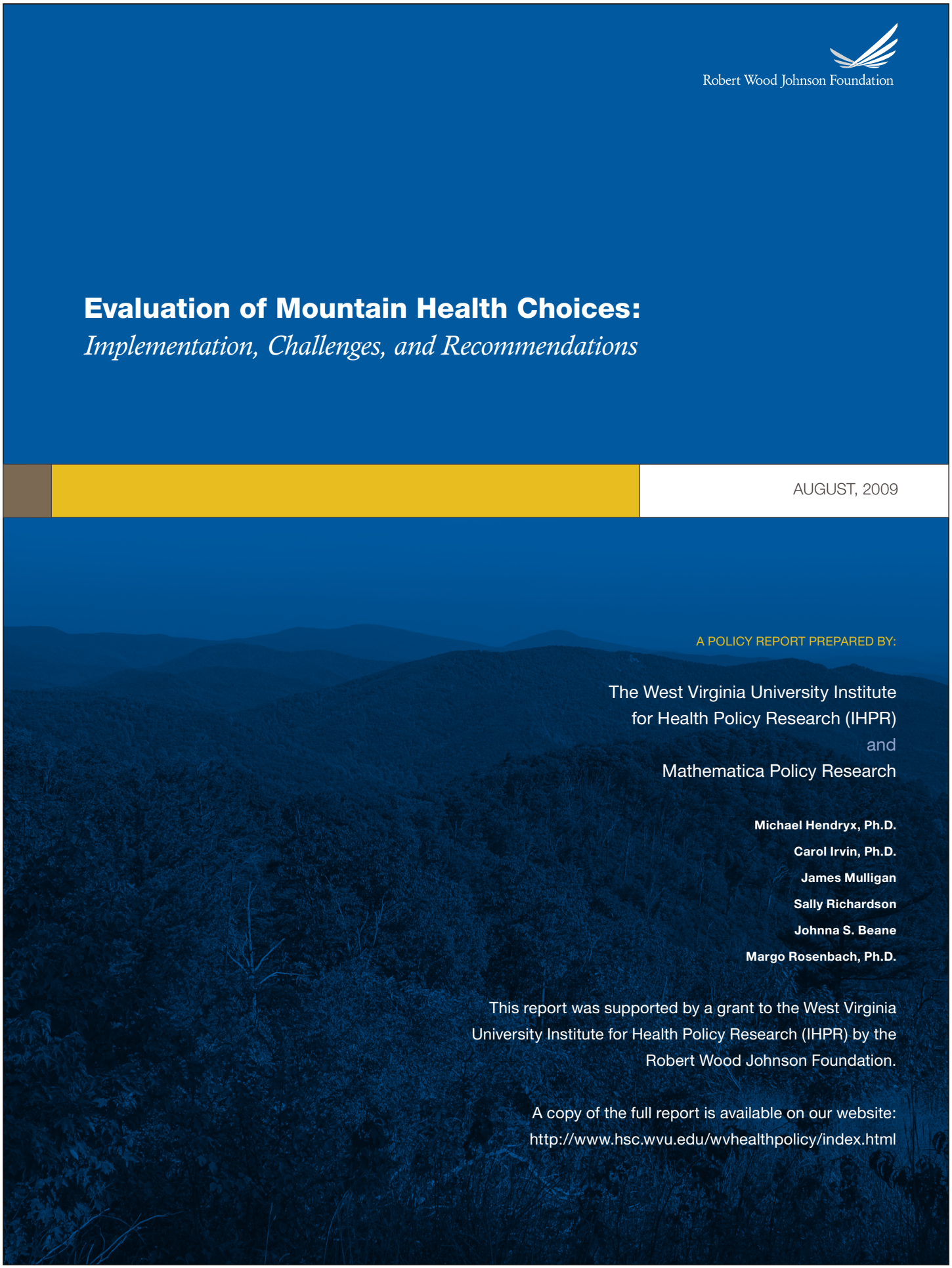

Robert Wood Johnson Foundation

Evaluation of Mountain Health Choices:

Implementation, Challenges, and Recommendations

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A POLICY REPORT PREPARED BY:

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A copy of the full report is available on our website:
http://www.hsc.wvu.edu/wvhealthpolicy/index.html

Executive Summary

The West Virginia Bureau of Medical Services (BMS) has been engaged in a major redesign of its Medicaid program. A key component of the redesign is a Medicaid state plan amendment that was approved in May 2006 and established Mountain Health Choices, a new program of benefits and rewards for low-income parents and children. This program operates under the authority of the Deficit Reduction Act of 2005. Mountain Health Choices began operations in three pilot counties in March 2007 and expanded to include almost all 55 West Virginia counties by November 2007. As of February 2009, approximately 149,000 children and adults were enrolled in the program.

The target population includes low-income Medicaid adults and children such as those in the state's Temporary Assistance for Needy Families (TANF) program. Eligible individuals have the opportunity to select "enhanced" or "basic" coverage for themselves and their covered children. If beneficiaries do not choose one of these plans voluntarily, they default into basic coverage. To choose enhanced coverage, beneficiaries must have a health assessment and sign a member agreement with their primary care provider. This agreement specifies members' rights, responsibilities, and expectations. Those who sign the agreement are expected to keep appointments, cancel any appointments they cannot keep, use the emergency room only for emergencies, and participate in health improvement programs. If they adhere to these expectations, they are entitled to receive additional benefits, known as "healthy rewards." If they do not comply, they may be moved to the basic benefit package. Possible sanctions for noncompliance have not yet been set by the BMS because it is awaiting approval from the Centers for Medicare & Medicaid Services (CMS) for the Healthy Rewards component of the program. Detailed descriptions of the benefit packages are provided in Appendix A.

To evaluate this program, the West Virginia University Institute for Health Policy Research (IHPR) and Mathematica Policy Research conducted a series of in-person and telephone interviews in late 2008 and early 2009 (roughly 18 months after implementation began). We interviewed individuals from a variety of stakeholder groups including state Medicaid representatives, health care providers and administrators, patient advocacy groups, and professional association representatives. The interviews collected information on early implementation experiences with the Mountain Health Choices program, including assessments of strengths, concerns, and recommendations.

Key Findings:

- There is widespread support for the program's goals such as promoting personal responsibility and strengthening the medical home.
- Many believe the program as currently implemented will not be able to instill personal responsibility because (1) West Virginia has not received approval for the Healthy Rewards program and this component has not been implemented, and (2) beneficiaries and providers have not been receiving continuous education and outreach designed to help beneficiaries make an informed choice of benefit plans.
- Providers and patient advocates are concerned about beneficiaries defaulting into the basic plan, not by choice but because of a lack of understanding of the enrollment process and the importance of the health assessment and the member agreement; a clear consensus on how to address this concern has not emerged.

Program Overview

The West Virginia Bureau of Medical Services (BMS) has been engaged in a major redesign of its Medicaid program. A key component of the redesign is a Medicaid state plan amendment that was approved in May 2006 and established Mountain Health Choices, a new program of benefits and rewards for low-income parents and children. This new program operates under the authority of the Deficit Reduction Act of 2005. Mountain Health Choices began operation in three pilot counties (Clay, Lincoln, and Upshur) in March 2007 and expanded to include almost all 55 West Virginia counties by November 2007. By February 2009, approximately 149,000 children and adults were enrolled in this program. (See Appendix B for a summary of county-by-county enrollment statistics as of February 2009.)

The target population includes low-income Medicaid adults and children such as those in the state's Temporary Assistance for Needy Families (TANF) program. Eligible individuals have the opportunity during the annual eligibility redetermination period to select "enhanced" or "basic" coverage for themselves and their covered children. (See Appendix A for a summary of services offered under basic and enhanced coverage compared to traditional Medicaid coverage.) To choose the basic or enhanced coverage plan, beneficiaries must visit their primary care provider and sign a member agreement. Beneficiaries who do not visit their provider or do not choose a coverage option are placed by default into the basic coverage plan.

The member agreement that beneficiaries sign to enroll in the enhanced coverage plan specifies their rights, responsibilities, and expectations. Those who sign the agreement are expected to keep appointments, cancel any appointments they cannot keep, use the emergency room only for emergencies, and participate in health improvement programs. If they adhere to these expectations, they are entitled to receive additional benefits, known as "healthy rewards." If they do not, they may be moved from the enhanced plan to the basic plan. A final decision on possible rewards for compliance or sanctions for noncompliance has not yet been made by the BMS because it is awaiting approval from CMS for the Healthy Rewards component of the program.[1]

In addition to the Mountain Health Choices benefit program, West Virginia's redesign of its Medicaid program includes a Medical Home component, although this component was not implemented at the time of this study. All Medicaid beneficiaries, regardless of their coverage plan, would be assigned to a medical home. The Medical Home component would require the primary care provider to conduct appropriate screening, education, and overall care coordination, and establish an action plan for addressing chronic conditions and health risks.

As indicated in the BMS proposal, intended impacts of the Mountain Health Choices program include significant improvement in clinical indicators, such as chronic conditions, hospitalizations, and costs for institutional and emergency care for chronic conditions. Although state officials indicated during interviews that they had no predetermined figures for the percentage of eligible beneficiaries who would enroll in the enhanced plan, the BMS proposal to CMS anticipated that 10 percent of members would be enrolled in the enhanced plan after 18 months, and that this percentage would increase to 15 percent during months 24 to 36.

[1] If implemented as designed, the Healthy Rewards program would provide an account that tracks utilization of appropriate health care services. The value of this account would increase with appropriate utilization and decrease with inappropriate utilization. The account could be used to access additional benefits such as vision or dental care, participation in wellness programs, or other rewards to be determined. Beneficiaries would receive account statements that would help them track their status in the program.

Interview and Data Analysis Methods

In-person and telephone interviews were conducted with 26 people representing four stakeholder groups: (1) state Medicaid representatives, (2) health care providers and their staff (including community health centers and community mental health centers), (3) patient advocates, and (4) professional association representatives. The interview protocols were developed by staff at IHPR and Mathematica. Mathematica staff traveled to West Virginia on two occasions in October and November 2008 to conduct in-person interviews. Some interviews were conducted jointly by IHPR and Mathematica staff, but most were conducted separately either by IHPR staff or Mathematica staff. In a few cases, Mathematica staff conducted interviews by telephone when travel logistics did not allow for an in-person interview. Interviews lasted from 30 minutes to approximately two hours each. Handwritten notes were taken during each interview.

We identified individuals to be interviewed through personal IHPR contacts, provider lists, and other documents including documents about the program from the BMS web site. Interviews were conducted with state officials, advocates, and professional association representatives located primarily in Charleston, and with providers in Upshur, Wood, and Raleigh counties. These counties were selected on the basis of three criteria: (1) at least one year of post-implementation experience, (2) level of enrollment in the enhanced program (including at least one county with relatively low enrollment and at least one county with relatively high enrollment in the enhanced plan), and (3) relatively large populations of Medicaid beneficiaries and providers.

After conducting the interviews, Mathematica and IHPR staff reviewed and analyzed all data. We analyzed the interview data qualitatively to identify main themes. Then we shared the results with all members of the project team for input and revisions, and checked them against original notes until all members agreed that we had achieved high levels of accuracy and reliability in the final report.

Findings

Based on the information collected, we identified important themes in five areas: (1) enrollment, (2) education and outreach, (3) services and benefit structure, (4) provider understanding and participation, and (5) program outcomes.

Enrollment

As of February 2009, approximately 19,000 people were enrolled in the enhanced plan (approximately 17,000 children and 1,700 adults), representing about 13 percent of eligible children and 10 percent of eligible adults (see Appendix B.) Although considerable county-to-county variation exists (ranging from 0 to 30 percent in the enhanced plan), the state achieved the 10 percent enrollment goal after one year. It is too early to determine whether the second enrollment goal, 15 percent after two to three years, will be reached. However, many people we interviewed, including state representatives, expressed disappointment in the slow growth of enrollment in the enhanced plan.

Selecting a coverage plan, something most employer-sponsored insurance plans require, is the first step to personal responsibility. For Mountain Health Choices to be effective, beneficiaries must make an informed choice of plans. Making an informed choice is particularly important for beneficiaries in Mountain Health Choices because, similar to employer-sponsored insurance plans, beneficiaries are locked into a plan until their annual redetermination of Medicaid eligibility.[2] Patient advocates and some providers expressed concerns that eligible adults and parents of eligible children are not receiving the help and support they need to make an informed choice of plans and that the enrollment levels reflect the program's default mechanism into the basic plan rather than beneficiaries' informed choice of plans. They expressed particular concern for the children who are dependent on their parents to make decisions on their behalf. Providers and advocates noted that parents need to receive full and clear information about the enhanced and basic plans to make the best choice. They worry that children's care might suffer if parents either choose not to enroll their child in the enhanced benefit plan or neglect to follow the proper enrollment procedures so that the child defaults into the basic plan. Beneficiaries with mental illness are also of concern to advocates and providers. They believe that, within the population eligible for Mountain Health Choices, those with mental illness may be the least able to make an informed choice of benefit plans and that these beneficiaries need considerable assistance when choosing a plan.

Because patient advocates and providers believe most Mountain Health Choices beneficiaries are not making an informed choice of plans, they would like the program to include a safety net provision to ensure that beneficiaries receive the care they need.[3] One suggestion focused on changing the default plan to either regular Medicaid or the enhanced plan. Another suggestion was to use risk factors or the

[2] We were told that it takes two months to complete the processing before a beneficiary can enroll in the enhanced coverage plan and, while they wait, beneficiaries are automatically placed in the basic plan until they complete their health assessment and member agreement. One patient advocate indicated that when eligibility is redetermined, beneficiaries in the enhanced plan are automatically placed in the basic plan and have to re-sign the member agreement to reestablish enrollment in the enhanced plan.

[3] At least one provider noted that beneficiaries can always get some level of care. Beneficiaries can turn to a federally qualified health clinic (FQHC) to get complete care because they use an all-inclusive billing rate and are mandated to provide care to all. One respondent called this the "FQHC loophole." While this assertion may be true for some beneficiaries, not all FQHCs provide a full range of services (for example, some focus on services for pregnant women and children) and they frequently operate at or above their capacity levels, which may result in long waiting times for services.

beneficiary's medical history as the basis for selecting the most appropriate plan. Both solutions have important implications for overall program costs that need to be considered to ensure the program meets its goals and is fiscally sound.

Beneficiary Outreach and Education

Patient advocates, providers, and professional associations are concerned about the lack of program information and they report inadequate outreach to beneficiaries. They believe that parents' knowledge and understanding of the program is often poor or nonexistent, both before and after they sign up. They indicated that initial mailings looked like junk mail and often were discarded. State officials, on the other hand, described the outreach efforts as "massive," including mailings, billboard advertising, and advertisements in local newspapers and newsletters.

At the time of the study, the state had no ongoing outreach and education campaign for beneficiaries and we did not hear about any local efforts run by community-based groups. During our visits to local providers and community-based groups, few had a supply of Mountain Health Choices brochures to distribute. The state improved the initial mailing to beneficiaries (they changed the envelope so that recipients would more easily know the material was from Medicaid and clarified some of the language). However, most of those interviewed believe that many beneficiaries do not understand the informational mailings, especially the initial mailings. Most programs benefit from ongoing and sustained outreach and education programs; the low education and literacy levels and highly transient nature of the population eligible for Mountain Health Choices necessitate such an effort.

Services and Benefit Structure

Perspectives on the two-tiered benefit structure were mixed. Some thought this structure was a cost-effective approach and Medicaid staff expressed the view that the basic plan offers good coverage. However, providers and patient advocates expressed the view that services in the basic plan were cut significantly relative to traditional Medicaid and they were concerned that those in the basic plan may not get the care they need and may end up using more costly emergency services that are covered. In fact, services in the basic plan are either similar to or less extensive than those in traditional Medicaid. A few key differences in coverage between traditional Medicaid and the basic plan include: for example, unlike traditional Medicaid, the basic plan includes a limit of four prescriptions per month, an annual limit of $1,000 for durable medical equipment, and a limit of 30 days per year for inpatient psychiatric services. The enhanced plan also offers services that are similar to traditional Medicaid, but it includes some additional services such as weight management services and nutritional education. See Appendix A for a more complete comparison of covered services under the basic, enhanced, and traditional plans.

Patient advocates and providers were primarily concerned with the basic plan's prescription drug limits and restrictions on mental health services. Since enrollment in the enhanced plan is only about 10 percent of the eligible population, services for most beneficiaries have been reduced and providers and advocates fear that the consequences of this for health and program costs over time could be severe.

Providers, advocates, association representatives, and state officials all largely agreed that rewards should be immediate, meaningful, and tangible if they are to be effective incentives. The delay in implementing the Healthy Rewards component of Mountain Health Choices has been recognized as an unfortunate drawback by most individuals we interviewed. However, getting Healthy Rewards in place has been a challenge; for example, giving people a monetary reward is problematic because it raises issues related to cash benefits tied to family income. As of this report, the BMS was still awaiting approval.

Provider Understanding and Participation

Providers in general reported poor understanding of the Mountain Health Choices program during its start-up months, even after the program went statewide. Providers stated that outreach and education to them and to their staff has been poor, for the most part. In addition, front desk staff have an important role in educating patients and recognizing the Mountain Health Choices paperwork that patients bring to them, but often these staff have received no information. Nevertheless, state officials reported that during the pilot test they had statewide meetings to explain the program to providers. In addition, they indicated that a vendor is responsible for visiting provider offices on a routine basis to educate them about the program and provide support.

Typically, providers we interviewed reported not understanding benefit structures, the enrollment process, or their responsibilities for monitoring compliance. State representatives have emphasized that providers are not expected to "police" their patients, and that determination of program compliance will be made using administrative data at the state level, but providers were largely unaware of this. Providers also were not familiar at first with the $20 reimbursement they could receive for every member agreement they completed with a patient and they were also unsure of the length of time covered by the member agreement. They sometimes found the paperwork unnecessarily complicated—for example, requiring a signature from both provider and patient in two separate places on the member agreement.

The providers we interviewed remembered hearing about the program at early informational sessions, but did not recall receiving details, such as when the program would start in their county, nor did they receive specific training about the program. The providers also reported they did not receive routine visits from the state's vendor. Moreover, they reported that they had not received any instructions on how to structure the health assessments or complete the member agreements. The lack of understanding about the program creates challenges when providers discuss the program with their patients. For example, they cannot tell beneficiaries the consequences of not complying with the member agreement or what types of rewards they would receive. (No one knows what standards will be used to determine compliance.) In addition, some providers do not know how to obtain approval for medically necessary services that exceed the limitations of the basic plan. Nevertheless, some provider offices indicated they take extra effort to work with beneficiaries, and some encourage all eligible patients routinely to sign up for the enhanced plan, as it offers more services and requires a minimal commitment from the enrollee. This may be a reason that enrollment levels in the enhanced plan are as high as they are.

At the time of the study, mental health providers were extremely frustrated with the program. Representatives of the mental health community stated that they were not included in program design discussions, and that it has been difficult to arrange meetings with Medicaid staff. However, Medicaid program staff report that mental health providers were represented when the program was designed. The mental health providers interviewed expressed considerable confusion about program policies related to their services and how these policies affect their ability to bill for services. For example, these providers believed that program policies associated with the four-drug limit in the basic plan, specifically the exemptions to this limit, were not clearly communicated. In addition, they noted that mental health services for children are limited under the basic plan and these limits affect providers' ability to serve children in the basic plan; for example, they commented that inpatient rehabilitation programs for adolescents can no longer be provided in a best-practices model. From their perspective, the program instituted a sudden change in the provider standards whereby providers who had delivered care for many years were no longer reimbursable; the standards shifted to a private practitioner model, and some geographic areas have no such providers. Case managers, for example, are now prohibited from conducting intake interviews. According to documents provided to us by one mental health clinic administrator, nine behavior clinics lost almost $600,000 in unreimbursed services over a 15-month period. Several providers noted that the mental health system treats people in crisis and these individuals may not fit well with a program focused on engaging people in healthy lifestyles.

We heard a few reports about providers refusing to participate in Mountain Health Choices. One patient advocate reported that some physicians who accepted traditional Medicaid are not taking patients in the basic plan because of reduced benefit levels. A mental health provider reported that one crisis center would not accept beneficiaries in the basic plan because the services would not be reimbursed.

Program Outcomes

Most interviewees were skeptical that the program would achieve its goals of instituting personal responsibility and improving health outcomes. An important goal from the state's perspective is for all beneficiaries to have a yearly assessment. Some interviewees felt that achieving that goal alone would make the program a success. We also heard consistently from state representatives that the initial impetus for the program came from the governor, and his primary concern was for improved health, not cost control. Some advocates and providers, however, were skeptical about this.

Different opinions were expressed about whether the program will save or cost money. Some providers noted that cutting services in the basic plan will cut costs, since most patients have basic coverage. But providers also indicated that patients' care might end up costing more if they use emergency rooms for illness more often or end up sicker over time.

Most providers and advocates believe that Mountain Health Choices, as currently implemented, will not change the health behaviors of beneficiaries. The program's incentives may not be meeting their potential given the lack of member education, the absence of the Healthy Rewards component, and the general lack of understanding regarding the criteria that will be used to determine compliance with the member agreement. Even if the program was operating smoothly and everyone had the information they needed, most believed that signing a contract was too simplistic a mechanism to change behavior. However, opinions differed on the most effective approach to bring about behavioral change.

Discussion

There appears to be widespread support for the general concepts promoted by Mountain Health Choices. Even people who otherwise expressed strong concerns about the program were supportive of its intent, and many appreciated the state's efforts to address the significant health problems that exist in the Medicaid population. People were especially appreciative of the medical home concept, and the goal of improving members' health through personal responsibility.

Nearly all providers and patient advocates believe that the program was taken statewide prematurely. Most felt the three pilot counties needed to test the program for a longer period of time and that the pilot test results needed more assessment before the program was expanded. State officials disagreed that the move had been premature, even though the Healthy Rewards component was not yet in place and the program could not be fully implemented.

The delay in implementation of the Healthy Rewards component was an unfortunate occurrence, and a source of frustration not only to patient advocates and providers but to state Medicaid officials. This delay has been partly beyond the state's control, as CMS had not approved the state's Healthy Rewards plan as of the time of this report. As several providers and patient advocates state, meaningful rewards are needed to encourage initial sign-up, to create the necessary incentives for individuals to engage in appropriate health behaviors, and to reinforce positive behavior. From the point of view of implementing a successful program, it may have been unwise for the state to move beyond the pilot counties to full-scale implementation without this key component in place.

State policymakers are committed to the program and to its health improvement goals. They acknowledge that there have been some implementation problems and that the program needs further work and refinement. From their point of view, however, helping beneficiaries obtain annual health assessments will be a significant accomplishment of the program.

Implementation improvements are warranted in several components of the program. It appears that outreach and education efforts for beneficiaries and providers need to be improved. For beneficiaries, outreach and education needs to be an ongoing and integral part of program operations. The targeted population needs consistent and frequent education and outreach because new adults and children become eligible for the program every day. In addition, members of the targeted population need considerable support when making a choice of plans. They need to be fully informed about their health care needs and how the benefits of each plan align with those needs. The information they receive must be clear so that they can make an active, informed choice about their enrollment options.

Providers also want more support and education, especially guidance on how to approach and conduct the health assessment. They need readily accessible information on how to apply for exceptions to plan limits to ensure that beneficiaries receive needed services. Mental health providers need more complete information about the differences in benefits between traditional Medicaid and Mountain Health Choices so they can better serve those requiring behavioral health services.

The information collected suggests that West Virginia should assess how the program can be improved. For example, the program's enrollment policies appear to have important implications for the state, providers, and beneficiaries and the state needs to consider whether beneficiaries should be allowed to default into a plan as opposed to making an active choice, which most employer-sponsored plans require. We also found considerable confusion and a lack of understanding about plan enrollment policies during the redetermination period. Many interviewees believed that beneficiaries in the enhanced plan were moved to the basic plan during the redetermination period and stayed in this plan until they renewed the

member agreement which, if true, would not conform to most employer-sponsored plans where members stay in the same plan unless they make an active choice to change.

An assessment of the two benefit plans is needed to plan for program improvements. Such an assessment would identify whether enrollment levels in the basic and enhanced plans are appropriate and whether those who need the services provided through the enhanced plan are enrolling in that plan. West Virginia needs to determine whether beneficiaries are receiving the services they need and experiencing improvements in their health. This information will help the state improve the planning of coverage levels not only for primary and specialty medical care, but for ancillary services such as dental care and durable medical equipment. Ongoing assessment of the adequacy of consumer protections for the most vulnerable beneficiaries will be needed should the state consider expanding Mountain Health Choices to additional categories of beneficiaries, including those with disabilities and serious mental health problems.

The key to the success of Mountain Health Choices will be its ability to promote personal responsibility among beneficiaries in the program. Few believe that signing a member agreement will be sufficient to change current behaviors. Psychological research has demonstrated that behavior change is best accomplished through rewards or reinforcements that are immediate and meaningful. Punishments or coercion, in contrast, are likely to be largely ineffective in promoting positive and sustained behavior change. The delay in implementation of the Healthy Rewards component is a major drawback for the program. Implementation of immediate and meaningful rewards for individuals in the enhanced program should occur as quickly as possible, both to encourage initial sign-up and to reward positive behavior changes.

Concluding Remarks

Medicaid programs around the country are experiencing financial strain as costs of medical care increase, and as general economic conditions have worsened over the recent period. In addition, the health of the Medicaid population is less than ideal; obesity rates have been increasing, poor health behaviors (such as smoking and lack of exercise) are common, and chronic illnesses such as diabetes are on the rise. States are therefore concerned about both cost control and health improvement, and have engaged in various experiments to address these concerns. West Virginia's Mountain Health Choices is one such effort. Medicaid officials consistently expressed that the goal of Mountain Health Choices was to improve members' health, and we found widespread support for this goal and for related concepts of personal responsibility, rewards for healthy behaviors, and the establishment of a medical home for patients.

It is perhaps inevitable that a novel, complex, and ambitious program such as Mountain Health Choices would encounter unexpected difficulties. Responding to these difficulties in constructive, proactive ways can provide the basis for continuous improvement in program operation and success. The results of our interviews have identified a number of potential opportunities for improvement. As described in this report, these opportunities include (1) ongoing and clear outreach and education to beneficiaries and providers, including the clarification of criteria determining continued eligibility for enhanced benefits; (2) reviewing the program's enrollment policies to determine whether the current default process is appropriate for the targeted population; (3) assessing program outcomes so that the program's benefit design can be adjusted properly, if appropriate to do so; and (4) working with CMS to develop and implement an effective Healthy Rewards component.

Appendix A: Covered Services Under Basic, Traditional, and Enhanced Medicaid - Adults

Benefits Comparison – Adult			
	Mountain Health Choices		Traditional Medicaid
Benefit Description	**Basic Plan**	**Enhanced Plan**	**Low-Income Families**
Inpatient Hospital Care	Prior authorization required	Prior authorization required	Prior authorization required
Inpatient Hospital Rehabilitation	Not covered	Not covered	Not covered
Inpatient Hospital Psychiatric Services	Not covered	Prior authorization required – maximum benefit of 30 days/year	Not covered
Outpatient Surgery/Services	Covered (prior authorization required for certain services)	Covered (prior authorization required for certain services)	Covered (prior authorization required for certain services)
Diagnostic X-ray, Laboratory Services, and Testing	Covered (prior authorization required for certain services)	Covered (prior authorization required for certain services)	Covered (prior authorization required for certain services)
Primary Care Office Visits	Covered	Covered	Covered
Physician Office Visits – Specialty Care[a]	Covered	Covered	Covered
Occupational/Speech/Physical Therapy	Covered – maximum benefit of 20 visits /year (prior authorization required)	Covered (prior authorization required)	Covered – 20/year (prior authorization required)
Weight Management	Not covered	Covered	Not covered
Home Health Services	Covered – maximum benefit of 25/year (prior authorization required)	Covered (prior authorization required)	Covered (prior authorization required)
Durable Medical Equipment	Covered – limit of $1000 per year with prior authorization required if limits exceeded (prior authorization required for certain services)	Covered (prior authorization required for certain services)	Covered (prior authorization required for certain services)
Non-emergency Medical Transportation	Covered – maximum benefit of 10/year (5 round trips)	Covered	Covered
Ambulance Services	Emergency only	Covered	Covered
Prescriptions	Covered – 4/month	Covered	Covered
Hospice	Covered	Covered	Covered
Emergency Dental Services	Covered	Covered	Covered
Orthotics and Prosthetics	Covered (prior authorization required for certain services)	Covered (prior authorization required for certain services)	Covered (prior authorization required for certain services)

Appendix A: Covered Services Under Basic, Traditional, and Enhanced Medicaid - Adults - continued

Tobacco Cessation Programs	Not covered	Covered	Covered
Family Planning	Covered	Covered	Covered
Cardiac Rehabilitation	Not covered	Covered (prior authorization required)	Not covered
Pulmonary Rehabilitation	Not covered	Covered (prior authorization required)	Not covered
Chiropractic Services	Not covered	Covered (prior authorization required)	Covered (prior authorization required)
Podiatry Services	Not covered	Covered	Covered
Chemical Dependency/Mental Health Services[a] (limited)	Not covered	Covered – maximum benefit of 20 visits/year	Covered
Diabetes Education/Nutritional Counseling	Not covered	Covered	Covered
Nutritional Educational Services	Not covered	Covered	Not covered
Nursing Home Services	Covered (prior authorization required)	Covered (prior authorization required)	Covered (prior authorization required)

Source: Mountain Health Choices web site, March 2007.

[a] Psychiatrist/Psychologist services are covered under specialty care.

Appendix A: Covered Services Under Basic, Traditional, and Enhanced Medicaid - Children

Benefits Comparison – Children			
	Mountain Health Choices		Traditional Medicaid
Benefit Description	**Basic Plan**	**Enhanced Plan**	**Low-Income Children**
Well-Child Visits (EPSDT Services)	Covered	Covered	Covered
Inpatient Hospital Care	Prior authorization required	Prior authorization required	Prior authorization required
Inpatient Hospital Rehabilitation	Prior authorization required	Prior authorization required	Prior authorization required
Inpatient Hospital Psychiatric Services	Prior authorization required – maximum benefit of 30 days/year	Prior authorization required	Prior authorization required
Outpatient Surgery/Services	Covered (prior authorization required for certain services)	Covered (prior authorization required for certain services)	Covered (prior authorization required for certain services)
Diagnostic X-ray, Laboratory Services, and Testing	Covered (prior authorization required for certain services)	Covered (prior authorization required for certain services)	Covered (prior authorization required for certain services)
Primary Care Office Visits	Covered	Covered	Covered
Physician Office Visits -Specialty Care[a]	Covered	Covered	Covered
Birth to Age 3 Services	Covered	Covered	Covered
Occupational/Speech/Physical Therapy	Covered – maximum benefit of 20 visits/year (total allowed for all therapies combined) (prior authorization required)	Covered (prior authorization required)	Covered 20/year (prior authorization required)
Weight Management	Not covered	Covered	Not covered
Home Health Services	Covered – maximum benefit of 25/year	Covered	Covered
Durable Medical Equipment	Covered – limited to $1000 per year with prior authorization required if limits exceeded (prior authorization required for certain services)	Covered (prior authorization required for certain services)	Covered (prior authorization required for certain services)
Non-emergency Medical Transportation	Covered – 10/year (5 round trips)	Covered	Covered
Ambulance Services	Covered	Covered	Covered
Prescriptions	Limited – 4 per month	Covered	Covered
Hospice	Covered	Covered	Covered
Vision Services	Comprehensive eye exam, glasses – maximum benefit of $750/year	Comprehensive eye exam, glasses, contact lenses, vision training	Comprehensive eye exam, glasses, contact lenses
Emergency Dental Services	Covered	Covered	Covered
Dental Exams (Dental Check-ups)	Covered – 2/year	Covered	Covered

Appendix A: Covered Services Under Basic, Traditional, and Enhanced Medicaid - Children - continued

Hearing Services/Aids/Supplies	Annual exam and hearing aids when medically necessary[b]	Covered	Covered
Orthotics and Prosthetics	Covered (prior authorization required for certain services)	Covered (prior authorization required for certain services)	Covered (prior authorization required for certain services)
Tobacco Cessation Programs	Covered	Covered	Covered
Family Planning	Covered	Covered	Covered
Cardiac Rehabilitation	Covered (prior authorization required for certain services)	Covered (prior authorization required)	Not covered
Pulmonary Rehabilitation	Covered (prior authorization required for certain services)	Covered (prior authorization required)	Not covered
Chiropractic Services	Not covered	Not covered	Covered
Podiatry Services	Not covered	Covered	Covered
Chemical Dependency/Mental Health Services (limited)[a]	Covered – maximum benefit 26/year (prior authorization required)	Covered (prior authorization required)	Covered (prior authorization required)
Diabetes Education/Nutritional Counseling	Covered	Covered	Covered
Nutritional Educational Services	Not covered	Covered	Not covered
Skilled Nursing Care (Private Duty Nursing)	Not covered	Covered (limited to 180 days/year - prior authorization required for certain services)	Covered

Source: Mountain Health Choices web site, March 2007.

[a] Psychiatrist/Psychologist services are covered under specialty care.

[b] Medically necessary services, as set forth in the Social Security Act, Section 1905 (42 USC 1396(a)) and identified by an EPSDT screening will be provided at themedical home or by referral to an appropriate provider.

EPSDT = early periodic screening, diagnosis, and treatment services.

APPENDIX B TABLE

TOTAL MOUNTAIN HEALTH CHOICES ENROLLMENT AND PERCENTAGE IN ENHANCED PLAN

BY POPULATION AND BY COUNTY

	Children		Adults	
County	Number	Percentage in Enhanced Plan	Number	Percentage in Enhanced Plan
Total	132,477	13	16,996	10
Program Started March 2007				
Clay	1,297	14	135	10
Lincoln	2,343	15	370	17
Upshur	2,085	24	180	22
Program Started September 2007				
Barbour	1,304	28	163	29
Boone	2,297	11	38	7
Braxton	1,413	19	193	12
Calhoun	703	14	76	14
Doddridge	643	18	82	13
Gilmer	49	25	52	17
Harrison	5,080	15	581	12
Kanawha	14,857	8	2,304	5
Lewis	1,512	30	159	19
Logan	3,460	23	572	8
Nicholas	2,290	14	263	13
Putnam	2,738	8	314	4
Randolph	2,282	16	209	12
Roane	1,466	11	172	12
Tyler	730	17	79	14
Webster	1,024	13	171	18
Wyoming	2,228	10	289	16
Program Started October 2007				
Fayette	4,026	13	450	11
Greenbrier	2,473	9	193	18
Jackson	2,270	9	325	8
Marion	3,688	18	527	14
McDowell	2,908	8	399	9
Mercer	5,813	6	876	6
Mingo	2,776	11	429	14
Monongalia	3,607	12	356	11
Monroe	932	9	72	10
Pleasants	448	19	39	10
Pocahontas	632	9	37	11
Preston	2,052	15	198	11
Raleigh	6,283	8	711	6
Ritchie	772	18	76	16
Summers	1,034	13	143	12
Taylor	1,184	19	123	16
Tucker	441	15	28	18
Wetzel	1,440	23	180	17
Wirt	501	18	78	10
Wood	6,795	20	883	8

APPENDIX B TABLE (*continued*)

	Children		Adults	
County	Number	Percentage in Enhanced Plan	Number	Percentage in Enhanced Plan
Program Started November 2007				
Berkeley	6,012	7	629	6
Brooke	1,333	17	170	13
Hampshire	1,689	10	192	9
Hancock	1,974	17	218	13
Jefferson	2,236	5	251	8
Marshall	2,457	16	298	13
Mineral	1,787	14	203	12
Morgan	1,105	10	111	13
Ohio	2,540	23	333	14
Program Started January 2008				
Cabell	7,122	11	1,175	5
Wayne	3,672	8	509	10
Program Start Not Known				
Grant	39	0	4	0
Hardy	64	0	4	0
Mason	119	4	25	4
Pendleton	10	20	3	33

Source: Mountain Health Choices Count Report for February 1, 2009.