Virtual Mentor
American Medical Association Journal of Ethics
January 2008, Volume 10, Number 1: 59-62.

CORRESPONDENCE
Comments on the West Virginia Pilot Medicaid Plan
A Response to Smoking and Medicaid Benefits

The State of West Virginia is implementing a new Medicaid plan with two levels of benefits: a scaled-back basic benefit package, and an "enhanced" benefit package available only to those who sign and conform to an agreement with the state [1]. Of note, the basic package eliminates mental health, substance abuse, and dependence-related treatment; diabetes care; and physical and occupational therapies. Further, this level of coverage limits prescriptions; dental, vision, and hearing treatment; skilled nursing care; and transportation services.

All children and parents who receive Medicaid by virtue of low income will receive this limited package unless they sign a "Medicaid Member Agreement" at their primary care physician's office. These contracts require, for example, that members keep their appointments, take their medications as prescribed, follow health improvement plans, and avoid unnecessary emergency room use. Physicians are expected to track four health markers and report to the state on the patient's compliance. Beneficiaries who do not fulfill these responsibilities forfeit "enhanced" benefits, and their coverage reverts to the basic plan [2]. The goals are to reduce health-related expenditures and prevent disease.

At first glance, such a policy may appear reasonable and fair. Calling these changes "common sense," the *Charleston Daily Mail* opined, "All the state is asking is that patients take their medications, follow their doctors' orders, and show up on time for their appointments" [3]. Sounds simple enough.

Yet closer examination reveals that this plan has both ethical and practical problems. Although personal responsibility is a laudable goal, punishing those who fail to achieve specified health-related objectives is both unfair and most likely ineffective. It is also at odds with current models of the patient-doctor relationship, which is not a directive model but one characterized by an ongoing process of mutually renegotiated goals within a context of increasing knowledge, support, and empathy on the part of the doctor, and trust and growing self-efficacy on the part of the patient [4].

Behavior change occurs in predictable stages [5] which can be facilitated but not directed by the physician. The development of necessary patient competencies is also predicated on having sufficient time for meaningful interaction between patients and physicians, no longer a given in today's environment [6]. Moreover, evidence

supports the conclusion that economically and educationally less-advantaged patients need more intensive and prolonged interventions. It is ethically problematic to punish patients who have not had a reasonable opportunity to gain the skills or do not possess the means to manage their disease [7].

The complex determinants of such behaviors as compliance with medication, diabetes control, weight loss, smoking cessation, and keeping appointments are not fully understood, and may not be entirely under anyone's control. An estimated 66 percent of U.S. adults are either overweight or obese [8], and achieving lasting weight loss is a relatively rare phenomenon. An identified subpopulation of heavy smokers is unable to stop smoking due to worsening depression [9]. It is highly unlikely that punitive measures will be effective in motivating patients to make complex lifestyle changes. State Medicaid programs would be better advised to make treatment available for tobacco dependence based on guidelines for medications, counseling, and behavioral approaches; currently only one state provides such complete coverage [10].

There are well-understood reasons why Medicaid beneficiaries have poorer health indicators and higher rates of noncompliance than many other patients. The poor are more likely to live in neighborhoods without safe recreational facilities, where stores lack affordable fresh produce, and where advertising for junk food, alcohol, and tobacco products is widespread [11]. Emergency rooms may be the only available alternative after doctors' offices are closed. Public and Medicaid-provided transportation is notoriously unreliable, and the poor have lower literacy, reduced access to child care, more life crises, and higher rates of untreated psychiatric illnesses, all of which can impede getting to appointments and taking medication.

Medicaid beneficiaries are less likely to have had the kinds of successful experiences that lead to confidence in their ability to improve their health. Poor and minority-group patients generally have greater mistrust of the health care system, and their noncompliance may be an expression of disagreement with a physician with whom they lack the confidence to openly disagree. West Virginia is asking the most vulnerable population to do more than other patients with less ability to accomplish what we ask of them [4].

The plan also discriminates against the sickest and least capable of these—the mentally ill, children, substance abusers, the least educated, and most impoverished—who are most likely to lose the benefits they need [4]. Approximately 75 percent are children who depend on parents or guardians for compliance. Persons with psychiatric illnesses that may compromise their willingness or ability to contract with the state or keep appointments stand to lose their mental health benefits because of such lapses. When their psychiatric illnesses are untreated, their physical health will deteriorate as well.

The Physician Charter on Medical Professionalism [11] enumerates three fundamental principles: the primacy of patient welfare, the principle of patient

autonomy, and the principle of social justice. The West Virginia plan potentially violates all three of these ethical principles. Physicians have an ethical responsibility to speak out on how such policies affect their practices and their patients' health.

References

1. Mountain Health Choices. *BMS Medicaid Redesign Mountain Health Choices*. http://www.wvdhhr.org/bms/oAdministration/Medicaid_Redesign/MedRedesign_main.asp. Accessed November 10, 2007.
2. Solomon J. *West Virginia's Medicaid Changes Unlikely to Reduce State Costs or Improve Beneficiaries' Health*. Washington, DC: Center on Budget and Policy Priorities; 2006. http://www. cbpp.org/5-31-06health.htm. Accessed November 10, 2007.
3. Medicaid changes are common sense. *Charleston Daily Mail*. June 2, 2006:P4A.
4. Bishop G, Brodkey AC. Personal responsibility and physician responsibility—West Virginia's Medicaid plan. *N Engl J Med*. 2006;355(8):756-758.
5. Diclemente CC, Prochaska JO. Toward a comprehensive model of change: stages of change and addictive behavior. In: Miller WR, Heather N, eds. 2nd ed. *Treating Addictive Behaviors*. New York, NY: Springer; 1998:3-24.
6. Ostbye T, Yarnall KS, Krause KM, Pollak KI, Gradison M, Michener JL. Is there time for management of patients with chronic diseases in primary care? *Ann Fam Med.* 2005;3(3):209-214.
7. Redman BK. Accountability for patient self-management of chronic conditions; ethical analysis and a proposal. *Chronic Illn*. 2007;3(1):88-95.
8. Centers for Disease Control and Prevention. Overweight and obesity. http://www.cdc.gov/nccdphp/dnpa/obesity/. Accessed November 10, 2007.
9. Glassman AH, Stetner F, Walsh BT, et al. Heavy smokers, smoking cessation, and clonidine. Results of a double-blind, randomized trial. *JAMA.* 1988;259(9):2863-2866.
10. Redmond P, Solomon J, Lin M. *Can Incentives for Healthy Behavior Improve Health and Hold Down Medicaid Costs?* Washington, DC: Center on Policy and Budget Priorities; 2007. http://www.cbpp.org/6-1-07health.htm. Accessed November 10, 2007.
11. ABIM Foundation. American Board of Internal Medicine; ACP-ASIM Foundation. American College of Physicians-American Society of Internal Medicine; European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med.* 2002;136(3):243-246.

Amy C. Brodkey, MD
Assistant professor of psychiatry, University of Pennsylvania School of Medicine
Medical director, Behavioral Health Service, Family Practice and Counseling Network, Philadelphia.

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.