Corrected Minutes- 10/26/07
Initiation Work Group, HSCRC
Friday, September 21, 2007
9:00 – 11:00 am
Room 100, 4160 Patterson Avenue
Baltimore, MD 21215

IWG Members Present: Dr. Trudy Hall, Chair**;** Dr. Charles Reuland, Johns Hopkins Medicine; Ms. Barbara Epke, LifeBridge Health; Ms. Kathy Talbot,Medstar; Ms. Pamela Barclay, MHCC; and Dr. Vahe Kazandjian, Dr. Nikolas Matthes and Mr. Frank Pipesh, Center for Performance Sciences; Dr. Grant Ritter, Brandeis University; Mr. Robert Murray, Mr. Steve Ports, and Ms. Marva West Tan, HSCRC.
On Conference Call: Ms. Joan Gelrud, St. Mary's Hospital; Dr. Beverly Collins, CareFirst BlueCross BlueShield; Ms. Renee Webster, OHQ; Ms. Marybeth Farquhar, AHRQ, Dr. Kathryn Montgomery, University of Maryland School of Nursing, Dr. Christian Jensen and Mr. Craig Weller, Delmarva Foundation; Mr. Gerry Macks, MedStar Health; Ms. Sylvia Daniels, University of Maryland Medical Center; Ms. Shirley Knelly, Anne Arundel Medical Center. (There may have been other unannounced callers).
Interested Parties Present: Mr. Don Hillier, former HSCRC Commissioner; Ms. Ing-Jye Cheng, MHA; Ms. Carol Christmyer and Ms. Deborah Rajca, Maryland Health Care Commission; Mr. Hal Cohen, HCI for CareFirst and Kaiser Permanente; Mr. James Case, KPMG LLP; Ms. Denise Otto; Mary Whittaker, Greater Baltimore Medical Center, Ms. Cindy Hancock, Fort Washington Medical Center.; Mr. Oscar Iberra, Dr. Cynthia Saunders, Mr. Ali Hasmi, HSCRC.

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I. Welcome and Introductions: Dr. Hall welcomed the work group and asked telephone participants to introduce themselves. The minutes of the April 13, 2007 meeting were approved.

II. New Confidentiality Policies to Comply with the Data Use Agreement: Mr. Murray described work conducted by HSCRC staff over the past months to secure a workable data use agreement with Delmarva Foundation, in its role as the Quality Improvement Organization (QIO) for Maryland, to access and use quality measures data stored in the QIO Clinical Data Warehouse. Mr. Murray noted that one challenge was that while Medicare is an advocate of value-based purchasing, much of its boiler plate contract language seems to have been designed for data access for research and not for quality-based reimbursement or public reporting. He thanked Mr. Stephen Jencks, Medicare, and Delmarva Foundation representatives for the assistance they provided.

Then, Ms. Tan reviewed some key confidentiality requirements of the Agreement for Use of Health Care Data in the Maryland Health Services Cost Review Commission's Quality-based Reimbursement Initiative (Agreement). Ms. Tan briefly highlighted various sections of the Agreement and discussed Section 11 which provides for identification of individual hospitals in hospital-level data and access to hospital-level data by HSCRC, the individual hospital or among all identified hospitals participating in the Quality Initiative. Ms. Tan reminded the Work Group that consent from the individual hospitals had been obtained for this data use. Ms. Tan also pointed out that Section 13 was the most controversial

section during the negotiations and pointed out how "third parties" and "findings" are defined in the Agreement. Section 13 also addresses when HSCRC must seek review of its analyses by the QIO, and possibly by CMS, prior to release of the information. Ms. Tan also noted that the Agreement spells out the consequences of non-compliance. Then Ms. Tan read the Confidentiality Policy for the Use of Health Care Data in the Maryland Health Services Cost Review Commission's Quality-based Reimbursement Initiative Pilot. She noted that this policy operationalizes how HSCRC will handle the QIO Clinical Warehouse data and any analyses during the Beta pilot period. Staff recognizes that the policy is quite restrictive but believes that it is necessary to assure compliance with the confidentiality requirements of the Agreement. There may be future changes or additions to this policy. Mr. Murray asked the Initiation Work Group members to review these documents and to sign a form acknowledging that they will comply with the confidentiality requirements of the Agreement and return the signed form to Ms. Tan.

Ms. Ing-Jye Cheng stated that while the Maryland Hospital Association was appreciative of the effort made by HSCRC staff in securing the Agreement, it did have some concerns regarding transparency both of patient level data and methodology. She noted that transparency was a hallmark of the rate setting process and that MHA would want to access data used by HSCRC as well as the methodology in order to run its own simulations and modeling. Mr. Hal Cohen, representing CareFirst and Kaiser Permanente, said that he concurred with Ms. Cheng's concerns and further noted that there should be balance among the parties and that the current Agreement provides for some access by hospitals but not payers. Ms. Epke suggested an off-line meeting by a small group to further clarify and discuss the concerns. Ms. Tan indicated that she would schedule such a meeting.

III. Modeling of Maryland Data from the Maryland Clinical Warehouse: Dr. Kazandjian said that access to more recent quality measures data was a step forward in the project but that no decisions had yet been made regarding the methodology to test or to correlate with payment. He then asked Dr. Ritter to review his initial data analysis. Dr. Ritter said that the QIO collects quality measures data from all Maryland hospitals for specific domains or conditions, Acute Myocardial Infarction (AMI), Pneumonia (PN), Heart Failure (HF), and Surgical Care Improvement (SIP, now SCIP). Dr. Ritter received QIO data for the time period 2005 and the first three quarters of 2006. For purposes of his initial analysis, Dr. Ritter used one year of data from the last quarter of 2005 through the first three quarters of 2006. Dr. Ritter reiterated that there are three commonly acknowledged methods for combining quality measures scores within a disease category: the opportunity model, the appropriateness model, and the graded or combined model. In the opportunity model, each opportunity to meet a measure is counted as one. In the appropriateness model, also called the all or none approach, all of the applicable measures in a diagnostic set must be met for the patient to achieve a score of one. Anything less than that scores zero. In the graded approach, a partial score could be achieved such as 3 of 6 measures met for a score of ½. Then the decision on how to combine the scores from all of the diagnostic domains, possibly in a composite of composites, still needs to be made. In the QIO data, each quality measure is represented as a ratio, with the denominator being the number of applicable patients and the numerator is the number of patients for which is the described criterion is satisfied.

Not all hospitals report on all 45 measures and, due to exclusions, not all measures in a measure set are applied to each patient with that diagnosis.

When Dr. Ritter looked at the distribution of patients at all hospitals at various percentiles for the 6 measures contained within the diagnostic measures set for AMI and for PN, he found that for certain of the AMI measures, very few patients, e.g. less than 15, were included due to exclusions in the data definitions. In general for the PN, HF and SCIP measures set, there were more patients included for every measure. Dr. Ritter said that this suggests that we may not want to include all measures for each hospital. In considering the number of measures for the appropriateness of care or graded composite score, Dr. Ritter noted that very few patients met all of the measures for each of the diagnostic categories. In response to a question regarding CMS auditing of compliance with exclusion specifications, Dr. Ritter said that there was auditing of a very small sample. Dr. Reuland asked if HSCRC should conduct more auditing. Ms. Epke said that there is great care given to the audit process even though it is a small sample. Dr. Matthes noted that in non-waiver states, there is considerable impact to failing the CMS audit in that the market basket update is not provided. Dr. Kazandjian questioned whether HSCRC could have the authority to conduct additional auditing.

Dr. Ritter then discussed his analysis of the range of AMI, PN, HF, and SCIP measures scores among all hospitals and noted that for some measures such as AMI 1 – Aspirin on arrival, that scores were very high at all percentiles and indicated little room for further improvement on this measures. On the other hand, there were several other measures that have a broad range of scores indicating that there is more room for improvement.

Lastly, Dr. Ritter reviewed his analysis of the distribution of composite scores for all diagnostic categories using the three composite methods. Scores for all three models trended in the same direction although scores in the appropriateness model were lower. Dr. Ritter noted that the correlation among models provided some comfort level. Dr. Kazandjian noted that in selection of a composite model, the group needs to consider practicality and buy-in especially from clinicians.

In the following discussion, Dr. Kazandjian stated that the plan was to have a working model by the end of this calendar year or possibly to test more than one model. Ms. Epke asked for more detail about the process and voting. Ms. Gelrud asked how small sample size would be treated. Dr. Kazandjian responded that the significance of small sample size depended on the model. In the opportunity model, sample size does make a difference. We may decide to vet indicators based on sample size. Dr. Ritter said that in this initial analysis, where there was a sample under 15 for a particular measure, he did not use that measure or used relative scores so to fairly treat all measures. In the graded model approach, which is patient-based, small samples are much less of an issue. Even small hospitals tend to have at least 25 AMI patients in a year. Dr. Reuland asked how did the data appear in the peer groups. Dr. Ritter said that he would look at that in the next analysis. He concluded that he was unsure how to include patient safety data in this pilot, a problem also faced by CMS. There is a great deal of risk adjustment needed to use these measures and CMS may use broad score categories such as satisfactory, below satisfactory and above satisfactory.

Dr. Reuland suggested that for the next meeting there is a need to update the project timeline and to identify the decisions that need to be made regarding the measures, methodology, composite scoring, etc. and to identify the dates these decisions need to be made. HSCRC staff concurred.

Next Meeting: After discussion it was agreed that the next meeting of the Initiation Work Group would be scheduled for October 26, 2007 from 9 am to 11 am at HSCRC. Dr. Hall then adjourned the meeting.