

Encouraging Health Plan Use of Provider Peer Grouping to Promote Utilization of Higher-Quality, Lower-Cost Providers

Minnesota Department of Health

January 2011



Health Economics Program
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Introduction

Minnesota's 2008 health reform law created the Provider Peer Grouping (PPG)¹ system to improve market transparency of health care quality and cost information and change incentives for health care providers and consumers to encourage higher quality of care and lower health care costs. PPG is a system to publicly compare the overall and condition-specific performance of health care providers using a population-based composite measure of risk-adjusted quality and cost, as well as the separate quality and cost components. PPG is a tool to provide transparency to the marketplace on value, or in other words, quality and cost.

Minnesota law requires various entities to use the PPG results.² The State Employee Group Insurance Program (SEGIP) and local units of government must use the PPG results as the basis of incentives for consumers to choose higher-quality, lower-cost health care providers. The Department of Human Services (DHS) is required to use the PPG results as the basis for a differential payment system for provider reimbursement for enrollees in state public health care programs such as Medical Assistance. DHS must also use the PPG results to create incentives for enrollees to use high-quality, lower-cost providers and foster collaboration among providers to reduce cost-shifting. All health plan companies must also use the PPG results to develop products that encourage consumers to use higher-quality, lower-cost providers. Health plan companies that operate in Minnesota's individual or small employer markets must offer at least one health insurance product that uses the PPG results to establish financial incentives for consumers to choose higher-quality, lower-cost providers through enrollee cost-sharing or selective provider networks.

The 2008 health reform law further requires the Minnesota Department of Health (MDH) to make recommendations on how to encourage health plan companies to promote widespread adoption of products that encourage the use of higher-quality, lower-cost providers by January 1, 2011.³ When the 2008 law was enacted, the timeline assumed that the PPG results would be publicly available before 2011. The timeline has since been modified and public release of the PPG results is planned for late summer of 2011. Given that the PPG results are not yet available, it is premature to make recommendations on how to encourage greater use of the information before health plans and other stakeholders have had an opportunity to view or start using it. MDH will first seek to understand how stakeholders, including health plans, are using the PPG results prior to making recommendations about strategies for enhancing use of the information. This report provides a progress update on MDH's activities to develop the PPG system, encourage future use of the PPG results as a tool to improve quality of care and lower health care costs and assess early uses of the PPG results.

¹ Minnesota Statutes 62U.04.

² Minnesota Statutes 62U.04, Subdivision 9 (a) and Minnesota Statutes 256B.0754, Subdivision 2. See Appendix A.

³ Minnesota Statutes 62U.04, Subdivision 9 (b). See Appendix B.

Activities to Date

MDH has engaged stakeholders at each step in the development of the PPG system. MDH's goal in these collaborative activities has been to encourage broad use of the PPG results in the future by listening to diverse perspectives, incorporating the best science, and building confidence in the PPG analysis.

The Department began its work on the PPG system almost two years ago. In February 2009, MDH issued a "Request for Information" through which stakeholders were invited to share ideas, concerns, and recommendations on methodological issues. In the summer of 2009, MDH convened an Advisory Group and Technical Panel to provide input on the conceptual framework for Provider Peer Grouping. MDH considered input received through the Request for Information in developing issue papers for Advisory Group members. The Advisory Group met intensively over a four month period as its members considered the following nine core issues outlined in Minnesota Statutes 62U.04:

- provider attribution of costs and quality;
- appropriate adjustment for outlier or catastrophic cases;
- appropriate risk adjustment to reflect differences in the demographics and health status across provider patient populations, using generally accepted and transparent risk adjustment methodologies;
- specific types of providers that should be included in the calculation;
- specific types of services that should be included in the calculation;
- appropriate adjustment for variation in payment rates;
- the appropriate provider level for analysis;
- payer mix adjustments, including variation across providers in the percentage of revenue received from government programs; and
- other factors that the Commissioner determines are needed to ensure validity and comparability of the analysis.

The Advisory Group issued a final report of recommendations in October 2009⁴ and this report was used as the basis for a procurement process to hire an analytical contractor. MDH signed a contract with Mathematica Policy Research in March 2010 to further develop and carry out the PPG analysis.

Subsequently, MDH created the Rapid Response Team (RRT) in May 2010, comprised of representatives from the Minnesota Medical Association, the Minnesota Hospital Association, the Minnesota Council of Health Plans, the American Association for Retired Persons, the Minnesota Business Partnership, and the Minnesota Department of Human Services. This group was convened to provide feedback to MDH on key methodological implementation issues. MDH has worked closely with the RRT on several issues, including how to approach the analysis of specific health conditions,

⁴ Provider Peer Grouping Advisory Group, "Provider Peer Grouping Recommendations," October 2009.
http://www.health.state.mn.us/healthreform/peer/advisory_finalreport.pdf

the specific method by which patient attribution to health care providers should occur, and how hospital peer groups should be constructed. MDH will continue to work with the RRT as additional details of the PPG methodology are determined.

The Department also convened a separate workgroup in December 2010 to provide advice on how to assess reliability of the PPG analysis. Members of the workgroup include representatives of physician clinics, hospitals, health plans, purchasers, consumers, Minnesota Community Measurement, the Department of Human Services, and the University of Minnesota. The purpose of the Reliability Workgroup is for stakeholders to provide advice to MDH on how to assess reliability of peer grouping results and for MDH to share information on reliability related to specific methodological issues.⁵ This workgroup will meet several times over the winter and spring of 2011 to provide input. In addition, MDH will consult with health care providers about how to design provider reports to ensure that information will be presented in a meaningful way and will facilitate provider understanding of and ability to act on the data.

In addition to these collaborative activities, MDH has also provided opportunities for the public to receive information about the PPG initiative and progress to date. MDH publishes PPG materials on its website and through its listserv and has provided regular updates to the Health Care Access Commission and to the Health Care Reform Review Council. MDH also holds a monthly conference call for anyone interested in updates regarding the PPG analysis. These calls are scheduled the second Monday of each month at 7:30 am to facilitate the ability of health care providers to participate.

MDH reached an important milestone in its PPG work by releasing its first statewide quality report in November 2010. By building on a successful history of private sector activities, MDH expanded the reach of quality reporting to include results for more than 520 physician clinics and over 40 hospital measures for more than 130 hospitals. In addition, MDH advanced the practice of public reporting by risk adjusting results. The purpose of risk adjustment is to adjust for factors that are outside the control of health care providers, such as severity of illness and demographic or socioeconomic characteristics. Risk adjustment facilitates more comparable public reporting of provider performance. The information in the MDH quality report will be included as part of a broader composite measure of quality for the PPG system.

MDH is collaborating with private sector entities in an effort to integrate PPG reporting and its component quality and cost measures on one website. This unified reporting will be another important step in further integration of public and private sector efforts to enhance market transparency and encourage enhanced use of population-based cost and quality information by payers, providers, and consumers to improve quality of care and lower health care costs.

⁵ Minnesota Statutes 62U.04 , Subdivision 3 (h)

Future Plans to Understand Uses of Peer Grouping Results

Although the first round of PPG analysis has not yet been completed, the Department has been successful in laying a strong foundation with public and private stakeholders to ensure that the state's PPG efforts will result in a high-quality tool and resource.

When Minnesota's 2008 health reform law was passed, the law assumed PPG results would be reported publicly prior to this legislative report being issued. The timeline has been modified and the first phase of PPG results will be publicly reported by late summer of 2011, which will be the first opportunity for health plans and other stakeholders to view and begin using the information. Given that the PPG results are not yet available, it is premature to make recommendations on how to encourage greater use of the information. However, MDH will study how payers and consumers use the PPG results after they become publicly available; the results of this study may be used to make future recommendations regarding ways to encourage enhanced use of the information to improve the quality of care and lower health care costs.

The Department was awarded a three-year grant from the Robert Wood Johnson Foundation in November 2010 to study how various payers use the PPG results and the early impact of the PPG system on consumer choice of health care providers. This work will be carried out in partnership with the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota. Through this grant, MDH will study how health plans and consumers are using the results once the first iteration of the PPG analysis is complete.

This project will study the initial use of the PPG system by payers and consumers. The objectives of the study are to assess the extent and manner of use of the PPG results by payers and the extent of change in consumer choice and utilization of providers. The project includes both qualitative and quantitative components. The qualitative portion of the project will take place through a series of interviews with various payers including the State Employee Group Insurance Plan, the Department of Human Services, and commercial health plans. Payers will be asked questions related to how the PPG results are similar to or different from existing payer-specific provider measures, how they will use the PPG results, whether they will continue using their own provider measures and methodologies, how consumers are reacting to the PPG results and associated uses, and what improvements could be made to the system. The quantitative portion of the project will compare changes in consumer choice and utilization of health care providers resulting from public release of PPG results and use of PPG results by payers to create financial incentives to change consumer behavior.

Minnesota Statutes 62U.04 requires various entities to use the population-based PPG results in order to leverage a critical mass of payers to create consistent market signals for providers and consumers to encourage higher quality care and lower health care costs. The results from this study will assist MDH in making future recommendations regarding whether and what type of strategies may be needed to enhance the use of PPG information in the development of products incenting the use of higher-quality, lower-cost providers.

Conclusion

Over the past two years, MDH has worked closely with stakeholders to develop confidence in and encourage the use of PPG as a tool for payers, providers, and consumers to improve quality of care and lower health care costs.

Public release of PPG results is planned for late summer of 2011. Various entities including the State Employee Group Insurance Program (SEGIP), local units of government, commercial health plans, and the Minnesota Department of Human Services (DHS) are required to use the PPG results. Given that the PPG results are not yet available, it is premature to make recommendations on how to encourage greater use of the information before health plans and other stakeholders have had an opportunity to view or start using it.

Prior to making recommendations to enhance the use of PPG results by health plans and other stakeholders, it is important to first understand how the market - including payers, providers, and consumers - responds to this information on value. MDH has received a grant to study payer and consumer use of PPG results and findings from this research will help inform future recommendations related to strategies to enhance the use of PPG as a tool to improve value.

Appendix A

Minnesota Statutes 62U.04, Subdivision 9 (a)

Subd. 9. Uses of information.

(a) By no later than 12 months after the commissioner publishes the information in subdivision 3, paragraph (e):

(1) the commissioner of management and budget shall use the information and methods developed under subdivision 3 to strengthen incentives for members of the state employee group insurance program to use high-quality, low-cost providers;

(2) all political subdivisions, as defined in section 13.02, subdivision 11, that offer health benefits to their employees must offer plans that differentiate providers on their cost and quality performance and create incentives for members to use better-performing providers;

(3) all health plan companies shall use the information and methods developed under subdivision 3 to develop products that encourage consumers to use high-quality, low-cost providers; and

(4) health plan companies that issue health plans in the individual market or the small employer market must offer at least one health plan that uses the information developed under subdivision 3 to establish financial incentives for consumers to choose higher-quality, lower-cost providers through enrollee cost-sharing or selective provider networks.

Minnesota Statutes 256B.0754, Subdivision 2

Subd. 2. Payment reform.

By no later than 12 months after the commissioner of health publishes the information in section 62U.04, subdivision 3, paragraph (e), the commissioner of human services shall use the information and methods developed under section 62U.04 to establish a payment system that:

(1) rewards high-quality, low-cost providers;

(2) creates enrollee incentives to receive care from high-quality, low-cost providers; and

(3) fosters collaboration among providers to reduce cost shifting from one part of the health continuum to another.

Appendix B

Minnesota Statutes 62U.04, Subdivision 9 (b)

(b) By January 1, 2011, the commissioner of health shall report to the governor and the legislature on recommendations to encourage health plan companies to promote widespread adoption of products that encourage the use of high-quality, low-cost providers. The commissioner's recommendations may include tax incentives, public reporting of health plan performance, regulatory incentives or changes, and other strategies.