July 2009

New York State Health Foundation's
DIABETES POLICY CENTER

Aligning Diabetes Incentive Programs Among New York's Health Plans

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In his speech to the American Medical Association, President Obama stated that the economic incentives in health care are designed to produce more services regardless of the quality of the outcomes produced by those services. In response, he called for reforms that would redirect the health care system toward "incentivizing excellence."

As a central component of its New York State Diabetes Campaign to reverse New York's diabetes epidemic, the New York State Health Foundation's Diabetes Policy Center and its partner Bridges To Excellence have created a strategy to promote incentives that drive excellence in diabetes care and outcomes. The Diabetes Policy Center is encouraging the alignment of incentive programs across health plans by launching a **Diabetes Incentive Program Endorsement**. Through this endorsement, the Center will publicly recognize plans that have implemented effective diabetes incentive and reward programs. The Center's goal is to encourage the majority of health plans in New York State to offer and deliver incentives to physicians and practices that demonstrate that they are delivering better care and achieving better outcomes for patients with diabetes. While financial incentives alone will not guarantee positive outcomes, well designed programs that are aligned across health plans are essential to send a clear signal to physicians and practices on what matters most in patient care and outcomes.

The Problem

At least 1.5 million New Yorkers have diabetes,[1] and that number is growing, with diabetes prevalence doubling in the last decade.[2] Therefore, it is crucial that resources across the State be directed to reversing the trajectory of diabetes and its complications. Many health plans in the State are already engaged in efforts to transform the health care delivery system and are offering both financial and non-monetary incentives to improve diabetes care and outcomes. While these efforts are important, the designs of incentive programs vary greatly, with both Medicaid and commercial plans defining, measuring, and rewarding diabetes quality differently. This has led to confusion and frustration among physician practices, as each is asked by health plans to monitor and report different metrics and receive different incentives based on different formulas. Additionally, in many areas of the State, no single health plan represents enough of a practice's members to motivate them to focus on any particular plan's incentive program.

Incentive Programs: What Works

Although incentive programs are relatively new in the health care landscape and evaluations are thus far sparse,[3] there is much that is known about how to design programs that motivate physicians and practices to achieve positive outcomes for patients.[4] Based on this emerging evidence, the Diabetes Policy Center has developed a Diabetes Incentive Program Endorsement that will recognize health plans whose programs adhere to a set of incentive program principles. The principles are:

Make incentives meaningful to physicians

The exact size of financial incentive needed to drive improvements in diabetes care is still unknown. However, a recent study

[1] New York State Department of Health, "The Diabetes Epidemic," New York State Department of Health Web site, http://www.health.state.ny.us/diseases/conditions/diabetes (accessed July 14, 2009).

[2] Ibid.

[3] Cheryl L. Damberg, Kristiana Raube, Stephanie S. Teleki, and Erin dela Cruz, "Taking Stock Of Pay-For-Performance: A Candid Assessment From The Front Lines," *Health Affairs* 28, no. 2 (March/April 2009): 517-525.

[4] Dianne Hasselman, "Provider Incentive Programs: An Opportunity for Medicaid to Improve Quality at the Point of Care," Center for Health Care Strategies, March 2009.

by Bridges To Excellence[5] shows that the likelihood of physician participation in an incentive program is tied to the amount of incentive at stake. Not surprisingly, the greater the incentive, the greater the participation. With greater participation comes more focus on achieving high-quality diabetes care and outcomes.

Use nationally endorsed measures

Measuring the quality of diabetes care has been well vetted for more than a decade. A set of diabetes measures have been endorsed by several national organizations, including the National Committee for Quality Assurance (NCQA) and the National Quality Forum, both of which convened experts to define uniform standards and measures for quality care and outcomes. (See measures on page 3.)

Use a minimum core set of outcome measures that are tightly linked to patient risk-reduction

Although all 10 measures ultimately matter in diabetes care and outcomes, the relative value of each measure is not equal. A Bridges To Excellence study[6] on the relative clinical and financial value of ambulatory care measures suggests that the measures that matter most for diabetes care are hemoglobin A1c, blood pressure, and low-density lipoprotein (LDL) cholesterol control measures. These control measures are closely linked to the reduction in patient risk factors most related to avoidable complications. Another study suggests that poor control measures are most indicative of the physician's "thumbprint," that is, the physician's ability to make a difference in the management of patients.[7] Indeed, the study showed that the reduction in the number of patients in the poor control zone of A1c and LDL cholesterol can be more directly impacted by the actions of the physician than other measures.

Reward improvement in performance as well as achievement of goals

A paper by Lawrence Casalino and colleagues[8] detailed the importance of creating incentives that reward improvement as well as achievement of specific goals. Doing so discourages adverse patient selection, which can especially exacerbate health

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[5] Francois S. de Brantes and B. Guy D'Andrea, "Physicians Respond to Pay-for-Performance Incentives: Larger Incentives Yield Greater Participation," *The American Journal of Managed Care* 15, no. 5 (May 2009): 305-310.

[6] Francois S. de Brantes, Paula S. Wickland, and John P. Williams, "The Value of Ambulatory Care Measures: A Review of Clinical and Financial Impact from an Employer/Payer Perspective," *The American Journal of Managed Care* 14, no. 6 (June 2008): 360-368.

[7] Sherrie H. Kaplan, John L. Griffith, Lori L. Price, L. Gregory Pawlson, and Sheldon Greenfield, "Improving the Reliability of Physician Performance Assessment: Identifying the "Physician Effect" on Quality and Creating Composite Measures," *Medical Care* 47, no. 4 (April 2009): 378-387.

[8] Lawrence P. Casalino, Arthur Elster, Andy Eisenberg, Evelyn Lewis, John Montgomery, and Diana Ramos, "Will Pay-For-Performance And Quality Reporting Affect Health Care Disparities?" *Health Affairs* 26, no. 3 (May/June 2007), http://content.healthaffairs.org/cgi/content/full/26/3/w405.

EXAMPLES OF HEALTH PLAN DIABETES INITIATIVES

Many health plans have implemented incentive programs that include diabetes measures. For example, Hudson Health Plan has a patient-centered pay-for-performance program that rewards primary care practices up to $300 per member per year for managing and improving care for patients with diabetes. Independent Health has deployed a robust registry system to collect medical record information from physicians in its network and is offering financial incentives. Fidelis Care rewards providers up to $800 per member per year for performing diabetes tests and screenings and provides additional bonus payments, including $400 for providers who demonstrate that their patients with diabetes achieved good hemoglobin A1c control. Monroe Health Plan assists primary care practices to develop and implement diabetes medical group visits and then reimburses for the visits. Monroe also helps many providers achieve high standards of diabetes care by paying the application fees for NCQA's Diabetes Recognition Program.

Led by New York Quality Alliance, multiple health plans in New York are collaborating in a statewide claims aggregation effort designed to measure quality of care on a set of measures, including hemoglobin A1c testing, LDL cholesterol testing, and eye exams. Through the P² Collaborative of Western New York, the Western New York Quality Collaborative's *My Quality Counts* initiative aggregates medical and prescription claims data from HealthNow, Independent Health, and Univera on 19 measures, including four diabetes process measures; develops performance reports that physicians can access through a secure Web portal; and provides quality improvement services and tools through P².

Several health plans, including Emblem Health, Excellus Health Plan, Empire BlueCross BlueShield, HealthNow, Fidelis Care, MVP Healthcare, and United Health Care, have launched or are participating in Patient-Centered Medical Home pilots and are encouraging a fundamental transformation of practices so that they deliver high-quality care to all patients, including those with diabetes. The Capital District Physicians' Health Plan (CDPHP) Patient-Centered Medical Home pilot introduces a risk-adjusted payment system and a performance-based bonus program that will reward participating practices for superior patient satisfaction, improved medical costs, and better patient outcomes. Depending on scoring, participating practices can qualify for up to $50,000 per physician in bonus payments with an additional $35,000 per physician to support the transition to medical home. CDPHP is also supporting the practices' clinical transformation through sponsored services provided by TransforMED.

In the New York City Department of Health and Mental Hygiene's Take Care New York quality measurement and reporting program, physicians report to the City's quality data warehouse and will be assessed on a series of preventive and chronic condition management measures, including diabetes measures. Participating health plans are looking at incorporating this process into their incentive programs. ■

disparities for minority, low-income, and underserved populations that are disproportionately affected by diabetes and its complications. It also encourages physicians and practices that currently are further away from performance thresholds to make improvements.

Recognize quality independent of "efficiency"

Consistent with the recommendations from the New York State Attorney General's office,[9] any attempt to measure and report the performance of physicians should have clear lines of delineation between the measurement of quality and the measurement of efficiency. Since the most commonly used measures of efficiency are controversial and still require validation, quality performance should be recognized and rewarded independently of assessments of efficiency. Doing so also sends a strong signal to physicians and practices that quality is essential.

Pay incentives across all product lines

Paying incentives on all product lines will help send a clearer signal to physicians and practices on what matters most for their patients, regardless of patients' specific coverage. Increasing the number of their patients included in incentive programs also reduces the administrative burden for physicians and practices to participate in incentive programs.

Leverage existing national and regional reporting efforts to reduce physician reporting burden

A paper by Casalino and colleagues[10] highlighted the significant administrative costs borne by physician practices to comply with various requests from public and private sector payers. To minimize additional burdens associated with participating in incentive programs, physicians and practices should be able to demonstrate and report their performance through any regional and/or national programs that uses the minimum core set of diabetes outcome measures. Therefore, a physician or practice that demonstrates performance through any one of the programs should not have to re-demonstrate performance through another program. Programs could include NCQA's Diabetes Recognition Program, the New York City Department of Health and Mental Hygiene's Primary Care Information Project/Take Care New York reporting program, Bridges To Excellence's Diabetes CareLink program, and potentially Patient-Centered Medical Home pilots.

Recognize that more effort demands greater support

Transforming practices and achieving high standards of diabetes care and outcomes can be difficult and often require additional investments. Because it is critical for the health of New Yorkers with diabetes that *all* physicians and practices achieve the quality standards—and not just the already high-performing practices—investments should increase as the difficulty of meeting the standards increases.

DIABETES MEASURES
Hemoglobin A1c > 9.0%*
Hemoglobin A1c < 8.0%
Hemoglobin A1c < 7.0%**
Blood pressure ≥ 140/90 mm Hg*
Blood pressure < 130/80 mm Hg
LDL cholesterol ≥ 130 mg/dl*
LDL cholesterol < 100 mg/dl (dl)
Eye examination
Foot examination
Nephropathy assessment
Smoking status and cessation advice or treatment

* Denotes poor control
** When appropriate

Give providers patient-specific, actionable information

Patient-specific, actionable information helps physicians and practices manage their patient populations and achieve the high standards of care and outcomes. Whether it is data on prescription fill rates, lab values, or emergency department utilization, information that is specific to their patients enables practices to conduct targeted outreach and implement interventions that can help their patients manage and control their diabetes.

Engage plan members in better self-management and adherence

Many health plans have developed active partnerships with physicians, practices, and members to support diabetes self-management. By implementing or supporting evidence-based member engagement and self-management strategies, health plans can make it easier for physicians to help their patients manage their diabetes.

Incentive Program Endorsement: NEXT STEPS

The goals of the Diabetes Incentive Program Endorsement are to publicly recognize health plans that have implemented effective incentive and reward programs and to encourage the alignment of incentive programs across plans. In addition to public recognition, the Diabetes Policy Center will work with health plans to implement and/or improve their programs and document their return on investment. The Center will begin issuing endorsements in the fall 2009. ■

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[9] Ann Greiner and Michelle Johnston-Fleece, "The Patient Charter: A Way To Enhance The Rigor And Relevance of Physicians Reporting Programs?" ABIM Foundation, http://www.abimfoundation.org/publications/pdf_issue_brief/Patient%20Charter%20Issue-final9_23.pdf (accessed July 14, 2009).

[10] Lawrence P. Casalino, Sean Nicholson, David N. Gans, Terry Hammons, Dante Morra, Theodore Karrison, and Wendy Levinson, "What Does It Cost Physician Practices To Interact With Health Insurance Plans?" *Health Affairs* 28, no. 4 (July/August 2009), http://content.healthaffairs.org/cgi/content/full/28/4/w533.

ACKNOWLEDGEMENTS

A special thanks to **James R. Knickman**, President and CEO, New York State Health Foundation; **Jacqueline Martinez**, Senior Program Director, New York State Health Foundation; and **Neil Calman, MD**, President and CEO, Institute for Family Health, and Director, New York State Diabetes Campaign, for their contributions on the endorsement principles.

We also thank the following people for their input to this effort:

Kathy Alexis, Program Coordinator, Community Health Care Association of New York State; **Edward Anselm**, Chief Medical Officer, Fidelis Care; **Maura Bluestone**, President and CEO, Affinity Health Plan; **Scott Breidbart**, Chief Medical Officer, Empire BlueCross BlueShield; **James Burnoski**, Assistant Vice President of Strategic Planning and Development, Fidelis Care; **Humayun (Hank) Chaudhry**, President and Chairman, American College of Osteopathic Internists; **Jessica DiLorenzo**, Operations Director, Bridges To Excellence; **Tom Early**, Executive Director, Health Plus; **Lori Evans**, Policy Committee Chair, National eHealth Collaborative; **Kim Fecher**, Director of Physician Practice Management, Independent Health; **James J. Figge**, Medical Director of the Office of Health Insurance Programs, New York State Department of Health; Thomas J. Foels, Medical Director, Independent Health; **Carrie B. Frank**, Vice President of Quality and Health Informatics, Excellus Health Plan; **Foster C. Gesten**, Medical Director of the Office of Health Insurance Programs, New York State Department of Health; **Vito Grasso**, Executive Vice President, New York State Academy of Family Physicians; **Amin Hakim**, Senior Medical Director of Medical Affairs, Emblem Health; **Dianne Hasselman**, Associate Vice President, Center for Health Care Strategies; **Nikki Highsmith**, Senior Vice President, Center for Health Care Strategies; **Kathy Hiltunen**, Vice President of Medical Services Projects and Compliance, Excellus Health Plan; **Shelley Hirshberg**, Executive Director, P² Collaborative of Western New York; **Jill Hummel**, Vice President of Health Services, Empire BlueCross BlueShield; **Kimberly Kelly**, Former Project Coordinator, New York Diabetes Coalition; **Margarita King**, Assistant Director of Provider Profiling, Emblem Health; **Mark Krotowski**, President-Elect, New York State Academy of Family Physicians; **Linda Lambert**, Executive Director, New York Chapter of the American College of Physicians; **Nancy Landor**, Senior Director of Strategic Quality Initiatives, Healthcare Association of New York State; **Janet Linder**, Project Coordinator of Diabetes Campaign, New York State Academy of Family Physicians; **Paul Macielak**, President and CEO, New York Health Plan Association; **John Maese**, Governor and Chapter Treasurer, New York Chapter of the American College of Physicians; **Clifford Marbut**, Chief Medical Officer, Health Plus; **Meg McCarthy**, Project Manager, New York Chapter of the American College of Physicians; **Ann F. Monroe**, President, Community Health Foundation of Western and Central New York; **Jeanhee Moon**, Program Officer, Center for Health Care Strategies; **Robert Morrow**, Chair, New York Diabetes Coalition; **Farzad Mostashari**, Former Assistant Commissioner, New York City Department of Health and Mental Hygiene; **Betsey Mulvey**, Project Coordinator, New York Quality Alliance; **Bruce Nash**, Senior Vice President and Chief Medical Officer, Capital District Physicians' Health Plan; **Stephen Peterson**, Governor and Chapter President, New York Chapter of the American College of Physicians; **Laurel Pickering**, Executive Director, New York Business Group on Health; **Raghu Ram**, Senior Medical Director, HealthNow; **Michelle Randall**, Manager of Physician Practice Management, Independent Health; **William Rollow**, Director of Quality Improvement, Centers for Medicare and Medicaid Services; **John Rugge**, CEO, Hudson Headwaters Health Network; **Jerry Salkowe**, Vice President of Clinical Quality Improvement, Mohawk Valley Physician Health Plan; **Mary Sienkiewicz**, Deputy Director, New York State Area Health Education Center; **Ellen Silver**, Medical Director of Health Services, Empire BlueCross BlueShield; **James Sinkoff**, President and CEO, Whitney M. Young, Jr. Health Center; **Lou Snitkoff**, Medical Advisor, New York Chapter of the American College of Physicians; **Randy Solomon**, Regional Vice President of Provider Strategy, Anthem BlueCross BlueShield; **Joseph Stankaitis**, Chief Medical Officer, Monroe Plan for Medical Care; **Susan Stuard**, Executive Director of Pay-for-Performance Project, Taconic Health Information Network and Community Regional Health Information Organization; **Janet Sullivan**, Chief Medical Officer, Hudson Health Plan; **Elizabeth Swain**, CEO, Community Health Care Association of New York State; **Raymond Sweeney**, Executive Vice President, Healthcare Association of New York State; **Robert Thompson**, President and CEO, Monroe Plan for Medical Care; **Richard Vienne**, Regional Medical Director, Univera Healthcare; **Lori Walton**, Director of Medical Services, Excellus Health Plan; **Dennis Weaver**, President and CEO, EastPoint Health; **Richard Weinberg**, Vice President of Health Services Management, Health Plus; **Eileen Wood**, Vice President of Health Quality Programs, Capital District Physicians' Health Plan.

Finally, we wish to thank **Denise Young Farrell** and **Normandy Villa** of the New York State Diabetes Campaign and **Margaret L. Figley** of the New York State Health Foundation for helping produce this brief. ■