Minnesota Statewide Quality Reporting and Measurement System:

Quality Incentive Payment System

Updated March 2011

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Executive Summary

Minnesota's 2008 Health Reform Law requires 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. The quality incentive payment system must be implemented by the Commissioner of Finance for the State Employee Group Insurance Program (SEGIP) by July 1, 2010 (Minnesota Statutes, § 62U.02). In addition, the Commissioner of Human Services must implement the quality incentive payment system for all enrollees in state health care programs to the extent it is consistent with relevant state and federal statutes and rules (Minnesota Statutes, § 256B.0754).

This is the first update to the Minnesota Quality Incentive Payment System since the initial framework was published in January 2010. This report describes both the methodology and the quality measures included the Minnesota Quality Incentive Payment System. The incentive payment system includes two quality measures for ambulatory care settings and three quality measures for hospitals. Payers interested in implementing the quality incentive payment system described in this report are encouraged to select measures from the list in order to send common signals about priority health conditions to the marketplace and maximize incentives for health care quality improvement. This flexibility 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 will galvanize market forces to reward excellent and improved performance by health care providers and will likely enhance the prospects of improved performance in treating priority health conditions.

It is anticipated that the quality measures and the methodology used in the quality incentive payment system framework will continue to be adjusted and refined in future years. New and/or modified quality measures may be included in subsequent years based on other initiatives, community priorities, changing 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 improving performance levels and variations in performance.

These changes to the quality incentive payment system framework will continue to be made via an annual update of this report. This first update of the report contains revised performance and improvement thresholds and an additional section regarding the impact of measure specification changes.

Background

STATUTORY REQUIREMENTS

The 2008 health reform law (Minnesota Statutes, § 62U.02) requires the Commissioner of the Minnesota Department of Health to develop a quality incentive payment system. The statute requires that the quality-based incentive payments be in addition to existing payment levels and that the quality-based incentive payments be based on:

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

The statute also requires the quality incentive payment system to be adjusted for variations in patient population to the extent possible, in order to reduce possible incentives for providers to avoid serving high-risk populations.

The quality incentive payment system must be implemented by the Commissioner of Minnesota Management and Budget for the State Employee Group Insurance Program (SEGIP) by July 1, 2010 (Minnesota Statutes, § 62U.02). In addition, the Commissioner of Human Services must implement the quality incentive payment system for all enrollees in state health care programs to the extent it is consistent with relevant state and federal statutes and rules (Minnesota Statutes, § 256B.0754). This system will be used by public health care purchasers, and its use by private purchasers is encouraged.

GOALS

The purpose of the quality incentive payment system is to encourage a consistent message to providers from the payer community signaling priority areas for improvement. The primary goals of the quality incentive payment system are to align and uniformly leverage provider payment incentives, and to accelerate improvement in key areas identified by the community (e.g., conditions that are costly, areas that are "actionable" by providers, and those with wide variations in quality).

The quality incentive payment system, along with the Statewide Quality Reporting and Measurement System, will create a more coordinated approach to measuring, reporting and paying for health care quality, create consistent incentives for health care providers to improve quality in specific priority areas, and will put more useful and understandable information in the hands of Minnesota health care consumers.

This is the first update of this report and it outlines the next iteration of the quality incentive payment system. This report contains revised performance and improvement thresholds based on the most recent periods of quality measurement data. It is likely that 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 other initiatives, community priorities, changing 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 the Quality Incentive Payment System

The Minnesota Department of Health utilized a community input process that included numerous stakeholder groups and content experts in developing this quality incentive payment system. The University of Minnesota produced an inventory and conducted a literature review about pay-for-performance methods and structures under contract with MN Community Measurement for the Minnesota Department of Health. This review found no consistency in the design and implementation of the pay-for-performance initiatives that have been evaluated in the published literature, and few evaluations of existing pay-for-performance programs from which to draw lessons. Additionally, the literature provides 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, there is no single, optimal pay-for-performance program structure.

Based on information they compiled during the inventory and literature review, the University of Minnesota developed a set of preliminary recommendations about the measures and methodology for the quality incentive payment system. Public meetings were held and both an Incentive Payment Work Group and a Hospital Quality Reporting Steering Committee were convened 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 ambulatory care 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 the 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 MDH. Some of the recommendations are listed below:

- 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 the Statewide Quality Reporting and Measurement System should be utilized for the quality incentive payment system;
- MDH should be cautious about including overuse measures during the initial years of the quality incentive payment system;
- 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 the Minnesota Quality Incentive Payment System.

The University's literature review highlighted a considerable amount of variation in potential rewards in existing pay-for-performance programs. Although very little research addresses the level of payment needed to achieve desired results in a pay-for-performance program, one of the recommendations the Department received was related to the amount needed for quality-based incentive payments for providers in order to achieve desirable results. The contractor recommended a payment to clinics that meet or exceed the absolute performance benchmark of $100 per patient. For clinics that meet or exceed the improvement target, the recommendation was for a payment of $50 per patient. Additionally, research shows 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 Quality Incentive Payment System

Although only the State Employee Group Insurance Program (SEGIP) and state public programs are required to use this quality incentive payment system, 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.

The remainder of this report describes the quality measures initially selected for inclusion in the incentive payment system, establishes benchmarks and improvement goals, and explains how providers can qualify for a quality-based incentive payment. This report does not, however, set specific dollar amounts for the quality-based incentive payments, in order to provide flexibility to payers that will need to take into account budget limitations and other considerations.

Data Sources

The source of data for the quality incentive payment system will be market-wide data (not payer-specific data) submitted by physician clinics and hospitals as required by the Minnesota Statewide Quality Reporting and Measurement System (Minnesota Administrative Rules, Chapter 4654). Market-wide data is being used to provide a comprehensive view of the full patient population treated at each physician clinic and hospital. Risk adjustment on the basis of primary payer type will then be applied to the quality measure results. This is explained in more detail in the Risk Adjustment section that begins on page 11 of this report.

Quality Measures and Thresholds

The quality incentive payment system includes quality measures for both ambulatory care settings 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 Statewide Quality Reporting and Measurement System. The measures are well established in

the community and were deliberately limited in number. The quality measures included in this iteration of the quality incentive payment system remain the same and are listed below:

Ambulatory Quality Measures:

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

Hospital Quality Measures:

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

Payers may choose one or more measures for quality-based incentive payments to providers.

Ambulatory Benchmarks and Improvement Targets

- The ambulatory quality measure absolute performance benchmarks are established using historical performance data for each measure. An initial target is based on the top provider results from the prior year that are tied to 20% of the identified population for each measure and a stretch goal of 3 percentage points was then added to encourage annual improvement. A clinic must meet or exceed the defined benchmark to be eligible for an absolute performance incentive payment.

- The improvement target goals are defined in the table on page ten; in order for a clinic to be eligible for a quality-based incentive payment for improvement, the clinic must have had at least a 10% reduction in the gap between their prior year's results and the defined improvement target goal. The defined improvement target goals were set by assessing current levels of performance and devising reasonable improvement targets given current performance.

Hospital Benchmarks and Improvement Targets

- The hospital absolute performance benchmarks are established using historical performance data for each measure. A target is based on the top provider results from the prior year that are tied to 20% of the identified population for each measure. (A "stretch goal" for annual improvement is not added to the hospital benchmarks given the high levels of performance already required to receive an incentive payment.) A hospital must meet or exceed the benchmark to be eligible for an absolute performance quality-based incentive payment.

- Improvement target goals are defined in the table on page ten; in order for a hospital to be eligible for a quality-based incentive payment for improvement, the hospital must have had at least a 10% reduction in the gap between the prior year's results and the defined improvement target goal. The defined improvement target goals were set by assessing current levels of performance and devising reasonable improvement targets given current performance.

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 the quality incentive payment system.

Measure Specification Updates And Impact on Thresholds

As science evolves, measures may change over time. For example, in 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 will be required. This measure specification change means more patients may meet the blood pressure standard in the "all or none" optimal diabetes care 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.

In order to more accurately compare improvement in performance from one year to the next, payers should make an adjustment to recognize changes in measure definitions. MDH 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, MDH recommends increasing the base improvement target goal of 85 percent by 7 percentage points as shown in the table on page ten to arrive at a modified improvement target goal of 92 percent. In addition, payers may consider reexamining clinics' base performance levels in determining their eligibility for improvement-based incentives.

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

Example of Payment Incentive for Improvement Eligibility Calculation

1	**Improvement target goal**	85%
1a	**Incremental change to target goal if needed to address changes in measure specifications.**	+ 7% (example)
1b	**Modified improvement target goal**	92%
2	**Your clinic's rate**	22 % (example rate)
3	Subtract your clinic's rate (line 2) from the modified improvement target goal (line 1b). This is the **gap** between your clinic's prior year's results and the modified improvement target goal.	70%
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**.	7%
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.**	29%

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 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 clinic or hospital becomes eligible for payment for improvement, and after which the 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. MDH will review this potential issue

based on implementation experience and may revise this policy if such oscillation occurs on a significant scale. See the table below for the absolute performance threshold and the improvement threshold for each measure in the 2011 quality incentive payment system.

Thresholds for Absolute Performance and Improvement

Ambulatory Quality Measures	Absolute Performance Benchmark	Modified Improvement Target Goal (see pages 8 & 9)	Current Performance	
			Statewide Average [1]	Range
Optimal diabetes care (ODC)	37%	85% + 7% = 92%	28%	0% - 57%
Optimal vascular care (OVC)	46%	100%	34%	0% - 69%
Hospital Quality Measures	**Absolute Performance Benchmark**	**Improvement Target Goal**	**Current Performance**	
			Statewide Average [2]	**Range**
Acute myocardial infarction (AMI) appropriate care measure (ACM)	99%	100%	97%	43% - 100%
Heart failure (HF) appropriate care measure (ACM)	96%	100%	85%	3% - 100%
Pneumonia (PN) appropriate care measure (ACM)	95%	100%	86%	34% - 100%

[1] Based on 2009 dates of service for Minnesota clinics that reported data under the Statewide Quality Reporting and Measurement System.

[2] Based on 12 months discharge dates ending March 2010

RISK ADJUSTMENT

The statute requires the quality incentive payment system to be adjusted for variations in patient population to the extent possible, in order to reduce possible incentives for providers to avoid serving high-risk populations. Quality measures used in the quality incentive payment system will continue to be risk adjusted by payer mix (i.e., primary payer type: private/commercial insurance, Medicare, Minnesota Health Care Programs, uninsured/self-pay) for the ambulatory care quality measures. By standardizing quality scores to the statewide average payer mix, variations that are due to different patient populations and that are not under the control of the provider can be adjusted and controlled for.

The following example illustrates the importance of this type of risk adjustment. In the table on page 12, Clinic A and Clinic B each have the same quality performance for their patients who are insured by different payers (each achieves 65% optimal diabetes care for private/commercial patients, 45% for state public programs, and 55% 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 adjustment for payer mix: Clinic A's unadjusted score is 60%, and Clinic B's score is 55%, despite the fact that the two clinics are achieving similar outcomes for similar patient populations.

MDH used a similar method to risk adjust clinic results in its first statewide quality report issued in November 2010 with some additional provisions to address when clinics have small numbers in particular product types. 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 .55 (the percentage of patients statewide with private insurance), the state public programs score is multiplied by .15, and the Medicare score is multiplied by .30. After this adjustment is made, Clinic A and Clinic B achieve the same overall quality score (59%), which is more accurately reflective of the fact that they achieve the same results for similar populations.

Example of Risk Adjustment Using Payer Mix

Unadjusted Rates: Optimal Diabetes Care				
	Private Insurance	MN Public Programs	Medicare	Total
Clinic A				
# of patients	250	50	100	400
% meeting measure	65%	45%	55%	60%
Clinic B				
# of patients	100	100	200	400
% meeting measure	65%	45%	55%	55%
Statewide average				
% distribution of patients [3]	55%	15%	30%	100%

Rates Adjusted to Statewide Average Payer Mix	
Clinic A	59%
Clinic B	59%

Although more sophisticated risk adjustment techniques that adjust for differences in patient severity and socio-demographic characteristics may be possible in future years, the work group convened to make recommendations on the quality incentive payment system concluded that risk adjustment by payer mix would be an acceptable proxy for differences in the severity of illness and socio-demographic characteristics of clinics' patient populations. The scope of any risk adjustment relies on data that must be submitted by providers as part of the Minnesota Statewide Quality Reporting and Measurement System. It is therefore important to consider the benefits of more comprehensive risk adjustment compared with greater administrative burdens on providers to submit additional kinds of data. Risk adjustment by primary payer type strikes a reasonable balance between the desire to adequately risk adjust quality measures and the desire to minimize the administrative burden of data collection for providers. MDH proposes to use this risk adjustment methodology again to calculate risk adjusted rates for public reporting purposes. SEGIP and the Minnesota Department of Human Services will also use these risk adjusted rates to

[3] Based on 2009 dates of service for providers that reported data under the Minnesota Statewide Quality Reporting and Measurement System.

determine whether particular clinics are eligible for incentive payments. In an effort to engage stakeholders on this issue, the Department will solicit comments on a more detailed description and application of its risk adjustment methodology through a separate public comment process this spring.

Consistency with Other Activities

The clinical conditions chosen for inclusion in the quality 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 Excellences (BTE) program, and the federal government's efforts to enhance the meaningful use of electronic health records (EHR), among other quality improvement initiatives. As part of the provider peer grouping 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 Minnesota Quality Incentive Payment System 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.

Next Steps

The Commissioner of Health will continue to annually evaluate and update the measures, performance targets, and methodology used in the quality incentive payment system. To facilitate this annual review, the Department anticipates soliciting comments and suggestions on the Quality Incentive Payment System 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 will release an updated report annually.

Other Resources

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

Measure specifications for the quality measures included in the Minnesota Quality Incentive Payment System can be found on the Minnesota Department of Health's Health Reform website at: http://www.health.state.mn.us/healthreform/measurement/index.html

Information about the Provider Peer Grouping (PPG) system can be found on the Minnesota Department of Health's Health Reform website at: http://www.health.state.mn.us/healthreform/peer/index.html