Minutes
Initiation Work Group, HSCRC
Friday, December 7, 2007
9:00 – 10:05 AM
Room 100, 4160 Patterson Avenue
Baltimore, MD 21215

IWG Members Present: Dr. Charles Reuland, Johns Hopkins School of Public Health; Ms. Pamela Barclay, MHCC; Dr. Vahe Kazandjian, Dr. Nikolas Matthes, and Mr. Frank Pipesh, Center for Performance Sciences; Dr. Grant Ritter, Brandeis University; Ms. Renee Webster, OHQ; Ms. Barbara Epke, LifeBridge Health; Dr. Trudy Ruth Hall, Mr. Robert Murray, and Mr. Steve Ports, HSCRC.

IWG Members on conference call: Ms. Kathy Talbot, MedStar Health; Dr. Donald Steinwachs, John Hopkins Bloomberg School of Public Health; Ms. Joan Gelrud, St. Mary's Hospital; Ms. Marybeth Farquhar, AHRQ.

Interested Parties Present: Ms. Ing-Jye Cheng, MHA; Ms. Traci Phillips, MHA; Mr. Greg Vasas, CareFirst; Mr. Hal Cohen, CareFirst; Mr. Don Hillier, former HSCRC Chairman; Mr. Rodney Taylor, MHCC; Sylvia Daniels, University of Maryland; and Deneen Richmond, Holy Cross Health.

Interested Parties on Conference Call: Mr. Gerry Macks, MedStar Health; Ms. Mary Beth Farquhar, ARC; Ms. Karol Wicker, Center for Perfomance Sciences; Ms. Carol Lannard for Dr. Lynne Adams, Upper Chesapeake Health; and Dr. Sam Ogunbo; Mary Wittaker, Greater Baltimore Medical Center.

I. Welcome and Introductions: Mr. Steve Ports welcomed the work group and asked telephone participants, work group participants, and others in attendance to introduce themselves. Dr. Trudy Hall arrived after the introductions. The minutes of the October 26, 2007 meeting were approved without corrections.

II. Summary of the November 16, 2007 Meeting of the IWG Subcommittee: Mr. Ports began by identifying the six members of the IWG Subcommittee:

Ms. Alycia Steinberg, DHMH
Mr. Chuck Orlando, LifeBridge Health Management Team
Ms. Ing-Jye Cheng, MHA
Dr. Hal Cohen, Carefirst and Kaiser Permanente
Mr. Kirk Stapleton, United Health Networks
Mr. Kevin Kelbly, Carroll Hospital Center

Mr. Ports then summarized the proceedings of the Subcommittee's recent meeting. He noted that Mr. Robert Murray read the Subcommittee's charge and that Mr. Vahe Kazandijan presented the timeline and measures to the Subcommittee. These events were followed by a discussion, led by Dr. Grant Ritter, on the current measures and models, "topping-off," peer grouping, benchmarking, and other topics of interest to the Subcommittee. Mr. Ports shared some of the concerns that came up during the Subcommittee's meeting with the IWG. These concerns included whether the chosen measures would be made available to hospitals by May of 2008, whether rate adjustments would be prospective or retrospective, whether the IWG

would take into consideration the diverse impact of rewards and incentives, whether rewards would be provided for maintenance or improvement, and which measures were currently under consideration. Mr. Ports reported that the IWG was able to respond to all of these concerns, noting that the IWG will keep in mind the May 2008 deadline, that rate adjustments will be made based on data collected after policy has been set, that the IWG is considering the diverse impact of rewards and incentives, that rewards will be provided for both maintenance and improvement, and that the list of measures currently under consideration was forwarded to interested parties.

III. Additional Modeling of Most Recent Maryland Data from the QIO Clinical Data Warehouse: Dr. Kazandijan began by noting that some measures may be particularly useful for some hospitals but not for other hospitals and that this will be an important consideration in developing models. He added that the IWG is very close in its philosophy to that presented in Medicare's blueprints for action regarding performance-based reimbursement. Finally, Dr. Kazandijan stated that the IWG will eventually be able to provide hospital specific analysis, and in this respect, the IWG is in compliance with its timeframe.

Dr. Grant Ritter began by discussing the consistency of sets of quality measures for hospital peer groups. He stated that each peer group contained roughly fifteen separate hospitals and that sets of quality measures were very consistent among each peer group. He made note of some specific aberrant measures that did not correlate well with other measures in their sets. He stated that most of these aberrant measures seemed to be topped-off. The exception to this trend was HF – 3, which was aberrant but not topped-off. Dr. Ritter added that all of the measures under consideration are process measures and that no risk adjustments had been made for them.

Ms. Barbara Epke inquired as to when the IWG would decide whether or not to use peer grouping. Mr. Robert Murray responded that the IWG would make that decision within the next month or two.

Ms. Kathy Talbot asked why the SIP measures were poorly correlated for Peer Group 2 but not for the other peer groups. Dr. Ritter stated that he did not know why those measures did not correlate well but added that he was looking into it.

Dr. Ritter continued the discussion by defining a few terms he would be using throughout the meeting. According to Dr. Ritter, a benchmark is a realistic standard of excellence; a threshold for attainment is the level at which attainment points start to be awarded; and improvement is when a hospital obtains a higher quality measure rating in the assessment year than it had in the prior year. Dr. Ritter went on to discuss some of the issues that the IWG would need to settle in establishing an incentive system. He noted that the work group would need to decide whether the threshold and benchmark points would be determined relatively or absolutely. He added that the incentive system should be "ramped" from the threshold to the benchmark, in contrast to the Premier system, which awarded hospitals equally whether they had attained the threshold or the benchmark. Dr. Ritter finished by discussing some alternative models, including opportunity models and appropriateness of care models, as well as aggregating measures. Dr.

Kazandijan inquired as to how the work group felt, generally, about the relative/absolute debate.

Mr. Murray inquired as to what additional costs were associated with aggregating measures. Dr. Kazandijan responded that in aggregating measures it was necessary to justify the weighting system used, and it takes time to reach a consensus on which system of weights is most appropriate. Mr. Gerry Macks stressed that the work group did not want to be seen as manipulating data or treating data as more accurate than it really is.

IV. **Analysis Relating to "Topped-off" Measures**: Dr. Ritter began his presentation on topped-off measures by stressing that they can only be used in a limited sense. A topped-off measure is a measure where most hospitals are scoring at the maximum score or close to it. It is therefore necessary to treat topped-off measures absolutely, i.e. set a low benchmark and any hospital that attains the benchmark receives full credit for the measure. Hospitals that do not attain the benchmark are docked points. As poorly performing hospitals catch up, the measure can be treated relatively.

Dr. Ritter noted that, under the proposed systems, it would be possible for a single hospital to receive quality points for attainment and improvement. He suggested that hospitals should receive credits according to the system which awards them the most. If a hospital is set to earn five credits due to attainment and eight credits due to improvement, then that hospital should receive eight credits in total, ignoring the credits it would have received due to attainment.

Dr. Trudy Hall inquired as to whether there were any questions regarding Dr. Ritter's presentation. Dr. Kazandijan further clarified the distinction between maintenance and improvement. He added that the measures had been selected on the basis that there was general consensus that they were linked to improving the quality of care.

Mr. Ports asked Dr. Ritter to clarify his claim that smoking cessation was poorly correlated with the other measures in its group. Dr. Ritter stated that the smoking cessation measure was topped-off in all peer groups and was poorly correlated with the pneumonia measure. Dr. Ritter added that Maryland is ahead of the curve in smoking cessation advice/counseling, but in line with hospitals across the country according to the AMI measures.

Mr. Murray concluded the discussion by stating that it was necessary to identify the decisions that the work group needs to make. Ms. Ing-Jye Cheng inquired as to how the IWG planned to include other stakeholders. Mr. Murray asked Ms. Cheng which stakeholders she had in mind. Ms. Cheng clarified her question by stating she was curious whether the IWG would convene a technical group. Mr. Murray replied that a technical group could be convened if it was deemed necessary.

V. **Other Business:** Mr. Ports noted that he had included a press release in the packets distributed at the meeting and had sent to the members of the IWG a copy of the report to CMS on value-based purchasing.

VI. **Next Meeting Date:** The next meeting of the Initiation Work Group was set for January 4, 2008 at 9:00 AM.

VII. **Adjournment:** The meeting was adjourned at 10:05 AM.