Incentives for Medicaid Members

Executive Summary

One of the goals of the Value Based Payments (VBP) Initiative in New York State is to design a program that incentivizes members to make life style choices proven to improve health and reduce downstream costs, or for choosing high-value care. The State aims to maximally focus on outcomes rather than efforts or process-steps.

Over the last 10-15 years there has been an increased interest, in both the private and public sector, to offer incentive programs to promote activating members, healthier lifestyles/behaviors, and other preventive care. Several studies have shown that financial incentives are effective for simple preventive care, such as well-child visits, immunizations, prenatal care or regular checkups, but there is still insufficient evidence to say if incentives are effective for promoting long-term behavior or lifestyle changes such as smoking cessation or weight management.[1] During this literature review, there was no information found stating for or against incentive programs driving members toward high-value healthcare providers.

One article reviewed ethical considerations but stop short in suggesting particular types of incentives. In 2010, the American College of Physicians (ACP) Ethics, Professionalism and Human Rights Committee Position Paper stated the ACP believes that programs that support the patient's role in promoting positive health outcomes should be evidence-based and focus on increasing access to strategies for prevention and treatment of disease; respect for autonomy; consideration of variables influencing comprehension and learning; and understanding of cultural, religious and socioeconomic factors. The committee further states that incentives to promote behavior change should be designed to allocate health care resources fairly without discriminating against a class or category of people. The incentive structure must not penalize individuals by withholding benefits for behaviors or actions that may be beyond their control. Incentives to encourage healthy behaviors should be appropriate for the target population.[2]

The purpose of this report is to provide an overview of some programs that have been initiated/implemented using incentives for Medicaid and private members to promote better health outcomes. Whereas some of the programs have been successful, and others not, there seems to be a common thread of lessons learned, and from those lessons learned, best practices that can be taken into consideration when designing a member incentive program.

There appears to be a common theme with challenges and lessons learned from the states that had formal incentive programs or studies. Although most of the lessons learned relate to programmatic issues and there is no conclusive consensus around what types of incentives or key considerations are most successful in designing incentives, there are certain characteristics of each program that could be considered best practice when designing an incentive program. Some of these best practices include (1) Take adequate time to plan the incentive project. Take into consideration the amount of staff and key positions required to implement a successful program. (2) Explore and develop alternate plans. Be flexible. (3) Involve, communicate and educate providers and other professionals of members who are participants in the incentive program. Consider creating a liaison/coach position who works with the physicians, as they may be unwilling or unable to participate as the "gatekeeper".[3] (4) Have a good understanding of the data collection requirements, methods to identify participants and ensure all the correct programs (software) and tools are in place to collect the data and report on it. (5) Ensure participants are willing to participate in the incentive program. Programs with default assignments are not effective.[3] (6) Develop clear and concise marketing materials, in several languages, that explain the incentive program, rewards and how to redeem the rewards. This should not only be for educating participants but also the community in which they live. (7) Ensure rewards, especially if monetary, are given to

participants in a timely manner. (8) Develop collaborative relationships with community-based organizations. (9) Consider implementing incentive programs for children or youth as this may be more effective if done in groups or activities include group work. (10) Respect and understand cultural, religious and socio-economic factors.

Incentive Programs: Federal Level

Affordable Care Act (ACA) Medicaid Incentives for the Prevention of Chronic Diseases (MIPCD) Program:

Overview

The Affordable Care Act mandated the creation of the MIPCD program for states to develop evidence-based prevention programs that provide incentives to Medicaid members to participate in and complete the MIPCD program. In September 2011, 10 States (Table 1) were awarded grants to implement chronic disease prevention approaches for their Medicaid members to test the use of incentives to encourage behavior change. By comparing participating Medicaid members to a control group, State demonstration evaluators will measure the effects of incentives and different levels and types of incentives on behavior, health outcomes, health care utilization, and costs.[4]

State	Smoking	Diabetes	Obesity	Hyperlipidemia	Hypertension
California	x				
Connecticut	x				
Hawaii		x			
Minnesota		x	x		
Montana		x	x	x	x
Nevada		x	x	x	x
New Hampshire	x		x		
New York	x	x			x
Texas	x	x	x	x	x
Wisconsin	x				

SOURCE: Kathleen Sebelius, *Initial Report to Congress: Medicaid Incentives for Prevention of Chronic Diseases Evaluation*

Details of the Program

The incentives for program participation vary by state, but all states are giving participants monetary incentives in the form of cash, gift card or other money-value item, or flexible spending account funds. Examples of incentives are:[4]

1. Money through debit cards
2. Money valued incentives such ranging from $20 to $1,860 annually
3. Flexible spending accounts for wellness activities
4. Prevention-related incentives, such as vouchers for farmers' markets, exercise equipment and healthy foods cookbooks
5. Treatment-related incentives, such as free nicotine replacement therapy patches
6. Points redeemable for rewards
7. Support to address barriers to participation such as meals, transportation and childcare

Challenges

Many of the states encountered issues implementing the program, that they had to address, resulting in delays of most programs. Some of the challenges reported by the states included:

1. Administrative delays and working through state bureaucracies
2. Provider engagement and participation: administrative burdens associated with program oversight and data collection, incorporating the program into providers' daily workflows, lack of funding to encourage provider participation and the inclusion of some services
3. Provider management and oversight
4. Participant identification
5. Managing member incentives, which was complicated by State decisions to use debit and finding a vendor to work with
6. Community perception of participants, in particular those with mental health conditions

As a result of these challenges, States have made a wide variety of changes to their plans and by exchanging information with one another through MIPCD Learning Collaborative activities have made adjustments to their implementation timelines; member recruitment and enrollment; member incentives; provider recruitment, training and incentives; and evaluation design.[4]

Lessons Learned

Lessons learned include (1) being flexible; (2) adopting a problem-solving approach, which includes a willingness to explore alternative options and develop alternative plans; (3) having political support from program champions; (4) taking time to adequately plan program implementation, hire a capable project manager, and implement comprehensive project management systems and infrastructure; (5) developing collaborative partnerships; (6) building relationships with partners and providers through ongoing communication; (7) training and incentivizing providers to participate; and (8) incorporating cultural and linguistic awareness into the program.[4]

Per Kathleen Sebelius's November 2013 report to Congress, there is insufficient evidence to recommend for or against extending funding of the programs beyond January 2016. Most of the State programs have been enrolling participants for only a short period and there are few data on the effect of the programs on health outcomes or health care

utilization and costs. The recommendation is to maintain current funding for the program through January 1, 2016, and deferring a recommendation on extension until more evidence of the programs' impact is available.[4]

Incentive Programs: State and Local Level

New York State MIPCD:

Overview

New York State implemented their MIPCD program by collaborating with the Medicaid managed care organizations, operating statewide or in select geographical areas. All of the participants are Medicaid-only members but allow participants who become Medicare-Medicaid members during the program to remain in the program.[4] The State is conducting randomized control trials to evaluate the effectiveness of their incentive program. This program does not provide any incentives for providers.

The New York State's program includes smoking, hypertension, diabetes management and diabetes onset prevention. In June 2013, a phased-in implementation was initiated with the diabetes prevention program. Enrollment of the other programs were to occur over the remainder of that year. They are targeting adults with or at risk of chronic diseases, and pregnant women and mothers of newborns with the intent of increasing smoking cessation, lower high blood pressure, prevent diabetes onset and enhance diabetes self-management.

Details of the Program

The program is targeting 6,800 participants with 5,100 for experimental groups and 1,700 for control groups. The outcomes to be examined are: (1) Smoking cessation: cessation status and service utilization; (2) Blood Pressure: blood pressure measurements, service utilization, Rx fills; (3) Diabetes Prevention: YMCA Diabetes Prevention Program attendance; (4) Diabetes Management: HbA1c levels, service utilization, and Rx fills.[4]

The maximum incentive amount, in the form of debit cards, is $250 for participants in the intervention and $50 for control group participants. No other incentives besides debit cards will be provided. [4]

Challenges

The lack of funding to entice participation, especially considering the program oversight needed by providers and the data collection requirements, made implementation difficult in New York. Other challenges reported by New York were administrative delays and managing member incentives. The grant award coincided with the timing of contract negotiations between the State and State employees, which lead to delays in hiring the program manager and research assistant. The State ran into problems finding a vendor to administer the debit cards and had to release more than one RFP to find a suitable vendor.[4]

Current Status of Program

At this time there are no published current updates on the status of this program.

Wisconsin Individual Incentive Initiative, April 2008 through September 2010:

Overview

Six health maintenance organizations were awarded two-year grants to test whether offering financial incentives, such as gift cards/certificates, sports equipment and free diapers would encourage BadgerCare Plus members to adopt healthier behaviors. The HMO's were required to address one of four key domains for improvement – well-child visits, including blood lead screening and immunizations; prenatal and post-partum care; childhood obesity; or smoking cessation.[5]

Details of the Program

The table below outlines each of the six HMO's Incentive Projects.

HMO	Goal	Target Population	Incentive
Children's Community Health Plan	To reduce childhood obesity	Youth ages 8-18 with BMI at or above 85th percentile	Transportation vouchers, stipends for attendance, fresh produce baskets, vouchers for athletic equipment and shoes, YMCA membership, gift cards for family members
Dean Health Plan, Inc.	To increase timely prenatal and post-partum care	Pregnant and post-partum women	Gift cards of $25 for initial prenatal visit. $25 for post-partum visit, entries into cash drawings for ten $100 rewards based on subsequent visits, completion of health classes
Managed Health Services, Insurance Corp	To increase well-child exams/identify children at obesity risk	Children 2-12 (Kenosha County - primarily Latino population)	$20 cash incentive for keeping appointment, additional $20 if child obese and agreed to participate in follow-up program; $10 if child kept food diary for one month and completed follow-up appointment
MercyCare Health Plans	To reduce childhood obesity	Youth 12-17 with BMI in 85th percentile	Gas cards; movie tickets for each visit with specialist plus choice of iPod shuffle with iTunes card or gift certificate for electronic dance pad or clothing
Security Health Plan	To increase blood lead screenings	Toddlers age 2	$25 gift card upon completion of screen
United Healthcare of WI	To increase well-child visits	Mothers who delivered and babies 0-1 year old	Coupon for jumbo pack of Pampers sent upon registration, at post-partum visit, and for each of the four well-child visits; $20 gift card if all appointments kept

Wisconsin Department of Health Services. *Do Incentives Work for Medicaid Members? A Study of Six Pilot Projects.* P-00499 (5/2013).

Challenges

The Initiative had very ambitious goals and each HMO articulated measurable outcomes, but as a whole, the Initiative found that it is not possible to assess the impact of the six projects on long-term health outcomes due to the short time-frames for the intervention.[5]

Lessons Learned

The study provided several valuable lessons for developing individual incentive programs to encourage Medicaid members to engage in healthier behaviors. Although the pilot projects did not achieve their stated goals, they did suggest that carefully designed incentives coupled with patient education can motivate individuals to make small, positive changes in their lives.

Wisconsin's Individual Incentive Initiative project experienced similar implementation challenges as the ten states participating in the MIPCD program. Results from the six pilot individual incentive projects suggest the following:[5]

- Incentives may be an effective tool in encouraging individuals to adopt modest behavior changes
- Clear and concise marketing materials, including how to earn and use the rewards, are critical to success. These materials should be readily available where members most often go and have a consistent message
- Timely reward redemption is critical to success
- For the low-income population, patient education appears to be valued equally to the incentives
- Interventions targeting children and youth may be more effective if done in groups or if at least some activities include group work
- Administrative records are a good tool for identifying the targeted population, although current contract information is frequently out-of-date
- Utilizing physicians and other professional staff as a source of referrals is challenging given clinic time pressures and other priorities
- The amount of time required to implement and adapt effective programs should not be underestimated

Also recommended in this report is the need for additional research to guide development of future financial incentives. Such studies would help determine: the costs/benefits of various approaches; the optimal size and frequency of the incentives; how to target specific populations; effective marketing and outreach strategies; and both short and long-term outcomes.[5]

Florida Enhanced Benefits Account Program:

Overview

This program was launched in September 2006 as part of an 1115 Medicaid waiver in five counties of Florida. Credits were earned by engagement of healthy behaviors – well-child visits, preventive screenings, disease management programs, smoking cessation programs or weight loss programs. The credits could be used at any participating pharmacy for non-Medicaid covered items such as over-the-counter medications, vitamins and first aid products.[5]

Details of the Program

The program provided up to $125 per year to any individual enrolled in one of the reform health plans. In the first 18 months of the program Medicaid members had been awarded credits for their healthy behaviors yet only about 10 percent of the credits had been redeemed – about one in eight of those participating in the reform pilots. It seemed that a substantial number of those earning credits were unaware of the program and how to redeem the credits. As sited in the Georgetown University Health Policy Institute report The Enhanced Benefits Reward$ Program: Is it changing the way Medicaid Beneficiaries approach their health? Florida's Experience with Medicaid Reform, there is little evidence to suggest that this program achieved their objective of improving members' health. In May 2014, the Florida Agency for Health Care Administration began phasing out the Enhanced Benefits Reward$ Program and implemented the Managed Medical Assistance program.

Challenges

Challenges of this program include both the structure of Florida's program and the challenge it faced upon implementation. Members had earned credits totaling more than $13 million with about $1.6 million redeemed for health-related products. Low redemption was due to the lack of awareness of the program and how to redeem credits, and did improve slightly after an additional marketing strategy was implemented in 2008.[6] It was also reported the program experienced high administrative costs, limited credits earned for complex behavior changes such as smoking cessation and little evidence that any behaviors had changed as a result of the program.

Idaho Preventive Health Assistance Program:

Overview

Idaho implemented the Preventive Health Assistance (PHA) Program in January 2007. There are two components of this program, the first being Behavioral Health, which originally included tobacco cessation and weight management but in January 2014 the tobacco cessation incentive was no longer offered. The second program is The Wellness Benefit and is part of the Children's Health Insurance Program, which rewards participants for keeping well-child exams and immunizations up to date.

Details of the Program

Members earn points by signing up to participate in monitored weight management activities and receive a $200 annual benefit to help pay for their weight management program fees at participating organizations. Members are eligible for the Wellness Benefit if they pay a monthly premium ($10 or $15) for their child's Medicaid coverage and earn 10 points per month for keeping their child's well-child checks and immunizations current. The points are subtracted from their monthly Medicaid premiums. According to Idaho Medicaid officials, the share of premium-paying children earning wellness points steadily increased, from about 40 percent in April 2007 to 73 percent in the third quarter of calendar year 2009.[7]

New York State DOH Tuberculosis Directly Observed Therapy (TB DOT) Program:

Overview

This study consisted of 365 patients in six inner city TB DOT programs over a 3-year period. One of the key features of the program was to motivate patients and increase adherence to therapy by providing incentives. The incentives in the basic package included snacks, food coupons and subway tokens. In addition a "progressive enhancement" package was implemented based on adherence to a 3 month treatment period. This package increased, incrementally, the number of subway tokens over the three months. The final conclusion of this study was increasing incentives is associated with improved adherence to therapy in inner city TB populations.[8]

Project Healthy Neighbors, Santa Barbara, California:

Overview

Project Healthy Neighbors, started in 2005, holds a two to three-day event every November which offers the homeless population services that include flu vaccinations, pneumonia shots, Veterans benefits, TB tests, HIV tests, addiction and recovery screenings, as well as Urgent Care medical services.[9] Volunteers, totaling over 100, include physicians, dentists, and other health care professionals. As an incentive to get the homeless to attend this event they are given a backpack that contains such things as a sweatshirt, socks, rain ponchos, blanket, hats and gloves, toiletries and first aid kit. Project Healthy Neighbors also gets donations of shoes so everyone who attends and receives services leaves with a pair of shoes.[10] This unprecedented approach to helping the homeless has evolved into an annual event helping people prepare for the winter season, and the numbers of homeless that attend has increased every year.

Incentive Programs: Employer Based

General Electric: Smoking Cessation Program

Overview

In a randomized, controlled study, an 18 month program to quit smoking was offered to employees where half of the employees were offered $100 to complete a community-based smoking cessation program in their area, $250 if they had quit smoking at some point within six months of study enrollment, and $400 if they remained smoke-free for another six months after that. The incentive group outperformed the information-only group. Based on this study, General Electric designed an incentive program for all 152,000 domestic employees effective January, 2010. Because of concerns by non-smokers about "rewarding smokers for bad behavior," they designed this as a stick-based approach in which smokers are charged an additional $625 per year in their health insurance premium. This difference is waived if the smoker provides evidence that they are enrolled in a smoking-cessation program.[11]

Incentive Programs: Research Studies

Medication Adherence - A Test of Financial Incentives to Improve Warfarin Adherence:

Overview

Adherence to taking medications is another significant source of waste in the health care system. It can lead to worsening of disease and poses serious and unnecessary health risks. Nearly three out of four Americans report that they do not always take their medication as directed, a problem that causes more than one-third of medicine-related hospitalizations, nearly 125,000 deaths in the United States each year, and adds $290 billion in avoidable costs to the health care system annually.[12]

Program Details

A study was done with volunteers, from the University of Pennsylvania Anticoagulation Center, prescribed warfarin, an anti-blood-clot medication. They participated in a lottery system where they had a 1 in 5 chance to win $10 or a 1 in 100 chance to win $100 each day they took the drug. Each participant was given a computerized pill box that would record if they took the medication and whether they won any money that day.[13] The outcome of the study provided initial evidence of the feasibility and potential promise of a lottery-based financial incentive in improving medication adherence for patients using warfarin. The researchers of this study felt this approach could potentially also be used to improve medication adherence for a wide range of other chronic conditions that require ongoing use of medications.[13]

Financial Incentives for Home-Based Health Monitoring - A Randomized Controlled Trial:

Overview

Participants from the University of Pennsylvania Health System participated in a study to test the impact of lottery-based incentives on adherence to home-based wireless device monitoring for chronic disease management. The study demonstrated that a daily lottery incentive worth an average of $1.40 per day was associated with significantly greater device usage than in a control group receiving no financial incentives, and was largely free of the substantial drop in post-incentive adherence seen with an incentive double that size.[14] The researchers suggested that future work should explore additional ways in which data collected through remote monitoring can be used to improve patient engagement (e.g., using remotely-collected data to set health goals and track performance). In addition, it would be useful to study the cost effectiveness of lotteries of different magnitudes to determine whether still smaller incentives can be used to increase adherence to self-monitoring regimens, and to gain insight into the issue of behavior maintenance upon withdrawal of incentives.[14]

Conclusion Summary

The intent of this report was to provide an overview of some programs that have been initiated/implemented using incentives for Medicaid and private members to participate in prevention programs, and if these incentives had any impact on changing their health risks and adopting healthy behaviors.

Incentives for the various state and private programs/studies included money-valued incentives such as debit cards or gift cards, flexible spending accounts, points redeemable for rewards, diaper reward programs for well-child visits, and tokens for transportation. Money-valued incentives were found to be highly motivating and resulted in improved adherence to treatment or taking prescribed medications, increased well-child visit rates, and encouraged individuals to change their behaviors and make small, positive changes in their lives. In the Wisconsin study patient education appeared to be valued equally to the incentives with lower-income families. Incentives to motivate the homeless in Santa Barbara has been highly successful for several years in keeping the homeless population healthier.

There appears to be a common theme with challenges and lessons learned from the states that had formal incentive programs or studies and although most of the lessons learned relate to programmatic issues and there is no conclusive consensus around what types of incentives or key considerations are most successful in designing incentives, there are certain characteristics of each program that could be considered best practice when designing an incentive program. Some of these best practices include (1) Take adequate time to plan the incentive project. Take into consideration the amount of staff and key positions required to implement a successful program. (2) Explore and develop alternate plans. Be flexible. (3) Involve, communicate and educate providers and other professionals of members who are participants in the incentive program. Consider creating a liaison/coach position who works with the physicians, as they may be unwilling or unable to participate as the "gatekeeper".[3] (4) Have a good understanding of the data collection requirements, methods to identify participants and ensure all the correct programs (software) and tools are in place to collect the data and report on it. (5) Ensure participants are willing to participate in the incentive program. Programs with default assignments are not effective.[3] (6) Develop clear and concise marketing materials, in several languages, that explain the incentive program, rewards and how to redeem the rewards. This should not only be for educating participants but also the community in which they live. (7) Ensure rewards, especially if monetary, are given to participants in a timely manner. (8) Develop collaborative relationships with community-based organizations. (9) Consider implementing incentive programs for children or youth as this may be more effective if done in groups or activities include group work. (10) Respect and understand cultural, religious and socio-economic factors.

Along with best practices, several successful incentives have been identified in reported programs or studies that lead participants to improving their health. These include (1) Monetary incentives in the form of debit cards. (2) Lottery-based monetary incentives. (3) Transportation tokens. (4) Coupons for food, diapers, toiletries, etc. (5) Backpacks with essential living/care items for those who are homeless.

Lastly, as recommended by the American College of Physicians, programs that support the patient's role in promoting positive health outcomes should be evidence-based and should focus on increasing access to strategies for prevention and treatment of disease; respect for autonomy; consideration of variables influencing comprehension and learning; and understanding of cultural, religious and socioeconomic factors. The committee further states that incentives to promote behavior change should be designed to allocate health care resources fairly without discriminating against a class or category of people.

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