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Minnesota Statewide Quality Reporting and Measurement System:

Quality Incentive Payment System

Updated May 2012

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Executive Summary

Minnesota's 2008 Health Reform Law directed the Commissioner of Health to establish a system of quality incentive payments under which providers are eligible for quality-based payments that are—in addition to existing payment levels—based upon a comparison of provider performance against specified targets, and improvement over time. Two government agencies are required to implement the quality incentive payment system by July 1, 2010: the Commissioner of Minnesota Management and Budget is directed to implement the system for the State Employee Group Insurance Program; and the Commissioner of Human Services is directed to do the same for all enrollees in state health care programs to the extent it is consistent with relevant state and federal statutes and rules. The Minnesota Quality Incentive Payment System (QIPS) was envisioned by the Legislature as a uniform statewide pay-for-performance system whose existence would reduce the burden of health care providers associated with accommodating varying types and methodologies of pay-for performance systems. It is therefore the hope that other health care purchasers in the state take advantage of the framework for their incentive payment initiatives.

QIPS was initially released in January 2010 and first updated in March 2011. This report represents the second revision to this framework, which includes thresholds for 2012 and 2013. The report describes both the methodology and the quality measures included in QIPS. For 2012, the incentive payment system includes two quality measures for physician clinics and three quality measures for hospitals; for 2013, an additional measure for physician clinics has been added.

Payers interested in implementing the quality incentive payment system described in this report are encouraged to select some or all measures from the QIPS approved measures to send common signals about priority health conditions to the marketplace and maximize incentives for health care quality improvement. This approach allows payers to use the quality incentive payment system in a way that best meets their needs, while setting a common set of priorities for improvement. The use of consistent conditions and measures as the basis of a broadly used incentive payment system is expected to stimulate market forces to reward excellent and improved performance by health care providers and enhance the prospects of improved performance in treating priority health conditions.

The quality measures and the methodology used in the QIPS framework will continue to be adjusted and refined in future years. With input from community stakeholders, new and/or

modified quality measures may be included in subsequent years based on activities by other initiatives, changes in community priorities, evolving evidence, or development of new and/or improved quality measures. Other aspects of the methodology may also be changed over time to reflect progress in the availability of data; improvement in performance levels and changes in variations of performance. These changes to the quality incentive payment system framework will continue to be communicated via an annual update of this report by the Minnesota Department of Health.

Background

Statutory Requirements

Minnesota's 2008 Health Reform Legislation[1] directed the Commissioner of Health to develop a quality incentive payment system (QIPS) under which quality-based incentive payments are made to providers in addition to existing payment levels based on:

- Absolute performance (i.e., "comparison of provider performance against specified targets"); and
- Improvement over time.

The statute also requires QIPS to adjust for variations in patient population, to the extent possible, to reduce possible incentives for providers to avoid serving high-risk patients or populations.

By July 1, 2010, the Commissioners of Minnesota Management and Budget[2] and Human Services[3] were directed to implement QIPS for the State Employee Group Insurance Program (SEGIP) and all enrollees in state health care programs to the extent it is consistent with relevant state and federal statutes and rules. Use of this system by private health care purchasers—which are not required by law to adopt it—is also encouraged.

With input from partners in the community, the Commissioner of Health annually evaluates and updates the measures, performance targets, and methodology used in QIPS. To facilitate this annual review, the Minnesota Department of Health solicits comments and suggestions on QIPS each year. Quality measures may be added, modified, or removed as necessary to achieve the goal of setting and meeting priorities for quality improvement. The Commissioner releases an updated report annually.

Goals

The purpose of QIPS is to encourage a consistent message to providers from the payer community signaling priority areas for improvement. The primary goals of QIPS are to align and uniformly leverage provider payment incentives, and to accelerate improvement in key

[1]Minnesota Statutes 2008, section 62U.02.

[2]Minnesota Statutes 2011, section 62U.02.

[3]Minnesota Statutes 2011, section 256B.0754.

areas identified by the community (e.g., conditions that are costly, areas that are "actionable" by providers, and those with wide variations in quality).

QIPS, along with the Minnesota Statewide Quality Reporting and Measurement System, is designed to create a more coordinated approach to measuring, reporting and paying for health care quality, produce consistent incentives for health care providers to improve quality in specific priority areas, and put more useful and understandable information in the hands of Minnesota health care consumers. In other words, QIPS is envisioned as a uniform statewide pay-for-performance system whose existence would reduce the burden of health care providers associated with accommodating varying types and methodologies of pay-for performance systems.

This update of the annual report outlines the next iteration of QIPS. This report contains revised performance and improvement thresholds for 2012 and prospective performance and improvement thresholds for 2013 quality-based incentive payments. It is based on the most recent periods of quality measurement data.

The quality measures and the methodology used in the quality incentive payment system will continue to be adjusted and refined in future years. Additional and/or different quality measures may be used for subsequent years of the quality incentive payment system based on activities by other initiatives, changes in community priorities, evolving evidence, or development of new and/or improved quality measures. The methodology may be changed for future iterations of the quality incentive payment system to consider current performance levels and variations in performance in Minnesota.

Development of QIPS

The Minnesota Department of Health utilized a community input process that included numerous stakeholder groups and content experts in developing QIPS. The University of Minnesota produced an inventory and conducted a literature review about pay-for-performance methods and structures under contract with Minnesota Community Measurement (MNCM) in 2009 for the Minnesota Department of Health. This review found no consistency in the design and implementation of the pay-for-performance initiatives that were evaluated in the published literature, and few evaluations of existing pay-for-performance programs from which to draw lessons. Additionally, the literature provided little guidance concerning the design of pay-for-performance programs under specific sets of

conditions. The researchers from the University of Minnesota concluded that because market conditions and the preferences of providers vary across locations and over time, a single, optimal pay-for-performance program structure had not emerged.

Based on information compiled during the inventory and literature review, the University of Minnesota developed a set of preliminary recommendations about the measures and methodology for QIPS. Under the direction of the Minnesota Department of Health, the university held public meetings and convened both an Incentive Payment Work Group and a Hospital Quality Reporting Steering Committee to serve in an advisory capacity to the Minnesota Department of Health to review and refine the preliminary recommendations. The Incentive Payment Work Group, which included health plan, health care provider, employer, medical group administrator, and state agency representatives, provided feedback on the physician clinic quality measures and the overall methodology included in the preliminary recommendations. The Hospital Quality Reporting Steering Committee, whose membership included representatives from rural and urban hospitals, health plans, employers, and consumers, reviewed the recommended hospital quality measures and the general methodology for the quality incentive payment system.

After considering feedback received at public meetings and from both of the work groups, MNCM submitted final recommendations to the Minnesota Department of Health as part of its contract with the Department. Some of the recommendations included:

- Well established performance measures should be used when introducing a statewide program of pay-for-performance;
- Only a subset of the measures already being used in the community and included in QIPS should be utilized for the quality incentive payment system;
- The Minnesota Department of Health should be cautious about including—during the initial years of the quality incentive payment system—measures of health care services overuse;
- The quality measures included in the quality incentive payment system should be risk adjusted by major payer type; and
- In future years, additional and more sophisticated risk adjustment models (e.g., co-morbidity, severity, and socio-demographic characteristics) should be evaluated for use in QIPS.

The University of Minnesota's literature review highlighted a considerable amount of variation in potential rewards in existing pay-for-performance programs. Although very little research addressed the level of payment needed to achieve desired results in a pay-for-performance program, one of the recommendations the Minnesota Department of Health received suggested a payment of $100 per patient to clinics that meet or exceed the absolute performance benchmark. For clinics that meet or exceed the improvement target, the recommendation was for a payment of $50 per patient. Additionally, research showed that even initially modest rewards of between one percent and three percent of provider revenue may be effective if providers know with certainty that the scope of the pay for performance effort, in terms of number of patients and payers involved, will increase in a relatively brief period of time.

How to Use This Document and the QIPS Framework

Although only SEGIP and state public programs are required to use QIPS, health plans and other payers are encouraged to participate in this aligned approach to paying for health care quality. Individual payers have the flexibility to use the quality incentive payment system in a way that best meets their needs and the needs of the specific populations they serve, including by using a subset of the available measures.

The remainder of this report describes the quality measures selected for inclusion in QIPS, establishes benchmarks and improvement goals, and explains how providers can qualify for a quality-based incentive payment. This report does not set specific dollar amounts for the quality-based incentive payments; instead it provides flexibility to payers to take into account budget limitations and other considerations as they make their individual decisions on the incentive payment amount.

Data Sources

The source of data for QIPS is market-wide data (not payer-specific data) submitted by physician clinics and hospitals as required by the Minnesota Statewide Quality Reporting and Measurement System.[4] Market-wide data are being used to provide a comprehensive view of the full patient population treated at each physician clinic and hospital. Risk

[4]Minnesota Rules, Chapter 4654.

adjustment or population standardization is applied to ensure that comparisons between clinics account as best as possible for differences in the patient population. Consistent with the availability of data, risk adjustment of quality measures is performed on the basis of the type of primary payer, i.e., Medicare, Medicaid/state health care programs, and private payers. This is explained in more detail in the Risk Adjustment section of this report.

Quality Measures and Thresholds

Quality Measures

QIPS includes quality measures for both physician clinics[5] and hospitals, and focuses on conditions and processes of care that have been identified as priority areas by the community. The measures identified for quality-based incentive payments were selected from those included for public reporting purposes in the Minnesota Statewide Quality Reporting and Measurement System.[6] The measures are well-established in the community and are deliberately limited in number. Payers (other than state agency purchasers) may choose one or more measures for quality-based incentive payments to providers. The quality measures included in the 2012 iteration of QIPS remain the same as 2011 and are as follows:

2012 Physician Clinic Quality Measures:

- Optimal diabetes care (ODC)
- Optimal vascular care (OVC)

2012 Hospital Quality Measures:

- Acute myocardial infarction (AMI) appropriate care measure (ACM)
- Heart failure (HF) ACM
- Pneumonia (PN) ACM

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[5]In previous versions of the QIPS framework, “physician clinic quality measures” were referred to as “ambulatory quality measures”. For this update to the framework, the term “physician clinic quality measures” is used to maintain consistency with Minnesota’s Quality Reporting and Measurement System.

[6]Information about the Minnesota Statewide Quality Reporting and Measurement System and measure specifications can be found on the Minnesota Department of Health’s Health Reform website at: http://www.health.state.mn.us/healthreform/measurement/index.html.

2013 Physician Clinic and Hospital Quality Measures:

This update to the report also sets the measures for 2013 quality-based incentive payments to provide the prospective benchmarks and targets. The 2013 quality measures for physician clinics and hospitals are the same as those for 2012, with the addition of "depression remission at six months" for physician clinics. By 2013, this measure will have been part of the Minnesota Statewide Quality Reporting and Measurement System for multiple years and is recognized as an important area for improvement by the quality improvement community.

Providers may be eligible for a quality-based incentive payment for *either* achieving a certain level of performance or for a certain amount of improvement, but not both. One of the benefits of basing incentive payments on absolute performance thresholds is that the reward process is easy to understand and the target is clear to providers. However, because rewarding incentive payments based only on absolute performance may discourage lower-performing clinics to invest in improving the quality of care they deliver, payments to reward improvement are also included in this framework. This allows providers performing at all levels of the quality spectrum to participate in QIPS.

The Minnesota Department of Health anticipates that future iterations of this report will provide prospective benchmarks and improvement targets. Considering that the 2013 prospective targets may not account for significant unanticipated improvement, the Minnesota Department of Health reserves the right to modify the prospective benchmarks and improvement targets if there are significant changes in 2012 performance rates (2011 dates of service) or modifications to measure specifications.

Physician Clinic and Hospital Benchmarks and Improvement Targets for 2012 and 2013

Physician Clinic and Hospital Benchmarks and Improvement Targets – 2012

The 2012 absolute performance benchmarks for physician clinics and hospitals are established using historical performance data for each measure (see table 1). First, the top 20 percent of eligible patients were identified for each measure. Then, benchmarks were calculated based on the lowest rate attained by providers who serviced these eligible patients. Moreover, for clinics, a "stretch goal" of 3 percentage points has been added to the absolute performance benchmarks to encourage annual

improvement. A stretch goal for annual improvement has not been added to the hospital benchmarks, considering the high levels of performance already required to receive an incentive payment. Clinics and hospitals must meet or exceed the defined benchmark to be eligible for absolute performance incentive payments.

Table 1. Thresholds for Absolute Performance and Improvement – 2012

	Absolute performance benchmark (%)	Improvement target goal (%)	Current performance	
			Statewide average[a] (%)	Range (%)
Physician clinic quality measures				
Optimal diabetes care (ODC)	51	85	39	3 – 65
Optimal vascular care (OVC)	58[b]	100	41	3 – 67
Hospital quality measures				
Acute myocardial infarction (AMI) appropriate care measure (ACM)	99	100	97	65 – 100
Heart failure (HF) ACM	96	100	85	27 – 100
Pneumonia (PN) ACM	95	100	86	46 – 100

[a]Statewide averages for physician clinics are based on 2010 dates of service for Minnesota clinics that reported data under the Minnesota Statewide Quality Reporting and Measurement System. Statewide averages for hospitals are based on 12 months discharge dates ending June 2010.

[b]During 2010, the OVC measure required a systolic reading of <140 and a diastolic reading of <90 only for those patients with ischemic vascular disease (IVD) and diabetes, while patient with just IVD required a systolic reading of <130 and a diastolic reading of <80. For 2011 dates of service a systolic reading of <140 and a diastolic reading of <90 will be required for all patients. As a result, the OVC data was recast to take this measure change into account and more accurately calculate 2012 performance on this measure.

For a physician clinic or hospital to be eligible for a quality-based incentive payment for improvement, it must have had at least a 10 percent reduction in the gap between its prior year's results and the defined improvement target goal (see table 1). The improvement target goals were set by assessing current levels of performance and devising reasonable improvement targets given current performance.

Physician Clinic and Hospital Benchmarks and Improvement Targets – 2013

In this iteration of QIPs, the Minnesota Department of Health added absolute performance benchmarks and improvement target goals for 2013 (see table 2). The 2013 absolute performance benchmarks for physician clinics and hospitals were also established using historical performance data for each measure. The benchmarks for

those measures that were also included in 2012, were based on the improvement trend of the top provider results from the prior 2 years. After taking measure specification changes into account and their impact on absolute performance improvement over time, the performance improvement trend resulted in a 3 percentage point increase for physician clinics. Therefore, the 2013 absolute performance benchmarks for optimal diabetes care and optimal vascular care have been increased using a "stretch goal" of 3 percentage points. Because hospitals already perform high on their specified quality measures, there was relatively minor variation so the benchmarks for 2012 and 2013 remain the same. The trend data for the physician clinic measure of "depression remission at six months" were more limited, as this was the first year of required reporting under the Minnesota Statewide Quality Reporting and Measurement System. Thus, the absolute performance benchmark for this measure was calculated using the same methodology and stretch goal as the other clinic measures and 2011 data (2010 dates of service). Clinics and hospitals must meet or exceed the defined benchmark to be eligible for an absolute performance incentive payment.

Table 2. Thresholds for Absolute Performance and Improvement – 2013

	Absolute performance benchmark (%)	Improvement target goal (%)	Current performance	
			Statewide average[a] (%)	Range (%)
Physician clinic quality measures				
Optimal diabetes care (ODC)	54	85	39	3 – 65
Optimal vascular care (OVC)	61	100	41	3 – 67
Depression remission at six months	10	50	5	0 – 30
Hospital quality measures				
Acute myocardial infarction (AMI) appropriate care measure (ACM)	99	100	97	65 – 100
Heart failure (HF) ACM	96	100	85	27 – 100
Pneumonia (PN) ACM	95	100	86	46 – 100

[a]Statewide averages for physician clinics are based on 2010 dates of service for Minnesota clinics that reported data under the Minnesota Statewide Quality Reporting and Measurement System. Statewide averages for hospitals are based on 12 months discharge dates ending June 2010.

To determine the 2013 improvement target goals for physician clinics and hospitals, the improvement trend from one year to the next was reviewed to again set a reasonable estimate for the prospective goal (see table 2). Consistent with 2012 physician clinic and hospital improvement targets, for an entity to be eligible for a quality-based incentive payment for improvement, it must have had at least a 10 percent reduction in the gap between its prior year's results and the defined improvement target goal.

The Minnesota Department of Health will continue to take into account the improvement trend from one year to the next as the improvement targets are updated in future iterations of this report.

Measure Specification Updates and Impact on Thresholds

As measurement science and available evidence evolves, measures may change over time. For example, during 2010, the blood pressure component of the optimal diabetes care (ODC) measure changed based on medical evidence. In previous years, the most recent blood pressure assessment in the measurement period required a systolic reading of <130 and a diastolic reading of <80. For 2010 dates of service, however, a systolic reading of <140 and a diastolic reading of <90 were required. This measure specification change means more patients may meet the blood pressure standard in the "all or none" ODC composite measure and physician clinics may therefore achieve higher rates of optimal diabetes care. Without taking this potential effect into account, physician clinics may appear to have made more substantial improvements in their optimal care rates that may in fact be related to the change in measure definition.

To more accurately compare improvement in performance from one year to the next, payers should make an adjustment to recognize changes in measure definitions. The Minnesota Department of Health recommends adjusting the base improvement target goal by the statewide average change in clinic performance under the new definition. This adjustment should be made regardless of whether physician clinics are likely to earn greater or lesser amounts of improvement incentive payments as a result. For example, taking into account the new blood pressure component of the optimal diabetes care measure, the statewide average rate for optimal diabetes care rose by 7.1 percentage points from 25 percent to 32.1 percent. To more accurately reward actual improvement on optimal diabetes care, the Minnesota Department of Health recommends increasing the base improvement target goal

by the statewide average increase based on the new measure specifications. In this example the target goal of 85 percent would increase by 7 percentage points to arrive at an improvement target goal of 92 percent. Additionally, payers may consider reexamining clinics' base performance levels in determining their eligibility for improvement-based incentives.

While the blood pressure component of the optimal vascular care (OVC) measure specification has changed in 2012 for 2011 dates of service, the improvement goal is currently at 100 percent so no adjustment is required.

Calculation of Improvement Over Time

The example in table 3 shows how to calculate a physician clinic's eligibility for a quality-based incentive payment for improvement over time:

Table 3. Calculation of Incentive Payment for Improvement in Optimal Diabetes Care (ODC) Over Time – Physician Clinic Example

1	**Improvement target goal**	85%
2	**Your clinic's rate in the previous year**	28 %
3	Subtract your clinic's rate (line 2) from the improvement target goal (line 1). This is the **gap** between your clinic's prior year's results and the improvement target goal.	57%
4	Required **annual reduction in the gap**.	10%
5	Multiply the gap (line 3) by the 10% required annual reduction in the gap (line 4). This is **percentage point improvement needed to be eligible for a payment incentive for improvement**.	6%
6	Add your clinic's rate (line 2) to the percentage point improvement needed to be eligible for a payment incentive for improvement (line 5). This is the **rate at which your clinic would be eligible for an improvement incentive payment.**	34%

Quality-based incentive payments for improvement are time-limited to encourage improvement while maintaining the goal of all physician clinics and hospitals achieving the absolute performance benchmarks. Each physician clinic and hospital that does not meet the absolute performance benchmark for a particular quality measure is eligible for incentive payments for improvement for a maximum of 3 consecutive years, beginning with the first year a physician clinic or hospital becomes eligible for payment for improvement, and after

which the physician clinic or hospital would only be eligible for the absolute performance benchmark payment incentive. It has been noted providers may oscillate between receipt of absolute performance-based and improvement-based incentive payments over time. The Minnesota Department of Health will review this potential issue based on implementation experience and may revise this policy if such oscillation occurs on a significant scale.

Risk Adjustment

As noted earlier, the complexity of any risk adjustment approach—for QIPS specifically and quality measurement reporting generally—is dictated by the availability of data. Minnesota Statutes, section 62U.02 requires QIPS to be adjusted for variations in patient population, to the extent possible, to reduce possible incentives for providers to avoid serving high-risk populations. Through its contractor, MNCM, the Minnesota Department of Health convened a work group to make recommendations on how to improve risk adjustment for the quality incentive payment system. This workgroup concluded that, considering available data, risk adjustment by payer mix (i.e., primary payer type: private/commercial insurance, Medicare, Minnesota Health Care Programs, uninsured/self-pay) would be an acceptable proxy for differences in the severity of illness and socio-demographic characteristics of clinics' patient populations. That is, by risk adjusting or population-standardizing quality scores to the average statewide payer mix, variations that are due to different patient populations and that are not under the control of the provider can be somewhat adjusted and controlled for. While it is possible to design more sophisticated methods and models of adjusting for differences in clinical and population differences among providers, these more comprehensive approaches would require additional data and result in greater administrative burden for providers related to submission of additional data elements for improved risk adjustment. Risk adjustment by primary payer type strikes a reasonable balance between the desires to adequately risk adjust quality measures and manage the administrative burden of data collection for providers.

For physician clinics, the Minnesota Department of Health will continue to risk adjust the ODC and OVC quality measures by payer mix for public reporting purposes.[7] SEGIP and the Minnesota Department of Human Services will also use these risk adjusted rates to determine whether particular clinics are eligible for incentive payments.

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[7]The hospital measures used in QIPS are Centers for Medicare & Medicaid Services (CMS) Hospital Compare "Process of Care" measures which are not risk adjusted.

MDH will risk adjust the "depression remission at 6 months" measure results for physician clinics by severity of the initial PHQ-9 score. Initial PHQ-9 severity scores will be grouped according to the following three categories:

- Moderate: Initial PHQ-9 score of 10 to 14
- Moderately Severe: Initial PHQ-9 score of 15 to 19
- Severe: Initial PHQ-9 score of 20 to 27

Severity was chosen as a risk adjustment variable based on concerns raised by stakeholders about the potential for differences in severity of depression among patient populations to unfairly affect results that are publicly reported. More specifically, stakeholders raised concerns that clinics treating a greater proportion of severely ill patients would have poorer remission rates compared to their peers treating less severely ill patients because patients with more severe levels of depression are less likely to achieve remission. This concern was corroborated in research summarized by the University of Minnesota in March of 2010.[8] The University of Minnesota research summary suggests that depression remission can vary as a function of initial severity and comorbidity. High initial severity scores are correlated with a worse response to treatment. The initial PHQ-9 score has been established as a validated indicator of initial depression severity. The ICD 9 code fifth digit was also considered, but it was determined that the fifth digit is not uniformly or consistently used, and research questioned whether severity levels would coincide with PHQ-9 severity levels.

Primary payer type was also considered for adjustment, but research indicated that while primary payer type may affect access to care, it may not affect the likelihood of an adequate course of care once treated. Questions remain about variation in medication compliance and preferred treatment models that warrant more examination of the data.

The risk adjustment by payer mix example in table 4 illustrates the importance of risk adjustment. Clinic A and Clinic B each have the same quality performance for their patients within payer category (each achieves 65 percent optimal diabetes care for private/commercial patients, 45 percent for Minnesota Health Care Programs/uninsured/self-pay, and 55 percent for Medicare). However, because Clinic A and Clinic B serve different proportions of patients from each of these payers, their overall quality scores are different if there is no

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[8]The Minnesota Department of Health requested that the University of Minnesota develop recommendations on risk adjusting the "depression remission at six months" measure by severity based on PHQ-9 scores at initial diagnosis of depression or dysthymia.

adjustment for payer mix: Clinic A's unadjusted score is 60 percent, and Clinic B's score is 55 percent, despite the fact that the two clinics are achieving similar outcomes for similar patient populations.

Table 4. Example of Risk Adjustment for Optimal Diabetes Care (ODC) Using Payer Mix

Unadjusted Rates				
	Private/Commercial insurance	Minnesota health care programs/ Uninsured/Self-pay	Medicare	Total
Clinic A				
Number of patients	250	50	100	400
Percent meeting measure	65%	45%	55%	60%[a]
Clinic B				
Number of patients	100	100	200	400
Percent meeting measure	65%	45%	55%	55%
Statewide average				
Percent distribution of patients[b]	48.6%	16.6%	34.8%	100%
Rates Adjusted to Statewide Average Payer Mix				
Clinic A				58%
Clinic B				58%

[a]Total unadjusted scores are calculated by summing the product of the number of patients and the percent meeting a measure for each payer and dividing the results by the total number of patients. For example, for Clinic A the calculation would be as follows: [(250 * 0.65) + (50 * 0.45) + (100 * 0.55)] / (250 + 50 + 100) = 0.6.

[b]Based on 2010 dates of service for providers that reported data under the Minnesota Statewide Quality Reporting and Measurement System.

The basic risk adjustment for payer mix is calculated as follows: each clinic's score for each payer type is multiplied by the statewide average distribution of patients by payer—in this illustration, each clinic's private insurance score is multiplied by 0.486 (the percentage of patients statewide with private insurance), the Minnesota Health Care Programs/uninsured/self-pay score is multiplied by 0.166, and the Medicare score is multiplied by 0.348. After this adjustment is made, Clinic A and Clinic B achieve the same overall quality score (58 percent), which is more accurately reflective of the fact that they provide the same quality performance for similar populations (see table 4).

Consistency with Other Activities

Consistent with the principals underlying QIPS, the clinical conditions chosen for inclusion in the incentive payment system are consistent with those identified for use in the Provider Peer Grouping (PPG) system (one of the other important components of Minnesota's broader health reform initiative), the Bridges to Excellence (BTE) program, and the federal government's efforts to enhance the meaningful use of electronic health records, among other quality improvement initiatives. As part of the PPG initiative, the Minnesota Department of Health is statutorily required to develop a method for comparing health care providers based on a composite measure of risk-adjusted cost and quality. The results of this analysis will be used to change incentives for both health care providers and consumers in ways that encourage lower costs and higher quality. The PPG system will utilize cost data obtained from health plans and third party administrators and quality data reported by physician clinics and hospitals as part of the Minnesota Statewide Quality Reporting and Measurement System.

Some of the precise mechanisms for calculating performance and incentive payments included in the QIPS differ from other incentive payment programs. For example, private purchasers in the BTE program do not use risk adjustment. The quality incentive payment system, however, is required by law to include this feature, and the Department will work with providers to ensure their full understanding of the value of risk adjustment and obtain their comment on the actual mechanisms of operationalizing it.

Moving forward, the Minnesota Department of Health and its partners will closely monitor trends nationally and in other states to identify efforts, initiatives, and partnerships that strengthen efforts of the QIPS and the other activities in the state focused on meaningful and lasting quality improvement.