

Medicaid and CHIP Child Health Beneficiary Incentives: Program Landscape and Stakeholder Insights

Connor A. Moseley, MD,^{ab} Madhulika Vulimiri, MPP,^{b,c} Robert S. Saunders, PhD,^b William K. Bleser, PhD, MSPH,^b Eliana M. Perrin, MD, MPH,^{a,d} Sarah C. Armstrong, MD,^{a,d,e} Gary X. Wang, BS,^b Peter A. Ubel, MD,^c Mark McClellan, MD, PhD,^b Charlene A. Wong, MD, MSHP^{a,b,c,d,e}

abstract

OBJECTIVES: To describe the landscape of Medicaid and the Children's Health Insurance Program beneficiary incentive programs for child health and garner key stakeholder insights on incentive program rationale, child and family engagement, and program evaluation.

METHODS: We identified beneficiary health incentive programs from 2005 to 2018 through a search of peer-reviewed and publicly available documents and through semistructured interviews with 80 key stakeholders (Medicaid and managed-care leadership, program evaluators, patient advocates, etc). This study highlights insights from 23 of these stakeholders with expertise on programs targeting child health (<18 years old) to understand program rationale, beneficiary engagement, and program evaluation.

RESULTS: We identified 82 child health-targeted beneficiary incentive programs in Medicaid and the Children's Health Insurance Program. Programs most commonly incentivized well-child checks ($n = 77$), preventive screenings ($n = 30$), and chronic disease management ($n = 30$). All programs included financial incentives (eg, gift cards, premium incentives); some also offered incentive material prizes ($n = 12$; eg, car seats). Loss-framed incentives were uncommon ($n = 1$; eg, lost benefits) and strongly discouraged by stakeholders. Stakeholders suggested family engagement strategies including multigenerational incentives or incentives addressing social determinants of health. Regarding evaluation, stakeholders suggested incentivizing evidence-based preventive services (eg, vaccinations) rather than well-child check attendance, and considering proximal measures of child well-being (eg, school functioning).

CONCLUSIONS: As the landscape of beneficiary incentive programs for child health evolves, policy makers have unique opportunities to leverage intergenerational and social approaches for family engagement and to more effectively increase and evaluate programs' impact.



^aDepartment of Pediatrics, School of Medicine, ^cSanford School of Public Policy, and ^bRobert J. Margolis, MD, Center for Health Policy, Duke University, Durham, North Carolina; ^dDuke Center for Childhood Obesity Research, Durham, North Carolina; and ^eDuke Clinical Research Institute, Durham, North Carolina

Dr Moseley conceptualized and designed the study, collected data, conducted the initial analysis, drafted the initial manuscript, and reviewed and revised the manuscript; Ms Vulimiri collected data, conducted the initial analysis, and reviewed and revised the manuscript; Drs Saunders and Bleser conceptualized and designed the study, collected data, and reviewed and revised the manuscript; Mr Wang conducted the initial analysis, assisted in drafting the initial manuscript, and reviewed and revised the manuscript; Drs Perrin, Armstrong, Ubel, and McClellan informed the design of the study and reviewed and revised the manuscript for important intellectual content; Dr Wong conceptualized and designed the study, coordinated and supervised data (Continued)

WHAT'S KNOWN ON THIS SUBJECT: Similar to incentive programs that are popular among commercial insurers, Medicaid and the Children's Health Insurance Program are increasingly offering beneficiary incentives to encourage health behaviors. Evidence is limited on beneficiary incentives to change behaviors that may impact child health.

WHAT THIS STUDY ADDS: We present the landscape of 82 Medicaid and Children's Health Insurance Program beneficiary incentive programs for child health, which most commonly target preventive health visits. Expert stakeholders provide insights on program rationale, family engagement, and program evaluation.

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Medicaid and the Children's Health Insurance Program (CHIP) insure one-third to one-half of children in the United States, mostly through contracts with managed care organizations (MCOs).^{1,2} Medicaid and CHIP are experimenting with delivery and payment reforms to improve value, including incentive programs for beneficiaries to encourage health behaviors.³ A growing number of public and private payers have developed incentives, framed either positively as gains (presenting potential rewards) or negatively as losses (presenting potential penalties), to promote appropriate health care use and healthy behaviors, such as physical activity and tobacco cessation.⁴⁻¹⁰ Incentives offered to Medicaid beneficiaries have spread since their first identified implementations in 2005; as of May 2018, Medicaid programs in 19 states and nearly all MCOs have developed beneficiary incentive programs for health behaviors, which have evolved in complexity over time.^{11,12}

Incentives are also used to target child health. Early evidence suggests incentives can influence behaviors affecting children's health, such as food choices in school,¹³⁻¹⁵ blood glucose self-monitoring in teenagers with diabetes,⁸ and publicly insured children's attendance at well-child checks.^{16,17} Reviews of incentive programs among the general Medicaid population have found mixed results,^{5,7,18} and efforts to synthesize data on beneficiary incentives for child health have not been previously published. Challenges identified for incentive programs have included limited evaluation, with little focus on child health outcomes,^{5,18} and difficulty engaging families with incentives.^{4-6,19-21} In this study, we aimed to provide the most comprehensive landscape to date of beneficiary incentive programs for child health in Medicaid and CHIP and to complement the program landscape with key stakeholder insights on incentive

program rationale, strategies for engaging children and families, and program evaluation.

METHODS

We conducted an in-depth literature review of Medicaid and CHIP incentive programs for child health in peer-reviewed articles, white papers, program evaluation reports, and other publicly available beneficiary materials, including MCO member handbooks. Two researchers used the following search terms in PubMed and common Internet search engines (ie, Google) to identify Medicaid beneficiary incentive programs: "healthy behavior incentives," "Medicaid," "CHIP," "incentives," "beneficiaries," "MCOs," "member rewards," "points," and "wellness programs." These findings and data from stakeholder interviews led to more directed searches. Other searches included the benefits and services listed by subsidiaries of 3 major national MCOs and program evaluations hosted by the federal and state governments. We reviewed programs that existed between January 2005 (year of earliest program identified) and May 2018. We defined children as those <18 years of age. We extracted the following program characteristics: policy mechanism, targeted behavior and age ranges, and incentive mechanism. Health behaviors were categorized on the basis of clinical and policy expert input as well-child checks, preventive screenings, chronic disease management, vaccinations, preventive dental care, and behavioral health care. Incentive mechanisms were classified as gift cards and/or vouchers, material prizes (ie, gift items), premium and coverage incentives (ie, reduced premiums or enhanced benefits), social supports and services (ie, community services), and loss-framed incentives (ie, presenting potential losses, such as reduced coverage).

In addition to the literature review, we interviewed 80 geographically diverse

stakeholders from September 2017 to March 2018. We selected stakeholders a priori, including leaders who implemented or evaluated incentive programs within state Medicaid offices, MCOs, and the Centers for Medicare and Medicaid Services; authors of key program evaluations; academic health policy experts and clinical-care-delivery leaders who authored key articles or represented national associations and think tanks; and representatives of patient advocacy organizations. Twenty-three stakeholders were selected for their specific expertise in child health policy or child incentive programs. The insights of child-health-expert stakeholders were highlighted and, when appropriate, contextualized among relevant themes identified from all interviews. Interviews were conducted by telephone, lasted 20 to 60 minutes, and were recorded and transcribed (excluding 1 per interviewee request).

The semistructured interviews focused on 3 key areas selected after our literature review: incentive program rationale, engagement of beneficiary children and families, and program evaluation.^{5,6,21} Thematic content analysis was conducted by using the NVivo 10 software package (2014; QSR International, Melbourne, Australia). Three researchers independently examined the transcripts using structural codes defined a priori through team consensus.^{22,23} Emergent thematic codes were identified with input from all team members. Codes and coding disagreements were resolved by consensus in weekly discussions. The study was deemed exempt by the Duke University Institutional Review Board.

RESULTS

Landscape of Beneficiary Incentive Programs for Child Health

We identified 82 incentive programs that targeted child health behaviors among 113 total programs for

beneficiaries of any age (Fig 1). Three of the programs targeted CHIP-insured children. In addition to MCO-led programs ($n = 74$), state agencies established incentive programs using Social Security Act Section 1115 demonstration waivers ($n = 4$),²⁴ state plan amendments ($n = 3$), and Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) grants under the Patient Protection and Affordable Care Act ($n = 1$).⁵ We provide 3 examples of programs using these policy mechanisms in Table 1.

Many incentive programs targeted >1 child health behavior. The most commonly encouraged behaviors included preventive services: well-child checks ($n = 77$), preventive screenings ($n = 30$; eg, blood lead tests, health risk assessments, and sexually transmitted infection screenings), pediatric immunizations ($n = 24$), and preventive dental visits ($n = 20$; Fig 2). Programs also offered incentives for chronic disease management ($n = 30$; eg, weight management, disease-specific screenings, and asthma medication refills) and behavioral health ($n = 16$; eg, attention-deficit/hyperactivity disorder [ADHD] medication

adherence and behavioral health admission follow-up). Two programs incentivized at-home health behaviors, such as hand-washing, toothbrushing, and physical activity, which were self-reported or parent reported online.

Some incentive programs specifically targeted beneficiaries <18 years old (eg, well-child checks) or children with particular health conditions (eg, asthma controller medications refills). Other programs had age eligibility that extended from adult down to pediatric ranges (eg, walking programs for beneficiaries >9 years old, substance use counseling for beneficiaries >16 years old). Some programs used additional sociodemographic eligibility criteria, such as family income eligibility for CHIP premium reductions or counties served by MCOs.

Most ($n = 79$) identified programs included some monetary incentive, such as gift cards, rewards points, or store vouchers (Fig 2). Some also offered material prizes as incentives ($n = 12$), such as diapers, car seats, or pedometers. One program offered transportation vouchers. Premium- and coverage-based incentives ($n = 3$) included premium reductions

(eg, among CHIP or Medicaid programs charging premiums) or enhanced insurance benefits (eg, vision or mental health).

Only 1 program incorporated both gain-framed and loss-framed incentives directed toward children. Children were offered an “enhanced” plan after parents signed a healthy behaviors contract requiring regular well-child check attendance. If the contract was not signed or regular visits were not made, children would lose some benefits and their coverage switched to a new “basic” plan that offered fewer benefits than either the previous traditional or enhanced plans.

Stakeholder Insights on Rationale for Incentive Programs for Child Health

Stakeholders identified several rationales for launching beneficiary incentive programs for child health. Some identified a morally and politically popular motivation to improve children’s health care access, which they believed could strengthen clinician-family partnerships and promote self-efficacy in navigating health systems: “I don’t think anyone’s going to dispute that getting kids in for well-child checkups is a good thing to do.” Some stakeholders felt that incentive programs in Medicaid should target children, who constitute substantial proportions of Medicaid beneficiaries.

Stakeholders universally felt that the policy goal of instilling “personal responsibility” was inappropriate, even unethical, for child beneficiaries. In adults, “personal responsibility” was often linked to the use of loss-framed incentives, which some stakeholders viewed as punitive. Stakeholders highlighted children’s unique vulnerability and dependence on adults. Some also questioned gain-framed incentives, viewing the failure to earn an available reward as a loss. Respondents further cautioned that loss-framed incentives targeting

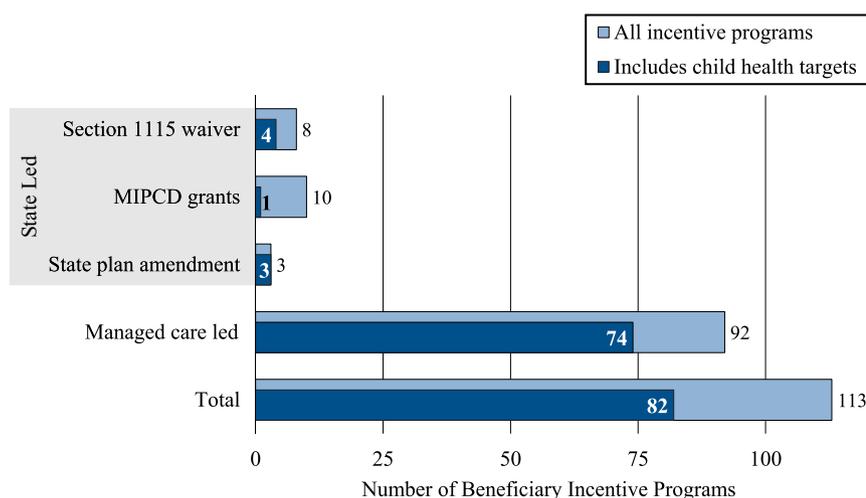


FIGURE 1 Medicaid and CHIP beneficiary incentive programs targeting child health versus any-age beneficiary health. Shown are the total identified beneficiary incentive programs, for any age, implemented by state Medicaid and CHIP agencies under various mechanisms and by MCOs. The portion of those that include incentives targeted at children is highlighted.

TABLE 1 Case Studies of Beneficiary Incentive Programs for Children's Health in Medicaid and CHIP

	Idaho Medicaid and CHIP ^{16,17,25}	Nevada Medicaid ^{6,26}	Florida Medicaid ²⁷⁻³⁰
Program name	Preventive Health Assistance Program	Nevada Health Choices	Healthy Behaviors Programs: Managed Medical Assistance
Policy mechanism	Medicaid and CHIP state plan amendments	MIPCD	Section 1115 waiver
Years active	2005–present in 2018	2013–2017	2014–present in 2018
Implementation	Primary care physician initiates enrollment in state-run program	Randomized controlled trial at Children's Heart Center Nevada (Las Vegas)	State requires MCOs to offer select incentive programs; MCOs can offer additional incentives
Targeted children	Wellness program: children in CHIP who are charged a premium Wt management program: adults and children (>5 y old) in Medicaid who have overweight or underweight	Children age 7–18 y at risk for heart disease (ie, overweight, dyslipidemia, hypertension, or hyperinsulinemia)	Adolescents and/or children enrolled in the MCOs (different age eligibility for different programs)
Targeted behaviors	Wellness program: attend well-child visits and receive pediatric immunizations Wt management program: Sign a wt management form	Participate in a 12-wk motivational coaching program with benchmarks: develop a personal health goal, meet goal, complete program, 12-mo follow-up	State-required incentive targets: smoking cessation, wt loss, alcohol and/or substance abuse management Optional incentive targets: well-child checks, dental visits, immunizations, lead screening, and behavioral health
Incentive design	Wellness program: points to pay monthly premiums; up to \$10 per mo and \$120 per y Wt management program: money to pay for wt management services; up to \$200 per y	Up to \$350 total points redeemable for prizes in a catalog (eg, books, sporting goods, electronics, and infant items) Incentive delivery arms in trial: child only, split between parent and child, no incentive	MCOs choose incentive structure and rewards for each program, most commonly delivered as gift cards or reward points; range of incentive values from \$5 to \$60 for a behavior
Evaluation	Wellness program: evaluation by Urban Institute; 116% relative increase in proportion of children up to date with wellness visits ^{16,17} Wt management program: no formal, publicly available evaluation	Contracted evaluation by the University of Nevada and RTI International Both incentives resulted in more wt loss than in the control; child only had larger short-term effect than split incentive. Children redeemed different prizes than adults ²⁶	Contracted evaluation by the University of Florida; findings pending in 2018 ³⁰ Internal monitoring: MCOs submit quarterly reports on incentive program engagement (eg, enrollment and completion)

adults may adversely affect children's health by reducing caregivers' economic power and health care access. One stakeholder said, "If you're gonna use sticks, you better be sure that the net benefit to the behavioral change that you're achieving swamps the losses that the kids or their families experience." Some stakeholders felt that certain policy mechanisms (eg, Section 1115) legally prohibited loss-framed incentives because they would not further the goals of the Medicaid program.

Stakeholder Insights on Engaging Children and Families With Incentive Programs

Stakeholders felt that engaging children and families was challenging

but critical for successful incentive programs. Engagement strategies were heterogeneous, ranging from automatic program enrollment to beneficiaries needing to enroll or complete health risk screenings. Clinician involvement in beneficiary incentive programs also varied from none (for incentive programs linked to claims) to clinicians confirming visit attendance. Stakeholders identified 3 unique opportunities for child and family engagement: intergenerational engagement, health-promoting material prizes, and incentives addressing the social determinants of health (Table 2).

Intergenerational Engagement

Because many health behaviors require activating both children and

caregivers, several stakeholders recommended an intergenerational, family-based approach. A key suggestion was to incentivize children and their caregivers to achieve a shared behavioral goal (eg, rewarding both parents and children for increasing physical activity together) rather than the more common model of delivering incentives only to parents, as we most commonly saw in program design. One stakeholder said, "It's very difficult for a sedentary household to help a 10-year-old be much more physically active. I think you've really got to deal with the whole family rather than the individual."

Stakeholders also shared examples of parental health promotion

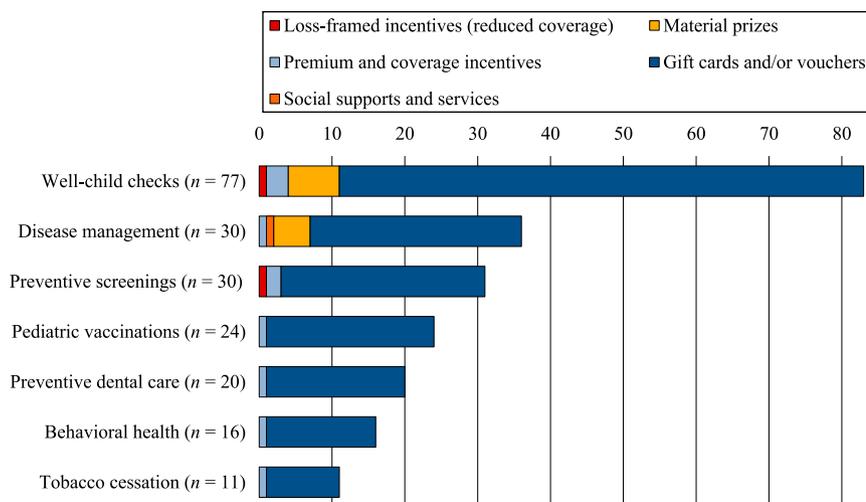


FIGURE 2

Health behaviors targeted by Medicaid and CHIP beneficiary incentive programs by incentive vehicle. Shown are incentivized behaviors and incentive design used to implement 82 incentive programs. Several programs offered >1 incentive for a given single behavior or targeted multiple behaviors, so not all bars sum to the totals listed.

services offered during well-child checks, such as parental depression or intimate partner violence screens and tobacco cessation counseling. Some stakeholders suggested linking incentives to these parental behaviors in Medicaid for their positive effect on children. However, stakeholders noted barriers to engaging parents who are not Medicaid insured in an intergenerational program; stakeholders suggested that such

approaches are more promising in states that expanded Medicaid.

Health-Promoting, Salient Incentive Prizes

Stakeholders noted that child health presents unique opportunities to use incentive prizes that may promote child health and be salient to low-income families. Suggestions included offering books as the incentive prize, considering the significant impact of Reach Out and Read programs (ie,

provide books to families, encouraging the celebration of reading).^{31,32} Other suggestions included diapers, car seats, or prizes with child and parental benefit, such as nicotine patches for parent smokers. Stakeholders acknowledged that prizes categorized as health items, such as diapers, have historically been easier to fund through Medicaid. Some stakeholders mentioned that early incentive programs were restricted to premium discount incentives rather than proposed prizes (eg, bicycle helmets); other stakeholders suggested that Medicaid regulations allow more flexibility than state and MCO officials sometimes perceived.

Incentives To Address Social Determinants of Children's Health

Stakeholders identified opportunities for incentives to address social determinants of health, which they stated were particularly relevant for lower-income children and families. Suggestions included providing social support incentives, such as child care, social work, healthy food vouchers, or transportation for visits.

Whereas stakeholders acknowledged many practical and regulatory challenges to addressing social

TABLE 2 Strategies for Engaging Children and Families With Medicaid and CHIP Beneficiary Incentive Programs for Child Health

Use intergenerational, family-based engagement approaches.
<ul style="list-style-type: none"> • Incentivize parallel behaviors in children and their families. <ul style="list-style-type: none"> o Offer incentives to both the parent and child for achieving a common goal rather than the more common model of incentives delivered only to parents: "I think that incentives that don't have a family orientation are probably less successful. ... [Diet and activity are] very difficult, frankly, to deal with on a child-only basis." • Consider incentives with family-based health benefits. <ul style="list-style-type: none"> o Offer incentives for parental health promotion within Medicaid and CHIP (eg, parental depression screen and tobacco cessation counseling) that have positive spillover effects onto child health.
Offer health-promoting, salient incentive prizes for child health.
<ul style="list-style-type: none"> • Offer prizes that promote child health. <ul style="list-style-type: none"> o Example: books have substantial evidence of impact from Reach Out and Read. "Books are a nonmonetary, long-term investment, providing something that can be taken home and reused, not just a bottomless pit of how much you're gonna pay me to get my child immunized."
Design incentives to address the social determinants of child health.
<ul style="list-style-type: none"> • Offer social support as the incentive. <ul style="list-style-type: none"> o Provide child care, care coordination, social work, healthy food vouchers, or transportation to visits for meeting behavioral targets. • Learn from families to personalize incentive programs to address social issues. <ul style="list-style-type: none"> o Move away from a one-size-fits-all approach: "As children's health issues become more complex, it's our job to provide more customized engagement. There [are] good data from families that they really respond to that." o Invite families to inform engagement techniques and incentive design. "Programs are constructed without much awareness of the realities these families are facing."

determinants of health, a few advocated for a more nuanced and personalized rather than a “one-size-fits-all” approach to incentives. Stakeholders cited families’ complex health and environmental issues as reasons for personalization that could be facilitated by care coordinators or social workers. Feeling that programs have historically lacked beneficiaries’ input, stakeholders recommended that program administrators learn from families to make program design and engagement efforts more family centric. Some suggested patient advisory boards in children’s hospitals as models for implementation.

Stakeholder Insights on Evaluating Beneficiary Incentive Programs for Child Health

Although stakeholders noted limited evidence of the impact of beneficiary incentive programs on child health,^{11, 3} 3 themes emerged from their comments on program evaluation (Table 3).

Limited Evidence on Health Impact of Some Behaviors Incentivized for Child Health

Although states and MCOs most commonly incentivized well-child check attendance, stakeholders cautioned that incentivizing visits had limited impact because of service variability and lack of evidence of impact on health outcomes. Stakeholders instead suggested incentivizing specific evidence-based components of well-child care to more effectively promote health, such as individual preventive services (eg, *Chlamydia* screening and oral health counseling) recommended by the American Academy of Pediatrics *Bright Futures Guidelines*²⁴ or the Early and Periodic Screening, Diagnostic, and Treatment benefit.³³

Delayed Time Horizon for Return on Investment From Currently Incentivized Behaviors

Stakeholders identified that the delay in improved health outcomes or cost

savings from commonly incentivized child health behaviors may limit payers’ willingness to invest in incentives targeting child health. Stakeholders also highlighted that most Medicaid- or CHIP-insured children are not covered by the same entity through adulthood, when many health or cost benefits may be realized, further obscuring the value proposition for payers.

Proximal Measures Meaningful to Child Health for Early Program Evaluation

Stakeholders recommended using more proximal and alternative measures that are meaningful to child health in program evaluation. In many cases, stakeholders recommended evaluating process measures (eg, childhood immunization rates and asthma or ADHD medication refills), especially when outcome measures are difficult to collect (eg, improved pulmonary function tests) or when improvements are difficult to detect over a short time horizon (eg, lower BMI). Stakeholders noted that evaluating some process measures may require parental report of childhood behaviors, such as sleep hours and diet choices, which may be vulnerable to gaming or recall bias and pose data verification challenges. The payer stakeholders interviewed were still determining their level of comfort with incentives linked to parental or child self-report of behaviors. Stakeholders also recommended alternative short-term measures of child well-being, such as school functioning (eg, missed school days and need for individualized education plans) or child and parent health-related quality of life.

DISCUSSION

In our landscape of Medicaid beneficiary incentive programs, we identified that most included incentives that targeted child health. Within this evolving landscape, stakeholders identified unique

opportunities to improve beneficiary engagement and better evaluate the impact of programs that target child health. Although well-child checks were the most frequently incentivized behavior with evidence for higher attendance when linked with incentives, stakeholders highlighted that visit attendance, although easily measured through claims data, may not be as effective as incentivizing specific evidence-based preventive services to promote child health.^{16,17} Low-income children insured by Medicaid and CHIP have higher rates of well-child care receipt than privately insured low-income children, although room for improvement exists across all insurance categories.^{34–36} Further research on the short- and long-term health impact of well-child checks, with or without incentives, is needed.^{37,38}

Intergenerational or family-based engagement strategies were stakeholder suggestions that are uniquely applicable to child health beneficiary incentives. Shared child-parent responsibility has been associated with improved health outcomes across a range of children’s health issues, including mental health, diabetes, and obesity.^{39–41} Although most programs delivered incentives to parents alone, a randomized trial in Nevada’s MIPCD program found increased short-term engagement when providing incentives to children compared with splitting incentives between children and parents.²⁶ Consistent with stakeholder input, programs should further evaluate incentives provided directly to children, especially adolescents, or those split between children and caregivers. Administrative barriers to incentive program implementation (eg, systems for monitoring behaviors and providing incentives^{11,42}) could be increased when linking child and adult populations.

With increasing evidence of the impact of social determinants on child health, stakeholders identified

TABLE 3 Stakeholder Insights on Evaluating Medicaid and CHIP Beneficiary Incentive Programs for Child Health

Limited evidence on health impact of commonly incentivized behaviors for child health

- Incentivize evidence-based components of well-child care to increase health impact.
 - Caution for limited impact of incentivizing well-child check visit because of variability in types and quality of services provided: "Checking a box...just to say they went to the doctor when the quality of what's happening in those doctor visits is not clear."
 - Link incentives to specific evidence-based well-child check components per professional guidelines (eg, *Chlamydia* screening and oral health counseling) for greater health impact.

Delayed time horizon for return on investment from currently incentivized behaviors

- Acknowledge potential delayed or unknown return on investment.
 - Well-child checks, health risk assessments, and preventive dental care may not yield improved traditional health outcome measures or lower costs for years to decades.
- Consider the churn of children off Medicaid or CHIP coverage for incentive program evaluation.
 - Most children insured by Medicaid or CHIP will not be covered by the same entity in adulthood, when many health or cost benefits are realized: "It's not worth it to invest in these programs for kids because [the insurers] know they're only going to cover a child for at most 2 or 3 years...and that's even a stretch."

Proximal measures meaningful to child health for early program evaluation

- Collect more proximal process measures, especially when outcomes measures may be difficult to use.
 - Examples: childhood immunization rates and adherence to asthma controller or ADHD medication refills.
- Assess alternative measures of child well-being.
 - Examples: school functioning (eg, missed school days and use of IEPs) and child and parent health-related quality-of-life measures.

IEP, Individualized Education Program.

opportunities for incentive programs to address children's social needs.⁴³⁻⁴⁶

Although the regulatory flexibility to broadly offer such programs is still developing, payers exhibit growing enthusiasm for interventions targeting social factors.⁴⁷ Social-needs screening and support incentives such as care coordination, social work, or transportation can have wide-reaching benefits, including more appropriate health care use and increased healthy behaviors.⁴⁸⁻⁵⁰ Incentivizing beneficiaries (and providers) to complete social-needs screenings may increase families' access to social support, aligning with movements toward children's integrated care models.^{50,51}

Stakeholders strongly objected to exposing children to loss-framed incentives. Building on concerns about punitive incentives for personal responsibility in adult programs,^{42,52} stakeholders emphasized that children are defined as a vulnerable population because of their developmental needs and caregiver dependence.⁵³ In the 1 program identified involving a loss-framed design, 93% of eligible children were ultimately converted to a plan that provided fewer benefits, primarily

because of parental noncompletion of a health agreement or nonadherence to well-child check schedules.⁵⁴

Similarly, when parental coverage is at risk, children's own coverage and continuity of care may be jeopardized; work requirements are a more recent loss-framed policy lever being explored that may negatively impact child health.⁵⁵⁻⁵⁸

Unintended consequences of incentives, regardless of their framing, must also be considered. For example, incentives may increase inequities among Medicaid beneficiaries if they are more effective among healthier, already-motivated families. In addition, families of children covered by Medicaid may face social and structural barriers affecting their health care access and engagement that cannot feasibly be modified with incentives.^{59,60} Further research is needed to identify the size and type of incentives that are effective but not coercive in the low-income population because evidence and recommendations for children are limited.^{61,62}

Our study has several limitations. First, MCOs may have implemented programs we did not identify through our literature review or interviews. However, to our knowledge, this is

the largest landscape of such programs yet identified, and we comprehensively identified programs run directly by state Medicaid and CHIP agencies under Section 1115 waivers, MIPCD, and state plan amendments. Second, we interviewed a convenience sample of stakeholders from several health care sectors. Although we intentionally selected geographically and politically diverse stakeholders from a variety of payer, provider, patient advocacy, and evaluation backgrounds, not all potential views on beneficiary incentives for child health were captured.

CONCLUSIONS

Medicaid and CHIP now offer beneficiary incentives to promote children's health, but the design and implementation strategies for the heterogeneous programs that target child health rely on a limited evidence base. At this nascent research stage, we summarize the insights of a diverse stakeholder group, which emphasized that engaging beneficiaries in children's health may require strategies that differ from those of adult programs, such as leveraging an intergenerational approach. Although evaluating

program impact is challenging, more evidence is needed to inform the next generation of incentive programs for child health. Rather than just offering gift cards for well-child checks, administrators of future beneficiary incentive programs should aim to offer incentives informed by families and engage beneficiaries with behaviors that have more evidence of health impact on children.

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ABBREVIATIONS

ADHD: attention-deficit/hyperactivity disorder
CHIP: Children's Health Insurance Program
MCO: managed care organization
MIPCD: Medicaid Incentives for Prevention of Chronic Diseases

collection, coordinated, supervised, and conducted the initial analysis, and critically reviewed the manuscript for important intellectual content; and all authors approved the final manuscript as submitted and agree to be accountable for all aspects of the work.

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Address correspondence to Charlene A. Wong, MD, MSHP, Duke University School of Medicine, 4020 N Roxboro St, Durham, NC 27704. E-mail: charlene.wong@duke.edu

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