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Evaluation of the Local Initiative Rewarding Results Collaborative Demonstrations: Interim Report

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EXECUTIVE SUMMARY

Work to revise payment policies in a way that would better support the delivery of high quality care has gained momentum in recent years after the Institute of Medicine's landmark report, *Crossing the Quality Chasm* (2001), cited it as a necessary change. Although a handful of commercial managed care companies had established physician performance incentives by 2000,[1] such incentives were quite scarce in Medicaid, and no systematic studies had examined their value. This report examines the first known collaborative effort to establish financial incentives within Medicaid among multiple plans with the same objective.

Specifically, the Local Initiative Rewarding Results (LIRR) Collaborative was established in Fall 2002 to implement incentives designed to improve care for low-income children enrolled in California's Medi-Cal and Healthy Families programs.[2] The collaborative, which includes seven "local initiative" low-income-focused health plans in California, is part of the national Rewarding Results demonstration program sponsored by the Robert Wood Johnson Foundation and the California HealthCare Foundation. The demonstration is being administered by the Center for Health Care Strategies, and Mathematica Policy Research (MPR) leads the evaluation. The demonstration and the evaluation are scheduled to run through December 2005.

The report provides an interim assessment of the progress and lessons learned to date under the demonstration. The assessment is based on several data sources. First, the plans are submitting aggregate data three times during the demonstration on the following: the number of physicians and members eligible for incentives, changes in the activities to promote quality that complement the incentives, aggregate payout information, and problems encountered in implementation; this report draws on their first two submissions, which cover the period from the start of their programs through December 2004. The second major data source is the first of two waves of telephone interviews with stakeholders, including key plan executives and staff, and four to six providers in each plan, usually physicians. The interviews were conducted approximately a year after the start of the demonstration. Plan-level HEDIS data is also trended for 2002-2004 and compared with national figures from NCQA. The final report will be based on analyses that draw on these same sources and additional ones including (1) the second wave of interviews with plan and provider stakeholders (2) provider-level data on performance and payout for 2003 through June 2005, and (3) additional aggregate data from plans.

INCENTIVE DESIGN AND IMPLEMENTATION

The incentives under the LIRR Collaborative are designed to improve HEDIS rates for well-baby visits by 15 months, well-adolescent visits, and/or the completeness of encounter data submission. However, the Collaborative plans' incentive designs vary on key dimensions

[1] Early payers using quality incentives include Aetna, Anthem BlueCross BlueShield New Hampshire, and BlueCross BlueShield of Illinois (Bailit Health Purchasing, date unknown).

[2] These are the state's Medicaid managed care and SCHIP programs, respectively.

including whether they address all three of these goals, the mix of provider and member incentives, the performance requirement to receive an incentive payment, the mechanism for demonstrating performance, and other features (Table 1). In most cases, the financial incentives are one part of a larger set of incentives being implemented at the plans. Most of the plans began providing other supports to improve quality along with the incentives during the demonstration period. In particular, five plans began giving providers feedback on their performance, and four began mailing periodic reminders to members needing care. Also, three provided training and technical assistance on encounter data submission, and two began consulting with low-performing providers.

Table 1: Number of Plans Newly Introducing Each Type of Incentive Design

	Well-Baby	Well-Adolescent	Encounter data
Shift risk pool criteria toward quality	1	0	0
Bonus payment for HEDIS-related measures	4	2	1
Member gift certificates	1	0	0
Member movie ticket(s)	0	2	0

Five of the original eight plans in the LIRR Collaborative implemented new incentives; four began between July and December 2003, and one began in July 2004. One of the five plans has substantially strengthened its incentives since that time, and another that had targeted incentives to only a few high-volume providers initially expanded the incentives to a few more. The three plans that did not implement the incentives made that decision for very different reasons. One reportedly withdrew from of the Collaborative because it felt the evaluation data requirements were too burdensome. A second announced a major incentive aimed at improving quality, only to find itself in a major financial crisis, making it necessary to cancel the planned incentive distribution. The third plan decided to try other quality improvement strategies instead.

Through December 2004, $2.6 million in incentives was paid out to providers under the Collaborative. The plans generally aimed to use the incentives to influence well-child care for the vast majority of babies and adolescents in their networks. A total of almost 150,000 children whose care could potentially be improved are served by physicians who were eligible for incentives in 2004. In addition to the provider incentives, about 145,000 adolescents (in two plans) and 56,000 parents of infants (in one plan) were eligible to receive movie tickets or a gift certificate (respectively) if they/their babies received timely well-child visits.

TREND IN HEDIS SCORES 2002-2004

The trend in HEDIS scores among Collaborative plans that implemented incentives is consistent with the idea that the incentives are having an effect, but this type of data is not strong

evidence on its own and will be reinterpreted together with a richer complement of data for the final evaluation report in late 2005. Specifically, the Collaborative plans with incentives that submitted HEDIS data to the evaluation for 2002-2004 showed a steeper upward trend in HEDIS scores relative to the upward trend nationally for the targeted measures (well-baby visits and well-adolescent visits). These plans started below the national average for Medicaid-serving plans; their improvement brought them generally close to the national means for these measures, which leaves considerable room for additional improvement. For calendar year 2004, an average of 48 percent of 15-month-old babies in Medicaid-serving health plans reporting these data nationally had had the recommended six or more well-baby visits. Among the Collaborative plans, the well-baby visit rates had improved to 44 percent, 47 percent, and 74 percent for the three plans with data. For Medicaid children 12 to 21 years old, an average of 38 percent had had a well-visit in the past 12 months nationally. For the same age group, both Collaborative plans with data had improved their rates to 37 percent.

LESSONS TO DATE

Several lessons emerge from the experience of the Collaborative to date.

1. ***Communication is critical.*** Communication with providers about the incentives is critical, since without their awareness of the incentives, there is no response. Awareness could not be systematically assessed from our data, but it appears to be mixed. One plan's incentive method allowed it to identify that in 2004, 55 percent of eligible physicians chose to participate in the well-baby incentive by submitting the documentation to receive a bonus for one or more of their patients. While all of the physicians we interviewed who were closely affiliated with the plan were aware of the incentives around the time they began, several of the community physicians without such ties were either were unaware of the incentive at all or learned about it only a few months before our call, rather than a year earlier when the incentive began. Plan and provider respondents were split in terms of the communication method they believed was required. Two plans believe that face-to-face discussions are essential, while others including some providers felt that sending the message clearly and simply in multiple ways at multiple times works. The latter approach could include notification of the incentive opportunity, check for amount of the incentive along with clear explanation of what was earned relative to what could have been earned for each relevant measure, followed by repeated rounds of the same.

2. ***Developing a common plan incentive structure would be difficult.*** The demonstration experience suggests that it would be very difficult for multiple plans to voluntarily reach agreement on a single incentive administered the same way across plans, despite advantages of this approach for influencing providers. Key differences among plans in philosophy, network size, contractual arrangements with providers, and administrative infrastructure/history are strong forces that have led them to implement different incentives targeted to the same measures.

3. ***Administrative effort is significant.*** The administrative process of implementing incentives was a significant effort for most of the plans; they were challenged by system and data issues. Only one plan had a relatively easier time with

implementation, as it modified its existing risk share distribution formula to incorporate a well-baby incentive.

4. ***Some provider response is apparent.*** The incentives have helped highlight the need for improvement in well-baby and well-adolescent visits in a number of high-volume physician offices, which are responding largely by attempting more outreach than in the past.

5. ***Population difficulties will limit success.*** Our interviews with providers suggest that the difficulties associated with a low income, as well as the general preferences of the adolescent population, will limit the potential for improvement of the well-baby and well-adolescent measures to some degree; how much improvement is possible given these population factors is unknown.

6. ***Office factors will inhibit success in some offices.*** In addition to population barriers, several factors related to office practice that limit improvement also became apparent through our interviews. Some offices are largely walk-in clinics, which are not conducive to ensuring that patients receive preventive visits on a clinically appropriate schedule (although they have other advantages for access and efficiency). Some office computer systems are very limited or nonexistent, making it very difficult for staff to check on whether people need a well-visit appointment. Some clinic employment contracts prohibit individuals from receiving incentives, which limits the use of financial incentives at the individual level. Finally, some offices report that their staffing levels are insufficient to assume any additional outreach responsibilities.

7. ***State Medicaid policy appears to be working to sustain plan interest in incentives.*** The state's decision to auto-assign members on the basis of HEDIS scores appears to be sustaining the plans' interest in retaining incentives in general by giving them a business case for doing so. However, the well-baby visit HEDIS measure is not one of the measures the state chose to include as a factor in auto-assignment, leaving the future of incentives and efforts relating to that measure in question. At this point, all the plans expect to retain their incentives for the next year.

In conclusion, five low-income focused plans found it feasible—though not easy—to implement incentives to improve the timeliness of well-child care for low-income babies and adolescents. Our information to date suggests that there is reason for both optimism and pessimism in terms of the likely impact of the provider incentives. On the one hand, some high-volume providers are clearly responding to the emphasis on these measures brought by the incentive programs by increasing outreach. A steeper upward trend in HEDIS scores among the Collaborative plans with incentives relative to Medicaid plans nationally may also be promising. On the other hand, there are signs that not all providers are aware of the incentives. Providers we spoke with did not seem very attuned to the incentives even when they were aware of them, and population and office factors conspire to frustrate providers' ability to improve their performance.

I. INTRODUCTION

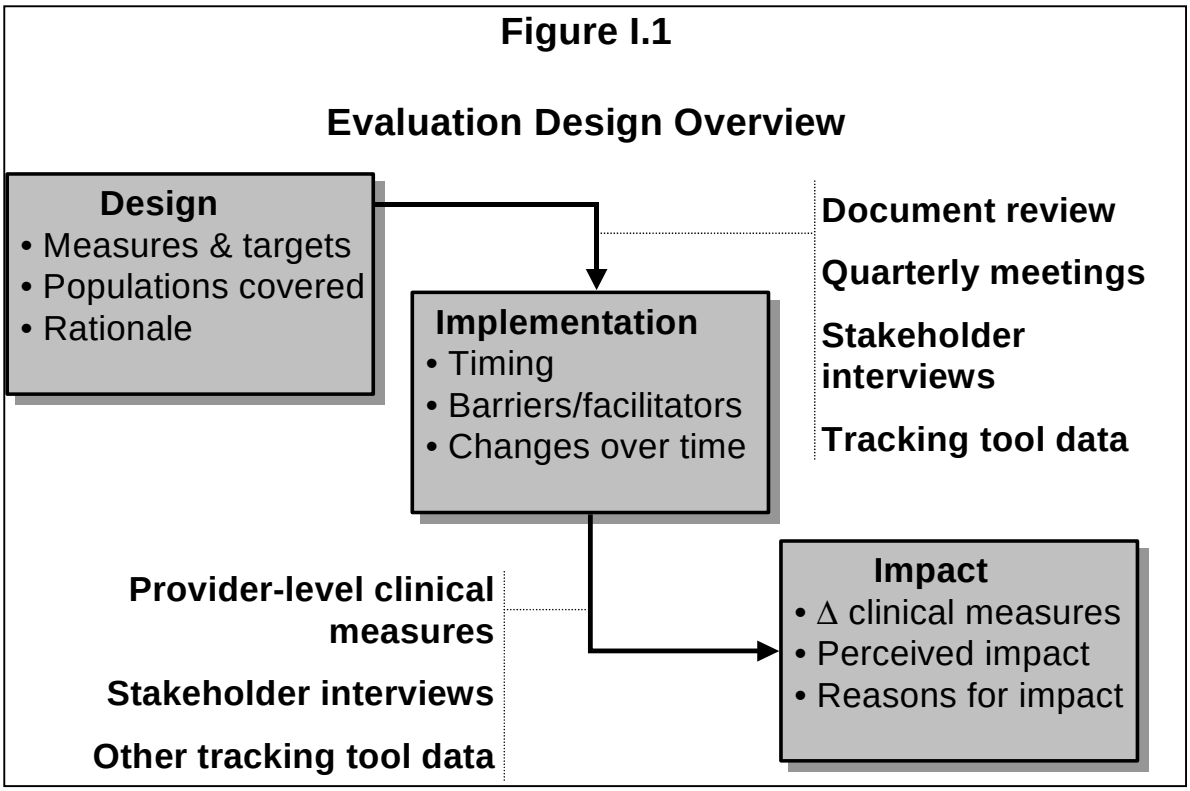
In February 2003, Mathematica Policy Research was named as the prime contractor to evaluate the Local Initiative Rewarding Results (LIRR) Collaborative demonstration through December 2005. The Collaborative is administered by the Center for Health Care Strategies (CHCS) and funded by the California HealthCare Foundation. It aims to improve the care of low-income children in Medi-Cal and Healthy Families in seven California counties through use of quality incentives for providers and members to improve the timeliness of well-child visits. The evaluation studies the implementation and impact of the quality incentives newly established by seven Local Initiative plans serving the Medicaid and Healthy Families populations in California.[3] This interim report of the evaluation focuses on implementation of the incentives and perceived initial provider response.

This chapter introduces the overall evaluation design and describes the data sources used in subsequent chapters. Chapter II describes the quality incentive designs that the plans chose under the demonstration and explains their origin and context. Chapter III assesses the implementation of the incentives to date, including the challenges and successes. Chapter IV tracks plan-level HEDIS scores to date and discusses initial physician response based on interviews with selected physicians in each plan. The report ends with a discussion of lessons learned at this stage of the evaluation.

A. EVALUATION DESIGN OVERVIEW

The evaluation design uses interviews and document reviews to assess the operational, organizational, and behavioral factors that will help determine the relative impact of the different incentive approaches. We are measuring their actual impact on access to and utilization of well-baby and well-adolescent care by (1) analyzing administrative (claims or encounter) data submitted by providers to the health plans, (2) comparing the plans' HEDIS scores over time to those of other Medicaid/SCHIP plans in California and nationally, and (3) conducting interviews with plans and providers. This mixed-method design minimizes the evaluation's vulnerability to the kinds of data misinterpretations that typically threaten the validity of non-experimental studies that rely exclusively on quantitative evaluation methods. It also enables us to provide health plans, providers, Medicaid agencies, foundations, and others interested in implementing rewards strategies with information on the factors that can contribute in important ways to the success or failure of performance incentive initiatives. Figure I.1 provides a schematic overview of the evaluation design, which is described below. The design includes two main components: an implementation/process analysis and an impact analysis.

[3] A quality incentive is an inducement or compensation given to a provider organization or to a person as a reward for providing services or outcomes that are associated with quality care.



1. Implementation/Process Analysis

The implementation/process analysis documents the achievements of the LIRR health plans, individually and collectively, in launching and sustaining their incentive systems, and identifies the factors that facilitated or inhibited these achievements. When used together with the quantitative estimates of impact, the implementation/process analysis examines why the various incentive systems did or did not produce their intended results. The implementation/process analysis has three main features:

- ***Collecting and reviewing project-related descriptions and other documentation.*** At the outset and during the project, we are obtaining and reviewing quarterly reports and project descriptions generated by the plans for CHCS, and meeting minutes generated by the Collaborative in the course of its work in order to fully understand the implementation decisions and actions taken by Collaborative members prior and subsequent to the initiation of the evaluation.

- ***Tracking progress in developing and implementing incentive systems.*** We are collecting qualitative information on each plan's implementation progress from an electronic tracking tool that plans complete annually. This tool captures basic information on participating providers, enrollees, and incentives. We are using it to obtain preliminary information on changes to the incentives as well as changes to the environment in which the incentives are being implemented (state policy changes, marketplace changes, and the like). We are obtaining additional information through follow-up telephone contacts with health plan staff annually to understand key changes to the performance measures and incentives that are reported, and by

attending key meetings of the Collaborative, including quarterly Steering Committee meetings (in person) and other relevant meetings (by conference call).

- ***Interviewing plans, providers, the Center for Health Care Strategies, and state Department of Health Services (DHS) officials using semi-structured telephone interviews.*** We are conducting two waves of interviews with key Collaborative stakeholders during the course of implementation: wave one was conducted from October 2004 to March 2005, and wave two will take place in Fall 2005. These interviews collect qualitative information on implementation successes and set-backs and the perceived impact and value of the incentive systems. In each wave, we aim to conduct interviews with six providers per plan and with key people at each plan (including the medical director, the CEO, and key staff working on the incentives effort). Providers are asked for their views on the incentive systems, and to explain any changes in practice that they believe affected their scores.[4] Interviews included both higher and lower-performing providers, and focused particularly on larger-volume providers. Two of the six providers requested for each plan were requested to be "leadership" physicians, that is, physicians likely to have relatively more broad-based knowledge about incentive design and implementation than the typical physician. In practice, the "leadership" physicians generally had relatively close ties to the plan but their understanding of the incentives and providers' reactions to it were not as different from other physicians as we had hoped. Plans provided the contact information for the providers.

2. Impact Analysis

The evaluation also assesses the Collaborative's incentive systems impact in terms of their perceived impact, changes over time in HEDIS scores and other plan-level measures, and changes in provider-level performance.

Perception of impact. As described above, we are collecting qualitative information on the perceived impact of each health plan's rewards systems through two waves of semi-structured telephone interviews with health plans, physicians, and other key stakeholders.

Changes over time in HEDIS scores and other plan-level measures. We are using information on plan-level HEDIS scores and other relevant data (e.g., Medi-Cal and Healthy Families enrollment, physician network size, etc.) to compare these measures descriptively over time (2002 to 2004) to determine whether the direction and magnitude of change supports the hypothesis that the Collaborative's incentive systems are improving plan-level performance. We compare the changes in HEDIS scores observed among the seven Local Initiative plans to the changes in scores observed among other Medicaid/SCHIP plans in California and nationally over the same time period. The national data will be obtained from the National Committee for Quality Assurance (NCQA).

[4] Providers interviewed are generally practicing physicians; in one case a nurse practitioner joined a physician on an interview, and we interviewed two heads of provider groups that receive encounter data incentives.

The impact of incentives on provider-level performance. Plans are also providing an annual Provider Level Data Submission for 2002-2004. For every provider in a plan's network, this submission supplies: provider demographics, clinical performance measures, encounter data measures, incentive payment measures, and utilization measures. To understand the impact of the various types of incentives, we are analyzing the patterns of change in performance as they relate to both the types of incentives implemented and the key characteristics of the providers themselves.

"Difference-in-difference" analysis will be used to evaluate the impact of the incentives. In other words, we will determine whether the different incentives established by the seven plans have different effects on provider performance over time. The design will compare groups of providers defined by the type of incentives they (and in some cases their patients) have. We do not anticipate that a true control group—providers with no incentives who are similar in other ways to providers with the incentives—will be available. However, we will use data from the two of the seven plans in the Collaborative that did not implement financial incentives as the best available comparison group.

We are not adjusting the data for differences in patient characteristics such as age, gender, or health condition. We do not believe that statistical adjustments at this level of detail are feasible or necessary because of the relative homogeneity of the pediatric Medi-Cal populations served by the local initiative plans and providers as well as the difficulty and cost of obtaining reliable and standardized data on these characteristics. Moreover, the difference-in-difference methodology we will use implicitly controls for differences in the patient populations that do not change over time. Assuming each provider's patient population remains relatively stable over the period of our study (2003-05), we will not need to adjust the impact estimates for differences in patient characteristics across providers.

B. DATA SOURCES FOR THIS REPORT

This interim evaluation report details what we have learned to date about program design and implementation and provider response. In keeping with the evaluation design, we draw on the following data sources:

- Tracking tools submitted by plans in October 2003 and December 2004
- Wave 1 interviews with stakeholders including health plan executives and staff, and selected physicians in each plan
- Plan-level HEDIS data on services provided in calendar years 2002, 2003, and 2004, and national data obtained from NCQA
- Various other relevant documents, including plan quarterly reports to CHCS, minutes of quarterly steering committee meetings, and materials submitted by some plans about their programs.

Analysis of the remaining data sources, including the provider-level data, will be included in the final report to be submitted to CHCS in December 2005.

II. DEMONSTRATION OVERVIEW

The goal of the LIRR Collaborative in California is to improve health care for low-income children enrolled in Medi-Cal and Healthy Families by offering financial and non-financial incentives to providers and enrollees. The plans are implementing incentives designed to encourage well-baby visits, well-adolescent visits, and improved provider submission of encounter data to plans.

The LIRR Collaborative demonstration is part of the national Rewarding Results demonstration program sponsored by The Robert Wood Johnson Foundation and the California HealthCare Foundation. The Collaborative is the only Rewarding Results grantee to focus on improving care for the Medicaid population. While collaborative activities are funded by the grant, the financial incentives established by the plans are all funded by the plans' own operating budgets.

A. VARIATION IN DESIGN

The sets of incentives that have been planned and implemented under the LIRR Collaborative are all designed to improve HEDIS rates for well-baby visits by 15 months, raise HEDIS rates for well-adolescent visits, and/or improve completeness of encounter data submission. However, incentive designs chosen by the plans have varied among the plans on several key dimensions:

- Whether they address one, two, or all three of the above-mentioned goals of the demonstration
- The mix of provider and/or member incentives used to achieve their goals
- The performance requirement to receive an incentive payment, and the relationship between achievement and amount of reward
- Whether incentives are paid in lump sums annually or semi-annually or paid on an ongoing basis (as relevant documentation is submitted)
- Whether plans pay based on administrative data (such that providers qualify automatically) or whether the plan requires submission of documentation for each case

Table II.1 provides more specifics about the five plans' incentives that have been implemented to date under the Collaborative. Although there were originally eight plans in the LIRR Collaborative, one formally withdrew during 2003. Two more did not implement any new incentives (discussed more in Chapter III). Since one of these two did design its incentives and in fact announced them, we include discussion of that plan where relevant. However, most discussion of implementation and impact (Chapters III and IV) is centered around the five plans that implemented some incentives.

OVERVIEW OF TABLE II.1

INCENTIVE PROGRAMS UNDER LIRR

	Well-Baby Care		Well-Adolescent Care		Encounter Data		
Plan	Type of Incentive	Payout/ Distribution by December 2004	Type of Incentive	Payout/ Distribution by December 2004	Type of Incentive	Payout/ Distribution by December 2004	Other Plan Incentives
Kern	Annual risk pool distribution to providers influenced by performance on well-baby visits	$901,000	One movie ticket for completing a well-visit; annual letter to member to create awareness	890 members received tickets	None		Mammograms, chlamydia screening, well-child visits ages 3-6, eye exams for people with diabetes
Health Plan San Joaquin	Bonus of $100 per baby who gets 6 or more visits by 15 months. Automatic to providers based on administrative data, paid semi-annually. Increased to $200 in July 2004. Financed from risk pool dollars	$43,100	Bonus of $50 per adolescent who gets their well-visits. Automatic to providers based on administrative data, paid semi-annually. Financed from risk pool dollars	$357,600			Mammograms, cervical cancer screening, chlamydia screening, providing BMI data
LA Care	Bonus of $25 for each set of 3 well-baby visits (total possible = $50 per child). Automatic to providers based on administrative data, semi-annually (annual 1st year)	$181,000	Two movie tickets for adolescents completing a well visit; annual letter to member's parent and members and list to providers.	2,324 members received tickets	Tiered pmpm payment to major provider groups ("PPGs") for meeting encounter data volume thresholds. Paid semi-annually but $ calculation based on monthly volume. Up to $.32pmpm.	$911,825	

Table II.1 *(continued)*

Plan	Well-Baby Care		Well-Adolescent Care		Encounter Data		Other Plan Incentives
	Type of Incentive	Payout/ Distribution by December 2004	Type of Incentive	Payout/ Distribution by December 2004	Type of Incentive	Payout/ Distribution by December 2004	
Inland Empire Health Plan	$100 bonus per child receiving 5th well-child visit by 13 months and Polio, Hep B and Hib vaccines. Another $100 for both another well-child visit by 15 months and relevant vaccines. Paid to providers as relevant documentation is submitted.	$148,300[a]	Offered movie tickets for a few months in 2003 but discontinued due to very low response.		None		Immunizations by age 2, ongoing bonus payments for each well-child and well-adolescent visit, pap tests, chlyaimdia screening, prenatal services, post partum, diabetes
San Francisco Health Plan	Tailored assistance to small number of high volume providers. Financial component: $50 per child if 4 or 5 visits by 15 months and $150 if 6 or more.	$20,050	Adolescent outreach incentive to one provider; $100 for every 5 outreach calls	$6,314	None		Ongoing movie tickets to adolescents, immunizations well-child ages 3-6, prenatal care

[a]In addition to this new incentive added under the LIRR, IEHP has had ongoing fee-for-service incentive payments (above capitation) that totaled $1.9 million for well-baby visits in 2004.

Because none of the plans had seen evidence that any particular type of design worked better than others, their choice of designs were based in large part on their history and structure and their theories about what might work best. For example, Kern and Alameda Alliance for Health already distributed risk pool dollars annually; therefore, shifting the criteria for risk pool distribution to incorporate performance appeared the most logical form for their incentives. LA Care by its structure is an organization that is far-removed from primary care providers, since it works through "plan partners" who in turn often pay capitated rates to large medical groups who in turn pay individual providers. However, LA Care believed its well-baby visit incentives would have to be paid directly to individual providers, and that the combination of provider incentives together with member incentives could be a powerful one.

The plans financed their incentives with either "new" money or reallocated money, which could affect provider perception and response. Three used what was essentially "new money," that is, administrative dollars freed up from lower costs relative to revenue and/or excess reserves. Two reshuffled existing dollars—one by changing risk pool distribution criteria and the other by revamping its existing incentives program to better align with HEDIS.

B. MOTIVATION AND FINANCIAL ABILITY TO BEGIN INCENTIVES

All five plans sought to improve their HEDIS scores through the incentives because of their importance: plans' standing relative to other plans in the state and the nation on various HEDIS measures is a matter of professional pride; their performance is important when seeking NCQA accreditation; plans believed that state-level incentives related to HEDIS measures were under development (this did occur as discussed below); and plans are non-profit, committed to quality care for low-income populations by their mission. The particular measures for the demonstration were selected primarily because of the low scores across the group of interested plans at the time the demonstration was being planned.

The potential for direct financial savings from improving well-baby and well-adolescent visits was not a motivating factor—and little discussed—probably because no relevant data were known to assess such potential, and because quality improvement, not cost reduction, was the demonstration's goal. However, because of the structure of Medi-Cal managed care in the counties in which the Collaborative plans operate, beneficiaries are in one of only two plans. Therefore, the plan is likely to incur costs from medical or behavioral health problems that could have been prevented or minimized through timely well-baby or well-adolescent visits, which likely contributed to some plan executives' interest. Some plans also believe that their non-profit status played a key role in moving forward, along with their commitment to pass as much money through to providers as possible to help them continue to serve the plan's Medi-Cal patients.

The demonstration reinforced the fact that health plan financial stability is a critical factor enabling incentives when one of the LIRR Collaborative members canceled its risk share distribution—through which it was to implement its incentives—as one of a series of major steps to try to regain a financial foothold after a crisis unrelated to the Collaborative.[5] Other

[5] A "risk share distribution" occurs on a periodic basis in some plans, usually annually, to distribute back dollars to providers that are withheld by the plan from capitated payments up-front in order to incentivize providers

participating plans have not thus far experienced any substantial financial problems during the demonstration.

C. LIRR INCENTIVES IN CONTEXT

1. Incentives Are Accompanied by Other Quality Supports

Other quality supports that could improve the same HEDIS rates targeted by the financial incentives were established by the plans before and during the demonstration. Table II.2 shows that two supports, performance feedback to providers on the targeted measures and reminders mailed to members, were often established during the demonstration period.[6] Consulting with low-performing providers began in two plans. Plans were generally already helping to link members to providers based on primary language spoken and/or distance/travel time prior to the demonstration. One plan also spearheaded a major effort to use its own staff to call the parents of all of its adolescent members who were due for a well-care visit, explaining the importance and encouraging them to make the appointment. That same plan hired a staff member to support outreach for well-baby visits and immunizations in several clinics that could not accept financial incentives.

2. LIRR Incentives are Part of a Larger Set of Financial Incentives

LIRR incentives are most often one piece of a larger set of financial incentives that the participating plans are using to help improve their HEDIS rates. Specifically, some plans give incentives for mammograms (2 plans), chlamydia screening (2), well-child visits ages 3-6 (2), immunizations (2), prenatal care (1), cervical cancer screening (1), and eye exams for people with diabetes (1).

Several plans also had financial incentives that targeted the same HEDIS measures as the demonstration, but they were not counted for evaluation purposes as LIRR incentives because they pre-dated the demonstration. For example, one plan had an ongoing incentive of movie tickets for adolescents who submitted documentation of a well-care visit, and three plans pay a fee-for-service amount to providers that supplements capitation for well-child visits (including well-baby and/or well-adolescent visits).

(continued)

along certain dimensions. Traditionally risk share distributions have been based on utilization measures and/or volume of members, however, quality incentives can also be built into the formula.

[6]Mailed reminders to members include an annual letter to adolescent members and/or their parents, and reminder letters to parents of infants.

TABLE II.2

QUALITY SUPPORTS OTHER THAN FINANCIAL INCENTIVES

	Number of Plans (of 6 submitting the information)	
	Began Activity During Demonstration Period	Already Had Activity In Place
Performance Feedback to Providers		
Well-Baby Visits	5	0
Well-Adolescent Visits	4	0
Consultation With Low-Performing Providers		
Well Baby Visits	2	0
Well-Adolescent Visits	2	0
Mailed Reminders to Members		
Well-Baby Visits	4	1
Well-Adolescent Visits	4	1
Reminders to Providers of Members Needing Care		
Well-Baby Visits	1	1
Well-Adolescent Visits	2	0
Generic Provider Mailings on Preventive Care Topics	2	1
Training and Technical Assistance on Encounter Data Submission	3	1
Periodic Reports to Providers on Encounter Data Volume	1	2
Linking Patients to Providers		
Based on Language Spoken	0	6
Based on Travel Time/Distance	0	5
Other	2	1

Source: Plan tracking tools submitted to MPR.

3. Competition was a Motivating Force, but the Collaborative Plans were Not Shadowing Other Plans' Programs

In evaluating the demonstration, it is important to document the Collaborative's market context and how it may affect the design, implementation, and response. For example, in theory, three types of possibilities could affect the demonstration implementation and outcomes.

First, are competing plans providing a major motivating force for implementing incentives in the participating plans? If so, understanding these dynamics could be important in making incentive programs appealing to other plans nationally. In fact, the plans' desire to improve their HEDIS scores relates to their market in the sense that they hope to demonstrate they are equal to or better than their competitor. However, plans were not responding to specific motivating actions of competitors. Several believed other plans in the market had some incentives in place that applied to providers for commercial and/or Medi-Cal populations, but they were not clear about the details and said they faced no competitive pressure (e.g., pressure from providers) to implement incentives. Several noted they were the dominant force in their Medi-Cal market area—the market leader not a follower. Thus, we do not find any specific unique market factors that motivated the demonstration.

Second, are other plans in the market (whether they compete for Medi-Cal business or not) implementing incentives that are similar to or different from the Collaborative's incentives? This may be important if the other incentives in the market interact in a combined or competing way with the LIRR incentives on LIRR providers who contract with multiple plans. Because we interviewed only a handful of providers in each plan, who tended to be high-volume providers with closer-than-average ties to the plan, we cannot rule this out as an issue. However, our interviews did not find this problem. Only one provider we interviewed reported having multiple plan contracts each with different incentives, but he did not view the differences or related paperwork as a problem, and noted that most focus on immunization. Health plans reported not hearing anything from their providers about other plans' incentives, although one plan believed its providers were becoming more vocal with other plans about its incentives.

Third, in what ways did the market dynamics facilitate or impede extending the LIRR collaboration to include other plans in ways that maximize the incentive's effect on providers? There were early discussions at the LIRR Collaborative Steering Committee meetings of attempting to collaborate with competitors on the incentives in order to have a larger impact on providers because each plan accounts for only a small share of their business. During the discussion, it was clear that some plans were open to this possibility, while others had such an acute rivalry with their competitors that the idea was viewed as not worth considering. In the end, it was considered infeasible for the LIRR Collaborative to take on extended collaborations under the demonstration.

III. IMPLEMENTATION

A. OVERVIEW

As described in Chapter II, five of the original eight plans in the LIRR Collaborative have implemented incentives. Most began their incentives during July to December 2003; one began in July 2004. Since then, one plan substantially strengthened its well-baby visit incentive by announcing a new requirement in mid-2004 that to receive *any* risk pool dollars for contract year 2005, providers must be above the 2004 median performance on the well-baby visit measure. The plan found that its initial incentives design—a point system that gave some credit to providers for each 15-month-old with four visits and more credit for five or six visits—resulted in poor performers who served a high volume of patients at the four-visit level receiving as much as or more than high performers who served fewer. With the revised design, poor performers who do not improve will get no risk pool distribution. The minimum threshold, calculated from administrative data only, is not a high hurdle—only about 15 percent. Another plan, which began by offering its incentives to only three high-volume providers, expanded the offering to several more. So far, other plans have not made major changes to the incentives they initially implemented.

The three plans that did not implement the incentives had very different reasons for not doing so. One withdrew from the Collaborative reportedly because it felt the evaluation data requirements were too burdensome. The second worked hard to overcome historical political barriers to implementing the incentives, and in fact announced a major shift in its method for allocating risk pool dollars, only to cancel the risk pool distribution entirely as one of many steps to recover financial viability after a crisis. The third plan decided not to implement any new incentives largely because it thinks it may be able to accomplish the same thing by re-advertising its ongoing fee-for-service payment for well-child care that supplements capitation, along with a campaign to get doctors to incorporate the components of well-visits into sick visits. The plan's analysis shows most of its adolescents see a plan primary care provider for at least one sick visit during the year. This plan also mentioned that providers on its board resist "tampering with" reimbursement.

In the course of the demonstration's implementation, both plans and the demonstration itself experienced turnover of key staff. Several plans experienced turnover of medical directors who had been key champions for the incentives and made the decision to participate in the LIRR Collaborative. While the turnover was unrelated to the incentives, it created challenges in terms of continuity. The loss of Helen DuPlessis at LA Care, who headed the Collaborative's encounter data workgroup, may have stalled momentum among some plans who were initially interested in improving their encounter data through incentives.[7] The demonstration itself began under the administration of the Integrated Healthcare Association (IHA), with Kathy Kim serving as the day-to-day project lead. Ms. Kim left and was replaced by Ellie Payne in

[7] In May 2003, the oral report from the encounter data subcommittee of the Collaborative indicated that encounter data incentives would be paid quarterly by all plans but one, however only two plans actually implemented an encounter data incentive.

September 2003. In July 2004, demonstration administration shifted from IHA to the Center for Health Care Strategies, under direction of Nikki Highsmith and Elizabeth Cobb.

B. ELIGIBILITY FOR AND DISTRIBUTION OF INCENTIVES THROUGH DECEMBER 2004

When they implemented incentives, the plans generally aimed to influence well-child care for the vast majority of babies and adolescents in their networks. A total of almost 150,000 children whose care could potentially be improved are served by physicians who were eligible for incentives in 2004 (61,800 babies ages 0-15 months and 88,000 adolescents).[8] In terms of provider eligibility, the vast majority of physicians who serve babies in the plans' networks (at least 73 percent) were eligible for the well-baby incentives. The only exception was one plan that took a far more targeted approach, offering the incentives to only seven high-volume providers by the end of 2004. In all, 2,431 physicians were eligible for the well-baby incentives (across all five plans),[9] and 923 physicians were eligible for well-adolescent visit incentives (in two plans) in 2004.

Incentives paid out to providers under the Collaborative through December 2004 total $2.6 million:[10]

- $1.3 million for well-baby visit incentives, across five plans
- $364,000 for well-adolescent visit incentives, in two plans
- $912,000 for encounter data incentives, in one plan

Several of the plans indicated the payout figures are under their allotted budgets for the incentives and hoped the payout would increase in the coming months to reflect more widespread participation and better performance. When available, the number of physicians participating in the incentive program is a meaningful indicator of physician involvement. This calculation was possible for the two plans that required physician offices to submit documentation to receive an incentive. For the one of these plans, the average three-month participation rate was 55 percent for the well-baby visits (of 428 eligible providers) and 53 percent for the well-adolescent visits (of 537 eligible providers). In a second plan, with targeted eligibility, three of seven eligible provider sites participated (fewer than 19 physicians).

In addition to the provider incentives, a few plans provided member incentives. About 145,000 adolescents (in two plans) and 56,000 parents of infants (in one plan) were eligible to receive movie tickets or a gift certificate (respectively) if they/their babies received timely well-

[8] Nearly all the babies were Medi-Cal members (99 percent) rather than Healthy Families members, and 84 percent of the adolescents were Medi-Cal members.

[9] Sixty-two percent of the eligible physicians were located in one plan (LA Care).

[10] This indicates the amount paid out by December 2004, but covers services for various periods consistent with plans' varying incentive payment strategies.

child visits. The number of these groups who actually participated and thus received the items in 2004 was much smaller: 3,200 adolescents and parents of 1,800 infants.

C. IMPLEMENTATION CHALLENGES

1. The Plan Perspective—Provider Incentives

Implementation challenges arose to some extent at almost every step of implementation except design. Overall, plans found that successfully implementing incentives took considerable effort, and more than they anticipated. Table III.1 shows the problems plans identified through the tracking tools they submitted to the evaluation. The text below explains the issues identified in our first wave of plan interviews.

TABLE III.1

IMPLEMENTATION PROBLEMS OR BARRIERS

	Number of Plans	
	2003	2004
Number of Plans Responding to the Question	6	4
Lack of Awareness or Understanding of Incentives		
By Physicians	3	3
By Members	3	0
Negative Physician Reaction to Incentives	1	0
Problems Obtaining Claims/Encounter Data Needed for Performance Measures	3	2

Source: Plan tracking tools submitted to MPR.

a. Design and Approval to Proceed

Unilateral approach to design kept the process simple. The plans did not struggle much with incentive designs, which were typically decided on a fairly unilateral basis, that is, without much provider input. Although a unilateral approach is not recommended by other qualitative research on incentives that has come out since the demonstration began (Verdier et al. 2004), we do not see evidence to date that the unilateral approach to initiating the incentives mattered much for these particular incentives, since the incentives were typically supported by the physicians we interviewed and the plans reported no negative feedback from providers. Note that these particular incentives relate to recommended access rather than to a particular clinical guideline. However, one plan convened focus groups of providers and members, and chose movie tickets for its adolescent well-care visit member incentive on the basis of the focus group comments. Members had ranked movie tickets as a desired item second only to concert tickets.

Only isolated resistance to approving the incentives. Health plan boards typically were presented with the proposed designs and readily approved them, except in one plan where the providers who sit on the board strongly preferred no changes to the reimbursement arrangements. The plan's CEO then became involved in persuading the relevant individuals, with eventual success. A key factor in changing their position was reviewing with them the actual data and improvements of greatest concern. Also, the plan that does not contract with individual providers, but wanted to pay individual providers, needed to negotiate this point with the organizations with which it contracts. There was some resistance by one of these organizations, which wanted to receive the money directly, but the organization relented.

b. Roll-Out

Gaining physician attention was difficult. The plans found it difficult to gain the attention of physicians in their network, and it appears that they had mixed success in gaining attention during roll-out, although we do not have statistically representative data to judge awareness. In 2004, three of four plans answering our question about implementation problems cited lack of physician awareness or understanding as a problem. The providers we interviewed who were closely connected with the plans (such as those on the board or quality committee) were typically aware in a timely manner, but several of the community physicians we interviewed were either unaware of the incentives or had learned of them only three to six months before our call, even though the programs had been rolled out about a year earlier. The plan that greatly strengthened its incentives in the second year made the greatest effort to ensure awareness at that time (summer 2004), mandating that all physicians attend one of three sessions to learn about the incentives as a condition of participating in the risk pool in 2005. Other plans typically sent letters, provider bulletins, or a more stylized page of information; some also included mention in their provider newsletter and some held meetings that were attended by a relatively small fraction of the network physicians. For plans that require provider offices to submit documentation, training of provider office staff was another important activity—both initially and on an ongoing basis because office staff change positions frequently.

Administrative challenges at start-up significant for three plans. The administrative aspects of roll-out were challenging for three of the plans for different reasons. LA Care faced a challenge because the plan does not contract with individual physicians, yet the well-baby incentives were to be paid to individuals in a large network. Therefore, it had to create a new database with tax ID numbers and ensure current contact information for the full set of eligible providers. Inland Empire Health Plan (IEHP) had to reorganize people and establish a process to handle incoming documentation, since it required providers to submit chart documentation of the visits and immunizations, which required substantial effort from several staff. Later the plan was able to shift to allow online submission, which reduced the effort. San Francisco Health Plan (SFHP) was implementing incentives as a component of a wholly revised strategy for interacting with and influencing providers; therefore major personnel and process changes were made along with implementation, though not solely due to the Collaborative's incentives.

c. Performance Feedback and Payout

System and data challenges. Two of the three plans that used administrative data to calculate providers' performance and payout amounts encountered data and system challenges, and one of the plans processing provider-submitted data cited programming issues as a problem with initial implementation. One plan has allowed providers to review their data for accuracy before finalizing the payout. The plan acknowledges that sometimes the data are wrong, and providers are allowed to send in records to support corrections. Correcting data does add to the cost of administering the incentives (and checking data adds effort on the provider side as well). In the other plan with system issues, the first payout was delayed by several months due to a major systems change at the plan from one data warehouse to another. The change affected access to the data and absorbed the time of personnel who were needed to check the data prior to payout.

Both plans and physicians mentioned miscoding of well-care visits as an issue that contributed to data inaccuracies and produced lower-than-accurate scores. To help with problem, one of the plans (Kern) is planning a forum for billing and administrative personnel to instruct providers on properly using codes to get "hits" for the incentive.

Ensuring the Incentives Reach their Targets. For two plans in particular, getting the incentives to the targeted individuals has been challenging in certain instances. Specifically, both plans have experienced difficulty with high-volume providers in their networks that employ physicians whose employment and/or contractual arrangements prohibit the employed individuals from receiving financial incentives. Sometimes this meant the money went into the clinic's general operating fund rather than the individual provider/staff. In other cases the problem has seemed unsolvable and the provider is deemed ineligible for the incentives. In one case where a financial incentive was not feasible, the plan made available a plan-employed staff member to conduct outreach to parents of babies who needed visits and/or immunizations.

While getting the payout to the targeted individual can be a problem, some of the plans target payment to a contracted entity, which is often an organization rather than an individual. Plans expressed uncertainty about whether any money is passed down to the relevant individuals when a contracted organization is paid, rather than an individual, and in fact, they assumed that it often was not passed down.

2. The Plan Perspective—Member Incentives

State approval. The need for state approval of the member incentive program delayed implementation in one plan by about six months.[11] The plan had to overcome initial state concerns to ensure the cash value of the gifts to an individual would not exceed $50 per year, and that the movie tickets were not at all health-related.

[11] A second plan that implemented a movie tickets incentive for adolescents earlier than this plan did not report any delay due to state approval. We plan to explore this different experience in the second wave of interviews with the plans and the state.

Automating the process. Working to automate the process of handling the cards that are sent in to claim the incentives has been a challenge requiring regular meetings and brainstorming among several different departments within the plan including claims, information systems, provider operations, health services. (The cards are sent to the adolescents and must be signed by the doctor providing the well-care visit in order for the member to redeem the movie ticket.)

Countering fraud. An initial spate of fraudulent cards was a problem at one plan, which reported that about 20 percent of the cards initially sent to the plan claiming movie tickets were either signed by the doctor without a well-visit, or the doctor's signature was forged by the member. The plan is confident that the problem has been ironed out.

3. The Provider Perspective

Physicians we interviewed in the five plans that implemented incentives raised two common themes regarding implementation.

Communication about the incentives is critical. In one plan, the providers were complimentary about the plan's communication on several dimensions. Communication in general was said to be fine with this plan (in contrast to its competitor). Regarding the incentives specifically, one provider remembered specifically discussing his/her scores with the plan, and found the plan's explanation around the measures very straightforward and helpful. Another said the feedback he/she receives on performance is "simple, quick to read, but gives you the essential information—how much you got, how much you could have gotten, and what you need to do to make up the difference." A physician from a large group explained that because they were quite large (over 50 physicians) they didn't have to go to the plan to hear about the incentives; rather, the plan sent a staff member to them to explain. A second plan received no complaints about communication, although one physician we spoke with just learned about the incentives on the call—while their staff member had attended the relevant meeting with the plan and was well-versed, the doctor knew nothing of it.

Providers in two plans identified communication trouble spots. In one, providers received a single check and aggregate data across several performance measures, so they did not have the ability to distinguish their performance on well-baby or well-adolescent visits from their performance on other measures, nor to see how much of their check was attributable to performance on the various component measures. In a second plan, the communication issues were more mixed, but included two types of comments: two providers suggested that it was difficult to understand how the incentives work or who the money went to, and one provider received a notice about the incentives that indicated she would be individually assessed and rewarded, only to find she could not receive the money as an individual because of her employment arrangement.

Providers appreciate when other supports for outreach accompany the financial incentives. Specifically, some of the plans provided support in the form of lists of children who were about to turn 15 months old, and one provided pre-addressed reminder cards that the office could stamp and send. Some of the practices we spoke with used and appreciated these tools. Conversely, several physicians believed the plans could be doing more; for example, several believed that the plan had better address information or change-of-address information for their patients than they did, and that information should be shared routinely to facilitate outreach. Some of the

physicians suggested the plan should do the outreach centrally, although it was not clear that they were suggesting eliminating the provider incentives.

Other Physician Comments on Design and Implementation. At least one physician commented as follows on each of several other design and implementation features:

- The clinical appropriateness of the structure of one of the incentive measures in one plan was questioned. Specifically, providers receive a $100 bonus for a patient if the patient has received a well-child visit between 12 and 15 months of age with full IPV, Hep B, Hib and DtaP (immunizations). There should be six months between the 3rd and 4th DtaP shot for it to be maximally clinically effective. Often, the 3rd shot is not given exactly on time, leaving the clinician with a choice between forgoing the incentive or ordering the DTaP earlier than is ideal.

- Because it is impossible to get some patients to come in for their visits, the plan should reward provider effort (e.g., reward for three attempts to schedule a patient) rather than actual visit timeliness.

- To enable coherent medical group management, the medical group should at a minimum receive a copy of the information on performance and amount of bonus being provided to its employed providers.

- For the particular measures in the Collaborative, the money should go to the group rather than the individual provider, since it is outreach by administrative staff that will contribute most to improving the visit rates.

- Member incentives (where not present) would be very helpful accompaniments to the provider incentives and could help overcome the difficulties providers have in getting people in for appointments.

- For the adolescent well-visit movie-ticket incentive, the plan should consider allowing the physician to submit a note authorizing movie tickets. The provider could then improve the effectiveness of its outreach by guaranteeing the adolescent would get movie tickets even if he/she did not have the card the plan sent on his/her birthday. This provider said that adolescents often lose the cards between their birthday and the sometimes much later appointment.

D. SUSTAINABILITY

To date, all the plans that implemented incentives are expecting to retain them for at least another year. They expect to refine them over time to make them more effective. In particular, the plans are anxious for more information about whether incentives work and which incentive strategies bring better results; they expect this information to come from the LIRR evaluation in late 2005.

In addition, state Medicaid policy changes have affected plans' thinking about their future incentives. By the time of our plan interviews in Fall 2004, plans were aware that the state Medicaid agency planned to begin using HEDIS measures as a major factor in auto-assignment

of Medi-Cal members, though the details had not yet been finalized. On the positive side, plans cite the state's new policy as an important reason to continue with their incentive programs, although not specifically the well-baby visit incentive, since that is not included as one of the state's selected measures. Plans cite the downside of the policy as inhibiting their willingness to work collaboratively with competing plans for quality improvement, since the plan in each county with the highest HEDIS scores will be rewarded with additional membership.

IV. PERCEIVED PROVIDER RESPONSE

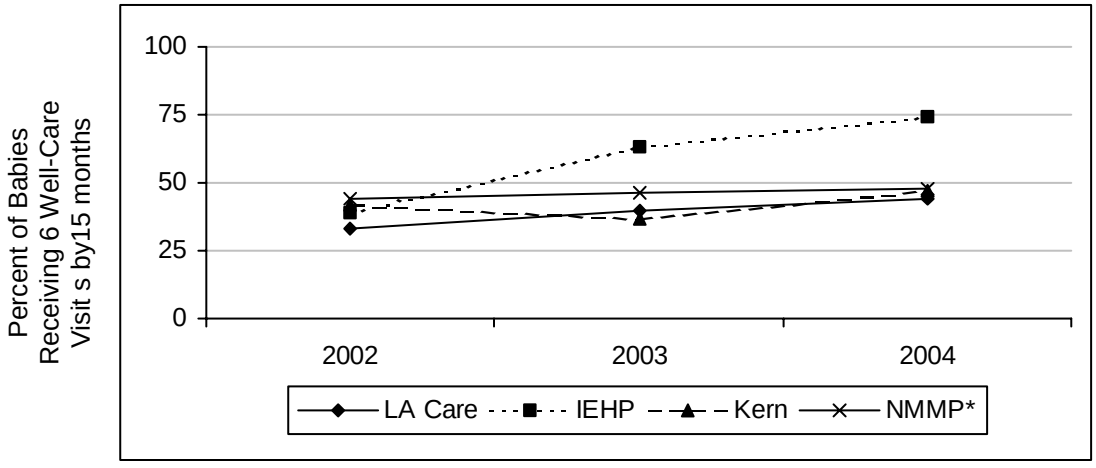
Detailed data are not yet available for a timeframe sufficient to analyze the effects of the Collaborative incentives. Therefore, most of this chapter offers insights from our physician interviews about providers' response to date. First, we review plan HEDIS scores for the targeted measures compared with the national trend for Medicaid-serving health plans, and then discuss provider response.

A. TREND IN HEDIS SCORES, 2002-2004

Among the plans that implemented incentives, three have provided 2002-2004 HEDIS data on well-baby visits and two have provided data on well-adolescent visits. These plans achieved an upward trend in their HEDIS scores for well-baby and well-adolescent visits that exceeded the upward trend for Medicaid-serving health plans nationally (Figures IV.1 and IV.2). Since they tended to start considerably below the national median, the steeper upward trend in most cases left them at a level close to the national mean. By calendar year 2004, an average of 48 percent of 15-month-old babies in Medicaid-serving health plans reporting these data nationally had had the recommended six or more well-baby visits. Among the Collaborative plans, the well-baby visit rates had improved to 44 percent, 47 percent, and 74 percent for the three plans with data. For Medicaid children 12 to 21 years old, an average of 38 percent had had a well-visit in the past 12 months nationally. For the same age group, both Collaborative plans with data had improved their rates to 37 percent. The trend shown here is consistent with the incentives having an impact, but we cannot draw positive conclusion about impact from these data alone.

FIGURE IV.1

TREND IN WELL-BABY VISIT HEDIS SCORES 2002-2004:
PLANS WITH INCENTIVES THAT SUBMITTED DATA

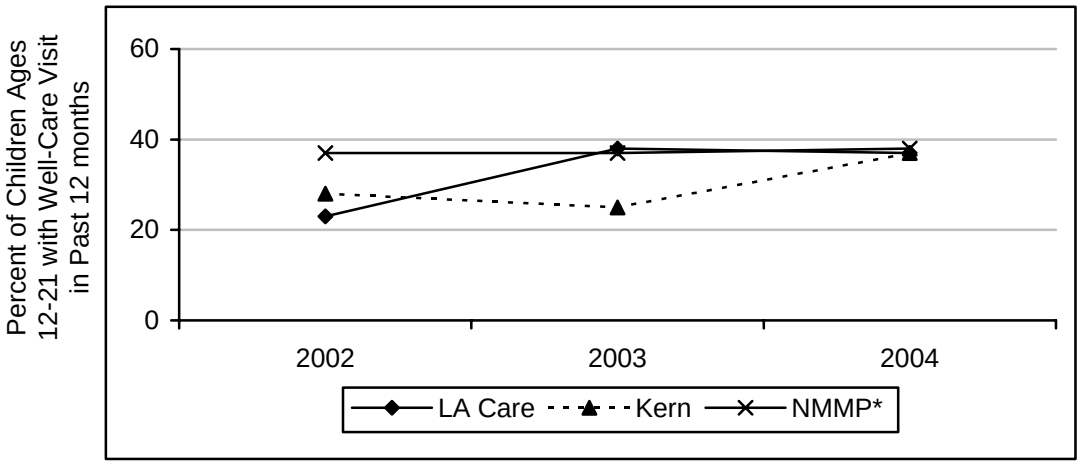


Source: Plan-specific data reported to the evaluation. National figures provided by NCQA.

*National mean for Medicaid-serving plans

FIGURE IV.2

TREND IN WELL-ADOLESCENT VISIT HEDIS SCORES 2002-2004:
PLANS WITH INCENTIVES THAT SUBMITTED DATA



Source: Plan-specific data reported to the evaluation. National figures provided by NCQA.

*National mean for Medicaid-serving plans

These data must be interpreted together with other data and information not yet available to the evaluation team. Specifically, two plans that implemented well-baby incentives and one that implemented well-adolescent incentives have not yet submitted HEDIS data for calendar year 2004 to the evaluation. Also, the full set of provider-level data due from plans in October 2005 offers many possibilities for analysis that will shed light on whether there was a significant improvement. For example, we can review whether providers who received incentive payouts from the plans improved performance more, on average, than others; look for whether there is a different response for providers with larger numbers of eligible member months; and examine trends in utilization figures that are more sensitive than HEDIS performance to changes in practice, such as total number of well-baby visits per member-year, for each six-month period during the demonstration. Moreover, another round of interviews with plans and providers will explore alternative explanations for rising HEDIS figures, such as changes in ability to capture the data.

We can conclude with certainty that the type of financial incentives tried here are not a panacea for bringing HEDIS measures up to their optimal levels within an eighteen month timeframe. However, the plans, demonstration sponsors, and evaluators did not expect that financial incentives could have resulted in a change that large.

B. PROVIDERS' RESPONSE TO DATE

For an incentive to influence providers, they must, at a minimum, be aware of the incentive. One might expect that the more knowledgeable the providers are about the incentive's details, the more they care about it and thus the more it might be influencing their practice. After examining the level of provider awareness, we discuss the level of activity and types of actions

providers have taken (or not) to improve, followed by the challenges to improvement that they discussed with us. The section concludes with a discussion of providers' overall attitudes toward the incentives.

1. Level of Awareness of Incentives

All of the physicians we interviewed who were closely affiliated with the plan knew that there were incentives in place, but several of the community physicians without close ties either were unaware or learned of the incentive only a few months prior to our call—about a year after the start of the incentives. Two knew there were incentives, but were unsure which plan offered them. In general, physicians were best able to talk about their experience with and attitudes toward the plan's full incentive program, rather than the specific Collaborative measures on well-baby or well-adolescent care.

Many of the physicians we interviewed were not very attuned to the incentives, beyond basic awareness that they existed. Of the 22 physicians we interviewed in the plans with active incentive programs, half were at least vaguely aware of the amount of the incentive paid to their practice, and half were not. However, among those that were aware of the amount paid to their practice, nearly half were in the plan that did not break the check or performance information out by measure, so they would have had no way of connecting their performance on well-baby or well-adolescent visits per se to the check. Among the half (11) that did not know how much they had received from the incentive, 7 said they never saw the amount (often in these cases the check was probably paid to their organization rather than to them personally), and 4 either could not remember (3) or said they saw the amount but did not pay attention/did not care (1).

Of note, one physician we spoke with who received an unusually large incentive check reported that he had received several calls from other physicians asking how he did it (word apparently traveled that he received a large check, but he said he does not reveal the amount of the check). He tells them how his office is completely structured around preventive medicine. Office staff will tell a mother that her child needs to come in for a well-visit, then he/she repeats it when the patient sees the doctor. After hearing it enough, the mother brings her child in. Another key factor this provider cites is the high volume of plan members he serves, which also factors into the amount of the payout.

2. Actions Providers Have Taken to Improve

A majority of the providers we interviewed had increased emphasis on outreach, and said the incentive had highlighted the need to do so (11 of the 17 for whom the question applied[12]). Many commented that it was not the potential for money that drove them to these actions, although they supported keeping the incentives and felt there were some providers who would be motivated by money. Note that those we interviewed were generally high-volume providers with

[12] Physicians we spoke with for whom the question did not apply included physicians in the plan that canceled its incentive, and a few physicians who were either new to the plan, received in-kind support but no financial incentive, or an adolescent specialist who did not receive a financial incentive but was able to comment usefully on the member incentive for adolescents.

Table IV. 1: Examples of Providers' Comments When Asked if they Responded to the Incentives

Better Outreach--More Reminders/Trying Harder

Me and my office staff responded positively to the incentive. Since we got the list of kids missing visits, the NP in my office goes through the charts, and calls 30-40 patients per month. We made this change for all our patients, not just [this plan's] patients—[this plan's] patients are not a large portion of our membership.

Overall we have changed in response to the incentive in that our staff is very engaged, is now constantly on the lookout for something. When the chart comes in we look for whether they need follow-ups, or what.

We decided to start calling people to come in to the extent we can, because it's the right thing. I admit the incentive did raise our awareness about the issue, and every penny counts to make this practice run.

For well-baby visits, we are in the process of trying to start calling them to come .n,

I think I have tried harder to get the patients in as a result of the incentive. Our office staff now send out more postcard reminders to patients. But this is a walk-in clinic, it's very hard to get babies in for 6 visits.

Monthly, the front desk staff calls all the patients to come in who are on the plan's list as about to turn 15 months of age. Here the incentive money is paid directly to the employees rather than to the clinic or the physician.

Taking Advantage of Sick Visits

If I see from my score that I am slacking, I step up my efforts. But only sick people come into this clinic.

I did not specifically try to increase the frequency of follow-up of patients, but what I would do is if a patient came in for a sick visit I would stretch it into a well-baby visit to do better on the incentives.

Changing Scheduling Frequency or Process

We are trying to change our scheduling a little bit to get some people in earlier. Some people come in at 15.5 or 16 months and we don't get the bonus for them.

Both my office staff and I have been taking steps. We have tried to track and follow up with eligible patients more, and schedule more frequent follow-ups.

No Change

I haven't changed my office practice…its just too difficult to get the patient to come in right on time at the proper time, so I don't try. Some physicians are abusing the system, giving kids immunizations before they are due, just in order to get the bonus.

We did an experiment with calling 20-30 adolescents to see if they'd come in, but many could not be reached and it came to almost nothing. It's discouraging and I don't feel like doing it anymore.

Our clinic is not as yet doing anything differently because of the incentive program. [The plan] sends out a list of our new enrollees, but we have no one to follow up on it. A lot of the problem is just a lack of manpower for someone to stay on top of these things.[later in the conversation] It's not obvious that we'll individually see a monetary reward [payment goes to group]… its not the monetary aspect by itself but the link to pushing for quality improvement that would influence our providers.

We have not done a thing in response to the incentives. And what would you expect, if awareness of the incentives is non-existent?

relatively close ties to the plan, so they are more likely to be acting on the incentive than the average plan physician. Table IV.1 provides some paraphrased examples from our interview for each type of change.

3. Challenges to Improvement

a. Well-Visit Rates

Many of the physicians we spoke with discussed the difficulties they face in improving well-visit rates for the Medi-Cal population. The two major types of challenges appear to be population factors and office system factors.

Population Factors. The low socioeconomic status of the population targeted for improvement was cited over and over as a major problem in getting the babies in for timely visits. Specifically, the factors mentioned included:

- Parents' focus on survival, which makes timely well-visit care for their children seem less important
- Lack of transportation
- Mobility, including changing health providers and/or plans, moving from city to city, and the associated likelihood of inaccurate contact information

The difficulties in getting adolescents in for well-visits were also bemoaned by many, although the issues mentioned were less often socioeconomic status and more a lack of willingness/ motivation to come in. Several noted that children involved in sports are often asked to get an annual physical, but those who are not involved in sports—who may be at risk for the most serious problems—are not.

Office Factors. The office factors that challenged improvement included the following:

- Clinics with a heavy walk-in population mentioned this arrangement was not conducive to trying to get people in on schedule
- Lack of enough staff to support outreach (or enough outreach), and not enough money to support expanding staff capacity
- System issues: lack of a computer (though this practice is getting one next year); no system to track patients across the clinic's 15 doctors to identify those that need follow-up; not taking advantage of technology on hand for follow-up, although "every bit of money would help us improve."
- Eclectic set of demands: A family practitioner explained that his practice includes many concerns beyond child health, Medi-Cal, and managed care (including minor surgery and OB), so it is difficult for him to be continuously attentive to meeting

well-baby and well-adolescent visit goals—"Last month, I focused on well-baby visits for [the plan] and this month I'm focusing more on workers' comp."

b. Encounter Data Incentive

LA Care found (and providers confirmed) considerable challenge in effectively implementing the encounter data incentive in a plan with complex arrangements for care delivery.[13] The first challenge is that only one entity can be the explicit target for the incentive, yet several organizations and individuals and their systems must all work smoothly together to permit a complete, accurate encounter dataset at LA Care. When only one of the relevant entities receives the reward for improvement, it may be less likely that the entire process receives the necessary attention. In this case, the "Primary Provider Group (PPG)" receives the incentive. The PPG is a large provider organization that may include multiple medical groups and/or IPAs, which in turn include multiple physician offices. Some pass down the incentive to smaller entities within the PPG, but some do not.

The second major challenge is that due to the multiple system interfaces as well as the human component required to produce complete, accurate data, it is challenging even to diagnose the origin of a data problem so that it can be addressed. In June 2004, LA Care held a summit to (1) discuss strategies to improve encounter data submission, (2) identify ways to help more medical groups meet the encounter data benchmarks, and (3) hear best practices from groups/IPAs that have been successful in earning the incentives. Over 40 individuals representing plan partners, medical groups, and IPAs joined plan staff for the day. Technical assistance from LA Care staff and its encounter data consultant was offered to the groups/IPAs to assist them in better success with the incentive program.

The third challenge is simply the limited amount of money available from the plan for the incentive, especially when the solution to the problem may be considerably more expensive. One PPG explained that it has its own internal incentive for its IPAs to improve encounter data, with one-third of a bonus pool distributed on that basis. The payout was $250,000 last year, in contrast to two payments it received from LA Care of $10-15,000. This PPG notes that it is the top-performing IPA on encounter data, in an environment where medical groups tend to do better since they can exert more direct influence on their physicians. However, despite its efforts, it is only in the mid-range of performance on this measure among LA Care PPGs. Plan staff noted hearing from some providers that it costs them much more to submit an encounter data form than the top incentive offered ($.32 pmpm).

4. Provider Attitudes Toward Incentives

A large majority of physicians supported the incentives. They were receptive both to (1) the idea of attempting to improve timeliness of well-baby and well-adolescent visits, and (2) being paid based on their performance. Underlying this acceptance was an appreciation of the value of preventive care, recognition that there is room for improvement, and agreement that financial

[13] The challenges are likely to be lessened in a plan that contracts directly with individual providers.

payments to encourage certain behaviors can be effective motivators, although they often noted that the financial payments were likely to influence some providers, but not themselves.

Along with their support, many had some reservations about the incentives (11):

- *Sense of limited ability to improve*: To varying degrees, physicians contend that performance is to some extent or perhaps a large extent out of the physician's control because of the population difficulties noted above. Many thought that member incentives might help overcome the population difficulties; that a small amount of money would mean more to a member than a physician and thus go further to prompt compliance with recommended care schedules. However, it was not clear these physicians were suggesting eliminating the current provider incentives.

- *Exact timing of 6th visit may not be clinically important:* Some physicians feel that there are no adverse clinical consequences to a slight delay in the visit timing, which would result in fewer than 6 documented visits by 15 months. Yet the plans' incentives were very much oriented toward achieving the 6th visit by 15 months, as per HEDIS. Also, the first well-visit for a baby is often recorded under the mother's ID number, so that for most babies there is at least one additional visit that is not counted under the incentive.

- *Small sample size*: Many individual physicians, in particular those whose membership is not largely pediatric, may have very few members eligible to count towards the incentive. Basing large payments on performance for these providers may not be fair. (In plans where potential incentive payments are small—those with fewer eligible members—this is less of a concern.)

- *Submitting forms burdensome*: Incentives that add to provider burden by requiring that separate forms be filled out is sometimes seen as a bureaucratic waste of time.

- *Unwillingness to attempt improvement*: One physician felt that the responsibility lies with the patient for coming in to receive care, and that the doctor has no role in changing that.

- *Immoral:* Changing one's practice of medicine in response to financial payments is morally wrong, charged one provider. While other physicians we spoke with would likely agree with this statement, the mention of incentives did not elicit this reaction among most.

- *No minimum threshold:* Some providers—both high and low performers—objected to one plan's use of a minimum performance threshold for receiving any incentive money. They stated that high performance was too difficult to achieve with the Medi-Cal population and the stakes should not be set so high. (The actual threshold set by the plan only requires the providers to exceed 15 percent of their members who turn 15 months old having the recommended 6 visits—it may be that the providers were not yet aware of the specific threshold they needed to accomplish.)

- *No budget-neutral incentives:* One provider was highly skeptical of a new incentive program when she realized that the amounts of other incentives were decreasing.

V. LESSONS LEARNED TO DATE

Several lessons can be learned from the experience to date of these Medicaid health plan pioneers and their affiliated providers. They did not have the benefit of other similar plans' experience when they designed and began to implement their incentives, and in fact still express hope that the evaluation can shed light on which strategies work.

1. ***Communication is critical.*** Communication with providers about the incentives is critical, since without awareness, there is no response. Awareness could not be systematically assessed from our data, but appears mixed. One plan's incentive method allowed it to identify that in 2004, 55 percent of eligible physicians chose to participate in the well-baby incentive by submitting the documentation to receive a bonus for one or more of their patients. While all of the physicians we interviewed who were closely affiliated with the plan were aware of the incentives on a timely basis, several of the community physicians without such ties either were unaware or learned of the incentive only a few months before our call rather than a year earlier when the incentive began. Respondents were split in what communication method they believed was required, with two plans believing face-to-face discussions were essential, while others believe that sending the message clearly and simply in multiple ways at multiple times works—notification, check with clear explanation of what was earned relative to what could have been earned for each relevant measure, followed by repeated rounds of the same.

2. ***Developing a common plan incentive structure would be difficult.*** The demonstration experience suggests it would be very difficult for multiple plans to voluntarily reach agreement on a single incentive administered the same way across plans, despite advantages of this approach for influencing providers. Key differences among plans in philosophy, network size, contractual arrangements with providers, and administrative infrastructure/history were strong forces leading them to implement different incentives targeted to the same measures.

3. ***Administrative effort is significant.*** The administrative process of implementing incentives was a significant effort for most of the plans; they were challenged by system and data issues. Only one plan had a relatively easier time with implementation as it modified its existing risk share distribution formula to incorporate a well-baby incentive.

4. ***Some response is apparent.*** The incentives have helped highlight the need for improvement in well-baby and well-adolescent visits in a number of high-volume physician offices, who are responding largely by attempting more outreach than in the past.

5. ***Population difficulties will limit success.*** Our interviews with providers suggest the difficulties associated with low income, as well as the general preferences of the adolescent population, will limit the potential for improvement of the well-baby and well-adolescent measures to some degree: how much is possible given these population factors is unknown.

6. ***Office factors will inhibit success in some offices.*** In addition to population barriers, several office practice factors limiting improvement also became apparent through our interviews. Some offices are largely walk-in clinics, which are not conducive to ensuring patients receive preventive visits on a clinically appropriate schedule (though they have other advantages for access and efficiency). Some office computer systems are very limited or nonexistent, making it very difficult for staff to check whether people need a well-visit appointment. Some clinic employment contracts prohibit individuals from receiving individual incentives, limiting the use of financial incentives at that level. Some offices feel that they do not have enough staff support to feel that they can take on any additional outreach responsibilities.

7. ***State Medicaid policy appears to be working to sustain plan interest in incentives.*** The state's decision to auto-assign members based on HEDIS scores does appear to be working to sustain plans' interest in retaining incentives in general, giving them a business case for doing so. However, the well-baby visit HEDIS measure is not one of the measures the state chose to include as a factor in auto-assignment, leaving the future of incentives and effort around that measure more questionable. At this point, all the plans expect to retain their incentives for the next year.

In conclusion, five low-income focused plans found it feasible—though not easy—to implement incentives to improve the timeliness of well-child care for low-income babies and adolescents. Our information to date suggests that there is reason for both optimism and pessimism in terms of the likely impact of the provider incentives. On the one hand, some high-volume providers are clearly responding to the emphasis on these measures brought by the incentive programs by increasing outreach. A steeper upward trend in HEDIS scores among the Collaborative plans with incentives relative to Medicaid plans nationally may also be promising. On the other hand, there are signs that not all providers are aware of the incentives. Providers we spoke with did not seem very attuned to the incentives even when they were aware of them, and population and office factors conspire to frustrate providers' ability to improve their performance.

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