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CLINICAL CASE
Smoking and Medicaid Benefits
Commentary by Cindy Tworek, PhD, MPH, and Kimberly Horn, EdD, MSW

Dr. Smith's spirits fell as soon as he noticed Jack fidgeting uncomfortably in the waiting area of his small private practice office. Jack usually dreaded even the thought of seeing a doctor.

Upon his first visit to Dr. Smith's office several years ago, Jack was diagnosed with diabetes and high blood pressure. As a result, Dr. Smith placed him on four different medications, one of which was insulin.

Whenever Jack came in for a checkup, Dr. Smith would repeat his pleas that Jack quit smoking and adopt healthier lifestyle choices. Jack's usual response to the former: "Why the hell should I stop smoking when I've done it for 20 years now?" His response to the latter: "Doc, I eat what I like and what I can afford. That's it. I'm not going to waste money on stuff I won't eat."

On this visit, Dr. Smith hoped things would be different. He reminded Jack, who received Medicaid benefits, that he had signed a contract with the state of West Virginia entitling him to additional health benefits—such as weight-loss and anti-smoking programs, mental health services, diabetes management classes, and cardiac rehabilitation—if he kept his medical appointments, took his medications, and followed health improvement plans. If he reneged on these obligations—and so far, Jack had—Dr. Smith would be forced to report this noncompliance to the state. Jack would still get basic Medicaid services but would only get four free drug prescriptions per month, among other limitations.

"So this is what happens when there's a crunch for taxpayer money," Dr. Smith thought to himself. "You end up doling out service based on compliance." What really worried Dr. Smith was that if Jack ever got sick with an infection, for example, one that required antibiotic treatment, and the prescription exceeded the dollar limit, there would be no telling what would happen to Jack or his kids.

Commentary

In July 2006 three West Virginia counties adopted a pilot Medicaid program that promotes personal responsibility for positive health behaviors [1-3]. The program includes basic and enhanced benefits. The enhanced plan provides, in addition to all mandatory services, age-appropriate wellness services and has no monthly

prescription limit (the basic Medicaid plan covers only four prescriptions per month). To qualify for enhanced benefits, members must sign a binding Medicaid Member Agreement valid for 12 months. The agreement essentially requires that members make reasonable efforts to stay healthy.

Incentives for Tobacco Cessation

Specifically, the program promotes patient responsibility for lifestyle choices (e.g., developing healthy eating habits, maintaining healthy weight, exercising, and quitting tobacco use) and adherence to physician advice (e.g., keeping appointments, taking required medications). The program rewards those who sign and adhere to the agreement with enhanced benefits [1]. If patients fail to follow the agreement, however, the state enrolls them in basic benefits for a year. The goal is to encourage patients with unhealthy lifestyles to practice responsible self-care and take advantage of free health improvement programs. In turn, the theory holds that health is improved and dollars are saved.

Significantly for the case study at hand, West Virginia monitors patient adherence to recommended screenings and health improvement programs, appointment schedules, and medication regimens and tracks patient compliance to the agreement using claims data. So the question arises: Who is responsible for reporting patient noncompliance? In the current scenario, the physician who receives reimbursement from the state for Jack's care, Dr. Smith, would be obligated to report.

Opponents of the plan believe that this requirement competes with current models of the patient-doctor relationship [3, 4]. Physicians feel conflicted between legal obligations and reporting situations that may harm their patients or their relationships with patients. In fact, the scenario faced by Dr. Smith creates tension between principle III ("A physician shall respect the law…") and principle VIII ("A physician shall, while caring for a patient, regard responsibility to the patient as paramount") of the AMA Principles of Medical Ethics [5].

Advocates assert that the plan promotes personal responsibility for health, an effective and necessary behavior change agent [6, 7]. The Health Belief Model identifies two convictions that influence a person's decision to adopt recommended preventive health actions: (1) perception of personal threat by a disease and recognition of its serious or severe consequences; and (2) recognition that the benefits of taking preventive action outweigh perceived barriers and costs of such action [8]. If patients hold these beliefs or convictions, they may well comply.

It may also be said that the redesigned Medicaid plan puts increased responsibility and accountability on the shoulders of the physician. The literature demonstrates that a less-than-ideal percentage of physicians counsel patients or provide them with appropriate referrals for unhealthy behaviors such as obesity and cigarette smoking [9-11]. A 2006 study in New York by Brissette, Gelberg, and Grey [12] found that, despite mandatory reporting laws, underreporting of disease conditions to public health authorities was extensive. Reporting chronic disease conditions has legal and

public health impacts [12]. An increased sense of responsibility and accountability on the part of both the patient and the physician may be our best assurance that patients will receive the treatments and services they need. Supporters of the West Virginia plan believe that the state has taken a bold and unprecedented step forward.

Noncompliance and Negotiation with a Patient

What makes each case challenging is that physicians like Dr. Smith are empowered to define compliance and noncompliance on a patient-by-patient basis. The physician must determine the difference between desirable behaviors and achievable ones for any given patient. Failure to achieve a goal does not necessarily define patient noncompliance; it may simply lead to renegotiation between the patient and physician. Negotiation is a critical aspect of behavior change and may require repeated efforts [13], allowing for physician flexibility in determining a patient's true desire to comply with health care advice.

In Jack's case, we can ask: Is a patient who received tobacco cessation information and who has not quit, but is closer to making a quit attempt, considered "noncompliant"? What cessation tools were initially recommended—are other services available that may be more effective for this patient? Is the patient aware of and educated concerning all cessation tools and programs that are viable options? These types of cases demand unique tailoring of patient services, including the collaboration of various providers involved in a patient's health care.

Physicians have an obligation to promote the well-being of their patients. The second part of Principle III of the AMA code of ethics states that "A physician shall…recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient" [5]. Is West Virginia's proposed Medicaid change in the patient's best interest? Or does it threaten patients' interests? If a physician concludes that this or any other plan jeopardizes the health of the patient, he or she must advocate for change.

Regardless of the Medicaid redesign pilot, an aggressive approach to interactive patient-physician health behavior monitoring is urgently needed in West Virginia and many states. A state that consistently ranks among the worst in the nation in health disparities [14, 15] must take measures for change and then assess those measures to foster and promote healthy behaviors among its residents. The West Virginia pilot program is undoubtedly controversial and in need of evaluation for many reasons. Only by giving the plan a fair try and providing appropriate feedback, will physicians be able to judge whether, on balance, it furthers patients' interests. Physicians participating in this pilot program have the opportunity to take part in unprecedented Medicaid reform and promote necessary change.

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