Draft Meeting Summary
Cardiac Services Advisory Committee
Tuesday, April 30, 2019
Maryland Health Care Commission
4160 Patterson Avenue, Baltimore, MD 21215

Work Group Member Attendees:

Jamie Brown, M.D. (phone)
Blair Eig, M.D. (phone)
Kristen Fletcher (phone)
Chris Haas, M.D. (phone)
Steven Hearne, M.D. (phone)
Keith Horvath, M.D. (phone)
Josemartin Ilao
Richard Pomerantz, M.D.
James Ridge
Rawn Salenger, M.D.
Jerry Segal, M.D.
Stuart Seides, M.D. (phone)
John Wang, M.D.
Stafford Warren, M.D.
David Zimrin M.D.

MHCC Staff Attendees:

Ben Steffen, Executive Director
Eileen Fleck, Chief, Acute Care Policy and Planning
Theressa Lee, Director, Center for Quality Measurement and Reporting (phone)
Paul Parker, Director, Center for Health Care Facilities Planning and Development
Suellen Wideman, Assistant Attorney General
Ose Emasealu, Program Manager, MHCC

Introductions and Meeting Overview

Ben Steffen welcomed members of the Cardiac Surgery Advisory Committee (CSAC) and all attendees introduced themselves. Ms. Eileen Fleck reviewed the meeting summary for the last CSAC meeting held on February 6, 2019. Some of the concerns about public reporting expressed by CSAC members at this meeting included ranking of programs, information overload for patients, risk averse behavior by surgeons with negative consequences for patients, and the utility of the STS composite star ratings. Ms. Fleck explained that because it was difficult to determine how many CSAC members agreed with the concerns raised, Maryland Health Care Commission (MHCC) staff sent a survey to all CSAC members. She reported that the results of the survey suggest that majority of the CSAC members support public reporting. The survey results also suggested strong support for using the STS composite star rating for coronary artery bypass graft surgery (CABG) cases as part of public reporting. There was not opposition to using the STS composite star rating for CABG in public reporting, but some respondents were neutral on use of it.

Overview of Literature on Public Reporting for PCI and Cardiac Surgery

Ms. Fleck summarized some of the conclusions from the articles distributed to CSAC members, and stated that there seemed to be greater concern about adverse physician behavior for percutaneous coronary intervention (PCI) cases than with CABG cases. She noted that there are some ways to mitigate the concerns raised about public reporting for PCI and CABG cases, including risk adjustment for outcomes and auditing data. She noted that in some states like California, public reporting is done at the surgeon level and the providers are given the opportunity to respond when necessary.

Stuart Seides, M.D. asked MHCC staff to explain the purpose of creating an additional platform for public reporting beyond what is currently available. Mr. Steffen responded that the intent is to hold the health system more accountable, to increase providers' awareness of the quality of the care available in public settings, and to provide information to consumers, patients, and their families. He explained that any publicly reported data will be an extra piece of information that may be used by patients in selecting where they seek care or treatment. He also added that transparency provides opportunities for improvement, and information should be available through multiple resources.

Ms. Fleck commented that the purpose is both to motivate providers to improve and to give consumers additional information that will help them to make decisions. She also suggested that linking from MHCC's web site to other sources for public reporting may be useful and should be considered. She acknowledged that providing information may not influence patients and providers as much as expected. Mr. Steffen commented that MHCC is not striving to be the single source for information, but it wants to be a trusted source for information.

Evaluation of Potential Measures for Public Reporting

Jose Ilao expressed skepticism about the value of public reporting that provides a lot more information above what is already available. He suggested that the average person assumes that their health care providers can be trusted because of oversight that is already in place. For this reason, it is not necessarily helpful to provide lots of details about the performance of health care providers through public reporting. He cautioned that once information is made available, it cannot be retracted.

Paul Parker read part of the Maryland statute, Health General Article §19-134(e), which addresses the system for comparable quality of care outcomes and performance measurement of hospital.

Dr. Segal cautioned that in fulfilling the mandate of the legislature, it was imperative for the group to remember the ethical provisions to do no harm. He noted that there was evidence of risk aversion that takes place from reported studies and asked how harm to patients may be avoided. He explained that risk aversion was particularly likely to occur in cases with cardiogenic shock, but these patients stand to benefit the most from emergency intervention. Mr. Steffen responded that published studies on CABG suggest that the magnitude of risk aversion may not be as consequential as was previously thought. There is more evidence of risk adverse behavior by

physicians for PCI cases. However, some of this is positive for patients when patients are transferred to more capable facilities that result in better outcomes for them. Dr. Segal agreed with Mr. Steffen, but he again restated his concern for patients in cardiogenic shock.

John Wang, M.D., argued that risk aversion is already occurring even at the current level of reporting. He suggested that the new public reporting by MHCC will further increase the level of risk aversion. He already sees less risk tolerance, although he is not sure if that is something positive or negative. Jamie Brown M.D., agreed with Dr. Wang. Dr. Brown explained that risk aversion is already happening and noted that it is a very difficult subject to study.

Josemartin Ilao stated that patients facing death will not be able to comprehend the denial of the chance to live because a physician considers a potentially lifesaving intervention is too risky. Mr. Ilao commented that the question is whether patients would prefer to accept less public reporting of information and receive potentially lifesaving or have more information publicly reported but no chance of getting care in certain circumstances due to risk aversion. Dr. Wang clarified that in some cases when care would be futile, it is reasonable not to provide it, and reducing overuse of care in those situations is good, but patients with a legitimate chance of survival should receive an intervention. Mr. Ilao explained that some patients benefit from complicated and experimental procedures in the absence of risk aversion and again expressed concern about possible consequences for patients who benefit from those types of procedures, if public reporting leads to excessive concern among physicians about undertaking risky interventions.

Mr. Steffen responded by noting that the public reporting in the context of this meeting refers to standard procedures and not experimental procedures. MHCC is not proposing to engage in public reporting on experimental procedures. However, for standard procedures, there should be reasonable expectations for success rates at a facility. Patients should be able to look across a range of programs in order to make an assessment of facilities' success rates.

Richard Pomerantz, M.D. noted that a patient does not get to choose a hospital during an emergency. He also added that because of co-occurring morbidities, it is be difficult to attribute mortality to a PCI procedure. For elective cases, a provider could get a better assessment of a patient's overall health profile and make better decisions for referrals. As a result, the performance of centers that do more emergency procedures compared to elective procedures may appear worse.

Stuart Seides, M.D., commented that most cardiac surgery programs have two stars in the STS rating system, and the system grades on a curve, so the discriminate value is questionable. As a clinician, he is more focused on referring to a specific surgeon based on the needs of the patient rather than the STS star rating for a hospital. In his view, some patients have better outcomes with a specific surgeon who practices at a two-star hospital than would be achieved by some other surgeons at a three-star hospital. He added that for PCI services, the performances of hospitals are so tightly bunched towards the top end of the scale for some quality measures that it may be difficult for a patient to use those indices to make a choice. The performance measurement systems for PCI and cardiac surgery services are useful for identifying outliers with the lowest

performance, but otherwise patients should trust the recommendations from reliable, ethical, informed physicians for referrals.

Keith Horvath, M.D. responded that while he appreciated Dr. Seides comments, he strongly disagreed with his negative assessment of the performance measurement systems for cardiac surgery and PCI services. He noted that the STS performance ratings have been demonstrated to show validity. STS public reporting has not been adopted at the surgeon level because patient outcomes are affected in numerous ways at the level of the hospital system. In his view, risk aversion may actually be an improvement in a physician's judgement that results in referrals for patients to centers in which they will receive better care. Rawn Salenger, M.D., agreed with Dr. Horvath that the STS database is an excellent way for patients to be informed about quality and suggested that patients should be provided with a hospital's STS star rating upon request. Dr. Salenger also agreed that public reporting is imperfect, and he suggested ways of mitigating those negative consequences. For example, he suggested that PCI cases with cardiogenic shock should be excluded from public reporting, as well as other certain high risk cardiac cases.

Dr. Wang asked if MHCC staff knew how many patients are actually using the public reporting sites because he thinks patients are primarily being referred within their own systems by their physicians. Mr. Steffen responded that data on referrals may not be available, but patients generally use information on public websites in conjunction with other sources of information they have in order to make decisions. He added that there is growing interest in the information available on public websites, and increasingly, payers are considering providing financial incentives for choice. Public reporting will never be and should not be the only source of information relied on by patients. However, providing patients with another source of information besides just a referral from a physician is valuable. Dr. Segal agreed with separating out emergency cases from public reporting. He also noted that patients will not have a choice for emergency cases anyway.

Ms. Fleck agreed that Dr. Segal had raised an important point. She clarified that the Commission does not have to do public reporting for all PCI cases that includes mortality rates, if that is regarded as problematic. She mentioned alternative approaches that could be considered, such as focusing on process measures or only reporting on outcomes for elective PCI cases. Dr. Salinger stated that there could be data on the utilization of public reporting information from some other states. Although every case cannot be reviewed, some states do adjudication of cases, and it could be considered. Ms. Fleck commented that it could be useful to do a study of how patients use information available through public reporting, if there is support for such a study.

Dr. Jamie Brown commented that a patient could be making a decision based on outdated information because of the delay in updating public websites, and he asked how this issue will be addressed to be fair to hospitals. Ms. Fleck responded that she thought the STS handles the issue by displaying information for only the most recent two years; if a hospital received a one-star rating more than two years ago, it is less likely to be known. Dr. Horvath confirmed that Ms. Fleck's description of the STS public reporting web site is correct.

Kristen Fletcher expressed concern about inconsistency across public reporting sites, and she added that the reported information also needs to be consumer friendly. She then asked about the period of time covered by data currently on the MHCC web site. Ms. Theressa Lee responded that the time period for data on the MHCC website varies by measure sets, and dates are usually provided for each set of data. She noted that MHCC cannot reword or rework measures to make them more consumer friendly because the Commission relies on validated measures from other sources, such as STS and CMS, for reporting. Recognizing these limitations, she added that the Commission still sees value in reporting this information so that providers can compare their performance with others. Mr. Steffen agreed with Ms. Fletcher and clarified that by default, priority will be given to clinical information rather than claims information. Ms. Lee clarified that it may not be claims information but rather information from medical records that is used for some measures.

Mr. Steffen suggested that CSAC members consider what criteria should be used for evaluating specific performance measures. Ms. Fleck referred CSAC members to a meeting handout with proposed criteria. She suggested that the list of criteria could be shortened, and the three most important criteria may be that a measure is unlikely to result in risk aversion, unlikely to be misinterpreted by consumers, and likely to be useful for decision making by consumers. She mentioned that other criteria may already be covered by those three criteria. For example, if the measure is endorsed by the National Quality Forum and other appropriate organizations then it may be unlikely to be misinterpreted by consumers or result in risk aversion because the measure has already been vetted and those types of factors considered. MHCC typically uses performance measures that have been endorsed or adopted by other organizations. Ms. Fleck also noted that the findings from the CSAC survey indicate that a majority of the respondents agree that the Commission's public reporting should rely on existing information from other sources, like the American College of Cardiology. Dr. Warren agreed with the three criterion identified by Ms. Fleck.

Dr. Seides and Ms. Fletcher agreed that existing performance measures should be used rather than developing new ones. Ms. Fleck explained that the Commission has the standards for Certificates of Ongoing Performance that require a simple yes or no response; a provider meets the standard or does not meet it. Some of that information could be useful for public reporting and could be considered by CSAC members as part of a discussion of specific performance metrics.

Mr. Ilao stated that the binary nature of some standards will be helpful, and he suggested that it will potentially motivate programs to meet the standards. From a patient perspective, the providers performing poorly should not be providing services. He added that the Certificate of Ongoing Performance process could be useful for everybody with its emphasis on meeting quality standards.

Ms. Fleck inquired if anyone had additional comments on the proposed criteria for evaluating specific performance measures. Dr. Salenger responded that the criterion should be the first six bullets on the handout and the last one. These criteria are listed below.

- Unlikely to result in risk aversion by surgeons or interventionalists

- Unlikely to be misinterpreted or misunderstood by consumers
- Useful for decision-making by consumers
- Endorsed by the National Quality Forum, Society of Thoracic Surgeons (STS), American College of Cardiology (ACC), or other appropriate organization with expertise in public reporting
- Cost-effective with respect to implementation by MHCC
- Cost-effective with respect to implementation by providers
- Data or source information underlying the measure can and will be routinely audited

Dr. Wang stated that available audited metrics come with a cost. He added that if the data in question is already available in the surgical societies, then it will not need to be audited. Mr. Steffen acknowledged that if there is segmentation of the patient population for public reporting, it may be different from the population reported by the STS. He asked for feedback from CSAC members on this issue. Dr. Salenger stated that the data needs to be audited at least once and added that even if is a subset of a larger dataset, it still is considered audited data. He noted that this will limit cost. Dr. Wang agreed. His understanding is that the goal is to have a website that basic information such as whether hospitals are participating in specific registries, and then a few metrics that will be agreed on for cardiac surgery and PCI programs. Ms. Fleck responded that the approach suggested by Dr. Wang is one possibility to consider and other suggested ideas are welcome too.

Consideration of Specific Potential Measures

Ms. Fleck suggested CSAC members discuss specific potential measures. With respect to the metric of program volume of PCI cases performed, Ms. Fleck stated that this was not treated as a quality metric by the ACC. However, there is a standard in MHCC's regulations that requires physicians who perform primary PCI at a hospital without on-site cardiac surgery to perform an average of 50 cases annually over a 24-month period. She noted that a majority of respondents to the MHCC survey did not consider program volume to be useful in helping a patient decide where to have an elective procedure. Dr. Salenger commented that program volume is not a good criterion for patients to rely on to decide where to go for PCI or cardiac surgery. James Ridge commented that the PCI program volume may be lower at his hospital, but the physicians performing PCI at his hospital practice at other hospital too; the program volume is not indicative of the experience level of the physicians performing PCI at his hospital.

Ms. Fleck suggested that MHCC could include as part of public reporting on PCI programs whether all interventionalists at programs without cardiac surgery on-site meet the requirement to perform an average annual volume of 50 PCI cases. Dr. Segal commented that most of the programs with cardiac surgery have over 50 PCI cases. Ms. Fleck clarified that the standard would

be addressing whether each physician at a program performed an average of over 50 PCI cases annually. She also asked whether stating, as part of public reporting, that the standard does not apply to hospitals with cardiac surgery programs would be acceptable.

Dr. Wang asked if the question should be whether every physician meets a volume threshold of 50 PCIs per year. Dr. Salenger commented that it may not be appropriate for a standard to refer only to a subset of hospitals. Ms. Fleck asked if other CSAC members agreed with Dr. Salenger. Dr. Wang commented that the relationship between volume and quality is complicated. In his view, volume matters and he would choose a higher volume program for himself. Dr. Salenger agreed but explained that the proposed approach could impugn an entire program if one physician performs less than 50 cases annually on average. Dr. Wang asked whether a program should be held accountable for physicians performing a low volume. Dr. Salenger emphasized that his concern is the public reporting of volume information and use of it by consumers. He stated that the proposed approach does not fit the criterion of endorsement by the ACC or other appropriate organizations, and it likely to be misunderstood by consumers.

Ms. Fleck suggested that public reporting on PCI volume could state that the standard of 50 PCI annually is not applicable to hospitals that have cardiac surgery onsite. Mr. Steffen expressed concern about that approach creating confusion. Ms. Fletcher stated that PCI procedure volume is already reported publicly for those voluntarily participating in the ACC's public reporting initiative. Dr. Seides commented that volume should not be an absolute surrogate to measure quality, but a volume of less than 50 cases is not an unreasonable standard to apply. If the intent is to protect the public from substandard practice, it would be imprudent to bury a low level provider at a high volume center. It may be a greater danger in some ways to the consumer. Dr. Wang agreed, but he also stated that there is no good way to present volume information. Dr. Salenger again expressed concern that patients may inappropriately use numbers to judge programs, assuming that a higher volume is always better. Dr. Pomerantz suggested that relying on minimum standards for a Certificate of Ongoing Performance for public reporting is reasonable, but he also acknowledged that the standards are not the same for everyone. Dr. Salenger again stated that it is not acceptable to have public reporting of metrics that are not applicable to all programs. Mr. Steffen suggested moving on to another performance metric.

Ms. Fleck explained that failure to meet the minimum volume requirement of 100 cases annually for cardiac surgery, and the target volume is 200 cases per year. Dr. Segal commented that he thought 200 cases is the minimum. Ms. Fleck noted that a focused review is triggered by case volume below 100 cases, but not by volume below 200 cases. Dr. Segal questioned how the standard could be explained to the public, and Ms. Fleck agreed that it could be challenging. Mr. Ilao commented that stating whether programs meet the minimum standard seems reasonable because a minimum standard has been adopted for Certificate of Ongoing Performance reviews. Mr. Parker read the volume standard for cardiac surgery programs included in COMAR 10.24.17. Suellen Wideman stated that there are generally not consequences for a program that drops below 200 cases. It is only when a program falls below 100 cases per year for two consecutive years that a focused review will be conducted. Suellen Wideman added that a new program has to perform 200 per year.

Ms. Fleck asked how useful information on cardiac surgery volume is for consumers. David Zimrin M.D. stated that low volume high quality programs should not be punished. The results of the focused review of a low volume program should be considered. Dr. Seides commented that case selection matters. A low volume provider could do very well by selecting cases appropriately and referring more complex cases to other providers. Mr. Steffen concluded that a minimum of 100 cases seemed to be accepted as the true minimum by most CSAC members. It was also noted by one CSAC member that a program that does less than 100 cases is financially difficult to sustain. Although it may not matter to patients, the State has an interest in providing economically efficient care.

Ms. Fleck requested feedback on to the next performance measure: risk adjusted mortality rates for PCI programs, relative to a national benchmark, for STEMI and non-STEMI cases. Dr Wang suggested surgical turn-downs be pulled out and high risk PCI prior to getting TAVR because these are often complex PCI cases. Risk adjustment may not be adequate to adjust for these types of cases if they are considered elective PCI procedures. Ms. Fleck asked if those cases were tracked at the hospitals and how much effort would be required to identify and exclude them. Dr. Wang responded that it is well documented at his program; however, it would require time consuming data extraction. He also noted that some low volume providers have very good outcomes because they are very selective about the cases that they take.

Dr. Warren agreed with Dr. Wang's identification of two categories of high risk PCI cases. However, he alluded to Mr. Ilao's comments and suggested that if a hospital meets the standards for the Certificate of Ongoing Performance, then the concerns raised are moot. It would be a much simpler approach. He inquired if performance for cases such as surgical turndowns will be assessed separately after they have been excluded from the standard PCI performance measures. Dr. Wang commented that the program may not be worse than the national benchmark, but a program would look better with those cases removed. He expressed concern about consumers interpreting quantitative information in a way that is not fair to hospitals. Dr. Warren asked if just stating that programs met the requirements will be a better option rather than adding extra data measures on mortality for programs to report. Dr. Wang questioned why the CSAC is discussing public reporting at all, if the consensus is always for stating whether a program meets minimal standards. Ms. Fleck responded that most of the measures listed in the meeting handouts are currently not part of the public reporting, but some of the measures are voluntarily reported by hospitals through the ACC.

Mr. Ilao commented that a physician's recommendation will matter and so will the perceptions of caregivers and other family members. He suggested that information that states whether a hospital meets the requirements for a Certificate of Ongoing Performance would be helpful along with a list of those requirements. Consumers can then use other sources together, like STS star ratings, to make a decision. Consumers can also use the information to ask questions of a physician.

Dr Wang cautioned that in settings where there are many indices for comparing that are available to the public, there may be data overload for consumers. Ms. Fleck responded that she wants to have a systematic consensus on what is important for public reporting. Dr. Pomerantz

asked if the legislature would be satisfied with minimum information on reporting. Mr. Steffen responded that historically MHCC has not taken that approach. He added that there needs to be an opportunity to drill down in the data. Most people are satisfied with an overall judgement, but a few people will prefer to drill down in the data. The measures will evolve over time, and the CSAC will need to discuss public reporting on a scheduled basis.

Paul Parker agreed with Dr. Pomerantz, noting that the statute refers to a comparative performance system. Dr. Warren interjected that you can interpret a comparative system to include how a hospital performs relative to a standard, rather than directly comparing one hospital to another hospital. Dr. Wang agreed with Dr. Warren and added that a comparative system could include whether a hospital meets a standard or not.

Mr. Parker commented that for Certificates of Ongoing Performance, MHCC staff has deliberately not taken a comparative approach; MHCC staff considers whether a hospital meets a standard or not. Ms. Fleck disagreed with Mr. Parkers description of Certificate of Ongoing Performance reports; she interjected that actual performance information is included in Certificate of Ongoing Performance reports, not simply whether a standard is met or not. Mr. Parker responded that, if there is no way to compare performance because it will always create problems, then MHCC could fall back on whether a program meets a standard. Mr. Parker added that the regulatory process already evaluates whether a program meets standards, and he sees that as a fundamental issue to address. Ms. Fleck noted that Certificate of Ongoing Performance reports are not the equivalent of public reporting. Mr. Steffen then adjourned the meeting at 9:10pm.