kaiser commission on MEDICAID FACTS

medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

July 2006

WEST VIRGINIA MEDICAID STATE PLAN AMENDMENT: KEY PROGRAM CHANGES AND QUESTIONS

On May 3, 2006, West Virginia obtained a state plan amendment for its Medicaid program, becoming one of the first states to utilize new options in the Deficit Reduction Act of 2005 (DRA). Under its amendment, West Virginia will change the benefit package for children and parents, parents will sign a member agreement for themselves and on behalf of their children to access certain benefits, and providers and managed care plans will monitor and report to the state their patients' status with regard to meeting the member agreement responsibilities.[1] Parents and children will continue to be covered for mandatory services, and the state must continue to provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to children.

Through these changes, the state is seeking to "emphasize personal empowerment and responsibility" and to "ensure that participants receive the right care at the right time by the right provider."[2] The Governor also has stated that they could help bring program costs down, while helping to prevent disease.[3] The changes could have significant implications for beneficiaries and providers and provide an early example of how states can use new DRA options.

The state plans to implement the changes on July 1, 2006 in three counties and eventually expand the changes statewide and to more populations. These changes are part of a broader four-year plan being pursued by the state legislature and state Medicaid program.[4] Further changes, including cost sharing and co-payments, will require additional state plan amendments.

How Did the DRA Change Medicaid Benefits?

The DRA was signed into law on February 8, 2006. It included a number of Medicaid policy changes to reduce federal program spending. West Virginia utilizes new DRA options that allow it to change its benefit package for already eligible beneficiaries and differentiate benefits across groups.

Prior to the DRA, states were required to provide certain mandatory services to mandatory populations. States could also receive federal matching funds to cover some people and services not mandated by federal law. States determined the amount, duration, and scope of services they offered. Once a state decided to cover a service, it generally had to offer it to all of its Medicaid beneficiaries. However, individuals were only covered for services that were medically necessary.

The DRA allows states to replace the Medicaid benefit package for certain already-eligible groups with "benchmark" coverage that includes: the standard Blue Cross Blue Shield Plan offered under the Federal Employee Health Benefits Plan, health coverage for state employees, health coverage offered by the largest commercial HMO in the state, or "Secretary-approved" coverage (i.e., coverage the Secretary of Health and Human Services determines is appropriate for a population). The DRA also allows states to provide different benefit packages across populations and/or areas of the state. Children can be enrolled in benchmark coverage, but states must continue to provide them EPSDT services as a wraparound benefit to cover all medically necessary care.

What Changes are Occurring in West Virginia?

Children and parents will be moved to "Secretary-approved" benefit packages. The eligibility groups affected are:

- Infants with incomes below 150% of poverty ($24,900 for a family of three in 2006),
- Children age one to six with incomes below 133% of poverty ($22,078 for a family of three in 2006),
- Children age six to nineteen with incomes below 100% of poverty ($16,600 for a family of three in 2006)
- Working parents with incomes below 37% of poverty ($6,142 for a family of three in 2006), and
- Non-working parents with incomes below 19% of poverty ($3,154 for a family of three in 2006).[5]

There will be a "Basic Plan" and "Enhanced Plan" for children and for parents. The Basic Plan includes all mandatory and some optional services but is more limited than the state's current benefits. Parents can access additional benefits for themselves and their children by signing a member agreement that allows them to enroll in the Enhanced Plan. Some of the additional benefits are prescription drugs above the four-drug limit in the Basic Plan and mental health services and diabetes care, which are not covered in the Basic Plan. Children are covered for the EPSDT benefit, which covers comprehensive screening, diagnostic, and treatment services, in both the Basic and Enhanced plans.[6]

Individuals must sign a member agreement to access Enhanced Plan benefits. The agreement includes broad responsibilities for individuals such as "I will do my best to stay healthy," "I will go to health improvement programs as directed," "I will show up on time when I have my appointments," and "I will use the hospital emergency room only for emergencies." It also includes member rights, such as, "I have the right to pick my medical home," "I have a right to decide things about my health care and the health care of my children," and "I will be treated fairly and with respect."

Physicians will monitor and report to the state patient status with regard to the member agreement. For individuals who sign the agreement to enroll in the Enhanced Plan, in the first year, the state will determine compliance with:

1. Screenings as directed by their provider
2. Adherence to health improvement programs
3. Missed appointments
4. Medication compliance

Physicians and managed care plans will monitor their patients and report to the state. If the state determines an individual has not met his or her responsibilities, the individual or the individual's child will be moved to the more limited Basic Plan. He or she must wait 12 months or until re-determination to re-sign the member agreement and re-enroll in the Enhanced Plan.

Key Questions

Will the new benefit packages meet the health care needs of affected children and parents? Under the changes, some adults will lose non-mandatory benefits since the Basic Plan is more limited than the state's current benefit package. Some may have needs beyond the limits in both the Basic and Enhanced Plans. The state has described the children and parents affected by the changes as generally healthy.[7] While these groups do not include those eligible for Medicaid based on disability, they may include people with more broadly defined disabilities or chronic conditions who have significant health needs. Some may have significant needs due to an accident or illness that requires acute care or long-term rehabilitation. Individuals would likely be unable to afford most uncovered services or services beyond plan limits given their low incomes (e.g., parents earning less than $6,142 per year for a family of three).

How will the new benefit packages interact with children's right to EPSDT benefits? As required under the amendment, the state has indicated that children will continue to have access to EPSDT services. Families will need to be educated about their right to EPSDT services and how to access them. It will be important to monitor families' knowledge of and access to these services under the new benefit structure.

How will the member agreement work? The member agreement creates a significant change in how parents and their children receive benefits by making some benefits conditional upon complying with certain responsibilities. If the state determines an individual did not meet the responsibilities, such as getting regular check-ups, the state may move him or her from the Enhanced Plan to the Basic Plan. A parent moved to the Basic Plan would lose certain benefits, including diabetes care and mental health care.[8] In the case of children, parents will sign the member agreement on their behalf. However, irrespective of the Basic and Enhanced Plan benefit structure, the state is required to continue to provide EPSDT services to children. It will be important for parents to be clearly educated about the agreement and its implications and to monitor any difficulties families face meeting their responsibilities. Individuals can appeal a determination that they have not met the member agreement, but there currently is no information available about this process.

How will the member agreement impact providers? The member agreement also creates a significant change in the provider and patient relationship. The provider or managed care plan will now be responsible for monitoring and reporting to the state patient status with regard to meeting the member agreement responsibilities. This may raise provider liability and privacy issues and complicate the provider-patient relationship. More information is needed on the process providers and plans will use to monitor and report to the state.

Will the state achieve its stated goals? The state is pursuing these changes to improve coordination of care and help bring program costs down while helping to prevent disease. Given that the majority of non-disabled children and adults have relatively low costs, the savings potential is unclear, particularly if children are still guaranteed EPSDT benefits. While adults and children make up two-thirds of West Virginia enrollees, they account for less than a quarter of spending, reflecting lower per capita spending for children ($1,545) and adults ($2,166) compared to disabled ($8,480) and elderly ($13,001) enrollees.[9] How the new benefit structure will impact individuals' ability to obtain needed care and their health status will need to be monitored.

Conclusion

West Virginia's state plan amendment will result in a significant change in the benefit structure for children and parents, providing them more limited benefits and making certain benefits conditional upon fulfilling a member agreement. It will also alter the role of providers and change the nature of the provider and patient relationship. The amendment's impacts will be magnified if it is expanded to more populations or if the state seeks to use other DRA options, such as cost sharing. Given the significance of the changes, they should be closely monitored and evaluated.

For additional copies of this publication (#7529), please visit www.kff.org/kcmu.

[1] West Virginia State Plan Amendment, May 3, 2006, Section 3.1, Attachment 2, pg. 1
[2] Ibid.
[3] "Medicaid Changes Approved," The Charlestown Gazette, May 4, 2006.
[4] Communication with State Official, June 22, 2006. The state has also indicated that there will be a Healthy Rewards Account that will allow beneficiaries to purchase services not covered by Medicaid, West Virginia Department of Health and Human Services, "State Plan Amendment Could Revamp Medicaid," May 3, 2006.
[5] Parents receiving Transitional Medicaid and Extended Medicaid child support are also impacted.
[6] As defined in Section 1905 of the Social Security Act, EPSDT services include periodic screenings to identify physical and mental conditions and vision, hearing, and dental problems, as well as "such other necessary health care, diagnostic services, treatment, and other measures [that can be covered under Medicaid] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan."
[7] West Virginia State Plan Amendment, May 3, 2006, pg. 1
[8] West Virginia State Plan Amendment, May 3, 2006, Section 3.1, Attachment 2, pg. 3
[9] Kaiser Commission on Medicaid and the Uninsured, West Virginia State Medicaid Fact Sheet, created June 7, 2006, www.kff.org