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MaineGeneral Health

Maine Health Management Coalition

Bringing Healthcare Value to the People of Maine

State Employee Health Commission And MaineGeneral Health

A Partnership for Better Health, Better Care, Right Cost

SEHC-MGH Pilot
February 7, 2013

State Employee Health Commission

- 24-member labor/management groups serves as plan trustees for 40,000 lives
- Comprised of plan participants – forest ranger, highway supervisor, corrections officer, classroom instructors, retirees
- Authority over plan design
- Activated by IOM report, Leapfrog and internal analysis of variation
- Founding member of Maine Health Management Coalition

Value-Based Purchasing Strategy

- Convinced of gaps in care – significant variations in quality, utilization, and cost
- Current FFS payment system provides wrong incentives
- In 2005 adopted value-based strategy:
  - Encourage members to make informed healthcare decisions
  - Provide incentives to seek higher-value care
  - Reward providers who demonstrate better value

Hospital Tiering – Initial Objectives

- Encourage public disclosure by providers
- Establish performance targets to be incrementally adjusted & expanded
- Drive quality & safety improvement
- Give members basic performance tools
- Offer modest incentives to shape decision-making

Hospital Tiering Phase 1

- July 2006, modest performance benchmarks
- Meet the national average performance for CMS core measures
- Merely complete the Leapfrog safe practices survey
- Demonstrate “progress” in MHMC medication safety survey
- Prompted creation of Pathways to Excellence (PTE), multi-stakeholder to produce consensus based measures and reporting

Early Results

- July 2006 only 14 of 36 acute care hospitals met “preferred” criteria
- January 2007 all Maine hospitals reported to Leapfrog and MHMC medication safety
- January 2007 “preferred” hospitals increased to 25
- 5% shift in outpatient services to preferred hospitals in first year

Evolution of Tiering

- July 2007 primary care practices are tiered based on PTE measures
- New hospital measures are introduced – HCAHPS in 2010
- Higher standards of performance are accepted
- Increased member incentives
- Comparative Cost introduced in 2011

Cost Moves to Front Burner

- Legislature flat funds SEHC plan for two fiscal years based on FY11 spend
- Analysis of CY11 claims reveals 60% of projected 10% trend due to provider price inflation:
  - Hospital IP = 14.4%
  - Hospital OP = 7.8%
  - Professional = 3.1%
  - Rx = 4.0%

SEHC Responds

- Cost is weighted more heavily in hospital tiering
- Far more significant member incentives introduced
- SEHC invites health systems to partner in meaningful payment and delivery system initiatives
- Initiatives must include risk arrangements

Key Takeaways

- Critical importance of reliable, current data and analysis to establish benchmarks and monitor performance
- Value of mutually developed benefits strategy in managing care and reducing total costs
- Purchasers must invest in member education to make benefit design relevant
- Introduction of cost into the value equation and more meaningful incentives changes provider perspective: once concerned with public reputation, now worried about loss of market share