



Beneficiary Incentives in Value-Based Care

What's changed, what works, what's next



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Why this conversation now



Every VBC model launching or updating in 2026-2027 **makes room for beneficiary incentives**

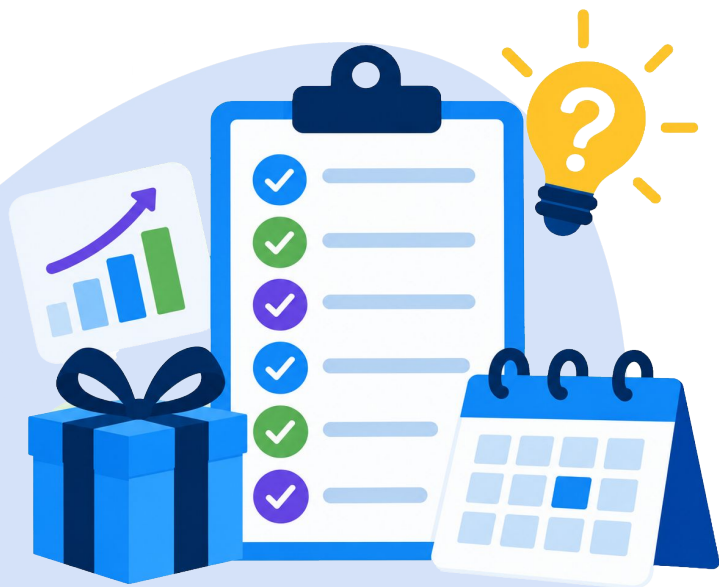


The **safe harbor framework** has caught up with what the models *want*



Yet the industry is still **asking whether incentives are allowed**

What we'll cover



- ✓ The three regulatory pathways
- ✓ What the evidence shows about ROI
- ✓ Engagement-and-rewards as a distinct operational category
- ✓ Where this is hitting the calendar right now
- ✓ What to do next
- ✓ Q&A



Three pathways at a glance



CMS-sponsored model safe harbor

42 CFR 1001.952(ii)(2)

TEAM, KCC, IOTA, REACH, LEAD,
MAHA ELEVATE



ACO Beneficiary Incentive Program

42 CFR 1001.952(kk)

MSSP two-sided risk ACOs

Up to \$20 per qualifying primary
care service



MA Rewards & Incentives

42 CFR 422.134

Medicare Advantage plans

The most flexible of the three, and
the most misunderstood



*Between the three, the design space is **broader** than most compliance teams treat it.*



What compliance teams typically get wrong



MA R&I is more permissive than most treat it.

Closed-loop, health-related retail rewards are allowed. The 2022 Final Rule ruled out only open-loop cash-equivalents.



The CMS-sponsored model safe harbor is not a generic template.

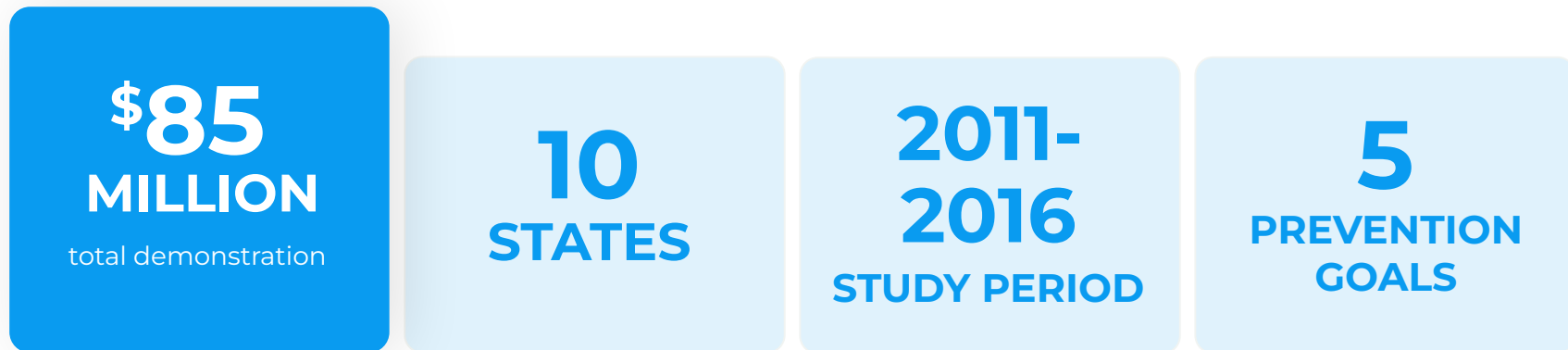
It is defined by the participation documentation. What qualifies as protected varies model to model.



The result: smaller, less effective programs than the regulation permits.



MIPCD in one slide



- **Prevention goals:** tobacco cessation, weight, cholesterol, blood pressure, diabetes prevention and management
- **New York:** \$100 at 3 months plus \$150 at 6 months for BP or HbA1c reductions against defined thresholds
- **California:** statistically significant increase in quit attempts and 30-day abstinence
- Short-term claims-based cost effects mixed; *longer-term utilization impact not ruled out*



What works and what doesn't



Works consistently



Immediate rewards for defined, verifiable behaviors



Clear communication of the incentive and how to earn it



Outcome-linked rewards paired with clinical infrastructure to verify



Fails consistently



Low beneficiary awareness of the program



Delayed rewards or ambiguous qualifying activities



Verification and fulfillment lag measured in weeks



The surprise: communication was the single largest predictor of program performance.



Four places ROI shows up

1

Quality performance

Stars, MSSP quality gates, LEAD quality withhold

2

Utilization avoidance

ED visits, admissions, readmissions

3

Retention and enrollment

MA-specific: AEP switching, voluntary disenrollment

4

Cost trend

Sustained engagement across a member panel



The most common design mistake:
optimizing for one and *missing the other three.*



What credible ROI modeling looks like



Baseline population defined and sized:
chronic condition, risk tier, panel size



Incentive design mapped to a specific behavior with published effect size evidence



Attribution Logic separating incentive effect from concurrent program effects



Total program cost: design, fulfillment, administration, verification, not just reward value



Time horizon appropriate to the behavior



Sensitivity ranges, not point estimates



What engagement-and-rewards requires operationally



Eligibility verification

Who qualifies for what, updated continuously



Activity verification

Proof the behavior actually happened



Incentive fulfillment

Reward delivered, documented, auditable



Audit trail

Defensible under CMS or OIG review



Reporting

Back to CMS on model cadence



Member communication

Multi-channel and sustained

All six. Well enough to hold up under audit.



Why this is not care management, quality reporting, a wellness benefit, or care navigation

CARE MANAGEMENT

Cadence

Episodic, clinical

Population

Clinically defined

Verification

Clinical judgment

QUALITY REPORTING

Cadence

Numerator / denominator

Population

Measure-eligible

Verification

Claims data

WELLNESS BENEFIT

Cadence

Benefit-linked

Population

Enrolled members

Verification

Participation attestation

CARE NAVIGATION

Cadence

Inquiry-driven, reactive

Population

Whoever reaches out

Verification

Request resolved or routed



Engagement-and-rewards runs on a different cadence, across a different population, with different verification requirements. Navigation routes people. Engagement-and-rewards verifies, pays, and documents.



Five design principles



WHERE THIS IS HITTING RIGHT NOW



LEAD ACO: the BEI hiding in plain sight



Chronic Disease Prevention Reward

ACO-funded and safe-harbor protected. Healthy food products tied to engagement in healthy-living activities and evidence-based prevention or management programs.



Medical Nutrition Therapy expansion

Broader coverage for diet-sensitive chronic conditions.



Part D Premium Buydown

Available 2029.



Optional Implementation Period: September 15 to December 31, 2026

Voluntary beneficiary alignment and provider network setup ahead of Performance Year 1, which begins **January 1, 2027**.

WHERE THIS IS HITTING RIGHT NOW



MAHA ELEVATE

3 years

VOLUNTARY MODEL

\$100M

UP TO, ACROSS
RECIPIENTS

30

RECIPIENTS

May 15, 2026

COHORT 1 CLOSED



Cooperative agreement structure, distinct in shape from LEAD



Whole-person functional and lifestyle medicine focus: nutrition, physical activity, restorative sleep, stress management



CMS references the CMS-sponsored model patient incentives safe harbor as available on a per-recipient basis, subject to separately documented guidance



*Applicants proposing whole-person interventions **can integrate compliant incentives, but need to be explicit about the pathway.***

WHERE THIS IS HITTING RIGHT NOW



MA Plan Year 2027 Rewards & Incentives

From marketing accessory to Stars operational lever



Tighter integration with Stars

R&I design mapped directly to quality measure architecture rather than run alongside it.



V28 risk adjustment pressure

Margin compression is driving smarter, more targeted R&I design.



Retention effects measured

AEP switching and voluntary disenrollment effects tracked, not assumed.



R&I is not a new pathway. It has been available since 2011.

What changed is how sophisticated plans are using it.

WHERE THIS IS HITTING RIGHT NOW



State Medicaid: The variation nobody accounts for

Medicaid incentive requirements are set state by state. There is no federal template.

1115 waiver authority

Sets what a state is permitted to do with beneficiary incentives, and for which populations.

MCE contract language

Where the actual obligation lives. Scope, reporting cadence, and audit expectations vary widely by state.

Quality withhold and reinvestment rules

Some states direct earned quality dollars back into member or provider incentives.



Indiana is the one to watch

In the current open procurement, Indiana is the first state to require incentive-based structures of its managed care entities. The unified RFP covers HIP, Hoosier Healthwise, Hoosier Care Connect, and Indiana PathWays for Aging, with contracts effective January 1, 2029.



If a state writes incentives into the contract, engagement-and-rewards stops being a differentiator and becomes a bid requirement.



Five questions for your next VBC strategy meeting

- 1 Which of the three pathways applies across our model participation portfolio?
- 2 Which of the four ROI vectors are we optimizing for, and are we tracking the other three?
- 3 What behaviors have published effect size evidence for our target population?
- 4 What does our operational stack for eligibility, verification, fulfillment, and audit look like today?
- 5 Where does our current program design break the safe harbor constraints, if anywhere?



Bring them to the model portfolio owner, the quality strategy owner, and compliance.
In one room.

WHAT TO DO NEXT

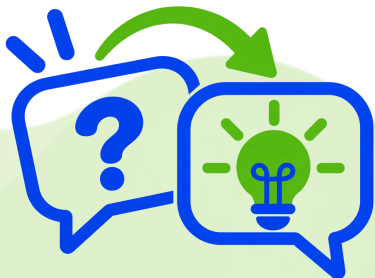


The build-versus-buy question, framed correctly

Narrow framing (the default)

Do we staff up to run engagement-and-rewards internally, or bring in a vendor?

Framed this way, it becomes a hiring question.



VS.

Correct framing

Is engagement-and-rewards a category in which this organization has genuine institutional expertise, or one better addressed through partnership with an organization that already operates in it?

Framed this way, it becomes a capability question.

Neither answer is inherently correct. The narrow framing produces default answers. **The correct framing produces better ones.**

WHAT TO DO NEXT



Where WellRight fits

Engagement-and-rewards infrastructure with natural alignment to VBC operational requirements

What we do

- ✓ Incentive program design
- ✓ Multi-channel engagement across Medicare populations
- ✓ Reward fulfillment and documentation
- ✓ CMS-cadence reporting

What we do not do

- ✗ Risk-bearing
- ✗ EHR functions
- ✗ Medical Nutrition Therapy delivery
- ✗ Care management or clinical workflow replacement

The scope has clear limits. That is part of what makes the fit credible.



Questions

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