Meeting #2

Date: September 10, 10:30am – 2:00pm

Location: Albany School of Public Health, Room 110A, 1 University Pl, Rensselaer, NY 12144

Attendance:

AE meeting 2
sign-in sheet.docx

Overview
This was the second meeting in a series of meetings for the Advocacy and Engagement (AE) Subcommittee (SC). The purpose of the meeting was to discuss key considerations for incentives, including the purpose and types of incentives, and guiding principles for creating incentive programs. The SC also reviewed the guidelines and mechanisms for designing recommendations, which included financial incentives, policy changes, and modifications to the MCO model contract. In addition, the end of the meeting was used to review two topics, Patient Reported Outcomes (PROs) and Medicaid members' right to know, in preparation for the next meeting.

The specific Agenda for this meeting included the following:

1. Welcome and Introductions
2. Key Considerations for Incentives
3. Guidance on Developing Subcommittee Recommendations
4. Patient Reported Outcomes (PROs)
5. Medicaid Members' Right to Know
6. Next Steps and Action Items

Key Discussion Points (reference slide deck "Advocacy and Engagement Subcommittee Meeting 2")

1) Key Considerations for Incentives

Purpose of Incentive Programs (Slides 5 to 10)
The SC reviewed the purpose of incentive programs and discussed ways in which the Medicaid member can be incentivized to play his/her part in creating a healthy lifestyle. Various types of incentives were discussed, including monetary incentives and the current Medicaid incentive maximum of $125 annually in the managed care contract for achieving health goals. The SC members agreed that this cap is very limiting and if a monetary incentive is recommended by the SC, the cap should be increased or eliminated altogether.

Discussion continued around preventive care and patient activation, and how to stimulate patients to be in control of their own care. Examples of patients incentivized to take control of their own care were highlighted, such as HIV patients having blood tests to monitor for viral suppression, diabetes management, smoking

cessation and mental health evaluations. Many of these incentive programs need care in how they are designed and should also take into account the patient's family.

The SC examined proper system utilization and there was much discussion of the benefits and challenges associated with incentivizing patients to seek high value providers who deliver care of higher quality at lower cost. Some SC members felt that the downside of patients seeking high value providers might be the effect it could have on rural providers who have a limited practice due to smaller populations. This could result in certain providers needing to close their practices, which could be a real threat for patient access to essential services.

Specific Goals of Patient (Medicaid Member) Incentives (slide 11)
The SC further discussed the definition of "high value" providers and the potential to take into account the patients' point of view in making choices about high value based on their experience, what others recommend and the results of PROs. Another challenge noted was longer wait times for these high value providers, which could lead to an increase in ED visits. Although most members felt that "Select high value providers" as a goal of patient incentives should be removed, it was suggested that the SC members think further about proper system utilization and continue the discussion at the next meeting.

SC members also discussed how certain providers within a health system may participate in VBP and others may not, and there might be the risk that the former could select only patients known to have good outcomes (i.e. cherry-pick which patients they want to see in their practice, and send all others to those physicians not participating in VBP). This would be greatest risk if patients are incentivized to utilize certain "high-value" providers because that particular provider could pick only the patient he/she wanted and leave the more medically complex patients for the providers. All agreed that, as a whole, VBP arrangements should ensure that "cherry-picking" of the lower cost, better outcome patients does not occur.

The SC continued to review the specific goals of patient incentives and after much discussion it was suggested that the goal "Make appropriate housing choices" be rephrased to "Avoid inappropriate living situations that have a negative impact on health".

Designing Incentive Programs (slide 12 to 14)
Discussion continued around what approach should be used when drafting recommendations to the State about patient incentives. Generally, members felt that recommendations could be defined in the following way, however more discussion is needed:
1) Critical (necessary for success),
2) Must do (could be detrimental if not done), and
3) Nice to have (could improve experience or outcomes).

The guiding principles and considerations on slides 12-14 were accepted by the group, with the following ideas and revisions brought forward:
- Recommendations should be well designed and carefully evaluated
- Any recommendation should include a good quality design and involve an outside evaluator
- A library of knowledge should be developed resulting in a learning collaborative statewide

- “Cultural competence” and “appropriate patient support” should be added to the guiding principles

A Department of Health representative attended the meeting to provide an update on a federal program called the Medicaid Incentives for the Prevention of Chronic Disease (MIPCD). The Affordable Care Act mandated the creation of the MIPCD program for states to develop evidence-based prevention programs that provide incentives to Medicaid member to participate in and complete the MIPCD program. The program was initiated in 2011 and will end in 2016. The New York State’s (NYS) MIPCD program includes smoking, hypertension, diabetes management and diabetes onset prevention. The representative informed SC members that the state is collecting data on the effectiveness of the program’s ability to change patient behaviors and a report should be available by the end of the year. It was noted that there has been difficulties in measuring outcomes/results of the MIPCD incentives.

2) Guidance on Developing Subcommittee Recommendations

The SC reviewed slides 16-26 and agreed that a pilot program for implementing incentives should be considered. Rather than developing an RFA for a new pilot program, it was recommended that the VBP pilots already being established could be a potential avenue for piloting an incentive program. There was extensive discussion on the Medicaid managed care contract incentive cap of $125 annually for completing a health goal (building on the earlier discussion described above in Section 1). The group agreed that the cap of $125 should be increased or removed from the model contract between MCOs and providers. It was felt that this amount was not significant enough to promote changes in patient behavior.

3) PROs

The SC discussed patient assessment tools and the difference between Patient Activation Measures (PAM) and PROs. Members felt that while there is a need to assess the perception of a patient’s care experience and outcomes after treatment, adding another assessment tool on top of what providers are already doing could be overwhelming. A process could be put in place to examine what is already occurring at a facility which could then be enhanced to collect the necessary data on PROs. Overall, a deeper dive on PROs will occur at the next meeting.

4) Medicaid Members’ Right to Know

Due to time constraints, this agenda item will be discussed at the next meeting.

Materials that were distributed prior to the meeting:

#	Document	Description
1	Advocacy and Engagement Meeting 2 Final	A PDF presentation of the slide deck created for Meeting #2, which details key considerations for incentive programs, guidance on developing subcommittee recommendations, patient reported outcomes, and Medicaid members’ right to know.

Key Decisions

The SC made the following decisions:

- Change “Make appropriate housing choices”, to “Avoid inappropriate living situations that have a negative impact on health”
- Leverage VBP Pilot Programs and/or VBP Innovator Program infrastructure for piloting incentive programs.
- Put into place a process for providers to examine how patients’ rate their care experience and the outcomes of medical interventions

Action Items

1. Please email Josh McCabe (joshuamccabe@kpmg.com) if you attended the meeting on the phone or did not sign the attendance sheet.
2. Please email Josh McCabe with any examples of incentives for patient activation; concerns around different types of incentives (cash, check, lottery, memberships, etc.); additional information about patient assessment tools.

Conclusion

The next meeting agenda will include a review of draft recommendations on incentives and a discussion on PROs, Medicaid members’ right to know and best practices on communication methods to members.