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

Elizabeth Mitchell
CEO
Maine Health Management Coalition
The Maine Health Management Coalition Foundation is a public charity whose mission 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.

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.

Employers
- 16 Private Employers
- 5 Public Purchasers

Providers
- 21 Hospitals
- 14 Physician Groups

Health Plans
- 5 Health Plans
Collectively 35% of Comm. Market

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MHMC’s Goal

value: change in health status +
employee satisfaction

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
“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
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

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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

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

- “Needed” variation may reflect maternity admits

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Significant savings are available within each supply sensitive category

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

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

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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.
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.
New Hospital Quality Measures

Maine Health Management Coalition

Maine Hospital Ratings

Blue Ribbons

Sort by: Highest Rated, Name, City, Miles

Hospital Ratings Explained
page last updated Oct 2009

 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

Select Clinical Quality
ratings explained

www.mhmc.info & www.mehmc.org
### Select Clinical Quality Ratings

**Maine Hospital Ratings**

#### Miles Memorial Hospital
- **Address:** 35 Miles Street, **Damariscotta 04543**
- **Rating:** Performs between 50th and 90th national percentile of hospitals.

#### St. Joseph Hospital
- **Address:** 360 Broadway, **Bangor 04401**
- **Rating:** Performs between 50th and 90th national percentile of hospitals.
SEHC Announce 7-07 PCP Tiering

New Visitors and Repeat Visits

May 15, 2007
May 18, 2007
May 21, 2007
May 24, 2007
May 27, 2007
May 30, 2007
Jun 2, 2007
Jun 5, 2007
Jun 8, 2007
Jun 11, 2007
Jun 14, 2007
Jun 17, 2007
Jun 20, 2007
Jun 23, 2007
Jun 26, 2007
Jun 29, 2007
Jul 2, 2007
Jul 5, 2007
Jul 8, 2007

New Visitors
Repeat

0
200
400
600
800
1,000
1,200
1,400
1,600
Current PTE Participation

<table>
<thead>
<tr>
<th>Practices</th>
<th>2007</th>
<th>2008</th>
<th>% Ch</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Blue Ribbon</td>
<td>131</td>
<td>171</td>
<td>+ 31%</td>
</tr>
<tr>
<td>2 Blue Ribbon</td>
<td>59</td>
<td>71</td>
<td>+ 20%</td>
</tr>
<tr>
<td>1 Blue Ribbon</td>
<td>70</td>
<td>69</td>
<td>-1%</td>
</tr>
<tr>
<td>0 Blue Ribbon</td>
<td>169</td>
<td>125</td>
<td>-26%</td>
</tr>
</tbody>
</table>
Group Measurement - Dashboard

PERFORMANCE SUMMARY: Medical Association, Primary Care, Group Results
Adult Patients (18 and over) for Period Ending Jan. 31, 2009

ABOUT THE GROUP'S PATIENTS

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Groups</td>
<td>17</td>
<td>N/A</td>
</tr>
<tr>
<td>Patients</td>
<td>67,469</td>
<td>N/A</td>
</tr>
<tr>
<td>Average Age</td>
<td>41</td>
<td>N/A</td>
</tr>
<tr>
<td>% Male</td>
<td>42</td>
<td>N/A</td>
</tr>
<tr>
<td>% Chronic</td>
<td>14.0</td>
<td>N/A</td>
</tr>
<tr>
<td>% Asthma</td>
<td>4.0</td>
<td>N/A</td>
</tr>
<tr>
<td>% CAD</td>
<td>3.0</td>
<td>N/A</td>
</tr>
<tr>
<td>% COPD</td>
<td>1.0</td>
<td>N/A</td>
</tr>
<tr>
<td>% Diabetes</td>
<td>8.0</td>
<td>N/A</td>
</tr>
<tr>
<td>% Heart Failure</td>
<td>0.0</td>
<td>N/A</td>
</tr>
</tbody>
</table>

PERFORMANCE SUMMARY

The overall distribution of groups’ performance.
Effective Care

Supply Sensitive Care in Dollars (per Patient per Year)

Preference Sensitive Care (Surgeries per 1000 Patients)

EFFECTIVENESS AND EFFICIENCY

The distribution of groups’ composite effectiveness and efficiency scores.

Adjusted Supply Sensitive Care Score

KEY RISK ADJUSTED UTILIZATION MEASURES

The distribution of groups’ use of services.

<table>
<thead>
<tr>
<th></th>
<th>Min</th>
<th>25th</th>
<th>Median</th>
<th>75th</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Acute Admissions</td>
<td>30</td>
<td>32</td>
<td>32</td>
<td>33</td>
<td>35</td>
</tr>
<tr>
<td>Emergency Dept Visit</td>
<td>99</td>
<td>124</td>
<td>139</td>
<td>161</td>
<td>581</td>
</tr>
<tr>
<td>Total Visit Count</td>
<td>4,555</td>
<td>4,762</td>
<td>4,979</td>
<td>5,184</td>
<td>5,775</td>
</tr>
</tbody>
</table>

Top/Bottom Performing Groups

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

<table>
<thead>
<tr>
<th></th>
<th>Top Performance, Effective Care</th>
<th>Top Performance, Supply Sensitive Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 7</td>
<td>81%</td>
<td>Group 1</td>
</tr>
<tr>
<td>Group 11</td>
<td>81%</td>
<td>Group 5</td>
</tr>
<tr>
<td>Group 13</td>
<td>80%</td>
<td>Group 4</td>
</tr>
<tr>
<td>Group 9</td>
<td>80%</td>
<td>Group 12</td>
</tr>
<tr>
<td>Group 2</td>
<td>79%</td>
<td>Group 6</td>
</tr>
<tr>
<td>MEDIAN OF GROUPS</td>
<td>76%</td>
<td>MEDIAN OF GROUPS</td>
</tr>
<tr>
<td>Bottom Performance, Effective Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 3</td>
<td>73%</td>
<td>Group 14</td>
</tr>
<tr>
<td>Group 10</td>
<td>65%</td>
<td>Group 3</td>
</tr>
<tr>
<td>Group 8</td>
<td>63%</td>
<td>Group 9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Bottom Performance, Supply Sensitive Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 14</td>
<td>$688</td>
</tr>
<tr>
<td>Group 3</td>
<td>$725</td>
</tr>
<tr>
<td>Group 9</td>
<td>$732</td>
</tr>
</tbody>
</table>
Measurement - it’s not just about what happens in primary care...

Unwarranted Variation in Quality – Preference - Efficiency
Q1: How easy do you think it is to find out how much medical treatments and procedures cost?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Easy</td>
<td>11</td>
</tr>
<tr>
<td>Somewhat Easy</td>
<td>52</td>
</tr>
<tr>
<td>Somewhat Hard</td>
<td>133</td>
</tr>
<tr>
<td>Very Hard</td>
<td>67</td>
</tr>
<tr>
<td>No Response</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>266</strong></td>
</tr>
</tbody>
</table>
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?**

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

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

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.”

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.
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

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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 63%
Effective care 12%
Preference-sensitive care 25%

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

www.mhmc.info & www.mehmc.org
<table>
<thead>
<tr>
<th>Conclusions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Conclusions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

Article:

Variations in Medicare Spending. Part 1: Availability of Care

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

Results: Average baseline health status of cohort was similar across regions of differing spending levels, but higher-spending regions received approximately 60% more care. The increased utilization was explained by more inpatient-based and specialist-oriented patterns 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.

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 = 59,393) and a representative sample (n = 18,190) drawn from the Medicare Current Beneficiary Survey.


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### A new payment model?

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Provider Incentives</th>
<th>Patient Incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supply Sensitive</td>
<td>Global Budget</td>
<td>High co-pays</td>
</tr>
<tr>
<td>Preference Sensitive</td>
<td>Pay for informed, evidence based choice</td>
<td>Low co-pays</td>
</tr>
<tr>
<td>Effective and Safe Care</td>
<td>Pay for Outcomes/ Incentives for results</td>
<td>No cost barriers/ Incentives for compliance</td>
</tr>
</tbody>
</table>
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%

- **Survival**
  - Slightly higher (5-15%)
  - Low (1-5%)

- **Cosmetics**
  - Not common
  - Rare

- **Recurrence**
  - Not common
  - Rare

- **Radiation**
  - Common 20-50%
  - Rare

- **Additional surgery**
  - Not common
  - Rare

www.mhmc.info & www.mehmc.org
Top three goals and concerns for different breast cancer decisions

<table>
<thead>
<tr>
<th>Decision: Goals</th>
<th>% top 3 Patient</th>
<th>% top 3 Providers</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery: Keep your breast</td>
<td>7%</td>
<td>71%</td>
<td>p&lt;0.01</td>
</tr>
<tr>
<td>Reconstruction: Look natural without clothes</td>
<td>33%</td>
<td>80%</td>
<td>p=0.05</td>
</tr>
<tr>
<td>Chemotherapy: Live as long as possible</td>
<td>59%</td>
<td>96%</td>
<td>p=0.01</td>
</tr>
<tr>
<td>Reconstruction: Avoid using prosthesis</td>
<td>33%</td>
<td>0%</td>
<td>p&lt;0.01</td>
</tr>
</tbody>
</table>

www.mhmc.info & www.mehmc.org
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.

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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

www.mhmc.info & www.mehmc.org
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”

- 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

PCP Practice + Partners = ACO

Inpatient Episodes
- Patient
- Testing & Specialists

www.mhmc.info & www.mehmc.org
Develop a Shared Understanding

A Five Year Plan

**Year 1**
- Steering Committee
- Contracting
- MGH expanded support of primary care and development of evidence-based referrals
- Baseline data

**Year 2**
- Multi-year workplan set
- Expansion of medical homes, evidence-based specialty referrals and decision support
- Aligned benefit structure
- First year of expanded data sets

**Years 3, 4, 5**
- Expansion of Medical Home/ACO model
- Expanded data sets with trends
- Aligned benefit structure

**Key Considerations:**
- MGH will put significant dollars at risk if it fails to fulfill its first year obligations
- Model gainsharing

**Shared Risk**
- Practice gainsharing and consider moving to global payments in later years

www.mhmc.info & www.mehmc.org
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 it’s 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 individualized to the target population once that is established
Calculating savings based on spending targets

- Projected Spending
- Target Spending
- Shared Savings
- Actual Spending

Growth vs. Time
A proposal between the State of Maine and Maine General 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
  - Incents use of HRA and adherence to a plan
  - Expands Worksite Wellness program
  - Incents shared decision making
### MaineGeneral Kennebec Valley Care Model

**Right Care, Right Place, Right Time**

<table>
<thead>
<tr>
<th>Community-Based Outpatient Setting</th>
<th>Hospital-Based Outpatient Setting</th>
<th>Impact</th>
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<tbody>
<tr>
<td>Adequate Supply of Primary Care Providers</td>
<td>On-site Advanced Medical Home for ED Triage</td>
<td>Reduce ED Utilization 10,500 annual visits by 2018 (14%)</td>
</tr>
<tr>
<td>Adequate Supply of Specialists</td>
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<td>Reduce Hospital Admissions 607 annual admissions by 2018 (2.5%)</td>
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<tr>
<td>Access Designed to Meet Patient Preference</td>
<td>Tests &amp; Treatments</td>
<td>Improved Coordination of Care for Chronic Disease</td>
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<tr>
<td>Access to Providers for Self-Triage/Care</td>
<td></td>
<td></td>
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<tr>
<td>Advanced Medical Home Patient Management</td>
<td></td>
<td>Optimal Levels of Diagnostic &amp; Interventional Utilization</td>
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**Impact**
- Reduce ED Utilization: 10,500 annual visits by 2018 (14%)
- Reduce Hospital Admissions: 607 annual admissions by 2018 (2.5%)
- Improved Coordination of Care for Chronic Disease
- Optimal Levels of Diagnostic & Interventional Utilization
Leveraging Multiple Factors in a Healthcare Delivery System

MHMC as integrating partner and oversight through Project Evaluation Council, to facilitate design of Transitional Payment System

Grant funders to provide insurance fund for payment transition

Primary Patient Experience Circle

TPA Activities
- Feeds claims data to Primary Care
- Collects data
- Administrates Transitional Payment System rewarding employer with savings while incentives are provided to employees and providers for doing the right things. Initial goal to be cost neutral (adjusted for inflation?). Incentives must be defined early and reported regularly.

The Patient
At the center of care
Timely
Efficient
Effective
Safe
Equitable

Employer Activities:
- Perform HRA
- Promote Wellness (Welcoa certification)
- Benefit design to incent healthy habits
- Partners with Primary Care Provider to share data

Health Care Provider Activities
- Patient Centered Medical Home, Specialists, Hospital, and Outpatient Services
- Enhanced Primary Care Provider role responsible for maintaining overall patient health.
- Efficient, effective decisions and information sharing communicated using a medium comfortable to the patient (individual visits, group visits, phone, email, other)
- Data mining
  **** high risk and high users of healthcare system
  **** population management
- Care Management of high risk and/or high healthcare users
- Quality Reporting on population
- Disease Management of medium to low risk patients
- Partners with Employer, TPA, to share information, as appropriate (guarding patient confidentiality, HIPAA, and other ethical items)

Transparency Encouraged
More Next Steps

- Increased Public Reporting of Cost, Utilization 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: ‘It’s 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