Date: September 22, 2010  
To: Provider Peer Grouping Rapid Response Team members  
From: Katie Burns, Health Economics Program  
Subject: Third issue for your consideration

Thank you for participating in the Rapid Response Team. In preparation for our third meeting, I wanted to distribute the attached memo from Mathematica Policy Research, Inc. It describes the next issue for which we would like your input:

1) Should all hospitals be included in one peer group or should separate peer groups be created for certain types of hospitals?

We will review the memo at our meeting this afternoon to ensure you have an opportunity to clarify your understanding of the issues and to ask questions.

Response deadline: We will need your feedback on these issues by Tuesday, September 28 at 4:00 pm. Responses may be provided via email to Katie.burns@state.mn.us
MN Hospital Association: Mark Sonneborn

On the call on Wednesday, we discussed several issues related to the recommendations that Mathematica put forward regarding hospital peer grouping.

MHA agrees with the basic recommendation that there should be one group for PPS hospitals and one group for Critical Access Hospitals (CAHs) when looking at total cost of care and for pneumonia. For total knee replacement there would be one hospital peer group.

During the call, it was mentioned that the highly-specialized hospitals, such as pediatric hospitals and others such as Phillips Eye Institute and Bethesda Hospital, would be difficult to put in a peer group. It was stated that the intention would be to exclude those types of institutions from any peer group, which we support.

We also talked about a couple of confounding issues.

- Teaching status: hospitals that train residents generally have a higher cost structure. Medicare recognizes this and adds reimbursement for both direct and indirect medical education. How will you adjust for this?

- There are several types of services that typically are not well-reimbursed but are offered so that those who need the service can get it, like a burn center, behavioral health, and nursing homes/long-term care, the latter of which is of particular concern to CAHs. A hospital generally raises the amount it charges for other services in order to cross-subsidize the burn center and the like. We are concerned that failure to account for these types of situations could create incentives for hospitals to discontinue their cross-subsidized services which decreases – if not eliminates – access to these types of services.
  
  o Simply excluding the burn center (and other types of services) does not adequately adjust the data. The costs of those services are built into the charge structure. So, if something would cost $1,000 if a hospital didn’t have a burn center, it might cost $1,100 because they do.
  
  o There can be wide differences in the cost structures of CAHs based on whether they have attached nursing homes. In our benchmarking projects, the CAHs with attached nursing homes generally want to benchmark against other CAHs with nursing homes. Again, the hospital may consider shutting down the nursing home if it makes their costs look out of line (there are other reasons the hospital may want to shut the nursing home down, but that is another topic entirely).
    ▪ There’s also the issue of swing beds. CAHs that can transfer patients into long-term care beds may have an advantage from a cost per case standpoint.

We will be very interested in how you plan to risk-adjust the data.
1) [Additional Hospital] Response to Hospital Peer Groups for Total Care and Condition Specific
(MDH Rapid Response Team Memo Dated 9/22/2010)

[Additional hospital] agrees with the recommendation to peer group CAHs separately from non-CAH for total care and pneumonia. Inclusion of CAH and non-CAH in one peer group for total knee also seems reasonable since the focus is primarily on the orthopedist and the variations in where orthopedists perform the surgery.

[Additional hospital] agrees with excluding specialty hospitals such as Philips Eye, Gillette, long term care hospitals, and other specialty hospitals where there is essentially little competition. While Children’s Hospitals & Clinics has historically served a specific and unique population, other hospitals (mainly Fairview’s Amplatz Children's Hospital) can now serve the same population, similar level of severity, and many of the same services. With the new creation of Amplatz in the market, it seems a comparison of pediatric hospital services would be extremely useful information for the community.

If risk adjustment can adequately account for differences in severity of cases, one suggestion is to isolate the pediatric costs for those hospitals that offer a full range of pediatric services and peer group them with Children's and Amplatz. However, it may make sense to delay peer grouping pediatric services until there is enough data collected for Amplatz.

As the RRT discussed, excluding services for specific services does not necessarily adequately adjust total costs for those hospitals that offer community needed/low reimbursement services such as burn units and adolescent behavioral health. Again, if risk adjustment can adequately account for the severity of these services, then hospitals offering these unique services are better served including them in their total care calculation. A final decision to exclude any services and associated costs can’t be made until we have the opportunity to review the risk adjustment methodology and any outlier methodology that will be applied in the analysis.

[Additional hospital] feels hospitals may want to see greater refinement in their comparison peer group. While the comparison calculations could still be performed across all non-CAH hospitals, MDH may want to offer more specific views and filters of the results to group only hospitals with similar bed counts, teaching status, metro/rural, etc.

Finally, [Additional Hospital] strongly support Physician peer grouping to occur at the clinic level. If the intent of PPG is to provide information that will drive improvement and change, reporting at the clinic level provides the most actionable level of information and best supports providers’ abilities to identify and implement meaningful improvements.
Thank you for the opportunity to provide feedback on the recommendations for peer groups for total care and condition specific care. As it relates to hospital peer groups, we agree with the Mathematica recommendation to peer group Critical Access Hospitals (CAH) as one group and all other hospitals as another group. That said, simply splitting the two cohort groups is not sufficient to ensure proper case mix adjusting among the non-CAH hospitals. We recommend the case mix adjustment method be further enhanced by eliminating certain tertiary or quaternary services only offered by a select few hospitals to service the entire state and surrounding states. Those exclusions include:

- Trauma claims
- Burn claims
- Transplant claims (or peer group in a category of their own)

Other considerations:
- A study of the data to identify exclusions of other low volume/high cost cases that may disproportionately skew results is advised.
- A reliable technical solution to combine claims with coordination of benefits (COB) will be needed for accurate comparisons. If a reliable technical solution is not feasible, consider excluding these claims so as to not artificially lower the total care expense.
- Exclude outliers (e.g. 3 standard deviations from the mean based on length of stay by DRG)
- Hospitals with low claims volumes should be excluded. Accurate mean estimates cannot be derived from small volumes of claims. An analysis including these hospitals runs the risk of being very volatile, as each subsequent high- or low-dollar claim could greatly impact the averages of low volume hospitals and their ranking within their peer group.

As for the contemplation in the memo of applying similar rules to physician clinics/medical groups we recommend the following consideration:

- In follow-up to the attribution methodology issue and the cohort question at hand, defining primary care in a manner that is comparable among groups is essential. For example, defining primary care at the group level will have implications for the Minnesota market as there is a mix of multispecialty and primary care only groups. A more refined methodology to define primary care within multispecialty groups will need further attention.
Instead of trying to summarize, I thought I would just forward Julie’s comments, which she ran by both me and Jeff Schiff. Thanks for letting us participate.

I participated in the call today, and any concerns I have are certainly shared. The concerns are around whether the risk adjustment will truly account for valid differences in case and service mix between hospitals. Many of the additional questions such as whether a critical access hospital (or a rural hospital) shifts costs to the inpatient side to account for losses if they also have a long term care facility. The same issue may also be raised with respect to larger trauma centers, burn centers, or transplant centers that may shift costs to account for losses on their specialty care. Same for teaching hospitals that receive higher reimbursement. Based on the call today, it appears that those types of concerns will be addressed more thoroughly when they have the discussion about how costs are allocated. We should probably note that if these concerns cannot be adequately addressed through cost allocation, then how they are peer grouped may need to be revisited. At this point, we will have to assume they will be able to manage it.

I would agree with their recommendation that hospitals be separated into primarily two peer groups – critical access and the rest of the hospitals. I would also support leaving out the children’s hospitals and the “highly specialized” (e.g. the Phillips Eye Institute or Bethesda Hospital) as their services and resource costs would be based on such a different population. They are not sure when or how these hospitals may be included in the future, but know they won’t be included in the first phase.

There was discussion about how these same factors will also need to be considered for how to group the physicians. That issue was not definitively decided on this call, of course, but they will take whatever is decided about hospital peer grouping and try to follow the same principles. They will come back to the group if there are further issues with defining the physician peer groups. They clarified that the hospital peer group costs will only include inpatient costs and the outpatient hospital costs will be attributed to the physician.

Overall, I don’t see why we wouldn’t support Mathematica’s recommendation, since the larger peer groups allow them to develop more precise benchmarks, which makes the comparisons more valuable to the consumer. Although the face validity argument is valid, it doesn’t necessarily mean that the risk adjustment is not adequately controlling for differences in service mixes. In addition, many of the concerns may also be alleviated through the cost attribution process.
MN Medical Association: Janet Silversmith

No response received.

MN Business Partnership: Beth McMullen

No response received.

AARP: Michelle Kimball

No response received.