Minutes

Quality-Based Reimbursement initiative
Evaluation Work Group Meeting
January 30, 2009
9:00 AM to 10:30 AM

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

EWG Members present: Trudy Ruth Hall, MD, (Chair); Don S. Hillier, Former Chairman, HSCRC (Vice Chair); Barbara Epke, MPH, MA, LifeBridge Health System; Renee Webster, OHCQ,DHMH; Pam Barclay, MHCC; Robert Murray, Steve Ports, and Dianne Feeney, HSCRC.

EWG Members on by conference call: Charles Reuland, ScD, Johns Hopkins Health System; Beverly Collins, MD, CareFirst BCBS; Cynthia Hancock, Fort Washington.

Interested parties present: Vahe Kazandjian, PhD, CPS**,** Grant Ritter, PhD, Brandeis University; Theressa Lee, MHCC; Beverly Miller, MHA; Donna Ryan, St. Joseph Medical Center; Hal Cohen, PhD.

Interested parties on by conference call: Nikolas Mathes and Sam Abumbo, CPS; Christina Stephenson, University of Maryland Medical System; Rena Litten, Western Maryland Health System; Suvana Sundaram, Holy Cross Hospital; Jerry Macks, Medstar Health.

- ***Welcome and introduction of EWG members and other participants-*** Trudy Hall called the meeting to order and invited EWG members and interested parties joining the meeting in person and by conference call to introduce themselves.

- ***Review and approval of the November 7, 2008 meeting minutes –***A motion to approve the minutes as amended was made and seconded with unanimous approval.

- ***Updates on Draft Maryland Hospital Acquired Conditions (MHACs), Potentially Preventable Complications (PPCs) and Potentially Preventable Readmissions (PPRs)***-
    - **MHACs**-Mr. Robert Murray provided a brief summary of the work to date on MHACs, noting that these were a set of highly preventable complications that are not present on admission, and that correct financial incentives needed to be put in place to decrease the occurrences of these complications. Mr. Murray noted that CMS put in place a payment decrease for a set of hospital acquired conditions not present on admission in October 2008, and that the Maryland initiative was intended to correct a similar flaw in the payment system that pays more for lower quality. In addition, as Maryland

hospitals all use the APR-DRG for payment, there is a large incentive to fully code the administrative discharge claims data, which also enables the state to better use these data to adjust payment incentives. Maryland also has the advantage of the Medicare waiver which allows the state to craft an all-payer, all-patient solution. Mr. Murray noted that the state had received a letter from CMS encouraging the state to address incentives to decrease complications and improve quality.

Mr. Murray noted HSCRC has conducted the following the vet the draft, proposed MHACs:

- Hospital-specific results on the proposed MHACs have been provided based on state FY 08 data.
- Hospital work sessions have been convened to provide a detailed overview of the proposed methodology and how it would work with specific MHAC cases at the hospital.
- HSCRC staff have begun to coordinate efforts with the Office of Health Care Quality to use administrative data to help support the mandatory reporting of serious adverse events.

Additional points Mr. Murray made about MHACs:

- There are currently 12 proposed MHACs being recommended for implementation.
- The MHACs are not 100% preventable, the reason a 90% adjustment in rates is being recommended at this time.
- The many exclusions built in to the methodology render this a conservative initiative.
- This effort should be implemented prospectively.
- There needs to be a high degree of transparency of the methodology.
- HSCRC staff planned to make a draft recommendation at the February 09 meeting regarding implementing MHACs as of April 1, 2009.

Ms. Barbara Epke noted that, based on study of their hospital specific MHAC case reports, some of those assigned require levels of review to determine if they were indeed preventable. Ms. Epke and Dr. Charles Reuland suggested that an appeal process should be considered for specific cases in question. Mr. Murray responded that there are several approaches to a review or appeal that could be considered.

- **PPCs and PPRs**- Mr. Robert Murray noted that HSCRC is considering use of the PPCs and PPRs for state FY 2010 and would analyze these data to consider whether this was appropriate and feasible.

- ***QBR measures benchmarks and thresholds for CY 07 and 08-*** Mr. Steve Ports reviewed the content of a memorandum of January 13, 2009 sent to all hospitals on the status the threshold and benchmark values of the 19 QBR process measures used in the first year of the QBR implementation, noting that several of the measures were

"topped off." Ms. Epke encouraged continued coordination with MHCC on the measures that would be added to the Performance Evaluation Guide to achieve economy on data collection and reporting for measures that may be appropriate for public reporting and quality based reimbursement. Mr. Ports noted that an education session for hospitals had been convened on January 9 that focused on calculating the thresholds and benchmarks for the measures. Mr. Gerry Macks asked whether anyone was aware if vendors would support data collection for measures for which CMS would no longer calculate the results. Ms. Barclay responded she thought this would be an issue that vendors would no longer support the measure and this should be considered as we refresh measures used for the QBR. Ms. Suvana Sundaram noted that Holy Cross would benefit from a tool or other technical assistance to calculate their measures' benchmarks and thresholds. Ms. Donna Ryan from St. Joseph noted that they had developed a tool to calculate their values in Excel. Ms. Beverly Miller suggested that MHA should work with HSCRC together on additional education sessions or other technical assistance hospitals may need.

Dr. Grant Ritter noted that the memorandum indicates the definition of a topped off measure is one where the 75th percentile is within 2 standard errors of the 90th percentile, not the 95th percentile which is in the memorandum. Dr. Ritter added he believes the 95th percentile would be more appropriate in Maryland with the small number of hospitals.

- ***Appropriateness of care scoring incorporating new process measures (VTE 1 and 2, PCI timing)***- Dr. Vahe Kazandjian provided introductory remarks noting that the discussion of topped off measures has technical implications but also means that improvement has occurred, and added that that the patient, rather than the measure is the unit of measure for appropriateness. In addition, appropriateness more clinically oriented than the more statistical opportunities approach.

  Dr. Ritter summarized the benefits of appropriateness approach:
  - There are less problems with topped off measures; a combination of
  - There are less problems with low cell sizes of cases.
  - This is a patient-centered/focused approach.
  - A composite obviously derived by patient.

  Dr. Ritter summarized the downside of the appropriateness model:
  - Data are not available nationally as QIOs do not consistently make this data available.
  - Hospital receives the same score, whether the patient receives one service or almost all of the services within a measurement area.
  - The measures are not transparent in terms of how they are calculated.
  - It is less apparent where the quality problems are (i.e., which measures are problematic) with a patient level composite score.
  - There would only be four measures at the present time based on the measurement domains.

Mr. Don Hillier noted that, if you could make the scores on individual measures within a clinical domain as well as the appropriateness scores on the numbers of patients who received all the right things, the quality concern areas would be apparent.

Dr. Ritter generally summarized the scores in Maryland with the EWG members reviewing hospital-specific confidential data.

Dr. Ritter added that CMS was considering various approaches in converting raw appropriateness scores to percentiles and point scores for value based purchasing (VBP):

- Standard VBP attainment approach.
- Attainment and improvement scores earning points only for performance above the 50th percentile.
- Relative Quality Index (RQI) attainment approach which removes points for performance below 50th percentile in addition to adding points above the 50th percentile.
- RQI attainment and improvement approach.

Dr. Ritter noted that the appropriateness scores did not change very much by adding in the new process measures under consideration by the EWG which are the new SCIP measures and the PCI timing measure.

Ms. Epke voiced concern about using the appropriateness model due to the small number of measures. Dr. Reuland agreed and suggested also that changing the benchmarks and thresholds would not be preferable over adding new measures, such as those added to the Performance Guide by MHCC.

Dr. Hall encouraged the EWG members and other attendees to consider the various options outlined by Dr. Ritter and to provide input to HSCRC via email and at subsequent EWG meetings.

- ***Update on PPC chart validation audit plan in Maryland-*** Ms. Feeney noted the chart review of the sepsis and heart failure PPCs would begin within the next few weeks.

- ***Adjournment-*** The meeting was adjourned at 10:35AM.