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

IWG Members Present: Ms. Joan Gelrud, St. Mary's Hospital; Ms. Pamela Barclay, Maryland Health Care Commission; 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; Dr. Grant Ritter, Brandeis University; Mr. Robert Murray, Mr. Steve Ports, Mr. John O'Brien, Mr. Oscar Iberra, and Ms. Marva West Tan, HSCRC.
On Conference Call: Ms. Marybeth Farquhar, AHRQ; Dr. Kathryn Montgomery, University of Maryland School of Nursing; Ms. Kathy Talbot and Mr. Gerry Macks, MedStar Health; Ms. Rina Litten, Western Maryland Health System; 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; (There may have been other unannounced callers).
Interested Parties Present: Ms. Ing-Jye Cheng and Mr. Sam Ogumbo, MHA; Ms. Carol Christmyer and Ms. Deborah Rajca, Maryland Health Care Commission; Mr. Don Hillier, former HSCRC Commissioner; Mr. Hal Cohen, HCI; Mr. Craig Weller, Delmarva Foundation for Medical Care.

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I. Welcome and Introductions: Mr. Robert Murray, HSCRC Executive Director, noted that Dr. Hall had a conflict with the meeting and that he would be chairing the meeting. Minutes of the February 9, 2007 meeting were approved as distributed.

II. Update on current CMS pay for performance and pay for reporting modeling: Dr**.** Kazandjian stated that the purpose of the session would be primarily educational and informational. Dr. Ritter would discuss some new information from the field. The Center for Performance Sciences was not recommending the CMS approach for HSCRC adoption but felt that the Initiation Work Group needed to be aware of current developments before the Beta Pilot begins. Dr. Ritter stated that Brandeis University had been engaged as a consultant for the Centers for Medicare & Medicaid Services (CMS) to develop a concept paper about a methodology for a CMS value-based purchasing initiative. Both CMS and HSCRC must address many similar issues in developing quality-based reimbursement programs. Moving from quality measures to a rewards program is a complex process. Dr. Ritter further noted that CMS has learned from the Premier demonstration project that the methodology should not limit the majority of the rewards to a very few hospitals and that they did not want a tournament type approach to rewards.

Dr. Ritter then presented and discussed the Brandeis proposal. (See attached slides for content.) Dr. Ritter highlighted the fact that certain of the core measures have "topped out" or are about to top out, i.e., almost all hospitals have very high compliance levels for that particular measure, such as aspirin on arrival in the AMI measure set. He also noted that CMS wanted one composite score to reflect overall hospital quality and did not want to "split hairs" so scores should clearly

differentiate between hospitals. He stated that CMS wanted the benchmark to be set at high but "feasible to achieve" levels. In this model, hospitals can achieve points both for attainment and improvement. CMS does not want to use peer groups. Dr. Ritter noted that the data in slide 13 provided some confidence that attainment levels are relatively similar for all types of hospitals, with urban/rural and rural hospitals 1-99 beds scoring somewhat higher at the 3rd quartile. Dr. Ritter also reported that CMS plans to use the update factor or existing funds as the source of funds for rewards as there is no "new money." Regarding small sample sizes, Dr. Ritter noted that CMS preferred to use 25 subjects per measure as the minimum sample for a stable measure. Using a moving average over two years of data for small samples was not a popular alternative.

Mr. Ogumbo asked a question about proportional versus continuous measures. There was further discussion about keeping almost topped out measures in the measures set to encourage continued compliance and the possibility of treating these measures differently in the composite score calculation. Mr. Macks asked if the CMS program would penalize hospitals that did not achieve certain scores. Dr. Ritter noted that since there is no new money, that if the update factor was not paid, that would be a penalty already. Dr. Kazandjian noted that the Work Group is getting to the synthesis phase in the Beta Pilot where we will be putting together statistics and policy issues. The Work Group will need to decide on matters relating to the measures, sample size, rewards and incentives, the opportunity model for attainment and improvement, and how appropriateness may fit into this model. Dr. Collins asked if a lower number of observations than 25 could be used in creating the composite score. Dr. Ritter noted that there was nothing magical about using the number 25 as the minimum sample size. There was some discussion about whether a sample of 25 opportunities within each diagnostic condition rather than 25 opportunities per measure could be employed. Someone asked if CMS is planning to add new measures to the measure set. Dr. Ritter answered that CMS is considering many new measures but in the short term is focused on mortality measures for a few conditions and the patient experience of care measures in HCAHPs. He added that topped out measures such as "aspirin on arrival" would be no longer used by 2009.

Mr. Murray asked what the next steps would be. Dr. Ritter said that probably within the next 3 weeks, CMS would come to some consensus about the use of the topped out measures, small sample sizes, and minimum number of a measures for a hospital to be a participant. Dr. Kazandjian reminded the group that we must continue to evaluate what is particular to Maryland. He suggested that for the HSCRC QI project, we need to consider what will be a ceiling and a floor or % of improvement for rewards and incentives, the number of measures, distributions, and probably peer groupings, which have been important in Maryland in the rate setting system. Mr. Ports noted that CMS seems to be moving from a system that provides rewards at the DRG level, for measures relating to that DRG, to one that will reward for performance on a limited set of measures across the entire revenue base of the hospital. He asked about a reason for this shift in policy. Dr. Ritter noted that, in CMS's Value Based Purchasing plans, measures are being sought that reflect the overall quality of a hospital. Mr. Cohen noted in the all payer system, the update applies to all specialties. Mr. Macks requested that modeling of just the Maryland hospitals for 2004-2005 be done using the Brandeis methodology. Dr. Morlock asked if slide 13 could be replicated using Maryland data. Dr. Kazandjian reminded

the group that the Maryland data will represent less than 50 hospitals, the statistics will be different from those discussed today, and the group should gauge its expectations. Mr. Murray requested that, as usual, if any of the attendees had any comments or questions to please forward them to Ms. Tan at mtan@hscrc.state.md.us.

III. **Update on the Hospital Forum:** Ms. Tan reported that the long planned Hospital Forum to introduce the HSCRC Quality-based Reimbursement Initiative to the hospital industry was held February 23, 2007 at the Maryland Hospital Association (MHA). Ms. Tan thanked the Maryland Hospital Association for its generous assistance in coordinating the Forum and for managing the operations. She particularly thanked Ms. Cheng for her valuable assistance. Ms. Cheng reported that finance and quality professionals from over 40 Maryland hospitals were represented at the Forum. Ms. Cheng will be bringing information from the Work Group back to the MHA's newly formed Technical Group on the HSCRC Quality-based Reimbursement Initiative.

IV. **Update on Data Request:** Mr. Murray asked Ms. Tan for an update on the status of the request to the CMS Clinical Data Warehouse for access to existing quality measurement data. Ms. Tan noted that the request is being coordinated via the Delmarva Foundation, in its role as the Quality Improvement Organization (QIO) for the State of Maryland. The request has three main parts: 1.) Consents from each hospital to access its data. HSCRC is waiting for only 2-3 consents: 2.) A letter of understanding with HSCRC's technical consultant regarding compliance with Delmarva confidentiality requirements. This letter is signed; and 3.) a Data Use Agreement or contract with the Delmarva Foundation. A few sections of this agreement remain to be clarified. Ms. Tan noted that the Delmarva Foundation staff have been very helpful in this complex, lengthy process. Mr. Murray urged that there be an intensive effort to finalize this data request as soon as possible. Mr. Weller, Delmarva Foundation, offered his assistance to expedite the process.

V. **Next Meeting:** The next meeting of the Initiation Work Group will be held April 13, 2007 from 9 am to 11 am at HSCRC. Mr. Murray then adjourned the meeting.