# Initial Report to Congress

# Medicaid Incentives for Prevention of Chronic Diseases Evaluation

**Kathleen Sebelius**
**Secretary of Health and Human Services**
**November 2013**

*[This page intentionally left blank.]*

**CONTENTS**


LIST OF ABBREVIATIONS ..... v

EXECUTIVE SUMMARY ..... 1

E.1 Background ..... 1

E.1.1 Purpose of the Report ..... 1

E.1.2 Organization of the Report ..... 1

E.2 Implementation of State Programs ..... 2

E.3 Challenges, Changes, and Lessons Learned ..... 3

E.4 Recommendations ..... 4

SECTION 1 INTRODUCTION ..... 5

SECTION 2 DATA SOURCES AND METHODOLOGY ..... 7

SECTION 3 AN ASSESSMENT OF PROGRAM IMPLEMENTATION AND LESSONS LEARNED FROM THE PROGRAM ..... 9

3.1 Overview of State Programs ..... 9

3.2 Project Startup Across State Programs ..... 9

3.3 Medical Conditions and Health Behaviors Addressed Across State Programs ..... 14

3.4 Targeted Special Populations ..... 14

3.5 Enrollment and Marketing Across State Programs ..... 17

3.6 Incentives Across State Programs for Participants and Providers ..... 19

3.7 Evaluation Designs Across State Programs ..... 23

3.8 Evaluation Progress ..... 24

3.9 Challenges Across States in Program Implementation ..... 24

3.10 Changes to State Implementation Plans ..... 26

3.11 Lessons Learned Across State Programs ..... 28

3.12 Learning Collaborative ..... 31

SECTION 4 BUDGETED GRANT FUNDS ..... 33

4.1 Administrative Costs ..... 33

4.2 Planned Analyses ..... 33

SECTION 5 RECOMMENDATIONS ..... 35

SECTION 6 SUMMARY ..... 37

REFERENCE ..... 39

Appendices

A. State Participant Enrollment as of August 31, 2013 ..... A-1
B. California ..... B-1
C. Connecticut ..... C-1
D. Hawaii ..... D-1
E. Minnesota ..... E-1
F. Montana ..... F-1
G. Nevada ..... G-1
H. New Hampshire ..... H-1
I. New York ..... I-1
J. Texas ..... J-1
K. Wisconsin ..... K-1

List of Tables

1. Overview of State programs ..... 10
2. Project startup across State programs ..... 13
3. Comparison of medical conditions and health behaviors addressed across State programs ..... 14
4. Targeted special populations across State programs ..... 16
5. State-estimated percentage of program participants with a primary language of English, Spanish, and other languages ..... 17
6. Enrollment across State programs ..... 18
7. Incentives across State programs for participants ..... 20
8. Incentives across State programs for participants ..... 21
9. Incentives across State programs for providers ..... 22
10. Evaluation designs across State programs ..... 23
11. State first-year grant award ..... 33

## LIST OF ABBREVIATIONS

CHC—Community Health Center

CME—Continuing Medical Education

CMS—Centers for Medicare & Medicaid Services

EMR—Electronic Medical Records

FB—First Breath

FOA—Funding opportunity announcement

FQHC—Federally Qualified Health Center

HMO—Health Maintenance Organization

ICHP—Institute for Child Health Policy

IRB—Institutional Review Board

MCO—Managed Care Organization

MDS—MIPCD State Minimum Data Set

MIPCD—Medicaid Incentives for Prevention of Chronic Diseases

NASHP—National Academy for State Health Policy

NRT—Nicotine replacement therapy

RCT—Randomized controlled trial

RFP—Request for proposals

TA—Technical assistance

UKPDS—United Kingdom Prospective Diabetes Study

UW-CTRI—University of Wisconsin School of Medicine and Public Health Center for Tobacco Research and Intervention

WTQL—Wisconsin Tobacco Quit Line

WWHF—Wisconsin Women's Health Foundation

*[This page intentionally left blank.]*

# EXECUTIVE SUMMARY

## E.1 Background

Section 4108 of the Affordable Care Act mandated the creation of the Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) program for States to develop evidence-based prevention programs that provide incentives to Medicaid beneficiaries to participate in and complete the MIPCD program. In September 2011, 10 States (California, Connecticut, Hawaii, Minnesota, Montana, Nevada, New Hampshire, New York, Texas, and Wisconsin) were awarded demonstration grants to implement chronic disease prevention approaches for their Medicaid enrollees to test the use of incentives to encourage behavior change. These States are required to demonstrate Medicaid beneficiary changes in health risks and outcomes. Consistent with the requirements of Section 4108 of the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) awarded a contract to RTI International to conduct an independent, national evaluation of the 10 State programs. As required by the law, this evaluation will focus on:

1. the effect of such programs on the use of health care services by Medicaid beneficiaries participating in the program;

2. 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;

3. the level of satisfaction of Medicaid beneficiaries with respect to the accessibility and quality of health care services provided through the program; and

4. the administrative costs incurred by State agencies that are responsible for administration of the program.

### E.1.1 Purpose of the Report

As part of the MIPCD authorization, the Affordable Care Act requires that the Secretary of the Department of Health and Human Services submit an initial and a final Report to Congress on the MIPCD programs. This initial Report to Congress is due no later than January 1, 2014. The report shall provide an interim evaluation of the effectiveness of the programs based on information provided by the States through their semi-annual reports; it should also contain a recommendation regarding whether funding for expanding or extending the programs should be extended beyond January 1, 2016. This Report to Congress is designed to meet these requirements.

### E.1.2 Organization of the Report

In the report, we first introduce the MIPCD program (Section 1) and describe the data sources and methodology used to create the report (Section 2). We used a mixed-methods approach to analyze information from State MIPCD applications and operational protocols; State Quarterly Reports and State-specific documents provided to CMS; State updates on monthly calls with the Implementation Contractor along with program-specific information and forms

provided by the State to the Implementation Contractor; program updates and discussions from the Learning Collaborative's all-State, in-person meetings in May and December 2012 and May 2013; telephone interviews by RTI with the State program staff; and the CMS State Minimum Data Set (MDS) template. Data included in this report are current through June 30, 2013. An Addendum Table in Appendix A shows State program enrollment through August 31, 2013.

In Section 3, we provide an assessment of program implementation and a review of lessons learned. The section includes an overview of the State programs; further details on each program are contained in Appendices B–K. The section describes program challenges, changes, and lessons learned. Section 4 provides our recommendation regarding whether funding for expanding or extending the programs should be extended beyond January 1, 2016. At this time, there is insufficient evidence to recommend for or against extending funding of the programs beyond January 1, 2016.

Section 5 briefly reviews specific uses of grant funds. Currently, we have information on planned expenditures, but insufficient data to report actual expenditures, including expenditures on administrative costs. Section 6 provides a summary of the report.

## E.2 Implementation of State Programs

Ten States received their grants on September 11, 2011. Half of the States implemented their programs by the end of the first year (September 10, 2012) and the remaining States implemented their programs during the second year. States collaborate with multiple partners on these programs, with other departments within State and local government, including State universities that often serve as the State's evaluator. For many States, these partnerships helped facilitate statewide implementation. Four States are implementing statewide programs with the remaining States focusing their efforts on specific geographic regions or facilities. Additionally, California, Hawaii, Minnesota, New York, Nevada, and Wisconsin have decided to implement their initial programs as pilots or in phases, as a way to identify and address potential challenges and issues before full implementation.

These programs target one or more of five medical conditions or behaviors—smoking, diabetes, obesity, hyperlipidemia, and hypertension. All States, except California, Connecticut, Hawaii, and Wisconsin, are targeting multiple conditions or behaviors. Even when a State is not targeting more than one condition, it may address other conditions that serve as barriers. For all States, program participants need to be enrolled in Medicaid and have or be at risk of chronic diseases. All States, except Texas and New York, will enroll those beneficiaries who have both Medicaid and Medicare coverage, known as Medicare-Medicaid enrollees, in their initiatives. All States are also targeting or engaging other diverse populations such as pregnant women, racial and ethnic minorities, children, and individuals with mental illness or substance abuse disorders. For example, California, Connecticut, New Hampshire, and Texas are targeting beneficiaries with mental illness, with California and Texas also targeting beneficiaries with substance abuse disorders. Additionally, all States, except New Hampshire and Montana, will include non–English-speaking participants, and plan to work on providing language translations and addressing cultural sensitivities.

As of June 30, 2013, all States have implemented their programs and enrolled participants. As a result of program startup being delayed for most programs, 8 of the 10 States are significantly below their goal of project participants or have not yet started enrollment in the second year of their grant. However, Texas is close to achieving its enrollment goal of 1,250 participants.

State programs provide varied types of incentives for program participation and health outcome attainment, which include (1) money through debit cards; (2) money-valued incentives, such as $20-valued gift cards; (3) flexible spending accounts for wellness activities; (4) prevention-related incentives, such as vouchers for farmers' markets, exercise equipment, and healthy foods cookbooks; (5) treatment-related incentives, such as free nicotine replacement therapy patches; (6) points redeemable for rewards; and (7) support to address barriers to participation such as meals, transportation, and childcare. All States are giving participants monetary incentives in the form of cash, gift card or other money-value item, or flexible spending account funds. Incentives range from $20 to $1,150 annually and are used to reward participants for program participation and for achieving specified health outcomes. States are also incentivizing participating providers. Connecticut, Hawaii, Minnesota, Montana, Nevada, and Wisconsin will use a combination of financial or continuing medical education credit incentives to encourage program participation by providers, and the provision of supportive services for participating enrollees.

States are required to evaluate the effectiveness of their incentives programs. To do so, seven States are implementing randomized controlled trials that include cost-effectiveness analyses. The remaining States—Hawaii, Montana, and New Hampshire—are implementing quasi-experimental, crossover, and equipoise-stratified randomized evaluation designs, respectively.

### E.3 Challenges, Changes, and Lessons Learned

As expected in the first year and a half of implementation, States have encountered challenges and issues that they have had to address, resulting in the delayed implementation of most programs. Challenges reported by participating States included administrative delays such as contracting limitations or submissions to multiple Institutional Review Boards; provider engagement and participation; provider management and oversight; participant identification, which includes identifying Medicaid beneficiaries and identifying individuals in a particular target population such as pregnant smokers; managing patient incentives, which was complicated by State decisions to use debit cards to offer cash; and community perceptions of participants, in particular those with mental health conditions.

States have made a wide variety of changes to their plans as a result of challenges they have faced in implementing their programs and by exchanging information with one another through MIPCD Learning Collaborative activities. State program changes include adjustments to implementation timelines; beneficiary recruitment and enrollment; beneficiary incentives; provider recruitment, training, and incentives; and evaluation design.

States' challenges and changes faced this past year contributed to many lessons learned in what implementing these types of programs entails. These lessons include (1) being flexible; (2)

adopting a problem-solving approach, which includes a willingness to explore alternative options and develop alternative plans; (3) having political support from program champions; (4) taking time to adequately plan program implementation, hire a capable project manager, and implement comprehensive project management systems and infrastructure; (5) developing collaborative partnerships; (6) building relationships with partners and providers through ongoing communication; (7) training and incentivizing providers to participate; and (8) incorporating cultural and linguistic awareness into the program.

## E.4 Recommendations

At this time, there is insufficient evidence to recommend for or against extending funding of the programs beyond January 1, 2016. Most of the State programs have been enrolling participants for only a short period, and there are few data on the effect of the programs on health outcomes or health care utilization and costs. Therefore, it would be premature to make a recommendation to extend funding to expand or extend the programs beyond January 1, 2016. Because the incentives may improve health outcomes or reduce health care costs, it would also be premature to recommend against extending funding. Consequently, we are deferring a recommendation on extension until more evidence of the programs' impact is available. Subsequent reports including the second Report to Congress and the Final Evaluation Report will include additional analyses and provide the necessary data for more in-depth analyses of effectiveness that will support recommendations on whether to extend funding for the program.

# SECTION 1
# INTRODUCTION

Section 4108 of the 2010 Patient Protection and Affordable Care Act (Affordable Care Act) mandated the creation of the Medicaid Incentives for Prevention of Chronic Diseases program for States to develop evidence-based prevention programs that provide incentives to Medicaid beneficiaries to participate in and complete the Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) program. In September 2011, 10 States were awarded demonstration grants to implement chronic disease prevention approaches for their Medicaid enrollees to test the use of incentives to encourage behavior change. These States are required to demonstrate Medicaid beneficiaries' changes in health risks and outcomes. By comparing participating Medicaid beneficiaries to a control group, State demonstration evaluators will measure the effects of incentives and different levels and types of incentives on behavior, health outcomes, health care utilization, and costs.

Consistent with the requirements of Section 4108 of the Affordable Care Act, the Centers for Medicare & Medicaid Services awarded a contract to RTI International to conduct an independent, national evaluation of these 10 State demonstration Grantees. The legislative requirements state that this evaluation is for the purpose of determining:

- 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 administration of the program.

The First Report to Congress was originally designed to evaluate the interim effectiveness of the State programs and to include a recommendation regarding whether funding for expanding or extending the programs should be extended beyond January 1, 2016. This Report was designed to be based on State-reported information and data about specific uses of grant funds, assessment of program implementation and lessons learned, assessment of quality improvements and clinical outcomes, and estimates of cost savings. At this time, however, most of the State programs have been enrolling participants for only a short period of time, and there are few data available on the effect of the programs on health outcomes and health care utilization and costs. Therefore, there is insufficient evidence on which to base a recommendation for or against extending funding of the programs beyond January 1, 2016. Consequently, this First Report focuses on the evaluation questions regarding States' program implementation. The second Report to Congress will include the in-depth analyses of effectiveness that will support recommendations on whether to extend funding for the program.

Data included in this report are current through June 30, 2013. An Addendum Table in Appendix A shows State program enrollment through August 31, 2013.

The evaluation questions addressed in this report follow:

- What are the characteristics of each State program?
- Are there common implementation characteristics across State programs?
- What marketing strategies have been successful in recruiting participants in the State programs?
- What challenges have States faced in implementing their strategies?
- What changes have States made to their implementation plans or evaluation?
- What key lessons have State programs learned in the implementation of their program?

## SECTION 2
## DATA SOURCES AND METHODOLOGY

This report focuses on programs' implementations, including the challenges, changes, and lessons learned during this implementation phase, both within and across States' programs. Using the evaluation questions as the foundation for the analyses, the following State data sources were used in preparing this initial Report to Congress:

- State Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) applications and operational protocols.
- State Quarterly Reports and State-specific documents provided to the Centers for Medicare & Medicaid Services (CMS).
- State updates on monthly calls with the Implementation Contractor along with program-specific information and forms provided by the State to the Implementation Contractor.
- Program updates and discussions from the Learning Collaborative's all-State, in-person meetings in May and December 2012 and May 2013.
- Telephone interviews by RTI with the State program manager and staff, evaluators, and contractors participating in the program.
- MIPCD State Minimum Data Set (MDS) template. The MIPCD State MDS collects data from each State for program performance monitoring and evaluation purposes. The MIPCD State MDS data will be collected each quarter beginning in August 2013.[1]

These data sources will be used throughout the MIPCD evaluation; as described in Section 7, additional sources will be analyzed as they become available. The data used in preparing this report are current through June 30, 2013.

Each State has an assigned RTI staff member, who serves as the liaison and technical expert on that State's program. This person has a thorough understanding of the program; reviews all program submissions; keeps track of program challenges, updates, and modifications as they occur; leads the telephone interview with the State; and informs the rest of the team about key developments.

We conducted a systematic review of materials to create a database to collect and organize the qualitative information for each State. To the extent possible, readily available data sources were used to minimize the burden on participating States. The State's application and operational protocol served as the baseline, supplemented by quarterly reports that provide critical information on implementation progress. Additionally, RTI conducted an informal

[1] MIPCD State MDS data are not included in this first Report to Congress because they were not available in time for the evaluation team to conduct analyses for inclusion in the report.

telephone interview with each State to confirm, elaborate upon, and further investigate the information provided in the reports. These conversations augmented the team's understanding of each program, including the unique contextual issues that may affect implementation and effectiveness. Finally, RTI and its subcontractor, the National Academy for State Health Policy (NASHP), joined the Implementation Contractor's monthly check-in calls and attended three in-person Learning Collaborative meetings with States to get further information on program implementation.

# SECTION 3
# AN ASSESSMENT OF PROGRAM IMPLEMENTATION AND LESSONS LEARNED FROM THE PROGRAM

## 3.1 Overview of State Programs

***Table 1*** provides an overview of the programs in the States that were awarded grants; details on each program are included in Appendices B–K. Implementing agencies are primarily health, human, or social service departments. States collaborate with multiple partners on these programs, with other departments within State and local government, including State universities that often serve as the State's evaluator. There are also numerous public/private partnerships, often with managed care plans and private health providers or with nonprofit organizations, such as community health centers (CHCs) and YMCAs. National organizations, such as the American Diabetes Association, the American Cancer Society, and the American Heart Association, are also listed as partners, all speaking to a wide representation of committed organizations.

## 3.2 Project Startup Across State Programs

***Table 2*** displays the projected or actual implementation dates of States' programs and identifies pilot programs and geographic areas where States are implementing their programs. States received their grants on September 11, 2011, and half implemented their programs by the end of the first year. Four States are implementing their programs statewide. The remaining States are implementing in specific geographic areas or facilities. For example, New Hampshire is implementing its program at all 10 community mental health centers in the State. Some States decided to implement their initial programs as pilots or in phases, as a way to identify and address potential challenges and issues before full implementation. California piloted its program in Sacramento County. Wisconsin piloted its First Breath program in one county, for example, before expanding this intervention to other counties, and will implement its Quit Line component in the same manner. New York had originally planned to pilot its Diabetes Prevention arm in Brooklyn before expanding to other medical condition arms and locations, but has since decided to take a statewide, phased-in approach. The pace of New York's phased-in implementation depends on finding providers and managed care plans to participate and on finalizing the contract for its incentive vendor. Nevada had originally planned to implement all five of its programs simultaneously, but since then it has decided to adopt a staggered implementation approach. Nevada's Children's Heart Center and the YMCA of Southern Nevada began enrolling participants in February and May 2013, respectively. The State plans to implement its remaining three programs in late summer or early fall of 2013. Minnesota has also adopted a staggered implementation approach focused on specific facilities. Five clinics in the seven-county Minneapolis-St. Paul metropolitan area of Minnesota began implementation in November 2012, and the State expanded to include a total of 19 clinics during the second project year. Hawaii also phased in its implementation, with four of a projected 14 Federally Qualified Health Centers (FQHCs) enrolling participants by April 30, 2013.

**Table 1**
**Overview of State programs**

| State | Project title | Grantee/State implementing agency | Partners |
|---|---|---|---|
| California | Medicaid Incentives for Prevention of Chronic Diseases: Medi-Cal Incentives to Quit (MIQS) Project | California Department of Health Care Services | California Tobacco Control Program (California Department of Public Health)<br>California Medicaid Research Institute (multi-campus program based at the University of California, San Francisco)<br>California Smokers' Helpline (University of California, San Diego)<br>California Diabetes Program (University of California, San Francisco)<br>Institute of Health & Aging (University of California, San Francisco) |
| Connecticut | Connecticut Rewards to Quit | Connecticut Department of Social Services | Connecticut Department of Public Health<br>Department of Mental Health and Addiction Services<br>Community Health Network of Connecticut<br>Connecticut Hispanic Health Council<br>Yale University<br>Obstetrics providers, local mental health authorities, mental health clinics, community health centers (CHCs) including Federally Qualified Health Centers (FQHCs), and hospital-based adult primary care practices |
| Hawaii | Hawaii Patient Reward and Incentives for Supporting Empowerment Project (HI-PRAISE) | Hawaii Department of Human Services | University of Hawaii (UH) John A. Burns School of Medicine<br>Department of Health<br>Hawaii Health Information Corporation<br>UH Center on Disability Studies<br>Section 330 FQHCs<br>Private providers<br>Hawaii Associations of Health Plans<br>Hawaii Primary Care Association (HPCA)<br>Managed Care Organizations (MCOs) |

(continued)

**Table 1**
**Overview of State programs (continued)**

| State | Project title | Grantee/State implementing agency | Partners |
|---|---|---|---|
| Minnesota | Minnesota Medicaid Incentives for Prevention of Diabetes | Office of the State Medicaid Director, Minnesota Department of Human Services | Minnesota Department of Health<br>HealthPartners Institute for Education and Research<br>YMCA of Greater Twin Cities |
| Montana | Medicaid Incentives to Prevent Chronic Disease | Montana Department of Public Health and Human Services, Medicaid Managed Care Bureau, and Chronic Disease Prevention and Health Promotion Bureau | American Diabetes Association<br>American Heart/Stroke Association Affiliates for Montana<br>Montana Department of Public Health and Human Services Diabetes Advisory Coalition<br>Lifestyle coaches from the 14 Health Care Facilities delivering the intervention statewide<br>University of North Dakota<br>Northwest Resource Consultants |
| Nevada | Medicaid Incentives for Prevention of Chronic Diseases | Department of Health and Human Services, Division of Health Care Financing and Policy; Department of Health and Human Services, State Health Division | Children's Heart Center, Nevada<br>Nevada's Medicaid Managed Care Organizations: Amerigroup & UnitedHealthcare, Health Plan of Nevada<br>YMCA of Southern Nevada<br>University Medical Center, Lied Clinic Outpatient Facility<br>Third Party Incentives Administrator – ChipRewards<br>Research Study Evaluators – University of Nevada, Reno |
| New Hampshire | Healthy Choices, Healthy Changes | State of New Hampshire Department of Health and Human Services, Division of Community-Based Care Services, Bureau of Behavioral Health, Office of Medicaid Business and Policy | 10 Regional community mental health centers<br>Dartmouth Centers for Disease Control Prevention Research Center<br>Dartmouth Institute for Health Policy and Clinical Practice |

(continued)

**Table 1**
**Overview of State programs (continued)**

| State | Project title | Grantee/State implementing agency | Partners |
|---|---|---|---|
| New York | Medicaid Incentives for Prevention of Chronic Disease Program | New York State Department of Health, Office of Health Insurance Programs, Division of Quality and Evaluation | University of Pennsylvania<br>Harvard Medical School<br>Carnegie Melon University<br>New York City Department of Health and Mental Hygiene<br>Alliance of New York State YMCAs<br>New York State Office of Mental Health<br>Medicaid Matters New York<br>American Cancer Society<br>American Diabetes Association<br>American Heart Association<br>Community Service Society of New York<br>Empire Justice Center<br>11 Medicaid Managed Care Plans |
| Texas | Wellness Incentives and Navigation (WIN) Project | Texas Health and Human Services Commission/ Department of State Health Services | Department of State Health Services, Texas' Mental Health and Substance Abuse Authority<br>Health and Human Services Commission (the State Medicaid agency)<br>Institute for Child Health Policy (ICHP), University of Florida, Gainesville (the State's External Quality Review Organization)<br>3 Medicaid-contracted HMOs |
| Wisconsin | Striving to Quit (STQ) | Wisconsin Department of Health Services (DHS) – Division of Health Care Access and Accountability (Medicaid) | Office of Policy Initiatives and Budget<br>Division of Public Health (Tobacco Prevention and Control Program)<br>The University of Wisconsin School of Medicine and Public Health Center for Tobacco Research and Intervention (UW-CTRI)<br>Wisconsin Women's Health Foundation (WWHF) |

**Table 2**
**Project startup across State programs**

| State | Projected or actual implementation date | Implementation as a pilot or in phases | Final implementation location |
|---|---|---|---|
| California | March 2012 | Yes (1 county) | Statewide |
| Connecticut | March 2013 | No | Statewide [a] |
| Hawaii | February 2013 | Yes (phased-in implementation by FQHC) | Fourteen FQHCs and the larger private providers throughout the six main inhabited islands of Hawaii |
| Minnesota | November 2012 | Yes (phased-in implementation by clinic) | Seven-county Minneapolis-St. Paul metropolitan area |
| Montana | January 2012 | No | Fourteen health facilities across the State |
| Nevada | *Children's Heart Center*: February 2013<br>*YMCA of Southern Nevada*: May 2013<br>*Amerigroup*: August 2013<br>*UnitedHealthcare*: August 2013<br>*Lied Clinic*: September 2013 | Yes (phased-in implementation by partner organization) | Las Vegas area |
| New Hampshire | May 2012 | No | Ten community mental health centers across the State |
| New York | June 2013 | Yes (phased-in implementation by MCO and program focus) | Statewide [b] |
| Texas | April 2012 | No | Nine counties in Houston area |
| Wisconsin | *First Breath*: September 2012<br>*Tobacco Quit Line*: April 2013 | Yes (1 county) | First Breath: Statewide [c]<br>Wisconsin Tobacco Quit Line: Statewide [d] |

FQHC = Federally Qualified Health Center; MCO = Managed Care Organization.

[a] The peer coaching component of the initiative will be available only to participants in three selected counties.

[b] New York will collaborate with the Medicaid managed care organizations to implement the Medicaid Incentives to Prevent Chronic Disease (MIPCD) program. Managed care organizations may operate statewide, or they may be located in select geographic areas.

[c] Wisconsin's First Breath arm will be in Kenosha, Milwaukee, Racine, Dane, and Rock counties and will expand to additional counties, with the initial focus on those with high numbers of pregnant BadgerCare Plus members.

[d] Wisconsin's Tobacco Quit Line arm will be implemented in Brown, Dane, Dodge/Jefferson (clinic is on border of two counties), Green, Milwaukee, Rock, and Winnebago counties where the biochemical nicotine test is currently available. Expansion to additional counties will take place in the future.

### 3.3 Medical Conditions and Health Behaviors Addressed Across State Programs

Targeted conditions and behaviors across State programs include smoking, diabetes, obesity, hyperlipidemia, and hypertension. The programs are encouraging participants to use quitlines and nicotine replacement therapy to stop smoking; lose weight and increase physical activity to prevent diabetes, hyperlipidemia, hypertension, and heart disease; and take an active role in preventing other chronic diseases. As shown in ***Table 3***, all but four States are targeting multiple conditions, and three States are targeting four or more conditions. Even when a State is not targeting more than one condition, it may address other conditions or behaviors that serve as barriers. Hawaii, for example, is targeting diabetes but will address smoking, weight management, high cholesterol, blood pressure control, and behavioral health issues if they are impeding diabetes self-management. The greatest number of States are targeting diabetes and smoking (six States each), while the fewest number of States are targeting hyperlipidemia (three States). In addition to the conditions listed in the table, Texas is also targeting managing behavioral health conditions, increasing satisfaction with health care, and making progress toward personal health goals.

**Table 3**
**Comparison of medical conditions and health behaviors addressed across State programs**

| State | Smoking | Diabetes | Obesity | Hyperlipidemia | Hypertension |
|---|---|---|---|---|---|
| California | ✓ | — | — | — | — |
| Connecticut | ✓ | — | — | — | — |
| Hawaii | — | ✓ | — | — | — |
| Minnesota | — | ✓ | ✓ | — | — |
| Montana | — | ✓ | ✓ | ✓ | ✓ |
| Nevada | — | ✓ | ✓ | ✓ | ✓ |
| New Hampshire | ✓ | — | ✓ | — | — |
| New York | ✓ | ✓ | — | — | ✓ |
| Texas | ✓ | ✓ | ✓ | ✓ | ✓ |
| Wisconsin | ✓ | — | — | — | — |
| Total | 6 | 6 | 5 | 3 | 4 |

### 3.4 Targeted Special Populations

Special populations (including adults with disabilities, adults with chronic illnesses, and children with special health care needs) are one of the key evaluation topics mandated to be evaluated by Section 4108. All of the States are targeting adults with or at risk of chronic diseases. ***Table 4*** shows that States are targeting diverse other populations, with some States correlating the medical conditions being addressed with particularly vulnerable populations. Four of five programs that specifically target pregnant women and mothers of newborns have a

smoking cessation component as part of their program. Four programs are targeting beneficiaries with mental illness, with two of these States also targeting beneficiaries with substance abuse disorders. All States, except Texas and New York, will enroll those beneficiaries who have both Medicaid and Medicare coverage, known as Medicare-Medicaid enrollees, in their initiatives. States' estimates of the number of participants that will be Medicare-Medicaid enrollees vary based on the characteristics of the population targeted. New Hampshire, for example, is targeting a population with a higher possibility of being on Medicare because of disabilities and estimates that up to 50 percent of participants will be Medicare-Medicaid enrollees. Montana, which is targeting beneficiaries in the general Medicaid population, estimates that up to 36 percent will be Medicare-Medicaid enrollees. Although New York and Texas are initially enrolling Medicaid-only beneficiaries in their program, they will allow participants who become Medicare-Medicaid enrollees during program participation to remain in the program.

**Table 4**
**Targeted special populations across State programs**

| State | Those with mental illness | Those with substance abuse disorders | Racial/ethnic minorities | Pregnant women and mothers of newborns | Children | Medicare-Medicaid enrollees |
|---|---|---|---|---|---|---|
| California[a] | ✓ | ✓ | ✓ | ✓ | — | ✓ |
| Connecticut | ✓ | — | — | ✓ | — | ✓ |
| Hawaii[b] | — | — | ✓ | — | — | ✓ |
| Minnesota[c] | — | — | — | — | — | ✓ |
| Montana[d] | — | — | — | ✓ | — | ✓ |
| Nevada | — | — | — | — | ✓ | ✓ |
| New Hampshire | ✓ | — | — | — | — | ✓ |
| New York[e] | — | — | — | ✓ | — | — |
| Texas | ✓ | ✓ | — | — | — | — |
| Wisconsin | — | — | ✓ | ✓ | — | ✓ |
| Total | 4 | 2 | 3 | 5 | 1 | 8 |

[a] California does not consider these populations to be a primary focus, but will be able to identify these populations and provide data on their participation.

[b] Hawaii does not consider those with mental illness and substance abuse disorders to be a primary focus, but will able to identify these populations and provide data on their participation.

[c] Minnesota does not consider these populations to be a primary focus, but will examine differences among racial and ethnic minorities to the extent that the data will support that level of analysis.

[d] In Montana, pregnant women are ineligible for the program, but mothers of newborns who meet the eligibility criteria are eligible for the program.

[e] New York does not consider mothers of newborns to be a primary focus, but this special population may be included in its programs.

Many States will include non–English-speaking participants, as shown in ***Table 5***, and will work on providing language translations and addressing cultural sensitivities. Although 6 of the 10 States will include participants with English and Spanish as their primary language, there are other States that will have to address the needs of participants who speak a different primary language. Hawaii, for example, estimates that 50 percent of its participants will not speak English as their primary language and instead will speak one of 10 languages, including Filipino (Ilocan and Tagalog), Samoan, Tongan, Micronesian (Chuukese and Marshallese), Vietnamese, Laotian, Chinese, and Korean. Minnesota estimates that up to 20 percent of its Medicaid beneficiary population speaks Somali and is working closely with the community to develop program materials and brochures that are culturally and linguistically appropriate.

**Table 5**
**State-estimated percentage of program participants with a primary language of English, Spanish, and other languages**

| State | English | Spanish | Other languages |
|---|---|---|---|
| California[a] | 99 | 1 | 0 |
| Connecticut | 75 | 25 | 0 |
| Hawaii | 50 | 0 | 50 |
| Minnesota[b] | 80 | Unknown | 20 |
| Montana | 100 | 0 | 0 |
| Nevada | 64 | 36 | 0 |
| New Hampshire[c] | 100 | 0 | 0 |
| New York[d] | 80 | 20 | Unknown |
| Texas | 89 | 10 | 1 |
| Wisconsin | 93 | 7 | 0 |

[a] Although California will provide services to people who speak all languages, its randomized trial will only include people with English and Spanish as their primary language.

[b] In Minnesota, Somali is the main language, other than English, that is spoken by participants. Participants also speak Hmong, Russian, Karen, and Vietnamese.

[c] Many of New Hampshire's participants are bilingual (English and Spanish), but all primarily speak English.

[d] New York expects to enroll participants speaking Chinese and Russian but the percentage is unknown.

### 3.5 Enrollment and Marketing Across State Programs

As of June 30, 2013, all States have implemented their programs and started enrolling participants, as shown in ***Table 6***. As a result of program startup being delayed for most programs, as of June 30, 2013, 8 of the 10 States were significantly below their goal of project participants.

**Table 6**
**Enrollment across State programs**

| State | Actual # enrolled as of June 30, 2013 | Total projected # of participants | Projected # of participants for experimental group(s) | Projected # of participants for control group(s) |
|---|---|---|---|---|
| California | 3,815 | 9,000 | 7,350 | 1,650 |
| Connecticut | 17 | 28,771 | 14,385 | 14,386 |
| Hawaii | 280 | 2,500 [a] | 2,500 | 634 |
| Minnesota | 110 | 1,800 | 1,200 | 600 |
| Montana | 181 | 726 | 363 | 363 |
| Nevada | 215 | 9,816 | 5,382 | 4,434 |
| New Hampshire | 1,175 [b] | 2,639 [c] | 880 | 873 |
| New York | 5 | 6,800 | 5,100 | 1,700 |
| Texas | 1,187 | 1,250 | 625 | 625 |
| Wisconsin | 285 | 3,250 | 1,625 | 1,625 |

[a] Hawaii's control group will be an external group and not a participant group. Therefore, the total projected number of participants does not include control group members.

[b] New Hampshire's total includes the estimated 360 participants who received a $10 incentive to complete a computerized education program. These same participants may also be included in the participation totals for the control or the intervention group.

[c] New Hampshire's total enrollment target includes 936 participants who will receive a $10 incentive for completing a computerized tobacco education course. These participants may fall in the control group or the intervention group and thus are included in the total target, but not in the experimental or control group targets.

States have worked closely with health providers, including private providers, MCOs, FQHCs, and community mental health centers in educating and training medical directors, health care providers, staff educators, and outreach workers to build awareness and incorporate program referrals from their patient base into their routine workflow. States have also sent mailings to potential applicants, conducted media campaigns, and provided brochures and posters at these sites, so that eligible beneficiaries interested in the program after seeing them could self-refer.

Texas took the unique approach of contracting with the National Opinion Research Center at the University of Chicago to use multiple methods for enrolling program participants. Texas started slowly with recruitment so it could work through issues. Strategies included mailings based on hospital records and third-party address updates; phone calls from bilingual staff on varying days and at different times of the day; providing a toll-free number for interested Medicaid enrollees to call; and door-to-door recruitment for hard-to-reach cases. Not all of these strategies were successful, but the overall approach was successful, and the State is close to reaching its enrollment goal.

### 3.6 Incentives Across State Programs for Participants and Providers

Incentives being provided by State programs for program participants include the following:

- Money through debit cards
- Money-valued incentives, such as $20-valued gift cards
- Flexible spending accounts for wellness activities (Texas only)
- Prevention-related incentives, such as vouchers for farmers' markets, exercise equipment, and healthy foods cookbooks
- Treatment-related incentives, such as free nicotine replacement therapy patches
- Points redeemable for rewards
- Support to address barriers to participation such as meals, transportation, and childcare

***Table 7*** shows that money is the most common type of incentive, and is offered through prepaid debit cards and a flexible spending account for wellness activities. Four States offer prepaid debit cards in combination with other incentives. All States are giving participants monetary incentives in the form of cash, gift card or other money-value item, or flexible spending account funds. ***Table 8*** shows the maximum monetary incentive amount that participants can receive in each program arm. Incentives range from $20 to $1,860 annually and are used to reward participants for program participation and for achieving specified health outcomes. In New Hampshire, for example, participants can receive cash rewards for healthy behaviors, obtain free access to fitness resources, and receive transportation assistance. Some States have found the use of debit cards challenging. California had planned on using debit cards, but decided against it when technical barriers arose. Texas found that it needed to coach participants and implement purchasing protocols to make sure that participants were only making authorized purchases with their accounts.

Nevada offers incentive coupons for screening or other preventive services that represent value points that can be redeemed from a catalogue of rewards. Minnesota is not only providing individual incentives but also offering additional incentives to participants in the "group incentives" program arm based on class participation and weight loss goals. In addition to providing monetary incentives, Connecticut is distributing "motivation" cards that provide words of encouragement to enrollees following their participation in smoking cessation counseling sessions and negative breathalyzer tests.

**Table 7**
**Incentives across State programs for participants**

| State | Money | Money-valued incentives | Flexible spending accounts for wellness activities | Prevention-related incentives | Treatment-related incentives | Points redeemable for rewards | Support to address barriers to participation |
|---|---|---|---|---|---|---|---|
| California | — | ✓ | — | — | ✓ | — | — |
| Connecticut | ✓ | — | — | — | — | — | — |
| Hawaii [a] | ✓ | ✓ | — | ✓ | — | ✓ | ✓ |
| Minnesota | ✓ | — | — | ✓ | — | — | ✓ |
| Montana | ✓ | — | — | — | — | — | ✓ |
| Nevada | — | — | — | — | — | ✓ | — |
| New Hampshire | ✓ | — | — | ✓ | ✓ | — | ✓ |
| New York | ✓ | — | — | — | — | — | — |
| Texas [b] | — | — | ✓ | ✓ | ✓ | — | ✓ |
| Wisconsin | ✓ | ✓ | — | — | — | — | ✓ |
| Total | 7 | 3 | 1 | 4 | 3 | 2 | 6 |

[a] Hawaii indicated that the community health centers (CHCs) have flexibility to determine the form of participants' incentive. It could be a gift certificate or fee for gym membership or exercise classes.

[b] Texas indicated that money is not a primary form of incentive; however, participants receive monetary compensation for completing intake and yearly assessments. Participants are also able to request prevention- or treatment-related incentives associated with their health goals.

**Table 8**
**Incentives across State programs for participants**

| State | Maximum financial incentive per person[a] |
|---|---|
| California | Eligible callers who ask for the Medi-Cal Incentives to Quit (MIQS) incentive: Maximum study incentive: $20 |
| | Randomized controlled trial (RCT) 1: Maximum study incentive: $60 |
| | RCT 2: Maximum study incentive: $40 |
| | Enhanced services non-RCT: TBD |
| Connecticut | Maximum annual amount: $350 |
| Hawaii | Maximum annual amount: $215 |
| Minnesota | Maximum study incentive: $545 |
| Montana | Maximum annual amount: $315 |
| Nevada[b] | Managed Care Organization (MCO) for diabetes management: Maximum study incentive: $355 |
| | MCO for weight management class: Maximum study incentive: $38 |
| | MCO for weight management support group: Maximum study incentive: $60 |
| | Lied Clinic Outpatient Facility at University Medical Center: Maximum study incentive: $345 |
| | YMCA of Southern Nevada: Maximum study incentive: $300 |
| | Healthy Hearts Program for Children: Maximum study incentive: $350 |
| New Hampshire | Weight Loss: Maximum incentive for 24 months: $3,097 |
| | Weight Loss: Maximum incentives for 12 months: $1,860 |
| | Smoking Cessation: Maximum study incentive: $415 |
| New York | Maximum study incentive: $250 |
| Texas | Maximum annual amount: $1,150 |
| Wisconsin | Wisconsin Tobacco Quit Line: Maximum study incentive: $270 |
| | First Breath: Maximum study incentive: $600 |

[a] Projected maximum incentive amounts are based on information from State operational protocols, Minimum Data Set templates, and quarterly reports. Amounts may change during implementation.

[b] Nevada provides points that are redeemable for rewards; 100 points is equal to $1.

Some States increase rewards as a person progresses, participates more fully in the program, and achieves milestones. Another State, New Hampshire, reduces the financial incentive over time for the first phase of participants to encourage their independence from external reinforcement and increased intrinsic motivation.

The Texas program differs from most of the other State programs in its focus, format, and size of incentives. This program focuses on Medicaid beneficiaries with mental illnesses and provides an annual flexible spending account for wellness activities of $1,150 that can be spent

on approved health care purchases. Participants work with a patient navigator to establish individualized health goals and a spending plan to meet those goals.

Six State programs will use financial or continuing medical education credit incentives to encourage program participation by providers, and the provision of supportive services for participating enrollees, as illustrated in ***Table 9***. Wisconsin, which did not originally include incentives for providers in its proposal, has had problems recruiting clinics to participate in the Wisconsin Tobacco Quit Line (WTQL). Therefore, the State modified its approach and will provide financial incentives to participatory primary care clinics that sign a Memorandum of

**Table 9**
**Incentives across State programs for providers**

| State | Incentives for providers | If yes, description of incentives for providers |
|---|---|---|
| California | No | — |
| Connecticut | Yes | Free online modules providing continuing medical education (CME) for provider training in smoking cessation treatments, the Connecticut Medicaid program, covered smoking cessation services, and the Rewards to Quit program. One-time $35 stipend for each new participant that providers enroll in Connecticut Rewards to Quit. |
| Hawaii | Yes | Up to $308 per participant for participating Federally Qualified Health Centers (FQHCs) and private providers who provide supportive, supplemental services to patients. |
| Minnesota | Yes | Under a new Request for Proposals released in April 2013, clinics now receive up to $278,000 to cover clinic's study-related costs including participants' supports, personnel, equipment and supplies. |
| Montana | Yes | Selected licensed health care professionals can bill a flat fee per participant and be reimbursed by Medicaid for providing the lifestyle intervention. |
| Nevada | Yes | Compensation for select providers for each participant for whom they enter enrollment and incentive data into a web portal. The compensation is $300 per participant for YMCA, $250 per participant for Children's Heart Center, and $275 per participant for Lied Clinic. |
| New Hampshire | No | — |
| New York | No | — |
| Texas | No | — |
| Wisconsin | Yes | Financial support will be provided to primary care clinics that agree to participate in the program's Wisconsin Tobacco Quit Line (WTQL). Clinics will receive $1,000 after they receive training and conduct testing. Clinics also can select to receive additional support per participant ($50–75 per participant). |

Agreement to screen BadgerCare Plus members for smoking, conduct the biochemical test to confirm smoking status, and make referrals to WTQL. Hawaii will provide financial incentives for participating providers who provide services, such as diabetes education, goal setting, and referrals for supportive services that address patients' barriers to improving their health.

### 3.7 Evaluation Designs Across State Programs

States are required to evaluate the effectiveness of their incentives programs. ***Table 10*** shows that the majority of States are conducting randomized controlled trials (RCTs), with participants randomly assigned to a control group that receives treatments but no incentives, or a treatment group that receives treatments and incentives. Hawaii is using a quasi-experimental design that lacks random assignment, whereas California is using both RCTs and a quasi-experimental design.

**Table 10**
**Evaluation designs across State programs**

| State | Quasi-experimental designs | Randomized controlled trials[a] | Equipoise-stratified randomized designs | Crossover designs[b] | Cost-effectiveness analyses[c] |
|---|---|---|---|---|---|
| California | ✓ | ✓ | — | — | ✓ |
| Connecticut | — | ✓ | — | — | ✓ |
| Hawaii | ✓ | — | — | — | ✓ |
| Minnesota | — | ✓ | — | — | ✓ |
| Montana | — | — | — | ✓ | — |
| Nevada | — | ✓ | — | — | ✓ |
| New Hampshire | — | — | ✓ | — | ✓ |
| New York | — | ✓ | — | — | — |
| Texas | — | ✓ | — | — | ✓ |
| Wisconsin | — | ✓ | — | — | ✓ |
| Total | 2 | 7 | 1 | 1 | 8 |

[a] Wisconsin has changed its initiative from a clinical trial to a quality improvement project; however, it is maintaining its randomized two-group design.

[b] Hawaii is considering adopting a crossover design for use with a participating private group practice.

[c] New York will conduct an informal cost-effectiveness study; a formal assessment of all the costs will not be undertaken.

New Hampshire is using an equipoise-stratified randomized design for both its weight management and smoking cessation programs. Participants select their treatment options within the program and within each treatment option; 50 percent of participants will be randomized as

to whether they receive incentives. However, the State is having difficulty in the distribution of participants in the weight management program, because although there are four treatment options, most enrollees are selecting both options that provide a personal trainer. The State did not anticipate that participants would prefer the treatment options that provide a personal trainer and, thus, did not have an adequate supply of personal trainers to meet the demand of participants. As a result, the State modified the duration of the intervention to increase personal trainer capacity and maintain the stratified equipoise design.

Montana is using a crossover design in its 14 intervention sites. During the first 18 months, seven sites will be selected to provide participants with incentives and the remaining sites will not provide incentives. After the first 18 months, the seven sites that did not previously provide incentives will provide them to new participants and the remaining sites where incentives were previously provided will no longer provide them to new participants.

### 3.8 Evaluation Progress

State program evaluation progress varies based on program implementation progress. States such as California and Montana that implemented in 2012 have begun conducting evaluation activities. Other States such as New York that began implementing in 2013 are in the initial stages of setting up their evaluations. Most States have begun collecting some participants' data to meet the August submission deadline for the Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) State Minimum Data Set (MDS) data. Minnesota and Wisconsin are working with data vendors to collect participant information for their evaluations and the MIPCD State MDS submission. Other States such as Nevada are working with program partners such as the YMCA to develop a portal to collect these evaluation data.

Some States have found reaching their enrollment targets difficult and, therefore, lack a large enough participant population to conduct their evaluation analyses. California is conducting a post-intervention 7-month follow-up assessment and has found it difficult to engage control group participants in this assessment. Connecticut found it challenging to recruit control participants. The State randomizes by recruitment site, and some control group sites have discovered that they are part of the control group and are less interested in recruiting participants. Some States have revised their evaluation plans and analyses to address enrollment challenges and other implementation delays. Montana, for example, excluded its first cohort of participants from its evaluation because implementation delays meant that the first cohort received their incentives late in the program.

### 3.9 Challenges Across States in Program Implementation

As expected in the first 21 months of implementation, States have found challenges and issues that they have had to address, which has resulted in the delayed implementation of most States' programs. In general, States found it challenging to implement a program that was both a health prevention program and a research study.

Additional State challenges include the following:

- **Administrative Delays:** Working through State bureaucracies was cited by almost every program as causing major delays in implementation. This included contracting

limitations, releasing Requests for Proposals (RFPs) and securing contracts, having to create and submit materials to multiple institutional review boards (IRBs), and trying to hire staff. New York mentioned that the grant award coincided with a time of contract negotiations between the State and State employees and the possibility of employee layoffs. Consequently, hiring the program manager and research assistant was delayed until these negotiations were completed. Both the program manager and research assistant have since been employed.

- **Provider Engagement and Participation:** Getting provider buy-in was also cited by several States as challenging. Wisconsin has had great difficulty in getting clinics to participate in its program. The State and cooperating MCOs assumed they would have an easier time getting clinics to sign on, but they underestimated the pushback from clinics on being required to screen for eligibility and for tobacco use. States also mentioned the challenge in trying to make the program into a routine part of their providers' daily workflow.

  States were also concerned about burdening providers with the completion of training forms, incentive payments, and data collection. Some prevention services, such as YMCA diabetes prevention classes, are not Medicaid-covered services. The lack of funding to entice provider participation, especially considering the program oversight needed by providers and the data collection requirements, has made implementation difficult in New York. Further, one State is grappling with the question of how to require or induce providers that are in the control group to report data when they are not receiving any incentives from the program.

- **Provider Management and Oversight:** State program staff found it hard to manage providers, particularly those who are far from the program's administrative center. Nevada found that having five providers 400 miles away from its administrative offices complicated program management. Each partner's program is unique, each has different reporting requirements, and each has its own issues to address in moving forward. The Program Manager has found it hard to keep everyone on track from such a long distance. California talked about the challenge of trying to reach more than 150,000 health care providers that participate in Medi-Cal.

- **Participant Identification:** Some States found it difficult to identify participants eligible for their programs either because the States lack target population data or they are uncertain whether individuals who meet the program criteria are enrolled in or eligible for Medicaid. Wisconsin said there was a dearth of data on how many pregnant women in the State's Medicaid program were smokers, so it did not know how many people were being targeted in this arm. Wisconsin also noted difficulties in being able to identify people who were actually eligible for the programs. California said that it needed a real-time verification process, particularly because some people with managed care do not even realize that they have Medi-Cal. Montana has found that Medicaid beneficiaries are difficult to recruit.

- **Managing Patient Incentives:** Implementing incentives, particularly for States offering cash available through debit cards, has been difficult. New York released an

RFP for a vendor to administer incentive debit cards and received only one response, which was subsequently disqualified. This required the release of another RFP, resulting in significant program delays. They are currently finalizing the contract. California had planned to provide a cash incentive, but decided against it because of technical barriers. Connecticut also talked about the complexity of implementing cash incentive payments and the amount of time it has taken to work through the technicalities of the process. Montana found that with time and work, it was able to acquire and distribute debit cards to program participants.

- **Community Perceptions of Participants:** States with programs targeting special populations found that there was sometimes a barrier, particularly if the targeted group had mental health conditions. New Hampshire, in particular, has sometimes seen a negative reaction from the community when participants go to the YMCA or attend Weight Watchers meetings.

Implementation challenges resulted in wide variation in States' enrollment progress. At one extreme, Texas has nearly reached its enrollment targets; at the other extreme, New York only recently began enrolling participants. Comparing the implementation process across States is challenging because of the variation in disease targets, incentive structures, and geographic coverage across States. For example, Texas' program is very attractive to participants because they receive a large incentive (up to $1,150 per year in a flexible spending account for wellness activities) for up to 3 years, and the incentive is linked not directly to achieving specific health outcomes but rather to continuing to participate. These features partially explain why Texas is close to meeting its enrollment goal. The Texas program is limited to a single metropolitan area, which may also have simplified implementation. At the same time, Texas took a number of steps that also contributed to rapid implementation, including paying for patient navigators within participating managed care plans, quickly moving through the IRB process, and modifying its recruitment process to encourage patient enrollment.

### 3.10 Changes to State Implementation Plans

States have made a wide variety of changes to their plans as a result of challenges they have faced in implementing their programs and through exchanging information with one another through MIPCD Learning Collaborative activities. State program changes include adjustments to implementation timelines; beneficiary recruitment, enrollment, and incentives; provider recruitment, training, and incentives; and evaluation design. Examples of program changes that have been implemented follow:

- **Timeline and Implementation:** With the exception of Montana, which had an existing program as a foundation, most States delayed their implementation dates because of administrative and implementation issues that took longer than had been envisioned. The implementation of States' programs was also modified, in some cases. Minnesota initially changed its plan for implementation to a small pilot program instead of full implementation, but then changed to a staggered implementation, with the first five clinics beginning to recruit participants in November 2012. New York had also planned on an initial pilot implementation, but has also changed to staggered implementation that started in June 2013 and will

continue throughout the year. Nevada had planned on implementing the program simultaneously in its participating sites, but has since moved to staggered implementation.

- **Beneficiary Recruitment and Enrollment:** Several States have made changes affecting beneficiary recruitment, screening, enrollment, and eligibility. Montana adopted a telephone recruiting script and process from information provided by the Texas project. California, Connecticut, Hawaii, New Hampshire, New York, and Wisconsin reduced enrollment targets for their programs. Connecticut revised the screening and enrollment process from individual self-enrollment to provider-based enrollment. To expedite the enrollment process, New Hampshire is attempting to involve case managers in the medical clearance and lab procedures by having them generate requests prior to the recruitment through staff or self-referral, and by offering more group introductory sessions. New Hampshire also modified its program to enable it to enroll two additional cohorts of participants. California's randomized trial initially planned to target participants with chronic disease, but it expanded its eligibility criteria to include those who have not yet developed a chronic disease but are at risk. Wisconsin will shorten the enrollment period from 12 to 6 months and establish centralized sites within specific counties to facilitate health status testing.

- **Beneficiary Incentives:** To maximize the effectiveness of incentives, States have made changes to the incentive size, type, or distribution. To reduce the lag between the completion of an activity and the incentive payment, Connecticut opted to explore the use of reloadable debit cards and move away from vendor-specific gift cards. Connecticut initially planned to implement high- and low-level incentives, but since has decided to only implement low-level incentives. California increased the value of its incentive from $10 to $20 and changed the type of incentive offered from a Visa bank card to a store gift card. Montana and New Hampshire revised their incentive distribution plans based on feedback from their program sites or an expert consultant. New Hampshire went from providing rewards every 3 months for smoking abstinence to rewards that are given if abstinence is demonstrated over a 2-week period. New Hampshire also adopted a two-phase approach for its weight management program. Phase 1 will provide incentives to participants over 24 months and Phase II will provide incentives over 12 months.

- **Provider Recruitment, Training, and Incentives:** To recruit providers to participate in MIPCD programs, States have made or are considering adjustments to provider training and reimbursement; they are also considering changes in the type of provider recruited. To address a shortage of providers who were trained in counseling smokers who want to quit, Connecticut decided to implement a provider-training curriculum with a module on how to counsel patients as they attempt to quit smoking. Connecticut also implemented a one-time $35 stipend for each new participant that providers enroll in the program. Nevada decided to compensate select providers for each participant for which they enter enrollment and incentive data into a web portal. Montana revised its reimbursement process for intervention sites so that

it can bill Medicaid a flat fee (not based on number of patients) for the prevention services provided. Wisconsin will provide financial support to primary care clinics that agree to participate in the WTQL arm of its program. Hawaii is considering replacing the private provider group with a health plan, Kaiser Permanente, which would offer the possibility of sustainability beyond the grant period. Minnesota released a new RFP to recruit 5 to 9 clinics to begin implementation in September 2013 for a total of 19 clinics. Under Minnesota's new RFP, clinics can receive up to $278,000 for study-related costs, including participant supports, personnel, equipment, and supplies.

- **Evaluation Design:** Several States amended their evaluation designs. Texas, Minnesota, and California made changes to their randomized designs. Hawaii is developing a randomized crossover design for implementation with its private provider group. Minnesota's original design was to randomize participants into three study conditions by clinic. The State was concerned that if a clinic were to drop out or account for a large share of enrollees, the reliability of the study results would be seriously reduced. Therefore, it decided to change the units of randomization and use the classes it offered as the unit of analysis. Texas decided to adopt a randomized consent design to allow potential participants to be randomized directly into either the control or intervention group prior to seeking consent. California's change allows eligible beneficiaries who choose not to participate in the trial to receive the same services as one of the randomized groups (counseling and nicotine patches). California also now informs select eligible beneficiaries that they can receive free nicotine patches and have the patches mailed directly to their home. All eligible beneficiaries who call and reengage in the program receive free nicotine patches, regardless of whether they were selected to receive an advertisement. The purpose of this design change is to determine the extent to which advertising influences re-engagement. California also added a 2-month evaluation call to its randomized trial. Additionally, Texas had a change in its evaluation contractor, opting to contract with the External Quality Review Organization for Texas Medicaid.

### 3.11 Lessons Learned Across State Programs

As a result of the challenges and issues that States have faced in implementing their programs, there have been many lessons learned, including the following:

- **Flexibility:** Almost unanimously, States reported that they needed to be flexible as they implemented their program. New York mentioned that it had to adapt its program implementation, based on a series of challenges that it has had to face thus far. For example, during the delays attributed to securing a debit card vendor, New York used the time to build partnerships with the Medicaid managed care plans, YMCAs, and program evaluators from the University of Pennsylvania.

- **A Problem-solving Approach:** States learned the importance of anticipating possible issues and developed alternative plans and options for areas that did not go as planned. For example, one State said that staggered enrollment and implementation was more effective than simultaneous implementation because it

allowed the State to troubleshoot with one program at a time rather than be overwhelmed with the multiple issues that can arise in getting a program up and running on a large scale. States talked about the importance of continually refining study protocols and having an outlined course of action. One State emphasized the importance of establishing clear guidelines and verification methods for the use of incentives. Another State specifically provided an example of a program participant who made unauthorized purchases using a flexible spending account for wellness activities. The State was able to identify this issue quickly and implemented a specific protocol to manage those rare instances. The State also implemented strategies to support participants in appropriately using incentives, including providing lists of agreed-upon incentive purchases, having participants sign an agreement on allowable expenses, counseling participants on appropriate incentives, and limiting the maximum amount of money that can be used for allowable expenses. The State established guidelines not only for participants, but also for staff members. The institution of performance parameters and concrete metrics enabled the State to readily identify and remediate performance issues. For example, the State was able to compare the performance of navigators and pinpoint specific areas for individual improvement.

- **Political Support:** Having high-level champions in State government was considered important. One State said that it had champions from the beginning of the project, including the Director of Medicaid Managed Care Operations, the State Mental Health and Substance Abuse Assistant Commissioner, the State Medicaid Director, and the State Health Commissioner. Their help minimized the State-level bureaucratic obstacles to implementation by expediting evaluation and intervention contracts and the establishment of a stakeholder relations process.

- **Adequate Project Planning, Staffing, and Management:** Numerous States highlighted the importance of taking more time to adequately plan how each stage of the proposal would be operationally implemented. Hiring a capable project manager and having a multidisciplinary team that works well together were important. Having the right people at the table as part of the necessary groundwork was repeatedly discussed. Wisconsin said that if it had included representatives from major health systems in its planning discussions, it would have been aware of the issues with clinic participation and would have been able to work through them far earlier and had their assistance in designing a detailed plan for clinic recruitment. The State also stressed the importance of not underestimating the amount of time and energy it takes to build a cohesive team and get everyone working toward a common goal. Minnesota stressed the importance of having a strong Advisory Board and making good use of it as the State moves toward implementation. Moreover, adherence to project timeframes and successful project implementation depend on having a comprehensive approach to project management in which certain key elements are addressed, according to one State. These elements include organizational accountability and resource allocation that supports accountability, clearly defined roles and responsibilities, adequate support for partner organizations, early identification of

"critical path" tasks and task dependencies, and a communication structure that is efficient, comprehensive, and responsive to organizational change.

- **Collaborative Partnerships:** Developing collaborative partnerships during the planning phase and nurturing those relationships were mentioned as important in addressing the needs of people being recruited. States that had a strong stakeholder group, that included local mental health authorities, care coordinators, advocacy groups, and Department of Social and Health Services board members, found their input valuable in designing their programs. New Hampshire indicated that establishing a partnership with its Quit Line and Weight Watchers before starting its program would have helped it train partner staff about the day-to-day challenges faced by participants who are poor or who have mental illness. If the State had done so, it might have alleviated some of the stigma that its participants have faced from the Quit Line and Weight Watchers staff.

- **Ongoing Communication With Partners and Providers:** Communicating often and in person to build relationships with health care providers was repeatedly discussed by States as being critical. Health educators at MCOs were mentioned as a tremendous resource for building relationships that could help in integrating services. One State suggested that navigators should be put within the health plans to make the health plan a real partner. Another State said that working with local FQHCs and Health Improvement Case Managers within the FQHCs, conducting outreach to primary care providers within the communities, and coordinating with the local Office of Public Assistance were their most effective recruitment strategies. Although many States communicate with their partners by phone or e-mail, the importance of in-person time to solidify these relationships was stressed. Nevada talked about the importance of meeting with its partners as a group and also individually, even if the meetings required long travel distances. As the program manager said, "It goes back to fundamentals… you get things done better when people are committed and enthusiastic. Now they can call and e-mail the partners and it's an ongoing communication, and that's a huge difference."

- **Trained Providers:** Several States mentioned the critical importance of determining whether there are sufficient providers with the training, capacity, and practice protocols to provide the service they are incentivizing. Some States assumed that there was sufficient capacity, but found that there was a shortage of providers, or providers did not have the necessary training or were unwilling to screen and test participants or deliver incentive payments. These States have addressed this challenge by implementing counseling training programs and financially incentivizing providers.

- **Cultural and Linguistic Awareness:** To provide meaningful access, translating forms and recruitment materials is critical, along with having interpreters at clinics for people who are not literate in English or who speak another language. Bilingual health coaches in clinics are also important. Other cultures approach prevention and health differently and States need to incorporate cultural awareness into their programs to have an impact on these populations. One State, for example, revised the

exercise recommendation for its diabetes prevention initiative to include walking alone based on feedback from its Somali participants that group exercise, particularly at a gym, may not be comfortable. Another important lesson mentioned by one State is that some immigrant communities prefer visual or oral communication over written materials, so this State is working to provide multimodal outreach and engagement materials.

### 3.12 Learning Collaborative

The Centers for Medicare & Medicaid Services (CMS), through a contract with Econometrica, Inc. and its subcontractors, collectively referred to as the Implementation Contractor, supports States throughout their implementation with collaborative learning activities. These activities are designed to engage, educate, and share lessons learned with all States engaged in the MIPCD effort. Activities include virtual and in-person meetings; a web-based support forum (MIPCD.net); and direct technical assistance (TA) from experts and others as facilitated by the Implementation Contractor.

RTI is tasked with assessing the MIPCD Learning Collaborative. A baseline survey conducted by RTI identified States' program goals and Learning Collaborative–specific goals. These goals were then compared to State achievements and feedback provided through quarterly surveys of Learning Collaborative activities; evaluation feedback from participants at the three in-person Learning Collaborative meetings; evaluation feedback from the September 2012 and April 2013 webinars; and the Implementation Contractor's TA request log.

Findings from our first and second interim evaluations (covering May 2012 through May 2013 activities) suggest that Learning Collaborative activities align with States' goals and influence short- and long-term activities of each State project. States' Learning Collaborative goals are related to program implementation and development strategies and contribute to their ability to accomplish program goals. Moreover, assessment results show that eight States find that the Learning Collaborative activities are helping them meet their program goals.

Exchanges between and among States and experts in Learning Collaborative activities have influenced or confirmed program design features or changes in participant and provider communication, recruitment, enrollment, and retention; incentive design and delivery; and data-sharing agreements, consent forms, and evaluation data submission. Examples from the first interim evaluation indicated that expert presentations and State sharing of materials resulted in States' adopting strategies for creating culturally sensitive materials and testing patient health status; the use or modification of existing State documents for participant education about program incentives and provider recruitment; and confirmation of State strategies for sharing information among providers, using advisory groups to recruit participants, and implementing motivational interviewing for participants. The second interim evaluation indicated that Learning Collaborative activities have resulted in States' adopting strategies for provider engagement, such as the identification of physician champions; developing new or fine-tuning existing informational websites; and learning more about submitting evaluation data. It also confirmed the use of telephone recruitment and transportation benefits for participants. Overall, concrete program design features or changes adopted or confirmed by States can easily be referred to the in-person meetings, which States rated highest among the Learning Collaborative activities.

*[This page intentionally left blank.]*

## SECTION 4
## BUDGETED GRANT FUNDS

### 4.1 Administrative Costs

Section 4108 of the Affordable Care Act legislation requires an independent assessment of the administrative costs of each State program. The Centers for Medicare & Medicaid Services (CMS) State Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) Funding Opportunity Announcement (FOA) defined administrative costs eligible for reimbursement as including "key personnel; MIPCD travel, training, outreach and marketing; information technology infrastructure to accommodate the MIPCD reporting requirements; and the costs for completing the satisfaction survey requirements." The FOA restricts administrative costs to 15 percent of each State's contract award, although States can request exemptions from this limit.

### 4.2 Planned Analyses

At this time, RTI does not have the data required to complete the analyses of States' associated administrative costs. RTI has the first-year grant awards for each State (as shown in ***Table 11***) and budget data from States' original proposals and operational protocols. However, these data reflect planned rather than actual expenditures, which could be significantly different from planned expenditures because many States have been delayed in their implementation and have incurred costs that were not originally budgeted. Additionally, State budget data are inconsistent in timeframe and do not provide the detail needed for administrative cost analyses.

**Table 11**
**State first-year grant award**

| State | First-year grant award |
|---|---|
| California | $1,541,583 |
| Connecticut | $703,578 |
| Hawaii | $1,265,988 |
| Minnesota | $1,015,076 |
| Montana | $111,788 |
| Nevada | $415,606 |
| New Hampshire | $1,669,800 |
| New York | $2,000,000 |
| Texas | $2,753,130 |
| Wisconsin | $2,298,906 |

For future analyses, RTI will use State expenditures reported to CMS using the Federal Financial Report Standard Form (SF425) filed annually, complemented by detailed expenditure

data provided by States. We will supplement these data sources with information collected during our initial site visits through meetings with State project staff responsible for program finances. Our assessment will include both (1) administrative costs covered by grants to the States and (2) in-kind administrative costs contributed by the States. The in-kind costs may be significant (according to State proposals and operational protocols, at least seven States are providing in-kind labor) and essential for operating an incentives program, so it is important to include them in our assessment.

## SECTION 5
## RECOMMENDATIONS

The legislation authorizing the Medicaid Incentives for Prevention of Chronic Diseases programs requires that this initial Report to Congress shall contain a recommendation regarding whether funding for expanding or extending the programs should be extended beyond January 1, 2016. At this time, there is insufficient evidence to make a recommendation for or against expanding or extending funding of the programs beyond January 1, 2016. Most of the State programs have been enrolling participants for only a short period of time, and there are few data on the effect of the programs on health outcomes and health care utilization and costs. Therefore, it would be premature to make a recommendation to extend funding for expanding or extending the programs beyond January 1, 2016. Because the incentives may improve health outcomes or reduce health care costs, it would also be premature to make a recommendation against extending funding. Consequently, we recommend maintaining current funding for the programs through January 1, 2016, and deferring a recommendation on extension until more evidence of the programs' impact is available.

*[This page intentionally left blank.]*

## SECTION 6
## SUMMARY

As part of the 2010 Patient Protection and Affordable Care Act, 10 States were awarded grants in September 2011 to establish Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) programs. As part of the program, States implemented chronic disease prevention initiatives for Medicaid enrollees, to test the use of incentives in encouraging behavior change. Each participating State has encountered challenges in implementation, sometimes resulting in program modifications. States that experienced a lack of provider engagement and participation made or considered adjustments to provider training and reimbursement; they are also considering changes in the type of provider recruited. Several States made changes affecting beneficiary recruitment, screening, enrollment, and eligibility. To maximize the effectiveness of incentives, States have made changes to the incentive size, type, or distribution. Lessons learned include (1) being flexible; (2) adopting a problem-solving approach, which includes a willingness to explore alternative options and develop alternative plans; (3) having political support from program champions; (4) taking time to adequately plan program implementation, hire a capable project manager, and implement comprehensive project management systems and infrastructure; (5) developing collaborative partnerships; (6) building relationships with partners and providers through ongoing communication; (7) training and incentivizing providers to participate; and (8) incorporating cultural and linguistic awareness into the program.

At this time, there is insufficient evidence to make a recommendation for or against expanding or extending funding of the programs beyond January 1, 2016. Most of the State programs have been enrolling participants for only a short period of time, and there are few data on the effect of the programs on health outcomes and health care utilization and costs. As a result, it would be premature to make a recommendation to extend funding for expanding or extending the programs beyond January 1, 2016. Consequently, we are deferring a recommendation on extension until more evidence of the programs' impact is available.

We will continue to assess program implementation and the performance of the Learning Collaborative through the end of the project. In addition, each State will conduct an evaluation of its program, including its effectiveness in improving health behaviors and outcomes. Results of the national and State evaluations will be included in a subsequent Report to Congress and the Final Evaluation Report. We expect that the results of these evaluations will support a recommendation on whether to expand or extend funding for MIPCD programs beyond January 1, 2016.

*[This page intentionally left blank.]*

## REFERENCE

Anderson, W. L., Armour, B. S., Finkelstein, E. A., & Wiener, J. M. (2010). Estimates of state-level health-care expenditures associated with disability. *Public Health Reports, 125*(1), 44–51.

*[This page intentionally left blank.]*

# APPENDICES

*[This page intentionally left blank.]*

## APPENDIX A:
## STATE PARTICIPANT ENROLLMENT AS OF AUGUST 31, 2013

| State | Actual number enrolled as of August 31, 2013 |
|---|---|
| California | 3,815 |
| Connecticut | 99 |
| Hawaii | 361 |
| Minnesota | 120 |
| Montana | 181 |
| Nevada | 274 |
| New Hampshire | 1,420[a] |
| New York | 9 |
| Texas | 1,250 |
| Wisconsin | 407 |

[a] This total includes the 454 participants that receive a $10 incentive to complete a computerized tobacco education program because these same participants may also be included in the participation totals for the control or the intervention group.

*[This page intentionally left blank.]*

# APPENDIX B:
# CALIFORNIA

| State | California |
|---|---|
| **State Abbreviation** | CA |
| **Project Title** | Medicaid Incentives for Prevention of Chronic Diseases (MIPCD): Medi-Cal Incentives to Quit (MIQS) Project |
| **Grantee/State Implementing Agency** | California Department of Health Care Services |
| **Partners** | ▪ California Tobacco Control Program (California Department of Public Health)<br>▪ California Medicaid Research Institute (multi-campus program based at the University of California, San Francisco)<br>▪ California Smokers' Helpline (University of California, San Diego)<br>▪ California Diabetes Program (University of California, San Francisco)<br>▪ Institute of Health & Aging (University of California, San Francisco) |
| **1st Year Grant Award** | $1,541,583 |
| **Total Enrollment Year 1 (9/2011–9/2012)** | 974 enrolled in randomized trial. |
| **Total Enrollment Year 2, Quarter 1 (10/2012–12/2012)** | 2,009 enrolled in randomized trial. |
| **Total Enrollment Year 2, Quarter 2 (1/2013–3/2013)** | 3,195 enrolled in randomized trial. |
| **Total Enrollment Year 2, Quarter 3 (4/2013–6/2013)** | 3,815 enrolled in randomized trial. |
| **Implementation Date / Projected Implementation Date** | Pilot began March 19, 2012. |
| **Implementation as a Pilot?** | Yes, statewide rollout began on July 9, 2012. |
| **Duration of Program Arms** | Enrollment comes from Callers to the Helpline. There are two RCTs.<br><br>RCT-1 includes three policy groups:<br>▪ Group 1 receives usual care<br>▪ Group 2 receives usual care, nicotine replacement therapy (NRT) shipped directly, and has no annual limit on quit attempts<br>▪ Group 3 receives usual care, NRT shipped directly, and has no annual limit on quit attempts, with incentive to continue through end of the demonstration<br>RCT-1 enrollment began July 2012 and ended May 2013<br><br>RCT-2 is focused on reengagement and includes eight groups:<br>▪ Groups 1- 4 receive nicotine replacement therapy patches that are not advertised and incentives that range from $0 to $40 depending on the group. |

(continued)

| State | | California |
|---|---|---|
| **Duration of Program Arms (continued)** | | ▪ Groups 5-8 receive a letter advertising the nicotine replacement therapy along with the patches and incentives that range from $0 to $40 depending on the group.<br>▪ Participants will be stratified by time since their last contact with the Helpline prior to randomization. Participants from 3, 6, 9, 12, 18 months, etc. prior will be selected and sent a re-engagement letter. Additionally, we will select half of participants to receive two re-engagement letters spaced two weeks apart, while the other half will receive a single letter. |
| **# Conditions** | | 1 |
| **Conditions** | **Smoking** | Yes |
| | **Diabetes** | No |
| | **Obesity** | No |
| | **Hyperlipidemia** | No |
| | **Hypertension** | No |
| | **Other** | No |
| **Special Populations Examined** | **Homeless/Housing Instable Populations** | No |
| | **Food Insecure Populations** | No |
| | **Those with Mental Illness** | Yes |
| | **Those with Substance Abuse Disorders** | Yes |
| | **Racial/Ethnic Minorities (e.g., Native Americans; Native Hawaiians; Asian Americans; Pacific Islanders)** | Yes |
| | **Pregnant Women and Mothers of Newborns** | Yes – through intervention only (pregnant women are ineligible for the randomized trial). |
| | **Children** | No |
| | **Medicare-Medicaid enrollees** | Yes |
| **Description of Target Population** | | All Medi-Cal beneficiaries who smoke. |
| **Potential Special Populations** | | ▪ Individuals with chronic conditions<br>▪ Mental health and substance users |
| **# Targeted Patients – Total and By Experimental and Control Group(s)** | | 9,000 total: 6,000 for experimental group(s) and 3,000 for control group(s). |
| **Languages** | **Languages spoken by program participants** | English, Chinese (Cantonese and Mandarin), Korean, Vietnamese, and Spanish. |
| | **Percent of participant population that speaks a language other than English – List percent for each language, if possible.** | ▪ The randomized trial will be in English and Spanish only. People with a different primary language will receive services but not be included in the randomized trial.<br>▪ Spanish 1.2%. |

(continued)

| State | | California |
|---|---|---|
| **Medicare-Medicaid enrollees: If a MIPCD participant is not enrolled in both Medicaid and Medicare upon initial enrollment into MIPCD, but becomes a Medicare-Medicaid enrollee during the course of MIPCD program participation, this participant will be:** | | Allowed to continue to participate in the MIPCD program. |
| **Type of Medicaid Population** | | Medicaid Fee-For-Service and Managed Care Populations. |
| **Description of Goals** | | Increase tobacco cessation among Medi-Cal beneficiaries who smoke. |
| **Description of Activities** | | ▪ Smoking cessation counseling through the Helpline.<br>▪ A simplified process for acquiring nicotine patches through the Helpline.<br>▪ Training health care providers on the Ask, Advise, and Refer intervention and increased awareness of the incentive program. |
| **Incentives for Eligible Beneficiaries** | **Money (e.g., $25 in Cash or Debit Card)** | No |
| | **Money-Valued Incentive (e.g., $25-Valued Incentive Such As $25 Gift Card to Grocery Store)** | Yes |
| | **Treatment-Related Incentives (e.g., Free Nicotine Replacement Therapy Patches)** | Yes |
| | **Support to Address Barriers to Participation (e.g., Meals; Transportation; Child Care)** | No |
| | **Prevention-Related Incentives (e.g., Vouchers for Farmers' Markets; Exercise Equipment; Healthy Foods Cookbooks)** | No |
| | **Flexible Spending Account for Wellness Related-Expenses** | No |
| | **Points Redeemable for Rewards** | No |
| | **Unspecified Incentives** | No |

(continued)

| State | | California |
|---|---|---|
| **Maximum Incentive Amount in Dollars** | | ▪ Eligible callers who ask for MIQS incentive: Maximum study incentive: $20<br>▪ RCT 1: Maximum study incentive: $60<br>▪ RCT 2: Maximum study incentive: $40<br>▪ Enhanced Services Non-RCT: TBD |
| **Description of Incentives for Eligible Beneficiaries** | | ▪ $20 gift card incentive (Wal-Mart, Target, Vons/Safeway & Ralphs/Kroger) to call the Helpline, complete the intake protocol, and participate in counseling sessions.<br>▪ Free NRT patches by calling the Helpline.<br>▪ $10 gift card for every relapse-prevention call completed up to $40 (in one randomized condition).<br>▪ After the first program year, $10–$40 to reenroll participants who did not quit or who relapsed (a randomized trial). |
| **Incentives for Others (e.g., CHCs and Private Providers)** | | No |
| **Description of Incentives for Others (e.g., CHCs and Private Providers) – If Not Applicable, Write NA** | | NA |
| **Are Incentives "Front-Loaded"?** | | No |
| **Evaluation Design(s)** | **Quasi-Experimental Design** | Yes |
| | **Randomized Controlled Trial** | Yes |
| | **Equipoise-stratified Randomization** | No |
| | **Crossover Design** | No |
| | **Cost-Effectiveness Analyses** | Yes |
| **Description of Evaluation Design** | | ▪ Quasi-experimental design to determine the effects of outreach strategies on accessing incentives and on the monthly call rate to the Helpline.<br>▪ Randomized, controlled trial on the effectiveness of barrier-free NRT patches and monetary incentives for Medi-Cal beneficiaries who smoke.<br>▪ Health economics evaluation to measure the cost-effectiveness of the incentives for encouraging Medi-Cal patients who smoke to call the Helpline and quit smoking, and to estimate the relative cost-effectiveness of different forms of outreach on changes in the rate of beneficiaries calling the Helpline. |
| **Outcomes Examined** | | ▪ How reductions in tobacco use will translate to reductions in a range of health-related outcomes.<br>▪ The cost-effectiveness of the program's different types of incentives to encourage tobacco cessation among a sample of Medi-Cal patients who call the Helpline.<br>▪ The cost-effectiveness of different financial incentives to motivate Medi-Cal patients with or at risk of chronic disease to call the Helpline. |

# APPENDIX C:
# CONNECTICUT

| State | Connecticut |
|---|---|
| **State Abbreviation** | CT |
| **Project Title** | Connecticut Rewards to Quit |
| **Grantee/State Implementing Agency** | Connecticut Department of Social Services |
| **Partners** | ▪ Connecticut Department of Public Health<br>▪ Department of Mental Health and Addiction Services<br>▪ Community Health Network of CT (CHNCT)<br>▪ Connecticut Hispanic Health Council (HHC)<br>▪ Yale University<br>▪ Obstetrics providers, local mental health authorities, mental health clinics, community health centers (CHCs) including Federally Qualified Health Centers (FQHCs), and hospital-based adult primary care practices |
| **1st Year Grant Award** | $703,578 |
| **Total Enrollment Year 1 (9/2011–9/2012)** | 0 |
| **Total Enrollment Year 2, Quarter 1 (10/2012–12/2012)** | 0 |
| **Total Enrollment Year 2, Quarter 2 (1/2013–3/2013)** | 0 |
| **Total Enrollment Year 2, Quarter 3 (4/2013–6/2013)** | 17 |
| **Implementation Date / Projected Implementation Date** | Launched program in March 2013; Began enrolling in April 2013 |
| **Implementation as a Pilot?** | No |
| **Duration of Program Arms** | **Year 1-3:** Effect of offering low-level incentives (treatment) compared to offering no incentives (control).<br>▪ Peer coaching also will be offered in three selected counties beginning in Year 3. Half of providers will be chosen to be lead providers.<br>▪ Enrollees consenting to participate in the Rewards to Quit program or receiving automated calls will receive an initial call upon enrollment in the Rewards to Quit program and follow-up calls at 3- and 12-month intervals after the initial enrollment call to screen them for tobacco use and to provide smoking cessation resources and referral.<br>▪ Individuals have a 12-month enrollment period, and each individual can have a maximum of two enrollment periods. Individuals are required to wait 12-months before re-enrolling in the program for a second time. Individuals receive incentives for other a portion of the 12-month enrollment period.<br>▪ Pregnant individuals may participate in the program during pregnancy (up to 8 months), and then 6 months postpartum. |

(continued)

| State | | Connecticut |
|---|---|---|
| **# Conditions** | | 1 |
| **Conditions** | **Smoking** | Yes |
| | **Diabetes** | No |
| | **Obesity** | No |
| | **Hyperlipidemia** | No |
| | **Hypertension** | No |
| | **Other** | No |
| **Special Populations Examined** | **Homeless/Housing Instable Populations** | No |
| | **Food Insecure Populations** | No |
| | **Those with Mental Illness** | Yes |
| | **Those with Substance Abuse Disorders** | No |
| | **Racial/Ethnic Minorities (e.g., Native Americans; Native Hawaiians; Asian Americans; Pacific Islanders)** | No |
| | **Pregnant Women and Mothers of Newborns** | Yes |
| | **Children** | No |
| | **Medicare-Medicaid enrollees** | Yes |
| **Description of Target Population** | | Medicaid recipients who smoke, with a focus on pregnant women and mothers of newborns and people with serious mental illness. |
| **Potential Special Populations** | | ▪ People with serious mental illness.<br>▪ Pregnant women and mothers of newborns. |
| **# Targeted Patients – Total and By Experimental and Control Group(s)** | | 28,771 total: 14,385 for experimental group(s) and 14,386 for control group(s). |
| **Languages** | **Languages spoken by program participants** | English and Spanish. |
| | **Percent of participant population that speaks a language other than English – List percent for each language, if possible.** | Spanish Speaking: 8% (this figure may indicate individuals who only speak Spanish).<br>CT estimates that ~25% of its beneficiaries use Spanish as their primary language. |

(continued)

| State | | Connecticut |
|---|---|---|
| **Medicare-Medicaid enrollees: If a MIPCD participant is not enrolled in both Medicaid and Medicare upon initial enrollment into MIPCD, but becomes a Medicare-Medicaid enrollee during the course of MIPCD program participation, this participant will be:** | | Allowed to continue to participate in the MIPCD program. |
| **Type of Medicaid Population** | | The State Medicaid program uses fee-for-service reimbursement only. Consequently, only fee-for-service beneficiaries participate in Rewards to Quit. |
| **Description of Goals** | | ▪ Reduce smoking rates among the estimated 25%–30% of Connecticut Medicaid recipients who currently smoke.<br>▪ Test the efficacy of financial incentives in increasing quit rates. |
| **Description of Activities** | | Encouraged participation in Rewards to Quit services through medical homes, obstetrics providers, and local mental health authorities, including:<br>▪ Counseling<br>▪ Access to a Quitline<br>▪ Nicotine-replacement therapy (NRT) and other medications<br>▪ Specific medications (e.g., bupropion)<br>▪ Access to peer coaches<br>Free online training for providers on smoking cessation treatment and information on Medicaid coverage for smoking cessation services and Rewards to Quit program services.<br>CT plans to stagger enrollment with Local Mental Health Authorities. |
| **Incentives for Eligible Beneficiaries** | **Money (e.g., $25 in Cash or Debit Card)** | Yes |
| | **Money-Valued Incentive (e.g., $25-Valued Incentive Such As $25 Gift Card to Grocery Store)** | No |
| | **Treatment-Related Incentives (e.g., Free Nicotine Replacement Therapy Patches)** | No |
| | **Support to Address Barriers to Participation (e.g., Meals; Transportation; Child Care)** | No |

(continued)

| State | | Connecticut |
|---|---|---|
| **Incentives for Eligible Beneficiaries (continued)** | **Prevention-Related Incentives (e.g., Vouchers for Farmers' Markets; Exercise Equipment; Healthy Foods Cookbooks)** | No |
| | **Flexible Spending Account for Wellness Related-Expenses** | No |
| | **Points Redeemable for Rewards** | No |
| | **Unspecified Incentives** | Yes |
| **Maximum Incentive Amount in Dollars** | | $350 per 12-month enrollment period (max two enrollment periods per person) |
| **Description of Incentives for Eligible Beneficiaries** | | ▪ $5 to smokers for each counseling visit or call to the Quitline (maximum 10)<br>▪ $15 for attending five counseling sessions or five Quitline calls (maximum two)<br>▪ $15 for a negative CO breathalyzer test (maximum 12)<br>▪ $10 bonus for three consecutive tobacco-free CO tests (maximum four)<br>▪ Note that the schedule for pregnant women is similar, but women have both a pre- and postpartum program. For those who quit smoking while pregnant, the postpartum treatment at the medical home pediatrician will include relapse prevention over a 6-month period, with opportunities to receive additional incentives. Cessation will remain the focus for those who have not quit.<br>▪ CT replaced cash/Visa gift card incentives with reloadable gift cards through a contract with Evolution 1.<br>▪ Providers will give R2Q enrollees "motivation" cards following their participation in smoking cessation individual or group counseling sessions and/or after a negative breathalyzer test. The cards will provide words of encouragement to the enrollees and remind them of their option to enroll in R2Q. |
| **Incentives for Others (e.g., CHCs and Private Providers)** | | Yes |
| **Description of Incentives for Others (e.g., CHCs and Private Providers) – If Not Applicable, Write NA** | | Free CME credit online modules for provider training in smoking cessation treatments, the CT Medicaid program, covered smoking cessation services, and the Rewards to Quit program. One-time $35 stipend for each new Medicaid recipient that providers enroll in CT Rewards to Quit. |
| **Are Incentives "Front-Loaded"?** | | No |

(continued)

| State | | Connecticut |
|---|---|---|
| **Evaluation Design(s)** | **Quasi-Experimental Design** | No |
| | **Randomized Controlled Trial** | Yes |
| | **Equipoise-stratified Randomization** | No |
| | **Crossover Design** | No |
| | **Cost-Effectiveness Analyses** | Yes |
| **Description of Evaluation Design** | | Randomization will occur at the provider rather than the individual level. In Year 1 of the study, medical homes, obstetrics providers, and local mental health authorities will be randomly selected to serve as Rewards to Quit providers and randomized into the control or the intervention arm of the study. The state also will solicit participation from group primary care and OB/GYN practices. An exception to this randomized study design is the pediatric medical home. Pediatric medical home providers will not be randomized. Instead, the State intends to recruit all pediatric medical home providers to participate in Rewards to Quit to support cessation postpartum, regardless of where a postpartum participant brings her children for prenatal care. Pediatric medical home providers will be required to screen parents for smoking as part of the routine health risk screening procedures, encourage use of smoking cessation services, and enrollment in Rewards to Quit.<br><br>During the summer of 2013, a large new community health center began participating in R2Q. They requested to randomize at the site level, whereas the remainder of providers are being randomized at the provider level.<br>Analysis will include:<br>▪ Propensity score matching on patient characteristics to increase the similarity between intervention and comparison groups.<br>▪ Power calculations to detect a difference in outcomes between smokers offered and not offered the incentive.<br>▪ Incremental cost-effectiveness analyses to determine whether the additional costs of each incentive offered are worthwhile compared to other Medicaid-funded health care interventions. |

(continued)

| State | Connecticut |
|---|---|
| **Outcomes Examined** | **<u>All smokers</u>:**<br>▪ Process outcomes (treatment initiation, treatment engagement, treatment prevalence)<br>▪ Outcomes measures (Quit Rate Aim 1: quitters at 6 months, Quit Rate Aim 2-4: at least one tobacco-free test in month, Quit maintenance: earning an incentive for three consecutive tobacco-free tests)<br>▪ Other smoking-related health care utilization (inpatient heart attacks, ED visits for asthma, adverse maternal birth complications)<br>▪ Health care costs<br>**<u>Pregnant women</u>:**<br>▪ Smoking at time of birth<br>▪ Birth weight of the baby<br>▪ Cost of the hospital delivery<br>▪ Smoking rate 6 months postpartum<br>▪ Birth outcome data are collected by the Department for all Medicaid births under an existing Memorandum of Understanding |

# APPENDIX D:
# HAWAII

| State | | Hawaii |
|---|---|---|
| **State Abbreviation** | | HI |
| **Project Title** | | Hawaii Patient Reward and Incentives for Supporting Empowerment Project (HI-PRAISE) |
| **Grantee/State Implementing Agency** | | Hawaii Department of Human Services |
| **Partners** | | ▪ University of Hawaii (UH) John A. Burns School of Medicine<br>▪ Department of Health (DOH)<br>▪ Hawaii Health Information Corporation (HHIC)<br>▪ UH Center on Disability Studies<br>▪ Section 330 Federally Qualified Health Centers (FQHCs)<br>▪ Private providers<br>▪ Hawaii Association of Health Plans<br>▪ Hawaii Primary Care Association (HPCA)<br>▪ Managed Care Organizations (MCOs) |
| **1st Year Grant Award** | | $1,265,988 |
| **Total Enrollment Year 1 (9/2011–9/2012)** | | 0 |
| **Total Enrollment Year 2, Quarter 1 (10/2012–12/2012)** | | 0 |
| **Total Enrollment Year 2, Quarter 2 (1/2013–3/2013)** | | 87 |
| **Total Enrollment Year 2, Quarter 3 (4/2013–6/2013)** | | 280 |
| **Implementation Date / Projected Implementation Date** | | February 2013 |
| **Implementation as a Pilot?** | | No |
| **Duration of Program Arms** | | 14 FQHCs in Years 1–4; Private Providers or Kaiser Permanente included in Years 3 and 4 |
| **# Conditions** | | 1 |
| **Conditions** | **Smoking** | No |
| | **Diabetes** | Yes |
| | **Obesity** | No |
| | **Hyperlipidemia** | No |
| | **Hypertension** | No |
| | **Other** | The project will address barriers to improving their self-management of diabetes, which can include smoking cessation, behavioral health education, weight management, cholesterol, and blood pressure control. |

(continued)

| State | | Hawaii |
|---|---|---|
| **Special Populations Examined** | **Homeless/Housing Instable Populations** | No (while not specifically targeting this population, an additional question on housing has been added to Hawaii's survey, so it will be possible to identify this population). |
| | **Food Insecure Populations** | No |
| | **Those with Mental Illness** | No (although not specifically targeting this population, an additional question on housing has been added to Hawaii's survey, so it will be possible to identify this population). |
| | **Those with Substance Abuse Disorders** | No (although not specifically targeting this population, an additional question on housing has been added to Hawaii's survey, so it will be possible to identify this population). |
| | **Racial/Ethnic Minorities (e.g., Native Americans; Native Hawaiians; Asian Americans; Pacific Islanders)** | Yes |
| | **Pregnant Women and Mothers of Newborns** | No |
| | **Children** | No |
| | **Medicare-Medicaid enrollees** | Yes |
| **Description of Target Population** | | Individuals with diabetes aged 18 and older, diagnosed with diabetes and receiving Medicaid benefits; especially ethnic groups that are subject to cultural and socioeconomic barriers to care, including indigenous Native Hawaiians and immigrant Asian Americans and Pacific Islanders. |
| **Potential Special Populations** | | Indigenous Native Hawaiians and immigrant Asian Americans and Pacific Islanders. Migrants from Compact of Freely Associated States. |
| **# Targeted Patients – Total and By Experimental and Control Group(s)** | | 2,500 total: 2,500 for experimental group(s) only. The control group will focus on 634 individuals. This is not a concurrent or randomized control group. The control group is an external group. Tentative access to patient-level HEDIS data of a non-FQHC Medicaid group of diabetes patients will be used for the control group. |
| **Languages** | **Languages spoken by program participants** | Approximately 10 languages other than English, Filipino (Ilocano & Tagalog), Samoan, Tongan, Micronesian (Chuukese, Marshallese, etc.), Vietnamese, Laotian, Chinese, and Korean. |
| | **Percent of participant population that speaks a language other than English – List percent for each language, if possible.** | Approximately 50%. Data will be collected by race, not by primary language, so the actual breakdown by language will not be known. |

(continued)

| State | Hawaii |
|---|---|
| **Medicare-Medicaid enrollees: If a MIPCD participant is not enrolled in both Medicaid and Medicare upon initial enrollment into MIPCD, but becomes a Medicare-Medicaid enrollee during the course of MIPCD program participation, this participant will be:** | Allowed to continue to participate in the MIPCD program. |
| **Type of Medicaid Population** | Managed care enrollees only |
| **Description of Goals** | ▪ Improve early detection of diabetes among individuals at high risk for diabetes.<br>▪ Improve diabetes self-management among individuals with diabetes, and address barriers, such as smoking, behavioral issues, and diabetes education. |
| **Description of Activities** | ▪ All participating sites will test individuals at high risk for diabetes<br>▪ A system of tiered incentives will be implemented<br>▪ Medical assistants, care coordinators, or community health workers will be trained as health coaches, to provide motivation and support to patients<br>▪ A system will be put in place to develop and monitor diabetes education programs<br>▪ Overall objectives include:<br>▪ Provide brief diabetes education interventions during clinical visits.<br>▪ Provide care coordination by working with physicians to screen and identify other risk factors and comorbidities, provide referrals, make appointments, and follow up with patients.<br>▪ Assess patients for problems and stressors in their lives that may serve as barriers to health improvement.<br>▪ Work with health coaches to follow and track patient progress.<br>▪ Assist FQHCs and larger providers to ensure that evidence-based diabetes self-management training is sustainable.<br>▪ Support ADA/AADE coalition.<br>▪ Host trainings on motivational interviewing and data entry.<br>▪ Provide ongoing technical support.<br>▪ Incentivize the first visit at behavioral health and smoking cessation classes provided by FQHCs. |

(continued)

| State | | Hawaii |
|---|---|---|
| **Incentives for Eligible Beneficiaries** | **Money (e.g., $25 in Cash or Debit Card)** | Yes |
| | **Money-Valued Incentive (e.g., $25-Valued Incentive Such As $25 Gift Card to Grocery Store)** | Yes |
| | **Treatment-Related Incentives (e.g., Free Nicotine Replacement Therapy Patches)** | No |
| | **Support to Address Barriers to Participation (e.g., Meals; Transportation; Child Care)** | Yes – option to offer transportation |
| | **Prevention-Related Incentives (e.g., Vouchers for Farmers' Markets; Exercise Equipment; Healthy Foods Cookbooks)** | Yes |
| | **Flexible Spending Account for Wellness Related-Expenses** | No |
| | **Points Redeemable for Rewards** | Yes |
| | **Unspecified Incentives** | Per discretion of FQHCs, they have flexibility to determine the form of incentive – it could be a gift certificate or fee for gym membership, exercise classes, massage. Also, FQHCs can adjust incentive amounts up to $50 or lower based on cost of living increases. |
| **Maximum Incentive Amount in Dollars** | | $215 annual for each year the participant maintains enrollment. |
| **Description of Incentives for Eligible Beneficiaries** | | ▪ ≤ $25 to attend the first session of diabetes management education<br>▪ ≤ $20-valued incentive for compliance with ADA-recommended preventive measures (annual LDL cholesterol test); annual retinal eye examination; and HbA1c (variable)<br>▪ ≤ $10 for receiving a pneumococcal or influenza vaccine<br>▪ ≤ $25-valued incentive for patients who attend smoking cessation group or individual classes; counseling for depression or other mental health issues<br>▪ ≤ $50 if achieve weight loss of 7% in 52 weeks<br>▪ There is a maximum allotment of $40 per year for blood test and improved results for (1) HbA1c decrease (goal < 7) (additional value ≤ $20); (2) HbA1c decrease (goal 1%) (additional value ≤ $20)Annual incentives not to exceed $215 per participant<br>▪ Incentivize the first visit at behavioral health and smoking cessation classes provided by FQHCs. |

(continued)

| State | | Hawaii |
|---|---|---|
| **Incentives for Others (e.g., CHCs and Private Providers)** | | Yes |
| **Description of Incentives for Others (e.g., CHCs and Private Providers) – If Not Applicable, Write NA** | | Up to $308 per participant for participating FQHCs and private providers who provide supportive, supplemental services to patients. |
| **Are Incentives "Front-Loaded"?** | | No |
| **Evaluation Design(s)** | **Quasi-Experimental Design** | Yes |
| | **Randomized Controlled Trial** | No (under consideration). |
| | **Equipoise-stratified Randomization** | No |
| | **Crossover Design** | No (under consideration to adopt this design for private group practice). |
| | **Cost-Effectiveness Analyses** | Yes |
| **Description of Evaluation Design** | | ▪ Primary test of effect using a within-person, pre- versus post-intervention comparison with adjustments for length of intervention and baseline characteristics of patients. HI is considering adding a randomized crossover design or randomized controlled trial for implementation with private provider group or Kaiser Permanente.<br>▪ A second analysis using a non-FQHC, non-Medicaid group of diabetes patients as a control group. |
| **Outcomes Examined** | | ▪ Increase diabetes screening and detection of new cases in Medicaid population measured by FQHC screening efforts and BRFSS<br>▪ Implement clinical outcome measures of hemoglobin A1c, blood pressure, and cholesterol<br>▪ Concordance with ADA guidelines of annual eye exam, influenza, and pneumococcal vaccination<br>▪ Decrease cost of hospitalization and emergency room visits<br>▪ Improve diabetes self-management of persons attending diabetes education programs<br>▪ Increase number of ADA/AADE certified diabetes programs in Hawaii |

*[This page intentionally left blank.]*

# APPENDIX E:
# MINNESOTA

| | | |
|---|---|---|
| State | | Minnesota |
| **State Abbreviation** | | MN |
| **Project Title** | | Minnesota Medicaid Incentives for Prevention of Diabetes |
| **Grantee/State Implementing Agency** | | Office of the State Medicaid Director, Minnesota Department of Human Services |
| **Partners** | | ▪ Minnesota Department of Health<br>▪ HealthPartners Institute for Education and Research<br>▪ YMCA of Greater Twin Cities |
| **1st Year Grant Award** | | $1,015,076 |
| **Total Enrollment Year 1 (9/2011–9/2012)** | | 0 |
| **Total Enrollment Year 2, Quarter 1 (10/2012–12/2012)** | | 0 |
| **Total Enrollment Year 2, Quarter 2 (1/2013–3/2013)** | | 31 |
| **Total Enrollment Year 2, Quarter 3 (4/2013–6/2013)** | | 110 |
| **Implementation Date / Projected Implementation Date** | | Implemented in November 2012 with five clinics and expanded to 19 clinics by May 2013. |
| **Implementation as a Pilot?** | | No |
| **Duration of Program Arms** | | >12 months for the control, individual incentives, and individual plus group incentive arms. |
| **# Conditions** | | 2 |
| **Conditions** | **Smoking** | No |
| | **Diabetes** | Yes |
| | **Obesity** | Yes |
| | **Hyperlipidemia** | No |
| | **Hypertension** | No |
| | **Other** | No |
| **Special Populations Examined** | **Homeless/Housing Instable Populations** | No |
| | **Food Insecure Populations** | No |
| | **Those with Mental Illness** | No |
| | **Those with Substance Abuse Disorders** | No |
| | **Racial/Ethnic Minorities (e.g., Native Americans; Native Hawaiians; Asian Americans; Pacific Islanders)** | MN will enroll participants from diverse populations. These populations are not a primary focus, but MN will examine differences among racial and ethnic minorities to the extent that data will support that level of analysis. |
| | **Pregnant Women and Mothers of Newborns** | No |
| | **Children** | No |
| | **Medicare-Medicaid enrollees** | Yes |

(continued)

| State | | Minnesota |
|---|---|---|
| **Description of Target Population** | | Medicaid beneficiaries between the ages of 18 and 75 who live in the Twin Cities metropolitan area and who have been diagnosed with pre-diabetes or who have a history of gestational diabetes and a body mass index ≥ 25 kg/m2 (22 kg/m2 for people of Asian descent). |
| **Potential Special Populations** | | Minority populations—American Indian, African American, Somali, Latino, Hmong, Vietnamese, Karen, other Asian immigrants, |
| **# Targeted Patients – Total and By Experimental and Control Group(s)** | | 1,800 total: 1,200 for invention groups and 600 for control group |
| **Languages** | **Languages spoken by program participants** | English, Hmong, Somali, Spanish, Russian, and Vietnamese. |
| | **Percent of participant population that speaks a language other than English – List percent for each language, if possible.** | Unknown at this point; however, it may be as high as 20 percent Somali. The Grantee will report the final percentage when enrollment is complete and data are available. |
| **Medicare-Medicaid enrollees: If a MIPCD participant is not enrolled in both Medicaid and Medicare upon initial enrollment into MIPCD, but becomes a Medicare-Medicaid enrollee during the course of MIPCD program participation, this participant will be:** | | Allowed to continue to participate in the MIPCD program. |
| **Type of Medicaid Population** | | Both managed care and fee-for-service populations. |
| **Description of Goals** | | To determine if incentives can increase weight loss as a primary step toward long-term goals of reduced diabetes incidence, improved cardiovascular health, and reduced health care expenditures. |
| **Description of Activities** | | Diabetes Prevention Program (DPP) self-management training to encourage moderate weight loss, increased physical activity, and improved dietary behaviors. |
| **Incentives for Eligible Beneficiaries** | **Money (e.g., $25 in Cash or Debit Card)** | Yes, in the form of reloadable debit cards. |
| | **Money-Valued Incentive (e.g., $25-Valued Incentive Such As $25 Gift Card to Grocery Store)** | No |
| | **Treatment-Related Incentives (e.g., Free Nicotine Replacement Therapy Patches)** | No |
| | **Support to Address Barriers to Participation (e.g., Meals; Transportation; Child Care)** | Yes |

(continued)

| State | | Minnesota |
|---|---|---|
| **Incentives for Eligible Beneficiaries (continued)** | **Prevention-Related Incentives (e.g., Vouchers for Farmers' Markets; Exercise Equipment; Healthy Foods Cookbooks)** | Participants in all three study arms will receive "weight loss tools" including cookbooks, measuring cups and spoons, cooking scale, bathroom scale, pedometer, and exercise bands,. All participants will have the opportunity to earn up to three 30-day YMCA passes, based on attendance. |
| | **Flexible Spending Account for Wellness Related-Expenses** | No |
| | **Points Redeemable for Rewards** | No |
| | **Unspecified Incentives** | Yes |
| **Maximum Incentive Amount in Dollars** | | $545 |
| **Description of Incentives for Eligible Beneficiaries** | | ▪ All participants will receive a $25 debit card for attending their first session.<br>▪ All participants receive supports to address barriers to participation, including meals during sessions, transportation to sessions, and child care during sessions.<br>▪ Participants in groups in the individual incentives arm receive monetary incentives of $10–$100 for attendance and weight loss goal attainment. Participants in the groups in the individual plus group incentives arm receive incentives of $10–$75 for individual attendance and for group attainment of attendance and weight loss goals.<br>▪ The research study offers all participants $25 added to their debit card when they have a follow-up clinic visit at the end of the 1-year period of their participation. This amount covers participant time and other costs such as travel to the laboratory. |
| **Incentives for Others (e.g., CHCs and Private Providers)** | | Yes |
| **Description of Incentives for Others (e.g., CHCs and Private Providers) – If Not Applicable, Write NA** | | Under a new RFP released in April 2013, clinics now receive up to $278,000 to cover their study-related costs, including participants' supports, personnel, and equipment and supplies. |
| **Are Incentives "Front-Loaded"?** | | No |
| **Evaluation Design(s)** | **Quasi-Experimental Design** | No |
| | **Randomized Controlled Trial** | Yes, a prospective cluster randomized trial with YMCA - delivered diabetes prevention program (Y-DPP) classes as the unit of randomization and analysis and participants nested within classes. |
| | **Equipoise-stratified Randomization** | No |
| | **Crossover Design** | No |
| | **Cost-Effectiveness Analyses** | Yes |

(continued)

| State | Minnesota |
|---|---|
| **Description of Evaluation Design** | Prospective group randomized trial. Participants will be randomized based on the Y-DPP groups they are placed in. The 15 participants will be part of one of three groups: control (no incentives), individual incentives, and individual plus group incentives. Analysis will assess:<br>▪ The impact of incentives on weight, HBA1c levels, and cardiovascular risk for participants in the three groups.<br>▪ Whether individual and group incentives facilitate increased attendance in the diabetes prevention program.<br>▪ The long-term cost-effectiveness of patient incentive programs. |
| **Outcomes Examined** | Age, sex, race, ethnicity, height, weight, smoking status, blood glucose levels, blood lipids levels, and blood pressure will be collected from participants' electronic medical records at baseline and follow-up. Study costs will be collected from program cost logs and Medicare and Medicaid data. Ten-year risk of cardiovascular risk and diabetes complication will be calculated using the UKPDS risk engine and EMR data. |

# APPENDIX F:
# MONTANA

| | | |
|---|---|---|
| State | | Montana |
| **State Abbreviation** | | MT |
| **Project Title** | | Medicaid Incentives to Prevent Chronic Disease |
| **Grantee/State Implementing Agency** | | Montana Department of Public Health and Human Services Medicaid Managed Care Bureau and Chronic Disease Prevention and Health Promotion Bureau |
| **Partners** | | ▪ American Diabetes Association<br>▪ American Heart/Stroke Association Affiliates for Montana<br>▪ Montana Department of Public Health and Human Services Diabetes Advisory Coalition<br>▪ Lifestyle coaches from the 14 health care facilities delivering the intervention statewide<br>▪ University of North Dakota<br>▪ Northwest Resource Consultants |
| **1st Year Grant Award** | | $111,788 |
| **Total Enrollment Year 1 (9/2011–9/2012)** | | 110 |
| **Total Enrollment Year 2, Quarter 1 (10/2012–12/2012)** | | 110 |
| **Total Enrollment Year 2, Quarter 2 (1/2013–3/2013)** | | 181 |
| **Total Enrollment Year 2, Quarter 3 (4/2013–6/2013)** | | 181 |
| **Implementation Date / Projected Implementation Date** | | ▪ MT's program is a continuation of a program established in 2008.<br>▪ As of January 2012, began recruitment and enrollment for the "new arm."<br>▪ 14 sites ready to participate – half getting incentives and half participating in Medicaid. |
| **Implementation as a Pilot?** | | No |
| **Duration of Program Arms** | | 16-week core program; 6-month after core weight maintenance program; entire 10-month intervention |
| **# Conditions** | | 4 |
| **Conditions** | **Smoking** | No |
| | **Diabetes** | Yes |
| | **Obesity** | Yes |
| | **Hyperlipidemia** | Yes |
| | **Hypertension** | Yes |
| | **Other** | No |

(continued)

| State | | Montana |
|---|---|---|
| **Special Populations Examined** | **Homeless/Housing Instable Populations** | No |
| | **Food Insecure Populations** | No |
| | **Those with Mental Illness** | No |
| | **Those with Substance Abuse Disorders** | No |
| | **Racial/Ethnic Minorities (e.g., Native Americans; Native Hawaiians; Asian Americans; Pacific Islanders)** | No |
| | **Pregnant Women and Mothers of Newborns** | Pregnant women are ineligible. Mothers of newborns who meet the eligibility criteria are eligible. |
| | **Children** | No |
| | **Medicare-Medicaid enrollees** | Yes |
| **Description of Target Population** | | Adult Medicaid beneficiaries who are 18 years of age and older, who are overweight (BMI ≥ 25.0 kg/m2) and have one or more of the following risk factors for CVD and diabetes: pre-diabetes, impaired glucose tolerance, impaired fasting glucose, a hemoglobin A1c between 5.7% and 6.4%, hypertension, dyslipidemia, a history of GDM or a history of having a baby weighing > 9 pounds. |
| **Potential Special Populations** | | Adults enrolled in Medicaid who meet the eligibility criteria listed above. |
| **# Targeted Patients – Total and By Experimental and Control Group(s)** | | 726 total: 363 for experimental group(s) and 363 for control group(s). |
| **Languages** | **Languages spoken by program participants** | English |
| | **Percent of participant population that speaks a language other than English – List percent for each language, if possible.** | 0% |
| **Medicare-Medicaid enrollees: If a MIPCD participant is not enrolled in both Medicaid and Medicare upon initial enrollment into MIPCD, but becomes a Medicare-Medicaid enrollee during the course of MIPCD program participation, this participant will be:** | | ▪ They will be allowed to continue to participate in the MIPCD program.<br>▪ MT will enroll individuals regardless of Medicare-Medicaid enrollee status. So whether they are dually enrolled in Medicare at the start of the program or become enrolled in Medicare during the course of the program does not matter. |

(continued)

| State | | Montana |
|---|---|---|
| **Type of Medicaid Population** | | ▪ Adults aged 18 years and older enrolled in Medicaid who meet the eligibility criteria described above are eligible for the program.<br>▪ MT does not have capitated managed care; only fee-for-service (FFS) and Primary Care Case Management (PCCM). |
| **Description of Goals** | | The prevention goals that the Montana DPHHS will target include reducing weight, reducing lipid and blood pressure levels, and preventing type 2 diabetes among adult Medicaid beneficiaries at high risk for developing CVD and diabetes. |
| **Description of Activities** | | ▪ An adapted evidence-based lifestyle intervention based on the National Institutes of Health's Diabetes Prevention Program (DPP).<br>▪ Trained health care professional delivery of the standardized diabetes self-management education curriculum to program enrollees. |
| **Incentives for Eligible Beneficiaries** | **Money (e.g., $25 in Cash or Debit Card)** | Yes |
| | **Money-Valued Incentive (e.g., $25-Valued Incentive Such As $25 Gift Card to Grocery Store)** | No |
| | **Treatment-Related Incentives (e.g., Free Nicotine Replacement Therapy Patches)** | No |
| | **Support to Address Barriers to Participation (e.g., Meals; Transportation; Child Care)** | MT is providing a small amount of funding to each intervention site that can be used to assist Medicaid enrollees with barriers to participating in the program. The Program also worked with Medicaid and other DPHHS partners to:<br>▪ Ensure that Medicaid participants and lifestyle coaches are aware of and can access transportation benefits to reduce this potential barrier to participation<br>▪ Ensure that they are aware of and can access technology to support participants who have hearing or vision impairments. |
| | **Prevention-Related Incentives (e.g., Vouchers for Farmers' Markets; Exercise Equipment; Healthy Foods Cookbooks)** | No |
| | **Flexible Spending Account for Wellness Related-Expenses** | No |
| | **Points Redeemable for Rewards** | No |
| | **Unspecified Incentives** | No |

(continued)

| State | | Montana |
|---|---|---|
| **Maximum Incentive Amount in Dollars** | | $315 annually |
| **Description of Incentives for Eligible Beneficiaries** | | ▪ Tiered and incrementally increasing financial incentives for participant self-monitoring and reduction of fat and caloric intake, and participant monitoring and achievement of more than 150 minutes of moderately vigorous physical activity per week.<br>▪ The maximum total cash incentive per participant is $315, provided through debit cards, which can be drawn down over an extended period of time.<br>▪ Established a contract with US Bank to deliver the incentives to participants and provide reloadable debit cards using electronic transfer funds. Staff from US Bank provided web-based training for staff and lifestyle coaches regarding the distribution of incentives to participants. The debit cards have been distributed to Medicaid enrolled participants in the incentive arm of the program and financial incentives are being provided to these participants upon completion of the behavioral goals for the program. |
| **Incentives for Others (e.g., CHCs and Private Providers)** | | Yes |
| **Description of Incentives for Others (e.g., CHCs and Private Providers) – If Not Applicable, Write NA** | | Working in coordination with the CMS Denver Regional Office, the Central CMS Office, and with its project the State has submitted an amended State plan, which will allow selected licensed health care professionals to be reimbursed by Medicaid for providing the lifestyle intervention. The amended plan has been approved by CMS, and sites are currently billing for the provision of services. |
| **Are Incentives "Front-Loaded"?** | | No |
| **Evaluation Design(s)** | **Quasi-Experimental Design** | No |
| | **Randomized Controlled Trial** | No |
| | **Equipoise-stratified Randomization** | No |
| | **Crossover Design** | Yes |
| | **Cost-Effectiveness Analyses** | No |

(continued)

| State | Montana |
|---|---|
| **Description of Evaluation Design** | ▪ A crossover design will be used to evaluate both the process and health outcome measures for participants receiving and not receiving the incentives. During the first 1.5 years of the grant (January 2012 through July 2013) seven of the intervention sites will be selected to provide the incentives to participants and the remaining seven sites will not provide incentives during that time period. After completing the first 1.5 years of this project, the incentives will be used by the sites that did not provide them during the first 1.5 years, but will no longer be provided by the sites that did. The new sites providing the incentives would do so for 2 years (August 2013 through July 2015) and the other seven sites would continue to provide the lifestyle intervention services to participants enrolled in Medicaid, but not the incentives. This crossover design will allow a comparison of Medicaid beneficiaries receiving the lifestyle intervention and incentives to those receiving the lifestyle intervention but not incentives throughout the period of the MIPCD program, both between and within sites providing incentives. This design will also minimize any potential bias in recruitment, retention rates, and outcomes between intervention sites.<br>▪ An intention-to-treat analysis will be used where each enrolled participant's last measured weight will be carried forward to measure the weight loss outcome at completion of the core, after core, and at 6-month follow-up (6 months after the completion of the 10-month intervention). |
| **Outcomes Examined** | The primary health status measures targeted are the proportion of participants achieving either the >5% or the 7% weight loss goal. Achievement of >5% weight loss and the 7% weight loss goal will be evaluated at the completion of the core (week 16), the after core (10 months), and at 6 months follow-up. |

*[This page intentionally left blank.]*

# APPENDIX G:
# NEVADA

| State | Nevada |
|---|---|
| **State Abbreviation** | NV |
| **Project Title** | Medicaid Incentives for Prevention of Chronic Diseases |
| **Grantee/State Implementing Agency** | Department of Health and Human Services, Division of Health Care Financing and Policy; Department of Health and Human Services, State Health Division |
| **Partners** | ▪ Children's Heart Center, Nevada<br>▪ Nevada's Medicaid Managed Care Organizations: Amerigroup; UnitedHealthcare; Health Plan of Nevada<br>▪ YMCA of Southern Nevada<br>▪ University Medical Center, Lied Clinic Outpatient Facility<br>▪ Third Party Incentives Administrator – ChipRewards<br>▪ Research Study Evaluators – University of Nevada, Reno<br>Note: The Southern Nevada Health District had been but is no longer a partner. It is serving in an advisory capacity. |
| **1st Year Grant Award** | $415,606 |
| **Total Enrollment Year 1 (9/2011–9/2012)** | 0 |
| **Total Enrollment Year 2, Quarter 1 (10/2012–12/2012)** | 0 |
| **Total Enrollment Year 2, Quarter 2 (1/2013–3/2013)** | 87 |
| **Total Enrollment Year 2, Quarter 3 (4/2013–6/2013)** | 215 |
| **Implementation Date / Projected Implementation Date** | ▪ NV was implementing staggered enrollment of participants in the five programs but now is considering implementing simultaneous enrollment of the remaining programs.<br>▪ Children's Heart Center began enrollment in February 2013 and the YMCA of Southern Nevada in May 2013.<br>▪ NV plans to begin recruitment at Amerigroup in August 2013 with enrollment to follow; recruitment at UnitedHealthcare in August 2013 with enrollment to follow; and recruitment and enrollment at Lied Clinic in September 2013. |
| **Implementation as a Pilot?** | No |
| **Duration of Program Arms** | ▪ Medicaid MCO's Diabetes Disease Management Program—follow-up through 12 months.<br>▪ Medicaid MCO's Weight Management Program —3 weeks of sessions.<br>▪ Medicaid MCO's Weight Matters Support Group —12 weeks of sessions and the ability to continue attending even after completing the 12 weeks. |

(continued)

| State | | Nevada |
|---|---|---|
| **Duration of Program Arms (continued)** | | ▪ University Medical Center, Lied Clinic Outpatient Facility—6 weeks of sessions; follow-up through 12 months.<br>▪ YMCA of Southern Nevada—16 sessions and the ability to participate in monthly meetings after the initial 16 sessions for an additional 8 months; in total, 12 month program but participants not incentivized after month 10.<br>▪ Children's Heart Center, Nevada—12-week program; follow-up through 12 months. |
| **# Conditions** | | 4 |
| **Conditions** | **Smoking** | No |
| | **Diabetes** | Yes |
| | **Obesity** | Yes |
| | **Hyperlipidemia** | Yes |
| | **Hypertension** | Yes |
| | **Other** | No |
| **Special Populations Examined** | **Homeless/Housing Instable Populations** | No |
| | **Food Insecure Populations** | No |
| | **Those with Mental Illness** | No |
| | **Those with Substance Abuse Disorders** | No |
| | **Racial/Ethnic Minorities (e.g., Native Americans; Native Hawaiians; Asian Americans; Pacific Islanders)** | No |
| | **Pregnant Women and Mothers of Newborns** | No |
| | **Children** | Yes |
| | **Medicare-Medicaid enrollees** | Yes |
| **Description of Target Population** | | ▪ Medicaid Beneficiaries with diabetes who are served by Nevada's Medicaid Managed Care Organizations.<br>▪ Adults diagnosed with diabetes and adults at risk of developing type 2 diabetes who are enrolled in fee-for-service Medicaid.<br>▪ Children between the ages of 7 and 18 with elevated BMI, dyslipidemia, hypertension, hyperinsulinemia, or other comorbidity that are enrolled in fee-for-service Medicaid. |

(continued)

| State | | Nevada |
|---|---|---|
| **Potential Special Populations** | | ▪ The entire program is focused around diabetics or pre-diabetics with Medicaid.<br>▪ There is a pediatric-only provider, so there is a child-focused population. |
| **# Targeted Patients – Total and By Experimental and Control Group(s)** | | ▪ 9,816 total: 5,382 for experimental group(s) and 4,434 for control group(s)<br>▪ Additional sub-treatment groups were added, which rectified inaccuracies in the original protocol. Each partner has two treatment groups and one control group. |
| **Languages** | **Languages spoken by program participants** | English, Spanish |
| | **Percent of participant population that speaks a language other than English – List percent for each language, if possible.** | There is a large Hispanic Medicaid population; the percentage of the population with Spanish as a primary language is unknown. The best estimate is the total monthly Hispanic Medicaid population; in November 2012, the percentage was 36.4%. |
| **Medicare-Medicaid enrollees: If a MIPCD participant is not enrolled in both Medicaid and Medicare upon initial enrollment into MIPCD, but becomes a Medicare-Medicaid enrollee during the course of MIPCD program participation, this participant will be:** | | ▪ Allowed to continue to participate in the MIPCD program.<br>▪ It is unclear whether Medicare-Medicaid enrollees will participate in the project. If they do participate, it will be in FFS. |
| **Type of Medicaid Population** | | Both fee-for-service and managed care populations |
| **Description of Goals** | | Control or reduce weight, lower cholesterol, lower blood pressure, and avoid the onset of diabetes or (in the case of a diabetic) improve the management of the condition. |
| **Description of Activities** | | ▪ Diabetes self-management education to adult Medicaid FFS or MCO beneficiaries. NOTE: The incentive structure for adult participants with diabetes in the FFS system will mirror that for program participants with diabetes in MCOs except all participants will be incentivized to receive the supplemental services offered and receive additional follow-up at the 3-month mark to measure outcomes.<br>▪ Participation in YMCA's Diabetes Prevention Program (YDPP) for those identified as high risk of developing type 2 diabetes. |
| **Description of Activities (continued)** | | ▪ Participation in a weight management program and support group for beneficiaries with a Body Mass Index of 30 or greater.<br>▪ The Children's Heart Center Nevada's Healthy Hearts Program includes individualized nutritional counseling with a registered dietitian; physical fitness assessment and monitored exercise program overseen by an exercise physiologist; and one-on-one counseling and motivational coaching with a psychologist for children at risk for heart disease. |

(continued)

| State | | Nevada |
|---|---|---|
| **Incentives for Eligible Beneficiaries** | **Money (e.g., $25 in Cash or Debit Card)** | No |
| | **Money-Valued Incentive (e.g., $25-Valued Incentive Such As $25 Gift Card to Grocery Store)** | No |
| | **Treatment-Related Incentives (e.g., Free Nicotine Replacement Therapy Patches)** | No |
| | **Support to Address Barriers to Participation (e.g., Meals; Transportation; Child Care)** | No |
| | **Prevention-Related Incentives (e.g., Vouchers for Farmers' Markets; Exercise Equipment; Healthy Foods Cookbooks)** | No |
| | **Flexible Spending Account for Wellness Related-Expenses** | No |
| | **Points Redeemable for Rewards** | Yes |
| | **Unspecified Incentives** | No |
| **Maximum Incentive Amount in Dollars** | | ▪ MCO for diabetes management: Maximum study incentive: $355<br>▪ MCO for weight management class: Maximum study incentive: $38<br>▪ MCO for weight management support group: Maximum study incentive: $60<br>▪ Lied Clinic Outpatient Facility at University Medical Center: Maximum study incentive: $345<br>▪ YMCA of Southern Nevada: Maximum study incentive: $300<br>▪ Healthy Hearts Program for Children: Maximum study incentive: $350<br>▪ Nevada provides points that are redeemable for rewards; 100 points is equal to $1. |

(continued)

| State | | Nevada |
|---|---|---|
| **Description of Incentives for Eligible Beneficiaries** | | ▪ Points redeemable for rewards on a tiered basis for participation in programs; efforts at behavior change (including completion of an evidence-based program); and achievement of improved health outcomes.<br>▪ The Third Party Administrator will provide a web-based point incentive technology platform system to distribute rewards to Nevada Medicaid and Nevada Check-Up recipients who participate in the MIPCD grant. The web-based product will be professional looking, HIPAA compliant, and a secure web-based portal with 24/7 access. |
| | | ▪ Once participants start accumulating points, they can start redeeming them. Participants do not get a hard copy of the catalog of rewards—it will be on the website. There is a large selection that they can choose from to purchase with their points. |
| **Incentives for Others (e.g., CHCs and Private Providers)** | | Yes |
| **Description of Incentives for Others (e.g., CHCs and Private Providers) – If Not Applicable, Write NA** | | Compensation for select providers for each participant for which they enter enrollment and incentive data into a web portal. The compensation is $300 per participant for YMCA, $250 per participant for Children's Heart Center, and $275 per participant for Lied Clinic. |
| **Are Incentives "Front-Loaded"?** | | No |
| **Evaluation Design(s)** | **Quasi-Experimental Design** | No |
| | **Randomized Controlled Trial** | Yes |
| | **Equipoise-stratified Randomization** | No |
| | **Crossover Design** | No |
| | **Cost-Effectiveness Analyses** | Yes |
| **Description of Evaluation Design** | | A State-level independent evaluation for the Nevada MIPCD Program conducted by the University of Nevada, Reno.<br>A test of the three hypotheses using three samples with control and treatment groups within each sample. Individuals will be assigned randomly into one of these groups, and multivariate and multivariate regression analysis will be used to analyze results.<br>**Hypothesis 1.** Incentivizing improvements in health measurements (such as A1c level), instead of focusing on concrete actions (such as going to get an A1c test) may be counterproductive, if individuals have low expectations of success. Adults enrolled in the MCOs' diabetes management programs will be invited to participate in the study. Participants will be randomly assigned to control and treatment groups. |

(continued)

| State | Nevada |
|---|---|
| **Description of Evaluation Design (continued)** | **Hypothesis 2.** Allowing individuals to choose whether to allocate incentive points to health measures may improve performance among the group that elects to award points to health measures, without adversely impacting the performance of the group that does not choose this option. Adult participants in the FFS program component receiving supplemental services designed to help individuals increase physical activity and lose weight will be invited to participate in the study. These participants will be randomly assigned to two groups: the control group and the treatment group.<br>**Hypothesis 3.** Supplementing incentive structures with rewards for the parent/family, in addition to the child, will induce more behavior change (by the child) than focusing the entire incentive rewards on the child. Children enrolled in the Healthy Hearts program will be invited to participate in this study. Participants will be randomly assigned to the control or treatment groups.<br>▪ There are two randomly assigned sub-treatment groups within Hypothesis Group 3 that can receive incentives. In the first sub-group, all the incentives will go to the child. In the second, the child and parent will each have separate accounts that can accumulate points.<br>▪ The claims and encounter data will be used to estimate short-term cost savings. The analyses described above for each hypothesis test will be repeated, with claims/encounter charges as the dependent variable. The independent variables will include indicator variables for membership in the treatment groups in each hypothesis test, along with control variables for demographic characteristics. The cost variable will be "net amount paid" for the FFS claims, and encounter cost for the MCO data. |
| **Description of Evaluation Design (continued)** | ▪ Incentives may lead to increased short-term costs, because of the increased expenditures for tests. It will be necessary to rely on published research to extrapolate the long-term impacts of the incentives on costs. |
| **Outcomes Examined** | **Outcomes related to Hypothesis 1:**<br>Multivariate regression analysis will focus on total rewards points, task-completion points, goal-achievement points, and goal-maintenance points as the key dependent variables.<br>**Outcomes related to Hypothesis 2:**<br>Multivariate analysis will be used to identify the characteristics of people who elect to assign rewards points to goal achievement and maintenance.<br>**Outcomes related to Hypothesis 3:**<br>Multivariate regression analysis will focus on total rewards points, participation-related points, goal-achievement points, and goal-maintenance points as the key dependent variables. |

# APPENDIX H:
# NEW HAMPSHIRE

| | | |
|---|---|---|
| State | | New Hampshire |
| **State Abbreviation** | | NH |
| **Project Title** | | Healthy Choices, Healthy Changes |
| **Grantee/State Implementing Agency** | | State of New Hampshire Department of Health and Human Services, Division of Community-Based Care Services, Bureau of Behavioral Health, Office of Medicaid Business and Policy |
| **Partners** | | ▪ 10 Regional community mental health centers<br>▪ Dartmouth CDC Prevention Research Center<br>▪ Dartmouth Institute for Health Policy and Clinical Practice |
| **1st Year Grant Award** | | $1,669,800 |
| **Total Enrollment Year 1 (9/2011–9/2012)** | | 167 people total randomized to the weight management or smoking cessation programs (160 randomized to one of the weight management programs, 7 randomized to one of the smoking cessation programs) |
| **Total Enrollment Year 2, Quarter 1 (10/2012–12/2012)** | | 400 people total randomized to the weight management or smoking cessation programs (333 randomized to one of the weight management programs, 64 randomized to one of the smoking cessation programs) |
| **Total Enrollment Year 2, Quarter 2 (1/2013–3/2013)** | | 645 people total randomized to the weight management or smoking cessation programs (515 randomized to one of the weight management programs, 130 randomized to one of the smoking cessation programs) |
| **Total Enrollment Year 2, Quarter 3 (4/2013–6/2013)** | | 815 people total randomized to the weight management or smoking cessation programs (625 randomized to one of the weight management programs, 190 randomized to one of the smoking cessation programs) |
| **Implementation Date / Projected Implementation Date** | | May 2012 |
| **Implementation as a Pilot?** | | No |
| **Duration of Program Arms** | | Weight management: 2 years (Phase 1 participants) and 1 year (Phase 2 participants); Tobacco Education and Smoking cessation: 1 year |
| **# Conditions** | | 2 |
| **Conditions** | **Smoking** | Yes, but the State found that the smoking cessation program has not been well received at the mental health centers because some medical directors are uncomfortable promoting smoking cessation for persons with mental illness because "smoking is all they have." As a result, the State rebranded their campaign from smoking cessation to tobacco education. In the tobacco education program, there is no requirement to quit smoking and participants can receive an incentive initially simply for receiving education. |

(continued)

| State | | New Hampshire |
|---|---|---|
| **Conditions (continued)** | **Diabetes** | No |
| | **Obesity** | Yes |
| | **Hyperlipidemia** | No |
| | **Hypertension** | No |
| | **Other** | No |
| **Special Populations Examined** | **Homeless/Housing Instable Populations** | No |
| | **Food Insecure Populations** | No |
| | **Those with Mental Illness** | Yes |
| | **Those with Substance Abuse Disorders** | No |
| | **Racial/Ethnic Minorities (e.g., Native Americans; Native Hawaiians; Asian Americans; Pacific Islanders)** | No |
| | **Pregnant Women and Mothers of Newborns** | No |
| | **Children** | No |
| | **Medicare-Medicaid enrollees** | Yes |
| **Description of Target Population** | | ▪ The WIP program will enroll Medicaid recipients receiving services at one of the 10 CMHCs in the State, who are overweight or obese or regular smokers.<br>▪ Supported Weight Management participants must (a) be at least 18 years of age; (b) be a Medicaid beneficiary currently receiving services at one of the 10 NH CMHCs; (c) have a BMI greater than 30 or a BMI greater than 25 with a failure to adhere to DHHS Physical Activity Guidelines (greater than 2.5 hours/week of moderate or 75 minutes/week of vigorous activity in more than one session).<br>▪ Supported Smoking Cessation participants must (a) smoke at least 10 cigarettes or mini cigars a day or equivalent; (b) have a carbon monoxide level of 8 ppm or higher or urine nicotine level of more than 100 mg/ml. |
| **Potential Special Populations** | | Populations with mental illness who are overweight/obese or regular smokers. |

(continued)

| State | | New Hampshire |
|---|---|---|
| **# Targeted Patients – Total and By Experimental and Control Group(s)** | | 2,639 total participants: 855 experimental group participants with 459 in the weight management program and 396 in the smoking cessation program and 848 control group participants with 468 in the weight management program and 380 in the smoking cessation program. In addition, the State is targeting 936 participants who receive a $10 incentive for completing a computerized tobacco education course. |
| **Languages** | **Languages spoken by program participants** | Many participants are bilingual but primarily speak English. |
| | **Percent of participant population that speaks a language other than English – List percent for each language, if possible.** | 0% |
| **Medicare-Medicaid enrollees: If a MIPCD participant is not enrolled in both Medicaid and Medicare upon initial enrollment into MIPCD, but becomes a Medicare-Medicaid enrollee during the course of MIPCD program participation, this participant will be:** | | Allow Medicare-Medicaid enrollees at initial enrollment and Medicare-Medicaid enrollees can remain in the program if they become enrolled in Medicare-Medicaid while participating in the State program. There are many Medicare-Medicaid enrollees in their population because they are disabled (mental health). |
| **Type of Medicaid Population** | | Only managed care enrollees are included in the program. |
| **Description of Goals** | | The WIP program targets cardiovascular disease or risk for cardiovascular disease. The goal is to reduce cardiovascular risk factors including rates of obesity and smoking among a high-risk group of Medicaid beneficiaries, people with mental illness.<br>Objectives include:<br>Increase exercise; improve nutrition; increase smoking cessation to lower blood pressure; reduce weight; reduce cholesterol, and blood glucose levels; and modify other related risk factors for cardiovascular disease. |
| **Description of Activities** | | The four Supported Weight Management options include:<br>Phase I:<br>(1) Gym Membership (e.g., YMCA) for up to 24 months (up to $20/month).<br>(2) In SHAPE, a motivational health-promotion program for persons with mental illness, which includes a free membership to a gym and 1:1 meetings with a fitness trainer, for up to 24 months.<br>(3) Membership to Weight Watchers for up to 24 months ($20/month).<br>(4) A combination of In SHAPE + Weight Watchers for up to 24 months. |

(continued)

| State | | New Hampshire |
|---|---|---|
| **Description of Activities (continued)** | | Phase II:<br>(1) Gym Membership (e.g., YMCA) for up to 12 months (up to $20/month).<br>(2) In SHAPE, a motivational health-promotion program for persons with mental illness, which includes a free membership to a gym and 1:1 meetings with a fitness trainer, for up to 12 months.<br>(3) Membership to Weight Watchers for up to 12 months ($20/month).<br>(4) A combination of In SHAPE + Weight Watchers for up to 12 months.<br><br>In each condition listed above, 50% of participants will be randomized to receive either the program as described or additional rewards..<br><br>All CMHC clients who smoke are encouraged to complete the Electronic Decision Support System (EDSS), a Web-based computer decision support system developed by the Dartmouth team to stimulate motivation to quit smoking. All smokers who complete the EDSS will receive $10. For people who express a desire to receive a smoking cessation program, three Supported Smoking Cessation options are available.<br><br>The Supported Smoking Cessation options for participants who express interest in quitting smoking following the EDSS include:<br>(1) Prescriber Referral for Smoking Cessation Treatment + Telephone-based Cognitive Behavioral Smoking Cessation Therapy (CBT).<br>(2) Prescriber Referral for Smoking Cessation Treatment + State Quit Line sessions.<br>(3) Prescriber Referral for Smoking Cessation Treatment (alone).<br><br>In each condition listed above, 50% of participants will be randomized to receive either the program as described or additional rewards. |
| **Incentives for Eligible Beneficiaries** | **Money (e.g., $25 in Cash or Debit Card)** | Yes |
| | **Money-Valued Incentive (e.g., $25-Valued Incentive Such As $25 Gift Card to Grocery Store)** | No |
| | **Treatment-Related Incentives (e.g., Free Nicotine Replacement Therapy Patches)** | Yes |

(continued)

| State | | New Hampshire |
|---|---|---|
| **Incentives for Eligible Beneficiaries (continued)** | **Support to Address Barriers to Participation (e.g., Meals; Transportation; Child Care)** | Yes |
| | **Prevention-Related Incentives (e.g., Vouchers for Farmers' Markets; Exercise Equipment; Healthy Foods Cookbooks)** | Yes |
| | **Flexible Spending Account for Wellness Related-Expenses** | No |
| | **Points Redeemable for Rewards** | No |
| | **Unspecified Incentives** | No |
| **Maximum Incentive Amount in Dollars** | | ▪ 24-month weight loss program's maximum incentive amount: $3,097<br>▪ 12-month weight loss program's maximum incentive amount: $1,860<br>▪ Smoking cessation program's maximum incentive amount for the study: $415 |
| **Description of Incentives for Eligible Beneficiaries** | | The four Supported Weight Management options include:<br>Phase I:<br>(1) Gym Membership (e.g., YMCA) for up to 24 months (up to $20/month).<br>(2) In SHAPE, a motivational health-promotion program for persons with mental illness, which includes a free membership to a gym and 1:1 meetings with a fitness trainer, for up to 24 months.<br>(3) Membership to Weight Watchers for up to 24 months ($20/month).<br>(4) A combination of In SHAPE + Weight Watchers for up to 24 months.<br>Phase II:<br>(1) Gym Membership (e.g., YMCA) for up to 12 months (up to $20/month).<br>(2) In SHAPE, a motivational health-promotion program for persons with mental illness, which includes a free membership to a gym and 1:1 meetings with a fitness trainer, for up to 12 months.<br>(3) Membership to Weight Watchers for up to 12 months ($20/month). |

(continued)

| State | New Hampshire |
|---|---|
| **Description of Incentives for Eligible Beneficiaries (continued)** | (4) A combination of In SHAPE + Weight Watchers for up to 12 months.<br>▪ In each condition listed above, 50% of participants will be randomized to receive either the program as described or additional rewards.<br>▪ All CMHC clients who smoke will be encouraged to complete the Electronic Decision Support System (EDSS), a Web-based computer decision support system developed by the Dartmouth team to stimulate motivation to quit smoking. All smokers who complete the EDSS will receive $10. For people who express a desire to receive a smoking cessation program, three Supported Smoking Cessation options are available.<br><br>The Supported Smoking Cessation options for participants who express interest in quitting smoking following the EDSS include:<br>(1) Prescriber Referral for Smoking Cessation Treatment + Telephone-based Cognitive Behavioral Smoking Cessation Therapy (CBT).<br>(2) Prescriber Referral for Smoking Cessation Treatment + State Quit Line sessions.<br>(3) Prescriber Referral for Smoking Cessation Treatment (alone).<br><br>In each condition listed above, 50% of participants will be randomized to receive either the program as described or additional rewards.<br><br>Group 2 (In SHAPE). Group 2 participants will receive the same incentive as in Group 1 (free gym membership up to $20/month for up to 24 months), plus the In SHAPE program, which includes weekly 1:1 sessions with a Health Mentor for up to 24 months.<br><br>Group 3 (Weight Watchers). Group 3 participants will receive free access to both the in-person and the online version of Weight Watchers ($20/month) for up to 24 months.<br><br>Group 4 (In SHAPE+ Weight Watchers). Group 4 participants will receive the same programs (In SHAPE & WW) as those in Groups 2 and 3 for up to 24 months. |
| **Incentives for Others (e.g., CHCs and Private Providers)** | No |
| **Description of Incentives for Others (e.g., CHCs and Private Providers) – If Not Applicable, Write NA** | NA |

(continued)

| State | | New Hampshire |
|---|---|---|
| **Are Incentives "Front-Loaded"?** | | Yes, Weight management: $5 for attending gym 3x per week during the first year; $3 for second year; $2 for third year. $10/week for attending Weight Watchers; $7 for second year; $5 for third year. |
| **Evaluation Design(s)** | **Quasi-Experimental Design** | No |
| | **Randomized Controlled Trial** | No |
| | **Equipoise-stratified Randomization** | Yes, but has not worked well because most are choosing an option with a personal trainer. |
| | **Crossover Design** | No |
| | **Cost-Effectiveness Analyses** | Yes |
| **Description of Evaluation Design** | | Equipoise-stratified randomization as a method for ensuring that the interventions offered are widely accessible to the targeted Medicaid population.<br>▪ Person-level evaluation of healthy behaviors, health, and cardiovascular risk.<br>▪ An analysis of "cost neutrality" and estimated "cost offsets" with respect to high-cost acute events (e.g., psychiatric or medical hospitalizations, emergency room visits, nursing home admissions), and overall cost neutrality and cost-offsets associated with program implementation.<br>**Specific Aim 1:** To evaluate the effectiveness of weight management programs for Medicaid beneficiaries receiving community mental health services. **Hypothesis 1a:** Superiority of Combined Supported Exercise + Weight Management. The combination of group-based weight management (WW + In SHAPE) will result in the highest rate of weight loss and greatest reduction in avoidable risk of death. **Hypothesis 1b:** Superiority of supported weight management programs. The supported weight management programs (In SHAPE and WW) will result in higher rates of weight loss and greater reduction in avoidable risk of death than gym membership alone. **Hypothesis 1c:** Enhanced Rates of Weight Loss with Incentives. Overall rate of weight loss for all conditions will be superior when incentives for participation are offered.<br>**Specific Aim 2:** Evaluate effectiveness of incentivized smoking cessation programs for Medicaid beneficiaries receiving community mental health services. **Hypothesis 2a:** Superiority of Telephone-based CBT. Telephone-based CBT will result in the highest rate of cessation and greatest reduction in avoidable risk of death, followed by facilitated use of the NH tobacco quit line, followed by prescriber referral alone. |

(continued)

| State | New Hampshire |
|---|---|
| **Description of Evaluation Design (continued)** | **Hypothesis 2b:** Enhanced Rates of Smoking Cessation with Incentives. The overall rate of smoking cessation for the three conditions will be superior to published rates for comparable publicly available programs not including incentives for participation and cessation. **Hypothesis 2c:** Program Costs Offset by Reduced Long-term Health Care Expenditures. The cost of providing telephone-based CBT with incentives will be offset by savings in long-term Medicaid expenditures and combined expenditures for Medicare-Medicaid enrollees). |
| **Outcomes Examined** | ▪ Primary proximal outcomes: exercise participation, and dietary behaviors.<br>▪ Primary distal outcomes: executive capacity, physical measurements (waist, BMI, blood pressure), self-efficacy, and avoidable risk of death (measured using the avoidable risk of death index).<br>▪ Secondary outcomes: subjective health status, glucose and lipids, health care costs and stage of change (diet/exercise).<br>▪ Fidelity. |

## APPENDIX I:
## NEW YORK

| State | | New York |
|---|---|---|
| **State Abbreviation** | | NY |
| **Project Title** | | Medicaid Incentives for Prevention of Chronic Disease Program |
| **Grantee/State Implementing Agency** | | New York State Department of Health, Office of Health Insurance Programs, Division of Quality and Evaluation |
| **Partners** | | ▪ University of Pennsylvania<br>▪ Harvard Medical School<br>▪ Carnegie Melon University<br>▪ New York City Department of Health and Mental Hygiene<br>▪ Alliance of New York State YMCAs<br>▪ NYS Office of Mental Health<br>▪ Medicaid Matters New York<br>▪ American Cancer Society<br>▪ American Diabetes Association<br>▪ American Heart Association<br>▪ Community Service Society of New York<br>▪ Empire Justice Center<br>▪ Eleven Medicaid Managed Care Plans |
| **1st Year Grant Award** | | $2,000,000 |
| **Total Enrollment Year 1 (9/2011–9/2012)** | | 0 |
| **Total Enrollment Year 2, Quarter 1 (10/2012–12/2012)** | | 0 |
| **Total Enrollment Year 2, Quarter 2 (1/2013–3/2013)** | | 0 |
| **Total Enrollment Year 2, Quarter 3 (4/2013–6/2013)** | | 5 |
| **Implementation Date / Projected Implementation Date** | | NY began phase-in implementation in June 2013 with the diabetes prevention program. Enrollment for the other program arms will occur over the remainder of 2013. |
| **Implementation as a Pilot?** | | No |
| **Duration of Program Arms** | | ▪ Smoking cessation: Two 90-day nicotine replacement therapy treatments or six counseling sessions/year<br>▪ Hypertension: Up to two PCP appointments per year<br>▪ Diabetes prevention: 16-week YMCA Diabetes Prevention Program<br>▪ Diabetes: Up to five PCP appointments per year |
| **# Conditions** | | 3 |
| **Conditions** | **Smoking** | Yes |
| | **Diabetes** | Yes |
| | **Obesity** | No |
| | **Hyperlipidemia** | No |
| | **Hypertension** | Yes |
| | **Other** | No |

(continued)

| State | | New York |
|---|---|---|
| **Special Populations Examined** | **Homeless/Housing Instable Populations** | No |
| | **Food Insecure Populations** | No |
| | **Those with Mental Illness** | No |
| | **Those with Substance Abuse Disorders** | No |
| | **Racial/Ethnic Minorities (e.g., Native Americans; Native Hawaiians; Asian Americans; Pacific Islanders)** | No |
| | **Pregnant Women and Mothers of Newborns** | Yes, mothers of newborns are not a primary focus of the program; however, they may be included in the program. |
| | **Children** | No |
| | **Medicare-Medicaid enrollees** | No |
| **Description of Target Population** | | ▪ Pregnant Medicaid enrollees who use tobacco.<br>▪ Adult Medicaid enrollees who use tobacco.<br>▪ Adult Medicaid enrollees with high blood pressure, pre-diabetes or diabetes. |
| **Potential Special Populations** | | MCOs providing services to beneficiaries with HIV will participate, but beneficiaries with HIV are not specifically targeted as a special population. |
| **# Targeted Patients – Total and By Experimental and Control Group(s)** | | 6,800 total: 5,100 for experimental group(s) and 1,700 for control group(s) |
| **Languages** | **Languages spoken by program participants** | NY expects that Spanish speakers will participate; it also expects Chinese and Russian speakers based on the makeup of their current Medicaid population and the neighborhoods and communities in which the MIPCD program will be marketed. |
| | **Percent of participant population that speaks a language other than English – List percent for each language, if possible.** | They cannot estimate this percentage at this time. However, based on the percentage of the Medicaid population that completes a CAHPS survey in Spanish, they estimate that up to 20% might speak Spanish. The percentage of the population that speaks Chinese or Russian is quite small based on the volume of Chinese and Russian translated Medicaid materials that are routinely mailed out. |
| **Medicare-Medicaid enrollees: If a MIPCD participant is not enrolled in both Medicaid and Medicare upon initial enrollment into MIPCD, but becomes a Medicare-Medicaid enrollee during the course of MIPCD program participation, this participant will be:** | | Medicare-Medicaid enrollees will not be enrolled. If they are enrolled in Medicare-Medicaid while participating in the program, they will remain in the program. |
| **Type of Medicaid Population** | | Medicaid adults and pregnant women in managed care or fee-for-service Medicaid. |

(continued)

| State | | New York |
|---|---|---|
| **Description of Goals** | | Increase smoking cessation, lower high blood pressure, prevent diabetes onset, and enhance diabetes self-management. |
| **Description of Activities** | | ▪ For participants in the smoking cessation program, debit cards with predetermined cash value for participating in smoking cessation counseling (process), filling nicotine replacement therapy prescriptions (process), and quitting smoking (outcome).<br>▪ For participants in the blood pressure control program, debit cards with predetermined cash value for attending primary care appointments (process), filling antihypertensive prescriptions (process), and decreasing or maintaining a decreased systolic blood pressure by 10mmHg or achieving another clinically appropriate target (outcome). |
| | | ▪ For participants in the diabetes management program, debit cards with predetermined cash value for attending primary care appointments (process), attending diabetes self-management education sessions (process), filling diabetes prescriptions (process), and decreasing their HbA1c by 0.6 percent or maintaining a level of 8.0 percent or less (outcome).<br>▪ For participants in the diabetes onset prevention program, debit cards with predetermined cash value for attending YMCA Diabetes Prevention Program sessions (process) and losing or maintaining a reduced weight (outcome). |
| **Incentives for Eligible Beneficiaries** | **Money (e.g., $25 in Cash or Debit Card)** | Yes |
| | **Money-Valued Incentive (e.g., $25-Valued Incentive Such As $25 Gift Card to Grocery Store)** | No |
| | **Treatment-Related Incentives (e.g., Free Nicotine Replacement Therapy Patches)** | No |
| | **Support to Address Barriers to Participation (e.g., Meals; Transportation; Child Care)** | No |
| | **Prevention-Related Incentives (e.g., Vouchers for Farmers' Markets; Exercise Equipment; Healthy Foods Cookbooks)** | No |
| | **Flexible Spending Account for Wellness Related-Expenses** | No |

(continued)

| State | | New York |
|---|---|---|
| **(Incentives for Eligible Beneficiaries continued)** | **Points Redeemable for Rewards** | No |
| | **Unspecified Incentives** | No |
| **Maximum Incentive Amount in Dollars** | | $250 for participants in the intervention; $50 for control group participants |
| **Description of Incentives for Eligible Beneficiaries** | | ▪ Up to $250 in incentives per participant assigned to an incentive arm in acknowledgement that some participants will be eligible to receive the full amount in incentives through positive changes in health behaviors and clinical outcomes and others will not; incentive amounts did increase from the initial proposal.<br>▪ Will provide debit cards as incentives, depending on the program arm; no other incentives besides debit cards will be provided.<br>▪ The comparison group will receive $50 debit card for participating, but the group will not receive incentives for meeting process or outcome measures. |
| **Incentives for Others (e.g., CHCs and Private Providers)** | | No |
| **Description of Incentives for Others (e.g., CHCs and Private Providers) – If Not Applicable, Write NA** | | NA |
| **Are Incentives "Front-Loaded"?** | | No |
| **Evaluation Design(s)** | **Quasi-Experimental Design** | No |
| | **Randomized Controlled Trial** | Yes |
| | **Equipoise-stratified Randomization** | No |
| | **Crossover Design** | No |
| | **Cost-Effectiveness Analyses** | An informal cost-effectiveness study will be done; a formal assessment of all the costs will not be undertaken. |
| **Description of Evaluation Design** | | ▪ For the smoking cessation, blood pressure, and diabetes management programs, randomization at individual level (confounding bias examined using logistic or log-binomial or linear multivariate modeling).<br>▪ For the diabetes onset prevention program, randomization at the level of DPP class (confounding bias examined using linear regression multivariate modeling).<br>▪ Rapid cycle evaluation for other ad hoc research questions. |
| **Outcomes Examined** | | ▪ Smoking cessation: cessation status and service utilization<br>▪ Blood Pressure: blood pressure measurements, service utilization, Rx fills<br>▪ Diabetes Prevention: YMCA Diabetes Prevention Program attendance<br>▪ Diabetes Management: HbA1c levels, service utilization, Rx fills |

# APPENDIX J:
# TEXAS

| State | | Texas |
|---|---|---|
| **State Abbreviation** | | TX |
| **Project Title** | | Wellness Incentives and Navigation (WIN) Project |
| **Grantee/State Implementing Agency** | | Texas Health and Human Services Commission / Department of State Health Services |
| **Partners** | | ▪ Department of State Health Services(Texas' Mental Health and Substance Abuse Authority)<br>▪ Health and Human Services Commission (the State Medicaid Agency)<br>▪ Institute for Child Health Policy (ICHP), University of Florida, Gainesville (the State's External Quality Review Organization)<br>▪ Three Medicaid Contracted Health Maintenance Organizations (HMOs) |
| **1st Year Grant Award** | | $2,753,130 |
| **Total Recruitment Year 1 (9/2011–9/2012)** | | 519 total: 262 in intervention group, 257 in control group |
| **Total Recruitment Year 2, Quarter 1 (10/2012–12/2012)** | | 1,234 total: 609 in intervention group, 625 in control group |
| **Total Recruitment Year 2, Quarter 2 (1/2013–3/2013)** | | 1,269 total: 644 in intervention group, 625 in control group |
| **Total Enrollment Year 2, Quarter 3 (4/2013–6/2013)** | | 1,187 total: 561 in intervention group, 626 in control group Note that this total number is less than the total number reported for the previous period. Some intervention group candidates who initially agreed to participate in the program did not enter the study because they decided not to participate, were unable to be reached, or became ineligible for the study prior to receiving an intake assessment. |
| **Implementation Date / Projected Implementation Date** | | April 2012 |
| **Implementation as a Pilot?** | | No |
| **Duration of Program Arms** | | Program arms will be available for a maximum of three years for each participant with the last participants completing the study in December 2015. |
| **# Conditions** | | 6 |
| **Conditions** | **Smoking** | Yes |
| | **Diabetes** | Yes |
| | **Obesity** | Yes |
| | **Hyperlipidemia** | Yes |
| | **Hypertension** | Yes |

(continued)

| State | | Texas |
|---|---|---|
| **Conditions (continued)** | **Other** | Behavioral health conditions such as serious and persistent mental illness (schizophrenia, bipolar disorder, or major depressive disorder) or other behavioral health conditions (e.g., anxiety disorder or substance abuse) coupled with a physical chronic health diagnosis. The most popular goals for participants thus far have been weight loss, increased physical activity, and healthy eating habits. |
| **Special Populations Examined** | **Homeless/Housing Instable Populations** | No |
| | **Food Insecure Populations** | No |
| | **Those with Mental Illness** | Yes |
| | **Those with Substance Abuse Disorders** | Yes |
| | **Racial/Ethnic Minorities (e.g., Native Americans; Native Hawaiians; Asian Americans; Pacific Islanders)** | No |
| | **Pregnant Women and Mothers of Newborns** | No |
| | **Children** | No |
| | **Medicare-Medicaid enrollees** | No |
| **Description of Target Population** | | Non-elderly adult (ages 21-55) Medicaid Supplemental Security Income (SSI) and related beneficiaries with behavioral health (mental health and substance abuse) diagnoses who are enrolled in the STAR+PLUS managed care program in the Harris County (Houston) Service Delivery Area (SDA) and do not reside in a nursing or ICF ID facility. Eligible candidates will have an SMI diagnosis or other behavioral diagnosis, coupled with a physical chronic health diagnosis. People with a diagnosis indicative of severe cognitive impairment (at time of enrollment) will be excluded. Medicaid-Medicare enrollees (at time of enrollment) will be excluded. |
| **Potential Special Populations** | | Persons with mental illness or substance abuse disorders. |
| **# Targeted Patients – Total and By Experimental and Control Group(s)** | | 1,250 total: 625 for experimental group(s) and 625 for control group(s). |
| **Languages** | **Languages spoken by program participants** | English and Spanish |
| | **Percent of participant population that speaks a language other than English – List percent for each language, if possible.** | 11% of participants speak a language other than English; 10% speak Spanish as a primary language and 1% are marked as speaking an "other language." |

(continued)

| State | | Texas |
|---|---|---|
| **Medicare-Medicaid enrollees: If a MIPCD participant is not enrolled in both Medicaid and Medicare upon initial enrollment into MIPCD, but becomes a Medicare-Medicaid enrollee during the course of MIPCD program participation, this participant will be:** | | Medicare-Medicaid enrollees will not be enrolled. If they are enrolled in both Medicaid and Medicare after joining the program, they will remain in the program. |
| **Type of Medicaid Population** | | The WIN incentives and supports will be integrated within the State's Medicaid managed care system, in partnership with the Managed Care Organizations (MCOs) serving Medicaid beneficiaries with disabilities in the Harris County (Houston) Service Delivery Area (SDA), who will employ the navigators. The managed care system, known as STAR+PLUS, is the dominant means of serving adult SSI beneficiaries in Texas. |
| **Description of Goals** | | Improve health self-management; increase use of preventive services and more appropriate use of health care services, as well as greater satisfaction with health care and with personal progress toward wellness. |
| **Description of Activities** | | A complement of person-centered incentives and supports to empower participants to take charge of their health; these evidence-based incentives include:<br>▪ Person-centered wellness planning facilitated by trained, professional health navigators, who employ Motivational Interviewing (MI) techniques to help participants define and achieve their health goals.<br>▪ A $1,150/year flexible wellness account that supports specific health goals defined by the participant.<br>All participants will be offered additional preparation in the form of Wellness Recovery Action Planning (WRAP) to enable them to take full advantage of person-centered wellness planning. |
| | | Yearly incentives will be administered to participants for three program years, ending on September 12, 2015. Program closeout and evaluation/ administrative wrap-up is funded through December 31, 2015. |
| **Incentives for Eligible Beneficiaries** | **Money (e.g., $25 in Cash or Debit Card)** | No, however participants receive compensation for completing in-take and yearly assessments. |
| | **Money-Valued Incentive (e.g., $25-Valued Incentive Such As $25 Gift Card to Grocery Store)** | No |
| | **Treatment-Related Incentives (e.g., Free Nicotine Replacement Therapy Patches)** | Yes, if requested toward health goals. |

(continued)

| State | | Texas |
|---|---|---|
| **Incentives for Eligible Beneficiaries (continued)** | **Support to Address Barriers to Participation (e.g., Meals; Transportation; Child Care)** | Yes |
| | **Prevention-Related Incentives (e.g., Vouchers for Farmers' Markets; Exercise Equipment; Healthy Foods Cookbooks)** | Yes, if requested toward health goals. |
| | **Flexible Spending Account for Wellness Related-Expenses** | Yes |
| | **Points Redeemable for Rewards** | No |
| | **Unspecified Incentives** | No |
| **Maximum Incentive Amount in Dollars** | | ▪ $1,150 annually for up to 3 years |
| **Description of Incentives for Eligible Beneficiaries** | | ▪ Intervention group participants will develop an individual wellness plan and, with Navigator authorization, will be able to draw on a $1,150 per year flexible spending account for wellness activities to help finance specific health goals that the participant defines.<br>▪ Texas has a transportation benefit.<br>▪ Texas was approved for $362,671 in 2012 carry-forward funding for use on "enhancements to the debit card strategy."<br>▪ Texas has a detailed Wellness Account Misuse Policy which defines minor misuse, serious misuse, and the consequences for each. In addition, participants are asked to sign a Wellness Agreement which outlines the responsibilities of the participants in using their card and also the consequences for misusing their card.<br>▪ Common items purchased with incentives include gym memberships, exercise clothing, exercise equipment, exercise DVDs, Wii Fit accessories, cookbooks, and cooking-related equipment. |
| **Incentives for Others (e.g., CHCs and Private Providers)** | | No |
| **Description of Incentives for Others (e.g., CHCs and Private Providers) – If Not Applicable, Write NA** | | NA |

(continued)

| State | | Texas |
|---|---|---|
| **Are Incentives "Front-Loaded"?** | | Difficult to characterize it as a front- or back-loaded, since the other programs have a clearer schedule of payments. For persons in the Intervention group, individuals establish a Wellness Action Plan with their navigator, and have access to a flexible account containing up to $1,150 that can be spent on approved purchases that are aligned with the Wellness Action Plan, including<br>▪ Devices that promote wellness goals (e.g., digital scale, BP monitor, mobile device, or app for physical activity)<br>▪ Transportation to wellness activities (e.g., support groups, gym)<br>▪ Subscriptions or memberships to promote wellness (e.g., YMCA, fitness magazine)<br>▪ Behavioral interventions not currently covered by STAR+PLUS (e.g., relaxation, visualization)<br>▪ Individual wellness education<br>▪ Family-based wellness training and interventions<br>▪ Nutritional or medical food<br>▪ Other items approved by the Harris Project Manager<br>The amount of funding loaded onto the incentive debit card will depend on the type and value of approved purchases. Anything over $200 requires direct approval of the ICHP project manager. |
| **Evaluation Design(s)** | **Quasi-Experimental Design** | No |
| | **Randomized Controlled Trial** | Yes |
| | **Equipoise-stratified Randomization** | No |
| | **Crossover Design** | No |
| | **Cost-Effectiveness Analyses** | Yes |
| **Description of Evaluation Design** | | ▪ A longitudinal randomized controlled experimental design, with a comparison group, including a large cohort of participants, using hierarchical general linear models and econometric techniques for cost-effectiveness analyses. Comparison groups in (a) Harris SDA, and (b) 400 persons in another part of the State.<br>▪ Independent evaluation by the University of Florida, Gainesville's Institute of Child Health Policy (ICHP). |

(continued)

| State | Texas |
|---|---|
| **Outcomes Examined** | Reported progress in achieving the person's individually defined targets/goals, for example:<br>▪ reduced smoking<br>▪ greater physical activity<br>▪ weight loss<br>▪ improved diet<br>▪ use of preventive services and more appropriate use of health care services.<br>▪ lower rates of inpatient recidivism<br>▪ fewer inpatient stays for ambulatory care conditions<br>▪ greater use of routine primary care and preventive services<br>▪ less use of emergency department care for nonemergency conditions<br>▪ better adherence to medication regimens prescribed to treat chronic conditions<br>▪ greater satisfaction with health care and with progress toward achieving health goals<br>▪ In addition, 12 possible health risks are measured: blood pressure, smoking, sedentary, eating habits, lose weight, alcohol consumption, arthritis/pain, emotional stress, health limiting factors, diabetes, COPD/respiratory, and stroke/cardiovascular. |

# APPENDIX K:
# WISCONSIN

| | | |
|---|---|---|
| State | | Wisconsin |
| **State Abbreviation** | | WI |
| **Project Title** | | Striving to Quit |
| **Grantee/State Implementing Agency** | | Wisconsin Department of Health Services (DHS) – Division of Health Care Access and Accountability (Medicaid) |
| **Partners** | | ▪ DHS—Office of Policy Initiatives and Budget (OPIB)<br>▪ DHS—Division of Public Health (Tobacco Prevention and Control Program or TPCP)<br>▪ The University of Wisconsin School of Medicine and Public Health—Center for Tobacco Research and Intervention (UW-CTRI)<br>▪ Wisconsin Women's Health Foundation (WWHF) |
| **1st Year Grant Award** | | $2,298,906 |
| **Total Enrollment Year 1 (9/2011–9/2012)** | | First Breath (FB) Program – 16<br>Wisconsin Tobacco Quit Line (WTQL) Program – 0 |
| **Total Enrollment Year 2, Quarter 1 (10/2012–12/2012)** | | **FB** – 78 women enrolled by December 31, 2012, 97 women enrolled as of February 8, 2013<br>**WTQL** – 0 |
| **Total Enrollment Year 2, Quarter 2 (1/2013–3/2013)** | | **FB** – 115<br>**WTQL** – 0 |
| **Total Enrollment Year 2, Quarter 3 (4/2013–6/2013)** | | **FB** – 203<br>**WTQL** – 82 |
| **Implementation Date / Projected Implementation Date** | | **FB** – September 2012<br>**WTQL** – April 2013 |
| **Implementation as a Pilot?** | | Yes |
| **Duration of Program Arms** | | **FB** – throughout pregnancy, and 12 months after birth; FB opportunity of enrollment continues through December 2014.<br>**WTQL** – 6 months; WTQL opportunity of enrollment continues through June 2015. |
| **# Conditions** | | 1 |
| **Conditions** | **Smoking** | Yes |
| | **Diabetes** | No |
| | **Obesity** | No |
| | **Hyperlipidemia** | No |
| | **Hypertension** | No |
| | **Other** | No |

(continued)

| State | | Wisconsin |
|---|---|---|
| **Special Populations Examined** | **Homeless/Housing Instable Populations** | No |
| | **Food Insecure Populations** | Yes |
| | **Those with Mental Illness** | No |
| | **Those with Substance Abuse Disorders** | No |
| | **Racial/Ethnic Minorities (e.g., Native Americans; Native Hawaiians; Asian Americans; Pacific Islanders)** | Yes |
| | **Pregnant Women and Mothers of Newborns** | Yes |
| | **Children** | No |
| | **Medicare-Medicaid enrollees** | Yes |
| **Description of Target Population** | | **FB** – The FB component of STQ targets *pregnant* BadgerCare Plus (Medicaid) and SSI members in 17 counties with high numbers of Medicaid deliveries: Brown, Chippewa, Dane, Dodge, Eau Claire, Kenosha, La Crosse, Marathon, Milwaukee, Ozaukee, Outagamie, Racine, Rock, Washington, Waukesha, Winnebago, and Wood.<br>**WTQL** – The WTQL program includes both BadgerCare Plus (Medicaid) and SSI members over 18 years of age who smoke in selected areas of the state where there are primary care clinics or other locations willing to conduct the biochemical test. Clinics are also able to screen their BadgerCare Plus and SSI patients for smoking and make referrals to the Quit Line; the Quit Line will then offer STQ if available. As of June 2013, the WTQL program will be/has been implemented in Brown, Calumet, Columbia, Dane, Dodge, Green, Jefferson, Milwaukee, Outagamie, Rock, Sheboygan, and Winnebago counties where a biochemical test is currently available. Expansion to additional counties will take place in the future.<br>Eligibility Criteria:<br>▪ 18 years of age or over<br>▪ Currently enrolled in BadgerCare Plus (Medicaid) or SSI<br>▪ Living in an area with STQ available services<br>▪ A member of a participating HMO (note: fee for service may enroll)<br>▪ A smoker, defined as having a positive cotinine level (Quit Line) or self-reporting smoking more than five cigarettes per day (First Breath)<br>▪ Signed consent form agreeing to the terms of STQ and allowing personal data to be shared with evaluators and DHS (First Breath only). For First Breath, members must also be pregnant (upon enrollment). |

(continued)

| State | | Wisconsin |
|---|---|---|
| **Potential Special Populations** | | Pregnant women |
| **# Targeted Patients – Total and By Experimental and Control Group(s)** | | 3,250 total: 1,625 for experimental group(s) and 1,625 for control group(s). |
| **Languages** | **Languages spoken by program participants** | English and Spanish |
| | **Percent of participant population that speaks a language other than English – List percent for each language, if possible.** | Approximately 13.7% of the BadgerCare Plus/Medicaid population identifies themselves as Hispanic with 6.5% reporting that Spanish was the primary language spoken at home. |
| **Medicare-Medicaid enrollees: If a MIPCD participant is not enrolled in both Medicaid and Medicare upon initial enrollment into MIPCD, but becomes a Medicare-Medicaid enrollee during the course of MIPCD program participation, this participant will be:** | | Allowed to continue to participate in the MIPCD program. |
| **Type of Medicaid Population** | | The majority of potential participants are BadgerCare Plus members and enrolled in managed care.<br>Fee-for-service/non-managed care members can also participate. |
| **Description of Goals** | | ▪ Engage a minimum of 2,000 (up to 4,000) targeted BadgerCare Plus and SSI smokers in STQ evidence-based treatment via WTQL.<br>▪ Engage a minimum of 1,250 targeted BadgerCare Plus and SSI pregnant smokers in STQ evidence-based treatment via First Breath. |
| **Description of Activities** | | ▪ **FB** – Activities are broken into two components – prenatal and postpartum.<br>▪ PRENATAL—Evidence-based trained counselors (often staff at a health clinic, WIC clinic, HMO, etc.) via face-to-face and telephone smoking cessation counseling. WWHF trains providers and oversees ongoing activities; prenatal counseling is not paid for by the MIPCD grant.<br>▪ POSTPARTUM—A Health Educator (WWHF employee) provides evidence-based smoking cessation counseling services for up to 12 months in the postpartum phase.<br>▪ Specially trained outreach staff work closely with primary care and obstetric clinics to facilitate understanding of what smoking cessation services are available for their patients; how the referral process works; and how to incorporate tobacco screening, counseling services, and referrals to additional resources into their clinic workflow. |

(continued)

| State | | Wisconsin |
|---|---|---|
| **Description of Activities (continued)** | | ▪ WI expanded the role of the postpartum health educator to include more face-to-face encounters, including after the initial screening via phone (when verbal consent is granted). Experience to date indicates that many women were unable to complete the initial screening process via the 30- to 40-minute phone call. The new enrollment protocol approved by University of Wisconsin IRB reduces the initial call to about 10 minutes, with the health educator completing the process via face-to-face contact.<br>▪ **WTQL** – Evidence-based tobacco cessation treatment services, managed by the University of Wisconsin's Center for Tobacco Research and Intervention, links members visiting primary care clinics and those independently making calls to evidence-based tobacco cessation treatment services via the Quit Line. BadgerCare Plus members enter STQ through several methods—members can call WTQL directly (screened by a Quit Coach and at testing site for eligibility), primary care clinics can refer members to WTQL, UW-CTRI is doing proactive outreach to previous WTQL callers, and testing sites welcome walk-ins. |
| **Incentives for Eligible Beneficiaries** | **Money (e.g., $25 in Cash or Debit Card)** | Yes |
| | **Money-Valued Incentive (e.g., $25-Valued Incentive Such As $25 Gift Card to Grocery Store)** | Yes |
| | **Treatment-Related Incentives (e.g., Free Nicotine Replacement Therapy Patches)** | No |
| | **Support to Address Barriers to Participation (e.g., Meals; Transportation; Child Care)** | Yes |
| | **Prevention-Related Incentives (e.g., Vouchers for Farmers' Markets; Exercise Equipment; Healthy Foods Cookbooks)** | No |
| | **Flexible Spending Account for Wellness Related-Expenses** | No |
| | **Points Redeemable for Rewards** | No |
| | **Unspecified Incentives** | No |

(continued)

| State | Wisconsin |
|---|---|
| **Maximum Incentive Amount in Dollars** | ▪ WTQL participants in the intervention group receive a maximum of $270 in incentives over 6 months, while those in the control group receive $80.<br>▪ FB intervention group participants receive a maximum of $600 over the course of their pregnancy plus 12 months postpartum; those in the control group receive $160. |
| **Description of Incentives for Eligible Beneficiaries** | ▪ Incentives contingent on participation in treatment and attainment of smoking cessation will be offered.<br>▪ WI did not set cessation goals; either participants quit smoking or they did not.<br>▪ Both the control and treatment groups receive the same treatment. Control group participants may receive incentives when they take biochemical tests. Treatment group participants are provided incentives for engagement in treatment (including taking biochemical tests) and additional incentives if they quit.<br>▪ **WTQL** participants in the treatment/experiment group receive a maximum of $270 in incentives over 6 months, while those in the control group receive $80.<br>– **WTQL** Treatment (high incentives) – $30/call, $40/urine test, $40 if passed.<br>– **WTQL** Control (low incentives) – $40/urine test<br>▪ **FB** participants receive a maximum of $600 over the course of their pregnancy plus 12 months postpartum – experiment/treatment groups only; those in the control group receive $160.<br>– **FB** Treatment (high incentives) – $40 enrollment, 6 visits $25 each, 6 calls $20 each, 2 home visits $25 each, 3 CO tests $40 each, additional $40/passed test<br>– **FB** Control (low incentives) – $40 enrollment, 3 CO tests $40 each |
| **Incentives for Others (e.g., CHCs and Private Providers)** | Yes |
| **Description of Incentives for Others (e.g., CHCs and Private Providers) – If Not Applicable, Write NA** | Support for Clinic Participation: WI received approval from CMS in November 2012 to provide financial support to clinics and public testing sites who agree to participate in STQ WTQL. For payment purposes, the clinic must sign a Memorandum of Understanding to screen BadgerCare Plus members for smoking, conduct the biochemical test to confirm smoking status, and make referrals to WTQL. Clinics receive $1,000 after they receive training and conduct testing. They also may select a "per member" option, which may provide additional support of $50–75 per member. |
| **Are Incentives "Front-Loaded"?** | No |

(continued)

| State | | Wisconsin |
|---|---|---|
| **Evaluation Design(s)** | **Quasi-Experimental Design** | No |
| | **Randomized Controlled Trial** | Yes |
| | **Equipoise-stratified Randomization** | No |
| | **Crossover Design** | No |
| | **Cost-Effectiveness Analyses** | Yes |
| **Description of Evaluation Design** | | ▪ Randomized experiment and control groups.<br>▪ Generalized Estimation Equations and meaningful covariates.<br>▪ Multiple imputations.<br>▪ Statistical modeling.<br>An informal clinical advisory group will convene periodically to provide feedback on new and existing components of each of the programs because clinics and health systems continue to identify challenges and improve processes.<br>WTQL program was reclassified in January 2013 from a "clinical trial" to a "quality improvement project." This modification provided the flexibility to adapt the program to meet the needs of clinics and health systems, as well as respond to challenges with member outreach and enrollment. |
| **Outcomes Examined** | | ▪ Enrollment in smoking cessation counseling<br>▪ Long-term engagement (e.g., complete the protocol)<br>▪ Quit rates as measured by subsequent biochemical tests<br>Also:<br>▪ Total number of identified smokers enrolled in STQ — WTQL and FB<br>▪ Total number of WTQL enrolled smokers who pick up NRT<br>▪ Total number of enrolled smokers who complete the WTQL call protocol<br>▪ Total number of WTQL enrolled smokers who complete the biochemical tests<br>▪ Total number of WTQL enrolled smokers who quit smoking as confirmed by the biochemical tests<br>▪ Total number of FB enrolled smokers who complete the FB protocol<br>▪ Total number of FB enrolled smokers who complete the biochemical tests<br>▪ Total number of FB enrolled smokers who quit smoking as confirmed by the biochemical tests |