This document contains questions and answers about the Minnesota Provider Peer Grouping initiative, and in particular the revised Hospital Total Care Report issued by MDH in April 2014. As MDH receives questions from hospitals and other stakeholders, we will update this document so that answers will be available to others.

General Questions

1. Will results from the analysis submitted to hospitals in April be publicly reported?

   Under current law (Minnesota Statutes §62.U04), the results of these reports may be shared publicly 120 days following the confidential report release. However, recent legislation introduced to the legislature in early March 2014 proposes to suspend PPG activities. If passed, this new legislation would result in no public reporting of these data subsequent to the confidential report.

2. Why is the Department undertaking this work?

   In 2008 Minnesota enacted a bipartisan health reform law to improve health care access and quality and to contain the rising cost of health care. This health reform initiative aims to help curtail unsustainable cost growth while simultaneously improving the quality of care and the health of all Minnesotans. The law created the Provider Peer Grouping (PPG) system to improve market transparency of health care quality and cost information and change incentives for health care providers and consumers to encourage higher quality of care and lower health care costs.

   Minnesota is the first state in the nation to develop a comprehensive system that provides information about health care value – both cost and quality. The current provider peer grouping report compares hospitals on risk-adjusted cost and quality to offer a clearer picture of the value of services offered by Minnesota hospitals.

3. How do these activities line up with national efforts?

   The goal of comparing providers based on value is in keeping with national efforts. Value-based purchasing, accountable care organizations, payment reform demonstration and pilot programs, the National Quality Strategy and health insurance exchanges are all efforts that strive to link payment more directly to quality. Value measurements include both quality and cost information. The

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1 Minnesota Statutes 62U.04
Department, in collaboration with its contractors, continues to monitor these activities to align efforts to the extent possible.

One distinguishing quality of the PPG initiative is that it draws on provider information across all payers. As such, it offers a standardized approach to value measurement and reporting in place of alternatives that might be limited to a specific payer’s “book of business” or market segments. This is particularly useful for activities focused on quality improvement that would rely on practice change for all patients, rather than patients who are members of a particular health plan.

4. How has the Department obtained input from the community on provider peer grouping?

Beginning in 2009, the Department convened multiple stakeholder groups as a part of its work on PPG. MDH has been committed to transparency throughout this process. MDH has conducted monthly public calls to update stakeholders on PPG, and in August 2012 the Commissioner appointed a PPG Advisory Committee composed of representatives from health systems/hospitals, physician clinics, health plans, state agencies, employers, academic researchers and organizations that work to improve health care quality in Minnesota.

Consistent with those early efforts, the Advisory Committee and Rapid Response Team met multiple times in 2013. The Advisory Committee and the Rapid Response Team, which was convened to address more technical issues, played an important role in identifying additional ways of strengthening the PPG methodology.

MDH has also worked closely with individual hospitals and healthcare systems throughout the state to validate previous reports, troubleshoot data problems and prepare for the confidential release of this report to hospitals.

All materials related to these two groups are available on MDH’s website: http://www.health.state.mn.us/healthreform/peer/index.html

5. What changes have been made in the 2014 reports from the version released in 2013?

MDH made a range of significant changes in the process of ongoing improvement efforts, refining its methodology and responding to concerns by providers, including:

- use of more timely data with additional payers;
- revision of the methodology used to derive the total quality performance score;
- inclusion of patient experience measures in the total quality composite for Prospective Payment System (PPS) facilities;
- revision of the methodology used for risk adjustment, including the treatment of outliers;
- revision of the method by which standardized pricing is developed;
- removal of add-on payments from the claims that are not directly attributable to the cost of care itself such as Indirect Medical education (IME) payments, Medicare Disproportionate Share Hospital (DSH) payments and Medicaid Disproportionate Population Adjustment (DPA) payments; and
- expanded exclusions of rare, usually high cost, specialized services that are offered only by few facilities in the state.
6. Why does the Department use different dates of service for the cost data for different payers?

The current confidential reports are based on federal fiscal year 2010 dates of service for Medicare beneficiaries and federal fiscal year 2011 for all other beneficiaries. This continues to be a necessary compromise in order to use Medicare fee for service data in the reports. MDH purchases Medicare data from CMS through its vendor but with a much longer claims lag than we experience with Medicaid and Commercial data. Current submissions to the All Payer Claims Database beginning in late 2014 will no longer have such a large disparity in the timeliness of Medicare claims. This is because MDH has made an alternative arrangement for the delivery of CMS Medicare data in the future.

7. Who sees this report and how can it be used?

The reports released to hospitals confidentially in April are only available to the specific facility that is the subject of the report. MDH anticipates that hospitals will work with the data to inform initiatives targeted at further quality and process improvement.

8. Why did some hospitals not get a report?

VA hospitals, US Public Health Services hospitals, community health centers, specialty hospitals, and children’s hospitals were excluded from the peer grouping process for several possible reasons. First, federal institutions are exempt from state jurisdiction. Second, specialty hospitals lack a sufficient number of quality metrics or a cost profile that would allow for meaningful comparisons of cost and quality. Third, some hospitals were excluded because they did not have enough patients to calculate a robust quality score.

Questions About What is Included/Excluded From the Data

9. Were out-of-state residents included in these data?

As required by law, the cost information in this report is based only on claims for Minnesota residents; out-of-state residents are NOT included. However, the quality measures from CMS, the Agency for Healthcare Research and Quality (AHRQ), and the Minnesota Hospital Association (MHA) infection measures reflect care provided to all patients served by each hospital, regardless of state of residence.

10. Are claim add-on payments included in the cost calculations?

The cost data used within the provider peer grouping reports come from Minnesota’s All Payer Claims Database. This database contains claims from over 70 health plans, third-party administrators, county-based purchasers and public agencies. From these organizations, MDH collects medical, pharmacy, and eligibility files containing a variety of elements such as diagnostics, procedural codes and pricing information. The pricing information includes charges, plan payments and a patient’s payment amounts.

If a payment is included within a claim it is included as part of the submission to the All Payer Claims Database. Payments that are generally paid outside of the claim stream are not captured within the All Payer Claims Database. Examples of payments or cost transactions not included in
the claims stream are Medical Education and Research Costs (MERC) grant payments made by
MDH directly to providers or intergovernmental transfers (IGT).

In the 2014 report, unlike previous iterations, MDH worked with its contractor Mathematica
Policy Research to develop a method to remove add-on payments from the claims that are not
directly attributable to the cost of care itself. These add-on payments typically compensate
providers for the cost of providing medical education or treating a higher proportion of
uninsured patients or patients on public assistance. Examples of these payments include IME
payments, DSH payments, and DPA payments.

11. Are costs associated with swing beds included in the cost calculations?

No. Inpatient hospital stays classified as SNF or swing bed stays are NOT included in the cost
analysis.

Questions About Quality Measures and Scores

12. If my hospital did not have enough eligible patients for some measures to be included in the
calculation, will this adversely affect my score?

No, this will not adversely affect your hospital’s score. If your hospital does not have data (or
enough cases) for a particular measure, that measure will not be included in the calculation.

13. Are the quality measures risk-adjusted?

The CMS process of care measures are not risk-adjusted because the measures are related to
whether or not a patient received appropriate treatment rather than whether a particular
outcome was achieved. The CMS mortality and readmission measures are outcome measures
that require risk adjustment to account for patient characteristics that influence the results; risk
adjustment was performed by CMS.

The AHRQ indicators are risk-adjusted with the exception of “Obstetric trauma- vaginal delivery
with instrument” (PSI 18) and “Obstetric trauma – vaginal delivery without instrument” (PSI 19).
These two measures are no longer risk-adjusted because there are not materially important risk
factors available in state inpatient discharge data.

In regards to the MHA infection measures, for the “Ventilator associated pneumonia bundle
compliance for ICU patients” and the “Central line bundle compliance for ICU patients,” these
measures are not risk-adjusted because the measures relate to whether or not a patient received
appropriate treatment rather than whether a particular outcome was achieved. However, the
“Hospital-acquired infection: surgical site infection rate for vaginal hysterectomy” does adjust for
patient risk.
Questions About Patient Experience

14. Why are there no indicators of statistical significance in the Patient Experience data?

The Patient Experience measures are reported consistently with how CMS reports the information through Hospital Compare. MDH is unable to calculate tests of statistical significance, because the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data we receive from Hospital Compare do not include the actual number of survey respondents for each hospital; only the range of respondents is indicated.

It is important to remember that for Critical Access Hospital’s, the current reported Patient Experience data are reported for informational purposes and do not affect your total care quality score. Patient experience was only included in the composite total quality score for PPS hospitals at the recommendation of the Peer Grouping Advisory Group.

Questions About Hospital Verification of Data

15. Can I have access to my hospital’s detailed data and calculations, so we can verify the information that is being reported?

In late April, MDH will email hospitals a detailed set of their summary cost data. This data will assist the hospitals in their review of the quality and cost information in their reports and help them gain an understanding of the underlying data.

Unfortunately, due to data classification under state and federal law, MDH is not able to provide individual claims-level data to hospitals.

16. Why didn’t the state use MS-DRGs rather than APR-DRG groupers? Some hospitals don’t use APR-DRG groupers, so cannot use the data provided by MDH for verification.

Currently, the All Payer Claims Database does not include “present on admission” data fields that are needed to appropriately calculate MS-DRGs.