

Getting What we Pay For: Moving to Value Based Payment in Maine

Elizabeth Mitchell
CEO

Maine Health Management Coalition



Maine Health
Management Coalition

*Bringing Healthcare Value
to the People of Maine*

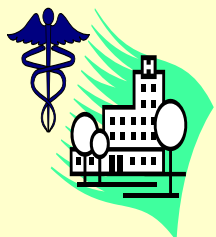
Maine Health Management Coalition

www.mhmc.info



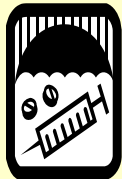
Employers

16 Private Employers
5 Public Purchasers



Providers

21 Hospitals
14 Physician Groups



Health Plans

5 Health Plans

Collectively 35% of Comm. Market

The MHMC is an employer-led partnership among multiple stakeholders working collaboratively to maximize improvement in the value of healthcare services delivered to MHMC members' employees and dependents.

The Maine Health Management Coalition Foundation is a public charity whose missions is to bring the purchaser, consumer and provider communities together in a partnership to measure and report to the people of Maine on the value of the healthcare services and to educate the public to use information on cost and quality to make informed decisions.

MHMC's Goal

Value:
$$\frac{\text{quality / outcomes} + \text{change in health status} + \text{employee satisfaction}}{\text{cost}}$$

- Best quality health care
- Best outcomes and quality of life
- Most satisfaction
- For the most affordable cost
- Ultimately for all Maine citizens.

How Do We Get to Value?

Work Areas:

- **Transparency**
- **Payment Reform**
- **Evidence Based Benefit Design**
- **Consumer Engagement**

Don Berwick Update – Nov. 07 (10 years later)

- “The chances of being injured by hospital care is greater than one in 10, and accidental death due to mismanaged care is about one in 300.”
- **2006 Maine Discharges:**
 - Total Discharges in Maine 163,705
 - Berwick: 1 in 300 result in death 546
 - Berwick: 1 in 10 result in inj./ill. 16,371
- **2008 MEA Benefit Trust**
 - Total MEA Non-Medicare Admissions 4,257
 - Berwick: 1 in 300 result in death 14
 - Berwick: 1 in 10 result in inj./ill. 426

To make matters worse...

- Maine has second highest commercial rates in the US (Kaiser)
- Rates are increasing at the second highest rate in the country.
- Maine's population is older, poorer, more likely to live in rural areas, and more likely to have one or more chronic diseases than the populations of the other New England states and the nation.

How Did We Get Here?

Our nation's health care system is the predictable result of the way we have chosen to pay for the services we receive. Providing more care to more patients is a financial imperative for health care organizations and caregivers. No one is responsible for helping patients and their families successfully navigate a fragmented and bewilderingly complex array of health care providers and services. No one has assumed ultimate responsibility for the quality of the care they receive. No one is accountable for assuring that the vast amounts we spend are deployed effectively as they can be to create healthy communities. The real question isn't 'How did we get here?' Its 'Why is anyone surprised?'

How to get from here to there

1. Understand the problem (beyond health care costs too much)
2. Define a vision – and everyone's role in it
3. Improve transparency for public and providers
4. Create business case
5. Build consensus/find early adopters
6. Support change (technical, financial, political)
7. Measure, Evaluate, Improve, Repeat

Conceptual Framework – Unwarranted Variation:

Variation that cannot be explained by illness or need, the dictates of evidence based medicine, or patient preferences

Effective Care: “Proven effectiveness, no significant trade-offs”

Beta blocker use among patients post heart attack varies from 5% - 92%, when it should be ~100%

Preference-Sensitive Care:

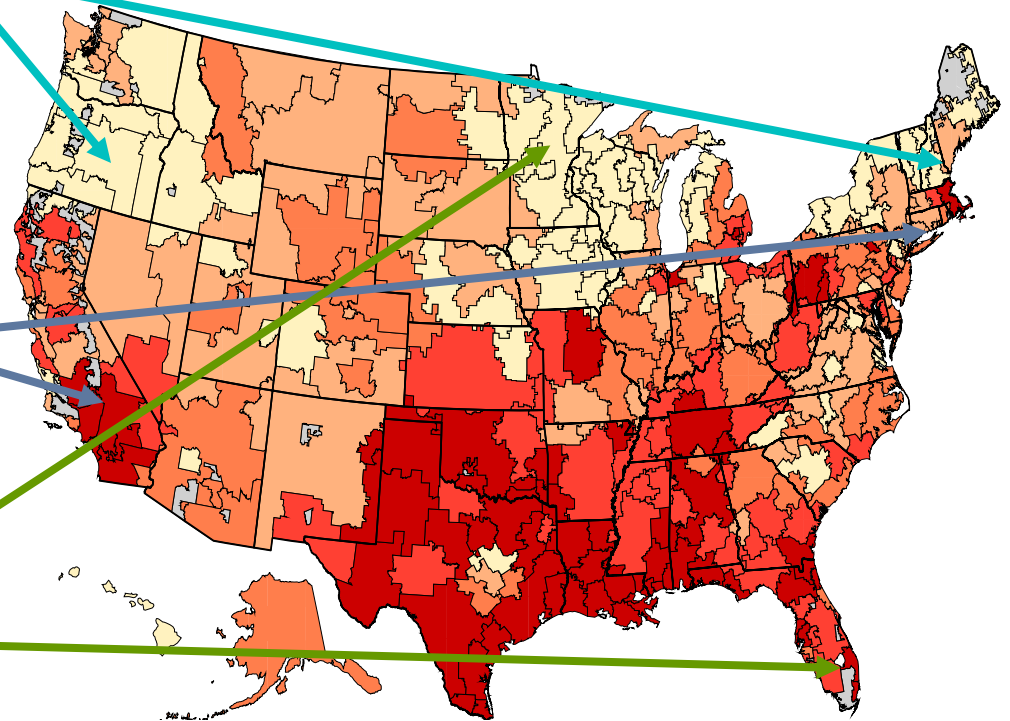
“Involves trade-offs, (at least) two valid alternative treatments are available”

In Southern California, a patient is 6 times more likely to have back surgery for a herniated disk than in New York City

Supply Sensitive Care: “If they build it you will come”

Per-capita spending per Medicare enrollee in Miami, FL is almost 2.5 times as great as in Minneapolis, MN

www.mhmc.info & www.mehmc.org



CMS/Medicare Variation

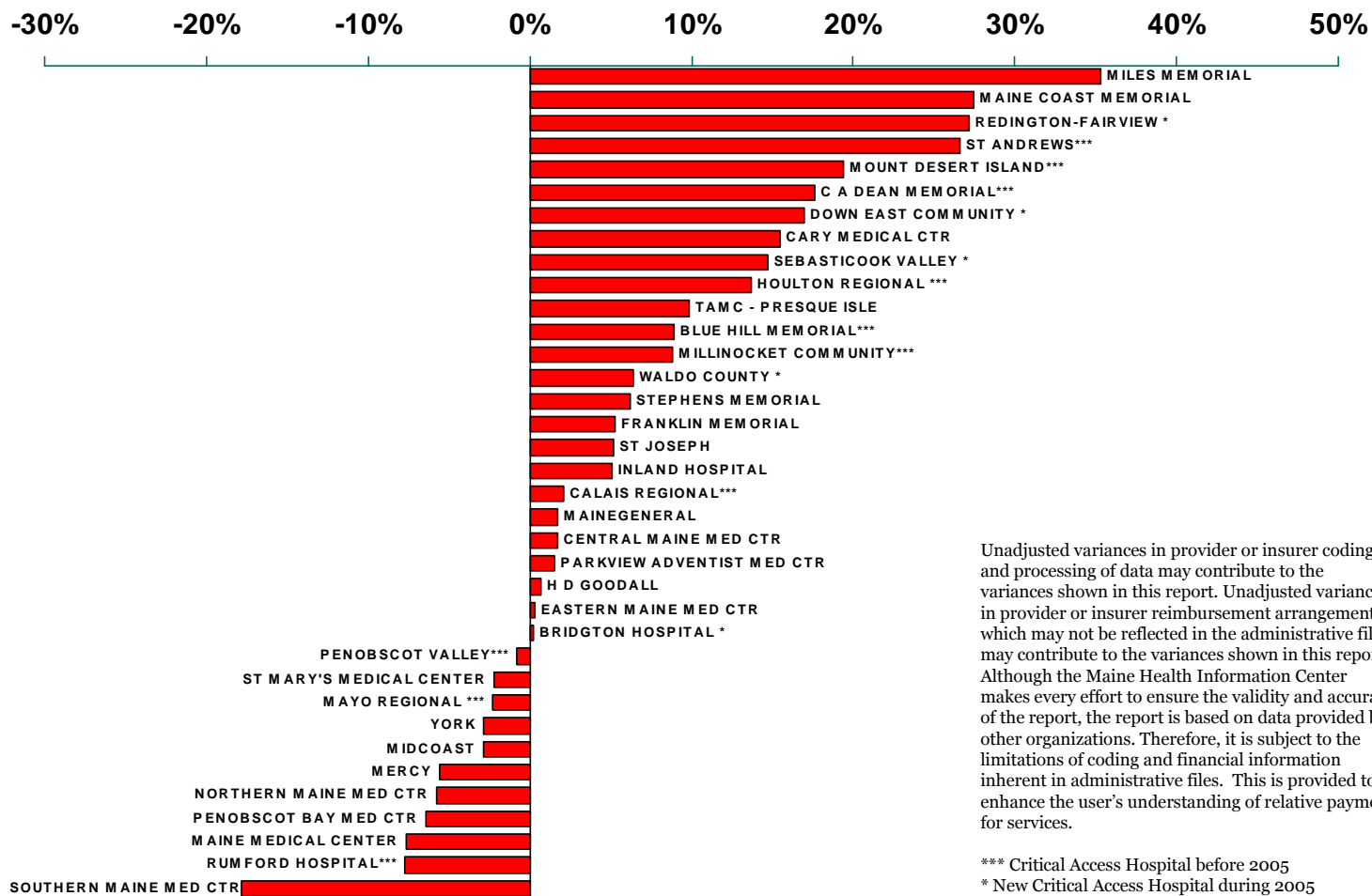
Coronary Artery Bypass Graft Average Cost

- UCLA Medical Center: \$93,000
- Mayo Clinic: \$52,000

Uwe Reihnardt, Princeton:

- How does the best medical care in the world cost twice as much as the best medical care in the world?

% Variance in Inpatient & Outpatient Hospital Allowed Payments, CY2005, Adjusted for Patient Mix by DRG & APG



Unadjusted variances in provider or insurer coding and processing of data may contribute to the variances shown in this report. Unadjusted variances in provider or insurer reimbursement arrangements, which may not be reflected in the administrative files, may contribute to the variances shown in this report. Although the Maine Health Information Center makes every effort to ensure the validity and accuracy of the report, the report is based on data provided by other organizations. Therefore, it is subject to the limitations of coding and financial information inherent in administrative files. This is provided to enhance the user's understanding of relative payment for services.

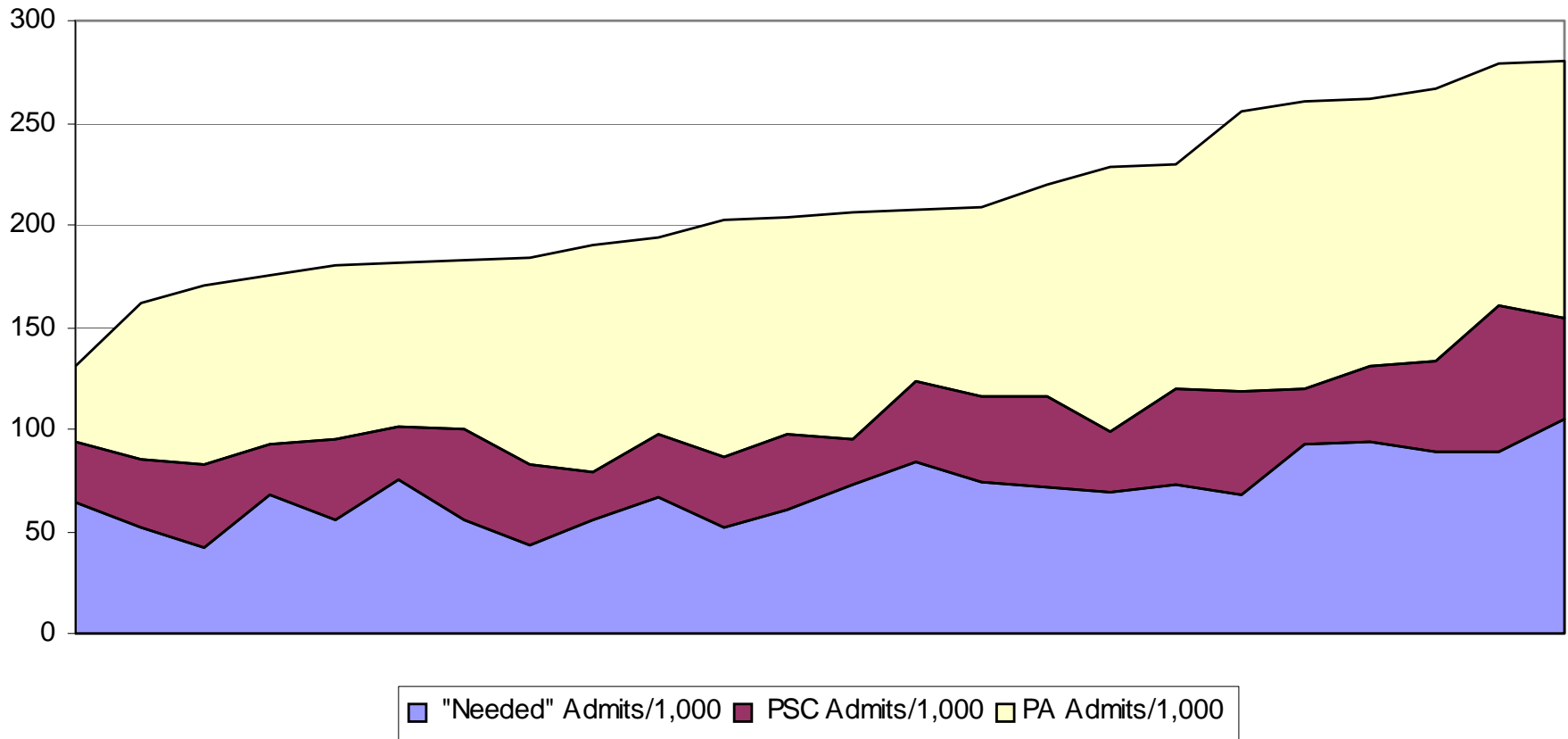
*** Critical Access Hospital before 2005
 * New Critical Access Hospital during 2005

Unwarranted Variation in Maine

- ‘Significant variation in per-capita spending exists across HSAs for both inpatient and outpatient care’
- Through reductions in potentially avoidable hospital admissions and in high variation high cost outpatient services, this study identifies savings of over \$350 million in annual health care expenditures in Maine.
 - Maine Quality Forum’s All-payer Analysis of Variation in Healthcare in Maine

Commercial Chronic Admission Rates: Potentially Avoidable admissions are high and variable

Commercial 46-64 Admissions by Type by HSA



▪ "Needed" variation may reflect maternity admits

Significant savings are available within each supply sensitive category

Type of Admission	Total PA Cost	Savings with 25% Reduction	Savings with 50% Reduction	Savings with 75% Reduction
Cardiac-Circulatory	\$56.5M	\$14.2M	\$28.3M	\$42.4M
Musculoskeletal	\$18.1M	\$4.5M	\$9.1M	\$13.5M
Respiratory	\$52.0M	\$13.0M	\$26.0M	\$39.0M
GI	\$37.2M	\$9.3M	\$18.6M	\$27.9M
Sub-Total top 4 Admission Types	\$163.8M	\$41.0M	\$82.0M	\$122.8M
All Other	\$119.8M	\$30.1M	\$59.9M	\$89.9M
Total	\$283.6M	\$71.1M	\$141.8M	\$212.7M

All-Payer Analysis of Variation in Healthcare in Maine. Conducted on behalf of Dirigo Health Agency's Maine Quality Forum & The Advisory Council on Health Systems Development Health Dialog Analytic Solutions, 2009.

Note: Savings are annual and calculated only for those individuals included in analysis. Total savings for the entire state would be higher.

Maine Employers Want

Health spending in Maine at or below national average within 3 years (24% reduction);

Health care quality above national average in all areas within 3 years;

A health care system with the following attributes:

- Transparent information on cost and quality
- Functional, interoperable IT systems
- Integrated, coordinated, patient-centered care across settings
- Reduced variation in cost and quality across state
- Reduction/Elimination of 'waste' (services that do not improve health)
- Primary care based

Who, What and How?

■ Employers

- Wellness
- Patient Incentives through Benefit Design
- Market Leverage

■ Providers

- High-value, coordinated, patient centered care
- Transparent cost and quality

■ Health Plans

- New roles, products and reimbursement systems

■ Patients

- Informed choice and engagement
- Acceptance of new 'limits' on care

Transparency: Foundation of Reform

- Transparent cost and quality data critical to change systems, track progress, protect consumers and understand impact.
- Lack of timely, usable data will impede change.
- Global budgets will challenge performance measurement – FFS billing codes will not work. Must be able to monitor quality and utilization ‘under the hood’.



"Let's never forget that the public's desire for transparency has to be balanced by our need for concealment."

Creating a Culture of Transparency

- Eight years later...6 indicators of quality and safety, all but 1 already publicly available.
- Longitudinal data showing statewide improvement on publicly reported measures.
- Anecdotal evidence that our reporting drives strategic planning.
- Growing tension regarding ‘use’ of information – challenge to consensus process.

Maine Doctor Ratings

Maine Hospital Ratings

Major Surgery Ratings

How Do I Get Quality Care?

Maine Doctor Ratings

Find out which Maine doctors do the best.



[View Results](#)

Doctor Ratings Explained

Maine Hospital Ratings

Information you can use to choose a hospital.



[View Results](#)

Hospital Ratings Explained

Major Surgery Ratings

Facing a high-risk procedure? Which New England hospital is best?



[View Results](#)

Surgery Ratings Explained

What's New in Maine Healthcare

Interested in sharing your thoughts about healthcare quality? [Take the 2009 Consumer Healthcare Opinion Survey »](#)

How Do I Get Quality Care? Ask. Learn. Decide.



Interviews with Maine Doctors & Patients



Easy to Use Tip Sheets



00:00

MAINE CANCER PATIENT CHESLEY TALKS ABOUT HER EXPERIENCE • [MORE »](#)



00:00

MAINE ASTHMA PATIENT RICK TALKS WITH HIS DOCTOR • [MORE »](#)

HEAR FROM MAINE PEOPLE WHO SUPPORT RATING QUALITY

Working Together to Ensure Best Care



Patients should feel comfortable that the care provided by their physician and hospital is safe, efficiently delivered, and of high quality. They should feel satisfied that their care is provided by caring, compassionate providers, and their questions and concerns are answered thoroughly. We at Maine Health Management Coalition are all working together to provide this information to our patients to ensure the best care possible.

[Read more »](#)

New Hospital Quality Measures



Maine Health Management Coalition

Maine Doctor Ratings

Maine Hospital Ratings

Major Surgery Ratings

How Do I Get Quality Care?

Optional: Search within 10 miles of 04101

View Results

Maine Hospital Ratings

Blue Ribbons

Sort by:

Highest Rated

Name

City

Miles

[view Specialty Hospitals »](#)

Select Clinical Quality ratings explained

« [Hospital Ratings Explained](#)
page last updated Oct 2009



Patient Experience

Patient Safety

[ratings explained](#) [ratings explained](#)

HEART ATTACK

HEART FAILURE

PNEUMONIA

SURGICAL INFECTION

Mercy Hospital

144 State Street, **Portland** 04101 • [view map](#)
located in zip code 04101



Maine Medical Center

22 Bramhall Street, **Portland** 04102 • [view map](#)
2.4 mi. from zip code 04101



SPECIAL RECOGNITION

SPECIAL RECOGNITION

Select Clinical Quality Ratings



Maine Health Management Coalition

Maine Doctor Ratings

Maine Hospital Ratings

Major Surgery Ratings

How Do I Get Quality Care?

Optional: Search of

[View Results](#)

Maine Hospital Ratings

Blue Ribbons

Sort by:

Highest Rated

Name

City

[view Specialty Hospitals >>](#)

Select Clinical Quality ratings explained

« [Hospital Ratings Explained](#)
page last updated Jan 2009



HEART ATTACK

HEART FAILURE

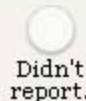
PNEUMONIA

SURGICAL INFECTION

Miles Memorial Hospital

35 Miles Street, **Damariscotta** 04543 · [view map](#)

UNABLE TO DETERMINE



Didn't report.



Performs between 50th and 90th national percentile of hospitals.



Performs at 50th national percentile of hospitals.



Performs between 50th and 90th national percentile of hospitals.

St. Joseph Hospital

360 Broadway, **Bangor** 04401 · [view map](#)



Performs between 50th and 90th national percentile of hospitals.



Performs between 50th and 90th national percentile of hospitals.



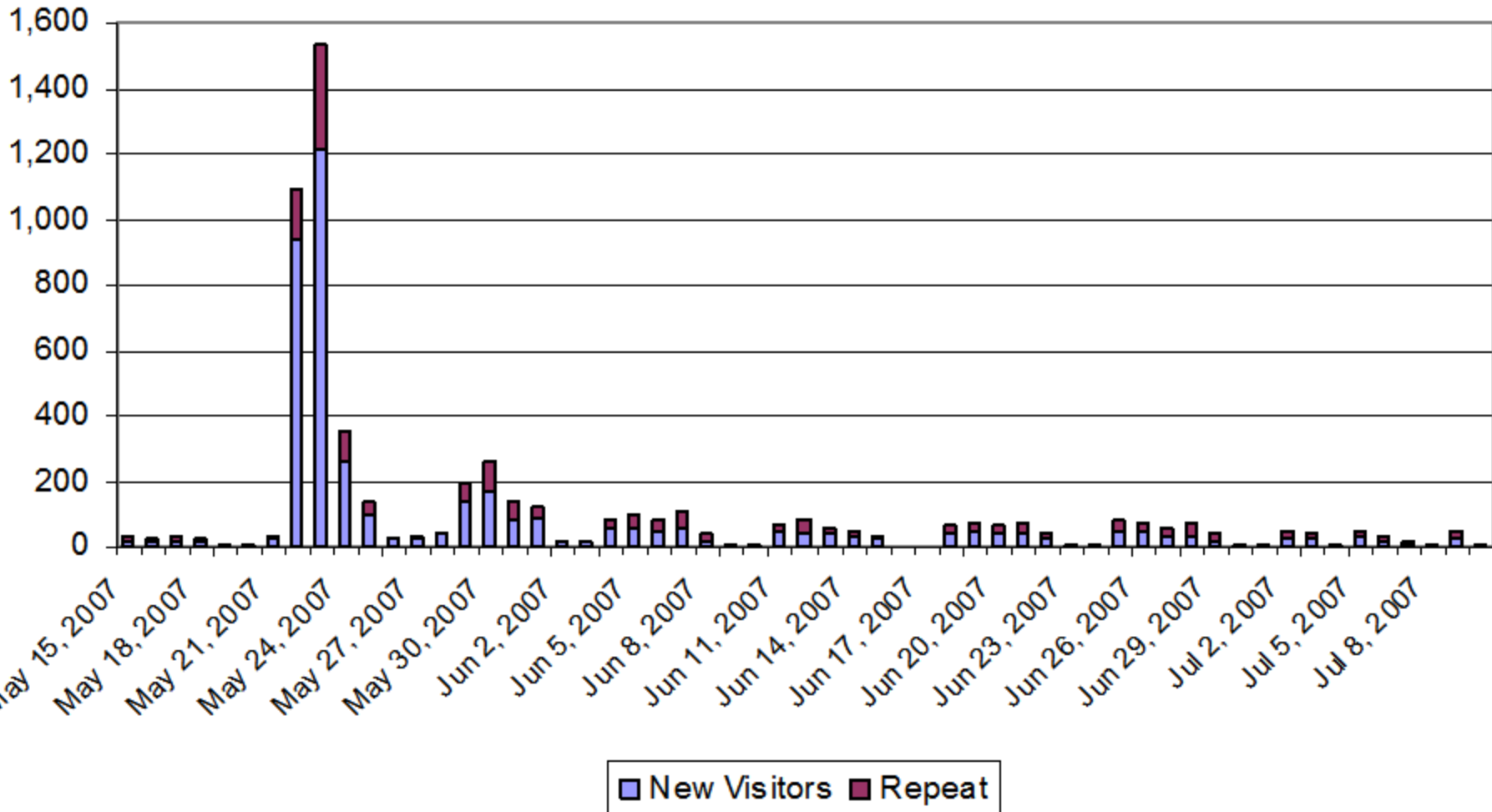
Performs between 50th and 90th national percentile of hospitals.



Performs at or above the 90th national percentile of hospitals.

SEHC Announce 7-07 PCP Tiering

New Visitors and Repeat Visits



Current PTE Participation

Practices	2007	2008	% Ch
3 Blue Ribbon	131	171	+ 31%
2 Blue Ribbon	59	71	+ 20%
1 Blue Ribbon	70	69	-1%
0 Blue Ribbon	169	125	-26%

Group Measurement - Dashboard

Health Dialog

PERFORMANCE SUMMARY: Medical Association, Primary Care, Group Results

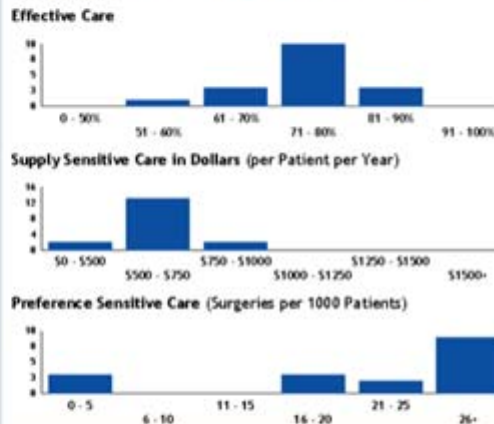
Adult Patients (18 and over) for Period Ending Jan. 31, 2009

ABOUT THE GROUP'S PATIENTS

Primary Care Patients	2009	2008
Groups	17	N/A
Patients	67,469	N/A
Average Age	41	N/A
% Male	42	N/A
% Chronic	14.0	N/A
% Asthma	4.0	N/A
% CAD	3.0	N/A
% COPD	1.0	N/A
% Diabetes	8.0	N/A
% Heart Failure	0.0	N/A

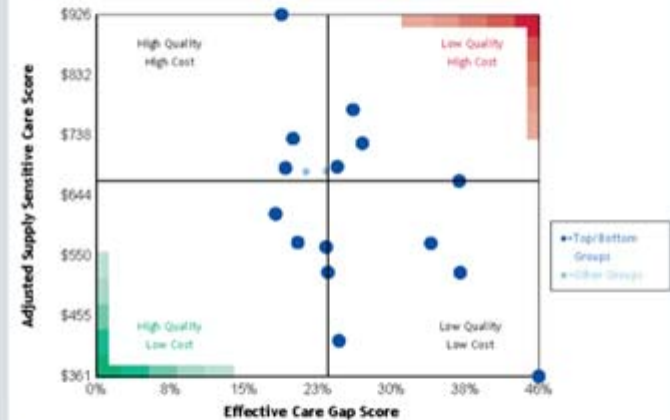
PERFORMANCE SUMMARY

The overall distribution of groups' performance.



EFFECTIVENESS AND EFFICIENCY

The distribution of groups' composite effectiveness and efficiency scores.



KEY RISK ADJUSTED UTILIZATION MEASURES

The distribution of groups' use of services.

	Min	25th	Median	75th	Max
(per 1000 patients per year)					
Total Acute Admissions	30	32	32	33	35
Emergency Department Visit Count	99	124	139	161	581
Total Visit Count	4,555	4,762	4,979	5,184	5,775
(per patient per year)					
Count of PCPs Seen	0.7	0.9	0.9	0.9	1.2
Count of Specialists Seen	0.5	0.6	0.6	0.7	0.7
Prescription Count	8.2	11.0	11.6	12.6	15.7

TOP/BOTTOM PERFORMING GROUPS

The groups with the top and bottom overall quality and efficiency scores.

Top Performance, Effective Care

Group 7	81%
Group 11	81%
Group 13	80%
Group 9	80%
Group 2	79%
MEDIAN OF GROUPS	76%

Bottom Performance, Effective Care

Group 3	73%
Group 10	65%
Group 8	63%

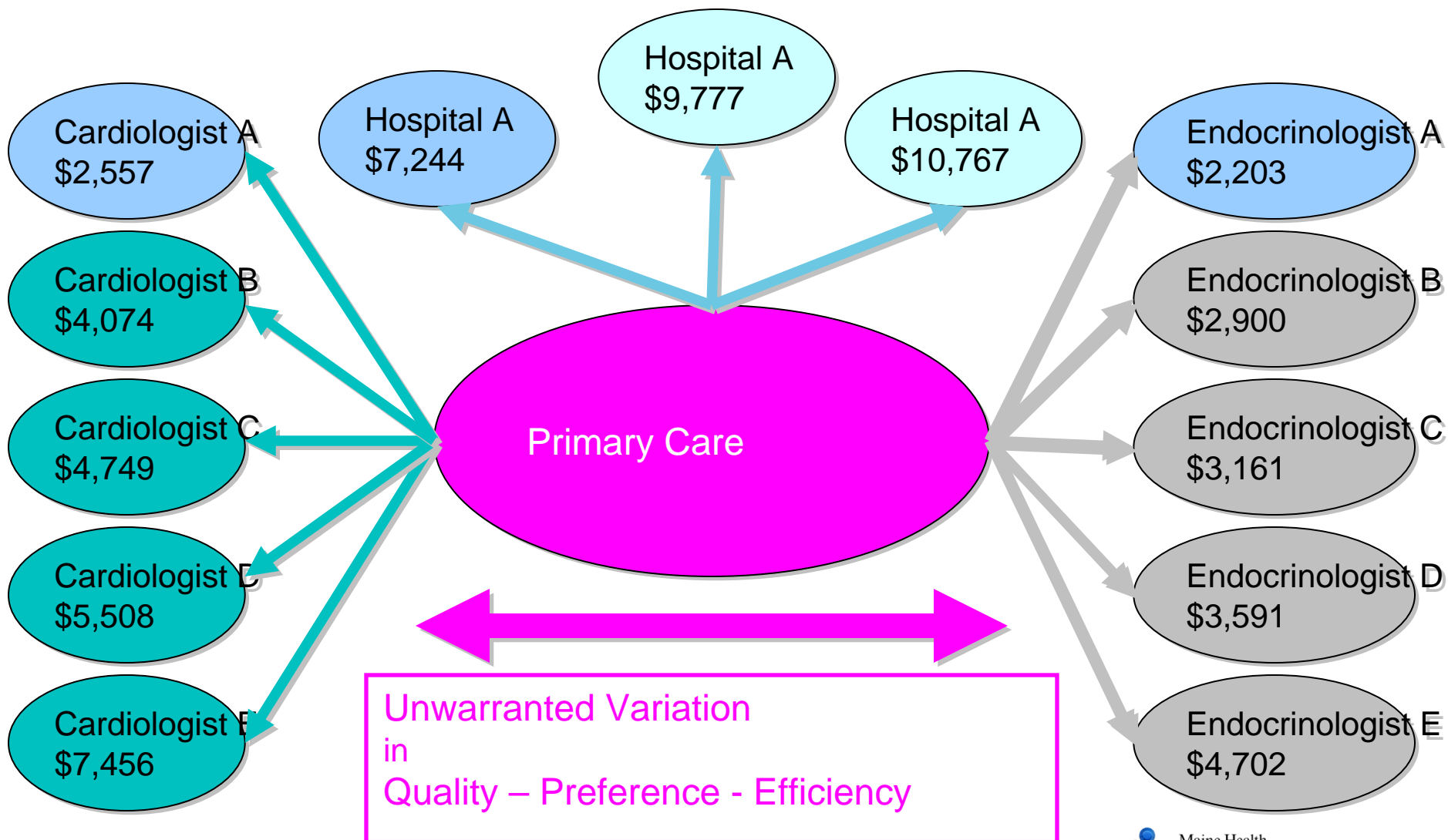
Top Performance, Supply Sensitive Cost

Group 1	\$361
Group 5	\$417
Group 4	\$523
Group 12	\$523
Group 6	\$563
MEDIAN OF GROUPS	\$666

Bottom Performance, Supply Sensitive Cost

Group 14	\$688
Group 3	\$725
Group 9	\$732

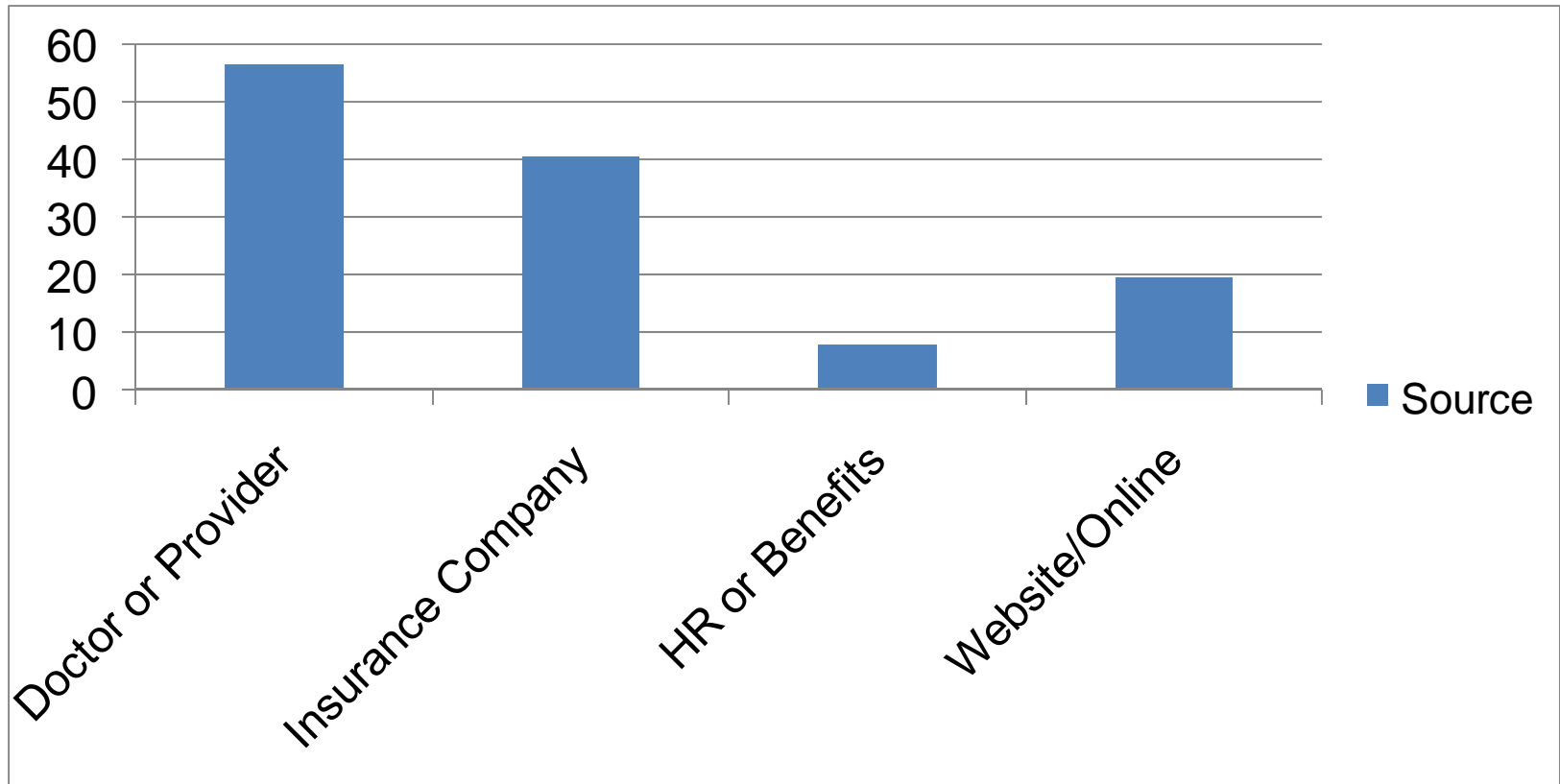
Measurement - it's not just about what happens in primary care...



Q1: How easy do you think it is to find out how much medical treatments and procedures cost?

	Frequency	Percent
Very Easy	11	4.1
Somewhat Easy	52	19.5
Somewhat Hard	133	50.0
Very Hard	67	25.2
No Response	3	1.1
Total	266	100.0

Q2: Where do you go to find information about how much medical treatments or procedures cost?



Q8: Which of the following statements do you think best describes why you have not talked to your healthcare provider about costs?*

Response	Percent
The provider has no control over healthcare costs	29.7
I have not been to a doctor or healthcare provider in the past 12 months	21.6
I feel uncomfortable asking	20.3
I do not think it is important	14.9
The provider is too busy to talk about things like that	13.5

*Of those respondents in Q7 who stated they had not asked their provider about costs



Maine Health Management Coalition

HEALTHCARE QUALITY MATTERS

July 2009

More is Not Always Better - Getting Just the Care You Need is Best

Getting the right amount of care – not too little and not too much – is part of good quality healthcare and a smart use of two important resources: time and money.



- Getting too little care can lead to more serious health problems that may be harder to treat. This can not only be bad for your health, but may also end up costing more in the long run.
- Getting too much care, or more care, than you need will take more time, will not help you get better any faster, and can sometimes be harmful. Some tests, surgeries, and medicines have risks. Sometimes simpler treatments work better and are safer.
- Getting care you do not need also adds costs. Whether the money comes out of your own pocket or is paid for by your health benefits, it is a waste of anyone's money to spend it on care that is not needed. When employees are given care they do not need, the cost adds up quickly for the whole company. This leads to higher premiums, less coverage, or higher out-of-pocket costs in the future.

Adapted from the AIR/National Business Coalition on Health
"Communication Toolkit: Using Information to Get High Quality Care"

About MHMC

The Maine Health Management Coalition (MHMC) is made up of employers, hospitals, health plans, and doctors working together to improve the value of healthcare in Maine. For more information about MHMC, or to obtain reliable quality data about local doctors and hospitals, please visit www.mhmc.info.

Success Story – Blake H.

Research and Shopping Around Can Lead to Better and Less Expensive Care

Having a high deductible health plan helped Blake to become a smart healthcare consumer when he tripped and hurt his knee. By shopping around, he got the right care at a lower cost.

After learning about his treatment options, Blake decided to get physical therapy to treat his knee injury. His doctor suggested that Blake go to one therapist close to where he lived, but since Blake had a high-deductible health plan and would be paying for the treatment out of his own pocket, he wanted to make sure to go to a physical therapy practice where he would get the best value.

He visited three physical therapy offices before making a decision. The physical therapist that the doctor recommended charged \$75 for every 15 minutes. The other two wanted about \$22 every 15 minutes. He chose one of the less expensive ones since the quality was good and also he got a month of free access to their equipment when the therapy ended.

"What I learned from this experience is that it is important to shop around,"



Maine Health Management

Bring it

You Get What You Pay For

Employers Want:

Informed Employees
Improved Outcomes
Care Coordination
Prevention
Functional Status
Return to Work

Employers Pay For:

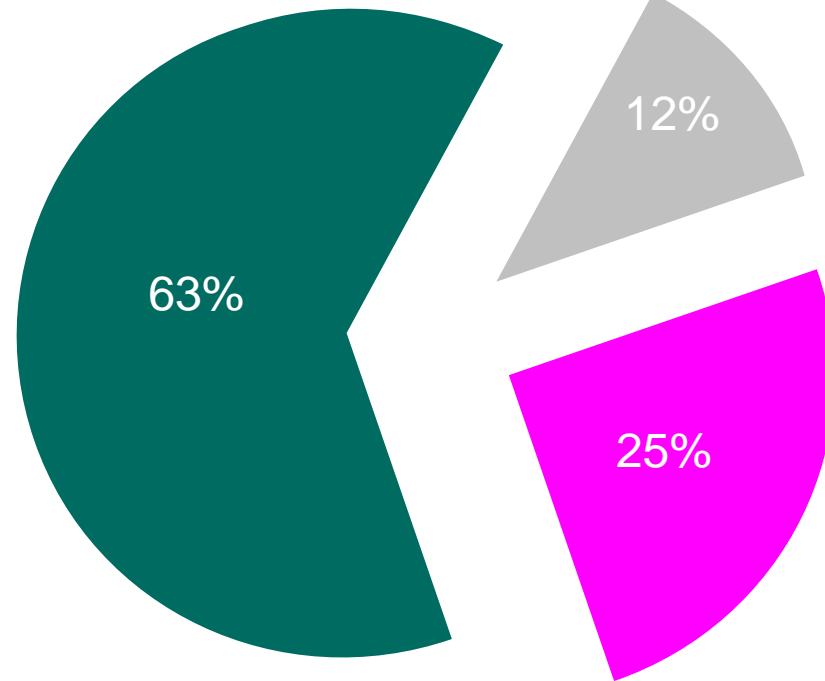
Tests
Visits
Procedures
Prescriptions
Errors & Complications

Why Are FFS Payment Systems the Norm?

- They are consistent with strongly held cultural values:
 - Of patients who want freedom to choose caregivers;
 - Of patients who want freedom to seek the care they need
 - Of providers who want to preserve clinical autonomy
 - Of providers who want to preserve their economic independence.
- They are expedient:
 - For Policymakers
 - For Payors
 - For Employers; and
 - For Providers
- They are easier to implement and administer
- They do not require entities capable of organizing the delivery of care and accepting accountability for both its quality and cost.

Proportion of health care costs

Supply-sensitive care



Effective care

Preference-sensitive care

The Dartmouth Institute for Health Policy and Clinical Practice
(Wennberg, Weinstein, Fisher, et al.)

www.mhmc.info & www.mehmc.org

Is More Supply-Sensitive Care Better?

App

ARTICLE

Conclusions:

Medicare enrollees in higher-spending regions receive more care than those in lower spending regions but do not have better health outcomes or satisfaction with care.

Efforts to reduce spending should proceed with caution, but policies to better manage further spending growth are warranted.

Variations in Medicare Spending. Part 1: Variability of Care

A. Stukel, PhD; Daniel J. Gottlieb, MS; F.L. Lucas, PhD;

Results: Average baseline health status of cohort similar across regions of differing spending levels, but higher-spending regions received approximately 6% more care. The increased utilization was explained by more

Conclusions:

Regional differences in Medicare spending are largely explained by the more inpatient-based and specialist-oriented pattern of practice observed in high-spending regions. Neither quality of care nor access to care appear to be better for Medicare enrollees in higher-spending regions.

The Implications of Regional Variations in Medicare Spending on Health Outcomes and Satisfaction

Elliott S. Fisher, MD, MPH; David E. Wennberg, MD, MPH; Therese A. Stukel, PhD; and Étienne L. Pinder, MS

Background: The health implications of regional differences in Medicare spending are unknown.

Objective: To determine whether regions with higher Medicare spending achieve better survival, functional status, or satisfaction with care.

Design: Cohort study.

Setting: National study of Medicare beneficiaries.

Patients: Patients hospitalized between 1993 and 1995 for hip fracture ($n = 614\ 503$), colorectal cancer ($n = 195\ 429$), or acute myocardial infarction ($n = 159\ 393$) and a representative sample ($n = 18\ 190$) drawn from the Medicare Current Beneficiary Survey

Results: Average baseline health status, but those in higher-spending regions received 60% more care. Each 10% increase in regional end-of-life spending was associated with the following relative risks for death: hip fracture cohort, 1.003 (95% CI, 0.999 to 1.006); colorectal cancer cohort, 1.012 (CI, 1.004 to 1.019); acute myocardial infarction cohort, 1.007 (CI, 1.001 to 1.014); and MCBS cohort, 1.01 (CI, 0.99 to 1.03). There were no differences in the rate of decline in functional status across spending levels and no consistent differences in satisfaction.

A new payment model?

Service Category

Provider Incentives

Patient Incentives

Supply Sensitive

Global Budget

High co-pays

Preference Sensitive

Pay for informed,
evidence based choice

Low co-pays
w/SDM

Effective and
Safe Care

Pay for Outcomes/
Incentives for results

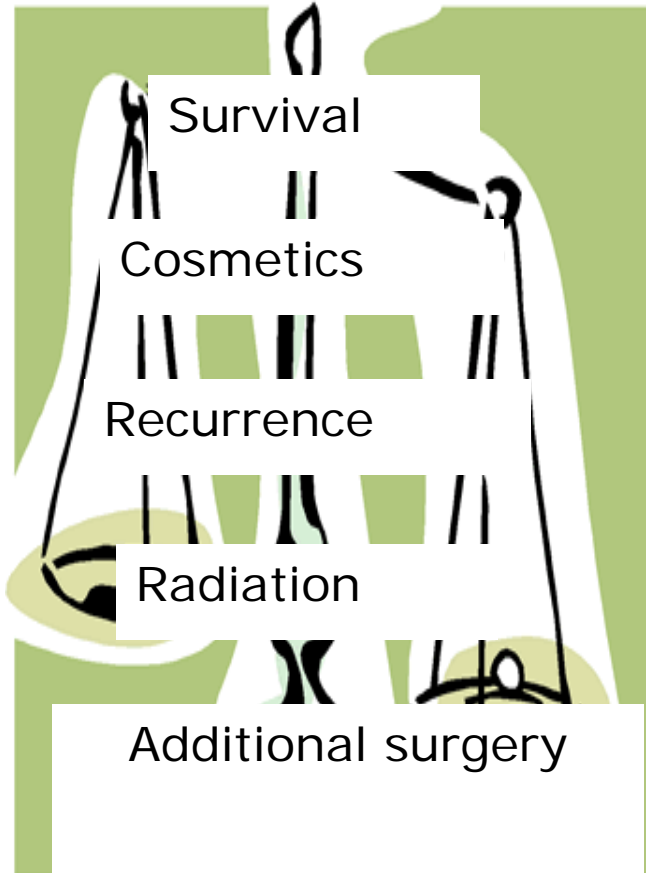
No cost barriers/
Incentives for

compliance

Providers, patients and preference sensitive care

Mastectomy

Same
Lose breast
Low (1-5%)
Not common
Rare



Lumpectomy

Same
Keep breast
Slightly higher (5-15%)
6+ weeks
Common 20-50%

Top three goals and concerns for different breast cancer decisions

Decision: Goals	% top 3 Patient	% top 3 Providers	p
Surgery: Keep your breast	7%	71%	p<0.01
Reconstruction: Look natural without clothes	33%	80%	p=0.05
Chemotherapy: Live as long as possible	59%	96%	p=0.01
Reconstruction: Avoid using prosthesis	33%	0%	p<0.01

Peter Lee: Value Policy #7: Consumer & Provider Incentives to Promote Shared Decision-Making

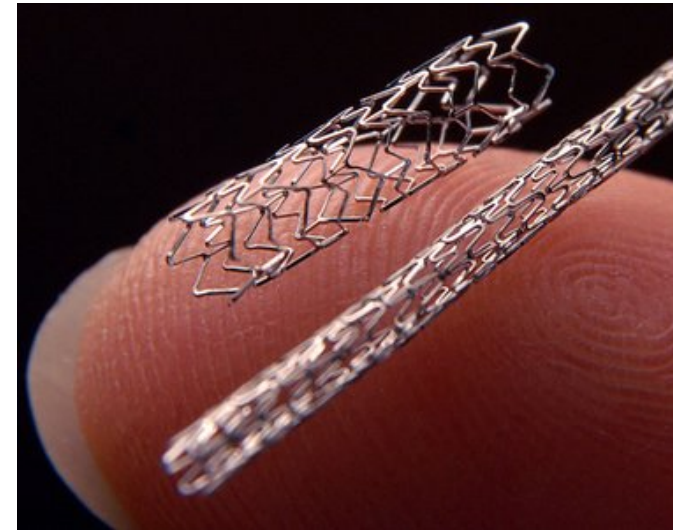
The right incentives for consumers and providers. For example:

Patients -- for individuals with low/moderate risk of heart disease:

- No copay for intensive diet and exercise support
- Some copay for medication (low/no for generic, etc)
- Bigger copay for stents and CABG (after shared decision-making)
- Biggest copay for stents and CABG (if NO informed decision-making)

Clinicians – for referring and providing physicians

- Higher/real payments for nutrition/lifestyle support (not necessarily by a physician)
- Payment rewards to referring providers who send patients to interventionists with better track record
- Payment rewards to those doing procedure: “full” payment only where patient completed approved shared decision-making process; 75% payment otherwise



Payment Systems under Consideration

- All require limits on patients' access to care
- All require a defined group of providers
- All require an 'Accountable Care Organization' to accept responsibility for coordinating the provision of services, determining how payments received will be distributed, and assume financial risk.
- All require the development of 'fair' payment rates, both at the outset of the arrangement and for subsequent periods.
- All require careful measurement of quality and transparency findings.

Building the Business Case

1. State Employee Health Commission Tiering on MHMC Quality Rankings
2. All large employer members (public and private) of MHMC issued a joint RFI to all health plans AND health systems in Maine
 - Support three things:
 - Transparency and Public Reporting
 - Local Care Management
 - Payment Reform
 - Now they have to buy it.

Supporting Early Adopters

3. Pilots:

- 1 Large System/Large Employer ACO pilot launched. 3 pilot proposals pending
- Shared Decision Making (incent patients with benefits, providers with appropriate payment)
- Reducing Readmissions (30 day ROI)
- Patient Centered Medical Home (shared savings)
- Local Primary Care Initiatives (BIW, Martins Point)
- Small Group Capitation

- Role(s) of MHMC: Convening/Matchmaking, Technical Support, Evaluation, Infrastructure, Public Reporting, and Communications

Accountable Care Organization

“An ACO is a provider-led organization whose mission is to manage the full continuum of care and be accountable for the overall costs and quality of care for a defined population.”

NEJM.....

Goal: Give PCPs the Capacity to Deliver “Accountable Care”

**PCP
Practice
+
Partners
=
ACO**

Data and analytics to measure and monitor utilization and quality

Coordinated relationships with specialists and hospitals

Capability for tracking patient care and ensuring followup (e.g., registry)

Method for targeting high-risk patients (e.g., predictive modeling)

Resources for patient educ. & self-mgt support (e.g., RN care mgr)

PCP w/ time for diagnosis, treatment planning, and followup



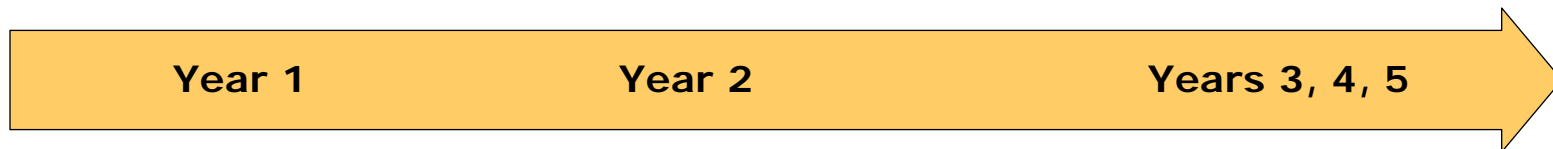
Inpatient Episodes

Patient

Testing & Specialists



A Five Year Plan



Key Considerations:

- | | Year 1 | Year 2 | Years 3, 4, 5 |
|---------------------|---|--|--|
| Key Considerations: | <ul style="list-style-type: none">• Steering Committee• Contracting• MGH expanded support of primary care and development of evidence based referrals• Baseline data | <ul style="list-style-type: none">• Multi-year workplan set• Expansion of medical homes, evidence-based specialty referrals and decision support• Aligned benefit structure• First year of expanded data sets | <ul style="list-style-type: none">• Expansion of Medical Home/ACO model• Expanded data sets with trends• Aligned benefit structure |

Shared Risk

- | | Year 1 | Year 2 | Years 3, 4, 5 |
|-------------|--|---|--|
| Shared Risk | <ul style="list-style-type: none">• MGH will put significant dollars at risk if it fails to fulfill its first year obligations | <ul style="list-style-type: none">• Model gainsharing | <ul style="list-style-type: none">• Practice gainsharing and consider moving to global payments in later years |

A proposal between the State of Maine and MaineGeneral Health

MaineGeneral Health's Commitments

Specialty Care

- Develop standardized, evidence-based protocols for referrals to specialists and for care of common conditions, minimum 2 specialty areas per year
- Expand decision support for patients
- Set Utilization and Quality targets for each year
- Collaborate with the State of Maine to prioritize most needed interventions

A proposal between the State of Maine and MaineGeneral Health

MaineGeneral Health's Commitments

Shared Risk in the first year

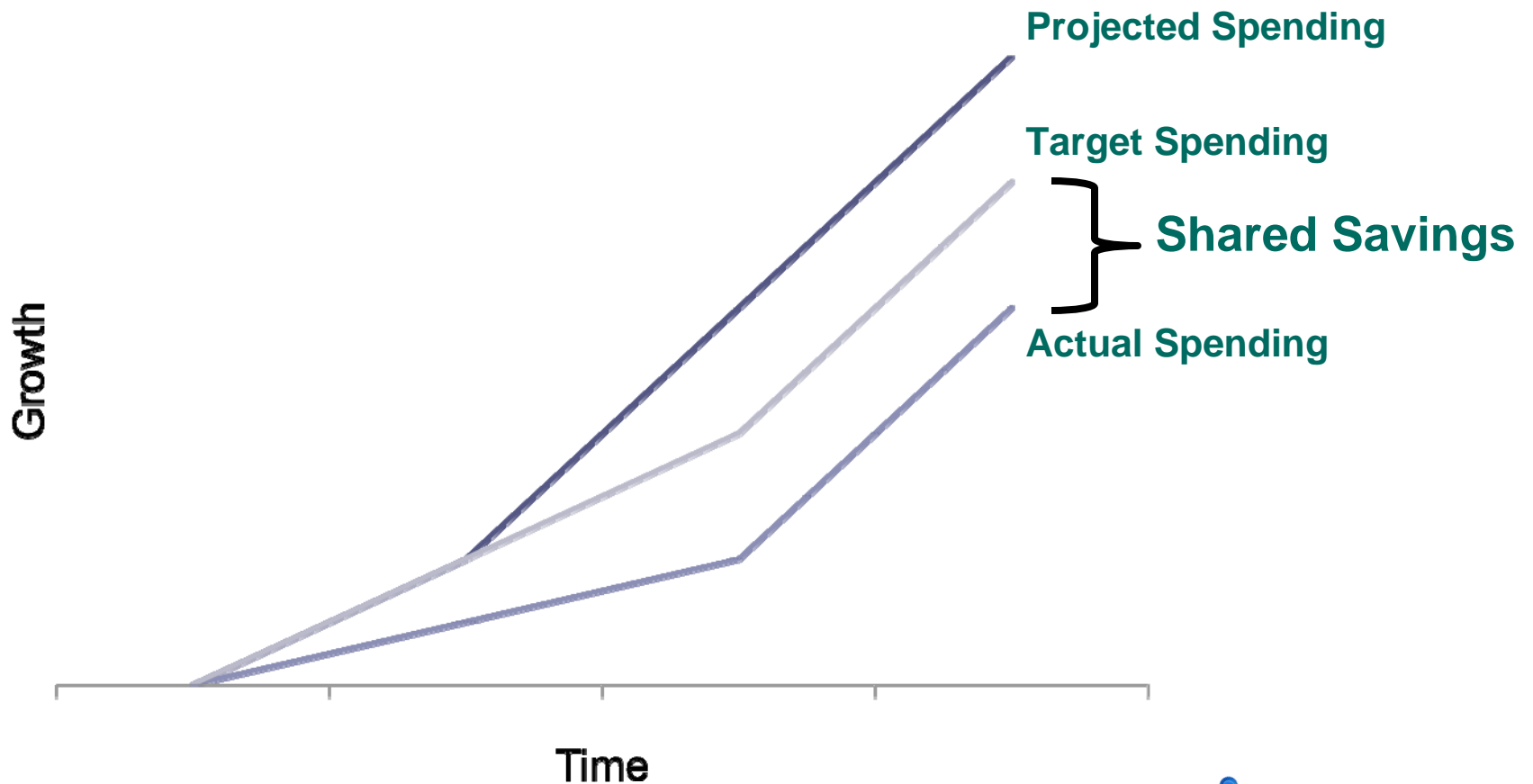
MaineGeneral will put \$250,000 at risk to the State if MGH is unable to fulfill its commitments to expand primary care and develop standardized protocols with at least two specialty areas in the first year

A proposal between the State of Maine and MaineGeneral Health

MaineGeneral Health's Commitments Utilization and Quality

- Targets will be set for each year
 - i.e. Readmissions will decrease by ____ in year 2
 - i.e ER Utilization will decrease by ___% per year
- Quality metrics, including those of PTE will be set for each year
- Again these need to be individualized to the target population once that is established

Calculating savings based on spending targets



A proposal between the State of Maine and MaineGeneral Health

Commitments that will be held jointly Contracting

- Establish a steering committee for this work
- Develop the specifics of a multi-year workplan and convert it into a contract by end of year 1
- Contract with a third party for purposes of overall guidance on the pilot and on-going development and analysis of data

A proposal between the State of Maine and MaineGeneral Health

The Employee Health Commission's Commitments

TPA and Benefits

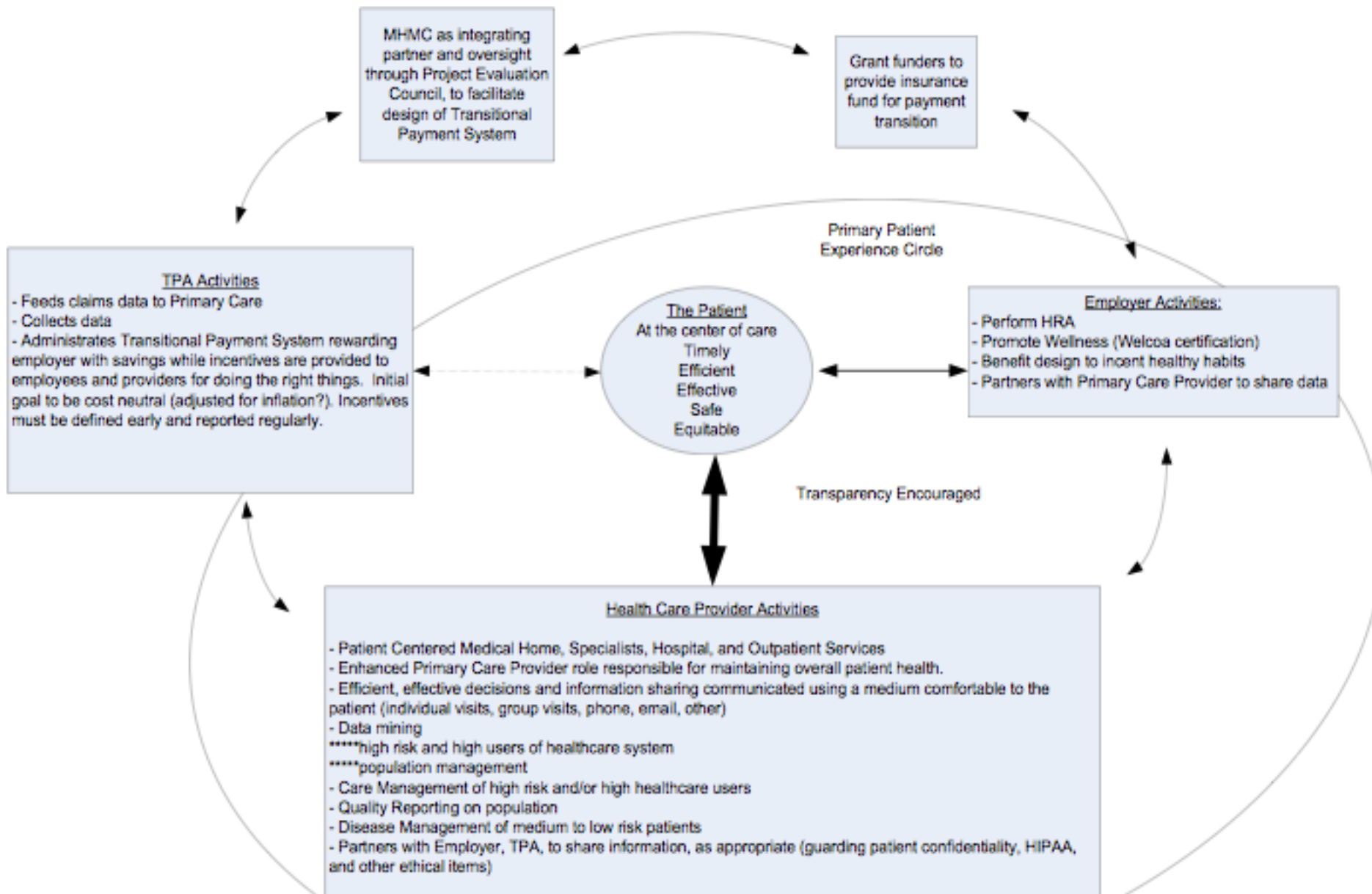
- Develop a benefit structure that is aligned with the pilot
 - Incentivize use of HRA and adherence to a plan
 - Expands Worksite Wellness program
 - Incentivize shared decision making

MaineGeneral Kennebec Valley Care Model

Right Care, Right Place, Right Time

Community-Based Outpatient Setting	Hospital-Based Outpatient Setting	Impact
Adequate Supply of Primary Care Providers	On-site Advanced Medical Home for ED Triage	Reduce ED Utilization 10,500 annual visits by 2018 (14%)
Adequate Supply of Specialists	ED Utilization	Reduce Hospital Admissions 607 annual admissions by 2018 (2.5%)
Access Designed to Meet Patient Preference	Tests & Treatments	Improved Coordination of Care for Chronic Disease
Access to Providers for Self-Triage/Care		Optimal Levels of Diagnostic & Interventional Utilization
Advanced Medical Home Patient Management		

Leveraging Multiple Factors in a Healthcare Delivery System



More Next Steps

- Increased Public Reporting of Cost, Utiliation and Quality
- Increased Consumer Engagement on Value/Appropriate Care through key partnerships (AF4Q, MQF, QC)
- Service Agreements: PCPs/Specialists
- Regulatory Review/Changes
- Waiver Application

Our perspective (for what its worth):

You get what you pay for – shared accountability for current system (no blame)

Complex change required - at all levels at the same time: payment, system design, consumer role, provider role: 'Its really difficult, but it's the only change that matters' - DW

Change must be collaborative – providers/ plans/consumers/purchasers – public AND private

Change must be gradual – can't change payment overnight because 1) the system we want doesn't exist and 2)we are talking about people's lives

Change is urgent – window of collaborative opportunity will be closed by cost pressures