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Medicaid Efforts to Incentivize Healthy Behaviors

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Introduction

In September 2006, Florida began implementing an innovative policy to reward Medicaid recipients up to $125 a year for engaging in specific wellness and healthy behaviors. Florida is not alone, several other states are starting to use financial incentives to improve Medicaid recipients' healthy behaviors. Idaho introduced a reward-based program in January 2007 to promote well child visits, tobacco cessation, and weight management; in May of 2006 the Centers for Medicare and Medicaid Services approved Kentucky's proposal to reward disease management; and Wisconsin has included consumer incentives for health promotion in the state's proposal to expand children's health coverage.[1,2] According to a recent survey of Medicaid agencies, using financial rewards to encourage healthy behaviors is being considered by more than half of all Medicaid agencies across the country.[3]

State Medicaid agencies have not traditionally sought to influence recipients' health-related behaviors. Wellness programs, like smoking cessation, are still not universally covered by Medicaid agencies.[6] Thus, encouraging healthy behaviors represents a new direction for Medicaid agencies, towards promoting health and wellness.

Policies to reward healthy behaviors have emerged as part of a national trend in health care toward *consumer direction*. Consumer directed health care encourages consumers to take charge of their health and health care, by promoting personal responsibility and cost conscious decision making. Health Savings Accounts (HSAs) are the most notable of these policies. In Medicaid, there are a growing number of consumer directed policies that emphasize recipient control over Medicaid dollars. These include giving disabled and frail elderly recipients monthly allowances for purchasing personal care services and supplies in what are known as Cash and Counseling programs, and the new Health Opportunity Accounts, which are savings accounts for purchasing health care services coupled with a high deductible version of Medicaid.[3] The Florida Agency for Health Care Administration (AHCA) views the financial incentive program as part of the consumer direction trend: "The program will provide a direct incentive to enrollees to take an active role in their health and further the consumer driven model as they will have direct control over funds earned."[7]

Improving Medicaid recipients' health and wellness-related behaviors is important for the long-term health of recipients. Unhealthy behaviors have become the top causes of mortality and morbidity in the United States.[8] Tobacco use, obesity, and misuse of alcohol account for over one third of all deaths in the country. The prevalence rates of these unhealthy behaviors are particularly high for those with low incomes and minorities.[9] If Medicaid agencies are successful in improving recipients' health-related behaviors, not only will long-term health outcomes improve, but there could be substantial cost savings to Medicaid. This is clearly stated in Wisconsin's BadgerCare Plus proposal: "Wisconsin believes that the only way to address rising health care costs in the long term is to help individuals get and stay healthy."[2]

This resource paper examines two Medicaid program's efforts to reward healthy behaviors. The first is Florida's Enhanced Benefits Accounts (EBA) program, which began implementation in Duval and Broward counties in September 2006. The second program is Idaho's Preventive Health Assistance (PHA) benefit that started statewide in January 2007. Both states implemented their financial incentive programs as part of larger Medicaid reform efforts.

The first section of the paper reviews the three key elements of incentive policies: which behaviors are rewarded, the amount of the reward, and the nature of the reward. For each of these elements, a brief synthesis of what is known from the public health literature is presented. Then the implementation strategies used in the two states are described, based upon interviews with Medicaid agency staff and a review of program documentation. Lastly, Medicaid recipients' attitudes toward elements of the policy are presented. This is based upon analysis of data gathered from four focus groups conducted in May of 2006 and a telephone survey conducted in the fall of 2006 with 800 parents and guardians of children with Medicaid.[a]

The second section of the paper discusses lessons learned from the two states. The lessons focus on the development stage and early implementation, given the short time the programs were in operation at the time this paper was researched and written.

[a] Four focus groups with a total of 36 people were conducted in Jacksonville, Florida in the spring of 2006. The telephone survey was conducted with a random sample of parents and guardians of children with Medicaid aged 4-18 in four counties in Florida (Duval, Broward, Escambia and Palm Beach).

Key Program Elements

States developing incentive programs should consider what behaviors they would like to reward, the amount of the rewards, and the nature of the reward (i.e., what can be purchased with the reward).

Behaviors to Reward

Literature Synthesis

While using incentives to encourage healthy behaviors is new to Medicaid, it is an approach that has been examined in a number of small, controlled settings. Prior studies have found that efforts to promote one-time health behaviors with financial rewards have generally been successful. A recent review article found that 15 out of 17 studies (88%) offering cash or coupon rewards increased rates of one time health behaviors, like TB skin testing for drug users and HIV/STD prevention.[10] The extent of improvement differed across studies, but was generally quite substantial. In one study, 90% of drug users returned for tuberculosis skin tests when given a $10 incentive, compared with 33% of those receiving no financial incentive.[11] This literature has focused on vulnerable, low income populations, so the findings are likely relevant for the Medicaid population. However, these prior studies have sought to promote different one time wellness behaviors than those targeted by the current Medicaid initiatives.

Financial incentives have also been found to be effective in changing fundamental lifestyle behaviors, such as smoking cessation and weight loss, however, less consistently so. Kane and colleagues review of the literature found financial incentives were effective in 5 out of 9 studies (63%).[10] Volpp and colleagues' recent study was typical in terms of the extent of the incentives' effect: 16% of those randomized to receive a financial incentive quit smoking after two and a half months, compared with 5% of those not receiving an incentive.[12] This study, as well as most other effective programs, provided rewards after ascertaining behavior change occurred (e.g. using blood tests to test for smoking). This differs from the approach used by the current Medicaid efforts, which reward participation in behavior change programs. Studies that have rewarded program participation have found higher attendance levels but little change in behavior.[13, 14] This may be due to the fact that participation was rewarded or it may be due to the small samples studied.

Few studies have followed up with participants to assess whether the behavioral changes were sustained over time. Two studies demonstrate that when incentives continue over a relatively long time frame (10 months), they are still effective.[15, 16] However, after the incentives have stopped, studies consistently find that the program effect disappears within one year's time.[12, 17, 18] These findings suggest that permanently changing lifestyle behaviors such as smoking and exercise will be a challenge for Medicaid reward programs.

Medicaid Approaches

Florida. AHCA created opportunities for all Medicaid recipients to earn rewards by engaging in healthy behaviors because the state wanted to broadly instill the importance of taking care of

oneself.[b] A preliminary list of qualifying behaviors was developed through a process of reviewing national quality standards and state initiative goals and then analyzing claims data to identify indicators with low adherence levels. The list of behaviors was finalized by the seven member Enhanced Benefits Advisory Panel, which is made up of agency staff, as well as a health plan and a recipient representative.

Nineteen behaviors were selected for earning rewards. They include simple wellness behaviors, participation in programs that seek to change fundamental lifestyle behaviors, and appropriate use of the health care system. The eight simple wellness behaviors chosen are check ups (dental exam, vision exam, well-child visit), immunizations (childhood immunizations and flu shots for those advised by a doctor), and cancer screenings (pap smear, mammogram and colorectal screenings). The rewards for appropriate use of health care are for those who do not skip any primary care appointments and those who comply with prescribed maintenance medications. Recipient EBA accounts are automatically credited for engaging in these behaviors through a process in which health plans submit a monthly claims-based report to AHCA.

To encourage fundamental lifestyle changes, AHCA rewards initial and six-month participation in alcohol and drug treatment, smoking cessation, weight loss, and exercise programs. Participation in disease management programs is also rewarded. Some, but not all of these programs, are offered by the Medicaid health plans. Recipients are not restricted to programs offered by health plans and may enroll in community programs that have "defined goals and or milestones" provide "information, guidance, and/or assistance for specific behaviors" and are "accessible to the public."[20] To be credited for participating in any of these programs, recipients must obtain the signature of the program sponsor on the EBA Universal form and send it to their health plan. Recipients receive mailings indicating all credits and debits to their EBA.

Idaho. The Medicaid agency developed the Preventive Health Assistance (PHA) program to serve two goals. The principal goal was to encourage recipients to be responsible for their health and well-being. "It pays to stay healthy" is the program's slogan. The secondary goal was to provide a financial "safety net" for recipients required to pay a monthly premium. While the agency was committed to having parents "invest" in their child's health through paying a premium, it wanted to minimize the number of recipients losing eligibility due to financial barriers.[c] Consequently, the money earned through wellness behaviors may be used pay the new Medicaid premium.

Idaho Medicaid has developed two PHAs to address the dual objectives of the program. The Wellness PHA is specifically for those children who are required to pay a monthly premium. Eligible children are rewarded for having an annual well-child visit and being up to date with immunizations. Idaho Medicaid uses claims data to check quarterly on children's status and automatically credits their accounts with reward points if they are up to date. Recipients are sent letters when they accrue reward points. The agency also sends letters to those not up to date on well-child visits and immunizations that explains no reward points were awarded and what recommended care the child is lacking.

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[b] Medicaid Reform applies to the vast majority of Medicaid recipients in Duval and Broward Counties as of September 2006. In the summer of 2007, Medicaid Reform expanded to Baker, Clay, and Nassau Counties.

[c] As part of Idaho's Medicaid Reform, recipients earning >133%-150% of the Federal poverty level began paying a $10 monthly premium for Medicaid coverage in late 2006. Those making above 150% previously paid a $15 monthly premium and continue to pay at this higher level.

The Behavioral PHA is intended to catalyze lifestyle changes for all recipients who use tobacco or have weight management problems (either underweight or obese based upon CDC criteria). As part of Idaho's Medicaid reform, all recipients are asked to complete a voluntary health questionnaire. Those indicating that they would like to stop tobacco use or that they would like to address their weight problem are invited by letter to participate in a Behavioral PHA.

For those who want to stop using tobacco, the Medicaid agency provides a list of approved smoking cessation vendors across the state, all of which provide free tobacco cessation classes. Once recipients submit a form stating they agree to participate in the program with the signature of the program representative, they receive their first reward. A second reward is given when they submit a certificate that they successfully completed the program.

Medicaid recipients participating in the weight management Behavioral PHA are rewarded once they have enrolled in an approved weight management program (weight loss, exercise class, physician monitored weight loss program, or gym membership) and have obtained their physicians' sign off that they are sufficiently healthy to participate in the program. The agency considered providing the second reward at program completion but that was ruled out as administratively too complex. Vendors discouraged rewarding weight loss, stressing the importance of becoming health oriented through program participation. The agency decided to allow participants to request their second reward at enrollment. That way, recipients would have enough reward points to apply toward the expense of a weight management program.

Recipients' Initial Attitudes

Respondents from our telephone survey overwhelmingly believed that Florida's incentive program would be effective at helping Medicaid recipients to become healthier (88%). Many believed it would be effective because it provides financial help for those with low incomes: "Any time you give people below the poverty line an incentive, it will help financially" and "most people on Medicaid need financial aid to purchase [over the counter] medications." A few respondents expressed support for the program's underlying intent: making comments like, "It will get them more involved with their health. I think it will be a good thing" and "If you live healthier and you're not spending as much Medicaid money because you are living healthier, that saves money."

A minority of respondents (12%) doubted that the incentive program would improve healthy behaviors of Medicaid recipients. Some expressed that "it is very difficult to get people to change their lifestyles." "If they are going to be healthy they are going to be healthy. If they are going to be sick, they are going to be sick. The rewards aren't going to make them any healthier." Others argued that "the rewards are too little." Several focus group members pointed out that Florida's Medicaid HMOs already provide an over the counter pharmacy benefit that does not require engagement in healthy behaviors. In addition, there was a vocal minority that felt the policy was demeaning. One respondent said, "it is ridiculous to [give a] reward for going to a doctor."

In the survey, parents of Medicaid recipients were asked whether their child would engage in five healthy behaviors (enrolling in an exercise class, annual dentist visit, annual well child visit, not missing any primary care visits, and enrolling in a weight loss program) if given an incentive. The majority of respondents noted that with an incentive their child would "very likely" have a

well child visit and a dental visit in the next year (72% and 79% respectively, among those not reporting a visit in the last year). Just over half (58%) reported that with an incentive their child would "very likely" take an exercise class and a similar percentage reported their overweight child would enroll in a weight loss program. Respondents were least likely to say that an incentive would keep their child from ever missing a primary care doctor's visit. One focus group participant commented, "That wouldn't work. We don't miss appointments intentionally."

Reward Amounts

Literature Synthesis

Studies have found that incentive programs can be successful using a range of reward amounts, from small payments (a one time $5 payment) to more substantial amounts (monthly $50 payments for achieving behavioral goals). Only a handful of studies have directly tested whether offering a higher reward has a greater impact on behavior than a smaller reward.[10, 15, 21] Two studies that randomized participants to different incentive levels found that higher incentives did result in greater behavioral change,[11, 18] while a third study found that higher incentives did not influence behavior.[22] Better understanding of how large a reward is needed to change wellness and fundamental lifestyle behaviors for Medicaid recipients will be an important question for Medicaid agencies to test as they implement reward strategies.

Medicaid Approaches

Florida. AHCA "backed" into their reward levels by first determining the maximum amount a recipient could earn in a year. The state settled on $125, which would enable recipients to spend approximately $10 per month on health related products. Once the upper bound was set, the state decided that rewards for annual behaviors would be $25, semiannual behaviors would earn approximately half that amount $15, and more frequent behaviors would earn $7.50. These amounts are considered initial "guesstimates" and the agency plans to monitor the frequency with which each reward is redeemed and will adjust the amounts as necessary in the future.

Idaho. The Idaho Wellness PHA was intended, in part, as a way for recipients to earn enough to pay the new $10 monthly premiums. Consequently, the amount recipients are eligible to earn in the Wellness PHA is equivalent to the amount of the premium. Recipients can earn 30 reward points (each point is equal to a dollar) per quarter for being up to date with a well child visit and immunizations. Participants in the Behavioral PHAs are eligible for two rewards of 100 points each, for a maximum total of 200 reward points (recipients can not participate in both weight loss and tobacco cessation to earn above that level).

Recipients' Initial Attitudes

The survey sought to test how important the amount of the reward was to parents of children enrolled in Medicaid in Florida. Parents were asked whether their child would engage in four healthy behaviors if a reward were given. The amount of the incentive was randomized, so that respondents either were told that the reward was $10, $25, or $50.

Table 1 shows that respondents did not appear to be influenced by the amount of the reward. Those who were told the reward was $10 were equally likely to report that their child would engage in the behaviors as those who were told the reward was $50.[d]

Table 1: Percent of Respondents Reporting Their Child Would Be "Very Likely" to Engage in Healthy Behavior Given Reward Levels

Amount of Reward	Healthy Behavior			
	Enrolling in Exercise Class	*Not Missing Any Primary Care Appointments*	*Annual Well Child Visit*	*Annual Dentist Visit*
$10	62.2	65.9	80.8	85.9
$25	61.6	64.1	79.8	79.7
$50	60.2	67.1	77.4	83.4

Data source: Telephone survey of 800 parents/guardians of children with Medicaid conducted in the summer/fall of 2006.

What Can be Purchased with Rewards?

Literature Synthesis

A few studies have examined the importance of the type of reward on influencing healthy behaviors. These studies have compared the influence of cash incentives with use of gift certificates. Cash incentives consistently resulted in higher rates of simple wellness behaviors than did gift certificates, though gift certificates were still quite effective.[23-25] Malotte and colleagues, for example, found that 95% of drug users returned for reading of their tuberculosis screening when offered a $10 cash incentive, compared with 86% and 83% respectively for those receiving two different types of $10 gift certificates (one for a grocery store and the other for a bus pass or fast food).[25] While less effective than cash, the gift certificates were still substantially more effective than providing no incentive. Only 49% of those receiving returned for the reading of their screening test when no incentive was offered. This literature is still undeveloped, and it is not known what types of gift certificates are the most effective.

Medicaid Approaches

Cash incentives were not considered by either Florida or Idaho's Medicaid agency. Both agencies wanted to make sure that recipients could only purchase products and services that were, in fact, healthy.

Florida. Medicaid recipients in Florida can use their reward money to purchase approved pharmacy products that are not covered by Medicaid. These include cough medicine, vitamins, dental supplies, first aid, and other specified over-the-counter products. All pharmacies that

[d] We find the same pattern of results when we examine only those respondents whose children did not report currently engaging in the behavior. The sample size is substantially reduced so we do not present those findings.

accept Medicaid are able to redeem the reward money from an individual's EBA account using an existing Medicaid pharmacy point of sale system.

AHCA had intended for recipients to be able to use reward money to pay for health care costs not covered by Medicaid. However, developing a debit card that limited the types of permitted purchases would have taken longer than Florida's Medicaid reform implementation time frame allowed. Because of this logistical problem, AHCA turned to using their existing pharmacy billing system so that recipients could purchase over the counter pharmacy products. AHCA still plans to implement a limited debit card at some point in the future.

Idaho. The Medicaid agency wanted recipients to be able to use the reward money to pay for health related courses, gym memberships, tobacco cessation supplies, and sports equipment for participating in a sports activity. In order to enable that flexibility, the Medicaid agency worked to develop community partners willing to accept vouchers from recipients (for which they then can bill Medicaid). Currently the YMCA, Boise Parks and Recreation, weight loss programs (including Weight Watchers and Curves), bicycle stores, pharmacies, department stores, and several other venders accept PHA vouchers. The Medicaid agency hopes in the future to partner with schools, so the money can be used to pay sports team related fees.

PHA participants can request vouchers to purchase health-related supplies or enroll in a health program by calling the Medicaid agency. For children who are not up to date on their premium payments, the PHA balance is automatically allocated to cover the cost of the premium.

Recipients' Initial Attitudes

The survey sought to examine whether the type of financial incentive influenced how likely children would be to engage in healthy behaviors. We asked whether respondents' children would engage in specific behaviors for a given reward. Respondents were randomized to hear different reward types when the question was asked: either over-the-counter pharmacy products, health care costs not covered by Medicaid, or, in one case, a sports program.

Table 2: Percent of Respondents Reporting Their Child Would Be "Very Likely" to Engage in Healthy Behavior Given Different Types of Rewards

Type of Reward	Healthy Behavior			
	Enrolling in an Exercise Class	*Not Missing Any Primary Care Appointments*	*Annual Well Child Visit*	*Annual Dentist Visit*
Over-the-Counter Pharmacy Products	55.3	66.7	81.0	82.3
Health Care Costs Not Covered by Medicaid	59.3	62.3	76.8	82.3
Payment for a Sports Program	68.7	n/a	n/a	n/a

Data source: Telephone survey of 800 parents/guardians of children with Medicaid conducted in the summer/fall of 2006.

Respondents showed no consistent preference between rewards in the form of over-the-counter pharmacy products and payment of health care costs not covered by Medicaid (Table 2).[e] More respondents reported their child would enroll in an exercise program when the reward was payment for the sports program. This sentiment was echoed in focus groups: “I think it would work better if it went toward the program you want me to sign my kid up for” and “I'm overweight and if I could get Medicaid to pay for me to go to a gym or something I'd do it.”

[e] Analyses that control for the randomized amount of the reward yielded findings that were substantively similar.

Early Lessons

Educating Recipients about Incentive Programs is Challenging

Educating Medicaid recipients about new initiatives is widely acknowledged to be challenging, given the low literacy skills of the population and the difficulty in reaching many recipients by mail.[26] Florida Medicaid staff report that introducing the EBA incentive program has been even a greater challenge than expected because the program differs fundamentally from other Medicaid initiatives. The concept of providing an incentive for engaging in healthy behaviors is unfamiliar to recipients, and consequently AHCA has found that it requires more explanation than other new initiatives.

Both AHCA and Idaho's Medicaid agency had the foresight to separate education on the incentive program from education about overall Medicaid reform. This reduced the sheer quantity of information recipients had to process, a sensible approach for a population with low literacy skills. AHCA was particularly concerned that recipients were able to differentiate the EBA program, in which recipients are automatically enrolled, from other Medicaid reform initiatives requiring up front decisions (e.g., which plan to join, whether to "opt out" of Medicaid, etc.). In Idaho, the roll out of the PHA programs was several months after other elements of Medicaid reform were implemented.

Both states are relying on recipient mailings to introduce the program. Despite developing materials at the 4th-grade level and conducting some pre-testing with recipients, AHCA found that there was substantial confusion over the universal form that was included in the mailing. This form is used to document enrollment in a health-related program, but a number of recipients submitted it trying to enroll in the EBA program (enrollment is automatic). AHCA no longer includes this form with the mailing and has made some minor changes to improve the clarity of their materials. This underscores the importance of testing all documents intended for recipient education and use.

Both states have phone numbers for fielding incentive program calls and have made key programmatic documents available on the Internet. While low income populations have relatively poor access to the Internet,[27] in the Florida parent survey over half of respondents (58%) had convenient access to the Internet. It remains to be seen whether recipients will rely upon Medicaid's online resources.

At this juncture, it is unclear whether the current efforts will adequately inform recipients about the incentive programs. Without recipient awareness and understanding of the incentive program, offering rewards will not be effective for catalyzing promotion of healthy behaviors. One recommendation is to use periodic account balance mailings as an opportunity to reinforce the key components of the program.

Educating Medicaid's Partners is Important

Medicaid agencies not only need to educate recipients about the program, but also need to educate Medicaid partners who recipients turn to when they have questions. In Florida's Reform counties, recipients are all enrolled in managed care plans. Thus, it is important that the plans have training on answering EBA questions and that the plan materials incorporate EBA

information. This is happening in Florida, but on a slightly delayed schedule. AHCA provided health plans a script for call centers several weeks after enrollment in reform plans began, and at the end of 2006 AHCA was still working to provide plans access to recipients' EBA balances. Health plans are not required to include EBA program information into member handbooks until September 2007, a year after the program began.

Idaho is relying heavily on PHA vendors to promote the incentive program. Vendors, like the YMCA are distributing program brochures. According to one Medicaid staff person, there is "'big' enthusiasm for how we can work together and promote each other."

It is Easier to Track Wellness Visits than Lifestyle Behavior Changes

Both Florida and Idaho are providing incentives for children who have an annual well-child check-up and are up to date on immunizations. These types of behaviors, as well as screening tests and other preventive visits, can be easily identified using CPT codes in claims data. In Idaho, where there are no Medicaid HMOs, the Medicaid agency can run the analysis of claims internally. In Florida the health plans run the claims analysis, since audited encounter data is not yet a reality. With this automated approach, recipients need not do anything to "deposit" credits for their healthy behaviors.

Changing lifestyle behaviors, like tobacco use and physical activity levels, holds the greatest potential for Medicaid savings, however, there are no existing systems to track whether Medicaid recipients make lifestyle changes or participate in relevant programs to support change. Tracking and rewarding behavioral accomplishments is far more difficult administratively than rewarding members who participate in programs that support behavioral change. Both Florida and Idaho have opted to reward participation in such programs. Both states developed forms that require program representative signature (and in one case a physician signature) to serve as triggers for crediting recipients' accounts.

Medicaid agencies can readily evaluate the impact of incentives on simple wellness behaviors through claims data analysis that compares program participants to a control group. Evaluating changes in lifestyle behaviors and/or participation in programs to support behavior change is more challenging due to the fact that there is no record of behaviors or participation prior to the incentive program or for comparison recipients.

There Are Benefits as Well as Limitations to Working with Existing Systems

Florida was able to take advantage of its existing pharmacy point of sale system for the incentive program. An account was established for each recipient, with only minor adjustments to the existing system. As a result, pharmacies that accept Medicaid have real time access to recipient EBA balances. This system required a relatively small amount of training for pharmacies (a PowerPoint presentation and informational materials), and the program was generally welcomed by large chain pharmacies.

The system was easy to implement, and the result is that recipients in Florida are able to purchase over the counter pharmacy products with their reward money using their Medicaid card. This presents some limitations, however. If, for instance, the agency wants to increase the reward level for a given behavior to spark more participation, it is questionable how much money

in pharmacy products would be attractive to recipients. One focus group respondent said, "I don't think we'd spend $30 in over-the-counter medications."

In contrast, Idaho was unable to create an electronic billing system for their PHA program. They have developed a manual billing process, in which recipients present a voucher to a participating vendor. The vendor, in turn, submits the voucher to Medicaid to be reimbursed for the cost of services. The Medicaid agency has faced some difficulty in getting major national chain pharmacies and stores to be willing to become PHA vendors because of the paper process.

Despite the logistical problems that Idaho has faced, the Medicaid agency has worked to identify community partners that are interested in offering health related programs to improve the health of Medicaid recipients. They found that many organizations have strategic goals that align with the state Medicaid agency. The voucher approach enables recipients to use their PHA funds to enroll and pay for approved health-related programs. According to the survey findings, being able to use reward money to pay for sports related programs will likely improve the effectiveness of the reward program.

Evidence-Based Policy Adjustments will Likely be Necessary

Incentive programs are new to Medicaid, and the literature on effective approaches to incentivizing healthy behaviors is quite limited. States have had little guidance on developing their incentive programs and have started with initial "guesstimates" for reward levels. Therefore, states should anticipate the need for careful program monitoring of what rewards are frequently earned and which are not. Florida is currently monitoring its EBA program results to determine whether there are some reward levels that need to be increased to stimulate greater participation in a given behavior.

Programs Should Address the Barriers Recipients Face in Engaging in Healthy Behaviors

When developing incentive programs, policymakers should be mindful of the barriers that Medicaid recipients face in engaging in healthy lifestyles. Three key barriers were repeatedly mentioned in parent focus groups and surveys in Florida. The first relates to accessing dental services. The majority of survey respondents (61%) report that it is difficult to find a dentist who accepts Medicaid. Focus group respondents further complained about long waits to see those dental providers accepting Medicaid patients. Second, transportation was a limiting factor that respondents mentioned repeatedly both with regard to accessing health care and healthy activities. Those who have a car cited the cost of gasoline, and those who didn't described being limited to where they could access health services. The third recurring issue that respondents mentioned was the high cost of sports related programs. One focus group member described trying to sign up for a Mommy and Me yoga class, "When I went to sign up for me and my son the lady told me it's $250 for the sign up but then it's $40 a month for the class. I said I can do Mommy & Me in my home."

Idaho's Behavioral PHA was developed to address some of the barriers recipients face in accessing affordable sports related programs. The Medicaid agency developed a list of approved providers, and the generous reward amount ($200) enables recipients to enroll in at least one physical activity class.

Other barriers can also be addressed by Medicaid agencies. For instance, several focus group participants requested that Medicaid develop and distribute a list of dental providers so it would be easier to locate providers that accept Medicaid. However, policymakers should acknowledge that in some cases the barriers, such as transportation problems, may not be overcome by providing a small financial incentive.[28]

Conclusion

Florida and Idaho are on the forefront of a trend in Medicaid to incentivize healthy behaviors. The two states have developed very distinct programs. Florida encourages all recipients in reform counties to participate, whereas Idaho's program is targeted to three groups (children paying monthly premiums, tobacco users, and people with weight management issues). Florida has created its program to align with existing systems, relying on the pharmacy billing system for controlling which products can be purchased with account balances. Idaho sought to enable recipients to participate in programs and buy supplies for physical activity and tobacco cessation they might not otherwise be able to afford. The state had to create new partnerships with community programs and develop new systems to enable recipients to access these opportunities.

The public health literature reflects positively on the potential for these incentive programs to improve rates of one-time wellness behaviors. Most prior studies were conducted with low income, vulnerable populations, and were effective at improving wellness behaviors. The evidence on using incentives to improve fundamental lifestyle behaviors, like weight management and tobacco cessation, is more mixed. There are only a few studies that have evaluated changes in health behaviors when program participation was rewarded. While they did not find the approach to be successful, the studies had small samples and are several decades old. If changes do occur, sustaining the changes will likely prove challenging. The handful of studies that have followed recipients after the incentives ended have consistently found the incentive effect dissipates. Volpp and colleagues have argued that starting the process of making lifestyle change is important, even if it is not sustained since most people who succeed in quitting smoking have had failed attempts in the past.[12]

There is little evidence from prior studies on how much incentive is needed to influence behavior change, the type of reward that is most effective, or which behaviors are most amenable to change. Clearly much remains to be learned about using incentives to encourage healthier behaviors. It is not clear how much money is needed to stimulate behavior changes or what types of rewards are the most effective. States can help add to this literature by conducting rigorous evaluations of their efforts. By identifying the most effective elements of these programs, successful consumer incentive strategies can be replicated in other states.

References

1. United States Department of Health and Human Services. *HHS Approves Historic Medicaid Reform Plans in Kentucky*. Washington, DC: United States Department of Health and Human Services, 2006.

2. Wisconsin Department of Health and Family Services. *Badgercare Plus Proposal*. Madison, WI: Wisconsin.gov, 2006.

3. Greene J. *State Approaches to Consumer Direction in Medicaid*. Center for Health Care Strategies, Inc. June 2007.

4. South Carolina Department of Health and Human Services. *South Carolina Healthy Connections: The Medicaid Transformation Plan*. Columbia, South Carolina: The South Carolina Department of Health and Human Services, 2006.

5. Bush J. *Medicaid Today: The States' Perspective*. Washington DC: The House Committee on Energy and Commerce, 2003.

6. Halpin H, McMenamin S, Cella C, et al. "State Medicaid Coverage for Tobacco-Dependence Treatments--United States, 2005." *Morbidity and Mortality Weekly Report*. 2006;55:1194-1197.

7. Florida Agency for Health Care Administration. *Florida Medicaid Reform Application for 1115 Research and Demonstration Waiver*. Tallahassee: Florida Agency for Health Care Administration, 2005.

8. Mokdad AH, Marks JS, Stroup DF, et al. "Actual Causes of Death in the United States, 2000." *Journal of the American Medical Association*. 2004;291:1238-1245.

9. US Department of Health and Human Services. *Healthy People 2010. 2nd Ed. With Understanding and Improving Health and Objectives for Improving Health*. Washington, DC: U.S. Government Printing Office, 2000.

10. Kane RL, Johnson PE, Town RJ, et al. A Structured Review of the Effect of Economic Incentives on Consumers' Preventive Behavior. *American Journal of Preventive Medicine*. 2004;27:327-352.

11. Malotte CK, Rhodes F, Mais KE. "Tuberculosis Screening and Compliance with Return for Skin Test Reading among Active Drug Users." *American Journal of Public Health*. 1998;88:792-796.

12. Volpp KG, Gurmankin Levy A, Asch DA, et al. "A Randomized Controlled Trial of Financial Incentives for Smoking Cessation." *Cancer Epidemiology, Biomarkers & Prevention*. 2006;15:12-18.

13. Follick MJ, Fowler JL, Brown RA. "Attrition in Worksite Weight-Loss Interventions: The Effects of an Incentive Procedure." *Journal of Consulting and Clinical Psychology*. 1984;52:139-140.

14. Jeffery RW, Thompson PD, Wing RR. "ffects on Weight Reduction of Strong Monetary Contracts for Calorie Restriction or Weight Loss." *Behaviour Research and Therapy*. 1978;16:363-369.

15. Donatelle R, Hudson D, Dobie S, et al. "Incentives in Smoking Cessation: Status of the Field and Implications for Research and Practice with Pregnant Smokers." *Nicotine & Tobacco Research*. 2004;6 Suppl 2:S163-179.

16. Donatelle RJ, Prows SL, Champeau D, et al. "Randomised Controlled Trial Using Social Support and Financial Incentives for High Risk Pregnant Smokers: Significant Other Supporter Program." *Tobacco Control*. 2000;9:iii67-iii69.

17. Gilbert DG, Crauthers DM, Mooney DK, et al. "Effects of Monetary Contingencies on Smoking Relapse: Influences of Trait Depression, Personality, and Habitual Nicotine Intake." *Experimental and Clinical Psychopharmacology*. 1999;7:174-181.

18. Stitzer ML, Bigelow GE. "Contingent Reinforcement for Carbon Monoxide Reduction: Within-Subject Effects of Pay Amount." *Journal of Applied Behavior Analysis*. 1984;17:477-483.

19. Harland J, White M, Drinkwater C, et al. "The Newcastle Exercise Project: A Randomised Controlled Trial of Methods to Promote Physical Activity in Primary Care." *BMJ*. 1999;319:828-832.

20. Agency for Health Care Administration. *Enhanced Benefits Accounts Program Frequently Asked Questions*. Tallahassee, FL: Agency for Health Care Administration,, 2006.

21. Giuffrida A, Torgerson DJ. "Should We Pay the Patient? Review of Financial Incentives to Enhance Patient Compliance." *BMJ*. 1997;315:703-707.

22. Jeffery RW, Gerber WM, Rosenthal BS, et al. "Monetary Contracts in Weight Control: Effectiveness of Group and Individual Contracts of Varying Size." *Journal of Consulting and Clinical Psychology*. 1983;51:242-248.

23. Kamb ML, Rhodes F, Hoxworth T, et al. "What About Money? Effect of Small Monetary Incentives on Enrollment, Retention, and Motivation to Change Behaviour in an Hiv/Std Prevention Counselling Intervention." *Sexually Transmitted Infections*. 1998;74:253-255.

24. Deren S, Stephens R, Davis WR, et al. "The Impact of Providing Incentives for Attendance at Aids Prevention Sessions." *Public Health Reports*. 1994;109:548-554.

25. Malotte CK, Hollingshead JR, Rhodes F. "Monetary Versus Nonmonetary Incentives for Tb Skin Test Reading among Drug Users." *American Journal of Preventive Medicine*. 1999;16:182-188.

26. Kaplan S, Greene J, Molnar C, et al. *Educating Medicaid Beneficiaries About Managed Care: An Overview of Approaches Taken in Thirteen Cities*. New York: Commonwealth Fund, 2000.

27. Madden M. *Internet Penetration and Impact*. Washington, DC: Pew Internet & American Life Project, 2006.

28. Post EP, Cruz M, Harman J. "Incentive Payments for Attendance at Appointments for Depression among Low-Income African Americans." *Psychiatric Services*. 2006;57:414-416.