Quality-Related Provider and Member Incentives in Medicaid Managed Care Organizations

By James Verdier
Suzanne Felt-Lisk
Fabrice Smieliauskas
Jaclyn Wong
Mathematica Policy Research, Inc.

Laurie Felland
Center for Studying Health System Change

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Executive Summary

Over the last several years, states and Medicaid managed care organizations (MCOs) have undertaken a variety of initiatives that seek to reward quality in Medicaid managed care. States have provided financial and other incentives to Medicaid MCOs tied to various measures of quality, and MCOs have in turn developed quality incentives for the providers and members in their networks.

This report builds on a 2001 Mathematica Policy Research survey of MCOs serving the Medicaid population in 11 states, which found that 39 of 102 plans were providing quality-related financial incentives to the providers in their networks. Since the survey provided very limited detail on these incentive programs, the Center for Health Care Strategies (CHCS) commissioned Mathematica to interview these health plans to find out more about their quality-related financial incentives, and to prepare up to six case studies of these MCO incentive programs, including interviews with representatives of the MCOs, physicians, consumers, and state Medicaid officials.

The report offers seven broad lessons for MCOs and states that are considering quality-related incentive programs, based on our detailed review of the programs developed by five leading Medicaid health plans in three states: California, New York, and Rhode Island. The lessons are set out briefly below with supporting information from the five case studies, which appear in full at the end of the report.

Lesson 1. Both the plan CEO and medical director must be committed to incentives to implement them successfully.

Financial and other incentives for quality require a significant investment of MCO time and resources to design and implement. The incentives generally use dollars that might otherwise be used for direct provider reimbursement or other MCO priorities. They also send signals about what the MCO values. These resource allocation and signaling decisions require CEO involvement and support.

The plan’s medical director also must be heavily involved. Communication and consultation with physicians are crucial to making quality incentives work. The incentives must be tied to activities that physicians agree are closely related to quality. The plan’s medical director must be the face of the plan in consulting with physicians, and is frequently the key internal champion in developing and sustaining incentive programs.

Lesson 2. Incentives must be consistent with the MCO mission and strategic goals.

Leadership support for quality incentives is more likely if the incentives are consistent with the plan’s mission and its strategic goals. We found quality-related incentive programs in both for-profit and not-for-profit plans. While a strict “business case” for
quality incentives cannot always be made, the plans we interviewed believe that at a minimum such programs can enhance a plan’s reputation and its ability to build provider networks and attract more members.

Financial incentives for quality are likely to be a better fit for an MCO if they are embedded in other quality initiatives, such as collecting and reporting of HEDIS and CAHPS measures. Providers are likely to view specific incentives for quality as more credible and likely to continue if they are part of a plan’s overall focus on quality.

**Lesson 3. The market environment can influence the adoption and shape of incentives.**

The market environment for Medicaid MCOs is strongly shaped by the state, which is the major purchaser of Medicaid managed care. The states’ requirement that plans report HEDIS measures and the states’ publication of the results appear to have provided an important impetus for implementation by our case study plans of incentives aimed at improving the plans’ HEDIS scores.

States also can provide some encouragement for MCO provider incentive programs when, as in New York and Rhode Island, the state provides quality-related financial incentives to the MCOs. States also can support MCO incentive programs by bringing plans together periodically to discuss quality-related issues, as has been done in New York and California.

Broader environmental forces can influence plan decisions to adopt incentive programs, and the shape of those incentives. One of our case study plans told us that their quality incentive plan was motivated at least in part by the 2001 Institute of Medicine *Crossing the Quality Chasm* report. The environment also is shaped by what other health plans are doing, especially other Medicaid plans. Plans use their incentive programs to increase public recognition, attract more members, and gain a competitive advantage.

As a result, it is perhaps not surprising that four of the five plans we chose for our case studies are in states where collection and reporting of HEDIS measures are well established, and where financial incentives for quality in both commercial and Medicaid markets are becoming more common.

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1 The Health Plan Employer Data and Information Set (HEDIS) is a series of measures of utilization and access to managed care services. HEDIS is a registered trademark of the National Committee for Quality Assurance. The Consumer Assessment of Health Plans Survey (CAHPS) is aimed at measuring the satisfaction and perceived access to care of health plan enrollees. CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.

Lesson 4. Incentives must be designed and implemented with an understanding of physician attitudes toward incentives and respect for their views.

Physicians are ambivalent in their attitudes toward financial incentives for quality. Most physicians believe they are practicing quality medicine and that it is their obligation as a physician to do so. They are often uneasy with the thought that special financial incentives for quality could motivate them to do better. At the same time, physicians appreciate being recognized for having done a good job. If that recognition takes a financial form, there may be an additional benefit, especially when the incentive is for care that is beyond the norm or hard to provide, or for extra staff and infrastructure investments needed to support quality improvement.

Our case study plans approached this issue in a variety of ways. What was common, however, was the belief that consulting physicians while developing the incentive programs is crucial to their success—a lesson that some plans learned painfully when some initial efforts that were based on insufficient consultation foundered.

A common concern among the providers and health plans we interviewed was the validity and reliability of the data upon which quality incentives are based. The measures and data need to be sound and have integrity in the provider community, and plans must have systems in place to collect the necessary data and report the results back to physicians in a timely manner. This presents a challenge for plans that rely heavily on HEDIS and CAHPS, which generally do not have sample sizes that are large enough to measure variations in physician-level performance reliably, and which are available only with substantial time lags. This has sometimes led to the use of other measures of service and utilization that have less stringent definitions, but that nonetheless capture important dimensions of quality.

Lesson 5. Plan decisions on the form incentives should take depend on the plan’s improvement priorities, improvement targets, data availability, provider network structure, payment system, and market context.

There is no one-size-fits-all approach to incentive design that will work in all settings. The considerations that our case study plans highlighted as the most important include the plan’s improvement priorities and targets, data availability, how network providers are organized, how the plans pay providers, how large the incentive payments should be, and when they should be paid.

Improvement Priorities

The plan, preferably in consultation with providers, must decide which services should have incentives attached to them. Our case study plans usually included services that were measured through HEDIS. The plans also focused on preventive care, and often
targeted services where performance was low, where there was room for improvement, and where recognized ways of improving performance were available.

**Improvement Targets**

Our case study plans also dealt with the issues of how much improvement would be needed to warrant an incentive, and whether providers’ performance should be compared to that of other providers, their own prior performance, or some other benchmark. We found considerable variation around these issues in our case study plans, and no consensus on a single approach. In general, plans sought to make incentives widely available by rewarding improvement as well as absolute performance, and looked for external bases for comparison when they were available.

**Data Availability**

The data needed to measure provider performance are never going to be as complete, reliable, and timely as plans and providers would like. All of our case study plans struggled with data and measurement issues, with most using HEDIS or “HEDIS-like” measures that use claims or encounter data to expand sample sizes and obtain data more quickly than can be done with medical record reviews. The key issue for all plans was provider perceptions of the validity and reliability of the data. Providers were generally supportive of plans’ incentive programs when they could be convinced that the data were as good as could reasonably be expected and that their performance was being measured fairly.

**Provider Organization**

How providers organize themselves—individual versus group practices and the extent of central direction in group practices—can significantly affect how plans provide quality incentives and whether the incentives reach the level of individual physicians in a way that can affect their behavior.

Four out of our five case study plans have not found it practical to provide incentives to individual physicians and instead provide incentives at the group practice level. Still, several of our interviewees told us that it is important for the incentives to be passed down to the individual physician level within the group in some meaningful way to affect physician behavior. The plans have experimented with various ways of doing this, such as by providing individual physician profiles to the practices that can be used to allocate incentives.

**Plan Payment Methods**

Plans have several options for payment of incentives: a standard amount per service, distribution from a common pool, or an add-on to capitated payments. Lump-sum distributions from a common pool will produce higher dollar amounts per payment, and
may thus be more likely to get a physician's or a group's attention. On the other hand, these distributions usually occur long after the physician provides the service, and the amounts can be unpredictable, so they may have less impact on physician behavior than payments made on a per-service or per-month basis that arrive more regularly and predictably. The impact on physician behavior may turn in part on prosaic operational details like whether the incentive payment arrives in a separate identifiable check or is clearly identified in the payment information that plans send to providers.

How Much to Pay

Plans are limited in the amounts they can pay for quality incentives, so they seek approaches that will give them the most bang for the buck in terms of how they affect physician perception and behavior. Unfortunately, there was no consensus in our case study plans about what type of payment was best and how much was enough, although we got some insights from plans that experimented with different plans and amounts.

When to Pay

Lump-sum payments that occur well after the service is provided can be larger and more visible to providers and others, which can be both a plus and a minus. Providers may be more likely to pay attention to large lump-sum payments and change their behavior accordingly, but large payment amounts also may attract the scrutiny of legislators, the media, and others, underscoring the importance for plans of having solid data on provider performance to justify the payments. Smaller monthly or per-service payments have the advantage of being linked more closely in time to the behavior being rewarded, but their relatively small size may result in their receiving less attention.

Lesson 6. The effects of provider financial incentives can be enhanced by combining them with member incentives, provider profiling, education and technical assistance, physician recognition, and other non-financial incentives.

Four of our five case study plans provide some kind of member incentive that complements the provider incentives—usually a modest gift certificate related to specific kinds of preventive services. Some of the plans with whom we spoke thought that member incentives for preventive services may be more effective in some cases than provider incentives, especially for the Medicaid population.

Some of the plans and providers we interviewed told us that distributing individual physician profiles can significantly affect physician behavior, especially when physicians believe the data are valid and that the measures relate to clinically important activities.

Some of the plans do profiles at the group or network level. One plan compiles network quality and member satisfaction scores in a report card that is included in enrollment packets to help members select a network based on quality indicators.
Several of the plans work extensively with physicians and their office staffs to help them improve their performance. These efforts include discussions of group and physician performance measures, providing information on how and why the data are being collected, and working with office staff to make the program less administratively burdensome.

Plans also hold dinners for providers participating in the financial incentive programs to formally recognize top performers. Provider newsletters are used to highlight quality success stories.

**Lesson 7. A commitment to experimentation, measurement, and consultation with providers is key to developing refinements and improvements.**

All of our case study plans have refined and changed their incentives in response to their own measurement efforts and feedback from providers. Three of the five plans are moving toward incentive programs in which providers themselves develop quality improvement measures and plans on the basis of which incentives will be paid.

**Conclusions**

The case study plans strongly believe their current incentive programs are making an impact, although solid data to support that belief is generally not yet available. Plans told us that it can take two to three years to get programs firmly established, and still longer to get firm evidence on their impact. The case study plans, while they are among the leaders in Medicaid nationally in terms of experience with incentives, are still refining their approaches to improve their effectiveness and better measure their impact. Their experience to date has nonetheless generated important lessons for plans new to incentives. Such programs require supportive plan leadership, a favorable market environment, full and continuing consultation with physicians in the community, good data, and a commitment to experimentation and improvement over time.
Introduction

In its March 2001 report on the U.S. health care delivery system (Crossing the Quality Chasm), the Institute of Medicine (IOM) said that “financial barriers embodied in current payment methods can create significant obstacles to high-quality health care.” “The goals of any payment method,” the IOM said, “should be to reward high-quality care and to permit the development of more effective ways of delivering care to improve the value obtained for the resources expended.”

Over the last several years, states and Medicaid managed care organizations (MCOs) have undertaken a variety of initiatives that seek to reward quality in Medicaid managed care. States have provided financial and other incentives to Medicaid MCOs tied to various measures of quality, and MCOs have in turn developed quality incentives for the providers in their networks. The Robert Wood Johnson Foundation and the California HealthCare Foundation are jointly funding an initiative in which eight Medicaid MCOs in California are providing incentives to physicians in their networks and plan members to increase well-baby and well-adolescent visits.

MCOs have significant potential advantages in providing financial and other incentives for quality to both providers and members because they have the administrative infrastructure, network relationships, and information and communication systems needed to facilitate such incentives.

In a 2001 survey of health plans serving the Medicaid population in 11 states for the Kaiser Family Foundation, Mathematica Policy Research found that 39 out of 102 plans were providing quality-related financial incentives to the providers in their networks. The survey obtained only limited detail on the nature of these incentives, however, and no information on why they had been established, how they were working, what their impact had been, and what lessons had been learned.

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5 For more details on this initiative, see the Center for Health Care Strategies Web site at: http://www.chcs.org [Accessed April 2, 2004].


7 The health plans reported only on whether the financial incentives were related to well-child visits, immunizations, pregnancy, lead screening, or asthma.
The Center for Health Care Strategies (CHCS) therefore commissioned Mathematica to interview these health plans to find out more about their quality-related financial incentives, and to prepare five or six case studies of these MCO incentive programs, including interviews with representatives of the MCOs, physicians, consumers, and state Medicaid officials.

Methodology

We began with a list of 40 health plans that reported they had quality-related financial incentives for providers, 39 from the Kaiser Family Foundation survey, and one that had participated in the CHCS Best Clinical and Administrative Practices (BCAP) project and that had financial incentives for providers. We eliminated eight plans from the list for various reasons: four had exited the Medicaid business, two had merged with other plans on the list, one did not have any provider incentives, and one had gone out of business. We then sent letters to the 32 remaining plans requesting an initial 10-minute interview to get basic information on their incentive programs, and to determine whether a more detailed one-hour interview was warranted. Eighteen of the plans agreed to participate in the initial interview. 8 Based on these initial interviews, we determined that 11 warranted a one-hour interview.

In choosing plans for the one-hour interviews, we had two “essential” criteria: the incentive program had to have some interesting characteristics, and it had to have been in place long enough for the plan to have some useful experience to discuss. We also considered other factors, including the extensiveness of the provider incentives, the plan’s commitment to continuous improvement through evolving or changing incentives, plans for future incentives, the interviewee’s knowledge and perspectives on incentives, and the geographic location of the plan.

Following the one-hour interviews and a detailed review of information provided to us by the plans, we selected, in consultation with CHCS staff, five plans for our case studies. Although we sought to obtain as much geographic diversity as possible, three of the five plans we chose for case studies were from New York State. (The other two are from California and Rhode Island.) As discussed further below, we believe health plans initiate quality-related financial incentives in part because other plans in their marketplace have done so. It is therefore not surprising to see this kind of geographic concentration in the early stages of this kind of new initiative.

For the five case studies, we conducted additional telephone interviews with the plans to fill in gaps and clarify responses from the initial interviews. We also interviewed physicians who had experience with the incentives and state Medicaid officials. In cases where the plans provided quality-related incentives to members as well as providers, we sought to interview consumer representatives who were familiar with the incentives.

8 Nine plans declined to participate and five did not return repeated phone calls requesting an initial interview.
Questions Asked

In our interviews with MCO representatives, we asked them to describe:

- Their financial and non-financial incentives, why they established them, how they had changed over time, and what prompted the changes.
- The incentives they considered but did not implement and their reasons for this decision.
- Additional incentives they were considering, their reasons for considering them, and what barriers they foresaw in implementing them.
- Their views on the pros and cons of financial versus non-financial incentives and on the financial, operational, and data issues raised by each type of incentive.
- The differences, if any, between incentives for providers serving the Medicaid population and other enrollees, and the reasons for those differences.
- The impact of their incentives on providers, beneficiaries, managed care purchasers, and public perceptions of the program.
- Which approaches appeared to be most and least effective in meeting the varying goals and interests of MCOs, state Medicaid officials, providers, and consumers.

In our interviews with providers, consumers, and state officials, we sought their perspective on the last two questions.

Audience and Goal

The primary intended audience of this report is Medicaid MCOs that are interested in developing or improving quality-related incentives for their providers and members. State Medicaid managed care purchasers, who establish the environment that can facilitate or inhibit such incentives, are another important audience.

The goal is not to prescribe a how-to cookbook. Even though the case study plans we feature in this report are among the leaders in Medicaid in terms of their experience with quality incentives, they all stress that they are still learning and experimenting with different approaches.

The goal instead is to lay out some of the important lessons these leading plans have learned about promising approaches and pitfalls to avoid. The body of the report is organized around seven broad lessons, with supporting examples from each of the case study plans. There are more detailed case studies at the end of the report that focus on
each plan individually. These individual case studies provide an overview of each plan’s incentives, how they evolved, evidence on their effectiveness, and the lessons the individual plans told us they have learned, many of which are reflected in the broader overview lessons.

**Characteristics of Case Study MCOs and Incentive Programs**

Table 1 briefly summarizes the characteristics of the case study MCOs and their incentive programs. The case studies, which appear at the end of the report, provide more detail. The case studies were reviewed in draft form by the plans to help assure their accuracy and completeness.
Table 1.
Overview of MCO and Incentive Program Characteristics

<table>
<thead>
<tr>
<th>MCO and Incentive Program Characteristics</th>
<th>Neighborhood Health Plan of Rhode Island</th>
<th>CalOptima (California)</th>
<th>Hudson Health Plan (New York)</th>
<th>Independent Health (New York)</th>
<th>Health Now (New York)</th>
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<tbody>
<tr>
<td>Type of Plan</td>
<td>Not-for-Profit</td>
<td>Government</td>
<td>Not-for-Profit</td>
<td>Not-for-Profit</td>
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<td>Number of Enrollees Medicaid/SCHIP Commercial</td>
<td>73,000</td>
<td>330,000</td>
<td>52,000</td>
<td>30,000</td>
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<td>235,000</td>
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<td>Characteristics of Provider Financial Incentives</td>
<td>Additional capitated payment at provider group level:</td>
<td>Bonus pool distributed at practice/network level on the basis of HEDIS access and quality measures (45%), member surveys and retention rates (20%), and provider satisfaction surveys (20%). Remaining 20% is rolled over to ensure program sustainability.</td>
<td>Bonus of up to $1 PMPM paid at practice level based on combination of nine HEDIS measures. Additional “fee-for-service” incentives for Pap tests ($50), special needs screen for SSI members ($50), immunizations and lead and TB screening for two-year-olds ($200), diabetes screening ($100), early identification of pregnant women ($100), and prompt post-partum care ($100).</td>
<td>Beginning in 2003, annual bonus payments of up to $10,000 each to eight provider networks based on reaching goals for HEDIS measures of their choosing in three categories: preventive health, chronic disease, and access/systems (replaced earlier 1999 HEDIS-based system that paid incentives to physicians and groups that exceeded community-level performance standards). $100 to obstetricians for each prenatal care referral form sent to plan within first trimester (added in 2001).</td>
<td>Payments to individual physicians or physician practices based on up to four claims-based clinical quality measures (40% of incentive payment), and generic prescribing and financial efficiency (60%). Providers can earn incentives of up to 10-20% of their total compensation from the plan. $100 to OB/GYNs for notifying plan of high-risk pregnancies in first trimester.</td>
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<td>$0.125 per member per month (PMPM) per measure based on HEDIS measures (childhood and adolescent immunizations and cervical cancer screening)</td>
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<td>$0.65 PMPM for JCAHO accreditation</td>
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<td>$0.65 PMPM for asthma treatment</td>
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<tr>
<td>Characteristics of Member Incentives</td>
<td>Improvement or a self-designed quality improvement project.</td>
<td>Department store gift card for well care and immunizations, prenatal care, and postnatal care.</td>
<td>$25 gift certificate for groceries if appropriate post-partum care is received within 25-60 days of delivery. $10 phone card incentive for SSI members who obtain appropriate primary care, dental screenings, and diabetic screenings (being pilot tested).</td>
<td>Diaper bag for pregnant members presenting for prenatal care. $5 phone or grocery cards for specific services received, such as retinal exams for diabetics.</td>
<td>New baby welcome kits and videos for pregnant mothers.</td>
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<td>Other Complements to Provider Financial Incentives</td>
<td>Group-specific quarterly and annual performance reports on HEDIS measures used for incentives. Low-performing provider networks may be terminated after two years. Quality and member satisfaction scores are compiled in a report card given to new enrollees.</td>
<td>Distribution of practice-specific performance measures to practices; beginning to distribute physician-specific measures. Plan representatives train doctors and staff on how to improve scores. Periodic dinners and an anniversary party for all participating providers, at</td>
<td>Plan highlights quality success stories in its monthly newsletter. HHP communicates in multiple ways with providers and office staff on how and why data are being collected and on ways to make the program less administratively burdensome.</td>
<td>Performance report card included with incentive payments, giving overall score and mean and variance for all physicians in their specialty.</td>
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<td>MCO and Incentive Program Characteristics</td>
<td>Neighborhood Health Plan of Rhode Island</td>
<td>CalOptima (California)</td>
<td>which top performers in Hudson Health Plan (New York)</td>
<td>Independent Health (New York)</td>
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<td>incentive programs are recognized.</td>
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<td>Luncheons and other informal incentives for office staff, particularly during chart reviews.</td>
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<td>Measures of Effectiveness</td>
<td>Change in HEDIS measures.</td>
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<td>Change in utilization of services with incentives.</td>
<td>Amount of incentive payouts to providers.</td>
<td>Change in utilization for services with incentives.</td>
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HEDIS = Health Plan Employer Data and Information Set  
JCAHO = Joint Commission on Accreditation of Healthcare Organizations
Lessons

Lesson 1. Both the plan CEO and medical director must be committed to incentives to implement them successfully.

Financial and other incentives for quality require a significant investment of MCO time and resources to design and implement. They generally use dollars that might otherwise be used for direct provider reimbursement or other MCO priorities. They also send signals, both internally and externally, about what the MCO values. These resource allocation and signaling decisions are generally made at the CEO level, so CEO involvement and support is necessary for the incentive program to be successful.

The plan’s medical director also must be heavily involved. Communication and consultation with physicians are crucial to making quality incentives work, our case study plans told us. The incentives must be tied to activities that physicians and other clinicians agree are closely related to quality. The plan’s medical director must be the face of the plan in consulting with physicians on incentive design and implementation, and convincing them that the incentives are aimed at improving clinical quality, not just saving money for the plan. Others in the plan—such as those involved in quality improvement, network management, customer service, communications, and information technology—are needed to carry out the operational details of these kinds of quality initiatives, but top-level physician leadership and commitment is essential.

In CalOptima, for example, our interviewees stressed that leadership was key in raising the health plan’s commitment to incentive programs and providers’ involvement in quality improvement. One of the providers we interviewed in this plan noted the importance of a proactive medical leader in designing the plan’s incentive programs, and that medical leadership alone may drive some of the improvements in providers’ performance. (“It is hard to separate . . . what is happening because of the bonus programs and what is happening due to the strong leadership of [CalOptima’s] Chief Medical Officer.”)

In Neighborhood Health Plan of Rhode Island (NHPRI), by contrast, some providers we interviewed indicated that the effectiveness of the incentive effort was hindered because medical leadership from the health plan was not actively involved “up front.” The plan recently signaled to medical leadership of provider groups that they will provide more opportunity for pre-implementation feedback on new measures the plan will be using in the future. The providers we spoke with said this may increase the program’s effectiveness.

Our NHPRI provider interviewees stressed that the health plan must convince both the medical and operational leadership in provider groups that the incentive program is addressing a real problem and that the issue at hand is clinically important for their patients.
In Independent Health, the plan medical director noted that the incentives did not start until the plan hired a full-time medical director who had administrative functions beyond those performed by the part-time physicians who had previously served in that role. He also mentioned that administration and physician leaders are necessary at the provider sites.

The importance of CEO and medical leadership can make incentive programs vulnerable to leadership turnover, especially in the earlier stages of design and implementation. A new CEO or a new medical director may not be as interested as the “champions” who provided the initial impetus for the incentive program.

Once incentives are in place and have become institutionalized—with systems at the MCO to administer them and physicians coming to expect that they will receive them if their performance warrants it—top-level plan leadership may be less essential. This is both a plus and a minus. As discussed further below, incentives may need to be rethought and modified based on experience and changing market conditions, but this refining and rethinking may not occur without leadership support, especially medical leadership.

In Health Now, plan interviewees said that senior management support was necessary to get the incentive program off the ground and that during implementation the medical director needed to constantly advocate for the program. When senior management later considered canceling the program, the network management, quality, and information technology departments protested. “We killed ourselves to do this,” they said. “Pain is part of this.” “If all of a sudden you jump ship,” the medical director said, “you don’t go back and do this a second time.” The plan’s management agreed to continue the program.

**Lesson 2. Incentives must be consistent with the MCO mission and strategic goals.**

Leadership support for quality incentives is more likely if the incentives are consistent with the plan’s mission and its strategic goals. If a plan sees its mission as providing a solid profit for its shareholders and expanding membership, quality incentives may play a role if a case can be made that the incentives will enhance the plan’s reputation and its ability to build provider networks and attract more members. If a plan sees its mission primarily as providing quality health care for its members and supporting its provider networks, financial incentives for quality may be more directly relevant to its mission and goals.

Among our five case study plans, four are not-for-profit and one is government. Among the 39 plans that we initially identified (based on the Kaiser survey) as having financial incentives for quality, 12 were not-for-profit and 20 were for-profit. (We were not able to determine the status of seven of the plans.) While a plan’s profit status is not a
definitive guide to its mission and goals, it is one indicator of the emphasis it may put on quality incentives.

Financial incentives for quality are likely to be a better fit for an MCO if they are embedded in other quality initiatives. If, for example, a plan’s commitment to quality is underscored by collection and reporting of HEDIS and CAHPS measures, and if the plan has set up systems to improve performance if these or other measures identify areas for improvement, it is more likely that financial incentives for quality will take root and flourish. Providers are likely to view specific incentives for quality as more credible and likely to continue if they are part of a plan’s overall focus on quality.

Our case studies found that several of the plans began their financial incentives for quality at around the same time that the states in which they were located began requiring plans to report HEDIS measures. By providing incentives to physicians that were closely tied to the measures reported in HEDIS, the plans hoped to improve their HEDIS scores. We found this impetus from HEDIS for CalOptima in California, and for the three plans in New York. In Rhode Island, NHPRI also started its provider incentive program to improve its HEDIS scores and to facilitate JCAHO accreditation, even though that state’s Medicaid agency puts somewhat less emphasis on HEDIS measures than on several MCO performance measures it developed itself.

Most of the case study plans had broader goals than just increasing HEDIS scores. Health Now, for example, told us that its quality incentives, which were first introduced in 1998, were established as a way to reward providers for their participation in the plan, to introduce an awareness of quality and population health among providers accustomed to thinking in terms of individual patients, and to start moving reimbursement from fee-for-service payments to quality performance.

Lesson 3. The market environment can influence the adoption and shape of incentives.

State Government

The market environment for Medicaid MCOs is strongly shaped by the state, which is the major purchaser of Medicaid managed care. As discussed in the prior section, the state’s requirement that plans report HEDIS measures and publication of the results by the state appears to have provided an important impetus for implementation by our case study plans of provider and member incentives aimed at improving the plans’ HEDIS scores.

In addition, New York State began paying financial incentives to Medicaid plans in 2002, based on their HEDIS and CAHPS scores. The incentive to a plan can be as much as a one percent increase in PMPM payments. New York began using plan performance

9 Counties play a significant role in Medicaid managed care purchasing in some states, including New York and California.
on quality measures when auto-assigning enrollees in 2001, and also takes quality performance into account when considering plan merger proposals. In addition, the state brings plans together periodically for discussions of quality-related issues such as management of diabetes and asthma, quality improvement strategies, improving preventive health care for adolescents, and provider profiling. The Medi-Cal program in California also has conducted collaboratives for plans in recent years on diabetes, immunizations, and chlamydia screening, and began an adolescent health working group in 2004.

Rhode Island has had a performance incentive plan for Medicaid health plans since 1998. The plans are eligible for financial incentives of up to $1.25 PMPM based on their performance on a series of administrative, access, and clinical performance measures, with the clinical measures now accounting for 50 percent of the potential score. In addition, the state increased Medicaid health plan capitated rates by $0.75 PMPM in 1999, with an explicit requirement that plans use the additional amount for incentive payments to primary care providers. Plans were allowed to determine the methodology for distributing these additional amounts, subject to state approval.

Officials in all three states say that they are not pushing plans to adopt either provider or member incentives. These are tools plans may choose to use to achieve quality goals, but state officials say they have not yet seen enough evidence on their effectiveness to push plans in one direction or another. They would prefer to let plans experiment with different approaches to see which ones work best.

**Broader Environmental Forces**

Plan initiatives also can be shaped by the larger health care environment. Hudson Health Plan (HHP) in New York told us that their quality incentive plan was motivated at least in part by the discussion of incentives in the 2001 IOM *Crossing the Quality Chasm* report cited earlier.

The environment also is shaped by what other health plans are doing, especially other Medicaid plans. As more plans in an area develop and implement these kinds of incentives, the pressure grows on their competitors to provide similar incentives. Independent Health in New York told us that one of their reasons for initiating provider incentives was to increase public recognition and attract more members. Health Now in New York uses its relatively generous physician incentive plan as a source of competitive advantage in a market where other plans offer more nominal incentives. HHP (a not-for-profit plan) is aware that the bonuses paid by other plans in the state are of different types and higher amounts, and that it feels pressure from physicians because of these differences. However, HHP does not believe it can pay as much as these other plans.

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There also can be spillover from commercial plans to Medicaid plans, since commercial and Medicaid provider networks generally overlap, at least to some extent. Health Now extends its Medicaid provider incentives to its commercial network, noting that pooling Medicaid and commercial members allows most providers to have enough total members to obtain reliable provider-level quality scores. Independent Health, by contrast, uses different performance measures for its commercial and Medicaid populations to reflect demographic differences in the Medicaid population and the larger performance gap on the Medicaid side. As a result, the plan is not able to offer incentives at the provider level in Medicaid, given the lower caseload per provider in Medicaid. (Independent Health has 235,000 commercial enrollees and only 30,000 Medicaid enrollees.)

CalOptima uses different incentives for its Medi-Cal (Medicaid) population than for its Healthy Families (SCHIP) population, reflecting in part the fact that it competes with private sector plans in the Healthy Families program. CalOptima is thus moving toward a tiered capitation model in the Healthy Families program that is similar to what commercial plans in the area are using.

Plans also may collaborate with other plans in the same marketplace, although we found only limited evidence of this. Health Now reports that local health plans have worked together to agree on common clinical guidelines for various diseases, driven by a 15 to 20 percent membership turnover every two years, and by the fact that “physicians go crazy with several guidelines.” However, the plans have not aligned their incentives in the same way, because the incentives form part of plans’ competitive advantage. More generally, Health Now typically creates its own distinct quality initiatives, assuming that other plans’ quality programs will benefit Health Now patients, regardless of whether or not Health Now collaborates with the other plans.

Because of the impact of state government and these various market factors, it is perhaps not surprising that the plans we ended up choosing for our case studies are clustered in states where collection and reporting of HEDIS measures are well established, and where financial incentives for quality in both commercial and Medicaid markets are becoming more common.

When The Robert Wood Johnson Foundation and the California HealthCare Foundation conducted a national competition in 2002 for grants to fund pilot projects aimed at rewarding physicians and hospitals for higher quality, four of the seven grantees were in California and New York, and the only Medicaid grantee was in California.11

Lesson 4. Incentives must be designed and implemented with an understanding of physician attitudes toward incentives and respect for their views.

Physicians are ambivalent in their attitudes toward financial incentives for quality. Most physicians believe they are practicing quality medicine, and that it is their obligation as a physician to do so. They are often uneasy with the thought that special financial incentives for quality care could motivate them to do better. Of course physicians, like the rest of us, appreciate being recognized for having done a good job. If that recognition takes a financial form, there may be an additional benefit. If, however, the incentive comes in a way that undermines the value physicians receive from the recognition, the benefit of the incentive may be reduced or eliminated. This might occur, for example, if the incentive was directly linked to a service that was so standard or routine that most physicians would think that no extra payment for it was warranted. Incentives aimed at offsetting the costs of office staff and infrastructure investments needed to support quality improvement may be welcomed more broadly.

Our case study plans approached this issue in a variety of ways. What was common, however, was the belief that consulting physicians while the incentive programs are being developed is crucial to their success. Some plans learned this lesson the hard way when initiatives begun without adequate up-front consultation foundered, but they were generally able to reestablish their programs by reaching out to physicians who initially felt excluded. Also important, the plans told us, is continuing to stress the goal of improving clinical quality, focusing in particular on areas where physicians themselves have the ability to improve quality, and where there is a reasonable professional consensus on what needs to be done and how to measure it.

Involving Physicians in Incentive Design and Implementation

Health Now stressed the importance of provider participation from the early stages of incentive development. Their original incentive measures were recommended by a consulting firm and by specialist societies. While clinically sound, the measures were often unsuccessful. Surgeons, for example, were measured on rates of congestive heart failure following surgery. But the surgeons wanted to be rewarded for good quality of care, rather than punished for poor quality. Health Now encourages the provider community to conceptualize the current standard of care in their practice areas and to suggest methods of measuring it. The incentives are then tied to those measures.

The CalOptima providers we interviewed said that the plan’s incentive programs raise physician awareness of quality issues, even though the money may not have a great impact on their behavior. One provider told us that the bonus CalOptima paid is more of a verification of what providers already do for quality with all of their patients; the money is “positive reinforcement” and helps offset low reimbursement.12

12 While low provider reimbursement has the potential to undermine the impact of performance incentives, we did not encounter any substantial evidence of this in our case study interviews. Some providers we interviewed in HHP...
CalOptima emphasized the importance of educating providers frequently and making participation as easy as possible. Be explicit about the program’s goals, they said, and try to reduce providers’ administrative burdens, such as by switching from medical record review to claims data. Also, give providers detailed information on how they are measured and better information on how individual physicians are performing so they can make changes in their practices. For example, one provider told us how the detailed pharmacy data he received from CalOptima helped achieve significant improvement in his practice’s asthma scores.

When we asked what important lessons they had learned, HHP underscored the importance of communication with providers. Plans, it said, should try to understand the normal operations of provider practices and make the incentive program compatible with those operations. HHP was founded by Federally Qualified Health Centers, and so is quite familiar with those kinds of clinical practices, but now has other types of practices in its network that also must be accommodated. HHP noted that while it is important to ask providers for their input during the design phase of incentive programs, “until they try to make it work in their office they won’t really know what the problems are.” Interviews with HHP providers confirmed the importance of the plan’s open lines of communication and receptiveness in shaping the incentive, provider participation, and provider understanding of their performance.

NHPRI encourages provider groups in its network to develop self-designed quality incentives that align with the group’s own quality improvement goals. NHPRI also has refined its communication strategy to complement the financial incentives for quality. There are quarterly face-to-face meetings with major provider groups that include both the operational and medical leadership of the groups. Last year, for the first time, site-specific HEDIS data were presented to the full group of clinical leaders from all the major provider groups, allowing for a discussion of why one group did better than another.

Independent Health says it has found that, while necessary, performance data and monetary incentives alone do not change physician behavior. It has developed an approach it calls “improvement literacy,” which emphasizes multiple types of communication with providers and their staff, including education for the providers on how and why the data are being collected and working with office staff to make the program less administratively burdensome.

Like Health Now and NHPRI, Independent Health is allowing providers to choose the measures on which they are judged, which the plan thinks may help increase provider compliance and improve their performance. With its new incentive design, Independent Health includes the office manager from each participating practice on the design team. This has helped the plan find out about operational issues in the practices, such as expressed concern that the plan’s quality incentive program could draw resources away from basic provider reimbursement in the future.
patient wait times and cycle times. The plan wants to involve senior hospital administrators as well to help with the many operational issues the hospital-based clinics confront by, for example, helping them acquire needed technology to improve patient scheduling.

**Physician Concerns about Data Validity and Reliability**

A common concern among the providers and health plans we interviewed was the validity and reliability of the data upon which quality incentives are based. The measures and data need to be sound and have integrity in the provider community. Using the industry standards of HEDIS and CAHPS was a common approach. The plan must have a solid information system to profile physicians accurately.

Health Now said that the providers in its network are often skeptical about the accuracy of the numbers and want to cross check the plan’s claims-based data with medical charts. At the same time, both the plan and providers resist relying on medical chart reviews for performance data, given its cost in time and resources. The plan now allows providers to submit charts and receive adjustments to their data and incentive payments if the original scores prove to be incorrect. Providers say this approach helps to maintain the credibility of the program, although some feel that the correction process is too burdensome.

**Lesson 5. Plan decisions on the form incentives should take depend on the plan’s improvement priorities, improvement targets, data availability, provider network structure, payment system, and market context.**

There is no one-size-fits-all approach to incentive design that will work in all settings. We outline here the considerations that our case study plans highlighted as most important, including the plan’s improvement priorities and targets, data availability, how network providers are organized, how the plan pays providers, how large the incentive payments should be, and when they should be paid.

**Improvement Priorities**

The plan, preferably in consultation with providers, must decide which services should have incentives attached to them. As discussed earlier, some plans allow or encourage providers to propose incentive programs that will address providers’ priorities. As shown in Table 1, the plans in our case studies usually included services that were measured in HEDIS, since there is general agreement that these services are related to quality, and the data needed for measurement are already available. The plans also focused on preventive care, such as immunizations and well-child visits, presumably because of a belief that these services are especially important for the Medicaid population and are likely to have a favorable cost-benefit ratio. Plans also targeted services where performance was low, where there was room for improvement, and where recognized
ways of improving performance were available. Well-adolescent visits and asthma treatment were commonly included for these reasons.

**Improvement Targets**

Our case study plans also dealt with the issue of how much improvement would be needed to warrant an incentive, and whether providers’ performance should be compared to that of other providers, their own prior performance, or some other benchmark. We found considerable variation around these issues in our case study plans, and no consensus on a single approach. In general, plans sought to make incentives widely available by rewarding improvement as well as absolute performance, and looked for external bases for comparison when they were available.

In CalOptima, for example, providers convinced the plan to provide bonuses to networks that demonstrated improvement, so that a network would not be denied a bonus just because of where it ranked in the distribution.

HHP evaluates provider performance compared to state Quality Assurance Reporting Requirements (QARR) averages, but most providers receive some payment even if they are below average, since the plan is focused on getting all providers’ attention and developing their commitment to quality improvement.

Independent Health now lets its provider networks choose the performance measures on which they will be monitored and set network-specific goals for each.

In NHPRI, by contrast, the incentives are paid only if a provider group exceeds a threshold set for all provider groups. We were told that some groups that already meet the threshold do not see a reason to work hard to improve. Another group that believes it provides excellent care felt that the data on which the incentives are based vary a lot from year to year by chance, so even if they are low, they do not believe they necessarily have a problem.

**Data Availability**

The data needed to measure provider performance are never going to be as complete, reliable, and timely as plans and providers would like. HEDIS measures usually have sample sizes that are too small to be reliable at the provider level without additional data collection, and the data are often not available until a year or more after the service is provided. Administrative claims data may be reasonably complete and timely if the plan pays providers on a fee-for-service basis, but encounter data for providers that are paid on a capitated basis are often incomplete and inaccurate. Claims and encounter data often lack clinical detail on the services provided and the patient’s condition and needs, but filling those gaps with medical record reviews is very resource-intensive and costly. CAHPS and other beneficiary satisfaction surveys can capture some important dimensions of provider performance but, like HEDIS, sample sizes are usually too small.
to be reliable for individual providers and the data are available only with substantial lags.

All of our case study plans struggled with these issues, with most using HEDIS measures or “HEDIS-like” measures that use claims or encounter data to expand sample sizes and obtain data more quickly. The key issue for all the plans was provider perceptions of the validity and reliability of the data. If providers could be convinced that the data were as good as could reasonably be expected, and that their performance was being measured fairly, they were generally supportive of the plans’ incentive programs. This underscores the importance for plans of working closely with the providers in their networks to both design and implement incentive programs. Providing good information to physicians on how their scores are calculated is an important element in obtaining their buy-in and support. As noted earlier, some plans gave providers an opportunity to supply additional information, such as medical records, to improve their scores.

Provider Organization

How providers organize themselves—individual versus group practices and the extent of central direction in group practices—can have a significant impact on how plans provide quality incentives and on whether the incentives reach the level of individual physicians in a way that can affect their behavior.

Four of the five case study plans have not found it practical to provide incentives to individual physicians. (Health Now, discussed below, is the exception.) This is partly because individual physicians generally do not have large numbers of Medicaid patients enrolled with a specific plan, and many of those who are enrolled may not be eligible for the services to which the incentive is attached. In addition, if plans use a combination of administrative and chart review data to measure the services provided, the chart review data may be too costly to collect from small offices at a level that would produce reliable indicators. (Some of our case study plans, such as CalOptima and Health Now, have moved away from chart reviews, in part for this reason.)

In large group practices, the volume of a plan’s patients seen by all the practice’s physicians may be large enough for a sample of performance data to be reliable, and the total dollar amount of incentives that the practice receives may be large enough to get the practice’s attention. The managers of the practice may be able to use the incentive dollars in ways that can improve the practice’s performance as a whole, through such things as reminder systems for patients and extra staffing to help with patient care. They also may give credit or recognition to those physicians in the practice who are most responsible for the practice’s incentive payments.

Still, several of our interviewees told us that it is important for the incentives to be passed down to the individual physician level within the group in some meaningful way in order to affect physician behavior, and Health Now has taken steps to facilitate that.
Health Now makes incentive payments either to individual physicians or to physician practices or other provider organizations. When payments are made at the practice level, the plan provides performance scores for individual physicians in the practice. This allows practices to hold all of their physicians accountable for their performance, and to pass on the incentive to individual physicians. However, at least one practice that receives the incentive money diverts it into a corporate pool to pay for health and retirement benefits, and its physicians do not individually receive the financial incentive.

Health Now told us that it is possible to overcome small sample sizes and extend Medicaid incentives to the individual level. Pooling Medicaid and commercial members allows most providers to have enough total members to obtain a reliable individual-level quality score. Even though the score is not Medicaid-specific, Medicaid members contribute to the score and providers have strong incentives to provide them with quality care.

Independent Health started with an incentive program that profiled performance at the community level rather than at the individual or practice level, but soon concluded that the incentive in that form was too weak. The physicians felt they were small players and that their own behavior would not make a difference in the overall scores or bonus amounts. The new incentive program focuses on the practice level, but the plan notes that practice leadership is critical in getting the bonus dollars distributed within the practice.

Hospital-based clinics may have contractual arrangements with their physicians that can make it difficult to pay incentives to individual physicians. In addition, nurses and staff in hospital-based clinics may object to doctors or other staff getting incentives, but not themselves. It also can be difficult to provide incentives to salaried physicians in community health centers and similar settings.

Plan Payment Methods

Plans have several options for payment of incentives: a standard amount per service, distributions from a common pool, or an add-on to capitated payments. Plans that normally pay physicians on a fee-for-service basis may find that a standard amount per service fits best with their payment system, while plans that use capitation may find it easiest to add an amount to the capitated payments for high-performing physicians or groups. Lump-sum distributions from a common pool will produce higher dollar amounts per payment, and may thus be more likely to get a physician’s or a group’s attention. On the other hand, these distributions usually occur at a considerable time after the physician provides the service, and the amounts can be unpredictable, so they may have less impact on physician behavior than payments made on a per-service or per-month basis that arrive more regularly and predictably. The impact on physician behavior may depend in part on prosaic operational details like whether the incentive payment arrives in a separate identifiable check, or is clearly identified in the payment information that
plans send to providers. It may even hinge on whether individual physicians see this information, or whether it is all handled by an office business manager or billing clerk.

The case study plans took a variety of approaches to the payment method issue:

- HHP uses a bonus program based on physician performance on a range of HEDIS measures, with the bonus added to the capitated rate at the practice level, and with fee-for-service add-ons for discrete services like Pap tests and immunizations paid directly to physicians.

- NHPRRI makes additional capitated payments at the provider group level, based on HEDIS and other measures.

- CalOptima makes payments out of a bonus pool at the practice or network level, based on HEDIS and other measures.

- Independent Health also makes annual HEDIS-based bonus payments at the provider network level out of a fixed pool of funds, but adds an additional $100 payment to physicians for prenatal care referrals.

- Health Now has a similar system of bonus payments at the individual physician or practice level, combined with a $100 payment to physicians for notifying the plan of high-risk pregnancies in the first trimester.

Independent Health expressed concern about going beyond the bonus payments for prenatal care referrals to fee-for-service incentives for other physician activities such as mammography or child immunization. The plan and some of the providers we spoke with believed that these kinds of direct monetary incentives to physicians for specific activities looked too mercenary and too much like “ransom.” The plan made an exception for prenatal care referrals, given the importance of early plan involvement in case management in these situations, but otherwise wanted to keep the focus on overall performance and population-based care.

**How Much to Pay**

Plans are limited in the amounts they can pay out for quality incentives, so they seek approaches that will give them the most bang for the buck in terms of the impact on physician perceptions and behavior. Unfortunately, there was no consensus in our case study plans about what type of payment was best, and how much was enough. Some insights are available, however, from plans that experimented with different approaches and amounts.

HHP, which has experimented with incentive payments ranging from $25 for Pap tests to $200 for full immunizations and lead and TB screenings for children up to age two, has concluded that amounts less than $50 are inadequate to change physician behavior and that $200 is adequate, but it is not certain about the adequacy of amounts in between.
An earlier version of Independent Health’s incentive program included all of the 40-plus sites in its network in the program, but now Independent Health limits the program to its eight core provider sites, which gives each of the eight sites the potential to earn more than $10,000 a year in incentives.

One large provider group in CalOptima received a bonus payment of more than $1 million in 2003, although we found few other specific examples of aggregate payments that were this high.

In Health Now, the plan’s incentives represent 10 to 20 percent of provider compensation from the plan, more than most other plans in our study. The plan says that nearly all doctors pay attention to the quality measures. At much lower amounts, the plan believes some doctors would try to improve because of peer pressure, but many others would not. In the long run, the plan believes, physician interest in quality might increase even without the money, but at a slower pace.

When to Pay

Lump-sum payments that occur well after the service is provided can be larger and more visible to providers and others, which can be both a plus and a minus. Providers receiving the lump sum and other providers who may receive such payments in the future will likely pay more attention to the incentive program if they see that sizable amounts of money are involved. Large payment amounts, however, may attract the scrutiny of legislators, the media, and others, so plans must be prepared to justify the payments with solid data on provider performance. Our case study plans did not express concern about this potential for outside scrutiny, perhaps because their current programs do not have very high external visibility.

As noted earlier, these lump-sum payments may have less impact on day-to-day physician practice than smaller and more predictable per-service or per-month payments. In part, the impact of either approach may turn on how visible each form of payment is to the physician and his or her office staff, so operational details like how the incentive payment shows up in the payment documentation provided to physician offices can be important. A report at the end of a quarter or a year on the total incentive payments a provider or a group has received during the period can combine some of the benefits of smaller regular payments and larger lump-sum distributions.

**Lesson 6. The effects of provider financial incentives can be enhanced by combining them with member incentives, provider profiling, education and technical assistance, physician recognition, and other non-financial incentives.**
Member Incentives

As shown in Table 1, four of our five case study plans provide some kind of member incentive that complements the provider incentives—usually a modest gift certificate for specific kinds of preventive services. Some of the plans thought that these kinds of member incentives for preventive services may be more effective in some cases than provider incentives, especially for the Medicaid population.

The plans in New York are limited in the amount and type of member incentives they can provide by their contract with the state. One plan also reported that the state permits plans to implement incentives only for one year, which makes it difficult to establish member and provider awareness and to measure the incentives’ long-term effectiveness. The state officials we spoke with confirmed that these durational limits existed, but were not certain about whether the source of the limits was federal or state rules. State officials said that review of these limits would be appropriate if there was evidence that larger and/or longer-lasting member incentives could have a beneficial impact on preventive care, and if federal rules permitted a change.

CalOptima said that participation in the member incentive program is associated with higher immunization rates and well-care visits, compared to rates among non-participants.

HHP reported that, for the postpartum member incentive, the percentage of postpartum visits attended increased from 55 percent with a blanket and reminder postcard and phone call intervention to 66 percent with those interventions, plus the $25 gift certificate. The $10 phone card incentive for SSI members was associated with an increase in the percentage of members with a dental visit from 43 percent when the incentive began in December 2002 to 51 percent in October 2003. The percentage of SSI members who received a needed primary care visit increased from 68 percent to 77 percent.

Independent Health has found that member incentives of significant monetary value, such as a breast pump previously included in its prenatal package, do affect enrollee behavior, but that incentives of minimal monetary value (as currently allowed by the state) do not have enough appeal to significantly alter behavior.

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13 The Medicaid managed care model contract states in Appendix D (“Marketing Guidelines”) that MCOs may offer their enrollees “rewards for completing a health goal, such as finishing all prenatal visits, participating in a smoking cessation session, attending initial orientation sessions upon enrollment, and timely completion of immunizations or other health related programs. Such rewards may not exceed $50 in fair-market value per Enrollee over a twelve (12) month period, and must be related to a health goal.” All such rewards must be approved by the state. The model contract is available on the Web at: [http://www.health.state.ny.us/nysdoh/mancare/macntrct.pdf](http://www.health.state.ny.us/nysdoh/mancare/macntrct.pdf) [Accessed May 6, 2004]. The language quoted is on p. 148.
Provider Profiling at the Individual Level

Some of the plans and providers told us that distributing individual physician profiles can significantly affect physician behavior, especially when physicians believe the data are valid and that the measures relate to clinically important activities. Physicians tend to be overachievers, they said, so peer pressure can be an important motivator.

Health Now, which pays incentives to individual physicians as well as physician groups, includes with the semi-annual bonus payments a performance report card that allows individual physicians to compare their overall score with the mean and variance for all physicians in their specialty. Providers we talked with in that plan told us that giving scores to individual physicians is important, since it allows practices to hold all of their physicians accountable for their performance. The physicians also told us that the reports and payments from the plan are frequent enough to allow them to change their behavior in response to the scores, but not so frequent as to overly burden the provider. (Performance reports are sent out monthly, four months after the end of the month covered by the report.)

HHP reports that it has been sending HEDIS scores to the medical directors of group practices for the last four years, but that many of the medical directors claim they have never seen the data. The plan says it will now start distributing the data to the practices with breakdowns for individual physicians in the practice, by name, in the hope that this will increase the impact.

Group or Network Profiling

CalOptima compiles network quality and member satisfaction scores in a report card that is included in enrollment packets to help members select a network based on quality indicators. One of the member representatives we interviewed was skeptical about the impact of including this information in the enrollment packets because many members do not read them. A network representative we spoke with, on the other hand, welcomed the public reports as a demonstration of the services they have been providing all along.

NHPRI Island gives profiles to providers at the group level on some HEDIS measures, based largely on administrative data.

Physician/Staff Education

HHP last year began actively using provider relations representatives to serve as a liaison between the plan and the providers. These representatives discuss the performance data with the provider offices and advise doctors and staff on how they could improve their scores. The plan also has changed the reporting processes based on provider feedback received through these liaisons. The physicians we spoke with said that they found the provider relations representatives very helpful and reported that HHP is more receptive
and communicative with them than commercial plans. (“[HHP] is willing to go that extra step to help providers and patients; they are organized and so whenever we have a problem we know who to contact.”)

NHPRI stressed that effective communication of data results is important and complements the incentives. The plan has quarterly face-to-face meetings with provider groups that include both the operational and medical leadership of the groups. Last year, for the first time, the plan presented site-specific HEDIS data to the clinical leaders of all the groups, allowing for a discussion of why one group did better than another.

Independent Health has found that, while necessary, performance data and monetary incentives alone do not change physician behavior. The plan believes that “improvement literacy” is the most important part of a successful quality program. This concept emphasizes multiple types of communication with providers and staff, including education for the providers on how and why the data are being collected and working with office staff to make the program less administratively burdensome.

**Physician Recognition**

HHP holds periodic dinners for providers participating in the financial incentive programs at which top performers are formally recognized. The plan also provides luncheons and other informal incentives for office staff, particularly during chart reviews. The plan believes that the appreciation dinners and anniversary parties are effective in increasing provider awareness of quality, especially in areas where bonus amounts are lower. For example, the plan thinks the dinners alone might spark enough interest in place of the practice-level $1 per-member per-month bonus payments that are based on a broad mix of HEDIS measures. On the other hand, the dinners reportedly do not add much to performance on immunizations, where the incentive can be as much as $200 per child.

CalOptima at one point held dinners at which physicians nominated by member advisory and provider committees as top performers were recognized. Budget constraints led the plan to limit this program to distributing plaques to the three top-performing physicians each year. The plan also has moved toward a more punitive disincentive—dropping low performers from its network. One provider we spoke with noted that this definitely increases providers’ awareness of quality issues.

Independent Health highlights quality success stories in its monthly newsletter. While the plan considers these monthly profiles to be a relatively weak incentive for quality, it wants to build on this incentive by highlighting providers that implement electronic medical record (EMR) systems. The plan believes that a strong EMR will support provider improvement on quality measures by enabling providers to determine which patients are not presenting for needed preventive and other treatment.
Lesson 7. A commitment to experimentation, measurement, and consultation with providers is key to developing refinements and improvements.

All of our case study plans have refined and changed their incentives in response to both their own measurement efforts and feedback from providers.

NHPRI started with an incentive for capitated physician groups that was based on performance above a threshold on several combined HEDIS quality measures. The plan’s analysis of group performance on these measures suggested that groups receiving the incentive did not improve any more than providers who did not. Provider groups performing above the threshold, did not see a reason to improve, while low performers tended to attribute their lower ranking to problems with the data rather than problems with the care they were providing. In response to these and other concerns, NHPRI now gives physician groups the option of receiving an add-on to their capitated payment based on their performance on a self-designed quality improvement project. The plan believes this new option for a self-designed initiative is more promising as a way of improving care quality, since by definition the groups that choose this option are committing to a specific improvement project on a quality issue they view as important.

CalOptima has experimented with a mix of provider and member incentives since 1999, always trying to get the most impact within increasingly stringent budget constraints. The plan’s overall HEDIS scores have been on an upward trend from 1999 to 2002, which the plan attributes to the provider and member incentive programs. In response to provider concerns, the plan agreed to provide bonuses to networks that demonstrate improvement, as well as to those that perform above an established threshold. The plan also has made efforts to reduce providers’ administrative burdens such as switching from medical record review to administrative claims data.

HHP has substantially expanded its provider and member incentives since 1999. The major change has been the addition of a series of fee-for-service incentives for specific services, such as immunizations and screenings, with dollar amounts per service ranging from $50 to $200. These new incentives in part responded to evidence that the original practice-level bonus payments of up to $1 per member per month based on a combination of nine HEDIS measures were having a very limited impact on provider behavior and were somewhat confusing to providers and administratively burdensome. While this original incentive plan continues, HHP is focused now on fine-tuning the fee-for-service incentives to determine what dollar amounts between $50 and $200 are most cost-effective. The plan also established some modest member incentives in 2002, and has evidence that they have contributed to an increase in preventive and other services subject to the incentives.

Independent Health phased out its original 1999 incentive program in 2003 and replaced it with a program that focuses on the eight highest-volume groups among the 40-plus provider groups in the plan, and lets provider groups both choose the HEDIS
measures on which they will be monitored and set goals for each. The original program used a series of plan-specified HEDIS measures, included almost all provider groups, and awarded incentives only if providers improved on their 1999 benchmark performance, which most did not. Performance was measured at the community level, rather than at the individual physician or group level. The plan found that this original program had little or no effect on provider performance. The physicians felt they were small players and their own behavior would not make a difference in the overall scores and bonus amounts. The providers we spoke with were not particularly knowledgeable about how much money they received under the program or how they scored. The plan believes the new program will facilitate more provider engagement because providers will be working on measures of their own choosing. In addition, the awards are distributed at the practice level with an agreement that the dollars flow down to physicians directly or indirectly, such as for the purchase of equipment. As noted earlier, by limiting the program to its eight core provider sites, the plan is directing the same award budget to the bulk of its membership, with each site having the potential to earn more than $10,000 annually.

Health Now developed its initial quality incentive program in 1998 with minimal involvement of providers. A portion of the incentive payments was funded out of withholds from providers with the rest funded out of the plan’s budget. The plan was revised in 2002, again with little provider involvement, and it retained the withhold feature. Provider animosity toward the use of withholds, and complaints by specialists about some of the incentive measures, almost led the plan to cancel the program. Instead, the plan decided to eliminate the withhold feature in January 2004, and finance the entire incentive program out of the plan’s budget, with more extensive consultation with providers about the specific incentive measures. In retrospect, plan officials told us, they should have partnered earlier with physicians in developing its incentive program. They now encourage the provider community to conceptualize the current standard of care in their practice area and to suggest methods of measuring it. The plan says about 80 percent of physicians now provide good input into the development process.

Conclusions

The case study plans strongly believe their current incentive programs are making an impact. Some were able to provide trend data to support their impression, while others with newly refined programs believe data for the coming year will provide convincing evidence. While the case study plans are among the leaders in Medicaid nationally in terms of experience with incentives, these plans are still refining their approaches to improve their effectiveness and better measure their impact. None claimed to have the perfect program, but their experience to date has generated important lessons for plans new to incentives. Such programs, we found, require supportive plan leadership, a favorable market environment, full and continuing consultation with physicians in the community, good data, and a commitment to experimentation and improvement over time.
Case Studies
Overview of Plan’s Incentives

NHPRI has four types of provider financial incentives for quality improvement. First, for the past three years, the plan has paid community health centers (CHCs), which form the core of its provider network, financial incentives based on several HEDIS quality measures: childhood immunization status, adolescent immunization status, cervical cancer screening, and adult access to care. CHCs, which receive capitated payment, get $0.125 additional per member per month per measure for meeting or exceeding thresholds that are set annually. Second, for the past four years, the plan has paid an additional $0.65 PMPM to each CHC annually for achieving and retaining JCAHO accreditation. Third, for the past four years, the health plan has had an incentive to improve patient satisfaction. In 2003, the plan provided incentives for the submission of a patient satisfaction plan and the administration of the Bureau of Primary Health Care’s patient satisfaction survey. The health plan also has provided consulting support to CHCs to support patient visit redesign and open access. Fourth, the plan pays an amount up to an additional $0.65 PMPM for projects based on either (1) the CHC’s rate of suppressive therapy for high-risk asthma patients, or (2) the provider completing a self-designed quality improvement project. The CHC can choose which of those options it will be evaluated upon. The plan also has incentives for administrative performance, such as submitting accurate electronic claims data and coding training.

Evolution of the Incentives

The incentive program started as an opportunity for the CHCs, which are capitated, to make extra money. The plan was aware that providers’ performance varied, and they also wanted to provide additional resources to sites and do better overall on the plan’s HEDIS measures. The plan selected incentive measures based on: 1) relevance to CHC patient population characteristics and size; 2) standardization of data collection and benchmarks (e.g., HEDIS); and 3) ease of data collection by the health plan.

The asthma or self-designed quality initiative incentive, which was new in 2003, was initiated to encourage CHCs to take on a quality issue important to their patient population. The plan was responding to strong feedback from the CHCs that the plan’s incentives should align with the CHCs’ other requirements pertaining to CHC federal funding, JCAHO requirements to demonstrate improvement, and state health department initiatives. The money allocated for the incentives has shifted over the past few years with less for administrative measures such as accurate electronic claims submission and more toward the clinical and satisfaction measures. In the future, the plan would like to add measures related to patient satisfaction, disease management, and prevention. The plan expects to continue with the self-designed improvement project
option, which it views as the most promising type of incentive currently in place for improving the quality of care.

**Effectiveness of Incentives**

It is not clear whether the HEDIS or JCAHO incentives have had any effect on quality improvement. Although the plan as a whole has improved on the measures, the plan’s data suggest that CHCs as a group have not had consistent improvement. The state Department of Health played an important role in improving childhood and adolescent immunization rates all across the state, with Rhode Island ranking high nationally for childhood immunization. The increased involvement of CHC medical directors in the selection of incentive measures improves the engagement of clinical staff at the health centers.

All CHCs in the state are accredited by JCAHO, so in the words of one, “you wouldn’t want to be the one not accredited.” These market pressures along with federal pressure to be JCAHO-accredited are more significant factors in CHCs’ decisions to be accredited than are the incentives. All three providers we spoke with also questioned whether JCAHO accreditation did much to improve quality at the CHCs, particularly in relation to its cost.

We heard from the sites that because the incentive is designed to pay out if a site exceeds a threshold set for all sites, sites that believe they will meet the threshold do not see a reason to improve. We also heard an example where a site feels it provides excellent care, and that the data vary from year to year by chance so that if the data are low, it does not mean the site has a problem.

The new option for a self-designed initiative appears more promising for improving care quality, since by definition sites that choose this option are committing to a specific improvement project on a quality issue they view as important. We heard two examples where CHCs believe they have significantly improved care after undertaking this option, one of which had reviewed charts and found significant improvement in the percentage of asthmatics that were assessed for their severity level. However, few sites in the first year chose the option to conduct their own improvement projects, preferring instead to be evaluated on a measure of the percentage of high-risk asthmatics on suppressive therapy. It may be that most sites felt they would meet the threshold set for the asthma measure and thus receive the money without incurring additional costs and effort associated with an improvement project.
Lessons Learned

To foster response, an incentive effort must convince medical and operational leadership that there is a real problem and that the issue at hand is clinically important for their patients. In two of the three CHCs whose medical leadership we interviewed, the medical leadership was not aware of the amount of the incentive at stake for their organization nor how much the CHC had been receiving. But in each case, they had undertaken improvement efforts when they believed there really was a problem that was clinically important for their patients. They had not undertaken improvements in other clinical areas where they did not believe the data showed a clinically relevant problem. For example, one respondent pointed to the fact that many children may come for immunization just over the cut-off date for being included in the HEDIS measure as having timely immunizations. The plan learned that both operational and medical leadership are important influences, since medical leadership can create and support the vision, but it often takes operational leadership to carry out an improvement effort.

Providers are critical of plan data, but negative feedback may spark providers’ own follow-up. Although it was not even part of the plan’s incentive program, all three providers we interviewed raised the example of chlamydia screening rates, which the plan had presented as being low. Upon follow-up, the plan learned that the many screenings done at the state’s laboratory had not shown up in the data and thus had not been counted. Sample sizes were raised as another issue; although the plan over-samples in order to generate provider-specific HEDIS measures for those that are part of the incentive program, sample sizes may still appear small to the provider relative to the entire patient population. One provider we spoke with discounted any particular year’s rates since measured performance varies year to year by chance. The providers we spoke with did value receiving data feedback on clinical measures, however, and one in particular gave an example of following up with her own review when the data seemed to show a problem. Providers get quarterly reports on disease management measures unrelated to the HEDIS incentives and receive annual feedback on HEDIS performance.

The incentive effort’s effectiveness is hindered without medical leadership from the network “upfront.” The plan has recently signaled to medical leadership of the CHCs that they will have more opportunity to provide pre-implementation feedback on the incentive program’s measures. Providers feel this may increase the effectiveness of the program in the future.

Implementation of the incentive should be separate from contract negotiation. When the incentive becomes part of the contract negotiation between the health plan and provider, there is a tendency to look at it as just part of the same total capitation/piece of money.
Effective communication of data results is important and complements the incentives. The plan has refined its communication strategy to complement the financial incentives. Quarterly face-to-face meetings with each CHC include both operational and medical leadership of the CHC. For the past two years, site-specific HEDIS results along with an analysis of performance by practice type (CHC, hospital, private practice) were shared with the full group of clinical leaders of the CHCs. The plan says it looks forward to working more closely with the CHC medical directors by sharing best practices and generating solutions for clinical and service improvements.
Overview of Plan’s Incentives

CalOptima has a competitive financial quality incentive program. Its eight provider networks (two of which are health plans) are measured in a number of clinical and member satisfaction areas and ranked in comparison to their peers. CalOptima allocates its incentive dollars according to three categories: (1) access and quality of care as measured through HEDIS (45 percent of pool money); (2) customer service and satisfaction, based on member surveys and retention rates (20 percent of pool); and (3) provider network partnerships based on provider satisfaction surveys (15 percent of pool). The remaining 20 percent of the pool is rolled over to the following year to ensure program sustainability. The four networks below the 50th percentile receive zero quality points for that measure; the two in the 50-75th percentile receive one quality point; and the two above the 75th percentile receive two quality points. The number of quality points multiplied by the number of members in the network determines how many Member Quality Points a network receives; this number is then used to calculate that network’s incentive payment. Also, if CalOptima as a whole does not meet its goal of a 10 percent reduction in the performance gap for each measure, only networks receiving two quality points for that measure will receive any incentive payment. In FY 2003, CalOptima paid approximately $5.8 million at the provider network level for this program.

Similar measurements are used in two non-financial contract performance measures. First, the Performance Measurement Set encompasses the same quality measures as the quality incentive program, with the exception of postpartum care. For each measure, networks that fail to meet at least the 25th percentile and achieve significant improvement (a 10 percent reduction in each measure’s performance gap) are deemed non-compliant on that measure. Networks that are non-compliant in four or more measures are deemed “contract deficient” and any network deficient for two years in a row is terminated from CalOptima. Second, the quality and member satisfaction scores are compiled in a “report card” that is included in enrollment packets to help members select a network based on quality indicators.

CalOptima also has a member incentive program designed to complement provider incentives by addressing measures not included in the provider incentives: well care and immunizations, prenatal care, and postnatal care. Provider involvement is necessary for the member to receive the incentive—generally a gift card to a local retailer—because the physician must complete a “Quality Counts” form after the member receives the care. There is no direct incentive to providers for their role. In 2003, CalOptima spent an average of $30,000 per month on member incentives.

16 This case study was prepared by Laurie Felland.
Evolution of the Incentives

CalOptima implemented its provider incentive program in 1999, the same time California required plans to report on HEDIS measures. Under the executive management's leadership, the incentives were the first of a number of quality initiatives implemented throughout the organization. The provider incentive program began assessing performance through both administrative data and chart review. By 2002, CalOptima had moved away from chart review because it was too labor intensive. As a result of that change, immunizations and prenatal care could no longer be adequately tracked and were dropped. In addition, CalOptima originally provided some incentive to networks in the 25th percentile to generate their interest. By 2003, CalOptima chose not to reward low performance and increased the minimum floor for the incentive to the 50th percentile. CalOptima also implemented the disincentive of potential termination from CalOptima for poor performance. Finally, CalOptima originally had a separate incentive for encounter data submissions, but removed it in 2002 because of improved reporting and budget constraints. CalOptima's original non-financial incentive was the Circle of Care recognition program, in which the member and provider advisory committees nominated the best performing physicians (pending confirmation by CalOptima that the provider had no quality problems on record) and the plan awarded plaques to the top performing physicians in a banquet ceremony. Budget constraints led the plan to limit this event.

Since implementation of member incentives in 1999, CalOptima has experimented with a mix of active and passive efforts geared toward both members and providers. Rewards are triggered either by administrative data or completion of a Quality Counts card, which is returned by the member or the physician office. CalOptima plans to rely more on administrative data for its member incentives to reduce costs and provider hassle. In addition, CalOptima surveyed members to determine their satisfaction with the program and, based on the results, switched to a different department store's gift card. The plan also is experimenting with raffles of varying amounts instead of the gift card for some measures and age groups. The raffle program gives CalOptima more control over expenditures.

CalOptima would like to expand its provider and member incentive programs, but because of its current budget constraints, it is considering ways to sustain quality improvements without major expenditures. The plan is considering rewarding performance only on randomly selected measures. The plan also may use any incentive dollars budgeted but not earned to invest in technical assistance to help networks improve their performance. Furthermore, CalOptima may consider withholding a certain percentage of capitation and repaying it to providers at varied tiers of performance, as it is currently doing with its Healthy Families (SCHIP) providers.
Effectiveness of the Incentives

CalOptima’s scores on the HEDIS effectiveness-of-care measures have risen each year from 1999 to 2002, placing the plan among the state’s top three overall performers. The plan attributes this improvement to the provider and member incentive programs. Yet, its data indicate that HEDIS performance for the asthma measure dropped between 2001 and 2002 and one measure, diabetic retinal exam, improved without an incentive.

CalOptima finds that the incentive programs have helped providers to better document and report the services they have been providing all along. The health plan network we spoke with agreed, and reported doing very well on most measures, while a private practice indicated that the incentive program was key in changing physician behavior and processes. Providers we spoke with reported a significant increase in their incentive amounts in the past year; indeed, one network received more than $1 million. There are some networks, those with the closed or staff model, that consistently perform well. These models reportedly facilitate a closer relationship between the network and its physicians.

CalOptima reports that unlike non-participants, participants in the member incentive program were associated with higher immunization rates and well-care visits. Although HEDIS rates for those two measures have trended upward since the implementation of the program, CalOptima acknowledges that the lag time between the service rendered and issuance of the gift cards using administrative data could inhibit behavior modification. One provider reported that member incentives are not particularly effective because doctors and members are not informed of or involved in the program. The provider also commented that, in its experience, very few physicians request the Quality Counts cards to submit for their patients, and patients who do receive the gift card probably would have accessed the services anyway.

Member representatives were more positive about the incentives as a whole, but do not believe they reach enough people. They believe that incentives do and can continue to make a difference even if CalOptima reduced revenues dedicated to the program in response to budget pressures. They noted that materials printed in multiple languages are important in reaching the desired population. One representative reported that publishing information about the incentives in the enrollment packets and newsletters is ineffective because many members do not read them. Another felt reminder cards were not particularly effective.

Lessons Learned

Leadership is key in raising the health plan’s commitment to incentive programs and providers’ involvement in quality improvement. CalOptima’s Board and executive leadership was the primary instigator of the plan’s incentive programs. In addition, one provider noted the importance of a proactive medical director in designing the plan’s incentive programs: “It is hard to separate…what is happening because of the incentive
providers and what is happening due to the strong leadership of [CalOptima’s] Chief Medical Officer.”

**Providers want to be judged on quantifiable measures and want to be rewarded for their relative improvement.** Measures and data need to be sound and have integrity in the provider community. Examples are adherence to the industry standards of HEDIS and use of the CAHPS survey methodology. Providers generally found the choice of measures within HEDIS reasonable, although some disagreed with specific guidelines for clinical reasons. In addition, providers reportedly convinced CalOptima to provide incentives to networks that demonstrated significant improvement, so that a network would not fail to obtain an incentive just because of where it ranked in the distribution.

**Providers report that incentive programs raise awareness of quality issues, but that the role of money varies.** One provider reported that the CalOptima incentive is more of a verification of what physicians already do for their patients; the money is considered positive reinforcement and helps offset low reimbursement. Another provider distributed the anticipated incentive dollars to physicians up front in an attempt to expedite the changes needed to succeed in the programs. Also, with its non-financial incentives, CalOptima moved away from the expense of recognition dinners for high performers and toward a more punitive disincentive—dropping low performers from their network. One provider noted that this change definitely increases providers’ awareness.

**Educate providers and members frequently and make participation as easy as possible.** Be explicit about the program’s goals and make efforts to reduce providers’ administrative burden, such as switching from medical record review to administrative data. Also, give providers detailed information on how they are measured and better information on how individual physicians are performing to make changes to their practices. For instance, one provider reported the need for data at the primary care physician level and that receiving detailed pharmacy data from CalOptima helped achieve significant improvements in their asthma scores.

Use of a slogan, such as “Quality Counts,” on correspondence is likely a helpful prompt for members, yet plans should consider ways to inform and remind patients more directly. Additional provider and office staff involvement and direct reminders would reinforce any printed information on the incentives. More education to providers about the member incentive programs may be helpful. Also, some type of survey or other means to determine which types of gifts or stores members would most appreciate would be helpful, especially if the information could identify preferences of predominant ethnic groups within the member community.
Hudson Health Plan

Overview of Plan’s Incentives

Hudson Health Plan of New York has a range of financial incentives in place to improve quality. First, the Quality Incentive Bonus (QIB) rewards provider performance on the following New York Quality Assurance Reporting Requirements (QARR) measures, which are largely based on HEDIS: well-baby visits, well-adolescent visits, lead screening and immunizations, cervical and breast cancer screenings, well-adult visits, asthma, and diabetes management. Almost all primary care providers (PCPs) in the plan’s network are included in the program and are measured and paid at the practice level. Providers are eligible to receive up to $1 per member per month (which is approximately five percent of capitation rates). The bonus is based on performance in three areas of equal weight: percentage of requested charts sent to plan, actual QARR scores based on a random sample, and scores for measures similar to QARR but using only claims data and based on all eligible enrollees. Performance is evaluated relative to state QARR averages and providers receive some QIB payment even if they are below average, because the plan is primarily focused on getting all providers’ attention and developing their commitment to quality improvement. For the most recent bonus based on 2002 data, practices were paid their individual percentile rank plus a factor that was determined to ensure that all the money set aside for QIB was distributed. From 1999-2001 practices were grouped into quintiles based on their percentile rank and paid 20 to 100 percent of the potential bonus based on their quintile. If physician scores improve significantly, HHP will move toward more absolute, targeted measures of performance instead of measuring relative performance against state averages.

In addition, HHP has five “fee-for-service” quality incentives to target performance. PCPs are eligible to receive $50 for each Pap test performed and $50 for completing a form indicating special needs of disabled members. Also, PCPs and pediatricians can receive up to $200 for every child who is fully immunized and screened for lead and TB risk by his or her second birthday (the bonus amount is reduced to $100 if the immunizations are not timely). The plan recently tested a new diabetes program in which providers received a $100 bonus if they completed the appropriate set of screenings for each diabetic member by the end of the year. The plan offered assistance with scheduling appointments, patient education, podiatry treatments, and nurse home visits. Finally, to prompt early notification of pregnancies and encourage post-partum care, OB/GYNs soon will receive $100 for timely registration of pregnant patients in the Mommy and Me Program, and $100 for filing an encounter for a post-partum visit within the appropriate timeframe after delivery.

In addition to financial incentives, HHP holds periodic dinners for providers participating in the financial incentive programs where top performers are formally

17 This case study was prepared by Laurie Felland.
recognized. HHP also provides luncheons and other informal incentives for office staff, particularly during chart reviews.

To encourage members to seek certain services, HHP offers, for instance, a $25 gift certificate for groceries if appropriate post-partum care is received within 21 to 56 days of delivery. Also, the plan offers a $10 phone card incentive to members with diabetes who complete the needed screenings and to disabled members who obtain primary medical and dental care.

Evolution of the Incentives

Since 1999, HHP has expanded its provider and member incentives. Though HHP does benefit from the state’s quality incentives to health plans, the QIB was initiated independently and before the state plan was announced. Following the IOM Quality Chasm report, the plan was motivated to expand the use of incentives. Since 1999, HHP increased its total budget for quality incentives from $1 PMPM to $6 PMPM but does not necessarily expect to recoup this investment through cost savings.

While there were some modifications to program design, the QIB budget did not change from 1999 through 2002. For 2003 the amount will be increased to $1.25/PMPM. Although somewhat confusing for the providers, HHP maintains the different combinations of chart review and administrative data calculations to underscore for providers that billing and coding information is vital. Indeed, whenever possible, HHP is moving away from chart review and relying more on administrative data collection to make the program less disruptive for providers. Some of the newer incentives do require information from the chart, but the rewards are sufficient that providers are willing to locate, copy, and send the needed documentation.

Fee-for-service incentives have increased, due both to experience indicating that lower incentives are ineffective and to competition from other regional health plans that pay higher bonuses. The Pap incentive was created in late 1999 because Pap rates were low and there was concern that Pap was not in the PCPs’ “medical culture.” PCPs did not consider this procedure as included in the capitation and were referring patients to OB/GYNs. This led to data being lost because New York allows beneficiaries to obtain family planning services out-of-network. In July 2002, the Pap incentive payment increased from $25 to $50. Also, the former $75 bonus to OB/GYNs for notifying the plan of a delivery was replaced with the new perinatal program that offers higher payments in order to encourage notification of the pregnancy and appropriate post-partum care. The immunization and diabetes incentives were new as of 2003. HHP is putting relatively more resources ($100,000 for the 4th quarter of 2003) into diabetes than some of the other programs in order to try numerous strategies and then transition to only the most effective outcome-based approaches.

Last year, HHP began actively using provider relations representatives to serve as liaisons between the plan and the providers. These representatives discuss the performance data
with the provider offices and train the doctors and staff on how they could improve their scores. HHP also has changed the reporting processes based on provider feedback received through these liaisons.

The two member incentives are more recent, implemented in 2002. HHP abides by state and federal regulations that limit the types of member incentives it may offer. For example, to promote increased physical activity, the plan was considering an incentive giving members a chance to win a health club membership but decided the high value of the award and its potential to target people with better health status might exceed regulatory limits.

**Effectiveness of the Incentives**

HHP finds that provider and member incentives are very important and make a “huge difference” in promoting quality. They told us that the QIB incentive has helped doctors understand the QARR measures and has sparked competition to win the awards, yet it has only been moderately successful in changing behavior. Overall, the plan’s QARR scores have improved. In some cases, however, the state average has gone up faster than the plan and individual provider scores. As a result, payouts under the QIB program increased from approximately $186,000 in 1999 to $288,000 in 2000, but then decreased to $219,000 in 2001, even as the number of providers included increased. For 2002 data, an adjustment was made to the methodology and $351,000 was paid out. For 2001, the typical practice received 60 cents of the possible $1 PMPM (ranging from three percent to 95 percent of possible). For 2002, the average payout was 81 cents and the range was 35 percent to 135 percent of $1 PMPM.

This year, for the first time, HHP distributed reports based on scores of individual physicians. Since 1997, HHP has distributed practice-level reports of results. With the implementation of the QIB in 1999, practitioners began to pay more attention to these reports. The plan reports that this was particularly true of those in private practices where the physicians were the direct recipients of the bonus. Clinicians employed at community health centers and hospital clinics were less likely to know about either the QARR or the bonus. The medical directors from affiliated health centers and hospitals who participate in the HHP Quality Improvement Committee have all along been interested in their QARR performance but have paid closer attention to the details since the scores for each site were reported publicly at the Quality Improvement meeting. Subsequently, HHP was invited to do on-site QARR “in-services” for clinical staff at several health centers. Some site administrators encouraged HHP to include an explanation of the bonus as part of the presentation while at other sites HHP was asked not to mention it. Even though the incentive money goes to the institution and not to the individual clinicians, when it was discussed the clinicians reportedly were very interested in the potential payments for their site and seemed invested in having their site do well.
The fee-for-service incentive changes were made because the initial bonuses were not having enough of an effect on physician behavior. At the higher $50 Pap rate, the plan found that Pap rates did increase, although it was difficult to discern how much of that increase was due to the provider incentive and how much was due to simultaneous increased education and reminders to members. Response to the $50 SSI incentive was “close to zero,” and the $75 post-partum incentive “didn’t do anything.”

Overall, HHP has found that amounts less than $50 are inadequate to change behavior, but that $200 is adequate, and they are trying to determine what amount in between would still be sufficient. The $200 immunization incentive has “generated results” by prompting providers to submit requested documentation. The bonus presented a particular challenge to clinicians because it requires, in addition to immunizations, that children be screened for lead poisoning and assessed for TB risk. Many offices reportedly were not accustomed to using a form to document TB risk assessment even if assessment was done; most offices cannot do lead testing on site and parents often fail to take children to another lab to be tested. Performance data are available for the four quarters of 2003: the payout amount by quarter was: $20,000, $20,000, $34,000, and $44,000. Despite the obstacles to screening, over the same period the percentage of two-year-olds fully immunized on a timely basis and screened for both lead poisoning and TB risk has increased steadily: 14 percent, 29 percent, 35 percent, and 42 percent. The plan’s goal is 80 percent or more. Indeed, the pediatricians we spoke with were focused on the immunization incentive and reported receiving significant bonuses from it. One indicated that incentives led his practice to change the schedule by which they give children immunizations and to focus more on lead screening. Because the documentation is retrospective, however, the plan will not know if actual immunization rates have increased (compared to just documentation changes) until 2006, when they see the 2005 data for the children born in 2004.

The plan believes that the appreciation dinners are effective at increasing provider awareness of quality, especially in areas where bonus amounts are lower. On the other hand, the dinners reportedly do not add much to performance in the immunization incentive where the financial bonuses are large. Also, physicians find the provider relations representatives very helpful and reported that HHP is more receptive and communicative with them than commercial plans. “[HHP is] willing to go that extra step to help providers and patients; they are organized and whenever we have a problem we know whom to contact.”

HHP has documented improvement under the member incentives, although its statistical significance is uncertain. For the post-partum incentive, HHP found that from a baseline of 46 percent the percentage of kept post-partum appointments increased to 57 percent with a baby blanket incentive and reminder postcard and phone call intervention to 65 percent with those interventions plus a $25 gift certificate. Under the SSI (disabled) incentive, the percentage of members who had a dental visit increased from approximately 43 percent in December 2002 when the incentive began, to approximately 53 percent in March 2004. The percentage of members who received a
needed primary care visit increased from approximately 68 percent to 77 percent. (Note: There were no appropriate member representatives to interview about their experience with and perceptions of the member incentives.)

**Lessons Learned**

*Comprehensive incentive programs that are capitated and based on external data are useful but limited.* An incentive program like the QIB is limited for a number of reasons: the payments significantly lag the performance (providers are paid based on data that are a year old); including so many measures makes it difficult to delineate how performance in a particular area affects the bonus payment; reporting on the measures can be burdensome for the practices; and providers are ranked relative to state averages instead of their own improvements. HHP finds that incentives with more immediate and concrete rewards work better. Yet, providers do not report a preference for one type of incentive over another; because they feel they are underpaid, they appreciate the support to their capitation rate that the QIB provides.

*Take the time to find the lowest dollar amount that will change behavior.* HHP finds that implementing incentives is an ongoing process and takes several cycles to stabilize, although investment in adaptable technology pays off by reducing that time, especially for new incentives. Although HHP finds that a bonus payment of $200 seems to be effective, the related incentive still requires a lot of plan time and effort. A slightly lower payment may have a similar effect—while one provider reported that the bonus dollars are a crucial component of the quality program and allow providers to make more in Medicaid than they would with private patients, another considered the money just the frosting on the cake.

*Strike a balance between the focus on performance and program appropriateness.* While expansion of the scope and bonus amounts of the incentives seems to increase their effectiveness, one provider noted concern that the plan may be doing too much with its most recent incentive programs. Providers express concern that programs are absorbing too many health plan resources and may become resentful if the incentive programs distract from provider reimbursement. There are clinical concerns as well. For example, the strong immunization incentive may result in some children being doubly immunized if their parents are unsure if they have been immunized and relevant medical records are not readily available. Also, the range of required visits and interventions under the diabetes program may be too comprehensive and intensive for what most patients want.

*Communicate with providers.* Plans should make efforts to understand the normal operations of the provider practices and make the incentive program compatible with those operations. Providers indicated how important HHP’s open lines of communication and receptiveness have been in shaping the incentive, affecting the level of provider participation, and helping to understand and evaluate provider performance.
Clarify and potentially modify state regulations on member incentives. HHP argues that member incentives work. While believing that member incentives must always remain modest to avoid impropriety, state and federal restrictions should be clarified and interpreted identically across health plans.
Independent Health’s original provider incentive program, the Quality Management Initiative Award-MediSource (QMIA-MS), tracked certain HEDIS measures for both pediatric and adult (internal medicine and family practice) primary care providers who had at least 35 Medicaid members. Pediatricians were measured on immunizations, well-adolescent visits, lead screening rates, and emergency room utilization. Adult providers were tracked on well-adult visits, cervical cancer screening rates, emergency room utilization, as well as member satisfaction. Performance was measured at the community level, rather than at the individual physician or group level. Primary care providers and pediatric groups received a maximum bonus of $2.50 per member per month—50 cents PMPM for each of the four components if the previous year’s performance was met, plus 12.5 cents per component for at least a 10 percent improvement above baseline.

In 2003, the plan phased out the original QMIA-MS and started a new demonstration project under the same name. This program allows eight of the health plan’s provider networks to choose the performance measures on which they will be monitored and set goals for each. Each network chooses measures within three categories: preventive health, chronic disease management, and access/systems improvement. A practice can achieve a maximum of 10 points (three points for each of the first two categories and four points for the access/service category) if they reach their goals within each area. An initial award payment has been distributed based on willingness to engage and participation in the initial meetings. Payments will be made every six months thereafter for a total of two years. Because final performance metrics will improve only gradually over the course of the demonstration project, payment will transition from paying for participation, to paying for appropriate processes, to paying solely for performance. The awards are distributed to the practice level with an agreement that the dollars flow down to the physicians directly or indirectly, such as for the purchase of equipment.

In addition, the Prenatal Case Management Quality Award program prompts obstetricians to notify the health plan of each pregnancy. The provider receives $100 for each prenatal care referral form sent in within the first trimester of gestation (the award is reduced to $50 for submission in the second trimester). This program helps the plan assign the patient to case management services (the plan assumes all MediSource pregnancies are high risk). Also, as a non-financial incentive for providers, the plan highlights quality success stories in its monthly newsletter.

Independent Health has two member incentive programs. First, pregnant members presenting for prenatal care receive a diaper bag. Second, the plan periodically issues $5 phone or grocery cards to members for specific services received, such as retinal exams for diabetics.

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18 This case study was prepared by Laurie Felland.
Evolution of the Incentives

Independent Health’s original QMIA-MS program was implemented as a more global strategy to transition toward pay for performance. As an alternative to raising provider rates, the plan froze the fee schedule and set aside dollars for an incentive program in an attempt to reduce variability in care delivery and patient outcomes, increase the plan’s HEDIS rates, and gain market recognition.

The incentive programs have evolved from a “build it and they will come” and “one size fits all” into more collaborative, customized initiatives. In collaboration with the health plan, providers choose preventive and chronic disease metrics most important to their individual site. The final result is an array of quality performance measures, a mixture of rapidly attainable goals as well as long-term improvement goals. The new effort also encourages and enlists office administrative staff and nurses to become more integrally involved in quality improvement projects.

By implementing the demonstration project in its eight high-volume provider sites instead of the 40-plus sites community-wide, the plan is still directing the same award budget across the bulk of its membership. Each site has the potential to earn more than $10,000 annually. Plan administration can focus on these few providers, as opposed to the past when the plan wanted the incentive program to be universal across provider groups. However, the new approach takes significantly more time and resources from health plan administration. For instance, an initial meeting was held with the providers in October 2003 followed by site visits to each clinic location to learn about unique characteristics that may make performance in the incentive program challenging.

The prenatal referral incentive was added in 2001 because the plan typically was not aware of a pregnancy based on claims data alone and therefore was unable to intervene with case management. The plan considered similar case payment incentives for mammography and child immunization, but feared it would be too focused on individuals instead of populations and perceived as a “ransom.”

While the plan considers its profiles of physician success stories in the monthly newsletter a relatively weak incentive, it wants to build on the incentive by highlighting providers that implement electronic medical record (EMR) systems. The plan believes a strong EMR will support provider improvement because it helps providers proactively determine which patients are not presenting for treatment. The plan finds that its inner-city clinics with EMRs perform better on certain measures than suburban doctors, even though the inner-city clinics treat more challenging patient populations.

Independent Health’s member incentives have remained on a small scale due to state restrictions. The state reportedly will approve only periodic and targeted incentives, such as the phone cards to encourage diabetic patients to obtain retinal exams.
Effectiveness of the Incentives

The original QMIA-MS program had little to no effect on provider performance. Providers could only receive a monetary award if they collectively bettered their score from the 1999 performance benchmarks, and bonus payments decreased steadily from $2.50 PMPM to $0 PMPM between 1999 (the benchmark year) and 2002. At that point, although individual provider performance varied widely, community aggregate performance fell below the award threshold. Indeed the providers we spoke with were not particularly knowledgeable about how much money they had received or how they had scored in the QMIA-MS program. One provider noted that his group’s Pap and mammogram rates were usually low, but he felt that was because many of their patients go to GYNs for those tests, which would not be captured in their data. Another provider reported that they scored lower on mammograms and colonoscopies because patient compliance is difficult, despite the practice’s efforts to offer transportation and other social support.

It is too soon to know how effective the new QMIA-MS demonstration project will be, although the eight demonstration sites have received approximately $6,000 as their first payment for participation. The physician groups we spoke with noted that no significant changes have taken place in their practices yet, but they have fairly high expectations for its success.

The plan has found its prenatal case management incentive to have “marginal impact.” The plan has not experienced a huge increase in pregnancy referrals. It paid out $6,400 for 85 referral forms in the 1st quarter of 2003, $4,900 for 64 pregnancies in the 2nd quarter, and $6,950 for 94 forms in the 3rd quarter (the dip in the 2nd quarter is believed to be due to seasonal differences in pregnancy rates).

Independent Health does not think there is a hard business case for the incentives, but rather that quality improvement efforts and improving HEDIS rates is consistent with its overall business mission and with best practice standards of care. Added public recognition also could enhance member enrollment. Although by 2002 providers were not bettering their scores enough to receive QMIA-MS payments, interestingly, Independent Health was the only area plan to receive the full one percent premium incentive from the state for meeting quality targets. The plan is using those dollars to fund community health outreach workers to serve as liaisons between the providers and the community on its new demonstration incentive programs.

The plan has found that member incentives of significant monetary value, such as a breast pump previously included in its prenatal package, do affect enrollee behavior. The plan noted, “It’s amazing how people would work to get that gift.” However, the plan has found that incentives of minimal monetary value as allowed by the state—such as the $5 grocery or phone cards—do not have enough appeal to significantly alter behavior. (Note: There were no appropriate member representatives to interview about their experience with and perceptions of the member incentives.)
Lessons Learned

**Improvement literacy or the “how-to” may be critical for future success.** Independent Health has found that, while necessary, performance data and monetary incentives alone do not change physician behavior. The plan is embracing “improvement literacy” as the most important part of a successful quality program. This concept emphasizes multiple types of communication with providers and their staff, including education for the providers on how and why the data are being collected and working with office staff to make the program less administratively burdensome. Furthermore, the plan argues that implementing the program in eight provider sites first will allow a better understanding of the challenges various provider sites face in their ability to improve quality performance. Permitting providers to choose the measures on which they are judged may help increase provider compliance with and performance in the program. Sitting down with the providers to discuss the program and select the measures appears to be a positive step for both parties. However, one provider is concerned that if a provider is permitted to only focus on certain measures and is “terrible at everything else,” it would not be good for the patients.

**Capture performance data and distribute bonuses at the lowest level possible.** Independent Health contends that its original provider incentive program was weak because it profiled performance at the community level, rather than at the individual or practice level. The doctors felt they were small players and that their own behavior would not make a difference in the overall scores and bonus amounts. In the new program, measurement is more individualized, although leadership is critical in getting the bonus dollars distributed within the practice. For example, one of the plan’s challenges is working with hospital administrators on how to distribute bonuses within the hospital-based clinics.

**Performance data must be credible.** Providers are skeptical about the accuracy of the numbers and often want to crosscheck the plan’s data with medical charts. A sound information system is important to profile physicians accurately. Independent Health also is concerned that its incentive programs are only as good as the competition’s, because if one health plan has poor quality data, the providers make generalizations that all such incentive programs are flawed (although the providers we spoke with did not voice this concern).

**Factors inherent to the Medicaid program may limit the effectiveness of targeted incentives.** The plan’s mediocre, but improving, experience with the targeted prenatal case management incentive points to a few lessons about inherent program design issues. First, because women only become eligible for Medicaid when they are pregnant, by the time they get enrolled and see a doctor, it is often far into the pregnancy. Also, many members obtain their care at clinics where doctors do not benefit in the same way because the bonus awards are distributed at the clinic versus the individual level.
State regulation hinders the prevalence and scope of member incentives. Independent Health has spent relatively little effort on member incentives because of concerns with legal issues around which types of incentives are allowed and for what purpose. The plan has found that member behavior does change when the incentive is considered valuable (e.g., a breast pump), but the monetary value of the incentives has become limited. Also, the state reportedly permits the plan to implement only periodic incentives, so seemingly it is difficult to obtain longitudinal information on the effectiveness of such programs. Also, providers are not always aware of the specific incentive in place for members, but think member incentives “are not a bad idea” because compliance is an issue and incentives are a “rational way to encourage quality.”
Overview of Plan’s Incentives

Health Now’s current incentive program is centered around a set of nearly 30 clinical quality measures drawn from claims data. Each specialty has its own measures, and points are allocated to individual physicians for achieving threshold levels of performance on each measure, where performance is measured across commercial, Medicaid, and Medicare lines of business. On a 100-point scale, physicians can earn a maximum of 40 points for clinical quality performance, and up to 60 points on a combination of generic drug prescription patterns, and risk-adjusted financial efficiency. The money in the plan’s performance pool is distributed to physicians based on their relative point total weighted by the withhold taken on their services. A total of $22 million in incentives was paid out in 2003, with providers earning incentive sums of up to 10 to 20 percent of their total compensation from Health Now. Settlements are calculated and paid out twice a year for individual physicians, around half a year after the end of the period of performance. Payments are made either to individual physicians or to physician practices or other provider organizations, although the understanding is that individual clinicians will receive the money in their pocket regardless.

On the performance report card given out with the settlements, providers can compare their overall score with the mean and variance for all physicians in their specialty. The health plan also provides breakdowns on comparative performance for each component measure upon request.

The Right Start incentive program stands apart from the main incentive program. OB/GYNs receive an incentive of $100 for notifying Health Now of high-risk pregnancies in the first trimester of pregnancy. Participating members receive non-financial incentives including new baby welcome kits and videos for pregnant mothers.

Evolution of the Incentives

Quality incentives were introduced at Health Now in 1998, and since then quality has played an increasingly important role in the plan’s relationships with providers. Following a trend among health plans in the region, Health Now established the initial incentives as a way to reward providers for their participation with the plan, to introduce an awareness of quality and population health among providers used to thinking in terms of individual patients, and to start moving reimbursement from fee-for-service payments to quality performance. Targeted solely at primary care physicians, these incentives rewarded performance of physician groups with annual payouts of 25 cents PMPM for

19 This case study was prepared by Fabrice Smieliauskas.
20 Although separate payouts are made for each line of business, they differ only according to the number of enrollees in each line of business; the same performance score is used for each calculation.
attaining threshold levels on HEDIS measures of cervical cancer screening, breast cancer screening, immunization, and well-baby visits. Member satisfaction scores and holding late and weekend office hours qualified groups for a potential additional $1 PMPM. These sums were funded out of the health plan budget. A separate program withheld a certain proportion of physicians’ income and paid back more or less than was withheld, based on the cost-efficiency of physicians’ practice patterns.

An entirely new incentive program was devised in 2002 by senior management, network management, and quality staff that combined the quality and efficiency incentives and their financing into a single program that extended quality incentives to specialists. The plan thought that this would simplify reimbursement for providers, and soften the sting of the withholds by repaying the money partly based on quality, a performance goal many physicians would sympathize with. In addition, the plan had become increasingly interested in the business case for quality, and implemented the expanded clinical incentives program and other quality programs with the faith that these programs would eventually result in improvements in the bottom line.

The plan’s ambitious changes did not go far enough. Provider animosity toward the continued use of withholds, and complaints by specialists about the incentive measures, nearly caused the senior leadership to cancel the program. Instead, Health Now decided to eliminate its withhold program in January 2004, following the lead of a competing health plan. Helped by a profitable year, the plan maintained its incentive program and began financing it entirely through the budget. Incentives are now a bonus on top of physicians’ regular fees, which the plan expects physicians to respond to more positively.

Health Now hopes that physicians gradually accept being judged and paid based on their quality performance as a matter of course. Ten years from now, the plan might even consider excluding poor performers from their network. For the moment, while quality incentives remain in their infancy, physicians would be “more than offended” if excluding providers were suggested.

Right Start was initiated in 1992 for Medicaid members only, and was expanded to commercial members the following year. Besides the existing non-financial member incentives, the plan has considered financial incentives for participating members, which it believes could convince enrollees to attend required visits. However, these would run into conflict with state regulations. In the future, the plan intends to roll this incentive into the main quality incentive program and make early notification of pregnancies one of the quality measures for OB/GYNs.

**Effectiveness of the Incentives**

Health Now performs quite well on New York State’s Quality Assurance Reporting Requirements Medicaid performance measures, often significantly exceeding the state average. The health plan attributes part of these increases to the incentive program. Indeed, over the period spanning the three incentives settlements, plan QARR
performance and average physician performance appears to have improved on several important measures.  

Among diabetes measures, hemoglobin A1C testing rates have gone up at the plan level, while eye exam and nephropathy testing rates have not, with different patterns of improvement for generalists and specialists. Part of the improvement in hemoglobin A1C scores can be attributed to making the patient an advocate for quality: keeping patients aware of test scores’ meaning and getting them to demand tests from their doctor. Eye exams cannot be performed in a PCP’s office, so performance depends on members making appointments and then showing up for them, which is largely out of the PCP’s control. The plan hopes that installing the appropriate testing technology in PCP offices will raise eye exam scores. Patient and physician education will likely be necessary to increase scores on nephropathy tests, which can already be performed in doctor’s offices.

Breast and cervical cancer screening rates are already high, due to widespread awareness of the tests’ importance in the health care community, although breast cancer screening decreased for OB/GYNs by several percentage points over the incentive period. The plan believes it has “reached the asymptote” on these measures, and scores are unlikely to improve further without substantial effort, while one provider believes OB/GYNs already provide the tests to all patients for whom it is appropriate.

For pediatricians and for the plan as a whole, immunization rates for H Influenza Type B and well-child visits (0-15 months) appeared to improve. The plan believes the well-child visit improvement is due both to incentives and to member education.

One PCP contends that 80 percent of physicians are happy or neutral about the incentive program, while only 20 percent, particularly specialists, are upset with it. “The physicians are happy because they get the money, the patients and employers are happy because they get better care, and the health plan is happy because they get higher scores by the accrediting agencies.” The number of providers participating in the quality incentive meetings has steadily increased since the beginning of the program, an indirect indicator of the success of the incentives.

Several design features of Health Now’s incentives appear to be quite popular. The providers we interviewed agreed that the reports and payments are frequent enough to allow them to change their behavior in response to the scores, but not so frequent as to overly burden the provider. Giving scores to individual physicians is important, allowing practices to hold all of their physicians accountable for their performance. However, at least one practice that receives the incentive money diverts it into a corporate pool to pay for health and retirement benefits, and its physicians do not individually receive the financial incentive.

The recently devised specialist incentives have proven far more problematic than the more established PCP incentives. Indeed, before the withhold was removed, one

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21 None of the changes mentioned for the individual measures have been tested for statistical significance.
specialist reports that nearly all specialists were dissatisfied with the program. One problem is that the plan has been penalizing physicians who do not administer tests to members for whom it would be inappropriate—such as Pap smears for women with hysterectomies—or for noncompliant members. In addition, while the plan has settled on appropriate quality measures in some specialties, like cardiology, the search has proven more difficult for other ones. For example, as mentioned earlier, scores for OB/GYNs are very near to 100 percent on several measures, and do not differentiate between providers. Such problems have led the plan to change some of its measures, causing confusion and extending data testing periods for certain specialties. Specialists have suggested that optimal measures should track use of appropriate treatment algorithms, including lengths of stay for certain procedures, and clinical guidelines for different conditions, although it is not clear whether these can be tracked in the current information system.

Lessons Learned

**Provider participation from the early stages of incentive development is essential.** If Health Now were to start over with its incentive program, it would have partnered earlier with physicians. The original incentive measures were recommended by a consulting firm and by specialist societies. While clinically sound, the measures were often unsuccessful. For example, surgeons were measured on rates of congestive heart failure following surgery. But the surgeons wanted to be rewarded for good quality of care, rather than punished for poor quality of care. They revolted against the measures, which were subsequently removed. Physician belief in the incentive measures is therefore crucial. Health Now currently encourages the provider community to conceptualize the current standard of care in their practice area and to suggest methods of measuring it. According to the plan, 80 percent of physicians now provide good input into the development process. Specialists have been slower to get involved, despite the need for better specialist measures. Providers often have very different opinions on quality measures, and time is required for them to achieve consensus. Once physicians buy into the measures, however, incentives are more likely to have their intended effect.

**Money matters, but is not indispensible.** With the plan’s incentives forming 10-20 percent of provider compensation, more than other plans in our study, nearly all doctors pay attention to the quality measures. At much lower amounts, the plan believes some doctors would try to improve out of peer pressure, but many others would not. In the long run, physician interest in quality might increase even without money, but at a slower pace.

**Commitment needs to come in many forms—leadership, time, and money.** The success of the incentive program depends on several stakeholders. Senior management support was necessary to get Health Now’s program off the ground, and the medical director needed to constantly advocate for the program during implementation. When senior management later considered canceling the program, the network management, quality, and information system (IS) departments that had invested a lot of time establishing the
program became its strongest advocates. Three to four years are necessary to allow the program to come up to speed before Health Now can judge whether it is enhancing performance. At the outset, it is not enough to have an overall conception of what needs to be done; pre-planning the sequence of implementation steps with a high level of detail is necessary, particularly for IS development. Developing the quality measures requires time and thoughtfulness. In addition, a financial commitment to the IS infrastructure, provider relations, and provider education is required. The IS should begin with a large claims database, and should receive ongoing support throughout implementation. The resources required for the program increase over time as more physicians get interested and engage the plan in discussion.

**Data integrity is necessary to maintain physician respect for the program.** The information system has been “the major challenge” for Health Now to implement its incentive program. Many of the providers’ grievances about the incentive program boil down to data problems. Data that providers believe do not accurately reflect performance, such as the OB/GYN measures, and measures that providers simply do not understand, cannot be effective. The incentives are based on claims data because going into doctors offices to perform chart reviews is “the end of the world” for the plan; providers we interviewed are also opposed to extensive chart reviews. One feature of the program allows providers to submit charts and receive adjustments to their data and payouts, if the original scores are incorrect. Providers deem this service essential to maintaining the credibility of the program, although some feel the correction process is too burdensome.

**It is possible to overcome small sample sizes and extend Medicaid incentives to the individual physician level, even for specialists.** Pooling Medicaid and commercial members allows most providers to have enough total members to obtain a reliable individual-level quality score. Even though the score is not Medicaid-specific, Medicaid members contribute to the score and providers have strong incentives to provide them with quality care. Very low-volume providers can be assigned the average quality point score for their specialty as a last resort. As well, grouping specialists into larger peer groups (for instance grouping adult and child endocrinologists) produces more robust plan-wide averages for specialty measures. These are used to set thresholds and to perform reliable peer group comparisons for specialists.

**Collaboration between plans on quality can only go so far.** The local health plans have worked together to agree on common clinical guidelines for various diseases, driven by a 15 to 20 percent membership turnover every two years, and by the fact “physicians go crazy with several guidelines.” However, the plans have not aligned their incentives in the same way, because the incentives form part of plans’ competitive advantage.

More generally, Health Now typically creates its own distinct quality initiatives, assuming that other plans’ quality programs will benefit Health Now patients, regardless of whether or not Health Now collaborates with the other plans.