



Creating Healthy States: Promoting Healthy Living in the Medicaid Program

Executive Summary

Medicaid provides health and long-term care coverage to more than 53 million Americans and maintains an annual operating budget of \$320 billion. Given Medicaid's broad reach and high cost to states, officials increasingly are looking to the program as a way to improve the health of state residents and reduce state expenditures associated with poor health conditions.

Health care costs in the United States are approaching \$1.8 trillion per year, with states paying upwards of \$21 billion annually to treat chronic—and often preventable—conditions such as diabetes, cancer, and cardiovascular disease. The Medicaid program is a major financier of treatment for these chronic conditions because of the demographics of the population it serves.

Experts have concluded moderate weight loss, exercise, and smoking cessation strategies can save billions of health care dollars each year—a strong incentive for states to promote healthy lifestyles among Medicaid beneficiaries.

Governors have opportunities to use three basic strategies to encourage healthy behaviors:



- **Providing Wellness Incentives for Beneficiaries:** Several states have proposed innovative programs to encourage Medicaid beneficiaries to practice healthy behaviors and use the health care system wisely. New flexibility under the Deficit Reduction Act (DRA) has enabled states to target and tailor programs for select populations, expand innovative strategies for beneficiary engagement, and identify practices that work.
- **Offering Tools and Incentives to Engage Medicaid Providers:** Many states offer payment incentives to encourage providers to recommend wellness or preventive services for beneficiaries, including fee-for-service payments to providers, partial capitation or enhanced payments for primary care case management, and capitation payments for managed care organizations.
- **Targeting and Tailoring Medicaid Benefits to Wellness:** Under DRA, states have the flexibility to create benefit packages aimed at the health care needs of different populations enrolled in the state program. This flexibility will allow states to address specific benefit needs by diagnosis or region. This may include tailoring health maintenance efforts and incentives for selected healthy populations at high risk for chronic diseases, or targeting intensive programs to promote prenatal smoking cessation in heavy-need localities.

Introduction

As the largest health insurance program in the United States, Medicaid provides more than 53 million Americans with health and long-term care coverage and maintains an annual operating budget of \$320 billion. Given Medicaid's broad reach, the high cost to states, and the growing costs of health care services, officials are increasingly looking to the program as a way to improve the health of state residents and reduce state expenditures associated with poor—and preventable—health conditions.

Medicaid primarily serves three groups of beneficiaries: low-income children and working adults, the elderly, and individuals with disabilities or special needs. Typically the elderly and individuals with disabilities or special needs have many complex health needs and use a number of services. Medicaid enrollees often are disproportionately affected by the nationwide epidemics of obesity and related chronic diseases, such as diabetes and heart disease.

To counter declining health among these groups and the rising costs associated with chronic conditions, states are implementing a number of strategies targeted at Medicaid beneficiaries and providers. States can and have expanded coverage to include wellness and preventive services, and used strategies—such as pay-for-performance, disease management, and incentives programs—to improve health outcomes. States can apply these strategies under current authorities or by seeking waivers from federal rules.

States are also beginning to use the Deficit Reduction Act (DRA) of 2005 as one tool to improve health services and the health condition of the Medicaid population. The DRA eliminates the requirement that certain efforts be implemented statewide, enabling states to target alternative benefit packages to specific subsets of Medicaid beneficiaries in the neediest regions. It also eliminates the 'comparability' requirement, allowing states to tailor benefit programs and services to meet the health care needs of different population groups.

Benefit changes that target and tailor Medicaid benefits may be approved through the State Plan amendment process. However, because DRA applies exclusively to current eligibility groups, states cannot use the law to expand eligibility to new populations. In addition, new benefit packages must be actuarially equivalent to one of the specified benchmark options. Children younger than 19 years who receive benchmark coverage still must receive early and periodic screening, diagnosis, and treatment (EPSDT) services from a combination of the benchmark plan and a wraparound plan.

Making the Case for Healthy Living in the Medicaid Program

Health care costs in the United States are approaching \$1.8 trillion a year, with states paying upwards of \$21 billion each year to treat chronic—and often preventable—conditions such as diabetes, cancer, and cardiovascular disease.¹ The Medicaid program is a major financier of treatment for these chronic conditions because of the demographics of the population it serves.

Preventive care and counseling yield substantial benefits for state budgets and patients. Research shows investments in disease prevention and health promotion strategies can result in financial returns for a state. In 1998, **North Carolina** implemented disease management program strategies for Medicaid beneficiaries suffering from diabetes, asthma, and cardiovascular diseases through the state's primary care case management (PCCM) program. An evaluation of the expenditures and use of services among diabetic and asthmatic Medicaid beneficiaries in 2002 revealed monthly savings of \$21 per member.² Additional research has demonstrated that diabetes management services yield a net benefit of \$2,702 per enrollee compared to traditional care, with the cost of services ranging from \$42 to \$84 per patient per year.³

Governors have opportunities to cut costs while promoting healthy living practices among beneficiaries through provider and enrollee incentives, care coordination, and disease management strategies. Experts have concluded moderate weight loss, exercise, and smoking cessation strategies can save billions of health care dollars each year. These efforts can reduce the number of healthy people who develop disease and the need for health care services among people who already have a chronic condition. Consider the following statistics.

- *Modest Weight Loss*: The Centers for Disease Control and Prevention (CDC) estimates the lifetime medical care costs for an overweight person who sustained a 10 percent weight reduction would decrease from \$2,200 to \$5,300.⁴
- *Moderate Exercise*: If 10 percent of adults began a regular walking program, an estimated \$5.6 billion in heart disease costs could be saved annually.⁵
- *Smoking Cessation*: Pregnant women who quit smoking gain substantial and immediate health benefits beyond the long-term benefits to the general population. Prenatal smoking cessation protects against adverse birth outcomes such as low birth weight and mental retardation and reduces the cost of neonatal health care.⁶ The CDC estimates Medicaid could save almost \$3.50 in averted neonatal medical expenditures for every \$1 spent on counseling pregnant smokers to quit.⁷

States can reap additional benefits through the multi-component programs within and beyond the Medicaid program. Within Medicaid, these programs can provide health behavior education, risk factor screening, referrals for additional services, health and fitness programs, and support systems.

¹Centers for Disease Control and Prevention, *Overweight and Obesity: Economic Consequences*. Available at: <http://www.cdc.gov/nccdphp/dnpa/obesity/economic_consequences.htm>

²Cecil G. Sheps Center for Health Services Research, <www.shepscenter.unc.edu/research_programs/rural_programs>.

³*Guide to Community Preventive Services: Diabetes*. Available at: <<http://www.thecommunityguide.org/diabetes/dm-econ.pdf>>.

⁴Centers for Disease Control and Prevention, *Preventing Obesity and Chronic Diseases Through Good Nutrition and Physical Activity*. Available at: <<http://www.cdc.gov/nccdphp/publications/factsheets/Prevention/obesity.htm>>.

⁵Ibid.

⁶Centers for Disease Control and Prevention, *Smoking Cessation for Pregnant Women* (2002). Available at: <http://www.cdc.gov/tobacco/research_data/economics/health_econ_impact.htm>.

⁷Ibid.

Governors also can combine Medicaid efforts with initiatives to provide supportive community structures that promote comprehensive healthy living—such as improved access to fresh produce, parks, and recreational facilities in urban areas—while working with Medicaid providers to encourage the use of these opportunities among beneficiaries. By taking a more systemic approach to wellness, states can realize savings and improvements for Medicaid recipients, enrollees in other public programs, and the general populace.

Recent State Medicaid Wellness Initiatives

Several state Medicaid programs have been advancing wellness initiatives steadily by providing healthy choice incentives for beneficiaries, tools and incentives for providers (such as care coordination, disease management, pay for performance, and other payment incentives), and tailored benefits (see Table 1).

Table 1: State Strategies to Promote Healthier Living in the Medicaid Programs

States	Wellness Incentives for Beneficiaries	Tools/Incentives for Provider Engagement		Tailored Benefits
		Care Coordination/ Disease Management	Payment Methods/ Pay for Performance	
Florida	+			+
Idaho			+	+
Illinois			+	
Indiana		+		
Kentucky				+
North Carolina		+	+	
West Virginia	+			

Note: This table indicates only the specific strategies highlighted in this paper. States may use a number of different strategies not reflected here.

Wellness Incentives for Beneficiaries

A number of states have proposed innovative programs to encourage beneficiaries to practice healthy behaviors and use the health care system wisely. The new flexibility under DRA has enabled states to target and tailor programs for select populations, expand innovative strategies for engaging beneficiaries, and identify practices that work.

State efforts to provide such incentives for healthy behaviors are quite new, but the private sector has used them in employee wellness programs and health plans. Although the potential for states to adapt private-sector approaches may be limited by the political environment or the beneficiary populations, these examples are worth noting.

West Virginia Extended Benefits Package

West Virginia is promoting healthier living among Medicaid beneficiaries by offering enrollees an optional, extended benefits package that includes services not traditionally offered. Enhanced services include access to—or expanded coverage for—tobacco cessation treatment, nutrition education, diabetes care, treatment for chemical dependency, mental health services, cardiac rehabilitation, chiropractic services, and dental care. Medicaid recipients will gain access to these enhanced services by signing a member agreement to attend scheduled preventive health visits and take medications as directed. The agreement also requires parents to take their children to regularly scheduled checkups, immunizations, and dental exams.

To encourage beneficiaries further to adopt healthier lifestyles, West Virginia will offer members enrolled in the enhanced benefit plan an opportunity to accrue credits toward health services in a Healthy Rewards Account. The credits, awarded for making healthy decisions and using the health care system appropriately, can be used to pay for a pre-set list of items or services determined by the state. Although the details of the credit program still are being determined, the state is considering allowing credits to cover nonemergency care services, co-pays, and uncovered health care services and products, such as over-the-counter medications.

Under the state's proposal, beneficiaries who choose not to sign the agreement will receive the standard Medicaid benefit package. In future years, however, beneficiaries who miss appointments, use emergency services for non-emergency care, do not comply with the preferred drug list, or smoke may receive disincentives.

West Virginia will focus communications efforts on educating and orienting beneficiaries to the new program and its benefit package. Beneficiaries in three counties will participate in a pilot program in 2007.

Florida Healthy Living Incentives

On July 1, 2006, **Florida** initiated its substantial waiver program with pilots to promote healthy living through incentives for enrollees who pursue healthy behaviors through preventive services and reduce the risk of poor health care outcomes. The pilot will assess a risk-adjusted premium that reflects each beneficiary's health status. With the premium value, the state will purchase coverage provided by state-approved managed care plans on behalf of beneficiaries. Many plans will assume risk for a state-specified set of comprehensive benefits and catastrophic health care. The plans can create customized benefit packages and provide beneficiaries the flexibility to choose the plan that best meets their needs.

Recipients enrolling in the new plans will receive monetary incentives for participating in healthy activities, such as smoking cessation, annual checkups, and disease management programs. The fiscal value of each activity will be deposited into an Enhanced Benefit Account. Initially, beneficiaries will have an opportunity to earn up to \$125 per year in these accounts and use funds for over-the-counter pharmaceuticals, first-aid supplies, and other items that can be purchased in a pharmacy. The program may be expanded to include other items such as non-covered health care services, including exercise programs, reading glasses and other health care items/services not covered by the Medicaid Reform plans in the future.

The enhanced benefits accrued in an enrollee's account will be available for use for up to three years after Medicaid eligibility has ended. Use of the funds during enrollment is limited to the list of approved items. Therefore, unused funds will remain in the recipients account for purchase of those items. However, if the individual regains Medicaid eligibility, unspent funds accrued during past enrollment will remain in the account and earning potential will be reinstated.

Florida anticipates that marketplace competition among managed care organizations will maximize benefit packages for the premiums offered by the state. To guide the development and evaluation of the Enhanced Benefit Plan, Florida has convened a panel of members representing the Division of Medicaid, patients, health plans, and the fraud and abuse agency.

Private-Sector Examples

In 1995, Johnson & Johnson launched a wellness program targeting its 18,000-member employee insurance pool. From 1995 to 1999, the corporation realized an average annual savings of \$8.5 million, which amounted to a \$225 medical care savings per employee each year. Johnson & Johnson enrolled more than 90 percent of all eligible employees and discovered that increases in employee enrollment coincided with increased financial incentive program offerings. For example, when Johnson & Johnson offered high-risk employees \$500 medical plan discounts, employee enrollment increased substantially.

In **California**, Blue Shield's Healthy Lifestyle Rewards pilot program offers cash incentives to members who work toward adopting healthy behaviors. Participants may register for the pilot program by filling out a health assessment on Blue Shield's Web site that indicates areas in which the participant can improve his or her health. The recommendations may include one of several lifestyle programs (e.g., smoking cessation, weight loss, and stress reduction) with tools to help people meet their goals. Participants must engage in at least one prescribed activity per week during a 12-week period to be eligible for a \$50 cash reward.

Tools and Incentives to Engage Providers

Many states have created tools and incentives to promote provider engagement, including care coordination, disease management, and payment strategies. Care coordination and disease management practices enable beneficiaries and providers to take a more strategic and comprehensive approach to health needs, while ensuring cost savings to the enrollee and the state. Providers, particularly primary care practitioners, offer considerable health care navigational assistance to Medicaid recipients by coordinating care, assisting in lifestyle modifications, and ensuring appropriate medical services for ailments and conditions.

Many states offer a variety of payment incentives to encourage providers to recommend wellness or preventive services to beneficiaries. These incentives are built into the existing provider payment strategies, which include:

- fee-for-service (FFS) payments to individual providers,
- partial capitation or enhanced payments for providers that provide primary care case management (PCCM), and
- capitation payments for managed care organizations (MCOs).

During the last 15 years, Medicaid increasingly has looked to MCOs as a way to increase beneficiaries' access to and use of appropriate services. Between 1991 and 2004, the number of Medicaid beneficiaries enrolled in some form of managed care grew from 2.7 million to 27 million.⁸ Managed care has reduced duplication of services and unnecessary care while increasing appropriate care, saving states millions in Medicaid expenditures. In some cases, these savings have been re-invested in the Medicaid program to provide incentives for MCOs to offer additional preventive and wellness services, such as tobacco cessation services and nutrition counseling. These additional services further reduce expenditures by decreasing acute or chronic care costs associated with preventable chronic diseases.

Care Coordination and Disease Management

Many private physicians need assistance caring for the more complex health conditions and hard-to-reach patients. In response, a number of states have developed care coordination and disease management programs to link Medicaid beneficiaries to prevention or health promotion resources and ensure they receive necessary medical treatment. These programs also provide navigational health care assistance to help recipients identify appropriate and necessary care providers.

Indiana Disease Management Program

The Medicaid program in **Indiana** has worked with the state department of health to develop the Indiana Chronic Disease Management Program (ICDMP) for Medicaid recipients with chronic conditions. The program provides a number of services and support programs to help beneficiaries with diabetes, heart disease, asthma, and kidney disease, and benefit providers.

Through the Indiana program, high-risk individuals receive the services of a nurse case manager who works with the primary care provider to provide one-on-one training in lifestyle changes and medical self-management. Lower-risk enrollees are served by a call center that is available outside regular office hours and makes pro-active calls to encourage compliance. Physicians, case managers, and the call center can use a recently developed centralized electronic medical record for enrolled Medicaid recipients to share claims information, clinical data, and care plans.

Indiana evaluated the ICDMP strategies in a random clinical trials and found cost savings among congestive heart failure (CHF) participants. Members participating in the CHF ICDMP saved, on average, \$439 per member per month, while hospital costs among high-risk CHF patients decreased \$87 per member per month and increased \$259 per member per month in the non-ICDMP participants, respectively.

⁸ Centers for Medicare and Medicaid Services, *Medicaid Managed Care*. Available at: <http://www.cms.hhs.gov/MedicaidManagedCare/>.

North Carolina Community Care

In 1998, **North Carolina** enhanced its basic primary care case management program, Carolina Access, by working with local physicians, hospitals, and public health and social service providers to improve the quality and reduce the cost of care for Medicaid beneficiaries. Under Community Care of North Carolina, 15 local provider networks throughout the state collaboratively develop care and disease management systems to support beneficiaries.

The North Carolina Medicaid program integrates disease management strategies, public health practices, provider groups, and social services to improve the health of beneficiaries by leveraging access to programs in the state. Each of the local provider networks maintains case managers that work with enrollees and primary care providers to manage asthma, diabetes, and congestive heart failure by developing a care plan and ensuring constant communication among both groups. These plans ensure beneficiaries receive necessary medication and preventive, primary, and specialty care services. Case managers also work with high-cost users, including patients who frequently use emergency services for non-emergency care.

By establishing 15 local provider networks, North Carolina maintains the flexibility to pilot projects within a network. For example, one network provides childhood obesity screenings in schools and community centers to identify and intervene on behalf of at-risk children at an early stage.

A key component of the Community Care Program is the partnership with community physicians. Physician leaders from participating networks come together to design and develop the clinical improvement initiatives implemented by the Community Care Program (see *North Carolina* under the Provider Payment Incentives section).

Provider Payment Incentives

Medicaid programs use a variety of methods to pay providers for services, including fee-for-service payments to providers, capitation payments for managed care organizations, and partial capitation or enhanced payments for primary care case management providers. In addition, Medicaid may pay for some administrative procedures such as outreach, health education, or care coordination. State Medicaid agencies have flexibility under federal rules to develop payment mechanisms that work within their state's health care system and attract qualified providers.

In addition to reimbursing office visit charges, some states encourage providers to offer and promote wellness services through additional payments for health risk assessments and preventive services—such as nutrition counseling for at-risk, overweight children without a diagnosis of diabetes.

Many states reward Medicaid providers by using pay-for-performance incentives to increase the use of preventive services. Some states have focused on rewarding providers who deliver better care to beneficiaries with chronic diseases such as asthma and diabetes; plans in Maryland, Nevada, New York, Pennsylvania, and Rhode Island use financial incentives or disincentives to encourage high quality care. California, Michigan, and New Mexico primarily reward high performing plans by auto-assigning beneficiaries who do not choose a plan. Although some of these programs are in the early stages of implementation, others have reported improved access to care.

North Carolina Fair Market Rates

North Carolina has been successful in providing access to health promotion and disease prevention by paying primary care providers at rates similar to those in the private sector. By paying a fair market rate, North Carolina has been able to ensure ready access to preventive services in all areas of the state. In addition, the primary care providers in the network receive \$2.50 per member per month (PMPM) to serve as the beneficiary's medical home, authorize referrals, implement evidence-based best practice guidelines, and provide basic case management. These reimbursement mechanisms have helped the Medicaid program enlist full cooperation from the medical community in disease management activities.

North Carolina also contracts with nonprofit administrative entities responsible for developing and managing its 15 provider networks. These entities receive a PMPM fee of \$2.50 to hire care managers, provide disease and case management, and implement utilization review and quality improvement across the providers in their network.

Illinois Children's Health Screening

Illinois is promoting important developmental screening tools to identify areas needing preventive or other health services. This approach of early identification, health promotion, and intervention can improve health outcomes and identify problems before they impact development. Illinois provides an extra payment to pediatricians for using a developmental screening tool in addition to the standard payment for a well child exam.

Georgia Financial Bonuses

Although not a Medicaid program, **Georgia** recently launched a statewide program to provide financial bonuses to physicians who improve care for the state's more than 500,000 residents with diabetes. Physicians who choose to participate in the incentive program will be evaluated on how well they improve care for patients covered by the Georgia Health Benefit Plan, which insures 640,000 state employees and retirees. State health officials say roughly 30,000 people covered under the plan have diabetes or are at risk of developing the disease.

Physicians who meet Georgia's quality standards will receive \$62 per year per patient who is covered by one of the participating employers, with an annual physician cap of \$20,000. Georgia will conduct this program for its employees; participating private sector employers include BellSouth and UPS. However, many of these same providers serve Medicaid recipients, and research demonstrates that physicians who change their practice with one set of patients will do so for others.

Targeted and Tailored Benefits

Under DRA, states have the flexibility to create benefit packages targeted to the health care needs of different populations enrolled in the state program. This flexibility will allow states to address specific benefit needs by condition, risk status, or region. This may include tailoring health maintenance efforts and incentives for selected healthy populations at high risk for chronic diseases, or targeting intensive programs to promote prenatal smoking cessation in localities identified as having heavy need. To date, three states—Idaho, Kentucky, and West Virginia—are launching tailored benefit packages.

Idaho Benchmark Plans

Idaho's Medicaid program will offer beneficiaries three benchmark plans that provide specialized care for enrollees under a primary care case management program:

- Basic Benchmark Plans for healthy, low-income children and working-age adults,
- Enhanced Benchmark Plans for individuals with disabilities and special medical needs, and
- Special Coordinated Plans for the elderly and dual-eligible recipients.

The Basic Benchmark Plan provides traditional coverage to over 80 percent of eligible Idaho residents, and the state is expanding covered benefits to wellness services, such as preventive screenings and nutritional services. The plan will offer participants personal health accounts to purchase goods and services that promote active lives and healthier living.

All three benchmark plans will offer annual preventive health care exams for adults to screen enrollees for developing diseases. They will cover current Medicaid State Plan benefits, with the exception of long-term care, extended mental health benefits, and organ transplants. Beneficiaries needing these services may transfer to the Enhanced Plan if the excluded services are deemed medically necessary.

Idaho also hopes to incorporate health risk assessments and other screening procedures into the program to help match beneficiary needs to a specific plan's benefits package. Recipients will retain the flexibility to move among plans should health care needs change.

Kentucky Benchmark Plans

Kentucky was the first state in the nation to provide a comprehensive plan to redesign its Medicaid program under the provisions of the DRA. To address competing health care needs among children, the elderly, the physically and mentally disabled, and the general Medicaid population. Kentucky KyHealth Choices program will offer Medicaid beneficiaries one of four benchmark plans:

- Family Choices for healthy children, including State Children's Health Insurance Program (SCHIP) recipients,
- Comprehensive Choices for elderly individuals who need nursing facility care and individuals with acquired brain injuries,
- Optimum Choices for individuals with mental retardation and developmental disabilities in need of long-term care services, and
- Global Choices for the general Medicaid population, including most adults, foster care children, and medically fragile children.

Under the new benchmark plans, beneficiaries in designated geographic regions who are suffering from pulmonary disease, diabetes or other cardiac conditions will receive disease management services and other enhanced benefits. Beneficiaries who participate in the disease management programs and follow treatment regimes may earn "Get Healthy" benefits, which include limited dental and vision services, visits to nutritionists and dieticians for meal planning and counseling, and smoking cessation treatment—including nicotine replacement therapy.

Kentucky has begun implementing the new benefit design throughout the state except in the Louisville area, where an existing Medicaid health care demonstration project, Passport, will continue to operate.

Conclusion

Medicaid programs play a key role in providing critical health care services to a vulnerable population and could make a major contribution to efforts to achieve better health nationwide. Policymakers increasingly recognize the potential value of encouraging and supporting healthy behaviors and sustainable lifestyle changes. DRA expands states' opportunities to assemble a coherent wellness strategy, pilot innovative approaches, and target their efforts to those Medicaid recipients with the greatest need and largest potential benefit. As the economic returns on these disease prevention strategies and health promotion services emerge, they will become even more attractive to states facing the rising costs of treating chronic diseases.

Acknowledgements: In connection with the development of this paper, the NGA gratefully acknowledges the contributions and research provided by Debbie I. Chang, Susan J. Tucker, Vonna Drayton, and Jennie Bonney of Nemours Health and Prevention Services in Newark, Delaware.