Commonwealth of Massachusetts
Health Care Quality and Cost Council
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Chair

KATHARINE LONDON
Executive Director

Health Care Quality and Cost Council

Meeting Minutes

Wednesday, May 21, 2008
1:00-4:00pm
One Ashburton Place, 21st Floor
Boston, MA

Council Members Present: JudyAnn Bigby (Chair), Charlie Baker, Kevin Beagan, Elizabeth Capstick, James Conway, David Friedman, Kenneth LaBresh, Joseph Lawler, Thomas Lee, Shannon Linde, Katharine London, Dolores Mitchell, Gregory Sullivan and Anya Rader Wallack

Meeting called to order at 1:10 PM

Secretary Bigby recognized former Council members Christopher DeLorey and Robert Seifert for their service on the Health Care Quality and Cost Council. Secretary Bigby presented a plaque to each of them for their work and contributions to the Council.

HCQCC Executive Director, Katharine London, introduced Geraldine Lantieri, the Council's new Executive Assistant and Young Joo, the Council's summer intern. Katharine also announced plans to hire a Policy Analyst and part-time Legal Counsel. The two positions are currently posted on the mass.gov Human Resources Division site.

I: Approval of Minutes of Council Meeting April 16, 2008

The Council approved the Minutes of its April 16, 2008 meeting.

II. Executive Director's Report

Budget

Katharine London reviewed the Council's FY09 budget. The Governor's budget and the House budget included $1.89m for the Council. The Senate Ways & Means budget included $1.43m for the Council, and another $1.5m cost & quality fund to be shared among 10 agencies, including the Council. Senator Moore filed an amendment to increase the Council's budget to $1.89 million. Additionally, Katharine stated the Senate is considering giving the Council a retained revenue account which will allow the Council, if it chooses to sell data, to retain sale revenues up to a ceiling of $100,000. Katharine noted that the State of Maine sold $85,000 in health care claims data in 2007.

Dolores Mitchell advised the Council to review the "retained revenue" language, and consult with her staff member, Bob Johnson, to ensure the Council can spend the retained revenue. Ms. Mitchell indicated that in some cases agencies are not permitted to spend accumulated retained revenue funds.

Annual Report
The Annual Report was published at the end of April; printed copies were sent to Council and Advisory Committee members, legislators and selected individuals. An email blast was sent to over 800 health care leaders and interested parties announcing the availability of the Annual Report. The Annual Report is available on the Council's website; for the period 4/19 - 4/30 there were 550 downloads of the report from the site.

Website Work Plan
Katharine London reported that website development is essentially on track and meeting current deadlines.

Advisory Committee Update
Katharine London reviewed some of the concerns expressed by Advisory Committee members during the May 5th Advisory Committee meeting. Members of the Council and the Advisory Committee discussed the Advisory Committee's roles and responsibilities, the Advisory Committee's communications with the Council and the structure of future Advisory Committee meetings.

III. Items for Discussion

A. Update on Claims Data Submissions and Compliance

Suanne Singer, Maine Health Information Center

- Suanne Singer from Maine Health Information Center gave an update on the data submission process and compliance.

  - Ms. Singer indicated that Nationwide and United Health Student Resources are the only two payers still not approved. At the April 16th Council Meeting, the Council voted to fine Nationwide and Unicare for non-compliance with submission deadlines. Unicare has since submitted data and has been removed from the non-compliance list. Nationwide will continue to face a fine of $1,000 per week for non-compliance. The MHIC sent United Health Student Resources its first compliance letter on May 14, 2008.

  - Midwest and MEGA are approved and partially submitted. Aetna Student Health was approved in mid April; however, Aetna indicated their live data will not be submitted until July 1, 2008 due to an Aetna internal resource issue.

  - Ms. Singer indicated except for the mentioned "stragglers", the database is essentially complete. On the pharmacy side, only Nationwide is missing. 2008 data is complete.

B. Progress report on initial set of website pages and measures for the Council's health care quality and cost information website
John Freedman, M.D. - Clinical Consultant

- John Freedman reported on the initial set of website pages and measures for the Council's health care quality and cost information website. John reviewed specific issues and recommendations related to the following:
  - Health care claims data set
  - Council principles for displaying quality and cost data
  - Selection of the quality and cost data for display
  - Data, analysis and reporting
  - Website design and supporting text

- Dr. Freedman discussed the use of the 3M severity-adjustment methodology for reporting data on the Council's website. The goal of the 3M methodology is to adjust each hospital's median to reflect statewide severity levels, so an individual hospital's average prices do not appear high due to high severity patients or low due to low severity patients. Dr. Freedman reviewed examples on why this method is useful and why it will work for the Council's website. Consumers generally do not know in advance whether their severity of illness will be minor, moderate, major or extreme. The severity adjustment allows consumers to see the expected cost for a service at a given hospital for a patient with average severity of illness for the state.

- Dr. Freedman reviewed the use of reporting volume for specific conditions and procedures. He stated that volume is an important indicator in determining a hospital's experience with particular conditions and procedures. He concurred with some members of the Council that volume should not be used in every condition and procedure, but, that it is useful to indicate experience and expertise.

- The Council discussed decision making points with respect to the website timeline. Inspector General Greg Sullivan requested that the Council setup a review period to allow Council members time to scrutinize the data and website content before it goes live. Mr. Sullivan suggested that two weeks be built into the website time table for the Council to review and verify the points and issues reviewed by John Freedman in his presentation. Mr. Sullivan indicated this additional time will provide an opportunity for discussion and feedback among Council members.

- Katharine London proposed two opportunities for the Council to review the data and the website content before it goes live. She suggested that 1) the Council could review summary data and backup for all the hospitals with respect to particular conditions and procedures; and 2) test the website and review the data in a website format, before it goes live.

- Katharine stated that the website team is scheduling test dates during the first two weeks of June at the Office of the State Auditor. Members of the Council are welcome to attend the test sessions and review the data and content. Katharine will provide a list of time slots to the Councilors for test sessions.

- The Council requested the following specific changes in the web display:
    - Refer to “death rates” rather than “mortality rates”;
    - Delete “lower is better” from cost ratings and data;
    - Delete “higher is better” from volume data;
    - Delete “Cost and quality are independent of each other” from text;
    - Clarify that angioplasty can be done on an emergency basis, but we are only showing data for scheduled angioplasties;
    - Explain that cost varies widely within an institution based on the service needs of an individual patient. An individual patient may pay an amount different from the median; and
    - Explain severity adjustment in detail in text content, for example in “About the Ratings.”

- The Council asked staff to further investigate the following options. These options would require analysis. Some options would require functional changes to the website design at additional cost to the Council, and some options may require the Council to expand or amend its data collection requirements.
    - Revisit display of cost measures. Specifically, review the decision to display severity-adjusted median costs. Consider the following alternatives:
        - Display median cost, not adjusted for severity;
        - Post severity-adjusted and unadjusted median cost;
        - Post median cost by severity level;
        - Report ratio of observed to expected cost;
        - Add an additional detailed back-up screen. Enable users to click on severity adjusted median to get median cost by severity level; and
        - Report cost by hospital group: AMC, teaching, large community, small community/
    - Lower threshold for display of inpatient discharges from 40 discharges to 30 discharges or another value. Conduct statistical analysis to identify the best threshold.
    - Analyze the statistical significance of the four star and dollar-sign rating categories.
    - Assign star and dollar sign ratings based on best practice benchmarks, rather than percentile cut-offs.
    - Use arrows to show direction of better performance (e.g. down arrow for mortality, lower is better; up arrow for provided all recommended care, higher is better).
    - Where available, display best practice guidelines for minimum volume of services. Arnold Epstein is expert on this.
    - Collect and report on supplemental lump-sum payments from payers to hospitals.
    - Use focus groups to evaluate site going forward. Determine whether specific language and symbols are helpful to users.
    - Arrange for consumers to test the website, perhaps using Health Care for All’s consumer forum. Investigate legal issues relating to data privacy.

- The Council would like to display cost data by severity level on the website.

- The Council wants to receive the data to be displayed on the website at least two weeks prior to voting to display it, and wants this data to include the number of discharges by DRG for each hospital.

- The Council reviewed the proposed recommendation made by the Hospital Association during the Advisory Council meeting on May 5, 2008. The Council discussed the pros and cons of adding additional weeks to the timeline. The Council also discussed the importance of giving hospitals enough time to verify the data and the information before posting.

- The Council voted to give hospitals two additional weeks for a total of four weeks to review and verify the data.

- The Council discussed the process for implementing changes and reviewing feedback after the verification process. Katharine London noted that the website development team will work to correct any data that is found to be inaccurate.

C. Emergency Regulation: 129 CMR 4:00 Disclosure of hospital claims data for review by hospitals (*vote)

- The Council's statute provides that "data submitted to the health care quality and cost council … shall not be deemed a public record … except as specified in regulations promulgated by the council or as approved by the council for display on the council's website." (M.G.L.c.6A, s.16L(e)) Therefore, the Council must have a regulation in place in order to give hospitals an opportunity to review their own data before it is posted on the Council's website.

- Katharine London reviewed the information that Council staff proposed to distribute to hospitals for verification. Each hospital would receive its own claims data used to calculate cost measures for display on the website, the backup material necessary to verify the data, the state average and its star and dollar sign ratings.

- JudyAnn Bigby requested that the Council vote on the Emergency Regulation CMR: 4:00. Katharine London reviewed the scope of and the restrictions under CMR: 4:00 and stated that a standard hearing process will proceed following the passing of the emergency regulation which must be in place before the Council can distribute the data to hospitals.

- The Council voted unanimously to approve the emergency adoption of regulation 129 CMR 4:00: Disclosure of Hospital Claims Data for Review by Hospitals.

D. Website Communications Plan & Short-Term Budget Proposal
This item was not addressed during the meeting due to time constraints.

E. Recommendations for Analytic Consultant RFP Revisions
Ray Campbell, Craig Schneider - Massachusetts Health Data Consortium

- JudyAnn Bigby introduced the Massachusetts Health Data Consortium (MHDC) to review their recommendations. The Council hired the MHDC after the Council

canceled the Analytic Consultant Request for Proposal (RFP) because the two bidders did not meet the Council's requirements. The Council hired the MHDC to recommend revisions to the RFP to ensure that it meets the Council's needs.

- Ray Campbell reviewed MHDC's findings. The findings fell under two categories. One points to the source of disconnects between the RFP and the bidders and the other points to miscommunication and a lack of information in the actual RFP.

  Sources of Disconnect between RFP and Bidders:

  - Bidders did not seem to understand "consultant" intent-viewed as contract to develop new measures
  - Bidders seemed to want to do the entire project at once, while the Council wanted to build website capacity incrementally
  - Terminology such as "verify" and "validate" were interpreted differently than intended (intent "quality assurance", not line-by-line validation of each data point)
  - Chapter 30B procurement rules limited ability of Council to negotiate
  - Range of setting (p. 18 #3) interpreted as requirement to develop measures across all 9 settings mentioned.

  Other findings:

  - Work between analytics consultant and operations vendor is iterative process
  - Needs to be more thought given to disparities analysis requested (p. 19 #5)
  - Available funding insufficient to do desired work
  - Council should recognize that bidders may have vested interest in actually doing analytic work
  - Limitations to clinical relevance of claims data – process measures vs. outcomes measures
  - Needs to be greater clarity regarding roles of each vendor in project (gap analysis)

- After reviewing the findings, Ray Campbell proposed the following recommendations to address the disconnect and the miscommunication:

  - Converting RFP to task order structure to make expectations clear
  - Clarify intent to advise Council on needed measures, rather than actually develop measures
  - Clarify that task I is to identify which measures currently in existence, widely accepted; vendor to build on work of Council's clinical consultant
  - Clarify relationship between analytics consultant vendor and other vendors involved in project (task IV)

Meeting adjourned at 4:25pm