



The Johns Hopkins University's

 **2010 ACG International
Risk Adjustment Conference**



MAY 10-12 
Tucson, Arizona
Loews Ventana Canyon

Provider Peer Grouping: Hospital and Provider Profiling Across Minnesota

Presented By

Rob Kreiger Ph.D.

University of Minnesota

Center For Care Organization Research & Development

May 11, 2010



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Provider Peer Grouping:

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Presentation Purpose

- Provide a general overview of the project
- Explore specific risk adjustment challenges
- Discuss project implications



What is Provider Peer Grouping?

Access Data From These Settings:

PROVIDERS

- All primary care providers
- Regardless of specialty
- Single clinic sites or multiples within a single medical group

HOSPITALS

- All acute care hospitals (individual)
- Includes critical access hospitals
- Excludes extended care settings



What is Provider Peer Grouping?

Pool Data From Multiple Payers:



MANY PAYERS

- Medicare
- Minnesota public health care programs (Medicaid + others)
- Commercial



What is Provider Peer Grouping?

Sort Data Using These Service Categories:

AGGREGATE MEDICAL

- All Medical

CONDITION SPECIFIC

- Diabetes
- Coronary artery disease
- Pneumonia
- Asthma
- Congestive heart failure
- Total knee replacement



What is Provider Peer Grouping?

Measuring:



COST

- **Two total care cost measures:**
 - actual paid amounts
 - standardized unit price based cost
- **Includes pharmacy, ancillary services**



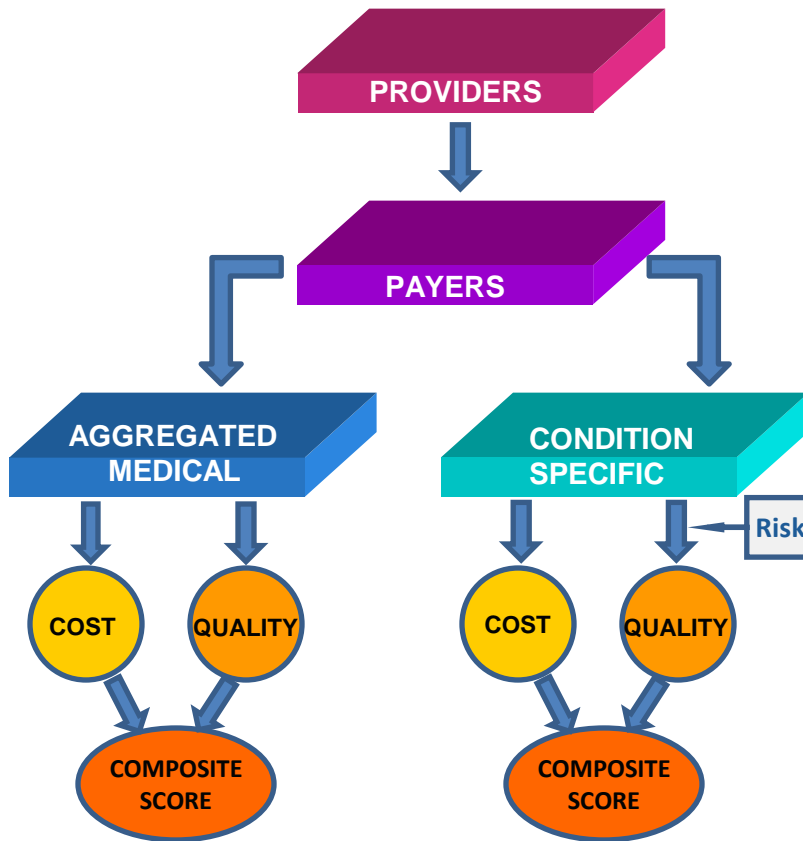
QUALITY

- **Some are claims-based**
- **Some are provider-submitted**
- **Separate sets for:**
 - aggregate physician
 - aggregate hospital
 - condition-specific

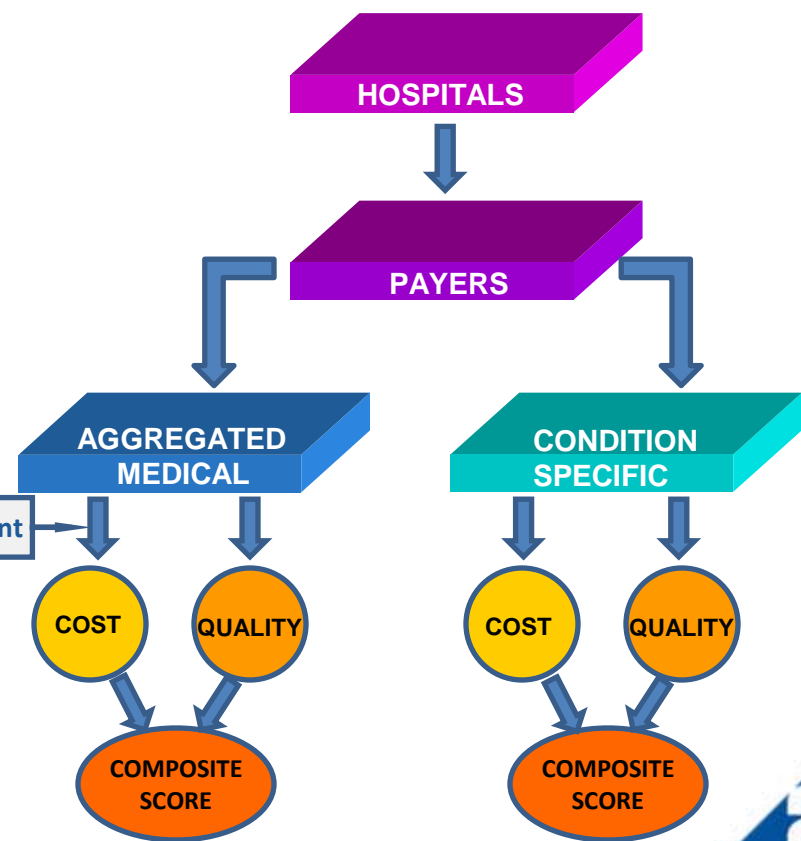


What is Provider Peer Grouping?

Clinic Domain



Hospital Domain



Risk Adjustment



Provider Peer Grouping - Déjà vu All Over Again?

Lessons learned from past profiling projects

- ❖ Unit of measurement is not the individual provider, nor aggregated health care system; it is the clinic or provider group
 - Assures sufficient patient counts for reliable analysis
 - Provides better balance of within and between group variances
- ❖ Features more provider stakeholder involvement and feedback
- ❖ Assesses and integrates both cost and quality performance
- ❖ Designed to complement other Minnesota health care reform projects
- ❖ Enhanced reporting will provide four optional levels for viewing results



Project Origins and Goals

- 2008 Minnesota comprehensive health care reform bill
- Provider peer grouping is called for under Statute 62U.04
 - ❖ Intended to slow the growth of health care costs
 - ❖ A second goal was to improve the quality and value of health
 - ❖ Calls for a public comparison of healthcare provider performance on both cost and quality
- Peer Grouping must include a combined measure of cost and quality
 - ❖ For a provider's population as a whole
 - ❖ Separately for selected specific health conditions



Health Improvement Logic Model

The Provider Peer Grouping Project is designed to:

- Motivate providers to improve quality and reduce cost using peer comparisons;
- Enable employers and health plans to choose high quality, low cost providers;
- Enhance consumer health care decisions;
- Provide a foundation for payment reforms encouraging better quality and value.



Project Leadership Team

- **Mathematica Policy Research, Inc.**
 - ❖ Randall S. Brown, Nyna Williams, Mary Laschober
- **University of Minnesota Center for Health Care Organization Research and Development**
 - ❖ Dave Knutson, Jon Christianson, Beth Virnig, Doug Wholey
- **Minnesota Community Measurement**
 - ❖ James Chase, Diane Mayberry, Anne Snowden
- **Minnesota Department of Health**
 - ❖ Katie Burns, Kevan Edwards



Risk Adjustment Challenges

- Potential data limitations
(coding resolution, sources; missing data patterns)
- Model selection and time-frame (concurrent, predictive)
- Attribution (which patients are associated with which providers)
- Enrollment duration/instability
- Outlier patterns and outcome distribution variations
- Interpretation (reliability and significance metrics)
- Risk adjustment logic for condition-specific episodes



ACG Use

- **ACGs have been used in Minnesota since mid 1990's**
 - ❖ Used by most health plans
(profiling, predictive models, rate setting)
 - ❖ MN public programs
(health plan rate setting, medical home risk stratification)
- **We will use Version 9.0 ACGs to risk adjust total provider cost**
 - ❖ Standardized
 - ❖ Actual
- **Will use either ADGs or ACGs for risk adjustment**



ACG Use (cont.)

- **May use concurrent or prospective model**
 - ❖ Experimental – depends on many factors
 - ❖ May used a combined approach
- **May need to adapt ACGs, ADGs, or ETCs to distinguish between true risk adjustment parameters and basic provider practice pattern variations.**
- **Heavy requirements for cross-source validation**
- **Will run data from 2008 and 2009**



Project Importance

- **Broad scope performance measurement**
 - ❖ Diverse data streams, providers, payers, outcome measures
- **Composite performance scoring for comparison**
 - ❖ Integrates cost and quality metrics
- **May model how insurance exchanges can use pooled data**
 - ❖ Use of risk adjustment to establish value equity in multiple settings
- **MN payers required to use provider peer grouping data to create enrollment incentives**
 - ❖ For selecting higher quality, lower cost care options



Future Developments

- **First Provider-specific reports distributed by OCT, 2010**
 - ❖ Distributed by mail to hospitals, providers, clinic groups
- **Regional provider meetings held 2-3 weeks later**
 - ❖ Three regional provider meetings with physicians
 - ❖ Three regional provider meetings with hospitals
- **Evaluation of the program will be conducted annually**
- **Beginning in JAN, 2011, the State Employee Group Insurance Program, local units of government, and health plans are required to use the provider peer grouping data to create incentives for enrollees to use higher quality, lower cost care.**

