Minutes
Quality-Based Reimbursement initiative
Evaluation Work Group Meeting
June 10, 2008
3:00 PM to 4:30 PM
Room 100, 4160 Patterson Avenue
Baltimore, MD 21215

EWG Members present: Trudy Ruth Hall, MD (Chair); Pam Barclay, MHCC; George Chedraoui, IBM; Beverly Collins, MD, MBA, CareFirst BlueCross BlueShield; Don S. Hillier, Former Chairman, HSCRC; Claudia A. Steiner, MD, MPH, AHRQ; Robert Murray, Steve Ports, and Dianne Feeney, HSCRC.

EWG Members on conference call: Robert Brooks, MD, PhD, MBA, Delmarva Foundation for Medical Care, Inc.; Barbara Epke, MPH, MA, LifeBridge Health System; Julianne R. Howell, PhD, Independent Technical Advisor, CMS; Charles Reuland, ScD, Johns Hopkins Health System.

Interested parties present: Grant Ritter, PhD, Brandeis University; Vahe Kazandjian, PhD, Center for Performance Sciences.

Interested parties on conference call: Ms. Joan Gelrud, St. Mary's Hospital; Ms. Sylvia Daniels, University of Maryland Medical Center; Ms. Lynne Adams, Upper Chesapeake Health; Mr. Gerry Macks, MedStar Health; Ms. Rena Litten, Western Maryland Health System; Jane Gordon; Ms. Deneen Richmond, Holy Cross Hospital; Ms. Karol Wicker, Center for Performance Sciences; Mr. Frank Pipesh, Center for Performance Sciences.

1. ***Welcome and introduction of members and participants*** – Dr. Trudy Hall, Chair, called the meeting to order and provided a brief overview of her role as Chair of the QBR Initiative Initiation Work Group (IWG) which has concluded its work, noting that she has agreed to continue as Chair of the Evaluation Work Group. Dr. Hall invited EWG members to introduce themselves and provide a brief summary of their quality based reimbursement interest and background.

2. ***Summary of QBR Initiative planning activities, 2005 to present*** –Bob Murray provided a brief overview of the Steering Committee and Initiation Work Group work and recommendations for the QBR Initiative that have been approved by the Commission in the June 4, 2008 meeting. The IWG Final Draft Recommendations are posted on the HSCRC website at www.hscrc.state.md.us.

   Steve Ports provided more detailed background of the QBR Initiative development as outlined in the slides posted on the HSCRC website at www.hscrc.state.md.us summarizing the Steering Committee and IWG work and their recommendations. Mr. Ports highlighted the collaboration of the HSCRC, MHCC, DHMH, the Maryland Hospital Association, and the Maryland Patient Safety Center to improve quality and safety in the state, and to

specifically develop the QBR Initiative. Mr. Ports noted that the primary focus of the HSCRC has been on finance, but it is also charged with ensuring efficiency and effectiveness of hospital services, which is also the primary focus of the QBR Initiative.

Mr. Ports noted the following regarding the measures:

- 19 AMI, HF, PN and SIP measures are being used.
- "Topped off" measures are included but a different threshold is applied.
- Equal weight is applied to each measure.
- Each measure is scored between 0-10 using greater of attainment and improvement score.

Mr. Ports noted the following about the model for measurement and scoring:

- Opportunity Model is being used with possible score of 10x number of measures reporting.
- Score is the sum of all attainment and improvement points divided by available points.
- Thresholds and Benchmarks are established in previous year:
    - Threshold is where points begin to accrue at the 50th percentile for attainment, 65th percentile for topped off measures, and above the 1st year score for improvement
    - Benchmark is the 95th percentile for attainment and improvement.

  (Dr. Ritter provided clarification about the threshold and benchmark levels)
- Points are aligned equally between benchmark and threshold.

Mr. Ports noted that a cube root function outlined in the slides is being used to translate performance into payment, and added that performance on the initial set of 19 process measures will be included in the calculation of the hospitals' update factors starting July 1, 2009, using calendar year 2007 as the base year and calendar year 2008 as the performance year.

3. ***Charge of the Evaluation Work Group*** – Dianne Feeney provided an overview of the EWG charge noting that its overarching role was to conduct periodic program assessments to determine if the Initiative is meeting its goals, and recommend ways to continuously update and improve the HSCRC Quality Initiative. Regarding measure changes and additions, the EWG will:
    - examine quality research, measures and outcomes nationally and make recommendations to the Commission/Staff on changes and additions.
    - continue to review data needs and make recommendations for future changes.
    - evaluate whether the HSCRC Quality Initiative is meeting its goals in general and whether the measures are indicative of quality outcomes.

    Regarding data auditing and systems, the EWG will:
    - make recommendations on the most appropriate way to audit quality data internally and externally.
    - investigate the long-term feasibility of an interoperable data system that would allow for the horizontal and vertical assessment of patient outcomes

across all modes of care.

To accomplish its work:

- HSCRC staff and consultants will develop and disseminate materials in advance of the meetings.
- Meetings will be open to the public and non-confidential information and materials will be distributed to interested parties providing opportunity for broad stakeholder input.
- In general, monthly 90-minute meetings will be held with participation in person or by teleconference, with EWG input and feedback on various issues and items between meetings.

4. ***Overview of current QBR scoring and reward model*** – Grant Ritter reiterated the scoring model outlined by Mr. Ports. Dr. Ritter noted that each measure was weighted equally and that obtaining an attainment score of 95%, accept for the topped measures, was difficult to do. Regarding the rewarding of both attainment and improvement, Dr. Ritter noted it was important to recognize the hospitals that make strides in improvement, and not only recognize/reward higher performers whose relative improvement is less. Dr. Ritter noted again that for the topped off measures, a majority of hospitals are scoring high and a few scoring low. Since hospitals are advantaged that report on a higher number of topped off measures, it is important to use a different threshold for these measures. Dr. Ritter noted the reasons for continuing to use the topped off measures: 1) to prevent backsliding, 2) to encourage stragglers to catch up, and 3) to allow hospitals to report positive statistic.

   Dr. Kazandjian added that the initial choosing of process measures allowed for immediate adoption without the need for adjustment. As we consider outcome measures for the next phase, we must consider the need for risk adjustment in terms of patient severity and acuity, stratification (e.g., in peer groups), and attribution (i.e., whether the outcome can be attributed to the hospital). The EWG must also consider whether outcome measures we select should be linked with or interrelated to the process measures and/or whether other outcome measures are most pressing and important to add.

5. ***New measures discussion*** – Dianne Feeney provided a summary of four categories of measures the EWG will consider including structure, process, outcome (intermediate and final) and patient experience. For each category, Ms. Feeney provided a definition, examples of measures in the category, examples for each category of pay-for-performance initiatives using such measures, and additional points/issues to consider for each category in terms of use in payment. The document entitled *Healthcare Performance Measures Overview, Categories and Examples: Discussion Document* details the information Ms. Feeney summarized.

   Dr. Hall indicated that the next step regarding new measures for consideration is that each EWG participant will be requested to provide input on new measure in the various categories of measures that should be on the table for consideration,

and on which measures they believe are ready for use and important to prioritize for the Initiative. HSCRC staff would be in touch electronically to solicit this input in advance of the next meeting.

6. ***Standing monthly EWG meeting dates and times*** – Dr. Hall proposed that the second Friday of the month from 9:00am to 10:30am be the regular standing meeting, and the next meeting date was set for Friday, July 11, 2008. Some EWG members noted this was not a good time and HSCRC staff will solicit input on workable days and times for subsequent meetings.

7. ***Adjournment*** – Dr. Hall ajourned the meeting at 4:35pm.