# Independent Assessment Report

# Medicaid Incentives for Prevention of Chronic Diseases Evaluation

**April 2016**

# INDEPENDENT ASSESSMENT REPORT

# MEDICAID INCENTIVES FOR PREVENTION OF CHRONIC DISEASES EVALUATION

RTI International

CMS Contract No. HHSM500201000021i, PO #HHSM-500-T0004

April 2016

This project was funded by the Centers for Medicare & Medicaid Services under contract no. 500-00-1234. The statements contained in this report are solely those of the authors and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. RTI assumes responsibility for the accuracy and completeness of the information contained in this report.

## CONTENTS

Appendixes



List of Figures



List of Tables

## LIST OF ABBREVIATIONS

CHC—Community Health Center

CMS—Centers for Medicare & Medicaid Services

ED—emergency department

FQHC—Federally Qualified Health Center

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

PMPM—per member per month

RCT—randomized controlled trial

TA—technical assistance

*[This page intentionally left blank.]*

# EXECUTIVE SUMMARY

## E.1 Background

Section 4108 of the Patient Protection and Affordable Care Act (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 focuses on

- the effect of such programs on the use of health care services by Medicaid beneficiaries participating in the program;
- the extent to which special populations (including adults with disabilities, adults with chronic illnesses, and children with special health care needs) are able to participate in the program;
- the level of satisfaction of Medicaid beneficiaries with respect to the accessibility and quality of health care services provided through the program; and
- the administrative costs incurred by State agencies that are responsible for 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. The initial Report to Congress was submitted in November 2013. The report provided an interim evaluation of the effectiveness of the programs based on information provided by the States through their semiannual reports; it also contained a recommendation regarding whether funding for expanding or extending the programs should be extended beyond January 1, 2016. The report concluded "At this time, there is insufficient evidence to recommend for or against extending funding of the programs beyond January 1, 2016."

The final Report to Congress is to include the results of the independent assessment required by the law, together with recommendations for such legislation and administrative action as the Secretary determines appropriate. The final Report to Congress is due to Congress no later than July 1, 2016. This evaluation report contains RTI's independent assessment and is designed to accompany the final Report to Congress.

### E.1.2 Organization of the Report

In the report, we first introduce the MIPCD program (***Section 1***) and describe the data sources used to create the report (***Section 2***). We used a mixed-methods approach to analyze and synthesize information from State MIPCD applications and operational protocols; State Quarterly Reports, the MIPCD Minimum Data Set (MDS), and other State-specific documents provided to CMS; information from the program's Learning Collaborative; site visits to each State; focus groups with beneficiaries; stakeholder interviews; a beneficiary survey; and Medicaid claims analysis. With the exception of Medicaid claims, data included in this report are current through November 15, 2015. We receive claims data directly from each State; the time lag before data become available varies and includes at least 6 months to allow for claims submission and processing.

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 and describes program challenges, changes, and lessons learned. ***Section 4*** assesses utilization of health care services by participants in the MIPCD programs. The section analyzes Medicaid claims to compare utilization and expenditures—a summary measure of utilization—by participants who receive incentives to utilization and expenditures by persons in control groups who do not receive incentives. In the section, we also analyze data on the use of incentives from the MIPCD MDS. ***Section 5*** evaluates whether special populations—including adults with disabilities, adults with chronic illnesses, and children with special health care needs—are able to participate in the program. We synthesize data from a variety of sources to answer this question. In ***Section 6***, we analyze Medicaid beneficiary satisfaction with the accessibility and quality of health care services provided through the MIPCD program. We conducted focus groups and a beneficiary survey to collect primary information on beneficiary satisfaction. ***Section 7*** examines administrative costs using data from State budgets, cost reports, and an Administrative Costs Form filled out by States.

## E.2 Implementation of State Programs

All States were able to establish the structural and logistical framework for a Medicaid incentives program. This is a basic, but important, accomplishment because States had relatively little experience with Medicaid incentive programs prior to MIPCD (Blumenthal et al., 2013). Building on an existing chronic disease prevention program, established relationship with Medicaid providers, or interagency agreement facilitated States' MIPCD program implementation. Still, States faced numerous challenges in implementing their programs, and starting up their programs took the majority of States longer than anticipated. "Everyone underestimates the challenges of logistics and implementation," noted a program stakeholder during a site visit. Reasons for implementation delays included the need to hire and train staff, obtain Institutional Review Board (IRB) approval, and formalize partnerships and contracts. Each component was critical and had a profound impact on the six States that took 6 months to 2 years longer than projected to implement their programs. States addressed implementation delays and program challenges by implementing numerous program changes, with programs continuously evolving.

Delays in implementing programs and the associated challenges in recruiting participants had a significant impact on States' enrollment targets, with seven programs reducing their initial

projections by between 42 percent and 85 percent. States worked hard to recruit participants, with three States expanding program eligibility to include additional Medicaid eligibles. With the exception of Texas, participation in State initiatives was slower than anticipated. States strove to make programs accessible by providing transportation, reimbursing participants for public transportation, meeting participants in their home, or providing services telephonically, so participants did not have to travel. Accessibility also encompassed cultural and linguistic sensitivity, with States hiring culturally competent staff who have worked with or are members of the target population and partnering with organizations familiar with these populations. States modified outreach strategies and incentives, based on their success in reaching the populations being targeted. The majority of programs found that collaborating with providers, clinics, and managed care organizations (MCOs) was an important tool in identifying potentially eligible participants and providing referrals and enrollment. Several States used provider incentives, and some modified them to increase provider engagement. States adapted and modified outreach strategies and program features during and throughout implementation as they sought to address challenges. Through the Learning Collaborative, States shared challenges and lessons learned with one another, and States used the information in modifying their programs. The 10 demonstration States have shown great flexibility as they have adapted to challenges and have all implemented their programs, continuing to evolve in efforts to meet the needs of their targeted populations in adopting healthier program behaviors.

### E.3 Utilization and Expenditures of Health Care Services

We analyzed Medicaid claims from eight States to evaluate whether MIPCD participants who had the opportunity to receive incentives had lower utilization of health care services and lower Medicaid expenditures than participants who were not offered incentives. One State program has not yet been able to provide claims data, and the other State program has not yet enrolled sufficient beneficiaries for analysis. We performed econometric analyses to compare utilization and expenditures before and after enrollment for the incentive and control groups. Most States randomized participants between the incentive and control groups; we found that the randomization provided good balance between the two groups on observed characteristics, suggesting that the two groups were similar.

In the econometric analyses, we found that the incentives had insignificant effects on utilization and expenditures during the time periods analyzed. Thus, at this point in the evaluation, no clear cross-State patterns have emerged to suggest that the MIPCD program is lowering rates of inpatient hospitalization, emergency department (ED) use, inpatient expenditures, ED expenditures, and total expenditures. However, States are still enrolling Medicaid beneficiaries, and future analyses will take advantage of additional participants and more post-participation claims data. Therefore, the results presented in the claims analyses should be considered provisional and preliminary.

It is important to note that even with more claims data to analyze, many of these interventions may not significantly reduce hospitalizations, ED visits, and total costs in the short term. The lack of effect does not mean that the intervention was unsuccessful. Instead, a better test of program effectiveness would be a positive change among participants in the health outcomes the States were targeting—for example, smoking quit rates, weight reduction, or improvements in hypertension or diabetic control. With the exception of California, many of the

health and behavioral outcomes included in each State's MIPCD MDS are missing data. These data continue to be collected by States as participants complete the program, so we will examine whether changes in these outcomes occur in the Final Evaluation Report, after States' data collection efforts are finished. Furthermore, States are evaluating their programs on a number of utilization and health outcome metrics, which is expected to complement the information provided through the MIPCD State MDS. We will review and incorporate their findings into the Final Evaluation Report. Taken together, analyses of the Medicaid claims data, MIPCD State MDS, and State-led evaluation findings will provide a comprehensive picture of the short-term impacts of the MIPCD program on service use, expenditures, and health outcomes.

For the one State with complete reporting of outcomes data (California), receipt of nicotine replacement therapy plus cash incentives was associated with a significantly higher ($p < 0.05$) likelihood of self-reporting a quit attempt and a 30-day period of abstaining from smoking compared with the control group. Reductions in smoking in the short run may avert smoking-related health conditions, causing long-term reductions in hospitalizations, ED visits, and costs. Thus, the lack of significant effects on utilization or costs in the short run does not imply that the MIPCD program will not affect these measures over a longer time horizon. California's positive finding aligns with the goals of the MIPCD program, but we caution that general conclusions regarding the effectiveness of the MIPCD program cannot be drawn from one State.

The MIPCD State MDS proved to be a rich source of information on the services and incentives received by program participants. Our findings on service utilization suggest that, for most of the MIPCD States, the incentive group uses more incentivized services than the control group. Future analyses will examine in greater detail how engagement in the program varies over time and by incentive type. For example, in States incentivizing attendance at a diabetes prevention program, does attendance wane over time, or are participants less likely to receive incentives for meeting predetermined milestones in health (e.g., weight reductions) compared with incentives for meeting process measures (e.g., meeting with a health coach)? As more participants complete the program, we will have greater statistical power to examine these evaluation questions.

### E.4 Participation by Special Populations

We found that special populations were able to participate in the incentive programs. All of the State programs targeted adults with or at risk of chronic disease programs, one of the three special populations highlighted in the legislation. Two of the programs—New Hampshire and Texas—focused on persons with behavioral health and/or substance use disorders, and most other programs also served adults with disabilities, the second group highlighted in the legislation. The largest program arm in Nevada served children with special health care needs.

### E.5 Beneficiary Satisfaction

We conducted focus groups, stakeholder interviews, and a beneficiary survey to collect information on beneficiary satisfaction with the accessibility and quality of the incentive programs. The results were largely complementary and consistent: beneficiaries expressed high levels of satisfaction with the program.

Based on qualitative findings from focus groups with MIPCD participants, overall impressions of the incentive programs, and particularly the program staff, were positive. Participants provided generally positive feedback on the enrollment process and access to program activities. Participants have identified a few barriers to access, including lack of transportation to program activities and limited cell phone minutes to access telephonic program components. Participants reported very positive experiences and satisfaction levels with program staff, using words such as "trustworthy," "caring," "supportive," and "motivational" to describe staff. Participants said that staff support and motivate them to achieve their health goals. Experience and satisfaction with program materials was limited, with some participants not recalling having received materials and others feeling overwhelmed with respect to the amount provided.

The majority of participants characterized the incentives as motivators ("a kick start") to enroll in the programs and, to a lesser extent, as an encouragement to remain in the programs. The following are typical comments from focus group participants: "The money was an incentive, I'm not going to lie. That made me call [the quitline] and it kept me aware of, 'I know I want to do this'," and "First it was about the card, then it got to me because I was getting something free. Then I started taking a look at it and I was like, 'Well, hey, maybe I need to do something about this breathing'." Some participants reported logistical challenges and confusion concerning the process to obtain incentives. Inherent differences in program designs across States contributed to different levels of beneficiary satisfaction. Participants enrolled in State programs with in-person counseling components, flexibility in program counseling activities, personal accountability in meeting health goals, and simple and clear incentive guidelines tended to report higher levels of satisfaction.

Overall, survey respondents were satisfied with the program and with accessibility of program activities and staff. Across all States, 66 percent of participants were very satisfied and another 28 percent were somewhat satisfied with the program overall. About three-quarters of participants said they would definitely recommend the program to family and friends, and another 22 percent said they would probably do so. Asked to rate the program on a scale from 1 to 10, where 1 is the worst program possible and 10 is the best program possible, about 40 percent of respondents rated the program a 10 and another 16 percent rated it a 9. The mean rating across all States was 8.4. Beneficiaries provided similarly high ratings for accessibility. They also reported that the program had helped them to make positive changes to improve their health. The findings suggest that females and racial and ethnic minorities may be somewhat more satisfied with the program. For example, a higher percentage of non-white respondents strongly agreed that incentives helped them set goals, work toward goals, and make positive changes in their life than white respondents.

We plan to conduct additional subgroup analyses and also multivariate analyses using logistic regression models. Specifically, we will estimate models of overall satisfaction and selected other outcomes that include multiple predictors. These analyses will identify which individual and program-level characteristics are associated with key outcomes of interest while controlling for potential confounding factors. Final survey results will be presented in the Final Evaluation Report.

## E.6 Administrative Costs

We estimate that administrative costs accounted for about 25 percent of overall expenditures in MIPCD programs during the first 3 years. This estimate comes with a number of caveats because the cost data are not reported uniformly across States and only 7 of the 10 States provided the information necessary for estimating administrative costs. More importantly, the administrative cost share of total costs fell in Years 2 and 3 as enrollment in the programs increased. That trend is likely to continue in Years 4 and 5 of the program. Therefore, over the full 5-year period, administrative costs may account for less than 25 percent of total costs. We will obtain additional data and report on administrative costs for the full 5-year period in our Final Evaluation Report.

Looking at costs more broadly, States spent about $2.2 million on incentive payments to participants during the first 3 years, representing about 7 percent of total costs. There are several reasons why incentive payments are relatively low. First, most States planned to spend significant amounts to provide services as integral parts of their program. For example, California provides nicotine replacement therapy, New Hampshire pays for gym memberships and Weight Watchers, Texas provides patient navigators, and several States pay for diabetes prevention programs. In some cases, States consider the services as part of the incentive provided to participants, and these services are also usually provided to participants in the control group who do not receive cash incentives. Second, delays in implementation and enrollment have slowed incentive payments. Most States spent less in total than they budgeted in Year 1 of their programs, and spending on incentives was correspondingly lower than budgeted. As enrollment continues to increase in Years 4 and 5 of the programs, incentives may account for a greater share of overall program costs. Third, some participants have not completed participation and may receive additional incentives before or shortly after completion. This is especially true of outcome incentives, which are paid to participants who achieve behavioral outcomes, such as weight loss or reductions in tobacco use. Fourth, it appears likely that some States initially overestimated the amount that would be paid as incentives to participants. Several of the States revised their initial estimates of enrollment downward; if fewer persons participate and incentive payments per person are fixed, total incentive payments also fall.

In the Final Evaluation Report, we will estimate the return on investment in each program. This estimate will account for the cost of the program (including administrative costs, incentive payments, and service costs) and any reductions in Medicaid spending attributable to the program. The cost impacts will also be evaluated alongside the health benefits achieved by the program. It is premature to estimate program return on investment at this time, because the impact of prevention of chronic diseases may accrue slowly over time and not be manifest in the short-term. Moreover, we do not yet have data on changes in health outcomes that would precede long-term savings in spending.

## E.7 Conclusions

States have demonstrated that they are able to design and implement incentive programs for Medicaid beneficiaries. Implementation was not always straightforward, and some States experienced delays in implementation. Nevertheless, all of the States were eventually able to implement their programs and begin enrolling participants. Their experiences may offer

valuable lessons learned for other States considering implementation of incentive programs. Some of the States experienced challenges in Medicaid recruiting participants and providers for the programs. These challenges are common among prevention programs, and States responded by increasing their recruitment efforts. In several cases, States lowered their enrollment targets.

Once enrolled, we found that beneficiaries were very satisfied with the accessibility and quality of the MIPCD programs. Most participants were very or somewhat satisfied with the programs and would recommend them to their friends or families. Participants thought the programs helped them make healthy changes in their behavior. Not surprisingly, participants liked receiving incentives, but they thought that the impact of the incentives was strongest in encouraging them to enroll in the program and less important later when improving health became a more important motivator.

Special populations appear able to participate in Medicaid incentive programs. Two States focused on persons with behavioral health or substance use disorders, one States' largest program arm focused on children, and all of the States focused on adults with or at risk of chronic diseases.

We estimated that administrative costs represented about 25 percent of overall program expenditures through the first 3 years of the program. Administrative costs may decline in Years 4 and 5 of the program as enrollment increases.

The largest remaining unresolved questions have to do with the effects of incentive programs on utilization, expenditures, and—perhaps most importantly—health outcomes. To date, the claims analysis has found that the incentive programs have statistically insignificant effects on utilization and expenditures. However, the claims data are not complete, and even if the incentives prevent chronic diseases, the effects of prevention on utilization and expenditures may not be apparent in the short term. From the analysis of the MIPCD MDS, we found that the incentives have led to significant increases in process measures, such as tobacco cessation counseling visits and diabetes prevention classes attended, but only limited information is available on health outcomes, such as smoking quits or weight loss. The State program evaluations will examine health outcomes in detail, and we will include these findings in our Final Evaluation Report.

Therefore, because the impacts of the MIPCD programs on utilization, expenditures, and health outcomes are unresolved, we believe at this time that there is still insufficient evidence for or against recommending that funding should be expanded for Medicaid incentive programs. We will focus on assessing these impacts as our evaluation continues and more information becomes available. We will issue our Final Evaluation Report in February 2017.

*[This page intentionally left blank.]*

# 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 (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 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.

Section 4108 mandates that the Secretary of Health and Human Services submit initial and final reports to Congress on the MIPCD program and its independent evaluation. The first Report to Congress was submitted by the Secretary in November 2013. Based on State program implementation and enrollment progress, the first Report to Congress focused on evaluation questions regarding States' program implementation. The first report found that while States encountered challenges that resulted in delayed implementation of most programs, the States made adjustments to begin enrolling participants successfully. At the time of the first report, the evaluation had insufficient evidence to recommend for or against extending funding of the programs beyond January 1, 2016.

This second Report to Congress describes available evidence and results of the independent assessment focused on the four above topics specifically mandated by Section 4108. In-depth analyses included in this report will support recommendations for such legislation and administrative action as the Secretary determines appropriate.

Data included in this report are current through November 15, 2015. The following evaluation questions are addressed in this report:

- What progress and changes have State programs made in implementing their initiatives?
- What challenges have States faced in implementing their strategies?
- What key lessons have State learned in implementing their initiatives?
- Have the State programs reduced Medicaid utilization and expenditures?
- Have the State programs reduced inpatient or emergency department (ED) admissions?
- Have the programs targeting diabetes had an effect on diabetes-related expenditures?
- Can special populations participate in the incentive programs?
- How does utilization of services by special populations compare with utilization of services overall within a State? How do Medicare expenditures for services by special populations compare with expenditures overall within a State?
- Are special populations satisfied with their programs overall, and do they experience the same reaction to program incentives as other beneficiaries in the State?
- To what extent are Medicaid beneficiaries satisfied with State programs overall?
- To what extent are Medicaid beneficiaries satisfied with State program accessibility and program incentives?
- To what extent do program incentives facilitate healthy behavior change?
- How have the States been spending their administrative funds, and how does this compare with the projected spending in their proposals? What are the annual costs of the incentives that are paid by the program as a fraction of total spending? Have administrative expenditures as a fraction of total spending changed across time?
- Were there additional financial costs of the program that were not covered by the program? How significant are in-kind contributions?
- What are the annual returns on investment across the different programs?

The State MIPCD projects provided incentives to participants through December 31, 2015. The 5-year awards to States end on September 12, 2016. As part of the evaluation, we will continue to assess outcomes for the program through December 2016. We will submit a Final Evaluation Report on February 1, 2017.

## SECTION 2
## DATA SOURCES

This report focuses on State programs' implementation progress, impacts on health care utilization and costs, participation by special populations, beneficiary satisfaction, and administrative costs. Using the evaluation questions as the foundation for the analyses, the data sources in ***Table 1*** were used in preparing this second Report to Congress. These data sources will continue to be used throughout the MIPCD evaluation. The data used in preparing this report are current through November 15, 2015.

**Table 1**
**Data sources**

| Data sources | Evaluation topics |
|---|---|
| State MIPCD applications and operational protocols | Implementation progress<br>Participation by special populations |
| State Quarterly Reports and State-specific documents provided to CMS | Implementation progress<br>Administrative costs |
| MIPCD Dashboard enrollment data | Implementation progress<br>Participation by special populations |
| Site visits and stakeholder interviews conducted in 2014 | Implementation progress<br>Participation by special populations |
| State updates on monthly calls with the Implementation Contractor along with program-specific information and forms provided by the State to the Implementation Contractor | Implementation progress |
| Program updates and discussions from the Learning Collaborative's all-State, in-person biannual meetings | Implementation progress |
| Telephone interviews with the State program manager and staff, evaluators, and contractors participating in the program | Implementation progress<br>Administrative costs |
| Focus group discussions with program participants in all States, and in-depth interviews with State program staff that have direct interaction with participants | Beneficiary satisfaction<br>Participation by special populations |
| Cross-sectional survey of Medicaid beneficiaries aged 18 or older who had participated or were participating in the experimental arms of State programs in the 6 months preceding survey administration | Beneficiary satisfaction<br>Participation by special populations |
| Quarterly Medicaid claims, encounter, and enrollment data available from 8 of 10 MIPCD States | Utilization and costs<br>Participation by special populations |
| MIPCD State MDS template data, collected on a quarterly basis | Utilization and costs<br>Participation by special populations |
| Administrative costs data reported by 8 of 10 MIPCD States | Administrative costs |

As part of the evaluation, 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 the above data sources to assess MIPCD program implementation, utilization and costs, special populations, beneficiary satisfaction, and administrative costs. We describe results from State-specific and cross-State analyses in the following chapters. To the extent possible, we draw conclusions based on available qualitative and quantitative data.

# SECTION 3
# IMPLEMENTATION AND LESSONS LEARNED FROM THE PROGRAM

Assessing States' implementation progress serves as the foundation of RTI's evaluation efforts. Implementation is an important issue because, prior to MIPCD, States had relatively little experience with Medicaid incentive programs, and the few existing programs were not extensively evaluated (Blumenthal et al., 2013). RTI seeks to answer the following five evaluation questions in this section of the report:

1. What are the characteristics of each State initiative, and are there common implementation characteristics across State initiatives?

2. What progress have States made in implementing their initiatives?

3. What changes have States made to their implementation plans or evaluations?

4. What challenges have States faced in implementing their strategies?

5. What key lessons have States learned in the implementation of their initiatives?

RTI uses a standardized approach to review State program materials periodically. For this process, each of the 10 State programs is assigned to an RTI team member, who serves as the State team expert and as the liaison between the State and the RTI and National Academy for State Health Policy (NASHP) evaluation team. RTI State team experts are also responsible for maintaining the evaluation team's State synthesis database where State background information is collected. RTI State team experts reviewed and included in RTI's database information obtained from State demonstration summaries posted on the Centers for Medicare & Medicaid (CMS) Web site, State operational protocols, and State quarterly reports provided by CMS. ***Sections 3.1*** through ***3.6*** outline the characteristics of each State initiative, including an overview of these programs, their enrollment progress, the incentives distributed across State programs, and the evaluation designs.

RTI's evaluation also assesses State implementation progress and collects lessons learned from these programs. This assessment combines information collected in the team's State synthesis database with qualitative data collected from site visits to State programs conducted from March to November 2014. ***Sections 3.7*** through ***3.14*** detail State implementation progress, changes made to State programs and their evaluations, challenges States face implementing their strategies, and key implementation lessons learned by State initiatives.

## 3.1 State Reporting

Typically, RTI receives State quarterly reports from CMS soon after they are received from the States. In all cases, the reports provide a fairly detailed perspective on the States' demonstration implementation. Although the reports have given the RTI and NASHP team tremendous insight into the States' implementation progress, the team has found it helpful to complement these reports with State updates provided at Learning Collaborative sessions and in conversations with State staff. In addition, RTI and NASHP conducted site visits to provide an

in-depth perspective on States' implementation progress and further augment information obtained from quarterly State reports and State updates and conversations.

### 3.2 Overview of State Programs

***Table 2*** provides an overview of the States' programs. States received their grants on September 11, 2011, and half implemented their programs by the end of the first year. 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. States that used a phased-in approach implemented all program arms by July 2014. California piloted its program in Sacramento County. Hawaii phased in its implementation over time at nine Federally Qualified Health Centers (FQHCs). New York had originally planned to pilot its Diabetes Prevention arm in Brooklyn before expanding to other medical condition arms and locations, but instead decided to take a statewide, phased-in approach. Similarly, Nevada had originally planned to implement all five of its programs simultaneously, but decided to adopt a phased-in implementation approach. Nevada began implementation in February 2013 for the Children's Heart Center, May 2013 for the YMCA of Southern Nevada, October 3013 for United Healthcare, December 2013 for Lied Clinic, and June 2014 for Amerigroup. However, Nevada's Lied Clinic closed for business in October 2014, and this program arm was terminated. Minnesota also phased in implementation with 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 25 clinics made up of 13 organizations in subsequent project years. Wisconsin piloted its First Breath and quitline programs in one county before expanding the First Breath intervention to 33 other counties and the quitline program to 16 other counties.

**Table 2**
**Overview of State programs**

| State | Project title | Implementation date |
|---|---|---|
| California | Medicaid Incentives for Prevention of Chronic Diseases (MIPCD): Medi-Cal Incentives to Quit (MIQS) Project | March 2012 |
| Connecticut | Connecticut Rewards to Quit | March 2013 |
| Hawaii | Hawaii Patient Reward and Incentives for Supporting Empowerment Project (HI-PRAISE) | February 2013 |
| Minnesota | Minnesota Medicaid Incentives for Prevention of Diabetes | November 2012 |
| Montana | Medicaid Incentives to Prevent Chronic Disease | January 2012 |

(continued)

**Table 2 (continued)**
**Overview of State programs**

| State | Project title | Implementation date |
|---|---|---|
| Nevada | Nevada Healthy Choices | *Children's Heart Center*: February 2013<br>*YMCA of Southern Nevada*: May 2013<br>*UnitedHealthcare*: October 2013<br>*Lied Clinic*: December 2013[1]<br>*Amerigroup*: June 2014 |
| New Hampshire | Healthy Choices, Healthy Changes | May 2012 |
| New York | Medicaid Incentives for Prevention of Chronic Disease Program | *Diabetes Prevention*: June 2013<br>*Diabetes Management*: April 2014<br>*Hypertension*: July 2014<br>*Smoking Cessation*: March 2015 |
| Texas | Wellness Incentives and Navigation (WIN) Project | April 2012 |
| Wisconsin | Striving to Quit | *First Breath*: September 2012<br>*Tobacco Quitline*: April 2013 |

[1] Nevada's Lied Clinic closed for business in October 2014, and this program arm was terminated.

Below, we briefly describe each State's MIPCD program. Further details on the programs are provided in Appendices A through J.

### 3.2.1 California

*Overview of program:* The goal of the Medi-Cal Incentives to Quit Smoking (MQIS) program, led by California's Department of Health Services, is to increase smoking cessation among Medicaid members who smoke. The program targets Medicaid beneficiaries from age 19 through 64. Originally, the program was intended to have a special focus on beneficiaries with chronic conditions, but the program was expanded to target all beneficiaries who smoke. Medi-Cal participants enter the program by calling the California Smokers' Helpline (the Helpline) operated through the University of California, San Diego and completing an initial intake and counseling call. Nicotine replacement therapy (NRT) and telephone counseling sessions are available to support participants in establishing a smoking quit date and in helping participants meet their goal to stop smoking.

*Incentives:* California provides a $20 gift card incentive for Medicaid verified beneficiaries that call the Helpline, request the incentive, and complete the initial intake and first

counseling call. There are also two incentive groups in the Randomized Control Trial 1 (RCT 1), which was held from July 2012 through May 2013. The incentives for one group included NRT shipped directly to the participant and free counseling. The second group received NRT shipped directly to the participant and $10 for each counseling session, up to $40. After analyzing the initial results of RCT 1, California decided to provide enhanced services to all Medi-Cal beneficiaries participating in the program. Enhanced services were provided from December 2014 through April 2015. Medi-Cal members were provided with NRT shipped directly to them and were offered $10 incentives for completing follow-up counseling sessions, up to $60. California is also conducting RCT 2, a re-engagement trial for Medi-Cal smokers who have relapsed. Depending on the group to which the beneficiary is assigned, incentives will range from $0 to $10, $20, or $40 to call and re-engage in counseling. Recruitment for RCT 2 began in May 2015, with plans to complete the trial in August 2015, depending upon whether enrollment goals can be met within that time frame.

*Enrollment*: Currently, California has enrolled 3,815 participants. Target enrollment is 9,000.

### 3.2.2 Connecticut

*Overview of program:* The goal of the Rewards to Quit (R2Q) program, led by Connecticut's Department of Social Services, is to reduce smoking among Medicaid members. The program targets Medicaid recipients aged 18 or older who smoke, with a special focus on individuals with serious mental illness. Originally, the program was intended to also have a special focus on pregnant women and mothers of newborns, but this population is no longer specifically targeted due to recruitment challenges. Participating mental health clinics, FQHCs, patient-centered medical homes, and other primary care sites recruit participants and provide individual and group counseling. Participants can also call the smoking quitline. In selected locations, participants also have the option to receive assistance from a peer coach.

*Incentives:* Participants in the intervention condition receive incentives for participating in counseling, using the quitline, and testing negative for tobacco in CO tests. Monetary incentives (in the form of a gift card) are $5 for participating in a counseling session or calling the quitline (up to 10 times each), with a bonus of $15 after five calls or counseling sessions. In addition, participants receive $15 for up to 12 tobacco-free CO tests and a $10 bonus for three consecutive tobacco-free CO tests.

*Enrollment*: Currently, Connecticut has enrolled 3,692 participants. Target enrollment is 6,210.

### 3.2.3 Hawaii

*Overview of program:* The Hawaii Patient Reward and Incentives to Support Empowerment Project (HI-PRAISE) is led by Hawaii's Department of Human Services through a contract with the University of Hawaii. The goal of the program is to improve the early detection of diabetes among individuals at high risk for developing diabetes and to improve diabetes self-management in individuals who have the condition. The program targets Medicaid managed care enrollees from age 19 through 64 at each of the nine participating FQHCs and at a private provider, Kaiser Permanente. Specifically targeted are indigenous Native Hawaiians and

immigrant Asian Americans and Pacific Islanders. All participating sites test individuals at high risk for diabetes. For individuals with diabetes who are enrolled by the FQHCs or Kaiser, a tiered incentive program is provided that includes diabetes education and health coaches to provide support and motivation along with care coordination to screen and identify other risk factors and co-morbidities, provide referrals, make appointments, and follow up with patients.

*Incentives:* Participants in HI-PRAISE receive incentives for participation and completion of specific behaviors or goals. Each FQHC can establish its own process for awarding incentives and decide what to provide as an incentive within the financial incentive amount. The majority of FQHCs provide gift cards, either to supermarkets and/or farmer markets or for gas. FQHCs can also adjust incentive amounts up to $50 or lower based on cost of living increases. The maximum incentive amount per participant is $320.

Incentives include ≤ $25 to attend the first session of diabetes management education; ≤ $20-valued incentive for compliance with ADA-recommended preventive measures, annual retinal eye examination, and HbA1c; ≤ $10 for receiving a pneumococcal or influenza vaccine; ≤ $25-valued incentive for patients who attend smoking cessation group or individual classes or counseling for depression or other mental health issues; ≤ $50 for achieving weight loss of 7 percent in 52 weeks; and a maximum allotment of $40 per year for completing blood tests and reaching specific goals in decreasing HbA1c.

*Enrollment*: Currently, Hawaii has enrolled 2,340 participants. Target enrollment is 1,400. Hawaii's enrollment was affected by the Supreme Court's decision regarding the provision of health care to immigrants. As a result, immigrants from the Compact of Freely Associated (COFA) States were removed from the Medicaid program as of February 2015. State-funded "Medicaid like" benefits will still be provided for COFA immigrants who are blind, aged, or disabled, but they will no longer be able to participate in HI-PRAISE.

### 3.2.4 Minnesota

*Overview of program:* The We Can Prevent Diabetes, Minnesota program is a joint venture between the Department of Human Services' Medicaid Department and the Department of Health's Diabetes Prevention Department. We Can Prevent Diabetes, Minnesota is a diabetes prevention program that hosts group classes at YMCAs in the Twin Cities area using the national DPP curriculum. Minnesota relies on 24 clinics made up of 13 organizations to identify and recruit DPP participants and is unique in targeting Hmong, Somali, and Native American participants.

*Incentives:* Participants in the intervention condition are randomized into one of three incentive arms for the 15-week core class. Participants in control group classes participate in free DPP sessions, receive an initial class attendance incentive of $25; up to 90 days of free YMCA access; and supports for child care, transportation, and weight loss tools. Individual incentive participants receive process incentives of an initial $25 attendance incentive, a $10 incentive for attending each of the 15 weekly sessions, a $30 incentive for attending 12 or more weekly classes and up to 90 days of free YMCA access, and an outcome incentive of up to $50 if they achieve a 10 percent weight loss. Group incentive participants receive similar process incentives as individual incentive participants; however, they only receive an attendance

incentive if their full class attends 12 or more sessions and an outcome-based incentive if the group meets at least a 7 percent weight loss goal. Participants also receive weight loss tools, such as food scales, cookbooks, portion plates, and measuring cups throughout the course. In addition to approximately 4 months of weekly DPP classes, participants can join monthly post-core DPP sessions for 8 months. Incentivized participants in the individual and group incentive arms receive up to $15 for participating in each monthly post-core session and up to $100 for meeting a post-core weight loss goal of up to 10 percent.

*Enrollment*: Currently, Minnesota has enrolled 957 participants. Target enrollment is 1,800.

### 3.2.5 Montana

*Overview of program:* Montana's MIPCD program aims to prevent type 2 diabetes, reduce lipid and blood pressure levels, and reduce weight among adult Medicaid beneficiaries at high risk for developing cardiovascular disease and diabetes. The program is led by the Department of Public Health and Human Services' Medicaid Managed Care Bureau and Chronic Disease Prevention and Health Promotion Bureau. Program enrollees participate in an adapted evidence-based lifestyle intervention based on the National Institute of Health's DPP. Trained health care professionals also deliver standardized diabetes self-management education to enrollees. Montana originally had 14 total program sites at health facilities, but two sites terminated their DPP contracts with the State at the end of 2014. The program currently has 12 participating sites statewide. Montana's program has a crossover design, with half of the program sites distributing incentives for the first 18 months of the program and the remaining sites not providing incentives. In January 2014, the crossover occurred and the sites that did not previously distribute incentives began to do so and the remaining sites no longer provided incentives.

*Incentives:* Participants at incentive sites are eligible to receive up to $315 annually from the program, provided via debit cards. The financial incentives are tiered and incrementally increasing 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.

*Enrollment:* Currently, Montana has enrolled 234 participants. Target enrollment is 724.

### 3.2.6 Nevada

*Overview of program:* The Nevada Healthy Choices program's goal is to work with participants to control or reduce their weight, lower cholesterol, lower blood pressure, and avoid the onset of diabetes or improve management of diabetes. Nevada Healthy Choices is led by the State's Department of Health and Human Services' Division of Health Care Financing and Policy and was implemented through five program partners. Amerigroup and UnitedHealthcare both offer weight management and diabetes disease management programs to Medicaid beneficiaries with diabetes who are served by the State's MCOs. The YMCA of Southern Nevada offers the National Institute of Health's DPP course to fee-for-service Medicaid beneficiaries with pre-diabetes or at risk for type 2 diabetes. The Children's Heart Center's Healthy Hearts Program enrolls children between the ages of 7 and 18 and provides

individualized national counseling, a monitored exercise program, and one-on-one counseling and motivational coaching. Nevada's fifth program partner, the University Medical Center Lied Clinic Outpatient Facility, had targeted adults diagnosed with diabetes or at risk for type 2 diabetes enrolled in fee-for-service Medicaid. The Lied Clinic closed in October 2014, terminating that arm of the study.

*Incentives:* Program enrollees receive points redeemable for rewards on a tiered basis for participation in programs, efforts at behavior change (including completing an evidence-based program), and achievement of improved health outcomes. Participants can view and redeem their points for reward items available in the online catalog maintained by the incentive vendor, ChipRewards. The Children's Heart Center also has a catalog worksheet that enables the center to order rewards on behalf of participants. The maximum monetary value of the incentives is $350.

*Enrollment:* Currently, Nevada has enrolled 1,840 participants. Target enrollment is 2,000.

### 3.2.7 New Hampshire

*Overview of program:* The goal of New Hampshire's Healthy Choices, Healthy Changes program is to reduce cardiovascular risk factors, including rates of obesity and smoking among a high-risk group of Medicaid beneficiaries: people with mental illness. The program is led by the Department of Health and Human Services, Division of Community-Based Care Services, Bureau of Behavioral Health, Office of Medicaid Business and Policy. Healthy Choices, Healthy Changes is implemented at 10 community mental health centers and offers a supported weight management and smoking cessation arms. Participants in the weight management program are randomized to receive different combinations of the following: an In SHAPE health mentor, gym membership, and a Weight Watchers membership. The smoking cessation program offers an introductory tobacco education and, if participants are interested, subsequent referral to cessation treatment and telephone quitline support.

*Incentives:* In addition to services, half of the participants in the intervention arms will receive extra rewards in debit cards. Participants can also receive an incentive for completing the tobacco education and for negative CO tests. The maximum annual incentive for the weight loss program is $1,860, and the maximum incentive for the smoking cessation program is $415.

*Enrollment:* Currently, New Hampshire has enrolled 1,997 participants. Target enrollment is 2,600.

### 3.2.8 New York

*Overview of program:* The goal of New York's MIPCD program is to reduce smoking, lower high blood pressure, prevent onset of diabetes, and enhance diabetes self-management. The program, led by the State Department of Health, Office of Health Insurance Programs' Division of Quality and Evaluation, targets adult Medicaid members, ages 18 to 64, who use tobacco and/or have high blood pressure, pre-diabetes, or diabetes. Pregnant women who smoke may also participate. All 16 Medicaid managed care and 3 HIV special needs MCOs are required to implement three programs: diabetes prevention, blood pressure management, and

diabetes management. Although not required to do so, all MCOs agreed to implement the smoking cessation program. New York sets target enrollment for each program for each MCO. Each managed care plan is responsible for recruiting participants into the diabetes prevention, diabetes management, and blood pressure management programs, and participants are randomized into one of four groups: (1) receive financial incentives for conducting certain activities, (2) receive financial incentives for achieving specific health outcomes, (3) receive financial incentives for both conducting certain activities and achieving health outcomes, and (4) do not receive any financial incentives for conducting certain activities or achieving health outcomes (i.e., the control group). The smoking cessation program has been modified so that recruitment occurs through the New York State Smokers' Quitline, and participants are randomized into either Group 1, Group 2, or Group 4. There is no Group 3 for the smoking cessation program.

*Incentives*: New York provides financial incentives in the form of mailed checks. Participants, including those randomized to the control group, who engage in at least one program activity receive a $50 enrollment incentive. Those randomized to the control group do not receive anything else. For each of the four programs, New York caps the amount of incentives disbursed at $250. In the diabetes prevention program, participants can receive up to $15 for attending each of 16 diabetes prevention program classes or making progress toward losing weight. For the diabetes management program, participants can receive up to $50 for every primary care appointment attended and/or filling diabetes-related prescriptions (up to five appointments or prescription fills), and/or they can receive up to $250 for decreasing HbA1c levels. For the blood pressure control program, participants can receive up to $50 for every primary care appointment attended and/or filling blood pressure-related prescriptions (up to five appointments or prescription fills), and/or they can receive up to $250 for decreasing blood pressure. For the smoking cessation program, participants can receive up to $50 for attending smoking cessation program sessions, making smoking quitline calls, or filling smoking cessation prescriptions, and/or they can up to $250 for smoking cessation confirmed through a saliva cotinine test.

*Enrollment:* Currently, New York has enrolled 3,141 participants. Target enrollment is 6,800.

### 3.2.9 Texas

*Overview of program*: The goal of the Wellness Incentives and Navigation (WIN) Project, led by Texas's Health and Human Services Commission and Department of State Health Services, is to improve health self-management and reduce the incidence and consequences of chronic disease among non-elderly adult Medicaid Supplemental Security Income (SSI) beneficiaries. WIN targets SSI beneficiaries with behavioral health (mental health and substance abuse) diagnoses, a population with especially high chronic disease incidence and costs. WIN participants set personal wellness goals with the assistance of health Navigators and use a flexible wellness account to pursue the wellness goals. The WIN project is offered in Harris County, Texas.

*Incentives*: WIN incentives include a flexible wellness account of $1,150 per year and person-centered wellness planning and navigation facilitated by trained, professional health

Navigators. The Navigators, who are dedicated specifically to the WIN project, use Motivational Interviewing (MI) techniques to help participants determine their wellness goals. Participants with more serious mental illnesses are offered additional support in the form of Wellness Recovery Action Planning to enable them to take full advantage of person-centered wellness planning.

*Enrollment*: Texas achieved its target enrollment of 625 persons in the treatment group and 625 persons in the control group during Year 2 of the program.

### 3.2.10 Wisconsin

*Overview of program:* The goal of Wisconsin's Striving to Quit program, which is led by the Department of Human Services' Division of Health Care Access and Accountability, is to provide smoking cessation services to adult smokers enrolled in BadgerCare Plus (Medicaid). Participants enroll into one of two programs: (1) a general program for all smokers who enroll through the Wisconsin Tobacco Quit Line, or (2) First Breath, an evidence-based program for pregnant smokers.

The State expects adults with Quit Line counseling to achieve an anticipated quit rate of 25 percent and for women enrolled in the First Breath program to achieve a 36 percent quit rate. Incentives include counseling and monetary incentives for participation and successful smoking cessation defined by passing a CO test.

*Incentives:* Each of the two programs has participants who get services and cash incentives, and a control group that receives treatment services only.

Wisconsin Tobacco Quit Line participants in the intervention group receive a maximum of $270 in incentives over 6 months (enrollment: $40, each call up to 5: $30, attendance to month 6 visit: $40, and 6-month nonsmoking test: $40), while those in the control group receive $80.

First Breath participants in the treatment group receive a maximum of $600 over 12 months ($40 enrollment, 6 visits $25 each, 6 calls $20 each, 2 home visits $25 each, 3 CO tests $40 each, additional $40/passed test); those in the control group receive $160 ($40 enrollment, 3 CO tests $40 each). As of July 1, 2014, Wisconsin officially transitioned its First Breath program from offering 1 year of postpartum services to 6 months. This change was made in an effort to extend the window of recruitment for the program. The 6-month First Breath version pays for 5 calls, 4 home visits, and 2 CO breath tests to confirm participants' smoking status.

*Enrollment*: The First Breath program stopped recruiting participants on May 21, 2015, and the Wisconsin Tobacco Quit Line stopped recruiting participants on May 31, 2015. Services in both programs continued until December 2015. The final enrollment count was 1,962 individuals in the Wisconsin Tobacco Quit Line program (979 in the treatment group and 983 in the control group) and 1,052 pregnant women in the First Breath program (513 in the treatment group and 518 in the control group). Out of the 1,052 total, 750 were enrolled in the 12-month program, and 302 were enrolled in the 6-month program.

### 3.2.11 MIPCD in the Context of Other Medicaid Incentives

MIPCD is part of a broader set of initiatives designed to encourage Medicaid beneficiaries to use preventive services and adopt healthy behaviors that subsequently improve health outcomes. This set of initiatives includes reductions or waivers of cost-sharing for preventive services. Some States are also implementing demonstrations to test how appropriate utilization of health care services changes when Medicaid beneficiaries are required to pay premiums or co-payments or make payments from a Health Savings Account paired with a high-deductible health plan. States testing such demonstrations for Medicaid beneficiaries include Indiana, Iowa, Michigan, and Wisconsin. Results from the MIPCD program will contribute to the broader exploration of how best to encourage Medicaid beneficiaries to use preventive services and adopt healthy behaviors.

## 3.3 Enrollment across State Programs

***Table 3*** shows progress in program enrollment across the State programs. Enrollment goals ranged from 724 participants in Montana to 9,000 participants in California. Texas reached 100 percent of its enrollment goal within the first year of program implementation. In addition, Hawaii exceeded its enrollment goal of 1,400 participants, reaching 2,340 participants. As of June 2015, the remaining States reached between 42 percent and 92 percent of their enrollment goals. After Texas and Hawaii, Nevada, Wisconsin, and New Hampshire had the most significant progress, reaching more than 75 percent of their enrollment goals.

**Table 3**
**Enrollment across State programs, through November 2015**

| State | Actual number enrolled as of November 15, 2015 [1] | Total projected number of participants as of November 15, 2015 [2] | Projected number of participant group(s) | |
|---|---|---|---|---|
| | | | Experimental groups | Control groups |
| California | 4,711 | 9,000 | 7,350 | 1,650 |
| Connecticut | 4,052 | 6,210 | 3,105 | 3,105 |
| Hawaii[3] | 2,323 | 1,400 | 1,200 | 200 |
| Minnesota | 957 | 1,800 | 1,200 | 600 |
| Montana | 261 | 724 | 362 | 362 |
| Nevada | 1,840 | 2,000 | 1,026 | 974 |
| New Hampshire | 2,009 | 2,600 | 1,300 | 1,300 |
| New York | 4,204 | 6,800 | 5,100 | 1,700 |
| Texas | 1,259 | 1,250 | 625 | 625 |
| Wisconsin | 3,017 | 3,250 | 1,625 | 1,625 |
| All States | 24,633 | 35,034 | 22,893 | 12,141 |

[1] Actual enrollment numbers were taken from the MIPCD dashboard data.

[2] Current enrollment targets were taken from each State's current operational protocol.

[3] Hawaii's control group from the community health centers will be an external group and not a participant group. Therefore, the total projected number of participants does not include control group members from the community health centers; instead, it only includes control group members from Kaiser Permanente.

### 3.4 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 NRT 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 4***, 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 4**
**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 |

### 3.5 Incentives across State Programs for Participants and Providers

All States are giving participants monetary incentives in the form of cash, gift card or other money-value item, or flexible wellness account funds. ***Table 5*** shows that money is the most common type of incentive and is offered through prepaid debit cards and a flexible wellness account. Four States offer prepaid debit cards in combination with other incentives. In New Hampshire, for example, participants can receive cash rewards for healthy behaviors, obtain free access to fitness resources, and receive transportation assistance.

**Table 5**
**Incentives across State programs for participants**

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

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

[2] 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.

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 providing peer coaching in two locations and is distributing "motivation" cards that provide words of encouragement to enrollees following their participation in smoking cessation counseling sessions and negative breathalyzer tests.

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 wellness 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.

### 3.6 Evaluation Design across State Programs

States are required to evaluate the effectiveness of their incentive programs. ***Table 6*** 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 an incentive group that receives treatments and incentives. California and Hawaii are using both RCTs and quasi-experimental designs.

New Hampshire is using an equipoise-stratified randomized design for 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 participant demand. As a result, the State modified the duration of the intervention to increase personal trainer capacity and maintain the equipoise-stratified design.

Montana is using a crossover design in its intervention sites. During the first 18 months, six sites provided participants with incentives, and the seven remaining sites did not provide incentives. After the first 18 months, in January 2014, sites that did not previously provide incentives began providing them to new participants, and the remaining sites where incentives were previously provided no longer provided them to new participants. During the latter period, one incentive site and one non-incentive site discontinued implementing the program due to internal administrative issues at their facility.

California's preliminary evaluation results of its first RCT resulted in the State providing services that were shown to be the most effective in helping people stop smoking to all qualified Medicaid beneficiaries calling the quitline. These enhanced services included nicotine patches, counseling, and small financial incentives and were provided through May 2015.

**Table 6**
**Evaluation designs across State programs**

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

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

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

### 3.7 Site Visits and State Program Assessment

The RTI and NASHP teams conducted site visits to State programs from March to November 2014. These site visits included up to 90-minute interviews with program managers; educators, such as lifestyle coaches and patient navigators; recruiters, including managed care staff, promotoras (lay Hispanic/Latino community health educators), or counselors; clinical staff; and evaluators. In each State, we interviewed up to 20 stakeholders about a wide range of implementation progress-related topics. Topics included implementation progress; participant outreach and engagement; the role of programmatic incentives; special populations; evaluation progress; and program challenges, successes, and lessons learned. The team took summary-level notes and audio-recorded the interviews. These data were then used to create an internal case study for each State. These case studies included a summary of stakeholder feedback and illustrative quotes. Case studies were then reviewed and coded to create a cross-State synthesis of program implementation progress and site visit findings. In ***Section 3.8***, we present these findings by first looking at program implementation progress and then summarizing key program features, such as methods of participant outreach and engagement; special populations targeted by the programs; and program challenges, successes, and lessons learned.

## 3.8 Program Implementation Progress

Over the past 3.5 years, the 10 MIPCD programs have evolved considerably. For State programs, implementation progress is ongoing. We used a theme-based inductive coding methodology to identify main factors that contributed to States' implementation progress. To ensure that we were reporting current implementation progress, we complemented our site visit findings with information collected in the State database from State operational protocols, proposals, quarterly reports, and other State summaries. Four main factors emerged as contributing to States' implementation progress: (1) building on existing programs, (2) making programs accessible, (3) hiring and training appropriate staff, and (4) implementing major program changes.

### 3.8.1 Building on Existing Programs

For nearly all programs, start-up took more time than anticipated. In particular, States that started new programs appeared to face more challenges than those that built on existing initiatives, relationships, or contracts. States built on existing programs in varying ways. Some States, such as Montana, Nevada, New Hampshire, and Wisconsin, built their MIPCD initiative on chronic disease prevention programs that were already operating. In these States, existing programs were simply expanded to include Medicaid beneficiaries. Montana expanded its evidence-based weight loss program to include Medicaid enrollees and was able to implement its MIPCD program 3 months after the grant was awarded. Other States, such as Hawaii and Minnesota, drew on relationships they had with clinics or providers that treat Medicaid beneficiaries. These clinics and providers were able to readily identify and recruit eligible Medicaid beneficiaries to participate in the States' initiatives. Hawaii's program, HI-PRAISE, recruits and runs its initiative through FQHCs because this is where the majority of Medicaid beneficiaries receive their care. Programs also built on existing interagency agreements or contracts, which helped States avoid contracting delays. Texas expanded its External Quality Review Organization contract with the University of Florida, Gainesville, to include the management, evaluation, and health navigator supervision for its project. Many States also used data collection systems and software that were already in place for other purposes. Wisconsin's "Striving to Quit" program built on its existing quitline infrastructure and was able to use a pre-existing data system provided by Alere to collect participant data and outcomes from day one.

### 3.8.2 Making Programs Accessible

Access to reliable and affordable transportation and certain health care services is often a challenge for Medicaid enrollees. Recognizing this challenge, half of the MIPCD programs adopted measures to ensure that their programs were accessible to participants. In Minnesota and New Hampshire, MIPCD programs provide participant transportation to their classes either through a shuttle or taxi service or reimburse participants for public transportation costs. In other States, participants are able to use Medicaid-funded taxi services to access their providers' offices for free and, in turn, engage in the program. In States or areas where transportation is limited or expensive, or program participants are dispersed throughout a large area or region, such as in California, Nevada, and Montana, programs are providing services to participants telephonically through a quitline and telemedicine. In these programs, participants can access services from remote locations and do not need to travel to engage in the program. California is also using the mail to send a component of its intervention, NRT, to participants. Other States,

such as Minnesota and Nevada, use the mail to disseminate incentives. Staff in Texas and sometimes in Hawaii travel to meet participants at their home or a convenient location. States also expanded their Medicaid covered services to ensure that MIPCD care is free to participants. Connecticut State officials, for example, changed the Medicaid policy to include group counseling sessions as a covered service. This change allows MIPCD participants to engage in smoking cessation group counseling for free.

### 3.8.3 Hiring and Training Appropriate Staff

Having the right number of staff and staff with the appropriate skill set is critical for MIPCD program implementation progress. One stakeholder shared that "starting a project like this requires a lot of community organizing and building. Buy-in from both top-level management and the people who are implementing the project is needed." Numerous States faced staffing challenges. California, Nevada, and New York indicated that implementation progress was significantly delayed because they had limited staff available during initial project implementation. Some States that began with an adequate number of staff had their implementation progress slowed by staff turnover. Connecticut and Minnesota experienced major staff turnover, which impacted their enrollment progress. States relying on partnerships and other organizations to help staff their initiatives also found these staffing arrangements to be difficult. In these arrangements, State teams lacked the authority to engage staff at partner organizations directly, making it difficult to ensure that partner staff were adequately trained.

Some staffing challenges reflect inadequate training. As one stakeholder noted, "It is not enough to just offer training to recruiters early in their engagement but also continuous detailing is needed over time…" To adequately train staff, States used a wide range of training techniques, such as job shadowing, multi-day educational trainings, peer-to-peer learning by pairing staff together, and weekly training meetings. State teams also indicated that internal, regular meetings were helpful for keeping staff informed of and engaged in program implementation. Programs also highlighted that having staff or partner organizations that were familiar with Medicaid populations was key. As one stakeholder shared, a partner organization must "…have the awareness of the challenges the Medicaid population faces day to day." To ensure this, some States partnered with organizations such as FQHCs and other community programs that already served large numbers of Medicaid enrollees.

### 3.8.4 Implementing Program Changes

The 10 MIPCD programs have changed significantly. During the 3.5 years of grant funding, all demonstration States have implemented numerous changes, including changes to (a) the implementation dates, (b) enrollment targets, (c) program target populations, (d) participant and provider/clinic incentives, and (e) evaluation designs. Although the goals of these changes vary, the impetus behind them was often to improve program implementation.

*Changes in Implementation Dates*

***Table 7*** shows the changes in implementation dates by State. All States received MIPCD grant funds in September 2011. They have 4 years to implement their incentive programs and 5 years to evaluate their progress. Four of the 10 States—California, Montana, Texas, and Wisconsin—implemented their programs close to their planned implementation date. California

and Montana built on existing programs, and Texas drew on its existing External Quality Review Organization contract with the University of Florida to implement its initiative in a timely manner. Also, Montana's use of telemedicine helped the State implement, in a timely fashion, an accessible intervention to participants living in remote, rural areas and without reliable transportation. Wisconsin originally planned to implement two programs in September 2012: First Breath, which targets postpartum women; and the Tobacco Quitline, which targets Medicaid beneficiaries in general. Both Wisconsin initiatives built on existing programs. As a result, the First Breath program was implemented as planned in September 2012. The Tobacco Quitline implementation, however, was delayed by 6 months while the State established memoranda of understanding with community clinics to recruit participants.

**Table 7**
**Changes in implementation dates by State[1]**

| State | Initial planned implementation date | Actual implementation date |
|---|---|---|
| California | Pilot in January 2012 | Pilot began March 2012 |
| Connecticut | Phased implementation beginning in March 2012 | Launched program in March 2013; began enrolling in April 2013 |
| Hawaii | Quarter 1 of 2012 | February 2013 |
| Minnesota | Clinic recruitment begins in February 2012 with participant recruitment beginning in March 2012 | Implemented in November 2012 with five clinics with participant recruitment in mid-December 2012 |
| Montana | Recruitment beginning November 2011 | Recruitment and enrollment began in January 2012 |
| Nevada | Not specified in the original operational protocol or application | Enrollment began in each of five program arms in February 2013, May 2013, October 2013, December 2013,[2] and June 2014 |
| New Hampshire | Phased implementation beginning in September 2011 | May 2012 |
| New York | 2012 | Four program arms began in June 2013, April 2014, July 2014 and March 2015 |
| Texas | Quarter 2 of 2012 | Quarter 2 of 2012 |
| Wisconsin | Enrollment beginning in September 2012 | First Breath: September 2012, Tobacco Quitline: April 2013 |

[1] Planned and actual implementation dates are compiled from State proposals, operational protocols, quarterly reports, and participation in MIPCD monthly State activity meetings.

[2] Nevada's Lied Clinic closed for business in October 2014, and this program arm was terminated.

Six State initiatives implemented 6 months to 2 years after their planned implementation date. Implementation delays were reportedly due to numerous factors, including time needed to hire and train staff; obtain Institutional Review Board (IRB) approval; formalize partnerships with other organizations, such as MCOs, community health centers (CHCs), or the YMCA; and develop contracts with incentive payment vendors. States such as New York originally planned to implement their multiple program arms simultaneously, but implementation delays made this impossible. Instead, New York implemented each program arm separately.

*Enrollment Target Changes*

***Table 8*** presents the current enrollment targets compared with the initial enrollment targets based on State operational protocols and applications. California, Montana, and Texas are the only States that did not change their enrollment targets. In fact, Texas also met its goal within 1 year of implementation. Seven States reduced their enrollment targets by between 42 percent and 85 percent. Connecticut made the largest reduction to its enrollment targets by decreasing its targets by 85 percent—over 36,000 participants. This change in enrollment targets reflects challenges Connecticut faced getting providers engaged to recruit participants as well as slow participant recruitment. In Wisconsin, a State with two program arms, enrollment targets were reduced for both arms for different reasons. Wisconsin's quitline program was delayed in its implementation, and, therefore, its enrollment goals were reduced by 70 percent from 11,000 to 3,250. At the same time, Wisconsin's First Breath program reduced its enrollment goals by 58 percent (from 3,000 to 1,250) because its original goals did not coincide with the number of Medicaid-enrolled pregnant women that smoke. Nevada originally planned to enroll 9,810 participants across five program arms. However, because of enrollment and recruiting challenges, Nevada reduced its enrollment goal by nearly 80 percent to 2,000 participants across all five program arms.

*Target Population Changes*

California, Connecticut, and Wisconsin changed their program target populations after implementation. California initially planned to target its smoking cessation program to Medicaid enrollees that had diabetes and other chronic diseases. Within the first 6 months of implementation, California changed its program to include all Medicaid enrollees who smoked and not just those with chronic diseases. This change was driven by concerns that the program would not reach its enrollment goals and did not have staff available to recruit sufficient numbers of Medicaid enrollees with chronic diseases. California expanded the number of individuals eligible for the program to all Medicaid enrollees and permitted all Medicaid enrollees to receive smoking cessation services regardless of whether they participated in the RCT. Connecticut changed its target population a few months into its grant implementation. Initially, Connecticut planned to focus its smoking cessation initiative on pregnant women because Medicaid only reimbursed smoking cessation services for this population. However, 3 months into the grant, the State changed its Medicaid coverage policy so that all Medicaid enrollees could receive smoking cessation services. As a result, Connecticut's initiative expanded to include all Medicaid-enrolled individuals.

**Table 8**
**Current enrollment targets as of November 2015 and initial enrollment targets as of May 2012 across State programs**

| State | Total projected number of participants as of November 2015 [1] | Total initial projected number of participants as of May 2012 [2] |
|---|---|---|
| California | 9,000 | 9,000 |
| Connecticut | 6,210 | 42,774 |
| Hawaii | 1,400 | 4,521 |
| Minnesota | 1,800 | 3,240 |
| Montana | 724 | 724 |
| Nevada | 2,000 | 9,810 |
| New Hampshire[3] | 2,600 | 4,500 |
| New York | 6,800 | 18,456 [4] |
| Texas | 1,250 | 1,250 |
| Wisconsin | 3,250 | 11,000 |
| Total | 35,034 | 109,275 |

[1] Current enrollment goals were taken from each State's current operational protocol.

[2] Initial enrollment goals were taken from each State's original operational protocol or application.

[3] New Hampshire implements an equipoise-stratified randomization design. Thus, the State's first set of enrollment goals did not include a control group target.

[4] New York's original proposal includes an enrollment goal of 18,456, and its operational protocol includes a lower enrollment goal of 16,898.

Wisconsin made two changes to its target population. Initially, the State's program arm targeting pregnant women, First Breath, planned to enroll Medicaid MCO members that were eligible for Medicaid as low-income individuals. After recognizing that it would not meet its enrollment targets, the State expanded the First Breath program to include individuals eligible for Medicaid as Social Security Income recipients. In addition, the State decided not to pursue Affordable Care Act funds to expand its Medicaid program and subsequently reduced its Medicaid eligibility threshold for parents and childless adults. For First Breath participants, this change in eligibility criteria meant fewer women would be eligible or could remain in the program. In response, the State decided to expand program eligibility to include Medicaid-eligible pregnant women and new mothers and those already enrolled in the program before the Medicaid eligibility criteria changed. The State paid to keep pregnant women and new mothers who were already enrolled in First Breath, but no longer eligible for Medicaid, enrolled in the program.

*Provider and Clinic Incentives*

In addition to participant incentives, some States provide incentives to providers and clinics for their role in recruiting and referring Medicaid patients to the programs. Originally, only three States—Hawaii, Montana, and Nevada—provided incentives to providers and clinics that recruited participants. However, 1.5 years into their implementation, Connecticut, Minnesota, and Wisconsin began incentivizing or paying providers to recruit participants. Connecticut paid providers a $35 stipend for each program enrollee they recruited and also paid for full- and part-time enrollment specialists to provide clinics with administrative support for recruitment and enrollment services. Minnesota offered up to $278,000 per participating clinic to cover its study-related costs, including possibly hiring a recruitment specialist for the program. This payment helped Minnesota increase the number of clinics and providers willing to recruit participants into its program from five to 25 clinics over a 1-year time frame. Wisconsin took a combined incentive and payment approach; it paid each clinic $1,000 for agreeing to recruit participants and gave providers $75 for each person they enrolled in the program.

*Evaluation Design*

In response to program delays, a few programs changed their evaluation designs. In Connecticut and Minnesota, the programs changed how they planned to randomize participants. Both States planned to randomize participants based on the clinic from which they were recruited. However, after implementation, they changed to randomizing at the participant level. Wisconsin's quitline program arm was changed from a clinical trial to a quality improvement initiative. This change aimed to give providers recruiting participants more flexibility to do so.

## 3.9 Outreach and Engagement

Programs used a multitude of strategies to identify, engage, and recruit participants. However, three main types of strategies emerged: (1) using data to identify participants and target outreach efforts, (2) collaborating with providers and clinics that serve Medicaid enrollees, and (3) working with MCOs. Program outreach strategies are not mutually exclusive, and, in many cases, States combine multiple strategy types to increase the likelihood of identifying and enrolling participants.

### 3.9.1 Using Data

States used data in unique ways to target their outreach efforts and identify participants. California, Hawaii, Montana, Nevada, and Texas all used Medicaid claims data to identify potentially eligible program participants. California and Montana used Medicaid claims data to identify potentially eligible individuals and send them direct marketing materials for the program. Nevada and Texas relied on MCOs to use their Medicaid claims data to identify potentially eligible individuals and contact them via mail or telephone. Texas' MCOs identified potential participants by reviewing MCO enrollee claims for a specific set of diagnosis codes. Once identified, MCO enrollees were contacted either by phone or in-person for screening and enrollment. Hawaii coordinated its outreach through FQHCs. Most FQHCs used electronic health record data or recent test results to identify patients with diabetes so that staff could engage them in the program. Some States used data to identify potential participants and reassess their recruitment strategies. California, for example, used Helpline data to identify the more effective outreach strategies and use them to tailor future outreach efforts.

### 3.9.2 Collaborating with Providers and Clinics

Half of the programs collaborated with providers and clinics to identify and engage participants in their programs. Programs recognized that Medicaid-serving providers and clinics are most familiar with the Medicaid beneficiary population and are, in many cases, best equipped to recruit for their programs. For example, in Hawaii, FQHCs identify program coordinators or health educators to review patient records and identify persons with diabetes. In some cases, FQHC providers engage the patient first and then invite the program coordinator or health educator to engage the patient in the HI-PRAISE program. This outreach and engagement model allows the program to engage participants in a culturally and linguistically sensitive manner and do so with someone that the patients already know from their interactions with the FQHC.

Nevada's Children Heart Center program arm, a pediatric health and lifestyle improvement education program, often recruits patients from its clinic waiting room. This program arm was so successful at recruiting participants that the diabetes management program arm decided to collaborate with the Children's Heart Center to recruit participants. Diabetes management program staff now spend time in the Children's Heart Center waiting room to recruit participants for its program arm.

As mentioned above, nearly all programs that rely on providers or clinics to engage and recruit participants provide incentives to these providers. The types of incentives provided range from a per participant fee to a large grant to be used for clinic study-related costs. As a stakeholder highlighted, "our model is strictly through the clinics so we weren't going to be successful if we didn't find a way to incent providers."

### 3.9.3 Working with MCOs

Similar to providers and clinics serving Medicaid enrollees, MCOs are well-situated to recruit participants. In Nevada, Texas, and Wisconsin, programs used MCOs to oversee some, if not all, of the participant recruitment processes. In Wisconsin, for example, the MCOs identified smokers in their plans and mailed outreach materials about the initiative. Similar outreach materials were sent to Medicaid providers to inform them about Wisconsin's program so that they could also refer Medicaid patients to the program.

## 3.10 Role of Programmatic Incentives

All programs provide some type of incentive to experimental group participants. Programs provide monetary and non-monetary incentives, such as food scales; cookbooks; and, in Connecticut, motivational cards. While each State is required to evaluate the impact of incentives on participant behavior change and retention, stakeholders were asked to provide insights on the perceived impact of incentives. Feedback on perceived impacts was mixed. Some stakeholders viewed incentives as critical for participant engagement and retention. In Connecticut, for example, stakeholders observed that control group participants were much less likely to agree to participate in its smoking cessation program. Stakeholders in Hawaii observed that monetary participant incentives helped encourage patients to make specific behavior changes and even helped them achieve self-defined goals. As one stakeholder shared, "it's one thing to set goals, but another to actually have the purchasing power to attain the goals."

Incentive distribution in some States, such as Hawaii, also helped program staff track participant accomplishments and specific behavior changes.

In other States, the monetary incentive served as a main method for retaining participants. Texas originally only provided monetary incentives to participants to help them reach their self-defined goals. After implementation, the program added a participation incentive of $30 each quarter for participants that met with or spoke to their lifestyle coach each month. This incentive helped the program retain and keep participants engaged. As one stakeholder indicated, "[t]his is a population where a $40 gift card is a lot of money."

For some programs, incentives were seen as a "nice little bonus." In these cases, participants were motivated by a desire to change their behavior and live healthier lives. In Minnesota, participants receive as much as $10 for attending a YMCA diabetes management class. While this money was viewed by stakeholders as helpful, it was not seen as significant enough to encourage dramatic behavior change. As a stakeholder recounted a participant's response to a smoking cessation program, "…the money didn't matter, I knew I needed to quit."

Despite mixed feedback, stakeholders overall highlighted that the success and meaningfulness of program incentives related in part to incentive desirability and appropriateness. In some cases, the necessity of providing incentives that were culturally sensitive was highlighted. For example, in Minnesota, program participants were given measuring cups, food scales to weigh their food, and portion plates; however, stakeholders indicated that these were not used by the Somali population served by the program. Minnesota recognized that beyond language needs, this population had cultural needs that were not initially addressed by these incentives. The Somali immigrants preferred visual or oral communication over written materials. So, Minnesota provided demonstrations in class on how to use these tools, and stakeholders then reported using them.

### 3.11 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 9*** shows that States are targeting diverse other populations, with some States correlating the medical conditions being addressed with particularly vulnerable populations. Four programs are targeting beneficiaries with mental illness, with two of these States also targeting beneficiaries with substance use disorders. Four of five programs that specifically target pregnant women and mothers of newborns have a smoking cessation component as part of their program. In addition, four programs target racial and ethnic minorities. Although Nevada did not initially identify racial and ethnic minorities as a primary focus, Nevada prioritized this special population after learning that a majority of program participants were Latino. Nevada began targeting Latino communities by reaching out to the Latino Chamber of Commerce in Las Vegas, communicating with colleagues who had existing relationships with people in Latino communities, and visiting sites that were treating potential enrollees. All States, except New York and Texas, will enroll Medicare-Medicaid enrollees (i.e., beneficiaries with Medicaid and Medicare coverage) 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 9**
**Targeted special populations across State programs**

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

[1] 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.

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

[3] 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.

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

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

During the site visits, program staff and stakeholders shared lessons learned for effectively engaging and retaining special populations in their programs. Ensuring that programs are culturally appropriate for the target population was a key lesson learned. In some cases, this

meant hiring culturally competent staff, such as individuals who are either members of the target population or have worked with the target population. In other cases, it meant adapting the programs to be more culturally competent. In Minnesota, for example, where 80 percent of program participants are Somali, the program adapted the YMCA's diabetes prevention program to the needs of the Somali population. These changes included providing recipes for diabetic-friendly, Somali foods and making a picture food diary for non-English speaking Somalis to complete weekly.

Part of creating culturally competent programs is having staff and materials that are language accessible. Numerous programs have hired bilingual staff and translated their program materials into the languages participants commonly speak. In Hawaii, the program ensures that at least one health educator in each clinic is able to speak with non-English speaking clinic participants and also maintains a database of participants' immigrant status so that it can track subcategories of participants and ensure that they have appropriate access to materials and program staff.

Outside of language access, programs also adapt to address special population's needs. In Montana, staff revised the diabetes prevention program to include audio instead of written food diaries for blind participants. The program also provides classes at a slower pace for cognitively impaired participants.

Programs indicated that collaborating or partnering with organizations familiar with their targeted special populations was extremely helpful. In California, for example, the State works closely with the Indian and Rural Health Offices to provide program outreach and engagement to Native American clinic patients. As mentioned, in Nevada, the State collaborates with the Latino Chamber of Commerce to help engage Latinos in its program.

## 3.12 Program Challenges, Successes, and Lessons Learned

Stakeholders interviewed during the site visits highlighted a broad range of program challenges, successes, and lessons learned. The sections below summarize States' feedback on implementing incentive programs among Medicaid populations. Some lessons are State specific, whereas others are generalizable across all States. In all cases, we have included examples to help contextualize these lessons.

### 3.12.1 Challenges

Programs highlighted a wide range of challenges that impeded or delayed their implementation progress, which are summarized below. This account is not comprehensive, but documents major challenges programs faced.

**Administrative challenges**, such as obtaining IRB approval, implementing partner and vendor contracts, reimbursing partners for participant services they provided, and coordinating partners' roles and responsibilities, can often delay implementation progress. Because most programs were implemented as research studies, they were required to obtain IRB review and approval before they could begin. For States such as Minnesota, the IRB process meant obtaining IRB approval not only from the State but also, in some cases, from clinic partners. As one managed care staff member highlighted, "We are not in the business of doing studies."

**Engaging and retaining populations with behavioral health and substance use disorders** was a challenge for some programs. Four programs target populations with behavioral health and substance use disorders. For these programs, ensuring that staff are appropriately trained and aware of the challenges participants with mental illness may present was important. New Hampshire program staff encountered challenges working with mentally ill participants. In response, staff decided to involve caretakers for these individuals in the program to help prevent issues from arising during group sessions.

**Verifying Medicaid eligibility when potentially eligible individuals call** a hotline was a challenge for some programs. For telephonic programs such as California, Connecticut, and Wisconsin smoking cessation programs, hotline staff had difficulty either obtaining real-time Medicaid eligibility information on callers or could not find the time to confirm Medicaid-eligibility while callers were on the phone. California initially thought it could rely on participants to accurately self-identify as Medicaid-enrolled. However, over time, the program realized that this process was insufficient. As a result, the quitline staff were given access to the Medicaid eligibility database. But even with access to the eligibility system, quitline staff still experience difficulty obtaining accurate and timely eligibility information.

**Engaging clinical staff and clinics to serve as participant recruiters** was a challenge already addressed above, but worth highlighting again. In States such as Minnesota, programs often had to implement provider incentives and reimbursement to encourage their assistance in recruiting participants.

**Navigating Medicaid reimbursement for certain program services** was a challenge for some programs, particularly those with limited or no familiarity or experience working with Medicaid. Montana built its program on an existing diabetes prevention program for non-Medicaid individuals. For some Montanan program staff, the grant was their first time working with Medicaid or handling Medicaid reimbursement. Some health care facilities involved in Montana's program indicated that they had difficulty navigating the Medicaid reimbursement process. They also found the reimbursement process very labor-intensive. New Hampshire's Medicaid reimbursement policy for NRT is very complicated and is a challenge for many providers. As a result, program management has recommended that this process be simplified.

**Ensuring that data collection is comprehensive and accurate** was a problem for programs and further delayed their evaluation progress. Hawaii spent considerable time working with partner CHCs to ensure that they were collecting comprehensive participant data correctly and accurately. State program staff even visited some CHCs to help them complete missing participant data and review their database to make sure data were collected accurately.

### 3.12.2 Successes and Lessons Learned

Stakeholders identified numerous program implementation successes. The most prominent successes that emerged from the site visits are summarized below.

**Reaching enrollment targets has been a big success for two States.** While implementation delays have impacted enrollment, two States (Texas and California) have managed to meet their enrollment targets. Texas met its overall enrollment target for the

experimental and control groups, less than 1 year into its implementation. California has a three-prong program, and it met its enrollment target for the first prong of the program—RCT-1.

**Developing strong partnerships with community organizations and clinics** has been a big success for many programs. Many programs worked hard to obtain partner buy-in from the beginning or during the initial implementation stages. In turn, programs have benefited from collaborative and effective partnerships. In Minnesota, for example, the State engaged community clinics that work largely with Medicaid populations and was able to design a culturally competent diabetes prevention program for racially diverse populations, such as Somalis and Native Americans.

**Fostering healthy and strong relationships between participants and program educators** is important. Stakeholders shared countless stories about the important role their program educators play in successfully implementing the programs. Stakeholders in New Hampshire highlighted that the program helps participants "…reclaim their lives." Stakeholders from Hawaii's HI-PRAISE program highlighted that patients have built relationships with their health coaches and feel that these coaches care about them and are willing to help them improve their health. As a result, many health coaches have seen patients meet and even exceed their goals for weight loss and diabetes management goals.

**Establishing effective administrative processes** is key for program implementation. Many stakeholders highlighted the importance of establishing administrative processes early in program implementation. All States worked with multiple partners. Across all of these programs, engaging partners in regular meetings was an important way to update staff on program rules and help oversee and ensure consistency in the processes taking place across sites. Wisconsin held recurring meetings with program staff and found it extremely helpful to ensure consistency across its five main partners. As mentioned above, Hawaii developed internal data review processes to help identify missing data from its partner CHCs. The State trained CHC staff on accurately extracting patient data from their electronic health records to ensure that they provide accurate and comprehensive data.

**Ensuring that all parties involved in program implementation are engaged in the program design process.** A few States shared the challenge of trying to implement impractical project plans and reach unrealistic project goals. In a few States, staff that developed the project proposals were not involved in program implementation. Thus, program implementation was much more challenging, and in some cases implementation plans were not realistic given staff availability or skill sets. Although State programs may have included letters from partner organizations in their proposals, establishing a comfortable and smooth working relationship with these organizations once the grants were funded took more time than expected. One stakeholder shared, "Everyone underestimates the challenges of logistics and implementation." Finally, in some States, partner organizations that participated in conceptualizing the project and writing the proposal were no longer available once the projects were implemented. Texas originally planned to work with the University of Texas to evaluate the program. After the grant was funded, Texas discovered that the University of Texas could not fulfill all of the roles needed for the program, so the State contracted with the University of Florida instead.

### 3.13 Impact of the Learning Collaborative on State Programs and Decisions

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. Learning Collaborative 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 assesses the MIPCD Learning Collaborative activities each quarter. Findings consistently demonstrate that Learning Collaborative activities, particularly in-person meetings, align with States' goals and influence short- and long-term activities of each State project. Exchanges between States and experts in Learning Collaborative activities have influenced or confirmed program design features or changes in the following areas: participant and provider outreach, recruitment, and retention; incentive design, tracking, and delivery; sustainability planning; and evaluation.

States have adopted or adapted a number of each other's recruitment, retention, and sustainability planning tools after learning about them during Learning Collaborative activities. For example, after a presentation by Hawaii at a 2013 In-Person meeting, Connecticut and New Hampshire created "accountability reports" with enrollment and retention progress data as a means to motivate program staff and providers to reach enrollment and retention goals. Minnesota developed guidelines for following up with hard-to-reach participants based on a hard-to-reach contact protocol developed by Texas, which the State shared at a 2014 In-Person meeting. A 2013 In-Person meeting featured a video presentation by New Hampshire of testimonials by MIPCD participants and family members. As a result, several States (Hawaii, Texas, and Wisconsin) began collecting similar participant success stories to document promising program components with an eye toward sustainability. A detailed assessment of the Learning Collaborative will be included in the Final Evaluation Report.

### 3.14 Summarizing Implementation

Building on an existing chronic disease prevention program, established relationship with Medicaid providers, or interagency agreement facilitated States' MIPCD program implementation. Still, States faced numerous challenges in implementing their programs, and starting up their programs took the majority of States longer than anticipated. Reasons for the delays included the need to hire and train staff, obtain IRB approval, and formalize partnerships and contracts. Each component was critical and had a profound impact on the six States that took 6 months to 2 years longer than projected to implement their programs. States addressed implementation delays and program challenges by implementing numerous program changes, with programs continuously evolving.

Delays in implementing programs and the associated challenges in recruiting participants had a significant impact on States' enrollment targets, with seven programs reducing their initial projections by between 42 percent and 85 percent. States worked hard to recruit participants, with three States expanding program eligibility to include additional Medicaid eligibles. With the exception of Texas, program participation in State initiatives was slower than anticipated. States strove to make programs accessible by providing transportation, reimbursing participants

for public transportation, meeting participants in their home, or providing services telephonically, so participants did not have to travel. Accessibility also encompassed cultural and linguistic sensitivity, with States hiring culturally competent staff who have worked with or are members of the target population and partnering with organizations familiar with these populations. States modified outreach strategies and incentives, based on their success in reaching the populations being targeted. The majority of programs found that collaborating with providers, clinics, and MCOs was an important tool in identifying potentially eligible participants and providing referrals and enrollment. Several States used provider incentives, and some modified them to increase provider engagement. States adapted and modified outreach strategies and program features during and throughout implementation as they sought to address challenges. Through the Learning Collaborative, States shared challenges and lessons learned with one another, and States used the information in modifying their programs. The 10 demonstration States have shown great flexibility as they have adapted to challenges and have all implemented their programs, continuing to evolve in efforts to meet the needs of their targeted populations in adopting healthier program behaviors.

*[This page intentionally left blank.]*

# SECTION 4
# UTILIZATION AND EXPENDITURES OF HEALTH CARE SERVICES

## 4.1 Evaluation Questions

MIPCD programs use incentives to promote changes in the utilization of specific services. MIPCD programs are also expected to improve the health of participants, which in turn may further affect service use and health care expenditures. We assessed the impact of the program on health care utilization and expenditures to answer the following evaluation questions:

1. Have the MIPCD programs reduced inpatient admissions and ED visits?

2. Have the MIPCD programs reduced total Medicaid expenditures, inpatient expenditures, and ED expenditures?

3. Have the MIPCD programs improved utilization of services incentivized by the MIPCD program?

Our hypothesis is that participants receiving incentives will obtain more services incentivized by the MIPCD programs. Because the goal of MIPCD programs is to encourage the use of services that prevent chronic disease, participants may see improvements in health, which may result in fewer inpatient admissions and ED visits. Reductions in inpatient admissions and ED visits will lead to reductions in inpatient expenditures, ED expenditures, and total expenditures. However, improvements in health often take time to achieve, and so the MIPCD programs may have no impact on these measures in the short run. For example, MIPCD programs focusing on smoking cessation will have little to no effect on utilization in the short run, but they may prevent smoking-related complications, thereby lowering utilization and costs in the long run. A better test of MIPCD program effectiveness in the short run is improved utilization of services incentivized by MIPCD programs. The utilization and cost analyses discussed here rely on data from two sources: (1) State Medicaid enrollment, fee-for-service claims, and/or managed care encounter data; and (2) the MIPCD State MDS. These data sources are briefly described below.

## 4.2 Data Sources

### 4.2.1 Medicaid Enrollment, Fee-for-Service Claims, and Managed Care Encounter Data

Medicaid enrollment data files include information used to describe the incentive and control group participants, such as why an individual is enrolled in Medicaid (i.e., low income or disability), date of birth, sex, and race/ethnicity. These data are used to control for variation between participants when conducting statistical modeling. Medicaid fee-for-service claims detail the services rendered to a beneficiary, including the type of service rendered, the dates on which services were rendered, the service provider, and the amount paid to the provider. Managed care encounters can be thought of as a "dummy" claim, and the managed care encounter data include the same types of information available in fee-for-service claims. The one significant difference between claims and encounter data is that some States do not record

the amount paid to the provider on encounter claims, which is the case in Minnesota's encounter data.

### 4.2.2 MIPCD State MDS

The MDS includes enrollment, demographic, service utilization, incentive, and health and behavior outcomes data for incentive and control group program participants at the time of enrollment in the program, during the program, and potentially for some period after enrollment in the program. The MDS consists of two core modules capturing enrollment and demographic data and one State-specific module reflecting key components of the State's program. Through this State-specific module, States report the services and incentives enrollees received through the program, as well as selected health and behavioral outcomes (e.g., weight, blood pressure, cholesterol). At the time of this analysis, States had reported data through the MDS through June 2015.

## 4.3 Analytic Approach

### 4.3.1 Study Population and Data Availability

To assess the impact of the MIPCD program on utilization and expenditures, we analyzed Medicaid enrollment, fee-for-service claims, and managed care encounter data for eight States: California, Connecticut, Minnesota, Montana, New Hampshire, Nevada, Texas, and Wisconsin. At the time of this report, Hawaii and New York had not yet provided Medicaid data for analyses. Medicaid claims were submitted for incentive and control group participants. Control group members were selected by the States. Most States enrolled adult beneficiaries older than 18 years of age. The analysis for Nevada is an exception as it is limited to children (younger than 18 years of age) in the Children's Heart Study. At the time of this analysis, beneficiary enrollment in Nevada's other program arms was very low.

States provided claims data for 2 years before entry into the MIPCD program for incentive and control group participants (i.e., "pre-period") and data for 1 to 2 years after enrollment into the program (i.e., "post-period"). ***Table 10*** describes the period over which claims data are available for each State.

Unlike the claims data, the MDS does not provide information on MIPCD participants prior to their enrollment in the MIPCD program. It is important to note that, at this point in the evaluation, the claims data and the MIPCD State MDS data encompass different time periods, with more recent information reported in the MIPCD State MDS. For that reason, the number of MIPCD participants varies by data source, with fewer participants in the claims data than in the MIPCD State MDS, as summarized in Table 10.

**Table 10**
**Time periods and number of unique enrollees in the Medicaid claims data and MIPCD State MDS, by State**

| State | Time period of Medicaid claims data | Number of enrollees in the Medicaid claims data | Number of post-period quarters of claims data | Time period of MIPCD State MDS | Number of enrollees in the MIPCD State MDS |
|---|---|---|---|---|---|
| California | July 2010–June 2013 | 3,556 | 5 quarters | January 2013–June 2015 | 3,847[1] |
| Connecticut | January 2012–March 2015 | 731 | 3 quarters | January 2013–June 2015 | 3,991[2] |
| Hawaii | — | — | — | January 2013–June 2015 | 2,325 |
| Minnesota | January 2011–September 2014 | 642 | 8 quarters | January 2013–June 2015 | 1,081 |
| Montana | January 2010–December 2014 | 171 | 10 quarters | January 2013–June 2015 | 261 |
| New Hampshire | April 2010–March 2015 | 1,081 | 5 quarters | January 2013–June 2015 | 2,031 |
| New York | — | — | — | January 2013–June 2015 | 3,857 |
| Nevada | January 2011–March 2015 | 1,545 | 6 quarters | January 2013–June 2015 | 1,674[3] |
| Texas | April 2010–March 2015 | 1,262 | 6 quarters | January 2013–June 2015 | 1,262 |
| Wisconsin (First Breath) | July 2010–September 2014 | 616 | 9 quarters | January 2013–March 2015[2] | 1,037 |
| Wisconsin (Quitline) | April 2011–September 2014 | 482 | 6 quarters | January 2013–March 2015[4] | 1,742 |

[1] California reports on 58,408 individuals across its program arms. There are 3,847 unique enrollees in the randomized trial program arm that is discussed in ***Section 4.4.1***.

[2] Connecticut reports on 4,015 individuals across its program arms. There are 3,991 enrollees in the adult, non-pregnant smokers program arm that is discussed in ***Section 4.4.1***.

[3] Wisconsin is reporting one quarter behind the other States; this was approved by CMS.

[4] Nevada reports on 1,767 individuals across its programs. There are 1,674 children in the Healthy Hearts Program that is discussed in ***Section 4.4.1***.

### 4.3.2 Measures of Interest

*Key Independent Variable.* The primary predictor of interest is whether a MIPCD participant received incentives for participating in the program.

*Claims-Based Utilization and Expenditure Measures.* Rates of utilization and expenditures for each participant are presented quarterly (i.e., per participant per quarter), with each quarter corresponding to an enrollee's time since enrollment in the demonstration (e.g., D1 = first quarter of enrollment in MIPCD, D2 = second quarter since first enrolled in MIPCD…D4 = fourth quarter since first enrolled in MIPCD) or each enrollee's time in Medicaid prior to MIPCD enrollment (e.g., B1 = first quarter in Medicaid at the start of the enrollee's "pre-period"… B8 = quarter in Medicaid right before quarter of enrollment in MIPCD). Not every enrollee had a claims history spanning the full 2 years prior to enrollment in the MIPCD program, and not every enrollee had the same number of quarters of post-enrollment in MIPCD. Those who enrolled in the program soon after the State implemented the program have more quarters of post-enrollment data than those who enrolled near the time when the State submitted its claims data for analysis.

The following measures were examined:

1. **Total expenditures:** This measure is defined as all payments made to providers on behalf of Medicaid enrollees. Payments made for all services rendered are included, unless otherwise noted in ***Section 4.5***. Total expenditures are reported as per member per month (PMPM) expenditures.

2. **Any inpatient visits:** This measure is a binary indicator of whether or not an enrollee had an inpatient stay in the quarter. Inpatient stays in long-term care, psychiatric, rehabilitation, or substance use hospitals/facilities are excluded to the extent these stays could be identified. Depending on the States' data, comprehensive identification of these stays for specialized care is not always feasible.

3. **Inpatient expenditures:** This measure is defined as the payments made to providers for the inpatient visits identified in the above measure. Expenditures are reported as PMPM expenditures.

4. **Any ED visits:** This measure is a binary indicator of whether or not an enrollee had an ED visit in the quarter. Visits to the ED for laboratory, pathology, or radiology tests only were excluded because these visits were considered non-emergency. The assumption is that the use of the ED for these services has more to do with the availability of laboratories and radiology equipment in the surrounding area and less to do with receipt of emergency care.

5. **ED expenditures:** This measure is defined as the payments made to providers for the ED visits identified through the outpatient claims. This measure also includes payments made to medical personnel (e.g., physicians) who provided services to enrollees in the ED. ED visits that lead to a hospitalization are found on the inpatient claims, and it is often not possible to distinguish the payments made only for the ED portion of the hospital visit from the rest of the hospital stay. For this reason,

payments for ED visits found in inpatient claims are not included in this expenditure measure, and ED expenditures are lower than one might generally expect. Expenditures are reported as PMPM expenditures.

6. **Outpatient visits for evaluation and management services:** This measure is defined as the number of visits for evaluation and management services received in office settings and FQHCs.[1] We calculated this measure for Minnesota, Nevada, and Wisconsin. Minnesota and Wisconsin do not provide amounts paid to providers in the claims data for their managed care enrollees. As a result, expenditures are underestimated, so we analyze this additional utilization outcome to expand our understanding of patterns of utilization among MIPCD participants. At this point in the analysis, Nevada's program primarily comprises children younger than 18 years of age; because children have fewer hospitalizations and emergency department visits than adults, we also examined this outcome to better understand patterns of utilization among the child participants.

Some program enrollees may not be enrolled in Medicaid for all 3 months of each quarter. Because of the differential time enrolled within a quarter, all enrollees' outcomes (except inpatient hospitalization and inpatient expenditures) were adjusted to mimic full exposure to Medicaid in the quarter. Inpatient hospitalizations and expenditures were not adjusted for partial-quarter enrollment in Medicaid because they are rare, costly events, and adjustment could result in large overestimates of these measures. All other cost and utilization measures were "quarterized" by multiplying each enrollee's non-inpatient utilization and costs by the inverse of the fraction of time that the patient was enrolled in Medicaid during the quarter. For example, a patient who was enrolled in Medicaid for 1 month during the quarter had non-inpatient costs and utilizations multiplied by 3, while a patient who was enrolled for 2 months during the quarter had these measures multiplied by 1.5.

*Claims-Based Covariates of Interest.* We describe the incentive and control group participants using several sociodemographic characteristics, including age, sex, race, ethnicity, reason for Medicaid eligibility in the year prior to enrolling in the MIPCD program, total months enrolled in Medicaid (defined as number of months the enrollee is in the Medicaid claims data file), whether the beneficiary was continuously enrolled in Medicaid (defined as whether or not a beneficiary is enrolled in Medicaid for every month starting when the beneficiary first enters the study period through his or her exit from the data set), and whether the beneficiary was also enrolled in Medicare (dual eligible).

[1] CPT codes defining evaluation and management services included 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339, 99340, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99358, 99359, 99366, 99367, 99368, 99374, 99375, 99376, 99377, 99378, 99379, 99380, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99405, 99406, 99407, 99408, 99409, 99410, 99411, 99412, 99420, 99421, 99422, 99423, 99424, 99425, 99426, 99427, 99428, 99429, 99441, 99442, 99443, 99444, G0402, G0438, G0439, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99495, 99496.

*Claims-Based Special Populations.* As described in Section 5 on Special Populations, all States are targeting adults with or at risk of developing chronic conditions. Additionally, States are targeting diverse populations, such as those with mental illness or substance use disorders and/or racial/ethnic minorities. Most States also consider participants dually enrolled in Medicare and Medicaid to be a special population, because these enrollees typically have higher morbidity and consequently have greater health care expenditures. Similarly, participants enrolled in Medicaid because they are low income and disabled can be considered a special population given their higher morbidity and expenditures compared with those enrolled in Medicaid only because they are low-income. Given the limitations of relatively small sample sizes in the Medicaid claims data received to date for analysis and the lack of detailed sociodemographic information on race/ethnicity, for this report, we limited our analysis of the impact of the MIPCD programs on utilization and expenditures to dual Medicare-Medicaid enrollees and those enrolled in Medicaid due to disability in all States, with two exceptions. In Texas, all participants are enrolled in Medicaid due to disability, and all have a behavioral health and/or substance abuse diagnosis, so we limited the special populations analysis to Medicare-Medicaid enrollees only. Nevada is excluded from this special populations analysis because none of the MIPCD participants were Medicare-Medicaid enrollees or disabled.

*MDS-Related Utilization Variables and Covariates.* To examine the impact of providing incentives on engagement in MIPCD program activities, we examined the outcomes of interest described in ***Table 11***. In analyses of these outcomes, we also controlled for the possible influence of the sociodemographic characteristics listed in Table 11. The MIPCD MDS captured information on sex, age, race, ethnicity, and education. States varied in the extent to which they reported complete data for these characteristics. If one of these characteristics is not listed below for a State, there were significant missing data for that characteristic (e.g., education was not well captured by many States). Some States have also started reporting which participants have completed the program[2]; States vary in the completeness of this variable. If the State reported these data, then we also controlled for completion of the program. Time enrolled in the MIPCD program also influences engagement in program activities; therefore, we controlled for the number of days a participant was enrolled, from date of entry into the program through program completion date or the end of the last quarter through which States reported data (June 30, 2015).

[2] The primary method for determining if a participant completed the program is calendar time from program enrollment. States vary in the amount of time that lapses before the State reports the participant completed the program (e.g., 6 months, 10 months, or 12 months from program enrollment).

**Table 11**
**Utilization of MIPCD program services, by State**

| State | MIPCD program service | Characteristic of interest |
|---|---|---|
| California | ▪ Number of quitline calls<br>▪ Ever reported a quit attempt<br>▪ Ever reported a 30-day period of no smoking | Age, sex, race, ethnicity, education, program time, program completion |
| Connecticut | ▪ Number of individual smoking cessation counseling sessions<br>▪ Number of quitline calls | Age, sex, race, ethnicity, education, program time, program completion |
| Hawaii | ▪ Number of visits with a health coach<br>▪ Number of individual only diabetes education sessions<br>▪ Number of behavioral health counseling sessions<br>▪ Number of individual only smoking cessation sessions | Age, sex, race, ethnicity, program time, program completion |
| Minnesota | ▪ Number of core diabetes prevention program sessions<br>▪ Number of post-care diabetes prevention program sessions | Age, sex, race, program time, program completion |
| Montana | ▪ Number of core diabetes prevention program sessions<br>▪ Number of post-care diabetes prevention program sessions | Age, sex, race, program time, program completion |
| New Hampshire | ▪ Number of gym sessions (weight program)<br>▪ Number of Weight Watchers meetings (weight program)<br>▪ Number of quitline calls (smoking cessation program) | Age, sex, race, ethnicity, education, program time, program completion |
| New York | ▪ Number of diabetes prevention program sessions (diabetes prevention program)<br>▪ Number of diabetes management primary care visits (diabetes management program)<br>▪ Number of diabetes-related prescriptions filled (diabetes management program)<br>▪ Number of hypertension management primary care visits (hypertension program)<br>▪ Number of hypertension-related prescriptions filled (hypertension program)<br>▪ Number of smoking cessation counseling sessions attended (smoking cessation program)<br>▪ Number of smoking-related prescriptions filled (smoking cessation program) | Age, sex, race, ethnicity, program time, program completion |

(continued)

**Table 11 (continued)**
**Utilization of MIPCD program services, by State**

| State | MIPCD program service | Characteristic of interest |
|---|---|---|
| Nevada | ▪ Number of patients attaining goal at week 12 of the program, child only incentive<br>▪ Number of patients attaining goal at week 12 of the program, child and parent incentive | |
| Texas | ▪ Number of patients receiving an incentive for purchasing wellness devices, gym membership or wellness program, nutritional item or health food, and/or behavioral health interventions | Age, sex, race, ethnicity, education, program time, program completion |
| Wisconsin | ▪ Number of quitline calls (Striving to Quit program)<br>▪ Number of prenatal smoking cessation counseling visits (First Breath program)<br>▪ Number of postpartum smoking cessation counseling visits (First Breath program)<br>▪ Number of postpartum smoking cessation quitline calls (First Breath program) | Age, sex, race, ethnicity, education, program time, program completion |

### 4.3.3 Statistical Analyses

Because each State's proposed program design, incentive structure, target conditions, and outcomes of interest are unique, we conducted a separate quantitative analysis for each State. Following an intent-to-treat approach, we did not exclude those who had not yet completed the program at the time the State submitted the Medicaid claims data and MIPCD State MDS data.

*Descriptive Analysis.* All States randomized participants into the incentive or control group, except for Hawaii. We assessed the success of each State's randomization process by calculating standardized differences in means (or proportions) in sociodemographic, enrollment, and pre-period total Medicaid expenditures between incentive and control groups. We also used *t*-tests and chi-square tests to test for significant differences between the two groups on these characteristics. Across States, incentive and control group participants were comparable on almost all characteristics we examined. As we receive more data from the States, we will continue to assess how well each State's randomization process succeeded in creating comparable incentive and control groups. Should groups become less comparable, we will employ a propensity score methodology to achieve greater comparability for the regression analyses. See ***Section 4.4*** for a summary of characteristics of MIPCD participants in the Medicaid claims data.

*Regression Analysis.* We employed a difference-in-difference regression framework to test for the effect of receiving incentives on our outcomes of interest. The difference-in-difference model was estimated as follows:

$$\text{Any Health Care Visit/Cost} = \beta_0 + \beta_1 \text{PostYear} + \beta_2 \text{Incentive} +$$

$$\beta_3 \text{PostYear} * \text{Incentive} + \beta_4 \text{Covariates} + \varepsilon$$

where separate models were estimated for each measure of utilization (e.g., did the MIPCD participant have an inpatient admission in the quarter, or did the participant have an ED visit in the quarter). "PostYear" is an indicator of whether the observation is from the pre- or post-intervention period, "Incentive" is an indicator of whether the participant was in the incentive group, and PostYear * Incentive is an interaction term. Covariates represent vectors of participant characteristics described above in *Claims-Based Covariates of Interest*. Under this specification, $\beta_3$ is the average intervention effect during the post-demonstration period. This term is the difference-in-difference estimate and the primary variable of interest. If the term *is positive and statistically significant*, the incentive group had *more expenditures/utilization growth over time* compared with the control group; if the term is *negative and statistically significant*, the incentive group had *less expenditures/utilization growth over time* compared with the control group. Statistical significance is measured at $p < 0.05$.

For the utilization measures, we fit a logit difference-in-difference model for binary outcomes. For the expenditures outcomes, we fit a linear difference-in-difference model. Once we have complete claims data on all participants who enrolled in the MIPCD program, we will explore the sensitivity of our results under alternative model specifications (e.g., log transforming the expenditure data, using count models for visit outcomes,[3] and assessing different approaches to model utilization and expenditures changes quarter-by-quarter over time).[4]

To examine outcomes among special populations, we tested whether program effects differed for Medicare-Medicaid enrollees compared with Medicaid enrollees and for disabled compared with non-disabled enrollees. To do this, we ran two additional sets of regression models, the first including an interaction term for whether the participant was a Medicare-Medicaid enrollee or just a Medicaid enrollee and the second including an interaction term for whether the participant was enrolled in Medicaid due to disability.[5]

---

[3] Poisson or negative binomial count models will be considered. With the relatively small study sample sizes, the number of observations with 0 inpatient admissions or 0 ED visits is large. Therefore, we chose to create binary measures of any utilization. When we obtain more data on more study participants, we will determine if we have enough observations to fit a count model.

[4] The current model assumes that an enrollee's baseline trends in expenditures are linear over time. When plotting expenditures over the quarters of interest for the incentive and control group participants by State, this was often the case. However, as we obtain more claims data, this pattern may no longer hold. To accommodate the possibility of nonlinear trends in expenditures, we will explore alternative model specifications, such as controlling for quarter in regressions through a quarterly fixed effect model.

[5] The interaction term for the Medicare-Medicaid enrollee/disabled enrollee is a three way interaction, specified as $\text{Any Health Care Visit/Cost}_i = \beta_0 + \beta_1 \text{PostYear} + \beta_2 \text{Incentive} + \beta_3 \text{PostYear} * \text{Incentive} + \beta_4 \text{Dual(Disabled)} + \beta_5 \text{Dual(Disabled)} * \text{Incentive} + \beta_6 \text{Dual(Disabled)} * \text{PostYear} + \beta_7 \text{PostYear} * \text{Incentive} * \text{Dual(Disabled)} + \beta_8 \text{Covariates} + \varepsilon$.

Because the evaluation design is characterized by repeated outcomes on the same enrollee over time, we made cluster adjustments to the standard errors in estimating demonstration effects in all regression models. Without taking into account this clustering, estimates of variance related to program effects would be understated. In some MIPCD programs, there are other levels of clustering than only the repeated outcomes over time. For example, when programs enroll participants into diabetes prevention class, participants are clustered under a particular teacher. Participants with the same teacher may do better (or worse) than participants with another teacher, based on the relative effectiveness of the teacher. However, by clustering for the repeated outcomes on the same enrollee, we sufficiently adjust the standard errors to also address this second level of clustering. An important point to note is that, compared with an independent sample, samples that adjust for clustering take a larger intervention effect or data from additional demonstration quarters to reject the null hypothesis of no effect of the program on outcomes.

*Special Considerations for the MIPCD MDS Analysis*. Similar to the approach taken for the Medicaid claims analyses, we assessed the distribution of sociodemographic characteristics between the incentive and control groups within each State. To assess the impact of receiving incentives on the outcomes of interest, we conducted regression analyses for all States except Texas and one component of Hawaii's program. Texas's control group, by design, does not receive the same set of services as the incentive group, so we are unable to compare service utilization between the incentive and control groups. Hawaii did not report on a control group for the "HI-PRAISE" component of its program. For these two programs, we present descriptive information on utilization for the incentive group. The MIPCD MDS data do not provide information on utilization of health services or health outcomes prior to enrollment in the MIPCD program. Therefore, we did not consider a difference-in-difference regression approach, but we did include sociodemographic characteristics in all regression models to control for the possible influence of these characteristics on utilization outcomes. We fit negative binomial models for all outcomes that reflect counts of visits, sessions, or calls. We fit a logit model for all outcomes that reflect if the participant ever received an outcome. As explained above, we followed an intent-to-treat approach. However, we controlled for whether a beneficiary completed the program. We did not conduct secondary analyses for Medicare-Medicaid enrollees and the disabled. Identification of these participants relies on information in the Medicaid claims data, and as described in Table 10, we do not yet have the claims data for everyone reported to date in the MIPCD MDS.

## 4.4 Results

### 4.4.1 Medicaid Utilization and Expenditure Analyses

*Characteristics of the Study Sample*

***Table 12*** summarizes characteristics of MIPCD participants in the incentive and control groups.

*California*. The goal of the California project is to demonstrate that tobacco cessation benefits and incentives are effective for reducing smoking prevalence, lowering costs, and improving health outcomes for smokers with Medi-Cal benefits. Medi-Cal recipients who call the California Smokers' Helpline and agreed to participate in a study were randomly assigned to

one of three groups: counseling only (control group); counseling plus free nicotine patches (incentive group 1); and counseling, patches, and a financial incentive to continue calling the Helpline (incentive group 2). Claims data included 1,293 patients in incentive group 1; 1,321 patients in incentive group 2; and 942 people in the control group. The incentive groups are similar to the control group in terms of sociodemographic characteristics, Medicaid enrollment, health care utilization, and expenditures. In each group, the average age is 46 years old, and 68 percent are female. The control group has a slightly higher fraction of white patients and a slightly lower proportion of Hispanic and black/African American patients (fraction of sample that is black/African American not shown in table for brevity). Across the three groups, approximately one-third of patients are eligible for Medicaid because they are low-income, and two-thirds are eligible for Medicaid because they are blind or disabled. During the baseline period, PMPM expenditures are very similar ($794 in incentive group 1, $770 in incentive group 2, and $757 in the control group).

**Table 12**
**Sociodemographic characteristics of incentive and control group MIPCD participants in the Medicaid claims data, by State**

| Characteristic | California | | | | | | Connecticut | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Incentive group (NRT) | | Incentive group (NRT + cash) | | Control group | | Incentive group | | Control group | |
| | N = 1,293 | | N = 1,321 | | N = 942 | | N = 381 | | N = 350 | |
| | Estimate | SD | Estimate | SD | Estimate | SD | Estimate | SD | Estimate | SD |
| Age in years, mean | 46 | (12) | 47 | (12) | 46 | (12) | 43 | (12) | 44 | (11) |
| Female, % | 68 | (46) | 68 | (47) | 68 | (47) | 54 | (50) | 57 | (50) |
| White, % | 59 | (49) | 59 | (49) | 61 | (49) | 75 | (43) | 73 | (45) |
| Hispanic, % | 10 | (30) | 10 | (30) | 9 | (28) | — | — | — | — |
| Dual, % | 33 | (47) | 32 | (46) | 29 | (46) | 15 | (36) | 15 | (36) |
| Continuously enrolled, % | 43 | (49) | 44 | (50) | 42 | (49) | 80 | (40) | 80 | (40) |
| No. months enrolled in Medicaid, mean | 25 | (9) | 25 | (9) | 25 | (9) | 23 | (6) | 23 | (7) |
| Reason for Medicaid eligibility, % | | | | | | | | | | |
| Low income | 31 | (46) | 31 | (46) | 31 | (46) | 69 | (46) | 71 | (46) |
| Disabled/blind | 65 | (48) | 65 | (48) | 65 | (48) | 31 | (46) | 29 | (46) |
| Aged | 3 | (17) | 3 | (16) | 3 | (16) | — | — | — | — |
| Baseline period total PMPM expenditures, mean | $794 | ($1,754) | $770 | $1,885 | $757 | ($1,542) | $1,341 | ($1,830) | $1,311 | ($2,125) |

(continued)

**Table 12 (continued)**
**Sociodemographic characteristics of incentive and control group MIPCD participants in the Medicaid claims data, by State**

| | Minnesota | | | | | | Montana | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Incentive group (NRT) | | Incentive group (NRT + cash) | | Control group | | Incentive group | | Control group | |
| | N = 220 | | N = 201 | | N = 221 | | N = 97 | | N = 74 | |
| Characteristic | Estimate | SD | Estimate | SD | Estimate | SD | Estimate | SD | Estimate | SD |
| Age in years, mean | 48 | (12) | 46 | (13) | 47 | (11) | 45 | (13) | 47 | (13) |
| Female, % | 71 | (45) | 73 | (44) | 65 | (48) | 75 | (43) | 73 | (44) |
| White, % | 15 | (36) | 27 | (44) | 12 | (33) | 93 | (26) | 95 | (23) |
| Hispanic, % | — | — | — | — | — | — | — | — | — | — |
| Dual, % | 11 | (31) | 09 | (29) | 8 | (27) | 59 | (49) | 65 | (48) |
| Continuously enrolled, % | 19 | (39) | 16 | (37) | 19 | (4) | 78 | (41) | 85 | (36) |
| No. months enrolled in Medicaid, mean | 37 | (10) | 37 | (10) | 36 | (11) | 59 | (12) | 59 | (11) |
| Reason for Medicaid eligibility, % | | | | | | | | | | |
| Low income | — | — | — | — | — | — | 8 | (28) | 3 | (16) |
| Disabled/blind | 2 | (15) | 5 | (23) | 2 | (15) | 59 | (49) | 66 | (47) |
| Aged | — | — | — | — | — | — | 1 | (10) | 5 | (23) |
| Baseline period total PMPM expenditures, mean | $376 | ($1,266) | $411.04 | ($1,030) | $459 | ($1,088) | $891 | ($766) | $934 | ($1,851) |

(continued)

**Table 12 (continued)**
**Sociodemographic characteristics of incentive and control group MIPCD participants in the Medicaid claims data, by State**

| | Nevada | | | | | | New Hampshire—Weight | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Incentive group (NRT) | | Incentive group (NRT + cash) | | Control group | | Incentive group | | Control group | |
| | N = 365 | | N = 342 | | N = 838 | | N = 446 | | N = 428 | |
| Characteristic | Estimate | SD | Estimate | SD | Estimate | SD | Estimate | SD | Estimate | SD |
| Age in years, mean | 11 | (3) | 11 | (3) | 11 | (3) | 43 | (12) | 44 | (12) |
| Female, % | 47 | (50) | 49 | (50) | 49 | (50) | 69 | (46) | 72 | (45) |
| White, % | 5 | (21) | 9 | (29) | 9 | (29) | 97 | (16) | 96 | (20) |
| Hispanic, % | 77 | (42) | 72 | (45) | 51 | (50) | — | — | — | — |
| Dual, % | — | — | — | — | — | — | 56 | (50) | 57 | (50) |
| Continuously enrolled, % | 77 | (42) | 82 | (39) | 79 | (41) | 78 | (42) | 75 | (44) |
| No. months enrolled in Medicaid, mean | 36 | (14) | 38 | (14) | 36 | (14) | 30 | (9) | 31 | (7) |
| Reason for Medicaid eligibility, % | | | | | | | | | | |
| Low income | 100 | (0) | 100 | (0) | 100 | (0) | 7 | (26) | 9 | (28) |
| Disabled/blind | — | — | — | — | — | — | 59 | (49) | 56 | (50) |
| Aged | — | — | — | — | — | — | 28 | (45) | 31 | (46) |
| Baseline period total PMPM expenditures, mean | $141 | ($337) | $146 | ($351) | $174 | ($721) | $1,020 | ($1,285) | $1,037 | ($1,678) |

(continued)

**Table 12 (continued)**
**Sociodemographic characteristics of incentive and control group MIPCD participants in the Medicaid claims data, by State**

| Characteristic | New Hampshire—Smoking Cessation | | | | Texas | | | |
|---|---|---|---|---|---|---|---|---|
| | Incentive group | | Control group | | Incentive group | | Control group | |
| | N = 185 | | N = 165 | | N = 632 | | N = 630 | |
| | Estimate | SD | Estimate | SD | Estimate | SD | Estimate | SD |
| Age in years, mean | 45 | (11) | 48* | (10) | 45 | (9) | 44 | (9) |
| Female, % | 65 | (48) | 68 | (47) | 62 | (49) | 61 | (49) |
| White, % | 96 | (19) | 95 | (22) | 35 | (48) | 41* | (49) |
| Hispanic, % | — | — | — | — | 16 | (37) | 19 | (40) |
| Dual, % | 63 | (48) | 64 | (48) | 5 | (22) | 6 | (23) |
| Continuously enrolled, % | 76 | (43) | 82 | (38) | 95 | (22) | 96 | (20) |
| No. months enrolled in Medicaid, mean | 30 | (9) | 31 | (9) | 48 | (5) | 48 | (4) |
| Reason for Medicaid eligibility, % | | | | | | | | |
| Low income | 4 | (19) | 4 | (20) | — | — | — | — |
| Disabled/blind | 58 | (49) | 52 | (50) | 100 | (0) | 100 | (0) |
| Aged | 34 | (47) | 35 | (48) | — | — | — | — |
| Baseline period total PMPM expenditures, mean | $1,080 | ($1,423) | $1,301 | ($2,710) | $1,569 | ($4,607) | $1,256 | ($2,859) |

(continued)

**Table 12 (continued)**
**Sociodemographic characteristics of incentive and control group MIPCD participants in the Medicaid claims data, by State**

| | Wisconsin—Striving to Quit | | | | Wisconsin—First Breath | | | |
|---|---|---|---|---|---|---|---|---|
| | Incentive group | | Control group | | Incentive group | | Control group | |
| | N = 290 | | N = 288 | | N = 310 | | N = 306 | |
| Characteristic | Estimate | SD | Estimate | SD | Estimate | SD | Estimate | SD |
| Age in years, mean | 43 | (11) | 43.70 | (11.23) | 27 | (6) | 27 | (5) |
| Female, % | 68 | (47) | 73 | (44.52) | 1 | (.) | 100 | (.) |
| White, % | 37 | (48) | 33 | (46.97) | 39 | (49) | 42 | (49) |
| Hispanic, % | 2 | (13) | 2 | (15.43) | 5 | (22) | 4 | (20) |
| Dual, % | 10 | (31) | 11 | (31.48) | 3 | (16) | 1 | (11) |
| Continuously enrolled, % | 84 | (37) | 84 | (36.37) | 64 | (48) | 54 | (50) |
| No. months enrolled in Medicaid, mean | 44 | (9) | 45 | (8.24) | 42 | (11) | 41 | (11) |
| Reason for Medicaid eligibility, % | | | | | | | | |
| Low income | 62 | (49) | 67 | (47) | 37 | (48) | 12 | (32) |
| Disabled/blind | 38 | (49) | 323 | (47) | 63 | (48) | 27 | (44) |
| Aged | — | — | — | — | — | — | — | — |
| Baseline period total PMPM expenditures, mean | $232 | ($1,213) | $213 | ($961) | $475 | ($970) | $434 | ($1,027) |

SD = standard deviation

* $p < 0.05$ for the difference between the incentive and control groups.

*Connecticut.* The purpose of the State's MIPCD program is to provide smoking cessation services to non-pregnant and pregnant smokers. Enrollment among pregnant smokers was low at the time these Medicaid claims data were provided for analysis. The claims file included 8 enrollees who were pregnant smokers, and they were excluded from the analysis. They will be examined in subsequent analyses when the enrollment numbers are higher. The resulting MIPCD study sample for the Medicaid claims analysis included 731 enrollees: 381 in the incentive group and 350 in the control group. The two groups are comparable in terms of sociodemographic and expenditure characteristics. They are similar in age (43 years), about half were female, and three-fourths are white. The percentage dually eligible for Medicare (15 percent), percentage continuously enrolled in Medicaid (80 percent), and total months enrolled in Medicaid (23 months) are comparable between groups. About two-thirds were enrolled in Medicaid because they were low-income only, and about one-third were enrolled because they were low-income disabled. The two groups were similar in total PMPM expenditures in the baseline period ($1,341 for the incentive group vs. $1,311 for the control group).

*Minnesota.* The purpose of the State's MIPCD program is to facilitate enrollment into a diabetes prevention program, a self-management training program for beneficiaries who are at risk of developing diabetes. There are three program arms: a group that receives incentives for individual performance, a group that receives incentives for individual performance plus group performance, and a control group. The resulting MIPCD study sample for the analysis includes 642 enrollees: 220 in the individual incentive group, 201 in the individual plus group incentive, and 221 in the control group. All three groups are comparable in terms of sociodemographic and expenditure characteristics. They are similar in age (48 years), approximately two-thirds are female (with slightly more females in the incentive groups than in the control group), and less than 20 percent of all participants are white. The percentage dually eligible for Medicare (10 percent), percentage continuously enrolled in Medicaid (18 percent), and total months enrolled in Medicaid (36 months) are comparable between groups. Approximately 3 percent were enrolled in Medicaid because they were low-income disabled. The three groups were statistically comparable in total PMPM expenditures in the baseline period ($376 and $411 for the two incentive groups vs. $460 for the control group). It is important to point out that total PMPM expenditures are lower than other States because Minnesota does not report paid amounts on claims for managed care beneficiaries. Also, Minnesota does not include claims for chemical dependency services, so total expenditures do not include expenditures made for all Medicaid services.

*Montana.* The purpose of the State's MIPCD program is to reduce weight, lower blood pressure, and prevent type 2 diabetes through incentives and lifestyle coaching. The target population is adult Medicaid beneficiaries who are overweight or obese and at risk for developing cardiovascular disease or diabetes. The Montana MIPCD study sample is relatively small, containing 97 individuals in the incentive plus lifestyle coaching group and 74 in the lifestyle coaching only group. Most demographic characteristics are well balanced across the incentive and control groups. The incentive group is 75 percent female and 93 percent white, and the average age is 45 years. The control group is 73 percent female and 95 percent white, and the average age is 46 years. Comparing Medicaid eligibility categories, the incentive group is more likely to be low income and less likely to qualify for Medicaid based on age or disability. Spending in both groups is similar at about $900 PMPM.

*Nevada.* The purpose of the State's MIPCD program is to provide diabetes prevention, weight, and hypertension management to adults and children through six unique programs. Enrollment in the adult programs was low at the time these Medicaid claims data were provided for analysis, so the Medicaid claims analysis presented here includes only children enrolled in a weight management program known as the Healthy Hearts Program. The MIPCD study sample included 1,545 participants: 365 in incentive group 1 (only the child receives incentives for meeting key goals), 342 in incentive group 2 (the child and parent/family receive incentives for the child meeting key goals), and 838 in the control group. The incentive and control groups were comparable on a number of characteristics; children were on average 11 years old, and about half were female. Three-fourths of the two incentive groups were Hispanic compared with half of the control group. None of the children were dually eligible for Medicare, and all were enrolled because their families were low-income only. The two incentive groups were very similar in total PMPM expenditures in the baseline period (about $140 PMPM), while the control group had slightly higher total PMPM expenditures ($174).

*New Hampshire.* The MIPCD study sample for the Medicaid claims analysis for the weight management program included 874 participants: 446 in the incentive group and 428 in the control group. The incentive and control groups were comparable. They are similar in age (43 years), sex (about 70 percent female), race (almost all white), percentage who are dually eligible for Medicare (56 percent), fraction continuously enrolled in Medicaid (about three-fourths), and total months enrolled in Medicaid (30 months). The majority of participants were enrolled in Medicaid because they were either low-income and disabled or low-income and older than 65 years of age. The two groups were very similar in total PMPM expenditures in the baseline period ($1,020 for the incentive group vs. $1,037 for the control group). The MIPCD study sample for the smoking cessation program included 350 participants: 185 in the incentive group and 165 in the control group. Similar to the weight management program, participants in the smoking cessation program were comparable on a number of characteristics. Participants' age, sex, race, percentage continuously enrolled in Medicaid, total months enrolled in Medicaid, and reason for Medicaid enrollment were similar to those of the weight management program participants. About 63 percent of participants were dually eligible for Medicare. In the baseline period, the control group had higher total PMPM expenditures ($1,301) compared with the incentive group ($1,080).

*Texas.* The MIPCD study sample for the Medicaid claims analysis included 1,262 enrollees: 632 in the incentive group and 630 in the control group. The two groups are comparable on a number of sociodemographic characteristics. They are similar in age (45 years), sex (almost two-thirds female), percentage who are dually eligible for Medicare (5 percent), percentage continuously enrolled in Medicaid (95 percent), and total months enrolled in Medicaid (48 months). All enrollees were eligible for Medicaid because they were low-income and disability. The control group has a greater proportion of white (41 percent) and Hispanic (19 percent) enrollees compared with the incentive group (35 percent and 16 percent, respectively). The incentive group has slightly higher total PMPM expenditures in the baseline period ($1,569) compared with the control group ($1,256).

*Wisconsin.* The State's MIPCD program is focused on smoking cessation for (1) adult Medicaid beneficiaries (this program is known as Striving to Quit) and (2) pregnant Medicaid beneficiaries and mothers of newborns with a special focus on African American women (this

program is known as First Breath). Both programs have an incentive group that receives cash incentives for making smoking cessation counseling calls or visits, taking a carbon monoxide test, and passing the test. Both programs also have a control group that does not receive incentives. In each program, the incentive and control groups are comparable on a number of sociodemographic characteristics. The incentive and control groups are similar in age (43 and 27 years for the Striving to Quit and First Breath programs, respectively), sex (almost two-thirds female in the Striving to Quit program, whereas by construction, all participants in the First Breath program are women), percentage who are dually eligible for Medicare (approximately 10 percent in Striving to Quit and 2 percent in First Breath), percentage continuously enrolled in Medicaid or Badger care plus (84 percent in both incentive and control groups in Striving to Quit, higher for the incentive group than the control group in First Breath), and total months insured (approximately 42 months across both programs). The Striving to Quit program has a PMPM expenditure equal to $231.84 in the incentive group and 213.26 in the control group. The incentive group in the First Breath program has slightly higher total PMPM expenditures in the baseline period ($474.92) compared with the control group ($433.67). It is important to point out that total PMPM expenditures are lower than other States because Wisconsin does not report paid amounts on claims for managed care beneficiaries.

## 4.5 Medicaid Claims Analysis: MIPCD Program Effects on Expenditures and Utilization

***Tables 13*** through ***17*** summarize expenditures and utilization within each State before and after participation in the MIPCD program. The tables include raw means and differences in spending and utilization and regression-adjusted estimates of changes due to participation in the MIPCD program.

For each incentive and control group, we calculated the change in average quarterly spending and utilization before and after MIPCD enrollment in the column titled Pre/Post Difference. For incentive group participants, this difference represents the change in spending and utilization due to participating in the MIPCD program plus the change resulting from other contemporaneous events (e.g., an age trend, time trend, or change due to economic conditions). To account for changes in spending and utilization not caused by participation in the MIPCD program, we used a difference-in-differences methodology, which compares the change in spending and utilization among MIPCD program participants to the same change among a control group not enrolled in the program. Under basic assumptions, the difference-in-differences isolates the effect of program participation on utilization and spending. We present the raw difference-in-differences in the column labeled Difference-in-Differences: Incentive and Control and the regression-adjusted difference-in-difference in the column labeled Covariate-Adjusted Regression: Difference-in-Differences.

We also consider differential effects of program participation for two special populations: dual Medicare-Medicaid enrollees and disabled beneficiaries. Regression adjusted-estimates are not presented in the tables, but the findings are discussed below in the State-specific summaries.

Our results show that the estimated changes in spending and utilization are generally small in magnitude and not statistically significant. The results for each State are summarized below.

**Table 13**
**Total PMPM Medicaid expenditures, by State**

| State | Group | Expenditures: Mean (SD) | | Pre/post difference | Difference-in-differences between incentive and control groups | Covariate-adjusted regression: difference-in-differences |
|---|---|---|---|---|---|---|
| | | Pre-MIPCD enrollment | Post-MIPCD enrollment | | | |
| California | Incentive 1 | $793 ($1,753) | $597 ($1,655) | −$196 | −$43 | −$68 (−$165, $30) |
| | Incentive 2 | $769 ($1,885) | $546 ($1,020) | −$223 | −$70 | −$87 (−$181, $8) |
| | Control | $757 ($1,541) | $604 ($1,466) | -$153 | | |
| Connecticut | Incentive | $1,341 ($1,830) | $1,747 ($2,636) | $406 | $161 | $168 (−$128, $465) |
| | Control | $1,311 ($2,125) | $1,556 ($2,610) | $245 | | |
| Minnesota | Incentive 1 | $454 ($1,144) | $364 ($1,097) | −$89 | −$85 | −$91 (−$227, $45) |
| | Incentive 2 | $485 ($1,000) | $493 ($1,217) | $8 | $4 | $54 (−$91, $200) |
| | Control | $434 ($890) | $438 ($990) | $4 | | |
| Montana | Incentive | $891 ($1,465) | $766 ($1,419) | −$125 | −$79 | −$80 (−$424, $264) |
| | Control | $934 ($1,851) | $888 ($1,273) | −$46 | | |
| Nevada | Incentive 1 | $141 ($337) | $156 ($249) | $15 | −$10 | −$1 (−$71, $69) |
| | Incentive 2 | $146 ($351) | $174 ($337) | $28 | $3 | $11 (−65, 87) |
| | Control | $174 ($721) | $199 ($599) | $25 | | |
| New Hampshire (Weight) | Incentive | $1,020 ($1,285) | $938 ($1,253) | −$82 | $25 | $38 (−$73, $150) |
| | Control | $1,037 ($1,678) | $930 ($1,482) | −$107 | | |
| New Hampshire (Smoking) | Incentive | $1,080 ($1,423) | 818 ($1,116) | −$262 | $250 | $224* ($4, $446) |
| | Control | $1,301 ($2,710) | 789 ($1,065) | −$512 | | |
| Texas | Incentive | $1,569 ($4,607) | $1,365 ($2,673) | −$204 | −$95 | −$110 (−$322, 102) |
| | Control | $1,256 ($2,859) | $1,147 ($2,703) | −$109 | | |

(continued)

**Table 13 (continued)**
**Total PMPM Medicaid expenditures, by State**

| State | Group | Expenditures: Mean (SD) | | Pre/post difference | Difference-in-differences between incentive and control groups | Covariate-adjusted regression: difference-in-differences |
|---|---|---|---|---|---|---|
| | | Pre-MIPCD enrollment | Post-MIPCD enrollment | | | |
| Wisconsin (Quitline) | Incentive | $142 ($495) | $203 ($772) | $61 | −$112 | −$116 (−$317, $86) |
| | Control | $158 ($459) | $330 ($1,535) | $173 | | |
| Wisconsin (First Breath) | Incentive | $50 ($196) | $312 ($304) | $262 | −$56 | −$34 (−$88, $20) |
| | Control | $42 ($177) | $360 ($378) | $318 | | |

SD = standard deviation

* $p < 0.05$

Notes: Minnesota and Wisconsin do not report paid claims for managed care beneficiaries. Total expenditures were calculated using fee-for-service payments. Minnesota also does not release claims for chemical dependency services, so total expenditures are underestimated.

**Table 14**
**Inpatient PMPM Medicaid expenditures, by State**

| State | Group | Expenditures: Mean (SD) | | Pre/post difference | Difference-in-differences between incentive and control groups | Covariate-adjusted regression: difference-in-differences |
|---|---|---|---|---|---|---|
| | | Pre-MIPCD enrollment | Post-MIPCD enrollment | | | |
| California | Incentive 1 | $94 ($1,039) | $78 ($1,134) | −$16 | $37 | $34 (−$14, $81) |
| | Incentive 2 | $107 ($1,367) | $35 ($450) | −$72 | −$19 | −$20 (−$68, $27) |
| | Control | $87 ($759) | $34 ($409) | −$53 | | |
| Connecticut | Incentive | $214 ($1,009) | $162 ($913) | −$52 | $16 | $14 (−$92, $121) |
| | Control | $193 ($1,025) | $125 ($684) | −$68 | | |
| Minnesota | Incentive 1 | $43 ($195) | $30 ($291) | −$13 | $3 | $0 (−$36, $37) |
| | Incentive 2 | $47 ($208) | $34 ($219) | −$13 | $3 | $14 (−$26, $54) |
| | Control | $28 ($123) | $12 ($94) | −$16 | | |
| Montana | Incentive | $95 ($713) | $72 ($558) | −$23 | −$19 | −$20 (−$140, $100) |
| | Control | $49 ($562) | $45 ($429) | −$4 | | |

(continued)

**Table 14 (continued)**
**Inpatient PMPM Medicaid expenditures, by State**

| State | Group | Expenditures: Mean (SD) | | Pre/post difference | Difference-in-differences between incentive and control groups | Covariate-adjusted regression: difference-in-differences |
|---|---|---|---|---|---|---|
| | | Pre-MIPCD enrollment | Post-MIPCD enrollment | | | |
| Nevada | Incentive 1 | — | — | — | — | — |
| | Incentive 2 | — | — | — | — | — |
| | Control | — | — | — | | |
| New Hampshire (Weight) | Incentive | $22 ($191) | $17 ($170) | −$5 | $8 | $8 (−$11, $27) |
| | Control | $33 ($388) | $20 ($155 ) | −$13 | | |
| New Hampshire (Smoking) | Incentive | $39 ($366) | $11 (109) | −$28 | −$18 | −$18 (−$48, $13) |
| | Control | $22 ($166) | $12 (122) | −$10 | | |
| Texas | Incentive | $309 ($2,209) | $388 ($1,949) | $79 | −$10 | −$3 (−$139, $132) |
| | Control | $225 ($1,458) | $294 ($1,784) | $69 | | |
| Wisconsin (Quitline) | Incentive | $79 ($334) | $123 ($632) | $44 | −$104 | −$107 (−$347, $134) |
| | Control | $93 ($279) | $241 ($1635) | $148 | | |
| Wisconsin (First Breath) | Incentive | $28 ($132) | $148 ($164) | $119 | −$45 | −$34 (−$67, −$1) |
| | Control | $26 ($118) | $189 ($236) | $164 | | |

* $p < 0.05$

Notes: Nevada was excluded given the study sample's low average PMPM inpatient expenditures. Minnesota and Wisconsin do not report paid claims for managed care beneficiaries. Inpatient expenditures were calculated using fee-for-service payments.

**Table 15**
**Emergency department PMPM Medicaid expenditures, by State**

| State | Group | Expenditures: Mean (SD) | | Pre/post difference | Difference-in-differences between incentive and control groups | Covariate-adjusted regression: difference-in-differences |
|---|---|---|---|---|---|---|
| | | Pre-MIPCD enrollment | Post-MIPCD enrollment | | | |
| California | Incentive 1 | $15 ($1,039) | $7 ($1,134) | −$8 | −$1 | −$1 (−$6, $3) |
| | Incentive 2 | $13 ($1,367) | $6 ($450) | −$7 | $0 | $0 (−$4, $4) |
| | Control | $15 ($759) | $8 ($409) | −$7 | | |
| Connecticut | Incentive | $47 ($110) | $38 ($88) | −$9 | −$3 | −$16* (−$30, −$2) |
| | Control | $42 ($111) | $48 ($136) | −$6 | | |
| Minnesota | Incentive 1 | $8 ($19) | $3 ($18) | −$4 | −$1 | −$4 (−$9, $1) |
| | Incentive 2 | $23 ($138) | $15 ($104) | −$7 | −$4 | −$1 (−$16, $13) |
| | Control | $8 ($33) | $4 ($19) | −$3 | | |
| Montana | Incentive | $14 ($713) | $10 ($558) | −$4 | −$4 | −$3 (−$7, $0) |
| | Control | $6 ($562) | $6 ($429) | $0 | | |
| Nevada | Incentive 1 | — | — | — | — | — |
| | Incentive 2 | — | — | — | — | — |
| | Control | — | — | — | | |
| New Hampshire (Weight) | Incentive | $24 ($72) | $20 ($81) | −$4 | −$3 | −$3 (−$13, $7) |
| | Control | $26 ($87) | $25 ($116) | −$1 | | |
| New Hampshire (Smoking) | Incentive | $31 ($89) | $20 ($64) | −$11 | $4 | $5 (−$5, $15) |
| | Control | $29 ($93) | $14 ($41) | −$15 | | |
| Texas | Incentive | $81 (233) | $56 ($176) | −$25 | −$20 | −$21 (−$56, $13) |
| | Control | $85 (466) | $80 ($590) | −$5 | | |

(continued)

**Table 15 (continued)**
**Emergency department PMPM Medicaid expenditures, by State**

| State | Group | Expenditures: Mean (SD) | | Pre/post difference | Difference-in-differences between incentive and control groups | Covariate-adjusted regression: difference-in-differences |
|---|---|---|---|---|---|---|
| | | Pre-MIPCD enrollment | Post-MIPCD enrollment | | | |
| Wisconsin (Quitline) | Incentive | $27 ($72) | $31 ($61) | $4 | −$4 | −$1 (−$15, $14) |
| | Control | $37 ($120) | $45 ($214) | $8 | | |
| Wisconsin (First Breath) | Incentive | $35 ($76) | $30 ($63) | −$5 | $0 | $4 (−$6, $14) |
| | Control | $35 ($68) | $30 ($60) | −$5 | | |

* $p < 0.05$

Notes: Nevada was excluded given the study sample's low average PMPM ED expenditures. Minnesota and Wisconsin do not report paid claims for managed care beneficiaries. Inpatient expenditures were calculated using fee-for-service payments.

**Table 16**
**Percentage of the population with an inpatient admission, by State**

| State | Group | Mean % (SD) | | Pre/post difference | Difference-in-differences between incentive and control groups | Covariate-adjusted regression: difference-in-differences |
|---|---|---|---|---|---|---|
| | | Pre-MIPCD enrollment | Post-MIPCD enrollment | | | |
| California | Incentive 1 | 28.67 (45.22) | 16.41 (37.04) | −12.26 | 2.64 | 9.98 (−15.44, 35.40) |
| | Incentive 2 | 28.16 (44.98) | 16.09 (36.75) | −12.07 | 2.83 | 8.79 (−16.98, 34.54) |
| | Control | 29.72 (45.71) | 14.82 (35.53) | −14.9 | | |
| Connecticut | Incentive | 33.16 (47.14) | 8.92 (28.55) | −24.24 | −10.71 | −14.69 (−67.13, 37.75) |
| | Control | 23.53 (42.48) | 10 (30.04) | −13.53 | | |
| Minnesota | Incentive 1 | 4.80 (12.67) | 3.01 (10.85) | −1.80 | −1.16 | −21.99 (−87.77, 43.89) |
| | Incentive 2 | 6.36 (13.49) | 4.70 (13.41) | −1.65 | −1.01 | −8.35 (−71.93, 55.22) |
| | Control | 3.94 (8.64) | 3.30 (10.66) | −0.64 | | |

(continued)

**Table 16 (continued)**
**Percentage of the population with an inpatient admission, by State**

| State | Group | Mean % (SD) | | Pre/Post difference | Difference-in-differences between incentive and control groups | Covariate-adjusted regression: difference-in-differences |
|---|---|---|---|---|---|---|
| | | Pre-MIPCD enrollment | Post-MIPCD enrollment | | | |
| Montana | Incentive | 22.79 (41.98) | 26.94 (44.39) | 4.15 | −2.14 | −49.56 (−146.85, 47.73) |
| | Control | 13.80 (34.52) | 20.09 (40.10) | 6.29 | | |
| Nevada | Incentive 1 | — | — | — | — | — |
| | Incentive 2 | — | — | — | — | — |
| | Control | — | — | — | | |
| New Hampshire (Weight) | Incentive | 15.96 (36.66) | 7.88 (26.98) | −8.08 | 0.96 | −1.24 (−53.12, 50.63) |
| | Control | 19.39 (39.58) | 10.35 (30.5) | −9.04 | | |
| New Hampshire (Smoking) | Incentive | 16.76 (37.45) | 7.03 (25.63) | −9.73 | 1.72 | 10.03 (−84.80, 104.86) |
| | Control | 17.58 (38.18) | 6.13 (24.07) | −11.45 | | |
| Texas | Incentive | 47.14 (49.96) | 46.51 (49.92) | −0.63 | −4.91 | −6.51 (−26.61, 13.59) |
| | Control | 43.02 (49.55) | 47.3 (49.97) | 4.28 | | |
| Wisconsin (Quitline) | Incentive | 2.92 (7.49) | 3.87 (12.16) | −0.96 | 0.17 | 11.29 (−46.45, 69.03) |
| | Control | 4.16 (9.57) | 4.94 (13.87) | −0.79 | | |
| Wisconsin (First Breath) | Incentive | 2.14 (7.61) | 17.39 (12.89) | −15.24 | −1.68 | −14.16 (−63.84, 35.51) |
| | Control | 1.76 (6.34) | 18.69 (13.07) | 16.92 | | |

* $p < 0.05$

Note: Nevada was excluded due to the low sample size of children with an inpatient admission.

**Table 17**
**Percentage of the population with an emergency department visit, by State**

| State | Group | Mean % (SD) | | Pre/post difference | Difference-in-differences between incentive and control groups | Covariate-adjusted regression: difference-in-differences |
|---|---|---|---|---|---|---|
| | | Pre-MIPCD enrollment | Post-MIPCD enrollment | | | |
| California | Incentive 1 | 30.13 (45.89) | 11.54 (31.96) | −18.59 | 1.16 | 7.23 (−35.15,20.67) |
| | Incentive 2 | 31.48 (46.44) | 10.70 (30.92) | −20.78 | −1.03 | −15.29 (−43.26,12.69) |
| | Control | 31.56 (46.48) | 11.81 (32.28) | −19.75 | | |
| Connecticut | Incentive | 77.01 (42.14) | 41.47 (49.33) | −35.54 | −7.79 | −19.64 (−44.76, 5.49) |
| | Control | 71.18 (45.36) | 43.43 (49.64) | −27.75 | | |
| Minnesota | Incentive 1 | 19.69 (22.66) | 14.60 (23.11) | −5.09 | −2.88 | −38.37 (−71.93, −4.81) |
| | Incentive 2 | 22.95 (26.80) | 19.58 (27.15) | −3.36 | −1.15 | −15.77 (−48.63, 17.14) |
| | Control | 16.77 (21.66) | 14.55 (23.35) | −2.21 | | |
| Montana | Incentive | 64.64 (47.84) | 60.16 (48.98) | −4.48 | −13.63 | −56.09 (−91.21, −20.97) |
| | Control | 55.02 (49.79) | 64.17 (47.99) | 9.15 | | |
| Nevada | Incentive 1 | 3.62 (18.71) | 2.20 (14.68) | −1.42 | −1.87 | 0.47 (−0.677, 1,61) |
| | Incentive 2 | 3.59 (18.64) | 2.35 (15.18) | −1.24 | −1.69 | -1.22 (−3.42, 0.98) |
| | Control | 1.34 (11.50) | 1.79 (13.27) | 0.45 | | |
| New Hampshire (Weight) | Incentive | 67.64 (46.84) | 47.52 (49.99) | −20.12 | 1.52 | −0.78 (−20.25,18.70) |
| | Control | 68.46 (46.52) | 46.82 (49.96) | −21.64 | | |
| New Hampshire (Smoking) | Incentive | 65.95 (47.52) | 42.7 (49.6) | −23.25 | 7.73 | −18.61 (−52.51, 15.28) |
| | Control | 75.15 (43.34) | 44.17 (49.81) | −30.98 | | |
| Texas | Incentive | 77.78 (41.61) | 68.1 (46.65) | −9.68 | −4.12 | −8.21 (−21.72, 5.29) |
| | Control | 76.51 (42.43) | 70.95 (45.43) | −5.56 | | |

(continued)

**Table 17 (continued)**
**Percentage of the population with an emergency department visit, by State**

| State | Group | Mean % (SD) | | Pre/post difference | Difference-in-differences between incentive and control groups | Covariate-adjusted regression: difference-in-differences |
|---|---|---|---|---|---|---|
| | | Pre-MIPCD enrollment | Post-MIPCD enrollment | | | |
| Wisconsin (Quitline) | Incentive | 18.84 (20.92) | 23.54 (27.05) | 4.70 | 0.94 | 15.35 (−10.54, 41.15) |
| | Control | 21.37 (23.80) | 25.13 (27.06) | 3.76 | | |
| Wisconsin (First Breath) | Incentive | 19.10 (22.14) | 24.77 (25.02) | 5.67 | −2.06 | −5.61 (−31.01, 19.79) |
| | Control | 18.99 (22.70) | 26.72 (25.97) | 7.73 | | |

* $p < 0.05$

*California*

- There are no statistically significant changes in total expenditures, inpatient expenditures, and ED expenditures between the incentive groups and the control group, indicating no effect of the MIPCD program on expenditures.
- There are no statistically significant changes in the proportion of participants that had an ED visit or had an inpatient admission between incentive group 1 and the control group or incentive group 2 and the control group, indicating no effect of the MIPCD program on utilization.
- There are no differential effects of the MIPCD program on expenditures and utilization for dual Medicare-Medicaid enrollees or disabled enrollees. For all outcomes, the estimated effect of the intervention is the same for dual and non-dual participants and for disabled and non-disabled participants.

*Connecticut*

- There are no statistically significant changes in total expenditures or inpatient expenditures between the incentive and control group, indicating no effect of the MIPCD program on expenditures.
- PMPM ED expenditures were $16 lower for the incentive group than for the control group during the intervention period.
- There are no statistically significant changes in the proportion of participants that had an ED visit or had an inpatient admission between the treatment and control group, indicating no effect of the MIPCD program on utilization.

- There are no differential effects of the MIPCD program on expenditures and utilization for dual Medicare-Medicaid enrollees or disabled enrollees. For all outcomes, the estimated effect of the intervention is the same for dual and non-dual participants and for disabled and non-disabled participants.

*Minnesota*

- There are no statistically significant changes in total expenditures, inpatient expenditures, and ED expenditures between the incentive groups and the control group, indicating no effect of the MIPCD program on expenditures.

- There are no statistically significant changes in the proportion of participants that had an inpatient admission between incentive group 1 and the control group or incentive group 2 and the control group, indicating no effect of the MIPCD program on utilization. While pooling both the individual and the individual plus group incentives shows no statistically significant change in the likelihood of ED or office visits, when we consider the impact of these two treatment options separately, we find that those who received individual incentives only had statistically lower ED visits compared with participants in other groups. It is premature to infer, however, that this represents an impact of the program; rather, it may reflect the high volatility in the distribution of outcomes across arms in a relatively small sample.

- There are no differential effects of the MIPCD program on expenditures and utilization for dual Medicare-Medicaid enrollees or disabled enrollees. For all outcomes, the estimated effect of the intervention is the same for dual and non-dual participants and for disabled and non-disabled participants.

*Montana*

- There are no statistically significant changes in total expenditures or inpatient expenditures between the incentive and control group, indicating no effect of the MIPCD program on health care spending. However, statistically significant estimates are unlikely to be obtained with a small sample size.

- There are no statistically significant changes in the proportion of participants that had an ED visit or an inpatient admission between the incentive and control group, indicating no effect of the MIPCD program on utilization.

- There are no differential effects of the MIPCD program on expenditures and utilization for dual Medicare-Medicaid enrollees or disabled enrollees. For all outcomes, the estimated effect of the intervention is the same for dual and non-dual participants and for disabled and non-disabled participants.

*Nevada*

- Nevada's analysis was restricted to children in the Children's Heart Study. Because the study sample were not frequent users of inpatient or ED services, the average

PMPM expenditures per child were too low to analyze inpatient or ED expenditures. Furthermore, the proportion of children who had an inpatient admission was too low to model use of inpatient services.

- There are no statistically significant changes in total expenditures between the incentive and control group, indicating no effect of the MIPCD program on expenditures.

- There are no statistically significant changes in the proportion of participants that had an ED visit or an office visit between the incentive and control group, indicating no effect of the MIPCD program on utilization.

*New Hampshire*

- In the weight management program, there are no statistically significant changes in total expenditures, inpatient expenditures or ED expenditures between the incentive and control group, indicating no effect of the MIPCD program on expenditures.

- In the smoking cessation program, the change in total expenditures is on average $224 greater for the incentive group compared with the control group, suggesting the MIPCD program was associated with higher total expenditures in the intervention period. There are no statistically significant changes in inpatient expenditures or ED expenditures between the incentive and control groups.

- In both the weight management program and the smoking cessation program, there are no statistically significant changes in the proportion of participants that had an ED visit or had an inpatient admission between the incentive and control groups, indicating no effect of the MIPCD program on utilization.

- In both the weight management program and the smoking cessation program, there are no differential effects of the MIPCD program on expenditures and utilization for dual Medicare-Medicaid enrollees or disabled enrollees. For all outcomes, the estimated effect of the intervention is the same for dual and non-dual participants and for disabled and non-disabled participants.

*Texas*

- There are no statistically significant changes in total expenditures, inpatient expenditures, or ED expenditures between the incentive and control groups, indicating no effect of the MIPCD program on expenditures.

- There are no statistically significant changes in the proportion of participants that had an ED visit or had an inpatient admission between the incentive and control groups, indicating no effect of the MIPCD program on utilization.

- There are no differential effects of the MIPCD program on expenditures and utilization for dual Medicare-Medicaid enrollees. For all outcomes, the estimated effect of the intervention is the same for dual and non-dual participants.

*Wisconsin*

- In the Striving to Quit program, there are no statistically significant changes in total expenditures, inpatient expenditures, or ED expenditures between the incentive and control groups, indicating no effect of the MIPCD program on expenditures.

- In the First Breath program, while there are no statistically significant changes in total expenditures, the change in inpatient expenditures is on average $35 lower PMPM for the incentive group compared with the control group. There are no statistically significant changes in inpatient expenditures or ED expenditures between the incentive and control groups.

- In the Striving to Quit program and the First Breath program, there are no statistically significant differences in the proportion of participants that had an ED visit or had an inpatient admission between the incentive and control groups, indicating no effect of the MIPCD program on utilization. However, the number of office visits decreased significantly (30%) in the Striving to Quit incentive group.

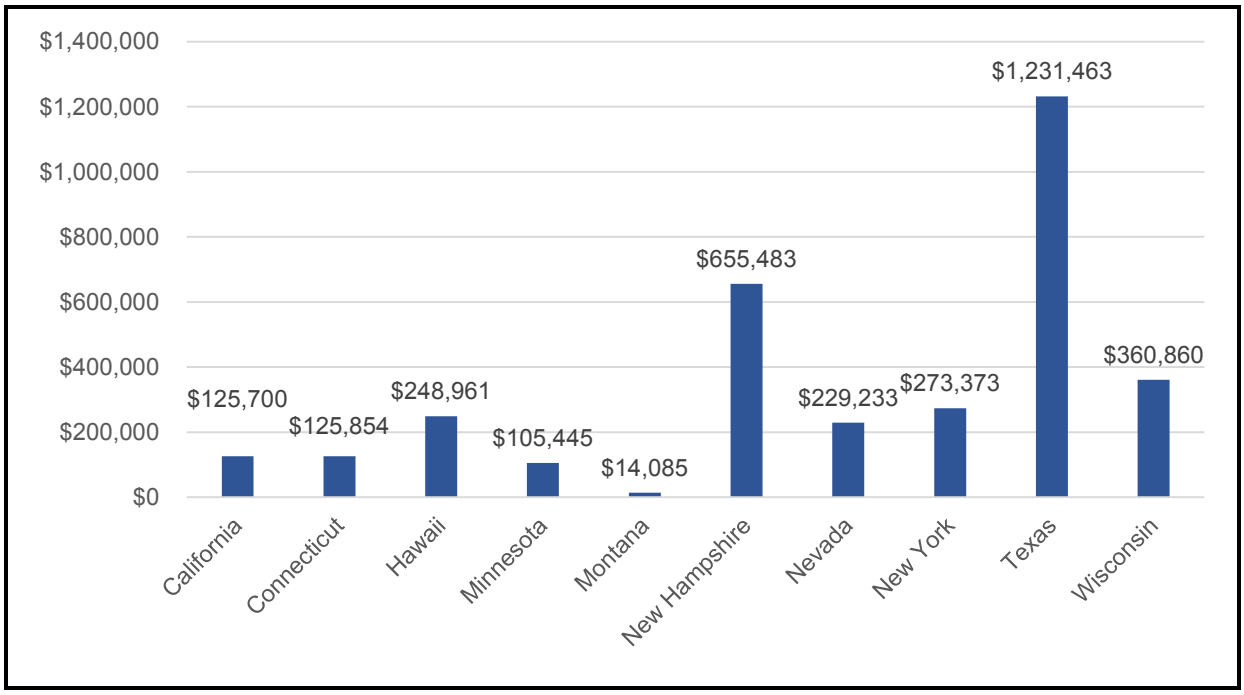
- In both the Striving to Quit program and the First Breath program, there are no differential effects of the MIPCD program on expenditures and utilization for dual Medicare-Medicaid enrollees or disabled enrollees. For all outcomes, the estimated effect of the intervention is the same for dual and non-dual participants and for disabled and non-disabled participants, with the exception of office visits in the Striving to Quit program. The number of visits for this subpopulation increases.

## 4.6 MIPCD State MDS Analysis: MIPCD Program Effects on Outcomes

### 4.6.1 Incentive Amounts Disbursed

All MIPCD programs are distributing financial incentives to pay for particular health promotion activities or for meeting milestones in health promotion utilization, health outcomes, or both. These payment amounts are reported in the MIPCD State MDS through June 2015 (***Figure 1***).

**Figure 1**
**Amount of incentives disbursed through June 2015, by State**




Disbursed incentives range from a low of $14,085 in Montana to a high of $1,231,463 in Texas. The amounts disbursed are a function of program design and the number of enrollees in a program. For example, Texas has over 630 treatment group participants who are each eligible for up to $1,150 per year in incentives. In contrast, Montana has 154 incentive group participants who average $91 per person in incentives. In addition, the payments reported may underestimate the value of incentives provided to participants to support them in meeting their health goals. For example, payments made for transportation to a class or a gym or child care are not necessarily included in the MDS.

### 4.6.2 Characteristics of the Study Sample

As we did in the Medicaid claims analysis, we assessed comparability of the incentive and control group within each State. Similar to what we observed in the claims analysis, the incentive and control groups were fairly similar in terms of age, sex, race, and ethnicity. However, as described in ***Section 4.3, Analytic Approach***, we still included these sociodemographic characteristics in regression analyses to control for any influence of these differences on the utilization measures.

### 4.6.3 State-Specific Findings for Utilization of MIPCD Program Services

As described in ***Table 18***, across MIPCD States, many program participants used significantly more of a service if they received a financial incentive compared with the non-incentivized control group. However, we cannot attribute increased service use to demonstrable

changes in health in the short-term. At the time of this analysis, a considerable number of participants had not yet completed the program, and States were still in the process of collecting health outcome data. Future analyses will examine whether the trends in service utilization described here persist and whether changes in health are observed. The following section of the report discusses the State-specific findings in greater detail.

**Table 18**
**Summary of utilization of MIPCD program services, by State**

| State | MIPCD program service | Findings |
|---|---|---|
| California | Quitline calls, quit attempt, 30 day period of no smoking | ▪ The incentive group made significantly more quitline calls than the control group.<br>▪ Individuals in the cash incentive group were more likely to report a quit attempt and 30-day period of no smoking than the control group. |
| Connecticut | Smoking cessation counseling sessions, quitline calls | ▪ The incentive group had significantly more smoking cessation counseling sessions than the control group.<br>▪ Among participants who used the quitline, there was no significant difference in the number of quitline calls between the incentive and control groups. |
| Hawaii | Visits with a health coach, diabetes education sessions, behavioral health counseling sessions, smoking cessation sessions | ▪ The HiPraise study arm had on average 5 meetings with a health coach, and 43 percent attended at least one diabetes education class. Less than 10 percent have attended a smoking cessation or behavioral health counseling session. There are no comparable data for a control group.<br>▪ There was no significant difference in the number of meetings with a health coach between the Kaiser incentive and Kaiser control groups.<br>▪ There was no significant difference in the number of Kaiser incentive and control group individuals who had a smoking cessation session or behavioral health counseling sessions. |
| Minnesota | Diabetes prevention program sessions | ▪ The individual incentives only incentive group had significantly more core diabetes prevention program sessions than the control group.<br>▪ The individual and individual plus group incentives groups had significantly more post-core program sessions than the control group. |
| Montana | Diabetes prevention program sessions | ▪ The incentive group had significantly more core and post-core program sessions than the control group. |
| New Hampshire | Gym sessions, Weight Watchers meetings, health mentor led personal training sessions, quitline calls | ▪ In the gym membership program, there was no significant difference in the number of gym sessions between the incentive and control group.<br>▪ In the Weight Watchers program arm, the incentive group attended significantly more meetings than the control group.<br>▪ There was no significant difference in the number of personal training sessions between the incentive and control groups.<br>▪ In the smoking cessation program, there was no significant difference in the number of quitline calls between the incentive and control groups. |

(continued)

**Table 18 (continued)**
**Summary of utilization of MIPCD program services, by State**

| State | MIPCD program service | Findings |
|---|---|---|
| New York | Diabetes prevention program sessions, diabetes management primary care visits, diabetes-related prescriptions, hypertension management primary care visits, hypertension-related prescriptions, smoking cessation counseling session, and smoking cessation-related prescriptions | ▪ In the diabetes prevention program, the incentive groups attended more program sessions than the control group.<br>▪ In the diabetes management program, there were no significant differences in the number of incentive and control group participants who attended at least one diabetes management primary care visit, and there were no differences in the number of diabetes-related prescriptions filled across groups.<br>▪ In the hypertension management program, there were no significant differences in the number of hypertension-related primary care visits or the number of hypertension-related prescriptions filled across groups.<br>▪ In the smoking cessation program, there were no significant differences in the number of cessation counseling sessions or the number of smoking cessation-related prescriptions filled across groups. |
| Nevada | Participants attaining goal at week 12 of the program, child only incentive, participants attaining goal at week 12 of the program, child and parent incentive | ▪ Thirty percent of participants in the child only incentive program and 26 percent of the child/parent incentive program have completed the program, and all those who have completed the program received an incentive for attainment of goals at week 12. Success at meeting program goals was not reported for the control group. |
| Texas | Receipt of incentive for purchasing wellness devices, gym membership or wellness program, nutritional item or health food, and/or behavioral health interventions | ▪ Over 87 percent of the incentive group has used funds from the wellness account to purchase wellness devices and/or nutritional items. Fewer participants are purchasing gym memberships or behavioral health interventions. There are no comparable data for the control group. |
| Wisconsin | Quitline calls, prenatal smoking cessation counseling visits, post-partum smoking cessation counseling visits, postpartum smoking cessation counseling calls | ▪ In the Striving to Quit program, the incentive group made significantly more quitline calls than the control group.<br>▪ In the First Breath program, the incentive group made significantly more prenatal smoking cessation counseling calls, prenatal counseling visits, and postpartum smoking cessation counseling calls. |

**California's** MIPCD program targets Medicaid beneficiaries who smoke for smoking cessation counseling. California has implemented an RCT, placing beneficiaries who call a smoking cessation quitline into three groups: usual care (i.e., control group, Policy A), usual care plus free NRT shipped to the home (Policy B1), and NRT plus a cash incentive for each cessation counseling session attended (Policy B2). The MIPCD MDS study sample included 3,847 participants: 1,012 enrollees in the control group, 1,416 enrollees in Policy B1 group, and 1,419 enrollees in Policy B2 group. As of June 2015, all participants in the RCT had completed their participation in the program. California has other program arms that have only recently

been implemented; these arms will be assessed in subsequent analyses. Participants randomized to the NRT plus cash incentives group have received, on average, $38 per person in financial incentives. They also had on average 5 quitline calls, versus 4 calls for the NRT only group and 4 calls for the control group. In regression analyses, receipt of the NRT plus cash incentives is associated with 34 percent more calls compared with the control group. This difference is statistically significant. Receipt of NRT only is not significantly associated with more calls to the quitline compared with the control group. California assessed whether participants made an attempt to quit smoking after program participation and whether participants abstained from smoking for at least 30 days. More participants in the NRT only and NRT plus cash incentives group reported a quit attempt (72 percent and 78 percent, respectively) compared with the control group (68 percent). In regression analyses, the NRT only and NRT plus cash incentives group are significantly more likely to report a quit attempt compared with the control group. Fewer participants reported a 30-day abstinent period, but among those that did, more participants in the NRT plus cash incentives group reported an abstinent period (48 percent) compared with the NRT only group (35 percent) and the control group (36 percent). The difference between the NRT plus cash incentive group and the control group is statistically significant in regression analyses.

**Connecticut's** MIPCD program targets non-pregnant and pregnant Medicaid enrollees who smoke for smoking cessation counseling, and each target population has an incentive and control group, for a total of four study samples. The MIPCD MDS study sample included 4,015 enrollees: 3,991 adult, non-pregnant smokers and 24 pregnant smokers. Because of the sample size of pregnant smokers, they were excluded from this analysis, and they will be examined in subsequent analyses. Among the adult, non-pregnant smokers, 2,459 enrollees are in an incentive group, and 1,532 are in the control group. As of June 2015, 30 percent of the adult, non-pregnant smokers had completed Connecticut's program. Connecticut provides incentives for attending smoking cessation counseling, either in person or via the Connecticut Quitline, meeting with a peer coach, or having negative carbon monoxide tests. Incentivized participants have received, on average, $51 per person in financial incentives. The incentive group had on average 2 smoking cessation counseling sessions, and the control group had 0.7 sessions, a difference that is statistically significant in regression analyses. Very few participants (about 1 percent) have worked with a peer coach. Although fewer enrollees have used the Quitline, among the 17 percent of participants who have, the incentive group has made on average 3.8 calls and the control group has made 3 calls, a difference that is not significant in regression analyses.

**Hawaii's** MIPCD program targets adult Medicaid beneficiaries with diabetes who are receiving their medical services from FQHCs. Through this program, known as HI-PRAISE, participants receive cash incentives for evidence-based care for diabetes and for meeting with a health coach, attending smoking cessation sessions, attending counseling for any behavioral health concerns, and/or attending diabetes education classes. Hawaii also collaborated with Kaiser Permanente (an MCO) to conduct an RCT that Hawaii implemented in May through June 2014. Thus, Hawaii currently has three arms: HI-PRAISE, Kaiser incentive group, and Kaiser control group. There are 2,005 enrollees in the HI-PRAISE arm, 159 enrollees in the Kaiser incentive group, and 161 enrollees in the Kaiser control arm. As of June 2015, no one has completed the program. The incentive group has received on average $131 per person in financial incentives in HI-PRAISE and $128 per person in the Kaiser incentive group. Within

the HI-PRAISE study arm, participants have had on average 5 meetings with a health coach. An estimated 43 percent have had at least one diabetes education class, 6 percent have had at least one smoking cessation class, and 7 percent have had at least one session related to behavioral health. Within the Kaiser study arm, incentive participants have had on average 10 meetings with a health coach, while the control group has had 11, a difference that is not statistically significant in regression analyses. The Kaiser group has had very few diabetes education classes, but 18 percent of the incentive arm has had a smoking cessation session compared with 12 percent of the control group. However, the difference between the incentive and control groups is not statistically significant in regression analyses. About 7 percent of the incentive group has had a counseling session related to behavioral health compared with 5 percent of the control group, and this difference is not statistically significant.

**Minnesota's** MIPCD program enrolls adult Medicaid beneficiaries who are at risk of developing diabetes into a 16-week diabetes prevention, self-management training program. The diabetes prevention program consists of 16 weekly classes (known as the core classes) and up to 6 monthly classes after the conclusion of the 16 week program (known as the post core classes). There are a total of 1,081 participants across three program arms: a group that receives incentives for individual performance, a group that receives incentives for individual performance plus group performance, and a control group. There were 381 enrollees in the group that receives incentives for individual performance, 335 enrollees in the group that receives incentives for individual performance plus group performance, and 365 in the control group. More than 50 percent of each group has completed the program (57 percent of the individual incentives group, 56 percent of the individual plus group incentives group, and 57 percent of the control group). The incentive group has received on average $139 per person in financial incentives, whereas the individual plus group incentives group has received $134 per person. The average number of core classes attended is higher in the intervention groups than in the control group (8 for the individual incentives group, 8 for the individual plus group incentives group, and 6 for the control group). In regression analyses, the individual incentives group attended statistically significantly more classes compared with the control group, but the difference in the number of classes attended was not statistically significant whencomparing the individual plus group incentives group with the control group. The average number of post core classes attended is also higher in the intervention groups compared with the control group (1 for the individual incentives group, 1 for the individual plus group incentives group, and 0.5 for the control group). In regression analyses, the differences between the two incentive groups and the control group are statistically significant. More participants in the incentive groups attended at least 9 or more core classes (a threshold for good program participation used in published evaluations of diabetes prevention programs)—52 percent of the individual incentives group and 52 percent of the individual plus group incentives group compared with the control group (36 percent); the difference between groups is statistically significant.

**Montana's** MIPCD program enrolls adult Medicaid beneficiaries at risk of developing diabetes into an adapted diabetes prevention program consisting of 16 core classes and 6 post-core classes, similar to the program described above for Minnesota. Montana provides tiered and incrementally increasing monetary incentives for completing diabetes prevention program sessions, monitoring fat intake, and achieving targets in physical activity and weight loss. The MIPCD MDS study sample included 261 enrollees: 154 in the incentive group and 107 in the control group. Most enrollees in the control group (91 percent) and the incentive group (75

percent) completed the program. The incentive group received on average $91 per person in financial incentives. The average number of core sessions among the incentive group was 12, and the average number of post-core sessions was 2.5. In contrast, the control group had an average of 11 core sessions and 1.6 post-core session. The difference in core sessions between the incentive and control groups was statistically significant in regression analyses; the incentive group had 16 percent more sessions compared with the control group. The difference in post-core sessions between the incentive and control groups is also statistically significant in regression analyses; the incentive group had 67 percent more sessions compared with the control group. Significantly more participants in the incentive group (77 percent) than the control group (63 percent) attended at least 9 or more core classes (a threshold used in published evaluations of diabetes prevention programs).

Among those who have completed the program (N = 213), the incentive group attended, on average, more classes than the control group (incentive group: 12 core classes and 3 post-care classes vs. control group: 11 core classes and 2 post-care classes); these differences are significantly different in regression analyses. As of June 2015, outcome data were still being collected; however, among those completing the program, most (N = 205) had at least two weight measurements, the first assessed at program start and the last assessed 3 to 9 months after program start. Among these program participants with at least two weight measurements, weight at program start was similar (244 pounds for the incentive group and 245 for the control group). The incentive group lost on average 6 pounds, while the control group lost 5 pounds. The difference in weight loss between groups is not significantly different. Additional outcomes, such as reported physical activity, will be assessed in future analyses.

**Nevada's** MIPCD program comprises six programs. As of June 2015, the majority of Nevada's enrollees were children enrolled in the Healthy Hearts Program, so we restrict this analysis to the Healthy Hearts Program. Two treatment arms focus on weight management in children; in treatment arm 1, only the child receives incentives for meeting key goals, and in treatment arm 2, the child and parent/family receive incentives for meeting goals. Nevada's control group consists largely of children who had participated in the program before the launch of the MIPCD initiative; success at meeting goals was not reported for this group in the MIPCD MDS. The study sample included 1,674 enrollees: 380 in treatment arm 1, 357 in treatment arm 2, and 937 in the control group. Treatment arm 1 has received on average $302 per person in financial incentives, and treatment arm 2 has received on average $304 per person. In treatment arm 1, 32 percent of children completed the weight management program, and in treatment arm 2, 26 percent of children and their parents completed the program; all those who completed the program have received an incentive for goal attainment at week 12.

**New Hampshire's** MIPCD program consists of a smoking cessation program and a weight management program offered to Medicaid beneficiaries receiving services in community mental health centers. Participants in the weight management program could elect to receive assistance with obtaining a gym membership, connecting with a health mentor for personal training, and/or enrolling in Weight Watchers, and cash incentives are provided for attending the gym, meeting with a health coach for personal training sessions, or attending Weight Watchers meetings. The MIPCD MDS study sample included 1,366 participants in the weight program: 532 in the incentive group and 834 in the control group. An estimated 38 percent of participants in the weight program completed the program. For the smoking cessation program, enrollees in

the incentive group receive cash for attending smoking cessation counseling calls, visits to a provider to discuss smoking cessation, and for taking carbon monoxide and urine cotinine tests. The MIPCD MDS study sample for the smoking cessation program included 665 participants: 340 in the incentive group and 325 in the control group. An estimated 51 percent of participants in the smoking cessation program have completed the program. Almost 300 participants were in both the weight management and the smoking cessation program. The incentive group participants in the weight program have received on average $496 per person in financial incentives, and the incentive group participants in the smoking program have received on average $414 per person.[6]

In the gym membership arm of the weight management program, incentive group participants had on average 36 gym sessions, whereas control group participants had on average 23 gym sessions. This difference is not statistically significant in regression analyses. In the Weight Watchers arm of the weight management program, incentive group participants attended 18 Weight Watchers meetings on average, whereas control group participants attended 5 meetings. This difference is statistically significant in regression analyses; the incentive group attended four times as many Weight Watchers meetings as the control group. For those meeting with a health coach for personal training sessions, the incentive group had on average 14 sessions and the control group had 15 sessions, but this difference is not statistically significant.

In the smoking cessation program, the incentive and control group participants had a similar number of smoking cessation counseling calls (3 calls). The difference in number of calls is not statistically significant.

**New York's** MIPCD program promotes diabetes prevention, diabetes management, hypertension management, and smoking cessation, for a total of four program arms. New York has reported on a total of 3,857 enrollees: 440 in the diabetes prevention program (344 receiving incentives and 96 in the control group), 902 in the diabetes management program (683 receiving incentives and 219 in the control group), 793 in the hypertension management program (595 receiving incentives and 198 in the control group), and 1,740 in the smoking cessation program (1,137 receiving incentives and 603 in the control group). More than half of diabetes prevention program participants (67 percent) have completed the program, whereas 42 percent of the diabetes management and 38 percent of the hypertension management program participants have completed the program. As of June 2015, no one had completed the smoking cessation program. New York provides incentives for process improvements (i.e., improvements in use of certain health services), improvements in health outcomes, or both. Across the three programs, fewer incentives have been disbursed for outcomes only compared with process improvements only or process improvements plus outcomes[7]: for the diabetes management program, incentives averaged $200 per person for process only, $44 for outcomes only, and $137 for process plus

[6] The average incentive amounts disbursed include incentives given to participants enrolled in both the weight management and the smoking cessation programs. Because these participants are in two programs, their average incentive amount is higher than those enrolled in only one program.

[7] Because outcomes are assessed at the end of program completion and not all participants have completed the MIPCD program as of this report, New York has disbursed fewer outcomes-related incentives than process-related incentives.

outcomes; for the diabetes prevention program, incentives averaged $105 for process only, $46 for outcomes only, and $62 for process plus outcomes; for the hypertension management program, incentives averaged $209 for process only, $37 for outcomes only, and $129 for process plus outcomes; and for the smoking cessation program, incentives averaged $49 for process only. Because no one has completed the program, no outcomes-only incentives have been disbursed in the smoking cessation program, and New York did not implement the process plus outcomes arm of the study for the smoking cessation program.

For the diabetes prevention program, the control group attended on average five diabetes prevention classes, whereas the process incentives only group attended seven classes, the outcome incentives only group attended six classes, and the process plus outcomes incentives group attended six classes. In regression analyses, the three incentives arms attended statistically significantly more prevention classes than the control group.

For the diabetes management program, the percentage of the population attending at least one diabetes management doctor appointment was similar across program arms: 55 percent in the process incentives only arm, 54 percent in the outcome incentives only arm, 53 percent in the process plus outcomes incentives arm, and 56 percent in the control group. None of these differences are statistically significant in regression analyses. All four groups also had on average three prescriptions filled related to diabetes control, and none of the differences between groups are statistically significant in regression analyses.

For the hypertension management program, the percentage of the population attending at least one hypertension management doctor's appointment varied across program arms: 50 percent in the process incentives only arm, 50 percent in the outcome incentives only arm, 53 percent in the process plus outcomes incentives arm, and 43 percent in the control group. None of these difference were statistically significant in regression analyses. All four groups also had on average 3 prescriptions filled related to hypertension control, and none of the differences between groups are statistically significant.

For the smoking cessation program, the control group made on average 1.5 smoking cessation counseling calls, and the process incentives only group made 1.6 calls and the outcome incentives only group also made on average 1.6 calls. All three groups also had on average 1 prescription filled related to smoking cessation. There are no significant differences between groups.

**Texas's** MIPCD program promotes weight loss, increased physical activity, healthy eating, and other wellness-related goals among Medicaid beneficiaries with serious mental illness, behavioral health concerns, or both. The MIPCD MDS study sample included 1,262 participants: 632 in the incentive group and 630 in a control group. Incentivized participants have used, on average, $1,949 from the wellness account. Most incentive participants (92 percent) have used the wellness account to purchase wellness devices, and 87 percent have purchased a nutritional item or health food. Fewer participants (35 percent) have used the incentives to purchase a gym membership, and very few (2 percent) have used the funds to promote behavioral health (e.g., yoga or meditation). Because the control group does not receive access to the same types of MIPCD services, there are no comparable utilization statistics for the control group.

**Wisconsin's** MIPCD program is focused on smoking cessation for (1) adult Medicaid beneficiaries (this program is known as Striving to Quit) and (2) pregnant Medicaid beneficiaries and mothers of newborns with a special focus on African American women (this program is known as First Breath). Both programs have an incentive group that receives cash incentives for making smoking cessation counseling calls to a quitline or visits, taking a carbon monoxide test, and passing the test. Both programs also have a control group that does not receive incentives.

The Striving to Quit incentive group had 872 participants, and the Striving to Quit control group had 870 participants. The First Breath incentive group had 524 participants and the First Breath control group had 513 participants. Approximately 48 percent of the Striving to Quit group has completed the program, and 37 percent of the First Breath group has completed the program. The Striving to Quit incentive group has received, on average, $166 in financial incentives, and the First Breath incentive group has received $219 in financial incentives. The incentive group in Striving to Quit has made on average 4 smoking cessation quitline calls, and the control group has made 3 quitline calls on average. The difference is statistically significant in regression analyses; the incentive group had 37 percent more smoking cessation quitline calls compared with the control group. The incentive group in First Breath had on average 0.9 prenatal smoking cessation counseling sessions, 2.4 postpartum smoking cessation counseling visits, and 3 postpartum smoking cessation counseling calls. In comparison, the control group had 0.7 prenatal smoking cessation counseling calls, 2 postpartum counseling visits, and 2 postpartum counseling calls. In regression analyses, the differences between the two groups are statistically significant; the incentive group had 23 percent more prenatal counseling visits, 22 percent more postpartum counseling visits, and 40 percent more postpartum counseling calls compared with the control group.

## 4.7 Discussion

At this point in the evaluation, no clear cross-State patterns have emerged to suggest that the MIPCD program is lowering rates of inpatient hospitalization, ED use, inpatient expenditures, ED expenditures, and total expenditures. However, States are still enrolling Medicaid beneficiaries, and future analyses will take advantage of additional participants and more post-participation claims data. Therefore, the results presented in these analyses should be considered provisional and preliminary.

It is important to note that even with more claims data to analyze, many of these interventions may not significantly reduce hospitalizations, ED visits, and total costs in the short term. The lack of effect does not imply that the intervention was unsuccessful. Instead, a better test of program effectiveness would be a positive change among participants in the health outcomes the States were targeting—for example, smoking quit rates, weight reduction, or improvements in hypertension or diabetic control. With the exception of California, many of the health and behavioral outcomes included in each State's MIPCD MDS are missing data. These data continue to be collected by States as participants complete the program, so we will examine if changes in these outcomes occur in the Final Evaluation Report, after States' data collection efforts are finished. Furthermore, States are evaluating their programs on a number of utilization and health outcome metrics, which is expected to complement the information provided through the MIPCD State MDS. We will review and incorporate their findings into the Final Evaluation Report. Taken together, analyses of the Medicaid claims data, MIPCD State MDS, and State-led

evaluation findings will provide a comprehensive picture of the short-term impacts of the MIPCD program on service use, expenditures, and health outcomes.

For the one State with complete reporting of outcomes data (California), receipt of NRT plus cash incentives was associated with a significantly higher ($p < 0.05$) likelihood of self-reporting a quit attempt and a 30-day period of abstaining from smoking compared with the control group. Reductions in smoking in the short run may avert smoking-related health conditions, causing long-term reductions in hospitalizations, ED visits, and costs. Thus, the lack of significant effects on utilization or costs in the short run do not imply that the MIPCD program will not affect these measures over a longer time horizon. California's positive finding aligns with the goals of the MIPCD program, but we caution that general conclusions regarding the effectiveness of the MIPCD program cannot be drawn from one State.

The MIPCD State MDS proved to be a rich source of information on the services and incentives received by program participants. Our findings on service utilization suggest that, for most of the MIPCD States, the incentive group uses more incentivized services than the control group. Future analyses will examine in greater detail how engagement in the program varies over time and by incentive type. For example, in States incentivizing attendance at a diabetes prevention program, does attendance wane over time, or are participants less likely to receive incentives for meeting predetermined milestones in health (e.g., weight reductions) compared with incentives for meeting process measures (e.g., meeting with a health coach)? As more participants complete the program, we will have greater statistical power to examine these evaluation questions.

## 4.8 Limitations of the Medicaid Claims Analysis and MIPCD State MDS Analysis

### 4.8.1 Medicaid Claims Analysis

The number of enrollees in the incentive and control groups varies substantially each quarter by State, ranging from 171 participants in Montana to 3,556 in California. With small sample sizes in some States, statistical differences in expenditures and utilization are difficult to detect. Even though expenditures and utilization may be different between the incentivized group and the control group, the differences may not be statistically significant. Once States have completed their programs and provided the Medicaid claims data for all incentive and control group participants, we will have more data on more individuals to analyze. Subsequent analyses may reach different conclusions than those described in this report. For this reason, these analyses should be considered preliminary.

Furthermore, as we have more data, we will add additional evaluation questions to the ones addressed here. For example, among States administering a diabetes prevention program (e.g., Minnesota and Montana), have MIPCD programs reduced diabetes-related inpatient or ED admissions?

The analysis described here also followed an intent-to-treat approach, as described above in the ***Analytic Approach*** section. As a result, findings may be biased toward the null because each State's study sample includes participants who have not yet experienced the full effects of the program. Once States conclude their programs, we will assess the impact of MIPCD program participation on those who completed the MIPCD program; by doing so, we will gain

insight into the impact of the program among those who fully participated. There may be different program effects when we only consider this group.

There are several notable data limitations. Total expenditures, inpatient expenditures, and ED expenditures are underestimated in the case of Minnesota. The State does not release amounts paid to providers for their managed care enrollees, so the expenditures reflect fee-for-service payments only. Over 90 percent of Minnesota's MIPCD claims data study sample are enrolled in managed care at some point, so the underestimate is significant. In addition, Minnesota does not release chemical dependency claims, so not all services provided are reflected in total expenditures. Because expenditures are underestimated, we examined one additional utilization outcome, use of office visits, to expand our understanding of patterns of utilization among MIPCD participants in Minnesota. Furthermore, this analysis does not incorporate Medicare claims data for MIPCD participants dually enrolled in Medicare and Medicaid. As a result, the assessment of utilization and expenditures for these participants is limited to their Medicaid utilization. The percentage of program enrollees reported to be Medicare-Medicaid enrollees in the Medicaid claims data ranges from 5 percent to 64 percent, depending on the State. Future analyses may incorporate Medicare data to obtain a complete picture of MIPCD program participants' utilization.

Finally, as described above in the ***Analytic Approach*** section, States varied in the amount of pre- and post-period data available. Participants who entered the program closer to program roll-out had more post-period data than those who entered the program closer to the date the State submitted the Medicaid claims data for analysis. This difference in post-period data may have biased the findings presented in this report toward no program effect because newer enrollees may have less time for any intended changes in utilization and/or expenditures to occur. Subsequent analyses that make use of additional data may lead to different conclusions than those discussed here.

### 4.8.2 MIPCD State MDS Analysis

Limitations of the Medicaid claims data analyses also apply to the MIPCD State MDS analysis. In particular, the effects of having a study sample that includes program completers, those newly enrolled, and those who have participated for an extended period of time but have not yet completed the program could bias our findings of differences in service utilization toward no significant findings. However, we controlled for program completion and time enrolled in the program, and in almost all States, we saw numerous examples in which the incentive group engaged in more services supported by the MIPCD program compared with the control group (i.e., those who did not receive incentives).

Furthermore, we did not examine the health and behavioral outcomes of participants. Because many of the States report that their participants had not completed the program, data are missing on many of the health and behavioral outcomes included in each State's MIPCD MDS. We expect these data should become more complete with future MDS submissions, and subsequent analyses will examine these health and behavioral outcomes in greater detail. Specifically, we will examine if participants experience improvements in health over the course of their participation in the program.

*[This page intentionally left blank.]*

# SECTION 5
# PARTICIPATION BY SPECIAL POPULATIONS

MIPCD State programs use incentives to promote changes in the utilization of specific services. MIPCD programs are also expected to improve the health of participants, which in turn may further affect service use and health care expenditures. We assessed the impact of the program on health care utilization and expenditures, as well as beneficiary satisfaction with the program, to answer the following evaluation questions regarding special populations:

1. How do utilization of services and Medicare expenditures for services by special populations compare with utilization and expenditures overall within a State? Are they increasing or decreasing for special populations in a similar manner to trends overall within the State?

2. Are special populations able to participate in the program? Do they experience and respond to program incentives in the same way as other beneficiaries in the State? Are they satisfied with program accessibility and with the program overall?

All of the State programs targeted adults with or at risk of chronic disease programs, one of the three special populations highlighted in the legislation. Two of the programs—New Hampshire and Texas—focused on persons with behavioral health and/or substance use disorders, and most other programs also served adults with disabilities, the second group highlighted in the legislation. The largest program arm in Nevada served children with special health care needs, the third special population highlighted in the legislation. Most States also consider participants dually enrolled in Medicare and Medicaid (dual enrollees) to be a special population because they typically have higher morbidity and consequently have greater health care expenditures. Beneficiaries for whom English is not their first language are often considered a special population because they often face challenges with reading and understanding program materials. Finally, beneficiaries who receive disability or SSI are often considered to be a special population because they, like dual-eligible beneficiaries, have higher morbidity and health care needs.

## 5.1 Methods

The data sources for the results presented in this section include Medicaid enrollment, fee-for-service claims, and managed care encounter data; focus groups; stakeholder interviews; and the beneficiary satisfaction survey. More information on these data sources, as well as the analytic methods used to obtain the results described herein, are presented in ***Sections 4*** and ***6.***

### 5.1.1 Special Populations for Utilization and Expenditures Analyses

Given the limitations of relatively small sample sizes in the Medicaid claims data received to date for analysis and the lack of detailed sociodemographic information on race/ ethnicity, for this report, we limited our analysis of the impact of the MIPCD programs on utilization and expenditures (Evaluation Questions #1 and #2 above) to dual Medicare-Medicaid enrollees and those enrolled in Medicaid due to disability in all States, with two exceptions. We excluded Nevada from this analysis because none of the MIPCD participants were dual Medicare-Medicaid enrollees or disabled. As described in ***Section 4.3.2, Claims-Based Special***

***Populations*,** in Texas, all MIPCD participants are enrolled in Medicaid due to disability and have a behavioral health and/or substance abuse diagnosis, so we limited the special populations analysis to Medicare-Medicaid enrollees only.

We examined the following utilization and expenditure variables for special populations using claims: inpatient hospitalization, emergency department (ED) use, inpatient expenditures, ED expenditures, and total expenditures.

### 5.1.2 Special Populations for Beneficiary Satisfaction Analyses

Using focus groups and stakeholder interviews, we examined the extent to which special populations (including adults with behavioral health or substance use disorders, and beneficiaries for whom English was not their native language) are able to participate in the program. To address this question, we looked at the incentive programs in four States that targeted these populations: New Hampshire and Texas (behavioral health and substance use disorders) and Hawaii and Minnesota (non-native English speakers).

Using a survey administered to participants in all States except Hawaii, we also examined special populations' opinions on their experiences in the program, including access to program activities and staff, quality of service they received in the program, incentives, how the program helped them, and overall satisfaction with and willingness to recommend the program. The only special population specifically examined in the survey results is the group of beneficiaries who reported that they received disability or SSI.

## 5.2 Utilization and Expenditure Results

***Table 19*** shows the results for the analyses used to examine patterns of utilization and expenditures for special populations (including beneficiaries dually eligible for Medicare and Medicaid services and disabled beneficiaries). For each State for which special populations analyses were performed using Medicaid claims data, we show the State, the MIPCD program service, the sample of special populations in the State, and the utilization and expenditure results noted for the special populations within the State.

For all States examined, the distribution of special populations was similar between the intervention and control groups. The two main reasons for Medicaid eligibility within the States were low income or disabled. Reasons for eligibility among Medicaid beneficiaries varied across States.

For all States examined, we found no differential effects of the MIPCD program on utilization and expenditures depending on whether participants are Medicare-Medicaid (dual) enrollees or disabled. For all outcomes, the estimated effect of the intervention was the same for dual and non-dual participants and for disabled and non-disabled participants.

**Table 19**
**Claims-based utilization and expenditure results for special populations: Medicare-Medicaid dual enrollees and disabled versus non-disabled participants**

| State | Claims-based utilization and expenditures | Sample | Results |
|---|---|---|---|
| California | ▪ Total expenditures<br>▪ Any inpatient visits<br>▪ Inpatient expenditures<br>▪ Any ED visits<br>▪ ED expenditures | Across the three groups, approximately one-third of participants are eligible for Medicaid because they are low-income and two-thirds are eligible for Medicaid because they are blind or disabled. | There are no differential effects of the MIPCD program on utilization and expenditures depending on whether participants are Medicare-Medicaid (dual) enrollees or disabled. For all outcomes, the estimated effect of the intervention is the same for dual and non-dual participants and for disabled and non-disabled participants. |
| Connecticut | ▪ Total expenditures<br>▪ Any inpatient visits<br>▪ Inpatient expenditures<br>▪ Any ED visits<br>▪ ED expenditures | The percentage who are dually eligible for Medicare (15%), percentage continuously enrolled in Medicaid (80%), and total months enrolled in Medicaid (23 months) are comparable between incentive and control groups. About two-thirds were enrolled in Medicaid because they were low-income only, and about one-third were enrolled because they were low-income disabled. | There are no differential effects of the MIPCD program on utilization and expenditures depending on whether participants are dual enrollees or disabled. For all outcomes, the estimated effect of the intervention is the same for dual and non-dual participants and for disabled and non-disabled participants. |
| Minnesota | ▪ Total expenditures<br>▪ Any inpatient visits<br>▪ Inpatient expenditures<br>▪ Any ED visits<br>▪ ED expenditures<br>▪ Outpatient visits for evaluation and management services | The percentage who are dually eligible for Medicare (10%), percentage continuously enrolled in Medicaid (18%), and total months enrolled in Medicaid (36 months) are comparable between incentive and control groups. A small fraction (approximately 3%) was enrolled in Medicaid because they were low-income disabled. | There are no differential effects of the MIPCD program on utilization and expenditures depending on whether participants are dual enrollees or disabled. For all outcomes, the estimated effect of the intervention is the same for dual and non-dual participants and for disabled and non-disabled participants. |
| Montana | ▪ Total expenditures<br>▪ Any inpatient visits<br>▪ Inpatient expenditures<br>▪ Any ED visits<br>▪ ED expenditures | Comparing Medicaid eligibility categories, the incentive group is more likely to be low-income and less likely to qualify for Medicaid based on age or disability. | There are no differential effects of the MIPCD program on utilization and expenditures for dual enrollees or disabled enrollees. For all outcomes, the estimated effect of the intervention is the same for dual and non-dual participants and for disabled and non-disabled participants. |

(continued)

**Table 19 (continued)**
**Claims-based utilization and expenditure results for special populations: Medicare-Medicaid dual enrollees and disabled versus non-disabled participants**

| State | Claims-based utilization and expenditures | Sample | Results |
|---|---|---|---|
| New Hampshire | ▪ Total expenditures<br>▪ Any inpatient visits<br>▪ Inpatient expenditures<br>▪ Any ED visits<br>▪ ED expenditures | **Weight management group**: The percentage who are dually eligible for Medicare (56%), percentage continuously enrolled in Medicaid (about 75%, and total months enrolled in Medicaid (30 months) are comparable between incentive and control groups. The majority of participants were enrolled in Medicaid because they were either low-income and disabled or low-income and older than 65 years of age.<br>**Smoking cessation group:** About 63% of participants were dually eligible for Medicare. The majority of participants were enrolled in Medicaid because they were either low-income and disabled or low-income and older than 65 years of age. | In both the weight management and smoking cessation groups, there are no differential effects of the MIPCD program on utilization and expenditures depending on whether participants are dual enrollees or disabled. For all outcomes, the estimated effect of the intervention is the same for dual and non-dual participants and for disabled and non-disabled participants. |
| Texas | ▪ Total expenditures<br>▪ Any inpatient visits<br>▪ Inpatient expenditures<br>▪ Any ED visits<br>▪ ED expenditures | Percentage who are dually eligible for Medicare (5%), percentage continuously enrolled in Medicaid (95%), and total months enrolled in Medicaid (48 months) are comparable between treatment and control groups. All enrollees were eligible for Medicaid because they were low-income and disabled. | There are no differential effects of the MIPCD program on utilization and expenditures depending on whether participants are dual enrollees. For all outcomes, the estimated effect of the intervention is the same for dual and non-dual participants. |
| Wisconsin | ▪ Total expenditures<br>▪ Any inpatient visits<br>▪ Inpatient expenditures<br>▪ Any ED visits<br>▪ ED expenditures | The percentage who are dually eligible for Medicare is low in both intervention and control groups. | In both the Wisconsin Tobacco Quit Line and First Breath groups, there are no differential effects of the MIPCD program on utilization and expenditures depending on whether participants are dual enrollees or disabled. For all outcomes, the estimated effect of the intervention is the same for dual and non-dual participants and for disabled and non-disabled participants. |

## 5.3 Beneficiary Satisfaction Results

### 5.3.1 Ability to Participate in the Program

Results from the focus groups and stakeholder interviews revealed that in the behavioral health and substance use disorder programs, the in-person components of the programs strongly resonated with the special population participants. Several commented on how the program benefited them by encouraging them to leave the house. They appreciated the one-on-one interaction not only with the program staff but also with others who were diagnosed with similar conditions. The stakeholders noted that more start-up time may be needed for programs targeting these audiences. For example, one week the staff and participant may drive to the gym, and the next week they may go in and take a tour, and so on. Also, some participants reported difficulties with misuse of incentives; for example, in Texas, stakeholders and participants reported on the development of stricter parameters on how the incentives could be used following issues with misuse. In Hawaii and Minnesota, we conducted focus groups with individuals who either did not speak English or for whom English was not their first language. These groups reported cultural barriers related to program materials (i.e., not written in their native or preferred language) and, to a lesser extent, use of incentives (i.e., not culturally appropriate to use co-gyms). Another barrier was the cultural stigma of visiting behavioral health providers, an enrollment requirement for Hawaii's HI-PRAISE program. Stakeholders reported a few approaches to help combat these barriers, such as translating materials into different languages and offering translators and bilingual program staff, although they also noted that resources are limited for these activities.

### 5.3.2 Beneficiary Experiences and Satisfaction with the Program

Overall, beneficiaries who reported receiving disability or SSI represented 33.5 percent of the total survey sample of respondents. Across States, the percentage of beneficiaries receiving disability or SSI ranged from 22.1 percent in New York to 57.4 percent in Texas (***Table 20***). ***Table 21*** shows the results of the beneficiary satisfaction survey administered to participants in all States except Hawaii. Results shown below are for beneficiaries receiving disability or SSI.

In general, satisfaction with the program was high among beneficiaries receiving disability or SSI. Satisfaction did not differ significantly between beneficiaries receiving disability or SSI and those who did not with two exceptions:

- The percentage reporting that they could always contact program staff when they wanted to was significantly higher among beneficiaries receiving disability or SSI than among those who did not (63.5 percent vs. 59.3 percent, $p < 0.05$).

- The percentage reporting that program staff always spoke their language was significantly higher among beneficiaries receiving disability or SSI than among those who did not (98.3 percent versus 97.0 percent, $p < 0.05$).

**Table 20**
**Percentage of beneficiaries receiving disability or supplemental security income**

| State | Percent (%) |
|---|---|
| Overall | 33.5% |
| California | 31.7% |
| Connecticut | 29.5% |
| Minnesota | 22.3% |
| Montana | 42.9% |
| New Hampshire | 41.3% |
| Nevada | 31.0% |
| New York | 22.1% |
| Texas | 57.4% |
| Wisconsin | 29.8% |

Source: Beneficiary survey

**Table 21**
**Percentage of beneficiaries receiving disability or supplemental security income that reported satisfaction with program overall, program accessibility, and program incentives**

| Satisfaction measure | Percent (%) |
|---|---|
| Overall satisfaction | |
| Very satisfied | 67.2% |
| Overall program rating (mean, out of 10) | 8.5 |
| Would definitely recommend program to family and friends | 76.6% |
| Satisfaction with program accessibility | |
| Could always contact program staff when wanted to[1] | 63.5% |
| Started program as soon as wanted | 90.9% |
| Amount of time spent on program was about right (% responding "yes") | 86.9% |
| Program schedule was convenient (% responding "yes") | 94.1% |
| Program location was convenient (% responding "yes") | 93.5% |
| Program staff spoke respondents' language (% responding "yes")[2] | 98.3% |
| Was always able to get help from program staff | 64.9% |

(continued)

**Table 21 (continued)**
**Percentage of beneficiaries receiving disability or supplemental security income that reported satisfaction with program overall, program accessibility, and program incentives**

| Satisfaction measure | Percent (%) |
|---|---|
| Satisfaction with program incentives (% "strongly agree") | |
| Happy with incentives overall | 77.5% |
| Liked getting incentives for taking good care of health | 80.5% |
| Happy with how often got incentives | 69.0% |
| Incentives are fair | 76.1% |
| Incentives helped set goals and work toward them | 65.1% |
| Incentives helped make positive changes in life | 67.4% |

[1] Significantly higher among beneficiaries receiving disability or SSI than among those who did not (59.3%) ($p < 0.05$).

[2] Significantly higher among beneficiaries receiving disability or SSI than among those who did not (97.0%) ($p < 0.05$).

Source: Beneficiary survey

## 5.4 Discussion

To date, no clear cross-State patterns have emerged to suggest that the MIPCD program is lowering rates of inpatient hospitalization, ED use, inpatient expenditures, ED expenditures, and total expenditures for special populations. However, States are still enrolling Medicaid beneficiaries, and future analyses will include additional participants and more post-participation claims data. Because substantial changes in hospital and ED utilization and expenditure patterns are often considered long-term health outcomes, a better test of program effectiveness might be a positive change among special populations in the health behaviors or outcomes the States were targeting: for example, smoking quit rates, weight reduction, or improvements in hypertension or diabetes control. To date, the outcome data reported by States in the MIPCD State Minimum Data Set (MDS) have been too sparsely populated to analyze for specific special populations. We plan to examine whether changes in these behaviors and short-term outcomes occur for special populations, using future MIPCD State MDS data. As more participants complete the program, we will have greater statistical power to examine these evaluation questions specifically for the special populations.

Based on qualitative findings from focus groups with MIPCD participants, overall impressions of the incentive programs, and particularly the program staff, were positive. The in-person components of the programs strongly resonated with the participants, particularly in the behavioral health and substance use disorder programs. Future MIPCD program components should consider providing specific funds to target materials for non-native English speaking beneficiaries to reduce or eliminate the cultural barriers related to program participation.

Satisfaction with the program overall and with program accessibility and incentives has been high among beneficiaries who receive disability or SSI. The only statistically significant results indicated higher satisfaction among the special population than among the overall sample of respondents (for being able to contact program staff and for program staff speaking their language). Based on these preliminary survey results, there is no indication to date that the special populations (those receiving disability or SSI) are less satisfied with the program than other program participants.

# SECTION 6
# BENEFICIARY SATISFACTION

In Year 3 of the evaluation, we conducted several activities with beneficiaries of State programs to evaluate their satisfaction with the quality, accessibility, and incentives provided by the State programs. Activities included focus group discussions, interviews with program stakeholders (i.e., staff that have direct interaction with participants), and a beneficiary care survey. We sought to answer the following evaluation questions:

1. *To what extent are Medicaid beneficiaries satisfied with the program overall?*

2. *To what extent are Medicaid beneficiaries satisfied with program accessibility (e.g., convenience of schedule and location)?*

   - *What are barriers to program accessibility for Medicaid beneficiaries?*

   - *What approaches do States use to identify and address potential barriers to accessibility?*

   - *How do experiences and satisfaction with accessibility to State programs differ across States?*

3. *To what extent are Medicaid beneficiaries satisfied with program incentives?*

4. *To what extent do program incentives facilitate healthy behavior change?*

Below we present the qualitative data from the focus groups and stakeholder interviews. See ***Section 6.5*** for a summary of the quantitative data from the survey of beneficiaries.

## 6.1 Focus Group Discussions and Stakeholder Interviews

### 6.1.1 Focus Groups

In Year 3, we conducted a first round of focus group discussions to assess State program participants' satisfaction with the quality, access, and incentives provided by the State programs. As of April 23, 2015, we held 31 focus group discussions across the 10 demonstration States for Round 1 (see ***Table 22*** for a summary of focus groups by State). We will conduct up to 10 focus group discussions in selected States for Round 2. Round 2 focus group discussions are scheduled to take place later in 2015 prior to the cessation of the incentive programs within the States.

In Year 1, we developed the supporting materials (e.g., recruitment materials, screener, and moderator guide) for inclusion in the Paperwork Reduction Act (PRA) package. We provided the study protocols and materials to RTI's Institutional Review Board (IRB), and reviewers deemed the project as exempt. In Year 2, while waiting for Office of Management and Budget (OMB) approval of the focus group materials, a sub-team held occasional teleconferences to refine the focus group discussion plans. Through these planning sessions, the team identified potential focus group locations, discussed possible participant recruitment

strategies for the focus groups, and worked with States to identify a focus group point person that can serve as the State-based coordinator and liaison for the focus groups. In Year 3, we conducted the groups, analyzed the data, and delivered PowerPoint presentations on the findings to States.

**Table 22**
**Actual number of focus group participants and stakeholders interviewed as of April 23, 2015, across State programs**

| State | Program name(s) | Actual number of focus group participants as of March 18, 2015 | Actual number of stakeholders interviewed as of April 23, 2015 |
|---|---|---|---|
| California | Medi-Cal Incentives to Quit Smoking | 23 (3 focus groups) | 5 interviews |
| Connecticut | Rewards to Quit (R2Q)[1] | 22 (3 focus groups) | 4 interviews |
| Hawaii | HI-PRAISE | 25 (3 focus groups) | 4 interviews |
| Minnesota | We Can Prevent Diabetes, Minnesota | 28 (4 focus groups) | 2 interviews |
| Montana | Billing's Clinic's Pre-Diabetes & Metabolic Syndrome Class<br>St. Vincent Healthcare's Diabetes Prevention Program<br>Bozeman Deaconess Hospital's ActNOW! National Diabetes Prevention Program | 12 (3 focus groups) | 4 interviews |
| Nevada | Nevada Healthy Choices: Health Plan of Nevada (HPN)[2] | 10 (2 focus groups) | 6 interviews |
| New Hampshire | Healthy Choices Healthy Changes | 19 (3 focus groups) | 5 interviews |
| New York | Diabetes Prevention Program | 21 (4 focus groups) | 3 interviews |
| Texas | WIN (intervention arm) | 21 (3 focus groups) | 3 interviews |
| Wisconsin | Striving to Quit[3] | 27 (3 focus groups) | 2 interviews |
| Total | | 208 (31 focus groups) | 38 interviews |

[1] Contains telephonic component to the incentive program.

[2] We did not conduct focus groups with participants in the Children's Heart Center's Healthy Hearts Program due to OMB age restrictions. However, the Healthy Hearts Program was one of the largest incentive programs in Nevada.

[3] Telephonic only program.

### 6.1.2 Stakeholder Interviews

In Year 3, we conducted 38 in-depth interviews with State program staff that have direct interaction with participants, such as health educators, peer coaches, navigators, hotline counselors, and outreach coordinators (see Table 22 for a summary of interviews by State). These interviews took place in conjunction with the Round 1 focus groups during Year 3 and focused on understanding the beneficiary experience and how each program addresses quality of care, accessibility, and beneficiary satisfaction. Stakeholder interview data are combined with focus group discussion findings to form a qualitative perspective on beneficiary satisfaction.

In Year 1, we drafted a stakeholder interview protocol and included it in the project's PRA package. In Year 2, we received OMB approval of this protocol and discussed the timeline and types of stakeholders the team subsequently interviewed in Year 3. The majority of these interviews were conducted in person during the same time period as the Round 1 focus groups. Telephone interviews were conducted after the conclusion of focus groups if scheduling stakeholders in person was not feasible.

The purpose of the focus groups and the stakeholder interviews was to assess participant satisfaction with

- program accessibility (e.g., convenience of location and hours, timeliness of program and services, availability by phone, waiting times, availability of services and resources in other languages),
- quality of health care services provided through the State programs (e.g., support from health care providers, patient-provider communication, patient-centered care), and
- incentives and the extent to which they affect beneficiaries' satisfaction with the program.

### 6.1.3 Methods

**Focus Group Recruitment**. Focus group recruiting procedures conformed to ethical practices for collecting data from human participants. In general, participants were responsible for contacting staff via a toll-free number to be screened for focus group eligibility (i.e., very frequent or somewhat frequent participation in the program within the past 6 months, enrolled in the program for at least 6 weeks, received incentives, currently on Medicaid). Information gathered during these screening calls was used to assist the focus group facilitator during the discussions. Focus group discussion recruitment strategies included obtaining participant lists from States and contacting some participants to join a focus group discussion.

**Stakeholder Recruitment**. We conducted stakeholder interviews with up to six individuals in each State. We targeted stakeholders who spend 50 percent or more of their time on the program, directly interact with beneficiaries, and have been in their role for 1 year or longer. Interviewees included program directors, clinicians, educators, and others who provide services and interact directly with beneficiaries on a regular basis. State program leadership was asked to help identify stakeholders who may be most informative about the beneficiary experience and satisfaction. We then contacted the potential interviewees to assess their interest and availability. Stakeholders contacted to participate in this set of interviews in some States overlapped with those interviewed during the site visit; however, the questions differed greatly from those asked during the site visit.

### 6.1.4 Data Collection

We conducted qualitative focus groups with beneficiaries and in-depth interviews with stakeholders to capture information about beneficiary satisfaction with their MIPCD programs. A team of two professionally trained interviewers on the project team conducted all focus groups

and interviews. The in-person focus groups were held at convenient locations for participants (i.e., CHCs, local hotel conference rooms, local professional focus group facilities) and lasted 90 minutes. Stakeholder interviews lasted 30 to 45 minutes on average. The majority of the interviews were held at the stakeholders' place of employment. All focus group participants completed a written informed consent prior to participating in the focus group discussion. Verbal consent was obtained by the stakeholders. Prior to the start of data collection, all participants were assured of their confidentiality (either via the written informed consent or in the verbal interview script). Beneficiaries were assured that they will incur no penalties if they wish not to respond to the information collection as a whole or to any specific questions. Participants were given an incentive of up to $75[8] in the form of a VISA gift card as a thank you for their time. In some States, participants were also given a travel incentive to help offset the transportation costs to and from the focus groups. This incentive did not exceed $25.[9] Stakeholders were not offered an incentive.

The focus group moderator guide included questions designed to address beneficiary satisfaction. Guide topic areas included an introductory warm up; overall impressions of the program; experience and satisfaction with enrollment, such as ease of enrollment and access logistics; reactions to program staff and materials; experience and satisfaction with incentives, such as preferences for incentives, perceived value of incentives, impact of incentives, and perceived health outcomes (i.e., how does the program help you manage your health?); and a closure and wrap-up question.

### 6.1.5 Data Analysis

All focus groups and interviews were audio-recorded and transcribed. The notes and transcripts were removed of identifying information and saved on secure network servers, and the findings are presented without personally identifying information. Data from the transcripts were aligned with the interview guide questions. Two study interviewers from each evaluation State team reviewed the data and verbatim transcripts and conducted thematic analysis to identify patterns and trends in the data.

### 6.1.6 Findings

Below we present the key findings from the focus groups and stakeholders across States followed by State-specific findings. Findings are presented according to the sections in the focus group and interview guides: overall impressions of the program, access to the program (e.g., ease of enrollment, access to program activities), experience and satisfaction with program staff and materials, perceptions on how the program has helped individuals manage their chronic condition, and reactions to program incentives.

---

[8] The focus group incentive by State. Some States offered $50, whereas others offered $75. We took into account the feasibility of transportation when setting the amount of the focus group incentives in each State.

[9] The travel incentive varied by State, and participants were asked whether they needed travel assistance during the screening process.

*Key Findings across States*

The **overall impressions** about the incentive programs, and particularly the program staff, were positive. The majority of participants had a clear understanding of the purpose of the program and its goal of helping beneficiaries lead healthier lives both physically and mentally. The stakeholders we interviewed observed positive changes among many of the participants. Although our findings indicated it takes time and extensive effort on the part of the stakeholders[10] for the participants to become engaged in the program activities, those who did reported subsequent challenges in maintaining health behavior changes as the program sessions decreased or ended ("I should have never got up in this program…because here I am being let down again." Participant, Texas). Participants reported benefits from physically meeting and interacting with health counselors and other beneficiaries with similar conditions and some level of dissatisfaction when they did not (i.e., tobacco cessation counselors who have not smoked).

Feedback on the **enrollment process** was also generally positive. Most participants found the process to be easy and timely. However, in three States (Nevada, New York, and Texas), participants reported initial skepticism about the program ("Why would someone call me up out of the clear blue sky, don't know me and here they're offering me some money?" Participant, Texas). Participants who enrolled in clinics did not express the same level of distrust. For example, physician referrals bolstered recruitment in California, "When my doctor checked my lungs and told me I needed to stop smoking, I'm like, 'Okay, I can call this line and I'll get $20 in the process.'"

Participants found **access to program activities** generally easy, but those enrolled in programs with telephonic components commented on the challenges of using publicly available cell phones, such as limited minutes or lack of callback features. Another key barrier mentioned across programs was the lack of transportation either to classes or locations of incentivized gyms ("There was no public transportation where she lived so she always had to find a ride. I took her home after class many times…One who didn't have a car missed quite a few classes." Stakeholder, Montana).

A strong key finding was participants' positive **experiences and satisfaction with program staff**. Participants valued their relationships with program staff. They used words such as "trustworthy," "caring," "supportive," and "motivational" to describe staff. Participants reported staff offered tools to handle challenges and setbacks in their health goals and enabled them to be more empowered regarding their health (e.g., gain confidence to go the gym or exercise class or talk to their health care provider). One exception to the rule was quitline coaches. Some participants described interactions with these staff that were "programmed" and less personable. They disliked that they did not typically speak with the same coach but rather with different coaches each time.

**Experience and satisfaction with program materials** were limited. Some participants could not recall receiving materials. Others who remembered receiving materials said the amount was overwhelming. Literacy issues were reported by a few participants ("Part of my issue is reading. Everybody says, 'Well, you just get it out of cookbook,' but if you don't know

[10] One stakeholder in Nevada reported program staff called 1,700 beneficiaries to enroll 68.

how to read, it's difficult." Participant, New Hampshire). In two States (Hawaii and Montana), participants said they would have preferred to see the materials in another language (i.e., Micronesian, Filipino, Vietnamese, and Somali).

Across the States, participants and stakeholders shared examples of **how the program helps participants manage their health** through behavior changes that they attributed to MIPCD programs. These changes included weight loss, reduced alcohol consumption, reduced stress, increased primary care visits, and improved eating habits. Primary ways in which the programs helped participants were related to learning how to eat better and having a support person to assist them with their health goals. Participants liked having someone to keep them accountable and to help motivate them ("[The health counselor] she encourages you. She doesn't make you feel bad. She says, 'You can do it!' She's like a cheerleader." Participant, New Hampshire). Other benefits mentioned included gaining confidence to leave the house, go to the gym, talk with their doctor, or help the entire family get healthy (particularly by eating healthier foods), and seeing health results in real time, such as in carbon monoxide breathalyzer results or scale weigh-ins.

When asked about their **experience and satisfaction with incentives**, the majority of participants said they were a motivator ("a kick start") to enroll and, although to a lesser extent, encouraged participants to stick with the program ("The money was an incentive, I'm not going to lie. That made me call [the quitline] and it kept me aware of, 'I know I want to do this.'" Participant, Wisconsin; and "First it was about the card, then it got to me because I was getting something free. Then I started taking a look at it and I was like, 'Well, hey, maybe I need to do something about this breathing.'" Participant, California). Yet, stakeholders were less clear about the impact of the incentives ("I think it helped a little bit with the recruitment of a couple of patients [but] I don't see how it helped with retention at all…Overall, patients appreciated the incentives, but I'm not convinced patients changed their behavior because of them." Stakeholder, Montana; "A lot of times, it's kind of mixed, we hear that it's great that they get the money. It's kind of a motivator for them to even start the program, in general. Sometimes we hear, 'The money's not a factor for me to want to do this, it's my health,' or 'it's my kids,' or other factors." Stakeholder, Wisconsin).

Logistical challenges were reported with the use of incentives in a few States, primarily Nevada and Texas. Challenges included limited pickup times, delays in loading money onto debit cards, difficulty in checking card balances, and inability to use full amounts on cards. In other States, there was confusion about obtaining incentives. Participants shared that they did not understand the incentive process ("They said I had so many points, but I don't have a computer. I'm basically computer illiterate, so the points is still there." Participant, Nevada; "The hard one is I have doctors outside [the clinic] and I thought [I would receive a] gift card, too, from them…It's hard because…I don't understand this program." Participant, Hawaii). As one participant said, "If you are going to offer it to us, don't make it so hard for us to get it" (Wisconsin).

Suggestions from participants to improve the incentive process included making the receipt of the incentives instantaneous and immediate, using cards from major discount stores such as Wal-Mart or cash, improving incentive tracking and balance services, and raising or retaining the incentive for fresh fruits and vegetables. In States in which it was offered,

participants appreciated the flexibility to choose they type of gift card they received. (Walmart, Target, CVS, grocery store).

In sum, with respect to incentives, participants and stakeholders indicated that incentives alone did not change participant behavior. Instead, incentives motivated participants to enroll in the MIPCD program. Health improvements and coaching from program staff helped sustain participant engagement and encouraged goal accomplishment.

*Differences between States*

Inherent differences in program designs across States contributed to different levels of beneficiary satisfaction. Participants enrolled in State programs that contained in-person counseling[11] tended to report higher levels of satisfaction than participants in States with telephonic counseling only.[12] The State programs that allowed for flexibility in program counseling activities were also associated with increased perceived satisfaction. Examples include a lifestyle coach/health mentor going to an exercise class with the participant or accompanying them to the grocery store to help them choose healthy foods. Another State-specific approach that resulted in increased reported beneficiary satisfaction was personal accountability in meeting health goals. For example, in States that had "real-time" monitoring of health behaviors, such as blowing into a carbon dioxide monitor or getting on a scale, satisfaction levels with the program in general were higher. State programs with simple and clear incentive guidelines increased participant satisfaction with incentives. Long delays in receipt of incentive payments or additional steps needed to receive incentives (i.e., traveling to a clinic on certain days of the week) decreased perceived satisfaction with the incentive.

*Special Populations*

As part of the evaluation, we examined the extent to which special populations (including adults with behavioral health issues or substance abuse issues, and beneficiaries for whom English was not their native language) are able to participate in the program. To address this question, we looked at the incentive programs in four States that targeted these populations: New Hampshire and Texas (behavioral health and substance abuse issues) and Hawaii and Minnesota (non-native English speakers). Due to the non-generalizable nature of qualitative data and small sample sizes, only emerging themes are presented here, and we do not repeat results that are similar to the findings across States. However, some findings in these groups are of note.

In the behavioral health and substance abuse programs, the in-person components of the programs strongly resonated with the participants. Several commented on how the program benefited them by encouraging them to leave the house. They appreciated the one-on-one interaction not only with the program staff but also with others who were diagnosed with similar conditions. The stakeholders noted that more start-up time may be needed for programs targeting these audiences. For example, one week the staff and participant may simply drive to

[11] Connecticut, Hawaii, Minnesota, Montana, New Hampshire, New York, and Texas were not included because data collection is not yet complete.

[12] California, Nevada, and Wisconsin.

the gym, and the next week they may go in and take a tour, and so on. Also, some participants reported difficulties with misuse of incentives; for example, in Texas, stakeholders and participants reported on the development of stricter parameters for use of incentives following issues with misuse.

In Hawaii and Minnesota, we conducted focus groups with individuals who either did not speak English or for whom English was not their first language. These groups reported cultural barriers related to program materials (i.e., not written in their native or preferred language) and, to a lesser extent, use of incentives (i.e., not culturally appropriate to use co-gyms). Another barrier was the cultural stigma of visiting behavioral health providers, an enrollment requirement for Hawaii's HI-PRAISE program. Stakeholders reported a few approaches to help combat these barriers, such as translating materials into different languages and offering translators and bilingual program staff, although they also noted that resources are limited for these activities.

*State-specific Findings*

California

Key takeaways from the focus groups and stakeholder interviews in California are as follows:

- Satisfaction
  - Most participants felt the program was helpful in their efforts to quit smoking, even if they had not quit entirely.
  - The most frequent criticism was that counselors do not have personal experience with quitting smoking or other addictions.
- Access/Materials
  - Participants learned of the program through various channels. Physician referrals seemed to be particularly influential for participants.
  - A few participants said they would have liked more frequent calls in the beginning of the program when they were first starting their quit attempts.
  - While patches were very motivating for participants, several had concerns about using them, such as their strength, side effects, and logistics of use. The "Why do you smoke?" worksheet and "My Plan [for quitting]" were useful materials for participants.
- Incentives
  - Participants reported that the incentives motivated them to enroll and to stay engaged, particularly the nicotine replacement patches. They appreciated the choice of gift cards (Walmart, Target, CVS, grocery stores) and the promptness with which they received them.

- They valued the accountability of weekly calls and appreciated the encouragement of the counselors.

Connecticut

Key takeaways from the focus groups and stakeholder interviews in Connecticut are as follows:

- Satisfaction
  - There was a high level of satisfaction with the in-person individual and group counseling. Many participants would recommend the program to others, although they wished the program was longer given the time it takes to successfully quit smoking. They said they felt they would benefit from more ongoing support.
- Access/Materials
  - Participants seemed to benefit from in-person support from the smoking cessation counselors, who are more supportive, understanding, and "get it" more than the quitline counselors.
  - Having multiple options for counseling and support has been beneficial. However, participants would appreciate more options for group sessions to make them more convenient for their schedules.
- Incentives
  - The monetary incentives seemed to be important for getting participants started in the program and as ongoing motivation. Some participants shared how the incentives motivated them to stop and think when they were tempted to pick up a cigarette.
  - Issues with timely delivery of incentives were often reported, and participants felt frustrated with the delays and problems getting the money loaded onto debit cards.

Hawaii

Key takeaways from the focus groups and stakeholder interviews in Hawaii are as follows:

- Satisfaction
  - HI-PRAISE had a positive impact on participants' lives. Participants and stakeholders shared examples of HI-PRAISE encouraging participants to better manage their diabetes and their overall health. Also, participants were satisfied with nearly all aspects of the HI-PRAISE program.

- Access/Materials
  - Participants reported easy access to the program and like receiving their incentive gift cards at the clinic. However, they experience barriers such as long wait times for incentives, long distances to the clinics, and the required visit to a behavioral health care provider (i.e., a barrier due to cultural stigma surrounding behavioral health). Having multilingual translators at the clinics and/or offering materials in other languages would be helpful.
- Incentives
  - Participants sometimes ended their participation once they achieved all of their goals and received their full set of incentives. Retention remained challenging.
  - Incentives were vital for participants who were on food stamps. They often used incentives to cover their food expenses for the full month and possibly buy more healthy items, such as fresh fruits and vegetables.

Minnesota

Key takeaways from the focus groups and stakeholder interviews in Minnesota are as follows:

- Satisfaction
  - Participants expressed overall satisfaction with the program.
  - They described multiple ways that the program has helped them improve and manage their health (e.g., lose weight, lower blood sugar, drink water more often, eat healthier, exercise).
- Access/Materials
  - Language was a barrier for Somali participants. Challenges included using course materials outside of the classroom and communicating with non-Somali-speaking lifestyle coaches.
- Incentives
  - Some incentives were not used by participants and could be better targeted to participants' needs or explained. Participants described cultural barriers that decreased access to program incentives. Examples included females not being able to use gym memberships because gyms were co-ed, which would violate cultural beliefs on keeping genders separate in particular settings, or males not using cookbooks because they did not cook within the household.

Montana

Key takeaways from the focus groups and stakeholder interviews in Montana are as follows:

- Satisfaction
  - Participants described the program as "motivational" and "inspirational."
  - Similar to other States, reduction in program duration is a concern. Participants reported challenges and loss of motivation as sessions decreased from weekly to monthly sessions at the end of 10 months and they no longer received instructor peer support or gym memberships ("They need to extend it out because you feel like you've been through this program for nine months and it's over. They drop you off the edge and you're on your own." Participant).
- Access/Materials
  - Transportation was identified as an issue by stakeholders but not by participants.
  - Some participants described the volume of materials they received as overwhelming.
- Incentives
  - Satisfaction with incentives varied. All participants enjoyed receiving the incentives, but many indicated that the incentives were not the reason that they enrolled in the program. They appreciated the incentives, but they did not consider them essential ("You get paid to do something you need to do anyway." Participant). Others, including stakeholders, said the incentives helped with the initial recruitment but not retention.

New Hampshire

Key takeaways from the focus groups and stakeholder interviews in New Hampshire are as follows:

- Satisfaction
  - Participants reported high levels of satisfaction with the program and shared stories about how the program had improved their health (and lives), including improved fitness, being able to stop or reduce medications for diabetes and high blood pressure, and avoiding surgery. Many had been at a crisis point in terms of their health when they joined the program; they expressed that the program "saved my life," "was a second chance at life," and was "the best thing to ever happen to me."
  - Several participants described the program activities as the "high point" of their day or week.

- Stakeholder reported on the value of the 2-year program as opposed to just 1-year, explaining that it takes time for this population to get started with program activities. Reduction in program duration is a concern.

- Access/Materials

  - Health mentor support is critical. Participants recalled receiving the materials, although they talked more about the value of hands-on instruction from the program staff.

  - Participants appreciated that the program staff were understanding about and accommodated the participants' behavioral health issues. Flexibility in their role is a plus.

- Incentives

  - Monetary incentives are the most important at the start; self-motivation increases over time and with successes.

  - Participants reported levels of satisfaction with the program incentives with gym memberships and Weight Watchers memberships being critical.

Nevada

The Nevada Healthy Choices program has several participating organizational partners. For the purposes of the focus groups and stakeholder interviews, we focused on two of these partners: Amerigroup and United HealthCare/Health Plan of Nevada (HPN), both MCOs. Other program partners implementing the MIPCD study are the Children's Heart Center and the YMCA of Southern Nevada. The Children's Heart Center offers a program on weight management, dyslipidemia, hypertension, and hyperinsulinemia among children; the YMCA delivers a diabetes prevention program for adults. We did not conduct focus groups with Children's Heart Center participants or their parents due to OMB restrictions, and the YMCA did not have a sufficient number of enrolled MIPCD participants to support a focus group. The Lied Clinic at the University Medical Center was formerly a partner, but the clinic closed in fall 2014. Because the Children's Heart Center program accounts for the majority of MIPCD participants in Nevada, the focus group findings may not generalize to all programs in the State.

Key takeaways from the focus groups and stakeholder interviews in Nevada are as follows:

- Satisfaction

  - There was limited engagement with the program staff, which may have lessened overall program impact. Both stakeholders and participants commented that at least some in-person contact would strengthen the program.

- Access
  - Stakeholders shared that it was difficult to recruit via telephone and letters alone. Outreach required significant effort with minimal return; for example, 1,700 recruitment calls yielded only 68 participants.
  - Stakeholders also reported several challenges to the telephone-based intervention, including high proportions of individuals with incorrect telephone numbers or limited cell phone minutes. Thus, only a few participants had more than one or two telephone sessions with program staff.
  - Participants said that the diabetes classes were offered at inconvenient times, transportation remained an issue, and it was challenging to go to multiple locations such as labs and doctor's offices ("It's just hard to get back and forth to different doctors, it takes hours to get there. So I try to limit myself to my area only." Participant).
- Incentives
  - Participants reported confusion about how to earn and receive incentives. There were barriers to using an online system for incentives, as many participants reported having limited access to computers and low computer literacy.

<u>New York</u>

Key takeaways from the focus groups and stakeholder interviews in New York are as follows:

- Satisfaction
  - Participants expressed an overall satisfaction with the program with readiness to change being a crucial factor in program retention.
  - Participants expressed a desire for the weekly program to continue beyond 16 weeks and/or to be engaged in a post-core program.
- Access/Materials
  - While many participants indicated the class times and locations were convenient, participants and stakeholders identified scheduling classes (i.e., times and locations) as a barrier to participation and retention. Some participants reported using incentive money for bus passes to attend classes.
  - Participants would have liked to have received healthy cooking demonstrations and for more cultural foods to be included in the calorie counter books.
  - Although they found it tedious and difficult to use initially, participants grew to appreciate the dietary food tracker.

- Incentives

  - The mixed incentive class structure was viewed as problematic, and participants reported that individuals in the control arm would often confront those in the experimental arm making them uncomfortable.

  - Participants were generally satisfied with the incentives. Some said the incentive was "the push" they needed to attend the classes.

  - Participants were initially skeptical when they heard they would be paid to participate in the program.

Texas

Key takeaways from the focus groups and stakeholder interviews in Texas are as follows:

- Satisfaction

  - The combination of receiving incentives and working one-on-one is key to the program's success, especially for individuals with behavioral disorders. Personal contact and establishing a motivational relationship between the participant and program was essential.

  - Although participants were initially suspicious about the program offerings, once enrolled and engaged, they expressed strong concerns about the program ending.

  - Participants reported that the program helped improve their health by helping them manage their depression, lose weight, and decrease alcohol use.

- Access

  - Participants valued the in-person meetings with staff at their homes or other location convenient for them. However, stakeholders reported having to travel long distances (i.e., more than 1 hour one way) to conduct in-person counseling appointments. This was challenging if participants missed appointments.

  - Participants were very satisfied with program staff once they were teamed with an appropriate staff member. A few participants said they voluntarily changed counselors or were teamed up with a few counselors early on in the program.

  - Access was enhanced by distributing program cell phones to some participants. This was well-received and increased participation, particularly among the homeless.

- Incentives
  - Parameters regarding the use and amounts of incentives changed and became more limited during the course of the program. For example, the incentive for purchasing fresh fruits and vegetables decreased from $75 to $30.
  - Participants appreciate the incentives and used them to purchase a wide variety of items to accomplish their health goals (i.e., cookware, workout clothes, and fitness equipment).
  - Feedback was mixed about whether the incentives are received in a timely manner.

Wisconsin

Key takeaways from the focus groups and stakeholder interviews in Wisconsin are as follows:

- Satisfaction
  - Participants were generally satisfied with the program. However, they disliked and were annoyed that they were unable to develop a relationship with staff and had to retell their story each time they spoke with someone.
  - Participants think the program should last longer than 6 months or, at a minimum, include a follow-up component.
- Access
  - Many participants found the quitline coaching calls helpful, and stakeholders reported hearing the same from participants.
  - One key feature of the program is the 24/7 access to the quitline so that participants can call whenever they needed to. However, participants said the incoming program calls came at inconvenient times or at different times than requested.
- Incentives
  - Monetary incentives provide a strong push to get people started in the program and also help with retention. As in other States, the importance of the incentives varies by level of self-motivation to perform the health behavior.

## 6.2 Conclusions

Based on qualitative findings from focus groups with MIPCD participants, overall impressions of the incentive programs, and particularly the program staff, were positive. Participants provided generally positive feedback on the enrollment process and access to

program activities. Participants have identified a few barriers to access, including lack of transportation to program activities and limited cell phone minutes to access telephonic program components. Participants reported very positive experiences and satisfaction levels with program staff. Participants said that staff support and motivate them to achieve their health goals. Experience and satisfaction with program materials was limited, with some participants not recalling having received materials and others feeling overwhelmed with respect to the amount provided. The majority of participants characterized the incentives as motivators to enroll in the programs and, to a lesser extent, as an encouragement to remain in the programs. Some participants reported logistical challenges and confusion concerning the process to obtain incentives. Inherent differences in program designs across States contributed to different levels of beneficiary satisfaction. Participants enrolled in State programs with in-person counseling components, flexibility in program counseling activities, personal accountability in meeting health goals, and simple and clear incentive guidelines tended to report higher levels of satisfaction. Additional quantitative findings regarding beneficiary satisfaction are presented in the remainder of Section 6, based on the beneficiary survey.

Focus group findings and beneficiary survey results were combined to assess the overall satisfaction with accessibility and quality of care across States. The goal of this data triangulation is to examine the predictors of overall satisfaction and of satisfaction with accessibility and with quality of care across States. The survey provides parameters of satisfaction, while the focus group data provide more in-depth information to offer context about participant satisfaction. In addition, we will use the findings from the Round 1 focus groups and stakeholder interviews in conjunction with the beneficiary satisfaction survey to identify States in which to conduct the Round 2 focus group discussions. These will be determined in conjunction with CMS and are scheduled to take place in contract year 4 (2015) and will focus on special populations or programs of interest. In particular, we will conduct Round 2 groups in States that have unique changes to their program, such as the addition of a peer component, offerings for repeat participants, or programs for non-English-speaking participants.

## 6.3 Overview of the Beneficiary Survey

RTI conducted this survey of program participants across the States to assess participants' overall satisfaction with the program and satisfaction with program accessibility, program materials, program staff, and incentives. In addition, the survey assessed whether the program had helped participants understand their health issues and make positive changes. The cross-sectional survey, conducted in two waves in 2014 and 2015, involved participants in the experimental arms of the State program. ***Table 23*** provides a summary of the survey topics and specific survey questions.

**Table 23**
**Overview of survey topics and questions**

| Topic | Survey question |
|---|---|
| Overall program satisfaction | How would you rate this program? Choose a number between 1 and 10, where 1 is the worst program possible and 10 is the best program possible. |
| | Would you recommend this program to your family or friends? (yes, definitely; yes, probably; no) |
| | Overall, how satisfied were you with this program? (very satisfied – very dissatisfied) |
| Satisfaction with program access | How often were you able to contact program staff when you wanted to? (always – never) |
| | 5a. I was able to start the program as soon as I wanted. (yes/no) |
| | 5b. The amount of time I spent on the program was about right. (yes/no) |
| | 5c. The program schedule was convenient for me (yes/no). |
| | 5d. The program location was convenient for me. (yes/no) |
| | 5e. The program staff spoke my language. (yes/no) |
| | 5f. I was able to get child care when I needed to attend the program. (yes/no) |
| | 5g. I was able to get transportation when I needed to attend the program. (yes/no) |
| | How often were you able to get the help you wanted from the program staff? (always – never) |
| Satisfaction with materials and resources | Did the program give you any educational materials or information about your health issue(s) (for example, written materials or a Web site)? (yes/no) |
| | How helpful were these materials or information? (very helpful – not helpful) |
| Program impact | 9a. The program helped me understand my health issues. (strongly agree – strongly disagree) |
| | 9b. The program helped me learn ways to take better care of my health. (strongly agree – strongly disagree) |
| | 9c. The program encouraged me to make lifestyle changes to improve my health. (strongly agree – strongly disagree) |

(continued)

**Table 23 (continued)**
**Overview of survey topics and questions**

| Topic | Survey question |
|---|---|
| Communication with program staff | 10a. The program staff explained things in a way I can understand. (strongly agree – strongly disagree) |
| | 10b. The program staff listened carefully to what I have to say. (strongly agree – strongly disagree) |
| | 10c. The program staff encouraged me to ask questions. (strongly agree – strongly disagree) |
| | 10d. The program staff encouraged me to talk about my health concerns. (strongly agree – strongly disagree) |
| | 10e. The program staff seemed to care about me as a person. (strongly agree – strongly disagree) |
| Satisfaction with incentives | 13a. Rewards or incentives helped me (or will help me) set goals and work toward them. (strongly agree – strongly disagree) |
| | 13b. Rewards or incentives helped me (or will help me) make positive changes in my life. (strongly agree – strongly disagree) |
| | 13c. I like getting rewards and incentives for taking good care of my health. (strongly agree – strongly disagree) |
| | 13d. I am happy with the rewards or incentives. (strongly agree – strongly disagree) |
| | 13e. I am happy with how often I got (or will get) the reward or incentives. (strongly agree – strongly disagree) |
| | 13f. The rewards or incentives are fair. (strongly agree – strongly disagree) |
| Assistance provided[1] | 17a. Did program staff help you learn ways to manage your [diabetes]?[1] (yes/no) |
| | 17b. Did program staff help you set goals to manage your [diabetes]?[1] (yes/no) |
| | 17c. Did program staff help you deal with problems that might come up with reaching your goals?[1] (yes/no) |
| | 17d. Did program staff give you medications to help manage your diabetes?[1] (yes/no) |

[1] The survey includes modules with similar questions tailored to each type of program: diabetes prevention program, diabetes management program (presented in table), tobacco program, weight management program, blood pressure program, and cholesterol program.

States were assigned to Wave 1 and/or Wave 2 based on the States' progress in meeting their target enrollment and the duration of their programs. This approach ensured that we were able to survey participants who had current or recent experience in the program. ***Table 24*** summarizes the two survey waves and which States were involved in each wave.

**Table 24**
**Overview of survey waves**

| State | Wave 1 | Wave 2 |
|---|---|---|
| California | — | ✓ |
| Connecticut | ✓ | ✓ |
| Hawaii[1] | — | — |
| Minnesota | ✓ | ✓ |
| Montana[2] | ✓ | — |
| Nevada | — | ✓ |
| New Hampshire | ✓ | ✓ |
| New York | — | ✓ |
| Texas | ✓ | — |
| Wisconsin | ✓ | ✓ |
| Total | 6 | 7 |

[1] Survey was not conducted in Hawaii due to language barriers (see ***Section 6.4, Survey Methodology***).

## 6.4 Survey Methodology

The survey was administered by mail with telephone follow-up of nonrespondents. Participants had the option to complete the survey in English or Spanish. Because a high proportion of program participants in Hawaii do not speak either English or Spanish, the beneficiary survey was not administered in the State.[13] However, Hawaii administered its own survey using selected items (with adaptations) from the cross-State beneficiary survey. Selected findings from the Hawaii survey are presented in ***Section 6.7.1***.

Each State MIPCD program provided a list of eligible participants for the survey. The sample consisted of Medicaid beneficiaries aged 18 or older who had participated or were participating in the experimental arm of their State's MIPCD program during the prior 6 months (***Table 25***).

[13] Program participants in Hawaii spoke 10 or more languages other than English, including Filipino languages (Ilocano and Tagalog), Samoan, Tongan, Micronesian languages (Chuukese and Marshallese), Vietnamese, Laotian, Chinese, and Korean.

**Table 25**
**Number of Medicaid beneficiaries sampled by wave of survey administration for States**

| State | Wave 1 sample | Wave 2 sample | Total |
|---|---|---|---|
| California | 0 | 759 | 759 |
| Connecticut | 366 | 534 | 900 |
| Minnesota | 306 | 50 | 356 |
| Montana[1] | 31 | 0 | 31 |
| Nevada | 0 | 75 | 75 |
| New Hampshire | 497 | 209 | 706 |
| New York | 0 | 664 | 664 |
| Texas | 522 | 0 | 522 |
| Wisconsin | 336 | 237 | 573 |
| Total | 2,058 | 2,528 | 4,586 |

[1] We originally planned to include Montana in the Wave 2 sample, but no participants met the eligibility requirements.

### 6.4.1 Data Collection Overview

Each wave of data collection lasted approximately 12 weeks. Wave 1 of the survey was conducted from November 2014 through January 2015, and Wave 2 was conducted from March to June 7, 2015. ***Table 26*** presents the data collection timeline for Waves 1 and 2 of the survey. The first step in the data collection process was mailing a prenotification letter, letting participants know that they would receive a questionnaire soon and encouraging them to complete it. The next step was mailing the questionnaire; if a response was not received in approximately 4 weeks, the survey was mailed a second time. Finally, participants who did not complete the mail survey were contacted by telephone.

**Table 26**
**Timeline of data collection activities by State and wave of survey administration**

| Activity | Wave 1 | Wave 2 |
|---|---|---|
| Prenotification letter mailed | 11/7/14 | 3/9/15 |
| Questionnaire #1 mailed | 11/14/14 | 3/16/15 |
| Questionnaire #2 mailed | 12/12/14 | 4/13/15 |
| Telephone follow-up | 1/5/15–2/14/15 | 5/1/15–6/7/15 |

### 6.4.2 Response Rate

We realized an overall response rate across both waves of 52.7 percent. The response rate was calculated as follows:

$$\frac{\text{Total Number of Completed Interviews plus Partial Interviews}}{\text{Total Number Sampled} - \text{Ineligible Cases}}$$

Reasons for ineligibility were if the participant was deceased, had language barriers (did not speak English or Spanish and no one to assist), was institutionalized, was physically or mentally incapable of responding and no proxy was available, or reported that he or she did not participate in the program.

### 6.4.3 Data Analysis

We computed sample weights for the California sample only. In all other States, we conducted a census survey (i.e., surveyed all eligible program participants), so weighting was not required. We then conducted descriptive analyses to provide estimates of weighted proportions and means (where appropriate) for each variable. We used unweighted data to compare differences between subgroups with statistical tests. Because a census of all eligible participants was conducted in all States except California, in this survey, there is minimal variation in the survey data due to sampling.

## 6.5 Survey Results

### 6.5.1 Overview of Survey Respondents

A total of 2,276 Medicaid beneficiaries responded to the survey: 994 in Wave 1 and 1,282 in Wave 2 (***Table 27***). About 62 percent responded to the survey by mail, and 38 percent responded by telephone (***Table 28***). Ninety-eight percent of respondents completed the survey in English and 2 percent in Spanish. Respondents could indicate whether they received help completing the survey and, if so, what type of help they received. About 18 percent of respondents reported receiving help, including someone reading or explaining the questions to them, writing down the answers the respondent gave, or translating the questions into the respondent's language.

Respondents identified the health focus of the program in which they participated (they could select more than one health focus, and many did). The highest percentage of respondents (64 percent) participated in a tobacco program. One third of respondents participated in a weight management program, 25 percent in a diabetes prevention program, 22 percent in a diabetes control program, 21 percent in a blood pressure program, and 17 percent in a cholesterol program (see Table 28).

Respondents' demographic characteristics are presented in Table 28. In terms of age, across all States, the highest percentage of participants were 53 to 58 years of age. Montana had the highest percentage of participants in the oldest age group, 59 years of age or older (43 percent). New Hampshire (35 percent) and Wisconsin (32 percent) had the highest percentages of respondents in the youngest age group (44 years of age or younger).

**Table 27**
**Number of responses overall and by State and wave of survey administration**

| State | Wave 1 number | Wave 2 number | Total number |
|---|---|---|---|
| Overall | 994 | 1,282 | 2,276 |
| California | — | 357 | 357 |
| Connecticut | 144 | 249 | 393 |
| Minnesota | 147 | 28 | 175 |
| Montana | 21 | — | 21 |
| New Hampshire | 210 | 93 | 303 |
| Nevada | — | 42 | 42 |
| New York | — | 385 | 385 |
| Texas | 338 | — | 338 |
| Wisconsin | 134 | 128 | 262 |

The majority of participants (63 percent) were female, and the most common marital status was never married (37 percent). About 26 percent of participants had less than a high school degree, 34 percent had a high school degree or the equivalent, 32 percent had some college or a 2-year college degree, and 8 percent had a college degree or higher.

In terms of employment status, the highest proportion of participants were unemployed and were receiving disability benefits or SSI (34 percent). About 7 percent of respondents were working full-time, 12 percent were working part-time, and another 21 percent were unemployed and looking for work. Texas had the highest percentage of respondents (57 percent) who received disability benefits or SSI and the lowest percentage of respondents who were employed either full-time or part-time (4.3 percent). In contrast, Nevada had the highest percentage of respondents (33 percent) who were employed either full-time or part-time.

About 57 percent of respondents were white, and 34 percent were black or African American. In Montana and New Hampshire, over 95 percent of respondents were white. Minnesota had the highest percentage of black or African American respondents (60 percent), followed by New York (54 percent), Wisconsin (51 percent), and Texas (49 percent). Overall, about 17 percent of respondents reported that they were Hispanic or Latino. New York had the highest percentage of Hispanic or Latino respondents (30 percent), followed by Nevada (26 percent) and Connecticut (24 percent).

**Table 28**
**Demographic characteristics of respondents overall and by State**

| Characteristic | Overall | | State | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | CA | CT | MN | MT | NH | NV | NY | TX | WI |
| | No. | Col. % | Col. % | Col. % | Col. % | Col. % | Col. % | Col. % | Col. % | Col. % | Col. % |
| Mode of survey administration | | | | | | | | | | | |
| Mail | 1,708 | 62.3 | 56.9 | 63.4 | 69.1 | 81.0 | 68.6 | 47.6 | 64.2 | 67.5 | 57.6 |
| Telephone | 1,032 | 37.7 | 43.1 | 36.6 | 30.9 | 19.0 | 31.4 | 52.4 | 35.8 | 32.5 | 42.4 |
| Health issue focus of program[1, 2] | | | | | | | | | | | |
| Diabetes prevention | 624 | 25.3 | 4.6 | 11.0 | 98.1 | 94.1 | 10.9 | 52.6 | 60.9 | 33.1 | 7.5 |
| Diabetes control | 552 | 22.3 | 6.3 | 9.3 | 48.1 | 36.8 | 10.2 | 90.2 | 58.2 | 35.7 | 6.8 |
| Tobacco use | 1,611 | 63.6 | 95.3 | 95.5 | 8.9 | 0.0 | 40.0 | 12.5 | 11.0 | 38.0 | 96.7 |
| Weight management | 831 | 33.2 | 5.4 | 7.0 | 70.3 | 75.0 | 79.2 | 27.5 | 38.3 | 83.7 | 6.1 |
| Blood pressure | 522 | 20.8 | 7.9 | 8.5 | 15.3 | 22.2 | 12.0 | 29.3 | 45.7 | 59.5 | 7.0 |
| Cholesterol | 414 | 16.6 | 5.5 | 8.4 | 25.5 | 22.2 | 16.1 | 17.1 | 33.0 | 38.6 | 6.6 |
| Age | | | | | | | | | | | |
| 44 years or younger | 631 | 24.3 | 19.2 | 27.4 | 23.9 | 23.8 | 34.9 | 12.5 | 16.9 | 27.0 | 32.4 |
| 45 to 52 years | 674 | 25.9 | 23.6 | 30.2 | 23.9 | 9.5 | 27.5 | 35.0 | 23.2 | 32.1 | 22.8 |
| 53 to 58 years | 696 | 26.8 | 26.8 | 24.7 | 20.9 | 23.8 | 20.7 | 22.5 | 27.0 | 38.1 | 26.8 |
| 59 years or older | 598 | 23.0 | 30.4 | 17.7 | 31.3 | 42.9 | 16.9 | 30.0 | 32.8 | 2.9 | 18.0 |

(continued)

**Table 28 (continued)**
**Demographic characteristics of respondents overall and by State**

| Characteristic | Overall | | State | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | CA | CT | MN | MT | NH | NV | NY | TX | WI |
| | No. | Col. % | Col. % | Col. % | Col. % | Col. % | Col. % | Col. % | Col. % | Col. % | Col. % |
| Sex | | | | | | | | | | | |
| Male | 993 | 36.9 | 41.3 | 40.4 | 26.5 | 28.6 | 33.3 | 45.2 | 34.3 | 36.0 | 33.3 |
| Female | 1,697 | 63.1 | 58.7 | 59.6 | 73.5 | 71.4 | 66.7 | 54.8 | 65.7 | 64.0 | 66.7 |
| Marital status | | | | | | | | | | | |
| Now married or living with a partner | 594 | 22.4 | 26.4 | 17.2 | 28.9 | 5.0 | 11.1 | 40.5 | 29.5 | 17.8 | 19.9 |
| Widowed | 158 | 6.0 | 8.1 | 3.2 | 6.6 | 15.0 | 4.7 | 0.0 | 5.8 | 5.5 | 5.5 |
| Divorced | 691 | 26.0 | 30.1 | 23.5 | 20.5 | 45.0 | 36.0 | 23.8 | 18.2 | 25.8 | 19.5 |
| Separated | 234 | 8.8 | 8.4 | 8.7 | 10.2 | 0.0 | 4.7 | 11.9 | 12.1 | 9.5 | 8.2 |
| Never married | 981 | 36.9 | 27.0 | 47.5 | 33.7 | 35.0 | 43.4 | 23.8 | 34.5 | 41.2 | 46.9 |
| Highest grade or level of school completed | | | | | | | | | | | |
| 8th grade or less | 189 | 7.1 | 6.3 | 7.2 | 9.1 | 9.5 | 4.7 | 4.8 | 10.6 | 7.3 | 5.6 |
| Some high school, but did not graduate | 504 | 19.0 | 18.6 | 20.2 | 11.5 | 4.8 | 8.8 | 7.1 | 21.0 | 28.4 | 22.9 |
| High school graduate or GED | 899 | 33.8 | 33.5 | 37.2 | 32.1 | 28.6 | 37.4 | 23.8 | 30.9 | 35.7 | 30.9 |
| Some college or 2-year college degree | 860 | 32.3 | 34.7 | 29.0 | 37.0 | 42.9 | 38.4 | 47.6 | 25.3 | 25.9 | 35.3 |

(continued)

**Table 28 (continued)**
**Demographic characteristics of respondents overall and by State**

| Characteristic | Overall | | State | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | CA | CT | MN | MT | NH | NV | NY | TX | WI |
| | No. | Col. % | Col. % | Col. % | Col. % | Col. % | Col. % | Col. % | Col. % | Col. % | Col. % |
| 4-year college degree | 164 | 5.5 | 5.2 | 3.5 | 7.3 | 4.8 | 7.4 | 9.5 | 9.3 | 2.4 | 4.0 |
| More than 4-year college degree | 60 | 2.3 | 1.7 | 2.9 | 3.0 | 9.5 | 3.4 | 7.1 | 2.9 | 0.3 | 1.2 |
| Employment status[1] | | | | | | | | | | | |
| Employed full-time | 184 | 6.9 | 6.8 | 8.4 | 8.8 | 4.8 | 3.7 | 16.7 | 9.5 | 1.2 | 9.0 |
| Employed part-time | 329 | 12.3 | 11.7 | 13.5 | 14.7 | 4.8 | 21.7 | 14.3 | 14.5 | 2.1 | 9.8 |
| Employed, not specified whether full-time or part-time | 38 | 3.7 | 100.0 | 0.7 | 2.0 | 0.0 | 2.4 | 100.0 | 100.0 | 0.9 | 4.3 |
| Unemployed and looking for work | 562 | 20.9 | 18.5 | 30.6 | 17.1 | 19.0 | 15.4 | 21.4 | 25.0 | 13.7 | 26.6 |
| Unemployed, not specified whether looking for work | 28 | 1.0 | 0.3 | 0.8 | 1.1 | 0.0 | 1.7 | 0.0 | 1.0 | 2.7 | 1.1 |
| Student | 106 | 4.0 | 4.8 | 4.2 | 6.5 | 4.8 | 5.0 | 0.0 | 1.8 | 1.8 | 4.3 |
| Homemaker | 278 | 10.4 | 8.3 | 8.2 | 15.3 | 9.5 | 8.4 | 14.3 | 13.2 | 15.2 | 8.2 |
| Retired | 332 | 12.4 | 19.9 | 8.2 | 17.6 | 23.8 | 6.4 | 9.5 | 11.6 | 4.3 | 9.4 |
| Receiving disability or supplemental security income | 919 | 33.5 | 31.7 | 29.5 | 22.3 | 42.9 | 41.3 | 31.0 | 22.1 | 57.4 | 29.8 |
| Other employment status | 118 | 4.4 | 3.4 | 4.7 | 4.7 | 19.0 | 3.3 | 0.0 | 6.1 | 5.2 | 3.9 |

(continued)

**Table 28 (continued)**
**Demographic characteristics of respondents overall and by State**

| Characteristic | Overall | | State | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | CA | CT | MN | MT | NH | NV | NY | TX | WI |
| | No. | Col. % | Col. % | Col. % | Col. % | Col. % | Col. % | Col. % | Col. % | Col. % | Col. % |
| Race[1] | | | | | | | | | | | |
| American Indian or Alaska Native | 203 | 7.9 | 9.6 | 7.7 | 13.3 | 9.5 | 6.8 | 5.1 | 3.5 | 6.3 | 9.4 |
| Asian | 56 | 2.2 | 3.0 | 0.9 | 3.0 | 0.0 | 0.0 | 5.1 | 6.4 | 0.3 | 0.0 |
| Black or African American | 865 | 33.8 | 20.7 | 32.5 | 60.2 | 0.0 | 1.7 | 38.5 | 53.6 | 49.4 | 51.0 |
| Native Hawaiian or Other Pacific Islander | 27 | 1.1 | 0.9 | 1.7 | 0.0 | 0.0 | 0.3 | 2.6 | 2.9 | 0.6 | 0.0 |
| White | 1,465 | 57.3 | 68.6 | 57.0 | 33.1 | 95.2 | 95.6 | 51.3 | 31.0 | 43.7 | 45.1 |
| Ethnicity | | | | | | | | | | | |
| Hispanic or Latino | 439 | 16.7 | 17.7 | 23.9 | 4.3 | 5.0 | 2.7 | 26.2 | 30.0 | 19.3 | 4.3 |
| Not Hispanic or Latino | 2,187 | 83.3 | 82.3 | 76.1 | 95.7 | 95.0 | 97.3 | 73.8 | 70.0 | 80.7 | 95.7 |
| Received help completing survey | | | | | | | | | | | |
| Yes | 310 | 18.3 | 15.8 | 18.5 | 16.1 | 5.9 | 15.0 | 5.3 | 19.9 | 28.3 | 16.9 |
| No | 1,387 | 81.7 | 84.2 | 81.5 | 83.9 | 94.1 | 85.0 | 94.7 | 80.1 | 71.7 | 83.1 |

[1] Column % may be greater than 100.0% because respondents could select multiple responses.

[2] The health issue focus of the program was self-reported by respondents; respondents could select multiple health issues.

Note: This table presents weighted survey data.

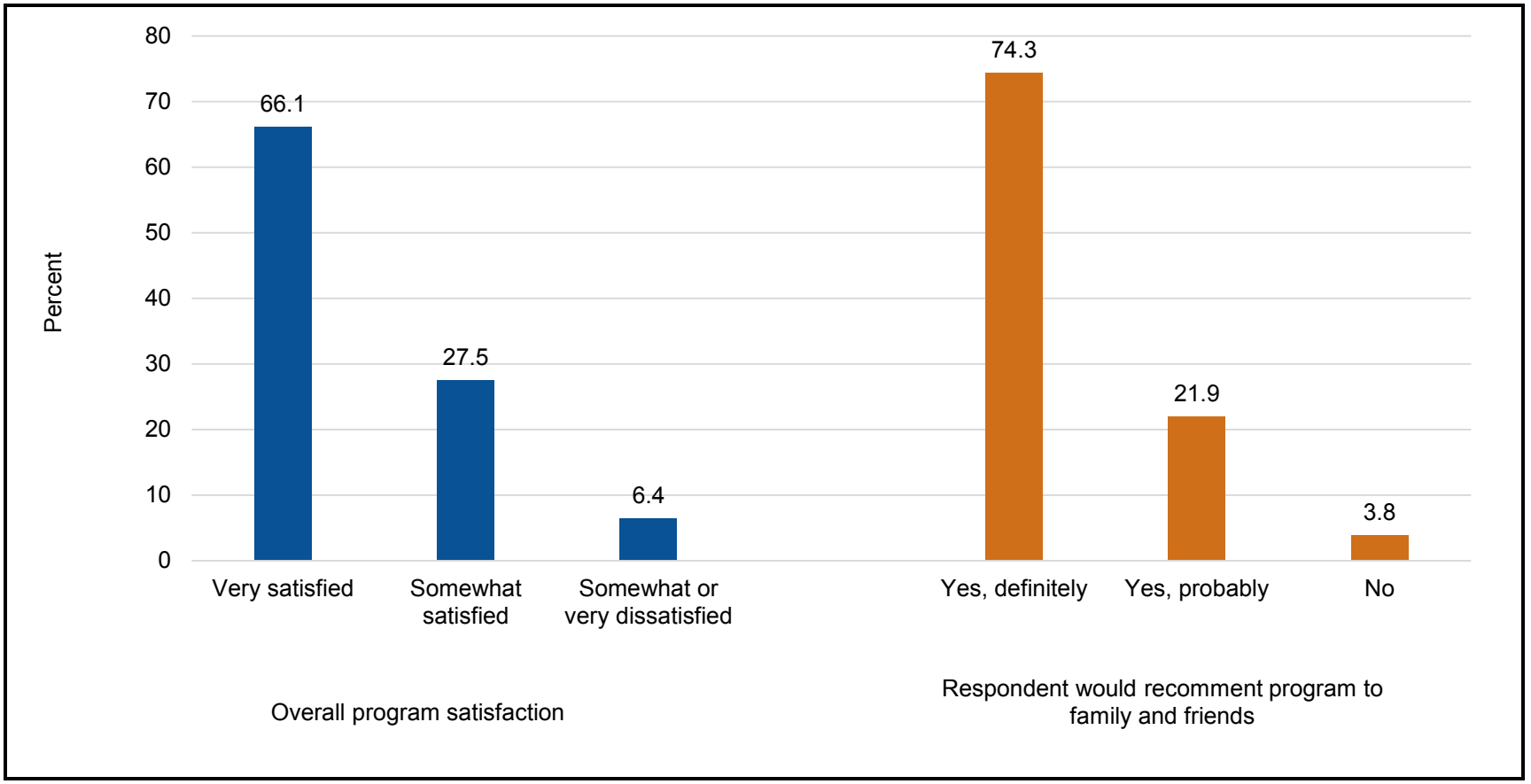
### 6.5.2 Overall Satisfaction

The survey asked respondents about their overall satisfaction with the program. Across all States, 66 percent of participants were very satisfied and another 28 percent were somewhat satisfied with the program overall (***Figure 2***). Overall program satisfaction was associated with the health focus of the program (***Table 29***). Seventy percent or more of respondents in blood pressure (76 percent), weight management (75 percent), cholesterol (75 percent), diabetes prevention (73 percent), and diabetes control (70 percent) programs were very satisfied with the program overall. Fewer respondents in tobacco programs (64 percent) answered "very satisfied."

In another measure of satisfaction, about three-quarters of participants said they would definitely recommend the program to family and friends, and another 22 percent said they would probably do so. Race was significantly associated with whether respondents would recommend the program; 77 percent of black or African American respondents said they would definitely recommend the program compared with 73 percent of respondents who were not black or African American (data no shown; $p = 0.023$).

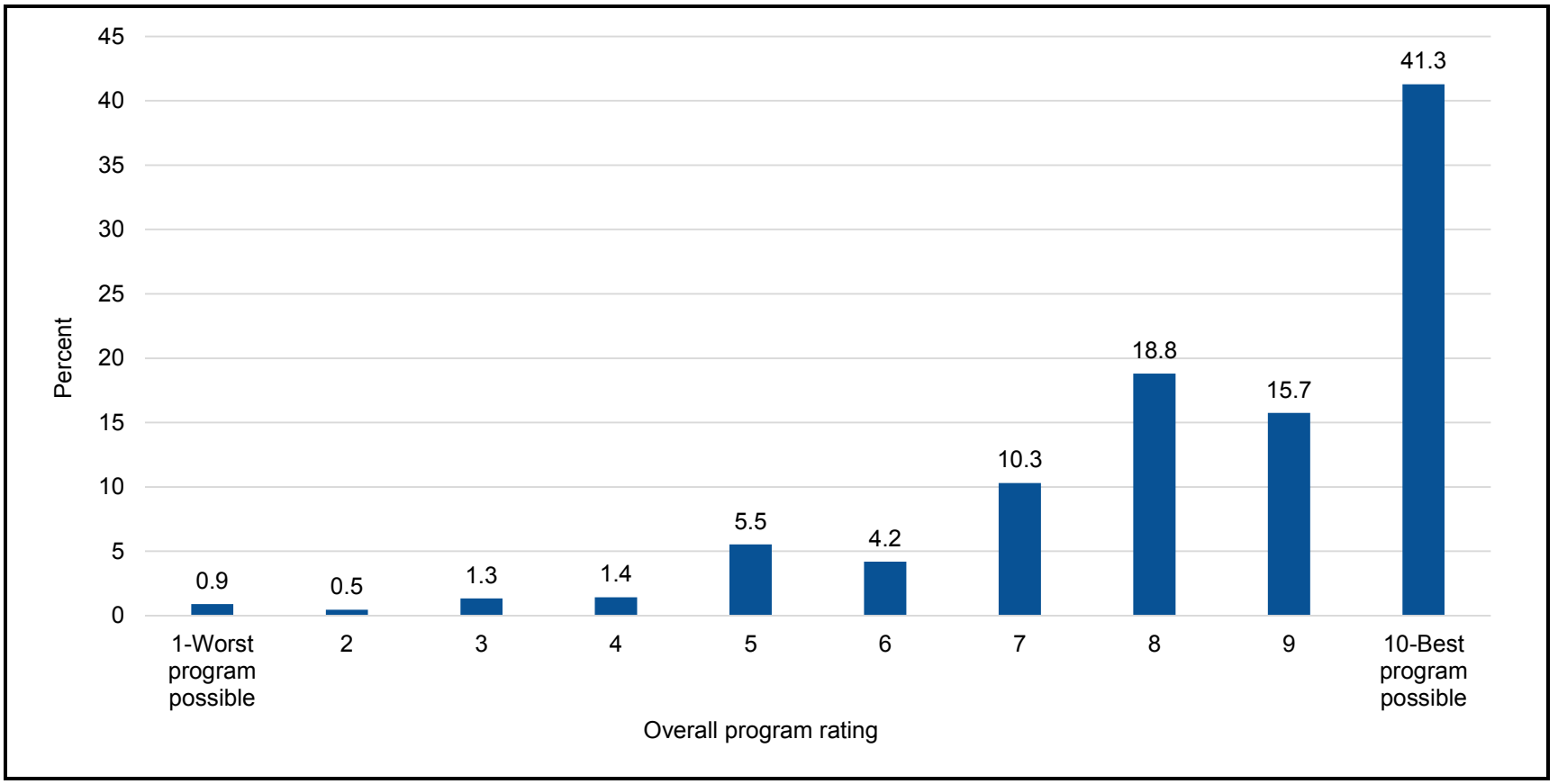
Finally, respondents were asked to rate the program on a scale from 1 to 10, where 1 is the worst program possible and 10 is the best program possible. About 40 percent of respondents rated the program a 10 and another 16 percent it a 9 (see ***Figure 3***). Less than 5 percent of respondents rated the program lower than 5 out of 10. The mean rating across all States was 8.4 (see Table 29). Although ratings across all racial and ethnic groups were high, white participants rated the program somewhat lower than non-white participants (mean of 8.3 vs. 8.6; $p < 0.05$).

**Figure 2**
**Overall program satisfaction**




Note: This figure presents weighted survey data.

**Figure 3**
**Overall program rating**




Note: This figure presents weighted survey data.

## Table 29
## Overall program satisfaction by respondent characteristics

| Characteristic | Overall satisfaction | | | | Overall program rating[3] | | Respondent would recommend program to family and friends | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | | | | Row % | | | |
| | Very satisfied | Somewhat satisfied | Somewhat or very dissatisfied | *p*-value[2] | Mean rating | *p*-value[4] | Yes, definitely | Yes, probably | No | *p*-value[2] |
| Total population | 66.1 | 27.5 | 6.4 | — | 8.4 | — | 74.3 | 21.9 | 3.8 | — |
| Health issue focus of program[1] | | | | | | | | | | |
| Diabetes prevention | 72.9 | 23.4 | 3.6 | <0.001** | 8.7 | <0.001** | 74.1 | 23.1 | 2.9 | 0.280 |
| Diabetes control | 70.2 | 25.1 | 4.7 | 0.053* | 8.7 | 0.0002** | 72.0 | 24.9 | 3.1 | 0.121 |
| Tobacco use | 64.2 | 29.1 | 6.8 | 0.172 | 8.3 | 0.0158** | 75.7 | 20.7 | 3.6 | 0.179 |
| Weight management | 74.7 | 19.7 | 5.5 | <0.001** | 8.7 | <0.001** | 76.5 | 20.2 | 3.4 | 0.129 |
| Blood pressure | 75.6 | 20.4 | 3.9 | <0.001** | 8.9 | <0.001** | 76.7 | 21.5 | 1.8 | 0.040** |
| Cholesterol | 74.8 | 20.1 | 5.1 | 0.001** | 8.8 | <0.001** | 75.8 | 21.6 | 2.6 | 0.162 |
| Age | | | | | | | | | | |
| 44 years or younger | 62.4 | 30.7 | 6.9 | 0.293 | 8.2 | RC | 72.9 | 22.8 | 4.3 | 0.377 |
| 45 to 52 years | 68.7 | 25.0 | 6.3 | | 8.4 | 0.180 | 76.3 | 20.5 | 3.2 | |
| 53 to 58 years | 65.0 | 28.8 | 6.2 | | 8.6 | 0.004** | 75.0 | 22.2 | 2.8 | |
| 59 years or older | 68.0 | 25.7 | 6.3 | | 8.5 | 0.150 | 72.8 | 22.7 | 4.4 | |
| Sex | | | | | | | | | | |
| Male | 65.5 | 28.9 | 5.6 | 0.683 | 8.3 | 0.0101** | 72.8 | 22.7 | 4.5 | 0.251 |
| Female | 66.5 | 26.7 | 6.8 | | 8.5 | | 75.4 | 21.6 | 3.0 | |
| Marital status | | | | | | | | | | |
| Now married or living with a partner | 64.2 | 28.3 | 7.5 | 0.803 | 8.3 | RC | 73.5 | 22.6 | 3.9 | 0.464 |
| Widowed | 72.3 | 23.2 | 4.5 | | 8.9 | 0.013** | 79.1 | 16.2 | 4.7 | |

(continued)

**Table 29 (continued)**
**Overall program satisfaction by respondent characteristics**

| Characteristic | Overall satisfaction | | | | Overall program rating[3] | | Respondent would recommend program to family and friends | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | | | | Row % | | | |
| | Very satisfied | Somewhat satisfied | Somewhat or very dissatisfied | *p*-value[2] | Mean rating | *p*-value[4] | Yes, definitely | Yes, probably | No | *p*-value[2] |
| Divorced | 67.4 | 25.8 | 6.8 | | 8.5 | 0.367 | 74.7 | 21.1 | 4.3 | |
| Separated | 62.9 | 29.9 | 7.2 | | 8.1 | 0.608 | 72.6 | 22.3 | 5.0 | |
| Never married | 66.2 | 28.5 | 5.4 | | 8.4 | 0.596 | 74.2 | 23.2 | 2.6 | |
| Highest grade or level of school completed | | | | | | | | | | |
| 8th grade or less | 74.3 | 20.8 | 4.9 | 0.254 | 8.8 | RC | 80.6 | 15.9 | 3.5 | 0.221 |
| Some high school, but did not graduate | 64.9 | 28.4 | 6.8 | | 8.3 | 0.051* | 74.0 | 22.2 | 3.8 | |
| High school graduate or GED | 67.0 | 27.2 | 5.8 | | 8.5 | 0.087* | 74.0 | 22.6 | 3.4 | |
| Some college or 2-year college degree | 65.7 | 27.7 | 6.6 | | 8.4 | 0.014** | 74.7 | 22.2 | 3.0 | |
| 4-year college degree | 58.4 | 31.8 | 9.8 | | 8.2 | 0.002** | 72.8 | 20.1 | 7.1 | |
| More than 4-year college degree | 65.6 | 27.8 | 6.7 | | 8.4 | 0.076* | 68.9 | 24.4 | 6.7 | |
| Employment status[5] | | | | | | | | | | |
| Employed full-time | 70.6 | 27.2 | 2.2 | 0.140 | 8.5 | 0.5558 | 76.2 | 22.7 | 1.1 | 0.319 |
| Employed part-time | 67.1 | 25.5 | 7.3 | 0.718 | 8.5 | 0.5848 | 73.1 | 22.8 | 4.1 | 0.650 |
| Employed, not specified whether full-time or part-time | 57.6 | 33.6 | 8.8 | 0.384 | 7.9 | 0.1442 | 69.1 | 22.1 | 8.8 | 0.529 |
| Unemployed and looking for work | 61.6 | 31.5 | 6.9 | 0.069* | 8.2 | 0.0085** | 72.1 | 23.9 | 4.1 | 0.157 |

(continued)

**Table 29 (continued)**
**Overall program satisfaction by respondent characteristics**

| Characteristic | Overall satisfaction | | | | Overall program rating[3] | | Respondent would recommend program to family and friends | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | | | | Row % | | | |
| | Very satisfied | Somewhat satisfied | Somewhat or very dissatisfied | *p*-value[2] | Mean rating | *p*-value[4] | Yes, definitely | Yes, probably | No | *p*-value[2] |
| Unemployed, not specified whether looking for work | 56.5 | 32.9 | 10.6 | 0.518 | 8.3 | 0.7155 | 71.7 | 17.7 | 10.6 | 0.100 |
| Student | 57.8 | 31.6 | 10.6 | 0.033** | 8.2 | 0.0281** | 67.8 | 25.4 | 6.9 | 0.063* |
| Homemaker | 68.3 | 23.9 | 7.8 | 0.706 | 8.5 | 0.1799 | 73.9 | 21.0 | 5.2 | 0.891 |
| Retired | 65.7 | 28.4 | 5.9 | 0.768 | 8.3 | 0.2879 | 73.2 | 21.9 | 5.0 | 0.569 |
| Receiving disability or supplemental security income | 67.2 | 25.4 | 7.3 | 0.092* | 8.5 | 0.2183 | 76.6 | 20.5 | 2.9 | 0.126 |
| Other employment status | 68.7 | 26.0 | 5.3 | 0.758 | 8.6 | 0.3258 | 78.2 | 18.3 | 3.6 | 0.670 |
| Race[6] | | | | | | | | | | |
| American Indian or Alaska Native | 62.1 | 29.1 | 8.8 | 0.438 | 8.3 | 0.9471 | 75.5 | 19.2 | 5.4 | 0.573 |
| Asian | 60.9 | 33.2 | 5.9 | 0.293 | 8.5 | 0.9179 | 70.4 | 25.5 | 4.1 | 0.419 |
| Black or African American | 67.7 | 27.3 | 5.0 | 0.242 | 8.6 | 0.0069** | 77.4 | 20 | 2.5 | 0.023** |
| Native Hawaiian or Other Pacific Islander | 70.3 | 26.0 | 3.7 | 0.876 | 8.5 | 0.6890 | 74.0 | 18.6 | 7.4 | 0.399 |
| White | 64.7 | 27.6 | 7.7 | 0.019** | 8.3 | 0.0003** | 73.1 | 22.5 | 4.4 | 0.057* |
| Ethnicity | | | | | | | | | | |
| Hispanic or Latino | 70.2 | 23.5 | 6.3 | 0.093* | 8.5 | 0.2920 | 75.3 | 21.9 | 2.8 | 0.440 |
| Not Hispanic or Latino | 65.5 | 28.0 | 6.5 | | 8.4 | | 74.3 | 22.0 | 3.7 | |

(continued)

**Table 29 (continued)**
**Overall program satisfaction by respondent characteristics**

| Characteristic | Overall satisfaction | | | | Overall program rating[3] | | Respondent would recommend program to family and friends | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | | | | Row % | | | |
| | Very satisfied | Somewhat satisfied | Somewhat or very dissatisfied | *p*-value[2] | Mean rating | *p*-value[4] | Yes, definitely | Yes, probably | No | *p*-value[2] |
| Received help completing survey | | | | | | | | | | |
| Yes | 65.4 | 28.8 | 5.9 | 0.991 | 8.3 | 0.7838 | 74.7 | 20.8 | 4.5 | 0.209 |
| No | 65.1 | 29.6 | 5.2 | | 8.4 | | 73.6 | 23.7 | 2.7 | |

RC = Reference category

* $p < 0.10$
** $p < 0.05$

[1] The health issue focus of the program was self-reported by respondents; respondents could select multiple health issues. Each row displays the percentage responding "yes" for the specific health issue, and each *p*-value compares "yes" versus "no" for the specific health issue.

[2] Chi-square tests are reported.

[3] Respondents were asked "How would you rate this program? Choose a number between 1 and 10, where 1 is the worst program possible and 10 is the best program possible."

[4] T-tests are reported for dichotomous independent variables. Regression tests are reported for independent variables with more than two levels.

[5] Respondents could select multiple types of employment (e.g., employed part-time and student). Each row displays the percentage responding "yes" for the specific type of employment, and each *p*-value compares "yes" versus "no" for the specific type of employment.

[6] Respondents could select multiple races. Each row displays the percentage responding "yes" for the specific race, and each *p*-value compares "yes" versus "no" for the specific race.

Note: This table presents weighted descriptive analyses and unweighted bivariate statistical analyses.

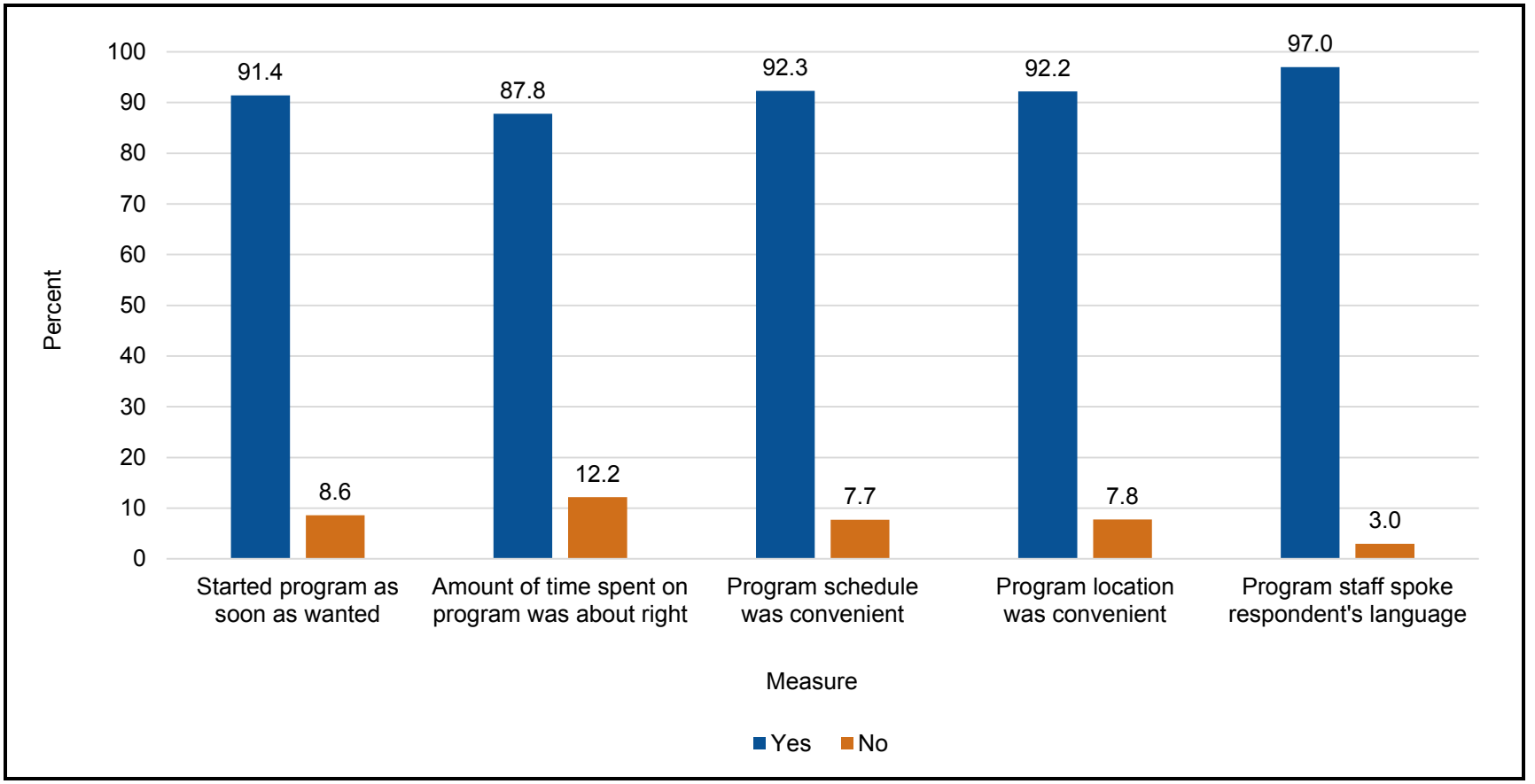
### 6.5.3 Satisfaction with Program Accessibility

The survey included several questions to assess program accessibility in terms of convenience of the program location and schedule and access to program staff. More than 90 percent of respondents said they were able to start the program as soon as they wanted (91 percent), the program schedule was convenient (92 percent), the program location was convenient (92 percent), and the program staff spoke their language (97 percent), and about 88 percent said the amount of time spent on the program was about right (see ***Figure 4***). Hispanic/Latino respondents were more likely than non-Hispanic respondents to say they started the program as soon as they wanted (96 percent vs. 91 percent, respectively; $p = 0.005$; see ***Table 30***). In addition, Hispanic/Latino respondents were more likely to say that the amount of time spent on the program was about right (91 percent vs. 87 percent for non-Hispanics; $p = 0.023$). Overall, 97 percent of respondents said the program staff spoke their language. However, about 7 percent of Hispanic/Latino respondents and 9 percent of Asian respondents said the program staff did not speak their language.

In another measure of program accessibility, about 59 percent of respondents reported that they were always able to contact program staff when they wanted to, and another 23 percent of respondents reported that they usually were able to do so (***Figure 5, Table 31***). About 62 percent of respondents reported that they always were able to get wanted help from program staff, and another 23 percent usually were able to do so.

The survey also asked whether respondents were able to get transportation and childcare when they needed to attend the program (see ***Table 32***). About 28 percent said they were able to get transportation when needed, 8 percent said they were not able to do so, and 64 percent said they did not need transportation. About 6 percent said they were able to get childcare when needed, 5 percent said they were not able to do so, and 89 percent said they did not need childcare (see ***Figure 6***).

**Figure 4**
**Satisfaction with program accessibility**




Note: This figure presents weighted survey data.

## Table 30
## Satisfaction with program accessibility by respondent characteristics

| Characteristic | Started program as soon as wanted | | | Amount of time spent on program was about right | | | Program schedule was convenient | | | Program location was convenient | | | Program staff spoke respondents language | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | Row % | | | Row % | | | Row % | | | Row % | | |
| | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] |
| Total population | 91.4 | 8.6 | — | 87.8 | 12.2 | — | 92.3 | 7.7 | — | 92.2 | 7.8 | — | 97.0 | 3.0 | — |
| Health issue focus of program[1] | | | | | | | | | | | | | | | |
| Diabetes prevention | 92.0 | 8.0 | 0.310 | 93.7 | 6.3 | <0.001** | 92.8 | 7.2 | 0.531 | 92.0 | 8.0 | 0.619 | 95.3 | 4.7 | 0.001** |
| Diabetes control | 91.8 | 8.2 | 0.347 | 92.8 | 7.2 | <0.001** | 93.3 | 6.7 | 0.173 | 93.4 | 6.6 | 0.282 | 95.4 | 4.6 | 0.007** |
| Tobacco use | 92.5 | 7.5 | 0.017** | 86.6 | 13.4 | 0.062* | 93.7 | 6.3 | 0.010** | 93.3 | 6.7 | 0.049** | 99.1 | 0.9 | <0.001** |
| Weight management | 90.2 | 9.8 | 0.445 | 92.6 | 7.4 | <0.001** | 92.7 | 7.3 | 0.297 | 93.4 | 6.6 | 0.132 | 97.0 | 3.0 | 0.918 |
| Blood pressure | 91.8 | 8.2 | 0.270 | 93.9 | 6.1 | <0.001** | 94.7 | 5.3 | 0.019** | 93.3 | 6.7 | 0.286 | 96.7 | 3.3 | 0.591 |
| Cholesterol | 93.0 | 7.0 | 0.072* | 93.0 | 7.0 | 0.004** | 94.5 | 5.5 | 0.028** | 92.4 | 7.6 | 0.807 | 96.1 | 3.9 | 0.159 |
| Age | | | | | | | | | | | | | | | |
| 44 years or younger | 88.4 | 11.6 | 0.089* | 90.5 | 9.5 | 0.128 | 90.2 | 9.8 | 0.027** | 92.5 | 7.5 | 0.264 | 98.0 | 2.0 | 0.134 |
| 45 to 52 years | 91.6 | 8.4 | | 87.4 | 12.6 | | 91.5 | 8.5 | | 93.1 | 6.9 | | 96.7 | 3.3 | |
| 53 to 58 years | 93.0 | 7.0 | | 87.5 | 12.5 | | 94.7 | 5.3 | | 92.8 | 7.2 | | 96.8 | 3.2 | |
| 59 years or older | 92.7 | 7.3 | | 86.4 | 13.6 | | 92.7 | 7.3 | | 91.6 | 8.4 | | 96.2 | 3.8 | |
| Sex | | | | | | | | | | | | | | | |
| Male | 90.3 | 9.7 | 0.131 | 88.1 | 11.9 | 0.728 | 91.5 | 8.5 | 0.165 | 91.7 | 8.3 | 0.691 | 97.0 | 3.0 | 0.632 |
| Female | 92.0 | 8.0 | | 87.7 | 12.3 | | 93.0 | 7.0 | | 92.8 | 7.2 | | 96.9 | 3.1 | |
| Marital status | | | | | | | | | | | | | | | |
| Now married or living with a partner | 92.9 | 7.1 | 0.249 | 89.5 | 10.5 | 0.324 | 91.5 | 8.5 | 0.843 | 91.1 | 8.9 | 0.495 | 96.0 | 4.0 | 0.001** |
| Widowed | 94.8 | 5.2 | | 90.0 | 10.0 | | 95.5 | 4.5 | | 94.8 | 5.2 | | 96.1 | 3.9 | |

(continued)

**Table 30 (continued)**
**Satisfaction with program accessibility by respondent characteristics**

| Characteristic | Started program as soon as wanted | | | Amount of time spent on program was about right | | | Program schedule was convenient | | | Program location was convenient | | | Program staff spoke respondents language | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | Row % | | | Row % | | | Row % | | | Row % | | |
| | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] |
| Divorced | 90.0 | 10.0 | | 87.2 | 12.8 | | 92.4 | 7.6 | | 91.4 | 8.6 | | 97.0 | 3.0 | |
| Separated | 89.2 | 10.8 | | 86.9 | 13.1 | | 91.4 | 8.6 | | 90.9 | 9.1 | | 93.3 | 6.7 | |
| Never married | 91.4 | 8.6 | | 86.8 | 13.2 | | 92.5 | 7.5 | | 93.7 | 6.3 | | 98.5 | 1.5 | |
| Highest grade or level of school completed | | | | | | | | | | | | | | | |
| 8th grade or less | 93.5 | 6.5 | 0.046** | 90.7 | 9.3 | 0.003** | 94.5 | 5.5 | 0.023** | 92.8 | 7.2 | 0.286 | 91.2 | 8.8 | <0.001** |
| Some high school, but did not graduate | 93.6 | 6.4 | | 89.4 | 10.6 | | 91.6 | 8.4 | | 90.5 | 9.5 | | 96.9 | 3.1 | |
| High school graduate or GED | 91.4 | 8.6 | | 90.3 | 9.7 | | 93.8 | 6.2 | | 93.6 | 6.4 | | 97.0 | 3.0 | |
| Some college or 2-year college degree | 90.0 | 10.0 | | 84.1 | 15.9 | | 91.9 | 8.1 | | 93.1 | 6.9 | | 98.7 | 1.3 | |
| 4-year college degree | 86.8 | 13.2 | | 84.8 | 15.2 | | 88.8 | 11.2 | | 89.6 | 10.4 | | 95.8 | 4.2 | |
| More than 4-year college degree | 94.9 | 5.1 | | 87.8 | 12.2 | | 84.4 | 15.6 | | 87.3 | 12.7 | | 93.0 | 7.0 | |
| Employment status[3] | | | | | | | | | | | | | | | |
| Employed full-time | 93.9 | 6.1 | 0.253 | 89.5 | 10.5 | 0.565 | 89.4 | 10.6 | 0.082* | 91.8 | 8.2 | 0.560 | 95.6 | 4.4 | 0.209 |
| Employed part-time | 89.9 | 10.1 | 0.228 | 88.5 | 11.5 | 0.862 | 91.4 | 8.6 | 0.351 | 94.2 | 5.8 | 0.395 | 95.6 | 4.4 | 0.205 |
| Employed, not specified whether full-time or part-time | 91.8 | 8.2 | 0.776 | 70.1 | 29.9 | 0.020** | 97.3 | 2.7 | 0.361 | 85.9 | 14.1 | 0.207 | 91.8 | 8.2 | 0.088* |
| Unemployed and looking for work | 89.8 | 10.2 | 0.404 | 85.7 | 14.3 | 0.847 | 89.9 | 10.1 | 0.078* | 91.5 | 8.5 | 0.741 | 98.0 | 2.0 | 0.135 |

(continued)

**Table 30 (continued)**
**Satisfaction with program accessibility by respondent characteristics**

| Characteristic | Started program as soon as wanted | | | Amount of time spent on program was about right | | | Program schedule was convenient | | | Program location was convenient | | | Program staff spoke respondents language | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | Row % | | | Row % | | | Row % | | | Row % | | |
| | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] |
| Unemployed, not specified whether looking for work | 85.3 | 14.7 | 0.260 | 89.0 | 11.0 | 0.999 | 92.7 | 7.3 | 0.913 | 89.0 | 11.0 | 0.470 | 89.0 | 11.0 | 0.022** |
| Student | 89.4 | 10.6 | 0.362 | 81.0 | 19.0 | 0.068* | 86.1 | 13.9 | 0.035** | 87.2 | 12.8 | 0.056* | 97.2 | 2.8 | 0.956 |
| Homemaker | 93.7 | 6.3 | 0.171 | 93.3 | 6.7 | 0.025** | 92.1 | 7.9 | 0.881 | 90.1 | 9.9 | 0.114 | 94.9 | 5.1 | 0.031** |
| Retired | 92.2 | 7.8 | 0.748 | 86.5 | 13.5 | 0.205 | 93.3 | 6.7 | 0.914 | 91.9 | 8.1 | 0.734 | 95.8 | 4.2 | 0.287 |
| Receiving disability or supplemental security income | 90.9 | 9.1 | 0.725 | 86.9 | 13.1 | 0.320 | 94.1 | 5.9 | 0.034** | 93.5 | 6.5 | 0.159 | 98.3 | 1.7 | 0.003** |
| Other employment status | 86.5 | 13.5 | 0.068* | 88.0 | 12.0 | 0.464 | 89.7 | 10.3 | 0.386 | 92.0 | 8.0 | 0.967 | 94.5 | 5.5 | 0.107 |
| Race[4] | | | | | | | | | | | | | | | |
| American Indian or Alaska Native | 91.8 | 8.2 | 0.844 | 83.9 | 16.1 | 0.456 | 90.1 | 9.9 | 0.401 | 91.3 | 8.7 | 0.659 | 96.8 | 3.2 | 0.982 |
| Asian | 94.0 | 6.0 | 0.316 | 95.7 | 4.3 | 0.064* | 88.5 | 11.5 | 0.384 | 84.6 | 15.4 | 0.020** | 90.9 | 9.1 | 0.001** |
| Black or African American | 91.0 | 9.0 | 0.970 | 89.5 | 10.5 | 0.151 | 92.0 | 8.0 | 0.967 | 91.8 | 8.2 | 0.988 | 97.3 | 2.7 | 0.740 |
| Native Hawaiian or Other Pacific Islander | 83.4 | 16.6 | 0.467 | 96.1 | 3.9 | 0.298 | 92.3 | 7.7 | 0.885 | 91.5 | 8.5 | 0.729 | 100.0 | 0.0 | 0.392 |
| White | 91.0 | 9.0 | 0.238 | 85.0 | 15.0 | <0.001** | 92.0 | 8.0 | 0.191 | 92.9 | 7.1 | 0.932 | 97.6 | 2.4 | 0.215 |
| Ethnicity | | | | | | | | | | | | | | | |
| Hispanic or Latino | 95.5 | 4.5 | 0.005** | 91.0 | 9.0 | 0.023** | 93.4 | 6.6 | 0.483 | 94.2 | 5.8 | 0.209 | 92.6 | 7.4 | <0.001** |
| Not Hispanic or Latino | 90.7 | 9.3 | | 87.2 | 12.8 | | 92.1 | 7.9 | | 92.1 | 7.9 | | 97.9 | 2.1 | |

(continued)

**Table 30 (continued)**
**Satisfaction with program accessibility by respondent characteristics**

| Characteristic | Started program as soon as wanted | | | Amount of time spent on program was about right | | | Program schedule was convenient | | | Program location was convenient | | | Program staff spoke respondents language | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | Row % | | | Row % | | | Row % | | | Row % | | |
| | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] |
| Received help completing survey | | | | | | | | | | | | | | | |
| Yes | 88.7 | 11.3 | 0.323 | 89.0 | 11.0 | 0.613 | 91.4 | 8.6 | 0.937 | 87.2 | 12.8 | 0.056* | 93.6 | 6.4 | 0.013** |
| No | 91.7 | 8.3 | | 87.1 | 12.9 | | 92.0 | 8.0 | | 92.1 | 7.9 | | 97.0 | 3.0 | |

* $p < 0.10$
** $p < 0.05$

[1] The health issue focus of the program was self-reported by respondents; respondents could select multiple health issues. Each row displays the percentage responding "yes" for the specific health issue, and each *p*-value compares "yes" versus "no" for the specific health issue.

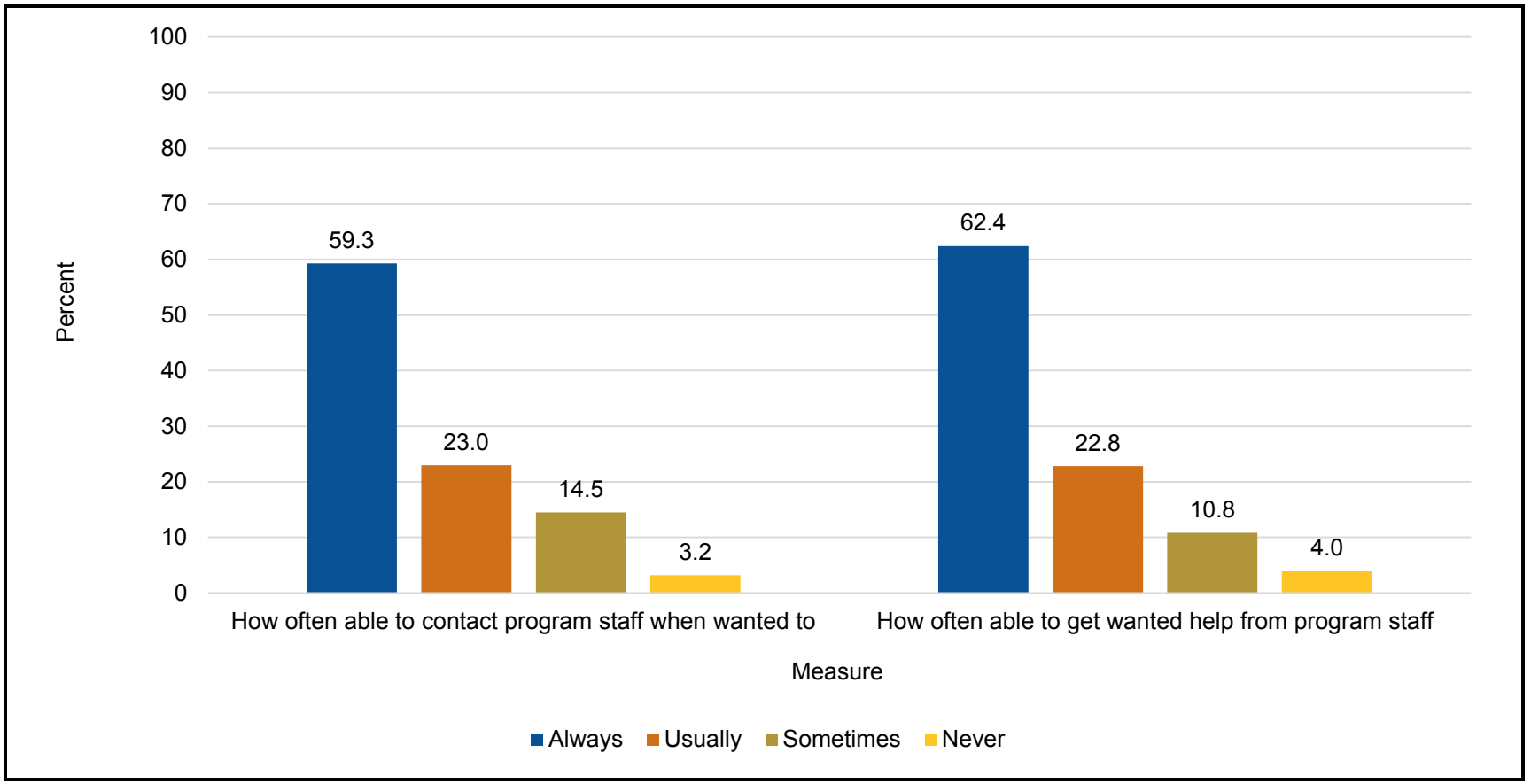
[2] Chi-square tests are reported.

[3] Respondents could select multiple types of employment (e.g., employed part-time and student). Each row displays the percentage responding "yes" for the specific type of employment, and each *p*-value compares "yes" versus "no" for the specific type of employment.

[4] Respondents could select multiple races. Each row displays the percentage responding "yes" for the specific race, and each *p*-value compares "yes" versus "no" for the specific race.

Note: This table presents weighted descriptive analyses and unweighted bivariate statistical analyses.

**Figure 5**
**Satisfaction with program accessibility: contacting and getting help from program staff**




Note: This figure presents weighted survey data.

**Table 31**
**Satisfaction with program accessibility by respondent characteristics: contacting and getting help from program staff**

| Characteristic | How often able to contact program staff when wanted to | | | | | How often able to get wanted help from program staff | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | | | Row % | | | | |
| | Always | Usually | Sometimes | Never | *p*-value[2] | Always | Usually | Sometimes | Never | *p*-value[2] |
| Total population | 59.3 | 23.0 | 14.5 | 3.2 | — | 62.4 | 22.8 | 10.8 | 4.0 | — |
| Health issue focus of program[1] | | | | | | | | | | |
| Diabetes prevention | 55.5 | 24.5 | 16.6 | 3.4 | 0.354 | 64.3 | 20.6 | 12.3 | 2.8 | 0.091* |
| Diabetes control | 56.9 | 23.0 | 16.4 | 3.6 | 0.599 | 61.4 | 22.6 | 11.3 | 4.7 | 0.533 |
| Tobacco use | 61.7 | 20.7 | 14.3 | 3.2 | 0.026** | 64.5 | 21.9 | 10.3 | 3.4 | 0.051* |
| Weight management | 60.0 | 23.8 | 12.6 | 3.7 | 0.192 | 65.7 | 21.9 | 10.9 | 1.5 | <0.001** |
| Blood pressure | 62.8 | 21.3 | 13.5 | 2.4 | 0.136 | 65.7 | 21.3 | 10.9 | 2.1 | 0.099* |
| Cholesterol | 60.5 | 21.0 | 14.1 | 4.4 | 0.309 | 65.0 | 21.2 | 10.5 | 3.3 | 0.320 |
| Age | | | | | | | | | | |
| 44 years or younger | 57.0 | 20.7 | 18.2 | 4.0 | 0.021** | 61.7 | 23.0 | 12.4 | 2.9 | 0.031** |
| 45 to 52 years | 60.3 | 26.0 | 12.1 | 1.6 | | 64.2 | 24.4 | 8.4 | 3.0 | |
| 53 to 58 years | 63.4 | 21.5 | 11.3 | 3.8 | | 64.7 | 21.4 | 9.7 | 4.2 | |
| 59 years or older | 55.6 | 24.3 | 16.9 | 3.3 | | 58.0 | 23.3 | 12.8 | 5.9 | |
| Sex | | | | | | | | | | |
| Male | 58.0 | 23.3 | 14.9 | 3.7 | 0.697 | 61.9 | 23.2 | 9.7 | 5.2 | 0.122 |
| Female | 59.9 | 23.0 | 14.3 | 2.8 | | 62.7 | 22.9 | 11.2 | 3.1 | |
| Marital Status | | | | | | | | | | |
| Now married or living with a partner | 56.9 | 20.9 | 16.2 | 5.9 | 0.608 | 60.4 | 21.8 | 11.7 | 6.1 | 0.548 |
| Widowed | 63.4 | 20.4 | 14.0 | 2.2 | | 68.7 | 22.5 | 6.2 | 2.7 | |
| Divorced | 60.4 | 23.4 | 13.4 | 2.8 | | 62.1 | 23.5 | 11.1 | 3.3 | |
| Separated | 60.9 | 25.8 | 11.7 | 1.6 | | 58.8 | 25.7 | 10.0 | 5.5 | |
| Never married | 58.5 | 23.8 | 15.4 | 2.3 | | 63.9 | 22.7 | 10.7 | 2.7 | |

(continued)

**Table 31 (continued)**
**Satisfaction with program accessibility by respondent characteristics: contacting and getting help from program staff**

| Characteristic | How often able to contact program staff when wanted to (Row %) | | | | | How often able to get wanted help from program staff (Row %) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Always | Usually | Sometimes | Never | *p*-value[2] | Always | Usually | Sometimes | Never | *p*-value[2] |
| Highest grade or level of school completed | | | | | | | | | | |
| 8th grade or less | 55.7 | 26.3 | 14.8 | 3.1 | 0.200 | 60.8 | 22.0 | 12.0 | 5.2 | 0.134 |
| Some high school, but did not graduate | 61.3 | 16.9 | 18.6 | 3.2 | | 62.6 | 20.2 | 11.9 | 5.2 | |
| High school graduate or GED | 61.6 | 22.5 | 12.8 | 3.1 | | 65.7 | 21.6 | 9.4 | 3.3 | |
| Some college or 2-year college degree | 58.6 | 25.2 | 13.8 | 2.4 | | 62.1 | 24.3 | 10.4 | 3.1 | |
| 4-year college degree | 53.8 | 26.4 | 16.4 | 3.3 | | 50.1 | 32.2 | 11.3 | 6.4 | |
| More than 4-year college degree | 42.7 | 36.4 | 12.2 | 8.7 | | 53.2 | 25.4 | 17.9 | 3.5 | |
| Employment status[3] | | | | | | | | | | |
| Employed full-time | 57.8 | 21.2 | 16.6 | 4.4 | 0.674 | 63.4 | 22.2 | 7.7 | 6.8 | 0.053* |
| Employed part-time | 53.5 | 29.6 | 15.8 | 1.0 | 0.071* | 57.1 | 29.8 | 9.8 | 3.3 | 0.017** |
| Employed, not specified whether full-time or part-time | 63.0 | 25.0 | 9.0 | 3.0 | 0.895 | 61.1 | 27.5 | 11.5 | 0.0 | 0.762 |
| Unemployed and looking for work | 57.1 | 22.2 | 17.6 | 3.1 | 0.361 | 60.9 | 22.6 | 13.4 | 3.2 | 0.322 |
| Unemployed, not specified whether looking for work | 63.0 | 20.6 | 4.1 | 12.3 | 0.021** | 63.4 | 25.6 | 3.7 | 7.3 | 0.461 |
| Student | 55.4 | 27.3 | 13.6 | 3.7 | 0.742 | 63.1 | 18.5 | 12.5 | 5.9 | 0.450 |
| Homemaker | 55.5 | 22.4 | 17.6 | 4.6 | 0.431 | 64.2 | 19.6 | 12.2 | 4.0 | 0.298 |
| Retired | 56.6 | 23.4 | 15.1 | 4.8 | 0.224 | 55.8 | 24.6 | 13.0 | 6.6 | 0.016** |
| Receiving disability or supplemental security income | 63.5 | 21.0 | 12.2 | 3.4 | 0.028** | 64.9 | 22.3 | 9.2 | 3.7 | 0.221 |
| Other employment status | 55.9 | 27.8 | 14.3 | 2.0 | 0.898 | 62.8 | 21.8 | 8.9 | 6.5 | 0.575 |

(continued)

**Table 31 (continued)**
**Satisfaction with program accessibility by respondent characteristics: contacting and getting help from program staff**

| Characteristic | How often able to contact program staff when wanted to | | | | | How often able to get wanted help from program staff | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | | | Row % | | | | |
| | Always | Usually | Sometimes | Never | *p*-value[2] | Always | Usually | Sometimes | Never | *p*-value[2] |
| Race[4] | | | | | | | | | | |
| American Indian or Alaska Native | 50.8 | 20.1 | 21.4 | 7.7 | 0.015** | 59.8 | 24.2 | 11.1 | 4.8 | 0.940 |
| Asian | 41.7 | 26.4 | 27.7 | 4.2 | 0.291 | 50.4 | 27.6 | 20.2 | 1.9 | 0.553 |
| Black or African American | 60.0 | 20.8 | 15.7 | 3.4 | 0.130 | 64.4 | 21.0 | 10.0 | 4.5 | 0.059* |
| Native Hawaiian or Other Pacific Islander | 58.2 | 25.1 | 12.5 | 4.2 | 0.815 | 56.4 | 35.9 | 7.7 | 0.0 | 0.459 |
| White | 59.9 | 24.3 | 13.2 | 2.7 | 0.062* | 61.7 | 24.2 | 10.3 | 3.8 | 0.115 |
| Ethnicity | | | | | | | | | | |
| Hispanic or Latino | 56.2 | 22.6 | 17.0 | 4.2 | 0.338 | 60.7 | 22.6 | 12.3 | 4.4 | 0.426 |
| Not Hispanic or Latino | 59.9 | 23.1 | 14.2 | 2.8 | | 62.9 | 23.3 | 10.2 | 3.7 | |
| Received help completing survey | | | | | | | | | | |
| Yes | 54.9 | 24.6 | 16.1 | 4.4 | 0.341 | 59.3 | 23.4 | 12.7 | 4.6 | 0.180 |
| No | 58.0 | 25.4 | 14.0 | 2.5 | | 60.6 | 26.4 | 9.6 | 3.4 | |

* $p < 0.10$
** $p < 0.05$

[1] The health issue focus of the program was self-reported by respondents; respondents could select multiple health issues. Each row displays the percentage responding "yes" for the specific health issue, and each *p*-value compares "yes" versus "no" for the specific health issue.

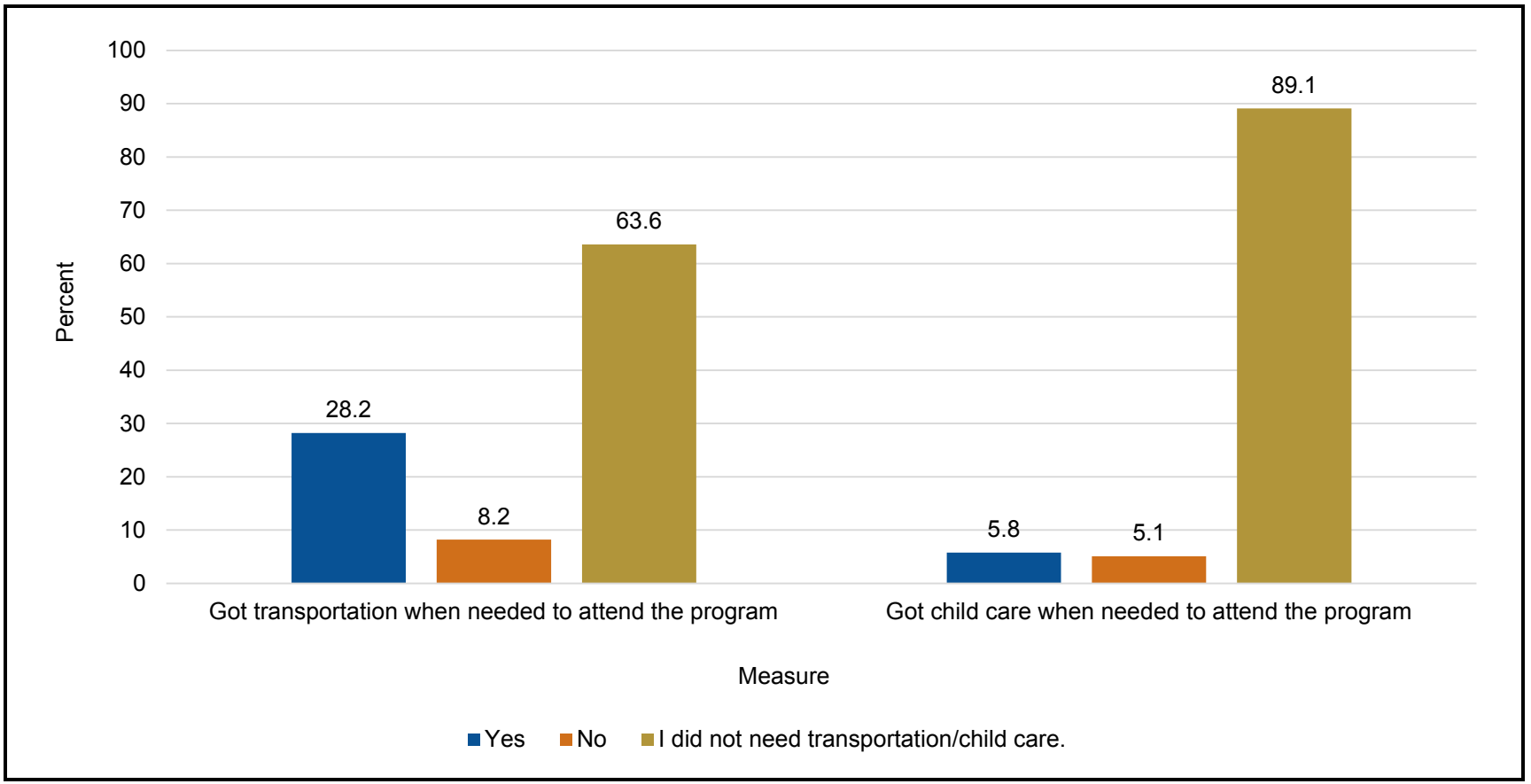
[2] Chi-square tests are reported.

[3] Respondents could select multiple types of employment (e.g., employed part-time and student). Each row displays the percentage responding "yes" for the specific type of employment, and each *p*-value compares "yes" versus "no" for the specific type of employment.

[4] Respondents could select multiple races. Each row displays the percentage responding "yes" for the specific race, and each *p*-value compares "yes" versus "no" for the specific race.

Note: This table presents weighted descriptive analyses and unweighted bivariate statistical analyses.

**Figure 6**
**Satisfaction with program accessibility: transportation and child care**




Note: This figure presents weighted survey data.

**Table 32**
**Satisfaction with program accessibility by respondent characteristics: transportation and child care**

| Characteristic | Got transportation when needed to attend the program | | | | Got child care when needed to attend the program | | | |
|---|---|---|---|---|---|---|---|---|
| | Row % | | | | Row % | | | |
| | Yes | No | I did not need transportation | *p*-value[2] | Yes | No | I did not need child care | *p*-value[2] |
| Total population | 28.2 | 8.2 | 63.6 | — | 5.8 | 5.1 | 89.1 | — |
| Health issue focus of program[1] | | | | | | | | |
| Diabetes prevention | 46.6 | 7.4 | 46.0 | <0.001** | 9.1 | 7.3 | 83.6 | <0.001** |
| Diabetes control | 37.0 | 6.6 | 56.4 | 0.001** | 7.4 | 6.9 | 85.7 | 0.062* |
| Tobacco use | 22.4 | 7.2 | 70.4 | <0.001** | 5.0 | 3.5 | 91.5 | 0.021** |
| Weight management | 41.7 | 8.0 | 50.3 | <0.001** | 7.3 | 7.7 | 85.0 | <0.001** |
| Blood pressure | 35.7 | 7.5 | 56.8 | 0.021** | 6.7 | 8.0 | 85.3 | 0.148 |
| Cholesterol | 42.8 | 6.8 | 50.4 | <0.001** | 8.6 | 10.8 | 80.5 | <0.001** |
| Age | | | | | | | | |
| 44 years or younger | 26.9 | 9.3 | 63.8 | 0.396 | 7.2 | 7.3 | 85.5 | <0.001** |
| 45 to 52 years | 26.8 | 9.0 | 64.1 | | 6.5 | 4.1 | 89.4 | |
| 53 to 58 years | 28.3 | 7.7 | 63.9 | | 5.0 | 4.2 | 90.8 | |
| 59 years or older | 29.0 | 6.0 | 65.0 | | 3.1 | 4.2 | 92.7 | |
| Sex | | | | | | | | |
| Male | 27.3 | 7.8 | 64.9 | 0.336 | 4.8 | 5.4 | 89.7 | 0.390 |
| Female | 28.5 | 8.4 | 63.0 | | 6.2 | 4.8 | 88.9 | |
| Marital status | | | | | | | | |
| Now married or living with a partner | 21.0 | 9.1 | 69.9 | 0.002** | 5.6 | 6.7 | 87.7 | 0.027** |
| Widowed | 30.2 | 13.4 | 56.4 | | 7.0 | 5.6 | 87.4 | |
| Divorced | 28.4 | 6.1 | 65.4 | | 4.3 | 3.0 | 92.7 | |
| Separated | 29.3 | 8.4 | 62.3 | | 6.4 | 8.4 | 85.2 | |
| Never married | 31.7 | 8.2 | 60.0 | | 6.4 | 4.4 | 89.2 | |

(continued)

**Table 32 (continued)**
**Satisfaction with program accessibility by respondent characteristics: transportation and child care**

| Characteristic | Got transportation when needed to attend the program | | | | Got child care when needed to attend the program | | | |
|---|---|---|---|---|---|---|---|---|
| | Row % | | | | Row % | | | |
| | Yes | No | I did not need transportation. | *p*-value[2] | Yes | No | I did not need child care. | *p*-value[2] |
| Highest grade or level of school completed | | | | | | | | |
| 8th grade or less | 30.7 | 6.7 | 62.5 | 0.018** | 4.1 | 11.2 | 84.7 | 0.003** |
| Some high school, but did not graduate | 30.3 | 10.5 | 59.3 | | 6.8 | 4.6 | 88.7 | |
| High school graduate or GED | 31.5 | 7.8 | 60.7 | | 6.5 | 6.0 | 87.5 | |
| Some college or 2-year college degree | 23.7 | 7.5 | 68.8 | | 4.9 | 3.0 | 92.2 | |
| 4-year college degree | 19.8 | 7.1 | 73.1 | | 2.8 | 1.4 | 95.8 | |
| More than 4-year college degree | 33.9 | 10.9 | 55.2 | | 5.5 | 8.9 | 85.6 | |
| Employment status[3] | | | | | | | | |
| Employed full-time | 22.1 | 7.9 | 70.0 | 0.289 | 6.6 | 6.6 | 86.8 | 0.141 |
| Employed part-time | 21.5 | 5.9 | 72.6 | 0.001** | 5.8 | 4.2 | 90.0 | 0.606 |
| Employed, not specified whether full-time or part-time | 22.1 | 14.1 | 63.7 | 0.190 | 8.8 | 5.3 | 85.9 | 0.975 |
| Unemployed and looking for work | 31.3 | 8.3 | 60.4 | 0.279 | 6.5 | 5.3 | 88.2 | 0.680 |
| Unemployed, not specified whether looking for work | 44.0 | 7.3 | 48.7 | 0.307 | 0.0 | 11.0 | 89.0 | 0.183 |
| Student | 26.9 | 8.8 | 64.2 | 0.951 | 8.2 | 5.0 | 86.8 | 0.830 |
| Homemaker | 31.9 | 10.7 | 57.5 | 0.116 | 10.2 | 6.3 | 83.5 | 0.009** |
| Retired | 25.9 | 8.5 | 65.6 | 0.990 | 4.7 | 5.1 | 90.2 | 0.530 |
| Receiving disability or supplemental security income | 27.8 | 8.6 | 63.6 | 0.881 | 3.7 | 4.2 | 92.1 | 0.003** |
| Other employment status | 35.6 | 7.3 | 57.1 | 0.127 | 6.4 | 7.4 | 86.2 | 0.259 |

(continued)

**Table 32 (continued)**
**Satisfaction with program accessibility by respondent characteristics: transportation and child care**

| Characteristic | Got transportation when needed to attend the program | | | | Got child care when needed to attend the program | | | |
|---|---|---|---|---|---|---|---|---|
| | Row % | | | | Row % | | | |
| | Yes | No | I did not need transportation | *p*-value[2] | Yes | No | I did not need child care | *p*-value[2] |
| Race[4] | | | | | | | | |
| American Indian or Alaska Native | 30.2 | 12.7 | 57.2 | 0.071* | 8.0 | 4.3 | 87.7 | 0.398 |
| Asian | 21.4 | 11.4 | 67.2 | 0.270 | 5.7 | 10.1 | 84.3 | 0.360 |
| Black or African American | 36.2 | 9.7 | 54.0 | <0.001** | 8.3 | 6.5 | 85.2 | <0.001** |
| Native Hawaiian or Other Pacific Islander | 32.0 | 3.9 | 64.1 | 0.769 | 13.3 | 4.0 | 82.7 | 0.790 |
| White | 24.3 | 6.6 | 69.1 | <0.001** | 4.4 | 3.1 | 92.5 | <0.001** |
| Ethnicity | | | | | | | | |
| Hispanic or Latino | 22.1 | 9.4 | 68.5 | 0.009** | 2.6 | 9.1 | 88.3 | <0.001** |
| Not Hispanic or Latino | 29.2 | 7.8 | 62.9 | | 6.1 | 4.0 | 89.9 | |

(continued)

**Table 32 (continued)**
**Satisfaction with program accessibility by respondent characteristics: transportation and child care**

| Characteristic | Got transportation when needed to attend the program | | | | Got child care when needed to attend the program | | | |
|---|---|---|---|---|---|---|---|---|
| | Row % | | | | Row % | | | |
| | Yes | No | I did not need transportation | *p*-value[2] | Yes | No | I did not need child care | *p*-value[2] |
| Received help completing survey | | | | | | | | |
| Yes | 38.7 | 11.4 | 49.9 | <0.001** | 10.4 | 11.4 | 78.2 | <0.001** |
| No | 27.1 | 7.9 | 64.9 | | 5.0 | 4.1 | 90.9 | |

* $p < 0.10$

** $p < 0.05$

[1] The health issue focus of the program was self-reported by respondents; respondents could select multiple health issues. Each row displays the percentage responding "yes" for the specific health issue, and each *p*-value compares "yes" versus "no" for the specific health issue.

[2] Chi-square tests are reported.

[3] Respondents could select multiple types of employment (e.g., employed part-time and student). Each row displays the percentage responding "yes" for the specific type of employment, and each *p*-value compares "yes" versus "no" for the specific type of employment.

[4] Respondents could select multiple races. Each row displays the percentage responding "yes" for the specific race, and each *p*-value compares "yes" versus "no" for the specific race.

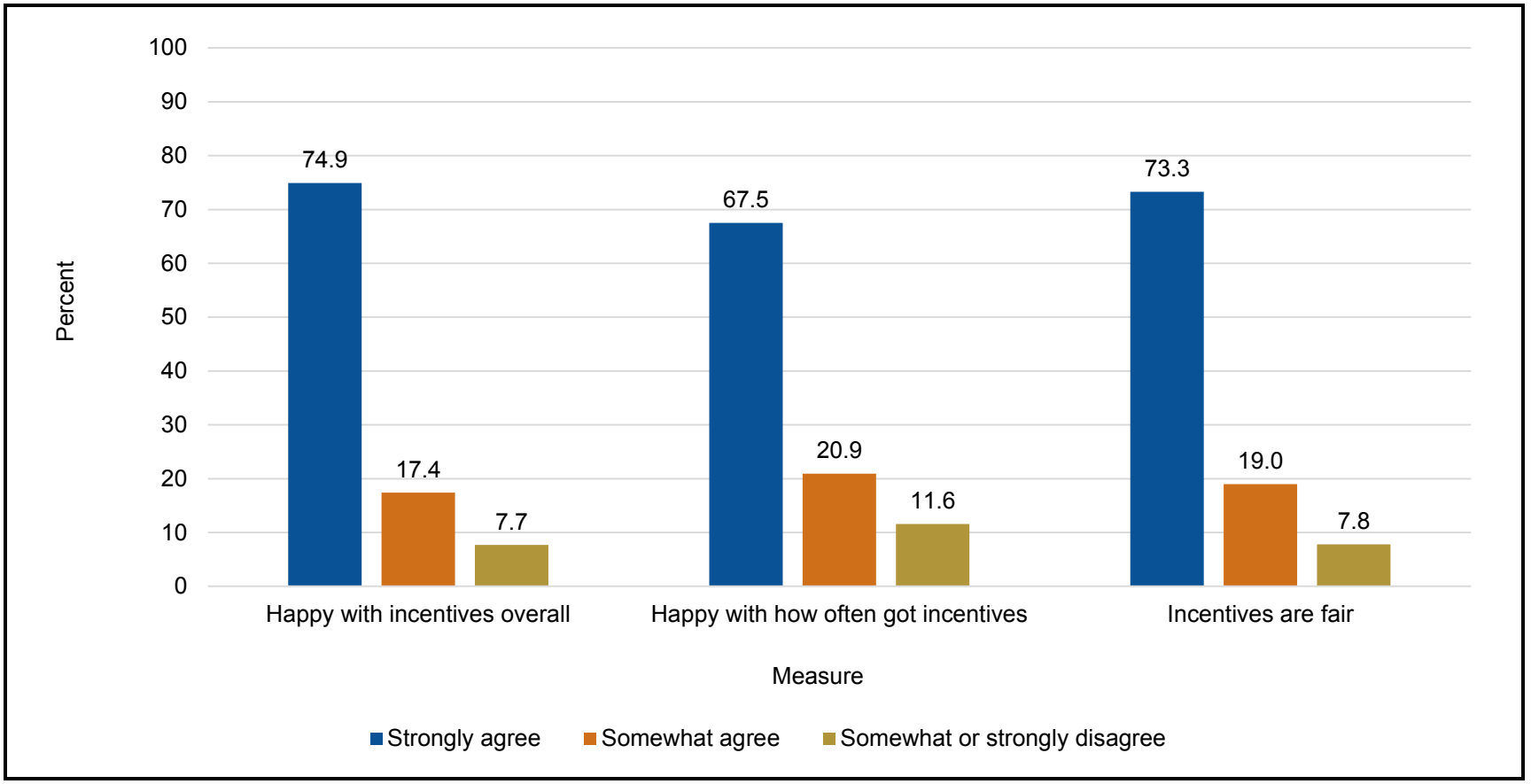
Note: This table presents weighted descriptive analyses and unweighted bivariate statistical analyses.

### 6.5.4 Satisfaction with Program Incentives

The survey included several questions to assess participants' satisfaction with the incentives and whether the incentives helped them work toward their health goals. About three-quarters of the respondents strongly agreed that they were happy with the incentives overall, about 68 percent strongly agreed that they were happy with how often they got incentives, and about 73 percent strongly agreed that the incentives were fair (***Figure 7***). In terms of helping them with their health condition, 78 percent of respondents strongly agreed that they liked getting incentives for taking good care of their health, 64 percent of participants strongly agreed that the incentives helped them to set and work toward health goals, and 64 percent strongly agreed that the incentives helped them make positive changes in their life (***Figure 8***).

There were some differences in satisfaction with program incentives by race and gender. Seventy-eight percent of females strongly agreed that they were happy with the incentives overall compared with 70 percent of males ($p = 0.001$). Female respondents were also happier with how often they got the incentives (70 percent versus 64 percent strongly agreed; $p = 0.019$) (***Table 33***). About 69 percent of non-whites strongly agreed that incentives helped them set goals and work toward them compared with 60 percent of whites (data not shown; $p \leq 0.001$). Race was also associated with agreement that incentives helped them make positive changes in life; 74 percent of American Indian or Alaska Native (AI/AN) respondents strongly agreed the incentives helped, compared with 64 percent of non-AI/AN ($p = 0.043$); 69 percent of non-white respondents strongly agreed the incentives had helped compared with 62 percent of white respondents ($p = 0.005$) (***Table 34***).

**Figure 7**
**Satisfaction with program incentives: happy with incentives overall, how often received, whether fair**




Note: This figure presents weighted survey data.

**Table 33**
**Satisfaction with program incentives by respondent characteristics: happy with incentives overall, how often received, whether fair**

| Characteristic | Happy with incentives overall | | | | Happy with how often got incentives | | | | Incentives are fair | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | | Row % | | | | Row % | | | |
| | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | p-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] |
| Total population | 74.9 | 17.4 | 7.7 | — | 67.5 | 20.9 | 11.6 | — | 73.3 | 19.0 | 7.8 | — |
| Health issue focus of program[1] | | | | | | | | | | | | |
| Diabetes prevention | 76.3 | 18.6 | 5.0 | 0.033** | 70.6 | 21.5 | 8.0 | 0.019** | 72.4 | 22.7 | 4.9 | 0.003** |
| Diabetes control | 75.3 | 18.9 | 5.8 | 0.085* | 69.4 | 20.3 | 10.3 | 0.587 | 72.5 | 20.4 | 7.1 | 0.412 |
| Tobacco use | 77.0 | 15.9 | 7.1 | 0.048** | 69.0 | 20.2 | 10.7 | 0.162 | 76.3 | 17.4 | 6.3 | 0.004** |
| Weight management | 79.4 | 15.3 | 5.4 | 0.001** | 74.2 | 17.6 | 8.3 | <0.001** | 76.6 | 17.3 | 6.2 | 0.054* |
| Blood pressure | 82.5 | 11.7 | 5.8 | <0.001** | 77.1 | 13.3 | 9.6 | <0.001** | 76.4 | 16.7 | 6.9 | 0.116 |
| Cholesterol | 78.4 | 15.1 | 6.4 | 0.230 | 74.5 | 15.8 | 9.7 | 0.002** | 75.3 | 18.2 | 6.6 | 0.444 |
| Age | | | | | | | | | | | | |
| 44 years or younger | 75.8 | 17.6 | 6.7 | 0.279 | 63.9 | 24.2 | 12.0 | 0.499 | 74.1 | 19.9 | 6.1 | 0.422 |
| 45 to 52 years | 75.0 | 16.4 | 8.6 | | 68.0 | 19.8 | 12.1 | | 73.2 | 17.3 | 9.4 | |
| 53 to 58 years | 76.9 | 16.3 | 6.8 | | 70.5 | 19.5 | 10.0 | | 75.2 | 17.4 | 7.4 | |
| 59 years or older | 71.8 | 19.4 | 8.8 | | 67.5 | 20.9 | 11.5 | | 69.9 | 22.6 | 7.5 | |
| Sex | | | | | | | | | | | | |
| Male | 70.0 | 21.6 | 8.5 | 0.001** | 63.7 | 23.5 | 12.8 | 0.019** | 70.5 | 21.6 | 7.9 | 0.252 |
| Female | 78.0 | 14.7 | 7.3 | | 70.0 | 19.4 | 10.6 | | 74.9 | 17.5 | 7.6 | |

(continued)

**Table 33 (continued)**
**Satisfaction with program incentives by respondent characteristics: happy with incentives overall, how often received, whether fair**

| Characteristic | Happy with incentives overall | | | | Happy with how often got incentives | | | | Incentives are fair | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | | Row % | | | | Row % | | | |
| | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] |
| Marital status | | | | | | | | | | | | |
| Now married or living with a partner | 75.5 | 17.9 | 6.7 | 0.858 | 67.7 | 20.2 | 12.1 | 0.360 | 75.7 | 16.9 | 7.4 | 0.614 |
| Widowed | 78.6 | 13.6 | 7.8 | | 72.6 | 16.4 | 11.1 | | 72.4 | 17.7 | 9.9 | |
| Divorced | 74.4 | 17.0 | 8.6 | | 68.5 | 19.6 | 11.9 | | 72.8 | 19.0 | 8.2 | |
| Separated | 71.6 | 21.1 | 7.3 | | 59.9 | 31.9 | 8.3 | | 67.2 | 26.0 | 6.7 | |
| Never married | 75.1 | 17.1 | 7.8 | | 68.2 | 20.5 | 11.3 | | 73.5 | 18.8 | 7.7 | |
| Highest grade or level of school completed | | | | | | | | | | | | |
| 8th grade or less | 75.3 | 18.9 | 5.7 | 0.821 | 71.0 | 22.0 | 7.0 | 0.026** | 70.3 | 20.1 | 9.6 | 0.467 |
| Some high school, but did not graduate | 78.3 | 14.7 | 7.0 | | 72.4 | 18.4 | 9.2 | | 77.6 | 14.6 | 7.8 | |
| High school graduate or GED | 73.4 | 18.7 | 7.9 | | 67.0 | 21.8 | 11.2 | | 73.3 | 19.2 | 7.5 | |
| Some college or 2-year college degree | 75.6 | 16.3 | 8.0 | | 66.4 | 21.5 | 12.1 | | 74.1 | 19.1 | 6.8 | |
| 4-year college degree | 74.2 | 17.0 | 8.8 | | 61.8 | 18.2 | 20.0 | | 67.8 | 20.9 | 11.3 | |
| More than 4-year college degree | 66.4 | 20.7 | 12.8 | | 62.8 | 14.7 | 22.6 | | 62.2 | 25.0 | 12.8 | |
| Employment status[3] | | | | | | | | | | | | |
| Employed full-time | 80.2 | 16.1 | 3.6 | 0.249 | 71.4 | 22.2 | 6.4 | 0.140 | 78.1 | 15.6 | 6.3 | 0.530 |
| Employed part-time | 78.6 | 14.1 | 7.4 | 0.462 | 69.6 | 17.6 | 12.8 | 0.137 | 74.9 | 17.9 | 7.2 | 0.755 |

(continued)

**Table 33 (continued)**
**Satisfaction with program incentives by respondent characteristics: happy with incentives overall, how often received, whether fair**

| Characteristic | Happy with incentives overall | | | | Happy with how often got incentives | | | | Incentives are fair | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | | Row % | | | | Row % | | | |
| | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] |
| Employed, not specified whether full-time or part-time | 65.4 | 29.0 | 5.6 | 0.076* | 56.9 | 31.8 | 11.3 | 0.060* | 65.4 | 29.0 | 5.6 | 0.112 |
| Unemployed and looking for work | 71.0 | 19.8 | 9.2 | 0.179 | 62.4 | 24.4 | 13.2 | 0.109 | 68.9 | 23.8 | 7.3 | 0.014** |
| Unemployed, not specified whether looking for work | 65.8 | 19.0 | 15.2 | 0.284 | 65.8 | 19 | 15.2 | 0.804 | 65.8 | 19.0 | 15.2 | 0.332 |
| Student | 64.3 | 23.2 | 12.5 | 0.086* | 58.8 | 20.9 | 20.3 | 0.016** | 58.8 | 29.7 | 11.5 | 0.003** |
| Homemaker | 77.4 | 17.2 | 5.5 | 0.179 | 70.0 | 19.9 | 10.1 | 0.290 | 71.5 | 20.6 | 7.9 | 0.798 |
| Retired | 70.5 | 22.8 | 6.7 | 0.077* | 64.5 | 25.5 | 10.0 | 0.114 | 72.3 | 21.7 | 6.0 | 0.715 |
| Receiving disability or supplemental security income | 77.5 | 14.3 | 8.2 | 0.039** | 69.0 | 18.8 | 12.1 | 0.443 | 76.1 | 15.7 | 8.2 | 0.059* |
| Other employment status | 68.5 | 16.7 | 14.8 | 0.143 | 65.6 | 20.8 | 13.6 | 0.787 | 67.7 | 18.9 | 13.4 | 0.146 |
| Race[4] | | | | | | | | | | | | |
| American Indian or Alaska Native | 81.6 | 13.0 | 5.4 | 0.098* | 73.2 | 17.1 | 9.7 | 0.482 | 79.7 | 16.9 | 3.4 | 0.205 |
| Asian | 72.1 | 14.4 | 13.6 | 0.728 | 70.7 | 17.9 | 11.4 | 0.975 | 63.6 | 27.2 | 9.3 | 0.389 |
| Black or African American | 74.0 | 17.9 | 8.1 | 0.713 | 67.8 | 20.3 | 11.9 | 0.957 | 71.3 | 19.9 | 8.8 | 0.156 |
| Native Hawaiian or Other Pacific Islander | 79.9 | 12.0 | 8.0 | 0.898 | 58.6 | 29.3 | 12.0 | 0.570 | 58.6 | 33.3 | 8.0 | 0.215 |
| White | 74.9 | 17.5 | 7.6 | 0.830 | 67.5 | 20.6 | 11.8 | 0.528 | 74.6 | 18.3 | 7.1 | 0.234 |

(continued)

**Table 33 (continued)**
**Satisfaction with program incentives by respondent characteristics: happy with incentives overall, how often received, whether fair**

| Characteristic | Happy with Incentives overall | | | | Happy with how often got incentives | | | | Incentives are fair | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | | Row % | | | | Row % | | | |
| | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] |
| Ethnicity | | | | | | | | | | | | |
| Hispanic or Latino | 76.9 | 15.4 | 7.7 | 0.520 | 68.0 | 21.0 | 11.0 | 0.833 | 74.1 | 18.2 | 7.7 | 0.771 |
| Not Hispanic or Latino | 75.1 | 17.2 | 7.7 | | 67.8 | 20.5 | 11.7 | | 73.7 | 18.7 | 7.6 | |
| Received help completing survey | | | | | | | | | | | | |
| Yes | 69.5 | 20.7 | 9.8 | 0.618 | 65.4 | 20.6 | 14.0 | 0.683 | 64.0 | 24.3 | 11.7 | 0.094* |
| No | 73.5 | 17.7 | 8.7 | | 65.9 | 22.2 | 12.0 | | 72.1 | 19.2 | 8.8 | |

* $p < 0.10$

** $p < 0.05$

[1] The health issue focus of the program was self-reported by respondents; respondents could select multiple health issues. Each row displays the percentage responding "yes" for the specific health issue, and each *p*-value compares "yes" versus "no" for the specific health issue.

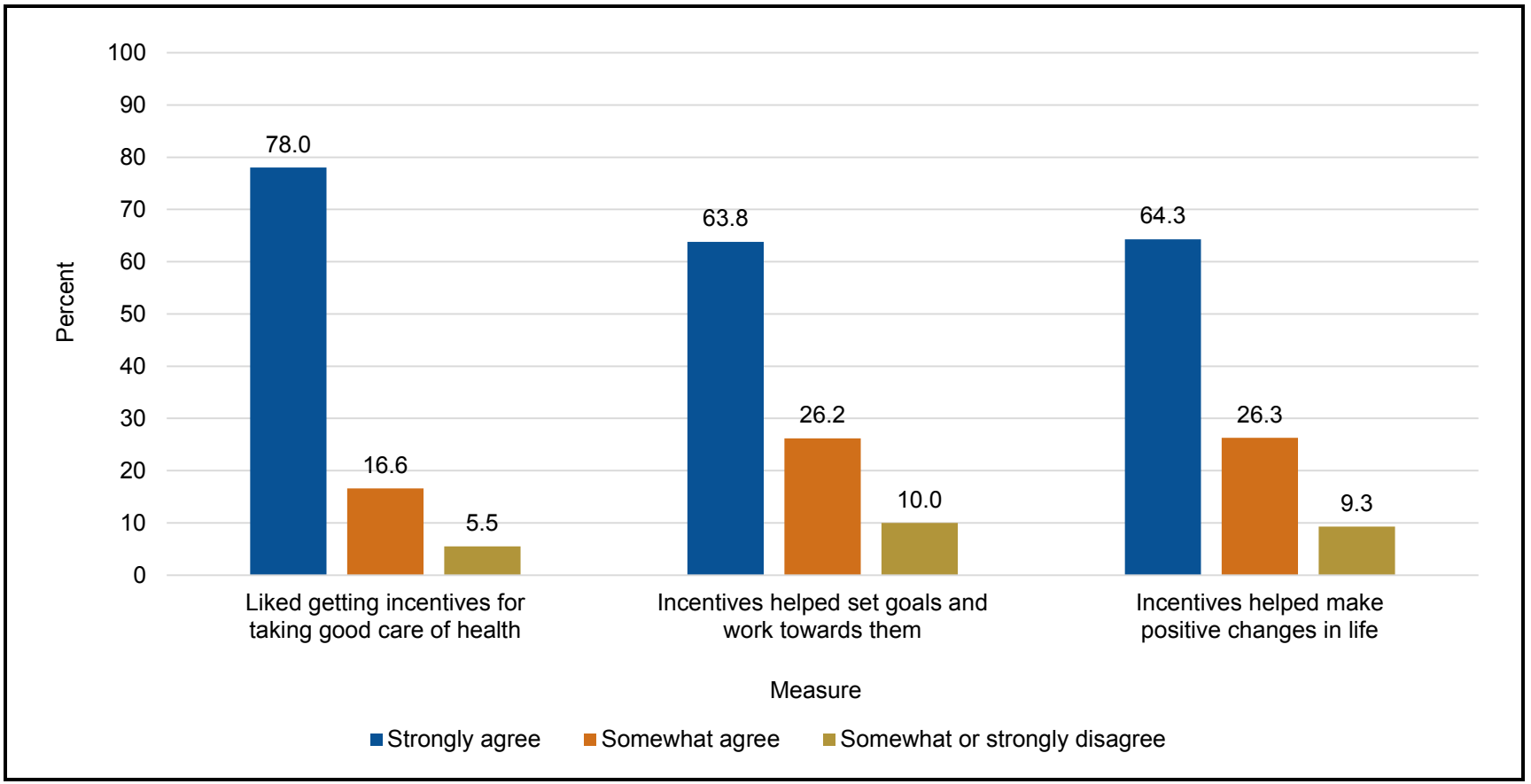
[2] Chi-square tests are reported.

[3] Respondents could select multiple types of employment (e.g., employed part-time and student). Each row displays the percentage responding "yes" for the specific type of employment, and each *p*-value compares "yes" versus "no" for the specific type of employment.

[4] Respondents could select multiple races. Each row displays the percentage responding "yes" for the specific race, and each *p*-value compares "yes" versus "no" for the specific race.

Note: This table presents weighted descriptive analyses and unweighted bivariate statistical analyses.

**Figure 8**
**Satisfaction with program incentives: taking care of health, setting goals, making positive changes**




Note: This figure presents weighted survey data.

**Table 34**
**Satisfaction with program incentives by respondent characteristics: taking care of health, setting goals, making positive changes**

| Characteristic | Liked getting incentives for taking good care of health | | | | Incentives helped set goals and work toward them | | | | Incentives helped make positive changes in life | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | | Row % | | | | Row % | | | |
| | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] |
| Total population | 78.0 | 16.6 | 5.5 | — | 63.8 | 26.2 | 10.0 | — | 64.3 | 26.3 | 9.3 | — |
| Health issue focus of program[1] | | | | | | | | | | | | |
| Diabetes prevention | 78.7 | 16.1 | 5.2 | 0.942 | 73.7 | 20.9 | 5.4 | <0.001** | 71.3 | 22.6 | 6.1 | 0.018** |
| Diabetes control | 80.8 | 14.3 | 4.9 | 0.440 | 73.1 | 22.0 | 4.9 | <0.001** | 69.4 | 25.0 | 5.5 | 0.015** |
| Tobacco use | 79.1 | 16.4 | 4.5 | 0.076* | 63.4 | 27.1 | 9.6 | 0.547 | 63.8 | 27.3 | 8.9 | 0.292 |
| Weight management | 81.2 | 14.0 | 4.8 | 0.084* | 72.6 | 20.0 | 7.4 | <0.001** | 72.1 | 20.8 | 7.2 | <0.001** |
| Blood pressure | 80.8 | 12.8 | 6.4 | 0.149 | 74.4 | 18.9 | 6.8 | <0.001** | 73.9 | 18.3 | 7.8 | <0.001** |
| Cholesterol | 79.7 | 12.9 | 7.4 | 0.059* | 71.5 | 20.6 | 7.9 | 0.026** | 70.9 | 20.2 | 9.0 | 0.018** |
| Age | | | | | | | | | | | | |
| 44 years or younger | 78.1 | 17.0 | 4.9 | 0.015** | 64.0 | 25.1 | 10.9 | 0.095* | 64.4 | 25.4 | 10.2 | 0.126 |
| 45 to 52 years | 79.4 | 15.5 | 5.2 | | 64.9 | 26.3 | 8.8 | | 65.4 | 26.2 | 8.3 | |
| 53 to 58 years | 81.0 | 15.4 | 3.5 | | 64.5 | 27.3 | 8.3 | | 64.6 | 28.0 | 7.4 | |
| 59 years or older | 72.9 | 19.0 | 8.2 | | 60.2 | 27.9 | 11.9 | | 62.3 | 25.6 | 12.1 | |
| Sex | | | | | | | | | | | | |
| Male | 75.1 | 18.2 | 6.7 | 0.068* | 63.7 | 24.7 | 11.6 | 0.068* | 64.1 | 24.3 | 11.6 | 0.016** |
| Female | 79.7 | 15.5 | 4.7 | | 63.8 | 27.1 | 9.1 | | 64.6 | 27.4 | 8.1 | |

(continued)

**Table 34 (continued)**
**Satisfaction with program incentives by respondent characteristics: taking care of health, setting goals, making positive changes**

| Characteristic | Liked getting incentives for taking good care of health | | | | Incentives helped set goals and work toward them | | | | Incentives helped make positive changes in life | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | | Row % | | | | Row % | | | |
| | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] |
| Marital status | | | | | | | | | | | | |
| Now married or living with a partner | 77.4 | 15.6 | 7.0 | 0.410 | 66.1 | 23.6 | 10.4 | 0.794 | 65.0 | 26.4 | 8.6 | 0.572 |
| Widowed | 86.2 | 9.7 | 4.1 | | 63.1 | 27.3 | 9.6 | | 66.6 | 21.3 | 12.1 | |
| Divorced | 76.8 | 19.0 | 4.1 | | 63.0 | 27.7 | 9.3 | | 64.4 | 28.5 | 7.1 | |
| Separated | 75.9 | 19.1 | 5.0 | | 64.0 | 22.5 | 13.5 | | 59.7 | 27.3 | 13.0 | |
| Never married | 78.1 | 16.2 | 5.7 | | 62.5 | 28.1 | 9.3 | | 64.7 | 25.1 | 10.2 | |
| Highest grade or level of school completed | | | | | | | | | | | | |
| 8th grade or less | 79.4 | 13.6 | 7.0 | 0.271 | 63.7 | 27.7 | 8.6 | 0.458 | 62.6 | 31.5 | 5.9 | 0.124 |
| Some high school, but did not graduate | 79.2 | 14.3 | 6.5 | | 69.1 | 21.9 | 9.1 | | 70.6 | 21.1 | 8.3 | |
| High school graduate or GED | 75.3 | 18.1 | 6.6 | | 64.4 | 25.7 | 9.9 | | 62.7 | 26.8 | 10.5 | |
| Some college or 2-year college degree | 81.0 | 15.7 | 3.4 | | 60.8 | 28.8 | 10.4 | | 64.6 | 26.6 | 8.8 | |
| 4-year college degree | 75.0 | 21.1 | 3.9 | | 61.1 | 27.3 | 11.6 | | 54.1 | 32.2 | 13.7 | |
| More than 4-year college degree | 71.9 | 18.9 | 9.2 | | 60.4 | 26.8 | 12.8 | | 67.0 | 20.2 | 12.8 | |
| Employment status[3] | | | | | | | | | | | | |
| Employed full-time | 77.8 | 17.3 | 4.9 | 0.988 | 62.7 | 27.9 | 9.5 | 0.920 | 64.3 | 25.5 | 10.2 | 0.757 |
| Employed part-time | 75.6 | 17.5 | 6.9 | 0.340 | 64.8 | 25.1 | 10.1 | 0.824 | 62.8 | 28.7 | 8.5 | 0.814 |

(continued)

**Table 34 (continued)**
**Satisfaction with program incentives by respondent characteristics: taking care of health, setting goals, making positive changes**

| Characteristic | Liked getting incentives for taking good care of health | | | | Incentives helped set goals and work toward them | | | | Incentives helped make positive changes in life | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | | Row % | | | | Row % | | | |
| | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] |
| Employed, not specified whether full-time or part-time | 64.5 | 27.0 | 8.4 | 0.116 | 34.6 | 32.7 | 32.7 | <0.001** | 31.8 | 41.1 | 27.0 | <0.001** |
| Unemployed and looking for work | 78.8 | 16.7 | 4.4 | 0.398 | 60.9 | 30.0 | 9.2 | 0.168 | 62.6 | 28.4 | 9.0 | 0.262 |
| Unemployed, not specified whether looking for work | 69.6 | 22.8 | 7.6 | 0.471 | 69.6 | 22.8 | 7.6 | 0.968 | 58.2 | 34.2 | 7.6 | 0.483 |
| Student | 76.3 | 17.5 | 6.3 | 0.794 | 48.4 | 37.8 | 13.8 | 0.021** | 46.4 | 31.8 | 21.8 | <0.001** |
| Homemaker | 79.4 | 15.1 | 5.5 | 0.615 | 71.3 | 19.2 | 9.5 | 0.087* | 71.7 | 20.4 | 7.9 | 0.038** |
| Retired | 73.8 | 20.9 | 5.3 | 0.098* | 60.7 | 28.2 | 11.2 | 0.485 | 64.7 | 25.5 | 9.8 | 0.768 |
| Receiving disability or supplemental security income | 80.5 | 14.1 | 5.4 | 0.164 | 65.1 | 24.8 | 10.1 | 0.801 | 67.4 | 23.7 | 8.9 | 0.113 |
| Other employment status | 79.7 | 14.8 | 5.5 | 0.808 | 65.7 | 27.9 | 6.4 | 0.853 | 54.5 | 34.6 | 11.0 | 0.238 |
| Race[4] | | | | | | | | | | | | |
| American Indian or Alaska Native | 86.3 | 11.5 | 2.2 | 0.098* | 64.9 | 28.0 | 7.0 | 0.470 | 73.9 | 22.1 | 4.0 | 0.043** |
| Asian | 70.0 | 23.8 | 6.2 | 0.263 | 58.5 | 34.7 | 6.8 | 0.325 | 67.0 | 28.7 | 4.3 | 0.494 |
| Black or African American | 80.3 | 13.5 | 6.2 | 0.084* | 69.1 | 21.6 | 9.3 | 0.019** | 68.2 | 22.1 | 9.7 | 0.047** |
| Native Hawaiian or Other Pacific Islander | 70.7 | 20.1 | 9.2 | 0.649 | 62.7 | 16.1 | 21.3 | 0.244 | 50.6 | 28.1 | 21.3 | 0.121 |
| White | 78.5 | 17.7 | 3.8 | 0.071* | 60.2 | 30.0 | 9.8 | <0.001** | 61.7 | 29.1 | 9.2 | 0.005** |

(continued)

**Table 34 (continued)**
**Satisfaction with program incentives by respondent characteristics: taking care of health, setting goals, making positive changes**

| Characteristic | Liked getting incentives for taking good care of health | | | | Incentives helped set goals and work toward them | | | | Incentives helped make positive changes in life | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | | Row % | | | | Row % | | | |
| | Strongly agree | Somewhat agree | Somewhat or strongly disagree | p-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | p-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | p-value[2] |
| Ethnicity | | | | | | | | | | | | |
| Hispanic or Latino | 74.4 | 15.9 | 9.7 | 0.001** | 65.3 | 23.4 | 11.2 | 0.245 | 64.1 | 26.5 | 9.4 | 0.987 |
| Not Hispanic or Latino | 79.0 | 16.3 | 4.6 | | 63.6 | 26.8 | 9.6 | | 64.6 | 26.0 | 9.3 | |
| Received help completing survey | | | | | | | | | | | | |
| Yes | 75.9 | 13.6 | 10.5 | 0.032** | 66.1 | 21.9 | 12.0 | 0.424 | 65.6 | 23.8 | 10.6 | 0.765 |
| No | 79.5 | 15.4 | 5.1 | | 61.6 | 28.8 | 9.6 | | 63.9 | 27.2 | 8.9 | |

* $p < 0.10$

** $p < 0.05$

[1] The health issue focus of the program was self-reported by respondents; respondents could select multiple health issues. Each row displays the percentage responding "yes" for the specific health issue, and each *p*-value compares "yes" versus "no" for the specific health issue.

[2] Chi-square tests are reported.

[3] Respondents could select multiple types of employment (e.g., employed part-time and student). Each row displays the percentage responding "yes" for the specific type of employment, and each *p*-value compares "yes" versus "no" for the specific type of employment.

[4] Respondents could select multiple races. Each row displays the percentage responding "yes" for the specific race, and each *p*-value compares "yes" versus "no" for the specific race.

Note: This table presents weighted descriptive analyses and unweighted bivariate statistical analyses.

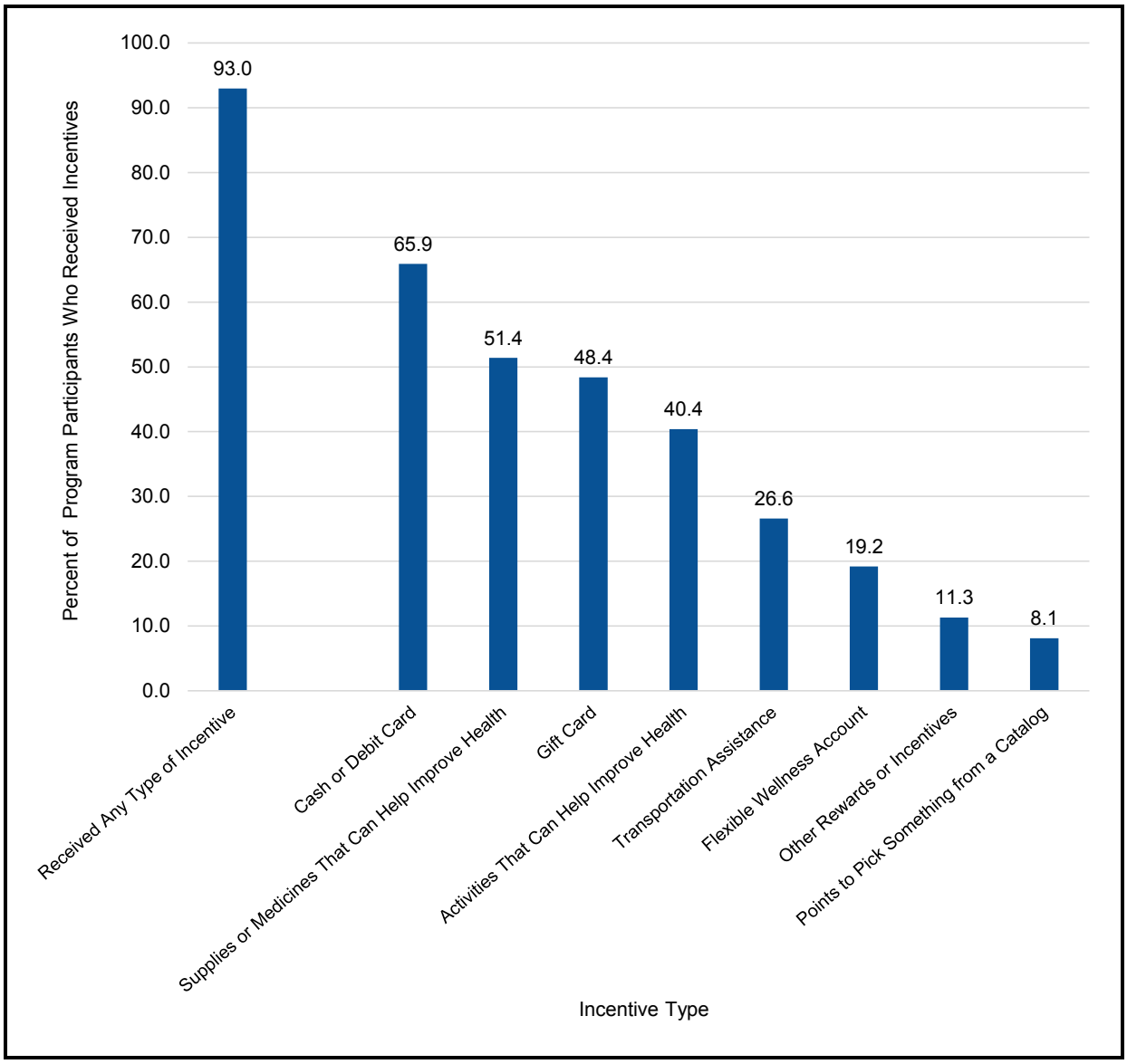
Each of the State programs provided some type of incentive to participants for participating in program activities (e.g., smoking cessation counseling, diabetes prevention class) and/or for achieving health goals (e.g., weight loss; lowering A1C, blood pressure, or cholesterol levels). Depending on the specific State program, participants could receive more than one type of incentive (see ***Section 3.5***).

Across all States, 93 percent of survey respondents reported that they received, or expected to receive, incentives (see ***Figure 9***). The largest proportion of respondents (66 percent) received (or expected to receive) cash or debit cards, followed by supplies or medicines that can improve health (51.4%), and gift cards (48.4%). The smallest proportion of respondents received (or expected to receive) points to select items from a catalog (8.1%).

***Tables 35*** and ***36*** present satisfaction with incentives among participants who received each type of incentives (e.g., cash or debit care, gift card, flexible wellness account). For each type of incentive, participants receiving the incentive were more likely to strongly agree with statements about satisfaction with incentive than participants who did not receive that incentive. Participants receiving flexible wellness accounts or points to pick something from a catalog were especially likely to strongly agree with statements about satisfaction with incentives. More than 80 percent of participants who received or expected to receive flexible wellness accounts strongly agreed that the incentives helped them (or would help them) set goals or work toward them, helped them (or would help them) make positive changes in their life, that they like getting incentives for taking good care of their health, and that they are happy with the incentives (see Tables 42 and 43). More than 80 percent of participants who received or expected to receive points to pick something from a catalog strongly agreed that that the incentives helped them (or would help them) set goals or work toward them, that they like getting incentives for taking good care of their health, and that they are happy with the incentives (see Tables 42 and 43). Among participants who received cash or a debit card, the most common incentive type, about 69 percent strongly agreed that incentives helped them set goals and work toward them, 68 percent strongly agreed that incentives helped them make positive changes, and about 80 percent strongly agreed that they liked getting incentives for taking good care of their health.

It is important to note that these findings are for program participants who actually received incentives. Some participants may have been eligible for incentives but did not receive them for various reasons, such as lack of awareness about how and when to get the incentives. The focus group findings revealed some challenges participants encountered with obtaining incentives, including participants not having computer access or skills to select items from an online catalogue or incentives not being loaded on reloadable gift or debit cards in a timely manner (see ***Section 6.1.6***).

**Figure 9**
**Types of incentives received by program participants**




Note: This figure presents weighted survey data.

**Table 35**
**Impact of incentives on goals, behavior, and health, by incentive type**

| Characteristic | Rewards or incentives helped set goals and work toward them (N=2,410) | | | | Rewards or incentives helped make positive changes in life (N=2,416) | | | | Respondent liked getting rewards or incentives for taking good care of health (N=2,416) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | | Row % | | | | Row % | | | |
| | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[1] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[1] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[1] |
| Total population | 63.8 | 26.2 | 10.0 | | 64.3 | 26.3 | 9.3 | | 78.0 | 16.6 | 5.5 | |
| Cash or debit card | | | | | | | | | | | | |
| Yes | 68.7 | 24.2 | 7.1 | <0.001** | 68.0 | 25.3 | 6.7 | <0.001** | 79.9 | 15.6 | 4.5 | <0.001** |
| No | 53.0 | 31.2 | 15.8 | | 55.6 | 29.9 | 14.6 | | 73.5 | 19.4 | 7.1 | |
| Gift card | | | | | | | | | | | | |
| Yes | 67.5 | 24.6 | 7.9 | <0.001** | 68.7 | 24.9 | 6.4 | <0.001** | 81.8 | 15.1 | 3.1 | <0.001** |
| No | 59.8 | 28.4 | 11.9 | | 59.6 | 28.2 | 12.1 | | 73.2 | 19.1 | 7.7 | |
| Flexible wellness account | | | | | | | | | | | | |
| Yes | 81.0 | 15.8 | 3.2 | <0.001** | 81.0 | 15.4 | 3.6 | <0.001** | 84.9 | 11.4 | 3.7 | <0.001** |
| No | 58.9 | 29.4 | 11.7 | | 59.8 | 29.4 | 10.9 | | 75.5 | 18.6 | 5.9 | |
| Points to pick something from a catalog | | | | | | | | | | | | |
| Yes | 80.5 | 13.1 | 6.4 | <0.001** | 78.3 | 15.8 | 5.9 | <0.001** | 85.2 | 9.5 | 5.3 | 0.008** |
| No | 61.9 | 27.8 | 10.3 | | 62.8 | 27.4 | 9.8 | | 76.6 | 17.9 | 5.5 | |

(continued)

**Table 35 (continued)**
**Impact of incentives on goals, behavior, and health, by incentive type**

| Characteristic | Rewards or incentives helped set goals and work toward them (N=2,410) | | | | Rewards or incentives helped make positive changes in life (N=2,416) | | | | Respondent liked getting rewards or incentives for taking good care of health (N=2,416) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | | Row % | | | | Row % | | | |
| | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[1] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[1] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[1] |
| Supplies or medicines that can help improve health | | | | | | | | | | | | |
| Yes | 69.9 | 23.2 | 6.9 | <0.001** | 71.2 | 23.3 | 5.6 | <0.001** | 81.9 | 14.8 | 3.3 | <0.001** |
| No | 56.4 | 30.1 | 13.6 | | 56.3 | 29.9 | 13.7 | | 72.7 | 19.3 | 8.0 | |
| Activities that can help improve health | | | | | | | | | | | | |
| Yes | 74.2 | 19.7 | 6.1 | <0.001** | 73.2 | 21.5 | 5.3 | <0.001** | 81.8 | 14.0 | 4.3 | <0.001** |
| No | 55.2 | 31.8 | 13.0 | | 56.9 | 30.6 | 12.5 | | 74.4 | 19.3 | 6.4 | |
| Transportation assistance | | | | | | | | | | | | |
| Yes | 74.7 | 19.3 | 6.0 | <0.001** | 73.7 | 20.6 | 5.6 | <0.001** | 80.9 | 14.1 | 5.0 | 0.120 |
| No | 59.0 | 29.3 | 11.6 | | 60.3 | 28.9 | 10.8 | | 76.6 | 17.8 | 5.6 | |
| Other rewards or incentives | | | | | | | | | | | | |
| Yes | 69.2 | 23.4 | 7.4 | 0.488 | 72.7 | 19.7 | 7.6 | 0.253 | 78.5 | 19.7 | 1.8 | 0.361 |
| No | 66.5 | 24.0 | 9.6 | | 64.8 | 26.1 | 9.2 | | 77.2 | 18.3 | 4.5 | |

* $p < 0.10$
** $p < 0.05$

[1] Chi-square tests are reported.

Note: This table presents weighted descriptive analyses and unweighted bivariate statistical analyses.

**Table 36**
**Satisfaction with program incentives by incentive type**

| Characteristic | Respondent happy with rewards or incentives overall (N=2,407) | | | | Respondent happy with how often got rewards or incentives (N=2,389) | | | | Rewards or incentives are fair (N=2,402) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | | Row % | | | | Row % | | | |
| | Strongly agree | Somewhat agree | Somewhat or strongly disagree | p-value[1] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | p-value[1] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | p-value[1] |
| Total population | 74.9 | 17.4 | 7.7 | | 67.5 | 20.9 | 11.6 | | 73.3 | 19.0 | 7.8 | |
| Cash or debit card | | | | | | | | | | | | |
| Yes | 76.5 | 17.1 | 6.4 | <0.001** | 69.6 | 20.9 | 9.6 | <0.001** | 75.6 | 17.9 | 6.5 | <0.001** |
| No | 70.6 | 18.7 | 10.7 | | 62.0 | 21.3 | 16.6 | | 68.2 | 21.5 | 10.3 | |
| Gift card | | | | | | | | | | | | |
| Yes | 80.9 | 14.5 | 4.6 | <0.001** | 74.0 | 19.0 | 7.0 | <0.001** | 78.7 | 17.1 | 4.3 | <0.001** |
| No | 68.4 | 20.5 | 11.1 | | 60.6 | 23.4 | 16.0 | | 68.1 | 20.9 | 11.0 | |
| Flexible wellness account | | | | | | | | | | | | |
| Yes | 81.7 | 13.8 | 4.5 | <0.001** | 79.3 | 15.5 | 5.2 | <0.001** | 79.7 | 16.0 | 4.4 | <0.001** |
| No | 72.7 | 18.5 | 8.8 | | 63.9 | 22.7 | 13.4 | | 71.5 | 19.9 | 8.6 | |
| Points to pick something from a catalog | | | | | | | | | | | | |
| Yes | 82.4 | 12.0 | 5.7 | 0.058** | 77.7 | 16.0 | 6.2 | 0.004** | 79.5 | 15.7 | 4.8 | 0.069* |
| No | 73.7 | 18.1 | 8.1 | | 66.2 | 21.5 | 12.3 | | 72.5 | 19.4 | 8.1 | |
| Supplies or medicines that can help improve health | | | | | | | | | | | | |
| Yes | 80.1 | 14.7 | 5.2 | <0.001** | 72.5 | 19.3 | 8.2 | <0.001** | 78.3 | 16.8 | 4.9 | <0.001** |
| No | 68.3 | 20.9 | 10.8 | | 61.5 | 22.9 | 15.6 | | 67.4 | 21.6 | 11.0 | |

(continued)

**Table 36 (continued)**
**Satisfaction with program incentives by incentive type**

| Characteristic | Respondent happy with rewards or incentives overall (N=2,407) | | | | Respondent happy with how often got rewards or incentives (N=2,389) | | | | Rewards or incentives are fair (N=2,402) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | | Row % | | | | Row % | | | |
| | Strongly agree | Somewhat agree | Somewhat or strongly disagree | p-value[1] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | p-value[1] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | p-value[1] |
| Activities that can help improve health | | | | | | | | | | | | |
| Yes | 79.6 | 14.9 | 5.4 | <0.001** | 74.5 | 18.1 | 7.4 | <0.001** | 78.3 | 16.0 | 5.7 | <0.001** |
| No | 70.9 | 19.6 | 9.5 | | 61.9 | 23.3 | 14.8 | | 69.6 | 21.0 | 9.4 | |
| Transportation assistance | | | | | | | | | | | | |
| Yes | 78.5 | 16.9 | 4.6 | 0.001** | 73.7 | 19.4 | 6.9 | <0.001** | 76.9 | 17.6 | 5.5 | 0.008** |
| No | 73.4 | 17.6 | 9.0 | | 64.8 | 21.7 | 13.4 | | 71.9 | 19.4 | 8.6 | |
| Other rewards or incentives | | | | | | | | | | | | |
| Yes | 79.4 | 10.6 | 10.0 | 0.192 | 69.3 | 16.7 | 14.0 | 0.458 | 75.6 | 16.1 | 8.3 | 0.524 |
| No | 78.3 | 16.3 | 5.4 | | 70.2 | 19.6 | 10.3 | | 77.6 | 17.6 | 4.8 | |

* *p < 0.10*

** *p < 0.05*

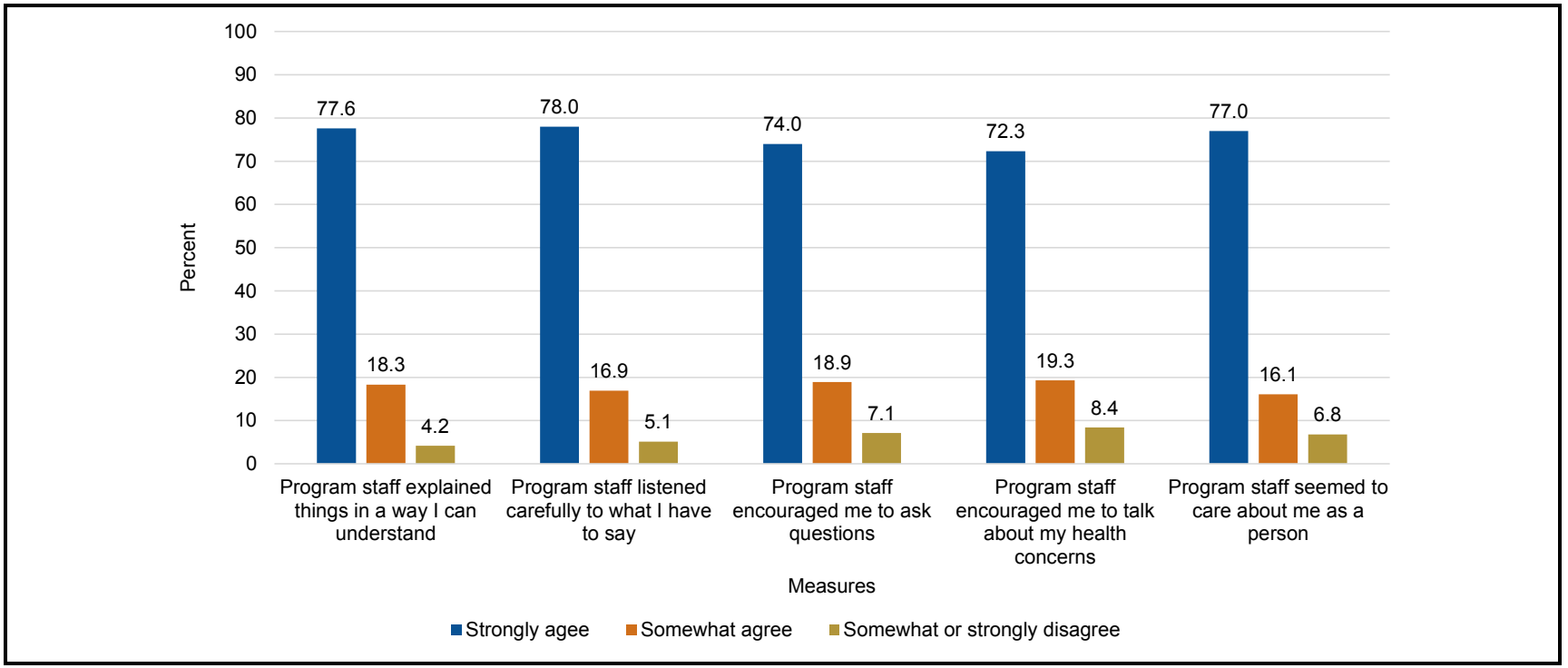
[1] Chi-square tests are reported.

Note: This table presents weighted descriptive analyses and unweighted bivariate statistical analyses.

### 6.5.5 Satisfaction with Communication with Program Staff

Respondents answered a series of questions about their communication with program staff, who could be diabetes educators, health coaches, quitline counselors or others. More than 70 percent of respondents strongly agree that program staff explained things in a way they can understand (78 percent), listened carefully to what they have to say (78 percent), encouraged them to ask questions (74 percent), encouraged them to talk about their health concerns (72 percent), and seemed to care about them as a person (77 percent) (see ***Figure 10***). On several of these measures, Black respondents were more likely than non-blacks to report higher satisfaction (80 percent strongly agreed that program staff encouraged them to ask questions vs. 72 percent of non-Blacks ($p < 0.001$); 77 percent strongly agreed that program staff encouraged them to talk about their health concerns compared with 70 percent of non-Blacks ($p = 0.005$); and 80 percent strongly agreed that program staff seemed to care about them as a person compared with 76 percent of non-Blacks ($p = 0.063$) (see ***Table 37***).

**Figure 10**
**Satisfaction with communication with program staff**




Note: This figure presents weighted survey data.

## Table 37
## Satisfaction with communication with program staff by respondent characteristics

| Characteristic | Program staff explained things in a way I can understand | | | | Program staff listened carefully to what I have to say | | | | Program staff encouraged me to ask questions | | | | Program staff encouraged me to talk about my health concerns | | | | Program staff seemed to care about me as a person | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | | Row % | | | | Row % | | | | Row % | | | | Row % | | | |
| | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] |
| Total population | 77.6 | 18.3 | 4.2 | — | 78.0 | 16.9 | 5.1 | — | 74.0 | 18.9 | 7.1 | — | 72.3 | 19.3 | 8.4 | — | 77.0 | 16.1 | 6.8 | — |
| Health issue focus of program[1] | | | | | | | | | | | | | | | | | | | | |
| Diabetes prevention | 82.4 | 14.3 | 3.3 | 0.079* | 81.5 | 16.1 | 2.4 | 0.015** | 79.7 | 16.0 | 4.3 | 0.001** | 80.2 | 16.3 | 3.4 | <0.001** | 82.2 | 14.2 | 3.6 | 0.002** |
| Diabetes control | 78.6 | 17.9 | 3.5 | 0.750 | 80.5 | 16.4 | 3.1 | 0.131 | 75.8 | 18.5 | 5.7 | 0.162 | 78.5 | 16.0 | 5.5 | 0.001** | 78.9 | 16.4 | 4.7 | 0.091* |
| Tobacco use | 77.9 | 18.4 | 3.6 | 0.130 | 79.0 | 15.7 | 5.2 | 0.052* | 74.0 | 18.3 | 7.8 | 0.261 | 71.4 | 18.8 | 9.8 | 0.014** | 76.8 | 15.8 | 7.4 | 0.328 |
| Weight management | 83.0 | 13.4 | 3.5 | <0.001** | 81.8 | 14.1 | 4.1 | 0.017** | 79.0 | 15.9 | 5.1 | <0.001** | 79.8 | 15.5 | 4.7 | <0.001** | 82.6 | 12.4 | 4.9 | <0.001** |
| Blood pressure | 79.6 | 17.5 | 3.0 | 0.413 | 82.1 | 14.9 | 3.0 | 0.014** | 77.0 | 18.2 | 4.8 | 0.029** | 79.7 | 16.2 | 4.1 | <0.001** | 83.3 | 12.3 | 4.4 | 0.002** |
| Cholesterol | 80.3 | 16.7 | 3.1 | 0.301 | 81.0 | 16.2 | 2.8 | 0.050* | 79.0 | 17.9 | 3.1 | 0.001** | 82.6 | 13.9 | 3.6 | <0.001** | 84.4 | 13.0 | 2.5 | <0.001** |
| Age | | | | | | | | | | | | | | | | | | | | |
| 44 years or younger | 78.9 | 16.6 | 4.4 | 0.328 | 77.5 | 16.8 | 5.7 | 0.219 | 75.0 | 17.9 | 7.1 | 0.136 | 72.4 | 19.6 | 8.0 | 0.013** | 76.6 | 14.8 | 8.7 | 0.313 |
| 45 to 52 years | 78.7 | 17.3 | 4.1 | | 79.5 | 15.0 | 5.5 | | 76.2 | 16.8 | 7.1 | | 74.4 | 16.8 | 8.8 | | 78.4 | 16.2 | 5.4 | |
| 53 to 58 years | 77.1 | 18.2 | 4.7 | | 79.0 | 16.0 | 5.0 | | 73.7 | 20.1 | 6.2 | | 74.2 | 18.5 | 7.2 | | 77.8 | 16.3 | 5.9 | |
| 59 years or older | 75.0 | 21.6 | 3.4 | | 75.6 | 20.6 | 3.8 | | 71.4 | 21.1 | 7.5 | | 66.3 | 22.9 | 10.8 | | 75.5 | 16.7 | 7.8 | |
| Sex | | | | | | | | | | | | | | | | | | | | |
| Male | 75.1 | 19.6 | 5.3 | 0.195 | 75.3 | 19.4 | 5.3 | 0.395 | 72.5 | 19.5 | 8.0 | 0.656 | 69.8 | 20.9 | 9.3 | 0.589 | 75.9 | 15.9 | 8.2 | 0.313 |
| Female | 78.8 | 17.6 | 3.6 | | 79.5 | 15.5 | 5.0 | | 74.8 | 18.9 | 6.3 | | 73.7 | 18.4 | 8.0 | | 77.9 | 16.0 | 6.1 | |
| Marital status | | | | | | | | | | | | | | | | | | | | |
| Now married or living with a partner | 75.9 | 18.8 | 5.3 | 0.431 | 77.0 | 16.9 | 6.1 | 0.990 | 73.0 | 18.6 | 8.4 | 0.865 | 72.4 | 19.1 | 8.4 | 0.778 | 75.7 | 18.1 | 6.2 | 0.371 |
| Widowed | 81.9 | 16.1 | 2.0 | | 81.1 | 15.6 | 3.3 | | 75.9 | 17.1 | 6.9 | | 74.4 | 20.8 | 4.8 | | 79.4 | 13.7 | 6.9 | |
| Divorced | 78.6 | 17.3 | 4.1 | | 79.7 | 15.4 | 4.9 | | 73.7 | 20.0 | 6.3 | | 74.1 | 17.0 | 8.9 | | 78.3 | 15.8 | 5.9 | |
| Separated | 71.2 | 21.4 | 7.3 | | 75.2 | 18.9 | 5.9 | | 72.0 | 17.9 | 10.1 | | 68.0 | 22.8 | 9.2 | | 70.4 | 19.9 | 9.7 | |
| Never married | 78.1 | 18.6 | 3.4 | | 77.3 | 17.7 | 5.0 | | 74.5 | 19.4 | 6.0 | | 71.1 | 20.0 | 8.9 | | 78.2 | 14.3 | 7.5 | |

(continued)

## Table 37 (continued)
## Satisfaction with communication with program staff by respondent characteristics

| Characteristic | Program staff explained things in a way I can understand | | | | Program staff listened carefully to what I have to say | | | | Program staff encouraged me to ask questions | | | | Program staff encouraged me to talk about my health concerns | | | | Program staff seemed to care about me as a person | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | | Row % | | | | Row % | | | | Row % | | | | Row % | | | |
| | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] |
| Highest grade or level of school completed | | | | | | | | | | | | | | | | | | | | |
| 8th grade or less | 78.6 | 18.6 | 2.8 | 0.107 | 78.4 | 17.3 | 4.3 | 0.645 | 70.7 | 22.4 | 6.9 | 0.250 | 72.7 | 19.9 | 7.3 | 0.405 | 78.9 | 15.6 | 5.4 | 0.035** |
| Some high school, but did not graduate | 73.0 | 21.3 | 5.7 | | 77.3 | 16.9 | 5.9 | | 75.4 | 16.7 | 7.8 | | 73.9 | 18.2 | 7.9 | | 79.2 | 12.3 | 8.5 | |
| High school graduate or GED | 75.6 | 19.7 | 4.7 | | 78.5 | 15.8 | 5.7 | | 73.9 | 20.0 | 6.1 | | 72.1 | 20.1 | 7.8 | | 77.5 | 16.3 | 6.2 | |
| Some college or 2-year college degree | 81.9 | 14.5 | 3.6 | | 78.8 | 16.7 | 4.5 | | 74.8 | 18.6 | 6.6 | | 72.8 | 18.7 | 8.5 | | 77.2 | 15.9 | 6.9 | |
| 4-year college degree | 77.8 | 18.7 | 3.5 | | 75.2 | 19.9 | 4.9 | | 70.0 | 23.6 | 6.3 | | 66.1 | 20.1 | 13.8 | | 67.7 | 22.3 | 10.0 | |
| More than 4-year college degree | 78.1 | 21.9 | 0.0 | | 74.6 | 23.7 | 1.7 | | 68.2 | 15.6 | 16.2 | | 69.4 | 19.7 | 11.0 | | 73.4 | 24.9 | 1.7 | |
| Employment status[3] | | | | | | | | | | | | | | | | | | | | |
| Employed full-time | 73.8 | 22.3 | 3.8 | 0.792 | 78.9 | 14.7 | 6.4 | 0.356 | 74.1 | 20.1 | 5.9 | 0.667 | 70.4 | 20.4 | 9.3 | 0.939 | 73.1 | 19.3 | 7.6 | 0.839 |
| Employed part-time | 81.2 | 15.3 | 3.5 | 0.182 | 77.4 | 17.8 | 4.9 | 0.808 | 72.6 | 20.2 | 7.2 | 0.703 | 73.6 | 18.2 | 8.1 | 0.957 | 75.5 | 17.9 | 6.6 | 0.649 |
| Employed, not specified whether full-time or part-time | 76.4 | 11.8 | 11.8 | 0.079* | 77.3 | 16.4 | 6.3 | 0.763 | 69.0 | 19.2 | 11.8 | 0.376 | 72.5 | 13.3 | 14.1 | 0.455 | 74.5 | 16.4 | 9.0 | 0.385 |
| Unemployed and looking for work | 76.7 | 18.3 | 5.0 | 0.820 | 77.6 | 16.3 | 6.1 | 0.585 | 76.7 | 17.6 | 5.7 | 0.149 | 72.0 | 21.2 | 6.8 | 0.314 | 75.8 | 16.5 | 7.7 | 0.578 |
| Unemployed, not specified whether looking for work | 82.3 | 10.6 | 7.1 | 0.459 | 78.8 | 17.7 | 3.5 | 0.935 | 61.1 | 24.7 | 14.1 | 0.114 | 64.7 | 28.3 | 7.1 | 0.340 | 77.7 | 18.7 | 3.5 | 0.836 |
| Student | 76.5 | 18.3 | 5.2 | 0.818 | 79.4 | 9.2 | 11.4 | 0.011** | 71.5 | 17.0 | 11.4 | 0.262 | 70.5 | 14.8 | 14.7 | 0.161 | 74.8 | 16.1 | 9.2 | 0.321 |
| Homemaker | 69.4 | 25.2 | 5.4 | 0.008** | 74.3 | 18.8 | 6.8 | 0.401 | 70.5 | 22.5 | 7.0 | 0.349 | 70.8 | 23.9 | 5.4 | 0.072* | 75.8 | 16.4 | 7.8 | 0.948 |
| Retired | 76.0 | 19.3 | 4.7 | 0.572 | 76.0 | 19.1 | 5.0 | 0.195 | 72.2 | 19.9 | 7.9 | 0.333 | 68.5 | 17.8 | 13.7 | 0.023** | 74.5 | 16.5 | 8.9 | 0.079* |
| Receiving disability or supplemental security income | 79.2 | 16.3 | 4.5 | 0.169 | 78.2 | 17.0 | 4.9 | 0.956 | 73.2 | 18.9 | 7.9 | 0.271 | 71.9 | 19.5 | 8.6 | 0.903 | 78.4 | 15.0 | 6.6 | 0.669 |

(continued)

## Table 37 (continued)
## Satisfaction with communication with program staff by respondent characteristics

| Characteristic | Program staff explained things in a way I can understand | | | | Program staff listened carefully to what I have to say | | | | Program staff encouraged me to ask questions | | | | Program staff encouraged me to talk about my health concerns | | | | Program staff seemed to care about me as a person | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | | Row % | | | | Row % | | | | Row % | | | | Row % | | | |
| | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] |
| Other employment status | 74.8 | 20.8 | 4.4 | 0.493 | 77.0 | 18.3 | 4.7 | 0.819 | 72.3 | 23.3 | 4.4 | 0.678 | 75.9 | 14.9 | 9.2 | 0.513 | 77.4 | 14.5 | 8.1 | 0.744 |
| Race[4] | | | | | | | | | | | | | | | | | | | | |
| American Indian or Alaska Native | 74.0 | 21.1 | 4.9 | 0.776 | 74.4 | 17.5 | 8.1 | 0.453 | 69.5 | 19.3 | 11.2 | 0.209 | 63.9 | 23.4 | 12.7 | 0.449 | 75.4 | 17.0 | 7.6 | 0.993 |
| Asian | 67.9 | 22.0 | 10.1 | 0.095* | 63.3 | 28.9 | 7.8 | 0.060* | 67.5 | 26.5 | 6.0 | 0.228 | 75.3 | 16.9 | 7.8 | 0.978 | 69.8 | 20.0 | 10.2 | 0.138 |
| Black or African American | 79.2 | 16.6 | 4.2 | 0.457 | 80.2 | 14.6 | 5.3 | 0.193 | 79.6 | 14.8 | 5.5 | <0.001** | 76.9 | 15.8 | 7.2 | 0.005** | 79.5 | 15.4 | 5.1 | 0.063* |
| Native Hawaiian or Other Pacific Islander | 66.8 | 24.3 | 8.9 | 0.787 | 88.4 | 11.6 | 0.0 | 0.514 | 84.6 | 15.4 | 0.0 | 0.439 | 71.8 | 15.4 | 12.7 | 0.982 | 75.7 | 24.3 | 0.0 | 0.333 |
| White | 78.1 | 17.9 | 3.9 | 0.971 | 77.6 | 17.3 | 5.0 | 0.465 | 71.6 | 20.4 | 8.0 | 0.001** | 70.0 | 20.7 | 9.4 | 0.007** | 76.1 | 15.9 | 8.1 | 0.017** |
| Ethnicity | | | | | | | | | | | | | | | | | | | | |
| Hispanic or Latino | 77.3 | 18.2 | 4.5 | 0.870 | 79.4 | 16.6 | 3.9 | 0.507 | 74.8 | 19.4 | 5.7 | 0.340 | 73.6 | 19.7 | 6.8 | 0.273 | 80.6 | 13.4 | 6.0 | 0.131 |
| Not Hispanic or Latino | 77.8 | 18.3 | 3.9 | | 77.7 | 17.1 | 5.2 | | 73.9 | 19.0 | 7.1 | | 72.2 | 19.2 | 8.7 | | 76.6 | 16.6 | 6.8 | |

(continued)

## Table 37 (continued)
## Satisfaction with communication with program staff by respondent characteristics

| Characteristic | Program staff explained things in a way I can understand | | | | Program staff listened carefully to what I have to say | | | | Program staff encouraged me to ask questions | | | | Program staff encouraged me to talk about my health concerns | | | | Program staff seemed to care about me as a person | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | | Row % | | | | Row % | | | | Row % | | | | Row % | | | |
| | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] | Strongly agree | Somewhat agree | Somewhat or strongly disagree | *p*-value[2] |
| Received help completing survey | | | | | | | | | | | | | | | | | | | | |
| Yes | 72.7 | 20.8 | 6.5 | 0.029** | 73.3 | 16.5 | 10.2 | 0.003** | 75.4 | 17.7 | 6.9 | 0.167 | 76.0 | 17.1 | 6.9 | 0.165 | 76.7 | 13.6 | 9.7 | 0.016** |
| No | 77.1 | 19.9 | 3.1 | | 77.8 | 18.4 | 3.9 | | 71.6 | 22.2 | 6.1 | | 71.0 | 20.7 | 8.3 | | 75.2 | 18.7 | 6.0 | |

* $p < 0.10$

** $p < 0.05$

[1] The health issue focus of the program was self-reported by respondents; respondents could select multiple health issues. Each row displays the percentage responding "yes" for the specific health issue, and each *p*-value compares "yes" versus "no" for the specific health issue.

[2] Chi-square tests are reported.

[3] Respondents could select multiple types of employment (e.g., employed part-time and student). Each row displays the percentage responding "yes" for the specific type of employment, and each *p*-value compares "yes" versus "no" for the specific type of employment.

[4] Respondents could select multiple races. Each row displays the percentage responding "yes" for the specific race, and each *p*-value compares "yes" versus "no" for the specific race.

Note: This table presents weighted descriptive analyses and unweighted bivariate statistical analyses.

### 6.5.6 How Program Helped Participants Manage Their Health Condition

The survey included modules for each type of health program: diabetes prevention program, diabetes management program, tobacco program, weight management program, blood pressure program, and cholesterol program. The numbers and percentages of participants reporting that they participated in each type of health program are presented above in Table 28; respondents could check more than one type of program. The first question in each module was a screening question, asking whether the program they participated in was about diabetes prevention, diabetes management, and so forth. Participants could answer questions in more than one module. If participants answered "yes" on the screening question, they were asked follow-up questions about how the program staff helped them manage their health condition. For example, participants who said the program they participated in was about diabetes management were asked the following follow-up questions:

*Did the program staff…*

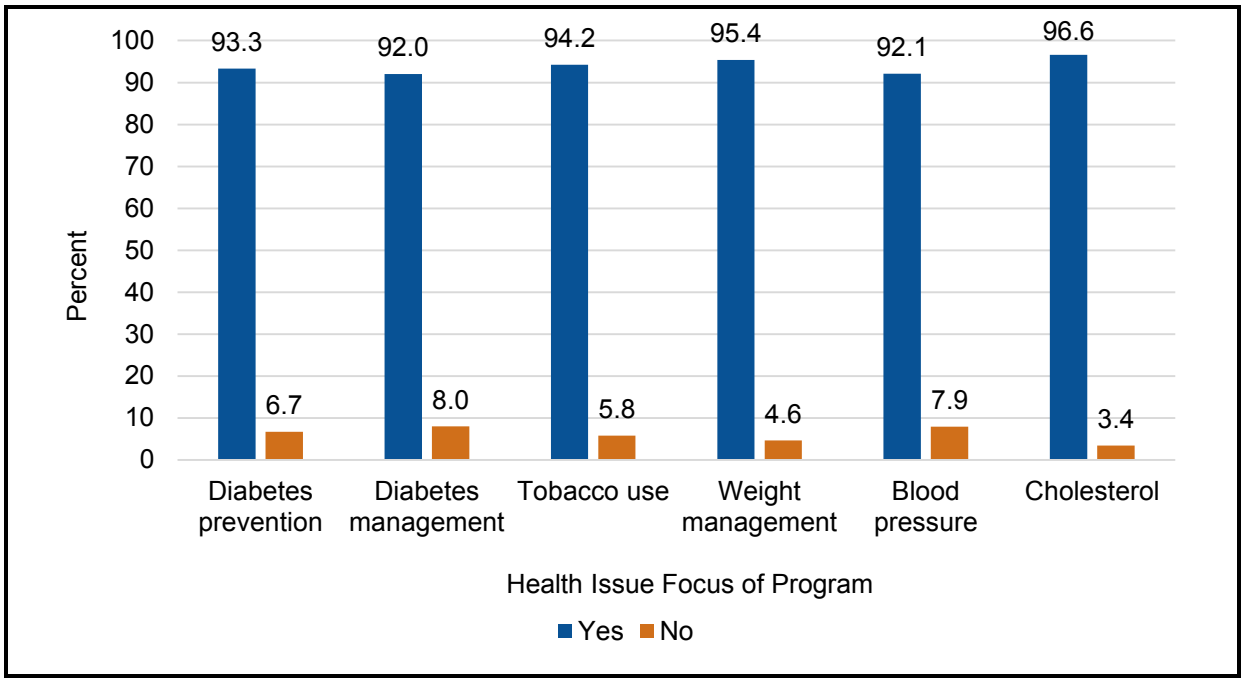
- *Help you learn ways to manage your diabetes?*
- *Help you set goals to manage your diabetes?*
- *Help you deal with problems that might come up with reaching your goals?*

Overall, the responses indicate a high level of satisfaction with how staff helped them manage their health issues. ***Figure 11*** presents the results for the question about whether program staff helped the participant learn ways to manage their health issue. More than 90 percent of respondents said the program helped them, with the highest percentages answering "yes" for "help you learn ways to lower your cholesterol" (96.6 percent) and "help you learn ways to manage your weight or lose weight" (95.4 percent).

***Figure 12*** presents the results from the question about whether the program staff helped them set goals related to their health issue (e.g., quit using tobacco, manage their weight, lose weight). About 90 percent or more of participants said the program had helped them set goals, with the highest percentage for the weight management and cholesterol modules (both about 94 percent).

***Figure 13*** presents the results from the question about whether the program staff helped them deal with problems that might come up with reaching their goals. Slightly lower percentages of respondents answered "yes" to these questions, ranging from 86.4 percent for the diabetes management module to 92.5 percent for the diabetes prevention module.

**Figure 11**
**Program staff helped learn ways to help with health issue[1, 2]**

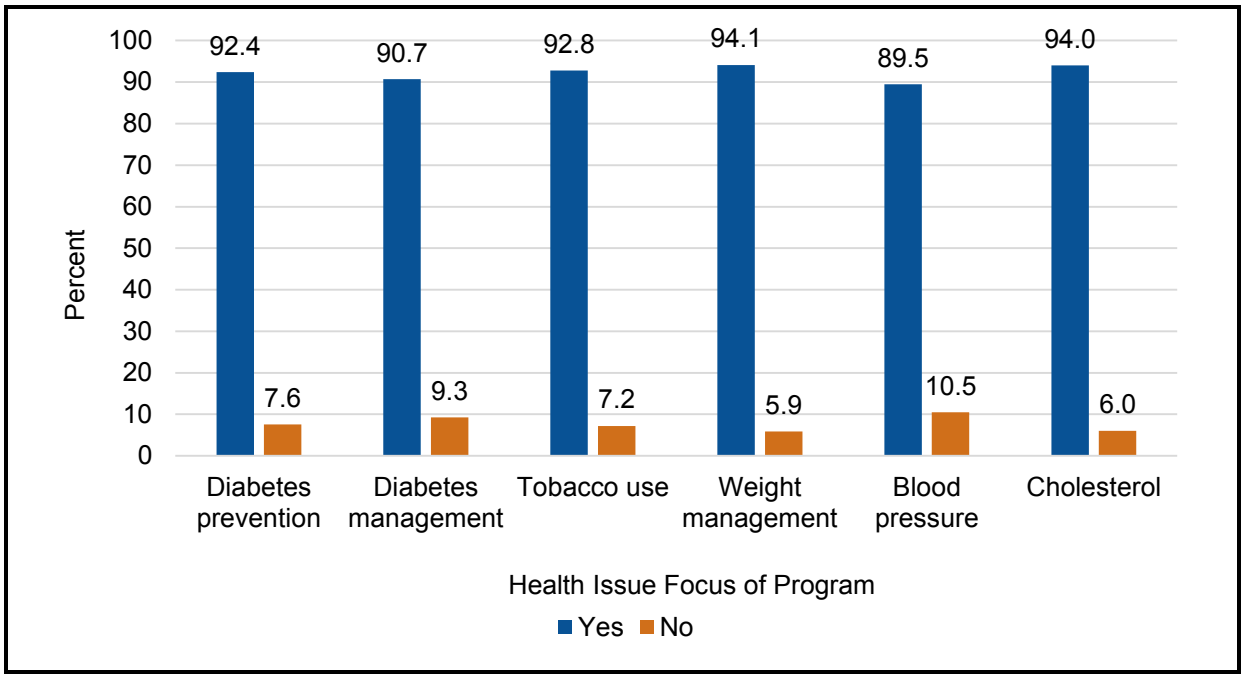



[1] The health issue focus of the program was self-reported by respondents; respondents could select multiple health issues.

[2] Question wording varies depending on the health issue: "help you learn ways to prevent diabetes," "help you learn ways to manage your diabetes," "help you learn ways to quit using tobacco," "help you learn ways to manage your weight or lose weight," "help you learn ways to manage your blood pressure," and "help you learn ways to lower your cholesterol."

Note: This figure presents weighted survey data.

**Figure 12**
**Program staff helped set goals to help with health issue[1, 2]**

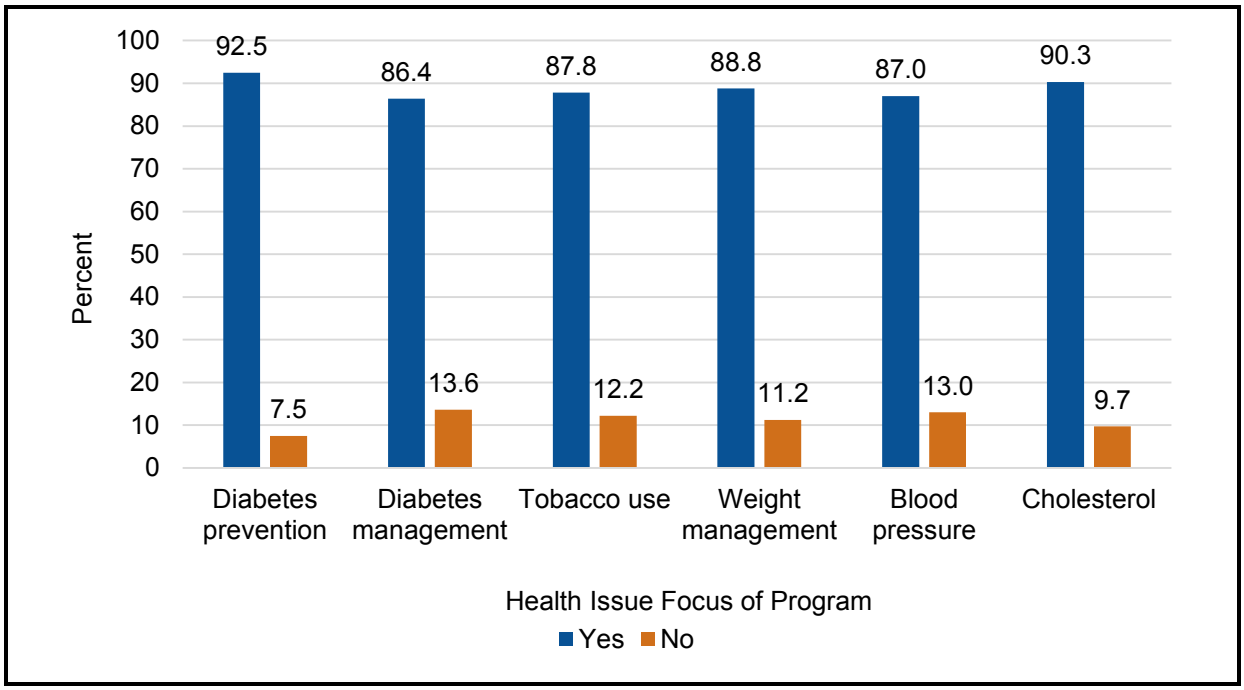



[1] The health issue focus of the program was self-reported by respondents; respondents could select multiple health issues.

[2] Question wording varies depending on the health issue: "help you set goals to prevent diabetes," "help you set goals to manage your diabetes," "help you set goals to quit using tobacco," "help you set goals to manage your weight or lose weight," "help you set goals to manage your blood pressure," and "help you set goals to lower your cholesterol."

Note: This figure presents weighted survey data.

**Figure 13**
**Program staff helped deal with problems reaching goals related to health issues[1]**




[1] The health issue focus of the program was self-reported by respondents; respondents could select multiple health issues.

Note: This figure presents weighted survey data.

***Tables 38*** through ***43*** show how each type of program helped participants, by participant characteristics. We found some significant differences (at the $p < 0.10$ and $p < 0.05$ levels) in responses to these questions by race, with African American respondents more likely than respondents of other races to say the program staff were helpful. African American respondents in the diabetes management program were more likely than respondents of other races to say that program staff helped them to set goals to manage their diabetes ($p = 0.067$) and deal with problems reaching their goals ($p = 0.042$) (see Table 39). African Americans in the weight management program were more likely than respondents of other races to say the program staff helped them learn ways to lose weight ($p = 0.004$), set goals to manage or lose weight ($p = 0.004$), and deal with problems reaching their goals ($p = 0.003$) (see Table 41). African American respondents in the blood pressure programs were more likely than respondents of other races to say the program staff helped them set goals to manage their blood pressure ($p = 0.078$) (see Table 42). Finally, African American respondents in the cholesterol program were more likely than respondents of other races to say that program staff helped them deal with problems reaching their goals ($p = 0.066$) (see Table 43).

**Table 38**
**Diabetes prevention programs[1]: ways program staff helped respondents by respondent characteristics**

| Characteristic | Program staff helped learn ways to prevent diabetes | | | Program staff helped set goals to prevent diabetes | | | Program staff helped deal with problems reaching goals | | |
|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | Row % | | | Row % | | |
| | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] |
| Total population | 93.3 | 6.7 | | 92.4 | 7.6 | | 92.5 | 7.5 | |
| Age | | | | | | | | | |
| 44 years or younger | 92.8 | 7.2 | 0.580 | 91.9 | 8.1 | 0.660 | 92.2 | 7.8 | 0.591 |
| 45 to 52 years | 92.5 | 7.5 | | 93.0 | 7.0 | | 92.5 | 7.5 | |
| 53 to 58 years | 91.6 | 8.4 | | 90.4 | 9.6 | | 89.7 | 10.3 | |
| 59 years or older | 95.6 | 4.4 | | 93.5 | 6.5 | | 94.2 | 5.8 | |
| Sex | | | | | | | | | |
| Male | 91.8 | 8.2 | 0.188 | 92.3 | 7.7 | 0.627 | 91.4 | 8.6 | 0.407 |
| Female | 93.9 | 6.1 | | 92.3 | 7.7 | | 92.9 | 7.1 | |
| Marital status | | | | | | | | | |
| Now married or living with a partner | 89.7 | 10.3 | 0.377 | 89.5 | 10.5 | 0.680 | 88.7 | 11.3 | 0.250 |
| Widowed | 96.3 | 3.7 | | 89.3 | 10.7 | | 92.9 | 7.1 | |
| Divorced | 92.3 | 7.7 | | 94.6 | 5.4 | | 95.4 | 4.6 | |
| Separated | 95.0 | 5.0 | | 95.0 | 5.0 | | 93.2 | 6.8 | |
| Never married | 95.2 | 4.8 | | 92.2 | 7.8 | | 93.1 | 6.9 | |
| Highest grade or level of school completed | | | | | | | | | |
| 8th grade or less | 93.1 | 6.9 | 0.834 | 87.8 | 12.2 | 0.874 | 90.4 | 9.6 | 0.849 |
| Some high school, but did not graduate | 93.2 | 6.8 | | 93.3 | 6.7 | | 93.1 | 6.9 | |
| High school graduate or GED | 92.1 | 7.9 | | 92.6 | 7.4 | | 93.7 | 6.3 | |
| Some college or 2-year college degree | 92.5 | 7.5 | | 91.9 | 8.1 | | 90.0 | 10.0 | |
| 4-year college degree | 94.9 | 5.1 | | 90.0 | 10.0 | | 92.5 | 7.5 | |
| More than 4-year college degree | 100.0 | 0.0 | | 100.0 | 0.0 | | 93.8 | 6.3 | |

(continued)

**Table 38 (continued)**
**Diabetes prevention programs[1]: ways program staff helped respondents by respondent characteristics**

| Characteristic | Program staff helped learn ways to prevent diabetes | | | Program staff helped set goals to prevent diabetes | | | Program staff helped deal with problems reaching goals | | |
|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | Row % | | | Row % | | |
| | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] |
| Employment status[3] | | | | | | | | | |
| Employed full-time | 89.8 | 10.2 | 0.335 | 90.0 | 10.0 | 0.490 | 83.7 | 16.3 | 0.023** |
| Employed part-time | 92.8 | 7.2 | 0.660 | 94.1 | 5.9 | 0.272 | 93.2 | 6.8 | 0.767 |
| Employed, not specified whether full-time or part-time | 85.7 | 14.3 | 0.236 | 100.0 | 0.0 | 0.507 | 85.7 | 14.3 | 0.170 |
| Unemployed and looking for work | 92.9 | 7.1 | 0.843 | 89.4 | 10.6 | 0.096* | 89.4 | 10.6 | 0.152 |
| Unemployed, not specified whether looking for work | 100.0 | 0.0 | 0.474 | 100 | 0 | 0.452 | 100 | 0 | 0.439 |
| Student | 95.2 | 4.8 | 0.697 | 95.0 | 5.0 | 0.662 | 90.5 | 9.5 | 0.783 |
| Homemaker | 96.4 | 3.6 | 0.215 | 92.5 | 7.5 | 0.574 | 91.5 | 8.5 | 0.799 |
| Retired | 97.0 | 3.0 | 0.230 | 95.6 | 4.4 | 0.377 | 97.0 | 3.0 | 0.147 |
| Receiving disability or supplemental security income | 91.7 | 8.3 | 0.259 | 92.9 | 7.1 | 0.985 | 94.7 | 5.3 | 0.214 |
| Other employment status | 89.0 | 11.0 | 0.336 | 89.0 | 11.0 | 0.429 | 88.6 | 11.4 | 0.442 |

(continued)

**Table 38 (continued)**
**Diabetes prevention programs[1]: ways program staff helped respondents by respondent characteristics**

| Characteristic | Program staff helped learn ways to prevent diabetes | | | Program staff helped set goals to prevent diabetes | | | Program staff helped deal with problems reaching goals | | |
|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | Row % | | | Row % | | |
| | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] |
| Race[4] | | | | | | | | | |
| American Indian or Alaska Native | 95.8 | 4.2 | 0.491 | 95.8 | 4.2 | 0.421 | 89.5 | 10.5 | 0.371 |
| Asian | 95.5 | 4.5 | 0.651 | 95.5 | 4.5 | 0.595 | 86.4 | 13.6 | 0.287 |
| Black or African American | 94.3 | 5.7 | 0.289 | 93.3 | 6.7 | 0.557 | 91.5 | 8.5 | 0.354 |
| Native Hawaiian or Other Pacific Islander | 100.0 | 0.0 | 0.436 | 100.0 | 0.0 | 0.418 | 100.0 | 0.0 | 0.410 |
| White | 90.5 | 9.5 | 0.133 | 89.3 | 10.7 | 0.143 | 93.3 | 6.7 | 0.670 |
| Ethnicity | | | | | | | | | |
| Hispanic or Latino | 92.5 | 7.5 | 0.592 | 92.4 | 7.6 | 0.762 | 92.5 | 7.5 | 0.997 |
| Not Hispanic or Latino | 93.2 | 6.8 | | 92.3 | 7.7 | | 92.2 | 7.8 | |
| Received help completing survey | | | | | | | | | |
| Yes | 93.6 | 6.4 | 0.838 | 90.1 | 9.9 | 0.534 | 92.4 | 7.6 | 0.963 |
| No | 93.8 | 6.2 | | 93.1 | 6.9 | | 91.8 | 8.2 | |

* *p < 0.10*

** *p < 0.05*

[1] The health issue focus of the program was self-reported by respondents; respondents could select multiple health issues.

[2] Chi-square tests are reported.

[3] Respondents could select multiple types of employment (e.g., employed part-time and student). Each row displays the percentage responding "yes" for the specific type of employment, and each *p*-value compares "yes" versus "no" for the specific type of employment.

[4] Respondents could select multiple races. Each row displays the percentage responding "yes" for the specific race, and each
*p*-value compares "yes" versus "no" for the specific race.

Note: This table presents weighted descriptive analyses and unweighted bivariate statistical analyses.

**Table 39**
**Diabetes management programs[1]: ways program staff helped respondents by respondent characteristics**

| Characteristic | Program staff helped learn ways to manage diabetes | | | Program staff helped set goals to manage diabetes | | | Program staff helped deal with problems reaching goals | | |
|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | Row % | | | Row % | | |
| | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] |
| Total population | 92.0 | 8.0 | | 90.7 | 9.3 | | 86.4 | 13.6 | |
| Age | | | | | | | | | |
| 44 years or younger | 93.4 | 6.6 | 0.605 | 86.4 | 13.6 | 0.387 | 83.7 | 16.3 | 0.531 |
| 45 to 52 years | 89.7 | 10.3 | | 88.8 | 11.2 | | 87.5 | 12.5 | |
| 53 to 58 years | 90.2 | 9.8 | | 89.0 | 11.0 | | 82.7 | 17.3 | |
| 59 years or older | 93.7 | 6.3 | | 94.6 | 5.4 | | 87.4 | 12.6 | |
| Sex | | | | | | | | | |
| Male | 91.6 | 8.4 | 0.357 | 90.4 | 9.6 | 0.732 | 81.3 | 18.7 | 0.007** |
| Female | 92.1 | 7.9 | | 90.6 | 9.4 | | 89.3 | 10.7 | |
| Marital status | | | | | | | | | |
| Now married or living with a partner | 89.9 | 10.1 | 0.205 | 88.2 | 11.8 | 0.154 | 81.7 | 18.3 | 0.123 |
| Widowed | 100.0 | 0.0 | | 100.0 | 0.0 | | 100.0 | 0.0 | |
| Divorced | 86.6 | 13.4 | | 87.2 | 12.8 | | 83.0 | 17.0 | |
| Separated | 94.6 | 5.4 | | 92.0 | 8.0 | | 87.3 | 12.7 | |
| Never married | 93.5 | 6.5 | | 91.9 | 8.1 | | 87.5 | 12.5 | |
| Highest grade or level of school completed | | | | | | | | | |
| 8th grade or less | 96.7 | 3.3 | 0.117 | 92.9 | 7.1 | 0.030** | 89.6 | 10.4 | 0.010** |
| Some high school, but did not graduate | 91.4 | 8.6 | | 93.3 | 6.7 | | 83.2 | 16.8 | |
| High school graduate or GED | 94.5 | 5.5 | | 92.6 | 7.4 | | 91.0 | 9.0 | |
| Some college or 2-year college degree | 88.7 | 11.3 | | 87.6 | 12.4 | | 86.1 | 13.9 | |
| 4-year college degree | 83.3 | 16.7 | | 80.0 | 20.0 | | 70.0 | 30.0 | |
| More than 4-year college degree | 83.3 | 16.7 | | 75.0 | 25.0 | | 66.7 | 33.3 | |

(continued)

**Table 39 (continued)**
**Diabetes management programs[1]: ways program staff helped respondents by respondent characteristics**

| Characteristic | Program staff helped learn ways to manage diabetes | | | Program staff helped set goals to manage diabetes | | | Program staff helped deal with problems reaching goals | | |
|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | Row % | | | Row % | | |
| | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] |
| Employment status[3] | | | | | | | | | |
| Employed full-time | 82.3 | 17.7 | 0.007** | 82.3 | 17.7 | 0.033** | 79.5 | 20.5 | 0.328 |
| Employed part-time | 96.8 | 3.2 | 0.187 | 85.0 | 15.0 | 0.465 | 84.0 | 16.0 | 0.654 |
| Employed, not specified whether full-time or part-time | 87.5 | 12.5 | 0.262 | 75.0 | 25.0 | 0.018** | 75.0 | 25.0 | 0.026** |
| Unemployed and looking for work | 88.6 | 11.4 | 0.186 | 90.0 | 10.0 | 0.996 | 80.7 | 19.3 | 0.019** |
| Unemployed, not specified whether looking for work | 85.7 | 14.3 | 0.507 | 71.4 | 28.6 | 0.071* | 100 | 0 | 0.301 |
| Student | 100 | 0 | 0.352 | 90.0 | 10.0 | 0.936 | 100 | 0 | 0.209 |
| Homemaker | 95.4 | 4.6 | 0.302 | 92.3 | 7.7 | 0.638 | 90.8 | 9.2 | 0.292 |
| Retired | 93.0 | 7.0 | 0.965 | 90.3 | 9.7 | 0.688 | 87.2 | 12.8 | 0.746 |
| Receiving disability or supplemental security income | 91.8 | 8.2 | 0.692 | 93.9 | 6.1 | 0.166 | 89.3 | 10.7 | 0.123 |
| Other employment status | 96.2 | 3.8 | 0.465 | 96.2 | 3.8 | 0.351 | 92.4 | 7.6 | 0.417 |
| Race[4] | | | | | | | | | |
| American Indian or Alaska Native | 84.1 | 15.9 | 0.233 | 86.9 | 13.1 | 0.807 | 86.9 | 13.1 | 0.568 |
| Asian | 96.0 | 4.0 | 0.450 | 88.1 | 11.9 | 0.595 | 84.2 | 15.8 | 0.649 |
| Black or African American | 93.8 | 6.2 | 0.148 | 93.3 | 6.7 | 0.067* | 89.5 | 10.5 | 0.042** |
| Native Hawaiian or Other Pacific Islander | 100.0 | 0.0 | 0.336 | 100.0 | 0.0 | 0.329 | 88.9 | 11.1 | 0.828 |
| White | 86.3 | 13.7 | 0.005** | 86.4 | 13.6 | 0.016** | 79.5 | 20.5 | 0.012** |

(continued)

**Table 39 (continued)**
**Diabetes management programs[1]: ways program staff helped respondents by respondent characteristics**

| Characteristic | Program staff helped learn ways to manage diabetes | | | Program staff helped set goals to manage diabetes | | | Program staff helped deal with problems reaching goals | | |
|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | Row % | | | Row % | | |
| | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] |
| Ethnicity | | | | | | | | | |
| Hispanic or Latino | 92.9 | 7.1 | 0.648 | 89.5 | 10.5 | 0.953 | 88.9 | 11.1 | 0.339 |
| Not Hispanic or Latino | 91.7 | 8.3 | | 91.0 | 9.0 | | 84.9 | 15.1 | |
| Received help completing survey | | | | | | | | | |
| Yes | 94.7 | 5.3 | 0.163 | 95.9 | 4.1 | 0.046** | 93.5 | 6.5 | 0.045** |
| No | 91.2 | 8.8 | | 90.3 | 9.7 | | 85.8 | 14.2 | |

* $p < 0.10$

** $p < 0.05$

[1] The health issue focus of the program was self-reported by respondents; respondents could select multiple health issues.

[2] Chi-square tests are reported.

[3] Respondents could select multiple types of employment (e.g., employed part-time and student). Each row displays the percentage responding "yes" for the specific type of employment, and each *p*-value compares "yes" versus "no" for the specific type of employment.

[4] Respondents could select multiple races. Each row displays the percentage responding "yes" for the specific race, and each
*p*-value compares "yes" versus "no" for the specific race.

Note: This table presents weighted descriptive analyses and unweighted bivariate statistical analyses.

**Table 40**
**Tobacco programs[1]: ways program staff helped respondents by respondent characteristics**

| Characteristic | Program staff helped learn ways to quit using tobacco | | | Program staff helped set goals to quit using tobacco | | | Program staff helped deal with problems reaching goals | | |
|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | Row % | | | Row % | | |
| | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] |
| Total population | 94.2 | 5.8 | | 92.8 | 7.2 | | 87.8 | 12.2 | |
| Age | | | | | | | | | |
| 44 years or younger | 94.6 | 5.4 | 0.456 | 92.8 | 7.2 | 0.070* | 90.2 | 9.8 | 0.665 |
| 45 to 52 years | 93.2 | 6.8 | | 94.0 | 6.0 | | 85.9 | 14.1 | |
| 53 to 58 years | 92.7 | 7.3 | | 89.6 | 10.4 | | 85.0 | 15.0 | |
| 59 years or older | 95.5 | 4.5 | | 94.7 | 5.3 | | 88.9 | 11.1 | |
| Sex | | | | | | | | | |
| Male | 94.3 | 5.7 | 0.715 | 92.6 | 7.4 | 0.782 | 88.3 | 11.7 | 0.402 |
| Female | 94.0 | 6.0 | | 92.9 | 7.1 | | 87.1 | 12.9 | |
| Marital status | | | | | | | | | |
| Now married or living with a partner | 93.8 | 6.2 | 0.606 | 94.5 | 5.5 | 0.760 | 89.3 | 10.7 | 0.292 |
| Widowed | 96.6 | 3.4 | | 96.6 | 3.4 | | 92.6 | 7.4 | |
| Divorced | 95.6 | 4.4 | | 92.7 | 7.3 | | 87.8 | 12.2 | |
| Separated | 92.3 | 7.7 | | 93.2 | 6.8 | | 85.1 | 14.9 | |
| Never married | 93.5 | 6.5 | | 91.1 | 8.9 | | 86.6 | 13.4 | |
| Highest grade or level of school completed | | | | | | | | | |
| 8th grade or less | 98.0 | 2.0 | 0.697 | 96.0 | 4.0 | 0.680 | 91.8 | 8.2 | 0.894 |
| Some high school, but did not graduate | 92.6 | 7.4 | | 92.5 | 7.5 | | 86.3 | 13.7 | |
| High school graduate or GED | 95.4 | 4.6 | | 93.5 | 6.5 | | 87.6 | 12.4 | |
| Some college or 2-year college degree | 93.6 | 6.4 | | 92.8 | 7.2 | | 88.1 | 11.9 | |
| 4-year college degree | 93.6 | 6.4 | | 92.1 | 7.9 | | 87.5 | 12.5 | |
| More than 4-year college degree | 95.8 | 4.2 | | 87.5 | 12.5 | | 87.5 | 12.5 | |

(continued)

**Table 40 (continued)**
**Tobacco programs[1]: ways program staff helped respondents by respondent characteristics**

| Characteristic | Program staff helped learn ways to quit using tobacco | | | Program staff helped set goals to quit using tobacco | | | Program staff helped deal with problems reaching goals | | |
|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | Row % | | | Row % | | |
| | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] |
| Employment status[3] | | | | | | | | | |
| Employed full-time | 95.0 | 5.0 | 0.282 | 88.0 | 12.0 | 0.768 | 88.1 | 11.9 | 0.456 |
| Employed part-time | 94.1 | 5.9 | 0.903 | 94.8 | 5.2 | 0.482 | 92.5 | 7.5 | 0.116 |
| Employed, not specified whether full-time or part-time | 100.0 | 0.0 | 0.385 | 100.0 | 0.0 | 0.323 | 86.6 | 13.4 | 0.633 |
| Unemployed and looking for work | 94.1 | 5.9 | 0.915 | 91.8 | 8.2 | 0.569 | 87.0 | 13.0 | 0.244 |
| Unemployed, not specified whether looking for work | 91.9 | 8.1 | 0.702 | 91.9 | 8.1 | 0.840 | 91.9 | 8.1 | 0.746 |
| Student | 89.7 | 10.3 | 0.515 | 94.9 | 5.1 | 0.395 | 87.1 | 12.9 | 0.549 |
| Homemaker | 89.4 | 10.6 | 0.005** | 91.4 | 8.6 | 0.605 | 87.5 | 12.5 | 0.873 |
| Retired | 97.4 | 2.6 | 0.142 | 97.4 | 2.6 | 0.059* | 92.8 | 7.2 | 0.045** |
| Receiving disability or supplemental security income | 92.5 | 7.5 | 0.117 | 91.4 | 8.6 | 0.084 | 83.3 | 16.7 | 0.010** |
| Other employment status | 96.9 | 3.1 | 0.499 | 96.9 | 3.1 | 0.342 | 90.2 | 9.8 | 0.638 |
| Race[4] | | | | | | | | | |
| American Indian or Alaska Native | 93.2 | 6.8 | 0.434 | 89.8 | 10.2 | 0.281 | 85.4 | 14.6 | 0.940 |
| Asian | 96.1 | 3.9 | 0.974 | 100 | 0 | 0.263 | 100 | 0 | 0.143 |
| Black or African American | 94.6 | 5.4 | 0.547 | 92.8 | 7.2 | 0.520 | 88.2 | 11.8 | 0.455 |
| Native Hawaiian or Other Pacific Islander | 81.2 | 18.8 | 0.275 | 81.2 | 18.8 | 0.401 | 94.3 | 5.7 | 0.498 |
| White | 94.2 | 5.8 | 0.950 | 92.9 | 7.1 | 0.699 | 86.5 | 13.5 | 0.180 |

(continued)

**Table 40 (continued)**
**Tobacco programs[1]: ways program staff helped respondents by respondent characteristics**

| Characteristic | Program staff helped learn ways to quit using tobacco | | | Program staff helped set goals to quit using tobacco | | | Program staff helped deal with problems reaching goals | | |
|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | Row % | | | Row % | | |
| | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] |
| Ethnicity | | | | | | | | | |
| Hispanic or Latino | 92.9 | 7.1 | 0.212 | 93.2 | 6.8 | 0.895 | 87.9 | 12.1 | 0.832 |
| Not Hispanic or Latino | 94.4 | 5.6 | | 92.7 | 7.3 | | 87.8 | 12.2 | |
| Received help completing survey | | | | | | | | | |
| Yes | 93.5 | 6.5 | 0.188 | 93.3 | 6.7 | 0.944 | 85.9 | 14.1 | 0.408 |
| No | 96.1 | 3.9 | | 93.7 | 6.3 | | 89.6 | 10.4 | |

* *p < 0.10*

** *p < 0.05*

[1] The health issue focus of the program was self-reported by respondents; respondents could select multiple health issues.

[2] Chi-square tests are reported.

[3] Respondents could select multiple types of employment (e.g., employed part-time and student). Each row displays the percentage responding "yes" for the specific type of employment, and each *p*-value compares "yes" versus "no" for the specific type of employment.

[4] Respondents could select multiple races. Each row displays the percentage responding "yes" for the specific race, and each
*p*-value compares "yes" versus "no" for the specific race.

Note: This table presents weighted descriptive analyses and unweighted bivariate statistical analyses.

**Table 41**
**Weight management programs[1]: ways program staff helped respondents by respondent characteristics**

| Characteristic | Program staff helped learn ways to manage or lose weight | | | Program staff helped set goals to manage or lose weight | | | Program staff helped deal with problems reaching goals | | |
|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | Row % | | | Row % | | |
| | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] |
| Total population | 95.4 | 4.6 | | 94.1 | 5.9 | | 88.8 | 11.2 | |
| Age | | | | | | | | | |
| 44 years or younger | 95.3 | 4.7 | 0.937 | 95.3 | 4.7 | 0.705 | 83.5 | 16.5 | 0.033** |
| 45 to 52 years | 96.4 | 3.6 | | 95.5 | 4.5 | | 88.3 | 11.7 | |
| 53 to 58 years | 94.2 | 5.8 | | 92.5 | 7.5 | | 90.5 | 9.5 | |
| 59 years or older | 96.5 | 3.5 | | 93.6 | 6.4 | | 92.1 | 7.9 | |
| Sex | | | | | | | | | |
| Male | 95.1 | 4.9 | 0.870 | 93.6 | 6.4 | 0.883 | 88.2 | 11.8 | 0.887 |
| Female | 95.9 | 4.1 | | 94.6 | 5.4 | | 89.0 | 11.0 | |
| Marital status | | | | | | | | | |
| Now married or living with a partner | 93.9 | 6.1 | 0.561 | 92.6 | 7.4 | 0.502 | 89.0 | 11.0 | 0.657 |
| Widowed | 97.7 | 2.3 | | 97.7 | 2.3 | | 93.2 | 6.8 | |
| Divorced | 93.8 | 6.2 | | 93.4 | 6.6 | | 87.9 | 12.1 | |
| Separated | 98.5 | 1.5 | | 98.5 | 1.5 | | 92.7 | 7.3 | |
| Never married | 96.4 | 3.6 | | 93.9 | 6.1 | | 87.1 | 12.9 | |
| Highest grade or level of school completed | | | | | | | | | |
| 8th grade or less | 100.0 | 0.0 | 0.006** | 95.1 | 4.9 | 0.024** | 95.1 | 4.9 | 0.137 |
| Some high school, but did not graduate | 95.2 | 4.8 | | 95.3 | 4.7 | | 90.9 | 9.1 | |
| High school graduate or GED | 95.4 | 4.6 | | 93.5 | 6.5 | | 87.8 | 12.2 | |
| Some college or 2-year college degree | 96.4 | 3.6 | | 95.7 | 4.3 | | 88.2 | 11.8 | |
| 4-year college degree | 85.1 | 14.9 | | 83.0 | 17.0 | | 78.7 | 21.3 | |
| More than 4-year college degree | 95.0 | 5.0 | | 95.0 | 5.0 | | 90.0 | 10.0 | |

(continued)

**Table 41 (continued)**
**Weight management programs[1]: ways program staff helped respondents by respondent characteristics**

| Characteristic | Program staff helped learn ways to manage or lose weight | | | Program staff helped set goals to manage or lose weight | | | Program staff helped deal with problems reaching goals | | |
|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | Row % | | | Row % | | |
| | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] |
| Employment status[3] | | | | | | | | | |
| Employed full-time | 95.6 | 4.4 | 0.922 | 91.1 | 8.9 | 0.339 | 88.9 | 11.1 | 0.959 |
| Employed part-time | 93.5 | 6.5 | 0.206 | 89.1 | 10.9 | 0.016** | 87.0 | 13.0 | 0.529 |
| Employed, not specified whether full-time or part-time | 100.0 | 0.0 | 0.611 | 100.0 | 0.0 | 0.542 | 100.0 | 0.0 | 0.367 |
| Unemployed and looking for work | 98.1 | 1.9 | 0.118 | 97.5 | 2.5 | 0.061* | 88.3 | 11.7 | 0.740 |
| Unemployed, not specified whether looking for work | 100 | 0 | 0.483 | 100 | 0 | 0.410 | 81.8 | 18.2 | 0.459 |
| Student | 92.3 | 7.7 | 0.359 | 96.2 | 3.8 | 0.681 | 69.2 | 30.8 | 0.002** |
| Homemaker | 97.8 | 2.2 | 0.301 | 98.9 | 1.1 | 0.041** | 94.6 | 5.4 | 0.053* |
| Retired | 98.6 | 1.4 | 0.261 | 95.9 | 4.1 | 0.677 | 94.7 | 5.3 | 0.147 |
| Receiving disability or supplemental security income | 94.3 | 5.7 | 0.632 | 92.6 | 7.4 | 0.279 | 88.3 | 11.7 | 0.971 |
| Other employment status | 90.0 | 10.0 | 0.103 | 93.3 | 6.7 | 0.812 | 86.2 | 13.8 | 0.673 |
| Race[4] | | | | | | | | | |
| American Indian or Alaska Native | 90.6 | 9.4 | 0.266 | 92.2 | 7.8 | 0.941 | 87.0 | 13.0 | 0.853 |
| Asian | 100.0 | 0.0 | 0.458 | 100.0 | 0.0 | 0.387 | 100.0 | 0.0 | 0.204 |
| Black or African American | 97.9 | 2.1 | 0.004** | 97.4 | 2.6 | 0.004** | 92.8 | 7.2 | 0.003** |
| Native Hawaiian or Other Pacific Islander | 100.0 | 0.0 | 0.572 | 100.0 | 0.0 | 0.542 | 100.0 | 0.0 | 0.371 |
| White | 92.8 | 7.2 | 0.001** | 90.9 | 9.1 | <0.001** | 83.5 | 16.5 | <0.001** |

(continued)

**Table 41 (continued)**
**Weight management programs[1]: ways program staff helped respondents by respondent characteristics**

| Characteristic | Program staff helped learn ways to manage or lose weight | | | Program staff helped set goals to manage or lose weight | | | Program staff helped deal with problems reaching goals | | |
|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | Row % | | | Row % | | |
| | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] |
| Ethnicity | | | | | | | | | |
| Hispanic or Latino | 96.7 | 3.3 | 0.276 | 95.2 | 4.8 | 0.379 | 95.2 | 4.8 | 0.007** |
| Not Hispanic or Latino | 95.1 | 4.9 | | 93.8 | 6.2 | | 87.5 | 12.5 | |
| Received help completing survey | | | | | | | | | |
| Yes | 96.4 | 3.6 | 0.775 | 95.4 | 4.6 | 0.489 | 92.7 | 7.3 | 0.361 |
| No | 95.3 | 4.7 | | 93.2 | 6.8 | | 89.3 | 10.7 | |

* *p < 0.10*

** *p < 0.05*

[1] The health issue focus of the program was self-reported by respondents; respondents could select multiple health issues.

[2] Chi-square tests are reported.

[3] Respondents could select multiple types of employment (e.g., employed part-time and student). Each row displays the percentage responding "yes" for the specific type of employment, and each *p*-value compares "yes" versus "no" for the specific type of employment.

[4] Respondents could select multiple races. Each row displays the percentage responding "yes" for the specific race, and each
*p*-value compares "yes" versus "no" for the specific race.

Note: This table presents weighted descriptive analyses and unweighted bivariate statistical analyses.

**Table 42**
**Blood pressure programs[1]: ways program staff helped respondents by respondent characteristics**

| Characteristic | Program staff helped learn ways to manage blood pressure | | | Program staff helped set goals to manage blood pressure | | | Program staff helped deal with problems reaching goals | | |
|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | Row % | | | Row % | | |
| | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] |
| Total population | 92.1 | 7.9 | | 89.5 | 10.5 | | 87.0 | 13.0 | |
| Age | | | | | | | | | |
| 44 years or younger | 94.3 | 5.7 | 0.939 | 91.4 | 8.6 | 0.912 | 87.1 | 12.9 | 0.985 |
| 45 to 52 years | 89.8 | 10.2 | | 88.3 | 11.7 | | 85.3 | 14.7 | |
| 53 to 58 years | 91.8 | 8.2 | | 87.9 | 12.1 | | 86.3 | 13.7 | |
| 59 years or older | 93.1 | 6.9 | | 90.5 | 9.5 | | 89.6 | 10.4 | |
| Sex | | | | | | | | | |
| Male | 93.4 | 6.6 | 0.494 | 89.6 | 10.4 | 0.981 | 89.0 | 11.0 | 0.207 |
| Female | 91.2 | 8.8 | | 89.5 | 10.5 | | 85.7 | 14.3 | |
| Marital status | | | | | | | | | |
| Now married or living with a partner | 94.3 | 5.7 | 0.261 | 91.2 | 8.8 | 0.166 | 87.3 | 12.7 | 0.717 |
| Widowed | 97.1 | 2.9 | | 91.3 | 8.7 | | 88.4 | 11.6 | |
| Divorced | 88.7 | 11.3 | | 87.1 | 12.9 | | 85.4 | 14.6 | |
| Separated | 88.4 | 11.6 | | 82.7 | 17.3 | | 81.7 | 18.3 | |
| Never married | 92.9 | 7.1 | | 91.3 | 8.7 | | 88.8 | 11.2 | |
| Highest grade or level of school completed | | | | | | | | | |
| 8th grade or less | 97.9 | 2.1 | 0.043** | 97.9 | 2.1 | 0.132 | 93.7 | 6.3 | 0.510 |
| Some high school, but did not graduate | 94.0 | 6.0 | | 87.4 | 12.6 | | 87.4 | 12.6 | |
| High school graduate or GED | 94.1 | 5.9 | | 92.9 | 7.1 | | 88.6 | 11.4 | |
| Some college or 2-year college degree | 85.8 | 14.2 | | 84.1 | 15.9 | | 81.7 | 18.3 | |
| 4-year college degree | 91.0 | 9.0 | | 86.5 | 13.5 | | 82.1 | 17.9 | |
| More than 4-year college degree | 77.8 | 22.2 | | 77.8 | 22.2 | | 88.9 | 11.1 | |

(continued)

**Table 42 (continued)**
**Blood pressure programs[1]: ways program staff helped respondents by respondent characteristics**

| Characteristic | Program staff helped learn ways to manage blood pressure | | | Program staff helped set goals to manage blood pressure | | | Program staff helped deal with problems reaching goals | | |
|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | Row % | | | Row % | | |
| | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] |
| Employment status[3] | | | | | | | | | |
| Employed full-time | 83.6 | 16.4 | 0.417 | 83.6 | 16.4 | 0.773 | 79.8 | 20.2 | 0.606 |
| Employed part-time | 95.8 | 4.2 | 0.401 | 95.9 | 4.1 | 0.175 | 87.1 | 12.9 | 0.743 |
| Employed, not specified whether full-time or part-time | 100.0 | 0.0 | 0.588 | 100.0 | 0.0 | 0.534 | 100.0 | 0.0 | 0.494 |
| Unemployed and looking for work | 93.7 | 6.3 | 0.722 | 88.0 | 12.0 | 0.528 | 86.0 | 14.0 | 0.618 |
| Unemployed, not specified whether looking for work | 88.9 | 11.1 | 0.696 | 88.9 | 11.1 | 0.925 | 77.8 | 22.2 | 0.373 |
| Student | 85.0 | 15.0 | 0.244 | 85.0 | 15.0 | 0.462 | 69.9 | 30.1 | 0.029** |
| Homemaker | 86.3 | 13.7 | 0.491 | 84.7 | 15.3 | 0.708 | 85.1 | 14.9 | 0.866 |
| Retired | 98.2 | 1.8 | 0.121 | 98.2 | 1.8 | 0.048 | 96.3 | 3.7 | 0.062* |
| Receiving disability or supplemental security income | 92.7 | 7.3 | 0.992 | 88.9 | 11.1 | 0.641 | 87.1 | 12.9 | 0.859 |
| Other employment status | 91.7 | 8.3 | 0.916 | 87.5 | 12.5 | 0.715 | 87.5 | 12.5 | 0.981 |
| Race[4] | | | | | | | | | |
| American Indian or Alaska Native | 96.6 | 3.4 | 0.369 | 81.9 | 18.1 | 0.496 | 81.9 | 18.1 | 0.772 |
| Asian | 93.5 | 6.5 | 0.901 | 93.5 | 6.5 | 0.680 | 100.0 | 0.0 | 0.150 |
| Black or African American | 93.5 | 6.5 | 0.168 | 91.9 | 8.1 | 0.078* | 90.0 | 10.0 | 0.204 |
| Native Hawaiian or Other Pacific Islander | 100.0 | 0.0 | 0.506 | 100.0 | 0.0 | 0.442 | 100.0 | 0.0 | 0.395 |
| White | 88.7 | 11.3 | 0.178 | 85.4 | 14.6 | 0.073 | 83.6 | 16.4 | 0.115 |

(continued)

**Table 42 (continued)**
**Blood pressure programs[1]: ways program staff helped respondents by respondent characteristics**

| Characteristic | Program staff helped learn ways to manage blood pressure | | | Program staff helped set goals to manage blood pressure | | | Program staff helped deal with problems reaching goals | | |
|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | Row % | | | Row % | | |
| | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] |
| Ethnicity | | | | | | | | | |
| Hispanic or Latino | 96.0 | 4.0 | 0.170 | 92.7 | 7.3 | 0.204 | 86.0 | 14.0 | 0.658 |
| Not Hispanic or Latino | 90.6 | 9.4 | | 88.3 | 11.7 | | 87.1 | 12.9 | |
| Received help completing survey | | | | | | | | | |
| Yes | 95.3 | 4.7 | 0.245 | 92.0 | 8.0 | 0.691 | 89.8 | 10.2 | 0.342 |
| No | 92.5 | 7.5 | | 91.2 | 8.8 | | 86.4 | 13.6 | |

* $p < 0.10$

** $p < 0.05$

[1] The health issue focus of the program was self-reported by respondents; respondents could select multiple health issues.

[2] Chi-square tests are reported.

[3] Respondents could select multiple types of employment (e.g., employed part-time and student). Each row displays the percentage responding "yes" for the specific type of employment, and each *p*-value compares "yes" versus "no" for the specific type of employment.

[4] Respondents could select multiple races. Each row displays the percentage responding "yes" for the specific race, and each *p*-value compares "yes" versus "no" for the specific race.

Note: This table presents weighted descriptive analyses and unweighted bivariate statistical analyses.

**Table 43**
**Cholesterol programs[1]: ways program staff helped respondents by respondent characteristics**

| Characteristic | Program staff helped learn ways to lower cholesterol | | | Program staff helped set goals to lower cholesterol | | | Program staff helped deal with problems reaching goals | | |
|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | Row % | | | Row % | | |
| | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] |
| Total population | 96.6 | 3.4 | | 94.0 | 6.0 | | 90.3 | 9.7 | |
| Age | | | | | | | | | |
| 44 years or younger | 94.2 | 5.8 | 0.102 | 90.3 | 9.7 | 0.026** | 86.1 | 13.9 | 0.028** |
| 45 to 52 years | 100.0 | 0.0 | | 99.0 | 1.0 | | 94.7 | 5.3 | |
| 53 to 58 years | 95.1 | 4.9 | | 90.0 | 10.0 | | 84.1 | 15.9 | |
| 59 years or older | 98.1 | 1.9 | | 97.0 | 3.0 | | 95.0 | 5.0 | |
| Sex | | | | | | | | | |
| Male | 98.9 | 1.1 | 0.025** | 92.8 | 7.2 | 0.385 | 89.9 | 10.1 | 0.896 |
| Female | 94.8 | 5.2 | | 95.2 | 4.8 | | 90.7 | 9.3 | |
| Marital status | | | | | | | | | |
| Now married or living with a partner | 95.9 | 4.1 | 0.329 | 90.3 | 9.7 | 0.629 | 83.3 | 16.7 | 0.499 |
| Widowed | 95.6 | 4.4 | | 91.2 | 8.8 | | 91.2 | 8.8 | |
| Divorced | 93.5 | 6.5 | | 95.6 | 4.4 | | 94.4 | 5.6 | |
| Separated | 100 | 0 | | 97.1 | 2.9 | | 94.3 | 5.7 | |
| Never married | 97.9 | 2.1 | | 94.4 | 5.6 | | 90.3 | 9.7 | |
| Highest grade or level of school completed | | | | | | | | | |
| 8th grade or less | 91.8 | 8.2 | 0.136 | 93.7 | 6.3 | 0.848 | 93.9 | 6.1 | 0.854 |
| Some high school, but did not graduate | 98.9 | 1.1 | | 94.3 | 5.7 | | 89.3 | 10.7 | |
| High school graduate or GED | 97.9 | 2.1 | | 95.6 | 4.4 | | 92.7 | 7.3 | |
| Some college or 2-year college degree | 96.5 | 3.5 | | 93.8 | 6.2 | | 86.2 | 13.8 | |
| 4-year college degree | 90.5 | 9.5 | | 90.5 | 9.5 | | 85.7 | 14.3 | |
| More than 4-year college degree | 100.0 | 0.0 | | 85.7 | 14.3 | | 85.7 | 14.3 | |

(continued)

**Table 43 (continued)**
**Cholesterol programs[1]: ways program staff helped respondents by respondent characteristics**

| Characteristic | Program staff helped learn ways to lower cholesterol | | | Program staff helped set goals to lower cholesterol | | | Program staff helped deal with problems reaching goals | | |
|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | Row % | | | Row % | | |
| | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] |
| Employment status[3] | | | | | | | | | |
| Employed full-time | 95.7 | 4.3 | 0.864 | 95.7 | 4.3 | 0.713 | 91.3 | 8.7 | 0.910 |
| Employed part-time | 97.4 | 2.6 | 0.736 | 94.6 | 5.4 | 0.879 | 89.6 | 10.4 | 0.749 |
| Employed, not specified whether full-time or part-time | 100.0 | 0.0 | 0.696 | 100.0 | 0.0 | 0.627 | 100.0 | 0.0 | 0.615 |
| Unemployed and looking for work | 97.6 | 2.4 | 0.568 | 91.0 | 9.0 | 0.474 | 88.4 | 11.6 | 0.663 |
| Unemployed, not specified whether looking for work | 80.0 | 20.0 | 0.048** | 80.0 | 20.0 | 0.185 | 80.0 | 20.0 | 0.398 |
| Student | 87.5 | 12.5 | 0.056* | 87.5 | 12.5 | 0.278 | 87.5 | 12.5 | 0.659 |
| Homemaker | 95.9 | 4.1 | 0.827 | 93.8 | 6.2 | 0.939 | 89.0 | 11.0 | 0.831 |
| Retired | 100.0 | 0.0 | 0.142 | 96.5 | 3.5 | 0.521 | 96.5 | 3.5 | 0.174 |
| Receiving disability or supplemental security income | 96.4 | 3.6 | 0.914 | 93.3 | 6.7 | 0.974 | 88.7 | 11.3 | 0.709 |
| Other employment status | 91.3 | 8.7 | 0.189 | 90.9 | 9.1 | 0.551 | 90.9 | 9.1 | 0.965 |
| Race[4] | | | | | | | | | |
| American Indian or Alaska Native | 100.0 | 0.0 | 0.279 | 92.5 | 7.5 | 0.531 | 85.0 | 15.0 | 0.619 |
| Asian | 100.0 | 0.0 | 0.437 | 86.7 | 13.3 | 0.256 | 86.7 | 13.3 | 0.641 |
| Black or African American | 97.8 | 2.2 | 0.158 | 95.6 | 4.4 | 0.182 | 93.4 | 6.6 | 0.066* |
| Native Hawaiian or Other Pacific Islander | 100.0 | 0.0 | 0.600 | 100.0 | 0.0 | 0.487 | 100.0 | 0.0 | 0.415 |
| White | 93.3 | 6.7 | 0.015** | 91.7 | 8.3 | 0.188 | 83.8 | 16.2 | 0.016** |
| Ethnicity | | | | | | | | | |
| Hispanic or Latino | 98.9 | 1.1 | 0.185 | 96.3 | 3.7 | 0.119 | 92.8 | 7.2 | 0.279 |
| Not Hispanic or Latino | 95.7 | 4.3 | | 92.9 | 7.1 | | 89.0 | 11.0 | |

(continued)

**Table 43 (continued)**
**Cholesterol programs[1]: ways program staff helped respondents by respondent characteristics**

| Characteristic | Program staff helped learn ways to lower cholesterol | | | Program staff helped set goals to lower cholesterol | | | Program staff helped deal with problems reaching goals | | |
|---|---|---|---|---|---|---|---|---|---|
| | Row % | | | Row % | | | Row % | | |
| | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] | Yes | No | *p*-value[2] |
| Received help completing survey | | | | | | | | | |
| Yes | 97.6 | 2.4 | 0.209 | 97.6 | 2.4 | 0.095* | 96.3 | 3.7 | 0.103 |
| No | 93.9 | 6.1 | | 92.1 | 7.9 | | 89.7 | 10.3 | |

* $p < 0.10$

** $p < 0.05$

[1] The health issue focus of the program was self-reported by respondents; respondents could select multiple health issues.

[2] Chi-square tests are reported.

[3] Respondents could select multiple types of employment (e.g., employed part-time and student). Each row displays the percentage responding "yes" for the specific type of employment, and each *p*-value compares "yes" versus "no" for the specific type of employment.

[4] Respondents could select multiple races. Each row displays the percentage responding "yes" for the specific race, and each
*p*-value compares "yes" versus "no" for the specific race.

Note: This table presents weighted descriptive analyses and unweighted bivariate statistical analyses.

### 6.5.7 Summary of Findings

Overall, respondents were satisfied with the program and with accessibility of program activities and staff. They also reported that the program had helped them to make positive changes to improve their health. The findings suggest that females and racial and ethnic minorities may be somewhat more satisfied with the program. For example, a higher percentage of non-whites strongly agreed that incentives helped them set goals, work toward goals, and make positive changes in their life than whites. Future research should explore the possibility that participation in incentive-based chronic disease prevention programs may be particularly effective for encouraging special populations to modify their behaviors and make healthier choices.

We plan to conduct additional subgroup analyses and also multivariate analyses using logistic regression models. Specifically, we will estimate models of overall satisfaction and selected other outcomes that include multiple predictors. These analyses will identify which individual and program-level characteristics are associated with key outcomes of interest while controlling for potential confounding factors. Final survey results will be presented in the Final Evaluation Report.

## 6.6 Selected Findings from Hawaii State Survey

As noted above, RTI did not administer the cross-State beneficiary survey in Hawaii because at least one-third of the program participants do not speak either English or Spanish. A number of the questions are the same or similar to questions included in the cross-State beneficiary survey.

Hawaii administers a survey annually. The methodology differs from the cross-State beneficiary survey. Staff at the FQHCs participating in the MIPCD distribute the questionnaires to program participants within a specified 2-week period; staff are available to provide translations and reading and writing assistance with the survey. More than half (55 percent) of participants said someone had helped them complete the survey, much higher than in the cross-State survey (19 percent). A total of 147 program participants completed the Hawaii State survey in 2014. Selected findings are presented below.

*Overview of Survey Respondents*

The mean age of Hawaii survey respondents was 55 years, and 57 percent of respondents were female (see ***Table 44***). In terms of race, the majority were Native Hawaiian or other Pacific Islander (about 63 percent) followed by Asian (about 15 percent) and two or more races (about 12 percent).

In terms of education, the highest proportion of respondents (44 percent) had a high school degree or equivalent, and about 28 percent had less than a high school degree. About 13 percent were employed full- or part-time, and another 27 percent were unemployed and looking for work. Just over one-quarter of participants reported that they were unable to work.

*Overall Satisfaction*

The respondents rated the program highly, with an average rating of 9.6 on a 10-point scale. Almost three-quarters of respondents considered it the best program possible (i.e., score of 10). Ninety-six percent indicated they were very satisfied with the overall program, and 97 percent would definitely recommend it to their families and friends. Additionally, 98 percent of the respondents said they definitely would like to see the program continue beyond the program ending date of December 2015.

*Satisfaction with Program Accessibility*

Most participants had good experiences with access to the program in terms of getting started right away (99 percent), time spent on the program (99 percent), convenience of the program schedule (98 percent) and location (98 percent), as well as getting help with language (93 percent), child care (63 percent of those who needed child care), and transportation needs (94 percent of those who needed transportation) (see ***Table 45***). About 93 percent said the program staff spoke their language.

**Table 44**
**Hawaii State survey: respondent characteristics**

| Characteristic | Percent (%) |
|---|---|
| Race (n=144) | |
| American Indian or Alaska Native | 0.0 |
| Asian | 14.6 |
| Black or African American | 2.8 |
| Native Hawaiian or Other Pacific Islander | 62.5 |
| White | 8.3 |
| Two or more races | 11.8 |
| Ethnicity (n=144) | |
| Hispanic | 9.9 |
| Not-Hispanic | 90.1 |
| Marital status (n=138) | |
| Now married or living with a partner | 31.2 |
| Widowed | 14.5 |
| Divorced | 12.3 |
| Separated | 10.1 |
| Never married | 31.9 |
| Education (n=136) | |
| 8th grade or less | 13.2 |
| Some high school, but did not graduate | 14.7 |
| High school graduate or GED | 44.1 |
| Some college or 2-year college degree | 19.1 |
| 4-year college degree | 1.5 |
| More than 4-year college degree | 7.4 |
| Employment (n=144) | |
| Employed full-time | 7.6 |
| Employed part-time | 5.6 |
| Unemployed and looking for work | 27.1 |
| Student | 1.4 |
| Homemaker | 6.3 |
| Retired | 18.1 |
| Unable to work | 25.7 |
| Other | 9.0 |

**Table 45**
**Hawaii State survey: program accessibility**

| Question | N | Percent (%) | | |
|---|---|---|---|---|
| | | Yes | No | Not needed |
| a. I was able to start the program as soon as I wanted. | 140 | 98.6 | 1.4 | N/A |
| b. The amount of time I spent on the program was about right. | 139 | 98.6 | 1.4 | N/A |
| c. The program schedule was convenient for me. | 142 | 97.9 | 2.1 | N/A |
| d. The program location was convenient for me. | 139 | 97.8 | 2.2 | N/A |
| e. The program staff spoke my language. | 140 | 92.9 | 7.1 | N/A |
| f. I was able to get child care when I needed it to attend the program. | 138 | 13.8 | 8.0 | 78.3 |
| g. I was able to get transportation when I needed it to attend the program. | 136 | 47.1 | 2.9 | 50.0 |

*Satisfaction with Program Rewards*[14]

Almost all respondents agreed or strongly agreed that they were happy with the rewards (97 percent) and liked getting rewards for taking care of their diabetes (96 percent) (***Table 46***). More than 90 percent of respondents strongly agree or agreed that they were happy with the amount (95 percent) and frequency (93 percent) of the rewards. They also felt that the rewards helped them set goals in diabetes management (95 percent strongly agree/agree) and make positive changes in their lives (95 percent strongly/agree). Almost all respondents strongly agreed or agreed that the rewards were fair (99 percent) and were easy to use (98 percent). However, about 11 percent of the respondents strongly disagreed or disagreed that the rewards were given to them on time and the rewards were easy to get. In addition, about 10 percent of respondents strongly agreed or agreed with the statement "Rewards DO NOT help me take care of my diabetes."

[14] The Hawaii program uses the term "rewards" rather than "incentives."

**Table 46**
**Hawaii state survey: satisfaction with program rewards**

| | N | % Strongly agree (4) | Agree (3) | Disagree (2) | Strongly disagree (1) | Mean (SD) |
|---|---|---|---|---|---|---|
| 1. I am happy with the rewards. | 132 | 80.3 | 16.7 | 0.0 | 3.0 | 3.74 (.61) |
| 2. Rewards were given to me on time. | 131 | 62.6 | 26.0 | 8.4 | 3.1 | 3.48 (.79) |
| 3. Rewards have helped me set goals and work toward them. | 130 | 66.2 | 29.2 | 2.3 | 2.3 | 3.59 (.66) |
| 4. Rewards have helped me make positive changes in my life. | 130 | 67.7 | 27.7 | 3.1 | 1.5 | 3.62 (.63) |
| 5. I like getting rewards for taking good care of my diabetes. | 130 | 70.8 | 25.4 | 1.5 | 2.3 | 3.65 (.63) |
| 6. Rewards DO NOT help me take care of my diabetes. | 123 | 4.9 | 4.9 | 29.3 | 61.0 | 1.54 (.80) |
| 7. I am happy with the dollar amount of each reward. | 130 | 60.8 | 34.6 | 3.1 | 1.5 | 3.55 (.64) |
| 8. I am happy with how often I got the rewards. | 128 | 64.8 | 28.1 | 4.7 | 2.3 | 3.56 (.70) |
| 9. It was easy for me to get the rewards. | 126 | 49.2 | 39.7 | 8.7 | 2.4 | 3.36 (.74) |
| 10. It was easy for me to use the rewards. | 128 | 68.8 | 29.7 | 0.0 | 1.6 | 3.66 (.57) |
| 11. The rewards were fair. | 129 | 65.9 | 31.8 | 0.8 | 1.6 | 3.62 (.59) |

Note: Q6 was reverse coded in calculating the overall mean.

Overall, findings for the Hawaii State survey indicate a very high level of program satisfaction. The proportion of respondents stating they are very satisfied with the program was higher than in the cross-State survey (96 percent vs. 66 percent), and the percentage saying they would definitely recommend the program to others was also higher (97 percent vs. 74 percent).

Satisfaction with program accessibility was similar to the cross-State survey, with more than 90 percent of respondents in the Hawaii and cross-State survey agreeing that the program started as soon as they wanted, the program schedule was convenient, the program location was convenient, and the program staff spoke their language.

Satisfaction with the incentives was also generally similar in Hawaii compared with the cross-State survey. The majority of respondents strongly agreed that they liked getting incentives for taking good care of their health (72 percent Hawaii and 78 percent cross-State), that the incentives helped them set goals and work toward them (67 percent Hawaii and 64

percent cross-State), and incentives helped them make positive changes in their life (69 percent Hawaii and 64 percent cross-State).

In comparing the Hawaii and cross-State survey findings, it is important to note that there are differences in survey administration (e.g., more of the Hawaii respondents had assistance), and some questions and responses were phrased and presented differently.

## 6.7 Synthesis of Focus Group and Survey Findings

The participant survey and focus groups were designed to complement each other by providing quantitative data about the participants' experiences and satisfaction with different aspects of the program and in-depth qualitative information that provides the "story" of their experiences with the program.

*Overall Satisfaction*

Both the focus groups and survey found a high level of overall satisfaction with the program. About 94 percent of survey respondents were very or somewhat satisfied with the program and about 96 percent said would definitely or probably recommend the program to family or friends. The focus groups provided insights into the reasons for this high level of satisfaction, including enthusiasm about the program staff and how the program had helped them make positive changes in their lives (e.g., losing weight, quitting smoking, exercising). For participants in group-based programs, many appreciated the social interaction and group support as well as the individual support from the program staff.

*Program Accessibility*

In general, participants found the programs to be very accessible. More than 90 percent of participants agreed with various measures of accessibility. More than 80 percent of survey respondents said they were always or usually able to contact program staff when they wanted to (about 82 percent) and get the help they wanted from program staff (about 85 percent).

The focus groups provided insights into the kinds of access barriers that some participants encountered, primarily with the in-person (vs. telephonic) programs. A limited number of participants faced transportation barriers and others found the times and locations of program activities to be inconvenient and wanted more flexibility and options. Participants in telephone programs (e.g., tobacco helplines) generally did not report access issues and appreciated that they could reach telephone counselors when they wanted and from the convenience of home.

*Incentives*

Overall, participants expressed satisfaction with the incentives and felt the incentives helped them to make positive changes in their lives. About 95 percent of survey participants strongly or somewhat agreed that they liked getting incentives for taking good care of their health, and about 90 percent strongly or somewhat agreed that the incentives helped them set goals and work toward them and helped them make positive changes. The focus groups provide additional insight into the role of incentives. Incentives seem to be particularly important in

getting people started in the program. Once participants are enrolled and engaged in the program and begin to see health benefits, the importance of incentives seems to diminish somewhat. Nevertheless, providing incentives for ongoing participation does seem beneficial in terms of participant retention. The focus groups also highlight the importance of providing incentives in a timely manner and making the process for getting incentives as easy as possible.

*Relationships with Program Staff*

The survey asked about participants' communication with program staff. Overall, about three-quarters or more of respondents strongly agreed that program staff communicated well (explained things in a way they can understand, listened carefully to them, encouraged questions) and seemed to care about them as a person. The focus group findings highlight the importance of participants developing a strong relationship with the program staff (whether a health coach, diabetes educator, or other). Participants appreciated when the staff made an effort to get to know them personally and demonstrated genuine care and concern about the participant's health.

The participant survey and focus groups overall are consistent in findings concerning the participants' high level of satisfaction with the program and specifically with accessibility, incentives, and communication with program staff.

*[This page intentionally left blank.]*

# SECTION 7
# ADMINISTRATIVE COSTS

Administrative costs—and, more broadly, overall program costs—are likely to be a major concern for policy makers considering whether to adopt or expand a Medicaid incentives program. Section 4108 of the Affordable Care Act requires the independent evaluator to determine the "administrative costs incurred by State agencies that are responsible for administration of the program."

In our assessment, we examined the relationship between administrative costs and other key components of MIPCD program costs, including incentive payments and services provided by the programs. We considered the following questions:

- How much does it cost to operate an MIPCD program?
- What share of costs are administrative costs, and what shares go for incentives and program services? Have the relative shares changed over time?
- Are there additional costs of the programs that were not covered by the CMS awards? How significant are in-kind contributions?

Answering these questions will provide a comprehensive understanding of the true costs of operating an MIPCD program. Ultimately, information on program costs can be combined with data on the impact of the programs on Medicaid spending to compute a return on investment. Because the programs are not yet showing a clear effect on Medicaid spending and because program costs are not yet complete, it is premature to include a return on investment calculation in this report. We will include a return on investment estimate in the Final Evaluation Report.

## 7.1 Background and Methods

Although Section 4108 of the Affordable Care Act requires the assessment of administrative costs, the legislation did not define administrative costs or set a limit on the administrative costs for the program. As part of its announcement for the MIPCD funding opportunity, CMS partially defined administrative costs by examples that included "key personnel; MIPCD travel, training, outreach and marketing; IT infrastructure to accommodate the MIPCD reporting requirements; and completing the satisfaction survey requirements" (CMS, 2011, p. 10). The announcement stated that administrative costs should not exceed 15 percent of each grant award, but CMS subsequently allowed States to exceed 15 percent with appropriate justification.

We generally followed CMS' definition of administrative costs and used several data sources to assess administrative and overall program costs, including States' initial budgets, operational protocols, and financial forms required for reimbursement and the MIPCD Minimum Data Set (MDS). In addition, we developed an Administrative Costs Form that States were asked to fill out voluntarily. This one-page form was filled out separately for Year 1 (September 13, 2011, to September 12, 2012), Year 2 (September 13, 2012, to September12, 2013), and Year 3 (September 13, 2013, to September 12, 2014) of the MIPCD award period.

The Administrative Costs Form divides costs funded by the MIPCD grant into three categories: incentives, services, and administrative costs. The Administrative Costs Form also tracks in-kind contributions, which are costs of the incentive programs that are not covered by the MIPCD grant. These cost components are described in further detail below.

1. **Incentive costs** are defined as the amount paid out of the MIPCD grant to fund MIPCD incentives to beneficiaries. Examples of incentive costs are cash incentives, flexible health accounts, gift cards, or incentive vendors' contracts. For States that give beneficiaries a flexible health account, services purchased through the account are counted as incentive payments. For example, if a beneficiary in Texas uses his/her flexible wellness account to purchase a gym membership or Weight Watchers program, this is counted as an incentive payment. However, if the State directly purchases the gym membership or Weight Watchers program, this is counted as a service.

2. **Service costs** represent the costs of providing services to beneficiaries. Services are an integral part of most MIPCD programs and may represent the cost of a quitline, NRT, breathalyzer testing, gym memberships, or Weight Watchers memberships (if these are paid directly by the State or its agent and not through a flexible wellness account). If a staff member provides programmatic MIPCD services and does not work directly for the MIPCD Grantee (he/she is a contractor or works for a partner organization), this person's salary and benefits can be included in the services category. Examples of staff in this category include health mentors, patient navigators, or peer counselors. However, if a staff member works for the MIPCD Grantee, his/her salary and benefits are included in the administrative costs personnel category.

3. **Administrative costs** include the costs of personnel, training, outreach and marketing, data systems, evaluation, satisfaction survey, and other costs not defined in the above categories.

   Personnel costs represent the amount paid in salaries and fringe benefits to MIPCD Grantee staff in return for work done on the MIPCD project. The salaries and benefits of partner organization and contractor staff are instead recorded under the category of work they are contracted to do. For example, if a contractor is hired to conduct an evaluation for MIPCD or if a contractor is hired to provide motivational interviewing training, their salary is recorded under evaluation and under training, respectively.

   Outreach and marketing costs may include the cost of patient recruitment materials, a telephone recruitment service, or program advertisements, but they do not include incentives for retaining participants. Some MIPCD State programs administer their own satisfaction surveys. Examples of satisfaction survey costs incurred include mailing, telephone, or survey design costs. Other types of administrative costs that are not described in the above categories include travel, IT infrastructure, materials/supplies, quarterly reports, or indirect costs.

4. Some programs may benefit from **in-kind** personnel contributions. For example, a Medicaid Director who spends 5 percent of his/her time on the MIPCD program but is not paid out of MIPCD grant funds would be counted as in-kind cost. Other in-kind contributions are the value of administrative resources (e.g., training, outreach and marketing, travel, IT, evaluation, materials/supplies, indirect costs) used for MIPCD program activities but not paid for directly by the MIPCD grant. In addition, if the program receives donations of gym memberships or memberships in a weight loss program, we asked the Grantees to provide their best estimates even if these contributions are not explicitly tracked. From an economic perspective, in-kind costs represent true opportunity costs of implementing and operating an incentives program. Another State considering implementation would need to find the resources to cover the in-kind costs.

## 7.2 Findings

State award budgets ranged from $634,510 to $10 million for the 5-year project period (***Table 47***). Montana had the lowest budget; its program has the lowest expected enrollment, and the State was able to leverage an existing grant from the Centers for Disease Control and Prevention (CDC) to provide a diabetes prevention program. Nevada had the second lowest award ($3.6 million), whereas the other eight States received awards of $9.2 to $10 million.

**Table 47**
**State award amounts**

| State | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 | Total |
|---|---|---|---|---|---|---|
| California | $1,414,478 | $2,241,544 | $2,530,847 | $2,692,968 | $1,119,525 | $9,999,363 |
| Connecticut | $730,578 | $1,533,236 | $2,781,041 | $3,345,281 | $1,606,092 | $9,996,228 |
| Hawaii | $1,559,985 | $2,236,422 | $2,462,752 | $2,575,917 | $1,101,922 | $9,936,999 |
| Minnesota | $1,015,076 | $1,615,420 | $3,491,269 | $3,488,453 | $388,152 | $9,998,370 |
| Montana | $111,791 | $133,176 | $133,328 | $134,766 | $121,449 | $634,510 |
| Nevada | $415,606 | $1,116,138 | $1,115,738 | $699,290 | $218,539 | $3,565,311 |
| New Hampshire | $1,663,466 | $2,382,242 | $2,435,269 | $2,455,238 | $1,048,742 | $9,984,957 |
| New York | $2,000,000 | $2,000,000 | $2,000,000 | $2,000,000 | $2,000,000 | $10,000,000 |
| Texas | $2,753,130 | $2,354,465 | $2,354,464 | $2,354,465 | $87,232 | $9,903,756 |
| Wisconsin | $2,298,906 | $2,537,544 | $2,478,568 | $1,779,117 | $146,478 | $9,240,613 |

Source: State proposals and operational protocols

As noted previously, the initial announcement for the MIPCD funding announcement stated that administrative costs should not exceed 15 percent of each grant award, but CMS subsequently allowed States to exceed 15 percent with appropriate justification. Four States submitted budgets and received awards with expected administrative costs exceeding 15 percent; the remaining States had budgeted administrative costs between 14.8 percent and 15.0 percent.

States generally spent less than expected in Year 1 of their projects, as described in their quarterly reports. Expenditures were less than expected because projects started slower than planned, enrollment (and therefore incentive and service payments) did not begin as soon as expected, and some expenses were incurred but not yet invoiced. The difference between budgeted and actual expenditures in the early years of the program is relevant to administrative costs because a relatively high proportion of administrative costs are upfront, fixed costs that are incurred regardless of enrollment. In contrast, incentive payments and service costs tend to rise proportionally with enrollment. Unspent Year 1 funds were carried over to subsequent years.

As of July 2015, seven States had returned the Administrative Costs Form for Years 1 through 3. In four cases (***Table 48***), we received both financial reports used for CMS reimbursement (SF 425 forms) and Administrative Costs Forms. On the Administrative Costs Form, some States included costs incurred but not yet invoiced, whereas the SF 425 form only includes costs that were incurred and invoiced. This difference complicates comparison of estimates between the two forms.

**Table 48**
**Responses to the Administrative Costs Form Years 1–3 to date**

| State | Administrative Costs Form | Financial report[1] |
|---|---|---|
| California | ✓ | ✓ |
| Connecticut | ✓ | — |
| Hawaii | ✓ | — |
| Minnesota | — | ✓ |
| Montana | ✓ | ✓ |
| Nevada | ✓ | ✓ |
| New Hampshire | ✓ | — |
| New York | — | — |
| Texas | ✓ | ✓ |
| Wisconsin | — | ✓ |

[1] Financial reports available for all 3 years for California only; for all other States, only available for Year 1.

***Table 49*** outlines some of the main differences across States in terms of target conditions, program enrollment, total expenditure, and the amount of incentives distributed. Because of these differences, it is challenging to compare costs and cost components across States. While most MIPCD programs focus on weight loss/diabetes or smoking cessation, a number of programs also address other chronic conditions or target vulnerable populations, requiring different test, counseling, and retention approaches.

**Table 49**
**Structural differences by type of program, target group and health condition, and type and amount of incentive**

| State | Target condition(s) | Type of program/aim | Cumulative participants (MDS up to 9/30/2014) | Cumulative costs (up to 9/12/2014 from Administrative Costs Forms) | Cumulative incentive costs (up to 9/12/2014 from Administrative Costs Forms) | Cumulative payments to participants (MDS up to 9/30/2014) | Cumulative service costs (up to 9/12/2014 from Administrative Costs Forms) | Estimated administrative costs |
|---|---|---|---|---|---|---|---|---|
| California | T, D | Smoking cessation | 6,643 | $6,161,597 | $4,633,490 | $93,278 | — | $1,528,107 |
| Connecticut | T | Smoking cessation for pregnant women and people with serious mental illness | 1,595 | $1,945,396 | $74,342 | $34,320 | $316,820 | $1,554,234 |
| Hawaii | T, D | Improve early detection, self-management of diabetes | 1,766 | $5,825,755 | $3,639,516 | $114,989 | $2,186,239 | $0 |
| Minnesota | D | Diabetes prevention through weight loss | 720 | $1,796,981* | NR | $134,000 | NR | NR |
| Montana | D, O, CH, BP | Diabetes prevention through 7% weight loss in 10 months and maintaining it over time | 224 | $333,127 | $19,455 | $11,075 | — | $313,672 |
| Nevada | D, O, CH, BP | Three components: weight management, dyslipidemia, hypertension, and hyperinsulinemia among children between 7 and 18; diabetes and weight management among adults; diabetes prevention among adults who are overweight or obese | 958 | $634,295 | $430,886 | $194,573 | — | $203,409 |
| New Hampshire | CVD, T | Smoking cessation and weight loss for people with mental illness | 1,503 | $4,738,051 | $266,798 | $469,898 | $3,799,465 | $671,788 |
| New York | T, D | Smoking cessation and diabetes prevention | 438 | NR | NR | $63,916 | NR | NR |

(continued)

**Table 49 (continued)**
**Structural differences by type of program, target group and health condition, and type and amount of incentive**

| State | Target condition(s) | Type of program/aim | Cumulative participants (MDS up to 9/30/2014) | Cumulative costs (up to 9/12/2014 from Administrative Costs Forms) | Cumulative incentive costs (up to 9/12/2014 from Administrative Costs Forms) | Cumulative payments to participants (MDS up to 9/30/2014) | Cumulative service costs (up to 9/12/2014 from Administrative Costs Forms) | Estimated administrative costs |
|---|---|---|---|---|---|---|---|---|
| Texas | T, D, O, CH, BP | Improved health self-management, use of preventive services, and more appropriate use of health care services for SSI beneficiaries with behavioral health diagnoses | 1,666 | $5,825,846 | $1,079,294 | $882,588 | $2,432,835 | $2,313,717 |
| Wisconsin | T | Smoking cessation | 1,593 | $3,162,895 [1] | NR | $180,490 | NR | NR |
| Totals (all States) | | | 17,106 | $30,423,943 | $10,143,781 | $2,179,127 | $8,735,359 | $6,584,927 |
| Totals (7 States responding to Administrative Costs Form) | | | 14,355 | $25,464,067 | $10,143,781 | $1,800,721 | $8,735,359 | $6,584,927 |

Note: BP = hypertension, CH = hyperlipidemia, CVD= cardiovascular disease, D = diabetes management or prevention, MDS = Minimum Data Set, NR = not reported, O = obesity, SSI = Supplemental Security Income, T = smoking cessation/tobacco use.

[1] As reported in State quarterly reports.

Table 49 shows the cumulative enrollment by State using data from the MDS corresponding to the date of the third year of administrative costs reported. Column 5 shows the monetary amounts participants received as incentives, also based on the MDS. Often, the MDS amounts represent a small percentage of the total amount of incentives reported on the Administrative Costs Form, which include other non-monetary benefits (e.g., transportation, gym membership, child care). In California and Hawaii, participants receive approximately 3 percent or less in direct payments, based on the MDS compared with the total incentive amounts reported by the States on the Administrative Costs Form over 3 years. It is worth noting that the end date for Year 3 in the Administrative Costs Form, September 12, 2014 (the end of the third year of the grant), does not coincide exactly with the end of the nearest MDS quarter, September 30, 2014. Therefore, the period for incentives reported on the Administrative Costs Form does not exactly correspond to the period reported in the MDS. Beyond the difference in periods, the incentive amounts reported on the MDS and the Administrative Costs Form do not always appear to be comparable. First, because some States included costs incurred but not invoiced, their incentive amounts may exceed those based on the MDS. Second, despite the Administrative Costs Form's instructions, some respondents had difficulty distinguishing between incentives and services. For example, California considers NRT kits to be part of its incentive for participants and included NRT costs as an incentive on the Administrative Costs Form. Subject to these issues, the MDS probably provides the most consistent estimate across States of the incentive amounts actually paid to participants.

We estimated administrative costs as the difference between total costs and the sum of incentive and service costs, as reported on the Administrative Costs Form. Given the differences in reporting between States, the sum of incentive and services costs may be more comparable across States than either incentive costs or services costs alone. Even here, there are some differences in reporting across States. For example, Hawaii reported that all of its costs were spent on incentives and services.

Despite the limitations of the data, the totals row in Table 41 reveals several important insights. First, incentive payments, as measured by the MDS, account for a relatively small share of overall MIPCD spending. Second, reported service costs account for one-third of total program costs, and service costs are probably understated in California and Nevada, which report no service costs, and in Hawaii, where incentive costs reported on the Administrative Costs Form are much higher than the MDS incentive costs. The high spending on services underscores the important role of services within the MIPCD programs. In all of the States except Hawaii and Texas, participants in both the incentive and the control groups receive services, but only participants in the incentive group receive incentives. Third, across the States that responded to the Administrative Costs Form, estimated administrative costs accounted for about 25 percent of total reported costs (the share would be even higher if Hawaii's actual administrative costs were included, rather than the estimated 0 percent). Fourth, although not shown in the table, incentive and service costs as a share of total costs are higher in Years 2 and 3 for most State programs, as shown in ***Sections 7.2.1*** through ***7.2.7***. This trend is likely to continue in Years 4 and 5 of the program, because most States are experiencing increasing enrollment and will provide more incentive payments and services. In addition, as more participants complete their programs, they are eligible to receive incentives tied to program outcomes. This may increase the share of costs for incentive payments. Together, these factors suggest that administrative costs are likely to decline as a share of total payments as the programs near completion.

In the sections that follow, we provide detailed results for the seven States that completed the Administrative Costs Form.

The following sections summarize by State the information presented in Table 41 for Years 1 (September 13, 2011, to September 12, 2012), 2 (September 13, 2012 to September 12, 2013), and 3 (September 13, 2013 to September 12, 2014). We group service and incentive costs in a single category because these are conceptually similar.

### 7.2.1 California

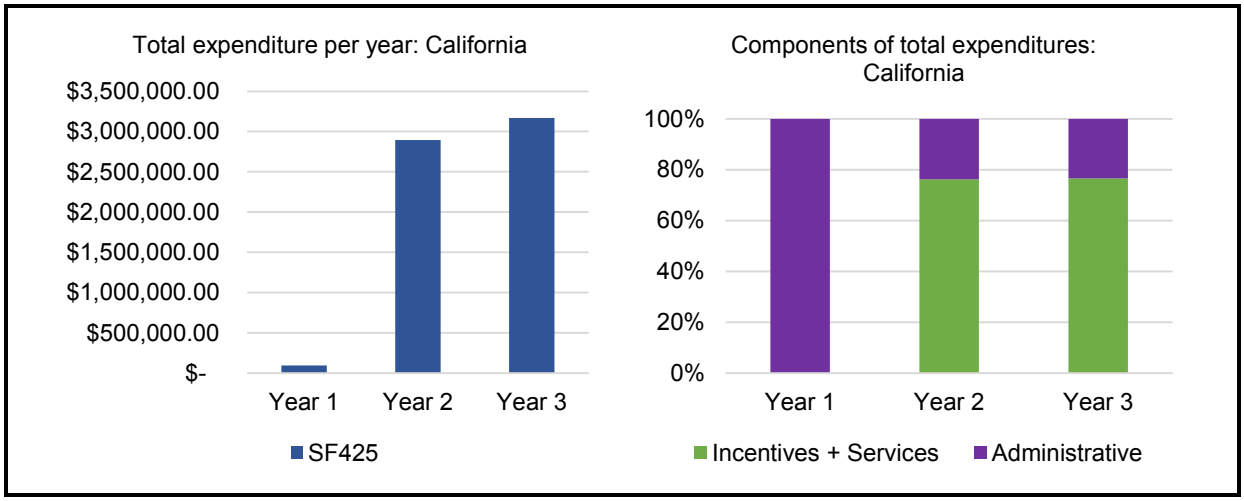
- California reported SF 425 figures. Consequently, reported Year 1 costs represent lower amounts than were actually incurred because some invoices had not been filed by the end of the grant year.

- California did not report service costs, only incentive costs. These average $1.5 million over 3 years. Reported incentives included counseling sessions and nicotine patches.

- In Year 1, California enrolled 913 participants and therefore incurred incentive costs, but these were recorded with a lag. In Years 2 and 3, enrollment tripled. Across all 3 years under consideration, incentives and services represent 75 percent of total expenditures. Administrative costs account for the remaining 25 percent.

- ***Figure 14*** presents reported total and component annual expenditures for California.

**Figure 14**
**Annual expenditures and components: California**



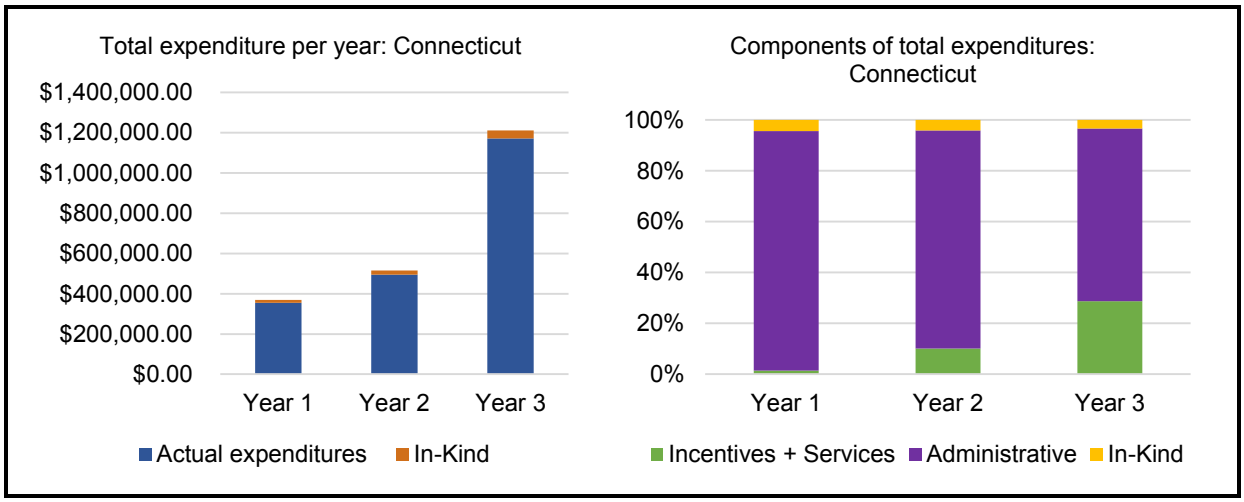
### 7.2.2 Connecticut

- Connecticut reported actual expenditures incurred in the time periods requested. For example, for Year 1, the State reported $62,955.03 in the SF 425 but reported $338,810.50, including contractors' incurred expenditures, in the Administrative Costs Form. Overall, however, the actual expenditure report over 3 years was much lower than the amount received ($2,020,690 versus $4,833,088).

- Administrative costs are higher than the 15 percent suggested in the solicitation due to a complex program design and partnership with Yale University. Connecticut had delays in enrolling participants into the program, and no beneficiaries were enrolled in Year 1. Therefore, there were no incentive or service costs in that year.

- Connecticut is one of two States reporting in-kind costs. In-kind costs represent on average 3.7 percent of total costs. These contributions include personnel and indirect expenses for the Department's staff; the Hispanic Health Council, which provided a reduced indirect rate for focus group administration; and Yale University, which provided a lower evaluation rate than its usual rate. ***Figure 15*** presents reported total and component annual expenditures for Connecticut.

**Figure 15**
**Annual expenditures and components: Connecticut**




### 7.2.3 Hawaii

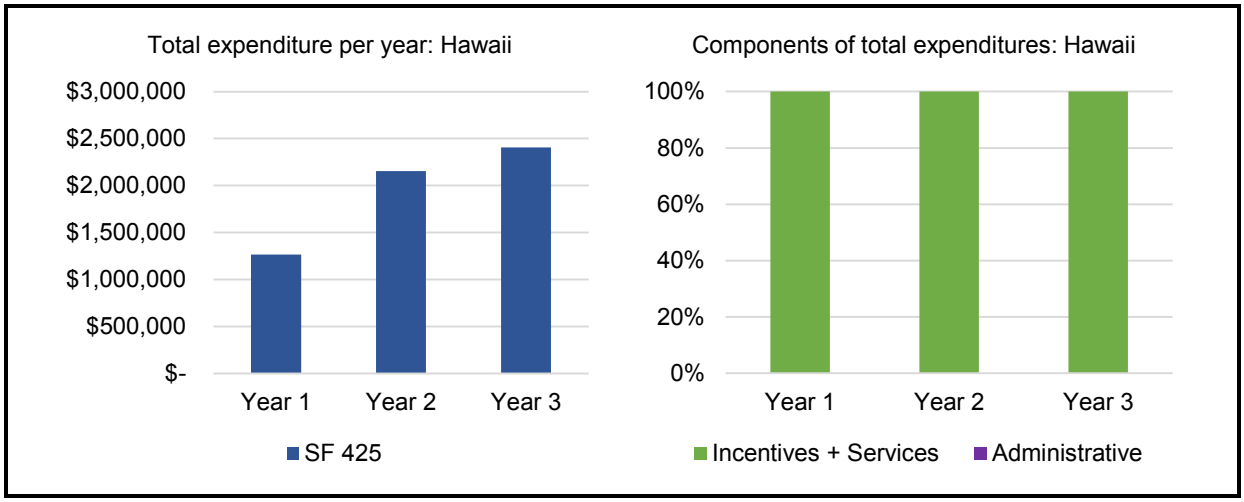
- All of Hawaii's grant was reported to be spent on incentives and service: 62.5 percent in incentives and 37.5 percent in services. This does not mean, however, that the program has no administrative costs. The State of Hawaii Department of Human Services (DHS) works in close partnership with the University of Hawaii at Manoa (UH) John A. Burns School of Medicine, the Center on Disability Studies at UH, and Federally Qualified Health Centers (FQHCs). FQHCs enroll patients using

using community outreach, flyers, community health worker referral, etc. FQHCs are also responsible for hiring staff and producing quarterly reports. Private providers are responsible for enrolling participants and producing quarterly reports. In future reports, we will ask Hawaii to provide an estimate of these in-kind contributions.

- At the end of Year 1, Hawaii had not yet enrolled participants; thus, no costs were incurred. Incentive and services numbers during this period reflect the original CMS approved budget. The entire Year 1 budget was approved as a carryover to Year 2 due to the delay of a fully executed contract. Charges were submitted to DHS from UH, but no funds were drawn down from the CMS account for Year 1.

- ***Figure 16*** presents reported total and component annual expenditures for Hawaii.

**Figure 16**
**Annual expenditures and components: Hawaii**




### 7.2.4 Montana

- Unlike the other reporting States, which reported an increased pattern of expenditures over time, Montana reported a stable pattern over time. The State has provided actual costs incurred rather than SF 425 amounts. Over 3 years, the State of Montana received and spent $333,127.29 in funding from CMS.

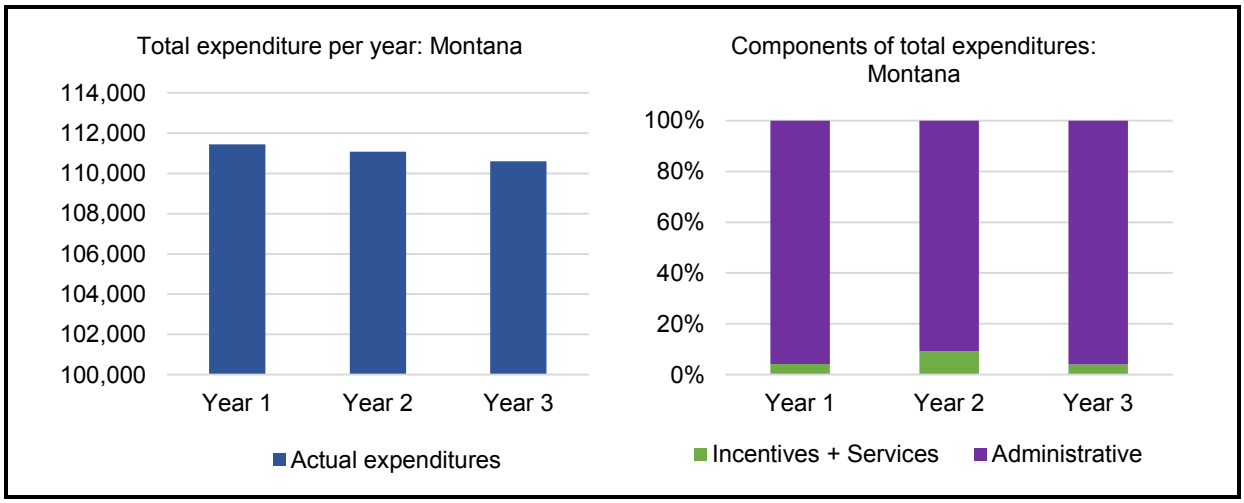
- From additional State materials, we know that the State received significant in-kind contributions, estimated at around $650,000. For example, the diabetes prevention program, salaries, evaluation, and traveling were funded by CDC or through State funding rather than through CMS funding.

- Taking into account the additional in-kind contributions, Montana's 10-month weight loss program would still be the second least expensive program, after Nevada.

- Similar to Connecticut, administrative costs represent the bulk of the program's expenditures.

- ***Figure 17*** presents reported total and component annual expenditures for Montana.

**Figure 17**
**Annual expenditures and components: Montana**




### 7.2.5 New Hampshire

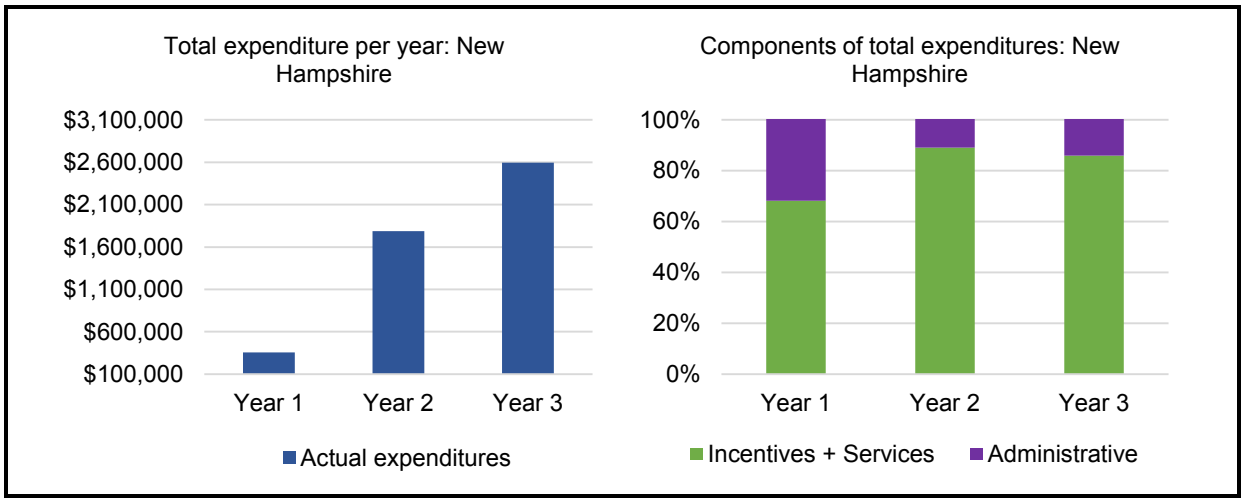
- In Year 1 of the program, the only grant expense that was incurred was reimbursement for the contingency management expert consultant's time and travel expenses to New Hampshire.

- In the next 2 years, expenditures included salaries for grant staff, incentive payments to participants, and project supplies. Grant services have been used by most or all of the active participants in the State's programs. Grant service utilization includes use of local fitness facilities, attendance at local Weight Watchers meetings, meetings with In SHAPE fitness trainers, use of transportation resources offered by the grant at the local community mental health centers, use of the electronic decision support system, and receipt of telephone cognitive behavioral therapy for smoking cessation.

- After Year 1, administrative costs have fallen below the 15% threshold of total expenditure (11% and 14%, in years 2 and 3 respectively).

- ***Figure 18*** presents reported total and component annual expenditures for New Hampshire.

**Figure 18**
**Annual expenditures and components: New Hampshire**



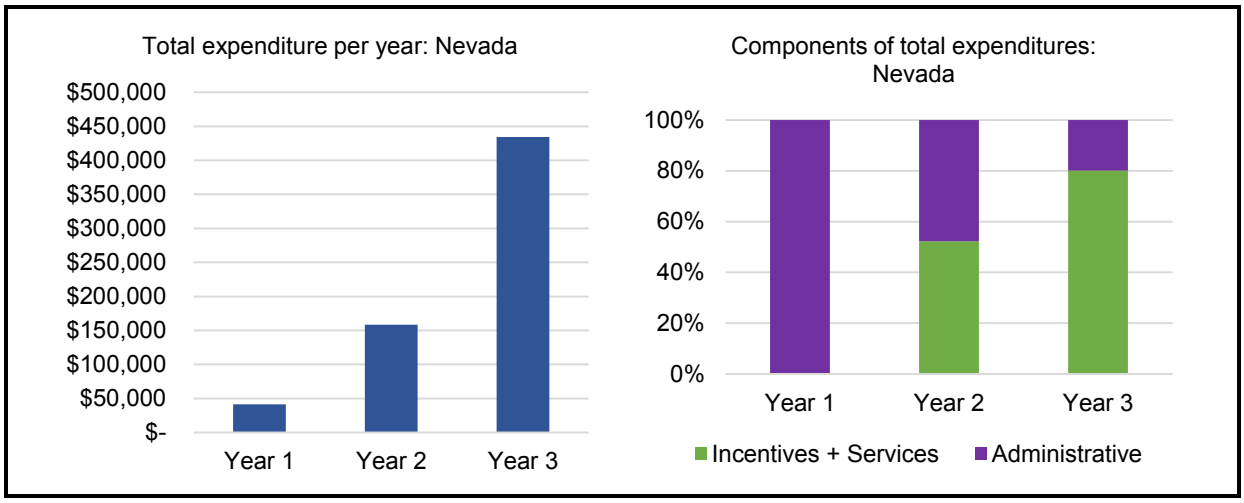

### 7.2.6 Nevada

- Nevada has provided actual costs incurred rather than SF 425 amounts. According to the financial forms, the cumulative cost total in Years 1 and 2 was $1,531,744.00, while in the Administrative Costs Forms approximately $200,000 was reported during the same period. This indicates that Nevada has incurred lower costs than anticipated.

- Nevada pays participants both for process and results. In Year 1, despite 200 enrolled beneficiaries, no payments were made to participants. The participants enrolled may not have become eligible for incentive payments by the end of the year.

- ***Figure 19*** presents reported total and component annual expenditures for Nevada.

**Figure 19**
**Annual expenditures and components: Nevada**




### 7.2.7 Texas

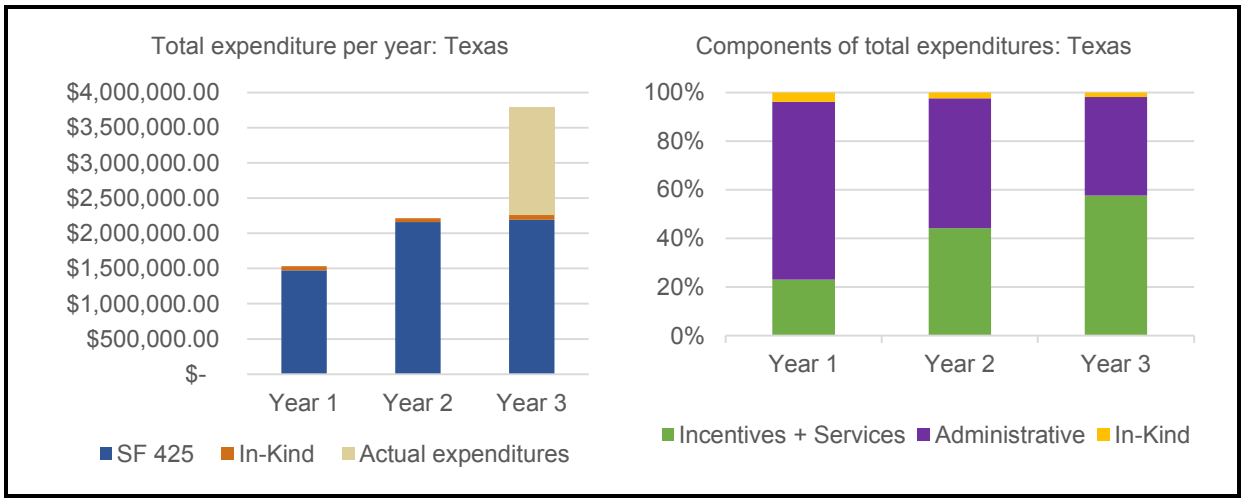
- Texas reports actual expenditures. In Years 1 and 2, SF 425 and actual expenditures are the same. In Year 3, the State incurred $1,526,024 in additional costs that were not reported in the SF 425.

- In-kind contributions represent roughly 3 percent of total costs.

- The fraction of incentive costs increases over time from 20 percent to 60 percent. Administrative costs, however, remain high. Texas, for example, administers its own survey.

- ***Figure 20*** presents reported total and component annual expenditures for Texas.

**Figure 20**
**Annual expenditures and components: Texas**




## 7.3 Summary

We estimate that administrative costs accounted for about 25 percent of overall expenditures in MIPCD programs during the first three years. This estimate comes with a number of caveats because the cost data are not reported uniformly across States and only 7 of the 10 States provided the information necessary for estimating administrative costs. More importantly, the administrative cost share of total costs fell in Years 2 and 3 as enrollment in the programs increased. That trend is likely to continue in Years 4 and 5 of the program. Therefore, over the full 5-year period, administrative costs may account for less than 25 percent of total costs. We will obtain additional data and report on administrative costs for the full 5-year period in our Final Evaluation Report.

Looking at costs more broadly, States spent about $2.2 million on incentive payments to participants during the first 3 years, representing about 7 percent of total costs. There are several reasons why incentive payments are relatively low. First, most States planned to spend significant amounts to provide services as integral parts of their program. For example, California provides NRT, New Hampshire pays for gym memberships and Weight Watchers. Texas provides patient navigators, and several States pay for diabetes prevention programs. In some cases, States consider the services as part of the incentive provided to participants, and these services are also usually provided to participants in the control group who do not receive cash incentives. Second, delays in implementation and enrollment have slowed incentive payments. Most States spent less in total than they budgeted in Year 1 of their programs, and spending on incentives was correspondingly lower than budgeted. As enrollment continues to increase in Years 4 and 5 of the programs, incentives may account for a greater share of overall program costs. Third, some participants have not completed participation and may receive additional incentives before or shortly after completion. This is especially true of outcome incentives, which are paid to participants who achieve behavioral outcomes, such as weight loss or reductions in tobacco use. Fourth, it appears likely that some States initially overestimated the

amount that would be paid as incentives to participants. Several of the States revised their initial estimates of enrollment downward; if fewer persons participate and incentive payments per person are fixed, total incentive payments also fall.

In the Final Evaluation Report, we will estimate the return on investment in each program. This estimate will account for the cost of the program (including administrative costs, incentive payments, and service costs) and any reductions in Medicaid spending attributable to the program. The cost impacts will also be evaluated alongside the health benefits achieved by the program. It is premature to estimate program return on investment at this time, because the impact of prevention of chronic diseases may accrue slowly over time and not be manifest in the short-term. Moreover, we do not yet have data on changes in health outcomes that would precede long-term savings in spending.

*[This page intentionally left blank.]*

# SECTION 8
# SUMMARY AND DISCUSSION

Under authority of Section 4108 of the Affordable Care Act, 10 States have implemented MIPCD programs. As part of the Act, Congress mandated this independent evaluation of the programs' impact on the use of health care services, participation by special populations, beneficiary satisfaction, and administrative costs. In addition, each State is required to evaluate the impact of its program on participants' outcomes. This report includes the findings of our independent evaluation through November 15, 2015. The MIPCD programs continued to serve participants and provide incentives through December 31, 2015. Our evaluation will continue through the end of the incentive period and beyond, to incorporate State evaluations and analyze the full claims histories of participants. Our Final Evaluation Report will be completed by February 1, 2017.

As described in Section 3, States have demonstrated that they are able to design and implement incentive programs for Medicaid beneficiaries. This is a basic but important accomplishment because incentive programs have rarely been implemented by Medicaid plans in the past (Blumenthal et al., 2013). Implementation was not always straightforward, and some States experienced delays in implementation. Nevertheless, all of the States were eventually able to implement their programs and begin enrolling participants. Their experiences may offer valuable lessons learned for other States considering implementation of incentive programs. Some of the States experienced challenges in Medicaid recruiting participants and providers for the programs. These challenges are not unique for prevention programs, and States responded by increasing their recruitment enrollment efforts. In several cases, States lowered their enrollment targets.

Special populations, including adults with disabilities, adults with chronic diseases, and children with special needs, appear able to participate in Medicaid incentive programs. Two States focused on persons with behavioral health or substance use disorders, and most others served adults with disabilities; all of the States focused on adults with or at risk of chronic diseases; and one State's largest program arm focused on children.

Once enrolled, we found that beneficiaries were very satisfied with the accessibility and quality of the MIPCD programs (***Section 6***). Across all States, 94 percent of participants were very or somewhat satisfied with the programs, and about 74 percent said they would recommend the program to their friends or families. Similarly, participants found the programs to be very accessible. With regards to the objective of preventing chronic disease, participants thought the programs helped them make healthy changes in their behavior. Not surprisingly, participants liked receiving incentives, but they thought that the impact of the incentives was strongest in encouraging them to enroll in the program and less important later when improving health became a more important motivator.

We estimated that administrative costs represented about 25 percent of overall program expenditures through the first 3 years of the program (***Section 7***). Administrative costs may decline in Years 4 and 5 of the program as enrollment increases. States spent about $2.2 million on incentive payments to participants during the first 3 years, representing about 7 percent of

total costs. Several factors account for this relatively low percentage: States planned to spend significant amounts on services as integral parts of their programs, delays in enrollment slowed incentive payments, many participants have not yet completed participation and therefore have not qualified for all of their incentives, and some States likely overestimated the amount that would be paid in incentives. As the evaluation continues, we will examine whether the share of costs for administrative costs declines and the share of costs for incentives increases.

The largest remaining unresolved questions have to do with the effects of Medicaid incentive programs on utilization, expenditures, and—perhaps most importantly—health outcomes. To date, the claims analysis in Section 4 has found that the incentive programs have statistically insignificant effects on utilization and expenditures. However, the claims data are not complete, and even if the incentives prevent chronic diseases, the effects of prevention on utilization and expenditures may not be apparent in the short term. From the analysis of the MIPCD MDS, we found that the incentives have led to significant increases in process measures, such as tobacco cessation counseling visits and diabetes prevention classes attended, but only limited information is available on health outcomes, such as smoking quits or weight loss. The overall objective of the MIPCD programs is to improve these outcomes, which in turn are associated with the prevention of chronic disease. With limited information on health outcomes, it is not yet possible to assess whether the MIPCD programs will succeed in preventing chronic disease. The State program evaluations will examine health outcomes in detail, and we will include these findings in our Final Evaluation Report.

The first Report to Congress concluded that, at that time, there was insufficient evidence to recommend for or against extending funding for MIPCD programs beyond January 1, 2016. Since that report, we have collected extensive evidence on the State MIPCD programs through site visits, focus groups, a beneficiary survey, claims and MDS analyses, and a review of State program documents. As described above, this evidence clearly shows that States have been able to implement Medicaid incentive programs successfully, participants are very satisfied with the programs' quality and accessibility, and the programs are able to serve special populations of interest. However, because the impacts of the MIPCD programs on utilization, expenditures, and health outcomes are unresolved, we believe at this time that there is still insufficient evidence for or against recommending that funding should be expanded for Medicaid incentive programs. We will focus on assessing these impacts as our evaluation continues and more information becomes available.

## REFERENCES

Blumenthal, K. J., Saulsgiver, K. A., Norton, L., Troxel, A. B., Anarella, J. P., Gesten, F. C., Chernew, M. E., & Volpp, K. G. (2013). Medicaid incentive programs to encourage healthy behavior show mixed results to date and should be studied and improved. *Health Affairs*, *32*(3), 497–507.

Centers for Medicare & Medicaid Services (CMS), Center for Strategic Planning. (2011, February 23). Patient Protection and Affordable Care Act. Section 4108: Medicaid Incentives for Prevention of Chronic Diseases (MIPCD). Initial Announcement. Funding Opportunity Number: CMS-1B1-11-001. CFDA 93.536. Retrieved from http://innovation.cms.gov/Files/fact-sheet/MIPCD-Funding-Opportunity-Announcement.pdf

*[This page intentionally left blank.]*

# APPENDIX A:
# 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 control trial (RCT 1) |
| Total Enrollment Year 2 (10/2012–9/2013) | 3,815 enrolled in RCT 1: 1,003 in the control group, 2,812 in intervention groups |
| Total Enrollment Year 3 (10/2013–9/2014) | 3,815 total enrolled in RCT 1: 1,003 in the control group, 2,812 in intervention groups |
| Total Enrollment Year 4, Quarter 1 (10/2014–12/2014) | 3,815 total enrolled in RCT 1: 1,003 in the control group,2,812 in the intervention groups |
| Total Enrollment Year 4, Quarter 2 (1/2015–3/2015) | 3,815 total enrolled in RCT 1: 1,003 in the control group, 2,812 in the intervention groups |
| Total Enrollment Year 4, Quarter 3 (4/2015–6/2015) | 3,815 total enrolled in RCT 1: 1,003 in the control group, 2,812 in the intervention groups |
| Implementation Date/Projected Implementation Date | Pilot began March 19, 2012. |
| Implementation as a Pilot? | Yes, statewide rollout began on July 9, 2012. |

| State | | California |
|---|---|---|
| Duration of Program Arms | | Enrollment comes from Callers to the Helpline. There are two RCTs.<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 was conducted from July 2012 through May 2013.<br><br>RCT 2 is focused on reengagement and includes eight groups:<br>• Groups 1–4 receive NRT patches that are not advertised and incentives that range from $0 to $40 depending on the group.<br>• Groups 5–8 receive a letter advertising the NRT 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, half of participants will receive two re-engagement letters spaced 2 weeks apart, while the other half will receive a single letter.<br>Recruitment for RCT 2 (the re-engagement trial) began in May 2015. The study was expected to begin in August 2015, depending on whether enrollment goals will be met within that time frame. |
| # 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 Use 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>Individuals with mental health and substance use disorders |
| # Targeted Patients – Total and By Experimental and Control Group(s) | | 9,000 total: 7,350 for experimental group(s) and 1,650 for control group(s) |

| State | | California |
|---|---|---|
| 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 RCT will be in English and Spanish only. People with a different primary language will receive services but will not be included in the randomized trial.<br>• Spanish 1.2% |
| 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 |
| 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: Maximum study incentive: $60 |

| State | | California |
|---|---|---|
| **Description of Incentives for Eligible Beneficiaries** | | • $20 gift card incentive (Wal-Mart, Target, Vons/Safeway, and Ralphs/Kroger) (when requested by participant) to call the Helpline, complete the intake protocol, and participate in initial counseling session<br>• Free NRT patches by calling the Helpline<br>• $10 gift card for every counseling call completed up to $40 (in one RCT 1 intervention group)<br>• $10–$40 gift card (depending upon intervention group) to reengage participants who did not quit or who relapsed (in RCT 2)<br>• Enhanced services available to non-RCT participants from December 2014 through April 2015 that includes free NRT patches and $10 for completing follow-up counseling sessions, up to $60 |
| **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>• RCT 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 B:
# 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 (10/2012–9/2013)** | 138 |
| **Total Enrollment Year 3 (10/2013–9/2014)** | 1,795 |
| **Total Enrollment Year 4, Quarter 1 (10/2014–12/2014)** | 2,557 |
| **Total Enrollment Year 4, Quarter 2 (1/2015–3/2015)** | 3,121 |
| **Total Enrollment Year 4, Quarter 3 (4/2015–6/2015)** | 4,022 |
| **Implementation Date/Projected Implementation Date** | Launched program in March 2013; began enrolling in April 2013 |
| **Implementation as a Pilot?** | No |
| **Duration of Program Arms** | **Years 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. Switched to live callers and limited face-to-face follow-up surveys due to problems with robocall, causing some delay in schedule. Added a $30 incentive for intervention and control participants for completion of the 3- and 12-month follow-up surveys.<br>High and low incentives reinstituted in Year 4. To ensure enough enrollees, the program was shortened from 1 year to 6 months (exception for pregnant women). |

| State | | Connecticut |
|---|---|---|
| **Duration of Program Arms (continued)** | | 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 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. |
| **# 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 Use 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)** | | 6,210 total: 3,105 for experimental group(s) and 3,105 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. |

| 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 CT 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), and<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 |
| | **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 (Peer Coaching) |

| State | Connecticut |
|---|---|
| **Maximum Incentive Amount in Dollars** | $350 per 12-month enrollment period (max two enrollment periods per person)<br><br>Selected clinical sites have a different incentive structure:<br>High Process group maximum = $480; High Outcome group maximum = $482 |
| **Description of Incentives for Eligible Beneficiaries** | In most sites, the incentive structure is as follows:<br>• $5 to smokers for each counseling visit (maximum 10)<br>• $50 smokers for each call to the Quitline (maximum 10)<br>• $15 bonus 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 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.<br>• Selected sites instituted high process or high outcomes incentives as of November 2015. In the high process sites, participants receive a higher level of incentives for participating in individual or group counseling or calling the Quitline; in the high outcome sites, participants receive higher incentives for negative breathalyzer CO costs.<br><br>High Outcome:<br>• $5 for each counseling visit (maximum 10)<br>• $5 for each Quitline call (maximum 10)<br>• $15 bonus for completing 5 counseling sessions or calls (maximum two)<br>• $22 for a negative CO breathalyzer test (maximum 12)<br>• $22 bonus for three consecutive tobacco-free CO tests (maximum four)<br><br>High Process:<br>• $10 for each counseling visit (maximum 10)<br>• $10 for each Quitline call (maximum 10)<br>• $30 bonus for completing 5 counseling sessions or 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) |

| State | | Connecticut |
|---|---|---|
| **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. $30 incentive for providers to complete survey with participants face to face. |
| **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** | | Revised incentive structure to Intervention group participants at certain provider sites. High process enrollees will earn higher incentive amounts for individual and/or group counseling services and Quitline services. High outcomes enrollees will earn higher incentive amounts for negative CO breathalyzer test results. Seven provider sites were randomized to high process or high outcome condition.<br>R2Q obtains outcome data from the 3- and 12-month follow-up surveys.<br>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>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. |

| State | Connecticut |
|---|---|
| **Description of Evaluation Design (continued)** | Analysis will include the following:<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 |
| **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<br><br>Refined outcome measures: (1) intervention initiation, (2) intervention engagement, (3) intervention prevalence, (4) quit rate, (5) quit maintenance, (6) other smoking-related health care utilization, (7) health care costs |

# APPENDIX C:
# 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>• Federally Qualified Health Centers (FQHCs)<br>• Kaiser Permanente<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 (10/2012–9/2013)** | | 437 total enrolled: 437 in intervention group, 0 in control group |
| **Total Enrollment Year 3 (10/2013–9/2014)** | | 1,755 total enrolled: 1,693 in intervention, 62 in control group |
| **Total Enrollment Year 4, Quarter 1 (10/2014–12/2014)** | | 2,268 total enrolled: 2,118 in intervention group, 150 in control group |
| **Total Enrollment Year 4, Quarter 2 (1/2015–3/2015)** | | 2,340 total enrolled: 2,180 in intervention group, 160 in control group |
| **Total Enrollment Year 4, Quarter 3 (4/2015–6/2015)** | | 2,340 total enrolled: 2,180 in intervention group, 160 in control group |
| **Implementation Date/Projected Implementation Date** | | February 2013 |
| **Implementation as a Pilot?** | | No |
| **Duration of Program Arms** | | 9 FQHCs in Years 1–4; 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 self-management of diabetes, which can include smoking cessation, behavioral health education, weight management, cholesterol, and blood pressure control. |

| 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 mental illness has been added to Hawaii's survey, so it will be possible to identify this population). |
| | Those with Substance Use Disorders | No (although not specifically targeting this population, an additional question on substance use 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 or 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 |
| # Targeted Patients – Total and By Experimental and Control Group(s) | | 1,400 total: 1,200 for intervention group(s) and 200 for the control group |
| Languages | Languages spoken by program participants | Approximately 10 languages other than English, Filipino (Ilocano and Tagalog), Samoan, Tongan, Micronesian (e.g., Chuukese, Marshallese), 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. |
| 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. |

| State | Hawaii |
|---|---|
| **Type of Medicaid Population** | Managed care enrollees only. Immigrants from the Compact of Freely Associated (COFA) states were impacted by the U.S. Supreme Court decision concerning health care for immigrant populations and were removed from the Medicaid program as of February 2015. The majority of COFA immigrants were to transition to coverage under the Affordable Care Act (ACA), while those who are blind, aged, and disabled will be provided with "Medicaid like" benefits by the State, but can no longer participate in MIPCD. |
| **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 the following:<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. |

| 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 | FQHCs determine the form of incentive (e.g., gift certificate, fee for gym membership, exercise classes, massage). FQHCs can adjust incentive amounts up to $50 or lower based on cost of living increases. |
| Maximum Incentive Amount in Dollars | | $320 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>• 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)<br>• Annual incentives not to exceed $320 per participant |
| 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 |

| State | | Hawaii |
|---|---|---|
| Evaluation Design(s) | Quasi-Experimental Design | Yes |
| | Randomized Controlled Trial | Yes, with Kaiser Permanente. |
| | Equipoise-Stratified Randomization | No |
| | Crossover Design | No |
| | 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<br>• HI implemented a randomized controlled trial with Kaiser Permanente. |
| 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>• Increase 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. |

# APPENDIX D:
# 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 (10/2012–9/2013)** | | 193 |
| **Total Enrollment Year 3 (10/2013–9/2014)** | | 796 |
| **Total Enrollment Year 4, Quarter 1 (10/2014–12/2014)** | | 890 |
| **Total Enrollment Year 4, Quarter 2 (1/2015–3/2015)** | | 919 |
| **Total Enrollment Year 4, Quarter 3 (4/2015–6/2015)** | | 957 |
| **Implementation Date / Projected Implementation Date** | | Implemented in November 2012 with five clinics and expanded to 24 clinics made up of 13 organizations. |
| **Implementation as a Pilot?** | | No |
| **Duration of Program Arms** | | >12 months for the control, individual incentives, and individual plus group incentive arms.<br>The post-core sessions held in 2015 will be biweekly vs. monthly to allow more participants to be enrolled and participate before the program ends. |
| **# Conditions** | | 2 |
| **Conditions** | **Smoking** | No |
| | **Diabetes** | Yes |
| | **Obesity** | Yes |
| | **Hyperlipidemia** | No |
| | **Hypertension** | No |
| | **Other** | No |

| State | | Minnesota |
|---|---|---|
| Special Populations Examined | Homeless/Housing Instable Populations | No |
| | Food Insecure Populations | No |
| | Those with Mental Illness | No |
| | Those with Substance Use 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 |
| 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. | In May 2015, it was reported that the primary language was Somali for 18%, Hmong for 3%, Spanish for .32%, other for 1% of participants. Primary language data were missing for 12% of participants. |
| 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 |

| State | | Minnesota |
|---|---|---|
| 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 |
| | 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 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 |

| State | | Minnesota |
|---|---|---|
| **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. Some clinic coordinators have also been providing incentives to providers and other staff to help increase participant referrals. Strategies being used include the following:<br>• Small gift cards and/or token gifts for the provider/staff that refers the most participants<br>• Giveaways (e.g., mugs, water bottles, calendars) with study logo on it<br>• Snacks for staff provided every time a clinic is able to start a class |
| **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 |
| **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; and<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 E:
# 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 12 health care facilities delivering the intervention statewide<br>• University of North Dakota<br>• Northwest Resource Consultants<br>• US Bank |
| **1st Year Grant Award** | | $111,788 |
| **Total Enrollment Year 1 (9/2011–9/2012)** | | 110 |
| **Total Enrollment Year 2 (10/2012–9/2013)** | | 150 |
| **Total Enrollment Year 3 (10/2013–9/2014)** | | 234 |
| **Total Enrollment Year 4, Quarter 1 (10/2014–12/2014)** | | 235 |
| **Total Enrollment Year 4, Quarter 2 (1/2015–3/2015)** | | 258 |
| **Total Enrollment Year 4, Quarter 3 (4/2015–6/2015)** | | 261 |
| **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>13 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 |

| State | | Montana |
|---|---|---|
| Special Populations Examined | Homeless/Housing Instable Populations | No |
| | Food Insecure Populations | No |
| | Those with Mental Illness | No, but a large percentage of the population happens to suffer from intellectual disabilities. |
| | Those with Substance Use 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 aged 18 or 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. |
| Type of Medicaid Population | | • Adults aged 18 or 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). |

| State | | Montana |
|---|---|---|
| **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 |
| **Incentives for Eligible Beneficiaries (continued)** | **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, and<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 |
| **Maximum Incentive Amount in Dollars** | | $315 annually |

| State | | Montana |
|---|---|---|
| **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.<br>• Starting in January 2014, the providers that are distributing incentives will no longer do so, whereas those not currently distributing incentives will begin to do so. |
| **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 |

| State | Montana |
|---|---|
| **Description of Evaluation Design** | • A crossover design will be used to evaluate 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).<br>• MT developed a survey administered to lifestyle coaches to learn about their experiences recruiting, enrolling, and providing coaching to the Medicaid beneficiaries who participated in the program. The survey instrument included questions on the lifestyle coach's professional background, recruitment and enrollment of participants, delivery of the lifestyle curriculum, use of the self-monitoring tool, provision of incentives, additional training, and technical assistance. |
| **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-month follow-up. |

# APPENDIX F:
# NEVADA

| State | Nevada |
|---|---|
| **State Abbreviation** | NV |
| **Project Title** | Nevada Healthy Choices |
| **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 (Note: As a result of financial difficulties, Lied Clinic Outpatient Facility closed for business on October 1, 2014. Therefore, this arm of the study has been terminated.)<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 (10/2012–9/2013)** | 507 |
| **Total Enrollment Year 3 (10/2013–9/2014)** | 1,504 |
| **Total Enrollment Year 4, Quarter 1 (10/2014–12/2014)** | 1,801 |
| **Total Enrollment Year 4, Quarter 2 (1/2015–3/2015)** | 1,840 |
| **Total Enrollment Year 4, Quarter 3 (4/2015–6/2015)** | 1,840 |
| **Implementation Date / Projected Implementation Date** | • NV is implementing staggered enrollment of participants in the five programs.<br>• Children's Heart Center began enrollment in February 2013.<br>• The YMCA of Southern Nevada launched its web portal in May 2013 and began enrolling participants in October 2013.<br>• UnitedHealthcare began enrolling participants in October 13.<br>• Lied Clinic began enrolling participants in December 2013.<br>• Amerigroup began enrolling participants in June 2014. |
| **Implementation as a Pilot?** | No |

| State | | Nevada |
|---|---|---|
| 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.<br>• 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 |
| Conditions (continued) | 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 Use Disorders | No |
| | Racial/Ethnic Minorities (e.g., Native Americans; Native Hawaiians; Asian Americans; Pacific Islanders) | Yes. A majority of program participants are Latino and, as a result, the program began targeting Latino communities by reaching out to the Latino Chamber of Commerce in Las Vegas, communicating with colleagues who have existing relationships with people in Latino communities, and visiting sites in which potential enrollees are being treated. The program also began targeting Native American communities, but is less optimistic about its ability to do so effectively. |
| | Pregnant Women and Mothers of Newborns | No |
| | Children | Yes |
| | Medicare-Medicaid Enrollees | Yes |

| State | | Nevada |
|---|---|---|
| **Description of Target Population** | | • Amerigroup and UnitedHealthcare: Medicaid beneficiaries with diabetes who are served by NV's Medicaid MCOs<br>• Lied Clinic: Adults diagnosed with diabetes and adults at risk of developing type 2 diabetes who are enrolled in fee-for-service (FFS) Medicaid<br>• Children's Heart Center: Children aged 7 to 18 with elevated BMI, dyslipidemia, hypertension, hyperinsulinemia, or other comorbidity that are enrolled in FFS Medicaid<br>• YMCA of Southern Nevada: Adults aged 18 or older who are overweight or obese, are at risk of developing type 2 diabetes or have pre-diabetes, and are enrolled in FFS Medicaid |
| **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)** | | • 2,000 total: 1,026 for experimental group(s) and 974 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 FFS 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.<br>• 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. |

| 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. |

| 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 maintains a HIPAA compliant, proprietary web-based software application, ValueSys [TM], capable of distributing rewards to Nevada Medicaid and Nevada Check-Up recipients who participate in the MIPCD grant. Program participants have 24/7 access to ValueSys [TM] that enables them to view the program activities for which have participated, view their earned incentive points, and redeem their points using a catalog of rewards. To the extent possible, access to the system will be made available at Program Partners' locations.<br>• Once participants start accumulating points, they can start redeeming them. Participants can view their earned incentive points and redeem their points using a catalog of rewards available on ValueSys [TM], which is accessible from a mobile phone or iPad. Since some participants may not have Internet access, Children's Heart Center also created a catalog worksheet that enables it to order rewards on behalf of participants. To avoid delivery issues, rewards are mailed to and distributed by the Center. Participants select their own rewards to purchase with their points, such as clothing, shoes, workout gear, cookbooks, and gift cards. Currently, NV caps the catalog and only displays rewards up to $400. |
| **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 |

| State | Nevada |
|---|---|
| **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.<br>**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 subtreatment groups within Hypothesis Group 3 that can receive incentives. In the first subgroup, 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.<br>• 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. |

| State | Nevada |
|---|---|
| **Outcomes Examined** | **<u>Outcomes related to Hypothesis 1</u>:**<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>**<u>Outcomes related to Hypothesis 2</u>:**<br>Multivariate analysis will be used to identify the characteristics of people who elect to assign rewards points to goal achievement and maintenance.<br>**<u>Outcomes related to Hypothesis 3</u>:**<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 G:
# 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 (CMHCs)<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 (10/2012–9/2013)** | | 995 total enrolled (725 in the weight management program, 270 in the tobacco cessation program) |
| **Total Enrollment Year 3 (10/2013–9/2014)** | | 1,555 total enrolled (1,085 in the weight management program, 470 in the tobacco cessation program) |
| **Total Enrollment Year 4, Quarter 1 (10/2014–12/2014)** | | 1,765 total enrolled (1,249 in the weight management program, 516 in the tobacco cessation program) |
| **Total Enrollment Year 4, Quarter 2 (1/2015–3/2015)** | | 1,922 total enrolled (1,249 in the weight management program, 516 in the tobacco cessation program) |
| **Total Enrollment Year 4, Quarter 3 (4/2015–6/2015)** | | 2,009 total enrolled (1,365 in the weight management program, 644 in the tobacco cessation program) |
| **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 CMHCs 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 its 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. |
| | **Diabetes** | No |
| | **Obesity** | Yes |
| | **Hyperlipidemia** | No |
| | **Hypertension** | No |
| | **Other** | No |

| State | | New Hampshire |
|---|---|---|
| Special Populations Examined | Homeless/Housing Instable Populations | No |
| | Food Insecure Populations | No |
| | Those with Mental Illness | Yes |
| | Those with Substance Use 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 Healthy Choices, Healthy Changes 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 or (b) have a carbon monoxide level of 8 ppm or higher or urine nicotine level of more than 100 mg/ml; (c) voluntary informed consent for participation in the study by the participant or by the participant's legally designated guardian or conservator; (d) an expressed willingness to learn about smoking |
| Potential Special Populations | | Populations with mental illness who are overweight/obese or regular smokers |
| # 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). |

| State | New Hampshire |
|---|---|
| **Type of Medicaid Population** | Only managed care enrollees are included in the program. |
| **Description of Goals** | The Health Choices, Healthy Changes program targets enrollees with 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 increasing exercise; improving nutrition; increasing smoking cessation to lower blood pressure; reducing weight; reducing cholesterol and blood glucose levels; and modifying other related risk factors for cardiovascular disease. |
| **Description of Activities** | Four Supported Weight Management options:<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)<br>(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 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 $50. For people who express a desire to receive a smoking cessation program, three Supported Smoking Cessation options are available:<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>• In each condition listed above, 50% of participants will be randomized to receive either the program as described or additional rewards. |

| State | | New Hampshire |
|---|---|---|
| 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 |
| | 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 | | Four Supported Weight Management options:<br>Phase I Supported Weight Management: Up to $20/month for each of the four options.<br>Phase II Supported Weight Management: Up to $20/month for each of the four options.<br>• In each of the Weight Management options, 50% of participants will be randomized to receive either the program as described or additional rewards.<br>• All CMHC client smokers who complete the EDSS will receive $50. For people who express a desire to receive a smoking cessation program, three Supported Smoking Cessation options are available.<br>Supported Smoking Cessation options for participants who express interest in quitting smoking following the EDSS. In each of the three Supported Smoking Cessation options, 50% of participants will be randomized to receive either the program as described or additional rewards. |
| 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 | | Clinics that meet their enrollment targets receive a $1,000 incentive. |
| 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. |

| State | | New Hampshire |
|---|---|---|
| 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.<br>**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). |

| State | New Hampshire |
|---|---|
| **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 H:
# 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>• New York City Department of Health and Mental Hygiene, Division of Chronic Diseases<br>• New York State Smoker's Quitline at the Roswell Park Cancer Institute<br>• Nineteen Medicaid Managed Care Plans<br>• New York State Quality and Technical Assistance Center (QTAC)<br>• Hooper Holms |
| **1st Year Grant Award** | $2,000,000 |
| **Total Enrollment Year 1 (9/2011–9/2012)** | 0 |
| **Total Enrollment Year 2 (10/2012–9/2013)** | 9 |
| **Total Enrollment Year 3 (10/2013–9/2014)** | 317 |
| **Total Enrollment Year 4, Quarter 1 (10/2014–12/2014)** | Total: 933<br>Diabetes Prevention: 237 participants enrolled<br>Diabetes Management: 418 participants enrolled<br>Hypertension Management: 278 participants enrolled |
| **Total Enrollment Year 4, Quarter 2 (1/2015–3/2015)** | Total: 1,460<br>Diabetes Prevention: 342 participants enrolled<br>Diabetes Management: 646 participants enrolled<br>Hypertension Management: 472 participants enrolled |
| **Total Enrollment Year 4, Quarter 3 (4/2015–6/2015)** | Total: 3,679<br>Diabetes Prevention: 433 participants enrolled<br>Diabetes Management: 857 participants enrolled<br>Hypertension Management: 696 participants enrolled<br>Smoking Cessation: 1,693 participants enrolled |
| **Implementation Date / Projected Implementation Date** | NY began phase-in implementation in June 2013 with the diabetes prevention program, and they rolled-out the diabetes management program in April 2014 and the hypertension program in July 2014. The smoking cessation program launched in Year 4, Quarter 2 (January–March 2015). |
| **Implementation as a Pilot?** | No |
| **Duration of Program Arms** | • Diabetes prevention: 16-week Diabetes Prevention Program<br>• For the diabetes management, hypertension, and smoking cessation programs, all reward activities and goals must be completed within 7 months after the date the beneficiary agrees to participate. |

| | | |
|---|---|---|
| **State** | | **New York** |
| **# Conditions** | | 3 |
| **Conditions** | **Smoking** | Yes |
| | **Diabetes** | Yes |
| | **Obesity** | No |
| | **Hyperlipidemia** | No |
| | **Hypertension** | Yes |
| | **Other** | No |
| **Special Populations Examined** | **Homeless/Housing Instable Populations** | No |
| | **Food Insecure Populations** | No |
| | **Those with Mental Illness** | No |
| | **Those with Substance Use 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 expected that Spanish speakers will participate, and the DPP has held two classes in Spanish. The also expect 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.** | This percentage cannot be estimated 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 be enrolled in the smoking cessation program. For the diabetes prevention, diabetes management, and blood pressure programs, Medicare-Medicaid enrollees will not be enrolled, but if MIPCD participants become Medicare-Medicaid eligible while participating in the program, they will be allowed to remain in the MIPCD program. |

| | | |
|---|---|---|
| **State** | | **New York** |
| **Type of Medicaid Population** | | Medicaid adults and pregnant women in managed care |
| **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, enrollees will receive a cash incentive for participating in smoking cessation counseling (process measure), filling nicotine replacement therapy prescriptions (process measure), and quitting smoking (outcome measure).<br>• For participants in the blood pressure control program, enrollees will receive a cash incentive for attending primary care appointments (process measure), filling antihypertensive prescriptions (process measure), and decreasing or maintaining a decreased systolic blood pressure by 10mmHg or achieving another clinically appropriate target (outcome measure).<br>• For participants in the diabetes management program, enrollees will receive a cash incentive for attending primary care appointments (process measure), attending diabetes self-management education sessions (process measure), filling diabetes prescriptions (process), and decreasing their HbA1c by 0.6 percent or maintaining a level of 8.0 percent or less (outcome measure).<br>• For participants in the diabetes prevention program, enrollees will receive a cash incentive for attending DPP sessions (process measure) and losing or maintaining a reduced weight (outcome measure). |
| **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 |
| | **Points Redeemable for Rewards** | No |
| | **Unspecified Incentives** | No |
| **Maximum Incentive Amount in Dollars** | | $250 for participants in the intervention; $50 for control group participants |

| State | | New York |
|---|---|---|
| **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>• Incentivized participants will receive cash incentives for meeting process measures, outcome measures, or a combination of process and outcome measures.<br>• The comparison group will receive $50 for initiating some activity, but the group will not receive incentives for meeting process or outcome measures.<br>• The smoking cessation program only has three instead of four incentive schedules; the program has a process, outcome, and control group incentive schedule. It does not have the process plus outcome incentive schedule. |
| **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: DPP attendance<br>• Diabetes management: HbA1c levels, service utilization, Rx fills |

# APPENDIX I:
# 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)<br>• Mental Health Association in Harris County to administer the Wellness Recovery Action Planning (WRAP) program |
| 1st Year Grant Award | | $2,753,130 |
| Total Enrollment Year 1 (9/2011–9/2012) | | 519 total: 262 in intervention group, 257 in control group |
| Total Enrollment Year 2 (10/2012–9/2013) | | 1,251 total: 625 in intervention group and 626 in control group. Enrollment completed by the end of the reporting period. |
| Total Enrollment Year 3 (10/2013–9/2014) | | Enrollment completed in Year 2. |
| Total Enrollment Year 4, Quarter 1 (10/2014–12/2014) | | Enrollment completed in Year 2. |
| Total Enrollment Year 4, Quarter 2 (1/2015–3/2015) | | Enrollment completed in Year 2. |
| Total Enrollment Year 4, Quarter 2 (4/2015–6/2015) | | Enrollment completed in Year 2. |
| 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 3 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 |
| | 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. |

| State | | Texas |
|---|---|---|
| Special Populations Examined | Homeless/Housing Instable Populations | No |
| | Food Insecure Populations | No |
| | Those with Mental Illness | Yes |
| | Those with Substance Use 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 use 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." |
| 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. |

| State | | 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 the following:<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 are offered additional preparation in the form of WRAP to enable them to take full advantage of person-centered wellness planning.<br>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. |
| | **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 |

| State | | Texas |
|---|---|---|
| **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 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)** | | Incentives are provided for retention of control group. |
| **Description of Incentives for Others (e.g., CHCs and Private Providers) – If Not Applicable, Write NA** | | Control group participants receive $20 gift cards for updating contact info on monthly basis and $75 for completing annual survey. |
| **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 the following:<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 |

| State | Texas |
|---|---|
| **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). |
| **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 J:
# 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 (10/2012–9/2013)** | **FB:** 315<br>**WTQL:** 324 |
| **Total Enrollment Year 3 (10/2013–9/2014)** | **FB**: 839 total; 421 in the treatment group and 418 in the control group<br>**WTQL**: 1,122 total; 558 in the treatment group and 564 in the control group |
| **Total Enrollment Year 4, Quarter 1 (10/2014–12/2014)** | **FB**: 839 total; 421 in the treatment group and 418 in the control group<br>**WTQL**: 1,122 total; 558 in the treatment group and 564 in the control group |
| **Total Enrollment Year 4, Quarter 2 (1/2015–3/2015)** | **FB**: 1,050 total; 534 in the treatment group and 516 in the control group<br>**WTQL**: 1,794 total; 896 in the treatment group and 898 in the control group |
| **Total Enrollment Year 4, Quarter 3 (4/2015-6/2015)** | **FB**: 1,052 total; 513 in the treatment group and 518 in the control group<br>**WTQL**: 1,962 total; 979 in the treatment group and 983 in the control group |
| **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. As of July 1, 2014, WI officially transitioned its program from offering 1 year of postpartum services to 6 months in an effort to extend the window of recruitment for the program. 750 were enrolled into the 12-month program and 302 in the 6-month program.<br>**WTQL**: 6 months; WTQL opportunity of enrollment continues through June 2015. Services continue until December 2016. |

| State | | Wisconsin |
|---|---|---|
| # 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 | Yes |
| | Those with Mental Illness | No |
| | Those with Substance Use Disorders | No |
| | Racial/Ethnic Minorities (e.g., Native Americans; Native Hawaiians; Asian Americans; Pacific Islanders) | Yes |
| | Pregnant Women and Mothers of Newborns | Yes, in FB. Not in WTQL. |
| | 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. In Year 4 Quarter 2, there were 124 active FB sites within the STQ regions, which includes 35 counties.<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>• Aged 18 or older<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) |

| State | | Wisconsin |
|---|---|---|
| **Description of Target Population (continued)** | | • 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). |
| **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).<br>• 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. |
| **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.<br>• Tobacco cessation: WI expects adults with QuitLine counseling to achieve an anticipated quit rate of 25 percent and for women enrolled in the FB program to achieve a 36 percent quit rate. Each treatment option in each one of the two programs will have participants who get services and cash incentives and a control group that will receive treatment services only. |
| **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. |

| State | | Wisconsin |
|---|---|---|
| **Description of Activities (continued)** | | • 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.<br>– 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 |
| **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. |

| State | | Wisconsin |
|---|---|---|
| **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>• 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 |
| **Evaluation Design(s)** | **Quasi-Experimental Design** | No |
| | **Randomized Controlled Trial** | Yes |
| | **Equipoise-Stratified Randomization** | No |
| | **Crossover Design** | No |
| | **Cost-Effectiveness Analyses** | Yes |

| State | Wisconsin |
|---|---|
| **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 |