Initial Comments from EWG Members Regarding PPC and PPR Methodology

Staff received preliminary comments from St. Mary's (Gelrud), JHMI (Reuland), MHA (Coyle), LifeBridge (Epke) and Ft. Washington (Hancock). Below is a compilation and summary of the comments and some preliminary staff responses.

1. Financial incentives already exist in the CPC and CPV structure to minimize complications. (Gelrud, Hancock, Coyle)

   Staff clarification: There are unintended financial incentives in the rate system currently (both the CPC and CPV constrain systems) that provide higher payments to hospitals with higher complication rates. This is true with our without the imposition of a cap or governor on Case Mix growth.

   The existence of a Case Mix cap or governor does not in any way change the existing incentives. The presence of a Case Mix cap does however reallocate the limited Case Mix funds away from hospitals with low complication rates to hospitals with high complications rates.

2. The 3M PPC methodologies are proprietary and not transparent, and, with exception of PPC 45 (post procedure foreign bodies) which is already on the MHA serious adverse event list, they require more definitive criteria and conditions. (Gelrud, Coyle, Epke)

   Staff discussion: The APR-DRG system is proprietary but the HSCRC working with 3M has provided the necessary documentation and software to enable hospitals to monitor their performance under the DRG constraints. The same will be true for the CPV methodology which utilizes Ambulatory Patient Groups (APGs). We have not encountered significant problems with either of these significant applications of a "proprietary product."

   3M has assured staff it will continue to provide the necessary level of transparency to enable hospitals to monitor their performance on PPCs and PPRs just as has been accomplished with the larger-scale payment related applications.

3. Potentially preventable does not necessarily reflect an error made by the hospital. (Gelrud, Coyle)

   Staff discussion: This point requires greater clarification. However, staff believes this is one of the reasons why the focus for most of the PPCs should be on "rates of complication" by hospital relative to an expected level. And that payment policy should be designed to focus only on "outlier hospitals" - providing rewards and incentives for the best performing hospitals (precisely analogous to our QBR Process Measure project).

4. PPC's can help point out areas that require further analysis so use it to evaluate performance instead of adjusting payment; in contrast to QBR Initiative thus far which uses payment as an incentive and not a penalty.

*MHA quote: "From a policy perspective, it is critical to separate when payment penalties should be used to hold hospitals accountable for their performance, and when payment rewards or focused education should be used to improve performance."…"Using penalties to assign blame when fault or responsibility is unclear will lead to a culture in which care challenges are hidden and not improved."(*Gelrud, Coyle)

Staff discussion: This focus of this approach is not "punitive" in nature. It is directed at rationalizing existing "unintended" incentives in the payment system – that result in overpayment for hospitals for less than optimal outcome performance (higher complication rates and re-admission rates) and under-compensates hospitals who have the best performance on complication rates and re-admission rates).

Education and reporting is an important way of changing behavior but payment has a stronger influence on behavior.

It appears that PPCs and PPRs can be used both as an education tool and a behavioral change tool through the use of the appropriate financial incentives.

Also staff would note this same argument has been raised with regard to nearly all initiatives that sought to place the hospital "at-risk" for activities that were partially or largely under their control: placing hospitals at risk for ALOS and utilization per case under DRG constraints, placing outpatient departments at-risk for per visit utilization under APG constraints, placing the medical team at risk under the QBR reimbursement methodology.

5. Reliability of the POA data and coding accuracy drive the reliability of PPCs. No feedback or process for feedback on POA has been described by HSCRC. Focusing on PPCs may equate to an increased focus on documentation, instead of care. (Gelrud, Coyle)

   Staff discussion: Staff would expect some data issues initially until data are used for payment purposes. However, preliminary evaluation of Maryland POA coding based on the first nine months of data was quite favorable (when compared to the coding of California hospitals - POA has been required by the state for the past 15 years). Staff has developed and will shortly discuss with the industry a process for verifying and improving the consistency of POA coding. This will include: 1) a list of necessary error and edit checks for use by HSCRC data vendor; 2) for the 5 hospitals whose POA data appeared to have errors, meetings within the next 2 weeks to discuss the specific problems with their data; 3) a regular POA data quality feedback report to hospitals beginning with the first quarter FY 09 data for which the initial submission is due 11/15 so that hospitals that still have problems can have a chance to correct them prior to the close of the data in December; 4) regular meetings with hospital case mix contacts on the progress and status of the POA data element; 5) follow-up action such as audits as needed; 6) hospitals are always subject to fines for delinquent and largely inaccurate reporting.

6. Sicker patients have more complications and poorer patients are sicker and often more challenged to comply with health care plans. Therefore, there may be a disproportionate impact on hospitals serving the underserved. (Gelrud)

   Staff clarification: Sicker patients are at risk for higher complication rates – this is precisely why outcomes measurement requires risk adjustment. The HSCRC has utilized APR-DRGs as a highly sophisticated risk-adjustment system for hospital payment purposes. This same methodology can be used to only compare groupings of patients based on comparable levels of illness severity. This risk adjustment method is further augmented by the focus on rates of preventable complications and rates of preventable re-admissions. When a hospital is experiencing a significantly higher rate of complication or re-admission there is need for this aberrant result to be addressed.

Certain categories of patients may indeed be more difficult to treat and at-risk for higher levels of complications. The HSCRC has considerable experience in attempting to account for these types of circumstances in the context of payment and make appropriate adjustments. The staff can perform analysis to determine if the PPC and PPR methodology need to be further stratified to account for other external effects.

7. The metrics and risk- adjustment methods have not been validated with reasonable research. To use PPCs/PPRs effectively and equitably in Maryland, audit and validation parameters would need to be defined and tested just as we have a validation program for indicators submitted to MHCC. (Gelrud, Reuland, Coyle, Epke)

   Staff discussion: Again, APR-DRGs have been used as a risk-adjustment system for purposes of reimbursement for seven years in Maryland. The concepts related to adjusting payment for variations in resource requirements based on severity of illness is directly applicable to the quality-based applications we are discussion now. The same administrative data used to adjust payment for severity categories are validated quarterly and will now be used to adjust payment for the QBR Initiative. HSCRC has a contract in place for chart audits to ensure coding in the administrative data set is concordant with the medical record.

8. PPCs and PPRs will require a second level of validation to determine whether either are truly preventable; chart review is laborious, but necessary for a process that identifies potentially vs. conclusively preventable events. Related to #7, the proposed plan has no additional criteria to ensure that the PPCs are a result of patient care errors. (Gelrud, Reuland, Coyle, Epke, Hancock)

   Staff discussion: Staff's interpretation of the general PPC approach is that it focuses not on whether something is preventable but rather on the **level** of preventability. The data clearly show varying rates of PPCs across hospitals, indicating there is some level of preventability hospitals can achieve (otherwise hospitals would have similar levels of PPCs after risk adjustment). Thus, the use of rates of PPCs relative to an expected level of PPCs will allow the Commission to construct a financial incentive structure that links relative preventability to the magnitude of payment reduction (and corresponding payment increases for the best performers). This approach should be significant enough to motivate hospitals to reduce complication rates, while at the same time doing so in a way that does not penalize hospitals for events over which they have limited control.

The chart audit activity currently conducted by IPRO and which we will also undertake in Maryland shortly will address this validation point.

9. When considering readmissions, many factors come into play: insurance coverage and SES status that affects patient ability to afford medications and aftercare, patient compliance, other supports such as family and transportation, timely access to care, and availability of services. (Epke)

   Staff discussion: Further analysis can be performed that can determine if factors like Socio Economic Status has a measurable impact on the potential preventability of complications and re-admissions. The calculation of PPRs by payer source also may be an important output of this analysis and may be used for purposes of modifying payment levels.

10. The inclusion of PPRs is opposed due to our small hospital size. For instance, there is a homeless patient who frequents the hospital with readmissions for congestive heart failure. Readmissions for individuals who refuse follow-up care can alter readmission rates not under the hospital's control. (Hancock)

    Staff discussion: Hospitals with small volumes will not be disadvantaged by the readmission rate calculation as the small volumes will not be sufficient to constitute statistically significant differences in readmission rates compared with larger volume hospitals.

Maryland Hospital Acquired Complications (MHAC)

1. CMS has identified 8 HACs for payment policy changes, MHA Policy lists 7 events. In contrast, the HSCRC 14 PPCs are not vetted by CMS or nationally for non-payment. Consider using the AHRQ/NQF endorsed and/or mandatory measures, such as the newly required reporting to National Healthcare Safety Network Central Line Associated Blood Stream Infections (CLABSIs) measure and the upcoming Active Surveillance Testing for Methicillin Resistant Staph Aureus screening measure. We need to improve on processes that are already required/endorsed before advancing to more complicated non-endorsed measures. (Hancock)

   Staff discussion:
   Regarding the blood stream infection measure, a GAO report that recently came out stated that hospitals may have an incentive to underreport their healthcare-associated

infections and states lack the ability to find out if the number of infections hospitals report is accurate, according to Health-Care-Associated Infections in Hospitals: The CDC's National Healthcare Safety Network system relies on self-reported data, which the GAO concludes, may be giving hospitals "an incentive to minimize the number of HAI cases they identify and report." Maryland's administrative approach to deriving this measure is not fraught with this concern.

MRSA surveillance testing in the ICU has not been nationally vetted.

2. Specific examples to "illustrate the confusing nature of conclusively determining accountability for a PPPC" include:

PPC 49- Iatrogenic Pneumothorax- Patient may have a lung condition such that lung tissue is already unhealthy, and a biopsy procedure or other comfort measure such as a pleural tap may cause a pneumothorax.

PPC 42- Accidental puncture/laceration during an invasive procedure- Pt conditions such as frailty and existing adhesions,polyps, Crohn's Disease, may risks significantly for perforation during colonoscopy.

Staff discussion: We will discuss each of the 14 PPCs proposed as MHACs for changes to the HSCRC APR-DRG payment policy.