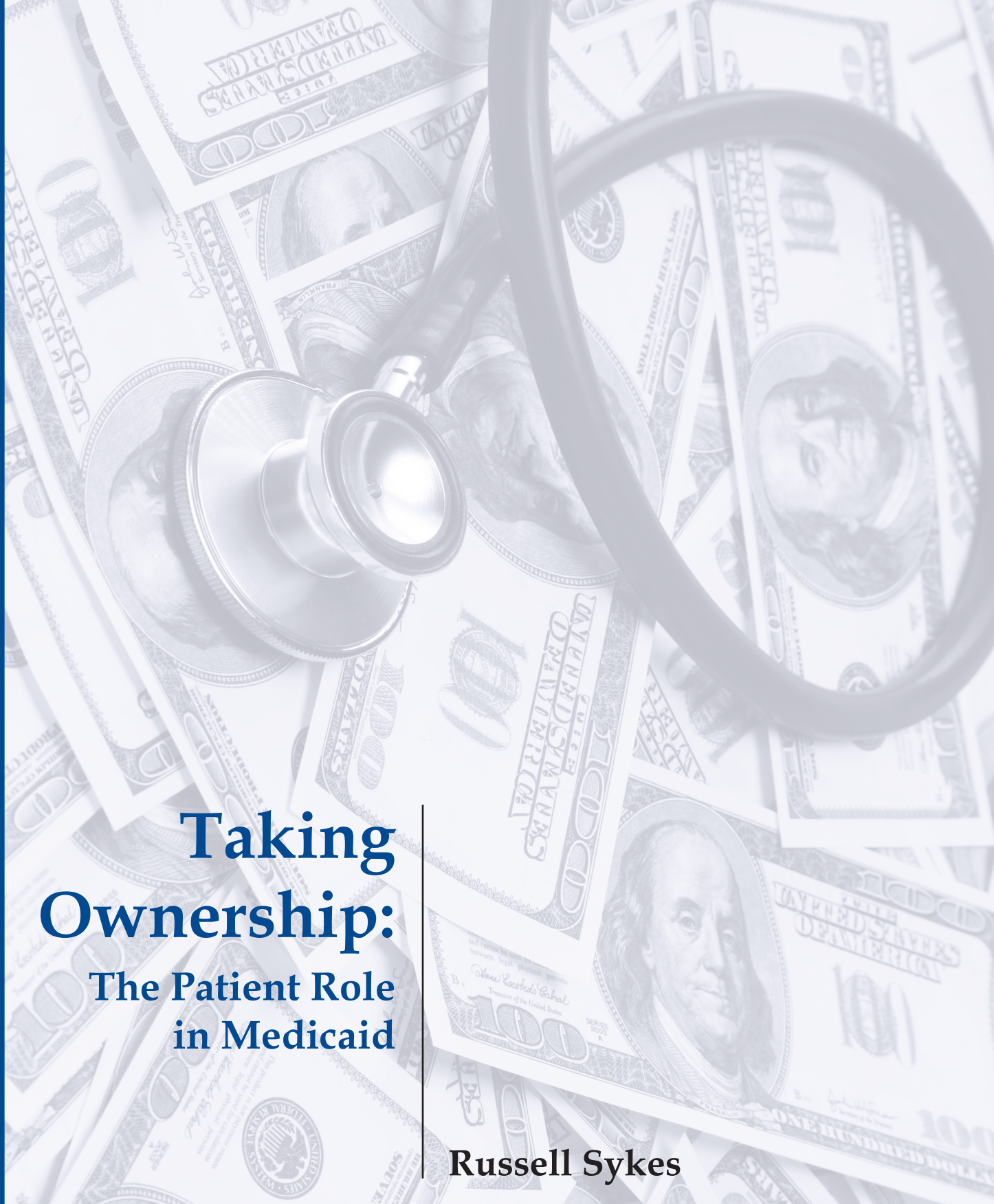
SPECIAL REPORT

SR13-12 December 2012



Taking Ownership:

The Patient Role in Medicaid

Russell Sykes

EMPIRE CENTER
FOR NEW YORK STATE POLICY
A project of the Manhattan Institute for Policy Research

TAKING OWNERSHIP

The Patient Role in Medicaid

TABLE OF CONTENTS

ABOUT THE AUTHOR

Russell Sykes is a senior fellow of the Empire Center for New York State Policy, a project of the Manhattan Institute for Policy Research. His recent work has focused on Medicaid, tax credits for low-income working New Yorkers and public benefit programs such as cash welfare and food stamps.

Prior to joining the Empire Center, Sykes was the deputy commissioner of New York's Office of Temporary and Disability Assistance where he was responsible for TANF, Food Stamps, Low Income Home Energy Assistance Program, welfare to work and the state's SSI Supplement. Sykes is also nationally recognized for his work in these areas, serving as a current board member of the American Public Human Services Association and as a former chair of the National Association of State TANF Administrators.

Printed by:

Modern Press
Albany, NY

ACKNOWLEDGEMENTS

Support for this work was provided by the New York State Health Foundation (NYSHealth). The mission of NYSHealth is to expand health insurance coverage, increase access to high-quality health care services, and improve public and community health. The views presented here are those of the author and not necessarily those of the New York State Health Foundation or its directors, officers, or staff.

EXECUTIVE SUMMARY

New York State has embarked on an ambitious multi-year effort to overhaul its taxpayer-funded Medicaid program, which has long combined high costs with less than impressive health outcomes. Governor Andrew Cuomo's "redesign" of Medicaid will be heavily focused on "complex, high-cost populations" – the roughly one million Medicaid recipients with long-term disabilities and chronic health problems such as diabetes, heart disease, substance abuse and mental illness.

While most Medicaid recipients in New York are enrolled in managed care, where conditions are carefully monitored and treatment costs controlled, the majority of the chronically ill are still covered on a fee-for-service basis, which tends to reward a high volume of treatments and procedures. The Cuomo administration wants to centrally coordinate and intensively manage health care for this particularly expensive group of patients, with a stronger emphasis on health education and prevention.

The proposed changes, which will require the federal government to waive many of its usual Medicaid rules, are both appropriately targeted and potentially transformational.

But there remains a missing element in the Medicaid redesign: the role of patients themselves.

Many of the most costly-to-treat health conditions – for example, those linked to obesity -- are caused or exacerbated by lifestyle and behavioral factors. Even the best-designed and best-coordinated system of managed care will fail to deliver the desired results if too many patients continue to smoke, or fail to exercise adequately or indulge eating and drinking habits that make their health problems worse.

This paper focuses on the Medicaid population with or at risk for chronic diseases (excluding the elderly and disabled in institutional care). It details how incentives to practice healthy behavior and reasonable requirements that patients take ownership of their health care by seeking early preventive care in appropriate settings can lead to better health outcomes and lower costs in Medicaid.

The persistence of unhealthy behaviors among some chronically ill individuals is a daunting problem – seemingly every bit as intractable as the dependency issues confronting welfare prior to major reforms in 1996.

Yet, in the case of welfare, a true transformation did eventually occur. The historic, bipartisan federal welfare reform of 1996, using the findings from multiple state experiments, turned public assistance from what had been a program with few expectations of the recipient into a system of incentives and responsibilities designed to encourage work. The result was that more people left welfare for work, especially single mothers, and states were able to experiment with finding avenues to encourage and reward work, including incentives, case management and various support services such as child care and transportation.

Some of the central lessons of welfare reform can be replicated in Medicaid, not in order to reduce the caseload, but by understanding that incentives matter, rewards can make a difference in promoting healthy behavior and client responsibility can play a major role in success.

Getting individuals to adopt healthier personal habits is a difficult and complex, but necessary challenge. As reviewed in this paper, several other states have pursued promising approaches in this area. New York can also draw from emerging insights from the field of behavioral economics and from private health insurance and employer innovations.

New York is already poised to take an initial step in this direction. It is among 10 states that have received small federal grants to provide direct cash or other rewards to Medicaid patients who enroll in disease prevention and management programs.

Building on this start, New York should become a leader in testing new avenues to engage patients in their health care and improving public health outcomes.

Specific recommendations include:

- Experiment with a variety of cash or cash-like incentives to encourage patients with chronic conditions to access primary and preventive services, adopt healthy behaviors and follow recommended treatment plans. Such incentives are often called conditional cash transfers, which predicate the receipt of payments on fulfilling certain responsibilities.
- Remove barriers that limit private managed care plans' ability to provide higher cash or cash-equivalent rewards for healthier behavior to their Medicaid clients.
- Incorporate proven approaches from other states that have already designed incentive programs and mechanisms to boost patient responsibility.
- Test multiple approaches on a small scale and evaluate them carefully both to add to the research literature on incentives and to expand successful programs.

1. NEW YORK MEDICAID AT A CROSSROADS

The nation's Medicaid program is at a turning point, and New York is in a position to help determine in which direction it will now go.

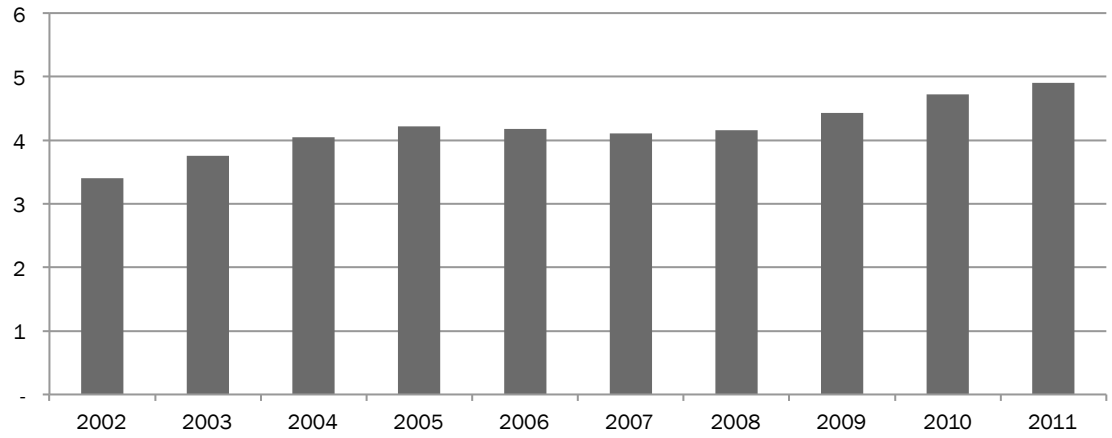
Castigated for its high costs and disappointing outcomes, Medicaid has become a political football in the country's increasingly rancorous debate over entitlement spending. The growing costs in New York also make the annual debate over Medicaid a contentious one. How well New York succeeds in fixing its program, particularly in using incentives to improve patient health and thus reducing demands on the system, could have wide implications nationally.

The state's program is the largest in the country, providing health care to 5.1 million people (see Figure 1), one out of four New Yorkers,[1] at an annual cost of $54 billion (see Figure 2).[2] It accounts for 13.4 percent of all national Medicaid dollars, and exceeds the spending in Florida, Illinois and Ohio combined.[3] On a per patient basis, New York spends $8,960 a year, second only to Connecticut's $9,577.[4] Almost 42 percent of all Medicaid spending in New York is for long-term-care for the elderly and disabled and over 52 percent of costs are for acute care, which is partially driven by chronic diseases.[5]

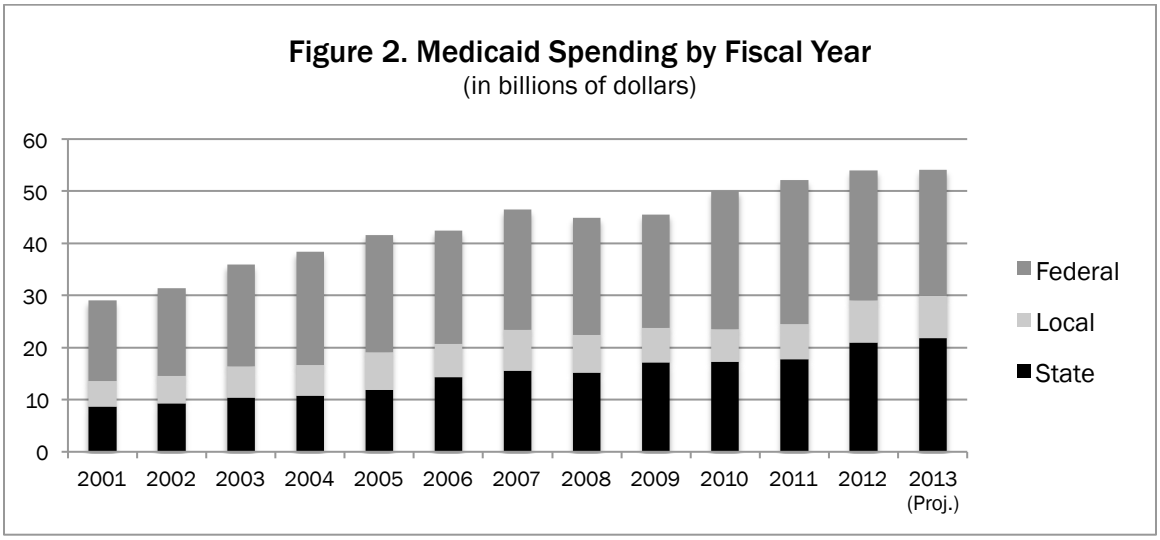
Yet for all that money, New York's program falls short on delivery. It ranks only 18th among the states in overall health system quality,[6] 41st in the quality of long-term-care services[7] and dead last in avoidable hospital use and costs. [8]

In early 2011, Governor Andrew Cuomo formed a broad-based Medicaid Redesign Team (MRT) to develop an in-depth plan to slow the growth of Medicaid spending, provide better care and improve health outcomes.[9] The initial package of recommendations, already implemented, included a number of cost-saving measures, notably a 4 percent annual cap on spending growth[10] and enhanced primary-care capacity and reimbursement rates.

Figure 1. Average Medicaid Eligibles by Calendar Year
(in millions)



Source: New York State Department of Health



Source: New York State Division of Budget

The final MRT report, released in 2012, went even further. It suggested moving all Medicaid recipients into managed care over the next three to five years and out of costly fee-for-service arrangements. The new system, which is awaiting approval of a federal waiver submitted in August 2012 to the Centers for Medicare and Medicaid Services (CMS), would promote primary and preventive care and shift the program focus to pay for better health outcomes rather than the volume of procedures conducted (See sidebar, "The Importance of an Expanded Federal Waiver," on page 4).

Seventy-two percent of New York's Medicaid population is currently in some form of managed care.[11] According to the New York State Department of Health (DOH), almost 70 percent of all heath care expenses in New York are driven by the most difficult and costly patients with chronic physical and mental-health conditions.[12] The percentage of Medicaid expenses is likely greater given the high incidence of chronic conditions among Medicaid recipients.

This paper focuses on the Medicaid population, excluding the elderly and disabled in institutional care, with or at risk for chronic diseases. It details how incentives to practice healthy behavior and reasonable requirements that patients seek early preventive care in appropriate settings can lead to better health outcomes and lower costs in Medicaid.

Simply moving patients into a managed care system will not be enough to achieve meaningful savings or better outcomes, however. To cross that line, the patients themselves must take a leading role by assuming greater responsibility for their health. That means changing certain habits and behavior that can cause or aggravate illness, notably through smoking, poor diets, obesity and lack of exercise. At the same time, the patients must agree to respect the health care process itself, by following treatment plans, taking prescribed medications, keeping doctor appointments and seeking early preventive care.

Incentives and requirements can fall into a number of categories including:

- conditional cash transfers or non-cash rewards such as vouchers for health products, gift cards and cell phones for hard-to-reach patients;

- enhanced health benefits, including wellness classes for those who practice healthy behaviors and comply with assigned health-care direction;
- insurance ownership programs like the Healthy Indiana Plan (HIP) with a health savings account (HSA) component; and
- education and personal support provided by peer counselors, health navigators, facilitated enrollers and nurses who make home visits, all working to help patients understand the system and seek early care to avoid diseases like obesity and diabetes.

Different incentives are likely to work with different demographic and medical groups, so flexibility in design as well as a mix-and-match approach will likely be needed in any menu of options.

While changing behavior is notoriously hard, conditional cash transfer incentive programs[13] designed specifically for that purpose already exist in a number of states, including Florida, Idaho, Indiana and West Virginia, and among private employers and insurance plans. In return for taking certain steps to improve their care, patients can receive outright payments or enhanced coverage. Sometimes, they are asked to pay small premiums, which are reimbursed if follow-up steps are taken. And patients can sometimes face reduced coverage if steps are not taken. The amount of cash incentives per patient is nominal, often $200 or less a year, but the potential savings are huge. Keeping just one patient from becoming diabetic could save hundreds of thousands of dollars in treatment costs over his or her lifespan.

But which of these incentive programs is more effective than others, and how the better ones might be improved, is not fully understood, since many of them are relatively new. The need for further research about the efficacy of incentives is clear.

By virtue of its commitment to change, and its sheer size, New York could help fill in this gap. It is one of 10 states to have recently received small federal grants to provide incentives. But it could do much more by adopting some of the programs being used elsewhere and testing them around the state in pilot efforts distributed among its 62 counties. By closely monitoring the results, it could expand programs that are working and drop those that aren't.

By broadening the use of incentives, the health of some of the most at-risk people in the system – patients with diabetes or pre-diabetic patients, those with cardiovascular problems, people with manageable mental disorders – could be significantly improved, resulting in substantial savings, once the right mix of incentives produces the desired changes in behavior.

In its negotiations with CMS on the MRT waiver, New York should push for the broadest possible waiver in terms of incentives and patient ownership, allowing it to test approaches that could help Medicaid patients not only in New York but throughout the country. It is a role that Albany seems ready to play.

As the state's Department of Health (DOH) has noted in a broader context, "New York is fully prepared to be the health-care reform laboratory for the nation."[14]

The Importance of an Expanded Federal Waiver

Based on recommendations from Governor Cuomo's Medicaid Redesign Team (MRT) and other stakeholders, New York has developed and submitted to the federal Centers for Medicare & Medicaid Services (CMS) an amendment to its existing Section 1115 Partnership Plan waiver, which has operated since 1997.

This request for a broadened waiver estimates that the proposed changes to Medicaid would save $34.3 billion in overall spending,[a] with the federal government realizing $17.1 billion over five years. It asks the federal government to reinvest up to $10 billion of those savings in New York to carry out the full package of MRT recommendations, as a means to both limit spending growth and improve health outcomes.

New York proposes to reinvest a portion of the estimated federal savings as follows:

- Primary care expansion ($1.25 billion)
- Health home development ($525 million)
- New care models ($375 million)
- Expansion of vital access and safety-net hospital provider programs ($1 billion)
- Public hospital innovation: new models of care ($1.5 billion)
- Supportive housing expansion ($750 million)
- Managed long-term-care preparation program ($839.1 million)
- Capital stabilization for safety-net hospitals ($1.7 billion)
- Hospital transition ($520 million)
- Workforce training ($500 million)
- Public health innovation ($395.3 million)
- Regional health planning ($125 million)
- MRT waiver and evaluation program ($500 million)[b]

The waiver is one of the largest ever submitted to CMS both in scope and funding requests. In several areas, it seeks Medicaid reinvestment beyond the scope of previous waivers granted by CMS.

[a] New York State Department of Health, MRT News, Volume 1, Issue 1, "Governor Cuomo Announces Medicaid Spending Finishes Year $14 Million Under Global Medicaid Cap; MRT Initiatives Will Save the State Medicaid Program $17.1 Billion Over Next Five Years," described at: http://www.sltrib.com/sltrib/news/53382898-78/medicaid-patients-utah-care.html.csp, page 1

[b] New York State Department of Health, June 12, 2012 Presentation, Overview of MRT Waiver Amendment Process, Albany, NY, slides 21-35, described at: http://www.health.ny.gov/health_care/medicaid/redesign/mrt_waiver.htm

c Ibid, page 13.

2. NEW YORK'S CALL TO ACTION

Upon taking office in January 2011, Governor Cuomo recognized that the $54 billion in Medicaid costs were no longer sustainable: "New York's bloated Medicaid program, which spends at a rate more than twice the national average, must be reformed to help our state begin to make ends meet."[15]

In an attempt to end years of talk about Medicaid cost containment and poor quality of care, the Governor asked his Medicaid Redesign Team to suggest changes that would reduce annual double-digit growth in spending and improve patient outcomes. The MRT membership was broad, reflecting all sectors of the health care industry.[16]

Besides the 4 percent annual cap on future spending growth (a so-called global limit on the state share of DOH Medicaid spending), the team's initial recommendations included significant reductions of assigned hours of personal care, reductions in pharmaceutical spending; and a one-time 2 percent across-the-board spending cut. In addition, $600 million in cost reductions were realized through voluntary efforts on the part of providers.

The DOH's commissioner was also granted extraordinary powers to impose automatic spending cuts if the MRT recommendations did not achieve their designated targets. In the first year of implementation, spending fell $14 million below the cap, avoiding the need for automatic cuts.[17]

But these measures merely slowed growth, albeit dramatically, from what would have been an estimated 13 percent annual increase, had previous automatic increases been allowed to stand.[18] The state share of Medicaid under DOH will still rise by 4 percent a year. What's more, Medicaid spending within other state agencies is not subject to the 4 percent cap under the MRT plan.[19] The question of whether the global cap is sufficient gained urgency when the Supreme Court earlier this year upheld the Obama Administration's health care plan, which could add many new recipients in New York (See sidebar, "Implications of the Supreme Court's Health Care Decision," on page 7).

The MRT, and the waiver application, call for greatly expanded primary-care availability, central care coordinators for all Medicaid patients, strong patient education and supports, and a system in which teams of providers will make sure that proper managed care for all is provided in the most cost-effective setting.[20]

A key part of the waiver request also focuses on public health initiatives. The state deserves credit for the proposal, which deals with underlying conditions of such chronic diseases as diabetes, cardiovascular disease and asthma, including tobacco use, poor diet, limited physical activity and obesity.

"Effective integration of community-based public health . . . will promote population health and reduce systemic costs, including Medicaid costs of care and treatment," New York argues in its waiver submission.[21] The DOH also notes that: "public-health prevention measures, particularly funding services rendered by paraprofessionals, [have] not traditionally been eligible for reimbursement by Medicaid."[22]

A number of concerns and hurdles must be overcome in the MRT plan beyond addressing the need for a greatly expanded patient role, these are addressed in Appendix A. Yet the success of New York's Medicaid reform plan depends not only on federal support in solving those issues but also on cultural shifts in the way Medicaid is viewed by all involved: insurers, providers and patients.

While many MRT recommendations, including cost containment initiatives, shift responsibility to payers and providers, insufficient attention is given to opportunities to contain cost through patient incentives and patient responsibility. Incorporating patient incentive programs as well as personal responsibility into Medicaid reform will add value, produce important new data and, if successful, assist in both reducing costs and achieving better health outcomes.

A Primer on Medicaid

Medicaid is a means-tested health and medical services program for certain individuals and families with low incomes. Oversight of the program is handled at the federal level, but each state develops a plan submitted to the Centers for Medicare & Medicaid Services (CMS) that does the following:

- Establishes its own eligibility rules
- Determines the type, amount and scope of services it will include
- Sets payment rates for provided services
- Defines how it will administer its program

Although states have the final voice over what their Medicaid plans provide, a number of federally required services must be included in order to receive federal matching funds. Among them are inpatient and outpatient hospital services, physician services, early and periodic screening for children under 21, nursing facility care and home care services for those eligible for skilled nursing care. States may also choose among 34 optional services and receive matching funds for those they elect to offer.

New York basically splits[a] the projected $54 billion cost of Medicaid evenly with Washington under what is known as the Federal Medical Assistance Percentage (FMAP).[b] Unlike most states, a portion of New York's non-federal share of Medicaid spending is passed on to county governments.[c]

Medicaid has been growing rapidly over the years in both numbers served and costs crowding out spending for other important programs. Further large changes are in store as the program's rolls increase because of provisions in the Patient Protection and Affordable Care Act (PPACA), beginning in 2014.

[a]Together the state and local share of Medicaid (the non-federal share) totals more than 50 percent. According to DOB, the combined state and local share of $29.86 billion currently exceeds 50 percent of total Medicaid costs due to the Comptroller classifying approximately $3 billion of federal Medicaid dollars that support the Mental hygiene system as state funds instead of federal. http://publications.budget.ny.gov/eBudget1213/financialPlan/FinPlan.pdf, page 61 chart, footnote 1.
[b]For FY2011, regular FMAPs – that is, excluding the impact of a temporary increase under the American Recovery and Reinvestment Act – range from 50.00 percent to 74.73 percent depending on various wealth and population factors. New York receives a 50 percent FMAP.
[c]Division of Budget July Update, the Financial Plan reflects the following shares of spending for FY2013: All Funds - $54.1B, State – 21.8B, Local - $8B, Federal - $24.2B.

Implications of the Supreme Court's Health Care Decision

Although the recent Supreme Court ruling upholding the Patient Protection and Affordable Care Act (PPACA) will have no direct bearing on New York's waiver submission, it does have implications for the broader Medicaid program and New York's implementation of a state health insurance exchange.

The Supreme Court ruled that the act's controversial individual mandate, which requires everyone to purchase health insurance, was constitutional. The justices didn't uphold the mandate as a matter of regulating commerce, but as a tax penalty imposed on those who refuse to purchase coverage through state or federal health insurance exchanges.[a]

This decision, even though inspiring a new controversy, allows New York to proceed with the implementation of its health insurance exchange, created by Executive Order on April 12, 2012.[b]

The individual mandate presumes that young, healthy New Yorkers will purchase insurance through the exchange, helping to offset the higher insurance costs of older, less healthy purchasers. Insurance companies hope as well that the exchange brings them previously uninsured customers for whom they will receive federal subsidies through tax credits to offset part of the new premium costs.

PPACA also relies greatly on Medicaid expansion as a foundation for covering more of the uninsured. The numbers added to Medicaid nationally have been estimated at just over 20 million, with as many as 1.1 million in New York, including 100,000 people newly eligible for coverage and 1 million others currently eligible but not enrolled.[c]

However, in another part of its ruling, the Supreme Court struck down the PPACA section allowing the Centers for Medicare & Medicaid Services (CMS) to withhold a state's full share of federal Medicaid funding if it did not implement the act's mandatory Medicaid expansion provisions. The justices found this section to be coercive.[d]

Nonetheless, New York appears ready to move forward with Medicaid expansion. The state already enrolls many of those made eligible under PPACA and therefore will receive some enhanced matching funds, beginning in 2014.[e] Also, failing to go forward with the PPACA Medicaid expansion would likely jeopardize CMS approval of New York's waiver.

But numerous other states may opt out of expanding Medicaid due to concerns about the long-term costs that they would have to share. New York, however, is "betting the house" on being able to compensate for increased costs through savings generated by its Medicaid redesign.

[a] Supreme Court of the United States, October Term 2011, Syllabus, National Federation of Independent Business et al. v Sibelius, Secretary of Health and Human Services et al.
[b] Sykes, Russell, NY Daily News, "What the Obamacare Ruling Means for New York State," June 28, 2012, http://www.manhattan-institute.org/html/miarticle.htm?id=8288#.UFc0xKRYuG4
[c] Holahan and Blumberg, The Urban Institute, "How Would States Be Affected by Health Care Reform," August 2010, page 2 and chart page 17
[d] Supreme Court Ruling NFIB et al. v Sibelius et al.
[e] Henry J. Kaiser Family Foundation, Focus on Health Reform, "Summary of New Health Care Reform Law," 2010, pages 1-2, Treatment of Medicaid

3. WHY EXPERIMENT WITH MEDICAID INCENTIVES

The federal welfare reform act of 1996 focused on personal responsibility and work by creating the Temporary Assistance for Needy Families (TANF) program.

TANF provides incentives in the form of so-called earnings "disregards," which enable working households to keep more of their welfare benefit until they reach a higher level of income. It also allows states to offset the costs of various work supports with TANF block grant funds including refundable tax credits, like the Earned Income Tax Credit (EITC), which promotes and rewards work.[23] Other incentives include guaranteed access to child care for children up to age 13 and case managers who assist clients with finding employment and addressing multiple other issues.

Just as it did with welfare reform, New York should play a leadership role in consumer-driven health care by focusing in a much broader fashion on linking benefits to patient incentives and responsibilities. With 62 counties, New York is a veritable testing ground in which to experiment and learn and, in the end, create a better and more cost-effective Medicaid system that best utilizes incentives as a tool to complement major reforms.

Experimental and behavioral economics are relatively new fields. (See sidebar, "New Insights from Behavioral Economics," on page 9.) What is known so far is that incentives can be complicated to design and manage. Therefore, policymakers should be diligent when designing programs to ensure the best possible chance of success. A recent study of multiple behavioral health incentives found that more than 70 percent of the programs worked.[24]

New York should learn from its own modest efforts as well as from programs tried elsewhere. In the initial stages of any incentive design, policymakers should first look to other programs that have been tried and study the measures of their performance. New experiments can be entertained, but must include real-time evaluation components to know when to alter or abandon them.

The most pragmatic course is to design a series of small policy experiments, and where there are successes, scale-up those programs so that only programs that have measured success receive more public resources for expansion.

A well-designed incentive would make the patient responsible for seeking earlier and appropriate health care. New York's Medicaid program, unlike the TANF program, currently expects little of patients on this front, thus resulting in more expensive reactionary care rather than cheaper preventive care.

Under a new system, care coordinators would stay in continuous contact with managed care patients and use various tools to teach them the importance of primary preventive care and to direct them to needed services. Incentives to practice healthy behaviors need to be expanded and wellness programs must become a mandatory component of Medicaid managed care, along with a requirement to follow prescribed treatment plans.

Given the fiscal unsustainability of many programs, tying program benefits to goals for individual improvement makes sense, just as it did in TANF. KPMG notes:

> . . . open-ended benefit programs are becoming increasingly unsustainable in an era of deficit reduction. Tying economic supports to other social goals, such as employment engagement or steps towards improved health and well being, can leverage the core investments made.[25]

Another concern is that Medicaid patients have no financial investment in their care. Unlike other insured populations, they don't even receive statements showing the cost of procedures that are provided.[26] Co-payments are either non-existent or very limited for most services.[27] Other than in the long-term-care area for the elderly, blind and disabled, there is no liquid asset resource test for Medicaid eligibility in New York.[28] Those most impoverished likely have few assets, but others may, and could be expected to make minimal premium contributions toward the cost of their care.

Concerns about cost sharing include that it can limit access to care. But cost sharing if thoughtfully employed can add value. Under the Patient Protection and Affordable Care Act (PPACA), states can use value-based insurance designs (VBID) in public programs like Medicaid, as well as for private insurance available on state-based health insurance exchanges. VBID utilize targeted (for specific populations) or non-targeted (general populations) financial incentives to encourage utilization of services (like preventive care or smoking cessation programs) or therapies (prescription drugs for chronic illnesses) that have high clinical value and to discourage utilization of services with low clinical value (such as utilizing the emergency room for non-urgent care).

New Insights from Behavioral Economics

The emerging field of behavioral economics is providing new insights into the psychology of judgment and choices. This approach could have major applications in Medicaid, by supplementing the program's insurance model, which has not greatly improved health outcomes.

Behavioral economics research suggests that equal focus should be placed on patient behavior. The approach stresses self-management of health care but also addresses problems in the provision of care and in the context in which health care choices are made. A central theme in recent research is that choices may be made against interest if they are reached when the decision maker/patient is under immediate financial strain, subject to information or emotional overload, unable to plan for the future or presented with choices that seem inconsistent with personal identity or have potential outcomes expressed in unfamiliar terms.

Practitioners of behavioral economics are increasingly finding that small changes in the applicable process or the decision-making context can markedly improve the decisions that are reached. Two pieces in the still-growing body of literature on behavioral economics are noted here.[a,b]

[a] Barack D. Richman, "Behavioral Economics and Health Policy: Understanding Medicaid's Failure," 90 Cornell Law Review, 705-768, (2005), http://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=2302&context=faculty_scholarship
[b] Digital Access to Scholarship at Harvard (DASH), Bertrand, Mullainathan and Shafir, 2006, "Behavioral Economics and Marketing in Aid of Decision-Making Among the Poor," Journal of Public Policy and Marketing 25(1):8-23, http://dash.harvard.edu/bitstream/handle/1/2962609/behavioral%20economics%20and%20marketing.pdf?sequence=2

VBID is a growing tool in the private insurance market. Large employers like Pitney Bowes have waived or lowered drug copays for employees with chronic diseases like diabetes and asthma, or who were at high-risk for heart disease. Such approaches have been associated with lower health care costs and reduced emergency room utilization.

New York's Medicaid program should consider allowing health plans to tailor VBIDs that offer different copays and benefits for specific populations based on their health status and income, improving engagement with evidence-based health management strategies. There is legitimate concern that some copays discourage appropriate care utilization and worsen health outcomes, particularly for low-income populations. But plan performance can be monitored based on the Health Care Effectiveness Data and Information Set measures to ensure that VBID designs improve patient health and lower costs compared to traditional Medicaid fee for service.

The Need to Address Chronic Health Care Problems and Spending

As discussed in the next section, New York's new $2 million grant under the Medicaid Incentives for the Prevention of Chronic Disease program (MIPCD) is a small step in the right direction. The MIPCD program will explore the effectiveness of incentives provided directly to Medicaid patients to change behavioral patterns and manage existing conditions.[29]

Because so much of the current cost and future increases in Medicaid expenses are tied to patients with chronic conditions, New York's modest incentive and disease management plans are not up to the task. As noted earlier, to lower costs and improve health outcomes, the state's integrated redesign can identify further opportunities to incentivize healthy behaviors and hold patients responsible for managing their care.

New York's modest incentive and disease management plans are not up to the task.

National data highlight the significant incidence and costs of chronic disease in Medicaid. Tobacco-related diseases disproportionately affect Medicaid recipients, as smoking is approximately 53 percent more prevalent among that group compared with the overall U.S. adult population.[30]

The twin crises of obesity and diabetes continue to worsen across America. In 2009-10, over 78 million adults and about 12.5 million children and adolescents were obese. This represents more than one-third of all adults and nearly 17 percent of youth.[31] Recent studies show a direct correlation between the consumption of sugar-sweetened beverages on childhood obesity, particularly among low-income households.[32]

The higher incidence of obesity translates into significant health-related costs at both the federal and local levels. In 2000, the total cost of obesity in the United States was estimated to be $117 billion.[33]

By 2020, an estimated 52 percent of the adult population will have diabetes or pre-diabetes, a new study has found. It estimates that health spending associated with diabetes and pre-diabetes is about $194 billion this year, approximately 7 percent of total U.S. health spending. That cost is projected to reach $500 billion by 2020.[34]

New York data reinforce the national data. New York's prevention quality indicators and readmission data for conditions such as hypertension and diabetes indicated major challenges in the management of chronic disease.[35]

The incidence of chronic diseases among New York's Medicaid recipients is troubling from both a health and cost perspective:

- In 2007, the state's Medicaid costs for cardiovascular-related problems were estimated as follows: heart disease - $528 million, hypertension - $1.7 billion, stroke - $1 billion and congestive heart failure - $234 million.[36]
- Twelve percent of all adults are estimated to have diabetes (376,000 individuals) with another 720,000 beneficiaries diagnosed with pre-diabetes.[37]
- More than 31 percent of enrollees smoke, resulting in tobacco-related health-care costs of approximately $5.4 billion. Smoking during pregnancy continues at high rates: more than 19 percent of women were identified as smokers in a medical chart review study conducted on a sample of Medicaid births in 2009. Since Medicaid pays for 47 percent of all births in the state, this translates into potentially more than 13,000 infants born to Medicaid mothers who smoked during pregnancy.[38]
- Hypertension, also greatly affected by obesity, lack of exercise and tobacco usage, is a major risk factor for cardiovascular disease, the leading cause of death in New York. Approximately 800,000 Medicaid beneficiaries have hypertension and up to 420,000 others may be undiagnosed. It is estimated that the cost of treatments associated with hypertension could be as high as $1 billion.[39]
- The mental health system serves more than 600,000 people and accounts for about $7 billion in annual expenditures. Substance-use disorders affect more than 250,000 beneficiaries and account for about $1.7 billion in expenditures annually.[40] There is a high incidence of co-occurring chronic diseases among these populations -- incentives and treatment plans could be employed for those in community-based settings.

Overview of Existing Incentives and Requirements

States are increasingly exploring ways to educate patients, promote wellness and increase the use of primary preventive care through cash or related incentive payments, stressing patient responsibility for disease management and the need to follow treatment plans. In some instances, these efforts are coupled with the offer of enhanced levels of coverage in return for patient cooperation.[41] The goal is to reduce costs among Medicaid patients due to chronic medical and behavioral conditions.

Incentives and patient-directed approaches to transform health systems have also been used effectively in other countries. Most notable have been efforts in Mexico, where the Oportunidades Rewards Program pays participants to change their behavior, including getting medical checkups for children and attending prenatal clinics.[42] An evaluation component has linked the rewards to substantial improvements in the program.[43]

Many other countries in Latin America, as well as in Asia and Africa, have implemented versions of this largely successful conditional cash-transfer program.[44]

Singapore has a health system based almost entirely on personal budgets, financed via mandatory HSAs and payment from earnings. It also promotes greater patient ownership of care.[45] With a population of 5 million, Singapore has a strong safety-net program akin to Medicaid for the very poor and has been widely praised as a potential model for replication, although some question whether its system can operate on a larger scale.[46]

Within Medicaid itself, a public-private demonstration program for community based long-term-care services for the elderly and disabled called "cash and counseling" has demonstrated success. Designed by the Robert Wood Johnson Foundation, the Department of Health and Human Services and CMS, the program was piloted in 1996 in Arkansas, Florida and New Jersey, and adopted subsequently in 11 other states. It allows the patient to control expenditures for personal care with the help of a case manager. A fixed spending plan is developed and paid prospectively to the consumer, who then makes the health care decisions and the payments, including care giving provided by relatives in many cases.

Evaluation of the program has shown that unmet needs have been reduced, health outcomes in several areas have improved and the quality of life for both patients and caregivers has increased. Slightly higher personal care costs were somewhat offset by the reduction of costs for institutional and other long-term-care, showing that the careful monitoring of a program's design can effectively hold down costs.[47] New York does not operate a cash-and-counseling program -- legislation to create such a program in the state was passed in 2008-09, but vetoed by then-Governor Eliot Spitzer.[48]

Utah has just been granted waiver authority for a new Medicaid wellness program.[49] Wisconsin implemented a Healthy Living component of its Badger Care Plus Medicaid Managed Care program in 2008 to test cash incentives designed by different state health plans in five pilot sites and implemented a voluntary member pledge that Medicaid recipients can sign in agreeing to practice healthy behavior.[50] Pennsylvania has recently floated, but not yet implemented, the concept of a reverse HSA incentive that would share projected savings from avoiding costly procedures with patients.[51]

Florida, Idaho, Indiana and West Virginia have all implemented patient incentive and responsibility programs that are discussed in the next section. West Virginia, for example, has developed a mix of incentives and compliance requirements by offering two separate plans: a basic plan and an enhanced plan, in which only patients who demonstrate compliance with healthy behaviors can enroll.

Ten states, including New York, have been awarded grants under the new Medicaid Incentives for Prevention of Chronic Disease (MIPCD) program, which is intended to offer rewards to beneficiaries who manage high-blood pressure, diabetes and weight issues. A broader incentive program, Opportunity NYC, was implemented by New York City Mayor Michael Bloomberg in 2007 in a three-year trial (Opportunity NYC is discussed further in the next section).

In the private sector, employers and insurers are increasingly offering wellness programs. For example, Safeway, AmeriGas and IBM offer premium discounts to employees who practice good health habits.[52] North Shore Long Island Jewish Health

Services, a major health and hospital organization on Long Island both there and in New York City, has been rated one of the top 100 places to work nationally, partly because of its wellness programs and bonus incentives to employees for seeking preventive medical care.[53] Capital District Physicians' Health Plan (CDPHP), a major insurer in upstate New York, offers wellness programs and bonuses for participation in fitness, nutrition and weight management programs[54] (CDPHP is discussed further in the next section).

As many of these incentive programs are still very new, their effectiveness has not been fully measured. Some analysts claim the programs have helped direct patients into more appropriate care settings, increased positive health outcomes and saved money.[55] Others say that the major health cost drivers stemming from tobacco use, poor nutrition and obesity and diabetes have deeper roots in socio-economic issues and that incentives, while perhaps helpful in encouraging the use of preventive care, are unlikely to have a major impact on more serious conditions.[56]

In 2004, the federal Agency for Healthcare Research and Quality stated that incentives could be effective in the short run for simple preventive care, but that insufficient evidence exists about their impact on long-term lifestyle changes.[57]

That same year, a University of Minnesota report reviewed 47 studies assessing the effects of economic incentives on consumers' preventive-health behaviors. It found that incentives that helped purchase preventive services were more than 70 percent effective in both simple and more complex preventive health areas, the latter requiring a sustained behavior change. [58]

Health promotion programs have also shown promise for employers and employees in work-site efforts.[59] Successful ones can provide models for similar efforts in Medicaid.

Patient misunderstanding was cited as a problem in some state programs. In many instances, beneficiaries did not pursue the incentive rewards while others accumulated them but didn't use them.[60] The confusion, which extended to providers, was often due to a lack of public education about the programs and to complex rules and procedures.

Such concerns can be addressed and factored into the design of new approaches. The Center for Health Care Strategies, a nationally respected public policy organization, offers four key lessons for states considering incentive programs as part of their overall approach to Medicaid reform and cost containment:

- develop a comprehensive education approach that recognizes the literacy level of consumers and provides information through multiple channels;
- provide community partners with information to help educate consumers about the incentive program and respond to questions;
- recognize that Medicaid consumers often face other barriers to participating in incentive programs (notably transportation and cost) and design interventions to address those barriers; and
- develop systems to collect data on consumer participation in programs fostering changes in lifestyle behavior.[61]

Additional elements required for success include:

- Primary care capacity must be expanded to ensure sufficient preventive care and wellness options – resulting savings could be shared with successful providers.
- Available incentives and expected behavior must be clearly explained to both patients and health care providers.
- Patient education and outreach have to be available on an ongoing basis.
- Incentives must be well designed and flexible.
- Pilot programs must be quickly evaluated.
- Patient rewards for success must be simple, understandable and quickly attainable so that their link to healthy behavior is clear.
- Requirements and consequences for non-compliance must be made equally clear.
- Incentives must be flexibly designed, allowing for changes as programs develop and lessons are learned.

As Medicaid reform moves forward in New York and around the nation, further experimentation with incentives and patient responsibility should be undertaken. As noted in a recent Kaiser Health News article:

> Research is scant on the effects of incentive programs on mitigating chronic diseases ... Few behavioral studies have attempted to determine whether people who receive the incentives are able to maintain their short-term success long term -- the ultimate goal of an incentive-based prevention program.[62]

4. A DEEPER LOOK AT INCENTIVE PROGRAMS

A variety of programs have been instituted around the country in recent years with the goal of changing behaviors that affect patient health and shifting more responsibility for care management to patients. Programs of this nature have been instituted by federal, state and local government agencies as well as by employers and private insurers. Some have involved Medicaid patients. All offer possible lessons to New York and the state's proposed redesign of its Medicaid program. The following section describes some of the leading programs.

Lessons from Opportunity NYC

Opportunity NYC, a cash incentive program to reward healthy behaviors and other positive client actions, was launched in 2007 by New York City Mayor Michael Bloomberg. The three-year trial, modeled after Mexico's successful Oportunidades program, tested the effect of economic incentives among those in poverty, comparing randomly enrolled clients against a control group that did not receive incentives. Rewards were offered for pre-specified activities and subsequent outcomes in children's education, family preventive health care and parents' employment.[63]

A preliminary evaluation of the first 18 months of the program focused on a randomized control trial involving 4,800 families and 11,000 children in six low-income sections of the city.[64] In the area of health care, so-called Family Rewards were offered for maintaining health insurance coverage for parents and their children and seeking appropriate preventive medical and dental checkups for all family members. Health incentives are detailed in Table 1 below.

Table 1. Annual Incentives from Opportunity NYC

Maintaining public or private health insurance (discontinued after Year 2)	
For each parent covered, public	$240
For each parent covered, private	$600
If all children are covered, public	$240
If all children are covered, private	$600
Medical checkup, per family member	$200
Doctor-recommended follow-up visit, per family (discontinued after Year 2)	$100
Early-intervention evaluation for child under 30 months old, pediatrician advised	$200
Preventive dental care for each child 1-5 years old	$100
Preventive dental care for each family member >5	$200

Source: Opportunity NYC/Family Rewards, "Towards Reduced Poverty Across Generations: Early Findings from New York City's Conditional Cash Transfer Program"

MDRC Inc., the organization contracted with to evaluate the program, concluded:

> The evidence so far suggests that Family Rewards produced a number of impacts on some important health indicators, even if only by a small amount ... For example, it increased the maintenance of health insurance coverage for participants who were not receiving TANF or SNA (Safety Net Assistance),

> increased the use of preventive dental care, reduced emergency room-based health care, reduced the reported number of health care needs that were not met because of prohibitive costs, and produced a significant shift in the perceived health status of the program group relative to the control group. This general pattern of positive findings was evident for both adults and children.[65]

A fuller outline of the impact on health measures of the Family Rewards program appears in Appendix B of this report. Further evaluation of the longer-term benefits of the program over its full duration will be conducted.

The MIPCD Grant Program

As part of the Patient Protection and Affordable Care Act, CMS created the Medicaid Incentives for Prevention of Chronic Disease (MIPCD) grant program, which will provide $85 million over five years in grants to states, including New York.[66] Those receiving the grants will use the funds to design incentive programs that reward Medicaid beneficiaries for pursuing certain healthy behaviors and participating in prevention programs. Patients with existing chronic health issues will receive rewards for participating in disease management programs.

Incentives to Medicaid beneficiaries of all ages would be provided to address at least one of several prevention goals: giving up smoking, controlling or reducing weight, lowering cholesterol, lowering blood pressure and avoiding the onset of diabetes.[67] In the case of a diabetic, the goal would be to improve management of the condition.

One of just 10 states to receive a grant, New York will use its $2 million award to fund MIPCD programs in the western part of the state and in New York City, a positive step in transitioning toward incentivizing health care. The states receiving grants are shown in Table 2 on pages 18 and 19.

New York's program will focus on 16,000 to 18,000 enrolled adult Medicaid beneficiaries, providing direct cash payments or lottery tickets to get them to quit smoking, lower high blood pressure and manage or prevent diabetes. Requests for proposals (RFPs) went out in New York in May 2012.[68] Appendix C provides a further account of the New York MIPCD program.

To study the program's effectiveness, incentives will be offered to three treatment groups but not to a fourth control group. CMS and DOH will monitor the program, using a rapid-cycle evaluation process that involves frequent analysis and sharing of data and collaboration among the grantee states to glean lessons.[69]

That evaluation will be important to making any mid-course corrections in the incentive structures as well as understanding effectiveness and potential for expansion.

The Florida Approach

In 2006, Florida's Agency for Health Care Administration established the Enhanced Benefits Rewards Program (EBRP) as part of its broader Medicaid reform efforts. EBRP provides up to $125 annually to patients for various healthy behaviors ranging from keeping appointments and getting screenings to disease management efforts.[70]

The pilot program was initiated in five Florida counties.[71] Incentives were offered as purchase credits that could be redeemed at participating state pharmacies for various state-approved health products.[72]

The state Legislature's Office of Program Policy Analysis and Government Accountability analyzed the program and found that Florida spent $2.17 million on administrative costs in the first two years and that 190,000 Floridians had earned credits totaling $13.8 million as of April 2008.[73]

Both recipients and participating providers were highly enthusiastic about the incentives. However, only 11.4 percent of the credits, or $1.6 million, were redeemed during that initial two-year period, thanks to an overly complex program design -- which made the monthly reward statements difficult to understand -- and because of insufficient communication about the program's rules and redemption process.[74]

The redemption rate has increased sharply since then, due to better client education efforts, grass roots outreach and improvements in the monthly mailings. The establishment of a call center to field questions has also helped. As of June 2012, cumulative credits totaled $53.8 million, with more than half, or $29.1 million, redeemed for allowable purchases. [75]

More analysis of the Florida findings will be forthcoming and lessons may still be learned from the program. However, Florida may be moving away from the benefit program, instead requiring Medicaid managed care plans to include a weight-loss component, tobacco cessation efforts and substance abuse treatment.

Idaho's Use of Incentives

Within its own broader Medicaid reform efforts, Idaho created the Preventative Health Assistance (PHA) benefit, coining, "It pays to stay healthy." The Wellness PHA is aimed toward children, while the broader Behavioral PHA targets adults and families.[76]

Through the Wellness PHA, participating parents with incomes between 134 and 185 percent of the federal poverty level invest in their children's health by paying a small monthly premium, but can earn up to $120 per year, through a point system, to offset those costs.

Points are earned for staying current on immunizations and well child visits, among other things. Heads of households are informed of points earned on monthly billing statements. Those not up to date with expected point levels, and therefore not earning enough to pay the premium, are alerted and told that they risk disqualification from receiving offsets until they comply.

The idea was not to deny coverage, but rather to increase participant responsibility for paying for children's health care and for pursuing good health habits. When sufficient points are earned, premiums are offset fully for those paying the $10 monthly premium or by two-thirds for those paying $15 monthly. Table 3 details both maximum and minimum premium amounts under this program.

Table 2. Medicaid Incentives for the Prevention of

State	Amount	Goals	Available Incentive
California	$1,541,583	Increase tobacco cessation among Medi-Cal beneficiaries in general and specifically among those with diabetes.	• Medi-Cal members will be offered a $20 incentive to call the Helpline, complete the intake protocol and participate in counseling sessions. • Free nicotine replacement therapy patches by calling the Helpline. • Eligible beneficiaries will also receive $10 for every relapse-prevention call they complete. • After the first year of the program, eligible beneficiaries who enrolled previously and did not quit or relapse may receive $5-40 to re-enroll.
Connecticut	$703,578	Reduce smoking rates among the estimated 25-30 percent of Connecticut Medicaid recipients who currently smoke.	• Incentives for counseling and using the Quitline range from $5 to smokers for each counseling visit or call to $15 for a negative CO breathalyzer test and for attending five counseling sessions.
Hawaii	$1,265,988	Improve early detection of diabetes among individuals at high risk and improve self-management for those with diabetes.	• $20-valued incentive for compliance with strategies recommended by the American Diabetes Association (such as blood tests, eye examinations and immunizations) to prevent, treat and manage the disease. • $25-valued incentive for patients who go to the first session of smoking cessation, behavioral health counseling and diabetes education. • The program will pay Community Health Centers and private providers up to $200 per patient for providing supplemental services for diabetes education, goal setting and referrals to services that will help break down barriers to improving health.
Minnesota	$1,015,076	Boost weight loss as a primary step toward long-term goals of reduced incidence of diabetes, improved cardiovascular health and reduced health-care expenditures.	• Incentives valued between $10 and $50 for participation, goal attainment and maintenance. • Additional incentives to participants in the "group incentives" group if the entire class meets participation or weight-loss goals. • Support will be provided to address barriers to participation, including transportation to the sessions and meals and child care during the sessions. • Health-related incentives, such as vouchers for use at farmers' markets, exercise equipment or health food cookbooks.
Montana	$111,791	Reduce weight, reduce lipid and blood pressure levels and prevent type 2 diabetes among adult Medicaid beneficiaries at high risk for developing cardiovascular diseases and diabetes.	• Tiered and incrementally increasing financial incentives will be offered during the course of the intervention to promote the essential behaviors to achieve weight loss. • Participant self-monitoring and reduction of fat and caloric intake. • Participant monitoring and achievement of more than 150 minutes of moderately vigorous physical activity per week.

Chronic Disease Grants to the States

State	Amount	Goals	Available Incentive
Nevada	$415,606	Control or reduce weight, lower cholesterol, lower blood pressure and avoid the onset of diabetes in those at risk or improve the management of those already diagnosed.	• Diabetes self-management education for adult Medicaid fee-for-service (FFS) beneficiaries. • Participation in the YMCA's Diabetes Prevention Program (YDPP) for those identified as high risk for developing type 2 diabetes. • Participation in a weight management program and support group for beneficiaries with a body mass index of 30 or greater. • Individualized nutritional counseling with a registered dietitian; physical fitness assessment and exercise program overseen by a physiologist; and one-on-one counseling and motivational coaching with a psychologist for children at risk of heart disease.
New Hampshire	$1,669,800	Increase exercise, improve nutrition and increase smoking cessation to reduce risk of cardiovascular disease.	• Participants will receive vouchers for community fitness centers and formal weight-loss programs. • Incentives for beneficiaries who get help to quit smoking. • Half of participants in both the weight loss and smoking cessation programs will get monetary incentives for healthy lifestyle behaviors.
New York	$2,000,000	Increase smoking cessation, lower high blood pressure, prevent diabetes onset and enhance diabetes self-management.	• An estimated 18,456 participants will be recruited, including 13,842 who will receive incentives under varying schedules and 4,614 who will not receive incentives. • NYS DOH expects to pay an average of $115-$122 in incentives per participant assigned to an incentive arm.
Texas	$2,753,130	Improve health self-management, increase use of preventive services and more appropriate use of health care services.	• A flexible spending account will be offered for wellness-related expenses.
Wisconsin	$2,298,906	Significantly reduce smoking among the state's adult BadgerCare Plus (Medicaid) population.	• Cash incentives contingent upon participation in treatment and meeting smoking cessation goals. • Participants in the control group receive treatment only, while those in the experiment group receive treatment and cash incentives. • Quit Line participants receive up to $350 in incentives over 12 months, while First Breath participants receive up to $595 over the course of their pregnancy plus 12 months post-partum.

Sources: CMS, states receiving MIPCD awards, http://www.innovations.cms.gov/initiatives/MIPCD/states-awarded.html

Table 3. Idaho's Wellness PHA Incentives				
Rate of Poverty Level	Monthly Premium	Annual Premium	Maximum Annual Points	Minimum Annual Premium
Between 134-149%	$10	$120	120	$0
Between 150-185%	$15	$180	120	$60

Source: Greene, Jessica, Center for Health Care Strategies, Inc. Resource Paper, "Medicaid Efforts to Incentivize Healthy Behaviors", July 2007, University of Oregon.

Preliminary results show the program was successful. According to a 2010 study of the Idaho results:

- The percentage of child enrollees who lost Medicaid coverage dropped from at least 15 percent before the introduction of the PHA benefit to 4 percent in 2008 and 1 percent in 2009, or only 100 children. [77]
- By February 2010, more than 20,000 children had earned compliance points, which have been used in turn to offset $1.5 million in premiums.[78]

The finding that resonates is that in Medicaid, as has been shown in other programs like TANF and food stamps, the great majority of beneficiaries will comply with requirements rather than risk losing benefits.

A follow-up study stated:

> The new wellness incentives introduced in Idaho appeared to increase rates of well-child care by a substantial amount among the children targeted by the incentive ... The automatic redemption of rewards (i.e. premium offset) in Idaho's program may be a unique feature, which contributed to its success.[79]

The broader Behavioral PHA program stressed exercise, weight control and tobacco cessation. Working with community partners, Idaho gave participants vouchers worth up to $200 annually that could be redeemed for health education and memberships in fitness programs and for supplies and over-the-counter smoking cessation medications.

At the time of enrollment, Idaho Medicaid beneficiaries fill out a brief health questionnaire. Participants five years or older expressing an interest in weight control (because their body mass index indicates they are either underweight or obese), exercise or quitting smoking can enroll in a fitness and weight management program or a program to stop smoking, but not both. The $200 they could earn in vouchers under either program must be used to purchase products that help reach the program's goals.

In 2009, again according to Idaho health officials, 1,061 adults and children were enrolled in the weight management program and 361 in the tobacco cessation program. Preliminary results of a small participant survey indicate some success in both areas.[80]

West Virginia's Carrots and Sticks

West Virginia's plan, started in 2007, mixes incentives with patient responsibility by offering enrollees an enhanced benefit plan through the Mountain Health Choices Program. This plan is limited to those who sign an agreement pledging to pursue certain behaviors, including keeping medical appointments, adhering to treatment plans, taking

prescribed medications and limiting emergency room visits. The pledge must be signed in a face-to-face visit with a primary-care provider at which health issues are discussed and an individualized plan is developed.[81]

The enhanced benefit plan provides services not previously available under Medicaid, including tobacco cessation, weight counseling, cardio and pulmonary rehabilitation, nutrition counseling/fitness services and additional access to prescription drugs. Enhanced benefits can be taken away if those enrolled do not comply with the membership agreement.

Evaluation of the West Virginia model based in part on surveys of more than 1,000 clients, showed that:

- Of the 162,000 Medicaid recipients eligible for the enhanced plan, just over 23,000 had signed up as of August 2009 -- confusion and misunderstanding about the program, lack of aggressive enrollment efforts and some difficulty in scheduling the required in-depth physician review were cited as reasons for the gap.
- Those enrolled in the enhanced plan like it, but worry about potentially losing its additional benefits – which 80 percent of responding adults felt they needed.
- Adults enrolled in the enhanced plan visited their doctors twice as often as those in the basic plan and children in the enhanced plan 60 percent more than those in the basic plan.
- Cited as particularly important under the enhanced plan are the ability to get more than four prescriptions monthly, the weight loss program and the tobacco cessation program.
- Members in the enhanced plan also cited the importance of various information sources and communications (mailings, phone calls and the availability of pharmacists, caseworkers and doctors).[82]

Further evaluation of the enhanced benefit plan is needed to determine if it is improving health outcomes and if the reason members have more contact with their physicians is because they have greater medical needs or because they are more engaged in their care.

The Healthy Indiana Plan – Health Savings Accounts

Indiana, with federal waiver approval, launched its Healthy Indiana Plan (HIP™) in 2008. Those eligible to join were uninsured parents with incomes below 200 percent of the federal poverty level and without access to employer-based coverage.[83] The federal government pays for 74 percent of HIP™ costs and Indiana pays the remainder, predominantly from cigarette tax revenues.[84] HIP™ also imposes modest co-payments for non-emergency use of ER services, which has led to a decrease in such usage among participants.[85]

HIP™ was the first waiver program approved by CMS that was based almost exclusively around a consumer-driven plan in which patients took much more control of their care. The three key components are:

- an HSA, called a Personal Wellness and Responsibility Account (POWER), with a provision allowing for annual rollover of unspent balances as long as a member has received qualified preventive services;

- an $1,100 annual deductible, shared by the state and the enrollee, based on a sliding scale of ability to pay; and
- free preventive services like physical exams, flu shots and cholesterol testing.[86]

A two-year evaluation of the program required by the Indiana waiver and overseen by CMS noted that:

- The program has been well received and there is a high level of satisfaction among members.
- Enrollment in HIP™ has been strong and the majority of members stay enrolled -- only 26 percent have left.
- Seventy percent of enrollees have incomes below the federal poverty level.
- More women (63 percent) than men (37 percent) enroll.
- Enrollees tend to be older and therefore eligible for Medicare sooner.
- Enrollees have a higher level of chronic conditions than the general Medicaid population.
- Only 3 percent of the nearly 62,000 enrollees were disqualified from HIP™ for not making their mandatory monthly contributions to the POWER account.
- Most HIP™ members visit physicians -- 91 percent in the first year -- and get the preventive care services required under HIP™.[87]

A subsequent survey found the following: more than 99 percent of HIP™ members would re-enroll in the program; 80 percent of members completed their preventive services requirement for their POWER account rollover; members have lower non-emergency ER usage than the traditional Medicaid population; members have higher generic drug use than comparable commercial populations, and 97 percent pay their required contributions on time.[88]

In 2010, Indiana passed legislation identifying HIP™ as their chosen coverage vehicle for the newly eligible Medicaid population under the PPACA. This legislation also added a requirement for enrollees to make a minimum contribution to their POWER account of $160 annually (but no more than 5% of their income) and allowed both non-profits and managed care entities to pay a portion of members' required POWER account contribution to incentivize positive health habits.[89]

The findings about HIP™ and the Power accounts are promising. Planned additional evaluation of the program will focus on financing, utilization patterns and healthier patient outcomes, all of which can inform experimentation and replication efforts elsewhere. However, the HIP™ waiver expires at the end of 2012 and the waiver extension submitted in late 2011 to run HIP™ for another three years was denied. CMS has been willing to approve only a one-year extension through 2013 in spite of customer satisfaction and an excellent evaluation.[90]

Indiana had planned to use the HIP™ model for potential Medicaid expansion under PPACA. However the CMS action leaves the future of the Healthy Indiana Program and the POWER accounts in potential jeopardy in spite of the program's innovative approach and positive outcomes.[91]

Capital District Physicians' Health Plan

Private insurers, like government, are also looking at utilizing patient incentives to promote better health. Healthy, long-term customers are better for a company's bottom line than short-term customers who consume expensive health services.

Progressive Auto Insurance offers a discount to drivers who install the company's Snapshot tool, which monitors all driving activity. If the tool determines that you are a safe driver, you get the discount.[92] Just as auto insurance tries to incentivize safe driving, so too are health insurance companies ramping up efforts to incentivize healthy habits.

An example of a private insurer looking for ways to promote better health is the Capital District Physicians' Health Plan's (CDPHP) Prevention and Wellness initiatives. The plan is available in New York. CDPHP incentives for healthy habits include:

- free wellness classes that teach members healthy behaviors, such as fitness and nutrition;
- the Life Points™ program, which provides gift cards and merchandise worth up to $365 per year for taking deemed healthy action, like joining a gym, getting an annual physical or participating in a wellness class; and
- Weigh 2 Be,℠ a program providing a weight logbook, nutritional guide and Weight Watchers® rebates to encourage weight loss.

Other private insurers such as United Health Care also offer an array of similar incentives and wellness approaches, but are limited by government regulations in providing incentives to Medicaid patients they cover in managed care plans approved by the states. (See sidebar, "Burdensome Regulations.")

Patient-Centered Support

Incentives must be matched with adequate primary care capacity, patient supports and public education. When all three interact, Medicaid patients can understand and more successfully navigate a greatly redesigned Medicaid program. And, with such appropriate supports, patients will be better situated to practice healthy behaviors, seek appropriate preventive care, follow prescribed medical regimens and have better heath outcomes. But with such support should come the expectation that they act responsibly.

New York already offers an array of patient supports in Medicaid for populations with special needs and as part of the redesign plan is broadening patient education and support throughout the Medicaid program.

Patients who are the hardest to serve and the most costly -- those with mental health and/or substance abuse issues and who often lack housing -- need ongoing support to change their health habits, understand how to use a redesigned system and seek more appropriate care.

Three promising patient-centered approaches to reduce emergency room usage, hospital admissions and readmissions and unnecessary institutional care are already being used successfully in New York: peer counseling, health navigators and supportive housing.

Burdensome Regulations

Private insurance plans are limited in what they can offer as incentives to Medicaid patients -- capped at $75 in cash or equivalent rewards annually.[a] While it is likely that private plans would like to do more to promote healthy behaviors, they face limits imposed by both state and federal regulations.

For instance, this cap has forced the Monroe Plan for Medical Care in upstate New York to focus solely on pre- and post-partum women to encourage the use of necessary health services. Changing this ceiling on incentives for Medicaid could allow plans to also target broader areas of disease management.[b]

[a]New York State Medicaid's Family Health Model Contract, Section 16.3A "The contractor may offer its enrollees rewards for completing a health goal.....Such rewards may not exceed seventy-five dollars in fair market value over a twelve month period, http://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf

[b]Conversation with Dr. Joe Stankaitis, Medical Director, Monroe Plan for Medical Care, http://www.monroeplan.com/ in which he opined that the $75 cap was too low to make a difference for other populations and therefore restricted their ability to do more with incentives.

Peer counseling relies on professional case managers in mental health or addiction recovery to counsel and guide patients to seek appropriate care and adhere to treatment regimens by providing case management, ER diversion services and respite care. Peer Bridgers are laypersons who are in recovery themselves and provide much the same community-based support and services to those discharged from institutional settings.

Data on the effectiveness of peer counseling efforts are compelling:

- Peer Bridger models have been shown to reduce inpatient readmissions by 60 percent in New York.[93]
- Data from PEOPLe Inc. in New York's Hudson Valley show a significant drop in hospital readmissions for people with mental illness from their Rose House Project. [94]
- Another study by Optum Health showed a 73 percent drop in Tennessee and 44 percent in Wisconsin of days spent in the hospital.[95]
- NYS Peer life coaches are poised to help thousands of beneficiaries to return to work while they keep their Medicaid benefits, a program that has been shown to reduce annual Medicaid use by 50 percent.[96]

Peer services for children and families that demonstrate a commitment to helping patients navigate the Medicaid system are used effectively in New York and in numerous other states in the mental health and substance abuse fields.[97]

Health navigators can be trained to act as effective case managers to educate patients about Medicaid changes and guide them in their choices.

Many of those testifying at the public hearings on the MRT waiver suggested expanded use of health navigators to help patients understand and transition to the new managed care system.[98]

Health navigators can be trained laypersons or health care workers who use case manager and care-coordination skills to build close relationships with patients. Through in-person, phone and other ongoing communication, they help the patient understand the complexities of the health care system and access primary preventive care and supportive services instead of more costly services.

The goal of health navigators is to help patients self-manage their care, which in turn leads to better health outcomes through less reliance on emergency room and inpatient care. One case study in Flint, Michigan, showed that the navigator program, after six months of working with a patient, improved lifestyle behaviors by:

- Increasing physical activity;
- Helping patients quit smoking;
- Improving self-management of diabetes;
- Reducing incidence of depression; and
- Reducing chronic pain.

After the navigator program was implemented in Flint, there was a 50 percent decline in hospital emergency visits and inpatient admissions.[99]

Another study and focus-group survey provides details on a health navigator program in Florida, Health Connect in Our Community (HCiOC) in Miami-Dade County, that employed navigators and community health workers to address health disparities among minority groups. Activities included linking clients with medical homes, making appointments for them and tracking them to see if they attend their appointments. The program is culturally sensitive, which is critical for reaching the most underserved children and families in Miami-Dade, particularly its large Haitian population. Clients of the program are very satisfied with the HCiOC services they receive. [100]

After the navigator program was implemented in Flint, there was a 50 percent decline in hospital emergency visits and inpatient admissions.

Providing supportive housing to those who are either homeless or institutionalized solely because they have no place to live has demonstrated effectiveness. Increasingly, research shows that such investments can result in significant Medicaid savings.[101]

The supportive housing model is simple. By housing people and providing them with a variety of individually based supportive services, Medicaid costs can be substantially reduced among groups with chronic health problems. Supportive services include case management, crisis intervention, counseling, linkages to health homes and care coordination, and coverage for emergency care and hospital inpatient treatment.[102]

Analysis of a sample of more than 28,000 Medicaid recipients in need of supportive housing demonstrates that the housing could save more than $1 billion in Medicaid costs, tied predominantly to inpatient, emergency room and long-term-care services.[103] Based on national data that show supportive housing saves 60 percent through reductions in emergency room use and inpatient costs,[104] New York could potentially save more than $650 million in these two areas over five years.[105]

Citing this evidence, New York is requesting permission from CMS, as part of its waiver request, to invest $750 million from projected federal Medicaid savings into expanding supportive housing services over five years.[106]

Together, these three patient-centered care coordination and case management efforts demonstrate a clear commitment by New York to help Medicaid clients with chronic conditions understand the changes in care delivery, navigate the system and gain access to cost-effective preventive care. Similar assistance is already provided to healthier Medicaid clients through facilitated enrollment, nurse home-visiting programs[107] and other avenues.

As in welfare reform, the primary point is that patients in publicly financed programs such as Medicaid need to take responsibility, in this case for their health care. When both financial incentives and appropriate patient supports are in place, the patient has a responsibility to adhere to care plans and effectively utilize primary preventive care, disease management and other wellness programs.[108]

5. RECOMMENDATIONS

A first step in Medicaid redesign should involve the expansion of patient incentive experiments beyond the MIPCD program to encourage consumers to utilize primary and preventive services effectively and to pursue healthier behaviors. Conditional Cash Transfer rewards such as those employed by New York City, cash equivalent benefits, vouchers to purchase pharmaceutical and other over-the-counter health products, payments for enrolling in fitness and wellness programs and numerous other incentives should be introduced on a small scale throughout the Medicaid system and tested for their effectiveness. Those pilot projects that work should be used on a larger scale.

As part of this effort, barriers should be removed that restrict the level of cash or cash equivalent incentives that managed care plans can provide to their Medicaid members. New York has contracts with a number of private managed care plans to serve Medicaid patients. The plans should be given flexibility to design cash incentive programs offering more than the current $75 cap and to structure other reasonable approaches to improve care and contain costs.

A longer-term approach, after New York expands its primary-care capacity and patient education and support services in the first three years of the MRT plan, is to incorporate a set of reasonable requirements regarding their own care, to which patients must adhere. These requirements might include the need to participate in preventive wellness programs, keep scheduled appointments, follow prescribed treatment plans for disease management and the like.

Although unhealthy behaviors and a failure to seek preventive care are not limited to the Medicaid population, Medicaid is totally publicly financed, and therefore it seems reasonable to stress some level of personal responsibility, as was done in TANF, as a condition of receiving benefits.

The emphasis in Medicaid redesign on care coordination and the use of health navigators, peer counselors, home visiting and other patient supports is similar to the efforts made by case managers in TANF programs to help clients understand the operating rules and their required behavior. Using this similar model in Medicaid, it becomes reasonable in turn to expect patients to exercise personal responsibility.

Unlike TANF, however, withholding benefits for non-compliance could be counterproductive because it may increase levels of illness and drive up costs. That said, New York should incorporate several approaches used successfully in other states:

- the requirement in West Virginia's Enhanced Benefits Plan that Medicaid enrollees must sign and follow a membership agreement in order to receive certain services;
- the requirement in the Idaho PHA model that patients pay for a small part of their Medicaid care in the form of a modest premium;
- the promotion of HSAs through a system in which a Medicaid recipient's contribution could be matched by public funds;
- the imposition of modest copayments for inappropriate ER utilization and perhaps other services; and

- the imposition of modest premiums on non-elderly patients with financial resources above a certain level.[109]

Various other approaches are worth pursuing, particularly as New York increases it primary-care capacity and primary care payment rates. These approaches include:

- providing constant communication and care direction for hard-to-serve groups;
- offering cell phones as an incentive to hard-to-reach patients;
- utilizing patient-to-patient counseling and health care navigators to direct patients to proper care settings;
- limiting the number of Medicaid-financed emergency room visits;
- expanding efforts, such as 24-hour nurse helplines, to prevent ER visits; and
- encouraging ER triage rather than extensive costly testing for non-acute care and co-locating primary-care services with ERs.

The federal government can be a partner in broadening incentive efforts by investing more in state experiments than the $100 million it has earmarked under the MIPCD program, a pittance compared with total Medicaid costs nationally of $383.5 billion.[110]

As much as it is doing on the technology side by offering enhanced matching funds to coordinate the operating systems of Medicaid, TANF and food stamps, the federal government could do more with policy integration experiments and other efforts. For instance, instead of denying health care to Medicaid patients who do not comply with care requirements, either cash assistance or food stamp benefits could be partly reduced. This could be implemented through a novel multi-agency waiver submitted jointly to CMS, the Administration of Children and Families at HHS and the U.S. Department of Agriculture's Food and Nutrition Service.

As long as successful patient supports and primary-care capacity are put in place during the first three years of the MRT plan, then reasonable requirements for shifts in behavior should be expected from the Medicaid population, including those who are homeless, have substance abuse and/or mental health disorders and have chronic diseases.

CONCLUSION

Medicaid is a program under which costs keep rising as the services it delivers fall further from the mark. Unless major changes are made, as New York proposes, it will be unsustainable from a cost and care standpoint.

The successful reform of the TANF program offers hope – the lessons learned in that effort are applicable to Medicaid and the overlapping groups that both programs serve. For that reason, incentives to encourage healthy behavior and rules to shift personal responsibility onto patients should be integral parts of New York's Medicaid redesign.

Realistically, though, Medicaid costs will continue to grow and overburden federal, state and local budgets even if current redesign efforts are reasonably successful. Comprehensive federal and state efforts being undertaken in New York and elsewhere to change these realities simply may not be enough on a fiscal and policy level.

In the long run, broader reforms are likely necessary to right the Medicaid ship including consideration of:

- converting Medicaid from a defined-benefit plan to a defined-contribution plan, with the patient winding up with far more ownership of health choices and governments exposed to far less liability;
- allowing Medicaid recipients to opt out of Medicaid, using instead either health insurance exchanges or other comparable subsidized private coverage;
- experimenting, as has Rhode Island, with a pure capitated dollar figure for all Medicaid expenditures, with far less federal intrusion regarding program operations and flexibility; and
- exploring block grants to the states for Medicaid funding under several federal guiding purposes, as was done successfully in 1996 with welfare reform by creating the TANF Block Grant. Unlike the TANF grant, in which a hard cap was created with a one-time federal contingency fund to help states navigate economic downturns, some exceptions might be necessary in a Medicaid grant. The exceptions would cover modest capitated annual growth, population adjustment and treatment of very high-cost populations, in addition to providing for economic downturns.[111]

These broader potential changes to Medicaid will continue to be debated. Regardless of what transpires from such discussions, a patient-centered focus, combining incentives with responsibilities, will be essential.

New York should begin to incorporate that approach now.

APPENDIX A
Other Concerns and Hurdles

To fix systemic problems in the New York Medicaid program, a number of concerns and hurdles have to be overcome in addition to increasing patient responsibility for their care. The most pressing issues include the following:

- Can New York continue to stay within the 4 percent global spending cap on growth, which in itself may be unaffordable? Ongoing enrollment pressures will drive costs up. Some relief is expected from the Patient Protection and Affordable Care Act (PPACA) in enriched funding for new enrollees and those that New York has already enrolled[a] but these gains could be more than offset by additional new costs. An estimated 1 million New Yorkers are already eligible for Medicaid, but not yet enrolled. If, as expected, many do enroll, they will be covered under the existing Federal Medicaid Assistance Percentage (FMAP) rate of only 50 percent, driving up New York's non-federal costs under what is called the woodwork effect of Medicaid expansion.[b]
- New York is relying heavily on a health home model in which all of an individual's health care and social service providers communicate regularly to address the patient's needs in a comprehensive and coordinated fashion. Under PPACA, enhanced federal funding of 90 percent of the cost of health homes is temporary. Will health homes become self-sustaining to bear the ongoing costs for patients?[c] Without much stronger provisions for patient responsibility to encourage physicians and patients to focus on behaviors that are the most cost inducing, will health homes become another cost driver in the future instead of a cost saver. Will health homes over time have the expected impact on the care and costs of the small percentage of Medicaid recipients with complex medical, behavioral and long-term needs that drive a significant portion of Medicaid spending?[d]
- Can New York build and afford adequate primary-care capacity -- particularly in currently underserved areas -- and pay primary-care physicians adequately to support managed care for all, especially when an estimated 2.3 million New Yorkers are underserved for primary care[e] and large numbers of costly new clientele will need to be served?
- Will investments in supportive housing and other service-oriented approaches save significant dollars by facilitating care coordination on-site?
- New York is negotiating with CMS on another waiver, the "People First Waiver". Previously New York has been able to federalize significant costs relating to its institutional behavioral health care system under the Office of People with Developmental Disabilities (OPWDD).[f] While negotiations will continue on the waiver, New York received a serious rebuke for their past practices of overbilling on September 21, 2012, that could cut federal Medicaid reimbursements to the state by $1 billion annually.[g] The House of Representatives Oversight Committee has released a report detailing this looming debacle in New York.[h] This issue not only has the potential to jeopardize the People First Waiver, but could also place a major fiscal obstacle in front of New York's entire Medicaid redesign effort. Can New York find a way to negotiate the waiver and mitigate the financial threat?
- New York is simultaneously proposing a demonstration program to enroll 260,000 of its 755,000 dually eligible Medicaid and Medicare enrollees in a new plan.[i] State proposals to operate dual-eligible demonstration projects were called too broad by the Medicare Payment Advisory Council in a recent letter to CMS.[j] Can New York manage the very complex OPWDD waiver, the proposed dual-eligible demonstration and the broad MRT Section 1115 waiver simultaneously or does it have too much on its plate?
- Additionlly, MRT recommends integrating the currently fragmented system of behavioral health care with physical health care, an important but highly complex process.[k] Behavioral health care encompasses community mental-health services, drug

and alcohol treatment and treatment for the disabled, at an annual cost of more than $8.7 billion.[l]

- Will a significant number of states refuse to implement the Medicaid expansion provisions of PPACA, and if so what impact could that have on the Medicaid program and on future federal funding decisions?
- Historically hospitals and other institutional providers have been very effective at employing their political clout to achieve the status quo of billing for volumes of procedures. While they have embraced the MRT approach currently, will that support endure over time?
- Will the growth in long-term-care costs driven by the aging of the baby boom generation exceed projections and can incorporating long-term-care recipients into managed care effectively constrain growth while improving quality?[m]
- Will federal officials look favorably on New York's ambitious 1115 waiver, which is essential for both proposed program changes and the financing of New York's redesign efforts? Given the federal budget crisis and the recent dispute regarding improper payments to OPWDD facilities in New York, will CMS (under either the current or a future administration) trust that estimated five-year savings are realistic in order to reinvest in New York?
- Even if the waiver is approved, New York's unaffordable Medicaid program will grow in cost. New York continues to struggle economically, with Medicaid being one of the principal causes according to a recent report by former Lieutenant Governor Richard Ravitch and former Federal Reserve Chair Paul Volcker.[n] Is the current waiver approach and the global cap on DOH Medicaid spending a sufficient long-term solution?

[a]Federal cost sharing will increase to 100 percent for new Medicaid enrollees in 2014, before dropping to 90 percent in 2019 and beyond. Because New York has already enrolled most of those requiring coverage under PPACA, it will receive a 90 percent federal share for them as well.

[b]Avik Roy, The Apothecary, July 13, 2012, 'Why States Have a Huge Fiscal Incentive to Opt Out of Obamacare's Medicaid Expansion," http://www.forbes.com/sites/aroy/2012/07/13/why-states-have-a-huge-fiscal-incentive-to-opt-out-of-obamacares-medicaid-expansion/

[c]Henry J. Kaiser Family Foundation, Focus on Health Reform, "Medicaid's New Health Home Option," January 2011. Note that the 90 percent federal share follows the eligible chronic care patient for only two years (eight quarters) before reverting to the regular 50 percent match rate.

[d]New York State Department of Health, Health Homes for Medicaid Enrollees with Chronic Conditions, http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

[e]New York Department of Health, August 24, 2012 Responses to CMS Questions re: MRT Waiver Amendment Request, http://www.health.ny.gov/health_care/medicaid/redesign/mrt_waiver.htm

[f]New York State Office of People with Developmental Disabilities, People First Waiver, http://www.opwdd.ny.gov/opwdd_services_supports/people_first_waiver/news/cms_posts_people_first_waiver_application

[g]Poughkeepsie Journal, "NY Faces $1B Medicaid Cut," September 21, 2012, http://www.poughkeepsiejournal.com/article/20120921/WATCHDOG/309210034/N-Y-faces-1B-Medicaid-cut?nclick_check=1

[h]U.S. House of Representatives Committee on Oversight and Government Reforms, The Federal Government's Failure to Prevent and End Medicaid Overpayments, Staff Report, September 20, 2012, http://oversight.house.gov/wp-content/uploads/2012/09/Developmental-Center-Staff-Report-for-Hearing-9-20-12.pdf

[i] New York State Department of Health, Demonstration to Integrate Care for Dual Eligible Individuals, Albany, NY, May 25, 2012, described at: http://www.health.ny.gov/facilities/long_term_care/docs/2012-05-25_final_proposal.pdf

[j] Medicare Payment Advisory Commission (MedPac), July 11, 2012 letter from Chairman Glenn M. Hackbarth to Marilyn Taverner, Acting Administrator, Centers for Medicare & Medicaid Services

[k] Medicaid Redesign Team: Behavioral Health Reform Work Group, Final Recommendations. October 15, 2011, Albany, NY, page 3

[l] New York State Department of Health, A Plan to Transform New York State's Medicaid Program, Multi-Year Action Plan, page 16, http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.pdf

[m]New York Times, September 7, 2012, "With Medicaid, Long Term Care of Elderly Looms as a Rising Cost," http://www.nytimes.com/2012/09/07/health/policy/long-term-care-looms-as-rising-medicaid-cost.html?pagewanted=all

[n]Seiler, Casey, Albany Times Union, Capitol Confidential, " Ravitch, Volcker unveil report on state budget crisis," July 17, 2012

APPENDIX B

Opportunity NYC: Family Rewards

Appendix Table D.10

Weighted Impacts of Families' Health Insurance Coverage and Parents' Receipt of Health Care Services

Outcome	Program Group	Control Group	Difference (Impact)	P-Value	Effect Size
Health insurance in previous month (%)					
Respondent had health insurance	95.8	92.2	3.6***	0.003	
Publicly funded	74.2	70.4	3.8**	0.013	
Privately, but not publicly funded[a]	21.5	21.9	-0.4	0.705	
All dependent children had health insurance[b]	94.5	93.7	0.8	0.367	
All children covered by public health insurance only[c]	78.7	75.4	3.3*	0.063	
All children covered by private health insurance only[c]	11.2	16.8	-5.6***	0	
Health insurance coverage since random assignment (%)					
Respondent had a period with no coverage	16.4	20.8	-4.4***	0.006	
Some or all of respondent's children had a period with no coverage	14.7	18.2	-3.5***	0.009	
Respondent's health care utilization (%)					
Has a usual source of health care	94.8	91.5	3.3***	0	
Clinic or health center	62	53.1	8.9***	0	
Doctor's office	19.2	22.2	-3.0*	0.077	
Hospital emergency room	3.8	5.1	-1.3*	0.064	
Hospital outpatient department	9.8	11	-1.2	0.259	
Other	0.1	0.1	0	0.954	
Has a personal doctor or health care provider	94.3	93.5	0.8	0.302	
Saw a personal doctor in the past 12 months	85.2	82.3	2.9**	0.023	
Had a health checkup since random assignment	92.8	90.3	2.5*	0.063	
Had a dental checkup since random assignment	85	84.5	0.5	0.748	
At least 2 checkups	61.3	58.6	2.7	0.142	
Stayed in hospital overnight since random assignment[d]	16.8	18.3	-1.5	0.523	
Unmet health needs					
Did not get needed medical care because of cost in past 12 months[e]	1.3	12.9	-11.7***	0	
Did not fill prescription because of cost in last 12 months	8.1	16.7	-8.6***	0	
Received help finding a dentist or health care provider from any NPO	5	9.8	-4.8***	0.001	
Respondent's health care satisfaction					
Average patient satisfaction score[f] (1=low; 5=high)	3.7	3.7	0.0*	0.088	0.014
General satisfaction[g]	3.6	3.6	0	0.149	0.018
Communication[h]	4	4	0	0.301	0.003
Technical quality[i]	4	3.8	0.1***	0.001	0.017
Time spent with doctor[j]	3.6	3.6	0	0.349	0.021
Accessibility and convenience[k]	3.5	3.5	0	0.905	0.001
Sample size (total=3,082)	1,574	1,508			

Source: MDRC calculations using data from the Family Rewards 18-Month Survey.

Appendix B NOTES:
Sample sizes vary because of missing values.
Statistical significance levels are indicated as follows: *** = 1 percent; ** = 5 percent; * = 10 percent.
Estimates were regression-adjusted using ordinary least squares, controlling for pre-random assignment characteristics of families or sample members.
Rounding may cause slight discrepancies in calculating sums and differences.
A two-tailed t-test was applied to differences between outcomes for the program and control groups.
The p-value indicates the likelihood that the differences between the program and control groups arose by chance.
The effect size is the difference between program and control group outcomes expressed as a proportion of the standard deviation of the outcome for both groups combined.

[a] Respondents with public coverage were not asked whether they have private coverage; therefore, it is not possible to estimate whether they also had private coverage. Seedco's program data indicate that 5 percent of families in the program group earned rewards for having both private and public insurance. Even more families may have had both public and private insurance but did not actively submit coupons for private coverage and, therefore, are not captured in the program data.
[b] Child health-related health insurance measures were calculated for sample members with at least one child at the time of the survey.
[c] The percentages of all children covered by public insurance and all covered by private insurance does not add up to the percentage of all children covered by any insurance because some families reported having children covered by both types of insurance.
[d] The items in this section of the survey were administered to a random subsample (N = 1,022) of the survey respondents.
[e] This excludes prescriptions.
[f] The items in this section of the survey were administered to a random subsample (N = 2,043) of the survey respondents. The five RAND Patient Satisfaction subscales are based on 10 items from the PSQ-18. Higher values (maximum = 5) reflect more satisfaction with medical care, whereas lower values (minimum = 1) reflect more dissatisfaction (http://www.rand.org/health/surveys_tools/psq/index.html). The average patient satisfaction score is the average of the five subscale scores.
[g] The "general satisfaction" subscale is an average of the responses to two questions about agreement with the following statements: "The medical care I have been receiving is just about perfect" and "I am dissatisfied with some things about the medical care I receive."
[h] The "communication" subscale is based on agreement with the following statement: "Doctors I go to are good about explaining the reasons for medical tests."
[i] The "technical quality" subscale is based on agreement with the following statement: "When I go for medical care, they are careful to check everything when treating and examining me."
[j] The "time spent with doctor" subscale is an average of the responses to two questions about agreement with the following statements: "Doctors usually spend enough time talking with me about my medical condition or treatment" and "Those who provide my medical care sometimes hurry too much when they treat me."
[k] The "accessibility and convenience" subscale is an average of the responses to four questions about agreement with the following statements: "Where I get medical care, I have to wait too long for emergency treatment," "I find it hard to get an appointment for medical care right away," "I have easy access to the medical specialist(s) I need" and "I am able to get medical care when I need it."

APPENDIX C

MIPCD State Summary: New York

The Medicaid Incentives for the Prevention of Chronic Disease grant program (MIPCD), which will provide a total of $85 million over five years to New York and other states, will test the effectiveness of offering incentives directly to Medicaid beneficiaries of all ages, with the aim of changing their health risks and outcomes by adopting healthy behaviors. Awards are subject to annual renewal. Grants must address at least one of the following prevention goals: tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure and avoiding the onset of diabetes or, in the case of a diabetic, improving the management of the condition.

State	New York
Project Title	Medicaid Incentives Program
Organization and Partners	**Grantee:** New York State Department of Health, Office of Health Insurance Programs, Division of Quality and Evaluation. **Partners:** • University of Pennsylvania • Harvard Medical School • Carnegie Mellon University • New York City Department of Health and Mental Hygiene • Alliance of New York State YMCAs • NYS Office of Mental Health • Medicaid Matters New York • American Cancer Society • American Diabetes Association • American Heart Association • Community Service Society of New York • Empire Justice Center • Eleven Medicaid Managed Care Plans
Condition	Tobacco cessation, lower blood pressure, diabetes management or prevention.
Target Population	Medicaid beneficiaries in New York State, specifically: • Adult Medicaid enrollees who use tobacco. • Pregnant Medicaid enrollees who use tobacco. • Adult Medicaid enrollees with high blood pressure. • Adult Medicaid enrollees with pre-diabetes or diabetes.
Goals	Increase smoking cessation, lower high blood pressure, prevent diabetes onset and enhance diabetes self-management.
Activities	• For participants in the smoking cessation program, direct cash payments for participating in smoking cessation counseling, filling nicotine replacement therapy prescriptions and quitting smoking. • For participants in the blood pressure control program, direct cash payments for attending primary care appointments, filling antihypertensive prescriptions and decreasing or maintaining a decreased systolic blood pressure by 10mmHg or achieving another clinically appropriate target. • For participants in the diabetes management program, direct cash payments for attending primary care appointments, attending diabetes self-management education sessions, filling diabetes prescriptions and decreasing their HbA1c by 0.6 percent or maintaining a level of 8.0 percent or less. • For participants in the diabetes onset prevention program, lottery tickets for attending YMCA Diabetes Prevention Program sessions and losing or maintaining a reduced weight.
Recruitment Approach	• Using Medicaid claims and encounter data and health records, the NYS DOH and insurance plans will identify existing eligible participants and notify them of available benefits and the possibility of receiving incentives for participating. • Highlighting the program in NYS DOH and health plan newsletters and health promotional materials that are sent to providers and Medicaid enrollees. • Encouraging outreach and identification through appropriate disease and case management programs.

Incentives	• An estimated 18,456 participants will be recruited for the NYS Medicaid Incentive Program, including 13,842 who will receive incentives under varying schedules and 4,614 who will not receive incentives. • NYS DOH expects to pay an average of $115-$122 in incentives per participant assigned to an incentive arm in acknowledgement that some participants will be eligible to receive the full amount in incentives through positive changes in health behaviors and clinical outcomes and others will not.
Evaluation Design	• For the smoking cessation program, randomization at the provider level (confounding bias examined using logistic or log-binomial multivariate modeling). • For the blood pressure control program and diabetes management program, randomization at the provider level (confounding bias examined using linear regression multivariate modeling). • For the diabetes onset prevention program, randomization at the YMCA level (confounding bias examined using linear regression multivariate modeling). • Rapid cycle evaluation for other ad hoc research questions.

Source: Centers for Medicare & Medicaid Services

ENDNOTES

[1]Follow-Up Responses to CMS Questions re: MRT Waiver Submission, August 24, 2012, Albany, NY, page 1, at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/waiver_questions.pdf. The New York State Division of the Budget further explains that the 5.1 million enrollees are from the global cap reports that bring caseload current with the reporting month's disbursements, the most recent being July 2012. This explains why Figure 1, using DOH data, shows latest eligible figures based on calendar year averages per month as just under 4.9 million. The DOH Calendar Year figures lag in time and do not take into account subsequent retroactive eligibility determinations, which can be made months after a calendar month.

[2] FY 2013 Executive Budget Financial Plan, February 17, 2012, Albany, NY, page 68, Medicaid

[3] The Henry J. Kaiser Family Foundation state health facts, Total Medicaid Spending, FY 2010 detailed at: http://www.statehealthfacts.org/comparemaptable.jsp?ind=177&cat=4

[4] The Henry J. Kaiser Family Foundation state health facts, Medicaid payments per enrollee, 2009, at: http://www.statehealthfacts.org/comparetable.jsp?ind=183&cat=4

[5] Henry J. Kaiser Family Foundation, State Health Facts, New York: Medicaid Spending, FY 2010, http://www.statehealthfacts.org/profileind.jsp?sub=47&rgn=34&cat=4

[6] Follow-Up Responses to CMS Questions re: MRT Waiver Submission, August 24, 2012, Albany, NY, page 1 at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/waiver_questions.pdf

[7] The Commonwealth Fund, AARP Public Policy Institute and the SCAN Foundation, "Raising Expectations: A State Scorecard on Long Term Care Services and Supports for Older Adults, People with Physical Disabilities and Family Caregivers," September 2011, Washington D.C.

[8] New York State Department of Health, A Plan to Transform New York State's Medicaid Program, Multi-Year Action Plan, page 21, http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.pdf

[9] Governor Cuomo Issues Executive Order Establishing the Medicaid Redesign Team, Press Release, January 5, 2011, Albany, NY

[10] New York State Department of Health, Monthly and Global Cap Updates, http://www.health.ny.gov/health_care/medicaid/regulations/global_cap/

[11] Medicaid Global Spending Cap June 2012 Report, New York State Department of Health, Albany, NY, chart page 7

[12] In a response to CMS regarding the waiver the Department of Health noted: "It has been estimated that $100 to $110 billion of New York's $160 billion health care bill goes for hospitalizations, medications, medical treatments, and long-term-care for patients with one or more chronic diseases, a group of patients that is expanding rapidly" Follow-Up Responses to CMS Questions re: MRT Waiver Submission at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/waiver_questions.pdf, August 24, 2012, Albany, NY, page 13

[13] Conditional cash transfers are a widely growing concept utilized in over 30 countries. The concept of CCT's is to predicate the receipt of cash rewards for beneficiaries who adhere to a set of expected actions, for instance in health care: keeping doctor's appointments, seeking appropriate care, avoiding unnecessary care and following prescribed treatment plans. CCT's should be seen as contracts with recipients for the delivery of a service, not as handout programs

[14] Follow-Up Responses to CMS Questions re: MRT Waiver Submission at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/waiver_questions.pdf, August 24, 2012, Albany, NY, page 13

[15] Governor Cuomo Issues Executive Order Establishing the Medicaid Redesign Team, Press Release, January 5, 2011, Albany, NY

[16] Members of the Medicaid Redesign Team are listed at: http://www.health.ny.gov/health_care/medicaid/redesign/members.htm

[17] Governor Cuomo Announces Medicaid Spending Finishes Year $14 Million Under Global Medicaid Cap, Press Release, Albany NY, May 1, 2012

[18] New York State Medicaid Redesign Team (MRT) Waiver Amendment: Achieving the Triple Aim, August 6, 2012, Albany, NY, page 3

[19] The Office for People with Developmental Disabilities, the Office of Mental Health and the Office of Substance Abuse Services

[20] Medicaid Waiver: Tool to Fully Implement the MRT Action Plan, NYS Department of Health, Summer 2012, Albany NY, page 2

[21] Follow up Responses to CMS Questions re: MRT Waiver Submission at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/waiver_questions.pdf, August 24, 2012, Albany NY, page 42

[22] Ibid, page 43

[23] New York State Office of Temporary and Disability Assistance Administrative Directive, April 18, 2012, http://otda.ny.gov/policy/directives/2012/ADM/12-ADM-02.pdf

[24] Robert L. Kane et al.: "A structured review of the effect of economic incentives on consumers' preventive behaviors," University of Minnesota, Minneapolis, Minnesota, American Journal of Preventive Medicine, Volume 27, Issue 4, November 2004, Pages 327-352

[25] KPMG Human & Social Services, Leading practices in the human and social services sector, http://www.kpmg.com/Global/en/IssuesAndInsights/ArticlesPublications/Documents/human-social-services-july-2012v2.pdf

[26] Conversation with Matt Salo, Executive Director of the National Association of Medicaid Directors

[27] NYS Department of Health, Other Eligibility Requirements, Co-Pay, January 2012, Albany, NY described at: http://www.health.ny.gov/health_care/medicaid/reference/mrg/january2012/pages509-511.pdf
[28] http://www.health.ny.gov/health_care/medicaid/ How do I know if my income or resources qualify me for Medicaid?
[29] Centers for Medicare & Medicaid Services Innovation, September 2011, Washington D.C., described at: http://www.innovations.cms.gov/initiatives/MIPCD/background.html
[30] Armour, Finkelstein and Fiebelkorn, Centers for Disease Control, State Level Medicaid Expenditures Attributable to Smoking, July 2009, http://www.cdc.gov/pcd/issues/2009/jul/08_0153.htm
[31] Ogden et. Al, NCHS Data Brief, No. 82, January 2012, Prevalence of obesity in the United States 2009-10 http://www.cdc.gov/nchs/data/databriefs/db82.pdfr
[32] Los Angeles Times, Studies Expand on Soda's Role in Growing Obesity, 2012, http://articles.latimes.com/2012/sep/21/science/la-sci-obesity-soda-link-20120922 and GAO report GAO-06-127R) http://www.gao.gov/new.items/d06127r.pdf. A joint proposal by NYS and NYC was submitted to the U.S. Department of Agriculture in 2010 to ban the purchase of sugar-sweetened beverages with food stamp benefits; it was rejected.
[33] Centers for Disease Control (2008). Preventing chronic diseases: investing wisely in health, preventing obesity and chronic diseases through good nutrition and physical activity, http://www.cdc.gov/nccdphp/publications/factsheets/Prevention/pdf/obesity.pdf.). Nearly half of all medical spending related to adult obesity is financed by the public sector, through Medicaid and Medicare (Government Accountability Office, 2005).
[34] United Health Center, Center for Health Reform and Modernization, The United States of Diabetes: challenges and opportunities in the decade ahead, Working Paper No. 5, November 2010, http://www.unitedhealthgroup.com/hrm/unh_workingpaper5.pdf
[35] New York State Department of Health, A Request for Proposal for Office of Health Insurance Programs, RFP No.1204091105, Medicaid Incentives for Prevention of Chronic Diseases. http://www.health.ny.gov/funding/rfp/1204091105/1204091105.pdf
[36] National Conference of State Legislatures, Heart Disease and Stroke Burden, New York State Profile Policy Report, 2007, http://www.ncsl.org/issues-research/health/new-york-state-profile-and-policy-report.aspx
[37] Ibid
[38] Ibid
[39] Ibid
[40] New York State Department of Health, New York State Medicaid Redesign Team (MRT) Waiver Amendment, Achieving the Triple Aim, http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08-06_waiver_amendment_request.pdf
[41] Redmond, Solomon and Lin, Center on Budget and Policy Priorities, Can Incentives for Healthy Behaviors Hold Down Medicaid Costs, June 2007, Washington, D.C., described at: http://www.cbpp.org/files/6-1-07health.pdf, and The Commonwealth Fund, Public Programs Are Using Incentives to Promote Healthy Behavior, Sept/October issue of States in Action: a bimonthly look at innovations in health policy, Washington, D.C., described at: http://www.commonwealthfund.org/Innovations/State-Profiles/2007/Oct/Public-Programs-Are-Using-Incentives-to-Promote-Healthy-Behavior.aspx
[42] Nigel Crisp, "Turning the World Upside Down: The Search for Global Health in the 21st Century," page 115, http://www.amazon.com/Turning-World-Upside-Down-Century/dp/1853159336
[43] Ibid, page 115
[44] Ibid, page 115
[45] Ibid, page 142
[46] Matt Miller, The Washington Post, "What we can learn from Singapore's health-care model," March 3, 2010, Washington, D.C., described at: http://www.washingtonpost.com/wp-dyn/content/article/2010/03/03/AR2010030301396.html)
[47] Ibid, page 2
[48] Veto Message No. 125 to the Assembly: "I am returning herewith without my approval Assembly Bill Number 1469 entitled, AN ACT to amend the social services law in relation to directing the commissioner of health to establish a cash and counseling demonstration program."
[49] Salt Lake City Tribune, January 26, 2012, "Feds: Utah can reward Medicaid patients for healthful moves," described at; http://www.sltrib.com/sltrib/news/53382898-78/medicaid-patients-utah-care.html.csp
[50] The Commonwealth Fund, States in Action Archive, Wisconsin Badger Care Plus Healthy Living Update, Washington, D.C. http://www.commonwealthfund.org/Newsletters/States-in-Action/2008/Apr/April-May-2008/Snapshots--Short-Takes-on-Promising-Programs/Wisconsin--Badg
[51] Commonwealth Foundation, Changing the Incentives in Medicaid, June 25, 2012, http://www.commonwealthfoundation.org/policyblog/blog_detail.asp?id=5379
[52] Lutes and Brill, Kaiser Health News, "The Missing Link in ACOs: Patients," March 15, 2011, http://www.beckershospitalreview.com/lists/100-great-places-to-work-in-healthcare.html
[53] Fields, Rachel et al., Becker's Hospital Review, "100 Great Places to Work in Healthcare," April 6, 2012
[54] CDPHP, Smart Moves, http://cdphp.smtmoves.com/
[55] Robert L. Kane et al.: Pages 327-352
[56] Redmond, Solomon and Liu, Center on Budget and Policy Priorities, "Can Incentives for Healthy Behavior Improve Health and Hold Down Medicaid Costs," June 1, 2007

[57] U.S. Department of Health and Human Services, Agency for Health Care Research and Policy, Economic Incentives for Preventive Care Summary, Evidence Report/Technology Assessment: Number 101, **http://archive.ahrq.gov/clinic/epcsums/ecincsum.htm**
[58] Robert L. Kane et al.: Pages 327-352
[59] Goetzel and Ozminkowski, "The Health and Cost Benefits of Work Site Health-Promotion Programs," Annu. RevPublic Heaslth 2008: 29:303-23
[60] This was particularly true in the early stages of reward programs in Florida and Idaho and in other programs, but as public education, the use of call centers and the provision of periodic client statements became more prevalent, confusion was lessened and more incentive benefits were redeemed.
[61] Barth and Greene, Center for Health Care Strategies, Inc., "Encouraging Healthy Behaviors in Medicaid: Early Lessons from Florida and Idaho," Issue Brief, July 2007, http://www.chcs.org/usr_doc/Encouraging_Healthy_Behaviors_in_Medicaid.pdf
[62] Miles, Amie, Kaiser Family Foundation, Kaiser Health News, Medicaid to Offer Rewards for Healthy Behavior, April 2011 described at: http://www.kaiserhealthnews.org/Stories/2011/April/08/Medicaid-incentives.aspx
[63] Riccio, et al., MDRC, Opportunity NYC – Family Rewards Program, "Towards Reduced Poverty Across Generations: Early Findings from New York City's Conditional Cash Transfer Program," March 2010, New York, NY, Overview page iii, http://www.mdrc.org/publications/549/execsum.pdf
[64] Ibid, page 6
[65] Ibid, page 234
[66] Centers for Medicare & Medicaid Services Innovation, September 2011, Washington D.C., described at: http://www.innovations.cms.gov/initiatives/MIPCD/states-awarded.html, the overall program is funded at $100 million with grants accounting for 85 percent of the total
[67] U.S. Department of Health and Human Services, Funding Opportunity Number CMS-1B1-11-001), February 2011, Washington D.C., described at: https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=12331
[68] New York State Department of Health, A Request for Proposal, Office of Health Insurance Programs, RFP No. 1204091105, Medicaid Incentives for the Prevention of Chronic Disease, May 15, 2012, Albany, NY, described at: http://www.health.ny.gov/funding/rfp/1204091105/1204091105.pdf
[69] Department of Health and Human Services, CMS Center for Strategic Planning, PPACA Section 4108 Medicaid Incentives for Prevention of Chronic Diseases (MIPCD), Funding Opportunity Number CMS-1B1-11-001, February 23, 2011, https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=12331
[70] Henry J. Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, "Summary of Florida Medicaid Reform Waiver: Early Findings and Current Status," October 2008, page 6, http://www.kff.org/medicaid/upload/7823.pdf
[71] Jessie Ball DuPont Fund and Georgetown University Health Policy Institute, "Florida's Experience with Medicaid Reform: What has been learned in the first two years?," October 2008, http://hpi.georgetown.edu/floridamedicaid/pdfs/briefing7.pdf
[72] Florida Agency for Health Care Administration, Enhanced Benefits Rewards Program, http://www.fdhc.state.fl.us/medicaid/medicaid_reform/enhab_ben/enhanced_benefits.shtml
[73] Florida Office of Program Policy Analysis & Government Accountability, "Medicaid Reform: Beneficiaries Earn Enhanced Benefit Credits but Only Spend a Small Proportion," July 2008, http://www.oppaga.state.fl.us/reports/pdf/0845rpt.pdf
[74] Ibid
[75] Florida Medicaid Reform 1115 Research and Demonstration Waiver, 4th Quarter Progress Report, April 1, 2012 – June 30, 2012, Demonstration Year 6, Agency for Health Care Administration, http://ahca.myflorida.com/Medicaid/medicaid_reform/pdf/FL_1115_Q4_YR_6_Report_4-1-2012_6-30-2012_final.pdf
[76] Idaho Department of Health and Welfare, Preventive Health Assistance Program (PHA) described at: http://www.healthandwelfare.idaho.gov/Medical/Medicaid/PreventiveHealthAssistance/tabid/221/Default.aspx
[77] Kenney, Pelletier, Health Policy Center, Urban Institute State Health Access Data Assistance Center and Robert Wood Johnson Foundation, "Medicaid Policy Changes in Idaho Under the Deficit Reduction Act of 2005: Implementation Issues and Remaining Challenges," June 2010, http://www.shadac.org/files/shadac/publications/IdahoMedicaidDRACaseStudy.pdf
[78] Ibid
[79] Kenney, Marton, Klein, Pelletier and Talbert, Heath Services Research and Educational Trust, DOI: 10.1111/j.1475-6773.2010.01199.x, The Effects of Medicaid and CHIP Policy Changes on Receipt of Preventive Care Among Children
[80] September 4, 2012 email from Matt Wimmer, State of Idaho, Bureau Chief Medical Care to Russell Sykes, Empire Center
[81] West Virginia Mountain Health Choices Manual, Chapter 527 Covered Services, Limitations and Exclusions for Mountain Health Choices, http://www.dhhr.wv.gov/bms/mhc/Documents/bms_manuals_Chapter_527MountainHealthChoices.pdf
[82] Gurley-Calvez, Ph.D., et al., Bureau of Business and Economic Research, West Virginia University, "Mountain Health Choices Beneficiary Report: A Report to the West Virginia Bureau for Medical Services," issued July 2009, updated January 2010, Morgantown, West Virginia, http://www.be.wvu.edu/bber/pdfs/BBER-2009-09.pdf
[83] IN.Gov, Indiana Family and Social Services Administration, Healthy Indiana Plan Home Page, About the Plan, http://www.in.gov/fssa/hip/2344.htm
[84] Irvin, Carol, Mathematica Policy Research, Inc., "Healthy Indiana Plan: The First Two Years," July 15, 2010, http://www.in.gov/fssa/files/Presentation_to_Health_Study_Committee_Final_7_13_10.pdf

[85] Indiana Family and Social Services Administration, 1115 Waiver Extension Application, submitted to CMS December 28, 2011, page 5, http://www.in.gov/fssa/hip/files/HIP1115RenewalSubmission.pdf
[86] MHS HIP POWER ACCOUNT described at: http://www.mhsindiana.com/for-members/hip-power-account/ http://www.in.gov/fssa/hip/2344.htm and Henry J. Kaiser Family Foundation Facts on Medicaid and the Uninsured, Summary of Healthy Indiana Plan described at: http://www.kff.org/medicaid/upload/7786_S.pdf
[87] Irvin, Carol, Mathematica Policy Research, Inc., "Healthy Indiana Plan: The First Two Years," July 15, 2010, http://www.in.gov/fssa/files/Presentation_to_Health_Study_Committee_Final_7_13_10.pdf
[88] Healthy Indiana Plan 1115 Waiver Extension, submitted to CMS December 28, 2012, Cover Letter to U.S. Department of Health and Human Services Secretary Kathleen Sibelius from Indiana Governor Mitch E. Daniels Jr., http://www.in.gov/fssa/hip/files/HIP1115RenewalSubmission.pdf
[89] Indiana Family and Social Services Administration, 1115 Waiver Extension Application, submitted to CMS December 28, 2011, page 5, http://www.in.gov/fssa/hip/files/HIP1115RenewalSubmission.pdf
[90] The Commonwealth Fund, Washington Health Policy Week in Review, "CMS Tries to Let Indiana Down Gently on Bush Era Coverage Expansion," August 17, 2012, http://www.commonwealthfund.org/Newsletters/Washington-Health-Policy-in-Review/2012/Aug/August-20-2012/CMS-Tries-to-Let-Indiana-Down-Gently-on-Bush-Era-Coverage-Expansion.aspx
[91] Wall, J.K., Indianapolis Business Journal, "GOP Govs: Not Enough Medicaid Flexibility," August 20, 2012
[92] Progressive Auto Insurance, http://www.progressive.com/auto/snapshot.aspx
[93] National Health Data Systems 1998 study for New York Association of Psychiatric Rehabilitation Services, September 17, 2012, email from Harvey Rosenthal to Russell Sykes: "re: the NYAPRS NHDS study: the follow-up re-hospitalization rate of matches while enrolled in the Peer-Bridger Project was significantly less than the baseline hospitalization rate (i.e., the 2-year period prior to enrollment). That is, during the 2-year baseline period, the matches were hospitalized an average of **60**% of the time; while enrolled in the program, however, they were re-hospitalized only **19**% of the time."
[94] Ulster County Mental Health Department, PEOPLe Inc., email from Steve Miccio to Russell Sykes, September 17, 2012: "Essentially 90% of registrants to the Rose Houses combined of the total 100 (N = 100) indicated that in the absence of the diversion offered by Rose House they would have accessed the Emergency Department Psychiatric Services," http://www.projectstoempower.org/
[95] New York Association of Psychiatric Rehabilitation Services, MHW: Optum Study Shows Peer Bridgers Reduce Hospitalization, Curb Costs, March 22, 2011, http://www.nyaprs.org/e-news-bulletins/2011/2011-09-09-MHW-Study-Show-Peer-Bridgers-Reduce-Hospitalizations-Curb-Costs.cfm
[96] Mathematica Policy Research Inc., Working With Disability: Medicaid Expenditures in Brief, Number 5, June 2007, Schimmel, Irvin and Liu, "How Do Buy-In Participants Compare with Other Medicaid Enrollees with Disabilities," described at: **http://www.chiip.org/pdf/Mathematica%20compare%20medicaid%20issue%20brief%205.pdf**
[97] A Plan to Transform the Empire State's Medicaid Program, Better Care, Better Health, Lower Costs, Companion Document: Final Reports of the MRT Workgroups described at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtcompanion.pdf, Behavioral Health Workgroup Report, pages 64-70
[98] New York State Medicaid Redesign Waiver Amendment: Achieving the Triple Aim, August 6, 2012, Albany, NY, p.39
[99] U.S. Department of Health and Human Services, Agency for Health Care Research and Quality, "Health Navigators Support Self-Management with Primary Care Patients, Leading to Improved Behaviors and Lower Utilization," described at: http://www.innovations.ahrq.gov/content.aspx?id=2905
[100] The Urban Institute, "Health Connect in Our Community: What Do Health Navigators, Community Health Workers and Families Say About the Program," described at: http://www.urban.org/publications/411824.html
[101] Dennis P. Culhane, Stephen Metraux and Trevor Hadley, "Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing," Departmental Papers (SPP) (2002), described at: http://works.bepress.com/dennis_culhane/4/
[102] New York State Medicaid Redesign Team (MRT) Waiver Amendment: Achieving the Triple Aim, page 57, described at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08-06_waiver_amendment_request.pdf, pages 57-63, and Supportive Housing Workgroup Companion Report described at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtcompanion.pdf
[103] Ibid, page 57
[104] Craig C., Eby D., Whittington J., "Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs," IHI Innovation Series white paper, Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011, at: (http://www.ihi.org/knowledge/Pages/IHIWhitePapers/IHICareCoordinationModelWhitePaper.aspx)
[105] New York State Medicaid Redesign Team (MRT) Waiver Amendment: Achieving the Triple Aim, page 57, described at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08-06_waiver_amendment_request.pdf
[106] Ibid, page 59
[107] Coalition for Evidence-Based Policy, Social Programs That Work, "Nurse Family Partnership," http://evidencebasedprograms.org/wordpress/1366/nurse-family-partnership/
[108] U.S. Department of Health and Human Services, Administration for Children and Families, "Major Provisions of the Personal Responsibility and Work Opportunity Reconciliation Act," (P.L. 104-193)
[109] The Affordable Care Act would however eliminate all asset tests in Medicaid, Blue Cross, Blue Shield, National Health Care Reform: The New Medicaid, http://www.bcbsm.com/healthreform/pubs/the_new_medicaid.pdf
[110] Centers for Medicare & Medicaid Services, Medicaid.gov, Medicaid Enrollment by State, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html
[111] Howard, Paul, Manhattan Institute for Policy Research, Issues 2012, "How Block Grants Can Make Medicaid Work," September 2012

The Empire Center for New York State Policy, a project of the Manhattan Institute for Policy Research, is dedicated to fostering greater economic growth, opportunity and individual responsibility in the Empire State.

Through research papers, policy briefings, commentaries and conferences, the Empire Center seeks to educate and inform New York State policymakers, news media and the general public. Nothing in this report is to be construed as necessarily reflecting the views of the Empire Center or of the Manhattan Institute, or as an attempt to influence the passage, defeat, approval or disapproval of any legislation or other matter before the State Legislature, the Governor, or any other state or local agency or official.

The Manhattan Institute is a 501(c)3 nonprofit organization. Contributions are tax-deductible to the fullest extent of the law. EIN #13-2912529

EMPIRE CENTER
FOR NEW YORK STATE POLICY
A project of the Manhattan Institute for Policy Research

www.EmpireCenter.org • PH: 518-434-3100 • FAX: 518-434-3130 • Info@EmpireCenter.org