

Preliminary Recommendations of Measures and Methodologies and for Minnesota's Quality Incentive Program

Submitted by the University of Minnesota to Minnesota Community Measurement

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Introduction

In previous work towards the development of a state quality measurement and payment incentive system, MN Community Measurement, through its subcontract with the University of Minnesota, has inventoried quality measures in use for public reporting and/or for payment incentive programs. In this document, the University of Minnesota, under subcontract with MN Community Measurement, has identified a subset of quality measures as the basis for a quality incentive payment system. This report presents these preliminary recommendations on measures and also some preliminary recommendations on quality incentive methods.

The preliminary recommendations address:

- Which subset of measures from the quality measures identified under Task One that we recommend as the basis for a quality incentive payment system.
- A rationale for why we recommend those measures, as well as a rationale for why the other measures identified in Task One are not recommended as the basis for a quality incentive payment system.
- In selecting a subset of measures, we will maximize the feasible use of outcome-related measures that improve care and lower costs for high volumes of people; focus on chronic conditions; and minimize both providers' administrative burden and duplication of related activities.
- What type of quality incentive methods appear to be most favorable for the state.

Background

Through MN Community Measurement, the Minnesota health care community has pioneered collaborative health care reporting: building a set of measures that have become both more sophisticated and less administratively burdensome; establishing a process that allow for the collection of quality measure data from medical groups as well as health plans; and providing for the reporting of Minnesota quality data to health care providers and to consumers. Now MN Community Measurement has contracted with the Minnesota Department of Health (MDH) to assist the state in establishing a unified statewide quality reporting system for health care providers. In turn, MN Community Measurement is working with community partners including Stratis Health, the Minnesota Medical Association, the Minnesota Hospital Association and the University of Minnesota School of Public Health to assist us in completing this work.

In December 2008, MN Community Measurement completed an inventory of measures in use across the country for public reporting of quality information. On February 6, 2009, Minnesota Community Measurement, along with community partners including Stratis Health, the Minnesota Medical Association, the Minnesota Hospital Association and the University of Minnesota, recommended a set of quality measures for public reporting for the State of Minnesota.

There are two important planning considerations in play:

- First, MDH does not envision selecting measures for public reporting or for incentive payments as a one-time process; new science or updated measurement methodologies may call for changes in previously existing measures or for replacement of existing measures with others of the same type.

- Second, MDH recognizes that the process that this health care community has followed to develop and implement measures in a collaborative way, takes time. Generally, it takes a year to develop a new measure, a year of voluntary data collection and voluntary public reporting to make sure, among other things, that health providers have appropriate systems in place to collect the information, and then the measurement information is ready for public reporting and perhaps use in awarding incentive payments on all data providers in the third year.

Over time, the Reporting Advisory Committee, comprising physicians and other clinicians, purchasers, consumers, technical specialists and health plans, worked together to establish priorities for these recommended measures. When considering new measures, the Reporting Advisory Committee used criteria that have been adapted from the National Quality Forum.

The criteria included:

1. Degree of impact
2. Degree of improvability
3. Degree of inclusiveness
4. National consensus
5. Degree of performance variation

The measures that were recommended on February 6, 2009 by the Minnesota Community Measurement are the following:

Ambulatory Care Measures

1. Optimal Diabetes Care - the percentage of patients with diabetes (Types 1 and 2) ages 18-75 who reached all five treatment goals:
 - a. HbA1c <7
 - b. Blood Pressure <130/80
 - c. Low Density Lipoprotein (LDL) <100
 - d. Daily Aspirin Use
 - e. Documented Tobacco Free
2. Optimal Vascular Care - the percentage of patients with vascular disease ages 18-75 who reached all four treatment goals:
 - a. Blood Pressure < 130/80
 - b. LDL <100
 - c. Daily Aspirin Use
 - d. Documented Tobacco Free
3. Use of Appropriate Medicines for Asthma - percentage of patients ages 5-56 with persistent asthma who were appropriately prescribed medication
4. Appropriate Treatment for Children with Upper Respiratory Infection - percentage of children ages three months to 18 years with diagnosis of URI who were not given antibiotic within three days of episode
5. Appropriate Testing for Children with Pharyngitis - percentage of children ages 2-18 years with sore throats who were given an antibiotic and a group A strep test for episode period.
6. Breast Cancer Screening -percentage of women ages 42-69* who had mammogram in past 2 years

* This will be the age range reported in 2009, changed from the currently reported age range of 32-69.

7. Cervical Cancer Screening - percentage of women ages 24-64 who received one or more Pap tests in past 3 years
8. Colorectal Cancer Screening - percentage of adults ages 51-80 who had appropriate colorectal cancer screenings
9. Cancer Screening Combined - percentage of adults ages 51-80 who received appropriate cancer screening services (breast, cervical, colorectal)
10. Chlamydia Screening - percentage of sexually active women ages 16-24* who had at least one test for chlamydia infection.

*This will be the age range reported in the 2009 report, changed from the currently reported age range of 16-25.

11. Childhood Immunization - percentage of children two years of age who had appropriate shots by second birthday
12. Depression measure, primary care –
 - Six Month Remission Rate (PHQ-9 score <5 at six months); outcome measure demonstrating improved mental health for patients with depression
 - Use of the PHQ-9 Tool (patient has a PHQ-9 done at least once during the time frame); process measure to track use of new tool used for diagnosis, treatment and monitoring depression care
 - Collected through Direct Data Submission
13. Depression measure, behavioral health specialists – Includes patients with primary depression diagnosis
 - Six Month Remission Rate (PHQ-9 score <5 at six months); outcome measure demonstrating improved mental health for patients with depression
 - Use of the PHQ-9 Tool (patient has a PHQ-9 done at least once during the time frame); process measure to track use of new tool used for diagnosis, treatment and monitoring depression care
 - Collected through Direct Data Submission
14. Health information technology –
 - Self-reported medical group survey assessing their use of HIT
 - As stated in IOM report, the use of IS has potential to improve each of the 6 aims of the health care system by helping clinicians manage large amounts of clinical information
 - Report available in mid 2009
15. Patient experience -
 - Using national CG-CAHPS survey; four domains:
 - Getting Appointments & Health Care When Needed
 - How Well Doctors Communicate
 - Courteous and Helpful Office Staff
 - Overall Rating
 - Surveys administered by medical groups (vendors) using MNCM specifications
 - First pilot report in early 2009
16. Lead Screening
 - The percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday
 - Relevance to MN Health Care Programs
 - Medical group performance variation exists
 - HEDIS hybrid method measure collected by health plans

17. Appropriate Management of Adult Acute Bronchitis

- The percentage of adults 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription
- An overuse measure – a higher rate indicates appropriate treatment of adults with bronchitis (i.e., the proportion for whom antibiotics were not dispensed)
- HEDIS administrative method measure collected by health plans

Hospital Care Measures

- Abdominal aortic aneurysm repair (AAA) – IQI 4
- AAA repair mortality rate – IQI 11
- Coronary artery bypass graft (CABG) – IQI 5
- CABG mortality rate – IQI 12
- Percutaneous transluminal coronary angioplasty (PTCA) – IQI 6
- PTCA mortality rate – IQI 30
- Hip fracture mortality rate – IQI 19
- Decubitus Ulcer – PSI 3
- Death among surgical patients with treatable serious complications – PSI 4
- Post-operative pulmonary embolism or deep vein thrombosis – PSI 12
- Obstetric trauma (3rd and 4th degree lacerations) – vaginal delivery with instrument – PSI 18
- Obstetric trauma (3rd and 4th degree lacerations) – vaginal delivery without instrument – PSI 19

Table I presents the multi-stage development process for the measures that will be included in the statewide quality reporting system. The measures shown in the chart are the minimum number of measures that will be added to the statewide quality reporting system in each year of the contract. The different colors are used to show how a measure works its way through the multi-stage development process over time. Measures used for quality incentives are to be selected from these measures.

Table I: Timeline for Measure Development and Implementation from Task One

Measurement Development Process Stages

	<u>Stage 1:</u> Determine and select future measurement priorities; Develop new measures	<u>Stage 2:</u> Data collection on new measures begins; Voluntary data submission; Voluntary public reporting	<u>Stage 3:</u> Public Reporting Statewide
<u>First Year:</u> 2009 Calendar Year	1 Primary care measure 1 Specialty care measure 5 New hospital measures supported by clinical-data enhanced database ¹	Depression measure – primary care Depression measure – specialty care Health information technology (HIT) measures Patient experience measures	Existing MNMCM and Minnesota Hospital Quality Report ² measures 12 Additional AHRQ ³ inpatient hospital measures

Second Year: 2010 Calendar Year	1 Additional primary care measure 2 Additional specialty care measures Continuation from first year of development of 5 new hospital measures supported by clinical-data enhanced database ¹	1 Primary care measure 1 Specialty care measure	Previous year's measures, plus: Depression measure – primary care Depression measure – specialty care HIT measures Patient experience measures 2 Additional AHRQ³ inpatient hospital measures
Third Year: 2011 Calendar Year	2 Additional specialty care measures	1 Additional primary care measure 2 Additional specialty care measures	Previous year's measures, plus: 1 Primary care measure 1 Specialty care measure 5 New hospital measures supported by clinical-data enhanced database¹ 2 Additional AHRQ³ inpatient hospital measures
Fourth Year: January 1, 2012 – July 1, 2012		2 Additional specialty care measures	Previous year's measures, plus: 1 Additional primary care measure 2 Additional specialty care measures 2 Additional AHRQ³ inpatient hospital measures

¹ Clinical-data enhanced database will integrate clinical data with administrative data ; ² The Minnesota Hospital Quality Report can be seen at www.mn.hospitalquality.org; ³ AHRQ is the Agency for Healthcare Research and Quality

Source: MNMCM Quality Measures for Public Reporting: Final Recommendations to the Minnesota Department of Health, February 6, 2009

Measures Currently in Use for Quality Incentive Programs for Minnesota Providers

There are a number of provider quality incentive programs that have been implemented in Minnesota. Appendix B provides tables listing measures that are currently in use for quality incentive programs in Minnesota.

Ambulatory Care Quality Incentive Programs

In general, physician incentive programs are sponsored by individual health plans using plan-specific or MNMCM measures. CMS sponsors the Physician Quality Reporting Initiative (PQRI) that began in 2007 and is expanding. The Minnesota Medical Association (MMA) maintains an annually updated inventory of measures that are being used for quality incentive programs that involve Minnesota physicians.

Hospital Quality Incentive Programs

The primary hospital quality incentive program that involves Minnesota hospitals is CMS Hospital Compare. Like the PQRI program, the incentive payment is in the form of a higher annual fee update for reporting measures. This program is expected to expand the number of reportable measures and evolve to a pay-for-performance program over time. The

CMS Hospital Compare program currently includes 40 measures. Hospital reported process measures are used as the basis for the financial incentive; but outcomes measures in the form of risk-adjusted mortality rates are also reported by CMS based on administrative data.

These measures include:

- Heart Attack (AMI) Care: 8 measures (7 process measures, plus mortality rates)
- Heart Failure Care: 5 measures (4 process measures, plus mortality rates)
- Pneumonia Care: 8 measures (7 process measures, plus mortality rates)
- Surgical Care: 7 measures (all process measures)
- Children's Asthma: 2 measures (both process measures)
- Experience of Care: 10 measures derived from HCAHPS patient survey

The MNMCM February 6 report recommended the universe of quality measures from which to select measures for the initial implementation of quality incentives. Regarding hospital measures, the report indicated that, "There are two distinct types of acute care hospitals in the state, as defined by their Medicare payment and reimbursement system: 53 PPS hospitals (Prospective Payment System, which are generally the medium and large hospitals) and 79 CAH (Critical Access Hospitals, which are small, rural hospitals). Minnesota has one of the largest numbers of CAHs in the state, both in terms of the number of hospitals, and in the number of hospitals per capita. A Minnesota quality measurement system ideally should assess the quality of care at both types of hospitals."

"Critical Access Hospitals are not subject to the same "Pay for Reporting" program, and only some of the above listed measures are relevant for the scope of services provided by CAHs. Specifically, the Heart Failure (6 measures) and Pneumonia (8 measures) are relevant and appropriate for small rural hospitals. In Minnesota, 68 of the 79 CAHs currently collect and report on at least one of these measures, demonstrating their commitment to quality and transparency, even though they do not have financial incentives for reporting."

The following is a list of the specific Hospital Compare Measures (excludes the mortality measures)

Heart attack:

- Patients given aspirin at arrival
- (†)Patients given beta blocker at arrival
- Patients given ACE inhibitor or ARB for left ventricular systolic dysfunction (LVSD)
- Patients given thrombolytic medication within 30 minutes of arrival
- Patients given PCI within 120 minutes of arrival
- Patients given smoking cessation advice/counseling
- Patients given aspirin at discharge
- Patients given beta blocker at discharge
- (*)Appropriate care measure

Heart failure:

- Patients given assessment of left ventricular function (LVF)
- Patients given ACE inhibitor or ARB for left ventricular systolic dysfunction (LVSD)
- Patients given smoking cessation advice/counseling
- Patients given discharge instructions (LVF)
- (*)Appropriate care measure

Pneumonia:

- (†)Patients given oxygenation assessment
- Patients having a blood culture performed prior to first antibiotic received in hospital

- Patients given initial antibiotic(s) within 4 hours after arrival
- Patients given the most appropriate initial antibiotic(s)
- Patients assessed and given pneumococcal vaccination
- Patients given smoking cessation advice/counseling
- (*)Appropriate care measure

Surgical care:

- Surgery patients who received preventative antibiotic(s) one hour before incision
- Surgery patients whose preventative antibiotic(s) are stopped within 24 hours after surgery
- Prophylactic antibiotic selection for surgical patients
- Surgery patients with recommended venous thromboembolism prophylaxis ordered
- Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery

Survey of patient's hospital experiences:

- Communication with doctors
- Communication with nurses
- Responsiveness of hospital staff
- Pain control
- Communication about medicines
- Cleanliness of hospital environment
- Quietness of hospital environment
- Discharge instructions
- Overall rating of the hospital
- Willingness to recommend the hospital to others

Hospital acquired infection:

- Cardiac surgery patients with controlled 6 A.M. postoperative blood glucose
- Surgery patients with appropriate hair removal
- Ventilator bundle compliance
- Central line bundle compliance
- Surgical site infection rate for vaginal hysterectomy
- Surgical site infection rate for total knee arthroplasty

To provide further context on the differences between PPS hospitals and rural hospitals, we quote from the February 6 report, "Measures such as those that focus on care in the emergency room or the experience of care are relevant to all hospitals regardless of volume or services provided and are aligned with other public reporting and quality improvement activities, and will be considered in the process for identifying and recommending new measures by July 2009.

Potential measures for consideration include:

- Emergency Department measures: Selecting from a set of 5 timeliness measures (from the recently announced CMS Outpatient Prospective Payment System measures, which are NQF endorsed) for patients presenting with chest pain that is likely to be a heart attack/AMI, and/or from a set of 3 NQF-endorsed measures of time to transfer/admissions for patients with a variety of conditions.
- Medication Safety: Selecting from a set of 34 measures in 7 domains of safe medication practices (as studied by the Center for Rural Health Policy Analysis).

- Experience of Care: Developing from the HCAHPS patient experience of care survey a composite measure(s) of patient assessment of quality of care.”

Preliminary Recommendations for Minnesota Pay for Performance

This section presents preliminary recommendations on measures and methods for the initial pay-for-performance implementation for Minnesota’s health care reform. See Appendix A for a description and analysis of quality incentive programs, methods in current use, and experience to-date with these initiatives, including a review of empirical research. These preliminary recommendations relate to a number of design issues that are addressed in depth in Appendix A.

General recommendations

We have observed that the implementation of any new pay-for-performance system is an iterative process that takes place over a number of years. When implementation is to be community or statewide, the need to prioritize the tasks in the initial phase of implementation becomes critical to its early success. For a state like Minnesota, with a well established existing quality performance measurement system at the physician practice level, and with the introduction of the Medicare Hospital Compare program and related public reporting of that performance, we believe that the initial phase should focus on the pay-for-performance methodology and not add to the implementation burden by introducing new performance measures.

In later phases, adjustments to the method will be inevitable and appropriate and we would anticipate that measures will be added.

It seems likely that three or more years will be required to introduce truly advanced comprehensive performance measures and to fully realize the comprehensive objectives of the state for an all-payer, value-based purchasing system.

Our recommendations for the initial phase are predicated on using measures and risk adjusters that are currently in place, with efforts to expand scale and scope taking place in a parallel to this initiation implementation period. The recommendations and related measures for quality assessment and public reporting are presented in the context of differentiating the initial implementation phase from later phases.

In the initial phase we recommend building on current MNMCM measures used for public reporting, as well as selected Hospital Compare measures used for pay-for-reporting and public reporting. More specifically, we recommend that the MNMCM Diabetes measure, the cardiovascular measure (s), asthma management measure, cancer screening measures, and HIT measures be used for pay-for-performance. We would delay using the depression measures, the overuse of antibiotic measures, and the important patient experience measures now under development.

For hospitals, it seems reasonable to build on the Hospital Compare methodology for pay for reporting and public reporting for those measures that have not “ceilinged” (that is, a substantial portion of hospitals have approached the maximum possible performance level.)

Design Issues and Related Recommendations

While empirical findings about the implementation and impact of pay-for-performance in general, and for comparing alternative approaches, are currently incomplete and somewhat inconsistent, we can outline issues and make some educated judgments to support designing and implementing a pay-for-performance system.

Measures

Recommendation 1) Use well established performance measures for introducing a statewide program of pay-for-performance.

Rationale: Large scale and community-wide examples of pay-for-performance usually followed or were associated with measures that had already been used for public reporting or the private profiling of providers, or piloted in “dry runs”. We think a statewide initiative, such as this, requires that the initial measures be well- established in the community, thus measures of physician practice already implemented by MNMCM and supported by health plans, as well as measures already implemented by MN hospitals for public reporting, should be regarded as the logical initial candidates for pay-for-performance, with other measures added after they have been piloted.

Another value of using existing measures is that benchmarks are available to use in translating performance into payment and also to assist purchasers in budgeting for the cost of pay-for-performance.

In addition, one of the most common concerns of providers regarding pay-for-performance initiatives that rely on new measures is the cost of collecting and reporting the data. This will be less of a concern in Minnesota, because of its history of MNMCM- reported physician performance and because Minnesota hospitals have their performance in the CMS Hospital Compare program reported by the MHA on the MHA website.

This implies that the State may wish to delay implementing the MNMCM depression measures until the Diamond project has progressed. Another example of potentially important measures for pay-for-performance concerns measures of patient experience. In this case, the state may decide that the MNMCM measures could be implemented in the near future, after the measurement and reporting process has had more time to evolve.

Type of Measures

Recommendation 2) While initially using a subset of existing MNMCM and Hospital Compare measures, the State should develop a plan to increase the use of outcome measures, including patient experience, and also to include more clinical outcomes measures. This will become increasingly feasible as more providers submit their data directly to MNMCM for measure construction and reporting.

Rationale: The principle of using well established measures limits the number of possible different measures available for the initial phase of implementation, but experimentation with new measures, and with redesign of existing measures, should be ongoing as a stimulus to performance improvement.

Recommendation 3) In the initial implementation phase, we recommend that the State not include “overuse” performance measures, such as an antibiotic use for URIs, in its pay-for-performance program.

Rationale: There is little experience with overuse measures and it may be controversial to establish a state-sponsored pay for performance program that may appear to pay for withholding a service. This more difficult issue should be addressed in a future round.

Number of measures

Recommendation 4) Begin with a relatively small subset of MNMCM and Hospital Compare measures that are already use.

Rationale: If recommendation 1 is adopted, the field of candidate measures is relatively limited for the first phase of implementation. However, there is little evidence to date that focusing rewards on a small set of measures leads to poorer quality in areas not eligible for rewards. Expanding the number of measures over time should be a relatively short-term programmatic objective, but scaling up a comprehensive value-based purchasing structure will require addressing most clinical care systems and processes in some way.

Methods

Amount of payment

Recommendation 5) The amount of the incentive in the initial phase must be considered in the context of an assessment of the potential impact on provider revenues once the program is scaled up. While determining the actual amount will require financial modeling, in general the research suggests that an initial pilot effort involving even a modest (e.g. 1-3%) proportion of provider revenue may be sufficient, if there is certainty that the program will expand to include multiple payers. In Minnesota, the plan is for the program to start with rewards for serving state employees and then quickly expand to all health plan enrollees.

Rationale: Studies show that even relatively modest rewards initially may be effective if providers know with certainty that the scope of the pay for performance effort, in terms of number of patients and payers involved, will increase in a relatively brief time.

Structure of payment

Recommendation 6) Implement a combination pay for improvement and pay for attainment approach. Improvement targets could be based on a percent improvement comparing the gap between the provider's current performance and either 100% or a community benchmark. Rewards also could be paid to providers for achieving a pre-determined benchmark. This two part system should be fine-tuned over time to ensure that providers continue to have an incentive to improve even after reaching the minimum target level. For example, the top performers and the top improvers could be awarded an additional bonus on a tournament basis.

This approach must be modeled so that the payers' budget management requirements and the desire for the incentive to have an impact on provider behavior are considered in the context of current performance levels and variation in performance in Minnesota.

Aggregation of measures

Recommendation 7) We suggest that the State adopt a point system to weight physician practice scores across all performance measures. Hospital Compare composite methods should be used for hospital scoring.

Rationale: An aggregated scoring system will allow fine tuning of the weighting process in addition to setting targets or benchmarks for specific measures. Because the typical weighting methods all have room for improvement, a hospital and also a physician performance scoring panel of experts should be assembled to review and improve upon current practices used to establish scoring weights. The panel should ensure that the weightings in some way reflect two objectives: 1) maximizing the health of the population and 2) maximizing the efficiency of care.

Accounting for case mix and risk

Recommendation 8) in the initial phase, we suggest that the State conduct a brief review of the current exclusion and inclusion criteria in the MNMCM and Hospital Compare measures and determine if any changes would be desirable for their use in structuring measures for the purpose of pay-for-performance. This is the first step in case mix/risk adjustment. It is likely that the existing exclusions and inclusion will be adequate for the initial phase.

In subsequent phases of expansion, the State should consider separate performance scoring for Medicaid, Medicare, and commercial populations if sample size problems can be overcome through expansion in the number of purchasers and payers. If stratification is made based on such proxies, or even on direct measures of social factors, the state may need to adjust the weighting in the scoring system to provide greater incentives for improvement for populations with

barriers. The issue for risk adjustment is how to be fair to those being assessed, without inadvertently establishing a policy that accepts lower quality care for populations with barriers.

Rationale: Most current P4P programs to date have not used risk adjustment as part of the construction of measures but have relied on both exclusion from the denominator and/or separate scoring for Medicaid, Medicare, and commercial populations. This probably is because payment typically has been made based on the presence or absence of a particular activity recommended in treatment guidelines. For the most part, one would expect that the treatment would be carried out irrespective of patient characteristics. However, as outcome measures are added to the program, this assumption may become less defensible.

Recommendation 9) The State should study the need for and feasibility of developing advanced statistical risk adjustment methods for three types of risk factors: 1) Co-morbidity /severity 2) Social complexity and 3) Patient behavior and non-adherence with recommendations.

Rationale: We do not currently have reliable data nor well tested risk models for introducing severity as a risk adjuster in many care settings. In addition, we do not have data on some critical social factors that can serve as barriers to providing care or improving outcomes. This will become an increasingly important methodological issue as pay-for-performance increases in scale and scope and as performance improves for the less difficult to treat. This objective should be a key element of the second phase of pay-for-performance implementation.

Recommendation 10) The State should study the application of the exception policies that are in use in the physician pay-performance in the UK, in which MDs can exclude specific patients from their denominator based on some nationally established and auditable reasons (e.g. Called patient more than X times to come for the test, but they refused or did not follow-up; or adhering to this guideline is contraindicated). Whether such an option for risk adjustment would work in Minnesota is an open question; however, the study itself could support the development of a new risk adjustment system based on new data and statistical modeling.

Recommendation 11) The State should develop risk adjustment methods for the new outcomes measures that may be included in the pay-for-performance program in the future. Hospital Compare measures include risk adjustment, and this approach should be adopted for MN as well.

Preliminarily Recommended Measures for Initial Implementation of Quality Incentives

Ambulatory Care

- Optimal Diabetes Care - the percentage of patients with diabetes (Types 1 and 2) ages 18-75 who reached all five treatment goals:
- Optimal Vascular Care - the percentage of patients with vascular disease ages 18-75 who reached all four treatment goals:
- Use of Appropriate Medicines for Asthma - percentage of patients ages 5-56 with persistent asthma who were appropriately prescribed medication
- Appropriate Testing for Children with Pharyngitis - percentage of children ages 2-18 years with sore throats who were given an antibiotic and a group A strep test for episode period.
- Breast Cancer Screening -percentage of women ages 42-69* who had mammogram in past 2 years
- Cervical Cancer Screening - percentage of women ages 24-64 who received one or more Pap tests in past 3 years
- Colorectal Cancer Screening - percentage of adults ages 51-80 who had appropriate colorectal cancer screenings

- Cancer Screening Combined - percentage of adults ages 51-80 who received appropriate cancer screening services (breast, cervical, colorectal) * This will be the age range reported in 2009, changed from the currently reported age range of 32-69.
- Chlamydia Screening - percentage of sexually active women ages 16-24* who had at least one test for chlamydia infection.
 - *This will be the age range reported in the 2009 report, changed from the currently reported age range of 16-25.
- Childhood Immunization - percentage of children two years of age who had appropriate shots by second birthday
- Health information technology – self-reported medical group survey assessing their use of HIT
- Lead Screening - percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday

Recommendations of Measures for Initial Implementation of Quality Incentives for PPS Hospitals

The initial implementation of quality incentives should build on Hospital Compare, where measures meet the following criteria:

- Sufficient variability in performance across Minnesota hospitals, and
- Sufficient sample sizes to apply to a large proportion of PPS hospitals.

Upon review of Minnesota Hospital Compare results, it appears that there will be very few measures that meet these criteria. The state must decide whether it wishes to establish a quality incentive program initially to get the methodology in place and begin the process of expanding measures as they are piloted for public reporting. The innovation initially may be restricted to moving from CMS's pay-for-reporting to actual pay-for-performance.

It should be noted that not-paying for medical errors is also a form of quality incentive that is being actively explored and implemented by purchasers and payers, but was believed to be out of context for this Task.

Recommendations for Rural Hospitals

There is no precedent we know of for pay-for-performance for rural hospitals. It is possible that such examples will be found in a wider search of private health plan programs and possibly for state Medicaid programs.

Because of this lack of history, because the reporting of these measures by rural hospitals has only very recently begun, and since the CAHs are paid on a very different basis than PPS hospitals, we recommend that an action plan be developed with the goal of implementing pay for performance for rural hospitals in either 2010 or 2011, depending on findings related to performance benchmarks and appropriate incentive methods.

Next Steps

These preliminary recommendations, made by the University of Minnesota School of Public Health under subcontract to MN Community Measurement, will be fully vetted by the public and by stakeholders. Written comments can be submitted to comments@mnhealthcare.org until Feb. 28, 2009. Two public meetings will be held in February to solicit input on the proposals. Please see <http://www.health.state.mn.us/healthreform/measurement/publicmeetings.html> for information on those public meetings. In addition, MN Community Measurement has established two stakeholder workgroups, one addressing recommendations for hospitals, the other for ambulatory providers. For information on meetings of those workgroups, which are open to public observation, please see

<http://www.health.state.mn.us/healthreform/measurement/workgroup.html>. MNMCM's final recommendations to MDH are due March 25, 2009.

Appendices

Appendix A

Appendix B