Maine Health Management Coalition

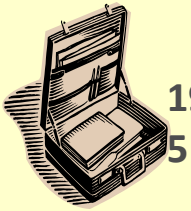
Multi-stakeholder Payment Reform and System Redesign: It Can Be Done

Elizabeth Mitchell

CEO

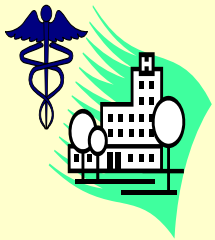
Maine Health Management Coalition

Maine Health Management Coalition
www.mhmc.info



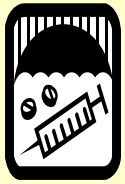
Purchasers

19 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 purchaser-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 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 healthcare services and to educate the public to use information on cost and quality to make informed decisions.

MHMC Value Equation

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

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

Good News and Bad News

The Good News:

Maine's health care quality is good and improving.

2010: Biggest improvement in US

The Bad News:

We can't afford it.

Maine's health care cost 2nd highest in US.

4 Steps to Improving Health Care Value

1) Performance Measurement and Public Reporting

2) Consumer Engagement

1) Value Based Purchasing

2) Reformed Payment/Effective Incentives

Maine Health Management Coalition

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

MAINE CANCER PATIENT CHESLEY TALKS ABOUT HER EXPERIENCE · MORE »

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 »

Maine Hospitals

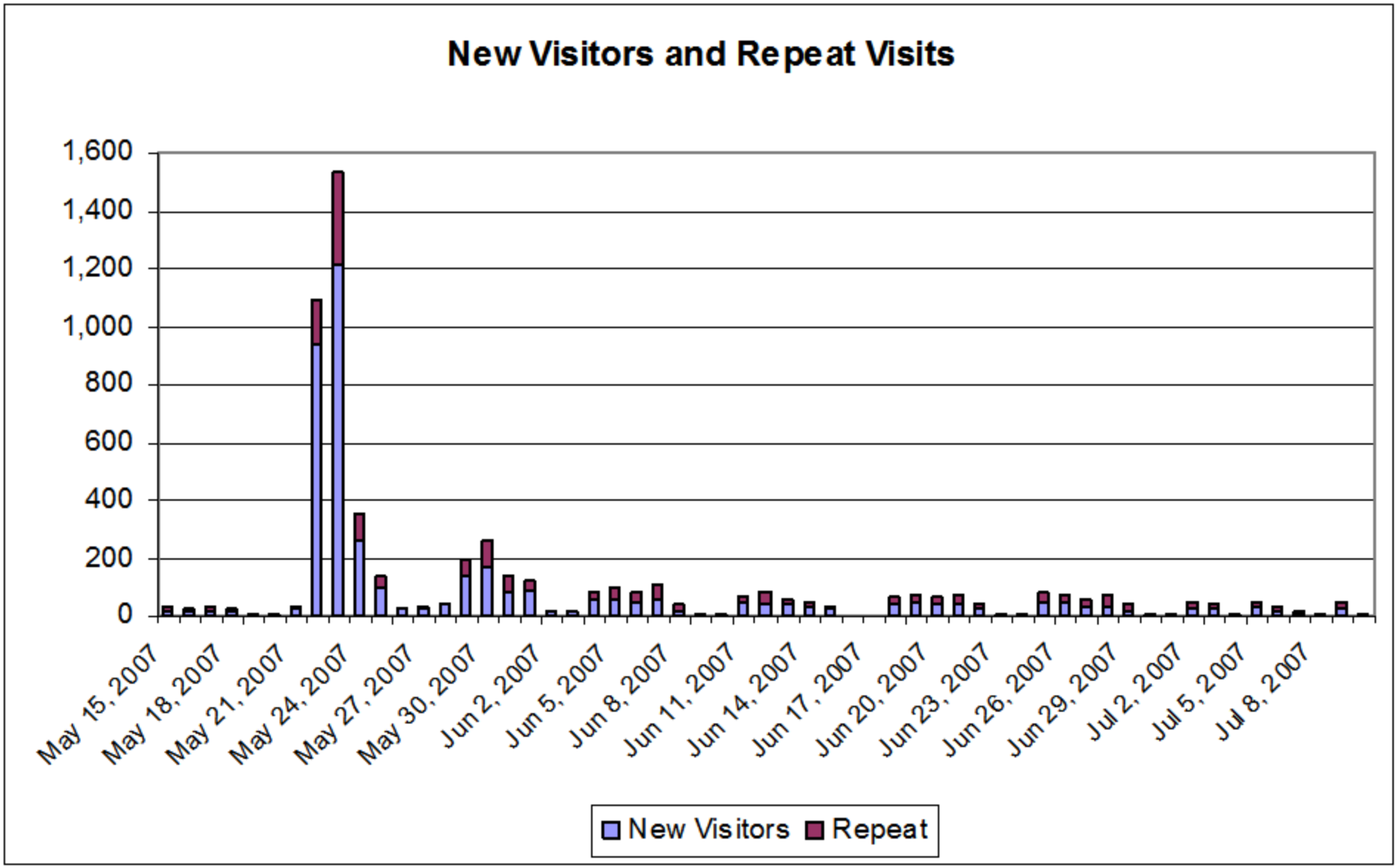
PTE Steering Committee Determines Pie and Blue Ribbon Cut Points.

Source:	**CMS**	**Leapfrog & MHMC**	**CMS**

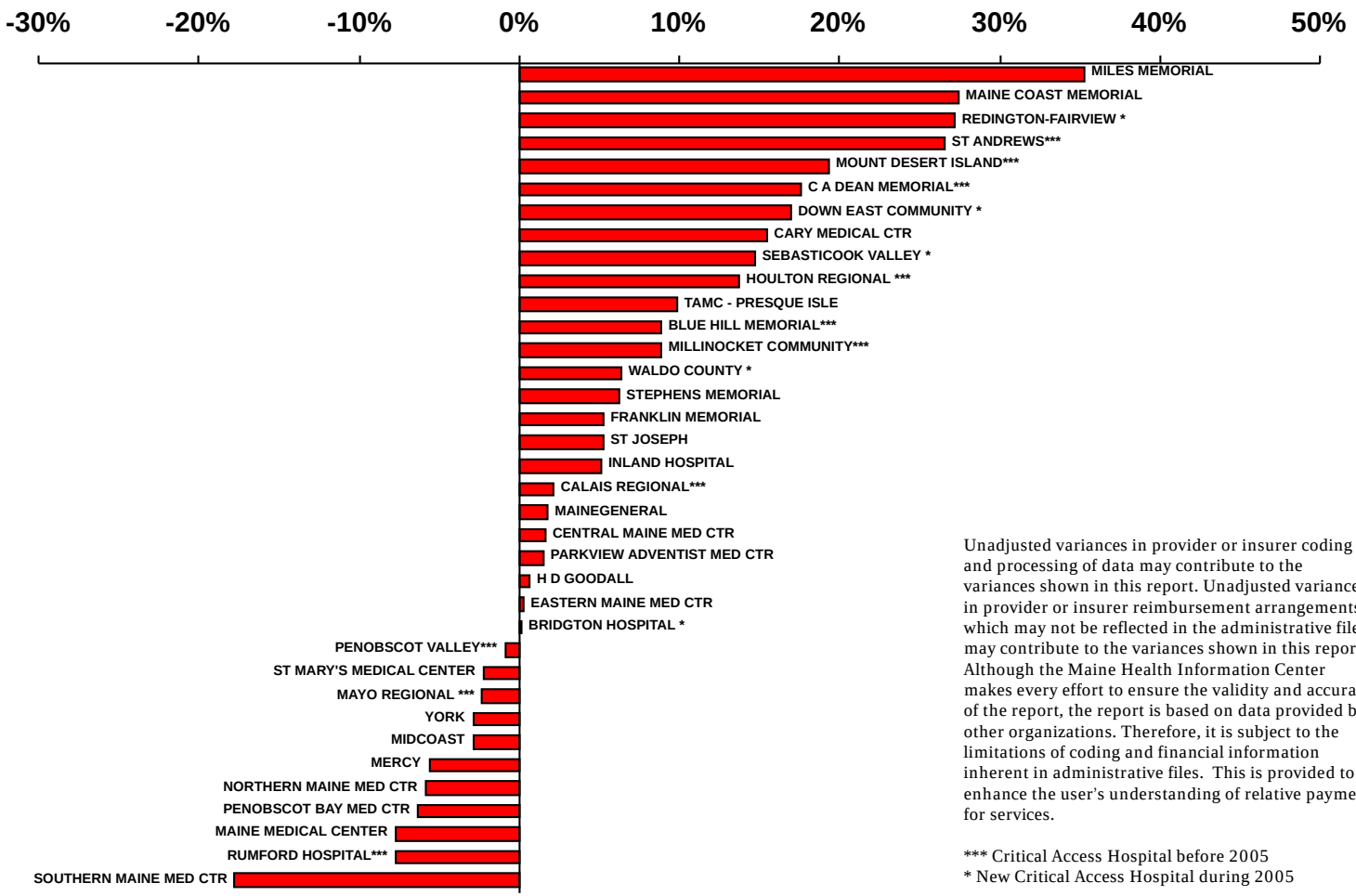
Health Plan - Employer Use

- State of Maine Tiered Networks
  - Hospital based on PTE Metrics - 2006
    - Waive $200 co-pay
  - PCPs based on PTE Metrics - July 2007
    - Waive co-pay and deductible on office visits
  - Deductible & co-pay waiver for diabetic pilot
- Jackson Laboratory now tiering
- Three other members in planning phase

SEHC Announce 7-07 PCP Tiering



% 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

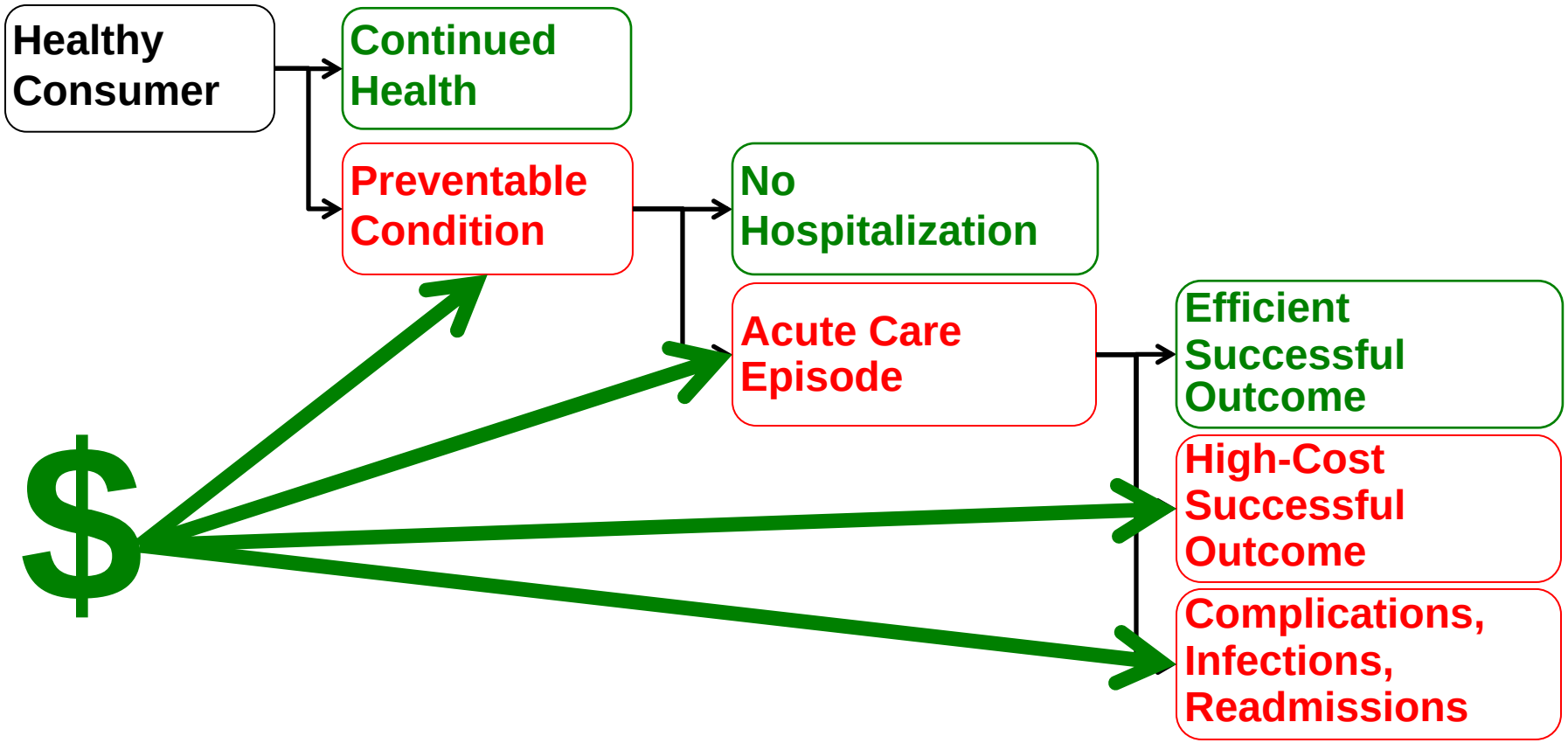
Significant savings are available within each supply sensitive category

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	$59.9	$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.

Current Payment Systems Reward Bad Outcomes, Not Better Health



You Get What You Pay For

Employers Want:

Informed Employees

Improved Outcomes

Care Coordination

Prevention

Functional Status

Return to Work

Employers Pay For:

Tests

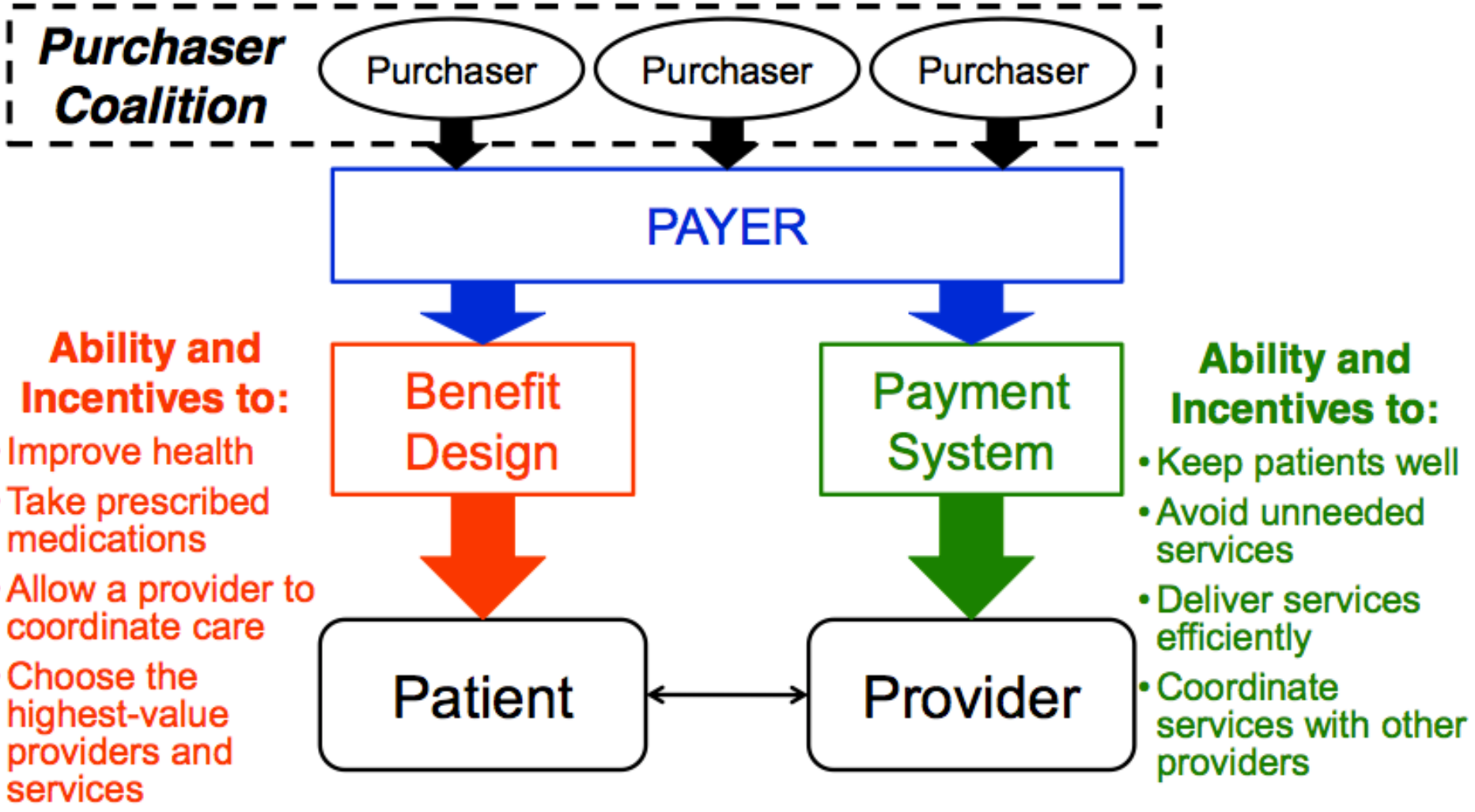
Visits

Procedures

Prescriptions

Errors & Complications

Key Role for a Strong Purchaser Coalition, Like MHMC



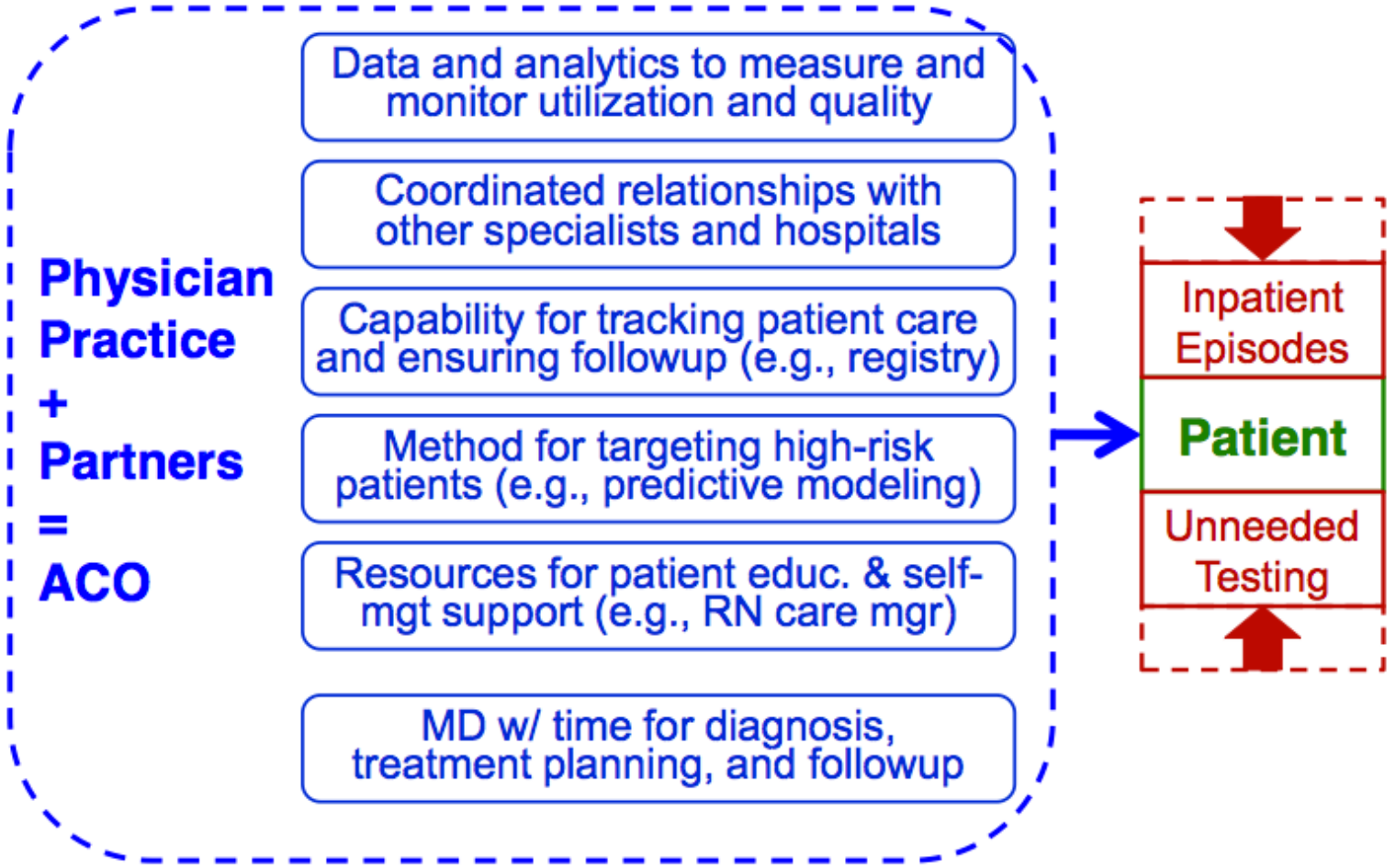
MHMC's Payment Perform Model

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

Current Multistakeholder Pilots

- State Employee Health Commission
  - MaineGeneral Health
  - Eastern Maine Health Systems
  - PenBay Healthcare
- Maine Education Association
  - Eastern Maine Health System
- University of Maine System
  - Eastern Maine Health System
- Bath Iron Works (and Bowdoin College)
  - MidCoast Health System
- Delhaize America/Hannaford
  - MaineHealth

Goal: Give MDs the Capacity to Deliver "Accountable Care"



MHMC Joint Principles for System Redesign and Payment Reform

- Transparency
- Primary Care Based
- Value-based Purchasing
- Benchmarked to Best Practice
- Shared Decision Making
- Collaborative Learning Experience
- Shared Risk
- Meaningful Patient Engagement
- Shared Accountability: Patients, Providers, Purchasers
- Reduced costs of care

MHMC System Redesign and Payment Reform Process

- Willing Provider Groups/Purchaser Partner(s)
- Create Multistakeholder Leadership Teams
- Data Analysis to Identify Improvement Opportunities
- Joint Priority Setting with Targets
- Develop Pilot Balanced Scorecard
- Share Cost and Quality Data
- Design Clinical/System Interventions*
- Identify Needed Payment Changes
- Identify Needed Benefit Design Changes
- Employee/Patient Engagement
- Measurement and Evaluation

Domains of Accountability

- Access
- Patient Engagement
- Patient Experience
- Care Coordination
- Clinical Quality
- Utilization
- Cost

Provider Scorecards

SEHC-MGH ACO Pilot - Year 1 Goals						FY-11			
		Measure	Entity	Goal	YTD	Q3-10	Q4-10	Q1-11	Q2-11
Primary Care	Access	Open Providers	MGH Primary Care	22					
		# of Practices with Open Access	MGH Primary Care	7	5				
		Net New Primary Care Providers	MGH Service Area	4	6/?				
	Coordination	Number of Practices who have adopted PCMH concepts	MGH Primary Care	5	5				
		Number of Practices who have engaged and developed workflow changes based on practice data reports	MGH Primary Care	13	11				
Patient Centeredness	Patient Engagement	Shared Decision Making	Specialty Areas	2	2 (incontinence, breast mass)				
		State of Maine Insureds on Practice Patient Advisory Councils	5 PCMH practices	5	4 (Winthrop FM and Peds, Four Seasons, and Belgrade)				
	Patient Experience	Patient Experience	Patient Experience metric as determined by PTE group		Not Met				
Clinical Quality	Standardization	Metrics and specialty areas to be determined by SEHC. See Employer Dashboard.							
	Clinical	Preventive Screening - Mammography	Women, age 40-64						
		Hospital acquired infections	CLABSI for ICU patients	0	0				
		PTE Core Measures		4 plus	4				
Efficiency	Utilization	Non-Urgent ER Visits	All MGMC patients	-3%	Exceeding				
		Hospital Readmissions within 30 days	All MGMC patients	-5%					
	Financial	PMPM	State Insureds in Pilot Population	<5%					

Purchaser Scorecards

		Measure	Entity	Goal	FY-11 YTD	Q3-10	Q4-10	Q1-11	Q2-11
Primary Care	Access	PCP declaration	SOM Insureds	100%					
	Coordination	SOM Insureds understand urgent care access and availability and know about practice hours of operation	SOM Insureds at MGMC	?					
Patient Centeredness	Patient Engagement	HRA Completion Percentage	SOM Insureds	?					
		State of Maine Insureds on Practice Patient Advisory Councils	5 PCMH practices	5					
	Patient Experience	?							
Clinical Quality	Standardization	Targeted programs -Wellness -Weight loss							
Efficiency	Utilization	Non-Urgent ER Visits - Education regarding avoiding non-urgent ER visits	SOM Insureds						
	Data	SEHC enusre delivery of administrative data to MGH or ACO partner							
	Financial	Benefit design - Deductibles, copays, and coinsurance, etc	SOM Insureds in Pilot Population						

Accountable Benefit Design

Option	Explanation/Rationale
Incent Selection of PCP provider in ACO	If primary care is to be foundation of ACO, plan must encourage use of selected practices
Incent PCP visits v. ER visits	Establish significant differential to obtain care at PCP or network urgent care
Incent compliance with preventive care	100% coverage or preventive services and age-sensitive screenings linked to health credit
Incent participation in practice based care management	Waive all co-pays for participation in practice based care management for members with chronic conditions

Accountable Benefit Design

Option	Explanation/Rationale
Incent Use of electronic visits	Waive co-pays for e-visits with appropriate criteria
Appropriate advanced imaging	Link member out-of-pocket to guideline compliance and/or diagnosis and unit cost
Waive Rx copays to increase compliance with chronic care medications	Link waiver to compliance with PCP treatment plan, office visits, participation in care management
Incent patient responsibility and wellness	Educate/reward patients on their role in patient centered system to include wellness participation

System Scorecards

FY10 BALANCED SCORECARD				Benchmark(s)			2011-12		
		INDICATOR	Practice	State	National	Best Practice	Good	Better	Best
Infrastructure Investment & Patient Experience	Access	% Practices with open providers	All				50%	75%	90%
		# of Practices with Open Access	Primary				50%	75%	90%
		Third Next Available appointment	Primary Care						
Patient Engagement	Patient Engagement	Shared Decision Making	Primary Care				10%	25%	50%
		HRA completion percentage	All				25%	50%	75%
		2 Patient-Family Advisors in Practices, Departments, etc.	All				25%	50%	75%
Patient Experience	Patient Experience	Recognition by PTE	All				50%	75%	90%
Plan Sponsor	Standardization	*Metrics and Specialty areas per employer/ plan sponsore*							
Care Coordination	Primary Care	Number of Practices who have adopted PCMH concepts	26 MGH Primary Care Practices				50%	75%	90%
		Number of Practices who have engaged and developed workflow changes based on practice data reports	27 MGH Primary Care Practices				50%	75%	90%
Clinical Quality	Clinical	% Recognition by PTE	All				50%	75%	90%
Health Risks	Outcomes	*Health Risk Assessments (Percent population having completed)*	All Population				50%	75%	90%
Functinoal Quality	Outcomes	*VR-12 Assessments (Percent population having completed)*	All Population				25%	50%	75%
Benefit Design		*Population Covered by minimum Value Based Benefit Design*	All Population				25%	50%	75%
Efficiency	Utilization	Non-Urgent ER Visits	% Practices improved by____				25%	50%	75%
		Hospital Readmissions within 30 days	% improved by____						
	Financial	PMPM (will review history to determine metric)	% improved by____						
		? More targeted initiative							

Proposed Measures for ACO Pilot Sites		
	Priority Areas	**Measures**
Starter Set of Measures	Overuse	Use of imaging studies for low back pain
		Appropriate testing for children with pharyngitis
		Avoidance of antibiotic treatment for adults with acute bronchitis
		Appropriate treatment for children with upper respiratory infection (URI)
	Population Health	Breast cancer screening
		Cervical cancer screening
		Colorectal cancer screening
		Diabetes: HbA1c management (testing)
		Diabetes: cholesterol management (testing)
		Cholesterol management for patients with cardiovascular conditions (testing)
		Use of appropriate medications for people with asthma
		Persistence of Beta-Blocker treatment after a heart attack
	Safety	Annual monitoring for patients on persistent medications
Testing Measures	Care Coordination	All-cause readmission measure
	Utilization	Hospital days (per 1,000)
		Hospital admissions (per 1,000)
		Hospital admissions for ambulatory sensitive conditions (per 1,000)
		Emergency room visits (per 1,000)
		Emergency room to inpatient admission rates
		Use of generics drugs
		Doctor visit within 7 days of patient discharge
		Imaging rates (per 1,000)
Next Phase Measures (requiring clinically-enhanced data)	Diabetes Measures	HbA1C Control (<8.0%)
		LDL Control (LDL-C <130 mg/dL; LDL-C <100 mg/dL)
		BP Control
		Eye Exam
		Kidney Disease Screen
		Aspirin Prophylaxis
	CAD Measures	Drug therapy for lowering LDL
		Aspirin Prophylaxis
	CHF Measures	Persistence of Beta-Blocker Treatment after a Heart Attack
		Beta-Blocker Treatment after a Heart Attack
		IVD: Blood Pressure Management
		IVD: LDL-C <100
	Hypertension Measure	BP Control
	Population Health Measures	Advising Smokers To Quit
		Discussing Smoking Cessation Medication
		Discussing Smoking Cessation Strategies
		Childhood immunizations
		Adult Body Mass Index (BMI) Assessment
		BMI records / Children (WCC)
		Flu Shots for Adults Ages 50-64
		Influenza Vaccine
		Pneumovax vaccine
		Medication reconciliation

System ('ACO') Performance

Focus	Measures
Keeping People Well	Population Health -Imunizations -BMI -Tobacco Use -Preventive Screenings
Improving Quality of Life	VR-12
Keeping People at Home and Happy	System Coordination -All cause readmissions -Hospital days (per 1000) -Hospital admissions for ASCs -Care Transitions -ER visits (per 1000)
Managing Resources Wisely	Resource Use -PMPM -Imaging Rates -Use of Generics

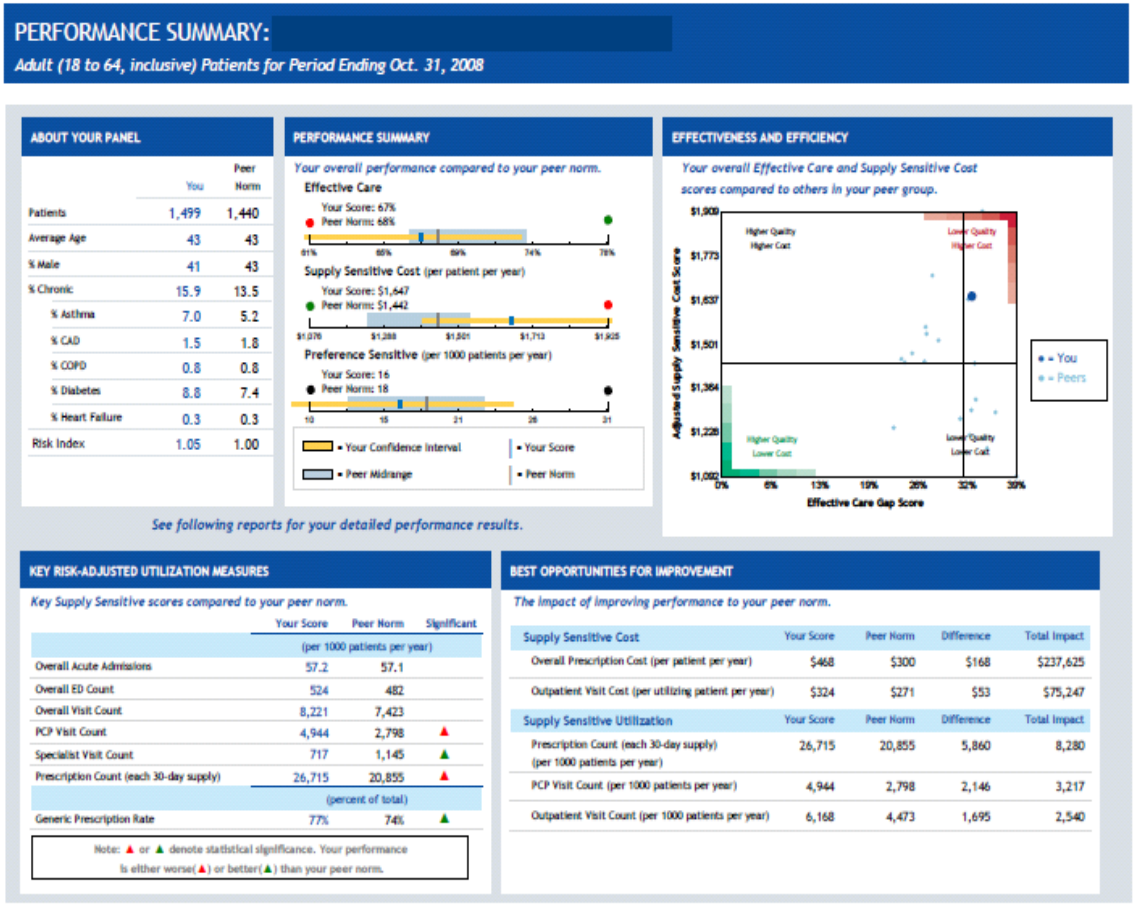
PCMH Public Reporting

Quality: Office Systems	Quality: Clinical Outcomes	Patient Experience	Cost of Care	Coordinated Care/ Informed Referrals	Medical Home Core Function
Level 1 or Higher on NCQA PPC-PCMH or Level 2 on other	Level 2 on two or more Outcome Measures	Currently measuring patient experience using validated instrument and rigorous process	Signed MOA with MHMC to participate in Cost of Care Initiative	Signed 'Service Agreements' with 1 or more specialties	Administers PHQ-9 with >75% of high risk populations

Performance Summary

Performance summary includes:

- Demographics about practice's panel
- Overall practice performance compared to peers in 3 areas of unwarranted variation
- Evaluation of overall effectiveness and efficiency
- Practice's score on 6 key utilization measures
- Best opportunities for improvement in the practice



PERFORMANCE SUMMARY:

Adult (18 to 64, inclusive) Patients for Period Ending Oct. 31, 2008

ABOUT YOUR PANEL

	You	Peer Norm
Patients	1,499	1,440
Average Age	43	43
% Male	41	43
% Chronic	15.9	13.5
% Asthma	7.0	5.2
% CAD	1.5	1.8
% COPD	0.8	0.8
% Diabetes	8.8	7.4
% Heart Failure	0.3	0.3
Risk Index	1.05	1.00

PERFORMANCE SUMMARY

Your overall performance compared to your peer norm.

Effective Care — Your Score: 67% — Peer Norm: 68%

Supply Sensitive Cost (per patient per year) — Your Score: $1,647 — Peer Norm: $1,442

Preference Sensitive (per 1000 patients per year) — Your Score: 16 — Peer Norm: 18

▪ Your Confidence Interval ▪ Your Score ▪ Peer Midrange ▪ Peer Norm

EFFECTIVENESS AND EFFICIENCY

Your overall Effective Care and Supply Sensitive Cost scores compared to others in your peer group.

Adjusted Supply Sensitive Cost Score — Effective Care Gap Score

Higher Quality Higher Cost | Lower Quality Higher Cost | Higher Quality Lower Cost | Lower Quality Lower Cost

● = You ● = Peers

See following reports for your detailed performance results.

KEY RISK-ADJUSTED UTILIZATION MEASURES

Key Supply Sensitive scores compared to your peer norm.

	Your Score	Peer Norm	Significant
	(per 1000 patients per year)		
Overall Acute Admissions	57.2	57.1	
Overall ED Count	524	482	
Overall Visit Count	8,221	7,423	
PCP Visit Count	4,944	2,798	▲
Specialist Visit Count	717	1,145	▲
Prescription Count (each 30-day supply)	26,715	20,855	▲
	(percent of total)		
Generic Prescription Rate	77%	74%	▲

Note: ▲ or ▲ denote statistical significance. Your performance is either worse(▲) or better(▲) than your peer norm.

BEST OPPORTUNITIES FOR IMPROVEMENT

The impact of improving performance to your peer norm.

Supply Sensitive Cost	Your Score	Peer Norm	Difference	Total Impact
Overall Prescription Cost (per patient per year)	$468	$300	$168	$237,625
Outpatient Visit Cost (per utilizing patient per year)	$324	$271	$53	$75,247
Supply Sensitive Utilization	**Your Score**	**Peer Norm**	**Difference**	**Total Impact**
Prescription Count (each 30-day supply) (per 1000 patients per year)	26,715	20,855	5,860	8,280
PCP Visit Count (per 1000 patients per year)	4,944	2,798	2,146	3,217
Outpatient Visit Count (per 1000 patients per year)	6,168	4,473	1,695	2,540

www.getbettermaine.org & **www.mehmc.org**

Maine Health Management Coalition

Maine PCMH Pilot/APC Demo

- CMS “Multi-Payer Advanced Primary Care” (MAPCP) demonstration
- Maine selected as one of 8 states to have Medicare participate as payer
- CMS requirements:
  - Pilot consistent with national PCMH defn’s
  - Majority of payers must be participating
  - Medicare will pay only for services covered by Medicaid & commercial payers (amounts can vary)
  - Must connect with community resources & supports

CMS/ AF4Q Goals (for PCMH Practices)

- Inpatient admissions:
  - - 6% reduction in respiratory admissions (COPD, Community Acquired Pneumonia)
  - - 7% reduction in cardiovascular admissions (Heart Failure, Coronary Artery Disease)
- ED visits:
  - - 5% reduction in Emergency Dept visits
- Specialties
  - - 5% reduction in Specialty Consultation visits
- Imaging
  - - 5% reduction in Standard Imaging
  - - 5% reduction in Advanced Imaging
- Total projected savings of $10.21 pmpm per Medicare beneficiaries in each practice

MHMC Foundation 2011

VISION: MHMC will serve as the collaborative statewide entity that

1) establishes cost and quality targets for healthcare systems; and

2) measures and reports performance in quality, utilization and cost

to be used collectively in at-risk healthcare purchasing arrangements.

Evolving Payment Structure

Year 1	Year 2	Year 3	Year 4
FFS with P4P and limited provider risk for select performance targets Overall PMPM Cost Reduction Targets Set	FFS, P4P and Shared Savings for reduced PMPM costs (aligned with baseline)	Partial Capitation and Shared Savings	Global Payment with Quality Incentives

Data: The Foundation for Improvement

MHMC Database will serve as the common database for payment reform pilots

- Timely Claims Data (will expand to include clinical)
- Multipayor
- Central Analytic Support through MHMC

'Democratization of Data': New data partner (HDMS) will greatly enhance access

- Desktop access
- Role-based authorization

Data: The Foundation for Improvement

- Ability to track in a timely way medical claims utilization data and perform aggregate or detail-level analysis across members
- Easy drill-down features, which quickly identify issues, trends and variations from benchmarks
- Identification of cost and utilization, allowing management of health and benefit plans to meet specific needs
- Pathway for determining priority focus areas for population health and disease management
- Ability to incorporate various data types: account structure, Rx, Lab, biometrics, dental, disease management, HRA, workman's comp, LTD, STD, and EMR.

The world has changed. So should we.

Historically

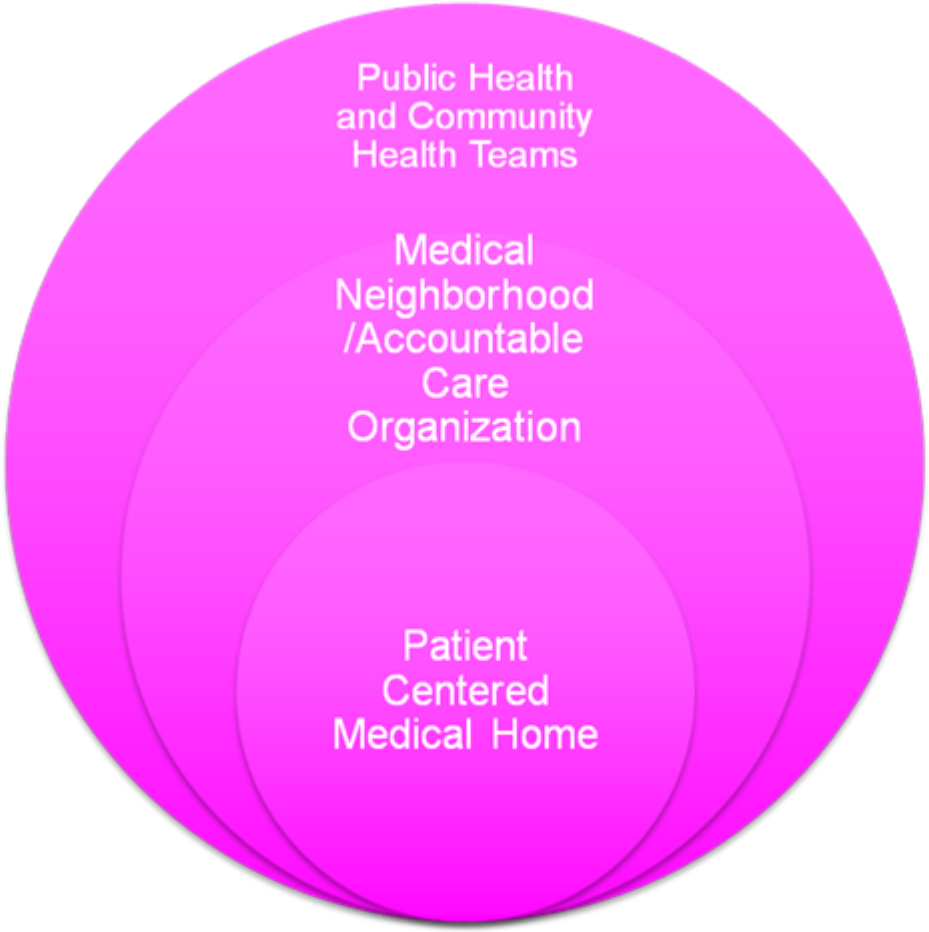
- Publish facility/practice quality information to support informed patient choice and benefit design.
- Basic cost and utilization data available for purchasers.
- Fragmented purchasing strategies increasing cost shifting.
- Resistance to change from provider members.

Future

- Publish system-wide utilization, cost and quality information to evaluate new models of care.
- Capacity to develop sophisticated analytic tools and reports.
- Shared framework, targets and incentives with PMPM reduction goals.
- Provider/purchaser partnerships for dramatic system transformation.

A 'New' System Model

- Primary Care Based System: PCMH
- Coordinated Relationships with Specialists and Hospitals
- Timely Multipayor Data
- Transparent Quality and Cost Information
- Payment for Outcomes
- Engaged Patients
- Population/Public Health



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