Providing comprehensive information for better health care choices

Background

In Minnesota and nationally, health care costs are rising at an unsustainable rate. Health care spending in Minnesota increased from $19 billion in 2000 to nearly $31 billion in 2006, a 60 percent increase in just six years. As a result, health care costs represent an increasing share of budgets for employers, consumers and government.

In 2008 the Legislature passed and the Governor signed a major health reform law to improve health care access and quality and to contain the cost of health care in Minnesota. Minnesota's health reform initiative aims to help curtail unsustainable cost growth while simultaneously improving the quality of care and the health of all Minnesotans. One component of the law provides for the development of powerful tools to promote quality, transparency and payment reform in the health care market.

Why do we need these tools?

It's easy to assume that the more you pay for health care, the better care you get. That's not necessarily true. Consumers need a way to compare providers that looks at both cost and quality. The health reform law requires the Minnesota Department of Health to develop this kind of method. This system, called the "provider peer grouping" system, will allow consumers and health plans to compare providers across the state based on uniform measures to get a clearer picture of each provider's cost and quality. It will provide a foundation for efforts to reform the way we pay for health care to encourage better quality and value.

How can consumers use the system?

The system is designed to help consumers make informed choices about their health care. If you have diabetes, you might use the provider peer grouping system to select a high-quality health care provider to help you manage the disease. In 2007 less than 14 percent of Minnesotans with diabetes were receiving optimal care, based on clinical standards set by the medical community. As a patient with diabetes, you could use the provider peer grouping system to select a clinic that offers high quality by providing that optimal care – at the lowest possible cost.

How will health plans and employers use the system?

Health plans and employers will use the provider peer grouping system to provide incentives for you to choose high-quality, low-cost providers. For example, your co-pays or out-of-pocket costs might be lower if you choose a clinic that offers high quality at a low cost. Health plans and employers will also use the system to strengthen incentives for providers to improve health care quality and efficiency.

How will the system be developed?

To make sure the provider peer grouping system is comprehensive and useful, it must include accurate, credible data about how patients use the health care system – and how much it costs. To do this the law requires that the state collect de-identified "encounter data."

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What is encounter data?

Encounter data covers people who have health insurance and includes information about both their eligibility and their health care claims. It offers details about an insured person's engagement with the health care system, including such "encounters" as clinic visits or drug prescriptions. The data provided to the state system will be de-identified, meaning that information about each person's health care usage and costs will feed into the provider peer grouping system, but the individual patient's identity cannot be known. The information will come from health care claims processed by health plans and third-party administrators.

What data will be collected?

Data that falls into the following categories will be collected:

- Who provided the service?
- What service was provided?
- What (de-identified) patient received the service?
- Where was the service provided?
- When was the service provided?
- What price was paid for the service?

What data will not be collected?

The state and its vendor will not collect Social Security numbers, medical records, lab results or other information that is not included in a health care claim. Likewise, neither the state nor its vendor will collect information in a manner that allows the data to be linked back to a particular individual.

Who will collect this data?

The law requires the state to contract with a private vendor to collect encounter data. State employees will not collect or have access to encounter data. In December 2008 MDH selected the Maine Health Information Center, now known as Onpoint Health Data, as its contractor through a competitive bidding process. Onpoint Health Data is a private non-profit organization with experience in successful, secure collection of encounter data in four other states.

Will the data be secure?

All transactions of encounter data will comply with nationally accepted standards and practices for health data security (e.g., HIPAA security regulations and National Institute of Standards and Technology).

Personally identifiable encounter data elements will be encrypted employing "one-way" encryption, meaning that when received, the data cannot be decrypted by either the state or its vendor. This encryption will take place prior to submission to Onpoint Health Data.

Transmission of data will occur directly from the health plan or third-party administrator to Onpoint Health Data via a secure connection.

The encounter data will be securely stored by Onpoint Health Data, subject to the requirements and restrictions specified by contract with the state. State employees will not have access to the data.

When will this data be collected?

The law requires provider peer grouping to begin in 2010 and requires the state to begin collecting encounter data to meet this schedule. The state will use its expedited rulemaking authority to develop a rule detailing the process and requirements for data submission to its contracted vendor. Data submitters – health plans and third-party administrators – will begin transferring encrypted health care claims and eligibility data to Onpoint Health Data by July 1, 2009.

The information in the provider peer grouping system will be reported on at least an annual basis beginning in September 2010.

How will the data be used?

The health reform law states explicitly that encounter data may be used only for the implementation of the provider peer grouping system.