Evaluation of Mountain Health Choices: Implementation, Challenges, and Recommendations

A Policy Report prepared by:

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And

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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 for Medical Services (BMS) received a grant from the Center for Medicare and Medicaid Services (CMS) to implement revisions to the Medicaid program to improve the health of Medicaid members through promotion of personal responsibility. This new Medicaid coverage plan is called Mountain Health Choices. It began operation in three pilot counties in March 2007, and expanded to include almost all 55 counties by November, 2007.

The target population includes Medicaid-covered Temporary Aid to Needy Families (TANF) children and adults with children, not other Medicaid populations such as persons on disability. Eligible persons have the opportunity to select "enhanced" or "basic" coverage for themselves and their covered children. People choosing the enhanced version sign a member agreement with their primary care provider. This agreement specifies member rights, responsibilities and expectations. Members who sign the agreement are expected to keep appointments, cancel appointments if they can't keep them, use the emergency room only for emergencies, and participate in health improvement programs. If they adhere to these expectations, they are entitled to receive "healthy rewards." If they do not, their services may be reduced from the enhanced to the basic benefit package; a final decision on possible sanctions for non-compliance has not yet been made by the BMS.

To evaluate this program, we conducted a series of in-person and telephone interviews in late 2008 and early 2009 with state Medicaid representatives, health care providers and administrators, patient advocacy groups, and professional association representatives. Interview protocols were developed and refined, and sample selection efforts undertaken to draw a range of views from a variety of stakeholder groups. The interviews collected information on early implementation experiences with the Mountain Health Choices Medicaid program, including assessments of strengths, concerns, and recommendations. The study methods are described in more detail in Section B.

Key Takeaway Findings:

- **There is widespread support for the program's general concepts and goals, but there are also serious concerns about how the program was implemented and its unintended consequences**
- **The key concept of personal responsibility, a laudable goal, has not lived up to its original intent: missing pieces include Healthy Rewards, and the need for more continuous and repeated education and outreach**
- **The two-tiered program offering basic and enhanced services is potentially very useful, but the fact that the basic program offers less care than traditional Medicaid, and is the default plan for most enrollees, is upsetting to providers and patient advocates**

Interview Highlights:

Strengths

- We found widespread support for the general concepts promoted by Mountain Health Choices (MHC). 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 member health through personal responsibility.
- State representatives are committed to the program, emphasize its health improvement goals, and acknowledge some implementation problems that were unanticipated and need further work.
- The target to achieve 10% enrollment in the enhanced plan after 1 year has been largely met.

Concerns and Challenges

- There was near universal agreement that the program was taken statewide prematurely without adequate testing in the three pilot counties and an insufficient assessment of the pilots' results. Even though the Healthy Rewards component is not yet it place,[1] state officials disagreed that the move had been premature. .
- Providers, patient advocates, and professional associations alike are concerned about program implementation.

  Most people interviewed reported inadequate outreach to members. The targeted population is highly transient and has literacy issues and most of those interviewed believe that a large proportion do not understand the informational mailings, especially the initial mailings. As a consequence, low enrollment in the enhanced plan reflected a lack of understanding that resulted in most patients falling into the basic plan by default, not by choice.

  Providers reported a lack of communication from the state, including lack of training on how to complete member agreements or how to structure the health assessment. Communication should be undertaken not only for providers but for support staff who have front desk contact with patients.

  No one knows what standards will be used to determine compliance, how the agreements will be monitored, or what the consequences or rewards will be. Some providers do not know how to obtain approval for medically necessary services that exceed the limitations of the basic plan.

  Mental health providers expressed frustration with poor communication about new credential requirements and service limitations under the basic plan.

[1] Although the Health Rewards portion of the program has been submitted to the Centers for Medicare and Medicaid Services (CMS), at the time of this writing CMS has not yet responded to the state's request.

- Most providers and advocates believe that MHC, as currently implemented, will not change the health behaviors of enrollees. The program's incentives may not be meeting their potential given the lack of member education, the absence of the Healthy Rewards program, and the general lack of understanding regarding the criteria that will be used to determine compliance with the member agreement. Although most believed that signing a contract was too simplistic a mechanism to change behavior, opinions differed on the most effective approach to affect behavioral change.

- Perspectives on the two-tiered benefit structure were mixed. Some thought it was a cost-effective approach, but providers were concerned that those in the basic plan may not get the care they need and end up using more costly emergency services that are covered. Some thought that enrollment in basic or enhanced services should be based on risk, not on parent or self-selection.

- Patient advocates and providers were primarily concerned about the basic plan's prescription drug limits and restrictions on mental health services.

- Since most MHC enrollees are children, people felt that it becomes even more important for parents to receive full and clear information about the enhanced and basic plans to make the best choice. The incentives for enrolling in the enhanced plan have to be attractive enough for parents to choose this option when it is appropriate.

- Although mental health providers acknowledged the importance of a medical home, they believe that their clients who need the enhanced plan may be the least capable of completing the MHC enrollment process.

- Coverage for some services in the basic plan are less than covered services had been in the traditional plan. This was of concern to many advocates and providers who felt that the basic plan should be at least equal to traditional coverage. Since enrollment in the enhanced plan is only about 10% of the eligible population, services for most MHC enrollees have been reduced, and the consequences of this for health and program costs over time could be severe.

- In sum, the major concerns and challenges include: premature state-wide implementation before the pilot-sites were evaluated; poor communication to members, especially early in implementation that may result in heavy default rates into the basic plan; incomplete communication and training for providers and provider office staff; unknown program aspects surrounding compliance issues and Healthy Rewards; and concerns about particular program components and populations, especially prescription drug coverage, mental health clients, and children.

Discussion Points

Based on our review of interview data and other documents, we present the following suggestions. These suggestions are designed not only to assist BMS staff in evaluating and improving the program, but also to help Medicaid officials in other states who may be considering similar programs to improve enrollee health and control program costs.

Suggestions for West Virginia:

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 their control as CMS has not approved the state's Healthy

Rewards plan as of the time of this writing. Nevertheless, implementation of immediate and meaningful rewards for persons in the enhanced program should occur as quickly as possible, both to encourage initial sign-up and to reward positive behavior change over time. It may have been unwise for the state to move beyond the pilot counties to full scale implementation without this key component in place.

Consideration should be given to examining what population groups are best suited for inclusion in a program such as MHC. For example, the program may not be well suited for people with serious mental health problems.

Criteria for determining program compliance and continued eligibility for the enhanced plan need to be clearly established and communicated. Consider whether persons in the enhanced plan should be automatically re-enrolled in the enhanced plan at annual redetermination periods.

Finally, coverage levels in the basic plan may need to be re-examined to determine whether some benefits that were reduced relative to traditional coverage should be reinstated. These include foremost the limitation of four prescription medicines per month, and the limits on durable medical equipment.

Suggestions for Other States to Consider

The primary goal of the program should be identified and communicated to all parties, and this goal must drive program implementation. At the simplest level, the goal may be either health improvement or cost control. If it is the former, coverage levels under even a basic coverage plan must be compatible with this goal and targets for enrollment in the enhanced plan identified and met; if the latter, both short-term and long term cost should be considered.

Second, 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 known to be largely ineffective in promoting positive and sustained behavior change. The delay in implementation of the Healthy Rewards component is a major drawback to the program. Implementation of immediate and meaningful rewards for persons in the enhanced program should occur as quickly as possible, both to encourage initial sign-up and to reward positive behavior change over time. For other states considering Medicaid program changes, methods of rewarding these positive changes should be a key consideration.

Next, the program's operational success or problems should be fully evaluated on a pilot basis. Sufficient time should be allocated to analyzing problems that may occur in the pilot sites and correcting those problems before going statewide.

Outreach and education efforts for enrollees and providers, and for contract entities, is another critical component for effective program implementation. These efforts should be tested, fully evaluated, and modified as necessary before a new program goes statewide. All eligible enrollees should have clear information and make an active, informed choice about enrollment options.

There should be careful planning of coverage levels not only for primary and specialty medical care but for ancillary services such as dental care, durable medical equipment, and prescription drug coverage.

Consideration should be given to examining what population groups are best suited for inclusion in a program such as MHC. For example, the program may not be well suited for people with serious mental health problems.

Determine what level of enrollment in the enhanced plan is desirable. If persons do not actively choose enhanced coverage, consider whether enrollment in reduced services should occur by default. This consideration will be influenced by whether reduced coverage is the same as, or less than, traditional coverage, and by whether the primary goal of the program is health improvement or cost containment.

B. Interview and Data Analysis Methods

In-person and telephone interviews were conducted with 26 people representing four different stakeholder groups: state Medicaid representatives, health care providers and their staff, patient advocacy organizations, and professional association representatives. The interview protocols were developed among IHPR and Mathematica staff based on prior experience with interviews of this type and the goals of this evaluation. Mathematica staff traveled to West Virginia on two occasions in October and November, 2008 to conduct in-person interviews, and additional in-person interviews were conducted by IHPR staff, sometimes jointly and sometimes separately. A few telephone interviews were conducted by Mathematica when travel logistics did not allow for an in-person interview. Interviews lasted from 30 minutes to approximately 2 hours each. Handwritten notes were taken during each interview.

Persons to be interviewed were identified through personal IHPR contacts, review of provider lists or other documents, and snowball sampling techniques. Interviews were focused on state officials, advocates and professional association contacts who were located primarily in Charleston, and on providers in three selected counties: Upshur, Wood, and Raleigh. These counties were selected on the basis of 1) at least one-year post-implementation experience, 2) representation of a range of counties where enrollment in the enhanced program varied from relatively low to relatively high, and 3) possession of relatively larger populations of providers and Medicaid enrollees.

Also reviewed were written documents about the program from the BMS website and other sources. This included information that described program components, covered services and enrollment statistics.

Mathematica and IHPR staff then reviewed and analyzed all data. Interview data were analyzed qualitatively to identify main themes, important points, and differing opinions. Results were drafted and shared with all members of the project team for input and revisions, and checked against original notes, until all members agreed that we had achieved high levels of accuracy and reliability in the final written report.

C. Context and Significance

The West Virginia Bureau for Medical Services (BMS) engaged in a major Medicaid program redesign through a state plan amendment initiative. This redesign included, among other components, development of a two-tiered benefit structure offering "basic" or "enhanced" services. The plan also included efforts to improve the health of Medicaid members through promotion of personal responsibility.

The target population includes only Medicaid-covered Temporary Aid to Needy Families (TANF) children and adults with children, not other Medicaid populations such as persons on disability. Eligible persons 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 the basic and enhanced versions compared to traditional Medicaid coverage.) Persons choose by visiting their primary care provider and signing a member agreement to select basic or enhanced coverage. Persons who do not visit their provider or do not choose a coverage option are placed by default into the basic plan.

This new Medicaid coverage plan is called Mountain Health Choices. It began operation in three pilot counties (Clay, Lincoln and Upshur) in March 2007, and expanded to include almost all 55 counties

during September-November, 2007. (See Appendix B for a summary of county-by county enrollment statistics as of December 2008).

People choosing the enhanced version sign a member agreement with their primary care provider. This agreement specifies member rights, responsibilities and expectations. Members who sign the agreement are expected to keep appointments, cancel appointments if they can't keep them, use the emergency room only for emergencies, and participate in health improvement programs. If they adhere to these expectations, they are entitled to receive "healthy rewards." If they do not, their services may be reduced from the enhanced to the basic benefit package; a final decision on possible sanctions for non-compliance has not yet been made by the BMS.

The original design for the healthy rewards program was that it would be operationalized through an account that members receive to track utilization of appropriate health care services. The value of this account will increase with appropriate utilization and decrease with inappropriate utilization. The account could be used to access additional health care services such as vision or dental care, participation in wellness programs, or other rewards to be determined. However, at the time of this writing the healthy rewards component had yet to be approved by CMS and has not been implemented in the Mountain Health Choices program.

Another important feature of the program was that all Medicaid members would receive a Medical Home. This is a designated primary care provider who will provide appropriate screening, education, overall care coordination, and an action plan for addressing chronic conditions and health risks.

As indicated in the BMS proposal, intended impacts of the program include significant improvement in clinical indicators, increased control of chronic conditions, reduced hospitalizations, and reduced costs for institutional and emergency care for chronic conditions. Although state officials indicated during interviews that they had no predetermined figures for the percent of eligibles who would enroll in the enhanced plan, the written BMS proposal to CMS anticipated that 10% of members would be enrolled in the enhanced plan after 18 months, and another 15% by months 24 to 36.

D. Findings

This section of the report outlines additional findings in more detail, organized by program component: eligibility, enrollment, education and outreach, services and benefit structure, provider understanding and participation, and program impacts. These are interviewee comments

<u>Eligibility</u>

Primary concerns regarding eligibility were expressed by patient advocates and some providers in two areas: children's care and mental health care. There was also a concern expressed by the professional association representative that new limitations on dental care and durable medical equipment in the basic plan were difficult for providers to track, who deliver care only to discover that the patient had already exceeded their benefit limit.

Since children are dependent on parents, children's care might end up suffering the most. This is partly a consequence of the imperfect education and outreach efforts (see below) that reduced parent understanding of and active enrollment in MHC.

Representatives of the mental health community stated that they were not included in program design discussions, and that it has been difficult to get meetings with Medicaid staff. Also ,

methods of exemption from the 4 drug limit in the basic plan have not been not clearly communicated. Mental health services for children are extremely limited under the basic plan; for example, inpatient rehabilitation programs for adolescents can no longer be provided in a best-practices model. There was also a sudden change in the eligibility standards whereby providers who had delivered care for many years were no longer reimbursable; the standards shifted to the private practitioner model, when some geographic areas have no such providers. Case managers, for example, are now prohibited from conducting intake interviews. According to documents provided to us from one mental health clinic administrator, nine behavioral health clinics lost almost $600,000 in reimbursed services over a 15 month period. The philosophy for MHC is to engage people in healthy lifestyles, but the mental health system treats ill people in crisis and does not fit the model.

Enrollment

Rather than self-selection, some advocates thought basic and enhanced enrollment should be based on risk (e.g., obesity programs should be targeted to obese children and not based on parent self-selection). On the other hand, some providers and association representatives pointed out that choosing a plan level is also what privately insured people do, and making people chose is the first step to personal responsibility.

Some advocates thought that enrollees should default to the enhanced, not the basic plan. However, providers sometimes expressed support for requiring patients to choose enhanced coverage, as that was the first step to taking greater personal responsibility. One advocate reported that newborns of mothers in either the enhanced or basic plan are automatically enrolled into basic, and questioned whether automatic enrollment into the enhanced plan would be better.

As of February, 2009, statewide enrollment in the enhanced plan was about 10% of eligible adults and 13% of eligible children. (See Appendix B). Although there is county-to-county variation (from a low of 0% to 30% in enhanced), the state approximately achieved the 10% enrollment goal after a year. It is too early to determine whether the second enrollment target, 25% after 2-3 years, will be reached. However, many people we interviewed, including state representatives, expressed disappointment that enrollment figures were growing slowly. There are several possible reasons that enrollment levels may not be higher. These include the inadequate outreach efforts to describe the program to enrollees and providers. There is also a "FQHC loophole" whereby patients regardless of insurance status can get complete care because of the all-inclusive billing rate that FQHCs follow and their mandate to provide care to all. One patient advocate indicated that people at redetermination who are in the enhanced plan get bumped automatically into basic and have to re-sign again; this may be only a computer glitch and easily solvable. Finally, we heard reports from providers and advocates that enrolling or re-enrolling in the enhanced plan takes 2 months for complete processing and in the meantime people are in the basic plan.

Education and Outreach

Parent's knowledge and understanding of the program is often poor or non-existent, both before and after they sign up. Initial mailings looked like junk mail and were often discarded. Views were expressed by several interviewees that most end up in basic by default, not because they chose it. State officials, on the other hand, described the outreach efforts as "massive" including mailings, billboard advertising, advertisements in local newspapers in newsletters, and the use of individual outreach workers who traveled office to office to education providers about the program.

However, the perspective from providers was different. Providers stated that outreach and education to them and to their staff has been for the most part poor. Staff who work the front desk would be very important to educate patients about options and to recognize the MHC paperwork that

patients bring, but often these staff have received no information. Providers reported knowing nothing about the program until confused patients started showing up with the MHC paperwork.

Services and Benefit Structure

Medicaid staff expressed the view that the basic plan offers good coverage, but many others expressed the view that services in the basic plan were cut significantly relative to traditional Medicaid. In fact, services in the basic plan are similar to traditional in some ways, but offer less coverage in other ways. The enhanced plan in some respects is closer to traditional than is the basic plan. A few key differences in coverage include, for the basic plan, that prescriptions are now limited to 4 per month, that durable medical equipment is limited to $1,000 per year, and that inpatient psychiatric services for children are now limited to 30 days per year. See Appendix A for a more complete comparison of covered services under the basic, enhanced, and traditional plans.

Providers, advocates, association representatives and state officials all largely agreed that rewards should be immediate, meaningful and tangible. The delay in implementing the healthy rewards component of MHC has been recognized as an unfortunate drawback by most if not all interviewed persons. Getting healthy rewards in place has been a challenge; for example, giving people a monetary reward is problematic because it raises TANF issues. The BMS has submitted their healthy rewards plan to CMS and has been awaiting approval.

Provider Understanding and Participation

Providers in general reported poor understanding of the MHC program during its initial start up months, even after the program went statewide. They did not understand benefit structures, the enrollment process, or the responsibilities they thought they might have to monitor 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 MHC contract they completed with a patient. Providers were also unsure of the length of time covered by the member agreement. They also sometimes found the paperwork unnecessarily complicated, for example, requiring a signature from both provider and patient in two separate places on the member agreement.

Some provider offices, however, take extra effort to work with enrollees, 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.

There were anecdotal reports that some physicians who accepted traditional Medicaid are not taking patients in the basic plan because of reduced coverage levels.

Impacts

There were different opinions expressed about whether the program will save or cost money. Cutting services in the basic plan, since most patients are in basic, will cut costs, but patients might end up costing more if they use emergency rooms for illness more or end up sicker over time.

An important goal from the Medicaid perspective is to get everyone in for a yearly assessment. That 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, expressed skepticism that the real goal of the program is to improve health, and not to save money.

There was also general skepticism that the program as currently designed would improve health, because most people end up in the basic plan by default, and because the incentives for changing health behaviors are not adequate. One provider stated that if MHC improves preventive visit rates it could improve immunization rates for children and the health of the Medicaid population might thereby improve.

E. Summary Comments

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 of time. In addition, the health of the Medicaid population is less than ideal; obesity rates have been increasing, poor health behaviors (e.g., smoking, lack of exercise) are common, and chronic illnesses such as diabetes are on the upswing. States are therefore concerned about both cost control and health improvement, and have engaged in various experiments to address these concerns. Mountain Health Choices is one such effort. Medicaid officials consistently expressed that the goal of MHC was to improve member 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 MHC 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 the implementation of Healthy Rewards, the clarification of criteria determining continued eligibility for enhanced benefits, outreach and education to all affected parties repeatedly over time, and the willingness to reconsider benefit design, covered populations, and enrollment default options not just once when the program begins, but on an ongoing basis.

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

Benefits Comparison – Adult Phase 1 (Only available to the AFDC populations)			
Benefit Description	**Mountain Health Choices Basic Plan**	**Mountain Health Choices Enhanced Plan**	**Traditional Coverage (no longer available for those in MHC)**
Inpatient Hospital Care	Prior Auth Required	Prior Auth Required	Prior Auth Required
Inpatient Hospital Rehabilitation	Not Covered	Not Covered	Not Covered
Inpatient Hospital Psychiatric Services	Not Covered	Prior Auth Required – maximum benefit of 30 days/year	Not Covered
Outpatient Surgery/Services	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)
Diagnostic x-ray, laboratory services and testing	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)
Primary Care Office Visits	Covered	Covered	Covered
Physician Office Visits – specialty care*[2]	Covered	Covered	Covered
Occupational/Speech/Physical Therapy	Covered – maximum benefit of 20/year (Prior Auth Required)	Covered (Prior Auth Required)	Covered – 20/year (Prior Auth Required)
Weight Management	Not Covered	Covered	Not Covered
Home Health Services	Covered – maximum benefit of 25/year (Prior Auth Required)	Covered (Prior Auth Required)	Covered (prior Auth Required)
Durable Medical Equipment	Covered – limited to $1000 per year with Prior Auth Required if limits exceeded (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth 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	Limited – 4/month	Covered	Covered
Hospice	Covered	Covered	Covered
Emergency Dental Services	Covered	Covered	Covered
Orthotics and Prosthetics	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)

[2] Psychiatrist/Psychologist Services covered under Specialty Care

Effective date March 2, 2007 -

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 Auth Required)	Not Covered
Pulmonary Rehabilitation	Not Covered	Covered (Prior Auth Required)	Not Covered
Chiropractic Services	Not Covered	Covered (Prior Auth Required)	Covered (Prior Auth Required)
Podiatry Services	Not Covered	Covered	Covered
Chemical Dependency/Mental Health Services[*] (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 Auth Required)	Covered (Prior Auth Required)	Covered (Prior Auth Required)

Source – Mountain Health Choices website March 2007

[3] Psychiatrist/Psychologist Services covered under Specialty Care

Effective date March 2, 2007

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

Benefits Comparison – Children Phase 1 (Only available to the AFDC populations)			
Benefit Description	**Mountain Health Choices Basic Plan**	**Mountain Health Choices Enhanced Plan**	**Traditional Coverage (no longer available for those in MHC)**
Well Child Visits (EPSDT Services)	Covered	Covered	Covered
Inpatient Hospital Care	Prior Auth Required	Prior Auth Required	Prior Auth Required
Inpatient Hospital Rehabilitation	Prior Auth Required	Prior Auth Required	Prior Auth Required
Inpatient Hospital Psychiatric Services	Prior Auth Required – maximum benefit of 30 days/year	Prior Auth Required	Prior Auth Required
Outpatient Surgery/Services	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)
Diagnostic x-ray, laboratory services and testing	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)
Primary Care Office Visits	Covered	Covered	Covered
Physician Office Visits -specialty care	Covered	Covered	Covered
Birth to Three Services	Covered	Covered	Covered
Occupational/Speech/Physical Therapy	Covered – maximum benefit of 20/yr (total allowed for all therapies combined) (Prior Auth Required)	Covered (Prior Auth Required)	Covered 20/yr (Prior Auth Required)
Weight Management	Not Covered	Covered	Not Covered
Home Health Services	Covered – maximum benefit of 25/yr	Covered	Covered
Durable Medical Equipment	Covered – limited to $1000 per year with Prior Auth Required if limits exceeded (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)
Non-emergency Medical Transportation	Covered – 10/yr (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[4]	Covered	Covered
Orthotics and Prosthetics	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)
Tobacco Cessation Programs	Covered	Covered	Covered
Family Planning	Covered	Covered	Covered
Cardiac Rehabilitation	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required)	Not Covered
Pulmonary Rehabilitation	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required)	Not Covered
Chiropractic Services	Not Covered	Not Covered	Covered
Podiatry Services	Not Covered	Covered	Covered
Chemical Dependency/Mental Health Services (limited)	Covered – maximum benefit 26/year (Prior Auth Required)	Covered (Prior Auth Required)	Covered (Prior Auth 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/yr - Prior Auth Required for Certain Services)	Covered

Source – Mountain Health Choices website March 2007

[4] Medically necessary services, as set forth in the Social Security Act, Section 1905 (42 USC 1396d(a)) and identified by an EPSDT (early and periodic screening, diagnostic, and treatment services) screen will be provided either at the medical home or referred to an appropriate provider.

Effective date March 2, 2007

Appendix B: Enrollment Figures in Basic and Enhanced Coverage as of February 2009

County and Population Group (Adults or Children)	Members in Basic Plan	Members in Enhanced Plan	Percentage of Eligible Enrolled in Enhanced	Date MHC Began in County
Barbour Adults	115	48	29%	09/01/2007
Barbour Children	936	368	28%	
Berkeley Adults	591	38	6%	11/01/2007
Berkeley Children	5598	414	7%	
Boone Adults	359	25	7%	09/01/2007
Boone Children	2048	249	11%	
Braxton Adults	170	23	12%	09/01/2007
Braxton Children	1151	262	19%	
Brooke Adults	148	22	13%	11/01/2007
Brooke Children	1113	220	17%	
Cabell Adults	1115	60	5%	01/01/2008
Cabell Children	6336	786	11%	
Calhoun Adults	65	11	14%	09/01/2007
Calhoun Children	606	97	14%	
Clay Adults	121	14	10%	03/01/2007
Clay Children	1120	177	14%	
Doddridge Adults	71	11	13%	09/01/2007
Doddridge Children	530	113	18%	
Fayette Adults	402	48	11%	10/01/2007
Fayette Children	3490	536	13%	
Gilmer Adults	43	9	17%	09/01/2007
Gilmer Children	366	125	25%	
Grant Adults	4	0	0	NA
Grant Children	39	0	0	
Greenbrier Adults	159	34	18%	10/01/2007
Greenbrier Children	2244	229	9%	

Hampshire Adults	174	18	9%	11/01/2007
Hampshire Children	1524	165	10%	
Hancock Adults	189	29	13%	11/01/2007
Hancock Children	1639	335	17%	
Hardy Adults	4	0	0	NA
Hardy Children	64	0	0	
Harrison Adults	513	68	12%	09/01/2007
Harrison Children	4328	752	15%	
Jackson Adults	300	25	8%	10/01/2007
Jackson Children	2057	213	9%	
Jefferson Adults	232	19	8%	11/01/2007
Jefferson Children	2127	109	5%	
Kanawha Adults	2187	117	5%	09/01/2007
Kanawha Children	13,656	1201	8%	
Lewis Adults	128	31	19%	09/01/2007
Lewis Children	1058	454	30%	
Lincoln Adults	308	62	17%	03/01/2007
Lincoln Children	2000	343	15%	
Logan Adults	526	46	8%	09/01/2007
Logan Children	2655	805	23%	
Marion Adults	452	75	14%	10/01/2007
Marion Children	3040	648	18%	
Marshall Adults	258	40	13%	11/01/2007
Marshall Children	2054	403	16%	
Mason Adults	24	1	4%	NA
Mason Children	114	5	4%	
McDowell Adults	364	35	9%	10/01/2007
McDowell Children	2666	242	8%	
Mercer Adults	820	56	6%	10/01/2007
Mercer Children	5455	358	6%	

Mineral Adults	179	24	12%	11/01/2007
Mineral Children	1541	246	14%	
Mingo Adults	371	58	14%	10/01/2007
Mingo Children	2472	304	11%	
Monongalia Adults	317	39	11%	10/01/2007
Monongalia Children	3192	415	12%	
Monroe Adults	65	7	10%	10/01/2007
Monroe Children	848	84	9%	
Morgan Adults	97	14	13%	11/01/2007
Morgan Children	991	114	10%	
Nicholas Adults	230	33	13%	09/01/2007
Nicholas Children	1974	316	14%	
Ohio Adults	288	45	14%	11/01/2007
Ohio Children	1959	581	23%	
Pendleton Adults	2	1	33%	NA
Pendleton Children	8	2	20%	
Pleasants Adults	35	4	10%	10/01/2007
Pleasants Children	362	86	19%	
Pocahontas Adults	33	4	11%	10/01/2007
Pocahontas Children	578	54	9%	
Preston Adults	176	22	11%	10/01/2007
Preston Children	1737	315	15%	
Putnam Adults	301	13	4%	09/01/2007
Putnam Children	2517	221	8%	
Raleigh Adults	667	44	6%	10/01/2007
Raleigh Children	5808	475	8%	
Randolph Adults	183	26	12%	09/01/2007
Randolph Children	1908	374	16%	
Ritchie Adults	64	12	16%	10/01/2007
Ritchie Children	634	138	18%	

Roane Adults	151	21	12%	09/01/2007
Roane Children	1298	168	11%	
Summers Adults	126	17	12%	10/01/2007
Summers Children	901	133	13%	
Taylor Adults	103	20	16%	10/01/2007
Taylor Children	957	227	19%	
Tucker Adults	23	5	18%	10/01/2007
Tucker Children	373	68	15%	
Tyler Adults	68	11	14%	09/01/2007
Tyler Children	606	124	17%	
Upshur Adults	141	39	22%	03/01/2007
Upshur Children	1580	505	24%	
Wayne Adults	460	49	10%	01/01/2008
Wayne Children	3364	308	8%	
Webster Adults	140	31	18%	09/01/2007
Webster Children	890	134	13%	
Wetzel Adults	150	30	17%	10/01/2007
Wetzel Children	1103	337	23%	
Wirt Adults	70	8	10%	10/01/2007
Wirt Children	412	89	18%	
Wood Adults	808	75	8%	10/01/2007
Wood Children	5443	1352	20%	
Wyoming Adults	242	47	16%	09/01/2007
Wyoming Children	2001	227	10%	
West Virginia Total Adults	15,332	1664	10%	
West Virginia Total Children	115,471	17,006	13%	