Minnesota Statewide Quality Reporting and Measurement System:

Quality Incentive Payment System

Updated May 2013

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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 were 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. Therefore, other health care purchasers in the state are encouraged to take advantage of the framework for their incentive payment initiatives.

QIPS was initially released in January 2010 and was updated in March 2011 and May 2012. This report represents the third revision to this framework, which includes thresholds for 2013 and 2014. This report describes both the methodology and the quality measures included in QIPS. For 2013 and 2014, the incentive payment system includes three quality measures for physician clinics and three quality measures for hospitals.

Payers interested in implementing QIPS are encouraged to select some or all of the approved measures to send common signals about priority health conditions to the marketplace and to maximize incentives for health care quality improvement. This approach allows payers to use QIPS in a way that best meets their needs, while setting a common set of priorities for improvement. Using 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 methodology used in the QIPS 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 input from community stakeholders, activities by other initiatives, changes in community priorities, evolving evidence, or development of new or improved quality measures. Other aspects of the methodology may also be changed over time to reflect availability of data, improvement in performance levels and changes in variations of performance. 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 implementation 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 QIPS—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 set and meet priorities for quality improvement. The Commissioner releases an updated report annually.

Goals

The purpose of QIPS is to encourage a consistent message to providers by signaling priority areas for improvement from the payer community. The primary goals of QIPS are to align and uniformly leverage provider payment incentives, and to accelerate improvement in key areas identified by the community such as conditions that are costly, areas that are "actionable" by providers, and areas 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,

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

[2]Minnesota Statutes 2012, section 62U.02.

[3]Minnesota Statutes 2012, section 256B.0754.

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. Through this coordination, QIPS establishes a uniform statewide pay-for-performance framework designed to reduce the burden on health care providers of 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 2013 and prospective performance and improvement thresholds for 2014 quality-based incentive payments. Thresholds are based on the most recent periods of quality measurement data.

The quality measures and the methodology used in QIPS will continue to be adjusted and refined in future years. Additional and/or different quality measures may be used for subsequent years of QIPS based on activities by other initiatives, changes in community priorities, evolving evidence, or development of new or improved quality measures. The methodology may be changed in future iterations of QIPS based on 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 to develop QIPS. In 2009, 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) 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 SQRMS should be utilized for the quality incentive payment system;
- The Minnesota Department of Health should be cautious about including measures of health care services overuse during the initial years of QIPS;
- The quality measures included in the QIPS 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 from 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 1 percent and 3 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.

Using QIPS

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 QIPS 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 account for budget limitations and other considerations as they make decisions about 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 provide a comprehensive view of the full patient population treated at each physician clinic and hospital. Risk 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 data availability, risk adjustment of the optimal diabetes care (ODC) and optimal vascular care (OVC) quality measures is based on the type of primary payer (i.e., Medicare, Medicaid/state health care programs, and private payers). The depression remission at six months quality measure, which is new to QIPS in 2013, is risk adjusted based on patient severity. 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 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.[5] The measures used in QIPS 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

[4]Minnesota Rules, Chapter 4654.

[5]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.

payments to providers. The quality measures included in the 2013 iteration of QIPS are the same as those for 2012, with the addition of depression remission at six months for physician clinics.

2013 Physician Clinic Quality Measures:

- Optimal diabetes care (ODC)
- Optimal vascular care (OVC)
- NEW: Depression remission at six months

2013 Hospital Quality Measures:

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

2014 Prospective Physician Clinic and Hospital Quality Measures:
This update to the report also sets the measures for 2014 quality-based incentive payments to provide the prospective benchmarks and targets. The 2014 quality measures for physician clinics and hospitals are the same as those for 2013.

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 from investing 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.

Beginning with the 2012 QIPS report, the Minnesota Department of Health provided prospective benchmarks and improvement targets. Prospective benchmarks are provided to assist users with improvement planning efforts. Considering that the 2014 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 2013 performance rates (2012 dates of service) or modifications to measure specifications.

Physician Clinic and Hospital Benchmarks and Improvement Targets – 2013

The 2013 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 – 2013

	Absolute performance benchmark (%)	Improvement target goal (%)	Current performance	
			Statewide average[a] (%)	Range (%)
Physician clinic quality measures				
Optimal diabetes care (ODC)	51	85	39.8	2.2 – 57.6
Optimal vascular care (OVC)	62	100	49.9	4.1 – 71.9
Depression remission at six months	12	50	6.1	0.0 – 24.4
Hospital quality measures				
Acute myocardial infarction (AMI) appropriate care measure (ACM)	98	100	95.5	0 – 100
Heart failure (HF) ACM	97	100	86.9	0 – 100
Pneumonia (PN) ACM	94	100	89.1	18.2 – 100

[a]Statewide averages for physician clinics are based on 2011 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 of discharge dates ending June 2011.

A physician clinic or hospital must have had at least a 10 percent reduction in the gap between its prior year's results and the defined improvement target goal to be eligible for a quality-based incentive payment for improvement (see table 1). Current statewide levels of performance are assessed to determine reasonable improvement target goals.

Physician Clinic and Hospital Benchmarks and Improvement Targets – 2014

Beginning with the 2012 QIPS report, the Minnesota Department of Health provided prospective benchmarks and improvement targets. This iteration of QIPS includes absolute performance benchmarks and improvement target goals for 2014 (see table 2). The 2014 absolute performance benchmarks for physician clinics and hospitals were established using historical performance data for each measure. The benchmarks for those measures that were also included in 2013 were based on the improvement trend of the top provider results from prior years. For physician clinics, accounting for measure specification changes and their impact on absolute performance improvement over time, the performance improvement trend resulted in a 2 percentage point increase for the optimal diabetes care and optimal vascular care measures and a 1 percentage point increase for the depression measure. Therefore, the 2014 absolute performance benchmarks have been increased using a "stretch goal" of 2 percentage points for optimal diabetes care and optimal vascular care and 1 percentage point for depression remission at six months. Because hospitals already perform high on their specified quality measures, there was relatively minor variation so the benchmarks for 2013 and 2014 remain the same. 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 – 2014

	Absolute performance benchmark (%)	Improvement target goal (%)	Current performance	
			Statewide average[a] (%)	Range (%)
Physician clinic quality measures				
Optimal diabetes care (ODC)	53	85	39.8	2.2 – 57.6
Optimal vascular care (OVC)	64	100	49.9	4.1 – 71.9
Depression remission at six months	13	50	6.1	0.0 – 24.4
Hospital quality measures				
Acute myocardial infarction (AMI) appropriate care measure (ACM)	98	100	95.5	0 – 100
Heart failure (HF) ACM	97	100	86.9	0 – 100
Pneumonia (PN) ACM	94	100	89.1	18.2 – 100

[a]Statewide averages for physician clinics are based on 2011 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 2011.

To determine the 2014 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 2013 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.

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	**Insert the clinic's rate in the previous year**	28%
3	Subtract the clinic's rate (line 2) from the improvement target goal (line 1). **This is the gap between the clinic's prior year 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 the percentage point improvement needed to be eligible for a payment incentive for improvement.**	6%
6	Add the 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. The possibility exists that providers may oscillate between receipt of absolute performance-based and improvement-based

incentive payments over time. The Minnesota Department of Health will review this possibility based on implementation experience and may revise this policy if such significant oscillation occurs.

Risk Adjustment

For QIPS specifically, and quality measurement reporting generally, the complexity of any risk adjustment approach is dictated by data availability. 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 QIPS. 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 more sophisticated methods and models of adjusting for differences in clinical and population differences among providers are possible, more comprehensive approaches would require additional data and result in greater administrative burden for providers. 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 optimal diabetes care and optimal vascular care quality measures by payer mix for public reporting purposes.[6] 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.

MDH will risk adjust the depression remission at six months quality 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

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

Depression remission at six months is risk adjusted for severity based on stakeholder input indicating that differences in severity of depression among patient populations can unfairly affect results that are publicly reported. Specifically, stakeholders and empirical research have demonstrated 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.[7] The University of Minnesota research 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 of the depression remission at six months measure, but research indicated that although 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 each 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, the overall quality scores are different without adjustment for payer mix; Clinic A's unadjusted score is 60 percent, and Clinic B's unadjusted score is 55 percent, despite the fact that the two clinics are achieving similar outcomes for similar patient populations.

[7]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.

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]	47.6%	18.3%	34.0%	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 2011 dates of service for providers that reported data under the Minnesota Statewide Quality Reporting and Measurement System. Statewide averages used for risk adjustment are updated annually.

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 the corresponding payer type. The statewide average distribution by payer type used for risk adjustment is updated annually to correspond with the year of the clinic level measure. For the example in table 4, each clinic's private insurance score is multiplied by 0.476 (the percentage of patients statewide with private insurance), the Minnesota Health Care Programs/uninsured/self-pay score is multiplied by 0.183, and the Medicare score is multiplied by 0.34. By applying this adjustment, Clinic A and Clinic B achieve the same overall quality score (58 percent), which more accurately reflects that they provide the same quality performance for similar populations.

Consistency with Other Activities

Clinical conditions chosen for inclusion in QIPS are consistent with those identified for use in the Provider Peer Grouping (PPG) system (another important component of Minnesota's health reform initiative), the Bridges to Excellence (BTE) program, and the federal government's efforts to enhance the meaningful use of electronic health records.

The PPG initiative implements the Minnesota Department of Health's statutory requirement to develop a method for comparing health care providers based on a composite measure of risk-adjusted cost and

quality. The results of PPG will be used to change incentives for both health care providers and consumers in ways that encourage lower costs and higher quality. PPG 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 QIPS differ from other incentive payment programs. For example, private purchasers in the BTE program do not use risk adjustment. However, QIPS is required by law to include this feature. The Department will work with providers to ensure their full understanding of the value of risk adjustment and obtain comments on the mechanisms for operationalizing risk adjustment.

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