



Issue:

Improving the Provider Peer Grouping Program

● MMA Position

The Peer Grouping program offers a unique opportunity to dramatically expand the amount of information and research available about health care delivery, costs, and utilization in Minnesota. In its current form, however, the provider peer grouping program is unachievable. The MMA strongly supports changes to the program to align the available data set with well-established and proven techniques for population-based, small area analysis, similar to that incorporated in the Dartmouth Atlas of Health Care.

● Background

The Peer Grouping program originated with Minnesota's 2008 health care reform act. The law requires the Minnesota Department of Health to develop "a uniform method of calculating providers' relative cost of care, defined as a measure of health care spending including resource use and unit prices, and relative quality of care." (M.S. §62U.04, Subd. 2) The purpose of the law was to generate results that health plans and other purchasers could use to encourage the use of hospitals and physician clinics that would be identified as "high-quality, low-cost" providers of care.

The data sources for the cost of care analysis are commercial insurance, Medicaid, and Medicare claims and payment data submitted by payers to a state contractor. The law protects the privacy of patients by allowing the collection of only de-identified data. The law calls for public reporting of the results at the clinic and hospital level and the incorporation of the results into insurance products offered to state employees and in specific products offered by commercial health plans.

Since the passage of the law, the MMA has expressed serious reservations as to the intended use of the results because of limitations in current analytical

methodologies and the constraints placed on clinics and hospitals in verifying the accuracy of results from de-identified data. Given the potential for serious errors, as well as damage to reputations and physician-patient relationships, the MMA has consistently called for a reframing of the project toward quality improvement.

Initial hospital reports were released confidentially to hospitals in September 2011. Minnesota hospitals identified a variety of errors in the reports; such problems have reinforced the MMA's concerns. In January 2012, the Minnesota Department of Health announced that it was delaying the public reporting of any hospital or physician clinic results, primarily due to concerns with the age of the underlying data (2008 Medicare data and 2009 commercial data). The department expects to obtain 2010 claims and payment data during 2012 and expects to proceed with the issuance of hospital and clinic reports sometime in late 2012 or 2013.

● Talking Points

- The state has a tremendous opportunity to advance understanding about variations in the cost, quality, and utilization of health care services in Minnesota. In its current form, that opportunity may be lost and, instead, clinic and hospital reputations may be harmed and patients may be confused.
- The focus of Peer Grouping should be on expanding information and data regarding variations in care delivery to drive improvement.
- Public reporting of clinic-specific performance can be useful, but changes to the law will be needed to ensure accurate results that can be verified by the clinics.