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," Robin Rudowitz, principal policy analyst at the Kaiser Family Foundation, said during a June 19 teleconference.

The 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 for a 90-day trial period.” 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 dependencem/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 Lichtenfeld, the American Academy of Family Physicians’ representative on the RUC, 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.”

The proposal was published in the June 27 issue of the Federal Register. The CMS is accepting comments until Aug. 21.

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 data at the same time.”

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 proposal rule is available online at www.cms.hhs.gov/PhysicianFeeSched. Associate Editor Joyce Frieden contributed to this report.