Minutes
Initiation Work Group, HSCRC
Friday, January 4, 2008
9:00 – 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. Joan Gelrud, St. Mary's Hospital; Dr. Vahe Kazandjian, Dr. Nikolas Matthes, and Mr. Frank Pipesh, Center for Performance Sciences; Dr. Grant Ritter, Brandeis University; Ms. Renee Webster, OHCQ; Ms. Barbara Epke, LifeBridge Health; and Dr. Trudy Ruth Hall, Mr. Robert Murray, and Mr. Steve Ports, HSCRC.

IWG Members on conference call: Dr. Donald Steinwachs, John Hopkins Health System; Ms. Beverly Collins, CareFirst; Ms. Kathryn Montgomery, University of Maryland School of Nursing.

Interested Parties Present: Ms. Traci Phillips, MHA; Ms. Mariana Lesher, Delmarva Foundation; Ms. Kristen Geissler, Navigant Consulting; Ms. Jean Acuna, Mercy Medical Center; Ms. Mary Whittaker, GBMC; Mr. Chuck Orlando, LifeBridge; Ms. Cindy Saunders, HSCRC; Ms. Carol Christmyer, Mr. Deme Umo, and Ms. Theressa Lee, MHCC; Mr. Hal Cohen, CareFirst and Kaiser Permanente; Mr. Greg Vasas, CareFirst; Mr. Craig Weller, DFMC.

Interested Parties on Conference Call: Ms. Jan Bahner, MedStar Health; Ms. Rena Litten, Western Maryland Health System; Ms. Carol Wicker, CPS; Ms. Denee Richmond, Holy Cross Health; Ms. Carol Christmyer, MHCC; and Mr. John O'Brien, Mr. Andy Udom, Ms. Cyndi Saunders, and Ms. Claudine Williams, HSCRC.

I. Welcome and Introductions: Ms. Trudy Hall welcomed the work group and asked telephone participants to introduce themselves. Ms. Hall inquired as to whether there were any changes to the minutes from the previous work group meeting. Dr. Charles Reuland noted that he was representing Johns Hopkins Health System and asked that this be reflected in the minutes. There were no further changes, and the minutes were approved unanimously.

II. Summary of the December 17, 2007 Meeting of the IWG Subcommittee: Mr. Steve Ports summarized the meeting of the IWG subcommittee. He stated that Dr. Ritter gave the same presentation to the subcommittee as he had to the initiation work group. Mr. Ports then proceeded to provide answers to some of the questions that had arisen during the subcommittee's meeting. He stated that Medicare is intending on implementing an unweighted, opportunity model with a threshold of 0.5 and a benchmark of the average of the top 10%. Mr. Ports also stated that Maryland or national data could be used to establish thresholds and benchmarks, although each data set carries its own advantages and disadvantages.

Mr. Ports reported that there was considerable discussion amongst the subcommittee as to how to reward for attainment and improvement. He stated that Dr. Ritter suggested using the greater of attainment or improvement for each hospital, while some of the hospital representatives suggested dividing the pool of available rewards by attainment and improvement. Mr. Ports also reported that the

payor representatives discussed whether hospitals should be rewarded for "downs then ups", e.g. for declining one year and improving to the original level the following year. Topped-out measures were also discussed at the subcommittee.

Data collection was also discussed at the subcommittee meeting, and three options were considered. The first option is to continue the current DUA, which expires in August. The second option is for hospital systems to submit data directly to the HSCRC in accordance with the Commission's specifications. The final option is to cooperate with MHCC and use a vendor to collect data directly from the hospitals or the hospitals' vendors. Mr. Ports reported that the two commissions (MHCC and HSCRC) see some advantages to the final approach, and that Ms. Pamela Barclay and Ms. Theressa Lee were drawing and Request for Proposals (RFP)and potential regulations for that option.

Mr. Ports noted that MHA representatives had suggested that an RFP should address issues regarding the "closing" of data, reducing data burden, and improving the timeliness of data submission. MHA also submitted a letter commenting on the timing and process of decision-making and the magnitude of the rate adjustment. Mr. Ports stated that the issues were within the purview of the Commission. Mr. Ports concluded by noting that the subcommittee is planning on holding its next meeting on January 14th or 15th.

Ms. Traci Phillips, a representative from MHA, clarified that MHA requested another subcommittee to be formed to examine payment methodology in particular. Mr. Robert Murray replied that it remains to be seen whether a separate subcommittee is necessary to investigate the payment methodology.

III. Analysis of most recent Maryland data from the QIO Clinical Data Warehouse: Mr. Vahe Kazandijan noted that hospital specific data was being made available for the first time, although the data was historical and did not represent a "present profile" of any of the hospitals. Dr. Ritter continued by explaining that the data was collected between October 1, 2005 and September 30, 2006, and that he employed the methodology used by CMS with a 50% threshold and the mean of the top 10% as a benchmark to score the hospitals. Hospitals that failed to have a minimum of 10 patients for a particular measure were not assessed on that measure. This included a particularly small, outlier hospital. Dr. Ritter noted that this raised some concerns about comparing large and small hospitals. Dr. Ritter also stated that he had implemented an appropriateness of care model, which he had designed. He then presented the results of applying these models to the work group, noting that there was one outlier hospital. Dr. Ritter concluded by stressing that his analysis was a data exercise.

Dr. Ritter compared two graphs depicting the opportunity model's distribution of points. One treated all measures equally, while the other treated topped-off measures differently. Dr. Ritter took care to note that treating the topped-off measures differently yielded a more normal distribution, although it penalized hospitals that underperformed on topped-off measures.

Dr. Reuland inquired as to whether Dr. Ritter had examined what point distributions these models would yield if peer grouping was utilized. Dr. Ritter

replied that even with peer grouping the outlier hospital would still deviate significantly from the norm.

Dr. Kazandijan reiterated his comment that one of the most important considerations the Initiation Work Goup will face is whether to use relative or absolute measures, as well as whether each measure will carry an equal weight.

Dr. Ritter continued by discussing the results of the appropriateness of care model in greater detail. He noted that the appropriateness of care model did not yield a bell-shaped curve, rather many hospitals clustered toward the bottom of the performance score. He also noted that the appropriateness of care model would be more "conservative" in its distribution of points, giving the majority of points to a few hospitals at the top of the spectrum.

Dr. Beverly Collins inquired as to how the topped-off measures were treated differently. Dr. Ritter reiterated his comments from the last meeting and noted that the topped-off measures were treated absolutely using 0.6 as a threshold and 0.9 as a benchmark. Dr. Ritter added that six measures were topped-off. A measure is topped off when the 75^{th} percentile is within two standard errors of the 90^{th} percentile.

Dr. Reuland requested that Dr. Ritter present a table with the threshold and benchmark for each measure. Dr. Ritter stated that doing so might give hospitals a false impression of the levels they needed to attain to be awarded points.

Mr. Murray inquired as to whether the appropriateness of care model might be more suited to encouraging hospitals to improve the quality of healthcare even if it is statistically less robust. Dr. Ritter agreed that this might be the case and added that a clinician would be able to provide a better perspective on this issue. Dr. Kazandijan commented that clinical weighting is a slippery slope and that the salient outcome data was not yet available. Accordingly, Dr. Kazandijan stated that the appropriateness of care model is not ready. Dr. Ritter noted that although the opportunity and appropriateness of care models use significantly different methodologies, they indicate the same top five hospitals. Dr. Kazandijan commented that the opportunity model seemed to be a fair model to start with, although a switch to an appropriateness of care model may be desirable later on. Mr. Murray asserted that in using either model it is necessary to obtain outcome data to analyze the efficacy of the approach.

It was inquired as to how many hospitals responded to all measures. Dr. Ritter replied that 20 hospitals responded to every measure, while most hospitals responded to 17 or 18 measures. There was one hospital that responded to less than 10 measures. A concern was expressed that hospitals which responded to only a few measures were at a statistical advantage in performance ranking.

Dr. Reuland inquired as to whether the work group intended on eventually producing anticipated performance data. Dr. Ritter replied that he did not expect to pursue that route. Dr. Kazandijan commented that this brings up an old debate regarding whether quality should vary with hospital size. Dr. Reuland expressed his concern that the work group may abandon peer grouping. Mr. Murray responded by stating that peer grouping is not frequently used by the work group.

Dr. Ritter stated that he would examine how the results of the models changed if peer grouping was utilized.

IV. **Other Business:** Mr. Ports distributed encryption software to work group members so that they can open confidential data, which will be disseminated at a later date.

V. **Next Meeting Date:** The next meeting date was tentatively set for January 25, 2008 at 9:00 AM.

VI. **Adjournment:** The meeting was adjourned at 10:20 AM.