

Renewed Focus on Prevention and Wellness in State Medicaid Programs

BY LOUISE KERTESZ

STATE MEDICAID PROGRAMS ARE INCREASINGLY emphasizing prevention and wellness to improve beneficiaries' health and hold down health care costs. Supporting states' goals are Medicaid managed care plans, which continue to innovate and augment prevention and wellness programs they have offered for years to Medicaid beneficiaries.

Invoking new flexibility in the Medicaid law enacted as part of the Deficit Reduction Act of 2005 (DRA), West Virginia last year began a pilot program offering enrollees in some counties a choice of two benefit packages—a basic plan and an enhanced plan that includes benefits not traditionally offered under Medicaid.



To enroll in the enhanced benefit plan, beneficiaries are asked to sign an agreement with the state to comply with all recommended medical treatment and wellness behaviors. The state will monitor compliance by reviewing

claims data, says Mitch Collins, regional director for Medicaid at UniCare in West Virginia, one of three managed care organizations serving Medicaid recipients in the state. Among the additional benefits in the enhanced plan are programs in tobacco cessation, nutritional counseling, diabetes care, and more generous coverage for chiropractic services.

Enrollees in both the basic and enhanced plans will have a "medical home," that is, a primary care provider who oversees and coordinates individuals' care to ensure they get the services necessary to remain healthy. "It's an interesting and innovative concept," Collins says, but adds, "What the state is doing [in Medicaid] is consistent with what managed care has been doing for about 20 years.

"I applaud the state for trying to do something different," continues Collins. "They are trying to look like the insurance industry by adopting programs we've had in place for a long time. But it will take a little time to get [Medicaid] enrollees focused on wellness. We've been stressing it for years, and it's still difficult."

UniCare has "a big push this year on educating our members about preventive care, the types of decisions they need to be making to remain healthy. We're trying to get more information out about weight management, asthma management, and blood pressure [control]," Collins says. Last year, UniCare began offering enrollees the Weight Watchers program. UniCare has also provided body mass index (BMI) training for clinical staff and provided its physicians CME sessions on identification, prevention, and management of obesity, he says.

About 8 percent of UniCare's total state Medicaid membership of 75,000 had transitioned into the enhanced benefits plan as of late June. UniCare spokesperson Leslie Porras explained that the relatively low percentage is due to the enhanced plan's being in place for less than a year. Pregnant women, who make up a large portion of UniCare's members in the state, do not qualify for the enhanced benefits plan. And finally, she says, "nearly half of our members have not come up on their redetermination date [for Medicaid eligibility] and have not yet had the opportunity to transition." Collins says, "It's going to take awhile, but I think the numbers will increase."



Wisconsin

Under the DRA, Wisconsin, among the national leaders in the use of managed care in Medicaid, has expanded its BadgerCare managed care program to more recipients. Among the expansions, BadgerCare Plus now covers pregnant women with incomes up to 300 percent of the federal poverty level (FPL) and all children under age 19, regardless of income.

In order to fund the expansion, two plans were created. The benchmark plan is for higher-income families, who pay a premium for their coverage as well as higher copayments than those in the standard plan. The benchmark plan has benefit limits comparable to a low-cost commercial plan.

The state also has begun to implement pay-for-performance incentives for managed care plans that increase member participation in prevention and wellness programs. Plans will begin a tobacco cessation initiative by conducting outreach. Going forward, plans will receive an incentive for the percentage of smokers they help quit the habit, says Sandra Tunis, senior vice president of government relations/compliance for Managed Health Services Insurance Corporation, a Medicaid health plan.

Another incentive rewards plans for increasing the percentage of members who receive appropriate dental care and for members under age 21 who receive a comprehensive HealthCheck. Plans also are meeting in workgroups with state officials to develop measures for healthy birth outcomes and care related to childhood obesity, Tunis says.

Managed Health Services is one of several plans that received a grant from the state to fund a two-year pilot project testing whether direct incentives to members are successful in boosting participation in prevention and wellness programs. For example, members would receive a \$20 Target gift card if their children get a HealthCheck and another incentive if they complete a diet history, Tunis says.

“One of the great aspects [of the program] is that it brings together health professionals from different disciplines to help fight obesity. . . from our intake nurse who contacts the patient to discuss expectations, to community-based physicians, to fitness, aerobics, and yoga instructors, all working together to help our citizens lead healthier lives.”

Wisconsin also has begun to incorporate the concept of a personal accountability agreement for Medicaid recipients. “It’s voluntary—not like the one in West Virginia. We created one, and we will encourage members to sign it,” Tunis says. Members agree to take care of their own health by following healthy behaviors including making and keeping preventive exam appointments, eating five servings of fruits and vegetables a day, and avoiding harmful behaviors such as smoking.

New Mexico

In a partnership to foster wellness, Medicaid health plans in New Mexico have collaborated with the state Department of Health and the New Mexico Medical Society to develop Clinical Practice Guidelines for Healthier Weight. “We view this as a continuation of our mission to provide preventive health and wellness programs,” says Art Bachechi, a quality improvement coordinator for Molina Healthcare of New Mexico, a managed Medicaid plan. “We are trying to be as proactive as possible,” he adds.

“One in five New Mexico adults is obese, and the state has the 10th highest rate of overweight youth ages 10-17, according to one report,” said Ann Wehr, M.D., president of Molina Healthcare of New Mexico, in a press release. Individuals are considered obese if they have a BMI of 30 or greater.

Once the guidelines were established, Molina worked with physicians to launch

a pilot program to identify 30 patients who needed to lose weight and assist them in reducing weight and maintaining the weight loss for at least one year. Participants in the voluntary program sign a Healthy Weight Program agreement committing to stay in the program for a year, during which Molina pays for their membership in a gym.

Participants also receive private instruction from a fitness trainer, meet with a registered or licensed dietitian, and have access to behavioral health counseling. Their primary care physicians monitor their progress during the year.

“Not only will our members lose weight, but they will significantly reduce their risk of health issues related to obesity, including diabetes, hypertension, coronary artery disease, and asthma,” Wehr said. “One of the great aspects [of the program] is that it brings together health professionals from different disciplines to help fight obesity. . . from our intake nurse who contacts the patient to discuss expectations, to community-based physicians, to fitness, aerobics, and yoga instructors, all working together to help our citizens lead healthier lives,” she said.

South Carolina

Compared with other states, managed care penetration has been low in the South Carolina Medicaid program. In a strategy to encourage beneficiaries to join managed care plans, which offer a range of prevention and wellness programs, the South Carolina Department of Health and Human Services (SCDHHS) launched Healthy Connections Choices in 2007. Although enrollment in a plan is voluntary, beneficiaries who do not choose a plan, or opt to stay in traditional Medicaid, will be assigned to a plan.

“Through partnerships with managed care organizations, Medical Home Networks, and special enrollment counselors, SCDHHS seeks to increase care coordination and disease prevention methods not found in traditional Medicaid. Those who choose to enroll in a health plan

also will establish crucial relationships with a primary care doctor. Currently, many Medicaid beneficiaries are left to navigate the health care system on their own, leading many to seek only sporadic care or emergency services," SCDHHS said in announcing the reform.

"Eighty thousand people have signed up for managed care just since we started the program last August," says Jeff Stensland, a spokesman for SCDHHS. "A good number have made the selection, and some have been assigned," he says.

"Right now, we have eight plans, all a little different, all offering services you don't get under fee-for-service Medicaid. The general feedback has been positive. Doctors are signing up for more plans, and we hear that doctors are suggesting to their patients, 'You might want to consider signing up, because our practice is in these plans,'" Stensland says.

As of June, 210,000 beneficiaries were in managed care or in a medical home network, out of about 850,000 who are in Medicaid over the course of a year. "From June to September, there's a big group of people coming up on their anniversary date. We're going to be outreaching, asking them to make a choice. We're going to see these numbers [in managed care] grow significantly by the fall," Stensland says.

Select Health of South Carolina, which became the first managed care Medicaid plan in the state in December 1996, has seen "quite a big influx" of members since the launch of Healthy Connections Choices, says Fred Volkman, M.D., Select Health's chief medical officer. The plan has grown from 75,000-80,000 to about 100,000 members since August 2007. "I think a lot has to do with the state encouraging managed care. Also, we've been here a long time, and people are comfortable with us. We offer good access and a deep and broad network," he says.

Select Health's new members, along with those previously enrolled, are benefiting from "evolved programs that have to do with prevention, immunizations,

obesity, and disease management for diabetes, asthma, and sickle cell disease, as well as case management for people with short- and long-term intensive medical needs," Volkman says. "We have a nurse dedicated to monitoring overuse of the ER" because that may be a sign that members are not focused on getting care in their physicians' offices, he says.

"Especially important to our population is Select Health's robust prenatal program. We make a full-court press to have our O/B members take a health risk assessment," so that high-risk pregnancies can be managed, Volkman says. "We'd love to do health risk assessments for all our members, but it's not realistic because many are not easy to contact," he explains.

Select Health also uses predictive modeling, based on internal and fee-for-service claims data provided by the state, which allows the plan to detect and/or help prevent the development of diseases such as diabetes, Volkman says.

Indiana

As it expands coverage to more state residents through its Healthy Indiana Plan (HIP), the state also is emphasizing prevention and wellness. The HIP plan was created in 2007 after the state received approval of a Section 1115 waiver from the Centers for Medicare and Medicaid Services. HIP began enrolling residents January 1.

The plan, which is available to low-income residents who don't meet Medicaid requirements but have incomes below 200 percent of the federal poverty level, combines a high-deductible health plan (HDHP) with an account called a Personal Wellness and Responsibility (POWER) account. HIP enrollees use funds from their POWER accounts to pay for covered health care services that apply to the \$1,100 deductible.


The POWER account is financed by contributions from the enrollee and the state, along with federal matching dollars. Enrollees contribute post-tax dollars on a sliding scale, based on the individual's

income. Employers of HIP enrollees are encouraged to contribute to employees' POWER accounts.

As the HIP plan was initially designed, each enrollee was to have an annual \$500 budget for first-dollar coverage of preventive services to encourage healthy behavior. However, members of the Anthem Blue Cross Blue Shield HIP receive an unlimited budget for appropriate preventive services, according to Rick Krum, process improvement director for the plan. "Part of this whole wellness initiative is that members receive unlimited preventive services, which [are not charged] to the POWER account."

The range of preventive care services that Anthem offers HIP enrollees is very wide, Krum says, but each year the state will determine the preventive care services enrollees must receive to be eligible to roll over remaining funds in their POWER accounts to the next year. This ensures members receive age- and gender-appropriate preventive care. For this first year of the program, the state requires members to have annual physicals. Among incentives offered to Anthem HIP members to encourage healthy behaviors, enrollees who complete an online health risk assessment will receive a \$50 gift card, which can be used for health-related services or items. Members whose assessments indicate they would benefit from a health coach will receive \$100 upon joining a health coaching program, and another \$100 when they complete the program.

As of late June, enrollment was more than 10,000 in Anthem's HIP plan, Krum says, adding that he sees enrollment continuing to grow because of the need and popularity of the plan.

Anthem and MDwise of AmeriChoice, the two managed care plans offering HIP, also serve Indiana Medicaid recipients in the Hoosier Healthwise Medicaid managed care program. 

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