Two States Tie Behavior to Medicaid Benefits

Kentucky and West Virginia try carrots and sticks to spur healthier lifestyles, medical home usage.

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Changes made possible by last year's Deficit Reduction Act are raising concerns in some sectors about reductions in care and conflicts of interest in West Virginia's Medicaid program.

The act also has allowed Kentucky to change its Medicaid program, although those changes are generating less controversy, and have less pediatric impact. "Kentucky's [plan] is more of a carrot; West Virginia's is more of a stick," Robin Rudowitz, principal policy analyst at the Kaiser Family Foundation, said during a June 19 teleconference.

The new West Virginia Medicaid program was approved in early May by the Centers for Medicare and Medicaid Services (CMS) under a Deficit Reduction Act waiver. It started in July in three counties, and officials anticipate a statewide rollout over 4 years.

Parents and children affected by the West Virginia plan will receive a "Medicaid Member Agreement" to be signed at the physician's office or clinic. The agreement entitles them to an enhanced benefit package in exchange for a promise to "do my best to stay healthy," to "go to health improvement programs as directed by my medical home [doctor] and go to my medical home when I am sick," according to the plan that the state submitted to the CMS.

During the program's first year, physicians and health plans that contract with the Medicaid program will be asked to monitor whether beneficiaries comply with the agreement. "If the member has fulfilled the responsibilities agreed to, he or she will remain in the Enhanced Benefit Plan," the plan notes. "If the member does not fulfill the responsibilities, he or she will be moved to the Basic Benefit Plan subject to good cause." Members will receive advanced notification if their benefits are reduced, and will have the right to appeal the decision.

An attachment to the West Virginia Medicaid plan shows differences between enhanced and basic coverage. Diabetes care is included in the enhanced plan, but not the basic plan. "Chemical dependency/mental health services" also are included in the enhanced plan, but excluded from the basic plan. The basic plan limits patients to four prescriptions per month.

No matter which plan they're in, "Children will get the services they need," John Law, assistant secretary for West Virginia's Department of Health and Human Resources, said in response to a question about diabetes and mental health care. Regarding prescriptions, "in our study of this population, we found that members use less then one prescription each month," Mr. Law added.

Families also will not be penalized for going to the emergency department "when ER use is needed," Mr. Law said. He emphasized that no groups were eliminated from coverage under the new Medicaid program.

In addition, children continue to be covered under the state Medicaid program's early periodic screening, diagnosis, and treatment (EPSDT) program, Mr. Law said. "Emergent medical problems, such as an emergency room diagnosis of diabetes, will be immediately treated, and the child will be referred to his or her health care provider for follow-up care."

But the Center for Budget and Policy Priorities (CBPP), a progressive Washington think tank, expressed concern about coverage under the basic package compared with what the state currently provides. Under the EPSDT program, "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," the CBPP said in a statement.

Also, the requirement that physicians monitor their patients' compliance with the member agreement may create problems for doctors, according to the Center for Children and Families (CCF) at Georgetown University, Washington.

Requiring physicians to report compliance "may create many ethical and legal dilemmas for doctors … who are asked to evaluate and report on their patients' confidential behaviors," the center noted.

Kentucky's plan, also approved in May, is aimed more at adults. For example, the "Get Healthy" benefits program provides incentives for members with certain targeted diseases to access additional benefits if they participate in certain "healthy practices." Initially, that program will be limited to those with pulmonary disease, diabetes, and cardiac conditions, but may be expanded. Those benefits will include additional dental and vision services, or counseling for nutrition or smoking cessation. Another difference: Patients also don't have to sign a contract. ■

Private Payers May Follow Suit

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tice costs," Dr. Cecil Wilson, AMA board chair, said in a statement.

If finalized as proposed, the evaluation and management increases would be good news for family physicians, according to Dr. Thomas Felger, the American Academy of Family Physicians' representative on the Relative Value Update Committee (RUC) of the American Medical Association. The RUC is a 29-member multispecialty committee that makes recommendations to the CMS annually on payment issues. The two main evaluation and management codes used by family physicians—99213 and 99214—are set to increase an average of about 10% in 2007. Ultimately, the impact for physicians could be greater than estimated by the CMS, because private payers generally adopt the RVUs set by CMS, Dr. Felger said.

Dr. Felger, associate director of family medicine residency at St. Joseph's Regional Medical Center in South Bend, Ind., said the AAFP and some of the other cognitive specialties had been pushing for these changes over the last few years. The work involved in an evaluation and management visit is much different from 10 years ago, when the CMS last made changes to how it values those services, he said.

For example, more preventive care is provided to Medicare patients and it's almost routine for a Medicare patient to have three chronic illnesses. The AAFP and others wanted the work RVUs to reflect the new requirements being placed on physicians, he said, noting the proposal "recognizes that an office visit is more intense and more complex than it was 10 years ago."

The changes also were praised by other primary care specialties. Dr. J. Leonard Lichtenfeld said the proposed changes to evaluation and management services would help address the underfunding of primary care. Dr. Lichtenfeld, a medical oncologist, is the American College of Physicians' representative on the RUC.

But although these changes go a long way in helping struggling physicians, it's not a complete solution, Dr. Lichtenfeld said, because it doesn't solve the underlying problem of inadequate funds in Medicare. "Someone's got to be there to be the captain of the ship," he said.

Primary care physicians aren't the only ones who will benefit from the increases for evaluation and management codes, he noted. Surgeons will see some benefit because of increases for surgical postoperative care, as well as physicians in cognitive specialties such as neurology, he said.

For Dr. Douglas Leahy, an alternate delegate to the RUC for the ACP and a general internist, the proposed increases would mean the chance to spend more time with patients. Dr. Leahy, who works in a large multispecialty practice in Knoxville, Tenn., said that with better reimbursement for evaluation and management services, he could devote more time to important areas such as diabetes prevention or counseling family members of an Alzheimer's patient.

Estimating the Impact

At press time, ACP officials were still calculating the financial impact of the changes for internists. But a rough estimate based on the CMS proposal shows that internists could see a $4,000-$6,000 increase in revenue in 2007 depending on the services they provide, said Brett Baker, ACP's director of regulatory affairs.

CMS estimates in its proposed rule that internists will see an increase of about 5% in allowed charges in 2007 based on the combined impact of both work and practice expense RVU changes.

Specialty Societies Speak Out

Although primary care groups have expressed support for the CMS proposal, some specialties are complaining about the way practice expense changes were calculated. The agency put out a notice asking various specialties to submit their own data for consideration by CMS. One member of the Practicing Physicians Advisory Council, which advises the CMS on issues affecting physicians, took the agency to task at the council's May meeting for allowing only some specialties to submit new data.

"I am more than a little frustrated that there [already] was a data set which admittedly was old, but it was collected from all specialties at the same time," said Dr. Tye Ouzounian, an orthopedic surgeon from Tarzana, Calif. "Now some specialties have selectively submitted new data, which is 10 years newer, which is probably going to be more extensive. Those societies are being allowed to use new data, whereas other societies were not allowed to use new data, and that's not fair."

The only way to make things fair, he continued, "is to allow all societies to participate equally on the same footing with the same survey at the same time. To cherry-pick data that is 10 years newer from four or seven specialties is not fair to the groups that didn't do it."

Don Thompson, senior technical advisor to the CMS, said that the agency had invited all the specialty societies to do surveys, "and we had criteria ahead of time about what we would [need] to accept surveys. The surveys that were done that met the requirements—random surveys, internally consistent—we had proposed to use them on that basis." Ideally, he said, "we would like to see more recent survey data for all specialties."

Dr. Ouzounian noted that the American Medical Association was discussing coordinating a survey of practice expenses for a large number of specialties. Mr. Thompson seemed receptive to that idea. "We would be supportive of the AMA going out and doing a survey, and if the data that resulted is better than what we have now, we'd want to incorporate that into our methodology," Mr. Thompson said.

Although the increased payments for evaluation and management services and surgical postoperative care are needed, they are accompanied by an average 5% across-the-board cut in payments, according to the AMA. That cut is the result of the budget neutrality adjustment that the CMS is required by law to make whenever changes in RVUs cause an increase or decrease in overall physician fee schedule outlays of more than $20 million. The proposed work RVU changes are estimated to increase expenditures by about $4 billion, said CMS.

The proposal was published in the June 29 issue of the Federal Register. The CMS is accepting comments until Aug. 21. ■

The proposed rule is available online at www.cms.hhs.gov/PhysicianFeeSched.

Associate Editor Joyce Frieden contributed to this report.