COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

PATRICK W. FINNERTY
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

September 25, 2008

The Honorable R. Edward Houck
Chairman, Joint Commission on Health Care
Post Office Box 1322
Richmond, Virginia 23218

Dear Senator Houck:

The 2008 Acts of Assembly, Chapter 879, Item 306 SS, directed the Department of Medical Assistance Services (DMAS) to develop a plan to implement a system of monetary incentives for Medicaid recipients to make healthy decisions and to engage in self-management of their healthcare. This plan was required to be submitted by October 30, 2008.

Attached is the DMAS plan fulfilling the requirement stated above. If you have any questions or would like to discuss this plan in detail, please do not hesitate to contact me.

Sincerely,

Patrick W. Finnerty

PWF/sf
Enclosure

cc: The Honorable Marilyn B. Tavenner
Secretary of Health and Human Resources

Report on Enhanced Benefit Accounts

Virginia Department of Medical Assistance Services

October 2008

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Executive Summary

The 2008 General Assembly directed DMAS to develop a plan to implement a system of monetary incentives (Enhanced Benefit Accounts or EBAs) for Medicaid recipients to make healthy decisions and to engage in self management of their healthcare. This directive indicated that the EBA program would include the deposit of incentive funds in EBAs to be accessed by participants to purchase healthcare services or items that are not covered under the Virginia Medicaid program. The directive is found in Appendix I.

To comply with the General Assembly's directive, the Department of Medical Assistance Services (DMAS) has developed a plan for a pilot project which would include a system of patient incentives (EBAs) to promote general wellness and to encourage Medicaid fee-for-service participants in the Disease Management (DM) program to engage in healthy behaviors. Under this proposal, DM participants with specific chronic conditions could be rewarded for complying with their plan of care and following through with appropriate testing and preventive care. The program could start on a small scale with a limited number of chronic conditions with rewards which would reinforce healthy behaviors known to be clinically effective at improving the health status of individuals. For example, a patient with coronary artery disease could be provided with a $100 reward for receiving his scheduled cholesterol screening. A debit card with this amount could then be used by the participant to purchase vitamins or other approved items at a pharmacy.

Virginia's current DM program targets high-risk Medicaid fee-for-service patients with specific chronic diseases and provides them with patient education materials, telephonic case management services, and opportunities to self-manage their care. DMAS believes that this population would be the best group to test the concept of patient incentives for several reasons. DM program participants have costly chronic diseases which severely reduce their quality of life. Any intervention which promotes general wellness and encourages these individuals to engage in healthy behaviors could potentially have a large positive impact on their quality of life and reduce the cost of their care. In addition, the contractor that manages the DM program already has the administrative resources to efficiently mange EBAs for this population. Working within this structure would keep operational costs to a minimum.

Until the full details of the proposal are known, CMS will not provide definitive guidance on whether this proposal can be implemented through a Medicaid State Plan amendment or whether it would require the submission of a waiver. However, based on preliminary information, CMS staff indicated that the program may require a waiver, which takes several months before federal approval is obtained.

In the event that the General Assembly decides to pursue EBAs, this report attempts to provide a framework for developing an EBA program for the Medicaid fee-for-service population enrolled in the current Disease Management program. First, the report provides a brief background on EBAs in general, what other state Medicaid EBA programs have done to date, and a summary of Virginia's DM program. Next, the EBA

proposal itself is described. Finally, the report outlines the steps which might be needed to implement EBAs in FY 2010, including state and federal regulatory requirements.

Background

What are Enhanced Benefit Accounts?

Enhanced benefit accounts (EBAs) can be defined as incentive-based health care programs designed to reward clients for healthy behaviors. Incentives are earned based on behaviors that promote good health. Examples of these behaviors include receiving all scheduled immunizations, receiving all scheduled well-child screenings, and following treatment protocols for chronic health conditions, such as diabetes and heart disease.

EBAs are a relatively new concept for Medicaid programs in general, but several states have implemented programs, and many states are considering some form of an incentive program. The federal Deficit Reduction Act of 2005 (DRA) grants states greater flexibility to provide certain healthy incentive programs.

The Case for Patient Incentives

Several literature reviews that were examined for this report provide qualified support for the effectiveness of patient incentives in influencing people to engage in healthy behaviors. The notion of financial incentives to reward adherence to a plan of care has the potential to be especially effective for low income individuals such as Medicaid recipients.

One researcher who reviewed the literature on patient incentives indicates that most studies show that financial rewards for low income populations have a positive impact on efforts to promote discrete behaviors. However, the ability of rewards to impact more comprehensive lifestyle changes is not as clear. Only a few studies have followed participants after they no longer received incentives, but these studies show that the effect of the incentives diminish once they are no longer offered.[1]

Another group of researchers who conducted an extensive literature review made the following observations:[2]

- Patient financial incentives can enhance patient compliance and increase positive health behaviors but have not been effective in smoking cessation efforts.
- Studies have not examined the impact of varying the amounts or types of rewards, or how different racial, ethnic or income groups respond to incentives.
- The financial incentives studied are part of larger educational efforts, making it hard to isolate the effect of the financial incentives themselves.

- The amount of incentives used in the studied groups are relatively small, but appear to be effective for some behaviors in low income populations, suggesting that modest funding amounts may produce positive results.

A third group of researchers stress the fact that there have been few rigorous studies that evaluate the impact of patient incentives. Furthermore, they cite programs in two states, California and Florida, where a very low percentage of participants eligible for the rewards actually redeemed them. They argue that fully funding programs that impact lifestyle issues, such as smoking cessation programs, would be a better use of scarce Medicaid resources.[3]

Thus, the available research appears to agree on the following: 1) that relatively modest financial rewards can help to promote healthy behaviors among low income patients when limited to one-time behaviors such as well child visits, immunizations and cancer screenings; 2) the ability of rewards to impact more complex lifestyle changes is questionable; and 3) the optimal amount of the reward and the type of reward that is most effective in motivating participants to engage in healthy behaviors is not well established.

Patient Incentive Programs in Other States

Although many states appear to be interested in implementing patient incentives for the Medicaid population, only a small number of states have actually implemented these programs. A brief summary of the EBA programs in Florida, Idaho, and West Virginia follows.

Florida

Florida implemented EBAs as part of their larger pilot Medicaid reform effort, starting in two counties. Medicaid recipients can earn up to $125 per year for engaging in healthy behaviors (e.g. receiving immunizations, attending well-child visits, participating in disease management programs) which can be used to purchase health care related goods and services such as over-the-counter medications. The Florida reform involved moving many Medicaid recipients into MCOs which are responsible for tracking participation in healthy behaviors and reporting these behaviors to the State. The State then awards credits to clients for their healthy behaviors and tracks their balances in an EBA database. When recipients go to a pharmacy to redeem their reward, their Medicaid eligibility swipe card lets the pharmacist know what their EBA balance is so the pharmacy can authorize the purchase of a health related item not covered by Medicaid.

The Health Policy Institute (HPI) at Georgetown University has examined various facets of Florida's Medicaid Reform Program and issued a report in July 2008 on the EBA program.[4] HPI found that in the first 18 months of operation, EBA participants have received $12.5 million in credits for healthy behaviors. However, through March 2008, only about 10 percent of the credits had been redeemed. Only one in eight participants are using their credits. Although use of the credits appears to be increasing, HPI concluded that it was likely that many beneficiaries are still unaware of the program.

Most of the credits earned were for keeping primary care appointments; behaviors requiring participants to submit special forms for more complex behavioral changes have earned few credits, and no credits have been earned for health improvement activities such as exercise, weight loss, or smoking cessation programs. For HPI, the fact that many of the credits would arguably have been earned without the program, coupled with the lack of awareness about the program, calls into question the very premise that rewards are increasing healthy behaviors in this population. The researchers concluded there was little evidence to suggest that the program is achieving its objective. The HPI study is provided in Appendix II.

Idaho

Idaho's incentive program, Preventive Health Assistance (PHA), implemented in January 2007, has two components. The Wellness PHA applies to the State Children's Health Insurance Program (SCHIP) children who are rewarded for keeping well child appointments and immunizations current by receiving 30 points or $30 per quarter. These points can be used to help pay the $10 to $15 per child monthly premiums that families between 133 and 150 percent of the federal poverty level (FPL) are required to pay. The second component, the Behavioral PHA, applies to children and adults who meet the criteria, and express an interest in managing their weight or who are in tobacco cessation activities. Clients who sign up for weight loss or tobacco cessation activities get rewards that can be used to pay for program fees, fitness class fees and tobacco cessation support. Clients can earn up to $120 per year under the Wellness PHA and up to $200 per year under the Behavioral PHA. Participation in the Behavioral PHA was initially somewhat lower than anticipated, but officials indicate that they are satisfied with the progress they have had to date and they plan to continue the program for the foreseeable future.

Center for Health Care Strategies State Review of Florida and Idaho's Programs

The Center for Health Care Strategies (CHCS) reviewed the literature on patient incentives and examined Florida's and Idaho's efforts to provide patient incentives. Given the short time that these states' programs had been in operation at the time the review was done, CHCS had three major observations based on the limited experience from these newly implemented programs: 1) The concept of patient incentives for healthy behaviors is new to most Medicaid recipients. Educating recipients about this program presents a unique challenge. Both Florida and Idaho relied on mass mailings but Florida found that there was substantial initial confusion despite their efforts to simplify the language used. 2) It is much easier to track wellness visits than lifestyle changes. 3) The mechanism used for patients to redeem their rewards should be considered carefully taking into account both the ease of implementation and the ability to expand the rewards as the program grows.

West Virginia

Some observers have commented that West Virginia's main Medicaid reform component, which includes patient incentives, is more of a stick than a carrot. Under their reform, if members do not sign an agreement to utilize a medical home, comply with scheduled appointments, use the emergency room only in an emergency, and comply with plans of

care, they will receive a basic benefit package that has fewer benefits than were available prior to the reform initiative. West Virginia did propose an additional component whereby participants with member agreements also will have access to "Healthy Rewards Accounts", in which "credits" will be deposited into member accounts for healthy behaviors. These credits can be used for co-payments, non-covered services or other health related goods and services. This component has not been implemented yet. Recent reports indicated that only 5.5% of adults and 7.5% of children are receiving the more comprehensive benefit package. West Virginia officials have indicated that it is too soon to judge the success of their reform program since it has only been in effect statewide for five months.[5]

Virginia's Disease Management Program

To the extent that State policy makers determine whether or not to provide patient financial incentives, DMAS is proposing to limit EBAs, at least initially, to fee-for-service individuals enrolled in the current Disease Management program. The reasons for starting with the participants in the DM program are provided in the next section, but below is a brief summary of the DM program to provide additional context for the EBA proposal.

In general, disease management programs attempt to alleviate individuals and society of the physical, psychological, social, and economic pressures associated with chronic conditions and diseases. The goal is to promote general wellness and improve both the quality of patient care and slow the growth of health care costs. Many health insurance plans and most Medicaid programs now offer some form of DM which typically includes the following activities: the targeting of high-risk patient populations, the promotion of evidence-based treatment plans with primary care physicians, patient self-management and education programs, patient monitoring and provider feedback, and, a rigorous system of evaluation.

Virginia's DM program, *Healthy Returns*, is managed by an independent entity, Health Management Corporation (HMC), and was implemented on January 13, 2006. *Healthy Returns* provides DM services to Medicaid and FAMIS fee-for-service participants with asthma (adults and children), congestive heart failure (age 18+), coronary artery disease (age 18+), diabetes (adults and children), and chronic obstructive pulmonary disease (age 18+). The program focuses on care management facilitated through the following interventions: 1) baseline health status assessment, 2) routine monitoring, 3) education on health needs and self-management, 4) monitoring of participant compliance with self-management protocols, and 5) facilitation of contact with providers and community agencies. Program participants also have a 24 hours per day, seven days per week toll-free nurse line available which provides clinical support to answer questions and assist participants with referrals.

DMAS is also in the process of developing a Chronic Care Management (CCM) program to address the needs of individuals with chronic conditions who account for a disproportionate amount of spending in Virginia's Medicaid and FAMIS fee-for-service

programs. These individuals need enhanced, comprehensive care management services with specific focus on cost reduction. Individuals eligible for enrollment in the DM program will not be enrolled in the CCM program. Enrollment in the CCM program will be voluntary. Depending on how this program is implemented and how it compliments the DM program, it might be appropriate to include EBAs for this population at some point. The preliminary implementation date for the CCM program is January 2009, but this will depend on the federal and state approval process.

Virginia's EBA Proposal

EBA programs are based on the idea that patient incentives would further incentivize individuals with chronic health conditions to manage their condition through adherence to a plan of care and through general healthy behaviors. This healthy behavior is anticipated to promote wellness and defer future healthcare costs related to acute episodes of care associated with unmanaged chronic conditions by preventing those episodes of care. Essentially, there are three main components to consider in implementing EBAs: 1) which healthy behaviors to reward, 2) the amount of the rewards, and 3) the nature of the rewards.

In response to the General Assembly's directive, DMAS is proposing to provide incentives to fee-for-service participants in the Medicaid DM program. Individuals with one of three chronic conditions could receive rewards for complying with specified measures which were chosen because of their potential to improve the health status of those individuals. Patients who engage in these healthy behaviors could receive financial rewards or credits that could be deposited in an Enhanced Benefit Account (EBA). For example, DMAS could provide a yearly $100 reward for participants with diabetes for complying with recommended screenings of average blood sugar levels.

DMAS proposes to link the EBA program to the DM program, at least initially, for several reasons. First, the individuals in the DM program have chronic conditions which severely reduce their quality of life and are very costly to treat. Second, the DM participants have expressed an interest in taking proactive measures to improve their health and general wellness. Offering patient incentives to this population might provide a little more motivation for them to make healthy choices which will improve their quality of life and reduce the cost of their care in the long run. Third, there are also sound programmatic reasons for working within the framework of the DM program. DMAS already contracts with an independent entity which administers the program. As such, this contractor has already identified these participants and has a record of their compliance with healthy behaviors. Since these behaviors are claim based, the administrative task of tracking the behaviors and crediting individual rewards is greatly simplified. Furthermore, the most efficient way to distribute patient rewards is through the use of debit cards which must be administered through an outside vendor. Any contractor overseeing the DM program could easily be able to manage a debit card program for the enhanced benefit accounts.

The goal of the EBA program is to provide additional incentives to encourage individuals to engage in healthy behaviors which are largely preventive in nature. The participants could improve their health, avoid additional complications associated with their chronic conditions and achieve a level of wellness that would not be possible otherwise. Not only does it make sense to focus on wellness activities from a health standpoint—it also is one of the most practical and cost-effective ways to implement an EBA program.

As the Center for Health Care Strategies has found from studying the early implementation stages of currently operating EBA programs, it is much easier to track wellness visits than lifestyle changes. One-time behaviors such as annual well-child checkups can be tracked through standard Current Procedural Terminology (CPT) codes using existing information systems and the participant incentive accounts can be automatically credited with no action required on the participants' part. Tracking lifestyle changes and activities on the other hand, requires greater cooperation on the part of participants and outside entities.

EBA Program Details

Medicaid fee-for-service recipients with the following conditions can enroll in Disease Management program: asthma, coronary artery disease, congestive heart failure, diabetes, and chronic obstructive pulmonary disease. The contractor administering the DM program currently tracks compliance rates for various preventive behaviors for each condition. The patient incentive program could provide rewards to participants with conditions where the compliance rate with specific healthy behaviors is significantly below the Contractor's average compliance rate for its other clients. Clinical experts believe that increasing compliance rates for the conditions and behaviors listed in Table I below would have the greatest potential to improve participants' health status. The current compliance rate for DM program participants is listed along with the average compliance rate for the Contractor's other clients.

Table I: Behaviors Rewarded

Condition	**Healthy Behavior**	**Contractor's Average Compliance Rate**	**Virginia's DM Compliance Rate**
Diabetes	A1C testing (Average blood sugar levels over several months.) OR LDL testing (Cholesterol level testing)	60%*	38%*
Coronary Artery Disease (CAD)	LDL testing	55%	16%
Asthma	Measure of patients' compliance with taking preventive or control medications.	81%	34%

* These rates represent a combined compliance rate for A1C testing and LDL testing.

The goal of the program could be to increase the compliance rates by 10 percent annually, for example. The program could provide a yearly, one-time reward of $100 to participants who comply with the selected healthy behaviors. The reward could be provided to the participants in the form of a debit card which could be used to buy health-related items at a pharmacy that are not covered under the Medicaid program, such as non-covered over-the-counter medications (certain over-the-counter medications can currently be covered by Medicaid if prescribed by a physician).

The cost estimate for the EBA proposal includes $1,148,503 in total funds for costs in the first year. In addition to the annual $100 reward amounts, DMAS is suggesting that a small administrative fee be paid to the DM contractor to cover the cost of promotional and educational activities, the cost of identifying the patients who have completed the healthy behaviors, and the administrative costs associated with the debit cards. Estimated program costs for the first year are summarized in Table II, with out year funding provided in Table III (administrative costs are increased by five percent annually).

Table II: First Year Cost Estimate

Condition/ Behavior	Projected Number of Participants Complying	Total Amount of Rewards	Administrative Costs	Total Cost (Total Funds)
CAD Annual LDL test	1,052	$105,230	$11,219	$116,449
Diabetes Annual LDL or A1C Test	2,421	$242,080	$25,810	$267,890
Asthma Rescue/ Control Medications	6,905	$690,540	$73,624	$764,164
TOTAL	10,378	$1,037,850	$110,653	$1,148,503

Table III: Cost Summary—FY 2010 - 2015

	General Fund Dollars	**Non-General Fund Dollars***	**Total Costs**
FY 2010**	$287,126	$287,126	$574,252
FY 2011	$577,018	$577,018	$1,154,036
FY 2012	$579,922	$579,922	$1,159,845
FY 2013	$582,972	$582,972	$1,165,945
FY 2014	$586,175	$586,175	$1,172,349
FY 2015	$589,537	$589,537	$1,179,074

* The nongeneral fund source is Federal Trust Funds. The Virginia Medicaid Program is funded with both federal and state funds. The current federal funding participation for medical assistance expenditures is 50 percent

** This cost summary assumes the program would be implemented January 2010, thus the FY 2010 costs represent half of the fiscal year.

While these cost estimates represent the potential costs of an EBA program, it may be more prudent to allow DMAS to design the program around the amount of funding made available to implement the EBAs.

Federal and State Requirements

Appropriations Language

If the General Assembly were to approve this project, the agency would need budget authority and funding to implement the program. Suggested Appropriations Act Language for 2009 to accomplish this is provided below:

> Contingent upon federal approval, the Department of Medical Assistance Services shall amend its disease state management program to include a patient incentive program for healthy behaviors, effective January 2010. Included in this appropriation is $287,126 from the general fund and $287,126 from nongeneral funds in the second year. This funding is intended to address incentives associated with measures for Asthma, Coronary Artery Disease, and Diabetes. Upon federal approval, the Department shall have the authority to implement this program on or after January 1, 2010, and prior to the completion of any regulatory process undertaken to effect this new program.

Federal Waiver Application

As mentioned earlier, DMAS contacted CMS with preliminary information about the EBA proposal. CMS staff indicated that this program would most likely require the submission of an 1115 Research and Demonstration Waiver. DMAS had hoped that the additional flexibility afforded by the DRA might allow for the implementation of the EBA program through a Medicaid State Plan amendment which is faster, but it looks like it may have to be done through the waiver process. The approval of a waiver by CMS can take 3 to 12 months.

State Regulations/State Plan Amendment

The agency would also have to amend the State regulations and the Medicaid State Plan to account for the changes called for in this program. The proposed Appropriations Act language above would provide authority to get emergency regulations passed to expedite the implementation of EBAs once federal approval is obtained.

Project Timeline

If the appropriations language is approved and funding is provided for the EBA program, the federal approval of the waiver would likely constitute the biggest impediment to starting the program. This waiver process can be somewhat time-consuming. For this reason, if the General Assembly decided to implement the program, it may not be

possible to start until January 2010 or even later if federal approval of the waiver is delayed.

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3. Redmond P, Solomon J, Lin M. *Can Incentives for Healthy Behavior Improve Health and Hold Down Medicaid Costs*? Center on Budget and Policy Priorities. June 2007

4. Alker, Joan, Hoadley, Jack. *The Enhanced Benefits Rewards program: Is it changing the way Medicaid beneficiaries approach their health?* Health Policy Institute, Georgetown University. July 2008.

5. Kaiser Daily Health Policy Report. June 19, 2008. http://kaisernetwork.org/daily_reports

Appendix I

2008 Acts of Assembly
Chapter 879
Item 306 SS

The Department of Medical Assistance Services (DMAS) shall develop a plan to amend the State Plan for Medical Assistance or submit a research and demonstration project waiver pursuant to Section 1115 of Title XIX of the Social Security Act, as amended, to implement a system of monetary incentives for Medicaid recipients to make healthy decisions and to engage in self-management of their healthcare, and the deposit of incentive funds in enhanced benefits accounts to be accessed by enrollees to purchase healthcare services or items that are not covered under Virginia Medicaid and which will assist enrollees in being personally responsible for their own healthcare. The plan shall include the development of necessary changes in funding, law or regulations for the implementation of the changes. The plan is to be submitted to the Governor, the Secretary of Health and Human Resources, the Joint Commission on Health Care, and the Chairmen of the House Appropriations and Senate Finance Committees by October 30, 2008, for consideration in the development of amendments to the 2008-10 Appropriations Act.

Appendix II

Evaluation of Florida's Enhanced Benefits Rewards Program

Health Policy Institute—Georgetown University

(Begins next page)

The Enhanced Benefits Rewards Program: Is it changing the way Medicaid beneficiaries approach their health?

Florida's Experience with
MEDICAID REFORM

Key Findings

- Beneficiaries have earned $12.5 million in credits, but only about 10 percent of those credits have been spent to date.
- Many program participants seem unaware of the rewards program, but those who are aware are enthusiastic about the ability to purchase needed items.
- Many beneficiaries and providers are skeptical that the program encourages healthy behaviors; furthermore, there is little evidence that beneficiaries are changing their behavior.
- Program administrative costs have been high, raising concerns about the program's efficiency.

Background

One of the objectives of Florida's Medicaid reform pilot program is to encourage "healthy practices and personal responsibility" by rewarding good choices. The state anticipated that "individual health outcomes will improve as people take an active role in managing and understanding their health needs."[1] The idea of the Enhanced Benefits Rewards Program[2] is simple on its face. By providing beneficiaries with rewards to encourage them to engage in "healthy behaviors," such as taking a child for a well-child visit, getting a flu shot or stopping smoking, the state would encourage participants to improve their health while presumably lowering costs.

Florida is one of a handful of states trying to incorporate incentives for healthy behaviors in its Medicaid program.[3] Policymakers at both the state and federal levels are interested in these approaches. The success or failure of this component of Florida's Medicaid reform, consequently, holds widespread interest.

Medicaid has a particularly challenging task in reaching a goal of informed beneficiaries able to control their "health destiny." Medicaid beneficiaries have more chronic physical and mental illnesses than the population as a whole, and also have lower rates of health literacy and higher rates of limited English proficiency. The limited incomes of Medicaid beneficiaries pose additional challenges: Did the beneficiary miss a doctor appointment because he could not afford the gas money or other transportation to get there? Can a mother enroll her child in an exercise program to earn a reward if the cost has to come out of her food budget?

Do incentive programs work in general?

Offering incentives for healthy behaviors is an idea with growing and intuitive appeal beyond the Medicaid program, especially as health challenges such as obesity continue to attract attention. In the private sector, much of the focus on wellness initiatives has come from employers searching for ways to keep costs down. Whether these programs will save money and improve health is not yet clear, in part because many of the programs are new.[4]

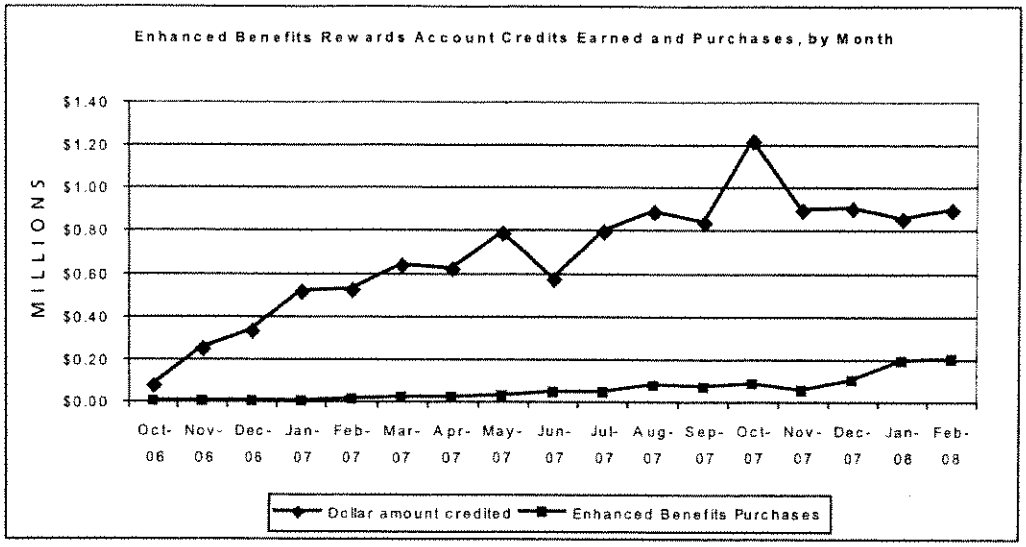
Rigorous studies of incentive programs in general have shown mixed results. The federal Agency for Healthcare Research and Quality (AHRQ) concluded in 2004 that "we may guardedly say that economic incentives are effective in the short run for simple preventive care.... There is insufficient evidence to say [they] are effective for long term lifestyle changes required for health promotion."[5] Later research done by AHRQ raised questions about the cost-effectiveness of these programs, given the costs of creating the necessary infrastructure to set them up, market them, and administer them, and noted the lack of evidence that they change clinical outcomes.[6]

How is Florida's Enhanced Benefits Rewards Program structured?

Every Medicaid beneficiary participating in Florida's Medicaid pilots, operating in Baker, Broward, Clay, Duval, and Nassau counties, is eligible to receive up to $125 in credits annually for engaging in certain activities. These range from single events such as well-child visits, other preventive office visits, immunizations, flu shots, and cancer screenings to more difficult lifestyle changes such as participating in a six-month alcohol or drug treatment program or a weight loss or exercise program.[7]

The Jessie Ball duPont Fund has commissioned researchers from Georgetown University's Health Policy Institute to examine the impact of changes to Florida's Medicaid program in Broward and Duval counties. This policy brief is the sixth in a series and provides insight into whether special components of the reform program are functioning effectively.

JESSIE BALL DUPONT FUND



Source: Georgetown analysis of data from Florida's Medicaid Reform Enhanced Benefits Program, Technical Advisory Panel Meeting presentation, April 11, 2008.

Amounts credited range from $7.50 for medication compliance up to $25 for a pap smear or a child wellness visit. Credits can be awarded in two ways – automatically when a provider submits billing paperwork with a diagnostic code matching one of the desired behaviors or, for more complex behaviors, when a beneficiary submits a signed form to their health plan indicating that they are participating in a disease management, weight management, smoking cessation or exercise program. The form must be signed by the beneficiary as well as the provider or program sponsor. Individuals receiving credits may redeem them at participating pharmacies for specified products, such as vitamins, bandages or over-the-counter medications.[8] Participants cannot redeem their credits for cash.

Separately from the Enhanced Benefits Rewards Program, some managed care plans participating in the pilots, like Medicaid managed care plans across the country, are able to offer expanded benefits. Of the plans operating in the five counties, most are offering extra services, such as $10 or $25 a month in over-the-counter medications, as part of their efforts to attract enrollees. The similarity of these extra services to the enhanced benefits program, however, is potentially confusing to beneficiaries.

How is Florida's program working so far? Are people earning credits?

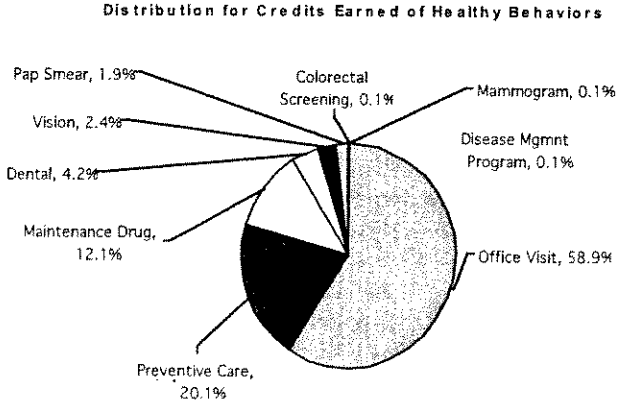
In its first 18 months since participation began in September 2006, Medicaid beneficiaries in the Enhanced Benefits Rewards Program have been awarded a cumulative total of $12.5 million in credits for their healthy behaviors. Yet as of March 2008, state data indicates that only about 10 percent of the credits ($1.2 million) had been redeemed. In all, 27,140 beneficiaries (about one in eight of those participating in the reform pilots) have used any of their credits. Use of the credits has consistently lagged behind the amount of credits accumulated each month throughout the program's history, although there has been an increase in use recently.

Beneficiaries receive an account statement each month or quarter (depending on their level of activity), and late in 2007 the program started inserting one-page flyers with the statements promoting specific products beneficiaries could purchase. The state credited these inserts for more than doubling monthly beneficiary spending in February 2008, compared with December 2007.[9] The increased use, however, still accounted for only 22 percent of the credits that beneficiaries earned that month. The discrepancy between credits earned and spent could be due to a number of causes; for example, some might be saving their credits towards larger purchases. But it seems likely that a substantial number of those earning credits are still unaware of the program – a significant problem in a program whose success is premised on the active engagement and knowledge of the participants.

What are people earning credits for?

Nearly 60 percent of Enhanced Benefits credits earned have been the result of adults and children keeping their primary care appointments.[10] The state's reports, however, do not distinguish primary care appointments for an illness from wellness visits. Another 20 percent of credits have been earned as a result of preventive care (mostly screenings and immunizations for children) and 12 percent for compliance with prescribed maintenance drugs. Other behaviors were far less frequent – for example, pap smears represented 2 percent of all credits.

Behaviors that require beneficiaries to submit a form for credit and involve a more complex behavioral change have garnered few credits. For example, disease management programs have been responsible for only 0.1 percent of all credits (fewer than 1,000 cases). No credits have been earned for participation in health improvement activities such as exercise, weight loss, or smoking cessation programs, even though most plans had developed criteria by April 2007 for awarding these credits.[11]



Source: Georgetown analysis of data from Florida's Medicaid Reform Enhanced Benefits Program, Technical Advisory Panel Meeting presentation, April 11, 2008.

Selected Activities for Which Medicaid Beneficiaries Could Earn Credits 9/06-6/08		
Healthy Behavior	**Credit Earned**	**Limit Per Year**
Keep all primary care appointments (Children)	$25	Any combination up to 5
Preventive screenings and immunizations (Children)	$25	
Wellness visits (Children)	$25	
Dental cleaning (Adults)	$15	2
Keeps all primary care appointments (Adults)	$15	2
Mammography screening (Adults)	$25	1
Colorectal screening (Adults)	$25	1
Vision exam	$25	1
Disease management participation	$25	1
Exercise program participation	$25	1
Exercise program 6-month success	$15	2

Selected Products and Supplies Available Through the Enhanced Benefits Rewards Program	
Antacids	Multivitamins (Children and adults)
Antidiarrheals	Nose drops
Baby care products	Pain medications
Bandages and wound dressings	Shampoo
Braces and related health aids	Sleep aids
Cough and cold preparations	Stomach acid reducers
Dental products	Sunscreens
Ear drops and wax removal	Thermometers
Eye drops	Topical creams and lotions
Hearing aid batteries	Vaginal preparations
Laxatives	Vaporizers and hot water bottles
Only over-the-counter products are covered	

Indeed, the most common behaviors being rewarded seem to be those for actions people might likely have taken in the absence of the program. This, together with the fact that many may not even be aware that credits are available, raises questions about the premise that beneficiaries are being directed toward healthier behaviors by tangible rewards. In fact, the state's advisory panel tentatively decided in March 2008 to award credits only for office visits in the first 60 days of enrollment and to reduce payments for adult visits by half to $7.50. These changes are scheduled to begin at the start of the program's third year (July 1, 2008).

Initial administrative expenses associated with the Enhanced Benefits program included two vendor contracts: (1) to create and maintain an information system to manage the accounts and (2) to establish a call center to handle inquiries.[12] Total first-year administrative costs were reported in September 2007 as $1.1 million, an amount that well exceeded the less than $300,000 total credits redeemed by beneficiaries in the program's first year, thus raising additional questions about the program's efficiency. Some of these are one-time costs and others are recurring, but it is difficult to determine the scope of ongoing costs.[13] The state has not reported information on the second year's administrative costs.

What do participants think of the program?

During three rounds of focus groups with 124 participants conducted in Broward and Duval counties by Georgetown University researchers, disabled adult Medicaid beneficiaries and the parents of children enrolled in Medicaid were asked what they knew about the Enhanced Benefits program. In the summer of 2006, after some initial publicity around the reform pilots but before enrollment had begun, most beneficiaries had not heard of this element of reform. In January 2007, beneficiaries had been enrolled in reform plans for a few months, but most still were unaware of the availability of credits. Some who seemed to know about the program appeared to confuse it with the "extra services" benefits for over-the-counter drugs available from some plans. By the spring of 2008, nearly half the beneficiaries in the focus groups were aware of the Enhanced Benefits program, although distinguishing it from the "extra services" was still an issue.

Both in 2007 and 2008, some of the beneficiaries who knew about the program were not sure how to redeem the credits they had earned. In the first year, some confused credit statements with a bill for services. After the state made the statements clearer, some beneficiaries reported difficulties identifying available products or purchasing them at pharmacies. The state reported about 300 complaints regarding the Enhanced Benefits program in the three most recent quarters; well over half had complained that they had problems purchasing items at a pharmacy, while others called about issues such as differences between the shelf price and what they were charged for over-the-counter items.[14] Still, by the program's second year researchers heard from a subset of enthusiastic participants who were eager to tell their fellow focus group participants how they could purchase diapers, children's cold medicines, or other products. Others wanted to know whether they were eligible and how to use their credits. The state has acknowledged problems in marketing the program, and improvements it has implemented, together with growing familiarity over time, may be helping.

It remains less clear, however, whether beneficiaries accept the idea that credits will change behavior. Another study of Florida's program found it unclear whether current efforts will succeed in informing participants about the program; "without recipient awareness and understanding of the incentive program, offering rewards will not be effective for catalyzing promotion of healthy behaviors."[15]

In 2006, after being told how the program would work, focus group participants debated with each other whether it was fair to reward people for doing things they would likely do anyway. A few even raised the possibility of penalties for failing to do things, such as keeping appointments, while others suggested that benefits were justifiable if the changed behaviors saved the state money. In 2008, participants remained generally skeptical that the program would encourage healthy behaviors. Most who knew about the program seemed to see the credits as rewards for things they would do regardless. One woman who had received credit for her regular pap smear jokingly asked whether she could get another credit if she had an extra one done.

What do providers think of the program?

Some physicians and other providers interviewed for this project in 2006 indicated cautious optimism about the Enhanced Benefit pro-

gram's potential to improve compliance with appointments, immunizations, and medications. According to one mental health provider, it "could be good," suggesting that some patients would use it. But others were more pessimistic. One provider in Broward County said, "I'm not convinced that giving people a coupon in exchange for taking a diabetes course is going to encourage them to do better. There will be some that do it, but I'm not sure it's the best encouragement. We've found that personal contact is really what gets people to do the right, healthy thing."

By 2008, many providers still are not aware of the program. In preliminary results from Georgetown's latest survey of physicians practicing in Broward and Duval counties, three quarters of those responding were unfamiliar with the program even when a description was provided.[16] In stakeholder interviews conducted on project site visits, providers who reported in 2006 that they knew about the program seemed to have grown more skeptical, despite some increase in beneficiary awareness. Some thought it was not working yet, while others pointed to bureaucratic glitches that kept their patients from receiving their benefits. One Duval County provider said, "There's no indication that patients know about the enhanced benefits or are altering their behaviors as a consequence."

In a second question on the most recent physician survey, most respondents said they thought that the program is not changing the way beneficiaries try to keep themselves healthy. Providers interviewed on site visits still reported low awareness of the program among beneficiaries; "When we tell the patients they're surprised," said one. In fact, one physician thought that the entire concept of "healthy behaviors" needed refinement, and another thought the money could be better spent on provider reimbursement.

Conclusion

Working with beneficiaries to improve their health is a worthy objective, but there is little evidence to suggest that this program is achieving this objective. Factors include both the structure of Florida's program and the challenges it has faced upon implementation. Economic incentives are more likely to work for simple objectives, such as obtaining well-child visits, but not for more complex behaviors, such as losing weight or tobacco cessation. But even when beneficiaries earn credits, it remains unclear whether the program actually changes behavior.

Some beneficiaries are enthusiastic about participating in the program, but many still appear unaware of the program or how to redeem credits. Many think the credits are rewarding behaviors that would have occurred anyway. Providers also appear to have little awareness of the program. Lackluster redemption of the credits beneficiaries are earning and high administrative costs raise questions about the efficacy of this approach. Little evidence is available to show whether health outcomes have been improved.

ENDNOTES

[1] Florida Medicaid Reform Application for 1115 Research Demonstration and Waiver, October 19, 2005, p. 3.

[2] As of July 1, 2008 Florida is renaming its program – its new name is used throughout this brief.

[3] Idaho and West Virginia also have Medicaid programs underway, although West Virginia's program incorporates a more punitive approach which limits benefits for those who do not comply (or whose parents do not comply). Wisconsin and Michigan are undertaking new efforts.

[4] See D. Draper et al. *Health and Wellness: The Shift from Managing Illness to Promoting Health*' Center for Studying Health System Change, Issue Brief No. 121, June 2008.

[5] R.I. Kane et al. *Economic Incentives for Preventive Care* AHRQ Publication No. 04-EO24-2. Rockville, MD. Agency for Healthcare Research and Quality, August 2004.

[6] AHRQ Consumer Financial Incentives: A decision guide for purchasers. AHRQ publication 07(08) 0059. November 2007. Available at www.ahrq.gov

[7] For a complete list of the behaviors and how much participants can earn for each one, see http://www.fdhc.state.fl.us/Medicaid/Enhanced_Benefits/approved_credit_amounts_090106.pdf.

[8] For a complete list of products that can be purchased, see www.fdhc.state.fl.us/Medicaid/Enhanced_Benefits/classes.shtml

[9] Enhanced Benefits Purchases were $96,411.42 in December 2007; $192,645.31 in January 2008; and $201,582.12 in February 2008. Incomplete spending data for March 2008 showed purchases of $278,815.80 as of March 28, 2008. "Florida's Medicaid Reform Enhanced Benefits Program," Technical Advisory Panel Meeting presentation, April 11, 2008.

[10] Data on credits are taken from the AHCA presentation at the Medicaid Reform Technical Advisory Panel Meeting, April 11, 2008.

[11] Office of Program Policy Analysis and Government Accountability (OPPAGA), "Medicaid Reform Implementation Memorandum No. 4", May 2007.

[12] "Agency's Response to Questions from Marc Ryan Regarding the Funding of the Enhanced Benefits Account Program," Medicaid Reform Technical Advisory Panel Meeting., September 14, 2007.

[13] OPPAGA, "Medicaid Reform Implementation Memorandum No. 4."

[14] Agency for Health Care Administration, Florida Medicaid Reform: Quarterly Progress Reports for January 1, 2008 - March 31, 2008; October 1, 2007 - December 31, 2007; and July 1, 2007 - September 30, 2007.

[15] J. Greene, "Medicaid Efforts to Incentivize Healthy Behaviors," Resource Paper, Pub. 299, Center for Health Care Strategies, July 2007. http://www.chcs.org/usr_doc/Medicaid_Efforts_to_Incentivize_Healthy_Behaviors.pdf

[16] These findings are preliminary results from a survey sent to physicians in Broward and Duval counties in June 2008. Results reported include initial responses from more than 200 physicians who are members of the Broward and Duval county medical societies.

This report is made possible through the generous support of the Jessie Ball duPont Fund, The Community Foundation in Jacksonville and United Way of Northeast Florida.

It may be found online at www.dupontfund.org and at hpi.georgetown.edu/floridamedicaid

For more information:

Sherry P. Magill
President
Jessie Ball duPont Fund
One Independent Drive,
Suite 1400
Jacksonville, Florida 32202
904-353-0890

AUTHORS

Joan Alker
Jack Hoadley
Health Policy Institute
Georgetown University
3300 Whitehaven St. NW
Suite 5000, Box 571444
Washington, D.C. 20057
202-687-0880