



**Department
of Health**

Medicaid
Redesign Team

Advocacy and Engagement Subcommittee Meeting #2

September 10, 2015

Meeting Schedule, Logistics and Focus

Meeting #	Confirmed Date	Time	Location
Meeting 1	8/13/2015	10:30-2:00pm	SPH Auditorium
Meeting 2	9/10/2015	10:30-2:00pm	SPH 110A
Meeting 3	10/9/2015	10:30-2:00pm	SPH 110A
Meeting 4	11/5/2015	10:30-2:00pm	SPH 110A

Meeting Focus

- Intro to VBP
 - Design effective culturally competent patient incentives
 - Suggest guiding principles and requirements for future incentives
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- Patient-Reported Outcomes(PRO)
 - Determine Medicaid Members' right to know
 - Recommend best practice communication methods to Medicaid members
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Agenda

- Key Considerations for Incentives
 - Purpose and Types of Incentives
 - Guiding Principles for Creating Incentive Programs
- Guidance on Developing Subcommittee Recommendations
 - Standard vs. Guideline
 - Mechanisms for Implementation
- Patient Reported Outcomes (PROs)
- Medicaid Members' Right to Know

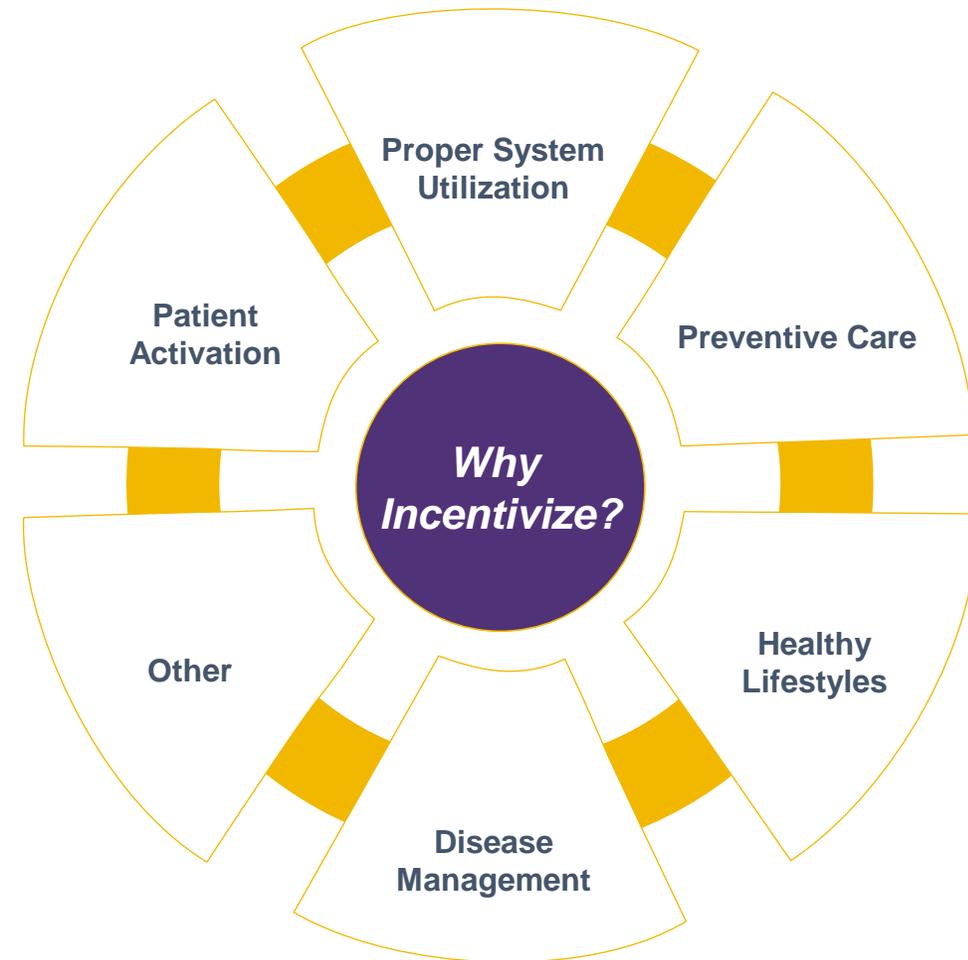
Key Considerations for Incentive Programs

Purpose of Incentive Programs

During the last meeting, the Subcommittee reviewed the purpose of patient incentives in the healthcare system.

The categories on the right are based on past and current incentive programs and lessons learned.

Overall, patient incentives should assist and encourage patients to make effective choices that ultimately result in reducing costs and improving outcomes.



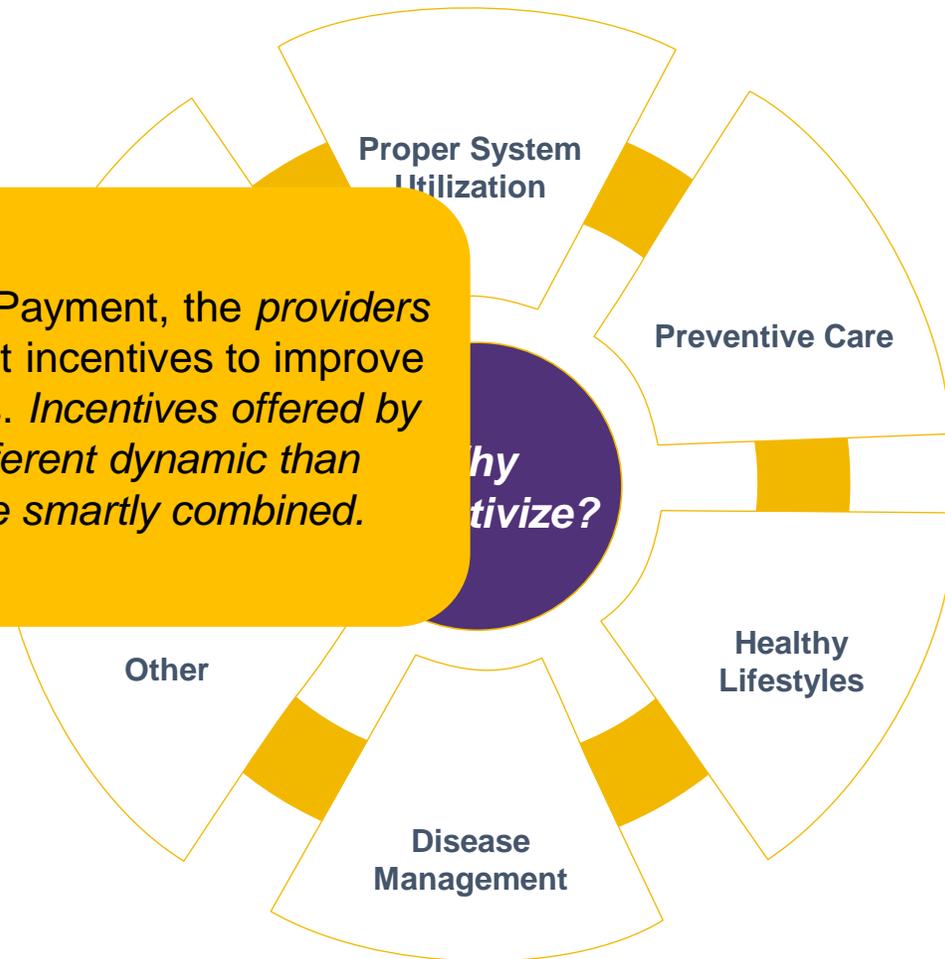
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The categories and current incentives learned.

Overall, patient incentives can assist and encourage patients to make effective choices that ultimately result in reducing costs and improving outcomes.

Importantly, in the context of Value Based Payment, the *providers* will become very interested in using patient incentives to improve outcomes and reduce (downstream) costs. *Incentives offered by providers themselves create a very different dynamic than incentives offered by MCOs, but can be smartly combined.*

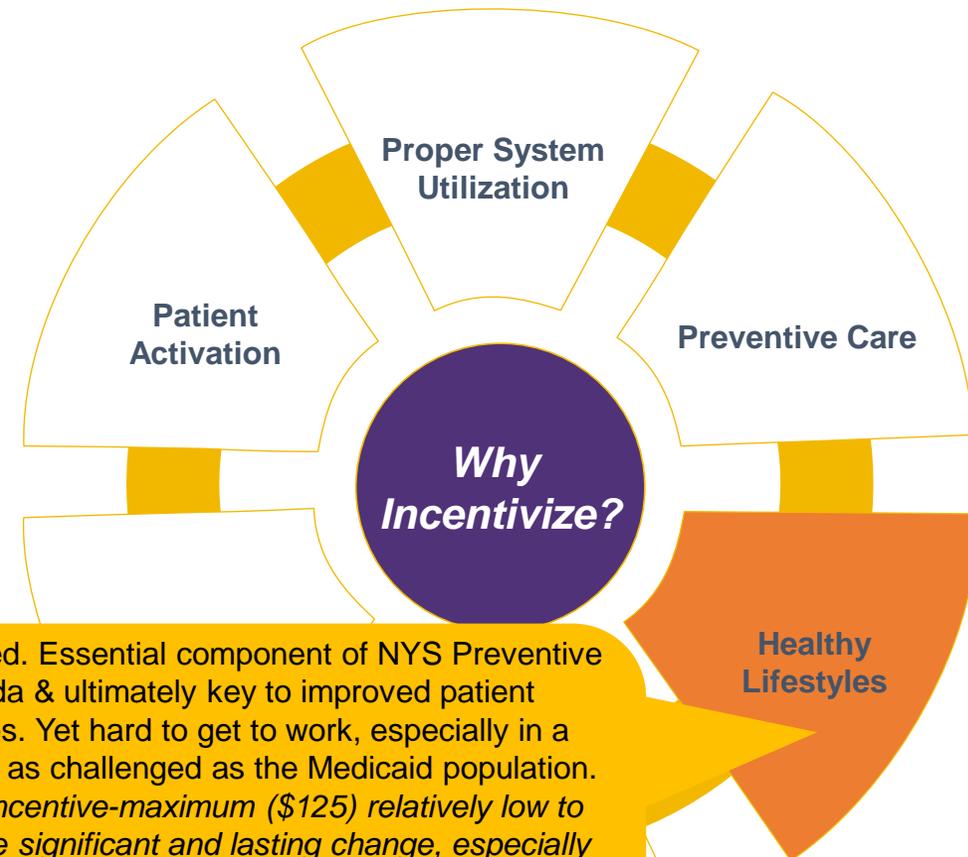


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Widely used. Essential component of NYS Preventive Agenda & ultimately key to improved patient outcomes. Yet hard to get to work, especially in a population as challenged as the Medicaid population. *Current incentive-maximum (\$125) relatively low to incentivize significant and lasting change, especially without accompanying measures (availability of fitness centers, healthy food, lifestyle coaches, housing, etc.). Often, the business case for these accompanying measures is there (link to Social Determinants Subcommittee).*

Legend:

 Difficult to achieve goals/limited information on successful incentives

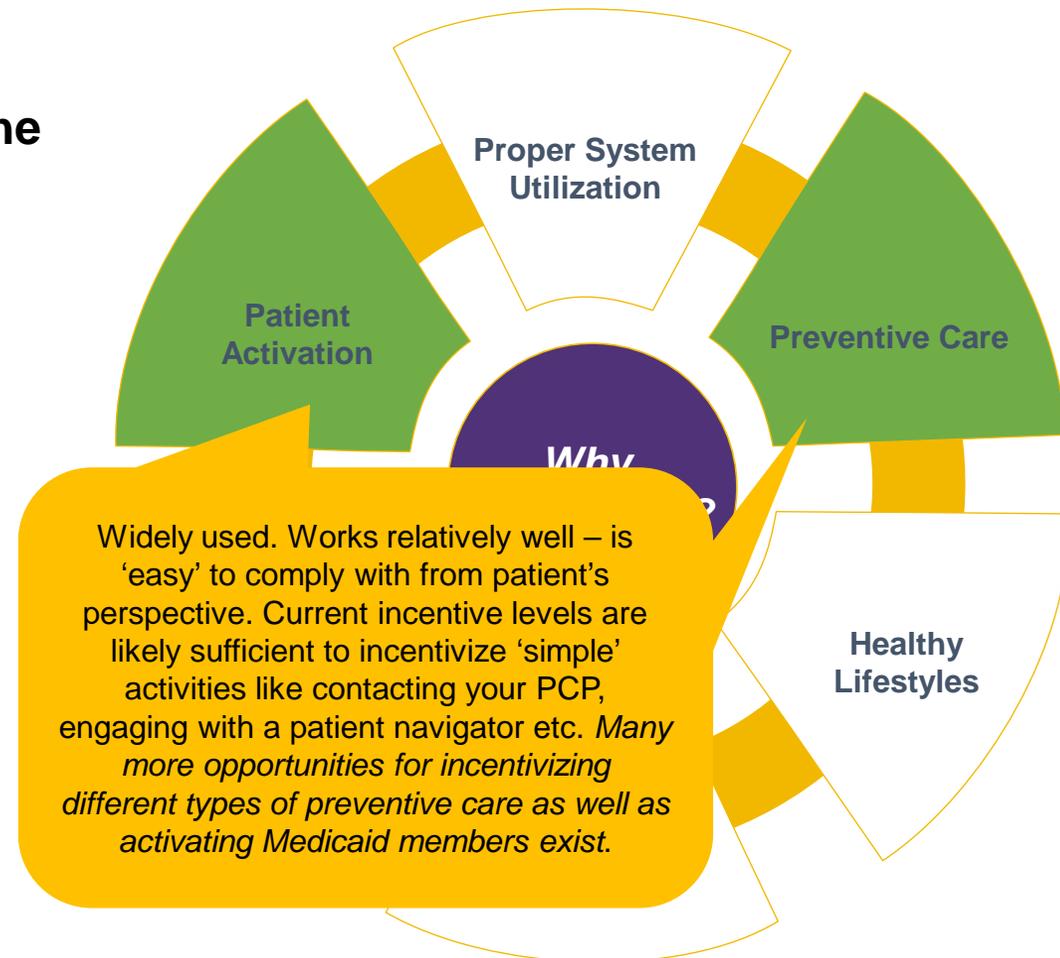
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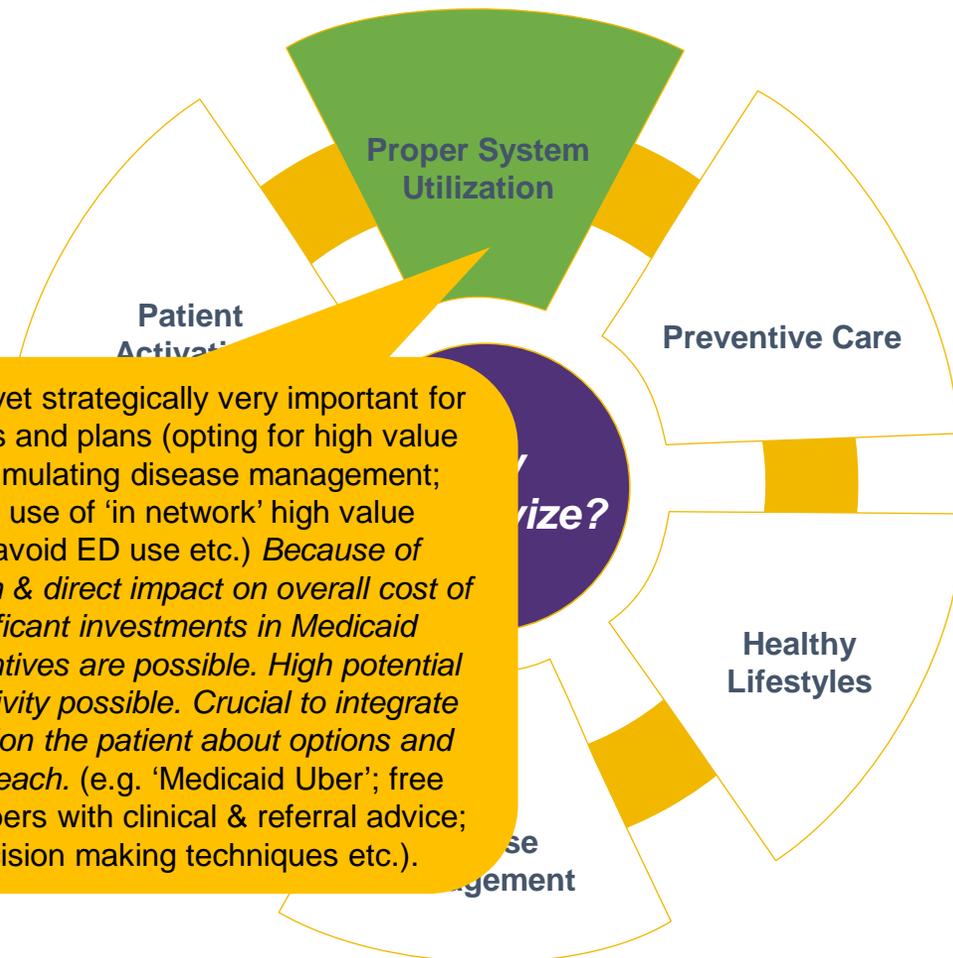
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Underutilized yet strategically very important for both providers and plans (opting for high value providers; stimulating disease management; stimulating use of 'in network' high value providers; avoid ED use etc.) *Because of potentially high & direct impact on overall cost of care, significant investments in Medicaid member incentives are possible. High potential & much creativity possible. Crucial to integrate with information the patient about options and the value of each. (e.g. 'Medicaid Uber'; free 24/7 call-numbers with clinical & referral advice; shared decision making techniques etc.).*



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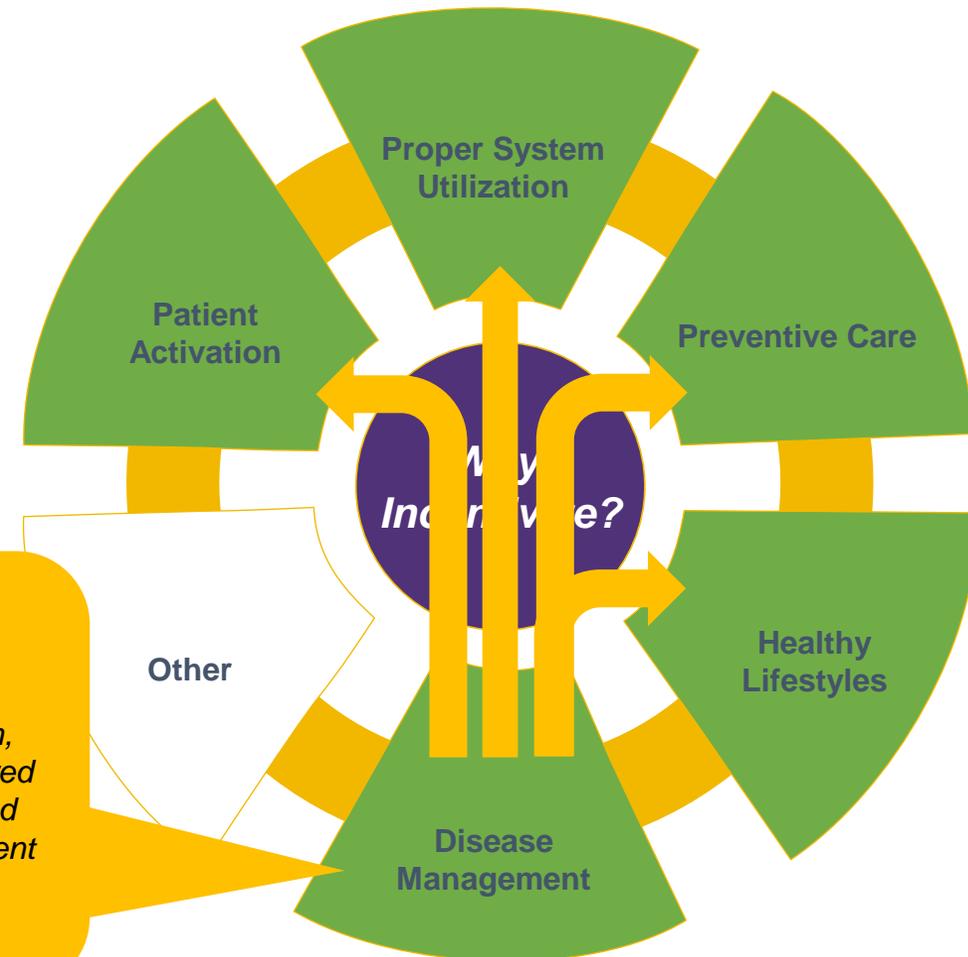
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The integration of these aims comes together in patient-driven disease management. *An integrated approach, using patient incentives, 'inclusive shared savings', accompanying measures and shared decision making (including Patient Reported Outcomes) is key.*



Legend:

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 High chance for success/information on successful incentives

Specific Goals of Patient (Medicaid Member) Incentives

Make appropriate housing choices

Engage with a patient navigator

Avoid improper ED

Encourage connection with PCP at point of service

Prevention across all populations

Obtain and/or maintain good health

Use transportation methods

Select high value providers*

Are there other types of patient incentives that the Subcommittee should consider?

How should high value providers really be defined? Consider both the MCO and patient perspective.

* "High value providers" deliver care of high quality at a lower cost

Designing Incentive Programs

The following guiding principles were discussed when considering how incentive programs could be designed. These are deemed to be critical to success and assists in creating boundaries and scope for plans/providers as they create new incentives.

Willingness to participate

Awards given in a timely manner

Unbiased

Equity not equality

Does not promote negative behavior

Flexibility in exploring alternative ideas

Ensure proper data collection tools are in place

Transparent design

Are there other guiding principles that should be included in the design of incentive programs?

Designing Incentive Programs

Additional considerations for discussion:

Meaningful/substantial enough to effectuate change in behavior

Should not negatively impact benefit status (i.e. incentives exempt from asset testing)

Cash vs non-cash incentives

Should be culturally sensitive and promote health literacy

Should consider underlying disparities and social determinants of health, including community needs, and local planning efforts

Must not reinforce disparities or perpetuate inequality within or between communities, particularly in terms of how disparate subpopulations access wellness services and support

Designing Incentive Programs

Additional considerations for discussion:

Measures should be consistent and evidence-based

MCO-initiated program for VBP contractor initiated program

Other?

Guidance on Developing Subcommittee Recommendations



Standard versus Guideline

Per option, the Subcommittee should recommend whether the State should set a **Statewide Standard** or a **Guideline** for the methodologies employed between MCOs and the providers. The State will consistently employ a standard in its own approaches regarding methodologies and data dissemination to both MCOs and providers. The Subcommittee should recommend whether MCOs and providers should adopt the same standard or are free to vary, using the State's methods more as a guideline.

- A **Standard** is required when it is crucial to the success of the NYS Medicaid Payment Reform Roadmap that all MCOs and Providers follow the same method.
- A **Guideline** is sufficient when it is useful for Providers and MCOs to have a starting point for the discussion, but MCOs and Providers may deviate without that harming the overall success of the Payment Reform Roadmap.

DOH Guidance for A&E Subcommittee

There are three primary mechanisms for the State to implement recommendations on incentives regardless of whether it is a **guideline or standard**:

1. **Financial Incentives** (key philosophy of VBP: align incentives with professional motivation)
2. **Program or Policy Changes** (e.g. model contract changes, regulatory changes, statutory changes, other policy levers)

To disseminate and/or test e.g. novel incentive or communication models:

3. **RFAs** (e.g. pilot funding, what considerations and/or criteria should exist for potential pilots)

Mechanism 1: Financial incentives

The State's main policy instrument to implement the Value Based Payment Roadmap is by incentivizing *both* plans and providers to contract or deliver high value care (high quality/efficient).

- Incentivizing Medicaid members is similarly essential to Value Based Payment programs: changing provider behavior is only one side of the coin
- Both MCOs and providers will be increasingly incentivized to realize good outcomes & ensure that Medicaid members make the right choices in their health care utilization
- *Is an additional stimulus for using Medicaid member incentives necessary?*

Mechanism 2: Policy Change

The State's main policy instrument to implement the Value Based Payment Roadmap is by modifying the Medicaid Model Contract between the State and the MCO

- This is how the definitions of the VBP arrangements are implemented as a 'standard'
- This is how protections against e.g. irresponsible acceptance of risk, are implemented
- This is where the possibility of using incentives for Medicaid members are currently outlined – and could be changed

Current Model Contract Language: MCOs

All Programs:

The Contractor may offer its Enrollees **rewards for completing a health goal**, such as finishing all prenatal visits, participating in a smoking cessation session, attending initial orientation sessions upon enrollment, and timely completion of immunization or other health related programs. Such rewards **may not exceed one hundred and twenty-five dollars (\$125.00)** in fair-market value per Enrollee over a twelve (12) month period and must be related to a health goal.

HIV SNP Program only:

- Contractor may offer incentives to promote the delivery of preventive care services
- May not be cash or instruments convertible to cash
- Must submit a plan for review and approval specifying the health goals and criteria that will be used to measure achievement of each health goal, and the associated incentive
- DOH will determine if the incentive meets requirements of 42 CFR 1003.101 and DHHS OIG Special Advisory Bulletin “Offering Gifts and Other Inducements to Beneficiaries” (dated Aug ‘02)
- Contractor may not make reference to these rewards in its pre-enrollment marketing materials or discussions and all such rewards must be approved by the SDOH

What modifications could be made to the model contract?

- **Increase the maximum**
- **Change the range of services**
- **Requirement to follow certain guidelines**
- **Other?**

Managed Care Plans Survey Results

Background: A survey of 18 Medicaid managed care plans on experiences with offering member incentives was conducted in early December, 2011.

- **Incentive programs:** those to increase compliance with screening, appointments and access, to promote immunization and smoking cessation.
- **Types of incentives:** gift cards and gift items (e.g. baby stroller for attending prenatal care visits, tapes, books, clothes, pedometer etc.)

Benefits

- Ability to use both administrative/claims data and documentation from the provider or member (e.g. reports, attendance, etc.)
- Variety of distribution options, centrally, mail, or using a vendor/third-party
- Can be provided at the point of service

Challenges

- Lag time between appointment or screening and when the claim appears in the system
- Fraud with provider or member documentation
- Variation in utilization depending on purpose and amount of the incentive
- Inability to track member's use of the incentive
- Inaccurate mailing address for members
- Variation in participation by provider

VBP Contractors

Additional question for consideration:

- *Are, or should there be, any restriction for ACOs, IPAs or providers to use incentives for patients in MCO Medicaid?*

Mechanism 2: Policy Change

In addition, the State could and/or may need to focus on regulatory changes, statutory changes, other policy levers:

- *Besides modifying the model contract, are there other policy changes that would assist in the adoption of incentive programs?*

Mechanism 3: RFA

Recommend the State issue an RFA to fund a number of pilot incentive programs to grow the evidence base and allow for lessons learned to be incorporated.

Pros	Cons
Would provide funding for incentive initiatives for plans and provider partners.	Could lead to a 'wait and see' attitude with other MCOs or VBP contractors.
Might be required to stimulate MCOs to venture into unknown territory.	Another program to design and administer, above and beyond those incentive based programs that MCOs are already participating in.

How to incentivize providers / MCOs?

- Financial incentives for providers / MCOs?
- Model Contract changes? For providers or MCOs?
- Requirement for regulatory changes?
- RFAs? For providers or MCOs?

Current Incentive Programs: Menu of Options

Incentive Focus

- Patient activation
- Proper system utilization
- Preventative care
- Healthy lifestyles
- Disease management
- Other?

Incentive Types

- Cash
- Gift cards
- Debit cards
- Gift items
- Lottery tickets
- Gym memberships
- Other?

Restrictions

- By store
- By dollar amount
- By choice of products
- Other?

Distribution

- By plan
- By provider
- By vendor
- In person
- By mail
- Other?

Patient Reported Outcomes (PROs)



PROs

The following items will be discussed in this section and discussed further in Meeting 3:

- What are PROs?
- Why would PROs be relevant for patient advocacy and engagement?
- Benefits of PROs
- Practical challenges
- Potential recommendations to the VBP Workgroup

What are PROs?

- Questionnaires not focused on *satisfaction*, nor on subjective *experience with care* (CAHPS), but on *assessment of success of treatment*
- In many instances (elective procedures, chronic care, palliative care, long term care, care for disabled etc.), **the best judge of success of treatment is the patient / family**
- It is also a key instrument in **activating the patient** and through **shared decision making** (e.g. the decision to treat, choosing between treatments, end of life decisions, etc.)

Why would PROs be relevant for patient A&E?

- **PROs put patients central in the (e)valuation of their care**
 - Decision making about treatment options
 - Evaluation of outcomes
- **Enormous stimulus for providers to become oriented towards patient goals rather than provider goals**
 - Especially key in areas where ‘goals of care’ are not self-evident (and those are more frequent than is often thought)
 - Compare ‘broken leg’ to ‘decision to replace hip in medium-level osteoarthritis’ or ‘C-section of vaginal delivery’
 - Compare ‘pneumonia’ in a vital 70 year old to ‘aggressive non-curative cancer treatment’ in multi-morbid 95 year old’ or ‘COPD’ or ‘surgery of pre-cancer lesion in prostate or breast’ etc...
- **Philosophy of PROs is key to DSRIP!**

Benefits of PROs

- **Patients** – PRO results can lead to better informed decisions for treatment and selection of providers
- **Purchasers** – PRO reporting can help to identify which providers deliver care that patients find most beneficial
- **Providers** – PRO results increase patients' engagement with care and create a powerful instrument for constant self-improvement

Practical Challenges

Some challenges to consider with PROs:

- Cost
- Burden for Medicaid members
- Administrative hassle
- Resistance from professionals / providers
 - ‘Shared decision making’ is increasingly popular & well-known
- Responsibility of VBP contractor or plan
- Lack of infrastructure to collect information on a population level

Potential Recommendations

- What potential recommendations could be made to the VBP Workgroup on PROs?
 - RFA?
 - Financial Stimulus?
 - Model contract change?

Medicaid Members' Right to Know



From the Roadmap:

“Consumer rights to know the incentives that affect their care must be considered when developing strategies around what and when information related to VBP and DSRIP more broadly, will be communicated to beneficiaries.”

What do Medicaid members need to know about VBP?

What is the best mechanism for communicating with Medicaid members?

How and when should this information be communicated?

Reminder: Meeting Schedule

The next meeting will take place on October 9, 2015 from 10:30 to 2 PM at SPH 110A.

Please be prepared to discuss the following topics:

- Patient Reported Outcomes (PRO)
- Medicaid members' right to know
- Best practices on communication methods to Medicaid members

Subcommittee Co-chairs

Harvey Rosenthal harveyr@nyaprs.org

Trilby de Jung trilbydejung@flhsa.org