



Are Carrots Good for Your Health? Current Evidence on Health Behavior Incentives in the Medicaid Program

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THEMES

- Medicaid beneficiary incentives for health behaviors have become popular in recent years, with great diversity in how states and Medicaid managed care organizations design incentives to target various health conditions and populations.
- The current, limited evidence on these incentive programs is mixed in showing overall impact on beneficiaries' health and health care costs. Some incentive programs, like those targeting one-time behaviors and smoking cessation, have stronger evidence on improving health outcomes.
- There are multiple operational challenges in implementing these incentive programs, including the need for data infrastructure to track behaviors and distribute the incentives. States reported that administrative challenges were greater than expected, and those issues affected whether the program was successful.

Introduction

In recent years, many state Medicaid programs and Medicaid managed care organizations (MCOs) have implemented beneficiary incentive programs for health behaviors. These programs typically use financial incentives like gift cards, prizes, reduced premiums or copays, or penalties to promote specific health behaviors like losing weight, going to preventive visits, getting vaccinations, or quitting smoking.

States report multiple motivations for trying these programs: instilling personal responsibility in entitlement programs, encouraging people to engage with their health, or incentivizing specific behaviors that affect long-term health and Medicaid costs.¹⁻³ Health behavior incentives have been embraced by both conservative and liberal policymakers as one of many tools in a state's toolbox as they work to improve health and lower Medicaid costs. Yet there is a need for strategies that can help these programs improve, given the nascent state of many programs and the mixed (but limited) evidence about impact on health outcomes.⁴⁻¹¹

This issue brief provides an overview of how Medicaid incentive programs for health behaviors have evolved, current evidence on their impact, challenges in establishing and operating them, and considerations for states interested in implementing them. We supplement existing published evidence with insights from interviews with over 70 Medicaid incentive program stakeholders, including state and federal officials, academic evaluators, health plan leaders, consultants, and patient and beneficiary leaders.

How Have Health Behavior Incentive Programs in Medicaid Changed Over Time?

As of May 2018, we identified Medicaid health behavior beneficiary incentive programs in 18 states, including one approved to be implemented in Kentucky. In addition to programs led by state Medicaid agencies, nearly all MCOs report providing incentives for health behaviors.¹²

Traditional Medicaid regulations do not allow Medicaid programs to offer financial incentives for health behaviors, so states are implementing these programs through different policy mechanisms like grant programs, MCO contracts, state plan amendments, and Section 1115 waivers. The mechanisms have

changed over time due to legislative action and other political and health care trends (see Figure 1). After the Deficit Reduction Act of 2005, states were able to use state plan amendments to implement these programs through alternative benefit packages to traditional Medicaid benefits.^{13,14} Between 2012 and 2017, 10 incentive programs emerged as part of the federal Medicaid Incentives for the Prevention of Chronic Diseases (MIPCD) grant program under the Affordable Care Act.¹⁵ From 2014 onwards, states have predominantly used Section 1115 demonstration waivers, often in tandem with Medicaid expansion.¹⁶ Medicaid MCOs are sometimes involved in 1115 waiver programs, but in other cases they may offer the incentive program because their contract with the state allows for flexibility.

Table 1 illustrates the most common features of the programs by implementation mechanism, although note that there is great diversity among programs. The mechanism influences what an incentive program can cover and how it can operate. For example, the MIPCD grant program required states to target chronic disease related behaviors and run randomized controlled trials, while 1115 waivers allow more flexibility in design and evaluation. Further, MCOs typically have to follow state limits on incentive amounts but have flexibility on other aspects of the incentive design.

Figure 1. Timeline showing the start year of Medicaid incentive programs for health behaviors, highlighting how the policy levers to implement these programs has changed over time.

Medicaid Beneficiary Incentive Programs by Implementation Start Year

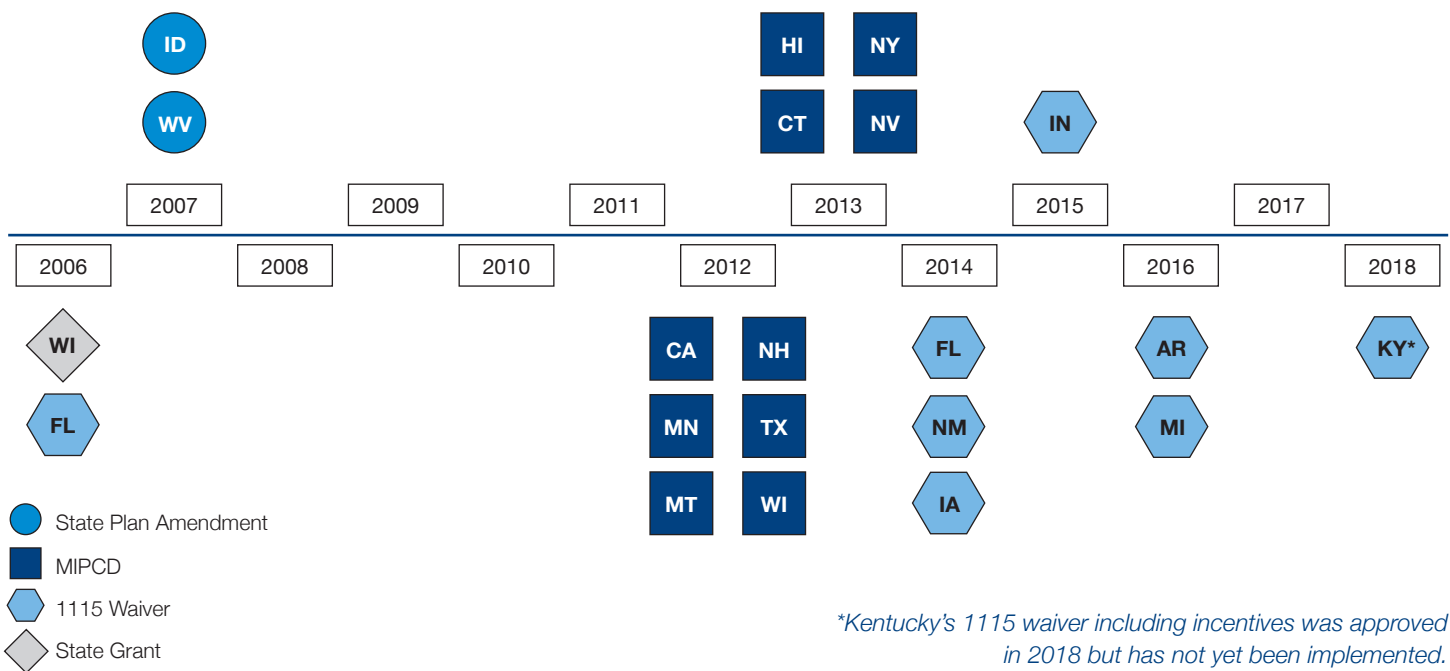


Table 1. Examples of design features for beneficiary incentive programs implemented under different policy mechanisms. There is substantial variation in each category.

Implementation Mechanism	Targeted Behaviors	Incentive Design	Population	Example States
Early State Incentive Programs (Before 2012) ^{14,17}	Typical: one-time, preventive services (e.g., well-child visits, diagnostic screenings, vaccinations) Occasional: chronic disease, smoking cessation, weight loss	Rewards: Points- or voucher-based incentives redeemable for health products or services	Varies: either all beneficiaries or subgroups (e.g., children)	FL, ID, WV, WI
MIPCD (2012–2017) ¹¹	Behaviors driving chronic disease (e.g., smoking cessation, diabetes prevention/management, weight loss)	Rewards: Gift cards, cash, vouchers, transportation, peer coaching	All Medicaid members with specific conditions or health risks	CA, CT, HI, MN, MT, NH, NV, NY, TX, WI
1115 Waiver Programs (2014 on) ^{18–20}	Mix of one-time, preventive behaviors and long-term, chronic disease behaviors	Rewards: HSA contributions, reduced cost-sharing, gift cards Penalties: copays (\$8–\$25), limiting access to services	Varies: all beneficiaries or Medicaid expansion population	AR, FL, KY, IN, IA, MI, NM
MCOs	Typical: one-time, preventive services (e.g., prenatal care, well visits, cancer/diabetes screenings, vaccinations) Occasional: smoking cessation, behavioral health visits, dental visits	Varies widely Rewards: Gift cards, incentive prizes (e.g., baby items)	Varies: either all members in MCOs, or specific populations (e.g., pregnant women, children)	Almost all MCOs operate some type of health behavior incentive program ¹²

(Note: HSA = Health Savings Account)

KEY TAKEAWAYS

- States have used a variety of mechanisms for implementing health behavior programs, including waivers and partnerships with MCOs.
- The design of incentives programs for health behaviors in Medicaid has evolved over time from rewards for one-time behaviors to more complex incentives (sometimes with penalties) for longer-term lifestyle behaviors.

What Do Incentive Programs Look Like in Practice?

This section outlines three different incentive programs to illustrate the diversity of program design and implementation. These examples include one from the MIPCD grant program, one Section 1115 waiver where the state and MCO implemented the program, and one program spearheaded by an MCO in multiple states.

Wisconsin received MIPCD funding from 2012 to 2015 to implement a smoking cessation program. The state Medicaid agency partnered with the University of Wisconsin Center for Tobacco Research and Intervention to design two randomized controlled trials to test incentives among adult smokers and pregnant smokers. The state implemented the program, but relied upon MCO partners to promote it to beneficiaries and engage clinics. Adult smokers could receive incentives up to \$270 in the form of gift cards for calling a quitline and for quitting smoking. After six months, 22% of smokers receiving incentives quit compared to 14% of smokers receiving counseling only.²¹ Pregnant smokers could receive up to \$500 for attending prenatal care and home visits, and for continuing to abstain from smoking after childbirth. Among pregnant women, 15% of women receiving incentives quit at six months postpartum compared to 9% in the control group.²²

In 2014, **Florida's** legislature mandated MCOs to provide incentives for three specific behaviors (smoking cessation, weight loss, and substance abuse) addressed through medically directed programs. Through an 1115 waiver, the

Implications for Work Requirements

In January 2018, Kentucky became the first state to receive CMS approval to implement work requirements along with incentives for disease management and preventive care;²⁶ other states are awaiting approval. The waivers are a response to a recent CMS guidance that “a broad range of social, economic, and behavioral factors can have a major impact on an individual’s health and wellness, and a growing body of evidence suggests that targeting certain health determinants... may improve health outcomes.”²⁷ This concept is likely to be accelerated by an April 2018 executive order encouraging public assistance programs to strengthen or institute work requirements.²⁸

Work requirement programs in Medicaid are likely to face similar implementation challenges as incentive programs. They require similar (and potentially more intensive) data on work efforts (similar to behavior tracking for incentive programs) to operate effectively. Both also require a complex administrative infrastructure.

Yet incentive programs and work requirements also have important differences. While rewards-based incentives have potential to improve access to care, imposing penalties on the financially disadvantaged Medicaid population could reduce access to needed services, particularly for individuals with certain health conditions (which would further exacerbate health disparities).

state created the “Healthy Behaviors” Program.²³ MCOs have flexibility to select incentive amounts, vehicle (gift cards vs. points), and are allowed to incentivize additional behaviors, such as well-child visits and pregnancy care. Early evaluation suggests that 10% of beneficiaries who enrolled in the Healthy Behaviors Rewards programs completed the incentivized programs. Beneficiaries were more likely to participate in the well-child visits and pregnancy care incentives than the smoking cessation, weight loss, and substance abuse incentive programs.²⁴ Future evaluations will have access to individual level data about the program that may allow for more outcomes-based assessments.

United HealthCare has operated the “Baby Blocks” incentive program in managed care plans across 21 states since 2011.²⁵ This program encourages pregnant mothers covered by their Medicaid managed care plans to receive prenatal care, postpartum care, and well-baby visits until 15 months of age. Pregnant women who complete visits are eligible for incentives (usually gift cards or baby items, like strollers or diapers), with states typically regulating the amount. UHC promotes the “Baby Blocks” program at every touchpoint with a member, including member welcome calls, outbound calls, letters, provider visits, and web links. Evaluations of the Baby Blocks program are not publicly available.

What Do We Know about the Impact of Medicaid Incentive Programs?

Despite the growing experience with Medicaid beneficiary incentive programs, there is limited evidence on their effectiveness.^{29,30} Existing research is mixed on whether they improve short or long term health outcomes or reduce cost (Table 2).^{10,31–34}

A consistent challenge identified in evaluations is the difficulty in raising awareness of incentive programs among beneficiaries. Most surveyed beneficiaries report low to moderate awareness about the existence of the incentive programs or how they work. This hampers participation; several 1115 states had less than a quarter of the eligible beneficiaries participating in the incentive in early years of implementation.^{18–20} Texas and Hawaii were the only two MIPCD states (out of 10) that met their enrollment targets.¹¹ In addition, there are other examples of successful participation levels. In Idaho, 66% of Children’s Health Insurance Program families attended well-child visits after being able to earn premium reductions, up from 40% who attended well-child visits before the incentive program’s implementation.³⁹ Finally, Indiana reported that 64% of Healthy Indiana Plan Plus and 45% of Healthy Indiana Plan Basic members in the eligible Medicaid expansion population completed the incentivized preventive services, although more detail is needed on what the incentivized services were.¹⁸

Table 2. Synthesis of publicly available research on Medicaid beneficiary incentive programs for health behaviors, with themes for different types of program outcomes. Much of the evidence comes from evaluations of the Medicaid Incentives Program for Chronic Diseases (MIPCD) grant program.¹¹

Program Outcomes	Synthesis of Available Evidence in Medicaid Setting
Beneficiary awareness of programs and satisfaction	Regardless of the program mechanism, beneficiaries often had low to moderate awareness and understanding of the incentive programs and low to moderate completion rates. ^{10,11,17-20,35} When they were enrolled, beneficiaries often expressed high levels of satisfaction with incentives. ¹¹
Utilization of preventive services	Some states found incentives significantly increased use of preventive services, particularly for attending diabetes prevention program classes and calling a tobacco quitline or attending counseling sessions, ¹¹ while other states had mixed results in encouraging preventive care. ^{14,18,20,36}
Smoking cessation	Beneficiaries receiving incentives to quit smoking along with other supports (like quitlines, pharmacotherapy, counseling) generally had higher smoking cessation rates at six months than those not receiving incentives. ^{11,21,37,38} Smoking cessation programs often had higher completion rates than programs that incentivized other chronic disease behaviors.
Chronic condition health outcomes	States targeting diabetes and blood pressure management generally did not see clinically significant effects on blood sugar control (measured by HbA1c), blood pressure, or weight loss. ^{11,19}
Effect on Medicaid expenditures	Few evaluations with inconsistent effects on Medicaid expenditures. Overall, impact has been mixed. ¹¹

The evidence is even more limited and mixed on whether Medicaid incentive programs affect health outcomes and Medicaid costs. The strongest effects came from programs that targeted smoking cessation; cost-effectiveness analyses from smoking cessation incentive programs in Wisconsin, Connecticut, and California showed lower cost-per-quit rates, higher incremental cost-effectiveness, and projected long-term cost savings over 60 years.^{11,21,37,38} In contrast, programs targeting incentives for weight loss, diabetes management, and blood pressure management had inconsistent results.^{11,40} Although Medicaid expenditures trended downward in MIPCD states, the changes were not statistically significant. The mixed health outcomes and costs may be due to measuring outcomes in a short timeframe (months or even years), since improving chronic disease management may not manifest into improved health outcomes (or avoiding poor health outcomes) until many years later. This suggests incentive programs alone will not keep short-term cost growth in check, but they may contribute to an environment where this is the case.

The quality of available evidence also varies significantly. States receiving MIPCD grant funding had the most robust evaluations—all MIPCD states used randomized controlled

trial designs and measured changes in care utilization, health outcomes, and Medicaid expenditures (including administrative and evaluation costs). In contrast, the few published evaluations of incentive programs implemented using 1115 waivers focused on program enrollment, participation, or completion, eliciting little to no data on health outcomes or costs.^{20,36} These evaluation challenges in 1115 waivers are not unique to incentive programs. A recent Government Accountability Office report concluded that the evaluations of 1115 waiver programs historically provided descriptive information but less evidence on outcomes and impacts.²⁹ Finally, MCO incentive programs typically conduct internal evaluations focusing primarily on return on investment and closing gaps in quality measures. The lack of published evidence about MCOs' incentive programs' effectiveness makes it difficult to assess the efficacy of programs and the strength of that evidence.

Currently, we do not have enough information to conclude whether incentive programs are effective in affecting longer-term health outcomes and costs in Medicaid, and further research is needed to address these questions. However, incentive programs could increase beneficiaries' use of preventive services and provide resources to a financially disadvantaged population.

KEY TAKEAWAYS

- Existing evidence suggests Medicaid incentives can increase beneficiaries' likelihood of accessing preventive services, but is more mixed on whether Medicaid incentive programs improve health outcomes or reduce cost.
- Among incentive programs targeting chronic disease behaviors in Medicaid, incentives for smoking cessation have seen more success than those targeting weight loss, diabetes, and blood pressure management. However, research across these types of programs is limited.
- Further research is needed to understand the longer-term impacts of incentives on health outcomes and costs in Medicaid, with particularly sparse evidence currently available on MCO-led programs.

How Does the Evidence from Workplace Incentive Programs Compare?

Medicaid is not unique in offering health behavior incentives; employers and commercial insurers offer similar programs. In 2017, 85% of large firms and 58% of small firms offered a workplace health and wellness program targeting smoking cessation, weight management, and/or behavioral or lifestyle coaching. Among these large firms with wellness programs, 32% specifically offered financial incentives for specific behaviors.⁴¹ As with Medicaid incentives, the design of workplace incentive

programs varies widely. Some programs provide simple, immediate rewards, while others incorporate more complex designs grounded in the field of behavioral economics.^{42–44}

The evidence on workplace incentive programs is more extensive than for Medicaid incentives, but similarly mixed. Several studies have demonstrated encouraging results on the impact of workplace incentive programs for behaviors such as smoking cessation and exercise in the short-term.^{42,45,46} Others find these programs have not been effective in encouraging weight loss, whether using simple or more complex designs.^{43,47} High attrition rates were also a problem, which is similar to the challenges Medicaid programs face in identifying and working with beneficiaries.⁴³

Though there are opportunities for Medicaid to learn lessons from employer settings, workplace incentive programs are unique from Medicaid incentive programs in some ways. First, workplace wellness programs benefit from easier access to and communication with beneficiaries, as employers have an inherent relationship with their employees. Medicaid beneficiaries, on the other hand, typically have loose relationships with the Medicaid program or MCO. Second, employers can more easily supplement financial incentives with social supports, stemming from natural relationships and cohesion from working for the same company. Finally, companies often offer higher incentive amounts due to fewer regulatory restrictions on the incentive design. In contrast, many Medicaid programs cap MCO incentives at a specific dollar limit, as noted by several of our interviewees.

Where Is More Evidence Needed on Health Behavior Incentives?

Identifying the optimal way to design and implement incentives for complex, long-term behavior, like weight loss or chronic disease management, is still a work in progress.⁴⁸ There are several open questions requiring more evidence to inform incentive programs (for all payers, not just Medicaid):

- Are financial incentives more effective for simple or one-time behaviors than longer term, complex behaviors?^{5,14,30,33,49,50}
- What value of incentive (e.g., monetary value amount) and delivered in what way (e.g., gift cards or prizes) effectively motivates behavior change? Do these choices differ for lower-income populations, like those insured by Medicaid?
- What is the optimal program length to encourage participants to establish and maintain healthy habits?^{9,45,51}
- Do extrinsic economic incentives crowd out intrinsic motivation to change behavior?^{9,52}
- Do incentive programs place an undue burden on vulnerable populations?^{53,54}

As Medicaid programs experiment with changes to incentive programs, they can consider adapting certain lessons from employer settings, such as improving how to communicate with beneficiaries, considering the use of support groups or health education classes, and allowing for more flexibility of incentive amount and design.

Operationalizing Medicaid Incentive Programs: Lessons Learned and Looking Forward

Interviewed stakeholders emphasized multiple challenges in implementing incentive programs.^{31,32} One stressed, “This is still very much an evolving and developing area, and states are learning lessons as they go.”

The final MIPCD evaluation estimated that 42% of the costs for Medicaid incentive programs came from administration, which included personnel, training, advertising, outreach, infrastructure, and evaluation.¹¹ Administrative costs among MIPCD states may be higher than for states using other mechanisms due to the expensive nature of randomized controlled trials, although it is difficult to make comparisons since CMS does not require 1115 states to report on administrative costs. Nonetheless, Medicaid incentive programs are likely to require substantial administrative costs to promote the program, disburse incentives, and evaluate the program.

One interviewee emphasized, “Nearly every state and MCO underestimated the time and resources needed to stand up an incentive program.” Another state official said, “It was a huge lion’s effort to get this off the ground.”

The implementation challenges, as detailed below, can delay the program launch by at least several months. States and MCOs should draw from successful practices in other states, particularly around implementation barriers discussed below.

Identify the Technology to Collect Data and Implement Incentives

Several stakeholders said identifying the right technology infrastructure to implement incentive programs was particularly important. States need effective platforms to track health behaviors and trigger incentive distribution.

Many states and most MCOs track health care utilization behaviors (e.g., attending well visits or pregnancy care) through claims data. One MCO leader we interviewed stated, “We can

get claims for an immunization or an annual well-child check-up, which can very easily and automatically feed our rewards program.” While claims data is administratively easier to use, it can lag for months, making it difficult for Medicaid agencies or MCOs to distribute incentives to beneficiaries in a timely manner after completing behaviors.

In order to track more complex behaviors not found in claims (e.g., smoking cessation, weight loss), states have had to be more creative and invest in alternative methods to monitor these behaviors. Several states built new databases or portals to collect incentive program data from patient self-reports or other data sources, such as biochemical lab tests for smoking cessation. This can allow for quicker disbursement of incentives, which is important for reinforcement of behavior change. Some MCOs and states used vendors to track behavioral data and deliver rewards to beneficiaries, which poses additional costs but may be easier than the state building their own infrastructure for tracking and disbursing rewards. Finally, some states used clinical data from completed health risk assessments or biochemical verification of smoking abstinence. This introduces new complexity because it requires transmitting data from clinical sites to Medicaid payers. One MCO leader mentioned, “When it comes to things like nutrition or exercise in childhood, we have just started exploring how to get comfortable with allowing members to self-report. Things like that wouldn’t come through clean and would take extra effort to administer.”

Tackle a Feasible Level of Complexity

Our interviews with Medicaid incentive programs demonstrated that states have chosen to implement incentives with varying levels of complexity, shown in Table 3.

Our analysis revealed that most programs used low levels of complexity, though some states (especially those that received MIPCD grant funding) are experimenting with all levels of implementation complexity. Tracking complex behaviors can require more substantial infrastructure development, though these systems could be valuable for future population health management. On the other hand, such designs can also increase costs (especially in the short term) and potentially hamper participation by providers and/or beneficiaries. For example, some states require patients or providers to submit documentation to the state that the patient has completed a behavior. For low-income patients with other daily priorities and busy providers with established workflows, this additional step can be a barrier to rewarding the patient for their behavior change. Another way programs can become more complex

Table 3. Matrix of incentive programs by level of implementation complexity, which often hinges upon the type of behavior and the data sources to track it.

Level of Implementation Complexity	Type of Behavior	Example Behavior	Potential Data Sources
Lowest	Single health care utilization behavior	Annual mammogram, annual well visit	Claims data
Low	Repeated health care utilization behaviors	Set of prenatal visits, set of calls to a quitline	Claims data, data from other agencies
High	Health care utilization or health outcome outside of claims	Health risk assessment completion, achievement of lower blood sugar control (A1c) or blood pressure	Outside database, clinical data in EHR
Highest	Complex behavior change	Physical activity, weight loss, smoking cessation	Outside database, lab tests, patient self-report through surveys

is if they require data that is outside the purview of the Medicaid agency. For example, some states have smoking cessation quitlines that operate outside of Medicaid, which would require data-sharing processes. Given the challenges with administering incentive programs, states considering implementing a new incentive program should consider starting with a simpler design at the outset. This would allow for less intensive data collection efforts and simplify the process for beneficiaries. With experience, states could transition to more complex approaches.

Decide on the Degree of Centralization and How to Partner Effectively with MCOs

States can choose to delegate implementation responsibilities to MCOs rather than implement incentive programs themselves (though states are still responsible for oversight of MCOs). In this approach, the amount of collaboration and decision-making authority between states and MCOs can lead to different types of programs. Initiatives that are centralized can enable more standardized platforms and common, comparable evaluation measures across MCOs. In contrast, decentralized structures offer greater flexibility, especially for MCOs, which may be able to customize programs to better meet local needs. Interviews with Medicaid and MCO stakeholders suggest the ideal set-up differs based on local needs and capabilities.

In states that were more decentralized, interviewees emphasized the value of regular contact with MCOs and other stakeholder groups. Some state officials said they used monthly meetings to “tackle policy or bureaucratic challenges and delegate work appropriately.” One interviewee mentioned that strong partnerships with MCOs helped the state leverage MCOs in providing critical outreach to beneficiaries and providers to meet the incentive program’s broader goals.

Recognize the Potential and Limits of Behavioral Economics

The field of behavioral economics provides insights into human decision-making and offers opportunities for novel approaches that engage and motivate patients, which could be incorporated in the design of incentive programs.⁵⁷ At the same time, states and MCOs should consider how to feasibly operationalize behavioral economics principles in a Medicaid context. Below, we provide some recommendations for how to incorporate behavioral economics into incentive programs, as well as commentary on when it may not translate to Medicaid incentives.

- **Salience**—*Prioritize tangible rewards (gift cards, prizes) over reduced cost-sharing that may go unnoticed by beneficiaries.* Kaiser Family Foundation’s focus group with Michigan Medicaid beneficiaries found that they perceived immediate gift cards as more motivating to complete behaviors than future reductions in premium payments.⁵⁵ Moreover, incentives administered through online accounts may not be seen or noticed by the majority of Medicaid beneficiaries, as with the case of only 30-40% of Indiana’s beneficiaries checking their HSA account.¹⁸
- **Immediacy**—*Identify which entity (state, MCO, vendor) can distribute incentives most quickly to beneficiaries.* A meta-analysis of incentive use for smoking cessation found that delays of more than one day between target behavior change (e.g., biochemical verification of smoking cessation) and incentive delivery was associated with a 50% reduction in incentive effectiveness.⁵⁶ Ideally, incentives should be provided immediately after a beneficiary completes a behavior, potentially at a clinic

or after a class. Wisconsin's MCO-led incentive program from 2008 found that incentives delivered onsite were most effective.⁵⁷ Another way to deliver incentives is using web-based platforms that verify behaviors (such as blood glucose level for diabetes, expired carbon monoxide for smoking cessation) and transfer incentives to beneficiaries electronically, as done by research studies.⁵⁸

- **Frequency**—*Prioritize frequent, smaller rewards over larger, one-time, annual rewards.* This has the added benefit of providing insight into beneficiary utilization or redemption of incentives. According to our interview, one state initially implemented a \$200 gym voucher, but had little insight into how many times beneficiaries actually went to the gym. By changing the incentive to a monthly voucher, they had more insight into how many beneficiaries were sustaining the behavior.
- **Loss aversion**—While behavioral economics research suggests that incentives framed as losses can be

KEY TAKEAWAYS

- States report that implementing beneficiary incentive programs is more complex, time-consuming, and resource-intensive than expected.
- The data systems required for tracking and administering the incentives are substantial, and many states had to build or buy additional data capabilities for the programs.
- States should consider starting with less complex incentives for feasibility in administering incentives.
- The science of behavioral economics can inform the design and implementation of incentive programs.

more effective than rewards, *penalties in a financially disadvantaged Medicaid population could hinder access to needed care or discriminate against beneficiaries with certain health conditions.* Some workplace incentive programs have found penalties to be effective in increasing participation in health behaviors, but these measures were largely voluntarily (such as opt-in deposit contracts), rather than mandatory.^{59,60}

Summary

More states, red and blue, are adopting beneficiary incentive programs for health behaviors in Medicaid. These incentive programs have evolved over time and some types of programs have shown more promise than others, such as incentives that target one-time behaviors and smoking cessation, though the evidence base overall is very limited. Further research is needed to understand effectiveness, especially on longer-term health outcomes and specifically within populations insured by Medicaid, who face their own set of unique social and financial challenges.

As noted in interviews with key stakeholders, implementing beneficiary incentive programs was often more challenging than anticipated, and likely contributed to the less than successful performance of several incentive programs. The most encouraging Medicaid incentive programs, like promising workplace wellness programs, have approached these programs as long-term investments and distributed resources accordingly. Regardless of behaviors targeted, states should recognize the significant investment needed to launch and maintain an incentive program.

Overall, Medicaid incentive programs are an increasingly used tool that can be part of a Medicaid program's toolbox to improve the health of their beneficiaries.

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