



# Mountain Health Choices: An Unhealthy Choice for West Virginians

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A year after West Virginia implemented its radical Mountain Health Choices program, evidence shows that enrolled families are faring poorly, for several reasons. First, a confusing enrollment process and lack of critical information about how to enroll have caused the vast majority of families to lose access to crucial health care services, and these families are not benefiting from new services that are meant to improve West Virginians' health. Second, the state is requiring very low-income families to adhere to unrealistic member agreements and health improvement plans.

This update builds on Families USA's first analysis of the West Virginia state plan amendment, *Radical New Changes in Medicaid for West Virginia* (available online at [www.familiesusa.org/assets/pdfs/state-medicaid-waivers/wv-state-plan-amendment.PDF](http://www.familiesusa.org/assets/pdfs/state-medicaid-waivers/wv-state-plan-amendment.PDF)), continuing our examination of the problems with the Mountain Health Choices program. We begin with some basic background information on the program and how it was developed, and then we discuss several of the program's shortcomings.

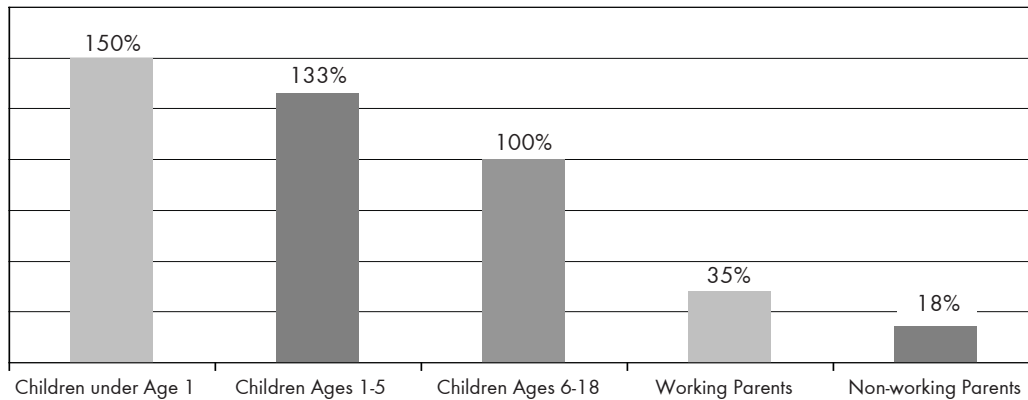
## Background

In May 2006, the federal Centers for Medicare and Medicaid Services (CMS) approved West Virginia's plan to create a new program, called Mountain Health Choices, that reduces the benefits available to children and parents in Medicaid. West Virginia was one of the first states to gain approval for such a plan under new Medicaid rules that were part of the federal Deficit Reduction Act of 2005 (DRA).<sup>1</sup>

The most significant way that Mountain Health Choices changed West Virginia's existing Medicaid program is that it offers a much more limited benefits package to enrolled children and parents than was previously offered. This limited benefit plan is referred to as the "basic" benefit plan by the state. Enrollees who sign a member agreement and who comply with certain requirements regarding "healthy behaviors" are eligible to enroll in what the state calls an "enhanced" benefit plan. This plan provides more comprehensive coverage, including a few additional services not traditionally covered by Medicaid, such as tobacco cessation and weight management services. The new plan requires all members to choose a "medical home," which is a primary care provider whom they will see for regular care and who will assist them with managing their health care needs.<sup>2</sup>

The Mountain Health Choices program provides coverage for children in families with incomes up to 150 percent of the federal poverty level (\$26,400 for a family of three in 2008) depending on the age of the child,<sup>3</sup> and for parents with incomes up to 35 percent of poverty (\$6,160 for a family of three in 2008).<sup>4</sup> While nationally 13 percent of the population is covered by Medicaid, 16 percent of people living in West Virginia are covered by Medicaid. And half of those in Medicaid in West Virginia are children.<sup>5</sup> Therefore, redesigning the state's Medicaid program has had far-reaching implications for the health of a significant number of West Virginia's children and very low-income parents.

Figure 1.  
Income Limits for Families in Mountain Health Choices as a Percent of the Federal Poverty Level



## Enrollees Face a Confusing Enrollment Process and Lack of Information

While advocates in West Virginia were concerned that children and their parents would lose enhanced coverage due to difficulties with fulfilling the requirements of their member agreements and/or health improvement plans, a year later, the evidence shows that most individuals are not enrolling in the enhanced plan at all. Advocates and enrollees report that the enrollment process for the enhanced plan is confusing, and there has been a lack of information provided to members regarding enrollment.<sup>6</sup>

When an individual enrolls in Mountain Health Choices, he or she is automatically placed in the basic health plan. Those who were already enrolled in Medicaid when Mountain Health Choices began were automatically placed in the basic plan when it was time to renew their coverage. In order to enroll in the enhanced plan, individuals need to schedule an appointment with their health care provider within 90 days of enrolling or renewing to sign a member agreement and agree to a health improvement plan.

Although enrollees are sent information about Mountain Health Choices in the mail 60 days before their eligibility renewal date, and a follow-up postcard reminder is sent later, there appear to be three problems that are causing people to fall through the cracks:

1. The material is sent by a private vendor that contracts with the state to manage enrollment in the basic and enhanced plans in Mountain Health Choices. Unfortunately, early on, the material was not clearly marked as coming from the Department of Health and Human Resources, nor did the material indicate that it pertained to Medicaid coverage, so individuals may not have read it carefully, or at all.
2. The material lacks clear explanations of the new benefit plans, and it does not make explicit the importance of signing a member agreement—or even what to do with the member agreement once it is signed. Nothing on the forms indicates that the signed forms should be returned, and no address or contact information is provided.
3. While providers play a critical role in ensuring that their patients sign these forms and develop a health improvement plan, providers also appear to lack information about what happens to those forms once they are completed.

## What Is the Difference between the Basic Plan and the Enhanced Plan?

Mountain Health Choices includes two basic plans: one for children, and a different one for adults. Generally, the basic plans cover only those services that are considered mandatory under pre-DRA federal Medicaid law, such as primary care visits, hospital services, specialty care, x-ray and lab services, and family planning services.

### So What's Missing?

The adult basic plan lacks several key health care services, including diabetes education, nutrition education and weight management programs, cardiac rehabilitation, and chiropractic care. The adult basic plan also does not cover clinic or rehabilitation mental health services that are provided by community-based behavioral health centers. In addition, the adult basic plan has strict limits on some other important services, such as prescription drugs; home health care; ambulance services; and occupational, speech, and physical therapy. All of these services are covered in the enhanced plan, most without limits.

The basic plan for children also excludes key services, including skilled nursing care, podiatry services, and nutrition education. Other important services are limited, including prescription drugs; behavioral clinic and rehabilitation mental health services; home health services; non-emergency medical transportation; and vision, dental, and hearing services. Virtually all of these services are available to children in the enhanced plan without limits. And most of these services were covered in West Virginia's pre-DRA Medicaid program.

Despite the service exclusions and limits that are articulated in the Mountain Health Choices program, West Virginia is still required under federal law to provide Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services to all children under age 21 who are covered by Medicaid. This means that all children are entitled to regular screenings and check-ups and any medically necessary treatment that is required after a diagnosis. And although the DRA allows states to design new benefit packages for children, it also requires them to ensure that EPSDT requirements are met.

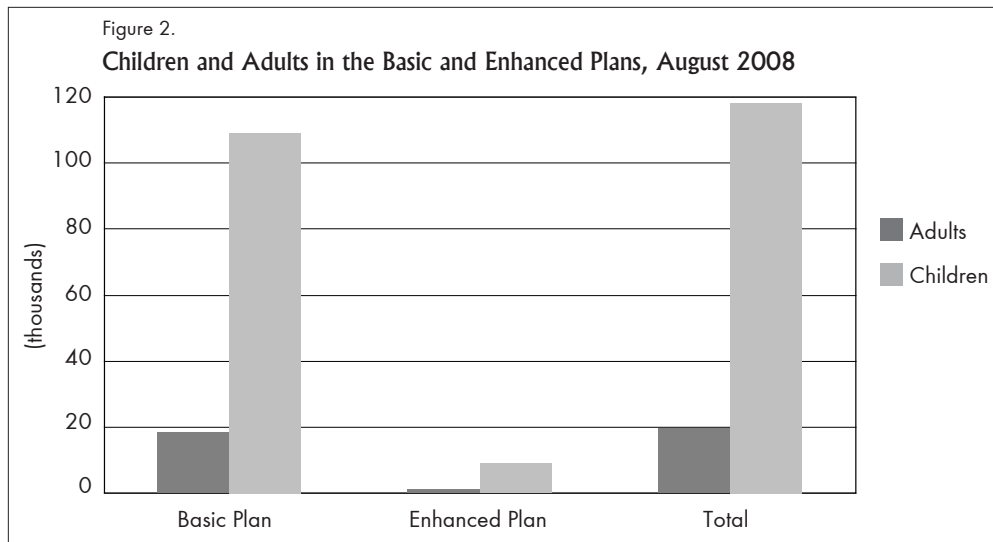
The fact that the basic benefit package for children lacks or limits coverage for many of the services that West Virginia is required to provide under EPSDT presents an additional complication in the program. Without clear information for both providers and enrollees that explains the disconnect between the benefit package and the EPSDT requirements, children may be wrongly denied coverage for needed health care.

For a complete list of services provided in each plan, see West Virginia Department of Health and Human Resources, *Mountain Health Choices Plan A Adults*, available online at [http://www.wvdhhr.org/bms/oAdministration/Medicaid\\_Redesign/redesign\\_BenGlanceAdult20070126.pdf](http://www.wvdhhr.org/bms/oAdministration/Medicaid_Redesign/redesign_BenGlanceAdult20070126.pdf),<sup>7</sup> and *Mountain Health Choices C Children*, available online at [http://www.wvdhhr.org/bms/oAdministration/Medicaid\\_Redesign/redesign\\_BenGlanceChild20070112.pdf](http://www.wvdhhr.org/bms/oAdministration/Medicaid_Redesign/redesign_BenGlanceChild20070112.pdf).<sup>8</sup>

## A Majority of Enrollees Don't Have Access to Key Health Care Services

In order for beneficiaries to get the most out of the Mountain Health Choices program, they must be enrolled in the more comprehensive enhanced benefit plan. Mountain Health Choices began in just three counties in March 2007.<sup>9</sup> In November 2007, the program was expanded to the entire state. At that time, 93 percent of those in Medicaid in the three counties were enrolled in the basic plan, and only 7 percent were enrolled in the enhanced plan.

As of August 2008, approximately 93 percent of adults and 92 percent of children were enrolled in the basic plan, while only 6.8 percent of adults and 7.7 percent of children were enrolled in the enhanced plan.<sup>10</sup> Total enrollment in the enhanced plan for both children and adults is just 7.5 percent of affected beneficiaries enrolled as of August 2008.<sup>11</sup> The bottom line is that many enrollees do not have access to important medical services that are covered only in the enhanced plan.



## Access to Mental Health Services Is Severely Limited

Reports from providers, advocates, and beneficiaries indicate that the Mountain Health Choices program is having a detrimental effect on families' ability to get medically necessary mental health care. Although both the basic and enhanced plans include coverage for visits to psychiatrists and psychologists to receive diagnostic services, medication management, and therapy, the basic plan for children limits inpatient hospital psychiatric services to 30 days per year, and it limits outpatient clinic and rehabilitation mental health services to 26 days per year. The basic plan for adults excludes these services altogether. A survey of all behavioral health centers in the state found that only 6 percent of Medicaid enrollees in need of mental health services had signed up for the enhanced plan.

Low enrollment in the enhanced plan for both children and adults means that the vast majority of Medicaid enrollees with mental health needs do not have adequate coverage for these critical services. This low enrollment has other negative consequences. For example, Medicaid recipients make up 40 percent of the patients at behavioral health centers, and they therefore make up a considerable portion of these centers' revenues.<sup>12</sup> However, since a large portion of these patients are now in the basic plan with limited coverage for mental health services, these behavioral health professionals are not being paid for providing care to many of their patients.

Moreover, although federal Medicaid law requires West Virginia to ensure that children receive access to medically necessary health care services under EPSDT, behavioral health care providers report that West Virginia is not currently reimbursing behavioral health centers for medically necessary services for children in the basic plan who have reached the benefit cap.<sup>13</sup> According to providers, children with serious mental illness who are enrolled in the basic health plan reach the limits for outpatient services very quickly, and the state has denied payment for additional services, even in cases where the state's administrative service organization for behavioral health has determined those services to be medically necessary.

The loss of payment for some of their services has put significant financial pressure on behavioral health providers. Some may be forced to turn patients away, while others may be forced to close their doors altogether.

## **Promise of Healthy Rewards Accounts Not Being Fulfilled**

As part of the effort to steer Medicaid enrollees toward more healthy behaviors, West Virginia promised to offer Healthy Rewards Accounts to individuals enrolled in the enhanced benefit plan who adhere to their health improvement plan. The money in those accounts could be used to pay for copayments or health care services not covered by Medicaid.

The state received a \$1.9 million Transformation Grant from CMS in early 2007 that was to be used, in part, to help develop the Healthy Rewards Program. However, more than a year has passed since West Virginia received the grant, and it has not yet designed the program or received approval from CMS to begin. So, while a few people have managed to enroll in the enhanced plan and are at least receiving a better benefit package, they are not yet receiving this additional promised benefit.

## **The Wrong Approach to Medicaid Reform**

One of the main objectives of the Mountain Health Choices program, according to the state, is to improve the health of West Virginians. The state ostensibly developed the basic and enhanced health plans to create an incentive for individuals to better use their medical homes, and to adhere to the member agreements and health improvement plans in order to get better health coverage and Healthy Rewards Accounts. However, the reality is that, rather than offer additional benefits to West Virginians enrolled in Medicaid, the state penalizes children and parents participating in Mountain Health Choices by reducing access to care.

There are two ways in which the state has taken the wrong approach: 1) by requiring enrollees to sign member agreements, which contain provisions that may be difficult or impossible to adhere to, in order to receive more comprehensive benefits; and 2) by taking away benefits if a member in the enhanced plan inadvertently fails to adhere to the member agreement because, for example, he or she misses a doctor's appointment. Not to mention the fact that, for the children who are affected by this redesign, their benefits are contingent on the actions of their parents or guardian.

## **Member Agreements Contain Unrealistic Demands**

In order to get the enhanced benefit package for themselves or for their children, parents are required to sign a member agreement. The agreement outlines certain "responsibilities" that parents must live up to, or they risk losing access to the additional services that are covered in the enhanced package. The responsibilities outlined in this agreement include keeping medical appointments, showing up on time for doctor's appointments, using the hospital emergency room only for emergencies, and following health improvement programs as directed by their physician.

While these may not seem like onerous requirements, anyone might have difficulty adhering to particular health behaviors or being on time for every scheduled appointment. For example, many jobs (particularly the low-wage jobs upon which many people in Medicaid rely) do not offer paid sick leave or allow workers to take time off of work for their own or their children's medical appointments. Other barriers include lack of access to efficient transportation, language access issues, and low health literacy. Indications are that the state failed to account for these potential barriers before implementing the new program. While anyone may be late to a doctor's appointment for reasons beyond their control (unexpected traffic problems, a late babysitter, a car accident), people with private health insurance do not risk losing their health insurance as a result.

This approach is not likely to condition an individual's behavior or have a positive impact on a child so that they become healthier. In fact, preventing enrollees from obtaining certain health care services could contribute to individuals becoming less healthy. When an enrollee in the basic plan gets sick and needs a service that isn't covered under the basic plan, he or she may forego care for as long as possible due to cost, exacerbating his or her condition, and end up seeking costlier care in a hospital emergency room.

Moreover, it is unclear whether the Mountain Health Choices program actually addresses the issues that would lead to improved health for West Virginia families. According to the West Virginia Bureau for Medical Services, 85 percent of non-elderly or disabled Medicaid beneficiaries in the state have one or more risk factors for chronic disease.<sup>14</sup> In particular, obesity is a major risk factor for a majority of these individuals: 64 percent of West Virginia adults are obese or overweight, the third-highest rate in the nation.<sup>15</sup> Research shows that investing in disease prevention, especially measures related to weight loss and tobacco cessation, can result in better health outcomes and substantial health care savings.<sup>16</sup>

One of the Medicaid health plans in West Virginia began offering its members the opportunity to enroll in Weight Watchers at the beginning of 2007, before the implementation of Mountain Health Choices, to address the obesity epidemic. Unfortunately, under the new program, this benefit will be available only to those in the enhanced plan. In 2006, Tennessee's Medicaid agency completed a similar pilot program for 1,400 Medicaid recipients who paid nominal fees to participate in Weight Watchers. Over a six-month period, participants lost a combined total of more than 8,000 pounds. West Virginia could have chosen to invest more in its Weight Watchers option instead of limiting its availability to only those in the enhanced plan. With only a small percentage of parents signed up for the enhanced plan, the state is unlikely to see much progress in reducing costs related to obesity.

In point of fact, it seems that those enrolled in the previous Medicaid program may have been better off. Surveys conducted in 2001 and 2003 by the West Virginia University Institute for Health Policy Research revealed that approximately 95 percent of children enrolled in West Virginia Medicaid and 82 percent of adults enrolled in the program had a regular source of medical care.<sup>17</sup> Another survey conducted by the United Way of Central West Virginia in 2004 showed that the majority (87 percent) of parents of children enrolled in Medicaid and the Children's Health Insurance Program (CHIP) took their children to well-child check-ups and acute care visits.<sup>18</sup> While adult Medicaid enrollees were less likely to go to the doctor for preventive care, 73 percent did go when they were sick, and 39 percent reported going to the doctor more than three times per year.<sup>19</sup>

## Conclusion

West Virginia is not fulfilling its goal of improving health care for the approximately 118,000 children and 20,000 parents who are currently enrolled in the Mountain Health Choices program. Rather than receiving access to new, preventive services that research shows to be promising, the vast majority of participants – 92 percent – have lost access to critical health care services. These problems stem from a combination of procedural hurdles and flawed program design.

By early 2009, all children and parents in West Virginia Medicaid will have reached their annual renewal date and will have “chosen” to participate in either the basic or enhanced health plan. It is imperative that West Virginia address the procedural hurdles that prevent individuals from enrolling in the enhanced plan as soon as possible so that enrollees have a meaningful choice, and so that people in both the basic and enhanced plans get coverage for the health care to which they are entitled.

## Endnotes

<sup>1</sup> The DRA allows states to deviate from current federal Medicaid requirements and alter their existing benefit packages for some groups of people in Medicaid, replacing the current federal benefit requirements with new benchmarks or standards of coverage. For more on the benchmark benefit package state option, see Families USA, *Benefit Packages Changes: Coming to a State Near You?* (Washington: Families USA, March 2006), available online at <http://www.familiesusa.org/assets/pdfs/DRA-Benefit-Package.pdf>.

<sup>2</sup> The state has not yet developed the criteria it will use to certify a provider as a medical home, nor has it defined what it means to “manage a patient’s care.”

<sup>3</sup> West Virginia Medicaid covers infants with family incomes up to 150 percent of the federal poverty level (\$26,400 for a family of three in 2008); children ages one to five with family incomes up to 133 percent of poverty (\$23,408 for a family of three in 2008); and children age 6-18 with family incomes up to 100 percent of poverty (\$17,600 for a family of three in 2008).

<sup>4</sup> Non-working parents are covered if their incomes are no higher than 18 percent of the federal poverty level in 2008 (\$3,168 for a family of three). The eligibility limits for working and non-working parents are the dollar amount listed, and those limits are not adjusted annually with the poverty level.

<sup>5</sup> Kaiser State Health Facts Online, *West Virginia: Health Insurance Coverage of the Total Population, States (2005-2006), U.S. (2006)* (Washington: Kaiser Family Foundation, 2008), available online at [www.statehealthfacts.org](http://www.statehealthfacts.org), accessed on June 26, 2008.

<sup>6</sup> “Revamped Medicaid Suspension Sought,” *The Charleston Gazette*, June 12, 2008.

<sup>7</sup> West Virginia Department of Health and Human Resources, *Mountain Health Choices Plan A Adults*, revised January 26, 2007.

<sup>8</sup> West Virginia Department of Health and Human Resources, *Mountain Health Choices C Children*, revised January 12, 2007.

<sup>9</sup> Mountain Health Choices began in Clay, Lincoln, and Upshur counties.

<sup>10</sup> West Virginia Department of Health and Human Resources, *Bureau for Medical Services, Mountain Health Choices August Enrollment Report* (Charleston, WV: West Virginia Department of Health and Human Resources, Bureau for Medical Services, August 2008).

<sup>11</sup> Ibid.

<sup>12</sup> Ibid.

<sup>13</sup> Letter from the West Virginia Behavioral Healthcare Providers Association to Martha Walker, Secretary of the West Virginia Department of Health and Human Resources, March 20, 2008.

<sup>14</sup> West Virginia Bureau for Medical Services, *Medicaid Transformation Grant Application, 2006*, available online at <http://www.healthtransformation.net/galleries/default-file/West%20Virginia.pdf>.

<sup>15</sup> “HMO Offers Weight Watchers to West Virginia Medicaid Enrollees,” *American Medical News*, February 19, 2007.

<sup>16</sup> Trust for America’s Health, *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities* (Washington: Trust for America’s Health, July 2008).

<sup>17</sup> Johnna S. Beane, Gail R. Bellamy, and Melissa Kolb McCormick, *Children’s Health Insurance Program Consumer Satisfaction Survey, 2003* (Charleston, WV: West Virginia University Institute for Health Policy Research, January 2004).

<sup>18</sup> The United Way of Central West Virginia Health Care Access Project, *Experiences in Receiving Care by West Virginia CHIP and Medicaid Families* (Charleston, WV: The United Way of Central West Virginia, Health Care Access Project, October 2004).

<sup>19</sup> Ibid.

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