Minutes
Initiation Work Group, HSCRC
Friday, May 2, 2008
9:00 AM – 10:20 AM
Room 100, 4160 Patterson Avenue
Baltimore, MD 21215

IWG Members Present: Dr. Charles Reuland, Johns Hopkins Health System; Ms. Pamela Barclay, MHCC; Ms. Barbara Epke, LifeBridge Health; Mr. Frank Pipesh, Center for Performance Sciences; Ms. Renee Webster, DHMH; Dr. Donald Steinwachs, John Hopkins Bloomberg School of Public Health; Dr. Trudy Hall, Mr. Robert Murray, Dianne Feeney, and Mr. Steve Ports, HSCRC.

IWG Members on conference call: Ms. Kathy Talbot, MedStar Health; Ms. Joan Gelrud, St. Mary's Hospital; Dr. Grant Ritter, Brandeis University.

Interested Parties Present: Mr. Hal Cohen, CareFirst; Ing-Jye Cheng, Maryland Hospital Association; Ms. Deme Umo, Ms. Debbie Rajca, Ms. Theressa Lee, MHCC; Mr. Frank Pipesh, Center for Performance Sciences; Ms. Mary Whittaker, Greater Baltimore Medical Center; Kristin Geissler, Navigant Consulting; Don Hillier, consumer.

Interested Parties on Conference Call: Ms. Sylvia Daniels, University of Maryland Medical Center; Dr. Lynne Adams, Upper Chesapeake Health; Mr. Gerry Macks, MedStar Health; Ms. Rena Litten, Western Maryland Health System; Chuck Orlando, Sinai Hospital.

I. Welcome and Introductions: Dr. Trudy Hall called the Initiation Work Group (IWG) meeting to order and asked telephone participants to announce themselves. Dr. Hall then solicited comments on the minutes from the previous meeting of the IWG. Dr. Hal Cohen noted that he had suggested that the level of revenue set aside for the P4P system should be "above 0.5% of revenue" not "about 0.5% of revenue." He requested that the minutes be amended accordingly. The minutes were approved unanimously with this correction.

II. Summary of the April 25, 2008 Meeting of the IWG Subcommittee: Mr. Steve Ports summarized the April 25, 2008 meeting of the IWG subcommittee as follows:

Dr. Grant Ritter presented the same analysis provided to the IWG at the last meeting using data from three quarters of 2007 and all of CY 2006. Dr. Ritter explained that CMS is considering a rule stating that not more than 40% of measures being used for pay for performance should be topped off measures. Currently, Maryland hospitals are showing between 25% and 33% topped off measures by hospital. Mr. Chuck Orlando stated that he understood why some of the smaller hospitals were reporting on 10 or fewer measures but did not understand why certain larger hospitals were. He stated that it is unfair to give a full score for a hospital that is only being scored on 2 measures. Dr. Vahe Kazandjian added that the number of measurers being reported is increasing from year to year and is comfortable with the status of the model going forward. Dr. Cohen mentioned that the model does not need to be overly refined given the fact that currently on about 1 tenth of a percent is at risk. Mr. Don Hillier said that the compression in scores shows the need to move forward with new measurers in the near future. Dr. Ritter

agreed and mentioned that mortality, readmissions, and other similar measures can be considered for the future.

Mr. Murray presented the list of unresolved issues as he did at the previous IWG meeting. He mentioned, relating to unresolved issue #1 (credit for missing topped off measures), that Dr. Ritter will provide additional analysis. He added that #2 (rule for down then ups) and #3 (rule regarding reporting too few measures) were close to being resolved. There was discussion regarding #4 (the magnitude of funding available) and #5 (data periods). On #4, Dr. Cohen said he understands why we are starting with a small amount at risk but feels that it needs to grow over time. He again stated that the amount to be redistributed should not be a percentage of the update factor but a percentage of the revenue, adding that using a percentage of the update factor perpetuates relegating it to a smaller amount.. Mr. Murray said that the dollar amount is the number that is most relevant. Whatever the percentage, staff will be focused on the dollar amount. Mr. Murray also stated that the magnitude issue will be part of the discussions of the Commission and the industries relating to the next 3-year payment arrangement. Mr. Orlando suggested that as the program moves forward the same compression will not be realized and that the spread of rewards will vary to a greater degree. Ms. Ing-Jye Cheng stated that if rewards were provided on attainment only, the spread would be greater. Dr. Cohen stated that he believes that rewards should be for both attainment and improvement. Mr. Murray added that the Premier project clearly demonstrated that it is important to use both attainment and improvement in rewarding hospitals on performance. On issue #5 (initial data period), Ms. Cheng suggested that we compare 9 months to 9 months – the period from July 2007 to March 2008 compared to July 2008 to March 2009 for FY 2010 rewards. Mr. Murray stated that if the issue is looking back, this looks back to July 1, 2007 and explained that these data have been collected and the measures have been used publically since before 2005 and that they have been on the MHCC performance guide as well. The HSCRC is using these measures because they have been vetted and published, he stated. The group also indicated that using 9 months exacerbates the issues of low case counts and the number of measures on which hospitals are reporting. MHA representatives said they will go back to the hospitals to consider this issue further.

Ms. Barbara Epke stated that she approved of initially comparing 9 month intervals, as long as it did not result in significantly lower case counts. She noted that the concern of many hospitals was that there might be a retroactive starting date and that this made the 9 month comparison period more appealing than a 12 month comparison period. Dr. Grant Ritter commented that there is a clear improvement in case counts in moving from a 9 month comparison period to a 12 month comparison period. He added that it was unclear, however, whether there was greater score stability. Ms. Cheng reiterated that the primary concern of hospitals was a retroactive starting date. Dr. Charlie Reuland offered an example of hospital that would be negatively affected by a retroactive starting date. Mr. Murray noted that since hospitals are rewarded relative to one another and that they would all be equally disadvantaged by a retroactive starting date, this disadvantage should wash out. He added that the amount of money at risk is very small. Dr. Reuland suggesting lowering the minimum case count to 8 instead of 10 for the 9 month comparison. Dr. Ritter replied that lowering the minimum case count for the topped off measures would probably not have any negative effects, but he did not recommend lowering the minimum case count for non-topped off measures. Ms. Joan Gelrud inquired as

to what the implications of a 9 month comparison interval were for small and rural hospitals. Ms. Epke stated that she did not believe that Dr. Reuland's example was atypical and added that there are disadvantages to both comparison periods. Dr. Reuland inquired as to whether the impact of a 9 month comparison interval. Ms. Epke inquired as to why it was not possible to use a calendar year interval. Mr. Murray stated it was not possible to use a calendar interval for the first measurement interval because it would be data overlap when the model switched to a a fiscal year interval.

III. Further Analysis of "Topped Off" Measures: Dr. Ritter began by explaining that some topped off measures have long tails due a majority hospitals scoring high and a few scoring low. Dr. Ritter reiterated the reasons for using topped off measures: 1) to prevent backsliding, 2) to encourage stragglers to catch up, and 3) to allow hospitals to report positive statistics.

Dr. Ritter continued by discussing ways to treat hospitals with less than 10 cases. He noted that both CMS and the IWG had developed three options for approaches: 1) extend the sampling time, 2) require fewer than 10 cases, or 3) use the lower of the hospital's own score or the mean score of all hospitals. Ms. Epke inquired as to which Dr. Ritter thought was the most statistically fair method. Dr. Ritter replied that he thought the third approach was the most fair.

IV. Preliminary Draft HSCRC Report and Recommendations on Quality-based Reimbursement: Mr. Murray summarized the draft report and solicited feedback from meeting participants. Mr. Murray noted that he wanted to include some examples of how the model is supposed to work in the report before it was sent to the HSCRC. Mr. Murray also read through the recommendations for the benefit of the meeting participants.

Mr. Murray stated that written comments should be submitted by May 8 or May 9 at the latest. Dr. Don Steinwachs suggested showing the percentage of discharges are covered by the model to illustrate why it is necessary to continue to expand the model. Dr. Steinwachs also suggested noting that Maryland is the only state in which all of the payors are under the same quality reward system. Mr. Murray responded he would make Maryland's unique opportunity clearer in the report. Ms. Barclay concurred with Dr. Steinwachs and suggested moving this statement forward in the document. Dr. Steinwachs recommended including language about how small volume hospitals are unique and how the IWG has tried to make the scoring process fairer. Dr. Cohen stated that Maryland should not always follow Medicare's lead in selecting the significant measures and should continue to look to other states for innovative ideas. Ms. Ing-Jye Cheng recommended stressing the incremental nature of the program. She also suggested that press releases and the public face of the P4P model should be coordinated with the MHCC. Mr. Murray agreed with Ms. Cheng that the model could benefit from the experience of the MHCC. Ms. Epke suggested noting that the movement toward capturing all data and not having to rely on sampling would be increasingly feasible as hospitals transition to automated record keeping. Dr. Reuland inquired as to whether any hospitals have had cases excluded due to failed audits. Ms. Dianne Feeney explained that some hospitals do fail, but it is unclear what the failure rate is relative to other states as this information is not available to the public. Mr. Ports commented that the data vendor RFP has more robust demands on data validation.

Mr. Gerry Macks inquired as to the cost establishing and operating our own data vendor that collects the data directly from hospitals. . Mr. Murray replied that there were few additional costs. Dr. Trudy Hall urged all participants to send their comments to Mr. Murray.

V. Responsibility, Makeup, and Timing of Evaluation Work Group: Mr. Ports noted the information included in the meeting about the Evaluation Work Group, and solicited comments via email regarding the responsibilities, makeup, and timing of the Evaluation Work Group.

VI. Other Business:

VII. Confirm related dates:

a. IWG Subcommittee – May 7, 2008 – 9:30 AM-11:00 AM
b. Draft Report to HSCRC – May 14, 2008 – 9:00 AM
c. IWG – May 23, 2008 – 9:00 AM-10:30 AM
d. Final Report to HSCRC – June 4, 2008 – 9:00 AM

VIII. Adjournment: The meeting was adjourned at 10:20 AM.