Taking Ownership

The Patient Role in Medicaid

Empire Center for New York State Policy
What’s up with Medicaid?

Average Medicaid Eligibles by Calendar Year (in millions)
Medicaid Spending by Fiscal Year
(in billions of dollars)
What’s up with Medicaid?

Chronic conditions drive costs up significantly.

Risk factors include:

– Diabetes and pre-diabetes: $8.7b*
– Smoking: $5.4b
– Obesity: $7.6b*
– Hypertension: $1b
– Mental health issues: $7b
– Substance Abuse: $1.7b

* All health care spending statewide
NY Medicaid today

In spite of spending, health outcomes are mediocre and access to primary care physicians poor – a critical issue that must be addressed in any redesign.
Enacted “MRT” Savings Measures

• 4% global cap on DOH spending
• reduced personal care costs
• 2% across-the-board spending reduction
• limited pharmaceutical spending
• voluntary spending restraint by providers
NY’s Proposed CMS Waiver

Major system reform in three steps:

1. Reduce costs
2. Improve patient care & supports
3. Improve health outcomes
### NY’s Proposed CMS Waiver

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Federal Savings</td>
<td>$17.1 Billion</td>
</tr>
<tr>
<td>Reinvestment</td>
<td>$10.0 Billion</td>
</tr>
<tr>
<td>Net Federal Savings</td>
<td>$7.1 Billion</td>
</tr>
</tbody>
</table>
What about the patient?

Simply reforming the Medicaid system is not enough – patients **must** take more ownership of their care.
Introducing Incentives

IDAHO Department of Health and Welfare

FLORIDA MEDICAID

OPPORTUNITY NYC family rewards

Mountain Health Choices
West Virginia’s New Medicaid Program
Introducing Incentives

- Conditional cash transfers or non-cash rewards
- Enhanced health benefits packages
- Wellness, fitness, nutrition classes
- HSA’s and other insurance ownership programs
# Opportunity NYC

## Annual Incentives from Opportunity NYC

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintaining public or private health insurance (discontinued after Year 2)</td>
<td></td>
</tr>
<tr>
<td>For each parent covered, public</td>
<td>$240</td>
</tr>
<tr>
<td>For each parent covered, private</td>
<td>$600</td>
</tr>
<tr>
<td>If all children are covered, public</td>
<td>$240</td>
</tr>
<tr>
<td>If all children are covered, private</td>
<td>$600</td>
</tr>
<tr>
<td>Medical checkup, per family member</td>
<td>$200</td>
</tr>
<tr>
<td>Doctor-recommended follow-up visit, per family (discontinued after Year 2)</td>
<td>$100</td>
</tr>
<tr>
<td>Early-intervention evaluation for child under 30 months old, pediatrician advised</td>
<td>$200</td>
</tr>
<tr>
<td>Preventive dental care for each child 1-5 years old</td>
<td>$100</td>
</tr>
<tr>
<td>Preventive dental care for each family member &gt;5</td>
<td>$200</td>
</tr>
</tbody>
</table>

Florida Enhanced Benefits

Early participation and redemption rates were lackluster for the program begun in 2006

Adjustments were made:
- Less complex
- Added call center
- Regular monthly mailings
- Broader patient education

In 2012 enrollees had accumulated nearly $54 million in credits and had redeemed $30 million.
## Idaho Wellness Programs

<table>
<thead>
<tr>
<th>Rate of Poverty Level</th>
<th>Monthly Premium</th>
<th>Annual Premium</th>
<th>Maximum Annual Points</th>
<th>Minimum Annual Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between 134-149</td>
<td>$10</td>
<td>$120</td>
<td>120</td>
<td>$0</td>
</tr>
<tr>
<td>Between 150-185</td>
<td>$15</td>
<td>$180</td>
<td>120</td>
<td>$60</td>
</tr>
</tbody>
</table>

West Virginia Mountain Health Plus

- Adults enrolled in the plan visited their doctor twice as much as those under the basic plan; children visited 60 percent more frequently.

- In spite of promising behavioral changes, enrollment is just 14 percent of those eligible. Factors include; confusion, poor marketing and a general misunderstanding of the plans.
Healthy Indiana Plan (HIP™)

Results include:

• A high level of satisfaction among members
• Only 26 percent of members have left the plan
• A low 3 percent disqualification rate
• Most members visit physicians -- 91 percent in the first year -- and get the preventive care services required
• Fewer non-emergency ER visits and use more generic drugs than non-HIP Medicaid recipients
Elements for Success

- Expand primary care capacity
- Unambiguous terms
- Patient education and outreach
- Rapid program evaluation
- Concise rewards and non-compliance terms
- Flexibility
Medicaid Incentives for Prevention of Chronic Disease (MIPCD)

- 10 States will receive $85 million over 5 years -- New York’s grant is $2 million per year
- Goal is to change health risks and outcomes through prevention and save on acute care costs
- 18,000 targeted in New York - three incentive groups and one control group randomly assigned
- Direct cash payments or gift cards up to $250/year for stopping smoking, lowering high blood pressure and managing/preventing diabetes
Lessons from TANF

• Supports must be in place before requiring certain behaviors from Medicaid recipients
• Analogy to TANF not about reducing caseload or taking away coverage but stressing personal responsibility
• TANF employed multiple incentives to encourage and support work -- Medicaid can use same philosophical approach to encourage healthy behavior
• Leverage could be employed on a trial basis to test whether withholding cash or food stamps could lead to healthier behavior
Recommendations

FOR THE STATE:

• Introduce Conditional Cash Transfer rewards, cash equivalent benefits, vouchers for drugs and other health products, payments for enrolling in fitness and wellness programs, and other incentives.
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• Incorporate healthy behavior agreements, mandatory participation in preventive wellness/treatment programs, and modest co-payments for inappropriate ER utilization, among other requirements.
Recommendations

FOR THE FEDERAL GOVERNMENT:

• Expand the federal MIPCD effort by investing more in state experiments than the $85 million it has currently, a pittance compared with total Medicaid costs nationally of $383.5 billion.
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• The Federal government should stop impeding the testing of individually designed state incentive and personal responsibility programs.
Longer Term Issues To Consider

- Converting Medicaid from a defined-benefit plan to a defined-contribution plan
- Allowing Medicaid recipients to opt out of Medicaid, using instead either health insurance exchanges or other comparable subsidized private coverage
- Experimenting with a pure capitated dollar figure for all Medicaid expenditures, with far less federal intrusion regarding program operations and flexibility
- Exploring block grants to the states for Medicaid funding under several federal guiding purposes