanced benefit package — unlike the basic package — does not limit dental, hearing, or vision services, prescription drugs, or medically necessary transportation. The enhanced package also includes a number of services not included in the basic package, such as diabetes care, tobacco cessation programs, nutrition education, and chemical dependency and mental health services.

Similarly, for parents, the enhanced benefits package does not limit the number of medically necessary prescription drugs or the use of medically necessary transportation. The enhanced package also includes several services not included in the basic package, such as cardiac rehabilitation, diabetes care, and chemical dependency and mental health services.

Yet because children and parents will not be covered for the services in the enhanced plan until they can see a health-care provider to sign a member agreement, they could be left without a way to pay for critical services until an agreement is signed. Moreover, children and parents could lose access to the services provided under the enhanced package if a decision is made that they did not comply with their member agreement.

Plan Not Likely to Improve Beneficiaries' Health

The plan's underlying assumption is that requiring beneficiaries to sign an agreement in order to receive certain health care benefits will lead them to use preventive care more, use the emergency room and other costly services less, and thereby improve their health. This assumption is unproven and untested. No state has previously attempted to alter benefits in this way.

West Virginia has provided no information showing that substantial numbers of Medicaid beneficiaries are not following their provider's instructions or are not taking their children for check-ups. Nor has the state presented data to show that large numbers of beneficiaries are using the emergency room inappropriately.

Interviews with just over 100 West Virginia families with children enrolled in Medicaid or the State Children's Health Insurance Program, conducted by staff members of the United Way of Central West Virginia, showed that 94 percent of the children had a health-care provider that was their usual source of care but that 42 percent of the families did not have access to their doctor after hours or on weekends and one-third were *told* to go to the emergency room when the doctor was not available.[13]

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[12] Beneficiaries will receive notice and a chance to appeal the decision. The state plan amendment also says that any reduction in benefits will be "subject to good cause."

[13] "Experiences in Receiving Health Care by West Virginia CHIP and Medicaid Families," The United Way of Central West Virginia Health Care Access Project, October 2004.

Following these interviews, a group of parents received information on what to do when their children were sick. This simple intervention reduced this group's use of the emergency room. Parents who received this information reported increased confidence in knowing what to do when their children were sick.[14] This study suggests that having parents sign a member agreement is unlikely to reduce their use of the emergency room for their children unless they also are given instructions on proper health care and/or better access to a health-care provider.

There is some evidence that educational and behavioral strategies, such as reminders and positive reinforcements, can increase the likelihood that patients follow treatment instructions.[15] Several studies suggest that when physicians and patients work together to set treatment goals, health-related behaviors may improve more than when the physician simply tells the patient what to do. For example, one study of patients with coronary heart disease showed that individualized personal action plans helped improve their health-care behaviors.[16] These studies do not shed light, however, on whether making health care benefits conditional on signing a standardized agreement would itself improve beneficiaries' behaviors.

West Virginia's plan actually could lead to poorer health for some beneficiaries. Those receiving the basic benefit package would not have access to critical health care services such as diabetes care and mental health services and might not be able to get all the prescriptions they need. Faced with these limits, some of these beneficiaries may end up using more costly services such as inpatient hospital care, which would be an unfortunate outcome both for beneficiaries and for the state.

An additional risk with the West Virginia plan is that having health-care providers monitor and report on compliance with member agreements could lead to uneven enforcement. One study showed that providers made inferences about patients' treatment compliance based on race and age; providers were more likely to doubt that African American patients as opposed to white patients followed treatment instructions, for example.[17] Another study, in Florida — a state that required providers to report mothers known to have used drugs or alcohol during pregnancy to health authorities — found that providers were ten times as likely to report a woman who used drugs or alcohol if she were African American than if she were white. Poor women were also more likely to be reported than non-poor ones.[18]

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[14] "What to Do When Your Child Gets Sick: A Parent Education Pilot Study," United Way of Central West Virginia, September 2005. The West Virginia project was based on a study of a California Head Start Program. The authors of the California study predicted that providing parents with easy-to-understand health care information could save $200 per year in Medicaid costs for each child by reducing unnecessary physician and emergency room visits. Ariella D. Herman, Gloria G. Mayer, Reducing the Use of Emergency Medical Resources Among Head Start Families," *Journal of Community Health,* 29:3 (June 2004).

[15] Rajesh Balkrishnan, The Importance Of Medication Adherence In Improving Chronic-Disease Related Outcomes: What We Know And What We Need To Further Know, *Medical Care,* 43:6 (June 2005).

[16] Margaret Handley and others, Using Action Plans To Help Primary Care Patients Adopt Healthy Behaviors: A Descriptive Study. *Journal of the American Board of Family Medicine,* 19:3 (May-June 2006).

[17] Karen E. Lutfey and Jonathan D. Ketcham, Patient And Provider Assessments Of Adherence And The Sources Of Disparities: Evidence From Diabetes Care, *Health Services Research*, 40:6 (December 2005).

[18] I.J. Chasnoff and others, The Prevalence Of Illicit-Drug Or Alcohol Use During Pregnancy And Discrepancies In Mandatory Reporting In Pinellas County, Florida. *The New England Journal of Medicine*, 322:17 (April 1990).

Plan Not Likely to Save Money for the State

The West Virginia state plan amendment does not include any details regarding its fiscal impact, but press accounts quote Governor Manchin as saying the plan will save the state money.[19] More recently, a state official has said that West Virginia does not expect any "immediate cost containment" and that savings would be from "long-term health outcomes."[20] The state has not, however, substantiated its claim that conditioning benefits on a member responsibility agreement will lead to better health care outcomes for children, and this appears to be a hope rather than a conclusion based on firm evidence.

Because spending on health care services for the children and parents affected by the plan already is relatively low — it accounts for less than one-quarter of the state's Medicaid costs — changing benefits for these beneficiaries is not likely to result in large savings. In 2003, even though children and parents made up more than two-thirds of the state's Medicaid beneficiaries, parents accounted for only 7 percent of West Virginia's Medicaid spending, while children accounted for 17 percent. Moreover, some of this 17 percent represented costs for children who will *not* be affected by the new plan, since the DRA does not allow states to enroll children who have disabilities or are in foster care in the alternative, scaled-back benefit packages.

Furthermore, care for children and parents in West Virginia already is relatively inexpensive: $1,458 a year per child[21] in 2002 and $1, 937 per adult, with the federal government paying 73 percent of these costs.[22] The federal government provides $2.70 in federal matching funds for every dollar that West Virginia spends on its Medicaid program.

Other than through hoped-for changes in long-term health outcomes, West Virginia has not said how its plan would achieve savings. The state apparently is assuming that beneficiaries who sign member agreements will engage in healthier behaviors and need less medical care. The state also may be assuming that some beneficiaries will remain in the basic benefits package and receive fewer benefits as a result. Even if both assumptions prove correct, the resulting savings are not likely to be large, since as noted, the cost of providing care to the affected beneficiaries already is relatively low.

Finally, even if the plan does turn out to result in lower expenditures for health care services, these savings are likely to be offset, at lease in part, by higher administrative costs. Changing benefits for large numbers of beneficiaries and administering the new member agreements will entail some increase in such costs. The state will have to track whether beneficiaries are in the basic or enhanced benefit package and change its reimbursement system to pay providers based on the different

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[19] See, for example Lawrence Messina, "Redesign of Medicaid rewards healthy choices," *Associated Press*, May 4, 2006; Scott Finn, "Medicaid changes approved: Patients who take care of themselves to be rewarded," *Charleston Gazette*, May 4, 2006.

[20] Shannon Riley, spokesperson for West Virginia's Medicaid program, quoted in Kevin Freking, "States begin overhaul of health insurance for the poor," *Associated Press*, May 23, 2006.

[21] This figure includes expenditures for children with disabilities and children in foster care, who are not included in West Virginia's new plan.

[22] The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from MSIS reports from CMS for FY2002 available at www.kff.org.

packages. It also will have to track compliance with the member agreements and provide notices and hearings to beneficiaries whose benefits are being reduced. Such activities will add costs. Moreover, some beneficiaries in the basic package who are denied services such as diabetes care could ultimately end up using more costly services as a consequence. For these reasons, the plan actually has a potential to result in a net *increase* in state costs.

Conclusion

The growth in Medicaid costs is a serious concern for both state and federal policymakers. The main sources of the problem, however, lie not in Medicaid itself — which provides coverage at a lower cost than private insurance, and whose costs are rising less quickly than those of private insurers — but in the increasing cost of health care throughout the U.S. economy and the continuing erosion of employer-based health coverage.

West Virginia's plan to reduce Medicaid costs by scaling back health care for low-income children and very-low-income parents is likely to prove ineffective. Low-income children and parents already are relatively inexpensive to cover, and the state's plan to require them to sign a standardized agreement in return for enhanced benefits is unlikely to improve their health or to have a large impact on state health-care costs. The plan does, however, carry the risk that some very vulnerable people may be denied health care they need.