Consumer Choice in Medicaid Reform

Analysis of Medicaid reform in Florida and West Virginia

Melissa Caron
Winter, 2009
Poverty 423: A Research Seminar

Washington and Lee University

Acronyms

AHCA, The Florida Agency for Health Care Administration
CBO, The Congressional Budget Office
CHCS, Center for Health Care Strategies
CMS, Centers for Medicare and Medicaid Services
DRA, Deficit Reduction Act
EBA, Enhanced Benefit Accounts
HIFA, Health Insurance Flexibility and Accountability Demonstration Initiative
HMO, Health Management Organization
PSN, Provider Service Network
SSI, Supplemental Security Income

Washington and Lee University

Medicaid has received significant attention in the past decade as rising costs in medical care have threatened to capsize state economies. Critics for some time have complained that this state and federally funded healthcare program for low-income citizens is inherently plagued with inefficiencies since recipients pay little, if anything, to receive medical care. A fee-for-service program, as was in place prior to reform programs, places no emphasis on preventive care and provides little protection against moral hazard, a condition by which an individual consumes more than he or she would if he or she bore the full cost of the action. Since 2001 there has been tremendous pressure on both federal and state governments to take a crack at reforming the state-administered Medicaid programs. As of the end of this decade, most states have made efforts to revitalize their programs, utilizing recent changes in federal policy. This paper explores the introduction of revolutionary consumer choice programs, in particular through Florida's and West Virginia's Medicaid reforms. Consumer choice represents a shift from fee-for-service programs to premium-based programs that place an emphasis on personal responsibility and disease management. By handing greater responsibility to Medicaid recipients, these programs try to give patients more control over their health and provide them with greater incentives to utilize needed and preventive care.

Washington and Lee University

Medicaid, which was introduced in 1965, provides healthcare to 58.7 million people (in 2006), or 20 percent of the nation's population.[1] This entitlement program is dually funded by the federal government and states and provides care to low-income children, adults, elderly, and individuals with disabilities. The matching formula is dependent upon the state's per capita income. On average 57 percent of Medicaid funding comes from the federal government, while

[1] The Henry J. Kaiser Family Foundation, *StateHealthFacts.org: Your source for state health data*, http://www.statehealthfacts.org/ (March 2009).

43 percent comes through the state's own government.[2] In 2006 state and federal expenditures totaled $314 billion, or 15 percent of the nation's total spending on health.[3] From 1990 to 2001, Medicaid spending increased at an average annual rate of 10.9 percent.[4] Cost increases were mostly due to expansions in the Medicaid program during the 1990s, the rising cost of healthcare in general, and increases in longevity.[5]

Recent legislation has made it easier for states to receive *Section 1115 waivers* to test innovative strategies. This "research and demonstration waiver" was included in the programs initial legislation in 1965 but has become less stringent in recent years. The waiver gives states liberty to reform their programs to reduce costs and improve quality of healthcare for recipients. States gained greater freedom in 2001 when the Bush administration approved the *Health Insurance Flexibility and Accountability Demonstration Initiative (HIFA)*. This allows states that seek Section 1115 waivers greater flexibility in providing alternative coverage and eligibility rules. This type of waiver, which Florida sought, requires rigorous evaluation of the reform.[6] States gained even greater flexibility with the introduction of the *Deficit Reduction Act* (DRA) *of 2005*. Under this act, states could now charge premiums and co-payments for Medicaid and alter coverage under the plan. This reform granted unprecedented program freedom,[7] and is the reform that West Virginia relied heavily on in altering its program. Since 2001, thirty-five states have made changes to their programs through waivers or the DRA. Critics have complained that

Washington and Lee University

[2] Michael F. Cannon, "Medicaid's Unseen Costs," *Policy Analysis.* Cato Institute, 15 August 2005: 2.
[3] Teresa A. Coughlin and Stephen Zuckerman, "State Responses to New Flexibility in Medicaid," *Milbank Quarterly*, June 2008: 210.
[4] Kaiser Foundation, *StateHealtfacts.org*.
[5] Cannon, "Medicaid's Unseen Costs," 3.
[6] Coughlin and Zuckerman, "State Responses to New Flexibility in Medicaid," 211.
[7] Ibid.

these reforms have given states too much flexibility and have left states overly concerned with cutting costs, not improving healthcare outcomes.[8]

Since the introduction of reform at the federal level, many states, including Florida and West Virginia, have started to require partial payments from certain low-income Medicaid recipients. Co-payments and premiums *(Option 1*, explored in this paper) are sought as a means of encouraging insurance recipients to take a greater role in their medical care by requiring them to take a direct financial stake in their health. However research shows that introducing payment at any level for low-income patients may lead to reductions in needed medical care as well as drops in enrollment. Florida and West Virginia have adopted "consumer choice" approaches to Medicaid reform. Both states have sought reforms that would place greater control back into the hands of Medicaid recipients. Florida enacted a managed-care program in late 2005 through private insurance companies (*Option 2A)* and health benefit accounts (*Option 2B*). The state's goal was to create better preventive care practices as well as discourage misuse of medical services that may inherently come with fee-for-service systems. West Virginia introduced a personal responsibility program (*Option 3*) that requires individuals to sign a document pledging that they will take greater responsibility in their healthcare in order to receive enhanced benefits. Those who do not sign the agreement are placed into a limited plan, losing several benefits that they had received in the state's pre-reform system.

Washington and Lee University

This paper focuses on Florida and West Virginia in particular because these two states have offered some of the most radical steps toward changes in the Medicaid system. Many advocates have highlighted Florida in particular as taking a step in the right direction toward reform. In his 2007 Federal Budget President George W. Bush lauded the Florida reform – in which his brother, Governor Jeb Bush, played a key role – as a model that other state

[8] Ibid., 212.

governments should look to for direction.[9] West Virginia, in turn, has presented a plan that places many of recipients who do not comply to a written agreement at risk of losing needed benefits. This paper explores how these reforms have fared in accomplishing their intended goals as well as each plan's ability to meet expectations of healthcare critics:

- Have these reforms slowed the spiraling costs of healthcare?
- How much do the new programs cost Medicaid recipients?
- How have reforms affected quality care for Medicaid recipients?
- Do recipients have greater freedom of choice?
- Are states taking sufficient steps to improve the health of Medicaid recipients, both in the short term and long term?

OPTION 1: Increase cost sharing

The DRA of 2005 lifted previous federal limits on co-payments and premiums for certain segments of the Medicaid population. A copayment is the percentage that an insured patient will pay to receive a certain medical service. A premium is the amount patients pay in order to receive healthcare coverage. For children in families with an annual income of 150 percent of the federal poverty line, states can now charge co-payments up to 20 percent of the service's cost and unlimited premiums. For children in families with an annual income of 100 percent of the federal poverty line, co-payment levels could be up to 10 percent of the cost of the service.[10] Cost-sharing is sought as a means of reducing moral hazard. As individuals take on partial financial responsibility in their healthcare, it is believed they will make smarter and more efficient decisions about the medical services they seek. As could be expected, co-payments have a greater influence on consumption than premiums, since co-payments are made for each individual service. The Congressional Budget Office (CBO) estimated that the introduction of

Washington and Lee University

[9] Joan Alker and Jack Hoadley, "Briefing #1: Medicaid Changes: What will they mean for Broward and Duval Counties and beyond?," Jessie Ball duPont Fund, September 2006: 1.
[10] The Kaiser Commission on Medicaid and the Uninsured, "Deficit Reduction Act of 2005: Implications for Medicaid," The Henry J. Kaiser Family Foundation, February 2006: 1-2.

premiums and cost sharing would reduce federal Medicaid spending by nearly $2 billion from 2006 to 2011 and nearly $10 billion in the decade after the DRA was introduced.[11]

As of January 2009 seventeen states, including Florida and West Virginia, have a co-payment in place for non-preventive physician care visits for children in families 151 percent or more above the federal poverty line. This co-payment ranges from $3 to $15 per visit. Florida charged $5, while West Virginia had the highest co-payment of all states at $15 per visit. Fourteen states had a co-payment in place for emergency room visits and ten had a co-payment for inpatient hospital visits for children in families at 151 percent of the poverty level. West Virginia has a $35 charge for emergency room visits. Nationwide this co-payment ranged from $10 to $100 per visit. West Virginia also had an inpatient hospital fee of $25. This fee on average nationwide ranged from $10 to 20 percent of the first day's cost. [12] It can be assumed that these co-payments were put in place to deter patients from using the emergency room for non-emergency care. However, as is discussed below, these co-payments could greatly deter Medicaid recipients from seeking needed care.

Washington and Lee University

Several states have also put into effect premiums for children in families at 101 percent or more of the federal poverty line. Florida is one of nine states that require a premium for those with annual familial incomes between 101 and 150 percent of the federal poverty level. For a family of three in Florida in this income bracket the annual premium for two children eligible for Medicaid was $180.[13] This was well above the national average of $138 for two children. However premiums varied sharply nationwide, ranging from $35 to $1,032 a year for two children. West Virginia requires a premium for families of three with annual incomes 200

[11] Ibid., 1.

[12] Donna Cohen Ross and Caryn Marks, "Challenges of Providing Health Coverage for Children and Parents in a Recession: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2009," Kaiser Commission on Medicaid and the Uninsured, January 2009: 58.

[13] Ibid., 54.

percent or more of the federal poverty level. For this family, the annual premium would cost $852 to cover two children. Twenty-four states have a premium in place at this level, with an average annual premium about $583. It is less clear why states have looked to adopt premiums, beyond the cost savings for the government. Unlike co-payments there is little proof that premiums will increase healthy behavior or deter misuse of medical services.

Evaluating Option 1: Cost-sharing

Cost-sharing has not fared well for low-income populations, as studies show. In general, healthcare use declines sharply for this group when cost sharing is imposed. Other studies have highlighted how co-payments and premiums may trigger increases in more expensive forms of care, such as emergency room visits.[14] According to a study that analyzed a change in prescription co-payments in Quebec, researchers found that once a co-payment was added lower-income adults filled fewer prescriptions for essential drugs. Researchers estimated that the introduction of the co-payment led to a nearly 90 percent increase in adverse events, such as hospitalization, admissions into nursing home, and even death. They also estimate that the co-payment resulted in an almost 80 percent increase in emergency room visits.[15] A 2004 study of a Minneapolis public hospital found that more than half of the Medicaid recipients surveyed had been unable or unwilling to fill their prescriptions at least once in the past six months because of newly introduced co-payments -- $1 for generic drugs and $3 for brand name drugs. Eleven out of the sixty-four patients in the study had 27 subsequent emergency room visits after failing to fill their prescriptions, far outnumbering those who continued their medication regiments.[16] While many studies have looked at the effect of prescription co-payments some studies have

Washington and Lee University

[14] Coughlin and Zuckerman, "State Responses to New Flexibility in Medicaid," 222; Leighton Ku and Victoria Wachino, "The Effect of Increased Cost Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities, 7 July 2005: 1.
[15] Ku and Wachino, "The Effect of Increased Cost Sharing in Medicaid," 5.
[16] Ibid., 6.

looked at the larger picture. According to the definitive RAND Health Insurance Experiment, low-income adults and children who had to pay a fraction of their healthcare costs were considerably worse off compared to those without a co-payment.[17] Likewise, co-payments tend to have a greater affect on those who are already in fragile health since they require more medical services and prescriptions.[18] From these studies it is clear that co-payments on curative methods – such as prescriptions or doctors visits – may have significant a effect not only on the short-term health of the individual but also in the long term. If individuals have trouble accessing needed medicine or care because of limited funds, a patient's health may worsen and result in increased uses of high-priced care. As a result long-term costs may rise.

Studies have found that the introduction of premiums tends to reduce enrollment and stable participation in Medicaid. A multi-state study found that a premium for low-income patients set as low as 1 percent of a family's income could lead to a 15 percent decrease in enrollment. A premium of 3 percent of a family's income could result in nearly half of all Medicaid recipients leaving the rolls.[19] Oregon officials experimented with Medicaid premiums and found that about half of those enrolled in areas affected by the pilot program lost coverage. (The state had raised premiums to $6 per month for those without any income and $20 per month for those at the poverty line.) Nearly three-fourths of those who dropped from the rolls went uninsured and were four to fives times more likely to report the emergency room as their primary source of care.[20]For a population with limited disposable income even the smallest premium may result in recipients choosing to go uninsured. Ultimately, this may leave the state paying for increased uninsured visits to the emergency room.

Washington and Lee University

[17] Ibid.
[18] Ibid., 7.
[19] Ibid., 7-8.
[20] Ibid., 8.

A state's decision to impose premiums and co-payments may not actually encourage recipients to take a more direct role and responsibility in their care or cut inappropriate uses of medical services. As a result of increased out-of-pocket costs, Medicaid recipients – who are already strapped for cash – may decide to forgo insurance completely or cut back on needed medical care. This formula overlooks the differing cost-pains that health consumers may face depending on their levels of disposable income. As noted above, low-income patients may become less healthy as they reduce prescriptions and do not go to the doctor for minor ailments. It is important to note that most states have focused co-payments on curative practices, like emergency room visits and non-preventive care doctor visits. Cost sharing overlooks the inherent imbalance of knowledge that comes with healthcare, especially amongst a population that is on average less educated than the general consumer. The reform reduces the freedom that Medicaid patients may have in approaching their healthcare since they are now limited to choices based on their ability or willingness to pay. Costs may be cut in the short run for the state's Medicaid program because of reductions in services; however, in the long term states may see higher costs as recipients forgo less costly medical services (e.g., going to the doctor for a cold or a wound) and must seek out more expensive care as the patient's health worsens (e.g., emergency rooms).

Washington and Lee University

OPTION 2A: Florida – Managed Care

Florida's Medicaid program provides healthcare coverage for nearly 26 percent of the state's children and pays for nearly 44 percent of births. The program also pays for nearly 59 percent of the state's nursing home care.[21] Florida has seen significant growth in program cost over the past decade, in part because of the state's large elderly population. From 1999 to 2005, Florida's Medicaid budget grew on average 13 percent each year. If the program continued along

[21] Alker and Hoadley, "Briefing #1," 2.

this track, it would have consumed nearly 60 percent of the state's budget by 2015.[22] Prior to Medicaid reform, Florida ranked among the top five states in both Medicaid enrollment and total spending.[23] In October 2005 the Centers for Medicare and Medicaid Services (CMS), the federal agency that overseas Medicaid, approved a Section 1115 waiver for Florida, allowing the state to experiment with its Medicaid reform. With a Section 1115 waiver, a state's reform program must be budget neutral, meaning that the federal government would limit growth in its matching program. In Florida, the federal match for per-person spending was capped at an 8 percent annual growth rate for Medicaid recipients statewide, not just in the five pilot counties that the reform would initially take place in.[24] Therefore, costs would needed to be cut significantly in the reformed counties in order to reduce the 13 percent annual growth rate that the state had seen in the previous decade; if not, the state would need to increase its own end of the matching formula.

Washington and Lee University

Florida's reformed Medicaid program offers a shift from a "defined-benefit program," where recipients are guaranteed a certain package of benefits, to a "defined-contribution program," where recipients are given choices to healthcare packages offered by private Health Management Organizations (HMOs) and Provider Service Networks (PSNs). Each plan must offer certain benefits, such as access to primary and dental care, but have the option to offer enhanced benefits and differing levels of prescription coverage.[25] An HMO is an insurance organization that offers care to enrollees through a pre-approved network of specialists who have agreed to certain guidelines of the organization. Typically, a primary care physician will act as a

[22] Michael Bond, "Florida's Medicaid Reforms: A Progress Report," *The James Madison Institute Backgrounder*, August 2007: 1.
[23] Ibid., 3.
[24] Alker and Hoadley, "Briefing #1," 2.
[25] Teresa A. Coughlin, et al. "Florida's Medicaid Reform: Informed Consumer Choice?" *Health Affairs* (Web Exclusive), October 2008: w523-w532.

"gatekeeper" or a care manager approving certain services for the patient and building a plan that fits the needs of the patient. A PSN is a network maintained and operated by a service provider or group of service providers where patients are allowed to choose providers who operate within the group.

The benefit packages of the HMOs and PSNs in the Florida reform must pass an "actuarial equivalency test," meaning the dollar value of the plans offered under the reform must be equal in value to the old plan. The state calculates a risk-adjusted premium for Medicaid beneficiaries and reimburses the managed care organizations accordingly. The reform has been put in place in two counties (Broward and Duval) in July 2006 and expanded to three additional counties (Baker, Clay, and Nassau) in July 2007. From September 2006 to April 2007 letters were sent to recipients in each of these counties informing them about the reform and that they needed to choose a health plan. If a health plan was not chosen by the patient, the state assigned one to them.[26] (Another main component of the program is the introduction of Health Benefits Accounts, which will be explored below in Option 2B.) State officials estimate that the reform will cut costs for the state by 13 percent in the 2010-11 fiscal year.[27] As of July 2008, 75 percent of children and families receiving Medicaid and 58 percent of Medicaid recipients with disabilities in the pilot counties were enrolled in HMOs. The remainder of recipients are enrolled in PSNs. Researchers at the Jessie Ball duPont Fund reason that this discrepancy between children and families and disabled recipients may be the result of the close relationship individuals with disabilities might form with their service providers.[28] PSNs generally are smaller networks that provide more face-to-face time with the physician.

Washington and Lee University

[26] Ibid., w524.
[27] Bond, "Florida's Medicaid Reforms," 12.
[28] Joan Alker and Jack Hoadley, "Briefing #7: Florida's Experience with Medicaid Reform: What has been learned in the first two years?," Jessie Ball duPont, October 2008: 3.

Evaluating Option 2A: Managed-care organizations

Managed-care organizations are often thought of as a way to cut unneeded costs in healthcare, while providing care specialized to the needs of the patient. Since managed-care plans are prepaid, it removes the incentive for physicians and specialists to prescribe inappropriate care to increase their own payments.[29] Patients themselves typically do not have the means to block any misuses of care because of the disparity of information that exists between patient and doctor. With a prepaid system doctors now have the incentive to seek the most affordable and effective treatments so as to preserve their own profit.[30] Managed-care systems also introduce a level of disease management where programs can be altered to fit the specific needs of the patient. Communication between the patient and doctor is essential to the success and implementation of the program. Disease management will be essential to lowering Medicaid expenditures. One study found that 10 percent of non-institutionalized Medicaid recipients (those not in nursing homes) accounted for more than 70 percent of expenditures because of severe chronic conditions.[31]

Washington and Lee University

However, problems do afflict managed-care systems. Premiums are determined bureaucratically and not through supply and demand, forces that the fee-for-service systems are subjected to. Therefore, the success of the model is dependent on the insurance company's ability (or in the case of Medicaid, the state's ability) to determine the level of risk patient's impose on the insurance company.[32] If a company is too generous in its prediction, it might find itself going out of business. If it is too cautious, the company may have trouble finding

[29] Bond, "Florida's Medicaid Reforms," 5.
[30] Robert E. Hurley, "Research driven Medicaid reform: the case of managed care." *International Journal of Public Policy* 2, no. 3-4 (2007): 253.
[31] Bond, "Florida's Medicaid Reforms," 21.
[32] Coughlin et al., "Florida's Medicaid Reform," w524; Coughlin and Zuckerman, "State Responses to New Flexibility in Medicaid, 229.

physicians willing to accept the low reimbursement rate. HMOs also require participation on the part of the patient. However, in order for a true marketplace to work, a level of information transparency must exist. Individuals must be able to make informed decisions in order to act as rational actors and chose those plans that fit their health needs best. However, studies show that nearly half of the general population has problems making informed decisions about their health and their health insurance.[33] But this problem may be further compounded for the Medicaid population:

> Making sound decisions may be an even greater challenge for Medicaid populations, as research indicates that advanced age, limited formal education, and poor health status – characteristics common among program recipients – are associated with poorer health literacy.[34]

Researchers have found that knowledge about the Florida reform is limited and may be hindering successful implementation of the program. One study conducted in Broward and Duval counties between November 2006 and March 2007 found that 30 percent of recipients were not aware that they were enrolled in the Medicaid reform, despite having the program in place for more than a year. Nearly three-quarters of these individuals reported that they had not received notification from the state about changes.[35] This statement is ambiguous and could mean that letters from the state were overlooked, lost, or never received by Medicaid recipients. Of those surveyed who were aware of the reform, more than half reported having problems understanding plan information and choosing a plan.[36] In part some of this problem stems from the educational levels of recipients. Between 20 and 37 percent of survey participants acknowledged deficiency in reading, while more than 40 percent of SSI survey participants had

Washington and Lee University

[33] Coughlin and Zuckerman, "State Responses to New Flexibility in Medicaid," 230.
[34] Coughlin et al., "Florida's Medicaid Reform," w524.
[35] Ibid., w525.
[36] Ibid., w526.

not completed high school.[37] About 20 percent of participants in the survey reported that they had unsuccessfully tried to get information about the reform.[38] The Florida Medicaid program has contracted with a private Texas-based company, ACS, to provide "choice-counseling." While counselors are available in person, Medicaid recipients can also reach counselors through a toll-free number. More than half of those surveyed were unaware that they had access to a choice counselor.[39]

Many recipients in the reform counties may find themselves being placed in plans by the state simply because they are not aware of the reform or because they have an insufficient understanding of the available plans. Therefore, this model of managed-care health may not be as efficient as it would be if the individual directly chose the plan that best suited his or her health needs. One study found that nearly half of all Medicaid recipients had been assigned a plan by the state.[40] If a Medicaid recipient does not choose a plan, the state will place the individual in a plan that that their current primary physician serves. Therefore individuals may be receiving the same level of care as prior to the reform. Researchers at the Jessie Ball duPont Fund found the number one priority for focus group participants was a plan that allowed them to stay with their current doctor.[41] Recipients may be choosing plans not because they will improve their quality of health, but because of the ease of staying with their current doctor. The reform may not result in changes in responsibility or the individual's wellness but simply maintain the status quo of the recipient's healthcare. Researchers at the Jessie Ball duPont Fund also found that most focus

Washington and Lee University

[37] Ibid., w530.
[38] Ibid., w527.
[39] Ibid., w526.
[40] Ibid., w526; There is some discrepancy between state figures and what researchers found. As of mid-2008, the state claimed that nearly 92 percent of Medicaid recipients had freely chosen their plans. However, this number includes new recipients who are not eligible for healthcare until they have chosen a plan. Therefore, they have a greater incentive to actively choose a plan, as compared to an individual who was enrolled in the old Medicaid system; Alker and Hoadley, "Briefing #7," 3.
[41] Joan Alker and Jack Hoadley, "Briefing #2: Florida's Experience with Medicaid Reform: Waving Cautionary Flags: Initial reactions from doctors and patients to Florida's Medicaid changes," Jessie Ball duPont, May 2007.

group participants mentioned they would like to keep the state's fee-for-service option, MediPass, which has been phased out in the reform.[42] Some participants acknowledged that they liked the flexibility and freedom of choice offered through MediPass in selecting doctors.[43]

There is some concern among critics that managed care could leave patients worse off. The Jessie Ball duPont Fund found that provider participation is declining, in particular among specialists, because of complications in the reform and lower reimbursement rates. Of nearly 190 doctors that researchers interviewed in Broward and Duval counties, 27 percent said that they had participated in the old Medicaid program and did not intend to offer services under the reformed system. Among doctors leaving the program, two-thirds were specialists. (One of the goals of the state's plan was to increase access to specialists.) Only 17 percent of those remaining in the program intended to participate in all available plans.[44] Nearly one-third of doctors interviewed said reimbursements were lower under the reform. More than 40 percent of doctors said paperwork claims had become more burdensome, while 6 percent said they found the new system less burdensome. Prior to the reform, researchers had asked physicians about their main concerns with the reform. Nearly all said they were concerned about increases in administrative burdens and lower reimbursement rates.[45]

Washington and Lee University

With fewer available physicians, doctors reported that they had seen many cases where they had been limited in their ability to provide a needed treatment. Nearly one-quarter of doctors surveyed by the Jessie Ball duPont Fund said they had many cases where they had to limit treatment because of the managed-care system. (Twenty-nine percent of doctors said they

[42] Ibid.; This data should be taken with some caution, since individuals may desire to stick with MediPass simply because they confused about current reform options or are not well-infomed about how the reform could help them.
[43] Alker and Hoadley, "Briefing #7," 2.
[44] Alker and Hoadley, "Briefing #2."
[45] Ibid.

had some cases and 30 percent said they had seen no cases like this.) More than one-quarter of doctors said they had many cases in which prior authorization prevented treatment. Of the 186 physicians interviewed, more than half said they had a harder time providing necessary services to children. This data is reflective of difficulties that a managed-care system may pose. Since treatment and services must be authorized by the insurance company and be provided by a list of pre-approved doctors and specialists, many primary care physicians are struggling to provide services and are simply leaving the system out of frustration.[46]

The reform in Florida has reached significant cost savings. In the first three quarters of the reform in Florida, per capita costs for Medicaid recipients with disabilities was 15 percent below budget across the state, while per capita costs for low-income children and adults was nearly 23 percent below budget.[47] However, it is hard to determine how much of this change is the result of the reform since the budget neutrality clause affects the entire state not just the pilot counties. Only about 10 percent of the budget as stated under the budget neutrality agreement actually is being used in the five counties.[48] A study by the University of Florida Medicaid Reform Evaluation project found that there has been a 3 percent decrease in spending in the pilot counties. (This number does not take into account increased spending from the enhanced benefit accounts, as will be explored below.)[49] Since not all aspects of the program are fully operational, it may be too early to judge the success of the program in reducing costs. For example, The Florida Agency for Health Care Administration (AHCA) is still developing an effective system

Washington and Lee University

[46] Ibid.
[47] Bond, "Florida's Medicaid Reforms," 19.
[48] Alker and Hoadley, "Briefing #7," 6.
[49] Ibid., 7.

for adjusting premiums for risk and until this system is fully operational the state will not have a clear understanding of how much the reform cuts costs.[50]

OPTION 2B: Florida—Enhanced Benefit Accounts

A key part of the Florida Medicaid program was the introduction of Enhanced Benefit Accounts (EBA), which works as a "reverse" Health Savings Accounts." Medicaid recipients can now earn up to $125 annually in credits for 19 different behaviors that focus on changes in unhealthy behaviors, appropriate use of healthcare, and simple wellness behaviors. Medicaid recipients can earn credits for activities like annual check-ups, following their prescription regiment, or signing up for a health fitness class. Credits can be redeemed at pharmacies for specified products, like over-the-counter medication, vitamins, diapers, bandages, and cannot be redeemed for cash. Initially, the state set "guesstimates" for the amount of credits, rewarding $25 for annual behavior, $15 for semi-annual behavior, and $7.50 for more frequent actions. Credits from appointments are generally accounted for through claims data from doctor's offices. However, instructors and counselors usually have to sign documents for participation in preventive programs such as weight loss or smoking cessation classes that will change behavior.[51]

Washington and Lee University

Evaluating Option 2B: Enhanced Benefit Accounts

Involvement in the program has been slow. According to a study done by the Jessie Ball DuPont Fund in March 2008, only 10 percent of credits had been redeemed -- $1.2 million of $12.5 million of credits that had been awarded since September 2006. Just over 27,000

[50] Ibid., 1-2.
[51] Jessica Greene, "Medicaid Efforts to Incentivize Healthy Behaviors," Center for Health Care Strategies, Inc., July 2007: 6.

beneficiaries had used any of their credits.[52] Of the credits earned, 60 percent were from keeping primary care appointments (both from illness and wellness) and 12 percent were from compliance with prescribed drugs. Only 0.1 percent of the credits were from enrolling in disease management programs. As of July 2008, no recipients had earned credits from participating in health improvement programs, such as weight loss, smoking cessation, or exercise programs.[53] Data like this has raised concerns that the benefit program may be rewarding only actions individuals would have taken even in absence of the program. As a result the program is not as effective or efficient in encouraging the type of behavior the program was designed to promote. (As of July 1, 2008, the state has stopped awarding credits for office visits after the first 60 days of enrollment and has halved the amount of credits adults receive from going to their physician.[54]) The program also has no system in place for rewarding changes in behavior beyond just participation in programs.[55]

Washington and Lee University

A telephone survey conducted by the Center for Health Care Strategies (CHCS) found that an overwhelming number of study participants (88 percent) believed that Florida's incentive program would be beneficial in encouraging healthier behavior. The main reason participants gave was that it helped impoverished individuals financially and encouraged them to "get more involved in their health." The remaining 12 percent of responders felt that program offered too small of a reward and was demeaning to Medicaid recipients.[56] A second part of the CHCS study randomized incentive rewards ($10, $25, $50) and asked three groups of respondents if they

---

[52] Joan Alker and Jack Hoadley, "Briefing #6: Florida's Experience with Medicaid Reform: The Enhanced Benefits Rewards Program: Is it changing the way Medicaid beneficiaries approach their health?," Jessie Ball duPont, Juyy 2008: 2.
[53] Ibid.
[54] Ibid., 3.
[55] John Barth and Jessica Greene, "Encouraging Healthy Behaviors in Medicaid: Early Lessons from Florida and Idaho," Center for Health Care Strategies, Inc., July 2007: 3.
[56] Greene, "Medicaid Efforts to Incentivize Healthy Behaviors," 5.

would participate in an activity at the specified incentive level. Behavior varied little across these three levels, leading CHCS to conclude that changes in incentive levels had little effect on individuals' decisions to participate. So long as an incentive existed, no matter at what level, individuals will be more likely to participate.[57] Studies have found that cash incentives are more effective than other forms of incentives, such as gift certificates.[58] CHCS did find that study participants were more likely to enroll their children in wellness programs like exercise classes if part of the incentive was a voucher to pay for the class. Shifts in incentives from over-the-counter products to partial payment of medical services had a minimal effect on doctor's visits.[59] This data suggests that Medicaid recipients are willing to participate in wellness programs but might be hindered by program cost.

The question remains why so few people have taken part in actions to change behavior or to even utilize their rewards. Florida Medicaid found that there was significant confusion over initial mailings at the start of the program, despite the state's efforts to develop materials at a fourth grade reading level. Many Medicaid recipients were not aware that they were automatically enrolled in the program and sent back forms that were intended for enrollment in health promotion programs, thinking they were the enrollment forms for EBA.[60] The Jessie Ball duPont Fund study found that only half of Medicaid recipients in the pilot counties knew about EBA. Similarly, some individuals thought that their account balances, which are mailed once a month, were bills. Many who knew about the program were unsure how to redeem credits.[61]

Washington and Lee University

[57] Ibid., 7.
[58] Ibid.; In 1999 study conducted by Malottee et al. researchers found that 95 percent of drug users in their study returned for a reading of their tuberculosis screening when offered a $10 cash incentive. Only 86 percent who received a gift certificate to a grocery store returned and 83 percent when offered a gift-certificate to the bus or fast food restaurant. Only 49 percent returned when no incentive was offered.
[59] Ibid., 8
[60] Ibid., 10
[61] Alker and Hoadley, "Briefing #6," 3.

Participation in EBA has increased in the past year and half, in part because of the state's increased outreach efforts. The state however, has had some difficulties in reaching out to the rural pilot counties. In a study contracted by Florida Department of Health and Human Service, researchers found that by early 2008 nearly 60 percent of Medicaid beneficiaries they surveyed in Broward and Duval counties -- the most populated counties in the pilot -- had heard of EBA. Of those who knew of the program, 62 percent had engaged in activities to earn benefits and 46 percent who had credits had redeemed them. Nearly three-quarters of those who had redeemed their credits felt that the program had helped them improve their health in the past six months. [62] Studies show a significant drop in EBA participation in the three pilot counties (Baker, Clay, and Nassau), a factor that is not fully accounted for because of the counties year delay into the reform. According to one study, only 40 percent of survey participants in these three counties knew about EBA. Of this group, 43 percent engaged in activities to earn credits and only 22 percent of those participating in activities redeemed their credits. Of those redeeming credits, 58 percent felt that the program had improved their health in the past six months, as compared to nearly 74 percent in Broward and Duval counties.[63] While the report offers no explanation for this discrepancy, in part the state may be facing challenges in publicizing the program in rural areas. Likewise, individuals may have a harder time participating in activities to earn credits because of limited resources, such as access to doctors or wellness programs. This may easily account for the significantly lower level of participation (43 percent in the rural counties versus 62 percent in the urban counties), despite knowledge of EBA. Of greatest concern is the small number of individuals who have redeemed credits (22 percent in the rural counties), despite

Washington and Lee University

[62] R. Paul Duncan, Allyson G. Hall, Babette Brumback, Jianyo Zhang, and Lorna P. Chorba, "Medicaid Reform Enrollee Satisfaction: Year 1 Follow-Up Study," The Department of Health and Human Services Research, Management and Policy (at the University of Florida), July 2008: 18.

[63] Duncan et. al., "Medicaid Reform Enrollee Satisfaction," 29.

knowing about the program and having earned credits. Further research is needed and could have a significant effect on how the program reaches out to this underserved area in the future.

The effectiveness of the EBA program in promoting healthier behavior is less clear. Studies have found that incentives are highly effective in encouraging one-time behavior (e.g., tuberculosis skin testing) and partly effective in encouraging changes in lifestyle. Studies have found incentives in health improvement programs to be effective in increasing participation, but as having little effect on changes in behavior over time.[64] Most studies do not follow individuals long enough to judge whether there has been a change in behavior. However, two studies that do found that incentives were effective in encouraging healthy behavior so long as they continued over a long period of time. When the incentive stopped, healthy behavior usually stopped within a year.[65] Participation in health improvement programs in Florida may remain low because credits are not rewarded automatically but require forms to be signed before submitting them. It is harder to track changes in behavior and health status since no benchmarks were set for individuals prior to their participation in the program.[66]

Washington and Lee University

Conclusion: Florida's Medicaid Reform

Whether healthcare costs for the state are reduced through the Florida Medicaid reform is still unclear. Evidence so far suggests that some reductions in cost will take place. As it stands, managed-care programs have reduced individual access to physicians, as doctors wrangle with increased administrative burdens and prior authorization for treatment. The use of doctor networks also limits the ability of individuals to access needed care. EBAs have done little to encourage health "beyond the prescription pad." Few measures are in place to evaluate how managed-care organizations and the incentivized EBA program affect individuals overall

[64] Greene, "Medicaid Efforts to Incentivize Healthy Behaviors," 3.
[65] Ibid.
[66] Ibid., 11.

wellbeing. Many of the problems that plague the Florida Medicaid program have occurred because of miscommunication between the state, providers, and patients. This disinformation has a significant effect on the state's ability to benefit from its marketplace approach to healthcare. The state has taken significant steps to close this information gap and has encouraged extensive documentation of the reform. Both external and internal studies have prompted the state to make changes to the program.

OPTION C: West Virginia – Personal Responsibility Agreements

In 2007 Medicaid paid for medical services for nearly 390,000 individuals living in West Virginia -- or more than one-fifth of the state's population. The services ranged from hospital care, nursing home care to physician visits and mental healthcare.[67] In 2005, the state received authorization from CMS to alter the state's Medicaid program for both non-disabled and non-institutionalized children and adults. The centerpiece of the West Virginia Redesign is an agreement that patients must sign with their doctor. This agreement states that Medicaid recipients will not misuse medical services or participate in certain activities, such as visiting the emergency room for non-emergency reasons. However, the agreement also carries vague duties, such as "I will do my best to stay healthy" (See Appendix, Figure 1). Those who sign the agreement are eligible for "Enhanced Benefits Plan," while those who fail to are placed in a "Basic Benefits Plan." Those in the latter plan are only eligible for four prescriptions a month and have limited access to mental health and rehabilitative services, losing some benefits that had been part of Medicaid prior to the redesign. The enhanced-benefit package offers added benefits not previously seen, in particular wellness-improvement programs like tobacco cessation

Washington and Lee University

[67] Ted Boettner and Renate Pore, "Medicaid Matters: Deciphering the Governor's FY 2009 Budget," West Virginia Center on Budget & Policy, 1 March 2008: 1.

classes and nutrition education. If a patient does not comply with the agreement, he or she is automatically placed back into the Basic Benefits Plan.

The reform went into effect in three counties in March 2007 and was spread across the state in November 2007. The redesign affects only children and parents without disabilities. As a result, 85 percent of those affected by itthe will be children.[68] Critics of the reform have raised concerns that patients are not fully aware of the redesign and as a result may lose previously held benefits by default. Previous benefits, like pulmonary and cardiac rehabilitation, diabetes counseling, mental health services, and unlimited access to prescription drugs, are now limited with the Basic Benefits Plan. All of these benefits, when denied, could have a significant effect on the individual's wellness.

Evaluating Option 3:Personal responsibility agreements

It is unclear if the state will achieve cost savings with the reform. West Virginia's Medicaid program receives three-fourths of its funding from the federal government. The remaining one-fourth is paid through the state's legislature, a lottery fund, taxes on providers, and a Medicaid program trust fund.[69] There is some evidence that Medicaid spending may be slowing in West Virginia. Healthcare nationwide has increased at a rate of about 8 percent per year, a rate much higher than general inflation.[70] In 2005, the year the reform took place, the state contributed nearly $527 million toward Medicaid.[71] In 2009 the state will contribute $653.8 million to the program,[72] or a 24 percent growth in spending since the reform.[73] At an 8 percent

Washington and Lee University

[68] Joan Alker, "West Virginia's Medicaid Redesign: What is the Impact on Children?,"Georgetown University Health Policy Institute Center for Children and Families, August 2008: 1.
[69] Boettner and Pore, "Medicaid Matters," 1.
[70] Ibid., 2.
[71] Ibid., 3
[72] Ibid., 1.

annual inflation rate, the state should be spending nearly $717 million annually in 2009. However, any cuts in funding that come through the reform have resulted from only a small segment of expenditures. While children and non-disabled and non-institutionalized adults made up about 65 percent of those enrolled in the state, they accounted for only 30 percent of Medicaid expenditures in 2007. About two-third of expenditures goes toward long-term care for the elderly and people with disabilities.[74] (Long-term care costs are expected to grow as the baby boomer generation ages toward retirement.[75]) Some critics have claimed that the redesign may actually increase costs as individuals with reduced benefits, such as diabetes care and mental health services, become sicker without access to these resources. They may seek out services, like in-patient hospital care, once their health needs become severe – leaving the state to incur even higher costs.[76]

The high number of individuals defaulting into the basic benefit packages may also have a significant effect on lower costs in recent years. Those who fail to sign the agreement at their annual redetermination date must wait a full year before they are eligible to sign up for the enhanced benefits. As of August 2008, 93 percent of children receiving Medicaid were in the Basic Benefits Plan.[77] Even in the three pilot counties – Clay, Upshur, and Lincoln – only 15 percent of children were signed up for the Enhanced Benefits Plan, despite having had the redesign in place for more than six months longer than the rest of the state.[78]

Washington and Lee University

---

[73] The 2009 budget does represent an $8 million decrease from spending in 2008. However, the entire decrease came from a reduction in the physician tax, which is to be phased out for individual physicians by 2011.

[74] Ibid.
[75] Ibid., 2.
[76] Judith Solomon, "West Virginia's Medicaid Changes Unlikely to Reduce State Costs or Improve Beneficiaries Health," Center on Budget and Policy Priorities, 31 May 2006: 5.
[77] Alker, 1.
[78] Alker, "West Virginia's Medicaid Redesign," 2.

With so few people signed up for enhanced benefits it is questionable whether the redesign will truly be successful in changing behavior. Similarly, there is some concern that the reform will have a detrimental effect on recipients' health. Even with the agreement signed, it is unclear (and untested) whether individuals will change their behavior and be deterred from misusing medical services. Even more so there is little evidence that individuals acted irresponsibly before signing the agreement. In October 2004 the United Way of Central West Virginia conducted over one hundred interviews with families whose children were enrolled in Medicaid. The study found that 94 percent of interviewees had a primary physician for care. More than 40 percent of those families said they did not have access to doctors after hours or on weekends and were told by the answering machines at the doctor's office to go to the emergency room when the doctor was unavailable.[79] (For liability reasons it is common for answering machines at doctor's offices to suggest that patients seek out an emergency room if care is urgent.)

Washington and Lee University

Some doctors, in an out of West Virginia, have expressed concerns that the reform will place physicians in an uncomfortable – and possibly unethical – position to deny recipients needed medical services.[80] Physicians are mainly responsible for reporting to the state's Department of Health and Human Services if a patient complies with the signed agreement. This policy could result in arbitrary compliance reporting. One study found that some providers make judgments about compliance based on the race and age of the patient, and are more likely to doubt African Americans as compared to white patients.[81] According to an editorial in the New England Journal of Medicine, having doctors judge a patient's compliance could violate "all three fundamental principles enumerated in the Physician Charter on Medical Professionalism:

[79] Solomon, "West Virginia's Medicaid Changes Unlikely to Reduce State Costs or Improve Beneficiaries Health," 4.
[80] Alker, "West Virginia's Medicaid Redesign," 3.
[81] Solomon, "West Virginia's Medicaid Changes Unlikely to Reduce State Costs or Improve Beneficiaries Health," 5.

the primacy of patient welfare, the principle of patient autonomy, and the principle of social justice."[82] As physicians become agents of the state, patients may lose trust in the physician, an element that is essential to proper treatment. Moreover, the agreement undermines a patient's ability to disagree with a doctor's diagnosis through noncompliance.[83]

West Virginia – much like Florida – has struggled to reach out to Medicaid recipients. The main source of contact has been through mailings. Critics have claimed that information is not clearly marked and is too general in content. While the letter states that recipients must sign the member agreement within 90 days of their annual redetermination date, it does not state when this date is or that the Basic Benefit Plan provides fewer benefits than before the reform. (See Appendix, Figure 2.) Individuals may as a result overlook the redesign, believing that they will keep their same benefit packages. Therefore, as many critics state, many who have been placed in Basic Benefit Plans have lost their benefits "as a result of shortcomings in the system that have led most families not to sign the agreement."[84] Yet despite low participation levels in the pilot counties the state pushed to expand the redesign to the entire state without significant changes to the program.

Washington and Lee University

Still even with greater knowledge about the program, it is unclear if more individuals will choose to sign up for the Enhanced Benefit Plans or be able to comply with the agreement's terms. The redesign does not take into account external factors that significantly affect a patient's ability to meet his or her healthcare needs, such as finding transportation to the pharmacy or time-off from a job to go see a doctor. Failing to follow a prescription regiment or missing a doctor's appointment despite these external factors could result in the Medicaid recipient losing

[82] Gene Bishop and Amy C. Brodkey, "Personal Responsibility and Physician Responsibility – West Virginia's Medicaid Plan," New England Journal of Medicine, 24 August 2006: 757.
[83] Ibid.
[84] Alker, "West Virginia's Medicaid Redesign," 3.

needed benefits for at least a year. Medicaid recipients are held responsible for many factors that are in fact outside of their control or consent. In particular, nearly three-quarters of those affected by the plan are children, who remain dependent on their parents to sign and follow the agreement.[85] The personal responsibility agreement also removes any level of negotiation that a doctor and patient might have over why the patient is having trouble adhering to a treatment or is late to appointments.[86] In many ways the personal responsibility agreement holds low-income individuals to a higher standard than those who receive private healthcare. Even under ideal conditions, medication compliance for the average population generally ranges from 43 percent to 78 percent. Private insurance holders may also choose not to listen to a doctor's advice if they do not agree with the diagnosis without the fear that they will lose benefits.[87]

Conclusion: West Virginia's Medicaid Reform

West Virginia's program could have a substantially negative effect on the health of individuals within the reform. Few know about the program, and the state has made no significant efforts to reach out to individuals. As a result, many patients may be receiving sub-par healthcare simply because of limited awareness. The reform takes freedom out of the hands of the patient by requiring him or her to sign a vague -- yet binding -- agreement. Yet there is no evidence that the agreement will encourage healthy behavior amongst participants beyond visits to the doctor's and prescription drugs. The program runs a significant risk of increasing long-term costs, as individuals receive inadequate preventive healthcare and limited access to curative practices. As the population becomes less healthy, emergency room and hospitalization costs will continue to rise. Of equal concern is the number of children who have even less choice or access to services. The reform leaves children increasingly vulnerable to the actions of their parents. If a

Washington and Lee University

[85] Bishop and Brodkey, "Personal Responsibility and Physician Responsibility, 757.
[86] Ibid.
[87] Ibid.

parent fails to sign the agreement, the child could lose much needed services. Likewise a child has little control over whether he or she is able to make an appointment or get a prescription filled. Yet they will be the one to suffer from adverse health outcomes.

IMPLICATIONS

In evaluating consumer choice in Medicaid reform, it is clear that some state initiatives may not actually decrease costs and may have a seemingly detrimental effect on an individual's health in the long term. Healthcare plans that look to reform benefits through a one-way dialogue are far less effective in transforming how patients seek preventive measures. For example, when states look to increase co-payments and premiums or to have individuals sign personal responsibility agreements they are taking options away from patients. This added barrier – financial and physical – could result in higher levels of disengagement amongst patients as well as limited access to needed care. Florida's program offers a two-way dialogue between patients and service providers, in particular through the formation of managed-care plans that are tailored to the needs of the individual. Patients also receive noteworthy incentives to take preventive measures in their healthcare.

Washington and Lee University

Many of the problems associated with Florida's Medicaid program stem from a lack of communication and understanding. Florida, in particular, has been proactive in learning from its mistakes: adapting information to a fourth-grade reading level and splitting up mailings to focus separately on the managed-care organizations and on the incentive program.[88] The state has sought out various channels to inform recipients: mailings, choice counselors, a toll-free call

[88] Barth and Greene, "Encouraging Healthy Behaviors in Medicaid,"1.

center, and easy to use information posted on the Internet.[89] But even with these measures, it is apparent that the state's free market approach to healthcare would be better improved through increased transparency and information. Similarly, as the state continues to improve knowledge of and access to Enhanced Benefit Accounts, patients may find a new motivation to get involved in their health and benefit from the credits. The Florida Medicaid program has greatly benefited from the quantity of both external and internal studies done about the reform. Over the past three and half years, the state has focused in on key areas of improvement, such as increased attention to "medically complex enrollees," as well as increased efforts to locate those who have not enrolled in the program within their thirty-day choice period.[90] For example, when state officials realized how few individuals were using health benefit credits, the state started inserting one-page flyers into monthly account summaries, promoting specific products that could be purchased with credits.[91]

Washington and Lee University

West Virginia has done little to evaluate its public program internally, and few outside studies have been conducted. Unlike Florida the state is not required under the DRA to provide an annual report of the program, and no such document currently exists. (Florida produces a lengthy report at the end of each quarter as well as an annual report of the program's progress.) The stick-based model, as represented by West Virginia's personal responsibility agreement, assumes that Medicaid recipients misuse medical services and that taking away benefits will encourage recipients to make smarter health decisions. The plan presumes that a document alone will encourage better behavior and that recipients will be able to fully recognize the implications that losing benefits will have on their health. For this population in particular, meeting daily

[89] Ibid., 2; A recent survey found that 58 percent of parents of children receiving Medicaid said they were readily accessible to the Internet.
[90] Coughlin et al., "Florida's Medicaid Reform," w530.
[91] Alker and Hoadley, "Briefing #6," 2.

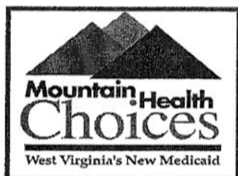
needs alone is a constant struggle and patients may not have the ability or will to overcome perceived barriers, such as signing agreements or following the outlined responsibilities. Those patients who are aware of the reform may choose to remain in the Basic Benefits Plan because it is the simplest way to maintain their healthcare. Similarly, the agreement calls upon the patients to achieve an idealistic state of health awareness that the average population – with heightened capabilities – is not able to reach.

Florida's carrot-based program is better suited to encourage healthier behavior amongst patients. There is room in the program to understand the external factors to health that West Virginia's program overlooks, such as limited transportation or limited knowledge about healthy behaviors. A patient and his or her physician participate in a dialogue to improve the individual's health and the individual receives physical incentives for seeking out certain services to improve his or her health. These credits further improve the individual's health as her or she is now better able to purchase needed medical supplies. There is still significant room for improvements in Florida program. So far researchers have not looked in-depth into how the program affects long-term wellness and whether individuals do in fact seek out better preventive health measures. The state has made great strides to improve information to individuals, but there is still room to make communication improvements. The state has successfully acknowledged that no plan will be perfect in its inception and that states must look to evaluate their programs and make changes. A carrot-based method with room for a two-way conversation between patients and medical providers so far proves to be the best method of approaching consumer choice-based health care for Medicaid recipients.

Washington and Lee University

APPENDIX

Figure 1 West Virginia Medicaid Member Agreement
Source: West Virginia Department of Health and Human Resources, Mountain Health Choices



West Virginia Medicaid Member Agreement

This Agreement outlines your Rights and Responsibilities as a person in the West Virginia Medicaid Program. It also is about ways you can work with your doctor and other health care providers to become healthier.

MEMBER RESPONSIBILITES

1. I will follow the requirements of the West Virginia Medicaid program.

2. I will do my best to stay healthy. I will go to health improvement programs as directed by my medical home.

3. I will read the booklets and papers my medical home gives me. If I have questions about them, I will ask for help.

- I will go to my medical home when I am sick.
- I will take my children to their medical home when they are sick.
- I will go to my medical home for check-ups.
- I will take my children to their medical home for check-ups.
- I will take the medicines my health care provider prescribes for me.
- I will show up on time when I have my appointments.
- I will bring my children to their appointments on time.
- I will call the medical home to let them know if I cannot keep my appointments or those for my children.
- I will let my medical home know when there has been a change in my address or phone number for myself or my children.

Washington and Lee University

4. I will use the hospital emergency room only for emergencies.

MEMBER RIGHTS

1. I have the right to pick my medical home. This is where I go for check-ups or when I am sick and where my health care records will be.

2. I have a right to decide things about my health care and the health care of my children. I have a right to see my medical records. I have the right to ask questions about my health care and the health care of my children.

3. I will be treated fairly and with respect. I will get the care and treatment I need as soon as possible. I will not be treated differently because I am in the Medicaid Program.

4. I have a right to know about all laws and rules of the Medicaid Program.

5. I can contact Medicaid or my health plan with any questions about my health care.

6. I have a right to be sent a written notice when West Virginia Medicaid decides to deny or limit my Medicaid eligibility. I have a right to appeal a decision about my eligibility.

7. I have a right to appeal a decision that says I have not kept the member responsibilities in this agreement.

MEMBER ACKNOWLEDGEMENT

The information in this paper has been explained to me and I agree to follow this Medicaid Member Agreement.

________________________________ _______________
West Virginia Medicaid Member Signature Date

____
Witness: Title:

Location: ____
Date

Washington and Lee University

Figure 2 Letter to Medicaid Recipients about Medicaid Redesign
Source: West Virginia Department of Health and Human Resources, Mountain Health Choices

IMPORTANT NOTICE ABOUT CHANGES TO YOUR MEDICAID BENEFITS

Your Medicaid Plan is now called
MOUNTAIN HEALTH CHOICES

When will my benefits change?

At the time of re-determination.

What are the changes in my benefits with Mountain Health Choices?

With Mountain Health Choices you will automatically be enrolled in a Basic Benefit Plan. You have 90 days from your re-determination date to call your doctor for a check-up and sign the Member Agreement to get Enhanced Benefits. A sample of the Member Agreement is enclosed. If you do not sign the Member Agreement within 90 days of your re-determination date, you will have the Basic Benefit Plan for one year.

Washington and Lee University

What are the differences between the Enhanced Benefits and the Basic Benefits?

The Enhanced Benefit Plan offers more services than the Basic Benefit Plan. Some of these services were offered before and some are new. The Basic Benefit Plan will still cover your health care needs. There will be limits on some services.

How do I get Enhanced Medicaid Benefits?

Call your medical home for a check-up and talk about the Member Agreement. This must be done within 90 days of your re-determination date. You and your doctor will decide on things you want to work on to become healthier. Some examples are losing weight, exercising, or stopping smoking. If you choose to sign the agreement you will receive Enhanced Benefits. To make sure that you receive Enhanced Benefits as soon as possible, make an appointment with your doctor.

What if I have questions about Mountain Health Choices and my Medicaid Benefits?

You can call Mountain Health Choices at 1-800-449-8466. The hours are from 8:00 am to 8:00 pm-Monday through Friday. You may also leave a message for them. Make sure you give them your phone number. Someone will call you back to answer your questions.

PLEASE TAKE THIS NOTICE TO YOUR APPOINTMENT TO TALK ABOUT YOUR MEDICAID BENEFITS.

Revised 4/17/07