HB 2859
Task Force on Individual Responsibility and Health Engagement

Recommendations to Engage Members of the Oregon Health Plan

November 2013

Prepared by
Oregon Health Authority

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The Oregon State Legislature
Per House Bill 2859

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http://www.oregon.gov/OHA/OHPR/Pages/irhe.aspx

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Roster
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Individual Responsibility and Health Engagement Task Force
Summary Report to the Oregon Legislature

Introduction

In 2013, the Oregon Legislature passed House Bill 2859 that established the Task Force on Individual Responsibility and Health Engagement. The task force was chartered to develop recommendations for the legislature to establish mechanisms that meaningfully engage members of the Oregon Health Plan (OHP) in their health and health care. Under the direction of the Governor and guided by principles in support of the Triple Aim, the task force convened on four occasions over two months during the fall of 2013 to review evidence-based and person- and family-centered approaches to patient engagement. The task force consisted of 11 members, including bi-partisan representation from the Oregon State House of Representatives and the Oregon State Senate, two OHP members, a patient health navigator, and four health care professionals, with representation from both urban and rural communities. This document describes the task force, the process used, and rationale for the final recommendations. This document should be used to inform specific next actions that may include additional stakeholder input and review as detailed action plans are developed.

Task Force Process

Staff with the Oregon Health Authority (OHA) provided the task force with an overview of Oregon's Medicaid delivery system, information on the OHP, and data on expenditures and utilization in Oregon's state Medicaid program (i.e. OHP). The task force thoroughly considered federal and state policy that governs Medicaid cost-sharing, including expanding options for cost-sharing in OHP. A national expert on patient engagement, Dr. Susan Butterworth, provided background and evidence on a broad array of patient engagement strategies, including how incentives and disincentives can affect patient engagement and health behavior change. She also presented on a range of other evidence-based strategies that seek to engage patients in their health and promote appropriate use of health care services.

Task Force Recommendations

The task force concluded that health engagement is not achieved solely through use of financial incentives or cost-sharing. Evidence shows that financial incentives work for simple health behavior change; however, complex behavior change requires a more comprehensive approach. The task force's recommendations seek to leverage existing health reform efforts and align with Oregon's commitment to local accountability and flexibility among coordinated care organizations (CCOs) and their community partners. Furthermore, the task force decided that imposing further legislative requirements on CCOs was not appropriate at this time. As an alternative approach, the task force recommends OHA adopt the recommendations below in an effort to provide targeted resources and technical assistance to CCOs, which will allow them to further support OHP members as active participants in their own health.

***Expand Options for Member Cost-sharing in the Oregon Health Plan*.** As part of comprehensive health reform, recent federal rules provide state Medicaid programs greater flexibility to vary enrollee cost-sharing. The task force identified an opportunity to expand options for cost-sharing in OHP through a Value-based Benefit Design (VBBD) model. VBBD aligns consumer incentives by reducing barriers (through no or low cost-sharing) to high-value health services such as preventive care, and discouraging (through higher cost-sharing) the use of low-value health services. These can include non-emergent use of the emergency department when an alternative for care is available, or the discouraged tests and procedures outlined in the evidence-based Choosing Wisely Campaign.

Recommendation—OHA request federal approval to expand options for cost-sharing in OHP at the service level to promote the use of appropriate and cost-effective care modeled after a Value-based Benefit Design, in alignment with Oregon's approved 1115 Medicaid Demonstration Waiver.

***Provide Resources and Support for CCOs*.** To foster innovative local solutions for CCOs to best serve their patient population and support individual members in meeting their needs and health goals, the task force recommends that evidence-based resources and technical assistance be made available to CCOs to facilitate the implementation of patient engagement strategies.

Recommendation—by the end of 2014, the OHA Transformation Center shall work with other OHA partners, as appropriate, to:

- Develop a resource guide for CCOs for adoption, implementation, and measurement of evidence-based member engagement strategies that target the use of appropriate and high-value health services, prevention, self-management, and individual empowerment.
- Work with CCOs to incorporate in their Transformation Plans a plan for member engagement, including identifying indicators for success, and foster information sharing of best practices across CCOs.
- Promote the use of the Choosing Wisely campaign as a shared decision-making tool to facilitate engagement among OHP members, providers and CCOs.
- Identify a list of standardized and validated health appraisal tools that CCOs may use with their members as part of their strategy to prevent disease, promote health and self-management, target interventions, and evaluate success in managing and improving health over time.
- Conduct a formal assessment to identify barriers to CCOs' use of traditional health workers to foster engagement, and take steps to address these barriers.

***Foster Statewide Strategies to Engage and Support OHP Members*.** The task force recommends that OHA leverage resources and activities statewide to disseminate best practices for health engagement that are appropriate for OHP members and their families, and are sensitive to and account for the needs of diverse communities.

Recommendation—by the end of 2014, the OHA Transformation Center shall:

- Work with traditional health workers, community-based organizations, and CCOs to identify strategies to support partnerships between these groups to foster health engagement.
- Work with professional health licensing boards to make available a list of evidence-based patient engagement training materials for use as part of their licensing or continuing education requirements.
- Ensure health engagement strategies are integrated within other OHA initiatives, such as health information technology.

Charter: Task Force on Individual Responsibility and Health Engagement

Authority

HB 2859 (2013) established the Task Force on Individual Responsibility and Health Engagement. Under the direction of the Governor, the task force shall develop recommendations for legislation to establish mechanisms that meaningfully engage members of the Oregon Health Plan (OHP).

Guiding Principles

The following principles will guide the Task Force to prioritize recommendations that:

- Align with Oregon's Triple Aim and leverage existing efforts underway by Coordinated Care Organizations (CCOs).
- Represent best practices, are evidence-based, and support person- and family-centered engagement and appropriate utilization of health services among OHP members including prevention, wellness and disease management.
- Empower individuals on OHP and their families/caregivers to engage in their care in ways that are meaningful to them, that offer actual and perceived benefits, and allow participation as fully informed partners in health system transformation.
- Are appropriate to the characteristics of OHP members—including their cultural, geographic and economic circumstance—to improve health equity, reduce health disparities, and avoid creating barriers to care for OHP members.
- Leverage available community resources and align with community-based priorities.
- Can be implemented rapidly upon receipt of any necessary federal approval.

Scope

This task force is responsible for developing recommendations for legislation that will establish mechanisms to meaningfully engage OHP members in their own health, disease prevention and wellness activities. Key areas of focus for the task force may include, but are not limited to: types/uses of incentives/disincentives to encourage healthy behavior(s); effective utilization of health care services; evidence-based patient-engagement strategies effective in but not limited to Medicaid populations; and other innovative approaches to encourage individual responsibility and health engagement. The task force will take into consideration the health status of Oregon Health Plan members, their needs, and potential policy impacts on the health care delivery system.

Membership, Roles & Responsibilities

Executive Sponsors:
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Melinda J. Muller, MD (Chair)
Kay Dickerson
E. Maurice Evans
Melissa T. Lu
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Major Deliverables
Recommendations for legislation in the form of an executive summary that will establish mechanisms to meaningfully engage medical assistance recipients in their own health, disease prevention and wellness activities.
Exclusions or Boundaries
Recommendations are to be submitted by the task force in the manner provided in ORS 192.245, to the appropriate interim committees of the Legislative Assembly no later than November 1, 2013. Policy implementation will not be carried out by the Task Force.
Schedule
The taskforce will meet on four separate occasions. The frequency of meetings may be altered to fit legislative timelines and/or other needs that arise. The task force charter will end by November 2013. • **9/10/13 – First Task Force meeting:** Appoint chair; adopt charter; overview of the Oregon Health Plan and health reform; overview of Medicaid Advisory Committee report on Person- and Family Centered Care and Engagement; introduce background and conceptual framework on patient engagement. • **9/27/13 – Second Task Force meeting:** Review menu of options; rate each option based on guiding principles. • **10/8/13 – Third Task Force meeting:** Review straw proposal for recommendation(s); develop draft recommendations. • **10/22/13 – Fourth & Final Task Force meeting:** Revise and adopt final recommendations/executive summary. • **11/1/12 – Recommendations due:** Submit recommendations to the appropriate interim committees of the Legislative Assembly no later than November 1, 2013.

Cost Sharing in Medicaid

This brief provides an overview of cost sharing in Medicaid (can include premium, deductibles, copayments, and coinsurance) including a summary of the federal guidelines and recent changes, describes Oregon's Medicaid program, the Oregon Health Plan (OHP), and outlines states' experiences with cost sharing in Medicaid.

Federal Guidelines on Cost Sharing in Medicaid

The Centers for Medicare and Medicaid Services (CMS) regulates cost sharing in Medicaid. Federal law limits the amounts that states can charge Medicaid beneficiaries for premiums, deductibles, copayments, and coinsurance (see page 7 for descriptions of terms). States have flexibility to impose cost sharing on certain children and adults with incomes between 100% and 150% of the Federal Poverty Level (FPL) and to impose higher cost sharing for beneficiaries with incomes above 150% FPL. Cost sharing for individuals below 100% FPL is generally limited to nominal amounts established in federal regulations (see Table 1 for federal cost sharing guidelines). Federal regulations on cost sharing include exemptions of a number of vulnerable groups and certain types of services. In addition, states must ensure that the total cost sharing for all family members does not exceed 5 percent of a family's income on a quarterly or monthly basis (see Table 2 for examples of allowed cost sharing by income level).[1]

Over the years, states have opted to use cost sharing to control costs in Medicaid, expand coverage by modifying income eligibility standards, encourage more personal responsibility for health care choices, and to better align public coverage with private coverage, particularly where states have expanded coverage.[2] The Deficit Reduction Act of 2005 provided states new flexibility to implement cost sharing in Medicaid beyond existing authority, by allowing states to vary their cost sharing by eligibility group and to make cost sharing enforceable, i.e. a provider could deny services if the cost-sharing is not paid. The Affordable Care Act (ACA) streamlines Medicaid cost sharing regulations and gives states additional flexibility (see Table 1). If a state opts to create a cost sharing structure beyond the federal limits, they need to meet the following requirements through a demonstration waiver approved by CMS[3]**:**

- Test a unique and previously untested use of copayments
- Limited to a period of not more than 2 years
- Provide benefits to the recipients reasonably expected to be equivalent to the their risks
- Based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area
- Voluntary, or make provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation

[1] Robin Rudowitz and Laura Synder of the Kaiser Commission on Medicaid and the Uninsured. Premiums and Cost-Sharing in Medicaid. February 2013.

[2] Ibid.

3 Section 1916(f) of the Social Security Act

Oregon Health Plan

Oregon's Medicaid program, the Oregon Health Plan (OHP), provides health care coverage to low-income Oregonians and is administered by the Oregon Health Authority (OHA). Today, the OHP has two main benefit packages. OHP *Plus* is a full benefit package that primarily serves Oregon's mandatory Medicaid populations, including low-income seniors, people with disabilities, low-income families, children, and pregnant women. OHP *Standard* is a limited benefit package that provides health coverage to low-income uninsured adult Oregon residents who are ages 19 and older. Federal authority to offer Standard will expire at the end of 2013 due to the Affordable Care Act's (ACA) Medicaid Essential Health Benefits (EHB) provision that requires states to offer a comprehensive package of services.[4]

The ACA allows states to expand their Medicaid programs in 2014, to adults under age 65, up to 138 percent of the Federal Poverty Level (FPL).[5] For the first three years (2014 through 2016), federal funds will pay 100 percent of the costs for people who are eligible under the increased income limit. Federal funding will gradually decline to 90 percent in 2020, where it will remain. In 2013, Governor Kitzhaber and the State Legislature approved opening OHP to more low-income Oregonians as allowed under the ACA. In 2014, a projected 240,000 newly eligible low-income Oregonians who are currently uninsured could be covered through OHP by 2016. Many of these adults are uninsured and work part-time or in low-wage jobs without access to health insurance.[6]

Starting in January, all members in the OHP will receive one benefit package, OHP *Plus*. Oregon's current OHP Standard population will become part of the newly eligible Medicaid expansion population and receive the same health benefits package as current OHP *Plus* members. The OHP *Plus* benefit package for adults includes access to preventive care, access to primary care doctors, check-ups and mental health treatment. In addition, members will receive management of chronic conditions like diabetes, heart disease and cancer. It also includes some vision and dental and benefits. Pregnant women and children in OHP *Plus* receive fuller vision and dental benefits.

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[4] 10 federal EHB Categories: (1) ambulatory patient services; (2) emergency services;(3) hospitalization; (4) maternity and newborn care;(5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices;(8) laboratory services;(9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

5 The ACA establishes 133% FPL as the income eligibility threshold for the Medicaid expansion population, but because it also provides that the first 5% of income is automatically disregarded, the effective income eligibility threshold is 138% FPL.

[6] Michael Perry and Naomi Mulligan with Lake Research Partners and Samantha Artiga and Jessica Stephens with the Kaiser Commission on Medicaid and the Uninsured. Faces of the Medicaid Expansion: Experiences of Uninsured Adults who Could Gain Coverage. November 2012.

Cost Sharing for the Oregon Health Plan

Currently, the OHP does not impose premiums or deductibles, but does require nominal copayments ($1-$3) for a range of covered services that include:

- Office and home visits
- Certain prescription drugs
- Hospital emergency services where there is no emergency
- Outpatient hospital services and outpatient surgery
- Outpatient treatment for mental health and chemical dependency
- Occupational, physical and speech therapy
- Restorative dental work and vision exams

In compliance with federal regulations, certain populations and services in OHP are exempt from cost sharing, and include the following groups[7]:

- Children under 19, including preventive services provided to children, regardless of income
- Foster children (through age 20)
- Pregnant women (all services related to pregnancy or a medical condition that might complicate pregnancy, e.g. smoking cessation)[8]
- Services to terminally ill beneficiaries receiving hospice care
- Services to institutionalized individuals (inpatients in a hospital, nursing facility, intermediate care facility, or other medical institute for individuals with developmental disabilities) who are required to spend most of their income for medical care costs
- Emergency services in an emergency situation as defined by law
- Family planning services and supplies
- Individuals receiving services under a federal home- and community-based CMS waiver
- American Indian/Alaska native populations in a federally recognized Indian tribe or receiving services through a tribal clinic
- Individuals receiving Medicaid coverage through the federal Breast and Cervical Cancer Treatment program (BCCTP)
- Each service may only be subject to one type of cost sharing

Today, the CMS 5 percent cap on cost sharing must be calculated individually for each member and taken into account by the Oregon Health Authority (OHA) and Coordinated Care Organizations (CCOs), creating administrative difficulties for clients in OHP and as incomes changes. As of July 2013, the majority of individuals in OHP are now enrolled in one of the 15 Coordinated Care Organizations (CCOs); most of which have elected not to collect copayments as of September 2012.[9] Only one of the fifteen OHA approved CCOs elected to collect copayments.[10]

[7] Section 1916A of the Social Security Act

[8] All services provided to pregnant women will be considered as pregnancy-related unless excluded in State Plan.

[9] http://www.oregon.gov/oha/healthplan/pages/managed-care/plans.aspx#choose

[10] Ibid.

States Experiences with Cost Sharing in Medicaid

Applying cost sharing in Medicaid creates administrative complexities at multiple levels—for the state agency administering the program, health plans, and providers—and can create unintended barriers to accessing care for Medicaid enrollees. For example, collecting copayments may be difficult because at the time of service a provider may not know the Medicaid reimbursement rate, or whether the individual has met the 5 percent family cap specified in the federal cost sharing rules. For states, the expense of administering cost-sharing may exceed anticipated state savings. For example, Arizona's state Medicaid agency concluded that the state would incur almost $16 million in administrative costs to collect just $5.6 million in copayments and other cost sharing measures. The Arizona study also noted that the administrative costs of collecting the copayments do not take into account increased healthcare costs that result from reduced use of medications by patients in need.[11]

Out-of-pockets expenses for a service can affect a patient's access to care on account that low-income individuals are particularly sensitive to such costs. Research shows cost sharing can act as a barrier in obtaining, maintaining, and accessing health coverage and health care services, particularly for individuals with low incomes and significant health care needs.[12] These barriers can result in unintentional consequences such as increased emergency care utilization, unmet health care needs, and adverse, avoidable health outcomes.[13] As individuals are unable to afford copayments and forego care, they often become sicker and eventually visit costly sites such as emergency rooms, increasing the state's overall health care expenses.[14] Although cost sharing can be appealing for states looking to reduce Medicaid expenditures, such cost sharing mechanisms may actually cost states more.

Oregon's Experience

In 2003, Oregon increased premiums and imposed copayments for federally allowable adults in OHP. As a result, approximately 50 percent of these enrollees lost coverage. Of those who lost coverage, two thirds became uninsured. An additional 24 percent reported not having the ability to pay the co-payment, and 17 percent reported being unable to receive needed health care because they owed their provider money. Increased premiums and copayments had the potential to generate revenue for the state. However, the amount the state received actually decreased due to lowered enrollment. A 2008 study conducted by Oregon researchers concluded that applying copayments to OHP Standard clients in 2003-2004 shifted treatment patterns but did not provide expected savings.[15] The study suggested that if copayments are to be applied successfully in Medicaid programs, there is a clear need for a greater understanding of how they work in this context and greater attention paid to the details of co-pay policies.

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[11] Fiscal Impact of Implementing Cost Sharing and Benchmark Benefit Provisions of the Federal Deficit Reduction Act of 2005. Arizona Health Care Cost Containment System. December 13, 2006.

[12] Laura Snyder Robin Rudowitz of the Kaiser Commission on Medicaid and the Uninsured. Premiums and Cost sharing in Medicaid: A Review of Research Findings. February 2013.

[13] Ibid.

[14] Basini, Leigha O.; *What a Difference a Dollar Makes: Affordability Lessons from Children's Coverage Programs that can Inform State Policymaking under the Affordable Care Act;* NASHP; April 2011

[15] Wallace, Neal T, McConnell, John, Gallia, Charles A., and Smith, Jeanene A.; *How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan;* Health Serv Res. 2008 April; 43(2): 515–530; © 2008 Health Research and Educational Trust.

Table 1: Federal Cost Sharing Requirements Compared to OHP Cost Sharing Policy

	Federal Cost sharing Requirements			Oregon Policy All FPL levels
	< 100 percent FPL**	101-150 percent FPL**	>150 percent FPL	
Aggregate Cap	5% of family income on monthly or quarterly basis (cap on total premium and cost sharing charges for all family members)			
Premiums	Not allowed	Not allowed	Allowed, with exemptions and limitations	None
Cost sharing (may include deductibles, copayments, or coinsurance)				
Most services	$4 maximum	Up to 10 percent of cost the agency pays	Up to 20 percent of cost the agency pays	$3 for non-diagnostic outpatient services; $0 co-pay for other services
Prescription drugs (all)	$4 or $8 maximum depending on the drug			$0, $1 or $3 depending on the drug
Inpatient stay	$75 maximum	10 percent of total cost the agency pays for entire stay	20 percent of total cost agency pays for entire stay	$0
Non-Emergency Use of the ER	$8 maximum	$8 maximum	No limit	$3
May service be denied for nonpayment of cost sharing?	No	Yes, state option	Yes, state option	No
Provider option to reduce or waive cost sharing?	Yes, on case-by-case basis			Yes
Tracking Requirements	If the state adopts premiums or cost sharing rules that could place beneficiaries at risk of reaching the aggregate family limit, the state plan must indicate a process to track each family's incurred premiums and cost sharing through an effective mechanism that does not rely on beneficiary documentation.			State's cost sharing rules do not place beneficiaries at risk of reaching the aggregate family limit

*"Maximum Nominal Out-of-Pocket Costs" are $2.65 deductible, $3.90 copayment, or 5% coinsurance. The maximum copayment that Medicaid may charge is based on what the state pays for that service. Source: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Cost sharing/Cost sharing-Out-of-Pocket-Costs.html

**To be increased each year, beginning October 1, 2015, by the percentage increase in the medical care component of the CPI-U

*** May be imposed on individuals otherwise exempt from cost sharing. Due to additional information requirements under the ACA for non-emergency ED visits, Oregon may wish to reconsider this particular co-pay.

Table 2: OHP Individual and Family of Four, Income and Monthly Aggregate Cap on Cost Sharing

	Individual Consumer		Family of Four	
FPL Level	**Annual Income**	**5% of Monthly Income**	**Annual Income**	**5% of Monthly Income**
100%	$11,490	$48	$23,550	$98
138%	$15,856	$66	$32,499	$135
150%	$17,235	$72	$35,325	$147

Terminology

Co-insurance: A defined percentage of total charges for a service.
Co-payment: Payment made for a health care service or product by an individual who has health insurance coverage. The payment is usually made (or billed) at the time a service is received. Copayments are charged to offset some of the cost of care and to control unnecessary utilization of services. The amount can vary by the type of covered health care service.
Cost sharing: Patient exposure to out-of-pocket costs associated with health services delivery. This term generally includes deductibles, coinsurance and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services.
Deductibles: Flat dollar amounts for medical services that have to be paid by the patient before the insurer or health plan picks up all or part of the remainder of the prices for services.
Out-of-Pocket Costs: An individual's expense for medical care that aren't reimbursed by their insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.
Out-of-pocket limit: The total amount of cost sharing allowed to be charged to a family or individual for health care services provided over a specified period of time.
Premium: The amount that must be paid for an individual's or family's health insurance or health plan coverage, usually paid monthly, quarterly or yearly.

Additional Resources

Artiga, S. (2005, May). *Increasing premiums and cost sharing in Medicaid and SCHIP: Recent state experiences*. Retrieved from http://www.kff.org/medicaid/upload/Increasing-Premiums-and-Cost sharing-in-Medicaid-and-SCHIP-Recent-State-Experiences-Issue-Paper.pdf

Carlson, M. and B. Wright (2005). The Impact of Program Changes on Enrollment, Access, and Utilization in the Oregon Health Plan Standard Population. The Office for Health Policy and Research. Retrieved from: http://www.oregon.gov/oha/OHPR/OHREC/docs/OHREC_cohortflwup_0305.rpt.pdf

Gardner, M. and J. Varon (2004, May). Moving Immigrants from a Medicaid Look-Alike Program to Basic Health in Washington State: Early Observations. Kaiser Commission on Medicaid and the Uninsured. Retrieve from: http://www.kff.org/medicaid/7079a.cfm

Guyer, J. (2010, August). Explaining health reform: Benefits and cost sharing for adult Medicaid beneficiaries. Retrieved from http://www.kff.org/healthreform/upload/8092.pdf

Hines, P., et al., (2003, December). Assessing the Early Impacts of OHP2: A Pilot Study of Federally Qualified Health Centers Impacts in Multnomah and Washington Counties. The Office for Oregon Health Policy and Research. Retrieved from: http://www.oregon.gov/oha/OHPR/OHREC/docs/presentations/assesimpohp211_01_ppt.pdf

Hudman and O'Malley, (2003, March). Health Insurance Premiums and Cost sharing: Findings from the Research on Low-Income Populations, Kaiser Commission on Medicaid and the Uninsured. http://www.kff.org/medicaid/upload/Health-Insurance-Premiums-and-Cost sharing-Findings-from-the-Research-on-Low-Income-Populations-Policy-Brief.pdf

LeCouteur, G., Perry, M., Artiga, S., and D. Rousseau (2004, December). The Impact of Medicaid Reductions in Oregon: Focus Group Insights. Kaiser Commission on Medicaid and the Uninsured.http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=50058

Value-based Benefit Design

Introduction

In the commercial market, health plans have been working to address behavior, lifestyle, and person engagement through new and innovative health insurance benefit designs. In an effort to promote personal responsibility, and quality- and cost-conscious decision-making, health plan are encouraging individuals to take ownership of their health and health care. Several of these consumer-directed approaches use mechanisms that focus on benefit design and the use of financial levers to urge individuals to make more cost-sensitive decisions. The underlying premise of many of these new benefit designs is to place the consumer in more control of his or her health care costs; and thus be better engaged, and make more appropriate health and health care utilization decisions.[16] While such approaches originated mainly in the commercial and Medicare markets, state Medicaid programs have started to experiment with consumer-directed approaches as well.

A relatively new approach, value-based benefits places a priority on preventive care and other effective (or high-value) health services. The intent is to restructure cost-sharing in a way that provides incentives for individuals around the use of appropriate and cost-effective care. This benefit structure also uses financial disincentives for less effective services or ones that have little impact on health. Traditional cost-sharing can reduce the use of appropriate and inappropriate care in "almost equal measure."[17,18] The valued-based benefit model, however, aims to increase health care quality and decrease costs by using financial incentives to promote cost efficient health services and consumer choices.

What is Value-based Benefit Design?

The value-based benefit model is intended to incentivize individuals to use low-cost, evidence-based services (i.e. value-based services). The model ties cost-sharing to high-value services, which are evidence-based, using financial incentives to reduce demand for certain kinds of medical care.[19] Value-based benefit design often eliminates cost-sharing for preventive services,[20] such as periodic screenings; vaccinations; screening for breast, cervical, colon, and prostate cancer; use of preferred providers; and participation in wellness programs.[21,22] The model may also offer full coverage for

[16] Dixon, A., Greene, J., and Hibbard, J. Do Consumer-Directed Health Plans Drive Change In Enrollees' Health Care Behavior? *Health Affairs*, Vol. 27, No. 4 (2009): 1120-1131.

[17] Lohr, K. Brook, R., Kamberg, C., Goldberg, G., Leibowitz, A., Keesey, J, et al. (1986). Effect of cost sharing on use of medically effective and less effective care. *Medical Care,* 24(9), 531-8.

[18] Thompson, S., Schang, L., & Chernew, M. (2013). Value-based cost sharing in the United States and Elsewhere can Increase Patients Use of High-value Good and Services. *Health Affairs,* 32(4), 704.

[19] Shah, N., Naessens, J., Wood, D., Stroebel, R., Litchy, W., Wagie, A., et al. (2011). Mayo Clinic Employees Responded to New Requirements for Cost Sharing by Reducing Possibly Unneeded Health Services Use. *Health Affairs,* 30(11), 2134-2141.

[20] The Affordable Care Act (ACA) eliminates cost-sharing for preventive services.

[21] See Thompson (2013).

tobacco and weight management and require coverage of generic drugs for chronic conditions such as to control blood pressure or diabetes at no cost. The approach can include incentives to encourage healthy behaviors, chronic illness management, and use of ambulatory clinics, rather than emergency departments, for non-emergency care. The intentional design feature is to create incentives by reducing or eliminating copays for valued-based services. The model uses disincentives as well, such as cost-sharing for health choices that may be unnecessary or repetitive (i.e. low value), or when the same outcome can be achieved at a lower cost, while not impeding access to essential care or making treatment unaffordable.

Value-based Benefit Design in Oregon

Oregon has been nationally recognized in its efforts to develop innovative ways to deal with increasing health care costs in an environment of limited resources while working to improve health. In 1991, Oregon pioneered an early form of value-based benefit design by adopted the Prioritized List of Health Services, which ranks health services from the most important to the least important. The List is used to specify covered benefits for OHP enrollees. Two decades later, the Oregon Health Fund Board (2008)[23] and the Oregon Health Policy Board (2010)[24] identified the concept of value-based services as a potential way to further Oregon's Triple Aim:

- Improves health without increasing overall costs
- Improves quality by encouraging most effective services
- Controls costs by discouraging less effective services

In 2010, Oregon adopted the use of value-based insurance design by implementing it in its public employee health plans. The Oregon Educators Benefit Board (OEBB) and Public Employees Benefit Board (PEBB), with a combined total of approximately 265,000 Oregonians have both incorporated value-based insurance deign in their health plans. The goal of Oregon's use of value-base services in PEBB and OEBB is to remove the barriers to proven effective and preventive care. In other words, promote positive health choices and create financial disincentives for poor health choices by applying minimal out-of-pocket costs for individuals.

Cost-sharing is used on a tiered basis for preventive care, medication for treating chronic disease, and emergency services. For example, in PEBB[25] copays are waived for provider visits at a recognized patient-centered primary care home (PCPCH), and for chronic conditions and use of generic drugs. Alternatively, cost-sharing through the use of copays are applied for overused or preference-sensitive services of low relative value. Preference-sensitive services are treatments that involve significant trade-offs for individuals. An example of a preference-sensitive service is back surgery for pain that could be treated by physical therapy or emergency room visits for minor illnesses. PEBB has increased copays for some of the these types of procedures such as some knee and hip surgeries to avoid over-utilization and encourage education and consideration of other potential treatments that might

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[22] Ibid.

[23] Oregon Health Fund Board (2008). Benefits Committee – Final Recommendations. http://www.oregon.gov/oha/OHPR/HFB/benefits/finalrecommendation.pdf

[24] Oregon Health Policy Board (2010). Comparative Pricing of Value-based Essential Health Benefit. http://www.oregon.gov/oha/OHPB/meetings/2010/agenda-pk-1010.pdf

[25] Varies among individual plans offered in PEBB.

improve health and quality of life before proceeding with a surgical procedure. These could be further connected to requirements of using shared decision-making tools as part of a pre-authorization process. Key to this benefit design is to remove barriers around the use of effective services and treatments. Services eligible for reduction or elimination of cost-sharing include:

- Ambulatory services (i.e. outpatient), and include medications, diagnostic tests, procedures, and some office visits
- Primarily offered in the medical home
- Primarily focused on chronic illness management, preventive care, and/or maternity care
- Of clear benefit, strongly supported by evidence
- Cost-effective
- Reduce hospitalizations or Emergency Department visits, reduce future exacerbations or illness progression, or improve quality of life
- Low cost up front
- High utilization desired
- Low risk of inappropriate utilization

The Health Services Commission, the predecessor to the current Health Evidence Review Commission identified 20 services that have over-whelming evidence that there should be no barriers to care. See Appendix A for the full list of Value Based Services.

A key objective in value-based benefit design is to empower individuals to understand and make choices based on the risks, costs, and potential outcomes of treatment options (HA 2010, p. 2032). In order for this model of benefit design to be effective, consumer education is critical. Individuals need clear, understandable and trusted information about what is covered and what their costs would be for a given service. Some techniques, which might be used, include promotional and educational materials and shared decision-making tools to facilitate conversations between individuals and their providers or care teams. In order to make good choices, individuals need access to accurate cost information as well as an adequate understanding of the benefits and risks of various treatment options. In the best case, this information will come from a source that is independent and trusted.

As part of comprehensive health reform, the concept of value-based services could be further explored as a possible model to redesign cost-sharing in the Oregon Health Plan (OHP) for federally allowable population groups. To better motivate desired behavior, cost-sharing could be placed strategically rather than across the board. Whether the concept could have a similar effect in OHP—complimenting the use of the Prioritized List of Health Services as it has in the commercial health insurance market is unknown. Value-based benefit design is a potential option to align individual and provider incentives, as well as align benefit design among public and commercial insurance plans to foster the delivery of “high-value” care.

Appendix A: Value-Based Services

Proposed "Barrier-Free" services for use within a value-based benefit package

Diagnosis	Medications	Labs	Imaging/Ancillary	Other
Asthma	Medications according to NICE 2008 stepwise treatment protocol	None	Diagnostic spirometry	None
Bipolar Disorder	Lithium, valproate	Lithium – lithium level (q3 months); creatinine and TSH (q6 months) Valproate -LFTs and CBC (q6 months)	None	Medication management
Cancer Screening	None	Pap smears Fecal occult blood testing	Mammography Colonoscopy/Flexible sigmoidoscopy	Per USPSTF recommendations, "A" and "B" recommendations only
Chemical Dependency Treatment	Buprenorphine for opioid dependence Acampromsate for alcohol dependence	None	None	Brief behavioral intervention to reduce hazardous drinking (SBIRT) Methadone maintenance treatment
Chronic Obstructive Pulmonary Disease(COPD)	Short-acting inhaled bronchodilator	None	None	None
Congestive Heart Failure (CHF)	Beta-blockers, ACE inhibitors, diuretics	CBC, CMP, lipid profile, urinalysis (annually) TSH once	EKG, Diagnostic echocardiogram	Nurse case management
Coronary Artery Disease (CAD)	Aspirin, statins, beta blockers	Lipid profile (annually)	EKG	Cardiac rehabilitation for post-myocardial infarction (MI) patients
Dental Care, Preventive	Fluoride supplements (age 6 months to age 16), if indicated Professionally applied fluoride varnish (twice	None	Pit and fissure sealants in permanent molars of children and adolescents	None

Appendix A: Value-Based Services

Diagnosis	Medications	Labs	Imaging/Ancillary	Other
	yearly in children aged 12 months to16 years old who are at high risk), if indicated			
Depression, Major in Adults (Severe Only)	SSRIs	None	None	Cognitive Behavioral Therapy (CBT) or Interpersonal Therapy (subject to limit, e.g. 10 per year) in conjunction with an antidepressant Medication management
Depression, Major in Children and Adolescents (Moderate to Severe)	None	None	None	Psychotherapy (CBT, interpersonal, or shorter term family therapy)
Diabetes – Type I	Insulin (NPH and regular only), insulin supplies, ace inhibitors	HgA1c (annually)	None	Diabetic retinal exam for adults (annually)
Diabetes – Type II	Metformin, sulfonyureas, ACE inhibitors, insulin (NPH and regular only), insulin supplies	HgA1c, lipid profile (annually)	None	Diabetic retinal exam for adults (annually)
Hypertension	Diuretics, ACE inhibitors, Calcium channel blockers, Beta blockers	Fasting glucose, fasting lipids (annually)	None	None
Immunizations	Routine childhood and adult vaccinations	None	None	Follow ACIP recommendations for non-travel vaccinations
Maternity Care	Folic acid, Rh immunoglobulin (when indicated)	Screening for hepatitis B, Rh status, syphilis, chlamydia, HIV, iron deficiency anemia, asymptomatic bactiuria,	None	None

Appendix A: Value-Based Services

Diagnosis	Medications	Labs	Imaging/Ancillary	Other
		rubella immunity, screening for genetic disorders		
Newborn Care	Ophthalmologic gonococcal prophylaxis, Vitamin K prophylaxis	Sickle cell, congenital hypothyroidism, PKU (cost borne by the state)	None	None
Reproductive Services	Condoms, combined oral contraceptives, intrauterine devices, vaginal rings, Implanon, progesterone injections, female sterilization, male sterilization	See STI screening and maternity care	None	None
Sexually Transmitted Infections	Syphilis – Penicillin IM or doxycycline Chlamydia – azithromycin or doxycycline Gonorrhea – ceftriaxone IM or cefixime po	In certain populations: chlamydia, gonorrhea, HIV, syphilis	None	According to USPSTF guidelines for appropriate populations to screen (A and B recommendations only)
Tobacco Dependence	Nicotine replacement therapy, nortryptiline, and buproprion	None	None	None
Tuberculosis (TB)	Per CDC guidelines – standard drug treatment for latent and active TB	Screening and diagnostic algorithm according to CDC guidelines	Chest x-ray per CDC guidelines	None

Guidelines based on empirical evidence (systematic reviews and health technology assessments), from trusted sources such as:
ACIP, AHRQ, Cochrane Collaboration, CDC, OHSU Center for Evidence-Based Policy, NICE, NIH, Ontario, SIGN, USPSTF, WHO

General principles

For medications

1) Generics unless no equivalent available
2) Medications for ≤ $4 per month are preferred to more expensive medications

Appendix A: Value-Based Services

Glossary

ACE: angiotension converting enzyme
ACIP: Advisory Committee on Immunization Practices
AHRQ: Agency for Healthcare Research and Quality
CBC: complete blood count
CDC: Centers for Disease Control and Prevention
CMP: complete metabolic panel
EKG: electrocardiogram
HgA1c: hemoglobin A1c
HIV: human immunodeficiency virus
IM: intramuscularly
LFTs: liver function tests
NICE: National Institute for Health and Clinical Excellent (England)
NIH: National Institutes of Health
OHSU: Oregon Health & Science University
PKU: phenoketonuria
SIGN: Scottish Intercollegiate Guidelines Network
SBIRT: screening, brief intervention, and referral to treatment
SSRIs: serotonin specific reuptake inhibitors
STI: sexually transmitted infection
TSH: thyroid stimulating hormone
USPSTF: US Preventive Services Taskforce
WHO: World Health Organization

Office for
Oregon Health Policy and Research

Person- and Family-Centered Care and Engagement

Medicaid Advisory Committee

Full Report and Recommendations

July 2013

Oregon Health Authority

Office for Oregon Health Policy and Research

John A. Kitzhaber, MD, Governor

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July 2, 2013

Chairs, Oregon Health Policy Board
Oregon Health Authority

Dear Chairs Parsons and Shirley and members of the Board:

The Medicaid Advisory Committee strongly believes that person- and family- centered engagement in health and health care serves as the most direct route to achieving Oregon's three-part aim for individuals served by the Oregon Health Plan (OHP). This conviction is reinforced by an increasing body of evidence that indicates individuals who are more engaged in their own health and health care experience better health outcomes, better experience of care, and incur lower medical costs. This is particularly the case when services and supports are tailored to their individual needs, goals, preferences, and circumstances with the input of the member and their families, in partnership with their health care team.

Recognizing the importance of OHP members' willingness and ability to engage in and manage their own health and health care, the Committee spent six months exploring a range of strategies to support this goal. The process comprised an extensive review of research and testimony from a diverse range of stakeholders and national experts on approaches and experiences from both commercial and state Medicaid programs. The Committee determined that strategies focused on cost-sharing, or the use of financial disincentives could have negative and unintended effects for OHP members. Furthermore, there is limited evidence that supports the use of financial incentives/disincentives in Medicaid, and is restricted by federal law.

The Committee opted to focus on a set of strategies and actions designed to coordinate, align and promote person- and family-centered activities statewide aimed at engaging OHP members in their health and health care. The goal is to further realize OHP members' full potential for improving and maintaining their health and for serving as active partners in a transformed health system that spans the Oregon Health Authority (OHA), Coordinated Care Organizations (CCOs), Patient-Centered Primary Care Homes (PCPCHs), other health care settings, and members' homes and communities.

Anchoring the Committee's work is the recognition that in order to *think* about health and health care differently policy makers, legislators, health care executives, providers, community leaders, and other key stakeholders participating in Oregon's historic Health System Transformation need to both *think* and *talk* about it differently. This entails continuing to shift away from the conventional medical model focused on disease treatment to thinking about, and caring for, the whole person, focusing on prevention and promoting health and wellness. For this reason, the Committee adopted preferred language, using the terms person (or individual) and family when talking about those who engage or are engaged in their health and health care.

The Committee also explicitly acknowledges that the prevailing nomenclature used in health care too often refers to individuals as patients instead of persons (i.e. individuals by categories as dual eligibles, patients, and consumers, rather than person). Examples include patient-engagement, patient-activation, and patient-centered care. In opting to move away from using the term "patient" and toward "person-centered" when possible, the Committee is also conscious of the undesirable and unintended connotations associated with the term patient. This subtle distinction recognizes that the term "patient" may connote passivity, as well as the historical patient-provider relationship, wherein a patient is one who relies on his or her providers to make health related decisions on his or her behalf. The Committee believes the preferred terminology, "person and family," transcends the varying roles and responsibilities individuals, their families, and representatives/advocates have regarding their health and well-being, and the characterization of those roles, which are often heavily influenced by their audience and context, are of particular importance for OHP members. This is an intentional effort to both encompass and respect an individual's needs, values, ability to engage, cultural traditions and family situation.

In closing, while concepts and strategies discussed in this report are applicable to a variety of populations, the Committee is charged with developing strategies for individuals enrolled as members in the Oregon Health Plan. The Committee believes the strategies put forward in this report, if implemented, will help further health system transformation in support of all Oregonians.

Sincerely,

Janet E. Patin, MD
Co-Chair, Medicaid Advisory Committee

Karen Gaffney, MS
Co-Chair, Medicaid Advisory Committee

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August 6, 2013

Chairs, Oregon Health Policy Board
Oregon Health Authority

Dear Chairs Parsons and Shirley and members of the Board:

The Medicaid Advisory Committee thanks the Oregon Health Policy Board for the opportunity to share its work on Person- and Family-Centered Care and Engagement, and appreciates the Board's support in its efforts to develop a framework for enhancing policies that support this work. Based on the Board's feedback and request, the Committee narrowed the initial set of strategies and actions to two recommendations, which serve as the desired starting point for this work over the next 6-12 months. The full list of strategies and actions[1] provide a broader framework as the Oregon Health Authority (OHA) works to align and spread models of coordinated and integrated care across the agency's health care programs, including Oregon's commercial marketplace.

The Committee prioritized its final recommendations in accordance with the Board's guidance summarized below:

- Consider the roles of all actors in the system and how responsibility can be appropriately assigned across the different parts of the health system.
- Leverage existing infrastructure and health system transformation efforts already underway, specifically the OHA Transformation Center and the Patient-Centered Primary Care Institute.
- Assure expectations placed on providers, practices, and the health care system is balanced with similar expectations and notions of accountability for local and state officials, communities, individuals, and their families/representatives.

[1] For the complete list of strategies and actions, please see the July 2013 MAC Report on Person- and Family-Centered Care and Engagement.

Recommendation #1: Each CCO and their delivery system partners empower individuals by providing education and support in how to navigate the delivery system and manage their own health by providing timely, complete, unbiased and understandable information in accessible and appropriate formats on health conditions and treatment options, taking into account cultural, linguistic, and age appropriate factors.

Recommendation #2: OHA partners with CCOs through the Transformation Center to achieve economies of scale to make the use of the Patient Activation Measure (PAM), shared decision-making tools, and health literacy tools more affordable to all practices and works with the Patient Centered Primary Care Institute to train and educate practices on the implementation of such tools.

With the upcoming expansion of Medicaid to low income adults up to 138% of the Federal Poverty Level, approximately 240,000 newly eligible low-income Oregonians are projected to enroll in the Oregon Health Plan (OHP) by the end of 2016. This is in addition to the 660,000 individuals currently eligible for the OHP that are projected to enroll within the same timeframe. This presents a historic opportunity to redefine the relationship, expectations, and roles of individuals on the OHP as active participants in Oregon's reformed health system. The overarching goal is to promote deeper engagement across all levels of the health system, and simultaneously encourage individual responsibility for managing one's own health and health care. The recommendations are intended to support individuals as equal partners in and accountable for their own health.

The Committee believes its report and recommendations should serve as a foundation for the Task Force on Individual Responsibility and Health Engagement, whose work will occur over the Fall of 2013. We appreciate the opportunity to create a new understanding of the roles and responsibilities of CCOs, health care professionals, local and state officials, communities, and individuals and families/representatives in support of person- and family-centered care.

Sincerely,

Janet E. Patin, MD

Co-Chair, Medicaid Advisory Committee

Karen Gaffney, MS

Co-Chair, Medicaid Advisory Committee

Medicaid Advisory Committee Report

Submitted to Oregon Health Policy Board

July, 2013

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If you would like additional copies of this report, or if you need this material in an alternate format, please call Lori Elliott at (503) 373-2275.

Executive Summary

The Oregon Medicaid Advisory Committee (MAC) believes that engaging a person and their family in their own health and health care is a critical aspect of achieving Oregon's three-part aim of:

- Improving the lifelong health of Oregonians;
- Increasing the quality, reliability, and availability of care for all Oregonians; and
- Lowering or containing the cost of care so it's affordable to everyone.

In an effort to build on the foundation of Oregon's health reform efforts, the Committee developed a set of strategies and key actions that will support Oregon Health Plan (OHP) members to become more engaged and informed decision-makers, enhance their ability to manage their health and health care, and support individuals in becoming more active participants in Oregon's health system.† The strategies, critical to improving health outcomes among less advantaged Oregonians, are presented as a framework for enhancing policies and interventions aimed at supporting person and family engagement at all levels of Oregon's Health System Transformation.[1] The actions are designed specifically to address the diverse backgrounds and complex needs of current and future OHP members.

In developing the strategies, the Committee carefully reviewed and identified gaps as well as opportunities to build on existing activities already supported by OHA's Patient Centered Primary Care Home (PCPCH) Program, Coordinated Care Organizations (CCOs), and other key reform efforts. The Committee's full report includes background information, an overview of the committee process, key policy considerations, and supporting evidence for the proposed set of strategies and actions. The executive summary provides a synopsis of the key recommended strategies, rationale and actions for each strategy, and is intended to inform and guide Oregon's transformation to a high-performance health system.

Committee Process

The Committee began its work by examining strategies designed to encourage individuals to take ownership of their health and health care by promoting personal responsibility and quality- and cost-conscious decision-making. Starting with the commercial market, the Committee reviewed consumer-directed approaches that use mechanisms focused on benefit design and the use of financial levers to urge individuals to make more cost-sensitive decisions. A common form of this approach is a health savings account linked with a high

† Broadly inclusive of groups such as Oregon Health Plan members, their families and/or representatives, providers, practices, community clinics, hospitals, local health departments, the Oregon Health Authority and Department of Human Services, other culturally and linguistically diverse community members (such as race/ethnicity, Limited English Proficient individuals, people with disabilities, across the life-span, people with mental health and/or addictions issues, social services organizations, consumer advocacy groups, the community-at-large, etc.).

deductible health plan. Proponents of this approach believe that a consumer in control of, and at greater risk for, his or her health care costs will be better engaged, and may make more appropriate health and health care utilization decisions.[2]

Early in the Committee's work, however, the MAC recognized that even nominal cost-sharing including premiums and co-pays, can serve as a barrier to accessing necessary preventive and primary care services for low-income and other vulnerable populations. Cost-sharing can also result in unintended consequences such as increased use of the emergency department after delaying care.[3,4] Furthermore, past experience in Oregon and in other states demonstrates that implementing cost-sharing in Medicaid is complex and administratively burdensome, wherein costs often outweigh anticipated state savings.[5] Finally, federal law imposes strict cost-sharing limitations and benefit design requirements for all Medicaid populations. Thus, federal requirements currently restrict the use of such approaches in Oregon's current health care environment.[6]

Subsequently, the Committee reviewed available research and information from state Medicaid incentive programs that use a variety of approaches, including financial and non-financial incentives, to promote healthy behavior and appropriate utilization of health care among their members. Examples include Florida's Enhanced Benefits Reward$ Program and Idaho's Preventive Health Assistance program. Early findings from these states indicate that program effectiveness would be improved by better addressing the *challenges* Medicaid members face to participating in such programs, such as lack of awareness and understanding of the program, and *barriers* to adopting healthy behaviors, such as limited transportation options to access both health care services and healthy activities. To date, there is limited evidence on the efficacy and cost-effectiveness of such approaches within state Medicaid programs.[7]

The Committee considered a growing body of evidence that shows individuals who are more engaged in their own health and health care, experience better health outcomes and incur lower medical costs.[8,9] Individuals that are more highly engaged and activated are less likely to have unmet medical needs; more likely to have regular check-ups, including screenings and immunizations; adhere to treatment and obtain regular chronic care services; and, engage in health behaviors such as eating a healthy diet, regular exercise, and avoid adverse behaviors such as smoking and illegal drug use.[10,11,12] This is particularly the case when services and supports are tailored to their individual needs, goals, preferences, and circumstances.[13] The Committee believes that innovative approaches, designed to improve individual engagement and accountability for one's own health in a person-and family-centered health system, will ultimately support the achievement of Oregon's three-part aim for all OHP members.

Recommendations

The recommended policy strategies seek to enhance alignment, coordination and create synergy among person- and family-centered efforts already underway through Oregon's Health System Transformation. The key is to effectively and equitably engage individuals and their families across all levels of the health system. Paramount to this is addressing the unique barriers and challenges experienced among OHP members. The continuum of person- and family-centered engagement in care is characterized across three levels: (1) direct patient care and partnership(s), (2) integration of patients' values in the design and governance of health care organizations, and (3) shared leadership and policy making that's responsive to patients' perspectives.[14]

The MAC envisions a number of key actors to help adopt and implement these strategies. Key partners include members of the OHP and their families and/or representatives; providers and practices, especially those in recognized, patient-centered primary care homes; the Patient-Centered Primary Care Institute (PCPCI); Coordinated Care Organizations (CCOs) and their community partners; the Oregon Health Authority and its Transformation Center, in addition partners such as Cover Oregon, health professional associations, and other stakeholders.

Strategy #1: OHP members provide information to providers and the OHA about how to effectively address barriers to individual and family engagement and improve the health system.

Rationale: To better understand how best to support individuals' efforts to participate in their health, there is a need to systematically and regularly collect information from OHP members on their level of engagement in their health and health care, their experience of care and satisfaction. This will identify specific opportunities, facilitators, and barriers for individuals to improve and maintain their health. The goal is to solicit information and understand members' barriers to accessing care, ability for self-management, and fostering shared responsibility for health.

- Action: Providers routinely and consistently engage OHP members and their families as key partners and participants in the health care process by providing timely, complete, unbiased and understandable information in accessible and appropriate formats on health conditions and treatment options, taking into account cultural, linguistic, and age appropriate factors.
- Action: Practices recognize and utilize members' experiences through outreach efforts including surveys, focus and advisory groups, and social media to guide practice level improvement.
- Action: OHP members and families directly partner with care teams, non-traditional health care workers, and community-based organizations to access and engage in community-based self-management programs.

- Action: OHA coordinates and aligns use of patient satisfaction and experience of care surveys statewide to address such things as purchasing strategies to assist practices and CCOs, preferred survey types (e.g. Picker, Press Ganey; HCAHPS, CG, & PCMH), use of benchmarks, survey timelines and redundancies with administration, and public reporting of information.

Strategy #2: Ensure ongoing education and training on evidence-based best practices for person- and family-centered engagement in health and health care.

Rationale: To fully support OHP members and their families in their own health and health care, practices and health care professionals, including community-based organizations, require education and sustained training in this arena. Such efforts should focus on effective use of techniques and best practices that create opportunities for individuals to make informed decisions and support health improvement of OHP members in their communities across Oregon.

- Action: Practices and providers receive regular and ongoing education and training from technical experts such as the Patient-Centered Primary Care Institute (PCPCI) and other learning forums on approaches to support person- and family-centered care. Examples include use of the Patient Activation Measure (PAM), shared decision-making and the use of decision aids, how to address low literacy and health literacy skills, and support for community-based self-management and wellness programs.
- Action: CCOs receive ongoing training and technical assistance from the OHA Transformation Center on how to work with practices to implement use of patient level data to inform practice and system level improvements.

Strategy #3: Leverage resources that support evidence-based best practices for person- and family-centered engagement and activation in health and health care.

Rationale: The Committee concluded that several evidence-based tools that would be helpful to sustain practice-level engagement efforts might not be affordable, individually, particularly for resource-limited small or rural practices.

- Action: PCPCI develop and disseminate practice-level tools for providers to routinely ask members and their families about their values, needs, knowledge, preferences and circumstances in culturally and linguistically appropriate ways. This will allow greater member feedback to be integrated into individually tailored and appropriate care plans.
- Action: OHA should work with CCOs and their delivery system partners to achieve economies of scale in order to make evidence-based tools more affordable and available to practices of all sizes throughout the state such as:
    - Patient Activation Measure (PAM)[‡] or other evidence-based activation measurement tool(s), to assess the skills and readiness of the individuals for

[‡] The Patient Activation Measure® (PAM®) assessment gauges the knowledge, skills and confidence essential to managing one's own health and health care.

engagement. Results can be used to determine the appropriate levels of intervention and allocation of resources. For example, a patient with complex and chronic health needs and low activation level may need the most intense interventions and resources versus someone with low acuity and a high level of activation.

- Shared Decision Making tools that are evidenced based, to engage individuals and their families about discrete health conditions and support medical decisions by providing information, helpful strategies, and other supports.

- Action: OHA works with community stakeholders to develop a sustainable system for evidence-based self-management program delivery and financing to ensure broader availability of community-based programs, such as Living Well with Chronic Conditions, across the state. The work should ensure linkages with PCPCHs and CCOs to the extent possible, working with the PCPCI and through the OHA Transformation Center to coordinate and align resources, provide targeted technical assistance and learning collaboratives.

Strategy #4: Create opportunities across all levels of the health system to support OHP members as integral partners in Oregon's Health System Transformation.

Rationale: A comprehensive person- and family-centered transformed health system will need to encompass patients, families, their representatives, health professionals, and community partners working in active partnership at various levels across the system—direct care, organizational design and governance, and policy making—to improve members' health and health care.

- Action: CCOs systematically and meaningfully engage representatives of diverse populations (including but not limited to cultural, language and age considerations) and community stakeholders to develop their community health assessments (CHAs) and community health improvement plans (CHIPs). For example, OHA should work closely with CCOs and their Community Advisory Councils to ensure the resources and support of person- and family-centered care strategies are available to foster the needs and primary goals of the members and community served by their CCO.
- Action: OHP members and their families serve as "equal and active partners" by fostering meaningfully and sustained participation in CCO advisory panels, provider/practice level advisory groups, and in local and state committees, councils, and boards, as OHP member advocates.

Strategy #5: Coordinate the adoption and spread of evidence-based best practices for person- and family-centered engagement in health and health care.

Rationale: Critical to this effort will be the promotion and alignment of multi-payer approaches to increase spread across provider practices and communities. OHA should work to ensure coordination and alignment of person- and family-centered models of care across the OHA, including CCOs, Public Employees' Benefit Board (PEBB), Oregon Educators Benefit

Board (OEBB), the PCPCH Program, Cover Oregon and other payers. The goal is for OHA to leverage resources and activities statewide to disseminate best practices appropriate for OHP members and their families.

- Action: OHA should incentivize and disseminate the use of evidence-based best-practices for person- and family-care models of care that are sensitive to and account for the needs of diverse communities. This may be accomplished through the OHA Transformation Center coordinating with Innovator Agents, CCOs, regional learning collaboratives, and recognized PCPCHs to incentivize and disseminate the use of evidence-based best-practices for person- and family-centered models of care that are sensitive to and account for the needs of diverse communities.
- Action: OHA works with CCOs to increase the number of recognized PCPCH practices; modify existing PCPCH Standards to support of more robust person- and family-centered care and engagement models; and consider alternative payment methodologies to incentivize practices with resources to adopt and sustain patient engagement activities.

[FULL REPORT]

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Introduction

As state policymakers, legislators, and health care leaders endeavor to improve a key determinant of health—the delivery system—individuals, families and communities must serve as key partners in reforming the system. By placing individuals, families and their communities at the center of health reform, efforts to increase access and quality, and to ensure that the health care system is held accountable, will be optimized. In Oregon, as new and innovative models of health care emerge, it will be important to design and test policy interventions that also influence factors beyond the delivery system, thus leveraging the critical work already led by CCOs. New policy approaches are needed to modify other determinants of health as an extension of broader health reform efforts, specifically addressing behavior and lifestyle determinants.[15]

> *"The most direct route to the Triple Aim is through implementation of patient and family-centered care in its fullest form."*
> Don Berwick, former administrator for CMS

Dozens of states are earnestly working to implement broad health reforms—addressing the financing, payment and delivery of health care services, both in Medicaid and the commercial marketplace—many of which are directly supported by the federal Affordable Care Act (ACA). Paramount to these reform efforts is the recognition by policy makers that an individual's health status and well-being are determined to a large extent by factors outside of insurance coverage and access to high-quality health care services.

Increasingly understood is that the health of a community and its residents is determined by a number of factors including access to, and use of primary and preventive health care services. Altogether, health care accounts for approximately 10 percent of an individual's health.[16,17,18] Therefore, comprehensive health reform efforts must also target broader social determinants of health such as education, housing and social cohesion, and personal behaviors such as diet, physical activity, tobacco use, substance abuse and addictions, approaches to safety, and coping strategies to stress. Combined, behavior and lifestyle account for over half the factors that influence one's health status, including premature mortality.[19]

In the commercial market, health plans have begun to fold in efforts to address behavior, lifestyle, and person engagement through new wellness programs, such as Oregon's Public Employee Benefit Board's (PEBB) Health Engagement Model. Many such efforts tie financial penalties to non-participation in such programs. However, due to federal restrictions, these types of approaches cannot be fully replicated in state Medicaid programs. Nevertheless, opportunity remains in directing limited federal and state resources for Medicaid to support the design of new programs that target preventable and

healthy behaviors through novel interventions aimed at increasing individual responsibility and engagement of the individual in their own health and health care.

As Oregon works to transform its health system, an important factor in achieving the three-part aim is supporting providers along with individuals and their families to engage in improving and maintaining their health. The desired outcome is for individuals and families to adopt preventive and healthy behaviors, such as reducing tobacco use, modifying poor diet by increasing intake of nutritious foods, increasing physical activity, and reducing substance abuse. Oregon's transformed health system can benefit by encouraging and empowering individuals to take ownership of their health, particularly outside the clinical setting.

> *"Person-centeredness is needed if we are really going to improve health and if we want a partnership with the person whose health we are trying to improve."*
>
> Gary Christopherson, former CMS Senior Adviser

This report includes key background information, an overview of the committee process, review of the literature and evidence, key policy considerations, as well as the rationale and supporting evidence for the set of recommended strategies and actions.

Background

Oregon, along with other states can benefit by experimenting with interventions that seek to address behavioral and social circumstances by influencing and increasing participation of Medicaid beneficiaries in their own health care, make informed decisions as a member of their care team, increase efforts and support in disease management and wellness programs, and take part in preventive health behaviors. Over the long-term, these efforts may contribute to improved population health and curb the growth rate of health care expenditures.

States have begun to explore new opportunities to provide individuals with low-income and other vulnerable populations, access to resources and coverage of community-based services and supports. A good example in Oregon includes the use of non-traditional health workers (NTHWs), who are experts in providing culturally competent care and are uniquely placed to work with community members to identify and resolve their own most pressing health issues by addressing the social determinants of health; thus, contributing to reducing health inequities in Oregon. Accordingly, NTHWs can assist individuals in overcoming barriers to engaging and sustaining in preventive and healthy behaviors.

Among the more than 65 million individuals served by Medicaid, the notion of individual responsibility and the use of penalties or incentives to encourage healthy behaviors is

complex and not well understood.[20] There are several key policy considerations in trying to foster approaches designed to encourage individuals to take ownership of their health care by promoting personal responsibility and quality- and cost-conscious decision-making. Such considerations are of particular importance for those insured through Medicaid. For example, the use of incentive programs aimed at promoting healthy behavior and controlling costs must be designed so that the proposed interventions do not result in unintended consequences and inadvertently discriminate those covered by Medicaid. States have a responsibility to ensure and protect against policy interventions that insufficiently account for community-based and socioeconomic factors associated among low-income and other vulnerable population groups that affect an individual's ability to engage in healthy behaviors and disease management.

To learn from and build on the foundation of recent health reform efforts the Oregon Medicaid Advisory Committee (MAC) examined evidence and best practices around person- and family-centered care and engagement. The Committee spoke with experts both in Oregon and in other states to develop a set of strategies and key actions that will support OHP members to become informed decision-makers, enhance their ability to manage their health and health care, and support individuals in becoming more active participants in Oregon's health care system (*Please see *Appendix A* on page 18 for complete list of invited speakers).

What's the Issue?

The landmark Institute of Medicine report (2001), *Crossing the Quality Chasm: A New Health Systems for the 21st Century,* called for reforms to achieve a patient-centered health care system. The report described a future state in which the U.S. health care delivery system "is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions."[21] The "new chasm" is bridging the loci of health care services for individuals through person-and family-centered care by linking the delivery system to the community. The next major step in federal and state health reform is transitioning to a system of person- and family-centered care.

For decades, Oregon has been working towards comprehensive reform of its financing, payment, and delivery system, with notable accomplishments in its Medicaid program. From the creation of the Prioritized List of Health Services in 1988; expansion of the OHP to adults up to 100% of the federal poverty level (FPL) in 1994; the creation of the Oregon Health Authority, the Health Policy Board, and the Patient-Centered Primary Care Home Program in 2009; and most recently, Coordinated Care Organizations (CCOs)—Oregon is now committed to its three-part aim:

- Improving the lifelong health of Oregonians;
- Increasing the quality, reliability, and availability of care for all Oregonians; and
- Lowering or containing the cost of care so it's affordable to everyone.

Historically, individuals have not served as equal partners in health care or been involved in systems-level reforms.[22] A key challenge is to redesign Oregon's health care system, including Medicaid, with the individual as the nucleus in a transformed system. Fundamental to this is recognizing and valuing individuals not as patients, or recipients of care, but rather as "partners" across all levels of the health care system. This includes interactions with providers and care teams, at the practice-level, in hospitals, community-based organizations, in local and state directed programs, CCOs, and by public bodies that engage in regional and state directed policy development and oversight functions (i.e. governance). The new model must move beyond any restrictions or nominal representation in these redesigned structures and processes. In other words, individuals and families need opportunities for meaningful engagement and for their input to be encouraged and valued across the continuum.

> *"Recognize that we are the most important part of the care team, and that we are ultimately responsible for our overall health and wellness."*
>
> Oregon Patient Centered Primary Care Home (PCPCH) Program Core Attribute

Fortunately, Oregon is well positioned to identify additional opportunities to build on what has already been accomplished and continue to work towards the ultimate goal of better health, better care and lower costs for Oregonians. It will be important to leverage efforts already underway including:

- Health System Transformation Center: provision of technical assistance and other support to CCO and their provider networks to help them meet their incentive measures, that include patient satisfaction and contract requirements that must demonstrate progress in provider- and patient-engagement, in addition to other critical patient-and family-centered care areas.
- Patient-Centered Primary Care Institute (PCPCI): fostering medical home transformation. The Institute has hosted several webinars relating to person- and family-centered care and engagement, as well as the tremendous work being led CCOs and PCPCHs across the state.

The next building block of health reform can be achieved—person- and family-centered care—for members of by Oregon Health Plan (OHP). The redesign of Oregon's health system emphasizes local accountability for health care and allocation of resources by each CCO. The next step is to address personal responsibility and engagement of the individual and their family. First, there are important challenges experienced by low-income populations, often covered by Medicaid that must be addressed prior to proposing policy recommendations.

Challenges Faced by Low-income, Vulnerable Populations

As states and policy makers consider policies aimed at improving individual engagement and influencing behavior modification, it is critical to account for the unique challenges low-income and other vulnerable populations experience with accessing, improving and maintaining their health and health care. Given limited financial resources, often poorer health status, complex health needs, and other barriers such as education and physical environment—strategies to engage low-income vulnerable populations including those in Medicaid in their health and health care—must take into careful consideration the unique challenges and barriers experienced by these populations.[23]

Frequently experienced challenges Medicaid beneficiaries encounter, include but are not limited to:[24]

- Limited education
- Limited literacy and health literacy
- Lack of resources
- Access to child care services
- Appropriate transportation
- Unhealthy physical environment
- Chronic stress
- Social exclusion/isolation
- Survival mentality
- Physical and mental capacity
- Health care professionals lack of cultural sensitivity toward low-income, diverse populations

Framework for Observations and Recommendations

The lexicon that encompasses person- and family-centered care is multidimensional, multi-layered, and expands across a continuum of engagement.[25] The term is also used synonymously with *patient engagement* and *patient activation*, which are related concepts but do not have an identical meaning. To help clarify the committee's work, these concepts first need to be defined to avoid confusion and increase comprehension.

Person- and Family-Centered Care

Person- and family-centered care[D] is an approach to the planning, delivery and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, individuals, families and communities. It redefines the relationships in health care by placing an emphasis on collaboration with individuals and families of all ages, at all levels of care, and in all settings—shifting from the traditional approach of *"doing to and for"* them to partnering "*with"* them.[26] It acknowledges that individuals and families are essential allies for quality and safety within any health care setting. Person-and family-centered care also acknowledges that emotional, social, and developmental supports are integral components of health care. It

[D] The Committee adapted the term "patient- and family-centered care" to use the word "person" or in lieu of "patient," in keeping with our approach of using person first language when possible and appropriate. The definition is from the Institute for Patient- and Family-Centered Care.

promotes the health and well-being of individuals and families and restores dignity and control to them.

Person and family-centered care offers a new framework for bringing about transformational change to health care by shaping policies, programs, facility design, provider and organizational culture, and staff day-to-day interactions.[27] It leads to better health outcomes, improved patient satisfaction, quality of care, improved allocation of resources, while reducing health care costs and disparities in health care.[28]

> "Research has shown that patient- and family-centered care that incorporates shared decision-making can reap potential healthcare savings of $9 billion over 10 years."
>
> *Commonwealth Fund 2013*

The core concepts of person- and family-centered care are:

- *Respect and Dignity*: Health care providers invite, listen to and honor individual and family perspectives and choices. Individual and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
- *Information Sharing*: Health care providers communicate and share complete and unbiased information with individuals and families in ways that are affirming and useful. Individuals and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
- *Participation*: Individuals and families are encouraged and supported in participating in care and decision-making at the level they choose.
- *Collaboration*: Individuals and families are also included on an institution-wide basis. Health care leaders collaborate with individuals and families in policy and program development, implementation, and evaluation; in health care facility design; and in professional education, as well as in the delivery of care.

Person- and family-centered care and cultural competence are inextricably linked. Respect for the beliefs, values, practices, preferences, needs and approaches to decision-making for individuals and families from diverse cultures and backgrounds are an essential aspect of person- and family-centered practice.[29]

Individual Engagement and Activation

The term "patient engagement" encompasses patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system—direct care, organizational design and governance, and policy-making—to improve health and health care.[30] Furthermore, engagement activities range along a continuum, from consultation to partnership with the willingness and ability of patients to engage being affected by multiple factors.[31]

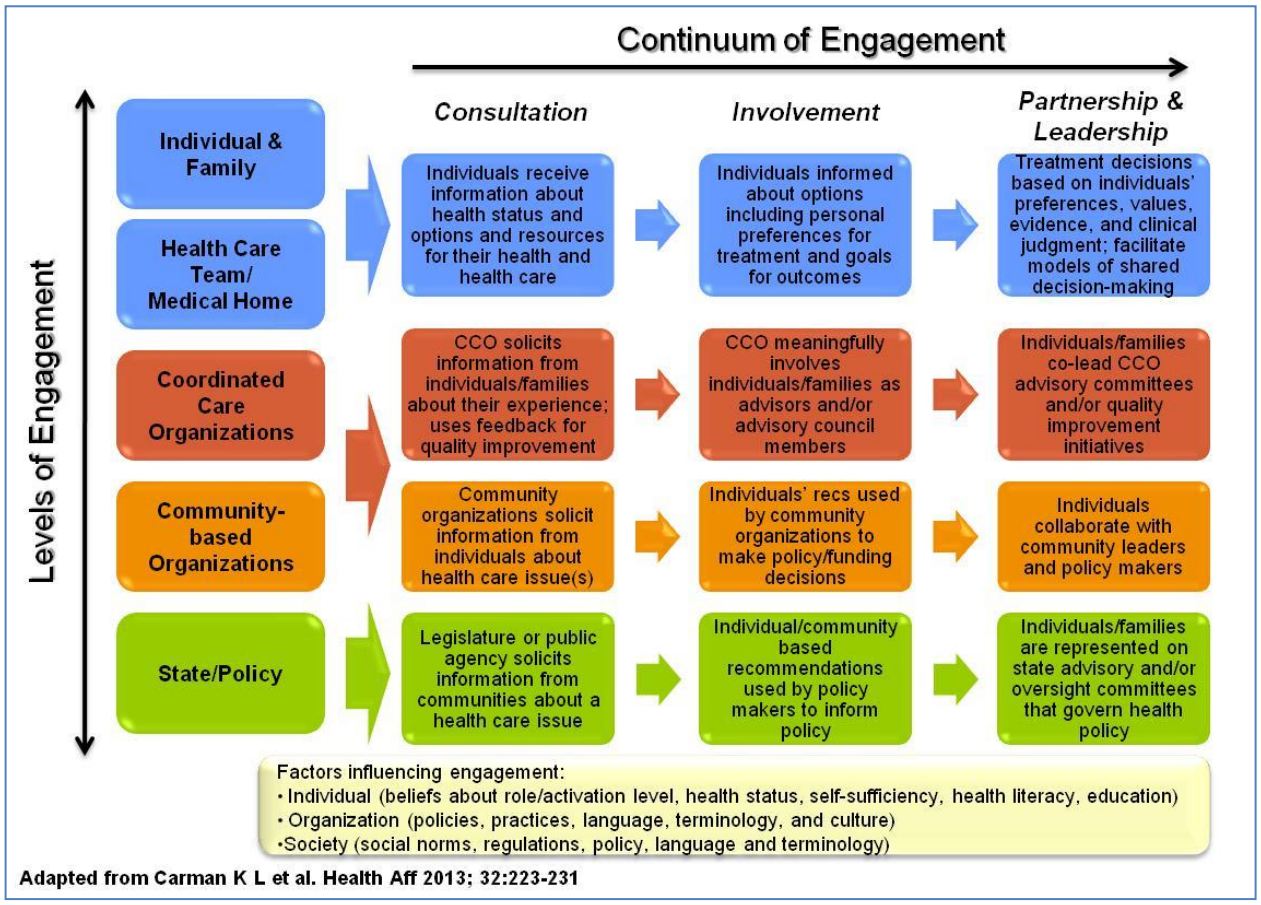
There is a growing body of research that indicates individuals who are more engaged, experience better health outcomes and help control health care costs.[32] This is particularly the case when services and supports are person- and family-centered. Meaning they are respectful of and responsive to individual and family preferences, needs, and values, and ensuring that individual values guide all clinical decisions. Research consistently finds that those who are more activated are more likely to:[33]

- Engage in preventive behaviors
- Engage in healthy behaviors
- Avoid health damaging-behaviors
- Engage in more disease specific self-management behaviors
- Engage in more health information seeking behaviors

Another important concept is patient activation, which refers to an individual's knowledge, skills, ability and willingness to manage his or her own health and health care.[34] Activation differs from compliance, where the emphasis is on getting individuals to follow medical advice. Individuals who are more activated have better health outcomes and experience of care. Activation is one aspect of an individual's capacity to engage in his or her own health. This term, however, does not address an individual's external context, nor does it focus on behavior.[35] (*Please see *Appendix B* on pg. 19 for additional information on evidence-based tools related to engagement, activation, and shared-decision making.)

The Committee adapted a multidimensional framework for patient engagement, developed by Carman et al. (2013), that reflects the Oregon context. See Figure 1 on the following page. Activities along the continuum of engagement remain the same, but the levels of engagement were modified to reflect the specific actors in Oregon's health care environment: individuals and their families; health care teams, including providers, front-office staff, non-traditional health workers, etc.; the medical home; CCOs; community-based organizations; and finally, state governance and policy.

Figure 1: Multidimensional Framework for Individual and Family Engagement



Committee Process and Rationale

Recognizing the importance of OHP members' willingness and ability to engage in, participate, and manage their own health and health care, the Committee spent six months (January-June 2013) exploring a range of strategies to support this goal. The process comprised of an extensive review of research and hearing from a diverse range of stakeholders and national experts on approaches and experiences from both commercial and state Medicaid programs. (*Please see *Appendix A* on pg. 18 for a full list of invited experts that presented to the Committee.)

The Committee determined that strategies focused on cost-sharing or the use of financial incentives and disincentives could have negative or unintended effects for OHP members. Furthermore, there is limited evidence that supports the effectiveness of such approaches in Medicaid, which are restricted by federal law, and are summarized in the next section.

The proposed strategies, important to improving health outcomes among less advantaged Oregonians, are presented as a framework for enhancing policies and interventions aimed at supporting person- and family-engagement at all levels of Oregon's Health System Transformation.[36] The actions are designed, specifically, to address the diverse background and complex health care needs of current and future OHP members.

The committee's overall deliberation process and key steps are summarized as follows:

- Examined a broad range of strategies designed to encourage individuals to take ownership of their health and health care by promoting personal responsibility and quality- and cost-conscious decision-making.
- Recognized even nominal cost-sharing including premiums and co-pays can serve as a barrier to accessing necessary preventive and primary care services for low-income, vulnerable populations.
- Reviewed available research from state Medicaid incentive programs that use a variety of approaches, including financial and non-financial incentives, to promote healthy behavior and appropriate utilization of health care among their members.
- Concluded there is insufficient evidence on the efficacy and cost-effectiveness of incentive based approaches within state Medicaid programs.
- Focused on innovative approaches designed to improve individual engagement and accountability for one's own health, using person- and family-centered approaches to care and engagement.
- Adopted a set of strategies and actions to enhance alignment, coordination and create synergy among person- and family- centered care efforts already underway through Oregon's Health System Transformation.

Key Considerations: What's the Evidence?

The Committee gathered input from a diverse group of stakeholders and representatives from various agencies within the Oregon Health Authority that included Addictions and Mental Health Division, Division of Public Health, and the Office of Equity and Inclusion, local and national experts on patient engagement and activation, non-traditional and community-based health workers, providers, and officials with Florida's Medicaid Program. The committee was provided with peer-reviewed articles on national and state-level patient engagement activities, evidence-based strategies, and relevant literature highlighting available research. Information shared by the stakeholders as well as current research informed the set of strategies developed by the MAC for consideration by the Oregon Health Policy Board (OHPB).

Consumer-Directed Health Care and Cost-Sharing

The Committee began its work by examining strategies designed to encourage individuals to take ownership of their health and health care by promoting personal responsibility and quality- and cost-conscious decision-making. Starting with the commercial market, the Committee reviewed consumer-directed approaches that use mechanisms focused on benefit design and the use of financial levers to urge individuals to make more cost-sensitive decisions. A common form of this approach is a health savings account linked with a high deductible health plan. Proponents of this approach believe that a consumer in control of, and at greater risk for, his or her health care costs will be better engaged, and may make more appropriate health and health care utilization

decisions.[37] While such approaches originated in the commercial and Medicare market, state Medicaid programs have started to experiment with these approaches. [See next section for more information.]

Policy approaches reviewed by the Committee related to consumer-directed health care in the context of Medicaid programs include:[38]

- Allocation of control over Medicaid funds to recipients – Medicaid recipients have greater exposure to the cost of their health care, which is believed to promote more cost-effective utilization decisions.
- Provision of financial and non-financial incentives for engaging individuals in healthy behaviors, chronic disease self-management programs, and cost-effective health care utilization.
- Requirements of beneficiaries to make financial contributions to care – require cost-sharing at nominal ($3-5) or substantive levels.
- Removal of barriers to high value care – individuals receive more high value, appropriate health care.
- Provision of assistance with decision support – provide individuals in Medicaid support, information, education and advice, facilitating informed choices they make related to their health and health care and assisting them to implement healthy lifestyle choices.
- Offering incentives to individuals to use "Centers of Excellence" providers shown to provide quality care at reasonable cost.

Early in the Committee's process, and informed by its previous work in developing the recommended Essential Health Benefit Benchmark Plan for Oregon's Medicaid expansion population(s), the MAC understood that even nominal cost-sharing, including premiums and co-pays can serve as a barrier to accessing necessary preventive and primary care services for low-income, vulnerable populations. Furthermore, evidence indicates that nominal cost-sharing can lead to unintended consequences such as increased use of the emergency department after delaying care.[39,40] Past experience in Oregon and in other states have demonstrated that implementing cost-sharing in Medicaid is complex and administratively burdensome, and costs can often outweigh anticipated state savings.[41] Federal law also imposes strict cost-sharing limitations and benefit design requirements for all Medicaid populations. Thus, federal requirements currently restrict the use of certain consumer-directed health care approaches in Oregon's current health care environment.[42]

Medicaid Incentive Programs to Encourage Healthy Behavior

Subsequently, the Committee reviewed information from state Medicaid incentive programs that use a variety of approaches, including financial and non-financial incentives, to promote healthy behavior and appropriate utilization of health care among their members. Several state Medicaid programs are offering economic rewards (i.e. financial incentives) for healthy behavior based on the assumption that financial incentives will improve the health of individuals enrolled in Medicaid and help control health care costs. A key challenge is to incentivize individuals to modify unhealthy behaviors and maintain those modified behaviors over the long-term.

According to a 2011 report, commissioned by CMS, a panel of national experts recommended that states consider adopting a broad definition of "incentive" (p. 3). The notion of incentives in terms of person- and family-centered care should surpass providing financial incentives or money to Medicaid beneficiaries for certain health promotion behaviors.[43]

According to the report, incentives can include but are not limited to:[44]

- Waiving premiums, deductibles, coinsurance payments for participation in health improvement programs and activities or achieving certain positive health outcomes;
- Reimbursement for community-based programs designed to target behaviors of interest (e.g. paying for physical activity classes, completion of a certified smoking cessation program, or paying for Weight Watchers);
- Transportation to and from medical appointments; and
- Gasoline debit cards or phone cards.

The report also recommends that states consider a tiered incentive approach to participation in programs in an effort to sustain behavior changes over the long-term, especially in the areas of physical activity, nutrition, and smoking cessation. For example:

- Engaging in counseling aimed at teaching individuals how to quit smoking, attempts at behavior change (e.g., completing a smoking cessation program), actual behavior change (e.g., not smoking one week after completing the program), and finally achievement of health goals (e.g., remaining "quit" after 6 months).
- Rewarding appointments with providers to discuss health improvement goals, making attempts to improve behavior (e.g., becoming more physically active, eating a more nutritious diet), and finally attaining a behavior change goal (e.g., losing weight, lowering cholesterol levels).[45]

When considering a broad definition of "incentive," the report asserts a "penalty" or "stick" approach to incentives is counterproductive.[46] Based on review of available evidence, individuals, generally, respond better to a "rewards" program instead of a program perceived to be punitive in nature. Another policy issue is ensuring that any "incentive" program is responsive to the needs of a particular community including ensuring available resources and programs. The report concluded by raising the issue around individuals with co-morbidities who often have limited ability and resources to engage in health improvement programs outside the medical system.[47]

The most frequently cited Medicaid incentive based programs are Florida's Enhanced Benefits Reward$ Program, Idaho's Preventive Health Assistance program and West Virginia's Mountain Health Choices Program. (*Please see *Appendix C* on pg. 21 for additional information on state Medicaid programs.)

Lessons learned by examining findings from these states indicate that program effectiveness would be improved by:

- Addressing lack of program awareness, perceived need for insurance, and misconceptions about program eligibility due to historic lack of eligibility for coverage, particularly among low-income adults, all served as barriers to enrollment.
- Educating Medicaid beneficiaries about new initiatives can be challenging due to the low literacy and health literacy levels of the population, and the difficulty of reaching them through traditional communication channels, such as phone, mail and email.[48,49,50]
- Ensuring that the behaviors tracked are relevant. While it is easier to track wellness visits than lifestyle behavior changes, lifestyle behavior changes offer the greatest potential for Medicaid savings. States have yet to identify effective systems to track recipients' engagement in these behaviors and it is more administratively burdensome to do so.
- Addressing recipients' barriers to engaging in healthy behaviors by design programs to help beneficiaries overcome barriers, such as transportation or cost to participate in sports and exercise programs.

Current Experiments with Incentives for Medicaid Recipients

There is limited evidence to date on the impact and cost-effectiveness of such approaches within state Medicaid programs.[51] This may change soon due to the Affordable Care Act's (ACA) section 4108 that provides an opportunity to test the effectiveness of incentives in engaging Medicaid enrollees in preventive health behavior and improving clinical outcomes. In September 2011, CMS awarded 10 states $85 million over five years to design, implement, and evaluate Medicaid incentive programs. Key goals of the ACA's section 4108 include: increasing tobacco cessation, controlling or reducing weight, lowering cholesterol and blood pressure, and preventing the onset of diabetes or improving diabetes management. [*See *Appendix D* on pg. 25 for a complete list of the 10 grants including key characteristics.]

Based on a broad definition of "incentive" as described including provisions in the ACA designed to encourage behavior modification, states may also be interested in programs that aim to:

- Create healthier school environments, including increasing healthy food options, physical activity opportunities, promotion of health lifestyle, emotional wellness, prevention curricula, and activities to prevent chronic diseases;
- Create infrastructure to support active living and access to nutritious foods in a safe environment;
- Develop and promote programs to increase access to nutrition, physical activity and smoking cessation, enhance safety in a community;
- Assess and implement worksite wellness programs and incentives;
- Work to highlight health options at restaurants and other food venues;
- Address special population needs, including all age groups and individuals with disabilities, and individuals in urban and rural areas.

The federal opportunity highlights the importance of rigorous evaluation for each of the 2011 Medicaid incentive state programs. Early findings from these programs indicate that Medicaid incentive programs should be better designed so that enrollees can understand them and incentives are attractive enough to motivate participation. Ideally, each of the ten states will address central questions about the relationship between reward magnitude and effectiveness.[52] Collectively, these efforts will help determine the degree to which incentive programs change health behavior, improve related health outcomes and are cost-effective within Medicaid programs. The Committee recommends tracking these efforts overtime to inform future work in Oregon that may consider the use incentives within OHP to improve health in a cost-effective manner.

Conclusion

Individuals who are more highly engaged and activated are less likely to have unmet medical needs; more likely to have regular check-ups, including screenings and immunizations; adhere to treatment and obtain regular chronic care; and, engage in health behaviors such as eating a healthy diet, regular exercise, and avoid adverse behaviors such as smoking and illegal drug use.[53,54,55,56,57] This is particularly the case when services and supports are tailored to their individual needs, goals, preferences and circumstances.[58] The Committee believes that such innovative approaches, designed to improve individual engagement and accountability for one's own health in a person-and family-centered health system, will ultimately support the achievement of Oregon's three-part aim for all Oregonians.

Recommendations in Full

The recommended policy strategies seek to enhance alignment, coordination and create synergy among person- and family-centered efforts already underway through Oregon's Health System Transformation. The key is to effectively and equitably engage individuals and their families across all levels of the health system. Paramount to this is addressing the unique barriers and challenges experienced among OHP members. The continuum of person- and family-centered engagement in care is characterized across three levels: (1) direct patient care and partnership(s), (2) integration of patients' values in the design and governance of health care organizations, and (3) shared leadership and policy making that's responsive to patients' perspectives.[59]

The MAC envisions a number of key actors that could help adopt and implement these strategies. Key partners include members of the OHP and their families and/or representatives; providers and practices, especially those in recognized, patient-centered primary care homes; the Patient-Centered Primary Care Institute (PCPCI); Coordinated Care Organizations (CCOs) and their community partners; the Oregon Health Authority and its Transformation Center, in addition partners such as Cover Oregon, health professional associations, and other stakeholders.

According to Carmen et al. (2013), it is difficult to "develop interventions at one level, such as direct care, when supports are needed at the levels of organization design and governance and of policy making to increase those interventions' effectiveness" (p. 227). The set of strategies and actions described below were developed based on available evidence and designed to target all three levels of the continuum. Ultimately, the strategies and actions recognize the new roles of health care professionals, policy makers, and individuals and families in working towards creating an accountable high-performance health system that *meaningfully* and *effectively* engages OHP members.

Strategy #1: OHP members provide information to providers and the OHA about how to effectively address barriers to individual and family engagement and improve the health system.

Rationale: To better understand how best to support individuals' efforts to participate in their health, there is a need to systematically and regularly collect information from OHP members on their level of engagement in their health and health care, their experience of care and satisfaction. This will identify specific opportunities, facilitators, and barriers for individuals to improve and maintain their health. The goal is to solicit information and understand members' barriers to accessing care, ability for self-management, and fostering shared responsibility for health.

- Action: Providers routinely and consistently engage OHP members and their families as key partners and participants in the health care process by providing timely, complete, unbiased and understandable information in accessible and

appropriate formats on health conditions and treatment options, taking into account cultural, linguistic, and age appropriate factors.

- Action: Practices recognize and utilize members' experiences through outreach efforts including surveys, focus and advisory groups, and social media to guide practice level improvement.
- Action: OHP members and families directly partner with care teams, non-traditional health care workers, and community-based organizations to access and engage in community-based self-management programs.
- Action: OHA coordinates and aligns use of patient satisfaction and experience of care surveys statewide to address such things as purchasing strategies to assist practices and CCOs, preferred survey types (e.g. Picker, Press Ganey; HCAHPS, CG, & PCMH), use of benchmarks, survey timelines and redundancies with administration, and public reporting of information.

Strategy #2: Ensure ongoing education and training on evidence-based best practices for person- and family-centered engagement in health and health care.

Rationale: To fully support OHP members and their families in their own health and health care, practices and health care professionals, including community-based organizations, require education and sustained training in this arena. Such efforts should focus on effective use of techniques and best practices that create opportunities for individuals to make informed decisions and support health improvement of OHP members in their communities across Oregon.

- Action: Practices and providers receive regular and ongoing education and training from technical experts such as the Patient-Centered Primary Care Institute (PCPCI) and other learning forums on approaches to support person- and family-centered care. Examples include use of the Patient Activation Measure (PAM), shared decision-making and the use of decision aids, how to address low literacy and health literacy skills, and support for community-based self-management and wellness programs.
- Action: CCOs receive ongoing training and technical assistance from the OHA Transformation Center on how to work with practices to implement use of patient level data to inform practice and system level improvements.

Strategy #3: Leverage resources that support evidence-based best practices for person- and family-centered engagement and activation in health and health care.

Rationale: The Committee concluded that several evidence-based tools that would be helpful to sustain practice-level engagement efforts might not be affordable, individually, particularly for resource-limited small or rural practices.

- Action: PCPCI develop and disseminate practice-level tools for providers to routinely ask members and their families about their values, needs, knowledge, preferences and circumstances in culturally and linguistically appropriate ways.

This will allow greater member feedback to be integrated into individually tailored and appropriate care plans.

- Action: OHA should work with CCOs and their delivery system partners to achieve economies of scale in order to make evidence-based tools more affordable and available to practices of all sizes throughout the state such as:
  - Patient Activation Measure (PAM)** or other evidence-based activation measurement tool(s), to assess the skills and readiness of the individuals for engagement. Results can be used to determine the appropriate levels of intervention and allocation of resources. For example, a patient with complex and chronic health needs and low activation level may need the most intense interventions and resources versus someone with low acuity and a high level of activation.
  - Shared Decision Making tools that are evidenced based, to engage individuals and their families about discrete health conditions and support medical decisions by providing information, helpful strategies, and other supports.
- Action: OHA works with community stakeholders to develop a sustainable system for evidence-based self-management program delivery and financing to ensure broader availability of community-based programs, such as Living Well with Chronic Conditions, across the state. The work should ensure linkages with PCPCHs and CCOs to the extent possible, working with the PCPCI and through the OHA Transformation Center to coordinate and align resources, provide targeted technical assistance and learning collaboratives.

Strategy #4: Create opportunities across all levels of the health system to support OHP members as integral partners in Oregon's Health System Transformation.

Rationale: A comprehensive person- and family-centered transformed health system will need to encompass patients, families, their representatives, health professionals, and community partners working in active partnership at various levels across the system—direct care, organizational design and governance, and policy making—to improve members' health and health care.

- Action: CCOs systematically and meaningfully engage representatives of diverse populations (including but not limited to cultural, language and age considerations) and community stakeholders to develop their community health assessments (CHAs) and community health improvement plans (CHIPs). For example, OHA should work closely with CCOs and their Community Advisory Councils to ensure the resources and support of person- and family-centered care strategies are available to foster the needs and primary goals of the members and community served by their CCO.
- Action: OHP members and their families serve as "equal and active partners" by fostering meaningfully and sustained participation in CCO advisory panels,

** The Patient Activation Measure® (PAM®) assessment gauges the knowledge, skills and confidence essential to managing one's own health and health care.

provider/practice level advisory groups, and in local and state committees, councils, and boards, as OHP member advocates.

Strategy #5: Coordinate the adoption and spread of evidence-based best practices for person- and family-centered engagement in health and health care.

Rationale: Critical to this effort will be the promotion and alignment of multi-payer approaches to increase spread across provider practices and communities. OHA should work to ensure coordination and alignment of person- and family-centered models of care across the OHA, including CCOs, Public Employees' Benefit Board (PEBB), Oregon Educators Benefit Board (OEBB), the PCPCH Program, Cover Oregon and other payers. The goal is for OHA to leverage resources and activities statewide to disseminate best practices appropriate for OHP members and their families.

- Action: OHA should incentivize and disseminate the use of evidence-based best-practices for person- and family-care models of care that are sensitive to and account for the needs of diverse communities. This may be accomplished through the OHA Transformation Center coordinating with Innovator Agents, CCOs, regional learning collaboratives, and recognized PCPCHs to incentivize and disseminate the use of evidence-based best-practices for person- and family-centered models of care that are sensitive to and account for the needs of diverse communities.
- Action: OHA works with CCOs to increase the number of recognized PCPCH practices; modify existing PCPCH Standards to support robust person- and family-centered care and engagement models; and consider alternative payment methodologies to incentivize practices with resources to adopt and sustain patient engagement activities.

Appendices

Appendix A: List of Invited Presenters and Experts

Cara Biddlecom, MPH, Public Health Division, OHA

Bill Bouska, Innovator Agent, OHA Transformation Center

Bryant Campbell, PEBB Member

R. Paul Duncan, PhD, Florida Medicaid Reform Evaluation Team

Danna Drum, Public Health Division, OHA

L.J. Fagnan, MD, Executive Director, Oregon Rural Practice-Based Research Network (ORPRN)

Judith H. Hibbard, DrPH, Institute for Policy Research and Innovation, University of Oregon

Mary Minniti, CPHQ, Program and Resource Specialist, Institute for Patient- and Family-Centered Care

Michael Morris, MS, Administrator, Addictions and Mental Health Division, OHA

Kelly Volkman, RN, MPH, Health Navigation Program Manager, Benton County Health Services

Julie Wu, Office of Equity and Inclusion, OHA

Appendix B: Evidence Based Tools

Tool	Description
Patient Activation Measure	The Patient Activation Measure (PAM) is a tool for measuring the level of an individual's capacity to manage his or her own health and health care. PAM is assessed through a series of answers to questions that gauge a person's self-concept as a manager of his or her health and health care. The measure is scored on a 0-100 scale, and people are categorized into four levels of activation, with level 1 the least activated and level 4 the most activated. The score incorporates responses to 13 statements about beliefs, confidence in managing health related tasks, and self-assessed knowledge. The measure has been proven to be reliable and valid across different languages, cultures, demographic groups, and health statuses.[f] *For more information on activation and PAM see*: http://www.insigniahealth.com/solutions/patient-activation-measure
Shared Decision-Making	Shared decision-making occurs when provider and individuals exchange important information: providers help individuals understand medical evidence about the decisions they are facing, and individuals help providers understand their needs, values, and preferences concerning these decisions.[g,h] Then, ideally after allowing time for reflection, individuals and providers decide together on a care plan consistent with medical science and personalized to each individual's needs, values, and preferences.[i] *For more information on shared decision-making and decision aids see:* http://sdmtoolkit.org/
Health Literacy	Improving health outcomes relies on patients' full engagement in prevention, decision-making, and self-management activities. Health literacy, or "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions"[j] is essential to those actions. However, relatively few Americans are proficient in understanding and acting on available health information.[k] Health literacy has also been described as "a shared function of social and individual factors such as education, culture, and language. Additionally, health care providers need to have strong communication and assessment skills, as do the media, the marketplace, and government agencies—to provide health information in a manner appropriate to the

[f] Hibbard, J. and Greene, J. What the Evidence Shows About Patient Activation: Better Health Outcomes and Care Experiences; Fewer Data on Costs. *Health Affairs*, 32, No.2 (2013):207-214.

[g] Fowler, F., Levin, C., and Sepucha, K. Informing And Involving Patients To Improve The Quality Of Medical Decisions. *Health Affairs,* Vol. 30, No. 4 (2011): 699–706.

[h] Charles C., Gafni A., & Whelan T. Shared Decision-Making in The Medical Encounter: What Does It Mean? (Or It Takes At Least Two To Tango*). Soc Sci Med*, Vol. 44, No. 5 (1997):681–92.

[i] Friedberg, M., et al. A Demonstration of Shared Decision-Making In Primary Care Highlights Barriers To Adoption And Potential Remedies. *Health Affairs*, Vol. 32, No. 2 (2013): 268-275.

[j] Ratzan, S. and Parker, R. Introduction. Selden, C., Zorn, M., Ratzan, S., Parker, R., Editors. In: National Libraries of Medicine Current Bibliographies in Medicine: Health Literacy. Vol. NLM No. CBM 2000-1. Bethesda, MD: National Institutes of Health, U.S. Department of Health and Human Services.

[k] Kutner, M., Greenberg, E. Jin, Y., and Paulsen, C. The Health Literacy of America's Adults: Results From The 2003 National Assessment Of Adult Literacy. Washington (DC): *National Center for Educational Statistics*; 2006 Sep.

Tool	Description
	intended audience. The complexity of the health care system and the way patients experience it contribute to the difficulty of being health literate. Addressing health literacy is no less daunting than the task of addressing disparities."[l] *For more information on health literacy see:* http://content.healthaffairs.org/content/32/2/357.abstract
Self-management	Self-management is a core requirement for person- and family-centered care. Individuals are empowered through education and information that help them to navigate the delivery system and seek appropriate and timely care.[60] The available evidence is relatively strong and suggests that expanding education and self-management support can be beneficial towards improving patient care outcomes and patient satisfaction at all levels of the delivery system.[61] For example, self-management leads to improved health outcomes and reduced hospitalizations for patients with chronic disease; self-management also results in better adherence to medications and improved chronic disease control without incurring higher costs.[m] The Oregon Health Authority and the Department of Human Services support several evidence-based self-management programs. The programs are also considered evidence-based by the US Centers for Disease Control and Prevention and/or the Administration on Aging. These programs provide individuals with the tools and connect them to resources to support self-and family-management or case management on a variety of issues such as nutrition, fitness, tobacco cessation, chronic health conditions, fall prevention, family violence, suicide prevention, and care transitions. *For more information on community-based self-management programs see:* http://public.health.oregon.gov/PreventionWellness/SelfManagement/Pages/index.aspx

[l] IOM (Institute of Medicine). 2009. Toward Health Equity and Patient-Centeredness: Integrating Health Literacy, Disparities Reduction, and Quality Improvement: Workshop Summary. Washington, DC: The National Academies Press.

[m] Epstein, M. A Review of Self-Management Interventions Targeting Academic Outcomes for Students with Emotional and Behavioral Disorders. *Journal of Behavioral Education*, Vol. 14, No. 3 (2005): 203-221.

Appendix C: Medicaid Programs Designed to Increase Individual Engagement and Personal Responsibility

Characteristics of Healthy Indiana Plan (HIP)	
Characteristics	**Details**
Authority	• State legislation; CMS 1115 Medicaid Demonstration Waiver (2008-2012)
Start date	• January 1, 2008
Financing	• Increased cigarette tax • As a Medicaid waiver, the program is eligible for federal matching funds but must be budget neutral to the federal government.
Eligibility and Enrollment	• Adults 19-64 years of age. • Parents and caretaker relatives between 22%-200% FPL. • Adults without children up to and including 200% FPL. • Individuals above 200% FPL who are uninsured for six-months and do not have access to ESI are allowed to purchase the plan at full cost.[62]
Goals	Put program enrollees in greater control of and at greater risk for his or her health care costs to promote engagement and more appropriate health and health care utilization decisions.
Coverage	• Coverage for preventive services up to $500 a year at no cost to participants. • A high deductible health plan that covered state-specified benefits up to $300,000 per year or $1 million of lifetime expenses, with no cost-sharing after the $1,100 deductible was met.[n] • A POWER account valued at $1,100 to pay for the deductible, available in full to the member after his or her first contribution was made. • A POWER Account "Roll Over" for HIP enrollees who met all of their preventive service requirements, the entire remaining balance of their POWER account rolled over to the following year, reducing the required contribution for that year. For enrollees who did not meet the preventive service requirements, only the individual's portion, based on his or her percent contribution, rolled over.
Cost-sharing	• POWER Account Monthly Contributions were made by enrollees on a sliding scale, from 2%-5% of income,[o] and could be reduced by payments from an enrollee's employer.[p] The State and the federal government subsidized the remaining amount at the state's regular match rate. • Co-pays of $3-$25 were required for all nonemergent use of the emergency department.[q]
Results	Results from the first three years of the demonstration show HIP had served a total of 77,466 members; 87% of those eligible made monthly contributions to their POWER Account; established enrollees were more likely to use preventive services, compared to new enrollees: 69% compared to 28%; 94% of members said they were satisfied with HIP and 99% indicated they would re-enroll.
Comments	In order to meet the Affordable Care Act's Medicaid expansion requirements, HIP would have to add vision, dental and maternity benefits. The enhanced HIP would cost 44% more than traditional Medicaid, totaling $1.85 billion for 336,500 HIP enrollees during the first full year of the expansion. It is undetermined whether CMS will approve HIP as the coverage vehicle for Indiana's Medicaid expansion populations in 2014.

[n] HIP's benefits differ from those offered through the Medicaid state plan as it does not provide coverage for maternity services, vision or dental services, and has annual and lifetime benefits.

[o] HIP policy requires that individuals make their monthly contributions within 60 days or face expulsion from the program for 12 months.

[p] While these employers did not offer health insurance to their employees their contributions supported "the program's goals to provide affordable consumer directed coverage." Employers are also allowed to contribute up to 50% of the required contribution.

[q] The copayment for caretakers is $3 to $25, depending on income, and is $25 for non-caretakers regardless of income.

Characteristics of Florida's Enhanced Benefits Reward$ Program	
Characteristics	**Details**
Authority	Florida's Agency for Health Care Administration's (AHCA), the agency responsible for the administration of its Medicaid program received approval to implement a CMS 1115 Research and Demonstration Waiver in Oct. 2005; the Legislature approved implementation of the waiver in Dec. 2005.
Start date	Began pilot program in Broward and Duval counties in September 2006; and expanded to Baker, Clay, and Nassau counties in September 2007.
Financing	AHCA assesses 2% of the monthly risk-adjusted capitated rate paid to each health maintenance organizations (HMOs) participating in the demonstration.
Eligibility and Enrollment	Medicaid beneficiaries in five pilot counties; required groups include disabled beneficiaries receiving Supplemental Security Income (SSI), parents, and children; other beneficiaries could participate on a voluntary basis. All Medicaid beneficiaries were automatically enrolled in the program and sent information after they chose a health plan.
Goals	Providing incentives (credits) for people to engage in healthy behavior
Target behavior	Receiving routine checkups, immunizations, and cancer screening; attending health appointments; adhering to medication regimens; and participating in programs for tobacco cessation, weight loss, diabetes
Incentive magnitude	$7.50–$25 per payment, $125 per year maximum
Incentive type	• Credits are earned for specific health care utilization and wellness and prevention visits outside of a clinical setting • Credits are used to purchase approved health-related products and supplies at a Medicaid participating pharmacy (using Medicaid gold card or Medicaid ID number and government issued photo ID) • Credits may be carried over but if the enrollee loses Medicaid eligibility for one year, all credits are forfeited
Results	Since implementation of the program in Sept. 2006 through June 30, 2012, a total of 499,209 recipients have earned $53.8M in credits; just over half redeemed; majority of credits earned were for childhood preventive care (45%) or adult/child office visits (25%), with <1% earned for participating in weight loss or tobacco cessation programs; lack of participation in programs that decrease chronic disease.[r]
Comments	Compliance, participation, success poorly defined; majority of credits (81%) earned by keeping routine physician visits and/or immunizations; < 1% earned for participating in a disease management program; none were earned for participating in other types of health improvement activities; analysis of program noted that most behaviors would have taken place in the absence of the program;[s] credit redemption rate of 50% suggests that credit amounts were too small and not salient to beneficiaries, or that participants had insufficient knowledge of program; qualitative interviews with health plans participating in the EBR program indicated that the program emphasized passive, more routine behaviors, rather than active behaviors requiring lifestyle changes.[t]

[r] Florida Medicaid Reform: Year 6 Annual Report (July 1, 2011 – June 30, 2012). 1115 Research and Demonstration Waiver. Florida Agency for Health Care Administration.

[s] Medicaid Reform: Beneficiaries Earn Enhanced Benefits Credits But Spend Only a Small Proportion. OPPAGA. July 2008.

[t] Duncan, P. Florida's Enhanced Benefits Reward$ Program. Presentation to the Oregon Medicaid Advisory Committee. January 23, 2013.

Characteristics of Idaho's Preventive Health Assistance (PHA) Benefits Program[u,v]		
	Details	
Characteristics	**Behavioral PHA**	**Wellness PHA**
Authority	Two State Plan Amendments; authority granted under the Deficit Reduction Act of 2005	Amendment to the state's Children's Health Insurance Program
Start date	January 2007	
Financing	Unpublished	Unpublished
Eligibility and Enrollment	Adult Medicaid beneficiaries are sent a health questionnaire at the time of initial Medicaid eligibility determination and annually thereafter; each beneficiary may only participate in one program at a time and may participate in the: • Tobacco cessation program if questionnaire indicates the individual or their child wants to quit using tobacco; or the • Weight management program if questionnaire indicates the individual or their child (> age 5) has a Body Mass Index in the obese or underweight range, and wants to improve their health through weight management.	Children in families with income between 134-185% FPL, who are also required to pay monthly premiums
Goals	Promoting healthy behavior	Promoting child wellness with financial premium support for child's CHIP coverage.
Target behavior	Weight management and tobacco cessation	Staying up-to-date on well-child visits
Incentive magnitude	$200 maximum in vouchers per beneficiary	10 points per month maximum (equivalent to $10)
Incentive type	Vouchers for weight management programs or tobacco cessation products	Points exactly offset the $10/mo. premium for children between 134-149% FPL, and offset two-thirds of the $15/mo. premium for children between 150-185% FPL
Results	Only 1,422 of the approximately 185,000 beneficiaries participated after 2 years	Significant increase in proportion of CHIP children up-to-date on well-child visits, compared to control
Comments	Limited impact on tobacco cessation and weight management; no data on success.	Children requiring only one annual visit had largest increase in adherence

[u] Greene J. Using consumer incentives to increase well-child visits among low-income children. *Med Care Res Rev*, Vol. 68 No. 5. (2011): 579–93.
[v] Idaho Department of Health and Welfare. Facts, figures, trends, 2008–2009. Available from: http://healthandwelfare.idaho.gov/AboutUs/FactsFiguresTrends/tabid/1127/Default.aspx

Characteristics of West Virginia's Mountain Health Choices Program[w]	
Characteristics	**Details**
Authority	State Plan Amendment under the Deficit Reduction Act of 2005
Start date	May 2006
Financing	Regular FMAP
Eligibility and Enrollment	Certain eligibility groups were moved to "Secretary approved" coverage. The affected groups were: • Infants with incomes below 150% FPL, • Children age one to six with incomes below 133% FPL, • Children age six to nineteen with incomes below 100% FPL, • Working parents with incomes below 37% FPL, and • Non-working parents with incomes below 19% FPL. To qualify for the enhanced plan, individuals have to sign a member responsibility agreement and enter into a health improvement contract with their physician that includes a wellness plan.
Goals	Providing incentives for people to take more responsibility for their health with a choice between an "enhanced" or "basic" plan. The objective is to steer participants into the lower cost basic plan unless they adhere to behavioral commitments to improve health.
Target behavior	Signing a member responsibility agreement and developing a wellness plan with physician to enroll in enhanced plan, which offers beneficiaries more extensive coverage than the basic plan; adhering to member agreement to maintain coverage under enhanced plan.
Incentive magnitude	Maintaining access to enhanced plan
Incentive type	More extensive coverage, including unlimited prescriptions, tobacco cessation services, diabetes and weight management programs.
Results	Only 10% of eligible adults enrolled in enhanced plan; enhanced plan members were more likely than others to have more doctor visits and take their medications, and to have physicians involved in decision to enroll.
Comments	Criteria for determining adherence and continued eligibility were ambiguous; low-literacy patients at risk of being assigned to basic plan by default.

[w] West Virginia Department of Health and Human Resources. Mountain Health Choices. Available from: http://www.dhhr.wv.gov/bms/mhc/Pages/default.aspx.

Appendix D: ACA Medicaid Incentives CDC Grants for States

Affordable Care Act: Medicaid Incentives for Prevention of Chronic Diseases Grants (10 states received 5-year grants in 2011)[x]

State	Goal	Incentive	Evaluation
California	Tobacco cessation and diabetes management	$10–20 per activity	Two evaluations: RCT and cost-effectiveness
Connecticut	Tobacco cessation	$5–15 per activity	Evaluation of the effect of the incentives on smoking cessation rates, receipt of evidence-based smoking cessation treatments, health care use, cost savings, incremental cost-effectiveness
Hawaii	Diabetes prevention, detection, and management	$20–25 per activity	Pre- versus post-intervention comparison; analysis using non-Medicaid patients with diabetes as control group
Minnesota	Increased weight loss and diabetes prevention, improved cardiovascular health, reduced health care spending	$10–50 per activity	Prospective group RCT; evaluation of effectiveness of group versus individual incentives; cost-effectiveness evaluation
Montana	Increased weight loss, reduced lipid and blood pressure levels, diabetes prevention	$320 maximum per Beneficiary	Crossover design will enable evaluation of process and health outcome measures in relation to incentives
New Hampshire	Increased exercise; improved nutrition; modification of risk factors for cardiovascular disease	Unknown	Evaluation using an Equipoise stratified randomization design; cost effectiveness evaluation
New York	Tobacco cessation, hypertension control, diabetes prevention, diabetes self-management	$250 maximum per beneficiary	Four separate RCTs; evaluation of effectiveness of process versus outcome incentives in each RCT to be conducted by the University of Pennsylvania
Nevada	Increased weight loss, lowered cholesterol and blood pressure, diabetes prevention and management	Unknown	RCT, evaluation of effectiveness to be conducted by the University of Nevada, Reno
Texas	Improved health self management among Medicaid patients with SSI or a mental health or substance abuse diagnosis	$1,150 maximum (flexible spending account) per beneficiary	Longitudinal RCT; cost-effectiveness evaluation to be conducted by the University of Florida
Wisconsin	Tobacco cessation (with focus on pregnant women)	$595 maximum for pregnant women, $350 maximum for other beneficiaries	RCT

NOTES: Incentive values based on publicly reported information. RCT is randomized controlled trial. SSI is Supplemental Security Income.

[x] CMS.gov. MIPCD: the states awarded [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services. Available from: http://innovation.cms.gov/initiatives/MIPCD/MIPCD-The-States-Awarded.html.

References

[1] Carman, K., et al. Patient and Family Engagement: A Framework for Understanding the Elements and Developing Interventions and Policies. *Health Affairs,* Vol. 32, No.2 (2013): 223-231.
[2] Dixon, A., Greene, J., and Hibbard, J. Do Consumer-Directed Health Plans Drive Change In Enrollees' Health Care Behavior? *Health Affairs*, Vol. 27, No. 4 (2008):1120-1131.
[3] Wright, B., Carlson, M., Smith, J., et al. Impact of Changes to Premiums, Cost-sharing, and Benefits on Adult Medicaid Beneficiaries: Results from an Ongoing Study of the Oregon Health Plan. *Commonwealth Fund*, (July 2005): 22 pages.
[4] Fronstin, P., Sepulveda, M., and Roebuck, M. Consumer-directed Health Plans Reduce the Long-term Use of Outpatient Physician Visits and Prescription Drugs. *Health Affairs*, Vol. 32, No. 6 (2013): 1126-1134.
[5] Bachrach, Deborah. Cost Sharing Requirements and Considerations for Oregon. Presentation to the Medicaid Advisory Committee. October 24, 2012.
[6] Ibid.
[7] Blumenthal, K., et al. Medicaid Incentive Programs to Encourage Health Behavior Show Mixed Results to Date and Should be Studied and Improved. *Health Affairs*, 32, No.3 (2013):497-507.
[8] Hibbard, J. and Greene, J. What the Evidence Shows About Patient Activation: Better Health Outcomes and Care Experiences; Fewer Data on Costs*. Health Affairs*, 32, No.2 (2013):207-214.
[9] Carman, K., et al. (2013).
[10] Hibbard, J., Mahoney, E., Stock, R., and Tusler, M. Do Increases in Patient Activation Result in Improved Self-Management Behaviors? *Health Services Research*, 42(4), (2007):1443-63.
[11] Mosen, D., Schmittdiel, J., Hibbard, J., et al. Is Patient Activation Associated with Outcomes of Care for Adults with Chronic Conditions? *The Journal of Ambulatory Care Management,* 30(1), (2007):21-9.
[12] Gerber, L., Barron, Y., Mongoven, J., McDonald, M., et al: Activation Among Chronically Ill Older Adults with Complex Medical Needs: Challenges to Supporting Effective Self-management. *The Journal of Ambulatory Care Management*, 34(3), (2011): 292-303.
[13] Epstein, R., Fiscella, K., Lesser, C., and Stange, K. Why The Nation Needs A Policy Push On Patient-Centered Health Care. *Health Affairs*, 29, No.8 (2010):1489–1495.
[14] Carman, K., et al. (2013).
[15] Adler, N. and Newman, K. Socioeconomic Disparities in Health: Pathways and Policies. *Health Affairs*, Vol. 21, No. 2. *(*March/April 2002): 60-76.
[16] McGinnis, J., Williams-Russo, P. and Knickma, J. The Case for More Active Policy Attention to Health Promotion*. Health Affairs*, Vol. 21, No. 2. (March/April 2002):78-93.
[17] Lee, P. and Paxman, D. Reinventing Public Health. *Annual Review of Public Health* 18 (1997): 1–35.
[18] Mokdad, A., et al. Actual Causes of Death in the United States, 2000. *JAMA*, (2004 Mar 10);291(10):1238-45.
[19] Mokdad, A., et al. (2004).
[20] Blumenthal, K., et al. (2013).

[21] Crossing The Quality Chasm: A New Health System For The 21st Century. Committee On Quality Of Health Care In America*, Institute of Medicine*. (2001): p.6.
[22] Mende, S. and Roseman, D. The Aligning Forces for Quality Experience: Lessons on Getting Consumers Involved in Health Care Improvements. *Health Affairs,* Vol. 32 No.6 (2013): 1092-1100.
[23] Maree, G. C. Personal Responsibility in Medicaid: Challenges and Opportunities. Legislative Briefing. Topeka, Kansas. February 19, 2009. *Kansas Health Institute*.
[24] Ibid.
[25] Carman, K., et al. (2013).
[26] Minniti, Mary. Successful Examples of Patient Engagement Strategies. Institute of Patient-And Family-Centered Care. *Presentation to the Oregon Medicaid Advisory Committee*, February 27, 2013.
[27] Epstein, R. Why The Nation Needs A Policy Push On Patient-Centered Health Care. *Health Affairs*, Vol. 29, No. 8 (2010): 1489–1495.
[28] Epstein, R. et al. (2010).
[29] Beach, M., Saha, S., and Cooper, L. The Role And Relationship Of Cultural Competence And Patient-Centeredness In Health Care Quality. *The Commonwealth Fund*. October 2006.
[30] Carman, K., et al. (2013).
[31] Ibid.
[32] Ibid.
[33] Hibbard, J. and Greene, J. (2013).
[34] Hibbard, J. and Mahoney, E. Toward A Theory Of Patient And Consumer Activation. *Patient Education and Counseling*, Vol. 78, No. 3 (2010):377-81.
[35] Ibid.
[36] Carman, K., et al. (2013).
[37] Dixon, A., Greene, J., and Hibbard, J. Do Consumer-Directed Health Plans Drive Change In Enrollees' Health Care Behavior? *Health Affairs*, Vol. 27, No. 4 (2009): 1120-1131.
[38] Green, J. Issue Brief: State Approaches to Consumer Direction in Medicaid. *Center for Health Care Strategies, Inc.* July 2007.
[39] Wright, B., et al. (2005).
[40] Fronstin, P., et al. (2013).
[41] Bachrach, Deborah. Cost Sharing Requirements and Considerations for Oregon. Presentation to the Medicaid Advisory Committee. October 24, 2012.
[42] Ibid.
[43] Thomson Reuters. Guidance Document on Preparing a Solicitation for Section 4108 of the Patient Protection and Affordability Act: Incentives for Prevention of Chronic Diseases in Medicaid. February 2011, pg. 3. Available from: http://innovation.cms.gov/Files/x/MIPCD-CME-Guidance.pdf.
[44] Ibid. p. 3.
[45] Ibid. p .4.
[46] Ibid. p. 4.
[47] Ibid. p. 5.
[48] Office of Program Policy Analysis and Government Accountability. Medicaid Reform: Beneficiaries Earn Enhanced Benefit Credits But Spend Only a Small Proportion. Report No. 08-45. July 2008.

[49] Alker, J. and Hoadley, J. The Enhanced Benefits Rewards Program: Is it Changing the Way Medicaid Beneficiaries Approach their Health. Jessie Ball DuPont Fund. Briefing #6, July 2008.
[50] Barth, J. and Greene, J. Encouraging Healthy Behaviors in Medicaid: Early Lessons from Florida and Idaho. *Center for Health Care Strategies, Inc.,* July 2007.
[51] Blumenthal, K., et al. (2013).
[52] Ibid.
[53] Hibbard, J. and Greene, J. (2013).
[54] Carman, K., et al. (2013).
[55] Hibbard, J., Mahoney, E., Stock, R., & Tusler, M. (2007). Do Increases in Patient Activation Result in Improved Self-management behaviors*? Health Services Research*, Vol. 42, No. 4 (2007): 1443-63.
[56] Mosen, D., et al. (2007).
[57] Gerber, L., et al. (2011).
[58] Epstein, R., et al. (2010).
[59] Carman, K., et al. (2013).
[60] Epstein, M. A Review of Self-Management Interventions Targeting Academic Outcomes for Students with Emotional and Behavioral Disorders. *Journal of Behavioral Education*, Vol. 14, No. 3 (2005): 203-221.
[61] Bodenheimer, T., Lorig, K., Holman, H., Grumbach, K. Patient Self-management of Chronic Disease in Primary Care. *JAMA.* 2002;288 (19):2469-2475.
[62] Healthy Indiana Plan 1115 Waiver Extension App. Indiana Family and Social Services Administration. Submitted 12/28/2011.

Q-consult
Evidence-based interventions for behavior change

Review of Literature: Patient Engagement – The Role That Disincentives & Incentives Play

September 2013

Presented To: Task Force on Individual Responsibility & Health Engagement (HB2859)

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Review of Literature: Patient Engagement – The Role That Disincentives & Incentives Play

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Review of Literature: Patient Engagement – The Role That Disincentives & Incentives Play

Purpose & Scope of Work

The purpose of this endeavor is to introduce options or mechanisms for patient engagement to the Task Force on Individual Responsibility and Health Engagement with the objective of assisting them in recommending the best strategies to incorporate for Oregon Health Plan members. After a brief overview of the health behavior change science that relates to patient engagement, a review of literature is provided on the role that incentives, disincentives and other evidence-based interventions play, including advantages and efficacy, disadvantages and selected references. This review is not intended to be an exhaustive review of the literature in its entirety nor is it intended to serve as a definitive guide on which options to use.

Methodology

Research sources included comprehensive searches in Medline, Google Scholar, RAND and Cochrane databases. In addition, the author has access to NIH and CHCS research findings as Primary/Co-Investigator in several research studies. In considering the evidence, more weight was given to comprehensive review articles and well-performed meta-analyses. Research findings from large well-controlled clinical trials are frequently highlighted and, occasionally, innovative or unique research findings/cases from smaller, less well-controlled studies are mentioned. In addition, research studies that targeted Medicaid populations were also given priority. Lastly, in considering lifestyle changes, there is a special focus on presenting smoking cessation efforts that have used engagement strategies, as this is a significant issue for the Medicaid population in Oregon.

Glossary of Terms

The following terms are key to understanding and applying the concepts covered in this review:

1. **Complex behavior change:** A behavior that requires sustained change; usually a lifestyle change or treatment adherence[1]
2. **Contingent:** Having a cause-and-effect (causal) relationship with the occurrence of something else; conditional; provisional[2]
3. **Cost-sharing:** Any contribution consumers make towards the cost of their healthcare as defined in their health insurance policy[3]
4. **Cultural competence:** The acceptance of the value of other perspectives and beliefs, along with the need to accommodate the patient by offering alternative options or modifying procedures[4]

Review of Literature: Patient Engagement – The Role That Disincentives & Incentives Play

5. **Disincentive:** Mechanisms such as fees, policies, procedures, rules or taxes that intentionally or unintentionally, directly or indirectly, discourage or prevent desirable or undesirable actions, behavior or decisions[2]
6. **Health Literacy:** The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions[4]
7. **Incentive:** Inducement or supplemental reward that serves as a motivational device for a desired action or behavior[2]
8. **Noncontingent:** Not attached with any conditions; not provisional upon anything [2]
9. **Patient Activation:** The knowledge, skills, beliefs and behaviors that a patient needs to become a successful manager of his or her health and health care[5]
10. **Personal Agency:** The understanding of oneself as an agent who is capable of having an influence over one's own motives, behavior, and possibilities[4]
11. **Self-efficacy:** An individual's confidence in managing his/her health or changing a health habit[4]
12. **Simple behavior change:** A behavior that can be accomplished directly; usually in a single visit or session[1]

Review of Literature: Patient Engagement – The Role That Disincentives & Incentives Play

INTRODUCTION

Although there are few more timely topics in health care today, patient engagement has not been well-defined or measured and involves numerous patient behaviors, depending on the stakeholder's interest. For the limited scope of this paper, per the framework suggested by Gruman et al.[1], patient engagement can be divided into two distinct sets of behaviors: (1) actively managing or navigating the health care system; and (2) actively managing one's own health. However, Carmen et al.[6] make a compelling case that we need to expand our scope to include both patient and family engagement in a multidimensional framework that occurs across the health care system, from the direct care setting to incorporating patient engagement into organizational design, governance and policy making. Moreover, the consideration and implementation of effective patient engagement strategies must be considered within the context of organizational and community milieu that consistently supports a person-centered approach.

BACKGROUND ON HEALTH BEHAVIOR CHANGE THEORY

Although there is little definitive literature that directly relates to patient engagement, there are theories and models in health behavior science that can be applied to health care settings and practice. There are basic and common traits in human nature such as the quest for autonomy and self-determination, the valuing of physical and emotional well-being, the ambivalence about change, the tendency to push back against forces that are perceived as controlling or demanding, and the motivation to take a difficult path only if the benefits are perceived as worth it[4]. Then there are variables that can be barriers to behavior change, such as mental illness, readiness to change, patient activation, self-efficacy, learned helplessness, and personal agency – all which are influenced by socioeconomic and education levels, as well as cultural, gender and age factors[4]. There are also barriers imposed by practitioners to patient activation that include lack of cultural competency, failure to accommodate low health literacy, failure to assess/adjust for the patient's readiness to change or activation level, use of an authoritarian approach and the absence of incorporation of best practices in patient engagement and health behavior change[7].

Layer the multiple risk factors and chronic conditions that many patients face on top of the complexity of motivation and self-regulation, and it's no wonder that health care providers are challenged to influence treatment adherence and preventive practices. In recent years, more attention has been placed on the role

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that incentives, disincentives and cost-sharing can play in engaging patients and inducing more individual responsibility for self-management and personal health[8].

Overview of Research on Patient Engagement

There is literature in the health psychology and behavior change science realms that can be applied to the health care setting, as well as current findings about patient engagement issues in the health management literature. This section provides a brief overview of some of the most relevant data, along with ramifications for health care interventions to address patient engagement.

1. **Patient with low activation generally do not engage easily.** Patient activation is defined as knowledge, skills, beliefs and behaviors that a patient needs to become a successful manager of his or her health and health care[5]. Typical stressors of a low SES population, along with mental illness and addictions, act as barriers to activation[5]. When a patient is not empowered to take charge of his/her health, has low self-confidence about his/her ability to manage chronic conditions, and/or has low health literacy, it is not surprising that engagement levels are correlated with patient activation level[9].
2. **Activation is developmental.** Judy Hibbard has identified four clear levels of patient activation, along with characteristics of each[5]. Like self-esteem, patient activation is influenced in part by experiences, example, educational level, economic means and the environment; likewise, the level also tends to be consistent over multiple activities or conditions and can develop over time.
3. **Patient activation can be addressed and improved with the proper intervention.** In a quasi-experimental design[10] over an eight-month period, employees with chronic conditions at a large medical university were enrolled into a health management program and received two to three health coaching sessions, based on an evidence-based approach. As compared to a similar control group, the treatment group had statistically significant improvement in patient activation levels, among other psychosocial outcomes, along with clinical outcomes.
4. **There are important similarities and differences between individuals who typically enroll in health management programs and those that do not.** In a follow-up evaluation study to a large clinical trial[11], the similarities and differences between full-, partial- and non-adopters were teased out via focus groups, interviews and surveys. Similarities between non-adopters and the adopters included: they were just as concerned about their health; the benefits of good health were more important to them then incentives; they wanted program variety, convenience and options for types of programming formats (online, health

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coach, social group, class, etc.). Differences were that full adopters had a much deeper understanding of their motivations for engagement in health management programs as compared to non-adopters; non-adopters expressed more perceived barriers to engagement; non-adopters needed more persistent (but not pushy) invitations to join health management programs; and opt-out provisions were more important to non-adopters than adopters.

5. **Engagement rates improve when practitioners use a patient-centered approach.** A recent correlation study showed a positive correlation between enrollment rates of nearly 5000 members of a commercial health plan and evidence-based health coaching skills of 52 nurses in a disease management program[12].
6. **Practitioners can inadvertently evoke resistance during patient interactions and decrease engagement.** Most individuals who are not following their treatment plan or making health lifestyle choices are ambivalent – they know what they "should" be doing, but it's challenging to make these lifestyle changes. A practitioner's interactions with the patient about these issues can evoke counter-change talk or discord from the patient if a directive, authoritative or confrontational approach is used, if the practitioner gently scolds, if s/he does not validate challenges/barriers, or if s/he repeats instructions the patient already knows[13]. As individuals defend their point of view, this perceived resistance to the behavior (which is actually an interpersonal tension that resulted from the practitioner's behaviors) leads to an increase in the confrontational behaviors of the practitioner[7]. This discord or interpersonal tension is actually a predictor of poor clinical outcome; the more discord during the session, the less likely the patient is to make the behavior change or engage in the practitioner's point of view[7]. Therefore, the least desirable situation in health care if we want to engage the patient is for the practitioner to argue for the change while the member argues against it. Yet, this type of interaction is a highly common one when patients are struggling to follow their treatment plan[4].

We can apply these insights directly to health care settings by training practitioners in an evidence-based health coaching approach and encouraging them to address important constructs such as patient activation, self-efficacy and personal agency. In addition, organizations may need to implement a workplace initiative to identify job aids, patient materials, policies and procedures that work against patient engagement and implement those that support it instead.

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The Role of Disincentives and Incentives in Patient Engagement

Disincentives

Disincentives are mechanisms such as fees, policies, procedures, rules or taxes that intentionally or unintentionally, directly or indirectly, discourage or prevent desirable or undesirable actions, behavior or decisions[2]. Currently, cost-sharing is the most prominent form of disincentive being considered in the health care setting[14]. Cost-sharing practices for Medicaid include: deductibles, copayments, coinsurance, premiums or enrollment fees.

On one hand, individuals can be significantly influenced in their health behaviors by policy changes that are widely marketed and/or if penalties are perceived as likely and unpleasant[15]. Examples include smoking cessation rules in workplaces and public arenas, drinking and driving laws, the seat belt law, and the motorcycle helmet law. There are numerous examples of successful compliance in employer-sponsored wellness programs to participant in health risk assessments and health screenings when additional health insurance premiums are required for non-participants[16]. In addition, a review of past cost-sharing practices clearly demonstrates that they significantly decrease utilization of health services and result in decreased health care spending[17,18,19], although there has been mixed results in the Medicaid population regarding emergency room and hospital utilization[14]. There doesn't appear to a negative effect on quality of care for individuals who are relatively healthy and have economic means – at least in the short-term follow-up studies[14,20,21]. Participants in cost-sharing plans have self-reported that they worry less about their health, have fewer restricted-activity days and generally are satisfied with care[20].

However, on the other side, the research is clear that premiums and enrollment fees act as barriers to obtaining and maintaining coverage for low-income groups[14,20,22,23]. Penalty fees also cause resentment on the part of participants and can damage relationships between payers and patients[22,24]. Penalty fees are also not effective for risky, entrenched behaviors or for changing complex behaviors on a long-term basis, such as weight loss[25,26]. A controlling, authoritarian approach also diminishes intrinsic motivation and is negatively correlated with behavior change[27,28]. In fact, even positive feedback given in what is perceived as a controlling manner, negatively affects intrinsic motivation[27].

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The benefits that have been seen in the literature for cost-sharing measures appear to be limited to those who are healthy and have means[14,21,23]. Seemingly, many patients cannot distinguish the differences between low and high value and necessary and unnecessary services; in some studies, using cost-sharing to reduce spending in low value areas has caused a rebound effect of patients substituting high cost services or going without needed care[14,29,30]. Since the spending cuts under cost-sharing practices were consistently across the board, regardless of the high or low value of the service, the result was decreased quality of care for the sickest and poorest, as well as a decrease in preventive services and medication compliance[14,21,23]. Beneficiaries forgo preventive care and medications under these practices[21,31], even when preventive services are fully covered, leading to higher incidents of serious medical conditions requiring more expensive care. In a review of CHHPs (Consumer Directed Health Plans), for every $10 increase in copay for statin medications, there was a five-point drop in medication compliance for those under Medicaid coverage[21]. There are concerns that changes in cost-sharing and premiums can result in increased demand and additional pressure on safety-net providers, as noted by a 20% increase in ER visits by the uninsured in Oregon after cost-sharing measures were enacted. This rebound effect would likely result in lower reimbursement rates for providers, contributing to the reluctance of providers to add individuals with Medicaid coverage to their practices[14].

In theory, using cost-sharing principles more deliberately could intentionally reduce health care spending in high cost, low value treatments/services[20,21,23]; however, even proponents of cost-sharing measures urge policymakers to consider unintended consequences[20].

Incentives

Incentives are an inducement or supplemental reward that serves as a motivational device for a desired action or behavior[2]. There are many different types of incentives including cash, gifts, lotteries, vouchers and point systems.

There is strong evidence that attractive and immediate financial incentives can increase initial participation in health management and community programs, such as health risk assessments, health screenings, health competitions and lifestyle management programs[16,32]. Economic incentives also appear to be effective for encouraging individuals to complete simple preventive care tasks (e.g. vaccinations, screenings) and for distinct, well-defined behavioral goals (at least short-term), with strong evidence for populations with low

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socioeconomic status[16,19,33]. Although understudied, the use of financial incentives to encourage medication adherence has some support in the literature, including those individuals with mental illness or addictions[34].

In a pooled, systematic review, researchers report that smokers are more than twice as likely to quit if they have full coverage for quit interventions versus having partial coverage[32]. In a review of six controlled clinical trials, researchers found systematic use of financial incentives had promise as an efficacious intervention for promoting smoking cessation among economically disadvantaged pregnant women (improving birth outcomes), as well as among recently postpartum women[35]. There is more evidence about the effectiveness of incentives in smoking cessation for short-term versus long-term outcomes, although in one smoking cessation clinical trial, with a significant amount of incentives ($750), the treatment group demonstrated long-term outcomes months after the incentives ceased[29].

There is insufficient evidence to suggest that economic incentives or competitions, by themselves, are enough to sustain the long-term complex behavior changes required for health promotion, such as exercising, losing weight and medication adherence, as the effect of the incentives diminishes as the reward disappears[16,18,19,33]. In a large clinical trail for weight loss[36], there was no correlation between weight loss and external incentives; rather greater weight losses were consistently associated with increases in autonomous (intrinsic) motivation instead. The research is mixed for smoking, with incentives mostly failing to elicit long-term change, and the most studied populations for long-term changes in smoking cessation are high SES, white and employed populations[37]. Although “social privilege” models exit in educational and correctional settings, as well as in the airline industry, there is a dearth of research about the application of this strategy in the health care setting.

Perhaps the most concerning findings for incentives lies in the research that has examined the effect that incentives have on intrinsic motivation. A large meta-analysis[27], followed later by well-controlled study[38] applying the same variables to the health care realm, demonstrated strong evidence that expected tangible rewards significantly decreased intrinsic motivation, particularly for task-contingent tangible rewards. In other words, in certain conditions, incentives could very well undermine individuals’ taking responsibility for motivating or regulating themselves[27,38]. This effect runs directly oppositional to the goal of activating or empowering individuals with chronic conditions. And even unexpected and task-noncontingent rewards have a neutral effect on intrinsic motivation, compared with positive feedback (given in an informational versus a

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controlling manner), which enhances intrinsic motivation[27].

Although more research is needed to identify the mechanics of how incentives work and the size needed to induce different behaviors; in general: (1) the amount of the cash incentive is positively correlated to the response rate[16,19]; (2) coupons are preferred to gifts, lotteries, or points[16,19]; and (3) unexpected (random) and task-noncontingent rewards do not seem to worsen intrinsic motivation as task contingent-based incentives do[27].

Combination

While it seems intuitive to use various options that complement each other, unfortunately, the literature is sparse in this area. There are some positive findings in the workplace – when incentives and competitions are coupled with client education, smoking cessation groups and telephone cessation support, there is significant increase in number of workers who quit using tobacco[18]. Additionally, incentives, disincentives and interventions have also been successfully used in various combinations in employer-sponsored wellness programs to increase participation and lower health risks[16]. However, in another clinical trial for smoking cessation[39], feedback for intrinsic motivation significantly outperformed both the group receiving external motivation (incentives) and the group receiving both external and internal reinforcement, leaving a question mark as to the value of adding the incentives to the intervention. All in all, there is inadequate well-controlled research regarding a combination of incentives, disincentives and interventions to make a definitive statement about the efficacy and cost-effectiveness of this option, especially within a Medicaid population.

The Use of Other Evidence-Based Approaches to Engage the Patient

Although the main scope of this project is directed towards a review of using of disincentives and incentives with a Medicaid population to increase patient engagement, it would be untoward not to include a mention of other evidence-based strategies to engage patients. One such evidence-based communication approach originated in the addictions and counseling field and does not rely on either incentives or disincentives to engage individuals. Motivational Interviewing is a "…collaborative, goal-oriented style of communication with particular attention to the language of change"[28]. Although there are limited well-controlled studies with a Medicaid population, there are over 200 clinical trials that demonstrate efficacy of the MI approach with topics common to a Medicaid population, such as addiction, mental illness and multiple chronic conditions[40].

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In a recent systematic review and meta-analysis of MI in medical care settings, researchers found that MI produced a statistically significant and positive impact on a range of outcome measures, including dental caries, death rate, cholesterol level, blood pressure, HIV viral load, obesity, physical strength, quality of life, amount of alcohol consumed, dangerous drinking, smoking abstinence, marijuana use, self-monitoring, sedentary behavior, patient confidence, intention to change, and engagement in treatment[41]. Other variables which support this approach as a viable option for engaging Medicaid patients are: (1) it tends to be most helpful for less ready, unmotivated, less activated individuals; (2) it is a standardized approach that can be taught and measured by validated assessment tools; and (3) it is a single framework with which to address shared decision-making, self-efficacy, personal agency and patient activation[28,42]. The downside of this approach rests in the complexity of the skill-set – it takes a concerted effort to train health care providers to a proficiency level linked with outcomes and an organizational change initiative is generally needed in addition to ongoing staff training[28].

While MI is the most studied and standardized approach for patient engagement, there is a growing body of evidence that addresses the importance of constructs such as patient activation, shared decision-making and health literacy[4,5,9]. Health coaching approaches have been developed for each of these areas, although none has been fully developed to the point where there is a validated instrument to measure fidelity to a certain set of criteria. However, as mentioned above, there is evidence that, with additional training, health care workers can use the MI approach to address these important variables and clinics may identify them as targeted behaviors in their health coaching interventions[10,43].

Another important area of consideration in addressing strategies to engage patients is the value of marshaling community support and resources. Oregon has made a concerted effort to build a health workforce (formerly called non-traditional health workers) that is comprised of community health workers, peer wellness specialist, patient health navigators, and doulas. The literature is clear about the success that these community resources play in engaging individuals, especially those underserved individuals who have not had a positive experience in previous health care experiences or who may not trust those in authority[44].

For a summary table of this review of patient engagement strategies see Appendix A.

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CONCLUSION

As more definitive research emerges on the value and efficacy of using various strategies to engage patients, it is clear that stakeholders must take into account the complexity of human nature and behavior change. It may be helpful to study what other states have incorporated to date to engage their Medicaid population. A recent review by Blumenthal et al.[8] of Medicaid incentive programs, whose objective was to encourage healthy behaviors, reflected mixed results to date. For an overview of this review see Appendix B.

In conclusion, this task demands that we think creatively and continue to pilot programs that test reasonable theories, so that we can develop new models of best practice for the health care system of the future.

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REFERENCES

[1] Gruman J, Rovner MH, French ME et al. From patient education to patient engagement: Implications for the field of patient education. *Pat Ed Couns*. 2010;78:350–356.

[2] Business Dictionary. Accessed September 17, 2013. Available at: www.businessdictionary.com.

[3] Agency for Healthcare Research and Quality. Cost-sharing. Accessed September 17, 2013. Available at: www.ahrq.org.

[4] Butterworth SW, Andersen B. Module 4: Health Coaching. In Chronic Care Professional (CCP) Health Coaching Certification Manual, 5th Edition. (2013) Saint Petersburg: HealthSciences Institute.

[5] Greene J, Hibbard JH. Why does patient activation matter? An examination of the relationships between patient activation and health-related outcomes. J Gen Intern Med. 2012;27(5):520-526.

[6] Carman K, Dardess P, Maurer SS, et al. Patient and Family Engagement: A Framework for Understanding the Elements and Developing Interventions and Policies.

[7] Miller WR, Rollnick S. *Motivational Interviewing: Helping People Change*. Third Edition. 2012. New York: Guilford Press.

[8] Blumenthal KJ, Saulsgiver KA, Norton L, Troxel AB, et al. Medicaid Incentive Programs to Encourage Healthy Behavior Show Mixed Results to Date and Should Be Studied and Improved. *Health Aff*. 2013;32(3):497-507.

[9] Butterworth, SW. Application of MI in Low Socioeconomic Group Setting: Overcoming Language, Cultural & Disability Challenges. Symposium participant at World Congress of Behavioral and Cognitive Therapies, Barcelona, Spain. (July 2007)

[10] Linden A, **Butterworth** SW, Prochaska JO. (2010). Motivational interviewing-based health coaching as a chronic care intervention. *Journal of Evaluation in Clinical Practice*, 16, 166-174.

[11] Butterworth SW. Prochaska JO, Burden V. Redding C. Evaluation of Project META (Motivating Employees Towards Action). Research Presentation to 2010 Art & Science of Health Promotion Conference, Hilton Head, SC (March 2010)

[12] Butterworth SW, Smithline N. Breakthrough Results in Engagement: Bridging Science and Practice. HealthSciences Institute Learning Collaborative (September 2012).

[13] Moyers TB, Martin T, Christopher PJ, Houck JM, Tonigan JS, Amrhein, P.C. Client Language as a Mediator of Motivational Interviewing Efficacy: Where is the Evidence? *Alcoholism: Clinical & Experimental Research*. 2007;31(3): 40-47.

Review of Literature: Patient Engagement – The Role That Disincentives & Incentives Play

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[14] Premiums and Cost-Sharing in Medicaid: A Review of Research Findings. Kaiser Commission on Medicaid and the Uninsured, February 2013. Accessed September 9, 2013. Available at: http://www.kff.org/medicaid/8417.cfm

[15] Sallis JF, Owen N, Fisher EB. Ecological Models of Health Behavior. Chapter in Glanz K, Rimer BK, Viswanath (ed). *Health Behavior and Health Education: Theory, Research and Practice*. 4th Edition. 2008. San Francisco: Jossey-Bass.

[16] Mattke S, Lui H, Caloyeras JP, Huang CY, et al. Workplace Wellness Programs Study: Final Report. A RAND Health Research Report. Sponsored by U.S. Department of Labor and U.S. Department of Heath and Human Services. 2013. Accessed September 3, 2013. Available at: http://www.dol.gov/ebsa/pdf/workplacewellnessstudyfinal.pdf.

[17] Halpin HA, McMenamin SB, Rideout J, Boyce-Smith G. The Costs and Effectiveness of Different Benefit Designs for Treating Tobacco Dependence: Results from a Randomized Trial. *Inquiry*. 2006;43:54-64.

[18] Leeks KD, Hopkins DP, Soler RE, Aten A, Chattopadhyay SK. Worksite-based incentives and competitions to reduce tobacco use. A systematic review. *Am J Prev Med*. 2010;38(2 Suppl):S263-74.

[19] Kane RL, Johnson PE, Town RJ, Butler M. A Structured Review of the Effect of Economic Incentives on Consumers' Preventive Behavior. *Am J Prev Med* 2004;27(4):327-252.

[20] The Health Insurance Experiment: A Classic RAND Study Speaks to the current Health Care Reform Debate. The RAND Corporation. 2006. Accessed September 3, 2013. Available at: http://www.rand.org/pubs/research_briefs/RB9174/index1.html.

[21] Lowsky D, Chari R, Hussey PS, Mulcahy et al. Flattening the Trajectory of Health Care Spending: Engage and Empower Consumers. The RAND Corporation. 2012. Accessed September 3, 2013. Available at: http://www.rand.org/content/dam/rand/pubs/research_briefs/2012/RAND_RB9690z3.pdf.

[22] Schmidt H, Voigt K, Wikler D. Carrots, Sticks, and Health Care Reform – Problems with Wellness Incentives. *NEJM*. 2010;362:e3.

[23] Rezayatmand R, Pavlova M, Groot W. The impact of out-of-pocket payments on prevention and health-related lifestyle: a systematic literature review. *Eur J Pub Health*. 2013;23(1):74-79.

[24] Thomson Reuters (Healthcare) Inc. Guidance Document on Preparing a Solicitation for Section 4108 of the Patient Protection and Affordability Act: Incentives for Prevention of Chronic Diseases in Medicaid: Final

Review of Literature: Patient Engagement – The Role That Disincentives & Incentives Play

Report. February, 2011. Accessed September 3, 2013. Available at: http://innovation.cms.gov/Files/x/MIPCD-CME-Guidance.pdf.

[25] John LK, Loewenstein G, Troxel AB, Norton L, Fassbender JE, Vopp KG. Financial Incentives for Extended Weight Loss: A Randomized, Clinical Trial. *J Gen Int Med*. 2011;26(6):621-626.

[26] Jeffery RW, Bjornson-Benson WM, Kurth CL, Johnson SL. Effectiveness of monetary contracts with two repayment schedules of weight reduction in men and women from self-referred and population samples. *Behav Ther*. 1984;15:273-279.

[27] Deci EL, Ryan RM, Koestner R. A meta-analytic review of experiments examining the effects of extrinsic rewards on intrinsic motivation. *Psychol Bull*. 1999;125(6):627-668.

[28] Miller WR, Rose GS. Toward a Theory of Motivational Interviewing. *Am Psychol*. 2009;64(6):527-537.

[29] Volpp KG, Loewenstein G, Asch DA. Choosing Wisely: Low-Value Services, Utilization, and Patient Cost Sharing. *JAMA*. 2012(308(16):1635-1336.

[30] Loewenstein G, Volpp KG, Asch DA. Incentives in Health: Different Prescriptions for Physicians and Patients. *JAMA*. 2012;307(13):1375-1376.

[31] Wood vs Betlach. The United States District Court for the District of Arizona, February, 2013. Accessed September 1, 2013. Available at: http://hr.cch.com/hld/WoodvBetlach.pdf.

[32] Cahill K, Perera R. Competitions and incentives for smoking cessation. [Review] The Cochrane Library. 2011;6:1-53.

[33] Lynagh MC, Sanson-Fisher RW, Bonevski B. What's Good for the Goose is Good for the Gander. Guiding Principles for the use of Financial Incentives in Health Behaviour Change. [Review] *Int J Behav Med*. 2013;20(1):114-20.

[34] DeFulio A, Silverman K. The use of incentives to reinforce medication adherence. [Review] *Prev Med*. 2012;55(1):S8-S94.

[35] Higgins ST, Washio Y, Heil SH, Solomon LJ, Gaalema DE, Higgins TM, Bernstein IM. Financial incentives for smoking cessation among pregnant and newly postpartum women. [Review] *Prev Med*. 2012;55(Suppl):S33-S40.

[36] Crane MM, Tate DF, Finkelstein EA, Linnan LA. Motivation for Participating in a Weight Loss Program and Financial Incentives: An Analysis from a Randomized Trial. *J Obesity*. 2012; Article ID 290589, 9 pages.

Review of Literature: Patient Engagement – The Role That Disincentives & Incentives Play

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[37] Troxel AB, Volpp KG. Effectiveness of Financial Incentives for Longer-Term Smoking Cessation: Evidence of Absence or Absence of Evidence. [Review] *AJHP*. 2012;26(4):204-207.

[38] Moller AC, McFadden HG, Hedeker D, Spring B. Financial Motivation Undermines Maintenance in an Intensive Diet and Activity Intervention. *J Obesity*. 2012; Article ID 740519, 8 pages.

[39] Curry SJ, Wagner EH, Grothaus LC. Evaluation of intrinsic and extrinsic motivation interventions with a self-help smoking cessation program. *J Consult Clin Psychol*. 1991;59(2):319-324.

[40] Mid-Atlantic ATTC. Motivational Interviewing: Bibliography. Accessed September 3, 2013. Available at: http://www.motivationalinterview.org/quick_links/bibliography.html.

[41] Lundahl B, Moleni T, Burke BL, Butters R, Tollesfson D. Motivational interviewing in medical care settings: A systematic review and meta-analysis of randomized controlled trials. Pat Ed Counseling. 2013; In press. Accessed September 3, 2013. Available at: http://www.sciencedirect.com/science/article/pii/S0738399113002887.

[42] Butterworth S, Linden A, McClay W. Health Coaching as an Intervention in Health Management Programs. *Dis Man Health Outc*. 2007;15(5):299-307.

[43] Butterworth, SW. Patient Activation and Motivational Interviewing. Motivational Interviewing Network of Trainers (MINT) Annual International Forum, San Diego, US (October, 2010).

[44] Rosenthal EL, Brownstein JN, Rush CH, Hirsch GR, et al. Community Health Workers: Part of the Solution. *Health Aff*. 2010;7:1338-1342.

Appendix A: Summary Table for Research Review Of Patient Engagement Strategies

Option	Advantages & Efficacy	Disadvantages	Selected References
Disincentives – Policy – Penalty fees – Cost-sharing ▲ Deductibles ▲ Copayments ▲ Coinsurance ▲ Premiums ▲ Enrollment fees – Demanding/ controlling approach	• Individuals can be significantly influenced in their health behavior by policy changes that are widely marketed and/or affect them adversely; smoking cessation, drinking and driving, wearing seat belts[34] • Successful compliance in employer-sponsored wellness programs to participate in health risk assessments and health screenings[13,23] • Cost-sharing significantly decreases utilization of health services and results in decreased health care spending, with mixed results regarding ER visits and hospitalization[3,25,26,27] • Cost-sharing does not seem to have effect on quality in care short-term on majority of patients[3,25,26] • Participants in cost-sharing plans have self-reported that they worry less about their health, have fewer restricted-activity days and generally are satisfied with care[25] • In theory, using cost-sharing principles more deliberately could intentionally reduce health care spending in high cost, low value treatments/services[14,25,27]	• Penalty fees cause resentment on part of participants and can damage relationship between payer and patient[17,19] • Premiums and enrollment fees act as barriers to obtaining and maintaining coverage for low-income groups[3,17,25,27] • Cost-sharing results in equal cuts for both highly effective and less effective services, including emergent and non-emergent ER visits[3,25,26] • Decreased quality of care for sickest and poorest; decrease in preventive services occur even when fully covered [3,25, 26] • Beneficiaries forgo preventive care and medications leading to higher incidences of serious medical conditions requiring more expensive care[2,26] • Penalty fees not effective for risky, entrenched behaviors or for changing complex behaviors on long-term basis; especially those that are challenging or entrenched, such as weight loss[1,7] • In a review of CHHPs (Consumer Directed Health Plans), every $10 increase in copay for statin medications equaled 5-point drop in medication compliance for Medicaid population[26] • State savings from cost-sharing and premiums may accrue due to declines in coverage and utilization more so than from increases in revenues[3] • Changes in cost-sharing and premiums can result in increased demand and additional pressure on safety-net providers, as noted by 20% increase in ER visits by uninsured in Oregon; can result in lower reimbursement rates[3] • [Many] patients cannot distinguish between low/high value and necessary/unnecessary services; in some studies, using cost-sharing to reduce spending in low value areas has caused a rebound effect of patients substituting high cost services or going without needed care[3,14,15] • A controlling, authoritarian approach diminishes intrinsic motivation and is negatively correlated with behavior change[11.16]	[1]John et al., 2011 [2]Wood vs. Betlach, 2013 [3]Kaiser Commission, 2013 [7]Jeffery et al., 1984 [11]Deci et al., 1999 [13]Madison et al., 2013 [14]Volpp et al., 2012 [15]Loewenstein et al., 2012 [16]Miller & Rose, 2009 [17]Schmidt et al., 2010 [19]Thomson Reuters, 2011 [23]Mattke et al., 2013 [25]RAND HIE, 2006 [26]Lowsky et al., 2012 [27]Rezayatmand et al., 2013 [35]Sallis et al., 2008

Appendix A: Summary Table for Research Review Of Patient Engagement Strategies

Option	Advantages & Efficacy	Disadvantages	Selected References
Incentives – Waiver of fees – Reimbursement of fees – Gifts – Gift cards – Cash payments – Vouchers – Lotteries – Point system – Special privilege	• In pooled, systematic review, researchers report that smokers more than twice as likely to quit if full coverage versus partial coverage[29] • In seminal smoking cessation clinical trial with $750 in incentives, treatment group demonstrated long-term outcomes, months after incentives had ended[18] • In review of six controlled trials, researchers found systematic use of financial incentives has promise as efficacious intervention for promoting smoking cessation among economically disadvantaged pregnant and recently postpartum women and improving birth outcomes[22] • In large review to determine whether competitions and incentives lead to higher longer-term quit rates, some evidence found that recruitment rates can be improved by rewarding participation, which may result in higher absolute numbers of individuals who quit[29] • Economic incentives appear to be effective for simple preventive care (e.g. vaccinations, screenings) and short-term for distinct well-defined behavioral goals, with strong evidence for vulnerable low SES populations[6,9,24] • Incentives increase participation in employer- and community-sponsored health risk assessments, health screenings, health competitions and other health management programs[13,23] • Although more research is needed to identify mechanics of how incentives work and size needed for different behaviors, in general: (1) amount of cash incentive correlated with response rate to incentive; and (2) coupons are preferred to gifts, lotteries, or points[6,24] • Unexpected and task-noncontingent rewards do not worsen intrinsic motivation as other incentives do[11] • Although understudied, incentive-based medication adherence interventions are promising, even among individuals with mental illness or addiction[20]	• Insufficient evidence to suggest economic incentives by themselves are enough to sustain the long-term lifestyle changes required for health promotion, such as quitting smoking, exercising, and losing weight[5,6,9,24] • In seminal smoking cessation clinical trial with $750 in incentives, the cost-benefit ratio is questionable; 30% drop-out rate from treatment group and only 9% abstinence rates after 6 months (compared with 4% information-only control group)[18] • In recent rigorous review of smoking cessation and incentive research in workplace, authors concluded that studies to date simply have been inadequately powered to address the question of whether incentives increase long-term smoking cessation rates; most studied populations for incentives and smoking cessation are high SES, white, employed[21] • In large review to determine whether competitions and incentives lead to higher long-term quit rates, it was concluded that they did not (with exception of one study)[29] • In large clinical trial for weight loss, no correlation with external incentive; rather greater weight losses consistently associated with increases in autonomous (intrinsic) motivation[10] • A large meta-analysis, followed later by well-controlled study applying same variables to health care realm, demonstrated strong evidence that expected tangible rewards significantly decreased intrinsic motivation, particularly for task-contingent tangible rewards; i.e., reward contingencies undermine people's taking responsibility for motivating or regulating themselves[11,12] • Although promising results applying incentives for medication adherence, little research to support outcomes that last beyond incentive period[20] • Positive feedback (given in informational vs. controlling manner) enhances intrinsic motivation; unexpected and task-noncontingent rewards do not[11] • Although 'special privilege' models exist in school and prison systems, as well as in airline industry, there is dearth of research about application in health care setting	[27]Kaper et al., 2005 [5]Leeks et al., 2010 [6]Kane et al., 2004 [9]Lynagh, 2013 [10]Crane et al., 2011 [11]Deci et al., 1999 [12]Moller et al., 2012 [13]Madison et al., 2013 [18]Volpp et al., 2009 [20]DeFulio & Silverman, 2012 [21]Troxel & Volpp, 2012 [22]Higgins et al., 2012 [24]Mattke et al., 2013 [23]Blumenthal et al., 2013 [29]Cahill & Perera 2010

Appendix A: Summary Table for Research Review Of Patient Engagement Strategies

Option	Advantages & Efficacy	Disadvantages	Selected References
Motivational Interviewing – A collaborative, goal-oriented style of communication with particular attention to the language of change[32]	• >200 clinical trials demonstrate efficacy of MI approach; include topics common to Medicaid population such as addiction, mental illness and multiple chronic conditions[34] • In recent systematic review and meta-analysis of MI in medical care settings, researchers found that MI produced a statistically significant and positive impact on range of outcome measures: dental caries, death rate, cholesterol level, blood pressure, HIV viral load, obesity, physical strength, quality of life, amount of alcohol consumed, dangerous drinking, smoking abstinence, marijuana use, self-monitoring, sedentary behavior, patient confidence, intention to change, and engagement in treatment[31] • Most helpful for less ready, unmotivated, less activated individuals[16,32] • Standardized approach that can be taught and measured by validated assessment tools[20,32] • Single framework to address shared decision-making, self-efficacy, personal agency and patient activation[32,33]	• Limited well-controlled studies with Medicaid population where MI proficiency was evaluated/assured • Complex skill-set and concerted effort needed to train health care providers to proficiency level linked with outcomes[16,32] • Organizational change initiative generally needed in addition to ongoing staff training[32]	[16]Miller & Rose, 2009 [30]Butterworth et al., 2007 [31]Lundahl et al., 2013 [32] Miller & Rollnick, 2012 [33] Linden, Butterworth & Prochaska, 2010 [34]Mid-Atlantic ATTC, 2012
Combination – Incentives – Disincentives – Interventions	• When coverage of drugs is conditional on participation in health coaching, Medicaid population did not decrease use of drug benefit as compared with control group[4] • When incentives and competitions are coupled with client education, smoking cessation groups and telephone cessation support, there is significant increase in number of workers who quit using tobacco[5] • Incentives, disincentives and interventions have been successfully used in various combinations in employer-sponsored wellness programs to increase participation and lower health risks[23]	• In clinical trial for smoking cessation, feedback for intrinsic motivation significantly outperformed group receiving external motivation (incentives) and group receiving both external and internal reinforcement[8] • Inadequate well-controlled research with combination of incentives, disincentives and interventions to make definitive statement about efficacy and cost-effectiveness, especially with Medicaid population	[4]Halpin et al., 2006 [5]Leeks et al., 2010 [8]Curry et al., 1991 [23]Mattke et al., 2013

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References:

[1]John LK, Loewenstein G, Troxel AB, Norton L, Fassbender JE, Vopp KG. Financial Incentives for Extended Weight Loss: A Randomized, Clinical Trial. *J Gen Int Med*. 2011;26(6):621-626.

[2]Wood vs Betlach. The United States District Court for the District of Arizona, February, 2013. Accessed 9/01/13. Available at: http://hr.cch.com/hld/WoodvBetlach.pdf.

[3]Premiums and Cost-Sharing in Medicaid: A Review of Research Findings. Kaiser Commission on Medicaid and the Uninsured, February 2013. Accessed 9/01/13. Available at: http://www.kff.org/medicaid/8417.cfm.

[4]Halpin HA, McMenamin SB, Rideout J, Boyce-Smith G. The Costs and Effectiveness of Different Benefit Designs for Treating Tobacco Dependence: Results from a Randomized Trial. *Inquiry*. 2006;43:54-64.

[5]Leeks KD, Hopkins DP, Soler RE, Aten A, Chattopadhyay SK. Worksite-based incentives and competitions to reduce tobacco use. A systematic review. *Am J Prev Med*. 2010;38(2 Suppl):S263-74.

[6]Kane RL, Johnson PE, Town RJ, Butler M. A Structured Review of the Effect of Economic Incentives on Consumers' Preventive Behavior. *Am J Prev Med* 2004;27(4):327-252.

[7]Jeffery RW, Bjornson-Benson WM, Kurth CL, Johnson SL. Effectiveness of monetary contracts with two repayment schedules of weight reduction in men and women from self-referred and population samples. *Behav Ther*. 1984;15:273-279.

[8]Curry SJ, Wagner EH, Grothaus LC. Evaluation of intrinsic and extrinsic motivation interventions with a self-help smoking cessation program. *J Consult Clin Psychol*. 1991;59(2):319-324.

[9]Lynagh MC, Sanson-Fisher RW, Bonevski B. What's Good for the Goose is Good for the Gander. Guiding Principles for the use of Financial Incentives in Health Behaviour Change. [Review] *Int J Behav Med*. 2013;20(1):114-20.

[10]Crane MM, Tate DF, Finkelstein EA, Linnan LA. Motivation for Participating in a Weight Loss Program and Financial Incentives: An Analysis from a Randomized Trial. *J Obesity*. 2012; Article ID 290589, 9 pages.

[11]Deci EL, Ryan RM, Koestner R. A meta-analytic review of experiments examining the effects of extrinsic rewards on intrinsic motivation. *Psychol Bull*. 1999;125(6):627-668.

[12]Moller AC, McFadden HG, Hedeker D, Spring B. Financial Motivation Undermines Maintenance in an Intensive Diet and Activity Intervention. *J Obesity*. 2012; Article ID 740519, 8 pages.

[13]Madison K, Schmidt H, Volpp KG. Smoking, Obesity, Health Insurance, and Health Incentives in the Affordable Care Act. *JAMA*. 2013;310(2):143-144.

[14]Volpp KG, Loewenstein G, Asch DA. Choosing Wisely: Low-Value Services, Utilization, and Patient Cost Sharing. *JAMA*. 2012(308(16):1635-1336.

[15]Loewenstein G, Volpp KG, Asch DA. Incentives in Health: Different Prescriptions for Physicians and Patients. *JAMA*. 2012;307(13):1375-1376.

[16]Miller WR, Rose GS. Toward a Theory of Motivational Interviewing. *Am Psychol*. 2009;64(6):527-537.

[17]Schmidt H, Voigt K, Wikler D. Carrots, Sticks, and Health Care Reform – Problems with Wellness Incentives. *NEJM*. 2010;362:e3.

[18]Volpp KG, Troxel AB, Pauly MV, et al. A Randomized, Controlled Trial of Financial Incentives for Smoking Cessation. *N Eng J Med.* 2009;360:699-709.

[19]Thomson Reuters (Healthcare) Inc. Guidance Document on Preparing a Solicitation for Section 4108 of the Patient Protection and Affordability Act: Incentives for Prevention of Chronic Diseases in Medicaid: Final Report. February, 2011. Accessed September 3, 2013. Available at: http://innovation.cms.gov/Files/x/MIPCD-CME-Guidance.pdf.

[20]DeFulio A, Silverman K. The use of incentives to reinforce medication adherence. [Review] *Prev Med*. 2012;55(1):S8-S94.

[21]Troxel AB, Volpp KG. Effectiveness of Financial Incentives for Longer-Term Smoking Cessation: Evidence of Absence or Absence of Evidence. [Review] *AJHP*. 2012;26(4):204-207.

[22]Higgins ST, Washio Y, Heil SH, Solomon LJ, Gaalema DE, Higgins TM, Bernstein IM. Financial incentives for smoking cessation among pregnant and newly postpartum women. [Review] *Prev Med*. 2012;55(Suppl):S33-S40.

[23]Mattke S, Lui H, Caloyeras JP, Huang CY, et al. Workplace Wellness Programs Study: Final Report. A RAND Health Research Report. Sponsored by U.S. Department of Labor and U.S. Department of Heath and Human Services. 2013. Accessed September 3, 2013. Available at: http://www.dol.gov/ebsa/pdf/workplacewellnessstudyfinal.pdf.

[24]Blumenthal KJ, Saulsgiver KA, Norton L, Troxel AB, et al. Medicaid Incentive Programs to Encourage Healthy Behavior Show Mixed Results to Date and Should Be Studied and Improved. *Health Aff*. 2013;32(3):497-507.

[25]The Health Insurance Experiment: A Classic RAND Study Speaks to the current Health Care Reform Debate. The RAND Corporation. 2006. Accessed September 3, 2013. Available at: http://www.rand.org/pubs/research_briefs/RB9174/index1.html.

[26]Lowsky D, Chari R, Hussey PS, Mulcahy et al. Flattening the Trajectory of Health Care Spending: Engage and Empower Consumers. The RAND Corporation. 2012. Accessed September 3, 2013. Available at: http://www.rand.org/content/dam/rand/pubs/research_briefs/2012/RAND_RB9690z3.pdf.

[27]Rezayatmand R, Pavlova M, Groot W. The impact of out-of-pocket payments on prevention and health-related lifestyle: a systematic literature review. *Eur J Pub Health*. 2013;23(1):74-79

[28] Kaper J, Wagena EJ, Severens JL, Van Schayck CP. Healthcare financing systems for increasing the use of tobacco dependence treatment. [Review] The Cochrane Library. 2005;1:1-39.

[29] Cahill K, Perera R. Competitions and incentives for smoking cessation. [Review] The Cochrane Library. 2011;6:1-53.

[30] Butterworth S, Linden A, McClay W. Health Coaching as an Intervention in Health Management Programs. *Dis Man Health Outc*. 2007;15(5):299-307.

[31] Lundahl B, Moleni T, Burke BL, Butters R, Tollesfson D. Motivational interviewing in medical care settings: A systematic review and meta-analysis of randomized controlled trials. Pat Ed Counseling. 2013; In press. Accessed September 3, 2013. Available at: http://www.sciencedirect.com/science/article/pii/S0738399113002887.

[32]Miller WR, Rollnick S. *Motivational Interviewing: Helping People Change*. Third Edition. 2012. New York: Guilford Press.

[33] Linden A, Butterworth SW, Prochaska JO. Motivational Interviewing-Based Health Coaching as a Chronic Care Intervention. *J Eval Clin Prac.* 2010;16:166–174.

APPENDIX A: SUMMARY TABLE FOR RESEARCH REVIEW OF PATIENT ENGAGEMENT STRATEGIES

[34] Mid-Atlantic ATTC. Motivational Interviewing: Bibliography. Accessed September 3, 2013. Available at: http://www.motivationalinterview.org/quick_links/bibliography.html.

[35] Sallis JF, Owen N, Fisher EB. Ecological Models of Health Behavior. Chapter in Glanz K, Rimer BK, Viswanath (ed). *Health Behavior and Health Education: Theory, Research and Practice*. 4th Edition. 2008. San Francisco: Jossey-Bass.

Appendix B: Medicaid Pilot Programs of Incentives For Prevention Of Chronic Diseases, 2011[23*]

State	Goal	Incentive	Research Support	Outcomes
California	Tobacco cessation and diabetes management	$10-20 per activity	Low	NA
Connecticut	Tobacco cessation	$5-15 per activity	Low	NA
Florida	Routine checkups, Immunizations, cancer screening, Clinic attendance, medication adherence, tobacco cessation, weight loss, diabetes management	$7.50 - $25; $125/year maximum	High (simple) Low (complex)	Only half of credits redeemed (200,000); majority for childhood preventive care (43%) or adult/child office visits (28%); <1% earned for weight loss or tobacco cessation; lack of participation in programs that decrease chronic disease
Hawaii	Diabetes prevention, detection and management	$20 - $25 per activity	Low	NA
Idaho	I. Weight management and tobacco cessation II. Well-child visits	I. $200 maximum in vouchers II. 10 points ($10)/ month	I. Low II. Medium	I. <1% participation; no data on success II. Significant increase in well-child visits as compared to control group
Minnesota	Weight loss, diabetes prevention, improved CV health, reduced health care spending	$10 - 50 per activity	Low	NA
Montana	Weight loss, reduction in lipids and blood pressure, diabetes prevention	$320 maximum	Low for long term	NA
New Hampshire	Increased exercise, improved nutrition, reduced CV risk factors	Unknown	??	NA
New York	Tobacco cessation, hypertension control, diabetes prevention and self-management	$250 maximum	Low	NA
Nevada	Weight loss, lowered cholesterol and blood pressure, diabetes prevention and management	Unknown	??	NA
Texas	Improved health self-management among patients with SSI or mental health or substance abuse diagnosis	$1150 maximum (FSA)	Medium	NA
West Virginia	Sign a contract and develop wellness plan; adhere to agreement to maintain coverage	Maintain access to enhanced plan	Low	Only 10% of eligible adults enrolled in enhanced plan; enhanced plan members more likely to have more doctor visits and to have physicians involved in decision to enroll
Wisconsin	Tobacco cessation with focus on pregnant women	I. $595 maximum/ pregnant women; II. $350 maximum/other	I. High for short-term II. Low for long-term	NA

**Table adapted from Blumenthal et al., 2013*