

Oregon Hospital Performance Metrics Advisory Committee
Meeting Minutes
July 7, 2014

Welcome and Introductions

Committee members present by phone: Manny Berman, Bob Dannenhoffer, Steve Gordon (Chair), Doug Koekkoek/Kristen Downey, David Labby, Jeff Luck, Janet O'Hallaren

Not attending: Pam Steinke, Phil Greenhill

OHA staff: Sarah Bartelmann, Lori Coyner, Sara Kleinschmit, Milena Malone, Judy Mohr-Peterson

OAHHS staff: Elyssa Tran, Diane Waldo

PowerPoint presentation referenced in these notes and additional meeting information can be found here: <http://www.oregon.gov/oha/Pages/http.aspx>

Guide to acronyms used in this document: CCO - Coordinated Care Organization; CMS - Center for Medicaid & Medicare Services; HTPP - Hospital Transformation Performance Program; OAHHS - Oregon Association of Hospitals and Health Systems; OHA - Oregon Health Authority

Update on CMS Negotiations

OHA staff explained that CMS approved OHA's waiver request on June 27 and provided 30 days to provide the following products:

1. Update quarterly reporting process to include progress on HTPP. CMS will likely want to see performance by hospital; OHA is clarifying
2. Update to "2% test" (i.e. OHA's commitment as part of the waiver to reduce the medical expenditure trend by two percentage points)
3. Finalize Attachment J, the Hospital Metrics Approval Protocol

Chair Gordon reminded the committee that it has recommended to OHA a set of measures and targets related to hospital performance. OHA is now updating its waiver with CMS to include these measures as part of a Hospital Transformation Performance Program. Staff added that OHA is still clarifying with CMS what exactly they expect to see with these three products. Chair Gordon asked whether these are fairly routine items, or is there a chance they could be rejected by CMS?

Judy Mohr-Peterson explained that the supplemental items are relatively straightforward and OHA does not anticipate difficulties. However, the measures and benchmarks may need revision as CMS has not yet signed off on the recommendations; that work is particularly relevant to this committee. There will be significant communication between OHA and CMS over the next few weeks. CMS has already suggested some changes to OHA's first submission, and there may be more. There is still some uncertainty whether and/or how many changes can be made after the 30-day period, but that should be made clear in the next few days.

Hospital Performance Measures Update

Lori Coyner summarized the details of the updated domains and measures (slide #5 in PowerPoint presentation). The committee had recommended nine measures under five hospital-focused domains, as follows:

- Domain One
 1. PC-01 Elective Delivery

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- Domain Two
 2. Hospital-Wide All-Cause Unplanned Readmissions
- Domain Three: Medication Safety
 3. Hypoglycemia in inpatients receiving insulin
 4. Excessive anticoagulation with Warfarin
 5. Adverse Drug Events due to opioids
- Domain Four: Patient Experience
 6. Staff always explained medicines
 7. Staff gave patient discharge information
- Domain Five: Healthcare-Associated Infections
 8. CLABSI (Central Line-Associated Bloodstream Infection) in all tracked units
 9. CAUTI (Catheter-Associated Urinary Tract Infection) in all tracked units

In response to this proposal, CMS requested more CCO-focused metrics and a higher level of coordination between CCOs and hospitals. OHA staff worked closely with the Hospital Association (OAHHS) to develop the following additional measures and domains:

- Domain Six
 10. Emergency Department Information Exchange (EDIE)
- Domain Seven: Behavioral Health
 11. Follow-up after hospitalization for mental illness
 12. Screening for alcohol and drug misuse, brief intervention, and referral to treatment (SBIRT) in the Emergency Department

The committee had previously discussed the EDIE measure. Lori Coyner noted that follow-up after hospitalization for mental illness is a CCO incentive measure and is an excellent opportunity for coordination between hospitals and CCOs. Alcohol and drug screening is already required for Trauma 1 level hospitals, but not all at this time.

The original proposal to CMS was for a four-year program with payments initially weighted more heavily toward the hospital-focused domains, gradually shifting to a 50-50 split between the hospital-focused versus CCO coordination-focused domains. However, CMS has only approved two years of the program. The current working draft weights the first year's performance and associated payments on the nine original hospital-focused measures at 75%, and the new CCO coordination measures at 25%.

Committee discussion, questions, and decisions included:

The first period, which ends September 30, is a data collection period and not based on performance; does that still apply and relate to all the measures? (Yes, the first year is data collection).

OHA staff asked for guidance on the extent to which the committee would like to be involved with measure specification:

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The committee would like to know benchmarks for each measure; staff will send them to the table listing the benchmarks by email. Benchmarks for the first nine measures did not change from the committee's recommendations.

Committee members discussed the implications of using Medicaid patient days to calculate "hospital size" and expressed concern that it may create a disincentive for hospitals to reduce patient stay. Elyssa Tran explained that staff considered this point, and in an effort to mitigate any disincentive the calculation is based on a fixed point-in-time and does not change. The committee suggested adjusting the measure to include a severity factor based on case mix. Chair Gordon reminded the committee that its mandate is limited to recommending measures; distribution methodology is left to OHA. Elyssa Tran added that OAHHS worked closely with hospitals when developing this methodology, which was agreed by OHA. This topic was discussed at length; however, the methodology is limited by the availability and reliability of data, and the decision to include Medicaid patient days was reached unanimously by OAHHS and hospital representatives. Lori Coyner suggested that the committee review the impact of patient days after the baseline data is submitted, and make a recommendation to OHA on how the methodology may be improved if/when Oregon applies for an extension to the program.

The committee discussed the floor payment and expressed concern about the relatively new Behavioral Health measures. Lori suggested that OHA might discuss with CMS whether, in the first year, the floor could be awarded based only on the original nine hospital domains and not on the additional CCO-focused domains. This would give hospitals time to make process changes in response to new and unfamiliar requirements. Elyssa suggested changing the floor methodology to 5 out of 7 rather than 100%. Committee members also suggested creating a challenge pool similar to the CCO payment methodology; however the committee had previously recommended a single payment, so this is not an option.

Next Steps and Wrap Up

OHA staff will provide benchmarks and measure specifications to the committee. OHA will also keep the committee apprised of negotiations with CMS, and develop a communication strategy with the hospitals moving forward. If further discussion is needed, a phone call may be scheduled.

Public Testimony

None was provided.

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Decision: OHA staff will work closely with OAHHS to develop measure specifications. OAHSS will help convene a panel of hospital representatives with technical expertise to review and provide feedback on the drafts. This will be done by email due to the short timeframe.

Decision: Consistent the committee's guiding principles to minimize the impact of additional data collection on participating hospitals, the committee would prefer OHA measure and report on follow-up after hospitalization.

Question: What does OHA have in mind for measure #10, EDIE? Is the goal adoption of a process, or full implementation?

Elyssa Tran explained that most hospitals have EDIE up and running, so this is an area where work is still needed on what exactly we want to report. There is capability in the system for hospitals to share ED visit info with other hospitals, and CMS expressed a desire for hospitals to share ED information with primary care providers. Right now that is not happening automatically; it has to be done manually. Staff will have to consider both EDIE's technical capabilities, and what is possible to do in a short timeframe. The benchmark for this measure will likely be pass/fail versus a percentage hospitals must meet.

The committee stated that it's important to strategically consider with whom the responsibility to report EDIE will lay. Both behavioral health measures have been thoroughly vetted by the CCO Metrics and Scoring Committee, and the task now is just to determine how to implement them at the hospital-level. However, EDIE is a new measure and is less clear. It can go in several directions but must be practical for the hospitals. Lori Coyner took note of this concern and reminded members that hospital association representatives will be involved in the development of measure specifications.

Quality Pool Distribution Methodology

Lori Coyner explained the methodology to the committee (please see slides #7-17 in the PowerPoint presentation for more detailed explanation with examples).

In the first year, hospitals receive credit for measures based on the submission of baseline data, subject to OHA review and acceptance. In the second year, hospitals receive credit for measures by meeting an absolute benchmark or individual improvement target. Each year, payment is allocated in two phases:

Phase 1: Hospitals can earn a "floor" of \$500,000 if they achieve at least one measure in each domain.

Phase 2: After floor payments are made, the remainder of the pool is allocated measure-by-measure. The five hospital-focused domains are together weighted 75% (or 15% each), and the two CCO-focused domains are together weighted 25% (12.5% each).

If a domain includes more than one measure, the weight is distributed equally among measures within that domain. For example, the Medication Safety domain includes three measures and is a hospital-focused domain, so each measure is worth 5% (15/3). This weighted initial amount is the "base amount" that each measure is worth overall.

Once the "base amount" for each measure is calculated, it is allocated among the hospitals that have achieved that measure, and adjusted based on hospital size. Hospital size is based on Medicaid discharges and Medicaid patient days, equally weighted (50% each).

Discussion of Performance Measures and Distribution Methodology