New evaluation of Medicaid incentive programs shows need for improvement

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Policymakers at both the federal and state levels have, in recent years, supported incentive programs designed to influence Medicaid beneficiary behavior, in the hopes that such behavioral changes will improve beneficiaries' health and save the program money. Section 4108 of the Affordable Care Act (ACA) mandated the creation of an incentive program specifically aimed at individuals with chronic diseases, known as the Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) program. In addition, some states have created Section 1115 demonstrations that include incentives for beneficiaries who comply with certain healthy behaviors. The recently released Medicaid managed care rule provides new authority for states to use incentive programs in the context of Medicaid managed care and even for network providers within Medicaid managed care organization (MMCO) networks.

A recent **US Department of Health & Human Services report** (HHS Report) to Congress that was based on an **independent evaluation of the MIPCD demonstrations by RTI International** (RTI Report) casts doubt on the short-term cost-effectiveness of these incentive programs. The HHS Report should be used by the Centers for Medicare & Medicaid Services (CMS) and states to emphasize the need for careful design of incentive programs.

Background

In September 2011 CMS awarded MIPCD demonstration grants to 10 states under the authority of ACA section 4108, which calls for states to "develop *evidence-based* prevention programs that provide incentives to Medicaid beneficiaries to participate in *and complete* the MIPCD program."[1] Section 4108 also requires the demonstrations to be evaluated on:

- The effect of such programs on the use of health care services by Medicaid beneficiaries participating in the program;
- The extent to which special populations (including adults with disabilities, adults with chronic illnesses and children with special health care needs) are able to participate in the program;
- The level of satisfaction of Medicaid beneficiaries with respect to the accessibility and quality of health care services provided through the program; and
- The administrative costs incurred by state agencies that are responsible for administering the program.

CMS awarded five-year grants to the following states:

- California ($9.9 million)
- Connecticut ($9.9 million)
- Hawaii ($9.9 million)

- Minnesota ($9.9 million)
- Montana ($0.6 million)
- Nevada ($3.6 million)
- New Hampshire ($9.9 million)
- New York ($10 million)
- Texas ($9.9 million)
- Wisconsin ($9.2 million)

The states used this opportunity to design prevention programs around different populations and different chronic conditions. Incentives and interventions were designed to address smoking cessation, diabetes prevention and management, hypertension and weight reduction. The amount of savings an individual could receive varied widely by type of activity, such as attending a class, completing a primary care appointment or filling a prescription. Participants in New Hampshire, for example, could receive up to $1,860 annually for weight loss and $415 for smoking cessation.

Key RTI Report findings

The demonstration results on the required evaluation elements described above are mixed, both individually and collectively. On the positive side, the results show that special populations are able to participate and that the level of satisfaction among beneficiaries is very high: "Across all states, 94 percent of participants were very or somewhat satisfied with the programs, and about 74 percent said they would recommend the program to their friends or families. Similarly, participants found the programs to be very accessible. With regards to the objective of preventing chronic disease, participants thought the programs helped them make healthy changes in their behavior. Not surprisingly, participants liked receiving incentives, but they thought that the impact of the incentives was strongest in encouraging them to enroll in the program and less important later when improving health became a more important motivator."[2]

However, the results concerning the effect on the use of health care services and administrative costs are substantially less promising. CMS had initially set a 15 percent limit on administrative costs, but the evaluators estimate administrative costs to represent about 25 percent of overall expenditures.[3] Administrative costs may decline over time as more people are enrolled and there is greater use of the incentives, but the higher-than-expected costs could be a deterrent to the spread of incentive programs if CMS or states impose hard caps on administrative costs.

The majority of expenditures were attributed to services. Of particular interest, incentive payments during the first three years represented only about 7 percent of expenditures. This is likely to change over time for several reasons—most states fell far short of their enrollment goals, individuals did not have sufficient time to complete their programs in order to receive incentive payments, and states likely overestimated the amount of incentives that would be paid. States were challenged by delays and changes as programs moved from design to implementation. As one interviewee described, "Everyone underestimates the challenges of logistics and implementation."[4]

The critical question of whether these incentive programs have reduced health care costs has not yet been answered. The demonstrations generally track process measures, but not outcomes. The RTI Report concludes, "[t]o date, the claims analysis … has found that the incentive programs have statistically insignificant effects on utilization and expenditures. However, the claims data are not complete, and even if the incentives prevent chronic diseases, the effects of prevention on utilization and expenditures may not be apparent in the short term."[5]

RTI acknowledges that claims data will continue to be analyzed and the evaluation continues. A final report to

Congress on the demonstrations is expected after the CMS evaluation is completed in April 2017.

Lessons for states and CMS

Even though the evaluation continues, there are lessons to be learned from these demonstrations. The report's findings raise a question as to whether MMCOs have sufficient incentive to invest in incentive programs. While incentive payments may qualify as "quality improvement" activities and thus can be treated favorably in calculating an MMCO's medical loss ratio (MLR), the cost of designing, implementing, and administering the incentive program is not. The demonstrations clearly show that administrative costs are higher than expected and remain so beyond the first year of a program.

RTI clearly indicates that, if there are health care savings, they are not apparent in the short term. Given the disruptions entailed in enrollment and disenrollment processes, MMCOs may be hesitant to start costly programs that may not produce a reasonable return on investment. CMS and states should consider ways to let an MMCO keep an individual as a member for longer periods of time without disruption, to encourage plans to invest in incentive programs and other efforts to improve health and lower costs over the long term. CMS should also consider changing how prevention and wellness incentives are treated under the MLR provisions of the Medicaid managed care rule.

Conclusion

Well-designed incentive programs have been successful in the commercial market. Although the recent outside evaluator report provides no clear consensus with respect to success with Medicaid populations, the report does provide some future direction. Dentons experts can assist states, health plans and their partners who specialize in offering incentive programs navigate the regulatory challenges they face.

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[1] US Department of Health and Human Services, *Second Report to Congress: Medicaid Incentives for Prevention of Chronic Diseases Evaluation* (HHS Report), June 2016 (available at **https://innovation.cms.gov/Files/reports/mipcd-secondrtc.pdf**), at 2 (emphasis added); RTI International, *Independent Assessment Report: Medicaid Incentives for Prevention of Chronic Diseases Evaluation* (RTI Report), April 2016 (available at **https://innovation.cms.gov/Files/reports/mipcd-secondrtc-indpassessmentrpt.pdf**), at 9 (emphasis added).

[2] RTI Report at 209.

[3] RTI Report at 209.

[4] RTI Report at 39.

[5] RTI Report at 210.

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