Minutes
Initiation Work Group, HSCRC
Thursday, April 17, 2008
9:00-10:30 AM
Room 100, 4160 Patterson Ave
Baltimore, MD 21215

IWG Members Present: Dr. Charles Reuland, Johns Hopkins Health System; Ms. Pamela Barclay, MHCC; Ms. Renee Webster, DHMH; Dr. Grant Ritter, Brandeis University; Mr. Craig Weller and Ms. Mariana Lesher, Delmarva Foundation (Maryland QIO); Dr. Nikolas Matthes, Dr. Vahe Kazandjian, and Mr. Frank Pipesh, Center for Performance Sciences; Mr. Robert Murray, Ms. Diane Feeney, and Mr. Steve Ports, HSCRC.

IWG Members on Conference Call: Ms. Kathy Talbot, MedStar Health; Ms. Joan Gelrud, St. Mary's Hospital; Ms. Beverly Collins, CareFirst;

Interested Parties Present: Ms. Jan Bahner, MedStar Health; Andy Udom, HSCRC; Ms. Ing-Jye Cheng, MHA; Mr. Don Hiller, former HSCRC Commissioner; Ms. Theressa Lee, Ms. Carol Christmyer, and Mr. Deme Umo, MHCC; Allison Lipitz, CPS; Mr. Greg Vasas, CareFirst.

Interested Parties on Conference Call: Ms. Deneen Richmond, Holy Cross Hospital; Ms. Rena Litten, Western Maryland Health System; Ms. Sylvia Daniels, University of Maryland Medical Center; Dr. Lynne Adams and Ms. Jane Gordon, Upper Chesapeake Health; Ms. Mary Whittaker, GBMC; Mr. Gerry Macks, MedStar Health;

1. **Welcome and Introductions of Members and participants:** Mr. Robert Murray called the Initiation Work Group to order. Following phone introductions, Mr. Murray introduced a new staff member, Ms. Dianne Feeny. Mr. Murray solicited comments on the minutes from the previous meeting of the IWG. There were no comments, and Ms. Pamela Barclay moved that the minutes be approved. Ms. Renee Webster seconded the motion. The minutes were approved unanimously.

2. **Summary of March 19, 2008 Meeting of the IWG Subcommittee:** Mr. Steve Ports summarized the March 19, 2008 meeting of the subcommittee. Mr. Ports stated that Mr. Murray summarized the preliminary staff draft recommendations. Mr. Murray highlighted a number of issues in the recommendations that remain unresolved. First, in evaluating improvement it is preferable to compare 12 months to 12 months, but the vendor may only be supplying data sufficient for 6 months to 6 months or 6 months to 12 months comparisons. Second, the issue of hospitals' performance declining from one year to the next was unresolved. Dr. Cohen suggested using the highest previous year's score as the base to alleviate this problem. This would have to be done at the level of individual measures. Declining scores could occur due to many reasons such as technology changes, changes in the hospital mission, and changes to the measures. Third, the

magnitude of the revenue to be withheld remains to be determined. Mr. Murray has been using 0.5% of revenue as an example, and Dr. Cohen has suggested setting the level in advance at above 0.5% of revenue and not as a percentage of the update factor. Dr. Cohen added that it should not be less than 0.5% of revenue. Ms. Ing-Jye Cheng said that the rate should not be determined a priori due to factors such as inflation, which can have significant impacts on hospitals' financial conditions, and other major changes that cannot be reliably predicted. Dr. Cohen stated that, looking at the exchange rate curve, no hospital has 0.5% at risk. He noted that at most, a hospital has 0.2% at risk. Mr. Murray stated that he understood the need for flexibility, and suggested that the policy state that the amount withheld be no more than a certain percentage of the update factor. Mr. Murray also suggested that a number could be set as a goal and changed under certain circumstances. Dr. Vahe Kazandjian said that adding the 2007 data would help the IWG to understand if a 12 month to 12 month comparison is necessary or if a 6 month to 12 month comparison might suffice. He added that the 2007 data might illuminate the issues of concave improvement, the effects of the topped-off measures, and the prevalence of the quality of data versus the quality of the care. There were no additions or corrections to Mr. Ports' summary.

3. **Update of Analysis of Maryland data from the QIO Clinical Data Warehouse using Opportunity Model and 2007 Data:** Mr. Murray asked Dr. Kazandjian and Dr. Grant Ritter to provide an update on the analysis of the Maryland data. Dr. Kazandjian stated that the Commission will be reviewing the relationship between attainment and improvement in the approved methodology for the benefit of the interested parties. Dr. Ritter noted that the data for 2007 spans only nine months and acknowledged that there may be a statistical problem in comparing performance over 9 months with performance over 12 months. In particular, Dr. Ritter noted that some hospitals will have difficulty meeting the 10 patient minimum on some measures given that they are sampling over a shorter time span. Dr. Ritter explained the definitional criteria for topped-off measures. He stated that a measure is topped-off if the 75^{th} percentile is within two standard deviations of the 90^{th} percentile. If a hospital is at 0.9 on a topped-off measure, then they are awarded 10 points. If the hospital is below 0.9, then they begin to lose points. Dr. Ritter asked if anyone had any questions regarding the topped-off measures. Dr. Charlie Reuland inquired as to whether more measures will become topped-off in later years. Dr. Ritter replied affirmatively and stated that there will be an increase in topped-off measures due to real improvement. Dr. Kazandjian also agreed and stated this may create an interesting dilemma in which it is necessary to discover new measures of hospital performance, because hospitals are performing ideally on the current measures. Dr. Ritter responded by suggesting that one option is to adopt an appropriateness of care model, due to its more discerning scoring criteria. Dr. Reuland commented that he does not believe that it would be beneficial to relax the topped-off measures criteria to reduce the number of topped-off measures. He would prefer, alternatively, adding new metrics. Dr. Ritter agreed with Dr. Reuland and added that there are some policy implications behind the definition of topped-off measures that should be

preserved. Dr. Ritter explained that there is the potential to get attainment points or improvement points, and the combination of the scores for each measure is the better of the two numbers. He added that the topped-off measures are an exception to this rule. Dr. Ritter reiterated the difference between attainment and improvement points, noting that they provided two chances for hospitals to be awarded points.

4. **Discussion of Charts using 2006 and 2007 Data to Create Concave Curve for Exchange Rate:** Dr. Ritter discussed the graphs in his handout and how points were distributed among different hospitals. Dr. Ritter pointed out that the results were similar to the previous year's although there was greater clustering. Mr. Ports noted that the lower hospitals have improved and there is greater compression amongst hospitals. Dr. Ritter noted that one of the most striking differences between this year's and last year's data is the narrower band of true scores; most hospitals are between a 0.4 and a 0.55. He explained that the greatest risk to revenue is about .15 and the greatest potential gain is about .05. Dr. Ritter noted some of the factors that might be contributing to the severe compression: 1) the improvement factor helps bring lower scoring hospitals up and 2) more hospitals scored all 10 points on the topped-off measures.

   Dr. Ritter described CMS's regulations regarding what counts in putting performance scores together:

   1) A hospital needs at least ten patients for a measure to be used ;

   2) In order to be eligible for the performance scoring, a hospital needs to have at least five measures; and

   3) No more than 40% of a hospital's reported measures can be topped-off.

   Dr. Ritter noted that no hospital in Maryland violates the third regulation. Dr. Reuland asks how these rules are enforced. Dr. Ritter acknowledged that CMS has not yet decided how to deal with violations of these regulations. Dr. Kazandjian raised the point that the curve showing the latest data has improved drastically and positively from the prior year's data. Dr. Kazandjian noted that because of this the model will need to be revised regularly. Dr. Kazandjian noted that, from a clinical perspective, not all measures are equal and that it is important to consider a mixture of measures. Dr. Kazandjian expressed his contentment that the new data has confirmed that the methodology is sustainable and addressed issues that were brought up with 2005-2006 data.

5. **Unresolved issues from the Preliminary HSCRC Staff Draft Recommendations relating to Quality-based Reimbursement:** Mr. Murray listed the following unresolved questions.

1) How might credit be given to hospitals disadvantaged by missing topped-off measures?

2) How to address scores that decrease in one year and increase in a subsequent year?

3) What should be done regarding hospitals reporting on too few measures?

4) How are the awards to be disbursed and at what magnitude?

5) What long will the comparison period be?

6) What is to be the function and composition of the Evaluation Work Group?

Mr. Murray described some of the responses to question #1 that have been discussed: 1) provide an average level of credit for that individual topped-off measure, 2) relax the minimum threshold of 10 patients to eight or five and use the score associated with that number, 3) provide the lower of the average for that measure and the actual score for that indicator based on less than ten patients, 4) extend the observation period until 10 cases are obtained, and 5) do nothing. Dr. Ritter asked for opinions about the responses presented. Dr. Reuland stated that extending the observation period seems reasonable. He also inquired about lowering the number of points awarded for topped-off measures to mitigate the degree to which they disadvantage certain hospitals. Dr Ritter stated that this would yield the same difficulties, although they might be less acute. Dr. Ritter stated that the root of this problem is hospitals that transfer their AMI patients to more suitable facilities and therefore do not report them. Dr. Kazandjian added that one of the challenges with extending the time period is that it may be influenced by changes during that time period such as changing technology and changing practices. This would make it difficult to analyze the whole time period as a homogeneous unit, but it is worth looking into extending the time period. Mr. Murray agreed and stated that response #3 (to question #1) seemed to be the most reasonable. Mr. Murray stated that the best way to address question #2 is to use the lowest scoring year as the base year in determining improvement.

Mr. Murray inquired about question #3. Dr. Ritter replied that they could take the average of their performance and a hospital's peer group performance, although it would be necessary to use a peer group method. Dr. Kazandjian asked if the peer group could be from the national level. Dr. Ritter replied affirmatively.

Mr. Murray commented on question #4. He mentioned that there was some discussion regarding magnitudes, and whether setting a fixed amount was preferable to waiting to see how the financial environment looks. He stated that the Commission is comfortable setting an amount of 0.5% or 10% of the update factor, and then finalizing this figure between September and early spring 2009.

Mr. Murray commented on issue #5. He said that in order to apply both attainment and improvement points, a base period should be set, and that the general preference would be a 12 month to 12 month period. He added that this will depend on the availability of data for 2008 when it is time to set the update factor for 2010. Mr. Murray noted that the MHCC is in the process of releasing an RFP to solicit the services of a vendor for the MHCC and the HSCRC to increase the timeliness of the data. Mr. Murray recommended waiting until June or July for the 2008 data. He stated that because of the tight clustering, most of the hospitals get their 0.5 contribution back, and if the data was obtained in June or July it might be possible to get the 12 month to 12 month period. Mr. Murray noted that staff prefers to have a fixed amount or a proportion that covers all three years as part of HSCRC's three-year payment arrangement. He added that the hospitals may want to negotiate the magnitude of the funding. Ms. Ing-Jye Cheng made comments on timing. She stressed the need for flexibility regarding the magnitude of the award and stated that it makes more sense to use a 12 month to 12 month comparison period. She explained that she was confused regarding using retrospective data going back two years. Mr. Murray replied that hospitals are aware of the fact that this data is being collected and will be used and added that the hospitals are aware that their performance is being examined. These data have been used for Joint Commission, CMS, and MHCC to report performance. He denied that using the retrospective data was negative on these grounds. He reiterated that it is important to look at attainment and performance and that the Commission wants this to be a fair process to adequately reward hospital performance. Mr. Murray asked whether there were any more comments about question #5

Mr. Murray noted that Mr. Ports and Ms. Feeney are working on question #6. Mr. Murray suggested an IWG subcommittee meeting for April 25 and an IWG meeting on May 2, with the aim of drafting recommendations for the HSCRC for its meeting on May 14. Mr. Murray also included a tentative IWG meeting for May 23. The targeted date for concluding the work group's activities is June 4. Dr. Kazandjian questioned the significance of the June 4 meeting. Mr. Murray explained that the June 4 meeting is to respond to potential revisions suggested by the HSCRC.

6. **Summary of Findings for Maryland from AHRQ 2007 State Snapshots Report:** Mr. Ports discussed the state snapshots from AHRQ. The snapshots have been described as showing declines in performance in Maryland. Mr. Ports mentioned that this snapshots ares based on 2004 and 2005 data and that more recent evidence suggests that the state of Maryland is performing better on many measures than many other states.

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

8. **Confirm next meeting date:** The next meeting for the Initiation Work Group, HSCRC is scheduled for May 2, 2008 at 9:00 AM

9. **Adjournment:** The meeting was adjourned at 10:30 AM