Medicaid Incentives for Prevention of Chronic Diseases—Evaluation Findings

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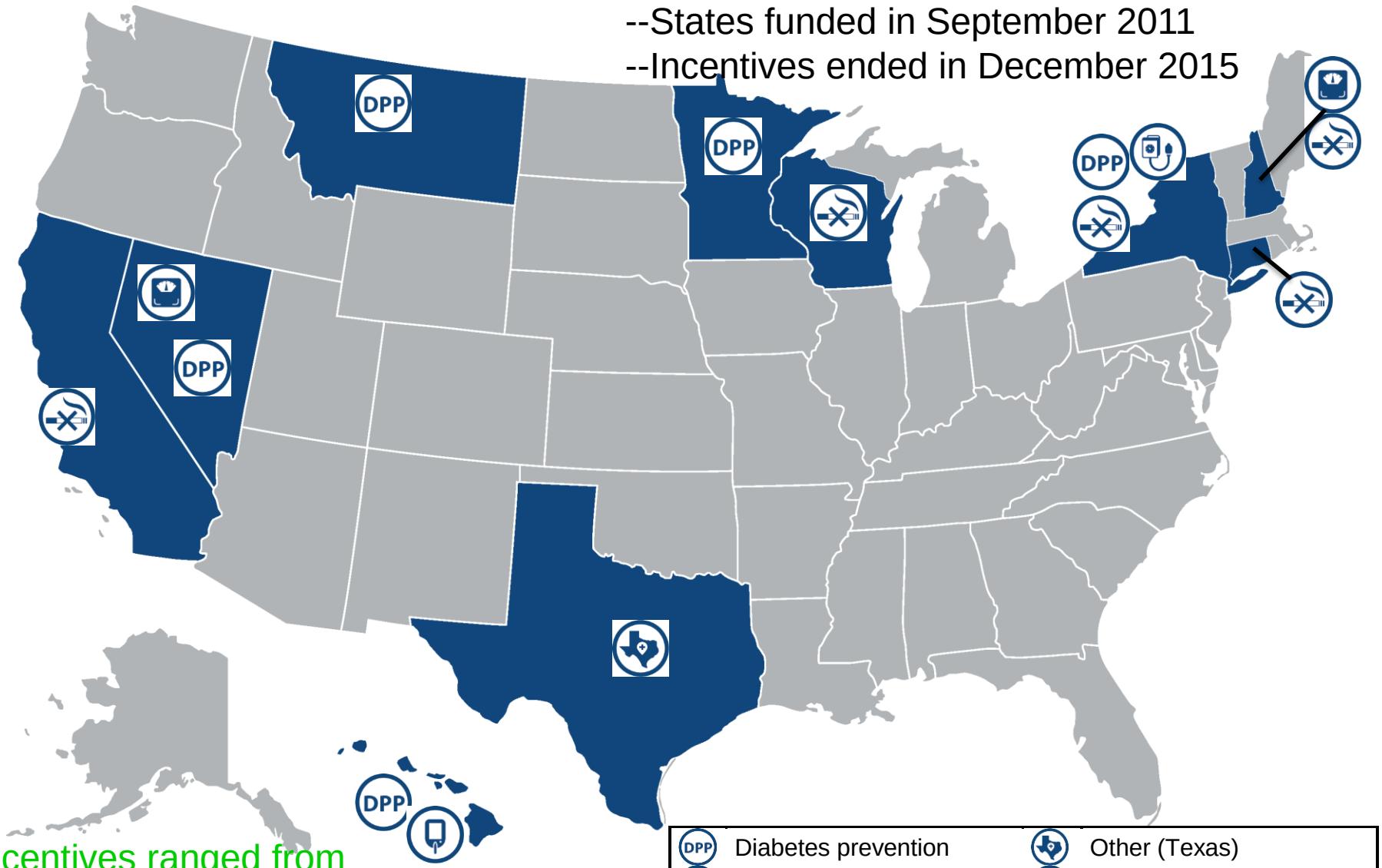
MIPCD Background

Established by Section 4108 of ACA
--States funded in September 2011
--Incentives ended in December 2015



Incentives ranged from
$50 (CA) to $1150 annually (TX)

5-year Evaluation

- Mixed methods
  - Site visits
  - Beneficiary focus groups
  - Beneficiary surveys
  - MIPCD Minimum Data Se
    - Participation, incentives, outcomes
    - Regression analysis
  - Medicaid claims
    - Difference-in-difference analysis
  - Administrative costs forms

- Topics
  - Implementation
  - Utilization and Medicaid costs
  - Satisfaction
  - Special populations
  - Administrative costs

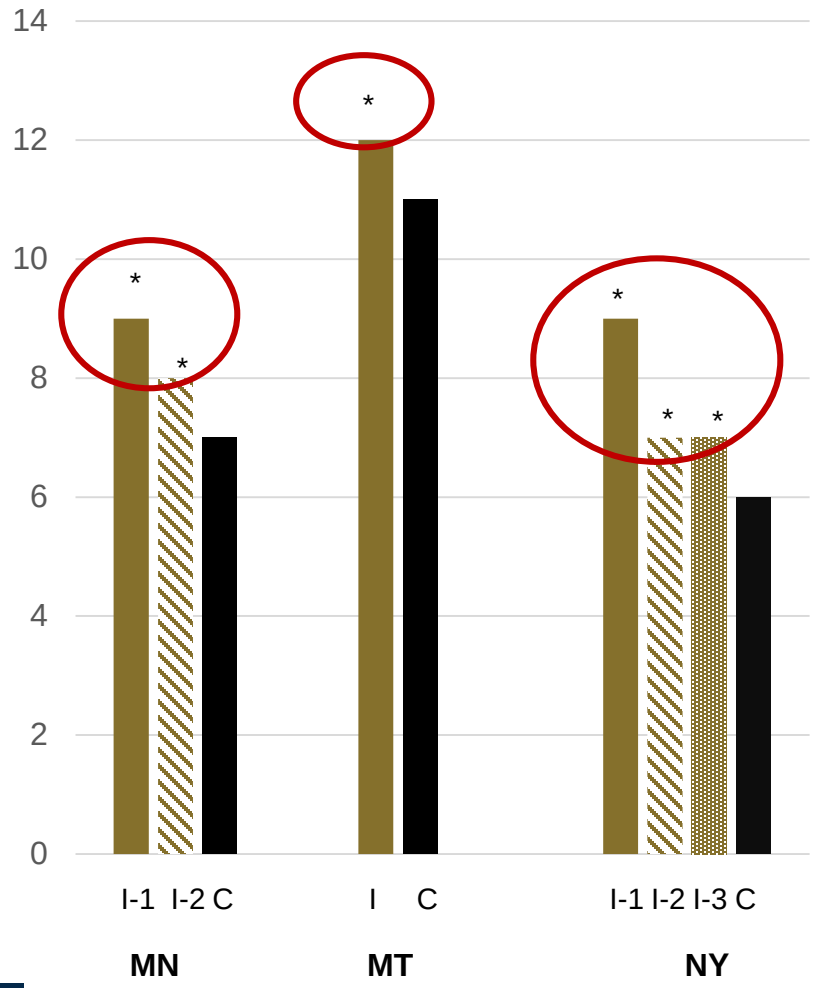
Can State Medicaid Programs Implement Incentive Programs for Chronic Diseases?

- All of the States were able to successfully implement their programs
  - Most had to overcome challenges and showed flexibility in doing so
  - Over 24,000 participants
  - State Medicaid programs can conduct randomized enrollment
- Biggest challenges
  - Start up
  - Recruitment
    - Only 2 of the States met enrollment targets
  - Getting incentives to participants
- States planned to sustain parts of their programs, particularly the services provided
  - With one exception, States did NOT plan to sustain cash incentives
  - Texas considering flexible wellness account as part of a self-directed care pilot program

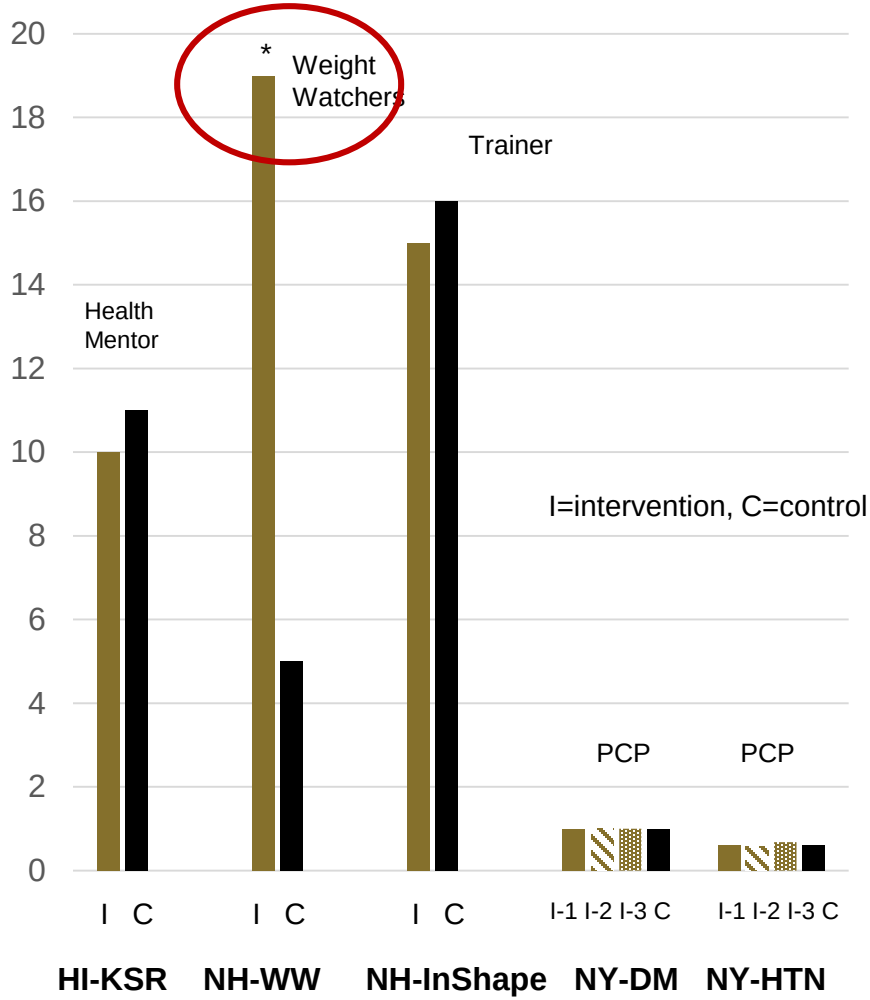
Diabetes and Weight-Related Programs

In many cases, participants use significantly more preventive services if they received a financial incentive

Diabetes Prevention Classes



Provider Visits

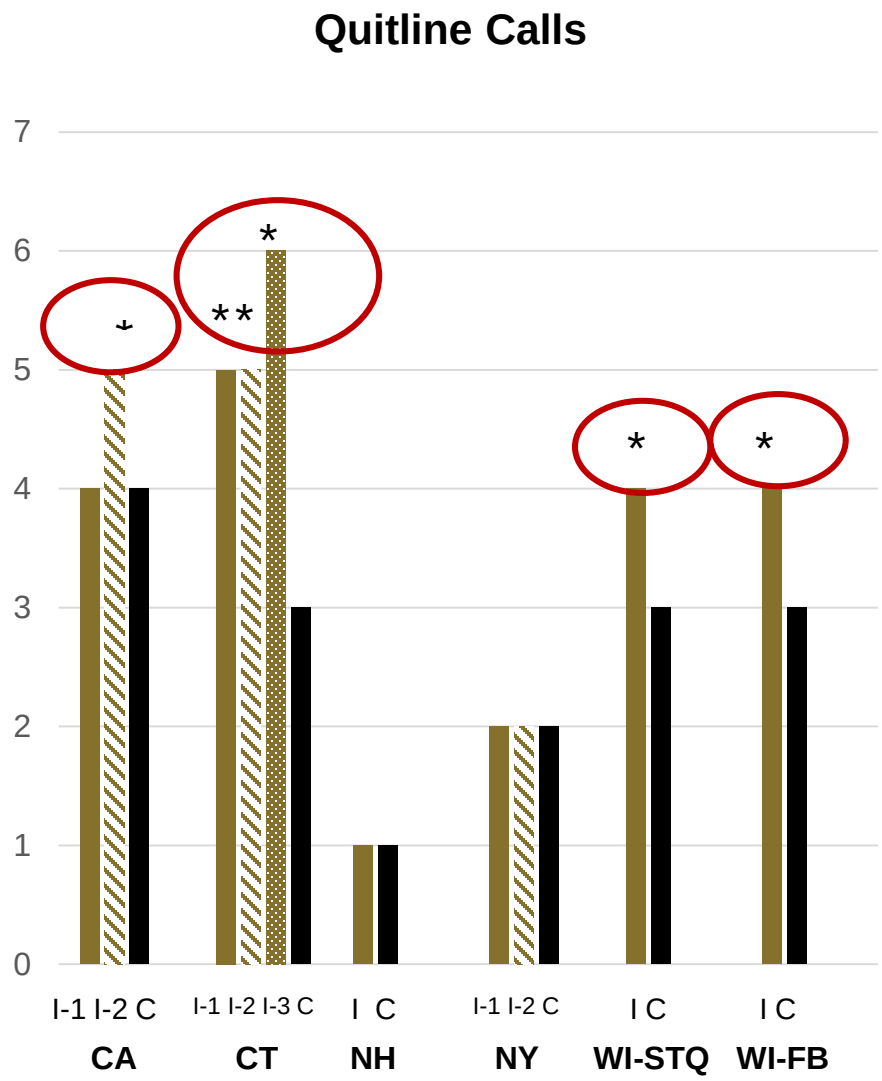


* Statistically different from control group (p<0.05)

Source: MIPCD MDS Data Set

Smoking Cessation Programs

In many cases, participants use significantly more preventive services if they received a financial incentive



A similar pattern is seen for attending smoking cessation sessions with a provider.

Connecticut's and Wisconsin's incentive groups had significantly more sessions than the control groups.

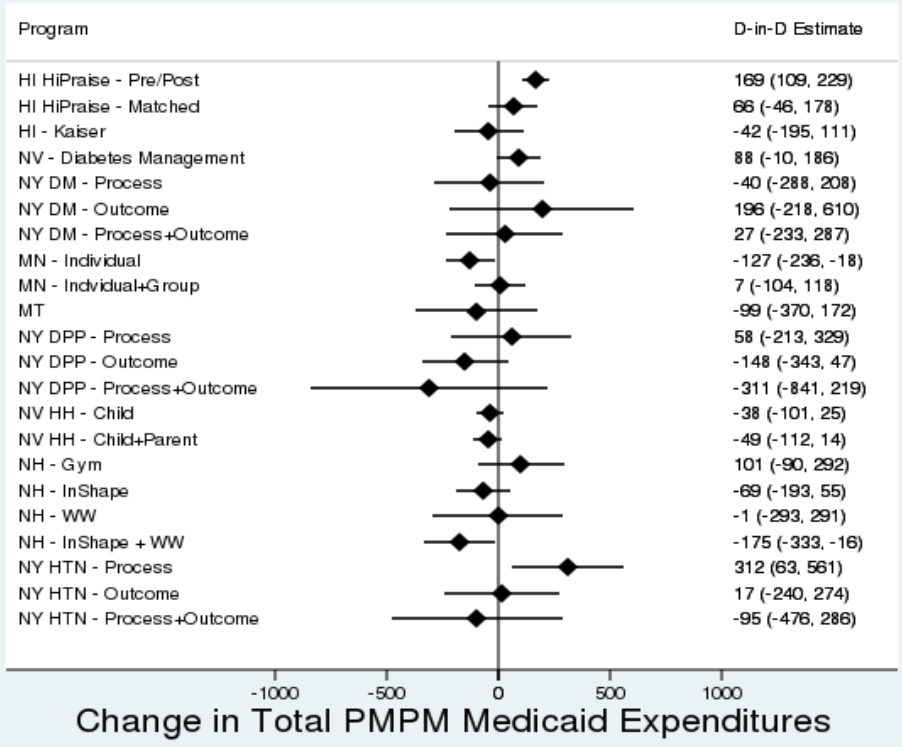
I=intervention, C=control

* Statistically different from control group ($p<0.05$)

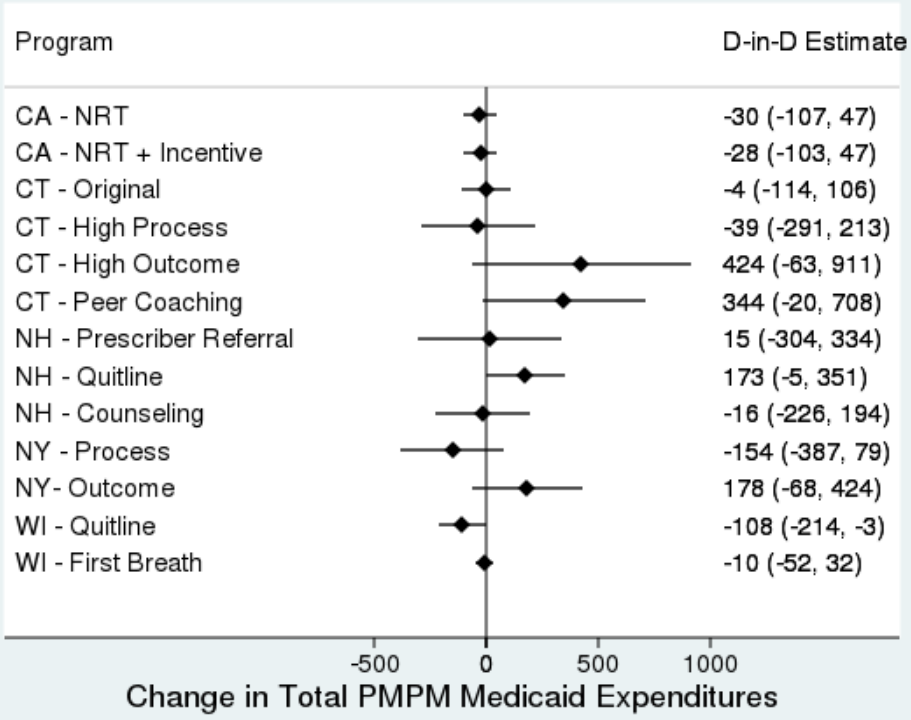
Source: MIPCD MDS Data Set

No Significant Effects of Incentives on Reducing Total Medicaid Per Member Per Month (PMPM) Expenditures

Diabetes or Weight Management Program



Smoking Cessation Programs



Similar findings for inpatient expenditures and admissions and ED expenditures and admissions

Select Health Outcomes Improve over Time for the Incentive Group

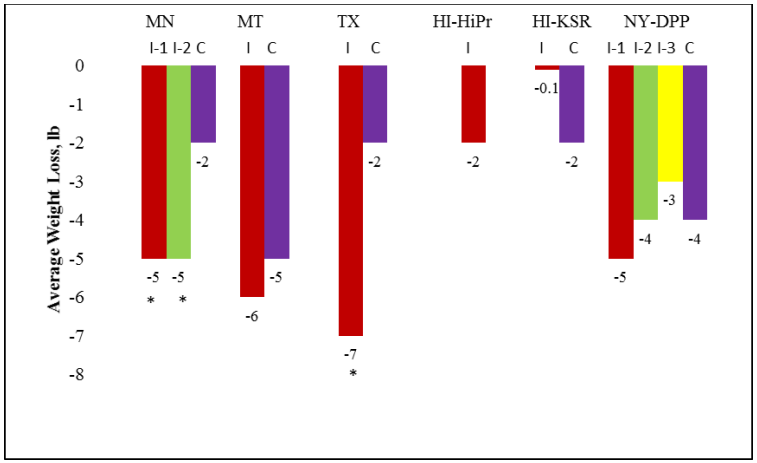
* = difference between groups was significant

Outcome	State	Findings
Weight Loss of 5% from baseline	MN	Individual Incentive Group > Control Group* Individual + Group Incentive Group > Control Group
	MT	Incentive Group > Control Group
	TX	Incentive Group > Control Group*
Increases in minutes of physical activity	MT	Incentive Group < Control Group
	NH	In Shape: Incentive Group > Control Group Weight Watchers: Incentive Group > Control Group In Shape + Weight Watchers: Incentive Group > Control Group
HbA1C < 7% after baseline	HI	HI-PRAISE: 38% of participants were in control of their HbA1c Kaiser: Incentive Group = Control Group
	NY	Process: Incentive Group > Control Group Outcome: Incentive Group = Control Group Process + Outcome: Incentive Group > Control Group
Self-reported health status	TX	Physical Health: Incentive Group > Control Group* Mental Health: Incentive Group > Control Group*
Self-reported quit attempt	CA	NRT only: Incentive Group > Control Group* NRT plus cash only: Incentive Group > Control Group*
	CT	Incentive Group = Control Group
	NH	Incentive Group = Control Group
Biochemical test indicating smoking cessation	NH	Incentive Groups > Control Group
	WI	Quitline: Incentive Group > Control Group* First Breath: Incentive Group > Control Group*

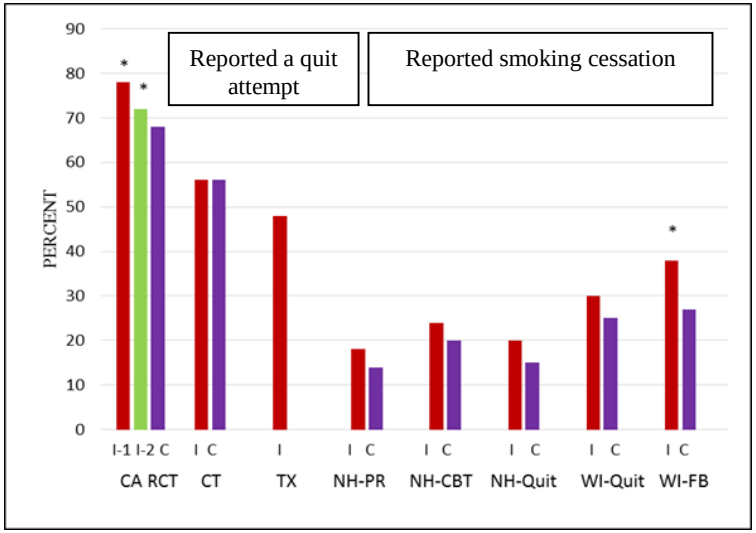
* Statistically different from control group ($p<0.05$)

Incentivized Participants Showed Improvements in Health, But These were Small and Not Always Significant

Average weight loss



Percent of the sample that self-reported a quit attempt or smoking cessation



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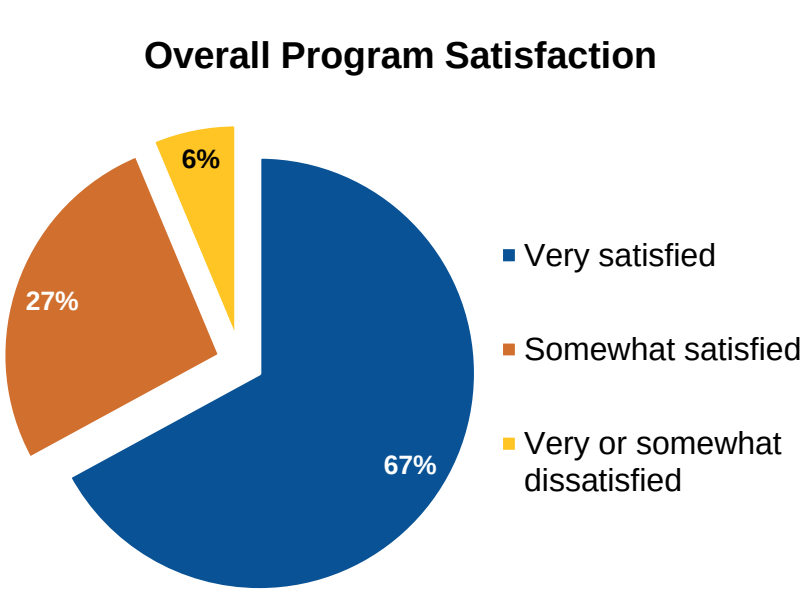
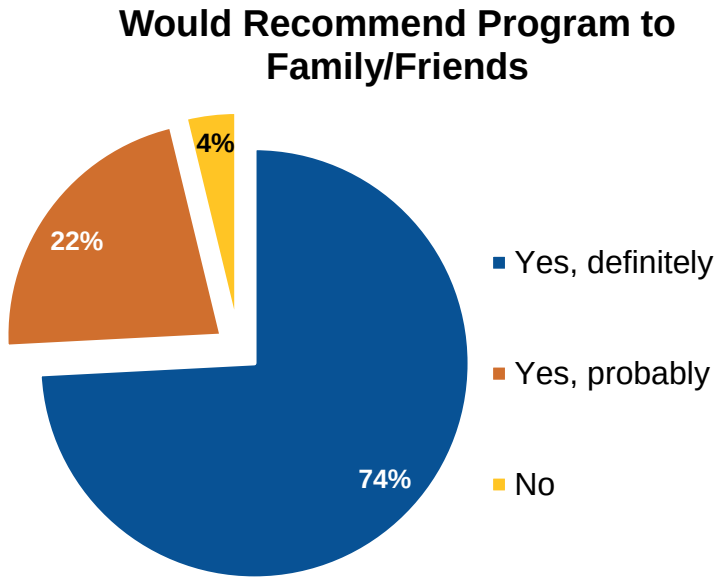
I=intervention, C=Control

Source: MIPCD MDS Data Set

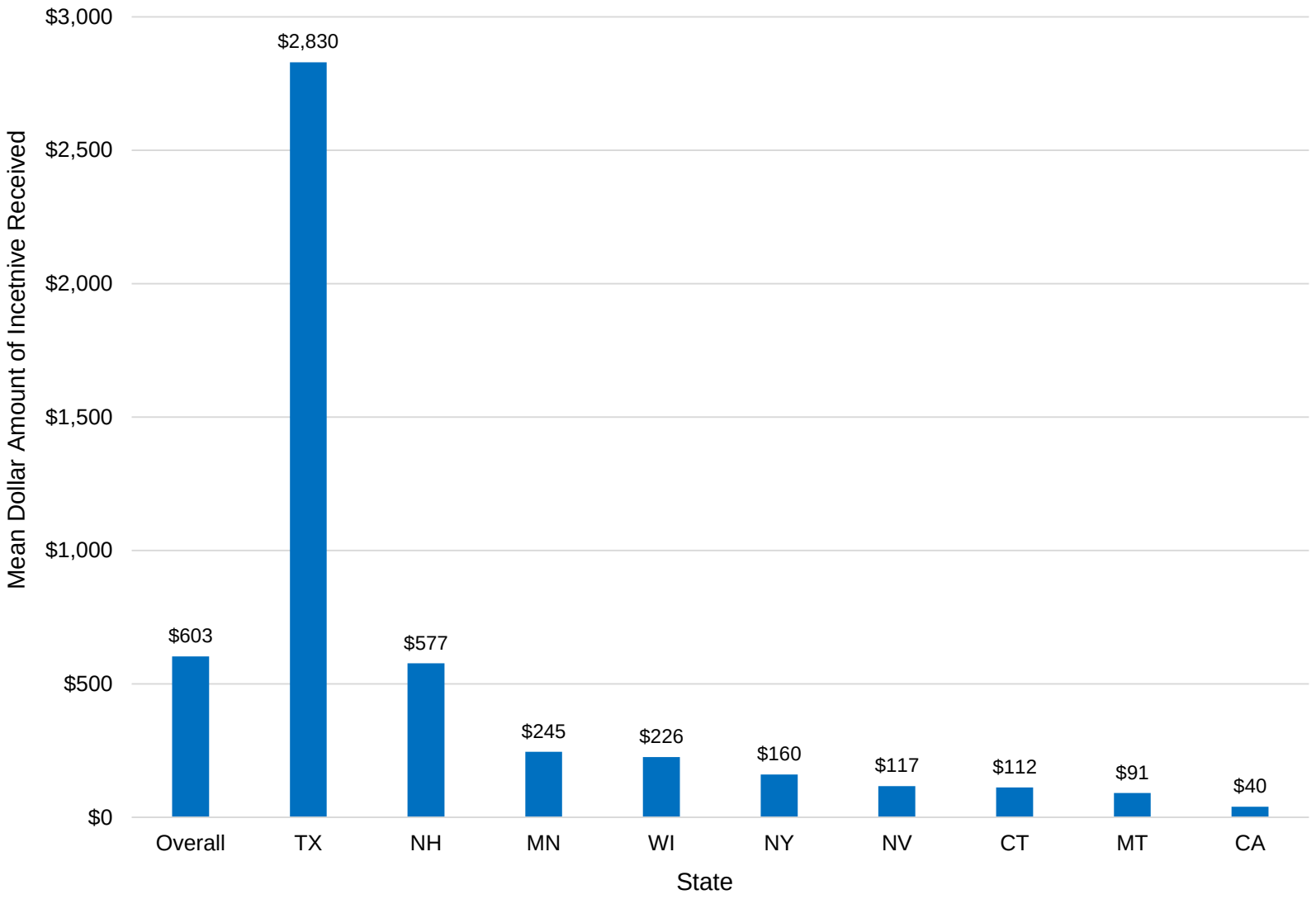
Overall Program Satisfaction was High





- Mean program rating was 8.5 out of 10

Mean Value of Incentives



Special Populations Can be Served by MIPCD Programs

State	Adults with behavioral health or substance use disorders	Medicare-Medicaid enrollees	Disabled beneficiaries or SSI recipients	Pregnant women and mothers of newborns	Children	Beneficiaries who speak English as a second language
California	—	✓	✓	✓	—	✓
Connecticut	✓	✓	✓	✓	—	✓
Hawaii	—	✓	✓	—	—	✓
Minnesota	—	✓	✓	—	—	✓
Montana	—	✓	✓	✓	—	—
Nevada	—	✓	✓	—	✓	✓
New Hampshire	✓	✓	✓	—	—	—
New York	—	—	✓	✓	—	✓
Texas	✓	—	✓	—	—	—
Wisconsin	—	✓	✓	✓	—	✓
Total	3	8	10	5	1	7

Administrative Costs

- Administrative costs were higher than expected
  - 42 percent of program expenditures
  - Caveat: these were not reported uniformly across states.

- Preventive services were integral parts of the programs and accounted for a significant share of total costs.

- Actual incentive payments to participants accounted for about 8 percent of program spending.

Conclusions

- States **can** implement incentive programs designed to prevent chronic diseases

- The programs can significantly increase use of preventive services
- No significant effects on utilization of other Medicaid-covered services or costs
- Limited evidence on health outcomes

- Special populations can participate in the programs

- Beneficiaries are highly satisfied with the programs

- Administrative costs account for a sizable share of program costs

Further information

- Final Evaluation Report: https://downloads.cms.gov/files/cmmi/mipcd-finalevalrpt.pdf

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Extra Slides

Recruitment

- Lack of awareness contributes to low program participation rates—messages need to be delivered in a way that makes it hard to miss
- States' recruitment was much slower and harder than anticipated—only Texas and Hawaii met/exceeded enrollment goals
- States used multiple, evolving strategies—focused efforts to address health disparities and be culturally sensitive
- Providers that worked with Medicaid beneficiaries were well equipped to recruit, but had competing priorities—six States gave providers incentives for recruiting and referring patients

State	Total Enrolled	Projected Participants	Percentage of Goal Met
California	4,300	9,000	48%
Connecticut	4,052	6,210	65%
Hawaii	2,323	1,400	165%
Minnesota	1,100	1,800	61%
Montana	261	724	36%
Nevada	1,840	2,000	92%
New Hampshire	2,031	2,600	78%
New York	4,279	6,800	63%
Texas	1,259	1,250	101%
Wisconsin	2,928	3,250	90%
All States	24,373	35,034	70%

Summary of Findings on Utilization and Costs

Use of Incentivized Services

- Across MIPCD programs, many program participants used significantly more of a service if they received a financial incentive

Expenditures

- No evidence to support the hypothesis that MIPCD program participation reduced spending

Utilization

- No systemic changes in inpatient admissions or ED visits after MIPCD participation can be attributed to receipt of incentives

Health Outcomes

- Findings suggest that program participants receiving incentives had greater improvements in select health outcomes, though the improvements were often small in magnitude and did not always reach statistical significance

Satisfaction with Incentives

Survey

- 78% of respondents strongly agreed that they liked getting incentives for taking care of their health
- Only 36% of respondents receiving points redeemable for awards strongly agreed that they were happy with how often they got incentives (vs. 65% for money valued incentives and 83% for flexible wellness account)

Focus Groups

- *It's motivating to me… both [the incentives and] losing weight. I'm doing something for myself, plus I'm getting something out of it too.*
- *[Program staff] told me I had 1600 points, but I'm not able to get to a computer and I'd have to have somebody do all that for me…I never collected [my incentive.]*