Advisory Council
Meeting Notes
12-12-2013

- Facilitator Jack Meyer calls meeting to order at 10:02am
  - Announcements
    - Status Report is due 12/31
    - Final Report due 1/31
    - Next meeting is January 9th from 10am to Noon at the HSCRC Conference Room.
    - Meeting Notes
      - Gene Ransom: Sent email asking for information from Chet Burrell on Carefirst Model, when will we see that information? Interested is what did you save and how did you save it, what are you asking practitioners to do and what are the checks and balances?
- Donna Kinzer, Executive Director of HSCRC
  - Announcements
    - Expected start date is still on track for 1-1-2014. Close to final completion..
- Jack Meyer: Starts with discussion with a review of the goals of the advisory council in working to create areas of consensus and to create Guiding Principles and Recommendations that can be given to the commission.
  - Slide 4- Emerging Consensus: Focus on Achieving Model Performance Requirements
    - Eric Wagner: Implementation Priorities make sense with the Guiding Principles we need to be careful not to be biased to payment models. If this is the only area on which we focus the ship will be sunk. Increasing the degree of confidence to focus on Guiding Principles 3 and 4 for increased intensity patients. This is where we will meet the targets.
    - Jack Meyer: I agree, should Guiding Principle 2 then read," Delivery System reform and payment models ensure that All-payer limits are met."?
    - Eric Wagner: Give credibility to those activities. We have to give Credibility to fact that we are going to bring number of units down.
    - Dean Farley: We need to be conscious of the role of the HSCRC in encouraging these reforms. Proposed change to Guiding Principle 2: Role of commission is to establish framework but stakeholders need latitude to make decisions. Guiding Principal 3: Increased nee and increased resource patient should be highlighted.
    - David Salkever: On one hand there needs to be strong incentives to encourage providers on the other there needs to be an information resource, providers need the tools.
    - Carmela Coyle: Agrees with Dean…there should be a Guiding Principle that will take a combination of payment principles and delivery system. What are the expectations of providers?
    - Donna Kinzer: One of the things that we are looking for is direction on is going to get the National data and run it through a predictive modeling program and work with the hospitals to make one investment State-wide in predictive modeling similar to the State-wide investment in CRISP.
    - Carmela Coyle: Perhaps there should be subcategories of Guiding Principles around analytical support.

- Kevin Sexton: The commission has two jobs: first as a regulator and second as catalyst. If you set Macro right everyone has to get there. Evolution of tactics and procedures. People will want tactics to hit the targets.
- Jack Meyer: What I heard is that while allowing flexibility the commission can still provide a "public good" which are resources of data, tools and analytics.
- Gene Ransom: SIM Grant activities are currently underway and some ideas overlap. It makes sense to coordinate with that process.
- Peggy Naleppa: Statewide predictive modeling to Dean's point. Limited funding cause's problems and we need to look to the private sector for opportunities for grants to do modeling. The U.S. as a whole is a lager and we need to push this. We need to be more inclusive and start discussion with the private sector around grant funding.
- Donna Kinzer: We are focused on SIM but it's a longer term process for funding which will come in the fall. Charles Milligan expressed need for Guiding Principle to coordinate among various players in Maryland for data needs.
- Carmela Coyle: Collaboration needs to be present. Hospitals are not just looking to the HSCRC.
- Robert Chrencik: what is our highest point of failure? Medicare Test is going to be the hardest point of success. We need to focus a lot of energy there. What can we act on quickly? Focus on near term to have impact on Medicare spending.
- Jack Meyer: Let's move to the Open Questions, are there any reactions?
- David Salkever: We should start with question 2. My bias is that role of regulator is the most important for the HSCRC
- Eric Wagner: Agree with David. HSCRC role should be supportive as compared to directive; assembling databases and addressing things the private sector can't address.
- Carmela Coyle: Data is the most important and only successful if we can track. We are missing shared data link and there needs to be a large table at which everyone can share data. Open access is greatly needed and the HSCRC is a catalyst to bring this together.
- Kevin Sexton: Basic construct around rate setting should be #1. Encourage hospitals to pick the best rate/incentive option. That marker will set up the road to success for year one. We all need to be focused on this.
- David Salkever: Novel element is if we succeed to set powerful incentives also increases concerns about monitoring access and quality. We need to make sure that we are monitoring so that there are not decreases in access and level of quality due to powerful incentives.
- Donna Kinzer (38:34): Quality has been a very heavy focus of the commission in the last few years and we are moving forward with two major Quality initiatives that are tied to payment and that have a fairly significant amount of revenue and risk under quality based incentives. Access to care has also been addressed through uncompensated care payments, and incorporating uncompensated care in the rates as been a core mission of the Commission. Also, focus on Quality through Maryland Hospital Acquired Conditions and Quality Based Reimbursement programs have been a strong focus of HSCRC.   Refer to Slide 7 for David's comment

        - Jack Meyer: What I have heard as areas of consensus: Great attention needs to be paid to year one on Medicare and All-payer. Role of HSCRC as regulator and catalyst. HSCRC does not have exclusive role, there are many parties. Flexibility is needed for Providers to help meet targets but also need tools and best practices.
        - Eric Wagner (43:58): I think there needs to be more focus on encouraging innovation of the private sector. It requires a lighter touch on regulation, and is more encouraging of the private sector to innovate.
        - Jack Meyer: Target is a combination of delivery system reforms and payment model reforms.
        - Kevin Sexton: Setting the target in such that we have comfort would have as a companion piece to support the fragile industry.
        - Dean Farley: Balance is important but we have to succeed in year one because if we do not there is no long run.
        - Jack Meyer: May need to be tougher early and then move towards more flexibility later.
        - Kevin Sexton: You need to get a formula that gives you the most comfort that you are going to hit your target. Give yourself a buffer.
    - Jack Meyer: Slide 5 Emerging Consensus: Alignment is Critical to Success
        - Gene Ransom: Checks and Balances are extremely important; each specialty can come up with ideas. Economically incenting is the key. Partnerships with private entities and hospitals. Dollars are key to move in the right direction. Gain sharing makes sense. Transparency is need as a protection. Doctors don't understand why or why there is not an incentive. ACO model is better because you can see where you are saving and what you are doing to generate those savings. Medical Home Model is good but there is lack of understanding of the results.
        - David Salkever (55:44): I need some enlightenment from some of the other folks on the council who are more familiar with what has been happening recently. My sense was that from the stand point of orchestrating delivery system changes that there are some fairly substantial boundaries in legislation in terms of what the HSCRC can and cannot do. Having a hard time sorting out for example in that case of things like encouraging gainsharing arrangements, I could imagine that the HSCRC could do something in terms of creating financial rewards but it seems to me that the commission under its current legislative mandate has some pretty substantial restrictions in terms of moving way beyond hospitals to the other providers.
        - Gene Ransom: I think the restrictions are you can't touch the professional fees for non-hospital providers.
        - Eric Wagner: Let private sector innovate. Incentives- get parameters from CMS. If there are those who want to Gainshare they should be allowed. Look to Mayo Clinic for ideas.
        - Carmela Coyle: Important next step is to pursue Gainsharing.
        - Dean Farley: Pay for Performance is kosher. But generally speaking Gainsharing and others would be problematic without waivers.
        - Gene Ransom: We always talk about Primary Care Providers but allowing specialty providers to experiment is important because they have big costs. Not just providers, nursing homes, diagnostics, etc.

- Robert Chrencik: Focus where the money is. Doctors are key (primary care). How do you get rid of excess utilization? Go to OIG for flexibility. We support physicians heavily to support others is a challenge.
  - Jack Meyer: Consensus that HSCRC should move on authority for Gainsharing.
  - Dean Farley: Beyond Gainsharing….Provide coordinated role between regulators and industry and provide infrastructure. HSCRC needs to monitor adherence to the waiver.
  - Joseph Ross: Agrees with Dean. Concerned about thinking that one shoe fits all. Monitor all areas of implementation. Need different types of Gainsharing for different types of hospitals. The pace worries me and can put us in jeopardy.
  - Carmela Coyle: HSCRC needs to be a strong advocate for regulation and legislation. Not just about meeting waiver test it's also about policy innovation.
  - Dean Farley: Maryland is not doing this by itself, innovations are happening elsewhere that we need to draw and learn from (Implementation Priority?)
  - Peggy Naleppa: reform around Tort needs to be considered. Physicians are held hostage around certain issues due to Tort.
  - Gene Ransom: Agrees with Peggy. It is a huge deal for Hospitals; no economic incentive is greater than being sued. Factor if private sector employment.
- Jack Meyer: Slide 6 Emerging Consensus: A Balanced Regulatory Approach is Needed
  - Dean Farley: Guiding Principle needs to be portrayed in a more positive manner.
  - Eric Wagner: I would use "supportive and balanced"
  - Kevin Sexton: Support of Macro approach needs to align incentives.
  - Joseph Ross: need a consensus on what is important to HSCRC, "Global report Card" will help guide strategies of local markets.
  - Jack Meyer: What I have heard consensus around: Supportive of Macro approaches to get incentives. Avoid surprises by creating score cared to track as the process moves forward.
  - Joseph Ross: Using rates are important but different from what the industry has always been doing
  - Dean Farley: another dimension. Look activities at adjacent parts of the industry….Ex. outpatient surgery being pushed out of hospitals. Monitor, collect information, track potentially unintended consequences (Commission Responsibility)
  - Carmela Coyle: HSCRC focus financial and quality, used rates, access, health status, and hospital financial statues. All hospitals are not interdependent.
  - Erin Wager: Dissemination of Best Practices is not a role of the HSCRC
- Jack Meyer: Slide 7 Emerging Consensus: Ensure Checks and Balances in System
  - Gene Ransom: Guiding Principle makes sense
  - Eric Wagner: expansion of communication piece that needs to take place for General Public to put minds at rest.
  - Carmela Coyle: We should substitute the word Consumer for Patient. The Consumer element is critical in waiver success.
  - Kevin Sexton: macro incentives is that money follows the people.
  - Eric Wagner: Clarification: need to take capacity out of the system. Need to be cautious on this element.
  - Kevin Sexton: Draw a distinction that the money doesn't follow spending versus the money following the people. You cannot reward doing more to a same or smaller number of people you are rewarding basically that you are doing less for

a larger number. Overtime it is a dynamic in those state populations which you want. Hospitals need to make sure that other areas not drop the piece that they may be picking up so that they have an opportunity to be rewarded.

- Peggy Naleppa: Work group can identify a consensus around data….transparency in order to succeed. Change mindset going forward away from Proprietary mindset around data.
- Jack Meyer: Encourages looking at Chart 8 which will be pushed to next meeting.
- David Salkever: Information request on information out there on how other geographic areas, countries, systems that have tackled this issue. Perhaps a workgroup issue.
- Donna Kinzer: Invited a Whitepaper on those issues. Kaiser Permenate is working on a submission.
- Daivd Salkever: Other demonstrations such as Finger Lakes, etc.
- Gene Ransom: what is the time table to appoint Workgroups and who will do that?
- Donna Kinzer: will begin this shortly and the HSCRC will review and appoint/

- Jack Meyer: Opens Questions to the Audience
  - Barbara Borcato: Reemphasize the Liability issue and need for reforms. If HSCRC is playing a large role we need to protect the doctors. Don't be prescriptive, allow physicians to work with others.
  - Lenni Preston: Patient and Consumer were used just under 10 times in the meeting. Guiding Principles are actually implementation principles. What really are Guiding Principles are the things that the coalition has submitted. Data access needs to be inclusive of researchers and the public.
  - Carmela Coyle: We need to pull out a letter from 2010 which set principles that have guided the history of this waiver process.

Adjournment at 12pm.