Centennial Care 1115 Waiver Renewal Subcommittee
Issue Brief: Member Engagement & Personal Responsibility
January 2017

Overview

One of the core principles of the New Mexico Centennial Care program is to encourage greater personal responsibility of members to facilitate their active participation and engagement in their own health so they can become more efficient users of the health care system. As the Human Services Department (HSD) seeks to renew the Centennial Care waiver, the Department is looking to build on and incorporate policies that seek to enhance beneficiaries' ability to make informed decisions about their health and health care, and to become more active, responsible and involved participants in the health care system.

Member Engagement – Centennial Rewards

The Centennial Rewards program was developed with the launch of Centennial Care in 2014 as a way of providing incentives to members for engaging in and completing healthy activities and behaviors, including:

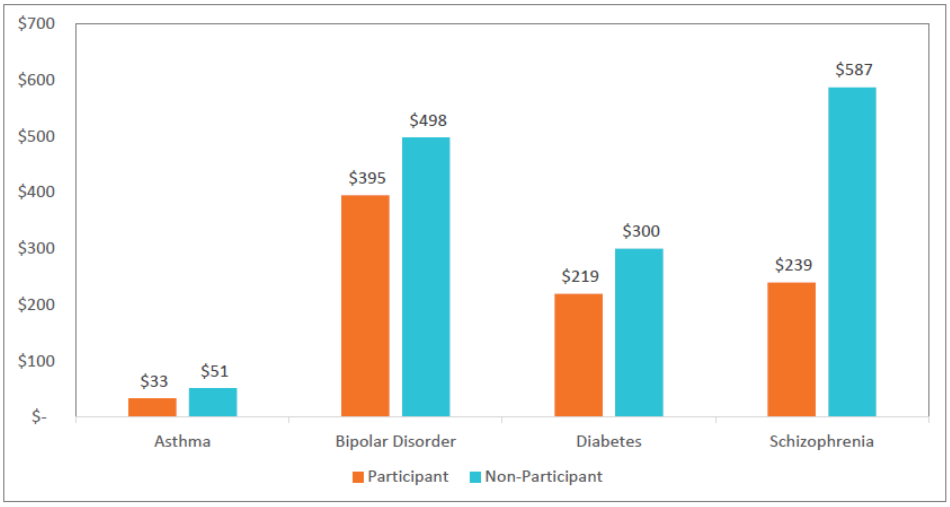
- **Healthy Smiles** to reward annual dental visits for adults and children;
- **Step-Up Challenge** to reward completion of a 3-week or 9-week walking challenge;
- **Asthma Management** to reward refills of asthma controller medications for children;
- **Healthy Pregnancy** to reward members who join their MCO's prenatal program;
- **Diabetes Management** to reward members who complete tests and exams to better manage their diabetes;
- **Schizophrenia and/or Bipolar Disorder Management** to reward members who refill their medications; and
- **Bone Density Testing** to reward women age 65 or older who complete a bone density test during the year.

Members who complete these activities can earn credits, which can then be redeemed for items in a Centennial Rewards catalog.

Centennial Rewards Accomplishments

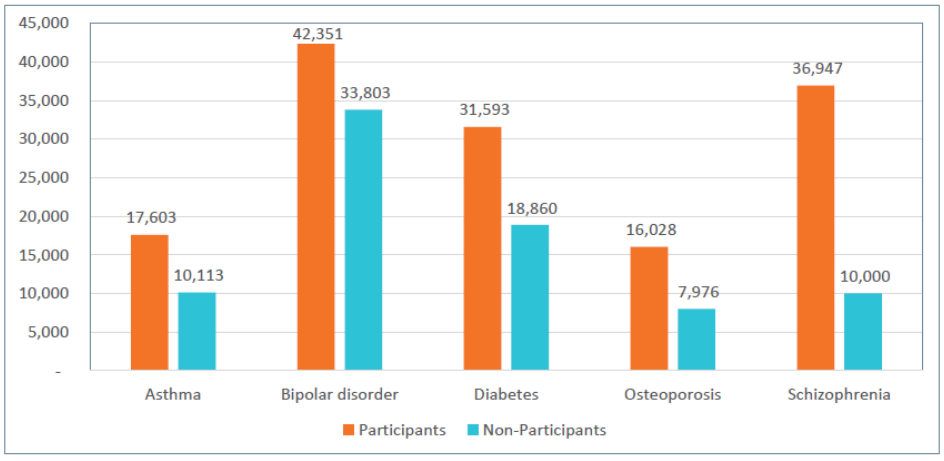
- Inpatient admissions have decreased among participants in the program, resulting in a cost-savings of approximately $23 million in calendar year (CY) 2015.
- The average redemption rate of earned rewards is 24 percent, with the notable exception of the Step-Up Challenge, which has a redemption rate of 85 percent. This suggests that the proactive enrollment required for the Step-Up Challenge has had a substantial positive impact on member use of their rewards.
- Overall cost-savings attributed to the Centennial Rewards program increased by one-third from 2014 to 2015. Reduced inpatient admissions and costs per admission have been the dominant driver behind cost-savings across conditions. See Table 1, below.

Table 1: Reduced Costs Across Conditions



- Participants across all conditions had higher compliance with HEDIS measures and other quality outcomes than non-participants.
- A comparison of risk scores indicates that higher risk members tend to participate in the Centennial Rewards program.
- With a full year of data for the Step-Up Challenge, HSD continues to see positive results regarding cost-savings, utilization and quality measures.
- Prescription drug refills are higher for participants compared to non-participants. Medication adherence for schizophrenia and bipolar disorder have both increased substantially year-over-year and were above 90 percent for participants in 2015. See Table 2, below.

Table 2: Prescription Drug Refill Rates



- HbA1c test compliance for participants increased substantially – nearly 20 percent from 2014 to 2015 – while the year-over-year increase for nonparticipants was only one percent.

Centennial Rewards Challenges

- Despite the decrease in inpatient admissions, emergency room visits were higher among participants in the program than among non-participants. This is true for all conditions in the Centennial Rewards program, except for schizophrenia.
- While the number of participants and redemption rate of rewards continues to increase, HSD seeks to continue growing the number of participants and improve member engagement and motivation. Approximately 206,000 Centennial Care members are currently enrolled in the Rewards program.
- HSD has made some changes to the program to reduce administrative costs and better align rewards with the acuity of the Centennial Care population.

Waiver Renewal Discussion Points

HSD might consider restructuring rewards to either focus on new conditions or to promote more proactive engagement, similar to the active enrollment process for the Step-Up Challenge. Ideas for discussion include:

- **Should Centennial Rewards remain tied to HEDIS or should HSD identify new focus conditions and behaviors?** Examples might include lowering blood pressure, meeting weight loss goals, or smoking cessation, and these conditions might be accompanied by a more proactive opt-in enrollment and tracking process, similar to the Step-Up Challenge.
- **Should the reward values change?** Examples might include items that encourage a healthier lifestyle, such as vouchers for a gym membership or weight loss program, or healthy nutrition assistance through gift cards or the WIC program. Higher-value rewards might also be offered for members that achieve major and sustained improvements in their health (i.e., reversal of diabetes or obesity). Rewards might also include exemptions from cost-sharing requirements, such as co-pays or premiums; or they might be restructured to allow members to accumulate rewards as a type of health savings account that could be used toward payment of cost-sharing responsibilities.
- **How can we improve member engagement through the Rewards program?** Examples might include mining data and risk assessments, using text and email to reach and inform members, and other means to allow members to more easily track their rewards (i.e., through mobile technology).

Member Engagement – Disease Management & Care Coordination

In addition to Centennial Rewards, the Centennial Care program has engaged members through multiple initiatives aimed at helping members better manage their chronic conditions. The Centennial Care MCOs have developed strategies that include member engagement through:

- Diabetes self-management programs and other disease-specific education classes
- Wellness programs
- Communication coaching
- Telephonic outreach
- Wellness benefits offering up to $50 per year in health/wellness purchases
- Care coordination targeting specific chronic conditions

- Targeted education and self-help materials
- Use of community health workers to engage members in meeting their care needs and addressing social determinants of health

The MCOs have also incorporated member engagement through their member advisory committees, ombudsman programs to assist members with understanding MCO processes, and by using care coordinators to develop alternative ways of engaging members who frequently use the emergency department. In addition, members in need of long-term services and supports are able to review Community Benefit services together with their care coordinator to determine which services they are interested in receiving through the Community Benefit Services Questionnaire (CBSQ). Self-Directed Community Benefit members are also actively engaged in developing their plan of care, hiring their own providers and determining rates of pay within the state's approved range of rates. These members are responsible for completing employer-related tasks, such as approving and submitting employee timesheets to the fiscal management agency for payment.

Personal Responsibility – Cost-Sharing

The Patient Protection and Affordable Care Act (ACA) expanded Medicaid eligibility to all nonelderly adults with incomes up to 138 percent of the federal poverty level (FPL). In 2012, the U.S. Supreme Court issued a ruling that effectively made Medicaid expansion optional for states. As of January 1, 2017, a total of 32 states – including New Mexico – have expanded Medicaid. The expansion of Medicaid to new low-income adults has resulted in a significant enrollment surge of nearly 600 percent compared to enrollment of low-income adults before the Adult Expansion. Additionally, enrollment in the Children's Health Insurance Program (CHIP) has increased by 85 percent since early 2014. Compared to other states, New Mexico has generous eligibility thresholds for both children and adults, with the CHIP program extending to 300 percent FPL for children age 0-5 and to 240% FPL for children age 6-18.

Under today's Centennial Care program, Medicaid Expansion Adults are not subject to any form of cost-sharing, and co-pays for CHIP recipients are minimal. In New Mexico, there are also minimal co-pays for individuals enrolled in the Working Disabled Individuals (WDI) program, which provides coverage for individuals up to 250 percent FPL.

For the Centennial Care waiver renewal, HSD is considering incorporating policies that will encourage greater personal responsibility and financial accountability for individuals in higher-income Medicaid categories, including the Adult Expansion, CHIP and WDI. Please note that Native Americans would be exempt from any cost-sharing proposal set forth by HSD. Ideas under consideration might include:

- **Requiring co-payments.** HSD is considering requiring co-payments for outpatient office visits, inpatient hospital stays, outpatient surgeries, and non-emergency medical transportation (in urban areas only) for Expansion Adults, CHIP and WDI enrollees. In addition, HSD is considering co-payments that would apply to most Medicaid enrollees for using certain non-preferred prescription drugs and for non-emergency utilization of the emergency room.
- **Assessing premiums for populations above 100 percent of poverty.** Premiums are the norm for private insurance and coverage on the federal marketplace, and HSD is considering whether they should be assessed to certain Medicaid populations as well. Many states are pursuing approval of premiums for the Adult Expansion population from the federal government, with some proposing to charge premiums for recipients with income as low as 50% FPL. For an

individual with income between 101-150 percent FPL, a monthly premium of one percent or less of income would be $10 monthly.

- **Minimizing appointment "no-shows".** With the Adult Expansion of Medicaid, providers have expressed serious concern about rising rates of missed appointments. Under current rules, Medicaid recipients cannot be required to pay fees or sign financial responsibility forms for missed appointments. HSD might consider whether policies should implemented under the renewed waiver to either allow providers to charge nominal fees for missed appointments or to more positively incentivize appointment adherence (i.e., expansion of the Treat First model).

Waiver Renewal Discussion Points

HSD might consider a movement toward policies that promote greater personal and financial responsibility for members, to include co-pays, premiums and ways to minimize missed appointments. Ideas for discussion include:

- **If cost-sharing (either co-pays or premiums) is imposed, how can it be structured to incentivize healthy behaviors and efficient use of the health care system?** Examples might include waiving cost-sharing requirements for members who engage in healthy behaviors, such as preventive visits and well-child checks, completion of the Health Risk Assessment (HRA) and/or Comprehensive Needs Assessment (CNA), or putting contributions into a health savings account to offset health care costs or to offer vouchers that support healthy behaviors.
- **If premiums are assessed, what type of hardship waiver should be developed?** Examples might include exemptions from premiums for individuals who are homeless, who are late paying their rent, mortgage or utilities, or who have had a large and unexpected increase in basic expenses.
- **What types of initiatives would work to reduce appointment no-shows in lieu of financial penalties?** HSD is considering expansion of the Treat First clinical model, which is designed to reduce the behavioral health missed appointment rate for second appointments. The Treat First approach emphasizes the initial clinical practice functions of establishing rapport, building trust, screening to detect possible urgencies, and providing a response to the reason the individual came to the agency during the first visit – rather than spending time at the first appointment on assessments. Results from the model show that it has reduced no-show rates and improved the quality of assessments and treatment plans over the first four encounters. How can this model be replicated? Is there an adjustment of this model that can be translated in the primary care practice environment?
- **What other ways can be used to align member engagement and value-based purchasing quality metrics?** Strategies could include member collaboration with providers to meet agreed-upon goals, such as adherence to medication, obtaining certain preventive screenings, or other outcomes that align with the member's individualized health targets.