Minnesota Hospital Association

2550 University Ave. W., Suite 350-S
St. Paul, MN 55114-1900
phone: (651) 641-1121; fax: (651) 659-1477
toll-free: (800) 462-5393; www.mnhospitals.org

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Comments regarding the October 23, 2009 Provider Peer Grouping Recommendations

On behalf of the Minnesota Hospital Association's members, including 148 hospitals and 17 health systems across Minnesota, I am honored to offer the following comments regarding the draft Provider Peer Grouping Recommendations.

The Minnesota Hospital Association (MHA) believes the provider peer grouping (PPG) initiative is an innovative and ambitious exercise that could eventually create a useful resource of comparative cost and quality information. We appreciate the opportunity to have representatives from our membership participate in the PPG Advisory Group and Technical Panel.

The nature of the PPG initiative requires that any publicly reported information produce reliable, meaningful and credible data and comparisons. To help maintain open communication and the ability to resolve issues that might arise, MHA encourages and invites the state to further the relationship we have developed so that MHA and other providers can provide input, raise questions and offer feedback as the analytical and methodological process for provider peer grouping moves forward.

Many of MHA's members have raised concerns that if the provider peer grouping does not produce reliable, meaningful and credible data and comparisons, providers inaccurately reflected by the data and the patients who might use misleading data to make health care decisions could be significantly harmed, which is not what this initiative is intended to do. Accordingly, this initiative should move forward on a practical, reasonable pace, recognizing and accommodating the daunting nature of its scope, rather than on a pace driven by artificial timelines if they prevent sufficient opportunity to collect the necessary data, thoughtfully develop the methodology, analyze the data, revise and refine the information used and displayed to the public.

Consequently, MHA encourages the state to move forward cautiously and thoughtfully with developing a PPG system on a timeline that allows for the deliberation, analysis and experimentation necessary to create the kind of resource our community can rely upon.

In that spirit of encouragement and constructive contribution, MHA offers the following comments, suggestions, support and questions regarding aspects of the report.

Current statutory timeline does not allow for sufficient collection, analysis and refinement of data sources:

Pragmatic and logistical reasons why statutory deadlines are unrealistic and jeopardize the provider peer grouping initiative

During the 2008 legislative session and throughout the state's implementation process of the various health care reform initiatives, MHA has repeatedly urged policymakers to set more realistic timelines, undertake the necessary deliberative and thoughtful work necessary to create the best possible product, and employ an open process that seeks out multiple stakeholder input. Practical necessities now demonstrate that the timelines imposed by the legislature create more than tension and pressure, they fail to allow for the data elements necessary for the provider peer grouping system to be available before that same system is scheduled to generate initial data for affected providers.

First, on a very pragmatic level, the statutory deadlines are unable to be met logistically. The statute requires the state to create the PPG methodology and provide hospitals and clinics with an opportunity to review their respective data by June 2010. However, the first set of hospitals' quality data on which the PPG system relies will not become available from CMS until June 2010. Therefore, the state should acknowledge this limitation and recognize that it cannot develop, test and refine the PPG methodology without the necessary hospital quality data, let alone be able to turn around and provide hospitals with their respective PPG information for review by the June 2010 deadline.

Consequently, while MHA agrees with the Advisory Group's recommendation that the "[v]alidity of data should not be compromised in order to meet deadlines," MHA believes that the recommendations dramatically under-emphasize the need to revise the deadlines to ensure that the data are accurate, credible and reliable. For the initiative's ultimate success, therefore, it seems prudent to set forth a new timetable that allows adequate time to ensure that the data are valid. As stated earlier, MHA welcomes the opportunity to play whatever role it can in working through the issues and concerns that arise as the data are collected and analyzed.

Furthermore, the PPG initiative is particularly sensitive for providers because (1) it is mandatory – there is no opportunity for providers who believe its methodology is flawed to opt out; (2) it will be used to potentially disqualify certain providers from participation in state public programs and those providers have no opportunity to avoid the as-of-yet-unknown discrepancies in the system; and (3) the potential harms associated with PPG – in particular, the risk of lost reputation, good will, and patient confidence – are difficult to measure, impossible to remedy afterwards, and long lasting.

For all of these reasons, MHA's members believe the PPG deadlines should be revised to allow for adequate collection and analysis of the source data, development and evaluation of the yet-to-be-created methodology, and experimentation with and refinement of that methodology so that the PPG information eventually released to the public is sound and reliable. To the extent the recommendations echo this position by stating that "[v]alidity of data should not be compromised in order to meet deadlines," MHA wholeheartedly agrees.

Composite scores v. cost and quality axes:

More complete and objective display of cost and quality data across two axes should replace statutory mandate of single, subjective composite score

MHA strongly supports the Advisory Group's recommendation that any representations of providers' quality and cost be displayed on a two dimensional scale rather than a single number or ranking. By displaying cost on one axis and quality on another, users may interpret the data according to their individual needs and impressions regarding the importance of certain quality measures, their price sensitivity, etc. Displaying the information on two axes, therefore, allows for an accurate and easy-to-use synthesis of information without the difficulties and ambiguities associated with a single composite score.

PPG success depends upon accuracy of data:

Limited information used for provider peer grouping will lead to inaccurate depictions of providers' cost and quality

The data sets proposed fail to capture all of the care provided and patients served by Minnesota's hospitals and health systems. As a result, because significant gaps in data exist, the resulting scores or depictions of hospitals' and health systems' quality and cost inevitably will be skewed. It is important for the state, therefore, to acknowledge these limitations of the PPG system and ensure that any public reporting contain clear and conspicuous explanations of these discrepancies.

The cost data inputs proposed fail to account for providers' uncompensated care, including the fastest growing category of uncompensated care which is care provided to insured patients who fail to pay their high deductibles and co-pays. This data gap puts hospitals and health systems that provide large amounts of charity and uncompensated care at a comparative disadvantage and could lead to the foreseeable but unfortunate result of creating an incentive for providers to decrease their commitment delivering charity care and uncompensated care in order to improve their perceived performance on the PPG composite scores.

Also, services provided to patients from outside of Minnesota are absent from the data used to calculate providers' costs. While most hospitals and health systems provide the vast majority of their care to Minnesota residents, those located along the state's borders provide a significant amount of care to patients from neighboring states. Moreover, because many of those border-crossing patients are insured, if at all, through Medicaid, the hospitals' financial losses from below-cost government payments from those states are left out of the PPG picture. Likewise, nationally renowned facilities, including, for example, Gillette Children's Hospital and the Mayo Clinic, have substantial portions of their patient mix from out of state. And, often, the out-of-state patients seeking care at these centers of excellence are often in need of some of the most resource-intensive care available anywhere in the world. A peer grouping system like the one proposed that fails to account for these costs, as well as the payments or lack thereof received by providers, is likely to produce misleading and inaccurate comparisons among providers.

Other meaningful and hazardous voids in the data are the costs hospitals and health systems incur to educate and train tomorrow's health care work force, to conduct cutting-edge research, and to meet other community needs. Hospitals and health systems that shoulder a disproportionate burden of addressing these needs – needs that if left unmet would cripple our health care system across the state, including the sustainability of other providers with whom these hospitals and health systems will be compared in the PPG system – should not suffer from loss of prestige, market share or other indirect but predictable impacts from the PPG system because of the costs associated with these community benefit programs.

Again, MHA remains hopeful that the PPG initiative can be improved to account for these issues so that the information reported ultimately can be more reliable and useful. MHA would like to play an active role in helping to develop the solutions and adjustments necessary to make the reporting envisioned by the legislature a fair and accurate reflection of any variations in cost and quality among providers.

Public initiative = public methodology:

Ensure transparency of PPG methodology, risk adjustment, grouper and other software

Although many MHA members remain gravely skeptical of the provider peer grouping initiative, one piece of consolation shared across our membership is the notion that the provider peer grouping methodology will be transparent. Unlike proprietary processes currently used to tier providers – processes that leave providers scratching their heads wondering what data other than costs are used, and what areas providers can attack to improve their position in the decreed tiers – the provider peer grouping process should be a "glass box" approach available to any member of the public, provider or health plan to examine, critique and analyze. The Advisory Group's recommendations are consistent with MHA's interest in a transparent and open process. MHA supports those aspects of the recommendations and encourages the state to take actions in negotiating contracts with vendors of analytical, risk adjustment, grouper and other software to ensure the open, transparent and non-proprietary nature of those elements and the entire peer grouping system.

Available quality data:

Avoid additional administrative burdens and reporting costs by restricting PPG quality data to those measures already collected through statewide quality reporting or encounter-level database

MHA applauds the Advisory Group's recommendation to restrict the quality measures used in the provider peer grouping system to those collected through the standard, statewide quality reporting requirements or available from the encounter level database. This recommendation is consistent with and in furtherance of a multi-year effort by MHA, the Minnesota Council of Health Plans and policy makers to streamline and simplify the administrative burdens and transactional costs associated with health care reporting, claims, eligibility and other "back office" processes. By precluding new or different quality data reporting for purposes of the provider peer grouping system, the Advisory Group appropriately recognized the importance of ensuring that this experimental and costly project does not create even further costs and administrative burdens for providers. Accordingly, MHA supports this recommendation.

At the same time, MHA is apprehensive about a possible contradictory interpretation of the recommendations. While the recommendations are clear that the Advisory Group felt strongly that quality measures should be limited to those already reported by providers or available from encounter data, other language in the report states that "MDH should explore and encourage additional sources of data to be used in peer grouping beyond those that are currently available." MHA hopes that further clarification will be added to ensure that the Advisory Group's suggestion in support of continuous improvement is not misinterpreted as a window of opportunity to deviate from the fundamental principle that the PPG system should not rely on additional reporting burdens or quality measures outside of those developed for the statewide, standard quality measures.

Favor reliability over comprehensiveness:

Evaluate and refine initial PPG system before adding more conditions, treatments, providers and patients

The report includes suggestions of dramatically expanding the scope of the initiative to several additional conditions and patient demographics over the next two years. MHA understands the interest in moving forward to create a more comprehensive picture of cost and quality among providers and that the PPG system proposed fails to capture significant portions of the health care delivery system or patients. However, because of the ambitious and novel nature of the project, MHA cautions against accelerated and ever-expanding application of the system until the inaugural version can be developed, used, evaluated and refined over a sufficient amount of time. Otherwise, the state runs the foreseeable risk of creating a misaligned, poorly performing or unreliable reporting system that continues to grow and expand rather than improve. Accordingly, MHA disagrees with the recommendation and, instead, encourages the state to allow for the PPG system to operate for a minimum of two or three years before adding significant numbers of new conditions or services into the mix.

Who are my patients and when were they my patients?

Attribution methodology recommendations are insufficient and need further clarification to account for patients receiving care from multiple hospitals and for chronological differences between cost and quality data sources

Although the recommendations contain substantial discussion regarding attribution of patients among clinical providers without necessarily proposing how the difficulties of such attribution will be achieved, further clarification addressing the complexity of patient attribution among hospitals would be helpful. It appears that the recommendations assume that a patient will be attributed to the hospital in which he/she is admitted without considering the realities and complexities of hospital care in today's delivery system.

Many patients receive care at multiple hospitals, some for the same incident or episode of care. For example, a patient suffering a heart attack may receive initial care at a local community hospital, transfer to a larger hospital with more cardiac care resources, and then transfer back again for further rehabilitation services. It is unclear to which facility such a patient will be attributed – the referring hospital, whose services accounted for a relatively nominal amount of the total cost of care; the receiving hospital that delivered the highest cost care but has little if any role in the overall longitudinal costs of care for the patient as a whole?

These attribution concerns are particularly acute for hospitals and health systems that deliver the most sophisticated and resource-intensive services, as well as hospitals that sustain in-patient psychiatric departments, burn units, or other high-cost/low reimbursement services. For these hospitals, the attribution methodology threatens to "tag" them with all of the costs associated with the most expensive, complex patients in the system, thereby distorting their patient population even with appropriate risk adjustment software.

Furthermore, MHA members have raised concerns about patient attribution if the data sets used for attribution, cost and quality are not chronologically aligned with one another. The anticipated data collection tools will provide more current cost information and less current quality information. In other words, the PPG system will have cost data from providers' most recent patients, but will have quality data from providers' patients from the previous year. Thus, if patients are attributed to providers based on the most recent year's encounter and cost data but those providers' quality measures are based on their care for patients from the previous year, the product of the PPG report will misalign a provider's total costs of caring for one year's patients with its quality performance for a different set of patients.

This chronological complexity is even more disturbing when it is applied to both patient attribution *and* risk adjustment. If the risk adjustments for health status, patient mix and other necessary "norming" are peformed on a provider's patients from one year, but the provider's costs of care reflect the services provided to patients from a different year then the statistical results will not be meaningfully or reliably risk adjusted. In other words, a provider whose patients and costs are attributed from year two and whose quality scores result from services provided in year 1, then the risk adjustment process will not align or adjust a provider's costs and quality for the same patients. As a result, a provider with a sicker or high-need patient mix in one year will likely show higher costs and resource use during that year, but its quality scores will be based on services provided to patients the previous year who may have been healthier. Accordingly, the method of attributing patients for calculating a provider's costs needs to be chronologically consistent with the patients attributed to the provider for purposes of measuring quality and risk adjustment.

Providers without data:

The academic challenge of scoring hospitals without reportable quality data

The recommendations are unclear about how hospitals that do not have reportable quality data or a sufficient number of patients to produce statistically significant quality data will be treated in the PPG system. Hospitals, such as children's hospitals, do not provide services subject to the quality measures used by the PPG system. Other hospitals, especially small, rural hospitals, do not enjoy sufficient patient volumes to produce statistically significant or reliable data for quality reporting. MHA encourages the state to clarify how these sets of hospitals will be handled in the PPG process.

Quality measure recommendations:

Several proposed quality indicators should be revised

In addition to the general concerns and comments discussed above, MHA offers the following suggestions and constructive criticism of the recommended quality measures contained in the report:

1. Total knee replacement: The proposed quality measures demonstrate the challenges of moving forward with peer grouping for this episode of care when new data will soon be available. After the PPG analysis is scheduled to be publicly reported, risk-adjusted surgical site infection data for Total Knee Arthroplasty procedures will become available. From a patient's perspective, surgical site infection data are more significant quality indicators than emergency room visits or readmissions, which may be totally unrelated to the knee replacement. Moreover, evidence does not suggest that rates of emergency room visits and readmissions within 30 days following total knee replacement surgery are a reliable measure for this procedure.

2. Surgical site infection rate for vaginal hysterectomy (Total Care Hospital Quality Measure 21): this is an outcome measure, not a process measure, and should be moved to the "composite patient complication" measurement category.

3. Surgical site infection rate for total knee arthroplasty (Total Care Hospital Quality Measure 22): This is an outcome measure, not a process measure, and should be moved to the "composite patient complication" measurement category.

4. AAA repair volume, CABG volume, and PTCA volume (Total Care Hospital Quality Measures 23, 24, and 25): These are volume-based, pass or fail measures. Either a hospital does more procedures than the recommended threshold or it does not. Thus, these are unlike the other process measures where a hospital receives a percentage score. Also, volume is more of a structural than a process measure. These three measures were intended to be used in conjunction with Measures 28, 30, and 31, so MHA recommends deleting 23, 24, and 25 from the list of measures to calculate a composite process score.

5. Mortality for selected medical conditions (Total Care Hospital Measures 32 through 37): These six separately identified measures in the recommendations are actually the components of a single measure – the "Mortality for Selected Medical Conditions" indicator – through the AHRQ Quality Indicators. AHRQ assigns unique weights to each individual component measure of the composite, whereas listing them separately would effectively weight each of them equally thereby distorting results between AHRQ and those used in the PPG system. Accordingly, MHA believes they should be one score, not six separate scores. If they remain individual measures, however, then hip fracture mortality is duplicated in Measure 36 and Measure 29.

6. Composite Pediatric Patient Safety (Total Care Hospital Measures 43-48): These measures are individual component measures of AHRQ's Composite Pediatric Patient Safety. They should be one composite measure because AHRQ assigns unique weights to each individual component measure of the composite, whereas listing them separately weights them equally.

7. Composite Patient Safety (Total Care Hospital Measures 49-56): These measures are individual component measures of AHRQ's Composite Patient Safety. They should be one composite measure because AHRQ assigns unique weights to each individual component measure of the composite, whereas listing them separately weights them equally.

8. Additional measures: MHA suggests including the following heart failure and pneumonia process measures which are reported to CMS but not listed in the report:
    - Heart Failure measures: Assessment of LV function, ACE for LVSD, Smoking cessation counseling, Discharge instructions
    - Pneumonia measures: Antibiotic timing, blood culture before antibiotic, initial selection of antibiotic, pneumonia vaccination, smoking cessation counseling
    - Appropriate Care Measures, or "all-or-none" measures, for AMI, Heart Failure and Pneumonia. Using these measures could replace all of the individual AMI Measures 5 through 11.

Hopefully the above comments help the state and PPG Advisory Group revise its recommendations in a manner that will make the PPG initiative more reliable and statistically sound, and move it closer to a successful undertaking by the state. If you have any questions or concerns about any of the comments or would like to discuss them further, please feel free to contact me anytime at (651) 659-1421 or manderson@mnhospitals.org.

Sincerely,

Matthew L. Anderson, J.D.
Vice President, Regulatory & Strategic Affairs
Minnesota Hospital Association