

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

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Executive Summary

The Minnesota Quality Incentive Payment System (QIPS) is a statewide pay-for-performance system for physician clinics. 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 seventh 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. As has been the case since 2013, the three physician clinic measures included in the system are Optimal Diabetes Care, Optimal Vascular Care, and Depression Remission at Six Months. QIPS will continue to risk-adjust performance experienced by diabetic and vascular patients by primary payer type, and risk-adjust the depression measure based on the severity of the patient's depression. MDH removed hospital measures from this iteration of the QIPS framework because state payers have not been using them, and Minnesota hospitals participate in a variety of federal-level value-based purchasing and pay-for-performance programs.

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 the quality of care measures that are part of QIPS. In 2016, MMB and DHS paid nearly \$900 thousand in incentive payments to providers in 228 clinics that achieved benchmarks or significantly improved care for diabetes, vascular disease, and depression.

DHS decided to conclude its participation in QIPS with the 2016 reward year, due to changes in federal Medicaid managed care regulations that require Medicaid programs to discontinue payments that occur outside the managed care capitation payments. MMB is participating in QIPS this year, and will discontinue future participation because the Minnesota Legislature repealed the requirement that MMB implement QIPS for participants in the state employee group insurance program. Part of this change was motivated by MMB's greater focus on restructuring its health care contractual arrangements by linking payment to performance goals on quality, with the expectation that the impact on quality improvement would be greater than under a pay-for-performance system and require substantively lower administrative costs from MMB.

Therefore, MDH is suspending future updates to the QIPS framework.

Context 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. 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.

The quality measures and methodology used in the QIPS framework are adjusted and refined annually. 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.

Two government agencies were required to implement QIPS by July 1, 2010: the Commissioner of Human Services was directed to implement the system for all enrollees in state health care programs to the extent it was consistent with relevant state and federal statutes and rules, and the Commissioner of MMB was required to do the same for the State Employee Group Insurance Program. DHS discontinued its participation in QIPS with the 2016 reward year due to changes in federal Medicaid managed care regulations that require Medicaid programs to discontinue payments that occur outside the managed care capitation payments. MMB will conclude its participation in QIPS after this year, because during the 2017 session, the Minnesota Legislature repealed the requirement that MMB must use QIPS.¹ Part of this change was motivated by MMB's greater focus on restructuring its health care contractual arrangements by linking payment to performance goals on quality, with the expectation that the impact on quality improvement would be greater than under a pay-for-performance system and require substantively lower administrative costs from MMB.

Payments

In 2016, MMB and DHS paid nearly \$900 thousand in incentive payments to providers in 228 clinics that achieved the benchmark or significantly improved care for diabetes, vascular disease, and/or depression. Of the 228 clinics, 65 achieved the benchmark or significantly

¹2017 Minnesota Session Laws, Chapter 6, Article 4, Section 3.

improved care for more than one measure, and some of these clinics were rewarded by both MMB and DHS.

Table 1. QIPS Rewards, 2016

	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	8	67	\$6,700	9	419	\$41,900	\$ 48,600
Improvement goal	49	316	\$15,800	76	2,251	\$112,550	\$128,350
Optimal Vascular Care							
Absolute benchmark	14	38	\$3,800	19	294	\$29,400	\$ 33,200
Improvement goal	54	147	\$7,350	107	1,465	\$73,250	\$ 80,600
Depression Remission at Six Months							
Absolute benchmark	46	551	\$55,137	48	4,701	\$470,100	\$525,237
Improvement goal	26	147	\$7,371	27	1,270	\$63,478	\$ 70,849
Total							\$886,836

Source: Minnesota Health Action Group, 2017.

MMB pays QIPS rewards for the State Employee Group Insurance Program (SEGIP) and Public Employees Insurance Program; this table only includes SEGIP rewards. DHS paid QIPS rewards for Minnesota Health Care Programs.

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.

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 describes the risk adjustment methodology. 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

The quality measures included in the 2017 update of QIPS are the same as 2016 for physician clinics: Optimal Diabetes Care, Optimal Vascular Care, and Depression Remission at Six Months.² MDH removed hospital measures from this QIPS update because state payers indicated that they were not using them, and because Minnesota hospitals participate in a variety of value-based purchasing and pay-for-performance programs offered by the federal Centers for Medicare & Medicaid Services.

The physician clinic measures included in QIPS focus 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.³ The measures used in QIPS are well-established in the community and are deliberately limited in number. For example, the measures 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, and DHS’s Integrated Health Partnerships initiative. The measures that are used in QIPS have also been endorsed by the National Quality Forum.⁴

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 in fulfillment of reporting requirements of the Quality Reporting System; no additional data is collected under the QIPS framework. Market-wide data provide a comprehensive view of the full patient population treated at each physician clinic. Risk adjustment or population standardization is applied to ensure that comparisons between clinics account as best as

²The measure steward of the physician clinic measures—MN Community Measurement—modified the Optimal Diabetes and Vascular Care composite measures for 2017 reporting as part of routine maintenance activities. MN Community Measurement implemented changes to its established patient criteria methodology to enhance the accuracy of identifying eligible patients with these conditions and increase alignment with methods used in federal programs.

³The 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 our [website](http://www.health.state.mn.us/data/hcquality) (<http://www.health.state.mn.us/data/hcquality>).

⁴The 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

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.

Performance Benchmarks and Improvement Goals

The absolute performance benchmarks for physician clinics are established using historical performance data for each measure (Table 2). MN Community Measurement recommends clinic measures, performance benchmarks, and improvement goals to MDH for inclusion in QIPS. MN Community Measurement followed the established methodology (described below) in calculating absolute performance benchmarks for this update, which resulted in slightly lower benchmarks from last year. MDH conferred with MMB, and determined that QIPS will maintain the absolute benchmarks that were used in 2016 to reward high quality and align with the benchmarks used in Bridges to Excellence.

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. Absolute performance benchmarks for clinics 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 Optimal Vascular Care absolute benchmark is 77 percent. Clinics must meet or exceed the defined benchmark to be eligible for absolute performance incentive payments. A physician clinic 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, 2017

	Absolute Performance Benchmark (%)	Improvement Target Goal (%)	Current Performance Statewide Average (%)	Current Performance Range (%)
Optimal Diabetes Care	63	100	46.5	0-76
Optimal Vascular Care	77	100	66	0-85
Depression Remission at Six Months	16	50	78	0-46

Statewide averages are based on 2015 service dates for Minnesota physician clinics 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 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.	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: $[(1.00 - 0.38) \times 0.10] + 0.38 = 0.44$.

Quality-based incentive payments for improvement are time-limited to encourage improvement while maintaining the goal of all physician clinics achieving the absolute performance benchmarks. Each physician clinic 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 becomes eligible for payment for improvement. After this, the physician clinic would be eligible for the absolute performance benchmark payment incentive. If the physician clinic 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.

Background

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. 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.

Assessment

There has been increasing interest and research in understanding the role of socio-demographic patient factors in risk adjustment. Additionally, the Minnesota Legislature directed MDH to assess the risk adjustment methodology established under Minnesota Statutes, section 62U.02, and report to the Legislature.⁵ Specifically, the Legislature directed MDH to:

- Assess whether the Quality Reporting System's risk adjustment methodology creates potential harms and unintended consequences for patient populations who experience health disparities and the providers who serve them; and
- Identify changes that may be needed to alleviate harm and unintended consequences.

Accordingly, MDH conducted a literature review, obtained stakeholder input, worked with researchers from the University of Minnesota to conduct an empirical analysis, performed an environmental scan of related local and national research activities, and submitted a report to the Legislature.⁶ The empirical component of the study showed available socio-demographic factor data that are not currently used in MDH's risk adjustment methodology do not meaningfully improve risk adjustment. To potentially improve risk adjustment, MDH and the community need new risk factor data with a strong link to quality measure outcomes and data that can be available at more detailed levels. Additionally, MDH's risk adjustment methodology does not appear to cause financial harm to providers who serve disadvantaged populations, or their patients. This is in part because the risk-adjusted measures are currently used only in QIPS which covers a very narrow subset of the population.

⁵Minnesota Laws 2014, Chapter 312, Article 23, Section 10.

⁶Minnesota Department of Health. (2017). *Quality Reporting System Risk Adjustment Assessment: Report to the Legislature*. Saint Paul, MN: Minnesota Department of Health. This report is available at [Health Care Quality Measures \(http://www.health.state.mn.us/data/hcquality\)](http://www.health.state.mn.us/data/hcquality).

Based on the findings of the study, MDH concluded that changes to its risk adjustment method would be premature and not produce meaningful improvements. However, MDH found that gains in measuring relevant concepts of patient factors that are conceptually related to provider performance, and availability of more granular data, offer opportunities for refining current risk adjustment approaches across the state. Implementing these changes over time would be most effective if there was alignment in measure risk adjustment across payers.

Methodology

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 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.

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

⁷Primary 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.

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	42.6%	39.2%	15.6%	2.6%	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 2015 service dates 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 0.426 (the percentage of patients statewide with commercial insurance), the Medicare score is multiplied by 0.392, the Minnesota Health Care Programs is multiplied by 0.156, and the uninsured and self-pay score is multiplied by 0.026. 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.

Conclusion

As mentioned earlier, the two mandated state users of QIPS—DHS and MMB—will no longer participate in the program. Since developing and maintaining a framework, including by updating the methodology and publishing performance goals, was done to serve these two clients, continuing to do so would not serve a purpose. For the foreseeable future, this framework is MDH’s last formal update.

It is possible that future market or legislative changes may prompt MDH to resume updating this framework, potentially with modifications to the methodology. To get a sense of how others are incentivizing provider care quality and what the impact would be from discontinuing framework development, we spoke with representatives of four health plans that operate in Minnesota and include performance incentives in their provider contracts.

Like QIPS, plans may reward providers for achieving performance benchmarks and showing significant improvement on outcome quality measures. Additionally, the plans are moving away from pay-for-performance models to value-based purchasing models which is consistent with the evidence that shows that pure pay-for-performance systems are generally not sufficiently set-up to accomplish substantial performance shifts. Therefore, the plans also tend to:

- Use cost, patient experience, and process quality measures;
- Include other reward mechanisms such as withholds and shared savings;
- Change quality measures and populations of focus from year to year, based on performance gaps and desired improvements; and
- Incorporate other performance criteria such as peer comparisons.

Health plan representatives emphasized the importance of using standardized quality measures that are aligned locally and nationally to mitigate measurement fatigue. They shared that purchasers, such as self-insured employers, care about the “full picture” of health care and want systems and metrics that show return-on-investment; therefore, incentive *systems* that include cost, patient experience, and quality metrics instead of rewarding performance in one area of measurement can provide that fuller picture.

Looking ahead, health plan representatives expect that their organizations’ quality incentive programs will increasingly include total cost of care methods and a population health management focus that align with the Triple Aim goals of improving the patient experience of care, improving the health of populations, and reducing the cost of health care.

Moving forward, MDH and its partners will continue to closely monitor trends nationally and in other states to identify opportunities to re-envision activities in the state focused on meaningful and lasting quality improvement.