CHCS Center for Health Care Strategies, Inc.

Issue Brief

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State Approaches to Consumer Direction in Medicaid

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Consumer-directed health strategies are increasingly being used to encourage people to make informed, cost-effective health care decisions.[1] Health savings accounts are the most notable of these strategies. While these approaches initially took root in the commercial and Medicare markets, state Medicaid agencies are also testing consumer-directed approaches in their programs.[2] For example, in West Virginia, Medicaid recipients who sign and abide by a pledge to be responsible health care consumers, receive more generous benefits than those who do not. In Florida, recipients now choose among health plans that differ in cost sharing and benefit limits, and they may "opt out" of Medicaid and use public funds to buy employer-sponsored coverage. Both Florida and Idaho have started programs to provide financial incentives for recipients who engage in wellness and healthy behaviors.

While these reform efforts have received considerable media attention, it is not widely known how many states are actually implementing consumer-directed approaches for Medicaid recipients. This issue brief summarizes findings from a recent survey of Medicaid agencies conducted to identify which of 17 consumer-directed approaches are being implemented and considered by states (Table 1).

This issue brief, developed through a national survey of Medicaid agencies, summarizes how states are incorporating a variety of consumer-directed strategies to help beneficiaries use health care dollars more efficiently.

Key Findings

The Trend Toward Consumer Direction in Medicaid is Growing. In mid 2006, Medicaid agencies reported, on average, having four of the 17 consumer-directed approaches already in place. By the end of 2007, on average, states planned to implement an additional 1.5 consumer-directed policies. The most common policies states planned to implement were disease management and Cash and Counseling programs. Cash and Counseling programs provide disabled and frail elderly recipients with a budget, out of which they purchase needed personal care services. Medicaid agencies reported that they were considering an additional three consumer-directed strategies on average for 2008 or later. Using financial incentives to encourage healthy behaviors was the approach most frequently considered.

Medicaid Agencies are Initiating Policies to Reward Health-Related Behaviors. At the time of the survey, one state reported using a financial incentive to encourage healthy consumer behaviors. Eight more states were planning to start a financial incentive program in 2007, and another 19 reported considering the strategy for the future.

Methodology

Forty-nine of the 51 state Medicaid agencies (including the District of Columbia) completed a short survey on consumer-directed health strategies during the late summer or fall of 2006 (response rate of 96%). For each of 17 consumer-directed strategies, respondents were asked whether the approach was part of the current Medicaid program, planned for 2006 or 2007, under consideration for 2008 or later, or not under consideration. The strategy did not have to apply to all Medicaid recipients in the state to count for the study. See Table 1.

Table 1. Medicaid Agency Plans to Implement Consumer-Directed Strategies (n=49)

Strategies	Current Strategy/ Planning for 2007	Considering for 2008 or later	Not Currently Considering	Did Not Report
Allocate Control Over Medicaid Funds				
Offer *Health Opportunity Accounts* or health savings account-like plans	5	11	32	1
Provide personal health accounts or vouchers for purchasing one's health coverage	5	5	36	3
Enable beneficiaries to use Medicaid dollars to purchase employer-sponsored health coverage	23	14	10	2
Offer cash and counseling program for home or personal care services	25	15	8	1
Incentivize Healthy Behaviors and Cost Effective Utilization				
Provide financial incentives for engaging in healthy behaviors	9	19	19	2
Provide optional Medicaid benefits to recipients engaging in healthy behaviors	6	12	28	3
Provide chronically ill beneficiaries individualized disease management assistance*	38	6	2	3
Use financial incentives to encourage use of cost effective health care (e.g., lower cost sharing for primary care than specialty care)	11	15	20	3
Recipient Financial Contributions to Care				
Require cost sharing at nominal levels ($3)*	32	4	10	3
Require cost sharing at substantive levels (above nominal levels)	9	8	28	4
Set annual per recipient maximum Medicaid payment cap	3	3	39	4
Health Plan Choices				
Offer recipients a choice between health plans with different cost sharing arrangements	10	4	31	4
Offer recipients a choice between health plans with benefits that may differ in amount, duration, or scope	7	6	32	4
Assistance with Decision Support				
Provide in-person one-on-one counseling to assist recipients in making health plan choices	21	7	19	2
Provide telephone counseling to assist recipients in making health plan choices*	27	6	14	2
Contract with local community organizations to assist recipients in making health plan choices	17	7	21	4
Provide quality data for recipients to compare health plans	24	13	10	2

*Some of these strategies may be long-standing policies (e.g., co-pays for prescriptions) or part of a broader agenda (e.g., disease management or telephone counseling) and are not necessarily attributable to a consumer-directed movement.

Medicaid Agencies are Increasingly Allocating Control of Medicaid Funds to Recipients. By the end of 2007, half of all states (25) will offer Cash and Counseling programs. Another approach growing in popularity is enabling recipients to use Medicaid dollars to "opt out" of Medicaid and purchase employer-sponsored coverage with public funds. Twenty-three states report they will have an "opt out" program in place in 2007. While these programs are popular with Medicaid agencies, it is noteworthy that they may be less so with recipients. In the first seven months of the Florida program, fewer than five families used the Medicaid "opt out" to purchase employer-sponsored coverage.[3]

States are Interested in Health Savings Account-Like Plans. Five states are planning to offer a Health Opportunity Account (HOA) or another health savings account-like plan in 2007. HOAs, which were established as part of the Deficit Reduction Act of 2005 (DRA), are spending accounts coupled with a high deductible version of Medicaid. Similar to health savings accounts, HOA members pay for health care services initially from their opportunity account, and then out of their own pocket until they reach the deductible level. Since HOAs were designed for Medicaid recipients, the maximum out-of-pocket costs in HOAs are relatively low: $250 for adults and $100 for children. Once the deductible is reached, Medicaid covers the cost of health care services. The DRA authorizes 10 states to implement HOAs. Based on the number of states considering this approach, by the end of 2008 there will likely be the full 10 programs in place nationally.

States are Increasingly Providing Health Plan Quality Data to the Public. A key component of consumer direction is providing consumers with comparative information to help them make informed and cost-effective health care decisions. While "report cards" on quality are not new, states are increasingly providing health plan quality data to Medicaid recipients. By the end of 2007, almost half of all states (24) will provide comparative health plan quality data to recipients and an additional 13 states are considering doing so in the future.

Conclusion

This survey finds that consumer-directed strategies are increasingly being adopted and considered in Medicaid programs across the country. A number of these approaches are new and untested. While Cash and Counseling strategies do not necessarily apply to all populations and typically only cover personal needs services, there are key lessons from the Cash and Counseling demonstrations that-should be considered:[4]

1. **Consumer direction for Medicaid needs to include "counseling" as well as "cash."** Cash and Counseling programs have acknowledged Medicaid recipients' relatively low health literacy levels and created structured supports to assist recipients (or their representative), including home visits and monthly telephone calls. A related need will be for informational materials about new consumer-directed strategies to be appropriate for low literacy readers. Recent studies demonstrate that efforts to simplify health information can improve comprehension and decision-making.[5] It will be important to test approaches and formats for presenting health plan comparisons to Medicaid recipients to see how best to present information to this population.

2. **Consumer direction is not for all Medicaid recipients.** In Arkansas almost one in five participants who opted for Cash and Counseling voluntarily disenrolled from the program with in a year.[6]

3. **Consumer-directed strategies may not save money.** While disabled and elderly recipients randomized to Cash and Counseling programs had lower hospitalization rates and better quality of life, their overall Medicaid costs were slightly higher than those receiving traditional personal care services.[7] It is possible that cost savings may not be achieved with other consumer-directed innovations as well. In fact, Health Opportunity Accounts are projected to increase Medicaid costs by 80 million dollars in the first five years of the program.[8]

4. **The cost effectiveness of Cash and Counseling programs has been established through rigorous evaluation.** While program costs have not declined, the findings from evaluations suggest strongly that Medicaid is achieving better value for its money through Cash and Counseling. It will be critical to study the program costs and benefits of the new consumer-directed strategies that are implemented across the country. This will enable identification of new cost-effective programs and foster additional state replication of these programs.

Endnotes

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About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving the quality and cost effectiveness of health care for Americans with chronic illnesses and disabilities, the elderly, and racially and ethnically diverse populations. CHCS works with state and federal agencies, health plans, and providers to develop innovative programs to better serve adults and children with complex and high-cost health care needs. Its program priorities are: advancing regional quality improvement, reducing racial and ethnic disparities, and integrating care for people with complex and special needs. For more information, visit **www.chcs.org**.

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