The guide to Medicaid member engagement:
Proven strategies and best practices from real-world programs
Executive Summary
Building healthy relationships with Medicaid members

The Medicaid market is at a tipping point. Reform has spiked growth in the Medicaid population and shifted the payment model from fee-for-service to fee-for-value. The new approach to payment by the Centers for Medicare and Medicaid Services (CMS) will reward payers and providers for improved care quality and outcomes, not the volume of care, and reduce reimbursement when goals are not met. Health care services are being capitated and combined like never before to force the issue of collaboration between payers, providers and patients, and accelerate achievement of far-reaching quality and efficiency goals.

The role of the payer in the brave new world has rapidly expanded. Likewise, the importance of the member has shifted to the center. Going forward, only the Medicaid health plans capable of reaching and engaging Medicaid consumers will succeed in the value-based economy of health care.

Content in this e-book will help you prepare, compete and flourish in the competitive Medicaid marketplace by targeting the most critical areas of plan performance. In six sections including numerous case studies, NovuHealth:

1. Examines the increasing financial, regulatory and membership pressures Medicaid payers face in light of shrinking state budgets and Medicaid expansion;
2. Defines Medicaid segments and their unique characteristics;
3. Provides guide rails for navigating new CMS rules and requirements;
4. Demonstrates the necessity for aligning member health and plan performance; and
5. Offers essential member-engagement strategies, a lesson in behavioral economics, and a multitude of case studies in which Medicaid plans successfully reach Medicaid beneficiaries to improve health outcomes and lower costs.

At the conclusion of this white paper, NovuHealth offers four tips for establishing successful Medicaid incentive programs for hard-to-reach Medicaid members.

NovuHealth designs and delivers health tools to affect industry-wide change while driving better health engagement and plan performance. By applying behavioral and data science and best practices from consumer marketing technologies, NovuHealth is an industry leader in the new era of consumer-centric health care.
Introduction

Medicaid managed care organizations under pressure to do more with less
**Introduction**

Medicaid managed care organizations under pressure to do more with less

In 2017, total enrollment in Medicaid reached 73.5 million.¹ Jointly funded by federal and state governments but administered by states under broad federal standards, Medicaid is sometimes identified by state “brand names,” e.g., Medi-Cal in California, BadgerCare in Wisconsin, or DenaliCare in Alaska. Each state operates its programs under unique financial arrangements to provide health coverage to eligible low-income adults, children, pregnant women, elderly adults and people with disabilities.

- Medicaid is the single largest payer for childbirth in the U.S. Fifty-percent of births in the U.S. are financed by Medicaid.²
- In 2017, Medicaid covered approximately 9.1 million adults with mental illnesses and 3 million with substance-use disorders.³
- Medicaid was the primary payer for long-term care, including $55 billion in 2015 for nursing homes. Medicaid covers 6 in 10 nursing home residents.⁴

State budgetary challenges with Medicaid payments combined with surging enrollment in Medicaid programs have exerted increasing pressure on states to do more to improve public health and decrease costs. To address these challenges, managed care organizations (MCOs) have become the primary health-care delivery system for Medicaid recipients. MCOs are formed to manage cost, utilization, and quality and are active in 39 states including the District of Columbia for at least a portion of state Medicaid populations (Figure 1)⁵.
By 2017, only three states had no managed care programs. In addition, 32 states with Medicaid MCOs reported at least 75 percent of all Medicaid beneficiaries were enrolled in MCOs.
Section 1:
Market disruption aligns member health & plan performance
Section 1 in brief: Factors affecting managed care organization margins

The fundamental payment system for Medicaid has shifted from a model in which the state assumes the risk for Medicaid patients in a fee-for-service paradigm, to a model in which risk is assumed by managed care organizations. The underlying assumption for the formation of MCOs is that these organizations can build in efficiencies—such as better provider rates—and also manage administrative and medical spend better than state-run programs.

Also, in 2016, CMS released new rules aimed at aligning Medicaid and Children’s Health Insurance Program (CHIP)-managed care with other insurance programs. Its focus on value-based care, quality, rate transparency, network adequacy and the member experience of Medicaid beneficiaries is designed to ensure children covered by this program receive high-quality care.

Because MCOs are paid on a capitated, per-member-per-month basis, they must understand their populations well enough to project and cover costs of care and administration and required statutory reserves to yield a margin that can be re-invested in their business.

As state budgets shrink, and MCOs address the health issues of more complex and unpredictable populations, the pressure to understand and motivate members to take action in their own health and health care is increasing.

The types of MCOs addressed below are those recognized by 42 CFR 438:6

1. Managed Care Organizations (MCOs)
   a. Comprehensive benefit package
   b. Payment is risk-based with capitation

2. Primary Care Case Management (PCCM):
   a. Primary care case manager contract with the state to provide case management services such as location, coordination and monitoring services
   b. A paid fee-for-service program for medical services rendered plus a monthly case-management fee

3. Prepaid Inpatient Health Plan (PIHP)
   a. Limited benefit package that includes inpatient hospital or institutional services (e.g., mental health)

4. Prepaid Ambulatory Health Plan (PAHP):
   a. Limited benefit package excluding inpatient hospitalization or institutionalization services, e.g., dental and transportation
   b. Payment may be risk- or non-risk bearing privately owned, for-profit companies.
Shifting Medicaid beneficiaries to the center of care

The disruptive changes in Medicaid offer plans tremendous opportunities for growth. Or failure. The new economic reality is that health plans must engage Medicaid beneficiaries in their health and health care and demonstrate improved outcomes and lower costs, or the value of their business and their role in the health eco-system will diminish. As in any business, a growth market is at once promising and difficult to navigate—because it features both risk and uncertainty. In the case of Medicaid, complicated legislation, new payment and quality policies and a rapidly growing but difficult to reach customer base for whom “whole person health” has become a key performance indicator.

Market share potential: ACA results in the influx of new members to marketplace
The Affordable Care Act (ACA) of 2010 increased enrollment in Medicaid by 15 million members as a result of raising the federal poverty level for eligibility to at or below 138 percent. States that expanded Medicaid are those that adopted this policy change. Although, even in states that did not expand, enrollment was expected to increase by 15 to 20 percent in the next decade as eligible members not previously enrolled claimed Medicaid benefits, as a result of simplified enrollment processes and the publicity surrounding coverage expansion. By 2021, annual Medicaid spending could total nearly $800 billion.

Opportunity to build value with CMS payment models
The payment model for Medicaid is also evolving. Many states are shifting their highest-acuity members from fee-for-service payment models to full-risk managed care programs that integrate and cover a comprehensive set of services. These changes are producing unprecedented heterogeneity and complexity in Medicaid, particularly in the coverage of new members and people covered by both Medicare and Medicaid (dual-eligible).

The push for quality, transparency and consumer-centric care
2015 changes by the Centers for Medicare and Medicaid Services (CMS) require states to develop a plan for quality improvement in managed care and establish quality rating systems for Medicaid managed care that will be publicly reported. In addition, CMS is:

- Requiring clearer and more consistent definitions of provider network adequacy for managed long-term services and supports (MLTSS);
- Strengthening state capacity to promote value-based purchasing, establishing performance targets, and promoting innovative and efficient models of care delivery;
- Aligning Medicaid managed care with the Health Exchanges and Medicare; and
- Enhancing beneficiary protections.
In 2016, CMS published the Medicaid and CHIP Managed Care Final rule that provided codification and expansion of the broad guidelines governing Medicaid managed care. The final rule is intended to align Medicaid, CHIP and other managed health programs, and modernize how states purchase managed care for beneficiaries. It includes improvements in member protections, transparency, actuarial soundness of state payment mechanisms, support for state efforts to improve care delivery and an increased focus on care quality. The final rule is the first major update to Medicaid and CHIP regulations in more than a decade.

Margin requirements and capitation variations
Capitation is the primary source of revenue for MCOs. When capitation rates accurately represent the cost of the covered population, an MCO’s margin targets can be achieved. Within the current regulatory environment, capitation rates are calculated with a “specific provision for margin ranges from 0.5% to 2.5%.” The laws governing MCOs do not guarantee earning a profit but provide the “opportunity to earn a fair and reasonable rate of return and a positive operating return (Figure 2).”
This map shows the established margins for Medicaid MCOs. However, four MCO characteristics can have an impact on margin: Size, for-profit vs. non-profit, provider-owned vs. insurer-owned and maturity.
The business imperative of sustainable margins is designed to attract and retain MCOs in state-managed Medicaid programs, while MCOs operate under the assumption that gains in efficiencies will be greater than the costs incurred to achieve them.

In most states, revenues paid by state Medicaid departments require that the MCO is a licensed insurer and regulated by state insurance departments—and therefore subject to the same regulations as other insurers. Also, Medicaid MCOs must meet federal regulations, including the CMS 2016 Medicaid and CHIP Managed Care Final rule.

The wide variation in MCO business models results in an equally wide variation in margin requirements. For example:

- **For-profit organizations** tend to seek higher margins and have a lower tolerance for underperformance;
- **Nonprofit organizations** tend to seek the lower margins built into state capitation rates;
- **Multistate organizations** have a higher tolerance for margin fluctuation in some of their states, as long as the overall portfolio performs at or near targets;
- **Multiproduct organizations** can tolerate underperforming lines of business, as long as the overall portfolio of products meet performance expectations over time; and
- **MCOs owned by provider delivery systems**, such as hospitals or physician groups, often measure their success by system-wide performance instead of performance of the MCO and the parent company. In these cases, the MCO-reported margin may not provide an accurate indicator of the overall margin attained by the parent company.

As each state administers its own Medicaid program, the majority of payments are paid in the form of annual capitated premium rates per month per member. Capitation rates vary depending on beneficiary category, benefits covered or carved out, demographic rate categories and the underlying historical costs of a geographic (or “rating”) area. Some states include an explicit provision for margin in an administrative expenses category, while others assume a provision for margin is included in capitation rate development.10

Annual recalculation or “rebasing” of capitation rates helps to reflect current cost and utilization patterns, but it also makes it more difficult for MCOs to achieve positive margins. MCOs are successful when they deliver care more efficiently than anticipated capitation rates. But their increased efficiencies are used to calculate future capitation rates. Therefore, each year, MCOs must find additional efficiencies to capture margin.

The issue with declining capitation rates is that investments in care management that successfully lower utilization may create a short-term financial benefit to the MCO, but a long-term decrease on their bottom line.

**MCO margins may be affected by:**

**Medical Loss Ratio requirements:** The final rule requires all states to use historical Medical Loss Ratio (MLR) as a point of comparison in rate setting to avoid excessive or under-funded rates. MLRs will be used to examine actuarial soundness and states may require MCOs to repay premium dollars until an MLR of 85 percent or higher is met. This provision could add pressure to margins.
Value-based payment contracting: The final rule clarifies states’ right to require MCOs to engage in value-based contracting via programs ranging from pay-for-quality, bundling, shared savings, to partial- or full-capitation. If successful, the risk-bearing entity (the provider) receives all or part of the savings captured from reduced utilization of high-cost services and care quality improvements.

Network adequacy: The final rule does not mandate specific network standards to ensure criteria such as distance, drive time or provider specializations. However, MCOs leveraging small provider networks to manage care costs are under scrutiny. Closed network, tightly-managed service delivery systems that offer no out-of-network coverage for services covered by contracts often fall short of ensuring access to health care for the poor. In the future, they may be required to expand their provider networks to increase patient access. If capitation rates do not reflect the potential higher cost of in-network care, network adequacy could reduce margins over time.

Actuarial soundness: The final rule compels states to ensure MCO rates are actuarially sound. New requirements have been implemented to prevent cross-subsidization of certain populations by ensuring that rates are adequate in each rating cell. Actuaries must certify to CMS that rate calculation meets the new guidance with data to support rate development, MLR calculations, and network access standards.

Did you know: MLR requires Medicaid plans spend a minimum amount of their revenue on health care services, covered benefits and quality improvement efforts. Rewards and incentives costs are classified as a quality improvement effort with positive impacts on the plan’s MLR Ratio.

Other factors that affect MCO revenue include:

- **State programs to mitigate risk:** Use of risk adjustment and corridors to redistribute payments based on the risk profile of each MCO.
- **Medical MLR:** MLR requirements cap positive margin but do not provide similar protection on the downside.
- **Cost variability:** Expanding managed care to Medicaid populations such as people with disabilities, children with medical complexity, and those with long-term care needs introduces more cost variability.
- **Quality programs:** When quality metrics are not met, states can withhold a portion of the capitation payment until quality targets are achieved.
- **Timing of payment:** Lag time between publication of old and new capitation rates can complicate MCO decision-making with regard to managing expenses—increasing the necessity for both margin and capital reserves.
- **Reporting requirements:** Most states with managed care programs require MCOs to submit detailed claims data periodically, also called encounter data. Implementing these requirements is sometimes costly and not always included in calculated administration costs—while not reporting encounter data can result in penalties.
Expense considerations and margin drivers
The substantial expenditure in the margin equation is the cost of health care to millions of Medicaid beneficiaries covered by MCOs. Variation is introduced with new populations and unanticipated costs, such as:

- **Pharmacy costs:** While state actuaries anticipate an increase in specialty drug cost trends in calculating capitation rates, they may not anticipate the magnitude of utilization of certain new specialty drugs.

- **Medical costs:** Although historical medical costs for populations tend to be stable and predictable, new benefits (behavioral, long-term care) and newly eligible populations are less predictable and can affect margins.

- **Expansion population:** The Affordable Care Act (ACA) expanded Medicaid coverage to low-income childless adults, and—in the states that implemented Medicaid expansion—offered benefits via Medicaid MCOs. Although the law built in risk-mitigation strategies for MCOs, such as risk corridors, the absence of historical risk data resulted in significant impact on MCOs margins.

In addition, states are shifting populations once covered by other fee-for-service programs (such as Temporary Assistance for Needy Families) to MCOs as well as pushing MCOs to cover more complex and unpredictable populations via managed care. The goal of states is to integrate benefits and services that lead to “whole-person” health care delivery, higher quality and lower costs. But the reversal of carve-out to carve-in benefits increases uncertainty and cost volatility.

**Populations and benefits entering into managed care programs include but are not limited to:**

- **Long-term services and supports (LTSS):** LTSS utilization and costs are less variable than other population costs. However, reliable data may not be as readily available for LTSS populations, and if available, may not match the population that will be covered. Also, risk adjustment is difficult because states have not adopted a common risk adjustment system.

- **Children with medical complexity:** The cost of children with medical complexity can be highly variable, and their administrative needs are different than other Medicaid populations. For example, they incur more non-medical costs, such as social services, than other populations.

- **New benefit carve-ins:** Some benefits or populations that have been carved out of managed care plans in the past, such as behavioral health and people with HIV, are being moved into managed care programs by states.

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**Nearly 16.6 million** additional individuals were enrolled in Medicaid and CHIP in December 2017 as compared to the period prior to the start of the first Marketplace open enrollment period (July - Sept. 2013). This represents a 29 percent increase over the baseline period for the 49 states that reported relevant data for both periods. (Connecticut and Maine are not included because they did not report data for both periods.)

Section 1 conclusion: The financial evolution of Medicaid managed care

While it’s interesting to review MCO performance over the last few years, it’s more important to consider how the factors and considerations discussed above may impact margins in the future, as Medicaid managed care evolves.

One market force that is certain to affect Medicaid reimbursement is each state’s ability to accommodate the rising costs of health care as a percentage of their annual budget. When state budgets are at risk, it’s likely that MCO capitation rates will drop—leading to insufficient margins.

States are pushing their managed care programs to expand covered services, reversing the trend of carving out populations and services.
Section 2:
Understanding Medicaid MCO member costs
Section 2 In brief: Population characteristics and social determinants of Medicaid populations

Medicaid covers a large and diverse portion of the American population. While per-member costs are relatively low, total Medicaid costs are high due to the sheer numbers of Medicaid-eligible Americans and a small fraction of beneficiaries with high needs. Medicaid is the primary or secondary source of coverage for wide segments of the U.S. population with low-income, medical, behavioral and substance abuse issues whose health outcomes are greatly affected by social determinants.

The following criteria identify Medicaid and CHIP beneficiaries:

- Infants and children
- Pregnant women
- Parents and other nonelderly adults
- Individuals of all ages with disabilities
- Very low-income seniors, most of whom are also covered by Medicare

Social determinants of health are the structural determinants and conditions in which people are born, grow, live, work and age, including factors like socioeconomic status, education, the physical environment, employment and social support networks. Social determinants account for 80 to 90 percent of wellness.

74,432,870 individuals were enrolled in Medicaid and CHIP in the 51 states reporting December 2017 data.15
- 68,045,556 in Medicaid
- 6,387,314 in CHIP

Seventy-five percent of nonelderly Medicaid enrollees are in working families. Children make up about half of all enrollees, nonelderly adults make up 25 percent, and seniors and people with disabilities make up one-quarter. Medicaid covers many but not all poor Americans (Figure 7).

Figure 7: Medicaid’s Role for Selected Populations11
Compared to private insurance, the per-member cost of Medicaid is low. In fact, if Medicaid beneficiaries were employed and able to purchase insurance through their employers, their costs would be more than 25 percent higher. However, the large number of beneficiaries and the very high costs of a fraction of Medicaid enrollees, such as seniors and people with disabilities, comprise nearly two-thirds of Medicaid spending due to long-term and/or acute care needs. More than half of Medicaid spending can be attributed to five-percent of the highest-cost enrollees.

Medicaid serves as a high-risk pool for the private health insurance market by removing people with the highest risk to keep premiums for healthy populations low (Figure 8)

**Figure 8: Distribution of Medicaid Spending by Eligibility Group**

<table>
<thead>
<tr>
<th>Enrollees</th>
<th>Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elderly</td>
<td>Adults</td>
</tr>
<tr>
<td>14%</td>
<td>9%</td>
</tr>
<tr>
<td>43%</td>
<td>19%</td>
</tr>
</tbody>
</table>

Enrollees Total: $80.7 Million
Expenditures Total: 462.8 Billion
Medicaid for adults has expanded in some states
Today, Medicaid covers services required by law and in some states, optional services such as prescription drugs, physical therapy, eyeglasses and dental care. The Affordable Care Act expansion for low-income adults raised the federal poverty level to 138 percent and provided coverage for ten essential health benefits, including preventive, expanded mental health and substance-use treatment services. In states where Medicaid was expanded to a wider range of low-income adults, rural coverage increased from 21 to 25 percent between 2013 and 2015. In rural areas that did not expand Medicaid, 15 percent of non-elderly individuals have no health insurance. With new populations, annual Medicaid spending could total nearly $800 billion.13

New CMS payment models integrate more services
The payment model for Medicaid is also evolving. Many states are shifting their highest-acuity members from fee-for-service payment models to full-risk managed care programs that integrate and cover a comprehensive set of services. These changes are producing unprecedented heterogeneity and complexity in Medicaid, particularly in the coverage of new members and people covered by both Medicare and Medicaid (dual-eligible).

Medicaid covers 52 million children and non-elderly adults in rural areas
Spread across 2,500 counties and concentrated in the South and Midwest, nonelderly individuals in rural areas are less likely to be employed and face increasing barriers to accessing health care as a result of rural hospital closures and geographical distance to providers. Medicaid helps fill the gap in private coverage for one in four non-elderly adults in rural areas.

One in three children is covered by Medicaid and CHIP
For children, Medicaid provides developmental pediatric coverage that includes early and periodic screening, diagnostic and treatment (EPSDT), which is particularly important to children with disabilities because private insurance often falls short of meeting their needs.

Six in ten nursing home residents are covered by Medicaid
Whereas private plans and Medicare do not cover long-term care, Medicaid covers nursing home care, as well as home and community-based long-term services and supports (LTSS) to enable seniors and people with disabilities to live independently. In 2015, there were 47.5 million Americans age 65 and older. Chronic disease among this population—such as heart disease, diabetes, and dementia—produce complex physical and behavioral health care needs, some of which are
not covered by Medicare. In addition to long-term care, Medicaid covers LTSS: assistance with self-care, meal preparation and other household activities. This cost-sharing makes Medicare more affordable for seniors with low incomes. Medicaid is responsible for half of the total spending in the U.S. related to long-term care and LTSS for people with disabilities and the elderly. Many states are striving to replace institutional care for these populations with home and community-based services (Figures 9 and 10).

**Figure 9: Rates of Disease and Disability by Type of Coverage (% Adults 18-64)**

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>Private</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

**Figure 10: Medicaid Share of Spending for Long-Term Service and Support (LTSS)**

- 52% Medicaid
- 20% Other Public & Private
- 11% Private
- 17% Out of Pocket

**Total LTSS Spending:** $332.7 Billion
Medicaid for working families
Over time, Medicaid has expanded to cover populations left out of employer-based private insurance because of low income, poor health status, age or disability. Nearly eight in ten Medicaid recipients are neither elderly or disabled and live with working families, or work themselves, but their employers offer limited or no employment benefits, such as health care coverage. Adult Medicaid beneficiaries who do not work are typically prevented from working by illness or disability.

Mental illness and addiction care accounts for 48 percent of Medicaid spending
Enrollees with behavioral health conditions have grown from 20 percent to 48 percent since 2011. Medicaid expenditures for this sector are high because these populations are more likely to have comorbid chronic physical conditions resulting in more intensive service utilization—such as office visits, inpatient stays, emergency department visits and prescription drugs (Figures 11 and 12).
Medicaid is a safety net for veterans

Medicaid covers some veterans who otherwise would be uninsured, and for others, supplements Medicare, private, veteran or military coverage. Medicaid coverage enables veterans to receive needed care and makes care affordable by limiting out-of-pocket costs.

Medicaid covers veterans with complex health care needs, such as chronic health conditions, behavioral health disorders and traumatic brain injuries. It provides federal matching funds with no pre-set limit and enhanced federal funding for states to cover many adults, including veterans, who previously were excluded from the program (Figures 13 and 14).

**Figure 13: Medicaid Coverage and Health Status of Veterans**

- 41% Medicaid & Military/Veterans
- 39% Medicaid only
- 11% Medicaid & Private
- 9% Medicaid & Medicare

**Total: $2.3 Million**

**Figure 14: Health Status of Veterans on Medicaid (875,000)**

- Case management/Care coordination: 25
- Intensive outpatient: 22
- Partial hospitalization: 17
- Other inpatient services: 27
- Inpatient detoxification: 32
Medicaid covers three in ten people with opioid addiction

Medicaid also plays a significant role in addressing the country’s opioid epidemic with early intervention and treatment. In 2015, more than two million people had an opioid-abuse disorder and more than 590,000, a heroin addiction. Medicaid and CHIP covered 3 in ten people with opioid addiction. Drug overdose deaths in 2016 most likely exceeded 59,000, the largest annual jump ever recorded in the United States, according to preliminary data compiled by The New York Times. The CDC reported in 2017, that drug overdoses are now the leading cause of death among Americans under 50 (Figures 15 and 16).

Figure 16: Medicaid covered Treatment Services for Opioid Addiction (Number of States with the Service)\textsuperscript{14}

<table>
<thead>
<tr>
<th>Health Status of Veterans on Medicaid (875,000)</th>
<th>0%</th>
<th>10%</th>
<th>20%</th>
<th>30%</th>
<th>40%</th>
<th>50%</th>
<th>60%</th>
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</thead>
<tbody>
<tr>
<td>Fair or poor health</td>
<td>35</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Substance use disorder</td>
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<td></td>
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<td>Severe mental illness</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have a disability</td>
<td>54</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2 or more chronic conditions</td>
<td>42</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Medicaid Coverage for Veterans

Medicaid only
Medicaid & Military/Veterans
Medicaid & Private
Medicaid & Medicare

39% Medicaid only
41% Medicaid & Military/Veterans
11% Medicaid & Private
9% Medicaid & Medicare

Figure 15: Medicaid Coverage and Services for Opioid Addiction\textsuperscript{14}

35% Private
30% Medicaid/CHIP
25% Uninsured
10% Other/Unknown
Health gaps and social determinants

Social determinants of health (SDoH) describe the conditions in the environment in which people are born, live, learn, work, play, worship and age that affect health outcomes and risks, functioning and quality-of-life. These social, economic and environmental conditions together with an individual’s behaviors impact 80 percent of a person’s well-being and health outcomes. Behavioral patterns and health-risk behaviors (40%), social circumstances (15%) and environmental exposures (5%) play a significant role in premature death in the U.S. These determinants disproportionately affect those in low-income brackets, a population that is served primarily by Medicaid.

There is a great deal of evidence that shows the connection between SDoH and health outcomes. In this e-book, we illustrate the relationship between childhood poverty and poor health. Figures 17, 18 and 19 show the strong correlation between poverty and poor health with $R^2$ of 0.81. Figures 18 and 19 show poverty rate and poor health rate by county. It is important to note that Alabama is not an outlier state, and our analysis of other states show similar relationships between SDoH factors—such as poverty and poor health (Figure 17-19).
Section 2 Conclusion: Medicaid population challenges

Medicaid’s most widely acknowledged function is to provide fundamental health insurance coverage for 55 million low-income children and parents. However, Medicaid’s role as a health insurer of low-income families is not its most unique or costly undertaking. The factors that make Americans eligible for Medicaid also increase the medical and behavioral costs of these populations.

Medicaid coverage of 12 million low-income people with disabilities and 8 million low-income elderly people with both medical care and long-term care services dominates Medicaid spending. Although children account for half of all Medicaid beneficiaries, they account for only a small share of spending. Together children and their parents represent three-quarters of all beneficiaries and 30 percent of all spending, while the elderly and disabled account for a quarter of beneficiaries and 70 percent of spending.16
**Section 3 in brief:** The four key regulatory challenges of Medicaid MCOs

Medicaid is financed and regulated at both state and federal levels. The federal share varies based on a formula in federal law that relies on states' average per capita income compared to the national average; states with lower incomes have a higher federal medical assistance percentage (FMAP). At the state-level, program design, quality, coverage, and cost diverge broadly. In this section, we summarize the four biggest regulatory challenges facing Medicaid MCOs:

1. Challenges associated with the CMS 2016 final rule
2. Differences in eligibility criteria and enrollment processes
3. Differences in payment and coverage initiatives across states with Medicaid managed care
4. Differences in quality programs
As stated earlier, in 2016, CMS introduced a final rule establishing a new regulatory framework for managed care. A policy watershed, the rule will touch the lives of tens of millions of low-income children and adults, and individuals with disabilities. Estimates suggest that a majority of today’s more than 70-million Medicaid beneficiaries are enrolled in managed care plans, and the number is expected to increase over the next decade.

The rule puts states in the driver’s seat for creating end-to-end health-care delivery systems for their Medicaid managed care beneficiaries. States have been working toward this end by tackling everything from marketing and enrollment to quality improvement in service delivery. They have built relationships with social service programs but still face unique challenges in terms of reaching the service integration managed care organizations must achieve to adequately serve Medicaid populations.

While the Affordable Care Act (ACA) fundamentally reformed the health insurance policy landscape, state Medicaid programs carry the burden of fulfillment among the poorest populations with the highest health risks.

Reaching medically underserved communities
The final rule adds teeth to the previous health-care provider network-adequacy standard. But it does not resolve the problem of medically underserved communities where Medicaid beneficiaries are more likely to reside, and provider shortages tend to occur. Safety-net providers such as community health centers and public and mission-driven hospital systems form the Medicaid managed care provider network backbone, but they, too, experience staff shortages. One recent study reported that by filling open positions, health centers could serve two-million more patients.

Unstable eligibility and enrollment
The ACA represented a turning point in coverage opportunities for low-income Americans. Yet eligibility for both Medicaid and the tax subsidies offered through the insurance marketplaces is closely tied to family income. Even with the massive efforts now under way to streamline enrollment and renewal, nothing can overcome the income fluctuations that affect coverage shifts over time. The risk of break-in-coverage remains, especially in states that have chosen not to expand Medicaid eligibility. The final rule makes it possible for health plans to participate in both the Medicaid managed care market and the qualified health plan marketplace, so consumers can remain enrolled in their plans whether it is provided by Medicaid or subsidized
according to ACA rules. This is an important opportunity for states, though only four in 10 insurance companies participate in both Medicaid and ACA marketplaces.

Organizing coverage and care and developing effective payment incentives
The final rule stresses value-based purchasing as a core Medicaid managed care policy aim. But designing Medicaid contracts poses a challenge with no equivalent in the private insurance market. In private insurance, coverage equals the benefits listed in the policy (e.g., speech therapy). In Medicaid, by contrast, coverage can extend beyond the health plan’s contracts. For example, a state could include up to 10 speech therapy visits in its contracts, while leaving the far-higher level of speech therapy needed by certain children with developmental disabilities in Medicaid’s fee-for-service program. Deciding what to include in a plan contract, what to carve out into separate specialized plans, or which services will remain in the fee-for-service system are decisions with downstream implications for the plan’s network needs, utilization management activities and its use of financial incentives to promote quality and efficiency.

Aligning managed care with health, education, nutrition and social services
With the exception of long-term services and long-term support plans, the final rule does not directly address partnerships between managed care plans and social, educational, housing and economic security programs. Nor does it consider the efforts made by nonprofit hospitals in managed care networks that devote a portion of community-benefit spending to population health interventions, such as smoking cessation or weight loss programs. But achieving greater integration of health and health care is emerging as a priority among states, and the rule permits states to continue to move in this direction by developing managed care systems that can bridge health and social services.

Information technology
The final rule’s emphasis on information exchange underscores that successful managed care requires access and data sharing. But information technology remains a fundamental challenge, particularly for long-term services and supports. Despite a $30 billion federal investment, health systems today remain woefully underfunded, particularly those that support long-term care, since the Health Information Technology for Economic and Clinical Health (HITECH) Act created incentives only for hospitals and clinical practices.
2. State differences in eligibility criteria, enrollment processes, premiums and cost sharing

**Eligibility criteria**
Medicaid and CHIP are the central sources of coverage for low-income children and pregnant women, with 49 states covering children and 34 states covering pregnant women with incomes at or above the 200-percent federal poverty level (FPL) as of January 2017. CHIP covers children in separate CHIP programs in 36 states, funds coverage for some children under Medicaid in 49 states and supports coverage for pregnant women in 19 states. In 2016, several states took up options to expand access to coverage for children and pregnant women.

Medicaid’s reach broadened under the ACA in 2017, with 32 states covering low-income parents and other adults with incomes up to 138% FPL ($16,394 for an individual or $27,820 for a family of three in 2016). This state total reflects Louisiana’s adoption of the expansion in 2016. In the 19 states that have not expanded Medicaid access, the median eligibility limit for parents is 44% FPL ($8,870 for a family of three as of 2016) and other adults are ineligible regardless of income, except in Wisconsin.

**Enrollment processes**
In 2016, states continued to upgrade and streamline Medicaid eligibility and enrollment systems and processes under the ACA, using available federal funding to support system development. As of January 2017, 50 states support online Medicaid application, 41 states offer online accounts for enrollees to manage their coverage, 39 states make real-time Medicaid eligibility decisions, and 42 states process automated renewals (Figure 20).

![Figure 20: Eligibility Criteria and Enrollment Process (Count of States)](image-url)
3. State differences in payment and coverage initiatives

Differences in premiums and cost sharing
Use of premiums and cost sharing in Medicaid and CHIP varies across states and groups. As of January 2017, 30 states charge their members premiums or enrollment fees and 25 states charge cost sharing for children in Medicaid or CHIP. In most cases, these charges are limited to children in CHIP, because CHIP covers children with higher family incomes than those in Medicaid and the program has different premium and cost-sharing rules. Given the low incomes of adults covered by Medicaid, most states do not charge adults for premiums, and cost-sharing amounts for adults, while small, may be difficult to afford. Overall, 39 states charge parents cost sharing, and 23 of the 32 states that have expanded Medicaid coverage charge cost sharing for expansion adults. Six states have received waivers to charge premiums or monthly contributions for adults that are not otherwise allowed under law.

Managed care and delivery system reforms
In 28 of the 39 MCO states, at least 75 percent of all Medicaid beneficiaries are enrolled in MCOs. Many states are implementing quality initiatives such as pay-for-performance, quality metrics reporting, or collection of adult and child care-quality measures. States are using MCO arrangements to promote value-based payment and increase attention on the social determinants of health. Twenty-nine states are also adopting or expanding other delivery system reforms in 2016 and 2017, such as patient-centered medical homes (PCMHs), Health Homes, Accountable Care Organizations (ACOs), Delivery System Reform Incentive Payment (DSRIP) programs, and other efforts to better manage the care of high-need populations.18

Long-term services and supports
In 2016 and 2017, most states reported expanding the number of people served in community settings through increased enrollment in home- and community-based service waivers and by implementing new HCBS state-plan amendments. Twenty-three states are providing some or all LTSS via managed care arrangements; and in July 2016, 15 states offered managed long-term services and supports for some LTSS populations.19

Provider payment rates and taxes
In 2016, more states increased provider rates and imposed fewer restrictions. However, this trend has declined as economic conditions change. Every state but Alaska use a provider tax or fee to help finance Medicaid. Eight of the states that expanded Medicaid reported that plans must use provider taxes or fees to fund all or part of the costs of the ACA Medicaid expansion beginning in January 2017, when states will be responsible for 5 percent of the costs of ACA expansion.20
4. Quality rating strategies

Benefits (including prescription drug policies)
Twenty-one states expanded or improved covered benefits in 2016, and 20 states are planning expansions for 2017. The most common enhancements include behavioral health and substance use disorder services. As a result of rising drug costs, in 2016, 31 states implemented or planned to implement pharmacy cost containment efforts, followed by 23 states in 2017. Most are targeting high-cost specialty drugs and expanding pharmacy management strategies to quell the opioid epidemic.21

States with MCO programs track one or more quality measures and require additional health plan quality activities designed to improve health-care outcomes and plan performance. In the Kaiser Family Foundation 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017, Medicaid directors and staff were asked to report on quality strategies for the years 2014-2016.

Thirty-three of the 39 MCO states (including the District of Columbia) had one or more quality strategies in place in FY2014. Twenty-three of those publicly reported or required MCOs to report quality metrics and more than one-third had pay-for-performance provisions, capitation withholds, and performance bonuses or penalties in FY2014.

In 2015, 21 states implemented new or expanded quality initiatives followed by 19 states in 2016. The most common new or expanded quality initiative was managed-care payment withholds tied to quality performance ranging from 0.15 percent (Virginia) to 5 percent (West Virginia and Minnesota).

Several states also reported expanding or adding new pay-for-performance requirements as well as performance bonus or penalties and initiatives to publicly report quality metrics. Minnesota required MCOs to participate in its ACO and value-based contracting.
Section 3 Conclusion: Medicaid is still a patchwork, but the final rule will govern MCO design

initiatives in FY 2016, and Pennsylvania required MCOs to participate in community-based care management programs in FY 2015 and planned to require MCOs to participate in physical health/behavioral health integration efforts in FY 2016 (Figure 21).

Figure 21: Medicaid Managed Care Quality Initiatives (Count of States)²²

<table>
<thead>
<tr>
<th>In Place in 2015</th>
<th>Added/Expanded in 2015</th>
<th>Added/Expanded in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay for performance</td>
<td>Managed care payment with/without</td>
<td>Public reporting of quality metrics</td>
</tr>
<tr>
<td>Performance bonus/penalty</td>
<td>Other quality initiatives</td>
<td>Any of select quality initiatives</td>
</tr>
</tbody>
</table>

The differences in program design and regulatory frameworks for Medicaid across the country highlight the fact that Medicaid is not a single insurance program with a well-defined and consistent set of rules and requirements. The uncertainties in the regulatory environment—from repeal and replace efforts to the debate around CHIP renewal—make it difficult to anticipate future impacts of health-care regulations. However, we can predict that the CMS final rule of 2016 will remain a primary influence, providing detailed guidance under which states design their managed care programs.

Despite these pressures, MCOs have continued to pioneer ways to deliver quality and cost efficiency, while addressing member needs. Making the American health care system work better is an American problem that demands innovation. In the same way that consumer industries have changed to adapt to consumer needs and preferences to improve “business,” so must health care respond to member needs to improve health and plan performance.
Section 4:
Innovation to improve Medicaid member health and plan performance
Section 4 in brief: Importing consumer insights and loyalty strategies in Medicaid engagement

Like a commercial operation that strives to understand its customers in order to optimize products and services and increase market share, it’s essential that health plans understand a range of variables about their members. Essential characteristics of Medicaid members include their health behaviors, their attitudes about health insurance and care delivery, and their channel preferences for health-related information and advice. In this section, we dive into consumer insights about Medicaid members, from health status to health care utilization rates, and begin to uncover the potential impact of converting members to full engagement in their own health and health care.

Perhaps more than other populations, for Medicaid members, enrollment in a health plan does not equal engagement with or adherence to health-care systems. As such, members are less likely to address minor health issues before they become emergent or to follow up with a specialist after an emergency room visit or discharge from the hospital.
Medicaid managed care population characteristics

While states have differing guidelines regarding Medicaid populations, effective member engagement—across the board—is the cornerstone for meeting quality metrics leading to improved results: increased clinical management quality, an improved member or patient experience, new efficiencies and healthier outcomes (Figures 22-23).

Figure 22: Medicaid Managed Care Enrollment by State

Figure 23: Medicaid Population Characteristics, by Ethnicity, Gender and Age

Medicaid Population by Ethnicity
- Black: 22%
- Hispanic: 12%
- Other: 25%
- White: 41%

Medicaid Population by Gender
- Male: 59%
- Female: 41%

Medicaid Population by Age
- 45-64: 18%
- 27-44: 12%
- 19-26: 10%
- 0-18: 12%
- 65+: 48%
To develop quantitative consumer insights about the Medicaid population, Macpac, the Medicaid and CHIP Payment and Access Commission’s non-partisan legislative branch agency, surveyed more than 1,100 consumers across the United States. The survey focused on the following groups: current Medicaid members (Medicaid and dual eligible members), people who are currently eligible for Medicaid but not enrolled (EBNEs), and people who became eligible for Medicaid as part of the ACA (new eligibles). The survey also included some commercially insured individuals to enable direct comparisons. The results revealed two key insights:

• In many ways, people entitled to enter the Medicaid program as part of the ACA, which includes both EBNEs and the new eligibles, are more similar to commercially insured individuals than to current Medicaid members. Nevertheless, there are several important differences between the potential entrants and commercially insured individuals. These differences have significant implications for plan design.

• Many dual eligibles are not being reached effectively, in part because of misconceptions about them. Managed care programs geared to these members will be more effective if grounded in a more accurate understanding of their needs, behaviors and attitudes.\(^{25}\)

A summary of findings from this study of Medicaid population segment behaviors and attitudes follows.\(^{26}\)

1. Behavior characteristics

• Fifty-six percent of the new eligible and 40 percent of EBNEs were employed, compared with only 26 percent of non-dual Medicaid enrollees.

• Over half of the employed potential entrants were working full-time.

• About 30 percent of the new eligibles reported having three or more health conditions, a rate similar to that reported by commercially insured individuals. In comparison, 39 percent of EBNEs and 60 percent of non-dual enrollees said that they had three or more health conditions.

• Approximately 60 percent of the new eligibles and commercially insured individuals, and 55 percent of the EBNEs, reported that they had never been smokers, but only 38 percent of non-dual enrollees made this claim.

• Just over 50 percent of the potential entrants said that they already had health insurance, usually through a job, union or school. However, eight percent of the new eligibles and 13 percent of EBNEs reported having purchased coverage directly (Figure 24).

• Lack of health insurance reported by almost half of the potential entrants appears to have influenced EBNE’s health care utilization levels. On average, the potential entrants were much less likely than current enrollees or commercially insured individuals to have visited a primary care provider (PCP) during the previous year.

• Even among the respondents with three or more health conditions, the rate of PCP visits was markedly lower among the potential entrants than among those with Medicaid or commercial coverage.

• Approximately 60 percent of the potential entrants said that they planned to visit PCPs more frequently once insured, and 48 percent of them were willing to be seen by non-physician providers.\(^{27}\)

Drilling down: Macpac survey reveals Medicaid member preferences, attitudes, values and engagement levels
The frequency of emergency room (ER) utilization—three or more visits in the previous year—was higher among new eligible (9 percent) and EBNE (7 percent) populations than among commercially insured individuals (1 percent). However, the potential entrants’ rate of ER utilization was far below that of non-dual Medicaid enrollees (16 percent).

The analysis did not find significant behavioral differences among ethnic groups. For example, Hispanic new eligibles were very similar to non-Hispanic populations in terms of employment (60 percent employed), insurance status (47 percent insured) and utilization (45 percent saw a PCP in the past year). Hispanic new eligibles differed only in that they reported slightly better health status (just 19 percent said that they had three or more health conditions) (Figure 24).

2. Attitude characteristics

All surveyed populations value PCP and prescription coverage

All of the groups in the Macpac analysis said that the feature they valued most in health insurance was coverage for PCP visits, followed by coverage for prescription drugs (Figure 25). The potential entrants, like commercially insured individuals, expressed little interest in specialty benefits, such as mental health or transportation coverage.

Network considerations of plan members

The potential entrants did differ from commercially insured individuals in their willingness to consider narrow provider networks. Thirty-eight percent of potential entrants and more than two-thirds of commercially insured individuals said provider network size was an important consideration in their choice of plans. However, both the potential entrants and commercially insured individuals ranked cost-sharing (premiums and deductibles), doctor visit co-pays, and prescription drug co-pays as the most important drivers of plan choice.

Younger and older adults have unique preferences

Age influenced some potential entrants’ attitudes. Among new eligibles, for example, 51-percent of adults over the age of 50 were much more likely than young adults (35 percent) to prioritize prescription drug benefits among the top three most important services to include in a health plan. People between the ages of 18 and 29, said dental care was a top-three priority, while only 13-percent of over 50 adults named dental in their top three list. Across all age groups, 75 percent of potential entrants listed primary care provider (PCP) visits in their top three.
### Figure 24: Medicaid Population Segments vs. Commercial - Select characteristics (%)

<table>
<thead>
<tr>
<th>Category</th>
<th>Non-Dual Enrollees</th>
<th>Dual Eligibles</th>
<th>EBNEs</th>
<th>New Eligibles</th>
<th>Commercially Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
<td>26</td>
<td>9</td>
<td>40</td>
<td>56</td>
<td>80</td>
</tr>
<tr>
<td>3 or More Health Conditions</td>
<td>60</td>
<td>75</td>
<td>39</td>
<td>30</td>
<td>27</td>
</tr>
<tr>
<td>PCP Visits in last 12 mos</td>
<td>84</td>
<td>89</td>
<td>60</td>
<td>52</td>
<td>79</td>
</tr>
</tbody>
</table>

### Figure 25: Medicaid Population Segments vs. Commercial – Perceived Value of Select Benefits (%)

<table>
<thead>
<tr>
<th>Service</th>
<th>Non-Dual Enrollees</th>
<th>Dual Eligibles</th>
<th>EBNEs</th>
<th>New Eligibles</th>
<th>Commercially Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Drug Coverage</td>
<td>69</td>
<td>83</td>
<td>65</td>
<td>55</td>
<td>67</td>
</tr>
<tr>
<td>Visits to an Eye Care Prof.</td>
<td>28</td>
<td>41</td>
<td>33</td>
<td>24</td>
<td>28</td>
</tr>
<tr>
<td>Visits to a Dentist</td>
<td>54</td>
<td>36</td>
<td>57</td>
<td>57</td>
<td>51</td>
</tr>
<tr>
<td>Visits to the Mental Health...</td>
<td>23</td>
<td>17</td>
<td>11</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Visits to the ER</td>
<td>49</td>
<td>42</td>
<td>52</td>
<td>55</td>
<td>65</td>
</tr>
<tr>
<td>Visit to the Hospital</td>
<td>17</td>
<td>13</td>
<td>24</td>
<td>28</td>
<td>41</td>
</tr>
<tr>
<td>Visits to a Specialist</td>
<td>47</td>
<td>56</td>
<td>40</td>
<td>48</td>
<td>65</td>
</tr>
<tr>
<td>Visits to a PCP Office</td>
<td>88</td>
<td>90</td>
<td>54</td>
<td>87</td>
<td>94</td>
</tr>
</tbody>
</table>
Like the other groups surveyed, dual eligibles placed a high value on coverage for PCP visits and prescription drugs (see Figure 6). Compared with other groups, however, they put greater weight on specialist visits and specialty services, such as mental health and transportation. Although one-third of dual eligibles rated provider network as an important driver of plan choice, two-thirds were willing to consider the use of non-physician providers for routine care (Figure 25).

There are few attitudinal differences among ethnic groups surveyed. However, some of the differences were striking. Hispanic new eligibles were much less likely to list prescription benefits as a top-three service priority and were much more willing to pay more for a broad network (Figure 26).

Figure 26: Similarities and Differences Between Hispanic and Non-Hispanic New Eligibles

<table>
<thead>
<tr>
<th></th>
<th>Hispanics Place Less Value on Drug Benefits</th>
<th>Are Willing to Pay for Network Choice</th>
<th>And Are Slightly Less Reliant on Internet Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Hispanic</td>
<td>43</td>
<td>22</td>
<td>53</td>
</tr>
<tr>
<td>Hispanics</td>
<td>27</td>
<td>47</td>
<td>38</td>
</tr>
</tbody>
</table>
3. Engagement levels
To help payers and providers find avenues to engage dual-eligible members, the Macpac survey included more than 100 dual eligibles. The results revealed several shortcomings in care management and outreach that, if addressed, could markedly enhance engagement with this population.

Multi-morbidity is common among dual eligibles—75 percent of them reported having three or more health conditions (most often, hypertension, depression and hypercholesterolemia). Ninety percent of this population visited a PCP in the previous year and eight percent reported three or more visits to the ER in the same period.

What is interesting about the engagement level of dual-eligible members, is that their engagement with plans and clinicians appears to be very limited.

- Twenty-two percent said they were never contacted by their provider outside of care delivery, and 46 percent reported they had never been contacted by their insurance company or program. For these members, better engagement alone could have a significant impact—both in terms of health outcomes and health care costs.

The survey also found that technology use is fairly high among dual eligibles. Websites were second only to television as a source of health-related information (28 percent versus 43 percent, respectively). One-third of dual eligibles said that they were interested in being reached via email for care management (Figure 27).

Figure 27: Sources of Health-Related Information by Medicaid Segments

<table>
<thead>
<tr>
<th></th>
<th>Non-Dual Enrollees</th>
<th>Dual Eligibles</th>
<th>EBNEs</th>
<th>New Eligibles</th>
<th>Commercially Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Search Engines</td>
<td>33</td>
<td>22</td>
<td>50</td>
<td>42</td>
<td>60</td>
</tr>
<tr>
<td>Magazines</td>
<td>36</td>
<td>26</td>
<td>23</td>
<td>28</td>
<td>35</td>
</tr>
<tr>
<td>Television</td>
<td>41</td>
<td>43</td>
<td>47</td>
<td>32</td>
<td>26</td>
</tr>
<tr>
<td>Websites</td>
<td>38</td>
<td>28</td>
<td>44</td>
<td>54</td>
<td>71</td>
</tr>
</tbody>
</table>
Section 5:
Seven essential Medicaid member engagement strategies
Section 5 in brief: How to foster engagement (with real-world examples)

To truly make an impact on member lives, your plan must effectively motivate members to complete high-value activities shown to improve their health outcomes. In doing so, plan performance will improve.

In this section, we recommend seven strategies for fostering member engagement in the Medicaid market:

1. **Understand the Medicaid population you serve.**
2. **Offer the incentives that members value.**
3. **Use mobile technology and text messaging; smart phones are increasingly the proxy for “home address.”**
4. **Be more visible in the lives of members.**
5. **Create community partnerships.**
6. **Accommodate low health literacy.**
7. **Continuously find and test creative engagement solutions for win/win outcomes.**

In the last 50 or so years of Medicaid, never has increasing engagement been so critical to affecting individual and public health. Why? Member engagement is crucial for motivating healthy activities that can improve outcomes and drive down costs. The most successful engagement methods include:

- Tools that initiate conversations with Medicaid members about their health status and their risk factors for preventable disease
- Respect for members’ health literacy levels;
- Multiple channels of communication;
- Strategies to meet members where they are; and
- Rewards and incentives that are most meaningful to members.
The seven secrets to member engagement strategies with use cases

1. Understand the Medicaid populations you serve

When a plan understands its consumers’ health status, risks for chronic disease, the socio-economic influences affecting their well-being, and their motivation to make changes for better health, it is able to diversify its approach to reaching and engaging people with complex circumstances and needs.

Just as misconceptions about consumers will foil a commercial campaign to convert prospects, so too will a blanket solution to encourage a generalized “Medicaid enrollee” to make use of health benefits.

The ability to close gaps in preventive care and deliver health screenings, relies on understanding the unique challenges members face, many of which are outside their control. Social and economic factors, such as access to food, transportation, employment opportunities and environmental conditions play a bigger role than health care in all people’s lives.

A higher level of engagement with members can help the health plan and provider identify and potentially influence social determinants of health to motivate healthy activities and reduce the risks of chronic disease.

Addressing social determinants of health is a primary approach to achieving health equity. Social determinants of health such as poverty, unequal access to care, lack of education, stigma and racism contribute to health inequities.

Getting to know your customers’ health risk assessments

A health risk assessment (HRA) at the core of an MCO’s Medicaid member engagement strategy, is one of the most effective tools for identifying and influencing social determinants of health. It’s powerful for gathering in-depth understanding of a member’s social determinants and needs, particularly when it includes questions customized to the individual’s experience. For example, where does the member shop for groceries? (Many low-income neighborhoods are classified as food deserts, with little access to fresh fruits and vegetables.) Does the family own a car or live within walking distance to a bus or train line? (A detail that impacts the member’s ability to access health care, employment and social activities.)
A health risk assessment designed to identify the unique needs of the Medicaid population can help:

- Encourage patient-provider dialogue and shared decision-making;
- Educate and motivate individuals to take a more active role in their health care;
- Help Medicaid health-care providers better develop and prioritize treatment plans and intervention programs;
- Identify key areas where individuals are ready to change behaviors so providers, care coordinators and health plans can target programs and interventions most likely to be achieved by an individual.

In addition to the member data collected in an HRA, the physician-patient interaction itself is invaluable. In reviewing the results of the HRA, the physician can help the patient understand and address root causes and specific health issues and kindle “aha moments” that inspire behavior change. The provider can help with setting goals and guide the patient with action-oriented advice, referrals to programs and services and educational materials.

With an estimated 35 million adults insured by Medicaid plans in the United States, HRA data for this population suggests that the greatest savings can be achieved by addressing behaviors or risks that contribute to chronic diseases, tobacco use, disabilities, long-term care, oral health issues, mental illness, depression and stress, and other health-related problems.

2. Offer incentives that members value

Research and experience has shown that incentive programs offer a potentially attractive means for better engaging Medicaid beneficiaries and encouraging them to engage in productive health interactions and/or change unhealthy behaviors.

Incentive program pilots: Medicaid health plan providers in 10 states are currently participating in a pilot study using grant funds from CMS. The goal is to improve Medicaid participation and engagement by using incentives. Enrollees can earn cash payments, pre-loaded debit cards and gift certificates for $20 to $1,150 in California and Texas.28

Other participating states provide incentives by offering Medicaid enrollees things like free classes, tobacco cessation products and counseling, health coaching and access to gyms.

3. Use mobile technology and text messaging to reach members where they live

A recent survey from the Pew Institute reported 86 percent of people with a household income below $30,000 own a cell phone. While other circumstances of their lives change, the smart phone number remains constant and serves as a modern proxy of a home address—and the leading channel for communication.

If you want to improve Medicaid participation and engagement, send text messages. A growing number of Medicaid health plans and providers have found that text
messaging is more engaging, interactive and immediate than phone call follow-ups and snail-mail notifications. It’s also far more cost-effective than call centers and snail mail notifications and reminders.

**Case study 1:** In a clinical trial at Montefiore Medical Center in New York, text messaging by one Medicaid health plan helped enrollees take medications as prescribed and keep appointments with health care providers.²⁹

**Case study 2:** In Michigan, OmniCare Health Plan launched a program to provide free cell phones to its Medicaid members, cover monthly service charges, and provide 250 minutes of free voice service. Cell phone communications with OmniCare didn’t count against the free minutes. The cell phone plan helped OmniCare increase Medicaid participation, get enrollees connected with care providers and help them keep appointments.³⁰

**Case study 3:** Wyoming Medicaid care management programs successfully used a smartphone app to address pregnancy complications. Launched in January 2014, “WYhealth Due Date Plus” helps pregnant Medicaid members in the state track their pregnancies on their phone. The rural nature of the sparsely populated state creates challenges for an expectant woman. When an issue with her pregnancy comes up, she might not want to travel the long distance to her health care provider for a check-up. Medicaid pays for about half the births in Wyoming.³¹

WYhealth recognized that reducing pregnancy complications could generate significant cost savings. In fact, Wyoming State estimated that the cost avoidance of one low-birth baby or neonatal intensive care unit baby, would pay for the whole cost of the program.³²

Though many residents live on remote farms, most have internet access and a smartphone. 90 percent of pregnant women in the state are millennials. Of these, 85 percent own a smartphone. The WYhealth Due Date Plus app is a free download that enables users to access:

- Health information: weekly/daily content, personalized milestones, health issue and symptom look-up
- Reminders: when to take prenatal vitamins and schedule appointments
- Provider look-up: locates obstetricians and pediatricians near user’s zip code
- Other resources: Community resources look-up and free 24/7 nurse hotline

**Results:** Providers and community-based organizations conducted outreach and promotion to get the word out about the app. It’s had more than 2,000 users since launch. Engagement data shows that each user opened the app an average of 8 days per month. 64 percent of users accessed Wyoming Medicaid health benefits information. WYhealth found that users of the app were statistically more likely to complete a first-trimester prenatal visit than non-users. They estimated that six low birth weight outcomes and 1 NICU
admission were avoided—translating to a total cost savings of $333,900 and an ROI of 3:1.

4. Be more visible in the communities and lives of members

Your Medicaid health plan, practice or clinic probably has regular office hours, a website and phone number. You may even send out regular mailings with information about Medicaid services and preventive care to current and past plan members or patients. But that doesn’t mean people are visiting your site, calling or reading your direct mail for health information.

That is why it is important to reach out to members in the channel of their choice, instead of waiting for the members to come to you.

Case study: In California, some Medicaid health plans send representatives to support group meetings, assisted-living facilities and dialysis treatment centers to meet with Medicaid enrollees. Other states send Medicaid care managers to places like parks and transit centers to visit with Medicaid enrollees, answer questions, and provide information and resources.

5. Create community partnerships

Medicaid engagement and participation won’t magically improve without action to increase your influence. Network and create partnerships with other organizations that serve people who rely on Medicaid for health care. Plans might think networking works best in the business world, and not for improving participation for people covered by Medicaid. But that’s just not the case.

Networking in any industry—corporate, non-profit, and even state-funded programs and agencies—will always help you and your organization make a bigger difference. And that’s exactly what Medicaid leaders in states like Ohio, Wisconsin, Massachusetts, Minnesota, New York and others are doing. Partnering with community health workers and non-profit organizations in the community builds trust, relationships and channels to deliver information about Medicaid services to vulnerable populations.

Case Study: In Massachusetts, where the ACO model requires community partnership in the care delivery model, one Medicaid health-plan provider partnered with the non-profit Together4Health to provide funding and support to deliver socks to Medicaid’s most vulnerable enrollees. The partnership helped build relationships of trust with the Medicaid population and ultimately helped people get transportation to see a doctor whenever necessary.

6. Accommodate and respect low health literacy

Only 12 percent of U.S. adults have proficient health literacy. More than a third of adults were in the basic (47 million) and below basic (30 million) health literacy groups. The majority of adults (53 percent) had intermediate health literacy skills. Health literacy is a significant barrier with negative impact on Medicaid participation and engagement.

Many states have moved to creating content for Medicaid enrollees with a third to eighth-grade reading level. Even if your state Medicaid program already has health literacy standards in place, take a closer look at all the documents and communications for Medicaid enrollees.
(emails, brochures, newsletters, web pages, blog posts, text messages, etc.) and test them using readability tools, such as Flesch-Kincaid Grade Level, Gunning-Fog Score or Automated Reading Index to ensure they can be understood.

**Case Study:** Health First Colorado (the state’s Medicaid Program) has set up a free, 24/7 nurse advice line (NAL) for Medicaid members. It is staffed by registered nurses and offers medical advice to callers. A goal of the program is to increase health literacy and patient engagement. Medicaid members often need help with chronic conditions, such as diabetes and asthma. The hotline can answer these questions and provide personalized, easy-to-understand advice.

The NAL directs patients to the right level of care, at the right time, in the right setting, to reduce costly ER misuse when an urgent care setting is more appropriate. Medicaid patients utilize the ER at twice the rate of those with private insurance; redirecting patients with non-urgent conditions to a lower level of care can substantially reduce Medicaid costs. Results of NAL “upgrades” and “downgrades” to the appropriate care setting were measured at 28 percent of callers being downgraded to a lower level of care and 32 percent to a higher level of care.³⁶

7. Continuously find and test creative engagement solutions for win/win outcomes

As economies change and populations shift, what underlying reasons might be keeping your Medicaid population from engaging with you? No transportation? See if you can arrange a bus pass or some low-cost but safe transportation to your office. Partnering with your community’s paramedics can also help meet Medicaid members where they are. Is childcare a challenge? Maybe you can set up a play area and engage someone to mind children during an appointment. Are homeless people part of your Medicaid population? Perhaps you can offer a “service” to watch over their belongings or provide a lock-up area where they can store items while they receive medical care.

To help improve Medicaid participation and engagement, look for ways to reduce barriers, use technology and increase your influence. You’ll be able to help more people, improve health and reduce costs.
Section 6:
Using rewards and incentives to promote health
Incentives have been shown to influence healthy behavior, enhance health outcomes and reduce health care costs. In this section, we explore the link between behavioral economics and financial incentives, along with findings from past Medicaid healthy-behavior incentive programs. In addition, we highlight current Medicaid incentive programs and share real-life insights into their success.

Medicaid plans are increasingly using financial incentives to encourage beneficiaries to engage in healthy activities, such as exercise, smoking cessation, disease prevention, and health screenings and assessments. The interest in incentive programs stems from growing evidence from non-Medicaid populations that financial incentives can help influence healthy behavior, enhance long-term health outcomes and reduce health care costs. There is also substantial discussion in some states regarding incorporating incentives into Medicaid expansion proposals under the Affordable Care Act (ACA).

Section 6 in brief: Growing evidence that incentives enhance health and reduce costs

States interested in requiring traditional or expansion Medicaid populations to participate in a healthy behavior incentive program must submit a State Plan Amendment or Section 1115 Waiver to the Centers for Medicare & Medicaid Services (CMS) for approval.
The role of behavioral economics in healthy incentive programs

Behavioral economics is a method of analysis that explores the psychology behind individual’s economic decisions. The field has demonstrated that the “rational choice model,” which assumes that individuals always know and adhere to their preferences, does not describe true human behavior. Instead, people often behave irrationally: contradicting previously stated preferences, going against their best interests, and choosing not to maximize outcomes or efficiency.

Increasingly, health-care policymakers are using behavioral economics concepts to design healthy behavior incentive programs that account for—or capitalize on—individuals’ biases to increase the likelihood of achieving a desired healthy activity or outcome.

For example, behavioral economic research suggests that individuals are more sensitive to immediate gratification than to delayed feedback—or are “present biased;” therefore, successful incentive programs should target current (not future) behaviors and offer rewards quickly following the completion of a desired task. Table 1 shows other behavioral biases that influence rational decision-making.

Table 1: Sample List of Behavioral Biases that Impact Rational Decision Making

<table>
<thead>
<tr>
<th>BIAS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Valuation</td>
<td>The value an individual experiences from a product depends on its price; the higher the price, the higher its perceived value.</td>
</tr>
<tr>
<td>Endowment Effect</td>
<td>People tend to demand a considerably higher price for a product that they own than they would be prepared to pay for it.</td>
</tr>
<tr>
<td>Framing Effect</td>
<td>The way in which a choice is framed or presented can strongly affect the decision that results.</td>
</tr>
<tr>
<td>Loss Aversion</td>
<td>Changes that are framed as losses are weighed more heavily than changes framed as gains.</td>
</tr>
<tr>
<td>Diminishing Sensitivity</td>
<td>Changes in a variable have less impact the farter the variable is from a reference point.</td>
</tr>
<tr>
<td>Status quo Bias</td>
<td>A preference for the current situation, as the unfamiliar territory of leaving the status quo is perceived negatively.</td>
</tr>
<tr>
<td>Sunk Cost Fallacy</td>
<td>Seemingly trivial alterations or influences can produce major changes in how people act.</td>
</tr>
<tr>
<td>Priming/Anchoring</td>
<td>The belief that further investment is warranted because resources already invested will otherwise be lost.</td>
</tr>
</tbody>
</table>
Research shows that financial incentives are effective at improving healthy behavior, though the effect of incentives may decrease over time. Financial incentives have shown positive results in:

1. Improving vaccination rates in vulnerable communities;
2. Improving the uptake of cancer screenings;
3. Promoting low-income patients’ adherence to tuberculosis testing and treatment;
4. Increasing attendance at prenatal and postnatal appointments;
5. Encouraging sexual health risk reduction education and counseling; and
6. Smoking cessation.

The least promising results for financial incentives are related to weight loss: while incentives can help motivate lifestyle alterations to lower cholesterol and adopt healthy behavior, the positive effects tend to diminish over time. All told, the impact of weight loss with financial incentives is inconclusive.\textsuperscript{39}
Impacts of six U.S. Medicaid incentive programs

Few academic studies, if any, have examined the impact of financial incentives within the Medicaid population—particularly with regard to whether incentive programs influence short- or long-term health outcomes or activities. Outcomes do exist, however, for some state-specific Medicaid incentive programs. In some cases, these results only address program participation; yet these early state findings can help inform the design of future Medicaid incentive programs.

- **Florida’s Enhanced Benefits Reward$ Program (2006 – 2014):** Medicaid beneficiaries earned $15 to $25 credits for compliance with 19 healthy activities. About half of available credits were redeemed, with the majority of credits earned for childhood preventive care (45 percent) or adult/child primary care office visits (25 percent).

- **Idaho’s Behavioral Preventive Health Assistance Program (2007 – 2014):** Medicaid beneficiaries who consulted with a doctor about losing weight or quitting smoking could earn a $100 voucher, to be used for gym memberships, weight management programs, nutrition counseling or tobacco cessation products. Of the approximately 185,000 eligible beneficiaries, 1,422 participated after two years.

- **Idaho’s Wellness Preventive Health Assistance Program (2007 – present):** Beneficiaries receive $10 per month for keeping well-child exams and immunizations up-to-date, which is used to pay for premiums. A quasi-experimental study found a 116 percent increase in CHIP children with up-to-date exams and immunizations, compared to a 13 percent increase among children without the incentives.

- **West Virginia’s Mountain Health Choices Program (2005 – 2014):** Provided access to an “enhanced” benefits package if beneficiaries signed and conformed to an agreement with the state that they would engage in healthy activities. Ten percent of eligible adults enrolled in the enhanced plan. Those who enrolled were more likely than others to have more doctor visits and take their medications, and to have physicians involved in the decision to enroll.

- **Wisconsin’s BadgerCare Plus Individual Incentive Pilots (2008 – 2010):** Six Medicaid health plans were awarded two-year grants to test if offering incentives would encourage enrollees to adopt healthier activities. None of the six projects reached their health outcome goals.

- **New Mexico’s Centennial Rewards Program:** under New Mexico’s §1115 waiver, Centennial Care, a managed care program for most New Mexico Medicaid beneficiaries, integrates physical health, behavioral health and long-term services and supports through four managed care organizations (MCOs). As of September 2014, there were nearly 560,000
individuals enrolled in Centennial Care, including approximately 150,000 adults who entered Medicaid under ACA expansion. Centennial Rewards, which began on January 1, 2014, covers all Centennial Care enrollees. Beneficiaries can earn points for completing the following healthy activities (see below), even if they are not aware of, or actively engaged in, the program:

- Annual dental visit (adult or child)
- Prenatal program participation
- Bone density testing
- Medication management for schizophrenia and bipolar disorder (Rx refills)
- Asthma (inhaler refills)
- Diabetes (various disease-related tests)

To redeem benefits after completing one of the healthy activities mentioned above, beneficiaries must register through the Centennial Rewards’ website or member services call center. Following registration, participants can choose a reward: an item from the Centennial Rewards catalog (such as a soccer ball, yoga mat or first aid kit) or a Centennial Rewards debit card that can be used for limited purchases (e.g., no cigarettes or alcohol) at certain stores.

All four New Mexico MCOs contract together with the same two vendors that manage the program components, including the website, catalog, call center and debit card implementation. The primary vendor receives a monthly enrollment file from the state and regular encounter data feeds from each of the MCOs. The MCOs make direct payments to the vendor for the administrative infrastructure and for the redeemed points.

The state, in turn, has built these costs into the MCOs’ monthly capitation payments, thus receiving federal matching funds for the program. **A unique quality of Centennial Rewards is the program’s portability across MCOs: points earned during individuals’ enrollment with one MCO can carry over to another if beneficiaries switch enrollment.**

Oversight of the program is accomplished by various stakeholders. State leadership has access to an administrative portal that allows near real-time monitoring of information, including points earned and redeemed, and participants registered. The MCOs are also contractually required to submit quarterly reports of their performance and their members’ activities. Finally, the Centennial Rewards vendors are able to provide significant detail on an ad hoc basis comparing MCO performance. A rigorous evaluation was also built into the program.

The success of an incentive program like Centennial Rewards hinges on engaged Medicaid beneficiaries. While New Mexico designed its Centennial Rewards program to allow individuals to earn points even when unaware of the program, the end result should be that a significant portion of the Medicaid beneficiaries participate in their own health care. Many individuals have gotten involved in the first year—whether they know it or not—and will be more likely to fully buy into Centennial Care goals, and work to improve their own health outcomes, as they learn more about the program.
Four tips for how to establish a successful Medicaid incentive program

The state and its contractors are actively engaged in outreach, communication and marketing. Currently, program information is included in MCO member materials and welcome packets; it is also mailed directly to beneficiaries. The call center is using outbound calls during non-peak hours to reach out to individuals who have accrued points but have not yet registered for reward redemption. The state is also working on a provider engagement program, as evidence suggests that the involvement of health care professionals is another positive factor in changing beneficiary behavior. A provider-specific portal is planned for later this year. Finally, a public website is now operational, allowing anyone to learn about the program without needing to register.

Informed by academic research and the results from our own Medicaid rewards and engagement programs, NovuHealth recommends the following strategies for plans looking to establish healthy behavior incentives in their Medicaid programs:

1. **Heavily advertise the program and its benefits**

Incentive programs may enroll fewer Medicaid beneficiaries than anticipated because individuals are not aware of the program. Simply stated, beneficiaries need to know a program exists to actively participate. Plans should use multiple information channels to advertise the program, including plan website, print media, and community health worker and provider education.

A survey from West Virginia’s incentive program found that information provided through mailers and trusted health care workers (physicians, case managers, pharmacists) was most helpful to beneficiaries.

Furthermore, plans can use messaging strategies to convey—in the simplest manner possible—why program participation is worth the individual’s time. Ideally, messaging about the program’s benefits would describe both its financial rewards and its potential to improve health.

2. **Pay attention to beneficiary characteristics**

Materials should be designed to be clear and understandable for multiple levels of education and health literacy, and cultural backgrounds. States should also consider how each Medicaid beneficiary segment might respond to incentives. While some individuals may be willing to undergo behavioral changes in exchange for small incentives, others may not want to participate if they cannot, for example, access or pay for necessary transportation costs. Medicaid beneficiaries with low health literacy may not understand how a behavior change will benefit their long-term health and may require a relatively large financial incentive to participate.
3. Establish a simple benefit structure

Overly complex or multi-step incentive programs can be hard to understand and/or perceived as not worth a beneficiary’s time. Plan administrators should work to design an incentive benefit structure that is as simple as possible, so it is clear what a beneficiary needs to do to qualify for the incentive and why or how the desired behavior change will improve that person’s health.

4. Incorporate a rigorous evaluation component

Data are needed to evaluate a program’s effectiveness. Before a new incentive program is launched, plans should develop a clear evaluation plan, which is required of plans authorized by the §1115 waiver. Where possible, states should consider initially offering the program to a subset of beneficiaries, then compare the results from the intervention group to a similar control group. This analysis will help program evaluators determine the intervention’s true effectiveness.
Summary
Measuring Success

Measuring success and creating value
Health plans can establish engagement and incentive programs to engage beneficiaries in their health care and promote the adoption of healthier behavior. While financial incentives can be powerful motivators, we encourage plans to make smart choices about program design and pay attention to the behavioral economic theories that help explain how and why people are motivated to change. Given CMS’ growing knowledge of past and current engagement programs’ successes and failures, it is likely to take an active role in assessing proposal design features and working with states to develop promising strategies. After an engagement program is up and running, plans should closely evaluate it with outcome data related to participation and health status to determine if the program is effective and worth continuing. That way, plans can be assured of creating value for their business, as well as the member—all while improving health.
Let NovuHealth help you design and implement a Medicaid engagement program that improves member health—and drives exceptional plan performance.

NovuHealth is the industry's leading consumer engagement company. Combining performance analytics, behavior science and proprietary technology solutions, our rewards and engagement programs enable health plans to increase high-value member activities at the lowest possible cost—improving member health and driving plan performance.

NovuHealth serves more than 35 of the nation's top health plans across all 50 states.

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The ultimate health engagement feat: Reaching hard-to-reach Medicaid members
Works Cited

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NovuHealth is the health care industry's leading consumer engagement company. Combining performance analytics, behavior science and comprehensive technology solutions, our rewards and engagement programs enable health plans to increase high-value member activities—improving member health and driving plan performance.