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

² Ibid.
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\textsuperscript{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\textsuperscript{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.\textsuperscript{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\textsuperscript{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


\textsuperscript{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,” \textit{The American Journal of Managed Care} 14, no. 6 (June 2008): 360-368.


\textsuperscript{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?” \textit{Health Affairs} 26, no. 3 (May/June 2007), http://content.healthaffairs.org/cgi/content/full/26/3/w405.
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, 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 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.

**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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