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MEDICAID 1115 DEMONSTRATIONS

Beneficiary Engagement Strategies In Medicaid Demonstrations

Vivian L.H. Byrd, Maggie Colby, and Katharine Bradley

Executive summary

Four states—Arkansas, Indiana, Iowa, and Michigan—implemented policies that are intended to engage beneficiaries in their health care as part of section 1115 Medicaid demonstrations that expanded coverage. In addition, Arizona has obtained federal approval for a beneficiary engagement program that is not yet implemented. While each state's set of engagement strategies and incentives is unique, the demonstrations share two broad goals: (1) building awareness of the costs of care, and (2) encouraging beneficiaries to change certain health behaviors. In return for considering the costs of their care and/or seeking preventive care, each state provides participating beneficiaries financial rewards and/or enhanced benefits. These implicit contracts between the state and beneficiaries can be simple or complex, which in turn demand differing levels of understanding and strategic behavior from participants to earn the potential rewards.

This brief describes beneficiary engagement strategies used by these four states and discusses the implications of incentive design and early evidence on healthy behavior completion rates for future efforts to formally evaluate demonstration outcomes. In three of the four demonstrations, less than half of eligible beneficiaries have participated in the incentivized behaviors, suggesting the need for continued beneficiary education if demonstrations are to meet their goals. Wide variation across states in the time lapse between completing incentivized behaviors and receiving the associated rewards—ranging from a month to a year or more—also offers the opportunity to validate whether more immediate rewards yield the most change in desired outcomes, the result predicted by economic theory. The national evaluation will explore these questions of participation and reward timing in greater detail, and will assess evidence of beneficiary understanding of incentives and potential unintended consequences to inform states' ongoing efforts to engage Medicaid beneficiaries in their health and health care.

Introduction

Patient engagement has become increasingly important as a principle underlying both clinical care and health insurance design. Mounting evidence on both commercially and publicly insured patients suggests that those who take an active role in their own health care can achieve improved health outcomes (see Hibbard & Greene 2013 for a review) and that this type of engagement can lower costs as well (Hibbard & Greene 2013; Hibbard et al. 2013). Patient engagement strategies can take multiple forms, from incentives that target specific health behaviors to programs intended to increase health literacy or support patient decision-making. Because low health literacy is correlated with low income (Kutner et al. 2006), and

THE MEDICAID CONTEXT

Medicaid is a health insurance program that serves low-income children, adults, individuals with disabilities, and seniors. Medicaid is administered by states and is jointly funded by states and the federal government. Within a framework established by federal statutes, regulations and guidance, states can choose how to design aspects of their Medicaid programs, such as benefit packages and provider reimbursement. Although federal guidelines may impose some uniformity across states, federal law also specifically authorizes experimentation by state Medicaid programs through section 1115 of the Social Security Act. Under section 1115 provisions, states may apply for federal permission to implement and test new approaches to administering Medicaid programs that depart from existing federal rules yet are consistent with the overall goals of the program and are budget neutral to the federal government.

Some of these new approaches being tested under 1115 authority draw on established practices in commercial health insurance, such as cost-sharing at levels that exceed Medicaid limits and financial incentives for pursuing healthy behaviors. Other new approaches involve partnerships with private-sector entities, such as issuers that offer qualified health plans. However, Medicaid beneficiaries have lower incomes and poorer health status than most privately insured individuals and Medicaid expansion demonstrations have required multiple beneficiary protections, such as limits on total cost-sharing, access to certain mandatory benefits, and rights to fair hearings.

because low health literacy is also associated with poor health outcomes (Berkman et al. 2011), non-disabled adults enrolled in Medicaid present an especially compelling target for beneficiary engagement programs. Moreover, strategies that encourage Medicaid beneficiaries to engage in high-benefit and/or cost-conscious care-seeking behaviors are of particular interest to state policymakers grappling with Medicaid budgets.

Beneficiary engagement is a primary policy goal for five states that obtained section 1115 demonstration authority to implement alternative Medicaid expansions under the Affordable Care Act. In this issue brief, we discuss the demonstrations that have been implemented in four states: Arkansas, Indiana, Iowa, and Michigan, and the strategies these states have used to encourage particular beneficiary behaviors; in early 2017 Arizona obtained federal approval for a beneficiary engagement program, but has not yet implemented it.[1] These engagement strategies fall into two broad types: (1) incentives and education that build awareness of the cost of care, and (2) incentives that encourage beneficiaries to change certain health behaviors. Arkansas, Indiana, and Michigan have implemented beneficiary engagement strategies that familiarize beneficiaries with the costs of care, a prerequisite for enabling beneficiaries to become prudent healthcare consumers—inside and outside the Medicaid program. Indiana, Iowa, and Michigan encourage beneficiaries' use of preventive care and have developed both financial and health-related incentives to encourage this behavior. All four states use cost sharing as a lever to encourage engagement.

What strategies have states designed to engage demonstration participants in their health care?

To engage beneficiaries in their health care, payers, health plans, or providers may seek to establish a contract or agreement with beneficiaries, under which beneficiaries can earn rewards for behavior change that is to their benefit. For example, some chronic disease management programs employ "commitment contracts" between the beneficiary and provider to address behaviors that will improve a chronic condition. While states have not explicitly referred to their demonstration designs in these terms, the beneficiary engagement strategies they have developed form an implicit contract between the state and each beneficiary. That is, in return for seeking preventive care and considering the costs of their care, the state will provide financial rewards and/or enhanced benefits. These implicit contracts can be simple or complex, which in turn demand differing levels of understanding and strategic behavior from participants to earn the potential rewards. Table 1 summarizes key program features. We include two columns for Arkansas as the state changed the design of its program beginning in 2017.

While the set of incentives in each state is unique, there are important commonalities and distinctions. For example, Arkansas,[2] Indiana, and Michigan place a high priority on educating beneficiaries about the costs of health care services to help them become informed consumers, anticipating that many may transition to employer-sponsored or private insurance in the future. Strong health literacy skills also underlay beneficiaries' ability to be informed participants in more complex incentive programs that provide financial or other rewards to encourage cost-conscious care-seeking behaviors. While Indiana, Michigan, and Iowa each encourage beneficiaries' use of preventive care, the level of customization varies; Iowa simply requires a health risk assessment and annual physician or dental visit, while Indiana has age- and gender-specific recommendations for preventive services, and in Michigan beneficiaries develop personal healthy behavior goals in partnership with their providers. Finally, while incentive structures in all four states require beneficiaries to make monthly payments,[3] the qualitative nature of those payments differs. In Arkansas and Iowa the amounts are not tied to the level of health care services consumed, while in Indiana and Michigan, the volume and cost of health care services consumed directly influences future monthly payment amounts. (For more detail regarding monthly payment requirements within current 1115 demonstrations, see Bradley et al. 2017.)

Below we describe each state's beneficiary engagement strategies, beginning with the least complex in Iowa and ending with the most complex in Indiana.

In **Iowa**, beneficiaries are exempted from monthly payments if they do two things on an annual basis: obtain a physician visit or a dental wellness exam, and complete a health risk assessment (HRA).[4] The HRA helps to identify chronic conditions or health behaviors that require attention, such as poor diabetes management, difficulties with activities of daily living, or feelings of depression. Completing these incentivized behaviors represents a $60 annual benefit for those between 50 and 100 percent of FPL, and a $120 annual benefit for those above 100 percent of FPL. (Beneficiaries with income below 50 percent of FPL do not make monthly payments.) When beneficiaries complete a dental wellness exam and follow-up dental visits in Iowa, they also become eligible for enhanced dental services coverage.

For beneficiaries with incomes above poverty, those who are required to make monthly payments because they do not complete the specified behaviors lose coverage if they fail to make those payments; however, they are eligible to re-enroll the following month. For beneficiaries between 50 and 100 percent of FPL, unpaid monthly payments can become a collectible debt.

From January 2015 to June 2016, **Arkansas** employed an "Independence Account" to support appropriate use of the health care system among beneficiaries with incomes above the federal poverty level.[5] Beneficiaries who made monthly payments to their Independence Account could present their MyIndyCard at the point of service to cover all copayments and co-insurance costs required by their qualified health plan (QHP). Those beneficiaries above poverty who did not contribute in one month could not use the Independence Account to cover cost-sharing in the next month; they were instead required to pay copayments and co-insurance out of pocket at the point of service. Beneficiaries received monthly statements describing their service use and the associated costs and could also access this information through the MyIndyCard website, as long as they presented their card at the point of service. Statements were meant to help educate beneficiaries about their spending and the value of making regular monthly payments: QHP copayments and co-insurance could be substantially more than the monthly payments to the Independence Account. For example, a beneficiary living at 101 percent of the poverty level and contributing $120/year ($10/month) had the potential to save up to $474 given the annual cost-sharing maximum of 5 percent of income.[6] Individuals did not lose Medicaid coverage if they did not make monthly payments.

Arkansas stopped collecting monthly payments in April 2014, and closed the Independence Accounts in June 2016, citing administrative costs of account operation. The state subsequently received approval for a new set of demonstration policies for the period 2017 through 2021, under the name "Arkansas Works." Arkansas Works requires beneficiaries with incomes above the poverty level to make monthly payments equal to 2 percent of annual income and pay cost-sharing at the point of service regardless of whether they make monthly payments. Beneficiary rewards and consequences are not yet specified.[7]

Michigan encourages annual completion of an HRA specifically developed for the Healthy Michigan demonstration. The HRA includes language resembling a three-way contract between the beneficiary, the provider, and the program—including a section in which the beneficiary and health care provider identify healthy behaviors the beneficiary should address or maintain, and a place for the provider to sign the HRA after identifying those behaviors. Healthy Michigan beneficiaries who complete the HRA receive a 50 percent reduction in their monthly payments or a $50 gift card (for those under 100 percent of FPL who do not make monthly payments). For a beneficiary living at 101 percent of FPL, this could mean reducing yearly payments by $158. In addition, once beneficiaries have paid two percent of their income in copayments, they become eligible for a 50-percent reduction in future copayments if they have completed the HRA (copayments stop entirely when beneficiaries reach the 5-percent out-of-pocket maximum). Beneficiaries begin making payments to their MI Health Account six months after enrollment and they are billed quarterly thereafter. Payments can be made all at once on a quarterly basis but most beneficiaries make monthly installments. The MI Health Account statements detail service use, copayment costs incurred in the previous quarter, payments received from the beneficiary, and any benefits the beneficiary may have accrued by completing the HRA. If individuals who are subject to monthly payments and cost-sharing do not make the required payments, they do not lose Medicaid coverage in Michigan; however, unpaid monthly premiums can become a collectible debt.

In **Indiana**, after beneficiaries are determined eligible, they have 60 days to make their first monthly payment to enroll in HIP Plus. Adults with incomes above the poverty line who do not make a payment do not receive coverage—the first monthly contribution is a requirement for enrollment into HIP for this income group. Those at or below the poverty line who do not make a payment are enrolled in a different coverage plan called HIP Basic. HIP Basic does not cover certain benefits included in HIP Plus, such as vision, dental, and enhanced pharmacy services. Members enrolled in HIP Plus do not have copayments (except for emergency department visits deemed to be non-emergent), while members enrolled in HIP Basic are charged Medicaid-level cost-sharing for services.[8]

Indiana uses a "Personal Wellness and Responsibility Account," or POWER account, which operates like a health savings account that is used to pay for the first $2,500 of HIP-covered services. This account is partly funded by beneficiaries' monthly contributions, and the balance is funded by the state. Monthly statements show each service used during the previous month and recommended preventive health screenings that are tailored to the beneficiary's age and gender. For example, a woman between the ages of 35 and 50 may be encouraged to have an annual physical, a mammogram, a pap smear, a blood glucose screen, a tetanus-diphtheria immunization, and a flu shot, as well as cholesterol testing if she is older than 45.[9] Preventive care costs are not deducted from POWER account funds to encourage their use.

Indiana gives HIP Plus beneficiaries incentives to use health services as prudently as possible by allowing a portion of unspent POWER account funds from one year to roll over to the next, potentially lessening the beneficiary's future monthly contributions. For example, a beneficiary who contributed $8 per month and had $400 remaining in his or her POWER account at renewal could see the required monthly contribution for HIP Plus decline to $6.72 per month in the subsequent enrollment year.[10] As an added incentive, the state doubles the rollover amount for members who receive at least one recommended preventive care service during the plan year. Members enrolled in the HIP Basic plan who obtain recommended preventive care also have the opportunity to reduce future required contributions by up to 50 percent if they chose to move to HIP Plus at renewal, but cannot earn reduced Plus payments if they fail to complete recommended preventive

care. For both Plus and Basic members, any discount available is directly related to the percentage of their POWER account balance remaining at the end of the plan year. If nothing remains in the account, there can be no rollover for HIP members regardless of their receipt of preventive care services.

If beneficiaries do not make monthly contributions and are enrolled in HIP Basic, their monthly statements will detail the copayment structure they are liable for under HIP Basic, the copayments that would have been waived under HIP Plus, and the monthly contributions they would pay under HIP Plus. The language and structure are meant to highlight that a single copayment under HIP Basic may cost more than the monthly contribution the beneficiary would make under HIP Plus. Indiana beneficiaries with incomes above poverty who fail to make payments are disenrolled for six months. Those below the poverty level who fail to make payments are moved into HIP Basic coverage, losing access to vision, dental, and pharmacy benefits available to HIP Plus members. They can also be billed for copayments at the point of service until the next renewal period, when they can opt to reenroll in HIP Plus by resuming monthly contributions.

Table 1. Comparisons of beneficiary engagement policies in state section 1115 demonstrations

State	Arkansas—current	Arkansas—former	Indiana	Iowa	Michigan
Program name	Arkansas Works	Arkansas Health Care Independence Program	Healthy Indiana Plan 2.0	Iowa Wellness Plan	Healthy Michigan
Program start date	1/1/2017	1/1/2014, amended 1/1/2015 to include monthly contributions (state stopped collecting on 4/30/2016)	2/1/2015	1/1/2014	4/1/2014
Income groups subject to beneficiary engagement policies	Adults with incomes >100–133% FPL	Adults with incomes >100–133% of the FPL	Adults with incomes up to 133% of the FPL	Adults with incomes up to 133% of the FPL	Adults with incomes >100–133% of the FPL
Monthly payments: 0–100% FPL	$0	$0	0–5% FPL: $1 6–100% FPL: 2% of income, equivalent to $1–$20[a]	0–49% FPL: $0 50–100% FPL: $5	$0
Monthly payments: 101–133% FPL	>100–133% FPL: 2% of income, equivalent to $20–$26[a]	>100–115% FPL: $10 116–133% FPL: $15	101–133% FPL: 2% of income, equivalent to $20–$26[a]	>100–133% FPL: $10	>100–133% FPL: 2% of income, equivalent to $20–$26[a]
Encouraged health behaviors	To be determined—the state will revise its operational protocols	None	At least one recommended preventive care service per year	Annual wellness exam (routine medical exams, physician office visits for acute care, and dental wellness visits were later deemed to satisfy the requirement) Annual HRA	Annual HRA Agreement to address or maintain healthy behaviors
Encouraged financial behaviors and health care cost education	Monthly payments; education on health care costs to be determined	Contributions to Independence Account; monthly statements of actual cost sharing, or cost sharing avoided by making Independence Account contribution	Contributions to POWER account (for those under 100% FPL; required otherwise); monthly statements recommending preventive services and cost sharing or cost sharing avoided by making monthly contributions for those under 100% FPL	Monthly payments if health behaviors not completed	Contributions to MI Health Account, monthly statements of actual cost sharing and credits earned by completing HRA
Financial incentives and timing	To be determined—the state will revise its operational protocols	**Immediate:** making an Independence Account contribution by the 22nd day of a month resulted in coverage of all cost-sharing obligations beginning the 1st day of the following month	**Immediate:** making a POWER Account contribution to initiate and maintain Plus coverage results in coverage of all cost-sharing obligations, with the exception of non-emergency ED use	**After one year of coverage:** monthly payments are waived for the second year of enrollment if healthy behaviors have been completed during the first year of enrollment	**After 4–6 months:** monetary credits for completion of HRA and healthy behaviors will appear in MI Health Account and can be used to reduce monthly payments and copayments (above 100% FPL)

(continued)

State	Arkansas—current	Arkansas—former	Indiana	Iowa	Michigan
Financial incentives and timing *(continued)*		**After leaving Medicaid:** account funds could be used to pay future insurance premiums when a beneficiary left Medicaid if he/she made 6 or more contributions to Independence Account	**After one year of coverage:** if unused POWER account funds remain after the first year of enrollment, HIP Plus members can reduce their POWER account contributions for the following year. For Plus members who receive recommended preventive care services throughout the year, the discount will be doubled. HIP Basic members can earn reductions of up to 50 percent in future monthly contributions for HIP Plus if they complete preventive services		**Within first year:** $50 gift cards for completing the HRA for those who do not make monthly payments (under 100% of FPL) **After leaving Medicaid:** account funds can be used to pay future insurance premiums when a beneficiary leaves Medicaid
Enhanced benefits and timing	To be determined—the state will revise its operational protocols	None	**Immediate:** individuals who make monthly contributions to initiate and maintain HIP Plus, receive access to dental, vision, and enhanced pharmacy benefits	**Immediate:** Members who complete an initial dental exam and a follow-up visit within 6-12 months can receive enhanced benefits such as restorations, root canals, non-surgical gum treatment, and some oral surgery. If members complete an additional periodic dental exam within 6 to 12 months, they can receive additional enhanced benefits such as crowns, tooth replacements, and gum surgery if necessary in future visits within the year	None
Consequences of non-payment for those subject to monthly payments	The state and/or its vendor may attempt to collect unpaid premiums but may not report the debt to credit reporting agencies, place a lien on an individuals' home, refer the case to debt collectors, file a lawsuit, or seek a court order to seize earnings. Revised operational protocols will include the state's disenrollment policy	If beneficiaries above 100% FPL did not make monthly contributions, they were required to pay QHP copays or coinsurance at point of service Beneficiaries were not disenrolled for non-payment	For the 101–133% FPL population, cannot enroll in HIP until the first contribution is made. There is a 60-day grace period to pay the contribution, followed by a 6-month lockout for beneficiaries disenrolled due to unpaid contributions For the 0–100% FPL population, failure to pay contributions within 60 days results in enrollment in HIP Basic, which requires point-of-service cost sharing	Beneficiaries have a 90-day grace period for monthly payments, after which they can be disenrolled, but the program does not include a lockout provision	Beneficiaries cannot be denied coverage for failure to pay copayments or make monthly payments, but unpaid monthly payments can become a collectible debt

ED = emergency department; FPL = Federal poverty level; HIP = Healthy Indiana Plan; HRA = health risk assessment; POWER = Personal Wellness and Responsibility; QHP = qualified health plan.

[a] Monthly payment amounts are 2% of income. This dollar estimate calculated for a family of one using 2016 FPL ($11,880/year).

Sources: Mathematica analysis of:
Arkansas Special Terms and Conditions, approval period September 27, 2013–December 31, 2016, and as amended January 1, 2015. Arkansas Special Terms and Conditions, Approval Period: January 1, 2017 – December 31, 2021.

Iowa Marketplace Choice Plan Special Terms and Conditions, approval period January 1, 2014–December 31, 2016, and as amended December 31, 2014. Iowa Wellness Plan Special Terms and Conditions, Approval Period: January 1, 2017 - December 31, 2019.

Indiana Special Terms and Conditions, approval period February 1, 2015–December 31, 2018; as amended May 14, 2015.

Michigan Special Terms and Conditions, approval period December 30, 2013–December 31, 2018; as amended December 17, 2015.

Key informant interviews with Medicaid officials in Arkansas, Indiana, Iowa, and Michigan conducted May - July 2015. Additional interviews conducted with Michigan officials in January and August 2016, with Iowa officials in February and April 2016, with Indiana officials in May 2016, and with Arkansas officials in August 2016.

What is the timing of incentives associated with beneficiary engagement strategies?

The time lapse between completing incentivized behaviors and receiving the associated rewards varies across the four states. This variation means that the strength of these incentives—and the likelihood of their influencing behavior for most beneficiaries—will likely vary as well. All else being equal, we expect that more immediate rewards will yield the highest levels of engagement, while those that accrue at a later date—and in some cases only in the case of continued Medicaid eligibility—may be less likely to change behaviors (O'Donoghue and Rabin 2000; Volpp et al. 2011). We discuss other factors that influence beneficiary engagement elsewhere, including state and health plan implementation of engagement policies (Contreary and Miller 2017) and beneficiaries' understanding of their incentives (Miller, Maurer and Bradley 2017).

Immediate rewards. The shortest lapse between behavior and reward is one month or less. Indiana HIP Plus enrollees have copayments waived and get immediate access to dental, vision, and selected enhanced pharmacy benefits on the first day of the month in which they make their first contribution. Likewise, in Iowa completion of dental exams and follow-up visits grants beneficiaries coverage of enhanced dental services within six months of the visits. Beneficiaries in Arkansas prior to 2017 who made a monthly contribution by the 22nd day of a month could begin using the Independence Account to cover their cost-sharing obligations as soon as the first day of the following month. This policy ended when the state closed the Independence Account program in June 2016.

Rewards within the first year of Medicaid eligibility. Less immediate incentives also accrue to beneficiaries in succeeding quarters and years. For Healthy Michigan beneficiaries with incomes above the federal poverty level, completion of the HRA is used by the MI Health Account vendor to calculate discounted monthly contributions and copayments in the succeeding quarters of the year. Those living below poverty may receive a $50 gift card from their health plans upon completion of the HRA, although the timing is subject to minor variations by plan.

Rewards that accrue to continuing Medicaid eligibles. Some rewards are only realized during a subsequent eligibility period, which means that as much as a year may elapse before beneficiaries are rewarded for the incentivized behavior. However, many people at or near the poverty level experience shifts in income and family circumstances over the course of a year (Sommer and Rosenbaum 2011). If beneficiaries are doubtful about their continued eligibility in future years, they may be less responsive to incentives aimed at beneficiaries who remain enrolled. Iowa waives monthly contributions in the year following completion of the HRA and wellness exams. Indiana can only calculate the rollover of POWER account contributions once a complete record of claims is available, reflecting the services that were received and debited against the account as well as the incentivized preventive services that were completed each year. Thus, beneficiaries' monthly contribution amounts only change after the value of the rollover is determined, generally four months after the coverage year ends to allow a complete claims record to accrue.[11]

Rewards that remain after leaving Medicaid. Michigan offers incentives to beneficiaries after they transition out of Medicaid, as did Arkansas during the 2015-2016 period. In Michigan, any balance in the MI Health Account can either be paid to the beneficiary or used to pay for employer-based or Marketplace coverage upon disenrollment from Medicaid. In Arkansas, making six or more contributions within a year to an Independence Account gave beneficiaries access to accrued contributions up to $200 that could be used to purchase commercial or Medicare insurance coverage in a future year when the beneficiary lost Medicaid eligibility. This policy ended when the state closed the Independence Account program in June 2016.

What are beneficiary engagement rates so far?

The following findings represent experience in the first one to two years of these demonstrations. They are early findings, and over time reported rates may change due to demonstration maturation and increased beneficiary experience. In Indiana, preventive service use and monthly payment rates are relatively high, but less than half of eligible demonstration participants in the three other states have engaged in the incentivized behaviors: healthy behavior completion rates in Iowa and Michigan are low, as are monthly payment rates in Michigan and in Arkansas' former Independence Account program. Differences in healthy behavior completion rates across states, together with early evidence on beneficiary understanding of incentives, suggest the opportunity for continued beneficiary education.[12] Differences in healthy behavior completion rates may also reflect the differing consequences for non-payment and the efforts of health plans to promote demonstration incentives.

In **Iowa**, among beneficiaries who were continuously enrolled for a year, had renewed coverage in March 2015, and did not claim a medical frailty or hardship exemption, 42 percent of those with incomes between 50 and 100 percent of the FPL and 37 percent of those above poverty earned monthly payment reductions by completing both a wellness exam and HRA.[13] In March 2016, one year later, these rates had fallen to 20 percent and 22 percent, respectively. The Dental Wellness Plan interim

evaluation report noted that 25 percent of beneficiaries enrolled for 6 to 12 months received a preventive dental exam.

In **Michigan**, the number of completed HRAs received by plans as a percentage of new enrollees for each quarter has ranged from 6 to 19 percent, starting in the first quarter of 2015, when the state began reporting HRA data. However, HRA completion rates reflect actions taken by both beneficiaries and providers: beneficiaries must visit primary care providers to discuss their health goals, and providers must submit completed HRAs to health plans for beneficiaries to receive credit. State officials report that a majority of Healthy Michigan Plan beneficiaries visit primary care providers soon after enrollment, but providers submit relatively few completed HRAs to health plans.[14] Payment rates for copayments and monthly payments are lower than expected: from the inception of monthly payments in October 2014 through August 2016, 37 percent of copayments ever owed were paid, and 31 percent of monthly payments ever owed were paid (Maximus 2016). As discussed in Miller and Contreary (2017), beneficiary account statements double as invoices, and the state recently revised the statements in an effort to increase payment rates.

Arkansas officials reported that as of July 2015, 25 percent of those eligible to activate the Independence Account card had done so, even though the potential benefits of making monthly contributions could be high and relatively immediate. After the Independence Accounts closed in June 2016, as discussed by Miller and Contreary (2017), the state reported that approximately 17 percent of beneficiaries with incomes above the poverty level made at least one monthly payment, and 5 percent made six or more payments during their previous enrollment year, making them eligible to receive up to $200 from the balance of their account when they left the program.

In contrast, monthly payment rates in **Indiana** are relatively high. According to the state's interim evaluation report, more than 90 percent of beneficiaries ever enrolled in HIP Plus made the monthly payments necessary to stay in HIP Plus during the first demonstration year. Of ever-enrolled HIP Plus members with incomes above poverty, 6 percent were disenrolled from HIP for failing to make monthly payments, and among ever-enrolled HIP Plus members with incomes at or below poverty, 8 percent transitioned to HIP Basic because they did not make monthly payments. The number of beneficiaries who completed preventive services and earned enhanced rollover benefits is also relatively high: of those enrolled in HIP Plus for a full year, 86 percent received a preventive care service that qualified them to double their rollover benefit. Of those enrolled in HIP Basic for a full year, 62 percent received a preventive care service that made them eligible to roll over account funds if they subsequently moved to HIP Plus.

Implications for the national evaluation

The differences in beneficiary engagement strategies across these four states create the opportunity for the national evaluation to draw comparisons between states, and between population groups within a state, to gauge the effects of incentives on health care use and health outcomes. In addition to looking at these patterns, we anticipate looking closely at participation rates, evidence of beneficiary understanding of incentives, and potential unintended consequences in assessing the effectiveness of states' strategies. Given the wealth of other ongoing research on patient engagement strategies, it will also be important to put the final evaluation results in the context of other emerging evidence on effective approaches.

Participation rates. Although these four demonstrations were implemented in 2014 and 2015, policies designed to engage Medicaid beneficiaries in their health care pre-date the Affordable Care Act. Idaho and West Virginia used authority granted by the Deficit Reduction Act of 2005 to implement programs that offered incentives to beneficiaries, and Florida implemented an incentive program as part of a section 1115 demonstration. The programs in Idaho and Florida extended small financial rewards, such as gift cards, when beneficiaries sought preventive care and made behavior changes such as quitting smoking, losing weight, and obtaining health screenings. West Virginia incentivized healthy behaviors by making enhanced Medicaid program benefits—such as nutrition counseling or cardiac rehabilitation—contingent on specific behaviors such as keeping doctor's appointments. The available evidence suggests that low beneficiary participation was a major reason these programs did not meet their goals (Blumenthal et al. 2013; Walsh et al. 2014; Gurley-Calvez et al. 2011; Hendryx et al. 2009). However, two studies found that incentives targeting parents in Idaho explained an increase in the receipt of well child checks (Greene 2011; Kenney et al. 2011). Given the key role that participation played in the effectiveness of prior Medicaid beneficiary engagement programs, the national evaluation will first look to understand the participation rate, and whether some subgroups of beneficiaries are more likely to have opted to engage in the offered incentives.

Beneficiary understanding of program incentives. Ensuring that beneficiaries understand the required behaviors and potential rewards is essential if these programs are going to succeed in engaging beneficiaries and influencing their behavior. All four states report that beneficiaries receive mailings and sometimes direct calls from either the Medicaid agency or managed care plans, to describe the encouraged behaviors and incentives, and all four states also make information about their programs available online.[14] To the extent that beneficiaries understand their individual incentives, behavior

changes may be greatest for enrollees subject to the highest levels of cost sharing, because their potential financial rewards are also the largest. As such the upcoming national evaluation will look for evidence of responsiveness that is correlated with the magnitude of individual incentives. For example, if all beneficiaries complete preventive care services at the same rates, regardless of whether they benefit financially from doing so, that pattern would suggest that the financial incentives linked with preventive care services were not well-understood by beneficiaries, and that other factors—such as relationships with primary care providers or messages from health plans—may primarily drive care-seeking behavior.[12]

Potential unintended consequences. While exposing beneficiaries to the costs of their health care and disenrolling them for failure to make monthly payments may motivate patient engagement, there is also the potential that beneficiaries may forego necessary health services due to expense, or become unable to seek services if they become locked out due to non-payment of financial contributions.[15] To help mitigate this risk, three of the states have policies that make it easier for beneficiaries to afford the required contributions. Indiana and Michigan accept payment from third parties, if family members and employers (and other types of organizations) want to contribute to a beneficiary's monthly payments. Arkansas' former program also allowed third-party payments. In addition, Iowa and Indiana allow financial hardship exemptions from required monthly payments. The national evaluation of these programs will help to investigate the effects of disenrollment consequences by looking at how frequently beneficiaries return to the programs immediately after their lock-out period ends, suggesting eagerness to regain coverage (Irvin et al. 2015).

Connections with other ongoing evaluations. In addition to the current array of section 1115 demonstrations, the Centers for Medicare & Medicaid Services (CMS) has made patient engagement the focus of the Medicaid Incentives for the Prevention of Chronic Diseases program, which made grants to 10 states that give Medicaid beneficiaries direct financial incentives for behavior changes that target chronic diseases.[16] Patient engagement is also a focus of several programs that received Health Care Innovation Award grants from CMS.[17] Data from the 1115 national evaluation and these other programs can build on the existing evidence about the beneficiary engagement strategies that are likely to be most effective in changing behavior among Medicaid beneficiaries, while minimizing the risk of harms.

ABOUT THE MEDICAID SECTION 1115 EVALUATION

In 2014, the Center for Medicaid and CHIP Services within the Centers for Medicare & Medicaid Services (CMS) contracted with Mathematica Policy Research, Truven Health Analytics, and the Center for Health Care Strategies to conduct an independent national evaluation of the implementation and outcomes of Medicaid section 1115 demonstrations. The purpose of this cross-state evaluation is to help policymakers at the state and federal levels understand the extent to which innovations further the goals of the Medicaid program, as well as to inform CMS decisions regarding future section 1115 demonstration approvals, renewals, and amendments.

The evaluation focuses on four categories of demonstrations: (1) delivery system reform incentive payment (DSRIP) programs, (2) premium assistance, (3) beneficiary engagement and premiums, and (4) managed long-term services and supports (MLTSS). This issue brief is one in a series of short reports based on semiannual tracking and analyses of demonstration implementation and progress. The reports will inform an interim outcomes evaluation in 2017 and a final evaluation report in 2019.

METHODS AND DATA SOURCES

Descriptive information about section 1115 demonstrations is based on Mathematica analysis of demonstration documents for Arkansas, Iowa, Indiana, and Michigan, as listed below.

- Arkansas Center for Health Improvement. "Arkansas Health Care Independence Program ("Private Option") Section 1115 Demonstration Waiver Interim Report." Little Rock, AR: March 30, 2016.
- Askelson, Natoshia M., Brad Wright, Suzanne Bentler, Elizabeth Momany, Brooke McInory, Tessa Heeren, and Peter Damiano. "Health Behaviors Incentive Program Evaluation Interim Report." University of Iowa Public Policy Center. Report prepared for the Iowa Department of Human Services. Iowa City, IA: University of Iowa, March 1, 2016.
- Lewin Group. "Indiana Healthy Indiana Plan 2.0: Interim Evaluation Report." Report prepared for the Indiana Family and Social Services Administration. Falls Church, VA: Lewin Group, Inc., July 6, 2016.
- McKernan, Susan, Peter Damiano, Julie Reynolds, Elizabeth Momany, Raymond Kuthy, Mark Pooley, Aparna Ingleshwar, and Brooke McInroy. "Dental Wellness Plan Evaluation—Interim Report." University of Iowa Public Policy Center. Report prepared for the Iowa Department of Human Services. Iowa City, IA: University of Iowa, March 1, 2016.
- Arkansas Special Terms and Conditions, Approval Period: September 27, 2013 – December 31, 2016; as amended January 1, 2015. Arkansas Special Terms and Conditions, Approval Period: January 1, 2017 – December 31, 2021. Section 1115 demonstration monitoring reports: 2014 Q1 – Q4; 2015 Q1 – Q4; 2016 Q1; 2014 annual report.
- Indiana Special Terms and Conditions, Approval Period: February 1, 2015 – December 31, 2018; as amended May 14, 2015.
- Iowa Wellness Plan Special Terms and Conditions, Approval Period: January 1, 2014 – December 31, 2016; as amended December 31, 2014. Iowa Wellness Plan Special Terms and Conditions, Approval Period: January 1, 2017 - December 31, 2019. Section 1115 demonstration monitoring reports: 2014 Q1 – Q4; 2015 Q1 – Q4; 2016 Q1 – Q2; 2014 annual report.
- Michigan Special Terms and Conditions, Approval Period: December 30, 2013 – December 31, 2018; as amended December 17, 2015. Section 1115 demonstration monitoring reports: 2014 Q2 – Q4; 2015 Q1 – Q4; 2016 Q1 – Q2; 2014 annual report.

We also conducted key informant interviews with Medicaid officials in the four states (Arkansas, Indiana, Iowa, and Michigan) in May, June, and July 2015. We conducted additional interviews with Michigan officials in January and August 2016, with Iowa officials in February and April 2016, with Indiana officials in May 2016, and with Arkansas officials in August 2016. Each interview included a lead interviewer and a note taker.

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Endnotes

[1] Arizona received CMS approval on January 18, 2017 to implement the AHCCCS CARE program, which will provide individual accounts to Medicaid beneficiaries with incomes above the poverty level, and will require coinsurance and monthly payments that, in total, must not exceed 5 percent of household income. Coinsurance amounts will be designed to discourage non-preferred services, and beneficiaries who complete recommended health behaviors will be exempt from coinsurance and monthly payments for six months. Beneficiaries may be disenrolled for non-payment but may re-enroll at any time without repayment of past-due amounts.

[2] As of this writing, many details about Arkansas' new Arkansas Works demonstration have not yet been specified, so it is unclear whether the new demonstration will seek to raise beneficiaries' awareness of the costs of their health care as the original demonstration did. The state The state was scheduled to submit operational protocols for the new demonstration design in April 2017. The state submitted a request to amend Arkansas Works on June 30, 2017.

[3] In this issue brief we use the term "monthly payments" to refer to premium payments in Iowa as well as to account contributions in Arkansas, Indiana, and Michigan.

[4] Initially, a comprehensive annual physical was required to satisfy the wellness exam requirement, but the state subsequently allowed routine medical exams, physician office visits for acute care, and dental wellness visits to satisfy the requirement (see Contreary and Miller 2017).

[5] Arkansas had section 1115 authority to apply contribution requirements to adults with household incomes between 50 percent and 100 percent FPL, but did not implement this policy.

[6] Federal regulations set forth in 42 CFR § 447.78 limit aggregate out-of-pocket Medicaid expenses—including premiums and cost-sharing—to five percent of income, calculated on a quarterly or monthly basis. See https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol4/pdf/CFR-2011-title42-vol4-sec447-78.pdf. For a family of 1 living at 101 percent of the FPL, annual income in 2016 was $11,999.

[7] For more information on the Independence Accounts, see Miller and Contreary (2017).

[8] Copayments are limited to nominal or minimal amounts for most services. For example, copayments are $4 for outpatient services, $4 for preferred drugs, $8 for non-preferred drugs, and $75 for inpatient services, including hospital stays. See https://www.medicaid.gov/medicaid/cost-sharing/out-of-pocket-costs/index.html

[9] Anthem Blue Cross and Blue Shield Healthy Indiana Plan Member Handbook. Available at https://www.anthem.com/national/noapplication/f1/s0/t0/pw_ad091093.pdf. Accessed August 5, 2015.

[10] Indiana's POWER Account and Copay Protocol supplies the formula for the rollover calculation as well as examples of the rollover calculation for those in HIP Plus and HIP Basic and those with and without preventive service visits.

[11] If a member becomes ineligible for HIP, either during redetermination or at another time, the managed care entity in which the beneficiary is enrolled must refund the member's pro rata share of his or her POWER Account balance, if any, within sixty calendar days of the member's date of termination from HIP.

[12] For a review of the early evidence on beneficiary understanding from the interim demonstration evaluation reports for Indiana, Iowa, and Michigan, see Miller, Maurer and Bradley (2017).

[13] There are multiple sources of data on HRA completion rates in Iowa. The state contracted with a vendor to track HRA completion, but the Iowa Department of Human Services (DHS) maintains its own records, which include beneficiaries'

self-reports. Completion rates reported by the HRA vendor are slightly lower than those reported by DHS. DHS records are used to track beneficiaries' exemptions from monthly payments and are the ones reported in this brief.

[14] Contreary and Miller (2017) provide more detail on two topics touched on in this issue brief: use of health risk assessments and beneficiary education strategies in Indiana, Iowa, and Michigan.

[15] Mathematica's national 1115 evaluation will also consider the effects of premiums on initial program enrollment. See Irvin et al. (2015).

[16] See section 4108 of the Affordable Care Act. California, Connecticut, Hawaii, Minnesota, Montana, Nevada, New Hampshire, New York, Texas, and Wisconsin were awarded demonstration grants to implement approaches to chronic disease prevention for their Medicaid enrollees to test the use of incentives to encourage behavior change.

[17] The Health Care Innovation Awards are funding up to $1 billion in awards to organizations that are implementing new ideas to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and Children's Health Insurance Program, particularly those with the highest health care needs. See https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/ for more information.