

Section 4108: Medicaid Incentives for Prevention of Chronic Diseases (MIPCD)

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Background

- Born out of recognition that growth in health care costs may be unsustainable
- Interventions that address the behavioral or social circumstances that influence participation in preventive health services may contribute to improving health and decrease growth in health care expenditures
 - Tobacco use
 - 430,000 deaths/year
 - largest cause of preventable morbidity and mortality in US
 - Diabetes
 - 7th leading cause of death in US
 - 24 million Americans living with diabetes
 - 186,300 people < 20 years have Type 1 or Type 2
 - 2007: \$116 billion in total US healthcare system cost
 - Overweight and obesity increases likelihood of certain diseases
 - 300,000 deaths per year
 - 2008: estimated annual healthcare cost of obesity = \$147 billion/year
 - 2009: 26.7% adults obese in US, up 1.1% from 2007

Overview

- Section 4108 of the Affordable Care Act
- Authorizes grants to States to provide incentives to Medicaid beneficiaries of all ages who participate in prevention programs
- Have to demonstrate changes in health risk and outcomes, including the adoption of healthy behaviors
- Initiatives or programs should be comprehensive, evidence-based, widely available, and easily accessible

Overview

- Competitive grant process
 - \$100 million total funding
 - Awards to 10 states for \$5-10 million
 - Grant period of 5 years, with 3 years of program operation
 - Grant period: August 2011 – December 2015
 - Anticipated enrollment of beneficiaries in January 2012
- State Medicaid agency must be the lead applicant
 - May partner with other agencies (public and private)
 - Public health agencies may be included as providers, coordinators, or facilitators of program

Grant Design and Development

- Must be successful in achieving one or more of these goals:
 - Ceasing use of tobacco products
 - Controlling or reducing weight
 - Lowering cholesterol levels
 - Diabetes prevention/management
- May address co-morbidities (including depression)
- May target multiple behaviors and allow multiple interventions
- May be targeted geographically or Statewide

Incentive Structure

- States propose type and amount of incentive to be paid to beneficiaries
- Prefer outcome-driven, tiered incentive structure
- May include cash, supplemental services not covered by Medicaid, alternative inducements (e.g. transportation support, reduced program fees)
- May be direct (to patient) or indirect (to family or community agencies)
- No punitive disincentives = Must be carrots, not sticks
- Predecessors: Pay for Performance and early incentive programs in WV, FL, and ID

Rigorous Evaluation

- Purpose will be to determine:
 - Effect of initiatives on use of services
 - Extent to which special populations (ABD, chronic illness, children with special health care needs) are able to participate
 - Level of satisfaction of beneficiaries with quality and accessibility of services
 - Administrative costs incurred by State agencies

CMS Priorities

- Preference given to States with:
 - Legislative support
 - System readiness
 - Provision of State Plan covered services
 - Evaluative capacity of State
 - State experience with prevention and incentive initiatives
 - Alignment of preventive services to CHIPRA and ACA initial core measures
 - Appropriate nesting of incentives and preventive services in systems of care such as Health Homes
 - Plans for incentive sustainability and diffusion beyond grant period

Grant Development

- Convened workgroup with members from Prevention Taskforce
- Focus:
 - Opportunities that can be sustained in tight budgetary times
 - Opportunities with a return on investment
 - Approaches that will impact ABD population

Option 1

- Identify enrolled ABD patients with chronic illnesses and provide incentives for them to engage in Community Care of North Carolina (CCNC)'s Chronic Care Program
 - Available statewide through 14 Community Care networks
 - Participating enrollees receive comprehensive support services and potential interventions, including:
 - Agree to work with care manager in setting self-management goals in a patient-centered care plan
 - Agree to participate in the Stanford self-management program
 - Agree to participate in coaching by care managers and health advisors

Option 2

- Identify enrollees with a dyad or triad of chronic conditions that are smokers and target to enroll in a smoking cessation program
- Identification would occur in the medical home with the primary care physician being the first person to assess readiness to engage
- Potential interventions:
 - PCP assessing readiness to engage through the 5 A's (Ask, Advise, Assess, Assist, and Arrange) or similar assessment
 - Referral to care manager by PCP for follow-up, care plan development, supports
 - Linkage to Quit Line
 - Appropriate medication support – prescribing smoking cessation medications, as appropriate
 - Ongoing outreach and support by care manager

Potential Incentives

- Tiered approach – incentive to engage and incentive to complete behavior change
- Gift cards, gasoline debit cards, phone cards
- Waiving premiums, deductibles, coinsurance payments
- Providing “points” that can be used as currency for products such as OTC medications
- Reimbursement for community-based programs focused on behavior (i.e. physical activity programs at the local YMCA)
- Transportation to and from medical appointments

Next Steps

- Submitted Letter of Intent to Apply on March 22, 2011
- Grant due May 2, 2011
- Awards expected by August 2011