Minutes
Initiation Work Group, HSCRC
Friday, February 9, 2007
9:00 – 11:00 am
Room 100, 4160 Patterson Avenue
Baltimore, MD 21215

IWG Members Present: Dr. Trudy Hall, Chair**;** Ms. Barbara Epke, LifeBridge Health; Ms. Pamela Barclay, Maryland Health Care Commission; Dr. Charles Reuland, Johns Hopkins Medicine; Dr. Beverly Collins, CareFirst BlueCrossBlueShield; Ms. Wendy Kronmiller and Ms. Renee Webster, OHQ; Dr. Vahe Kazandjian, Dr. Nickolas Matthes and Mr. Frank Pipesh, Center for Performance Sciences; Mr. Robert Murray, Mr. Steve Ports, Mr. John O'Brien, and Ms. Marva West Tan, HSCRC.
On Conference Call: Ms. Marybeth Farquhar, AHRQ; Dr. Kathryn Montgomery, University of Maryland School of Nursing; Ms. Sylvia Daniels, University of Maryland Medical Center; Dr. Laura Morlock, Johns Hopkins University, Bloomberg School of Public Health; Ms. Karol Wicker, Center for Performance Sciences; Ms. Joanne Koterwas, St. Mary's Hospital; Ms. Brigid Krizek, Interested Party. (There may have been other unannounced callers).
Interested Parties Present: Ms. Ing-Jye Cheng, Maryland Hospital Association; Ms. Carol Christmyer and Ms. Deborah Rajca, Maryland Health Care Commission; Mr. Don Hillier, former HSCRC Commissioner; Mr. Hal Cohen, HCI.

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I. Welcome and Introductions: Dr. Hall welcomed the attendees and asked telephone participants to identify themselves. She noted that Ms. Kathy Talbot, Vice President, Rates and Reimbursement, MedStar Health, would be replacing Mr. Joseph Smith as a hospital finance representative on the Work Group. Minutes of the January 5, 2007 meeting were approved as distributed.

II. Quality Initiative Reimbursement-Timeline, payment structures, and issues: Mr. Robert Murray, HSCRC Executive Director, reviewed a timeline that he had introduced at the January 2007 meeting and introduced a two-page document that outlines some of the major issues related to payment. (See attached timeline and reimbursement issues outline for content.) Mr. Murray briefly reviewed the reimbursement outline and noted that an expanded document would be the focus of future discussions. In addition to the issues listed in the outline, Mr. Murray noted that the methodology would have to be dynamic over time. New measures, particularly outcomes measures, would be introduced over time and some of the original measures might be deleted. He also referred to an outline, prepared by Ms. Tan, of the payment structures of some of the major national pay-for-performance programs. This outline was distributed at the meeting. (See attached outline for content) Mr. Murray noted that the source of funds for the HSCRC program would likely be existing funds or direct funding (new money) because data on generated savings is not yet available. In regard to the mechanics of incentive payments, Mr. Murray noted one additional model from the Premier demonstration is to direct the incentive to the service area or DRG that meets certain performance thresholds. Mr. Murray reminded the Work Group that the source of funds and magnitude depended, in the rate-setting system, on where the system stood compared to the

nation and how much room there was for incentives and rewards. If health care in Maryland were very unaffordable, HSCRC staff would be less likely to recommend new money. If the Maryland system has done well, then there would be more opportunity to introduce new money and larger magnitude of incentives.

Mr. Murray then asked for questions. The first question was regarding who made the decision about funding. Mr. Murray said that the usual approach for HSCRC initiatives was that a work group, after deliberation, develops recommendations, HSCRC staff takes those recommendations to the Commission, and the Commissioners make the ultimate decision. Another question or comment related to the need to further develop the details of the mechanics. Mr. Murray concurred that there was work to be done on the reimbursement detail once the work on the measures was further along. Mr. Murray introduced Mr. John O'Brien, the new HSCRC Deputy Director, Research & Methodology, who developed the reimbursement issues outline.

III. Further Discussion in the Construction of Composite Measures: Appropriateness of measures for rewarding performance and analysis of data from Hospital Compare: Dr. Kazandjian gave a presentation on the appropriateness of measures for rewarding performance and analysis of data from Hospital Compare. (See attached slide show for content.) Dr. Kazandjian noted that this presentation pointed out some of the issues that the Work Group needs to consider regarding which measures to include in the measure set, which measures should be retired or suspended, a quantitative method for consideration of the usefulness of the measures, and a way to consider the "fairness" issue. He noted that another issue, which is being discussed both locally and nationally, is the use of both process and outcome measures. Mortality is the most common type of outcome measure being considered. However, mortality is a statistically rare event and use of mortality measures raise issues regarding severity adjustment and gap analysis. Dr. Kazandjian noted that one must be able to rank hospitals for a quality-based reimbursement program as well as demonstrate improvement over time for an individual hospital, and mortality measures do not facilitate that gap analysis. Regarding consideration of new measures, he pointed out, as the electronic medical record or some method of electronically linking records improves, newer episodes-of-care measures will evolve. There are also other dimensions of quality, such as efficiency, safety, patient satisfaction and culture, that were approved by the Commission for the feasibility model two years ago, that will gradually be added to the measure set. Dr. Kazandjian noted that Dr. Matthes has been doing some work on data from Critical Access hospitals, which show some particular differences. Critical Access hospitals or those hospitals with some of those types of characteristics should be considered separately in data analysis. Ms. Epke noted that both the data reporting and the data grouping would be important.

Dr. Kazandjian then reviewed how the coefficient of variation (CV) might be used to identify the potential for improvement. After explaining the whisker plot slides (slides 8,11 and 12), he noted, that in the Beta Pilot, before there is any discussion of clinical relevance, it may be useful to do an initial diagnostic screening using this statistic and delete immediately measures with very little room for improvement from any further consideration. Mr. Murray asked that if one retired a measure, is it necessary to monitor it or will the behavior leading to high performance be discontinued? Dr. Kazandjian said there is a need to look measure-by-measure to

see if there has been a true cultural change so that the behavior will not be dropped if it is no longer monitored. He also pointed out that even when a measure is not particularly useful alone any longer, it may be useful as part of a regression model or a composite scoring model. Ms. Epke noted that this is why the early discussions we have had about a composite measure are so important. She agreed that there is some concern that if a measure is no longer monitored that there might be a decline in performance. We may need to continue to look at all of the measures for AMI, for example. She also mentioned that there would be a steady stream of new measures that are being approved by the Maryland Health Care Commission (MHCC) for public reporting. HSCRC can look to MHCC for some of that early vetting of measures for Maryland.

Mr. Cohen noted that the Michigan Hospital Association, in their discussion with BlueCross/ Blue Shield regarding a pay-for-performance program, is using two methods to address Mr. Murray's concern. One is the use of composite measures. The second is the use of preconditions; that is, in order to continue to participate in the incentive pool that the hospital needs to maintain a 95% performance level on each "retired" measure. The measure may not count for the ranking or distribution of the funding but still is a precondition for participation in the pool.

Dr. Matthes noted that the variation or lack of variation of a measure is not just related to the statistical properties but also to the clinical content of a measure and how easy it is to make the system changes to achieve good performance. Some interventions are much more complex to make. Continued monitoring has both a clinical and process aspect to it.

Dr. Kazandjian then turned to slides 13-to-15 which illustrated setting 80% thresholds and the resultant distribution of rewards by measure. He noted that this approach led an uneven distribution of rewards by peer group. He concluded that this analysis demonstrated that looking at measures only is inadequate. One must look at composite measures, but whether that means one composite, a composite of composites, or a composite of composites plus some additional adjustment, is not yet clear. Dr. Kazandjian said that his opinion was that it might be some combination of these approaches.

Dr. Kazandjian concluded that the elements that we need to accomplish in the next phase are:

- To agree on the criteria for which measures are "keepers,"
- To have a thorough understanding of the profile in Maryland, and
- To have a thorough understanding of what is happening nationally so that we can gauge where we are.

He further noted that all of these elements need to move along in parallel in the Beta phase. When all of these pieces are put together, then more work on the reimbursement mechanics can occur. Access to Maryland data is a critical next step.

Dr. Collins noted that she was interested in efficiency measures and would like to start that dialogue. She wondered how efficiency was currently looked at in the rate setting system. Mr. Murray noted that there are a variety of ways in which the rate setting system looks at efficiency. One is the use of screens and reasonableness of charges (ROC). Grouping of hospitals is used as well as various adjustments for factors that are not within the hospital's control such as case mix or uncompensated

care. A standard cost is set within each group and those hospitals that are average or below are considered relatively more efficient, and hospitals that are above the average are relatively less efficient. Those hospitals that are 3% above average are deemed high cost and might be subject to rate reductions. Those that are 2% below average are deemed more efficient and might be eligible for a rate increase. He noted that it is an elaborate process and that no one calculation is precise enough to define efficiency in a fair way. Dr. Collins noted that the rate setting system seems to take the place of what market forces might do in another state. Mr. Murray responded that market forces in health care do not work and tend to be perverse. He also noted that for payment in the rate system, there are constraints by DRG in the form of case weights.

Dr. Hall said that she was interested in the discussion regarding what to do with measures in which high performance has been achieved overall. Important questions for her are whether performance will deteriorate if not monitored and if it matters if these measures are kept in the measure set. These are issues to consider as we move forward.

Dr. Kazandjian noted that the ratio of expected to observed and the resultant gap will be an important issue as we continue. He emphasized that "expected" is not based just on personal opinion but on national and Maryland data. Over time, we likely will look at various arrangements of putting in and taking out measures and the resulting effect.

Dr. Morlock asked whether it might be possible to put certain measures on a "Watch List" that was tracked but not used in the pay-for-performance calculations? People would know that the measures were still being monitored. She also asked, in the last few slides, if it is the CV that accounts for the differences in the different hospital peer groups? Dr. Kazandjian answered the second question first. He thought that it might be the CV that accounted for the differences but that those calculations were not made. In regard to the Watch List, he noted that this is very similar to the current practice of the CDC, which conducts both interventions and surveillance. He said that we could put certain measures on surveillance. Initially, his inclination would be to include them in the composite score and see the resulting interaction.

IV. **Update on Hospital Forum Planning:** Ms. Tan thanked the Maryland Hospital Association, which has been generous in planning and managing the operational details of the forum. Ms. Cheng noted that, although full implementation of the Quality-based Reimbursement Program seems far away, it is not too early to begin to orient a broader group of hospital representatives to the initiative. MHA has asked hospitals to identify a finance and a quality representative to invite to the Hospital Forum. The Hospital Forum will be February 23 in the morning at the Maryland Hospital Association in Elkridge. (Refer to the Forum agenda.)

V. **Next Meeting and Adjournment:** After some discussion with the group, Dr. Hall stated that the next meeting of the Initiation Work Group would be March 9, 2007 from 9am to 11 am at HSCRC. Ms. Tan indicated that she would try to locate an appropriate date and time for a standing meeting schedule. Dr. Hall then adjourned the meeting.