Minnesota Statewide Quality Reporting and Measurement System: Quality Incentive Payment System

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MDH Minnesota Department *of* Health
HEALTH ECONOMICS PROGRAM

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Quality Incentive Payment System

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Executive Summary

The Minnesota Quality Incentive Payment System (QIPS) is a statewide pay-for-performance system for physician clinics and hospitals. It is built on the measures of the Statewide Quality Reporting and Measurement System (Quality Reporting System), Minnesota's standardized set of quality measures for health care providers. The Minnesota Department of Health (MDH) updates QIPS on a yearly basis. This is the sixth update of the system, which was established by Minnesota's 2008 health care reform law.

The system rewards providers for two types of accomplishment: (1) achieving absolute performance benchmarks or (2) improvements in performance over time. The three physician clinic measures included in the system are Optimal Diabetes Care, Optimal Vascular Care, and Depression Remission at Six Months. The 10 hospital measures relate to patient satisfaction.

Since 2010, Minnesota Management and Budget (MMB) and the Department of Human Services (DHS) have used the system to make incentive payments to clinics based on their performance on available quality of care measures. In 2015, MMB and DHS paid nearly $1.3 million in incentive payments to providers in 241 clinics that achieved benchmarks or significantly improved care for diabetes, vascular disease, and depression. MMB and DHS currently are not providing incentive payments based on the hospital measures.

In 2016, the system will continue to use the same three physician clinic quality measures and 10 hospital quality measures used in 2015 with some modifications to clinic measure specifications by the measure steward, MN Community Measurement, that were also incorporated into the Quality Reporting System.

QIPS will continue to risk-adjust performance experienced by diabetic and vascular patients by primary payer type. MDH will continue to risk-adjust the depression measure based on the severity of the patient's depression, rather than payer type. Looking ahead, MDH is in the process of assessing the system's risk adjustment methodology at the request of the Minnesota Legislature.

Background and Goals

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 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 MMB 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. To develop QIPS, MDH used a community input process that included numerous stakeholder groups and content experts.

In general, pay for performance systems operate on the theory that financial incentives for quality performance will produce improvements in quality of care while slowing the growth in health care spending. The purpose of a statewide framework such as QIPS is to encourage a consistent message to providers by signaling priority areas for improvement from the payer community and to align payment incentives in a way that may accelerate improvement. QIPS offers a possibility of a uniform statewide pay-for-performance system which would reduce the burden associated with accommodating varying types and methodologies of pay-for-performance systems for health care providers.

To achieve statewide reach, other health care purchasers in the state 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, although they are not required to do so. 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. As part of the annual process of evaluating and updating the measures, performance targets, and methodology used in QIPS, the Commissioner of Health solicits comments and suggestions on QIPS from community partners each year. Quality measures may be added, modified, or removed as necessary to set and meet priorities for quality improvement. 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, changes in community priorities, or evolving evidence. The Commissioner releases an updated framework annually.

Payments

In 2015, MMB and DHS paid nearly $1.3 million in incentive payments to providers in 241 clinics that achieved the benchmark or significantly improved care for diabetes, vascular disease, and/or depression. Of the 241 clinics, 60 achieved the benchmark or significantly improved care for more than one measure, and some of these clinics were rewarded by both MMB and DHS.

Table 1. QIPS Rewards, 2015

	Minnesota Management and Budget (MMB)			Minnesota Department of Human Services (DHS)			Total Rewards Paid
	Clinics Providing Care	Members at Clinics	Rewards Paid	Clinics Providing Care	Beneficiaries at Clinics	Rewards Paid	
Optimal Diabetes Care							
Absolute benchmark	15	67	$6,700	21	976	$97,600	**$104,300**
Improvement goal	28	109	$5,466	42	760	$37,989	**$43,455**
Optimal Vascular Care							
Absolute benchmark	17	48	$4,800	29	559	$55,900	**$60,700**
Improvement goal	46	176	$8,000	84	1,421	$71,050	**$79,850**
Depression Remission at Six Months							
Absolute benchmark	70	812	$81,246	73	7,310	$731,098	**$812,344**
Improvement goal	42	454	$22,725	45	3,515	$175,757	**$198,482**
Total							**$1,299,131**

Source: Minnesota Health Action Group, 2016.

MMB pays QIPS rewards for the State Employee Group Insurance Program (SEGIP) and Public Employees Insurance Program; this table only includes SEGIP rewards. DHS pays QIPS rewards for Minnesota Health Care Programs. In 2015, DHS began rewarding clinics for performance on Depression Remission at Six Months.

Eligibility for QIPS rewards is based on a clinic meeting either the absolute benchmark or improvement goal per quality measure for all patients seen at that clinic for the specified conditions (diabetes, vascular disease, and depression). A clinic successfully meeting a benchmark or goal receives payments for each member or beneficiary seen at its facility regardless of whether the individual member or beneficiary is included in the performance measure. Clinics that met the QIPS absolute benchmark for the respective quality measure received $100 per member or beneficiary, and clinics that met the improvement goal received $50 per member or beneficiary.

Although only MMB and DHS are required to use QIPS, commercial 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, explains how providers can qualify for a quality-based incentive payment, and reviews the history and goals of this initiative. 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. 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.

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 selected with input from stakeholders. The measures identified for quality-based incentive payments were selected from those included in the Quality Reporting System.[1] The measures used in QIPS are well-established in the community and are deliberately limited in number.

The quality measures included in the 2016 update of QIPS are the same as 2015 for both physician clinics and hospitals. The physician clinic quality measures are Optimal Diabetes Care, Optimal Vascular Care, and Depression Remission at Six Months.[2] The hospital quality

[1]The Quality Reporting System is also called the Minnesota Statewide Quality Reporting and Measurement System (Minnesota Rules, chapter 4654). Information about the system and measure specifications can be found on MDH's Health Reform website at www.health.state.mn.us/healthreform/measurement.

[2]The measure steward of physician clinic measures—MN Community Measurement (MNCM)—modified the three measures for 2016 reporting as part of routine maintenance activities. MNCM added a Statin Medication Use component to the Optimal Diabetes and Vascular Care composite measures. MNCM implemented a technical change to the Depression Remission at Six Months measure. Previously, new patients became subject to the measure if they had an elevated PHQ-9 result and accompanying diagnosis of major depression or dysthymia, and returning patients only needed an elevated PHQ-9 result; the

measures include 10 indicators from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey, a tool to measure patient experience with a hospital visit.[3]

Payers may choose one or more measures for quality-based incentive payments to providers. Providers are eligible for a quality-based incentive payment for *either* achieving a certain level of performance (absolute 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 and benefit from the potential opportunity of an incentive reward.

The data source for QIPS is market-wide data (not payer-specific data) submitted by physician clinics and hospitals in fulfillment of reporting requirements of the Quality Reporting System; no additional data is collected under the QIPS framework.[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 and Optimal Vascular Care quality measures is based on the type of primary payer to the extent possible (i.e., commercial, Medicare, Minnesota Health Care Programs, and uninsured and self-pay); the Depression Remission at Six Months quality measure is risk adjusted based on patient severity. The risk adjustment methodology is explained in more detail in the Risk Adjustment section of this report.

technical change require that all patients—new and returning—have an elevated PHQ-9 result and a diagnosis to be included in the measure.

[3]MMB and DHS do not use QIPS with hospitals and do not have plans to use QIPS hospital measures in the immediate future. Additionally, the federal Centers for Medicare & Medicaid Services administer a number of hospital value-based purchasing and pay-for-performance programs in which Minnesota hospitals participate. Therefore, MDH is considering discontinuing the inclusion of hospital measures in future QIPS updates.

[4]Historically, physician clinics have been able to submit sample population data for the Optimal Diabetes and Optimal Vascular Care quality measures. However, in 2015, because the National Committee for Quality Assurance retired the Cholesterol Management for Patients with Cardiovascular Conditions measure—which health plans used to identify patient counts to then calculate rewards for clinics that submit sample data—clinics were required to submit total population data to be eligible for Optimal Vascular Care rewards. Considering the advancements clinics have made in meaningfully using health information technology and that the vast majority of clinics reporting to the Quality Reporting System submit total population data, MDH is also applying this total population requirement to Optimal Diabetes Care beginning in 2016. MDH has always required physician clinics to submit total population data for the Depression Remission at Six Months measure.

Performance Benchmarks and Improvement Goals

The absolute performance benchmarks for physician clinics and hospitals are established using historical performance data for each measure (Table 2). MN Community Measurement, in collaboration with the Minnesota Hospital Association, recommends clinic and hospital measures, performance benchmarks, and improvement goals to MDH for inclusion in QIPS.

For physician clinic benchmarks, the top 20 percent of eligible patients were identified for each measure. Then, initial benchmarks were calculated based on the lowest rate attained by providers who serviced these eligible patients. For hospitals, the initial benchmarks were set based on the top 10 percent of hospital results reported for each HCAHPS measure. Absolute performance benchmarks for both clinics and hospitals were established by adding a "stretch goal" of three percentage points to the lowest rate attained in the top eligible range. For example, in 2015 the lowest rate for the top 20 percent of clinics reporting Optimal Vascular Care was 74 percent. By adding the three percent stretch goal to this rate, the 2016 Optimal Vascular Care absolute benchmark is 77 percent. Clinics and hospitals must meet or exceed the defined benchmark to be eligible for absolute performance incentive payments. 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.

Table 2. Absolute Performance and Improvement Thresholds, 2016

	Absolute Performance Benchmark (%)	Improvement Target Goal (%)	Current Performance Statewide Average (%)	Current Performance Range (%)
Physician Clinic Quality Measures				
Optimal Diabetes Care	63	100	46.6	0-84
Optimal Vascular Care	77	100	65.9	9-85
Depression Remission at Six Months	16	50	7.6	0-44
Hospital Quality Measures, HCAHPS				
Percent of patients who reported that their nurses "Always" communicated well.	89	84	81	71-97
Percent of patients who reported that their doctors "Always" communicated well.	94	87	84	68-100
Percent of patients who reported that they "Always" received help as soon as they wanted.	85	77	73	53-98
Percent of patients who reported that their pain was "Always" well controlled.	80	75	72	47-100
Percent of patients who reported that staff "Always" explained about medicines before giving it to them.	77	69	66	47-90

	Absolute Performance Benchmark (%)	Improvement Target Goal (%)	Current Performance Statewide Average (%)	Current Performance Range (%)
Percent of patients who reported that their room and bathroom were "Always" clean.	90	81	78	56-95
Percent of patients who reported that the area around their room was "Always" quiet at night.	79	69	66	45-100
Percent of patients at each hospital who reported that YES they were given information about what to do during recovery.	97	91	88	56-96
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	86	77	74	44-89
Patients who reported YES they would definitely recommend the hospital.	88	77	74	43-91

Statewide averages for physician clinics are based on 2014 dates of service for Minnesota clinics that reported data under the Quality Reporting System. Statewide averages for hospitals are based on 2014 discharge dates for Minnesota hospitals that reported data under the Quality Reporting System.

Current statewide performance levels are assessed to determine reasonable improvement target goals. 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. Example of Incentive Payment Calculation for Improvement in Optimal Diabetes Care over Time

Calculation	Percent (%)
1) Improvement goal.	**100%**
2) Insert the clinic's rate in the previous year.	**38%**
3) Subtract e 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.**	**62%**
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 an improvement incentive payment.**	**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.**	**44%**

For example, the clinic improvement calculation is as follows: [(1.00 – 0.38) X 0.10] + 0.38 = 0.44].

The measure steward of the Optimal Diabetes Care and Optimal Vascular Care composite measures—MN Community Measurement—added a statin usage component to both measures for 2016 reporting to reflect changes in clinical best practices. This addition changed last year's four-component diabetes measure to a five-component measure this year, and a

three-component vascular measure to a four-component measure. To determine improvement rewards for clinics under QIPS in 2016, the measures reported in 2016 will be recast using 2015 specifications for the four-component diabetes composite measure and the three-component vascular disease measure to make accurate performance comparisons between the two years.

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 three consecutive years, beginning with the first year a physician clinic or hospital becomes eligible for payment for improvement. After this, the physician clinic or hospital would be eligible for the absolute performance benchmark payment incentive. If the physician clinic or hospital achieves the absolute performance benchmark payment incentive, then it could be eligible for either award in the subsequent year.

Risk Adjustment

For QIPS specifically, and quality measurement reporting generally, the complexity of any risk adjustment approach is dictated by availability of data and empirical research. 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.[5]

Through its contractor, MN Community Measurement, MDH convened a work group in 2009 to make recommendations on how to improve risk adjustment for QIPS. This workgroup concluded that, considering available data, risk adjustment by payer mix—distinguishing between Medicaid, Medicare, and commercial payers, and the uninsured—would be an adequate 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 adjusted and controlled within the calculation of the measure. While more sophisticated methods and models of adjusting for differences in clinical and population differences among providers exist, more comprehensive approaches would require collection of additional data, thereby resulting in greater administrative burden for providers. Still, by itself, the current risk adjustment approach does not suggest that other patient or provider factors outside of the control of physicians do not play an important role in explaining performance measure outcomes.

[5]The HCAPHS hospital measures used in QIPS are collected by the Centers for Medicare & Medicaid Services and are not risk adjusted.

Current risk adjustment by primary payer type strikes a balance between the dual goals to adequately risk adjust quality measures and manage the administrative burden of data collection for providers.

However, there has been increasing interest and research in understanding the role of socio-demographic patient factors in risk adjustment. Additionally, the 2014 Minnesota Legislature directed MDH to assess the risk adjustment methodology established under Minnesota Statutes, section 62U.02, and report to the Legislature in 2016.[6] The results of this assessment may shape risk adjustment for QIPS in subsequent updates.

For the performance period covered in this report, MDH will continue to risk adjust the Optimal Diabetes Care and Optimal Vascular Care physician clinic quality measures by primary payer type (i.e., commercial; Medicare; Minnesota Health Care Programs; and uninsured and self-pay). MMB and DHS will also use these risk adjusted rates to determine whether particular clinics are eligible for incentive payments.

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.[7] 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 2010. 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. Questions remain about variation in medication compliance and preferred treatment models that warrant more examination of the data.

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; and
- Severe — Initial PHQ-9 score of 20 to 27.

[6] Minnesota Laws 2014, Chapter 312, Article 23, Section 10.

[7] 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.

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 commercial patients, 60 percent for Medicare patients, 45 percent for Minnesota Health Care Programs, and 40 percent for uninsured and self-pay patients). 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 61 percent, and Clinic B's unadjusted score is 57 percent. By adjusting scores using payer mix, we see that Clinics A and B are achieving the same level of optimal care at 59 percent.

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

	Commercial	Medicare	Minnesota Health Care Programs	Uninsured and Self-pay	Total/Score
Clinic A Number of patients	250	100	35	15	**400**
Clinic A Percent meeting measure (unadjusted score)	65%	60%	45%	40%	**61%**
Clinic B Number of patients	100	200	75	25	**400**
Clinic B Percent meeting measure (unadjusted score)	65%	60%	45%	40%	**57%**
Statewide Average Percent distribution of patients	43.2%	38.3%	15.3%	3.2%	**100%**
Clinic A Rates adjusted to statewide average payer mix (adjusted score)					**59%**
Clinic B Rates adjusted to statewide average payer mix (adjusted score)					**59%**

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 is as follows: [(250 * 0.65) + (100 * 0.60) + (35 * 0.45) + (15 * 0.40)] / (250 + 100 + 35 + 15) = 0.61.

Statewide averages are based on 2014 dates of service for providers that reported data under the Quality Reporting 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 commercial insurance score is multiplied by 0.432 (the percentage of patients statewide with commercial insurance), the Medicare score is multiplied by 0.383, the Minnesota Health Care Programs is multiplied by 0.153, and the uninsured and self-pay score

is multiplied by 0.032. By applying this adjustment, Clinic A and Clinic B achieve the same overall quality score (59 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 Health Care Homes (another important component of Minnesota's health reform initiative), the Bridges to Excellence program, DHS's Integrated Health Partnerships initiative, the Physician Quality Reporting System, and the federal government's efforts to enhance the meaningful use of electronic health records. The measures that are used in QIPS have also been endorsed by the National Quality Forum.[8]

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 Bridges to Excellence program do not risk adjust performance measures. QIPS, in contrast, is required by law to adjust rates as best as possible for factors outside of the provider's influence that might affect performance rates.

Moving forward, MDH and its partners will continue to 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.

Public Comments

In a dynamic health system environment, MDH is interested in assessing how well tools like QIPS serve the broader goals of improving health outcomes, aligning measurement and performance incentives across health care purchasers, reducing costs, and advancing health equity. MDH invited public comment on the proposed QIPS framework, and with this update also requested feedback on four questions:

1. Quality measures currently included in QIPS have largely a clinical focus. National discussions on measurement priorities suggest broader population health measures are as well important in driving improvements in quality of care. Should QIPS consider metrics that

[8]The National Quality Forum (NQF) is a not-for-profit, nonpartisan, membership-based organization. One of its primary functions is to endorse consensus standards for performance measurement. www.qualityforum.org

more explicitly reflect population health concepts (e.g., well-being, overweight and obesity, addictive behavior, and others)? How should QIPS balance a focus on population health with evolving the selection of clinical measures?

2. Currently QIPS users (the State Employee Group Insurance Program within MMB, and DHS) offer a greater award for absolute performance than for incremental change. Should QIPS incentives be re-balanced to shift rewards towards improvement? What factors favor the status quo or changes to it?
3. Currently, clinic and hospital quality measures are included in QIPS; however, QIPS users do not tie performance rewards to hospitals and have no immediate plans to do so. Additionally, the federal Centers for Medicare & Medicaid Services administer a number of hospital value-based purchasing and pay-for-performance programs in which Minnesota hospitals participate. Should MDH continue to include hospital measures in the QIPS framework?
4. Alignment in measurement and performance incentive helps reduce administrative burden and has the potential to strengthen the "improvement signal." How well does QIPS align with other existing pay-for-performance approaches in Minnesota's market? Does there continue to be value in operating a separate, statewide incentive payment system in which only certain payers (i.e., MMB and DHS) participate with a narrow volume of incentives?

MDH received two formal responses during the comment period, one from a public purchaser and one from a medical group in Minnesota. Key themes in the responses were as follows:

- QIPS ought to focus on measures that providers can directly impact rather than on population health measurement that generally extends beyond providers' control.
- Equalizing the rewards for achievement and improvement might not be compatible with the goal of QIPS to incentivize high quality health care.
- Removing hospital measures from QIPS would have little impact, and their continued inclusion could create additional reporting burden without meaningful and actionable gains in provider quality.
- The inclusion of hospital measures might also decrease the financial rewards available for clinics, thereby blunting the effect of that effort.
- QIPS is well-aligned with other pay-for-performance programs in Minnesota, but alternative provider payment methods that are linked to quality—such as total cost of care models with shared savings—may create more powerful incentives than those that are available through pay-for-performance programs such as QIPS.

MDH appreciates the feedback these two entities provided, and will take these ideas and insights into consideration in determining what changes, if any, should be made to QIPS in 2017 and beyond.