



MN Peer Grouping Hospital Total Care Report Frequently-Asked Questions (and Answers)

General Questions

1. 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)¹ 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 provider peer grouping system compares hospitals, and in the future will compare physician clinics, based on a combined measure of risk-adjusted cost and quality to offer a clearer picture of the value of services offered by Minnesota providers.

2. 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 Department, in collaboration with its contractors, continues to monitor these activities to align efforts to the extent possible.

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

The Department convened multiple stakeholder groups as a part of its work on provider peer grouping. In 2009 an advisory group met to develop a framework and recommendations for implementing provider peer grouping. This group was composed of members appointed by a broad cross-section of stakeholder organizations. The group issued its final recommendations on the provider peer grouping methodology in October 2009. The Department also convened a technical panel in 2009 which supported the work of the advisory group. In April 2010 the Department created a Rapid Response Team of stakeholder representatives. This group provided input on more detailed methodological issues. Additionally, the Department convened

¹ Minnesota Statutes 62U.04

a Reliability Work Group of stakeholders to help the Department ensure the reliability and usefulness of peer grouping results. This group first met in December 2010. The Department also conducted one-on-one interviews with hospitals regarding the hospital report design in the spring of 2011. Finally, the Department holds monthly conference calls to update stakeholders on peer grouping activities on the second Monday of each month.

Additional details about the activities mentioned above can be found on the Department's website.

- *Advisory Group:*
<http://www.health.state.mn.us/healthreform/peer/advisory.html>
- *Technical Panel*
<http://www.health.state.mn.us/healthreform/peer/technical.html>
- *Rapid Response Team:*
<http://www.health.state.mn.us/healthreform/peer/rrt/index.html>
- *Reliability Work Group:*
<http://www.health.state.mn.us/healthreform/peer/reliability/index.html>
- *Monthly Conference Calls:*
<http://www.health.state.mn.us/healthreform/peer/index.html>

4. Why did the Department use data from 2008 and 2009 instead of newer data?

The data used for the cost portion of the provider peer grouping reports comes from Centers for Medicare and Medicaid Services (CMS) and Minnesota's all-payer claims database (APCD). At the time the peer grouping analysis began, the most recent complete data set available for fee-for-service Medicare was for calendar year 2008. Within the APCD, adjudicated claims data is submitted by health plans, third-party administrators, county-based purchasers, and the Minnesota Department of Human Services at least once per six months. Additionally, to ensure that claims contained within an analytical data set are final, provider peer grouping requires an additional three to six months run-out period from the date of service.

To produce a viable analytic data set, at least 15 months of data – a 12month observation window with a three-month run-out period – must be submitted by a critical mass of payers. Data collection efforts for Minnesota's APCD began in July 2008, with several critical payers taking more than a year to successfully submit their initial data. This initial delay in data submission resulted in a longer than expected lag between the data period used for peer grouping and the release of the peer grouping reports.

The Department recognizes that it would be useful to provide hospitals with more current data and believes it will be able to improve the timeliness of the data going forward. In future iterations the Department will continue to use the most current data possible, while allowing for appropriate run out periods.

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

The Minnesota Department of Health (MDH) plans to make additional data available to a hospital by request. These data will provide additional information about the patients and care included in the report for that hospital. Due to data classification under state and federal law, MDH cannot provide individual claims- level data. MDH and its contractor, Mathematica Policy Research (Mathematica), have yet to finalize the delivery method format, or the specific data elements to be shared as additional information with hospitals. To some extent, the information

made available will be customized to hospitals' specific request. In general, it is our intent to provide additional detail on patient demographics, discharge volumes, diagnostic summaries and procedural counts to help hospitals better understand the data used in their reports and compare them with their own data records.

6. What information will be publicly reported? How will it be presented?

MDH has not yet finalized its plans on the composition or form of public reporting. However, public reporting will not contain data elements beyond what was reported in hospitals' individual reports. In addition, data will be published at a higher level of reliability than what was reported to hospitals confidentially. (Hospitals received their cost breakdown by services categories to satisfy a moderate reliability threshold, 0.4; publicly reported data will need to satisfy a more rigorous standard, 0.8.)

Also, MDH will provide hospitals an embargoed version of public reporting prior to its final release.

7. How will the Provider Peer Grouping results be used?

The statute which directs the Department to conduct this work specifies that within 12 months of publicly reporting Total Care results for both hospitals and physician clinics, the State Employee Group Insurance Program, local units of government, and health plans in Minnesota will be required to use provider peer grouping information to create incentives for enrollees to use higher quality, lower cost providers. The Minnesota Department of Human Services is also required to use peer grouping results as part of a differential payment system for providers.

MDH anticipates that providers will also be users of this the information to further their own efforts at improving the quality of care and reducing associated health care costs. Consumers will be able to use the information to make more informed health care choices as well.

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

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.

9. Why did some hospitals not get a report?

VA hospitals and US Public Health Services hospitals, community health centers, specialty hospitals, and children's hospitals were excluded from the peer grouping process. Some other hospitals were excluded either because they did not have enough data to calculate a quality score, or because they did not have enough discharges to calculate costs with sufficient reliability for any of three types of payer (Medicare, Medicaid, or Commercial). In addition, one PPS hospital was excluded because it opened in December 2009 and did not yet have any medical claims to submit for the analysis.

Questions About Total Care Quality

10. Isn't it unfair to give a hospital a low score on a Process of Care measure, even when its actual performance rate was very high?

For several of the Process of Care measures, peer group performance is routinely high and the difference between "achievement thresholds" (30th percentile) and "performance benchmarks" (75th percentile) is very small. In its initial report to hospitals, MDH included these "topped-out" measures to recognize that many hospitals perform very well on them and that excluding these measures would mean that some hospitals would not have a sufficient number of measures to qualify for a Total Quality score.

*Since the non-public release of initial result to hospitals, MDH has received much feedback on how these measures are scored. **MDH and Mathematica are currently exploring alternative ways to assess these measures for the current reporting period.***

11. 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 a 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. Each category score is calculated by dividing the total points earned by the total points possible, counting **ONLY** those measures for which a hospital has data.*

12. Why is the actual number of complications not shown in the Inpatient Complications table? How can I get this information for my hospital?

Exhibit 1.4 does not show number of complications for each measure, because these numbers are not used directly to calculate the risk-adjusted performance rate. (For similar reasons, the actual number of deaths are not shown in the Mortality Exhibit 1.5). The 2010 Statewide Quality Report does provide information on the number of complications for measures (where the denominator is 25 or greater) for each hospital. The relevant report for each region can be accessed online at <http://www.health.state.mn.us/healthreform/measurement/report/>, and the hospital measures appendix contains detailed information on these measures for each hospital in the region.

13. In the Inpatient Complications table, the dates of service for "Hospital-acquired infection: surgical site infection rate for vaginal hysterectomy" are shown as October, 2008 – September, 2009. Is this accurate?

*No – this was an error. **The correct dates of service for this measure are July, 2009 to June, 2010.** MDH will ensure that the correct time period is noted for this measure when these data are publicly reported.*

14. 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. However, the CMS mortality and readmission measures are outcome measures which require risk adjustment to account for patient characteristics that influence the results.

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.

15. Does this report replace the 2010 Minnesota Health Care Quality report?

The Hospital Total Care Report does not replace the Minnesota Health Care Quality Report. The Health Care Quality Report has additional quality measures that are not included in the Hospital Total Care Report. Also, the Hospital Total Care Report creates quality score composites not included in the Minnesota Health Care Quality Report. The Department will continue to report quality measures collected under the Statewide Quality Reporting and Measurement System (Minnesota Administrative Rules, Chapter 4654) on their own, as well as continue to include a subset of these measures in the provider peer grouping system. As noted previously, this report can be accessed online at: <http://www.health.state.mn.us/healthreform/measurement/report/>.

Questions About Total Care Costs

16. Why are the number of discharges shown for different payer and service types so much lower than our own records would indicate?

There are several factors that may account for lower numbers of discharges in the Total Care reports. The cost data in the reports exclude discharges that (1) were out-of-state discharges, (2) resulted in less than \$300 per day in payment, (3) were not assigned any diagnostic codes, and (4) had inaccurate lengths of stay (less than 0 or more than 730 days). The majority of excluded discharges (60 percent) and costs (90 percent) were out-of-state discharges.

Additionally, for many hospitals, the discrepancies in payer type appear to derive from the way Medicare and Medicaid managed care stays have been classified during the initial analysis. MDH and Mathematica are currently investigating this issue and will revise the data analysis for this reporting period accordingly. Finally, for some hospitals the data set used for the initial analysis appeared to lack some claims. MDH and Mathematica are in the process of replicating the analysis with an improved data set that is more current and represents a more complete accounting of Minnesota hospital claims.

17. 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 64 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 patient's payment amounts.

If a charge or payment is included within a claim it is included within the all-payer claims data; however, 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). Examples of payments that are included in the claims stream include Indirect Medical Education (IME) payments, Medicare Disproportionate Share Hospital (DSH) payments, and Medicaid Disproportionate Population Adjustment (DPA) payments.

18. 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.

19. How does the risk-adjustment model account for the socioeconomic characteristics of hospital patients?

Payer type (Medicare, Medicaid, and Commercial), and dual-eligibility (Medicare and Medicaid) status serve as proxies for socioeconomic characteristics in the risk-adjustment model.

20. Does the risk-adjustment model account for a hospital's teaching status, trauma care, burn care, safety-net status, or other characteristics that may increase the cost of care?

*No. These hospital characteristics are NOT included in the model. **However, in response to feedback from hospitals, MDH and Mathematica are currently evaluating methods for assessing a subset of hospital characteristics differently from the initial approach.***

21. What are the actual thresholds that define the "high-cost outliers" truncated from the data analysis?

*We selected the 99th percentile to truncate costs, with two exceptions: raw costs in PPS hospitals paid by Medicaid and commercial payers, respectively are truncated at the 99.5th percentile. The dollar amounts associated with these thresholds are shown in the table below. **It is important to note that the truncation thresholds will likely change as a result of MDH and Mathematica considering alternative approaches to accounting for certain hospital characteristics.***

Cost Type	Hospital Type	Payer Type	Truncation Threshold
Raw	CAH	Medicare	\$27,048.00
Raw	CAH	Medicaid	\$15,428.72
Raw	CAH	Commercial	\$38,128.72
Raw	PPS	Medicare	\$49,008.12
Raw	PPS	Medicaid	\$65,130.91
Raw	PPS	Commercial	\$105,177.19
Standardized	CAH	Medicare	\$25,232.20
Standardized	CAH	Medicaid	\$14,501.77

Standardized	CAH	Commercial	\$32,817.28
Standardized	PPS	Medicare	\$49,385.32
Standardized	PPS	Medicaid	\$49,849.49
Standardized	PPS	Commercial	\$60,207.54

22. How is risk adjustment performed and what clinical factors were used.

All cost statistics are risk adjusted to account for factors that have an independent effect on hospital costs, including patients’ clinical history and severity of illness. To adjust for clinical risk factors, the model used the Johns Hopkins Adjusted Clinical Groups (ACG) system, version 9.0, which can produce up to 32 Adjusted Diagnosis Groups (ADGs) for each discharge, based on major diagnostic category, patient’s prognosis, and likely resource use, assigned based on diagnoses from claims for the index stay. Additional adjustments were made to account for transfer patients, psychiatric stays, and rehabilitative or administratively necessary stays. In addition, a patient’s primary source of health insurance was used in this report as a proxy for sociodemographic characteristics. A patient’s status as a “dual eligible” (one who qualifies both for Medicare Part A and/or Part B and for state Medicaid benefits) was also included as a variable in the risk adjustment model for Medicare and Medicaid payers. Risk-adjusted costs were calculated as the mean cost times the sum of observed over expected costs, where the expected cost is the cost projected from the regression model. When values are reported for each individual MDC category - medical, surgical, and newborn—as well as for individual MDCs these values were calculated separately for discharges in—those categories. Payer-mix adjustment was performed similarly, as the ratio of observed to expected costs, summed across payer types, multiplied by the overall mean.

While the current risk adjustment method does not take into consideration hospital characteristics, MDH and Mathematica in replicating this analysis are exploring alternative methodological approaches to account for a subset of hospital characteristics that may disproportionately lead to high-cost outlier cases, such as burns, transplants, and neonatal care cases.

23. What DRGs are included in the medical and surgical service categories?

The cost summaries by service type shown in Exhibit II.1 are based on major diagnostic categories (MDCs), rather than specific DRGs. The MDCs for each hospital are further broken out in Exhibit II.2. A detailed crosswalk of the All-Patient Refined Diagnostic Groups (APR-DRG) – the classification system used by MDH and Mathematica – can be found online: http://www.hcup-us.ahrq.gov/db/nation/nis/v261_aprdrq_meth_ovrview.pdf

24. Could you elaborate on the how the number and type of discharges (medical and surgical) were derived from the all payer claims database?

The major diagnostic and service categories were calculated using APR-DRGs grouper software, which determines diagnostic categories and service type based on diagnoses, patient age and sex, and other factors. A detailed methodology overview of this classification system is available online: http://www.hcup-us.ahrq.gov/db/nation/nis/v261_aprdrq_meth_ovrview.pdf

Questions About Patient Experience

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

The Patient Experience measures are reported as they are reported by CMS on Hospital Compare. We are 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 member survey respondents for each hospital; only the range is indicated.

Please bear in mind that these data are reported for informational purposes and do not affect your Total Care Quality score.

26. Will the HCAHPS data be publicly reported by MDH?

The Department intends to publicly report the HCAHPS data, though the structure and content of public reporting have not yet been finalized.