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

Elizabeth Mitchell
CEO
Maine Health Management Coalition
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

quality / outcomes +
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.
“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
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.
How Do We Get to Value?

Work Areas:
- Transparency
- Payment Reform
- Evidence Based Benefit Design
- Consumer Engagement
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

Interviews with Maine Doctors & Patients
Easy to Use Tip Sheets

Maine Cancer Patient Chesley Talks About Her Experience
Maine Asthma Patient Rick Talks With His Doctor

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.

## Maine Hospital Ratings

### Blue Ribbons

See Specialty Hospitals

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Location</th>
<th>Rating</th>
<th>Recommendations</th>
<th>Patient Experience</th>
<th>Patient Safety</th>
<th>Select Clinical Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miles Memorial Hospital</td>
<td>35 Miles Street, Damariscotta 04543</td>
<td>Blue Ribbon</td>
<td>Overall Recommend</td>
<td>Patient Safety</td>
<td>Select Clinical Quality</td>
<td></td>
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<tr>
<td>Mayo Regional Hospital</td>
<td>897 West Main Street, Dover-Foxcroft 04426</td>
<td>Blue Ribbon</td>
<td>Overall Recommend</td>
<td>Patient Safety</td>
<td>Select Clinical Quality</td>
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<tr>
<td>St. Joseph Hospital</td>
<td>360 Broadway, Bangor 04401</td>
<td>Blue Ribbon</td>
<td>Overall Recommend</td>
<td>Patient Safety</td>
<td>Select Clinical Quality</td>
<td></td>
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</tbody>
</table>

**Source:** CMS, Leapfrog & MHMC, CMS
## 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>
Drivers of Quality Improvement

1. Community leadership
2. Performance measurement & public reporting of quality data
3. Assistance to physician practices to improve quality of care
4. Consumer education & empowerment
5. Incentives for change (payment system)
6. Health IT infrastructure & incentives
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
% 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
Commercial Chronic Admission Rates: Potentially Avoidable admissions are high and variable

- “Needed” variation may reflect maternity admits

www.mhmc.info & www.mehmc.org
Q1: How easy do you think it is to find out how much medical treatments and procedures cost?

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Easy</td>
<td>11</td>
<td>4.1</td>
</tr>
<tr>
<td>Somewhat Easy</td>
<td>52</td>
<td>19.5</td>
</tr>
<tr>
<td>Somewhat Hard</td>
<td>133</td>
<td>50.0</td>
</tr>
<tr>
<td>Very Hard</td>
<td>67</td>
<td>25.2</td>
</tr>
<tr>
<td>No Response</td>
<td>3</td>
<td>1.1</td>
</tr>
<tr>
<td>Total</td>
<td>266</td>
<td>100.0</td>
</tr>
</tbody>
</table>
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 AHP/National Business Coalition on Health
“Communication Toolkit: Using Information to Get High Quality Care”

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
What 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

www.mhmc.info & www.mehmc.org
## A new payment model?

<table>
<thead>
<tr>
<th><strong>Service Category</strong></th>
<th><strong>Provider Incentives</strong></th>
<th><strong>Patient Incentives</strong></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 w/SDM</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>
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
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>$59.9</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.


www.mhmc.info & www.mehmc.org
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.
Next Steps

- **Pilots:**
  - Shared Decision Making (incent patients with benefits, providers with appropriate payment)
  - Reducing Readmissions (30 day ROI)
  - Patient Centered Medical Home
  - Local Primary Care Initiatives (BIW, Martins Point)
  - Small Group Capitation
  - Others

- **Role(s) of MHMC?**
  - Convening/Matchmaking, Support, Evaluation, Infrastructure, Public Reporting and Communications
More Next Steps

- ACOs – if they form them, we will pay
  - Regional ACOs to self-identify, define volume and payer mix
  - Consensus process among all payers on global payment structure
  - Consensus process to define maximum acceptable bid
  - RFP for (multiple) ACOs to bid (preserving patient choice)
(and more) Next Steps

- Increased Public Reporting of Cost and Quality
- Service Agreements: PCPs/Specialists
- Regulatory Review
- Waiver?
Our perspective:

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 – the stimulus $ is buying us time