HSCRC Advisory Council
Meeting Minutes
November 21, 2013

- Jack Meyer, Facilitator called the meeting to order at 12:00pm.
    - Discussed the packet materials for the meeting as well as the minutes from previous meeting and comments from the MD Women's Coalition.
    - Presented guidance to the council on twin goals: to achieve consensus on guiding principles to guide the implementation of the model, and to help set implementation priorities.
- Donna Kinzer, Director of HSCRC, presented Slides discussing the All-Payer Model Performance Requirements
    - 4 Requirements
        - All Payer Test
        - Medicare Savings requirement
            - **Chet Burrell:** When you talk about Medicare, Part A Part B, What is the Scope of Payments?
            - **Donna Kinzer:** All-Payer test is a hospital inpatient and outpatient test and the Medicare savings test is a hospital inpatient and outpatient test. It is all hospital Part A and [hospital Part B per beneficiary] ? not sure what this phrase means calculation. Includes just residents in the State of Maryland but includes services provided at hospitals in the state as well as services provided by hospitals out of state for MD residents.
            - **Chet Burrell:** Is it regulated only?
            - **Donna Kinzer:** It is not "regulated only" because it includes some providers in Maryland that are not regulated as well as those outside of Maryland that are not regulated by the commission who are part of the test.
        - Reduce Admissions
        - Reduce MHACS
            - **Kevin Sexton**: Those targets are all listed but have different implications for the maintenance of the waiver, correct?
            - **Donna Kinzer:** Yes the first 2 have specific implication for maintenance of the waiver. So if we don't make the first two targets then there is a review process and a corrective action plan that will be discussed with CMS and CMMI on how to execute that plan. Assuming that we have a satisfactory correction, then we will move forward. If not, there will be a transition to the national Medicare payment system. Those are very critical for the pass/fail of the test. The other two tests, readmissions targets and the quality improvement test don't go down the same route. If we don't make the Readmissions test, then the hospitals would

become part of the national program and hospitals above the national level would be penalized according to the rules in the national Medicare program.

- Historic Trends (Slides)
  - All-Payer Per capita rate and Medicare per Capita Rate Diagram
  - National vs. Maryland Medicare FFS Per Beneficiary Growth Trends
- Implementation Plan (Slide)
  - Short, Mid and Long Term goals
    - Most significant focus is the avoidable utilization because it crosses both the quality and cost lines.
    - Global Models will be in place for a few years but will use population-based metrics even if we are still using global models or hospital payment.
- Ranking Criteria- important to assure success (Slides)
  - Meeting requirements
  - Early Medicare performance
  - Managing implementation risks
  - Capability to implement
  - Alignment with other reforms
- **David Salkever:** Can you talk more about quality and avoidable utilization? Are there metrics that the staff has talked about to track avoidable utilization?
  - **Donna Kinzer:** yes, we have been working on several metrics and have a few more. We have invited White Papers on this but we are focused on readmissions and re-hospitalization for potential preventable complications, admissions for ambulatory-sensitive conditions, and also focused on frequent utilizers and care for patients in Long Term Care Facilities that can be avoided with better quality and interaction between the hospitals.
- **Carmela Coyle:** I think we are on the same page, but I wanted to discuss the Short Term, Midterm and Long Term priorities with the Physician Alignment issue. The challenges that are faced with the global budget and model is made more difficult with the absence of Physician Alignment Policies. My hope is that this is addressed by 2015 as opposed to 2017.
  - **Donna Kinzer**: we have physician alignment as a priority in the short term as well as in the midterm. It is at the0 top of my priorities because we cannot execute without the alignment with our colleagues and alignment with some of the care coordination strategies as well.
- **Gary Simmons:** As I look at the hospital global models and we start to move into that I think that one of things that we have got to add is the quality of affordable utilization. As we start to think about these Global Models, we now need each individual hospital to start embedding targets for lowering utilization and higher quality that sets the path for next year, so that their rates get adjusted based on their own performance. I think we need to start transitioning to that approach. I am worried about TPR budgets, and we

need a commitment to performance measures. This should work in a way that if individual hospitals don't hit these targets, then next year TPR global budget gets affected. We need to start this transition and it needs to be a short-term goal.

- **Kevin Sexton**: I do not see it that way. Most importantly we need to accomplish meeting the requirements and we need to be focused on that absolutely. I think what you are describing are steps that any rational hospital is going to have to take to meet these incredibly, incredibly tight targets. From our stand point, we want to set as simple a target as we can and try to align incentives. I agree with you that those are important elements but when you start having instead of one thing to focus on, instead 3 and 4 and 5 things to focus on, it's actually going to detract from our ability to hit what is a very difficult number, which we have not traditionally come close to hitting. I would urge we focus on the most important targets and align incentives to hit them. If you hit them, you gain; if you fail to hit them, you lose. I think rationality will prevail instead of micro-managing.
- **Chet Burrell**: Echo what both Carmela and Kevin said. Based on volume incentives the system as a whole can live within a target limit. If you don't align incentives early on it would seem to threaten the ability of any hospital or system as a whole to work within these very tight limits. If that is not addressed early, it will catch up with you later.
- **Dean Farley**: There are waivers that CMS is making available to various organizations. Are those waivers potentially on the table here in Maryland, which can help meet some of the established targets? For specific things like 3-day hospital stays and Gain sharing?
    - **Donna Kinzer**: For physician alignment, Gain sharing is on the table. Putting structure around the 3-day waiver would be critically important before we would move down the road on that. HSCRC staff does not have the infrastructure to do any waiver currently. This is an infrastructure question that should be thought through.
- **Dean Farley**: I would recommend identifying these issues and they would be a Work Group question. They certainly go to the heart of alignment between providers along the continuum.
- **Donna Kinzer**: We are already in the process of developing a plan for the Physician Gain sharing, and this will be an item taken up by the Work Groups.
- **Carmela Coyle:** Just to speak to Dean's question, both of those issues were part of the conversation around what this ultimate waiver framework would look like, but they were removed. I think your right, that this doesn't mean we don't have an opportunity, and Gene and I had a conversation about what needs to the shaped and thought through and how do we do that quickly to get those critical issues identified.
- **Donna Kinzer**: They are actually addressed in the waiver document and CMMI is expecting Maryland to come back to them on that.
- **Chuck Milligan:** It's my understanding that in the approved waiver nursing facilities are not a part of the waiver. Nursing homes are still subject to the regular national payment rules.

- **Gene Ransom:** MedChi met with some of our doctors and had a whole list of Gain sharing ideas. They were told that this would require a whole other waiver application process. It seems to me that doing that quickly is optimistic at best. We should think about this, acknowledge it, and figure out what we are going to do with it. Gain sharing is very important to MedChi's Membership.
- **Donna Kinzer**: There are initiatives that are Gain sharing that don't require federal approval, and these initiatives can be done sooner. Those are things that we need to bring to the work groups and explore.
- **Gene Ransom:** I would love to see a list of what requires approval and what doesn't. I think we would all be interested in a framework or guidelines around Gainsharing initiatives. My understanding was that a lot of this stuff was federally required on the waiver application. We should take this into consideration as we work towards our goals.
- **Robert Chrencik**: What are the distinctions between Global Models and Population based Models? What are the changes that are made as you move towards a population based model?
    - **Donna Kinzer:** The HSCRC has developed some population based models called PBR that actually takes a service area and a set of zip codes and defines that as an area. For example, right now in a Global Model one of the simplicities is that a hospital can be responsible for its own revenue and cost budget, but in a population based model that hospital would be responsible for the service area which would include services that it didn't provide. So the distinction is that going from a model where you are responsible only for what you do to a model where you are now responsible for every all of the services that are provided to a patient regardless of whether you provided them or not. A Population Based Model is a lot more complicated to administer, and it requires a lot more collaboration among hospitals, and it's not something that can be implemented very quickly.
- **Robert Chrencik:** Patients moving between hospitals gets very complicated in a hurry.
- **David Salkever:** There is still a Care Coordination Issue.
- **Donna Kinzer**: Yes Care coordination is still an issue and it is at the top of our list.
- **Jack Meyer:** Capturing a few Priorities. I would like to discuss the council's advice to the commission on setting priorities. I have heard two things so far: First, the vital importance of earlier rather than later alignment of physician incentives for both cost management and quality, and bringing about the transitions among physicians from volume to quality and outcomes. Second, forging a consensus around not forgetting about nursing facilities and gainsharing arrangements regarding facilities fees and patients moving back and forth between nursing facility and a hospitals.
- **Gene Ransom**: I see those as separate issues. I think gainsharing facility fees is a priority because it helps achieve alignment with the physicians.
- **David Blumenthal**: We have set some targets; now we are figuring out the route to get there, and you are asking us for advice about how to prioritize the interventions. There

are two targets; one is a per capita expenditure target and the other a Medicare savings target. The priorities are different for each. It may be better for discussion to separate it into those two buckets. I think that the alignment for physicians' incentives is key to both but there may be other things that we talk about that are not so important to one or the other. Another point is to determine which of the things that we can do will be the most impactful in the short term, i.e., the next year or two. I would guess that the most impactful thing would be to address high utilizers of hospital services and understand why they are high utilizers and use proven techniques for reducing utilization. The Models I know of to accomplish this all require careful care coordination, a substantial amount of infrastructure and collaboration between primary care and hospitals. To what extent is there anything approaching that in existence around the state of Maryland, and if it exists, how can we augment it, and if it doesn't exist how do we put it in place?

- **Chet Burrell:** We have the largest model in the country here in Maryland. 1.1 million People, $5 billion spent in primary care/patient-centered medical home;, 350 nurses in the field, 50 thousand patients in care plans. What you see is dramatic differences in hospitalization rates, readmission rates, and ER visit rates when we compare the population that is in the program vs. the population that is not. The lessons learned are available in rich detail. What we are seeing is that primary care physicians, when properly incentivized, are driving towards picking out more cost effective specialists by episode of care. When you drive towards more cost effective episode, you drive your patients towards certain hospitals and away form others. One of the issues that may need to be addressed early on is how referrals based on cost and quality lead to sensible market share shifts, and how those are accounted for. What constitutes legitimate or good volume shifts, and what is not good volume shifts and change? If we don't account for this you may end up with inequity in the hospitals, impossible targets or in some cases, too easy targets. How will that get resolved and how does it tie to aligning physician incentives? If it is not thought of and modeled, you can run into trouble quickly.
- **David Blumenthal:** Great to hear about the Maryland experience. It is hard to pull off especially if you haven't been doing it already. Example from Massachusetts. A Model worked at Mass General Hospital, and then we tried to extend it within our own system to the Brigham and Women's Hospital and also at North Shore hospital, where it didn't work. It didn't work because of one crucial detail; instead of assigning nurses to a central pool they were assigned to providers. This caused the diversion under which these nurses were doing blood pressures, checking in patients, etc., rather than focusing on their job which was to develop care plans and intervene is a crisis. The details really matter. The technical support that you are going to need is going to be substantial. Point about Chet's concern about what happens when volumes get distributed; it's something you should be delighted to have because it means your system is working and you are beginning to shift patients in the direction of a better combination of cost and quality.

- **Peggy Naleppa:** Applauds Chets work and the model. The challenge is that we are in disruptive change and we need to move to adaptive change. What is most challenging for us is the pace of change. In terms of degree of readiness of hospitals in the state, there is a high degree of variability. We have the frame but we don't have the tracks to take us there. The Infrastructure requirements are not connected between the hospitals and payers. CRISP is in its elementary stages with admissions, discharge and transfer information and its not creating a roadmap for an immediate degree of change. Medical staff is saying finally we get an opportunity to manage the patients along the continuum but the tools and incentive are absent. Gainsharing is a key lever to this process. Incentives are critical, partnerships are critical but they are absent. Many hospitals are going to have significant financial challenges building the infrastructure, case management system and IT systems. The time and infrastructure it takes to manage one chronic disease patient was significant and we don't have the resources built into our system today.
- **Jack Meyer**: Summarizing points: Critical to Identify the most complex patients and to develop evidence based care management initiatives tailored to each patient. Incentives to reward such activities are just as critical.
- **Carmela Coyle:** I think we now have two agendas and we need to be clear. There are the Rate setting commission implementation priorities. Kevin's point from last meeting is that there a bias along the spectrum from micro to macro regulation. The concern is too much micro regulation. Then there are other supplementary policies apart from the model rules and regulations governing hospital revenues. These include such initiatives as Health Enterprise Zones. With regard to the micro/macro split, to what degree do we want to sequence matters, as we get to implementation through regulation and policy? In other words, as we put some policies and regulations forward, we can assess if those are successful, take stock, and then we go to another tier? If we do proceed this way, we could be really looking at a much more micro regulation.
- **Kevin Sexton**: My comments are related to Carmela's If you are going to affect these costs you are going to affect those who run up these costs. In short term Global budgets are the best chance. They guarantee you will not go above the total amount and they free up flexibility to start building and putting money elsewhere.
- **Gary Simmons:** Kind of a reality check; gainsharing piece means somewhere along in the system utilization has come down so something has been avoided. Some entity is going to lose some money there in order to have the opportunity to do the gainsharing. Worried about matching global budgets and committing to gainshare.
- **Kevin Sexton:** if you take 3.58% and compare to what the actuaries say will be the spending the rest in the country, a billion and a half dollars come out of the Maryland system in 3 years. That's the difference of Maryland hitting that number and Maryland hitting the national average. You are already playing with house money.
- **Donna Kinzer**: Gainsharing needs care management in order to make it work. The State has been investigating evidence based models for some time with a CMMI grant. We have research and data.

- **David Salkever**: I want to sort out the scenario presented by Kevin. Are you suggesting once the budget is determined, in a sense every hospital has some incentive to try and beat the budget, and the leaving hospitals to their own choices and strategies takes advantage of that incentive that doesn't require micromanagement. How does that relate to figuring out a way to tweak the system to create incentives? Can you explain that a little more?
- **Kevin Sexton:** I think I generally agree with your description. A couple of things need to be added. I don't think we know how to do this; we are a long way from a sustainable model. People need to know where to look. It gives regulators a chance to have a second line. Money has to follow the people (eventual goal) and that would reinforce the idea now.
- **Chet Burrell:** Give weight to what Kevin is saying. What is the perspective brought to Global Budgeting from a regulatory stand point? To what degree do you give hospitals regulatory freedom and to what degree do you interfere with that? If a Global budget is going to work, then you don't want to micro manage the innards of that or what you will end up with is a target that will paralyze hospitals.
- **Carmela Coyle**: I would just like to add as an example that the hospital association is already looking at 3 or 4 things we need to focus on to meet the requirements. Already looking at where the best practices are and how can we organize and share those best practices in the hospital field. Global budgets give lot of control for hospitals to hit targets.
- **David Blumenthal**: I would caution not to assume everyone knows what they are doing because experience has proven that they don't. A robust plan. Innovation is great over the long term but doesn't always yield results in the short term.
- **Gene Ransom:** Really important role for Department of Health and HSCRC is to protect patients with checks and balances because this is not a free market. Regulation around HSCRC. What about other regulating bodies that regulate the many stakeholders in this process. What are the other regulatory burdens that will limit the implementation that the HSCRC is doing with the waiver?
- **David Salkever:** Hospital fixed budget are a very powerful incentive to meet cost targets. From patients' perspective cost targets are being met by doing something that don't impair access or quality. Question becomes how you worry about the undesirable incentives and penalties for those. Do you leave it to stories in the newspaper or through regulations? You have you worry about the down sides as well.
- **Jack Meyer**: All the emerging care management models are great, but don't forget we need to advise HSCRC about the rules of the game. Step one is for group to suggest clear priorities on the principles that should guice HSCRC as the implementation parameters are set and the dials are spun, and establish a process of learning from mistakes. Don't forget to look at and learn from the home-grown initiatives in the State. Consensus seems to be to avoid overly engineered, top-down micro managed regulations, and at same time pay attention to best practices.

- **Gene Ransom**: Regulation to protect patients is extremely important as is transparency throughout this process.
- **Carmela Coyle**: Challenge is restructuring starting through Hospital rates. Is there another table that convenes sooner rather than later? We need coordination around other issues with the waiver implementation.
- **Donna Kinzer:** (slides) here are 7 items that were brought forward by the hospitals and payers as themes, principles, or guidelines to implementation.
- **Jack Meyer:** Our goals is to take this list of seven items and add and modify
- **David Salkever:** What do we mean when we say Global Model? The more we build in volume adjustments, the more we end up in a fee for service type of arrangement. Are there exceptional circumstances for which we adjust? We need to be careful how we calibrate and adjust.
- **Gary Simmons:** Use of differential as last recourse. It's the last place we go if we can't get the Medicare savings. I don't want to lose sight of that.
- **Dean Farley:** Call out a focus on clinical performance and health status of population. We need to be mindful of that. Most of these areas are utilization, cause oriented or tactics. And we don't want to lose sight of where we need to go. Monitoring needs to think about infrastructure as a critical component. We need to collect the data and what we will need 5 to 10 years out and put those in place now.
- **Peggy Naleppa:** I have a process question. The HSCRC has guiding principles provided through legislation. How were these lined up with the process?
- **Donna Kinzer:** We are always mindful of the legislation for HSCRC. Mindful that down the road things may need to be tweaked or changed.
- **Jack Meyer:** 11:48am opens questions to the audience. No question or comments
- **Gene Ransom:** Can you please provide us with a list of Gainsharing authority? What can be done without federal regulation?
- **Donna Kinzer:** Yes, we can send information on what hospitals are doing today without having to go through a federal process. There are many P4P approaches that could be considered.
- **Gary Simmons:** HSCRC staff gave a presentation on the difference of the New Model test from the old model test and it was very useful. It may be beneficial for others on the council.
- **Donna Kinzer**: We have been hosting 45 minute webinars and we can set another up if there is interest.
- **Carmela Coyle:** along with that it may be beneficial for create common vocabulary and present in webinar form.
- **Robert Chrenck:** Are the CMS folks still tracking for a January 1 implementation?
- **Donna Kinzer**: Yes, they say that they are. We should start to see documents in the next two weeks.

Meeting adjourned at 11:55pm