Positive ROI from Provider PFP Incentives in Diabetes Care: The RIPA Experience

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Rochester Individual Practice Association

The Disease Management Colloquium
May 11, 2006

Overview

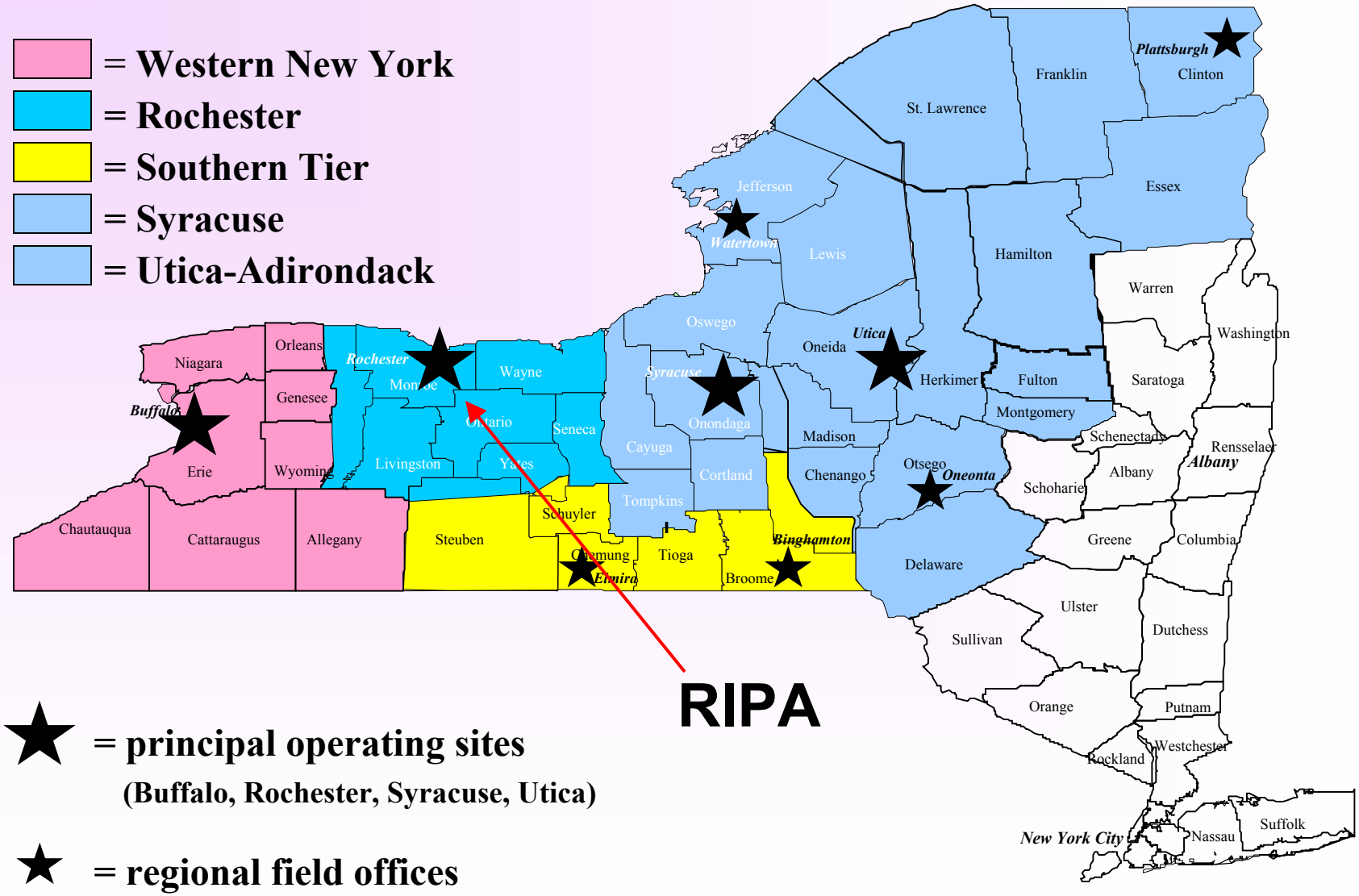
- Introducing RIPA
- Overview of the RIPA PFP system
- Highlights of our outcomes in diabetes
- Calculating the ROI
- Lessons learned
- Future directions

RIPA – Who we are

- Rochester Individual Practice Association, a physician-led IPA of 3000+ physicians (900 in primary care) in upstate New York
- Provides professional services for 300,000 Blue Cross HMO members in Rochester area
- 67% of commercial managed care market
- Profiling started 1999; PFP starting 2001
- Efficiency indexes – 1999; Care pathways – 2000; RWJ Chronic Disease Measures – 2002

Excellus BCBS Coverage Area

= Western New York
= Rochester
= Southern Tier
= Syracuse
= Utica-Adirondack



RIPA

★ = principal operating sites
(Buffalo, Rochester, Syracuse, Utica)

★ = regional field offices
(Binghamton, Elmira, Oneonta, Plattsburgh, Watertown)

The RIPA Pay for Performance System

RIPA Profiling and PFP

- Market share allows individual physician PFP
- PCPs plus 20 specialties
- PFP Structure
  - 20% Patient satisfaction survey
  - 40% Quality measures (PCPs, Ob-gyn, GI, Cardiology, Allergy, Mental Health, PT)
  - 40%* Efficiency Index based on episodes of care (ETG®s)

* 80% efficiency index if no quality measures

Episode Treatment Groups® and ETG® are trademarks of Symmetry Health Data Systems, an Ingenix company

Funding the PFP Program

- Each year RIPA distributes $12-15 million
- Sources:
  - Risk withhold 40 – 60%
  - Gain sharing 40 – 60%
  - Other sources
    - Site of service shift
    - Stop loss reinsurance
- Gain sharing programs have provided
  $2 - $10 million per year

JOHN DOE MD (CCP000000000)
INTERNAL MEDICINE (11)
February 2004

ripa

Dear DR. DOE.:

Here is your final 2003 Value of Care Plan (VCP) profile. It is based on Excellus data paid through December 31, 2003. The purpose of this data is to help RIPA practitioners improve the quality and value of the services provided in our community. You can find a summary of the Value of Care Plan at the end of the profile, and at www.ripa.org. The VCP profile is the first and only physician profile in the U.S. to be reviewed by the National Committee for Quality Assurance (NCQA), who found it to conform to the industry's highest methodological standards.

How to use your profile

The profile has a top-down structure. This executive summary gives a high-level view. Succeeding pages provide more detail. There is a guide to the profile at the end of this executive summary. You can use the yellow Fax Back Response Form to request more detailed information.

Care Pathway results and suggestions

Chronic Care Adherence	Your Rate	Specialty Average	Target Rate	Largest Opportunities for Improvement
Diabetes	0.83	0.68	0.85	Dilated Eye Exam Influenza Vaccination
Asthma	0.40	0.43	0.85	E & M Visits Yearly Comprehensive Review

Acute Care Adherence	Your Rate	Specialty Average	Target Rate	Comments
Sinusitis	0.41	0.65	0.75	Don't skip First Line Antibiotics Use fewer Less Effective Abx
Otitis Media	0.57	0.63	0.75	Use fewer Less Effective Abx Too few episodes to include in Value of Care scoring

Value of Care Plan Performance

VCP Component	Your Results	Specialty Average	Your Score	VCP Weight	Comments
Chronic Care Pathways			2.8	20%	
Acute Care Pathways			2.1	15%	
Mammography Rate	69.4	79.8	0.0	5%	
Patient Satisfaction Survey	97.6	94.4	4.0	20%	See your Patient Satisfaction Survey Results
Age - Sex Adjusted Weighted Efficiency Index	0.99	1.00	3.8	40%	See Efficiency Index Analysis Sheet

Your responsible efficiency index is 0.97 and your total efficiency index is 0.99. Your efficiency indexes are adjusted for your case mix and for the age-sex distribution for your patients.

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Sample Profile

Care Pathway results and suggestions

Chronic Care Adherence	Your Rate	Specialty Average	Target Rate
Diabetes	0.83	0.68	0.85

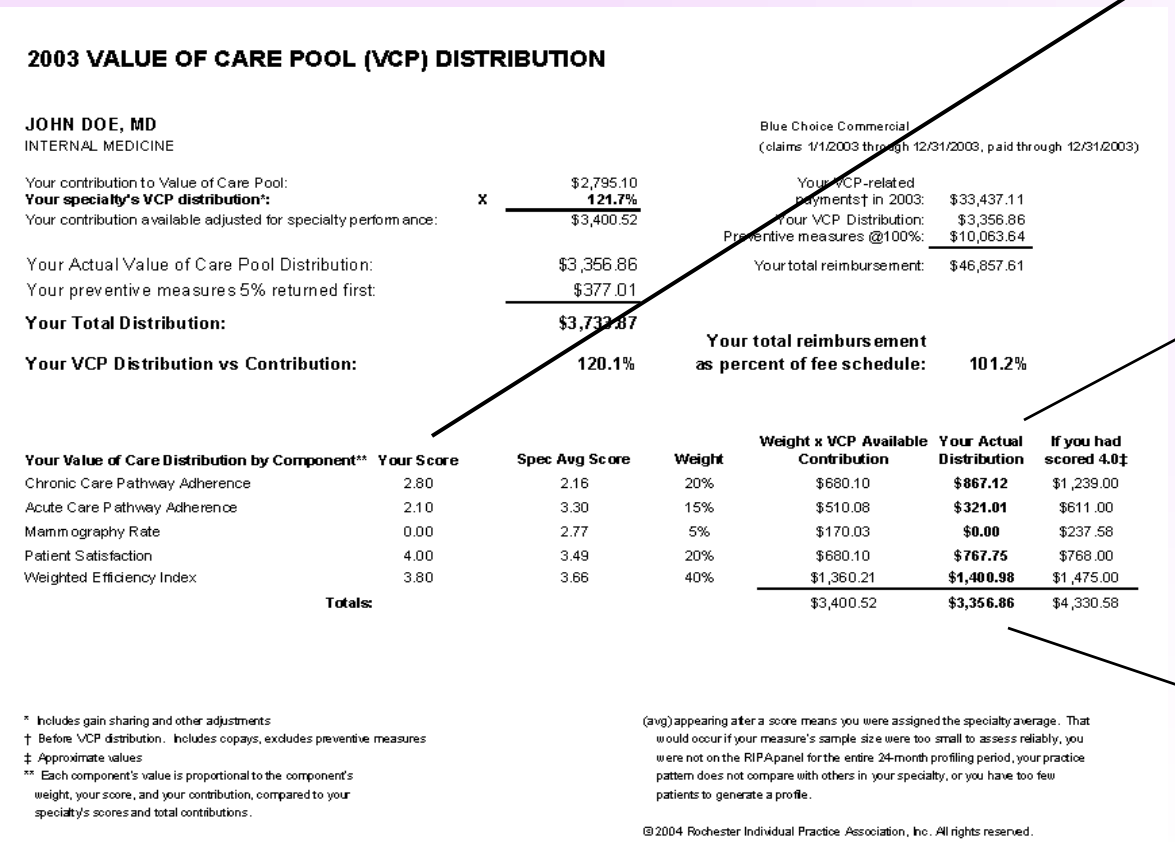
Specific Action Items Up Front:

Largest Opportunities for Improvement
Dilated Eye Exam
Influenza Vaccination

Your Score
2.8
2.1
0.0
4.0
3.8

February profile scores determine PFP payment (see next slide)

Each practitioner receives a receipt in March, when checks come out, connecting profile scores to payment = PFP



2003 VALUE OF CARE POOL (VCP) DISTRIBUTION

JOHN DOE, MD
INTERNAL MEDICINE

Blue Choice Commercial
(claims 1/1/2003 through 12/31/2003, paid through 12/31/2003)

Your contribution to Value of Care Pool:		$2,795.10
Your specialty's VCP distribution*:	x	**121.7%**
Your contribution available adjusted for specialty performance:		$3,400.52
Your Actual Value of Care Pool Distribution:		$3,356.86
Your preventive measures 5% returned first:		$377.01
Your Total Distribution:		**$3,733.87**
Your VCP Distribution vs Contribution:		**120.1%**

Your VCP-related payments† in 2003:	$33,437.11
Your VCP Distribution:	$3,356.86
Preventive measures @100%:	$10,063.64
Your total reimbursement:	$46,857.61
Your total reimbursement as percent of fee schedule:	**101.2%**

Your Value of Care Distribution by Component**	Your Score	Spec Avg Score	Weight	Weight x VCP Available Contribution	Your Actual Distribution	If you had scored 4.0‡
Chronic Care Pathway Adherence	2.80	2.16	20%	$680.10	**$867.12**	$1,239.00
Acute Care Pathway Adherence	2.10	3.30	15%	$510.08	**$321.01**	$611.00
Mammography Rate	0.00	2.77	5%	$170.03	**$0.00**	$237.58
Patient Satisfaction	4.00	3.49	20%	$680.10	**$767.75**	$768.00
Weighted Efficiency Index	3.80	3.66	40%	$1,360.21	**$1,400.98**	$1,475.00
Totals:				$3,400.52	**$3,356.86**	$4,330.58

* Includes gain sharing and other adjustments
† Before VCP distribution. Includes copays, excludes preventive measures
‡ Approximate values
** Each component's value is proportional to the component's weight, your score, and your contribution, compared to your specialty's scores and total contributions.

(avg) appearing after a score means you were assigned the specialty average. That would occur if your measure's sample size were too small to assess reliably, you were not on the RIPA panel for the entire 24-month profiling period, your practice pattern does not compare with others in your specialty, or you have too few patients to generate a profile.

Your Score
2.80
2.10
0.00
4.00
3.80

Incentive to do better!

Your Actual Distribution	If you had scored 4.0‡
$867.12	$1,239.00
$321.01	$611.00
$0.00	$237.58
$767.75	$768.00
$1,400.98	$1,475.00
$3,356.86	$4,330.58

Paid for Performance!

ROI on a Diabetes PFP Program

Diabetes Care Pathway and Quality Results

Chronic Care Pathways for diabetes, asthma, & CAD

Created with RWJ
Rewarding Results grant

Number of Eligible Patients:	16
Diabetes Care Adherence Rate:	0.83

Rate ties back to Executive Summary

Diabetes Care Pathway
JOHN DOE MD, INTERNAL MEDICINE
October 2001 - September 2003

RIPA February 2004 Profile
Based on claims paid through December 31, 2003

Number of Eligible Patients: 16
Diabetes Care Adherence Rate: 0.83

RIPA endorses the Rochester Health Commission Diabetes Community Practice Guideline as summarized in the following points:

* Quarterly PCP visits should include or address: foot check; blood pressure check (goal < 130/80); weight; review of medication, diet, and exercise; glucose monitoring; review of hypo/hyper-glycemic symptoms, prevention, and treatment; smoking cessation; and assessment for depression and pain.
* Annual visits should include or address: comprehensive foot check; medical dental assessment; nutrition status and dietary compliance; exercise; sick day management; sexuality; and advanced care directives.
* Other interventions include twice yearly HbA1c with target < 6.5%; yearly fasting lipid check with goal LDL < 100; yearly routine urinalysis and microalbuminuria measure if no protein; yearly dilated eye exam by an optometrist or ophthalmologist; yearly influenza vaccination; S. pneumoniae vaccination; consideration of endocrinology consult for type 1 diabetes; and use of lipid lowering agents, low-dose aspirin, and ACE inhibitors or AT II blockers as clinically appropriate.

Service	Number of Recommended Services per Year	Number of Expected Services (1)	Number of Actual Services (2)	Your Adherence Rate	Specialty Average Adherence Rate	Target Adherence Rate
HbA1c	2	32	29	**0.91**	0.74	0.85
Lipid Profile	1	16	16	**1.00**	0.77	0.85
Dilated Eye Exam (3)	1	16	8	**0.50**	0.52	0.85
E & M visits	4	64	54	**0.84**	0.72	0.85
Influenza Vaccination	1	16	11	**0.69**	0.47	0.85
UA and/or Microalbumin Screen (4)	1	16	14	**0.88**	0.70	0.85
Total:	**10**	**160**	**132**	**0.83**	**0.68**	**0.85**

Diabetes Mellitus

RIPA uses the following criteria for diabetes: two office visits, one ER visit, or one hospital admission for diabetes, or a prescription for diabetic medication. We identify patients with diabetes in the year 10/1/2001 - 9/30/2002, and then look for the following services in those same patients from 10/1/2002 through 9/30/2003

* Two glycosylated hemoglobin tests (HbA1c, CPT4 83036)
* A lipid profile (full profile, LDL, etc. CPT4 80061, 83715, 83716, 83721)
* A dilated eye (retina) examination performed by an optometrist or ophthalmologist
* Four E & M visits by any practitioner with a diabetes diagnosis (see diagnosis codes below)
* An influenza vaccination (CPT4 90658,90659, 90660).
* A urinalysis (CPT4 81000, 81001, 81002, 81003) or microalbumin screening (spot ratio to urine creatinine, timed collection, 24 hour collection, or reagent strip assay CPT4 82042 - 82043)

Identifying diagnoses for patient encounters: 250 - 250.93, diabetes mellitus; 357.2, polyneuropathy in diabetes; 362.0 - 362.02, diabetic retinopathy; 366.41, diabetic cataract; 648.0 - 648.04, diabetic who is pregnant.

Excluding diagnoses: 251.8, steroid-induced diabetes; 256.4, polycystic ovaries; 648.8 - 648.84, gestational diabetes or abnormal glucose tolerance test during pregnancy; 962.0, corticosteriod over dosage.

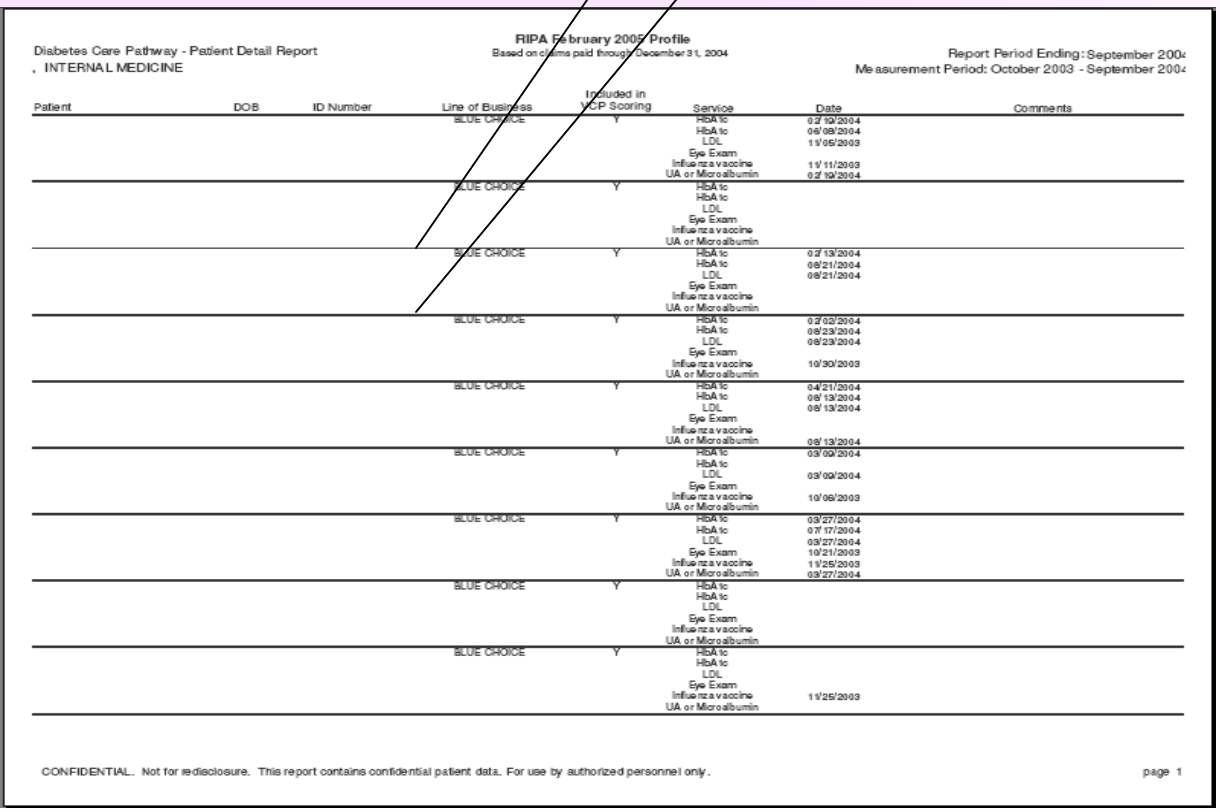
(1) Number of eligible patients multiplied by the number of yearly services recommended
(2) Up to a maximum of the expected services per eligible member, e.g. no more than 4 E&M visits are counted for any one patient
(3) For profiling purposes, patients with a diagnosis of profound visual impairment or total blindness of both eyes (ICD-9 369.0x) are counted as having an eye examination.
(4) For profiling purposes, patients with secondary nephropathy, chronic or unspecified renal failure, or proteinuria/albuminuria (ICD-9 codes 583.81, 585, 586, and 791.0) are counted as having a urinalysis or microalbumin screen.

Service	Your Adherence Rate
HbA1c	0.91
Lipid Profile	1.00
Dilated Eye Exam (3)	0.50
E & M visits	0.84
Influenza Vaccination	0.69
UA and/or Microalbumin Screen (4)	0.88
Total:	0.83

Services with lowest rates appear as action items on Executive Summary

Actionable data: Patient registries for all 3 chronic diseases in every PCP profile

(Actual profiles have patient names here)



Diabetes Care Pathway - Patient Detail Report
, INTERNAL MEDICINE

RIPA February 2005 Profile
Based on claims paid through December 31, 2004

Report Period Ending: September 2004
Measurement Period: October 2003 - September 2004

Patient	DOB	ID Number	Line of Business	Included in PCP Scoring	Service	Date	Comments
			BLUE CHOICE	Y	HbA1c	02/19/2004	
					HbA1c	06/08/2004	
					LDL	11/05/2003	
					Eye Exam		
					Influenza vaccine	11/11/2003	
					UA or Microalbumin	02/19/2004	
			BLUE CHOICE	Y	HbA1c		
					HbA1c		
					LDL		
					Eye Exam		
					Influenza vaccine		
					UA or Microalbumin		
			BLUE CHOICE	Y	HbA1c	02/13/2004	
					HbA1c	08/21/2004	
					LDL	08/21/2004	
					Eye Exam		
					Influenza vaccine		
					UA or Microalbumin		
			BLUE CHOICE	Y	HbA1c	02/02/2004	
					HbA1c	08/23/2004	
					LDL	08/23/2004	
					Eye Exam		
					Influenza vaccine	10/30/2003	
					UA or Microalbumin		
			BLUE CHOICE	Y	HbA1c	04/21/2004	
					HbA1c	08/13/2004	
					LDL	08/13/2004	
					Eye Exam		
					Influenza vaccine		
					UA or Microalbumin	08/13/2004	
			BLUE CHOICE	Y	HbA1c	03/09/2004	
					HbA1c		
					LDL	03/09/2004	
					Eye Exam		
					Influenza vaccine	10/06/2003	
					UA or Microalbumin		
			BLUE CHOICE	Y	HbA1c	03/27/2004	
					HbA1c	07/17/2004	
					LDL	03/27/2004	
					Eye Exam	10/21/2003	
					Influenza vaccine	11/25/2003	
					UA or Microalbumin	03/27/2004	
			BLUE CHOICE	Y	HbA1c		
					HbA1c		
					LDL		
					Eye Exam		
					Influenza vaccine		
					UA or Microalbumin		
			BLUE CHOICE	Y	HbA1c		
					HbA1c		
					LDL		
					Eye Exam		
					Influenza vaccine	11/25/2003	
					UA or Microalbumin		

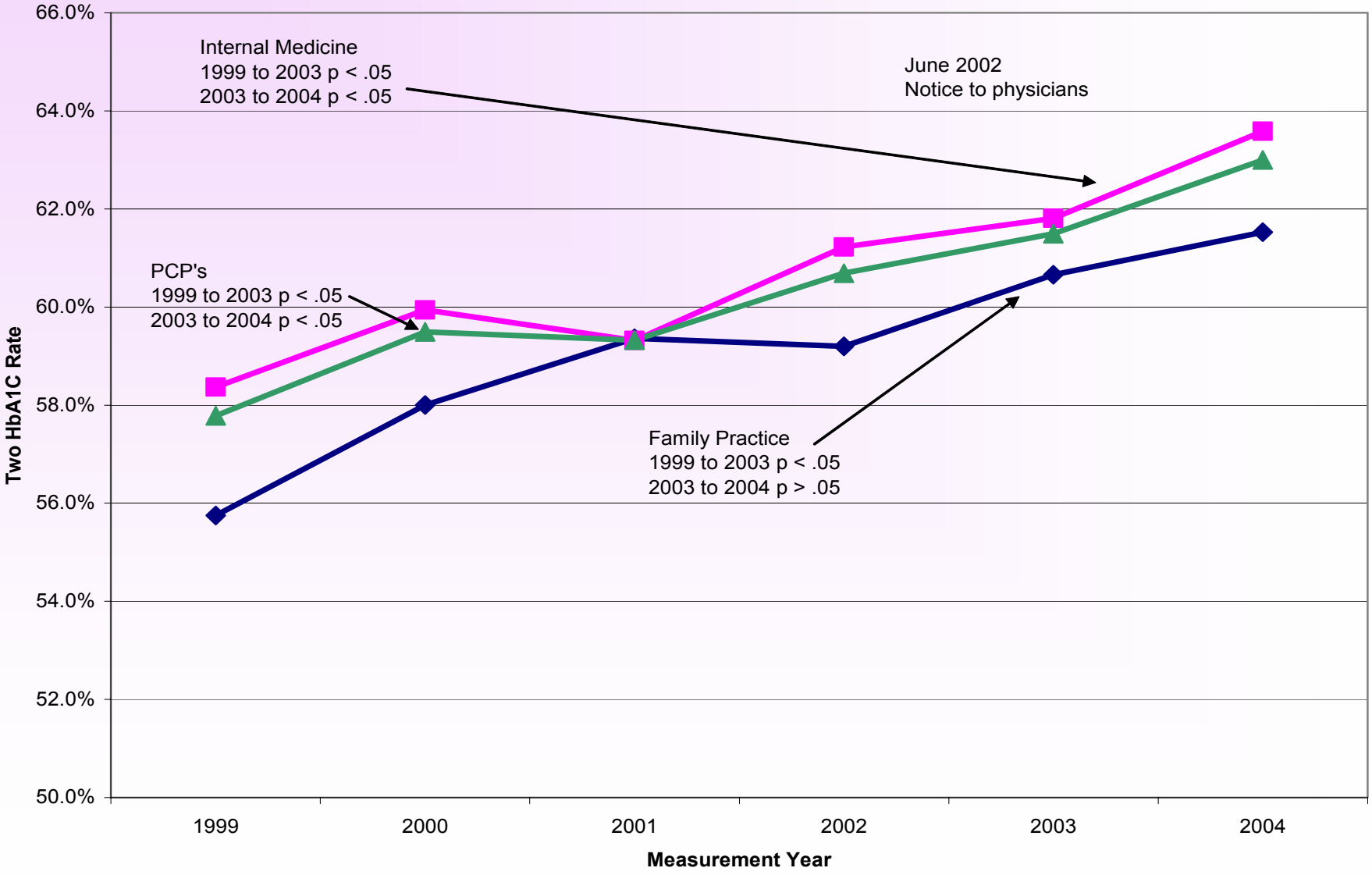
CONFIDENTIAL. Not for redisclosure. This report contains confidential patient data. For use by authorized personnel only.

page 1

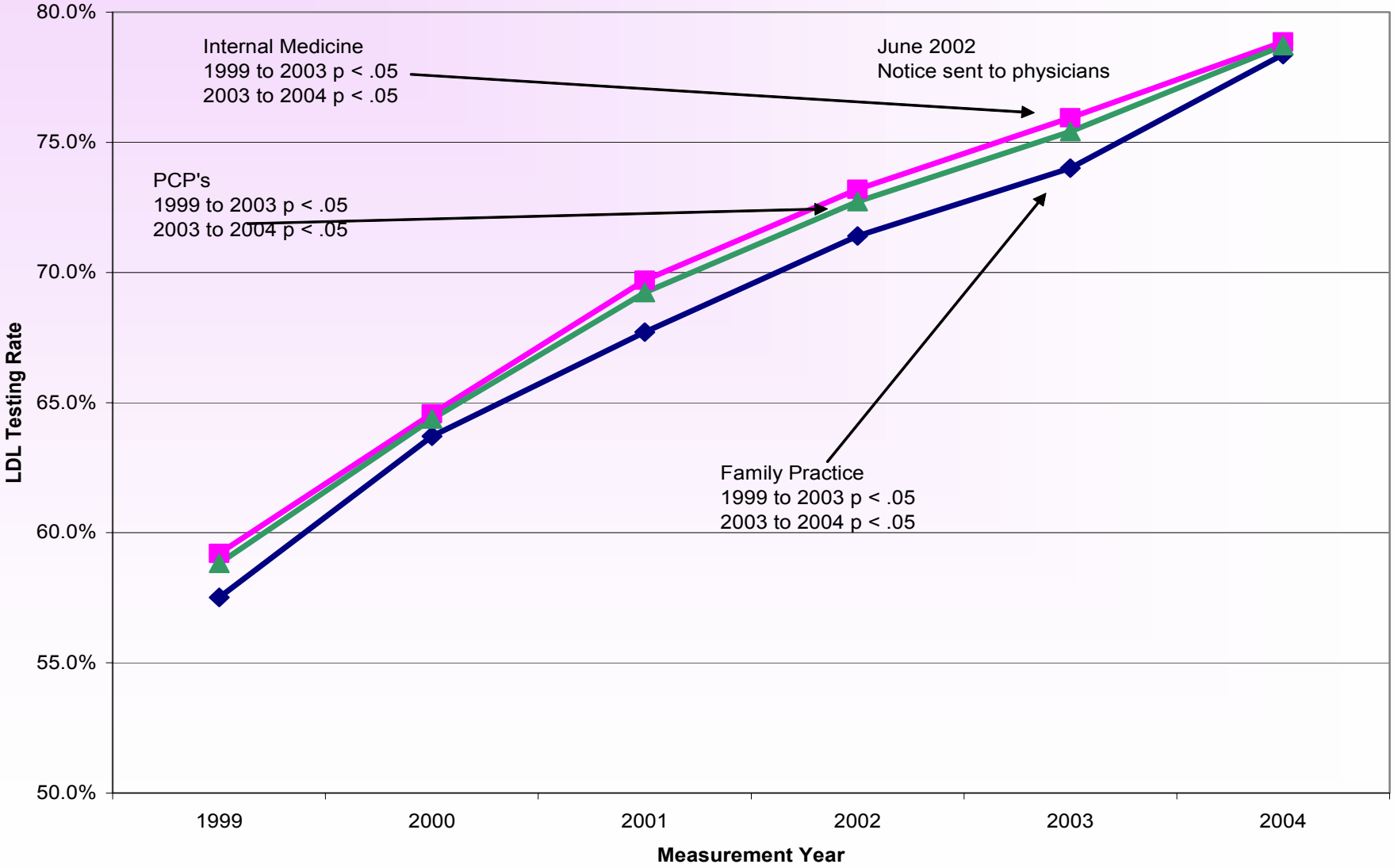
Here is a patient who needs an eye exam and an influenza vaccination.

Registries are disease management tools that ***empower*** practitioners.

Diabetes Care: Two HbA1C tests per year



Diabetes Care: Yearly LDL testing

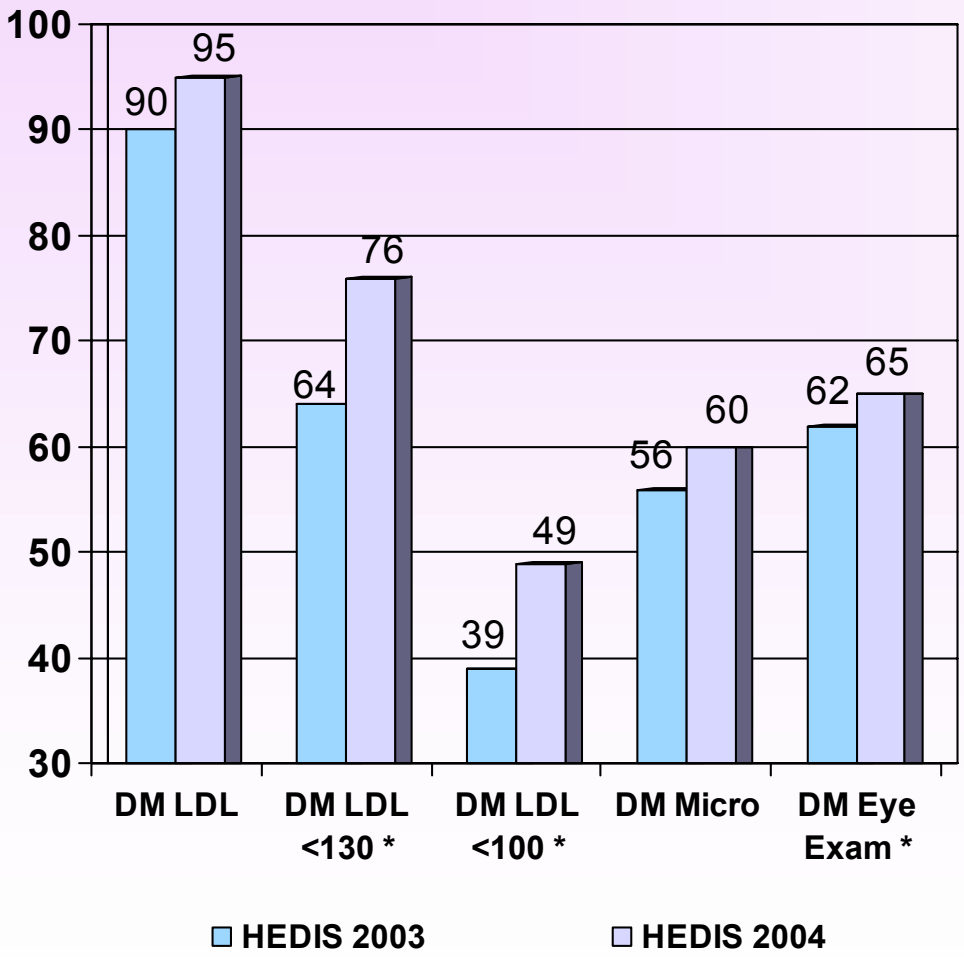


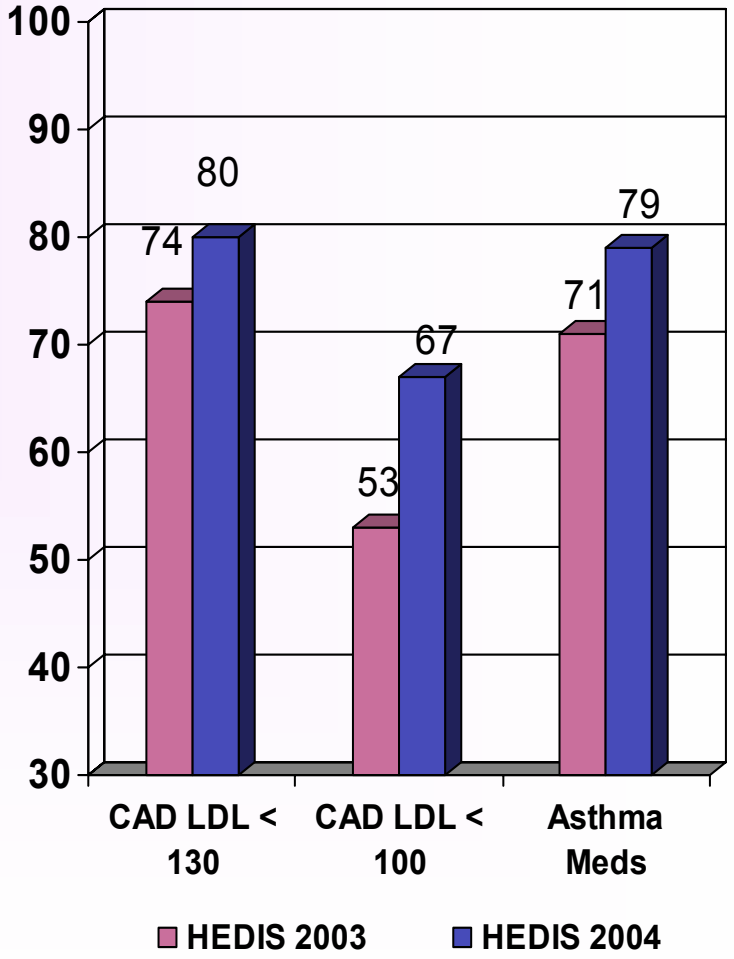
Comparison Diabetes HEDIS Results

- Did prior improvement trends simply continue, or did PFP make a difference?
- "Control" 1: the other major local HMO
  - Same physicians, same community
  - Other HMO had chronic care reports without patient reminders, POS reminders, registries, or PFP
  - **RIPA-Excellus improved more**
- "Control" 2: Excellus HMO in a neighboring city, without reports or PFP
  - **RIPA-Excellus improved more**

Source: Pesis-Katz, I. et al., "Pay for Performance - The impact on patient quality of care in the community setting." Abstract accepted for presentation at the AcademyHealth HSR 2006 annual meeting.

Results: Chronic Care Improvements





* **Statistically Significant**

ROI on a Diabetes PFP Program

Calculating the Return on Investment

Step 1: Defining Diabetics

- Members aged 18 – 75 who in 2002 met criteria similar to HEDIS:
  - Two or more ambulatory visits with a diagnosis of diabetes
  - 1 or more filled prescriptions for insulin, oral hypogylcemics or antihyperglycemics
  - One or more ER visits for diabetes
  - One or more inpatient admissions for diabetes
- Tagged retrospectively and prospectively
- Result: One cohort for entire study

Step 2: Determine the “I” in ROI

- Conceptual Work
  - Committees to develop reports and scoring
  - Staff
  - Analytic work (testing denominators, e.g.)
- Production of the reports
  - Software licenses
  - Software development
  - Analytic time (validation, e.g.)
  - Distribution
- Maintenance
- Estimate for profile as a whole: $1,150,000 yearly

Step 3: Determining Cost Trends and Calculating Savings Against Trend

- Use total cost of care of each diabetic
- Calculate two-year average trend on cost
  = (Trend 2000 to 2001 + Trend 2001 to 2002) / 2
- Determine following year (2003) expected cost
  = Actual 2002 PMPM x Average Trend
- Calculate annual savings against trend for 2003 expected cost
  = Expected 2003 Cost minus Actual 2003 Cost
- Repeat process for 2004

Two Year Rolling Trend
Diabetes Total Costs, 2003 and 2004

	Avg Trend 2000-2002	Expected 2003	Actual 2003	2003 PMPM Savings	2003 Plan Savings
Year 1	13.85%	$546	$536	$10.37	$1,894,471
Expected 2003 = actual 2002 x two-year average trend					

	Avg Trend 2001-2003	Expected 2004	Actual 2004	2004 PMPM Savings	2004 Plan Savings
Year 2	14.21%	$612	$594	$17.70	$2,923,760
Expected 2004 = actual 2003 x two-year average trend					

Results: Return on Investment
Diabetes and CAD Care

- Actuarial Rolling Trend Analysis, baseline 2001-2002
- Results for
  - Diabetes - $1,900,000 in 2003 and $2,900,000 in 2004 (plan savings)
  - CAD Provided Additional ~$3 million in 2004

Rolling Trend Analysis	2003	2004
Annual Savings on Trend	**$1,900,000**	**$5,800,000**
Annual Cost	**$1,150,000**	**$1,150,000**
ROI	**1.6 : 1**	**5.0 : 1**

Strengths and Limitations of Our ROI Methodology

- Strengths
  - Used total cost of care of diabetic patients
  - Savings on two-year trend
  - Two conditions compared to total profile cost
  - Attempted to account for all staffing costs
- Limitations
  - Not a randomized controlled study
  - Saving on trend, not actual savings
  - Underestimates savings - Does not include other areas affected by program
  - May not generalize
    - HMO population
    - A rare IPA / plan partnership

ROI on a Diabetes PFP Program

Lessons Learned

Key Lessons for a Successful Program

1. Define goals and core values
2. Anticipate and manage predictable stages of change
3. Employ a relationship-centered process to introduce measures and respond to questions/concerns
4. Align incentives to support the program
5. Use a clear, concise reporting system
6. Reframe “quality vs cost” into underuse, overuse, and misuse
7. Create a “balanced portfolio” of measures
8. Support improvement with action items

1. Clearly define your goals and core values

Goal: Create a balanced, data driven incentive system that honestly and fairly encourages each practitioner to increase the value of services our panel offers to Blue Choice members

Core Values: respect, honesty, integrity

Beware: Process without values = manipulation

2. Anticipate and manage the predictable stages of changes

Denial

→ Anger

→ Bargaining

→ Acceptance

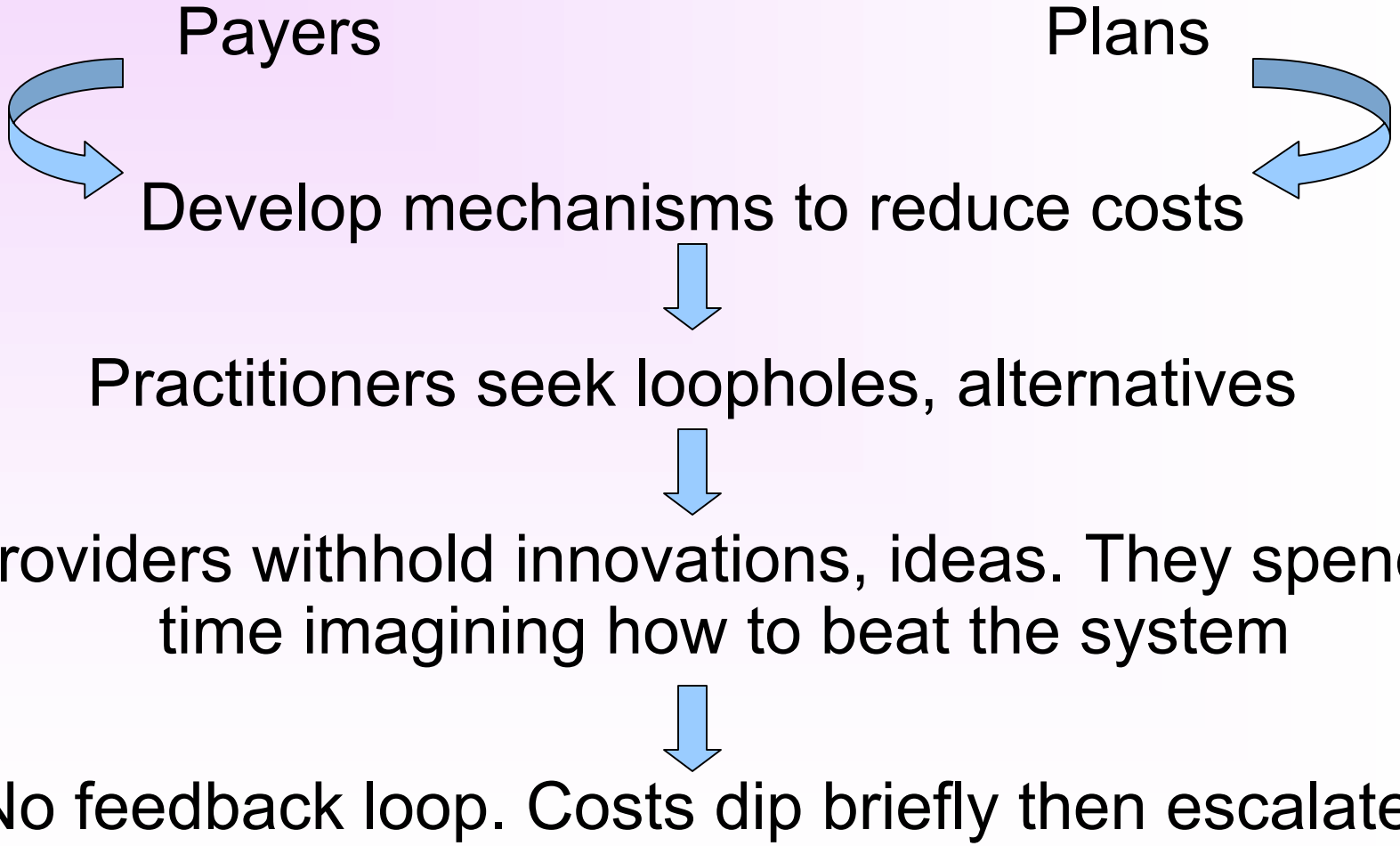
(Kubler-Ross. Death: The final stage of growth. 1975)

3. Employ a respectful, relationship-centered process

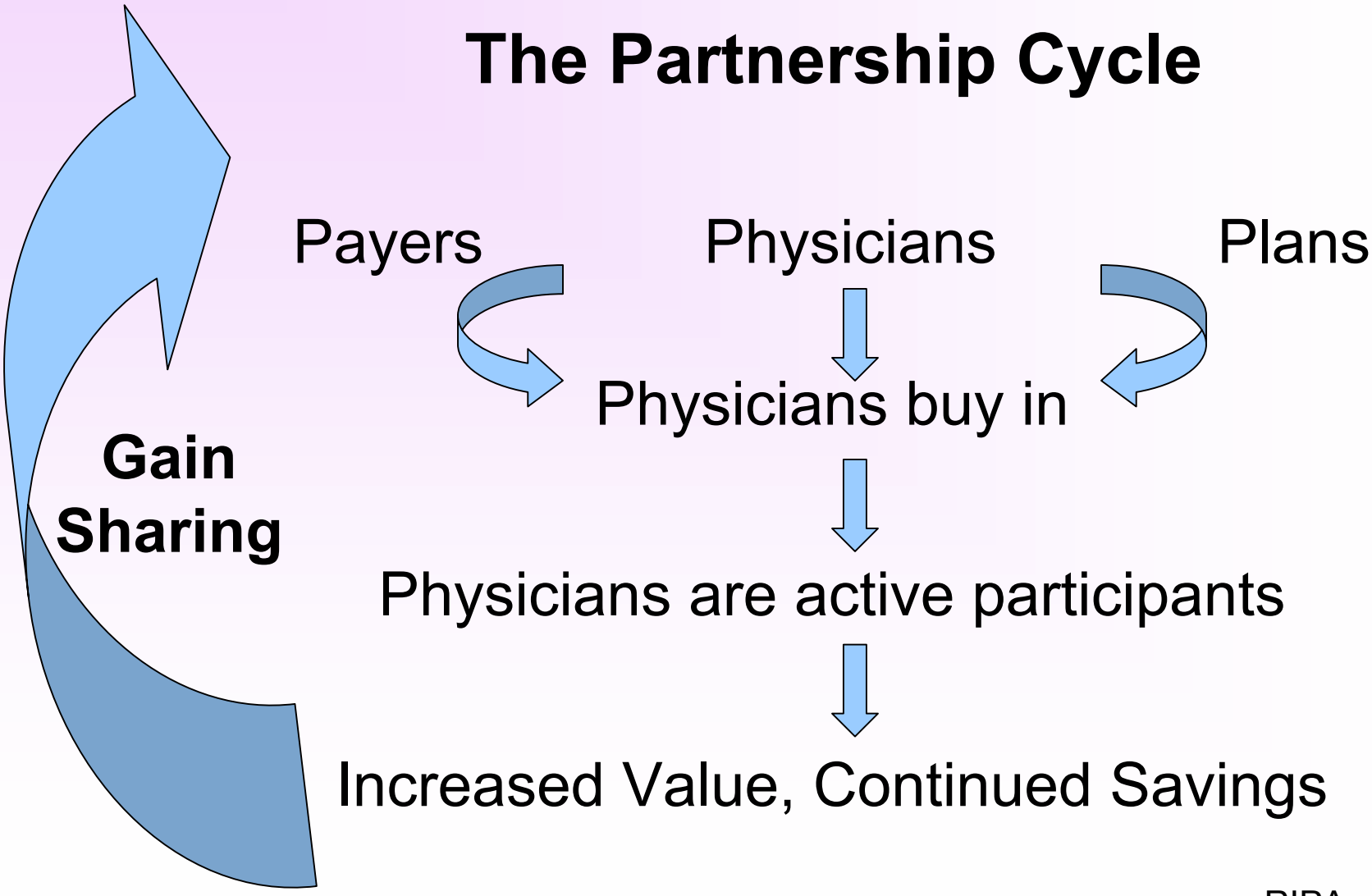
- Engage practitioners from the start
- Only choose measures that make clinical sense
- Make specs available (“transparency”)
- Choose realistic targets
- Provide actionable, **nonjudgmental** feedback. Poor scores can reflect:
  - Poor performers
  - Data or process problems
  - Practitioners with atypical groups of patients
- *Accept* feedback (data accuracy/process)
- Incorporate appeal process in P4P payment program

4. Align incentives to support the program

The Win – Lose Cycle



Instead, Create a Win-Win Cycle



Key Lessons for a Successful Program

1. Define goals and core values
2. Anticipate and manage predictable stages of change
3. Employ a relationship-centered process to introduce measures and respond to questions/concerns
4. Align incentives to support the program
5. Use a clear, concise reporting system
6. Reframe “quality vs cost” into underuse, overuse, and misuse
7. Use a mix of overuse and underuse measures
8. Support improvement with action items

6. Reframe cost reduction vs quality

- A false dichotomy and a difficult conversation
  - Quality is largely thought of as reducing underuse, e.g. increasing rates of HbA1c or statin use after MI
  - For payers, that implies short-term increased costs for uncertain long-term savings
  - But “cost reduction” to physicians suggests withholding treatments from patients and reducing their income
- Result: Talking about working on quality vs working on cost gets us stuck!
- Instead reframe the discussion into decreasing underuse/overuse/misuse (IOM)
- It’s **all** about quality!

7. Use a Mix of Overuse and Underuse Measures

RIPA Profile Element	Overuse or Underuse?
• Sinusitis/Otitis Antibiotics	Overuse
• Diabetes Management	Underuse
• Asthma Management	Underuse
• CAD Prevention and Management	Underuse
• Mammography rate	Underuse
• Efficiency Index	**Overuse**

Important Financial Implications

- A mix of underuse and overuse/misuse measures creates a “Balanced Portfolio”
- Reducing overuse/misuse generates savings right away
  - The first time someone prescribes amoxicillin instead of azithromycin saves $50
- Reducing underuse requires an initial investment (although ROI may be quicker than you think)

8. Support Improvement with Action Items

- For chronic disease, registries are a “virtual EHR”
- Case study: A large Cardiology group decided to systematically improve their CAD performance
  - They created a chart data extract form
  - Their staff used the forms and registries
  - Result: A perfect 4.0 in first year of the measure

Future Directions at RIPA – Replacing the Efficiency Index

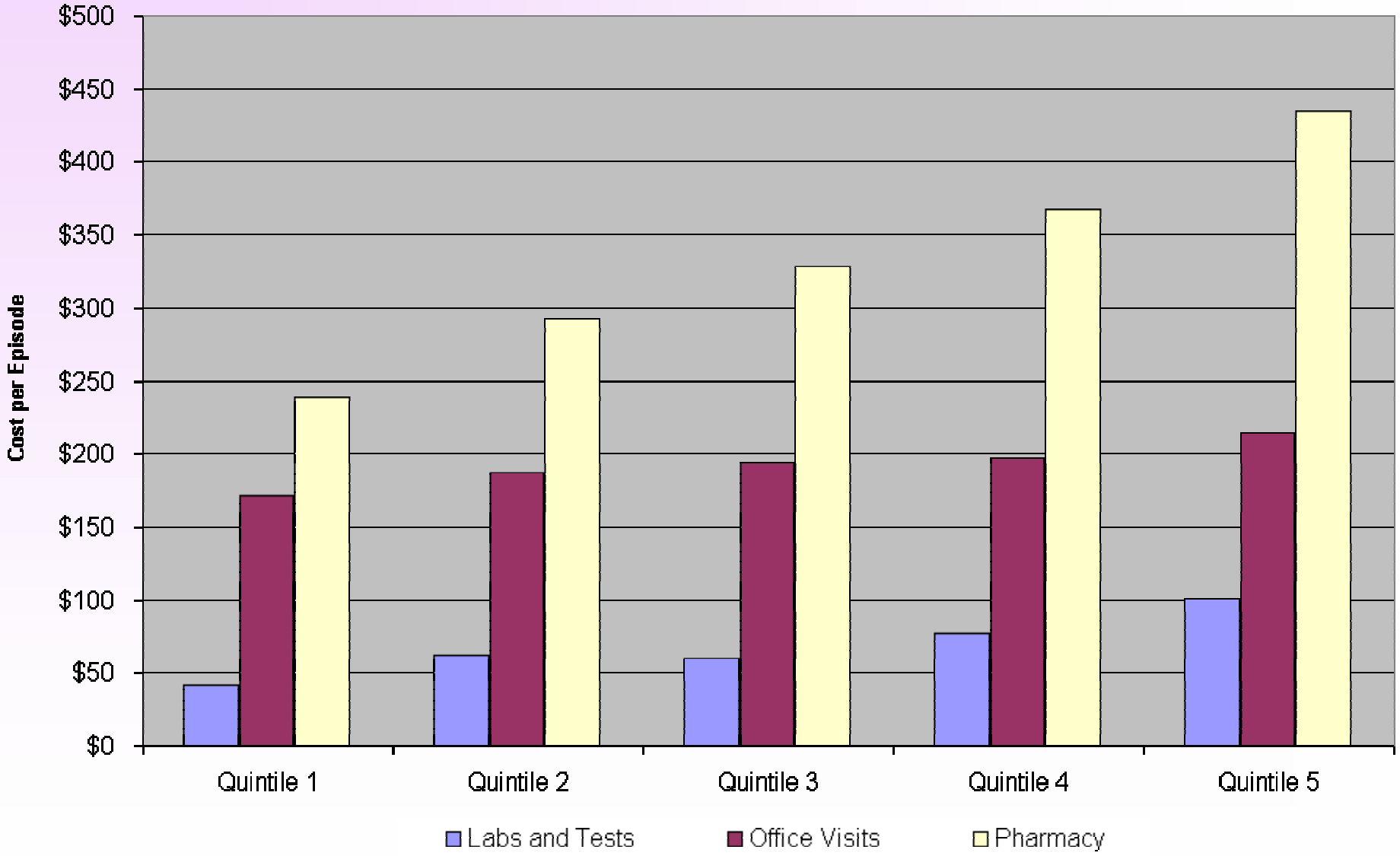
- Efficiency Index = ratio of actual / expected cost
- It gives no actionable information
- Key question: How to identify specific overuse issues?
- Our answer: Systematically analyze practice variation
- A new tool was needed: the Medical Practice Pattern Tool™ (MPPT™)

Medical Practice Pattern Tool™ and MPPT™ are trademarks of Focal Medical Analytics, LLC.

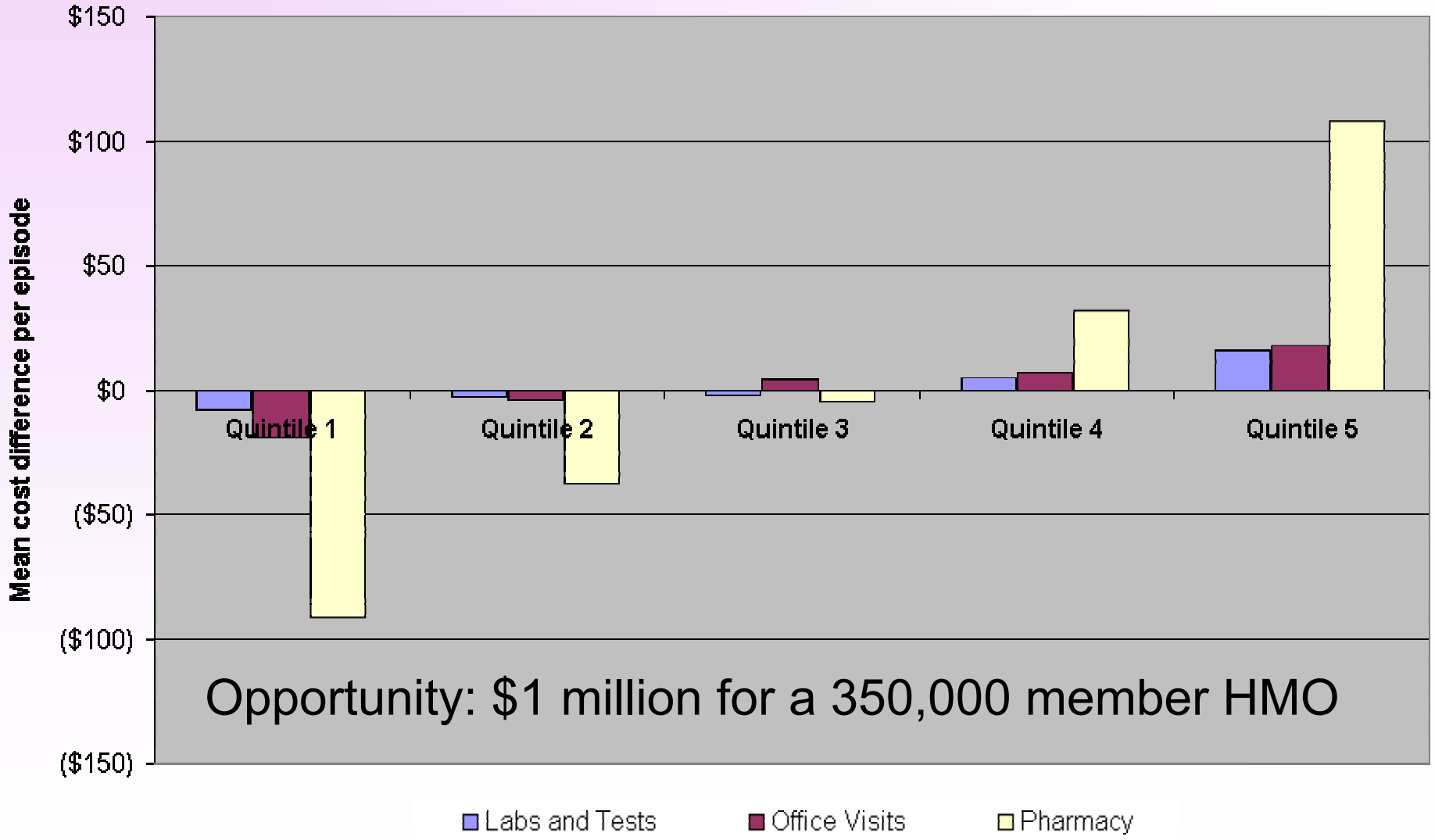
MPPT technology is patent pending and otherwise proprietary.

MPPT Analysis of Hypertension

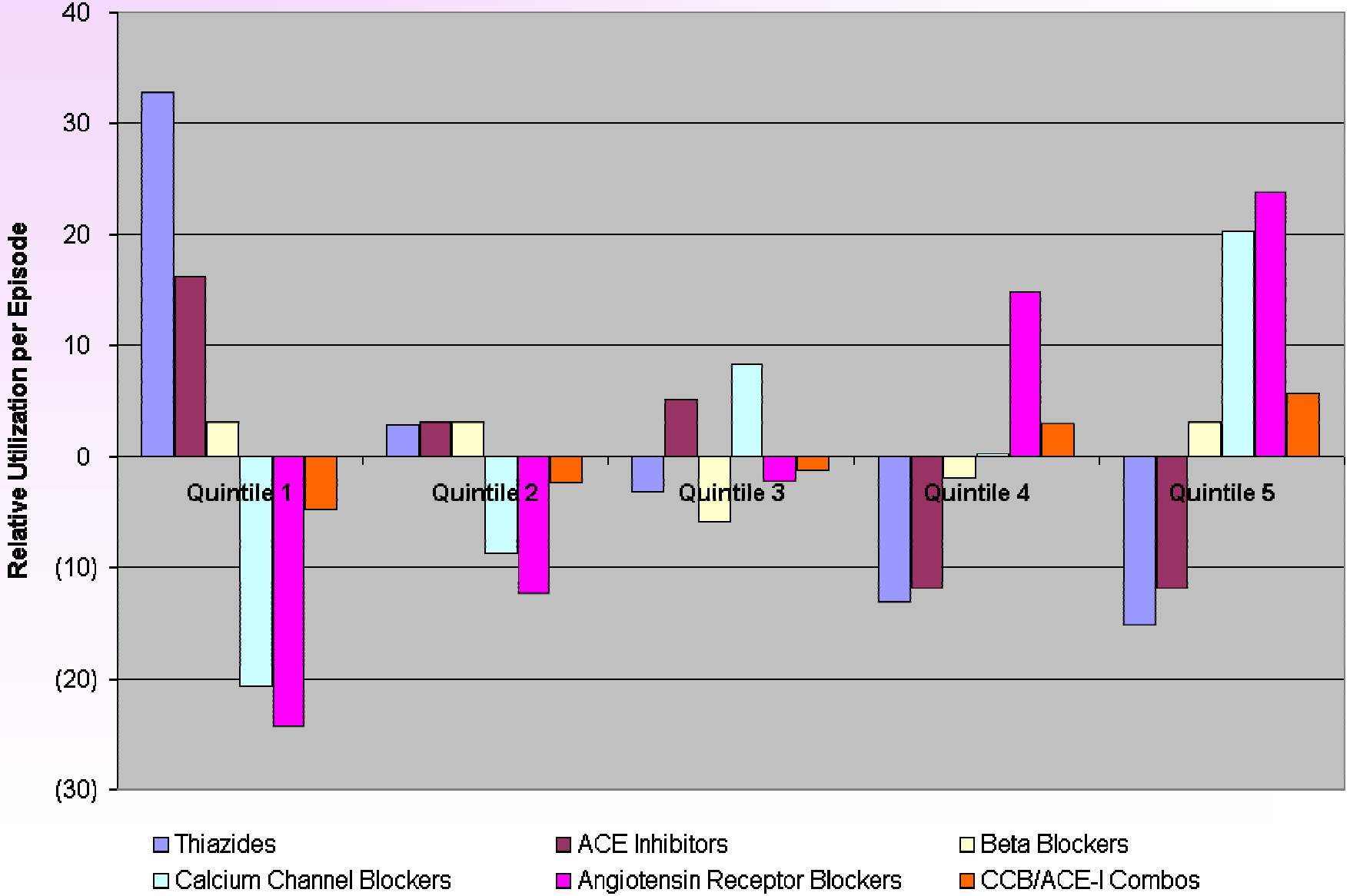
(Benign HTN without comorbidity, among 260 internists)



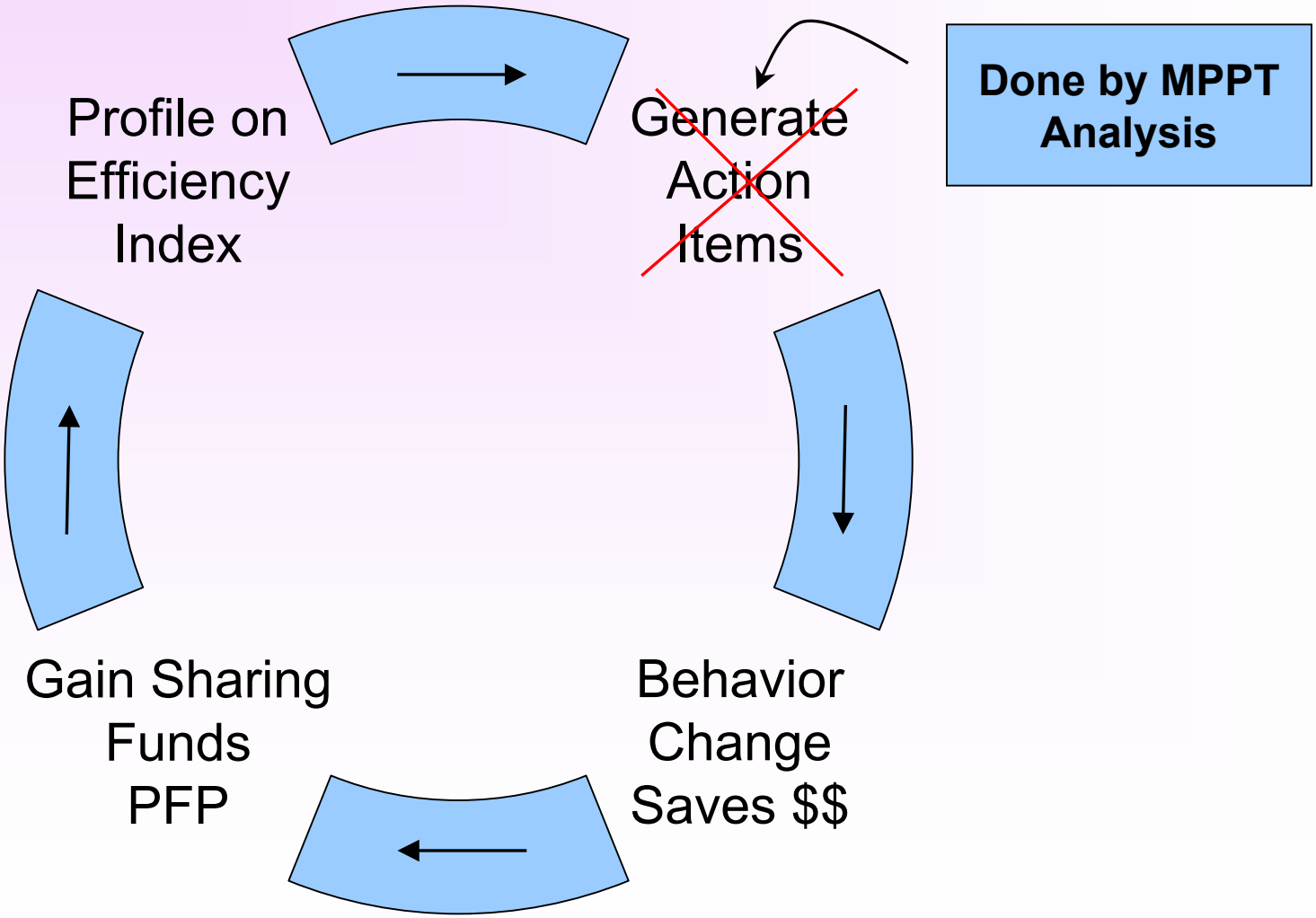
Cost Variation – All in Rx's



Analysis of Pharmacy Reveals Best Practice is Quintile 1 !



Reworking Medical Management



Future Directions – Beyond PFP

- Interlocking programs across specialties
  - HTN: work with both the Internal Medicine and Family Practice communities
  - Dermatitis: Gain sharing for dermatologists; they work with IM and FP
- Promote best practices directly through physician outreach
- Coordinate efforts with Rx benefit management
- Disease and case management for high quintile patients
- *Targeted* precertification – apply only to the physicians in highest quintiles
- *Focused* claims edits – pend highest quintiles, get documentation

A Schematic for Success

Align incentives, e.g. gain sharing

↓

Reframe work as reducing underuse, overuse, and misuse

↓

Focus on quality with specific action items

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Create a balanced portfolio of measures

Conclusions

- Win-win-win scenarios are within our grasp; explicit determination of ROI drives appropriate shared saving models
- Payers have to create meaningful **targeted** incentives to encourage success
- Clinical data must be used to identify **action items** to reduce overuse, misuse, and underuse
- A balanced portfolio of performance measures will improve the value of care your MCO delivers

Thank You!

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