Minutes
Initiation Work Group, HSCRC
Friday, February 22, 2008
9:00 – 10:10 AM
Room 100, 4160 Patterson Avenue
Baltimore, MD 21215

IWG Members Present: Ms. Pamela Barclay, MHCC; Dr. Grant Ritter, Brandeis University; Ms. Barbara Epke, LifeBridge Health; Ms. Kathy Talbot, MedStar Health; Dr. Nikolas Matthes, Center for Performance Sciences; Mr. Robert Murray and Mr. Steve Ports, HSCRC.

IWG Members on conference call: Dr. Charles Reuland, Johns Hopkins Health System; Ms. Mariana Lesher and Craig Weller, Delmarva Foundation (Maryland QIO); Ms. Renee Webster, DHMH; Dr. Christian Jensen, Delmarva Foundation.

Interested Parties Present: Mr. Paul Sokolowski, MHA; Mr. Hal Cohen, HCI; Mr. Deme Umo, MHCC.

Interested Parties on Conference Call: Mr. Gerry Macks, MedStar Health; Mr. Greg Vasas, CareFirst; Mary Whittaker, GBMC; Ms. Karol Wicker, Center for Perfomance Sciences; Ms. Sylvia Daniels, University of Maryland Medical Center; Ms. Deneen Richmond, Holy Cross Hospital; Mr. Don Hillier, former HSCRC Commissioner; Ms. Jean Acuna, Mercy Medical Center; Ms. Traci Phillips, MHA; Ms. Carol Christmyer, MHCC

I. Welcome and Introductions: Mr. Robert Murray called the Initiation Work Group to order and asked telephone participants to announce themselves. Mr. Murray then solicited comments on the minutes from the previous meeting of the IWG. Dr. Hal Cohen stated that in the third paragraph of the third section of the minutes, the phrase "fewer than 17 measures" should be changed to "17 or more measures." The minutes were approved with this alteration.

II. Summary of the February 13, 2008 Meeting of the IWG Subcommittee: Mr. Steve Ports summarized the February 13, 2008 Meeting of the subcommittee. Mr. Ports stated that Dr. Grant Ritter presented on the appropriateness of care model and the correlation between hospital performance and reporting on 17 or more measures. Responding to Dr. Ritter's presentation, Dr. Cohen suggested adjusting scores so that those hospitals reporting on fewer topped-off measures are not disadvantaged. Ms. Mariana Lesher commented that adjusting the exclusion criteria for topped-off measures may alleviate this problem. Mr. Ports noted that the Delmarva Foundation and the HSCRC will be following up on Ms. Lesher's comment. Mr. Ports also noted that Mr. Murray outlined the preliminary draft recommendations for the IWG. Mr. Chuck Orlando and Mr. Greg Vasas stated that they would prefer to see improvement comparisons based on a 12 month period, as opposed to 6 months, due to the consideration that a shorter comparison period may aggravate the problem of underreporting on topped-off measures.

III. Follow-up Analysis on Topped-Off Measures, Number of Measures Present, and Exclusions: Dr. Ritter began by commenting on the variation in scores due to the number of topped-off measures on which a hospital reports. Dr. Ritter provided the work group with a list of all of the measures and noted which were topped-off. He added that many of the AMI measures that are not topped-off are very close to

being topped-off by his criteria. Dr. Ritter offered three reasons for continuing to use topped-off measures in the model: 1) they are the oldest measures, and it is important to prevent backsliding, 2) they still provide an incentive to the lowest scoring hospitals, and 3) they allow hospitals to report favorable performance. Dr. Ritter added that although there are 220 potential topped-off measure reports (44 hospitals x 5 measures), only 131 are actually reported. Of those 131, 110 reports received 10 out of 10 points. Dr. Ritter noted that bigger hospitals are almost always receiving 10 points on all topped-off measures and that smaller hospitals are disadvantaged if they do not report on topped-off measures. The primary reason for not reporting on topped-off measures was not meeting the minimum requirement of 10 patients.

Dr. Ritter proposed two solutions to correct this problem. The first solution is to award the average score (9.5) to all hospitals not reporting on the topped-off measures. The other solution is to eliminate the 10-patient requirement. Dr. Ritter added that this latter option had a big affect on score but did not change the ordering of the hospitals very much. Dr. Ritter also expressed his opinion that the latter option was fairer and eliminated any correlation between reporting and performance. Dr. Ritter stated that the primary reasons for exclusions were transferring patients out or in, procedure not applicable, and procedure medically not advised.

Dr. Ritter inquired about the auditing procedure. Ms. Barbara Epke reported that the auditing procedure involved rigorous review of five charts and is rather expensive.

Dr. Ritter reported that exclusion rates were very high for some hospitals, and that the mean exclusion rate is around 50%. Dr. Ritter postulated that this may eventually prompt the IWG to find more robust measures. Ms. Epke concurred with this idea.

Dr. Charlie Reuland suggested lengthening the time horizon for the hospitals not reporting on the topped-off measures in order that they can meet the minimum patient requirement. Dr. Ritter stated that he thought this adjustment was intriguing and replied that he would look into it. Mr. Ports inquired as to whether the time horizon would be lengthened for all hospitals or just the non-reporting hospitals. Mr. Murray wondered whether measures changing over time might interfere with implementing this strategy. Dr. Reuland noted that according to his own analysis, it looked like 10 of 19 measures may be topped-off next year. Dr. Cohen inquired about whether an appropriateness of care model could be used for the AMI topped-off measures in the event that they all become topped-off. Ms. Epke expressed her concern that it would confuse matters to use two models in the first year of implementation.

IV. Preliminary HSCRC Draft Recommendations: Mr. Murray stated that he was unable to complete a simulation for this meeting but will have one prepared for the next subcommittee meeting. Summarizing the recommendations, he noted that the HSCRC was not recommending any additional funding above the usual update factor and added that Medicare is likely to reduce funding to the update. There is a possibility that additional funding will be available after 2011.

Mr. Murray stated that the HSCRC is considering doing comparisons between Maryland hospitals' performance and national hospitals, as well as correcting for concave improvement and other unintended behavior.

Ms. Epke stated that she wanted to hear more about the relative weighting of attainment and improvement. Dr. Reuland and Ms. Talbot concurred with Ms. Epke and stated that the matter had not been adequately discussed. Dr. Reuland and Ms. Epke said that the Commission should consider weighing attainment greater than improvement. They were concerned that weighing both attainment and improvement equally would penalize those hospitals that were early adopters of the evidence-based practice. Ms. Talbot said that the addition of new measures over time would continually penalize hospitals that were attaining earlier on measures that the HSCRC considers at a later date. Grant Ritter explained that the way the methodology is being proposed already advantages the early adopters.

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Ms. Pamela Barclay inquired about rewarding hospitals for maintaining performance. Dr. Ritter replied that that was the intent of awarding points for attainment. Mr. Murray noted that in a UK-based attainment-only model, there was very little improvement in performance and quality.

Mr. Murray noted that during the spring, the HSCRC was looking to set-up the Evaluation Work Group.

Ms. Epke inquired about adding indicators and whether that role will fall upon the Evaluation Work Group. Mr. Murray responded it would probably fall under the purview of the Evaluation Work Group.

V. **Other Business:** There was no other business.

VI. **Next Meeting Date:** The next meeting was set, by email, for March 14, 2008 at 9:00 AM

VII. **Adjournment:** The meeting was adjourned at 10:10 AM.