Patient Incentives and Medicaid

Presented by Thomas J. Hoerger, PhD

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Disclaimer

- The opinions expressed in this presentation are solely those of the author.

The Question

- Can monetary incentives help Medicaid beneficiaries stop smoking, lose weight, and prevent chronic diseases?

Warning: I'm only going to raise the question, not answer it

The Challenge of Chronic Disease

- Even if you want to stop smoking or lose weight, it's difficult
  - It's not a one-time decision
  - It's a constant battle between today and tomorrow
- Challenge may be exacerbated for Medicaid beneficiaries
  - Competing needs
  - Lack of resources
- Economics: incentives can help
- Behavioral economics: well-designed incentives can help even more

What do we know from previous research?

- Only 3 examples of Medicaid incentive programs
- Florida: Enhanced Benefits Rewards Program
  - Maximum incentive: $125 annually
  - Most received credits for childhood prevention or office visits
  - Smoking prevention: only 2 people
  - Exercise: only 2 people
- Idaho: Preventive Health Assistance
  - Maximum incentive: $200
  - Behavioral PHA: weight management and tobacco cessation
    - 1,422 out of 185,000 beneficiaries participated
  - Wellness PHA: child wellness visits
    - Significant increase in children up-to-date

What do we know from previous research?

- West Virginia: Mountain Health Choices Program
  - Individuals sign agreements to develop wellness plan and take responsibility for following plan
  - Incentive: maintain access to enhanced plan that covered meds, tobacco cessation, and diabetes and weight management programs
  - Only 10% of eligible adults signed up
  - Participants more likely to have office visits and take meds

Blumenthal et al. Medicaid Incentive Programs To Encourage Healthy Behavior Show Mixed Results To Date And Should Be Studied And Improved. *Health Affairs* 2013 32(3): 497-507.

Observations on the Previous Literature (Blumenthal et al.)

- Limited evaluation of program effectiveness
- No clear evidence of relationship between reward type and effectiveness
  - Incentives may have been too small to have an effect
  - People respond more to immediate costs and benefits than to delayed costs and benefits
- Low levels of program awareness
- Don’t make incentive structure too complicated for participants
- Don’t rely on providers to publicize
- Avoid administrative complexities

Current Research: Medicaid Incentives for Prevention of Chronic Diseases (MIPCD)

- Authorized by Section 4108 of the Affordable Care Act
- 10 states received grants from the Centers for Medicare & Medicaid Services (CMS) in 2011 to set up MIPCD programs
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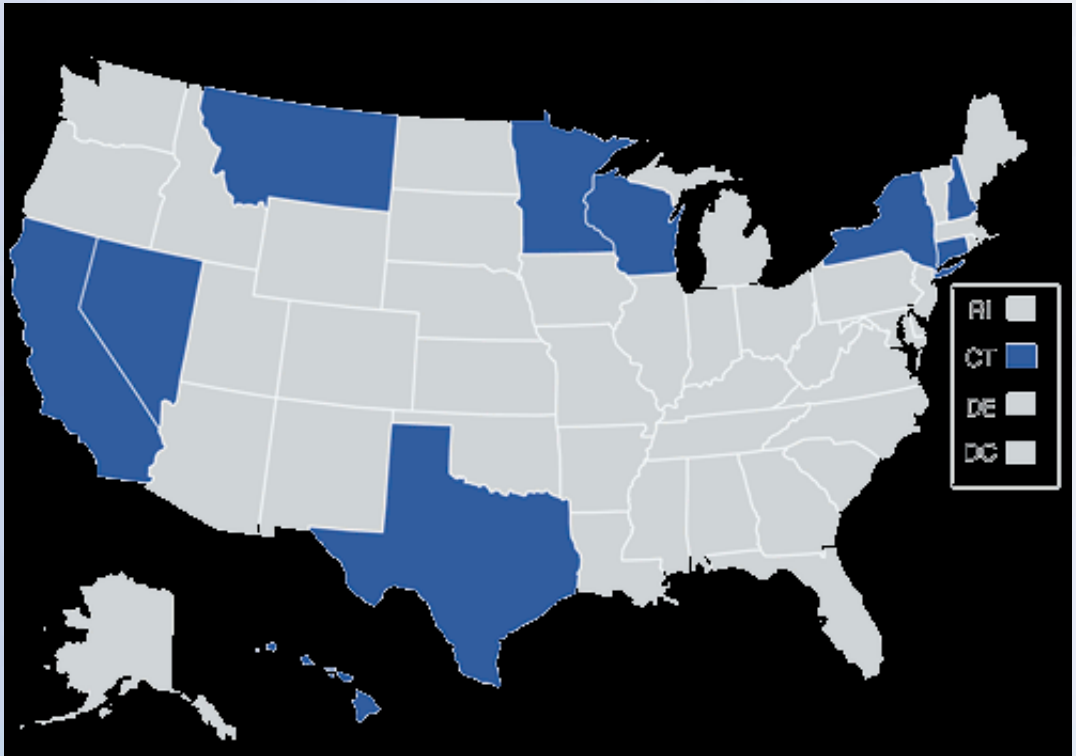

Source: CMS

The States Target a Variety of Behaviors

State	Smoking	Diabetes	Obesity	Hyperlipidemia	Hypertension
California	✓	—	—	—	—
Connecticut	✓	—	—	—	—
Hawaii	—	✓	—	—	—
Minnesota	—	✓	✓	—	—
Montana	—	✓	✓	✓	✓
Nevada	—	✓	✓	✓	✓
New Hampshire	✓	—	✓	—	—
New York	✓	✓	—	—	✓
Texas	✓	✓	✓	✓	✓
Wisconsin	✓	—	—	—	—
Total	6	6	5	3	4

Some of the States Target Special Populations

State	Those with mental illness	Those with substance abuse disorders	Racial/ethnic minorities	Pregnant women and mothers of newborns	Children	Medicare-Medicaid enrollees
California	✓	✓	✓	✓	—	✓
Connecticut	✓	—	—	✓	—	✓
Hawaii	—	—	✓	—	—	✓
Minnesota	—	—	—	—	—	✓
Montana	—	—	—	✓	—	✓
Nevada	—	—	—	—	✓	✓
New Hampshire	✓	—	—	—	—	✓
New York	—	—	—	✓	—	—
Texas	✓	✓	—	—	—	—
Wisconsin	—	—	✓	✓	—	✓
Total	4	2	3	5	1	8

Incentives Vary Across States

State	Money	Money-valued incentives	Flexible spending accounts for wellness activities	Prevention-related incentives	Treatment-related incentives	Points redeemable for rewards	Support to address barriers to partici-pation
California	—	✓	—	—	✓	—	—
Connecticut	✓	—	—	—	—	—	—
Hawaii	✓	✓	—	✓	—	✓	✓
Minnesota	✓	—	—	✓	—	—	✓
Montana	✓	—	—	—	—	—	✓
Nevada	—	—	—	—	—	✓	—
New Hampshire	✓	—	—	✓	✓	—	✓
New York	✓	—	—	—	—	—	—
Texas	—	—	✓	✓	✓	—	✓
Wisconsin	✓	✓	—	—	—	—	✓
Total	7	3	1	4	3	2	6

Incentive Amounts Also Vary

State	Maximum financial incentive per person
California	Eligible callers who ask for the Medi-Cal Incentives to Quit (MIQS) incentive: Maximum study incentive: $20
	RCT 1: Maximum study incentive: $60; RCT 2: Maximum study incentive: $40
	Enhanced services non-RCT: TBD
Connecticut	Maximum annual amount: $350
Hawaii	Maximum annual amount: $215
Minnesota	Maximum study incentive: $545
Montana	Maximum annual amount: $315
Nevada	Managed Care Organization (MCO) for diabetes management: Maximum study incentive: $355
	MCO for weight management class: Maximum study incentive: $38
	MCO for weight management support group: Maximum study incentive: $60
	Lied Clinic Outpatient Facility at University Medical Center: Maximum study incentive: $345
	YMCA of Southern Nevada: Maximum study incentive: $300
	Healthy Hearts Program for Children: Maximum study incentive: $350
New Hampshire	Weight Loss: Maximum incentive for 24 months: $3,097
	Weight Loss: Maximum incentives for 12 months: $1,860
	Smoking Cessation: Maximum study incentive: $415
New York	Maximum study incentive: $250
Texas	Maximum annual amount: $1,150
Wisconsin	Wisconsin Tobacco Quit Line: Maximum study incentive: $270
	First Breath: Maximum study incentive: $600

Evaluation

- Each state is evaluating its program
- Under contract to CMS, RTI and the National Academy for State Health Policy are performing an independent evaluation of MIPCD focusing on 4 issues
  1. Utilization of health care services by participants
  2. The extent to which special populations are able to participate
  3. The level of satisfaction of Medicaid beneficiaries with respect to the accessibility and quality of program services
  4. The administrative costs incurred by state agencies that are responsible for administration of the program.
  - We are also synthesizing results across states

First Report to Congress (End of 2013)

- Largely descriptive, covering implementation
- Recommendation: “At this time, there is insufficient evidence to recommend for or against extending funding of the programs beyond January 1, 2016. Most of the State programs have been enrolling participants for only a short period, and there are few data on the effect of the programs on health outcomes or health care utilization and costs. Therefore, it would be premature to make a recommendation to extend funding to expand or extend the programs beyond January 1, 2016. …”

Initial Report to Congress. Medicaid Incentives for Prevention of Chronic Diseases Evaluation. November 2013. http://innovation.cms.gov/Files/reports/MIPCD_RTC.pdf

Implementation Challenges

- Administrative delays
- Provider engagement and participation
- Provider management and oversight
- Participant identification (identifying Medicaid beneficiaries and persons in target populations)
- Managing patient incentives
- Community perceptions of participants (e.g., those with mental health conditions)

Implementation Lessons Learned

- Be flexible
- Adopt a problem-solving approach and be willing to explore alternative options and develop alternative plans
- Have political support from program champions
- Take time to plan program implementation, hire a capable project manager, and implement comprehensive management systems and infrastructure
- Develop collaborative partnerships
- Build relationships with partners and providers through ongoing communication
- Train and incentivize providers to participate
- Incorporate cultural and linguistic awareness

Still to Be Evaluated: The Big Questions

- Can monetary incentives help Medicaid beneficiaries stop smoking, lose weight, and prevent chronic diseases?
- Do these effects last?
- Do the programs reduce health care services and costs?
- How much does it cost to run an incentives program?

Discussion

More Information

Thomas J. Hoerger

Senior Fellow

919.541.7146

tjh@rti.org