MINNESOTA DEPARTMENT OF HEALTH
Provider Peer Grouping Advisory Group
July 17, 2009 8:00 am – 12:00 pm
Meeting Summary

Advisory Members Present:		MDH & Facilitators:	Absent:
Charles Fazio, MD	Doug Hiza, MD	Julie Sonier	Darryl Dykes, MD
Jan Malcolm	Nathan A. Moracco	Jim Golden	Paul Mueller
Terry Cahill, MD		Ann Robinow	
Timothy Crimmins, MD	Christine Norton	Andrea Kao	
Peter Dehnel, MD	Karen Peed		
	Candace Simerson		
John Frederick, MD	David K. Wessner		
Keith D. Harvey	Doug Wood, MD		

Topic	Summary
• Welcome	Co-chairs convened the meeting and introduced Dr. Tim Crimmins from General Mills. Co-Chair Malcolm noted an editorial printed in the July 10th Star Tribune that discussed the work of the Provider Peer Group. Meeting was then turned over to Ann Robinow.
• Follow-up questions from previous meeting	• Two clarifications were made to the July 10 meeting summary: On p.2 of the meeting summary, panel members recommended looking at functional outcomes as part of quality measures but it should also be noted that the discussion also focused on looking at the impact to other systems and to society as a whole. • Summary should also note the group discussed the value of the data being collected for Provider Peer Grouping and a recommendation the State should consider opportunities outside of Provider Peer Grouping the data presents to inform MDH regarding variation and the overall burden of health. • Clarification was made the three categories for payer groups discussed were Medicare, Medicaid, and commercial.
• Follow-up Responses from Technical Panel	Technical Group clarified the following points and recommendations: • Data does not support peer grouping at individual clinician level at this time. Outcome of surgery also dependent on hospital so individual clinician reporting may not be appropriate. • An episode with a hospital component is included with the physician clinic or group as the unit of analysis. • Attribute with greater credibility more preferable than attribute a greater number.
• Revisit: Condition Specific Attribution & Unit of Measure	Ms. Robinow reviewed the specific conditions the Group selected, what entity will be measured, the unit of analysis, and peer group for each condition. Two members raised some disagreement with inclusion of hospitals costs with the physician as part of the unit of analysis due to a) variation of hospital admissions within same episode category and b) degree of influence physicians have directing patients to particular hospitals. Panel member commented it may be more feasible for larger groups that are part of integrated delivery systems to influence where a patient is admitted than it is for smaller groups in smaller communities. Variation among hospitalizations within the same episode is addressed to some degree by the sub-categorization within an episode that grouper software utilizes and also by applying a second risk adjuster as recommended by the Group. While the Technical Panel recommended not analyzing at the individual physician level due to data issues at this time, Group discussed the value to providers and consumers of measuring at the individual level for physician and hospital, specifically for Total Knee. *Group recommended hospital specific reporting for all surgeons, as granular level surgeon reporting that data supports, and continued development of data collections to support individual physician reporting, particularly for surgical procedures.*

To give members a better understanding of episodes, Ms. Robinow reviewed examples of specific episode descriptions and sub-categorizations within the episode. Ms Robinow described how these sub-categories would need to be rolled up and standardized to a standard ETG mix across providers to allow for comparability.

Group discussed options to attribute episodes to one physician or to multiple physicians. Technical Panel recommends attributing to providers that supports more credible attribution rather than pursuing a goal of attributing as many episodes as possible. Point was raised that attribution to single or multiple providers does not have to be uniform for all six conditions. Issue was raised that attributing to only primary care is not always realistic representation of where patient is getting majority of care and who is directing the care. Particularly for certain types of conditions, such as heart failure and coronary artery disease, patients have interventions with other physicians. Cost and quality information on these secondary levels of attributed providers can also help inform primary care physicians where to send and refer their patients. *Group recommended single physician attribution for diabetes, pneumonia, asthma, and total knee and multiple physician attribution for coronary artery and heart failure.*

Ms. Robinow reviewed Condition Specific cost summary recommendations.

Issue	**Recommendation**
Episode Software	Commercial software
Cost	Calculate Actual & Reprice methodologies but not necessarily report both for varied audiences.
Outlier Adjustment	• Set thresholds specific to population size; • Remove low outliers; • Truncate high outliers with any necessary actuarial corrections for small clinics/groups; • Continued analysis of outliers
Severity of Illness Demographic Risk Adjustment	• Apply two levels of risk adjustment • Consider some adjustment for income via zip code
Payer Mix Adjustment	Compare by payer categories AND Normalize to standard payer mix
Attribution to one or many providers?	Single : diabetes, asthma, pneumonia, total knee; Multiple: CAD and heart failure Continuous improvement for attribution rules.

Comment was made by panel member that consideration of income adjustment is appropriate but education level is potentially better indicator of health outcomes. Also, while it is important, recommending methodological developments in the area of income and education adjustments may be a better as a longer term recommendation for the Commissioner and not an immediate priority for provider peer grouping.

- Quality Measurement for Condition Specific

Ms. Robinow introduced new discussion topic, Quality Measurement for Specific Conditions. Technical Panel provided some comments and considerations when discussing selection of measures and weighting of measures to develop a quality score for Specific Conditions. Ms. Robinow reviewed different types of measures, the pros/cons of selecting a single quality measure or multiple quality measures, and the challenge of creating a composite measure if multiple measures are used.

Ms. Robinow and Ms. Kao will solicit input on specific quality measures from Advisory members via a survey sent via email. Results will be shared at the July 22 meeting. Survey will ask whether a single or multiple measure be used for each condition and which specific

measures.

As Group reviewed the available quality measures for each condition, discussion ensued regarding use of already constructed composite measures that exist for diabetes, pneumonia, and coronary artery and advantages and disadvantages of using the composite measures for peer group. Group also commented on the potential influence of PPG selected quality measures to focus efforts and behavior towards improvement in particular quality areas.

- Cost Measurement for Total Care

Ms. Robinow reviewed a description of Total Care and the previously agreed to recommendations for Total Care units of measurement. The law requires provider peer grouping to occur on a Total Care basis for physician and hospital separately.

The Group discussed some concerns with measuring Total Care for hospitals such as the measure will not address inappropriate admission or avoidable admissions. Ms. Robinow commented that measuring total cost for hospitals will not address this but potentially through the Total Care for physicians where population health is measured. Concern was also raised regarding how hospital transfers would be accounted for in the hospital cost, if there were issues with Medicare reimbursement for critical access hospitals, and ability to adequately adjust for severity upon admission.

The Group then focused discussion on Total Cost for physicians. Clarification was asked about how principle provider will be defined and designated and how patients with no care during a year will be attributed. Ms. Robinow explained these are determined through the attribution methodology and often patients with no care during the year are evenly distributed across providers. Some concerns were raised that providers can provide care through outreach or other innovative, cost effective ways that do not generate claims and would not allow appropriate attribution back to the provider. Additionally, there were concerns that some patients may ignore primary care directives and seek a more expensive course of care on their own that may be attributed back to the primary care.

Group recommended that as Health Care Homes develop and products emerge that require a designated assignment to a managing provider, the data capture any provider assignment and utilize actual assignment rather than attribution.
Group recommended utilizing more than one year's worth of data to determine if non-users in one year could be attributed based on another year's worth of day.
Group also identified another opportunity to use provider peer grouping data in another way: to evaluate impact of health care homes and whether care will cost less over time for members assigned to health care homes.

Group reviewed the Cost Measurement for Condition Specific recommendations and discussed if any of the recommendations needed to be different for Total Care. *Group made below recommendations for Cost Measurement for Total Care:*

Issue	**Recommendation**
Episode Software	Commercial software
Cost	Calculate Actual & Reprice methodologies but not necessarily report both for varied audiences.
Outlier Adjustment	• Set thresholds specific to population size; • *Include* low outliers; • Truncate high outliers with any necessary actuarial corrections for small clinics/groups; • Continued analysis of outliers
Severity of Illness Demographic	• Apply one level of risk adjustment • Consider some adjustment for income via zip code

	Risk Adjustment	
	Payer Mix Adjustment	Compare by payer categories AND Normalize to standard payer mix
	Attribution to one or many providers?	Single Continuous improvement for attribution rules.
• Preview Next Meeting	Next meeting will follow-up on Quality Measures for Condition Specific, discuss Quality Measures for Total Care, and if time, begin discussion of Combining Cost & Quality.	
• Next Meeting	**Wednesday, July 22 2:30 pm to 6:30 pm** Fanny Wilder Room**,** Wilder Center, 451 Lexington Parkway North, St. Paul 55104 **Monday, July 27 2:00 pm to 6:00 pm** Amherst H. Wilder Room, Wilder Center, 451 Lexington Parkway North, St. Paul 55104	
• Follow-up	1. Specific Condition Quality Measurement survey will be sent to Advisory members. 2. Discuss/recommend PPG input to review progress and follow-up after initial year. 3. Discuss/recommend how law requiring 10% threshold be implemented	