

Physician

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HOPE Clinic

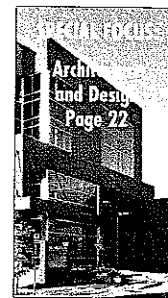
Caring for the underserved

By Ruth Westra, DO, MPH

Sitting on folding chairs in a room with mattresses on the floor and bunk beds with rumpled blankets and backpacks, the physician faculty and the pharmacy faculty await the medical and pharmacy students. The floor is clean. The walls are bare. The room is stark, but it works ideally as a conference room for the student presentations. Later, it will turn back into the dormitory for the CHUM (Churches United in Ministry) drop-in center. We are at the HOPE (Health of People Everywhere) Clinic, a student-run free clinic for patients at the CHUM drop-in center.

Without the students' desire to serve the community where they receive their professional education, there would have been no clinic. But after three years of discussion and planning, the

Department of Family Medicine and Community Health at the University



Provider peer grouping

By Julie Sonier, MPA, and Katie Burns, MA

In Minnesota and the nation, we are facing challenging times. Nowhere are the challenges more clear than in health care. Costs continue to rise 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. Employer-based health insurance is eroding: Between 2001 and 2007, the percentage of Minnesotans with health insurance through an employer fell from 68 percent to 62.5 percent. And consumers are paying more for their health care: Between

Developing the state's provider peer grouping system

2000 and 2007, the annual average out-of-pocket cost for Minnesotans with private health insurance more than doubled, from \$221 to \$619.

At the same time, research has shown that higher spending on health care does not necessarily mean better care. The Dartmouth Atlas Project, for example, has studied Medicare enrollees and found that higher spending is not correlated with better quality, access to care, health outcomes, or patient satisfaction.

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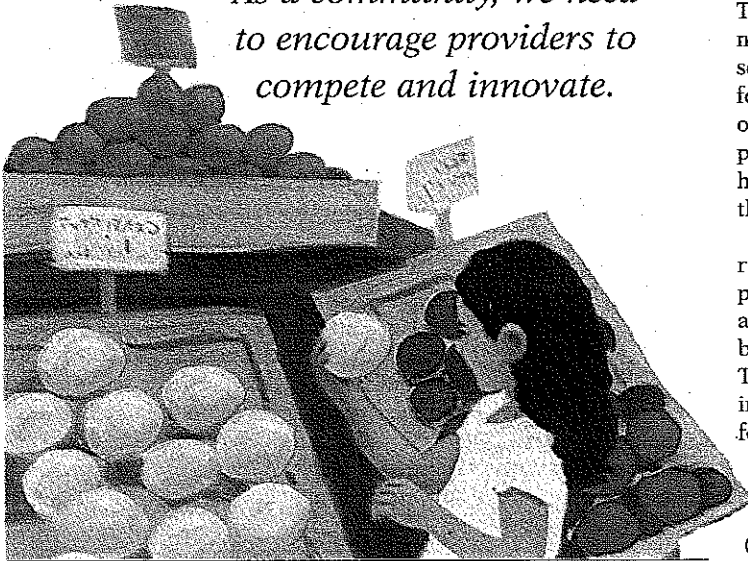
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Provider from cover

Although the challenges are numerous, so are the opportunities for improvement. As a society, we want—and need—to control costs in order to make sure that people have access to health care. But we also need to improve quality, which too often is uneven. For example,

the percentage of diabetics receiving optimal care ranges from 3 percent to 33 percent across Minnesota clinics. Even the best clinics have room for improvement. As a community, we need to establish priorities for quality measurement and improvement. And as a community, we need to encourage providers to compete and

As a community, we need to encourage providers to compete and innovate.



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To accomplish all of these essential goals, we need more of a key ingredient: information.

Transparency in cost and quality

Providing more and better information about health care was what lawmakers had in mind in 2008, when the Minnesota Legislature passed and Gov. Tim Pawlenty signed into law a nation-leading, comprehensive set of health reforms. The reforms aim to improve the health of all Minnesotans, enhance the patient experience, improve health care quality, and reduce the cost of health care.

One of the key tools in the reform package is a "provider peer grouping" system that will allow comparisons of providers based on both cost and quality. The results of this peer grouping will be published separately for hospitals, primary care providers, and specialty providers that care for select health conditions (the specific health conditions to be included have not yet been determined).

When the system is up and running in September 2010, it will provide greater transparency about the cost and quality of health care in Minnesota. It will also lay the foundation for future payment reforms to encourage better quality and value. The system will have a variety of uses:

- Consumers will be able to use it to make more informed choices about their health care, based on quality and cost.
- Health care providers will have new information on how they compare to other providers in the community on measures of quality, resource use, and price, and they will be able to use this information to develop strategies for improving quality and reducing cost.
- Employers and health plans will use the system to strengthen consumer incentives to choose high-quality, low-cost providers.

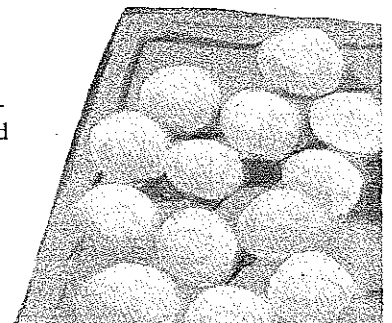
Developing the system

The provider peer grouping system methodology will be developed using a transparent and public process. The peer grouping system will include providers' relative cost of care—considering both resource use and unit prices—and relative quality of care.

The data for the peer grouping system will come from a variety of sources. Information on resource use and cost will come from claims data required to be provided by health plans and other third-party payers. There are several potential sources of quality data for the calculations, including a set of publicly reported quality measures that is currently being developed through a contract with MN Community Measurement; existing quality measures published by the Centers for Medicare and Medicaid Services; and existing quality measures that can be calculated using administrative claims data.

In March, MDH put out a request for information (RFI) soliciting input and comments on a number of methodological issues that will need to be considered in developing the provider peer grouping system. The responses to that RFI are currently being synthesized into a set of issue papers to form the basis of public discussion around the methodology. Examples of the issues to be addressed include methods of attributing patients to providers, and methods of adjusting for severity of illness to ensure that comparisons of cost and quality are fair.

MDH has also convened an advisory panel of about 20 members (including several members designated by the



Minnesota Medical Association), which began meeting this month. The group's charge is to advise the state commissioner of health on a methodology for the provider peer grouping system. It plans to release a preliminary report by Aug. 15.

This group will reconvene after Labor Day and produce a final report by mid-October, at which point there will be an opportunity for the public to comment. MDH must then finalize the specifications for the provider peer grouping system by Jan. 1, 2010.

Once the methodology is finalized, the state plans to contract with a vendor to implement the system. The initial set of comparisons will be complete by June 2010 and disseminated confidentially to providers. If providers have concerns about the data, they can appeal the results to the commissioner of health before they are published in September 2010.

Benefits of the system

The state's provider peer grouping system extends practices that currently take place in the market, but it also makes provider comparisons more uniform, public, and clear. Health plans and other insurers already use their own systems to compare providers, such as plans that place providers in different tiers or groups and establish different enrollee cost-sharing by tier. Although those peer grouping systems aren't necessarily publicly reported or transparent about how calculations are done, they are a common feature of insurance benefit designs.

Often, providers are not sure what they're being measured on. In addition, health plans may do the comparisons differently, and often the comparisons are based solely on cost, without factoring in quality.

The state's provider peer grouping system will be more transparent. Comparisons will be made

on a composite measure of cost and quality, and the comparisons will be uniform across the state. As a result, providers will be able to see how they compare for their patient population as a whole, not just for patients with a specific type of insurance. They will be able to look at specific metrics and see where they do well—and where they can improve—in order to better serve their patients. Providers can also use the peer grouping system to benchmark and compare their practices against others.

Considerations to ensure fairness

It is critical that the provider peer grouping system be fair to all providers. The system should not penalize providers who care for seriously ill patients with severe conditions. As required by law, it will incorporate adjustments for the variations in risk across the patient populations of different providers. Adjustments will also be made for outlier or catastrophic cases.

Other important factors to think about to ensure that the provider peer grouping system is fair include:

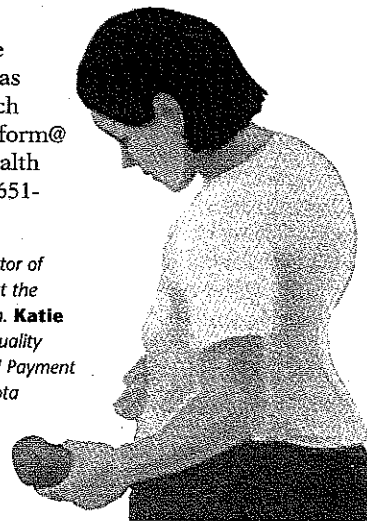
- Determining which providers are primarily responsible for an individual's care.
- Determining specific types of providers that should be included in the calculation.
- Determining specific types of health care services that should be included or excluded in the calculation.
- Appropriately adjusting for variation in payment rates.
- Determining the appropriate level for analysis—individual, clinic or medical group, or health system level.
- Adjusting for payer mix, including the variation across providers in the percentage of revenue received from government programs.

How you can get involved

As we develop the provider peer grouping system, there will be formal opportunities for your comments, such as after the advisory group makes its recommendations to the commissioner of health

this fall. But we welcome your suggestions and ideas at any time. You can reach us via e-mail at health.reform@state.mn.us or via our health reform comment line at 651-201-5530. ☐

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