



Maine Health Management Coalition

*Bringing Healthcare Value
to the People of Maine*

Member Update

December, 2009

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MHMC Members and Friends:

You are receiving this newsletter because of your valued involvement in the Maine Health Management Coalition (MHMC) or MHMC Foundation. This monthly Member Update is designed to keep you and your colleagues informed about all MHMC initiatives.

Thank you for your continued support of the Coalition.

With best wishes for the happiest of holidays,

Elizabeth Mitchell, CEO

Action Items

Attention Hospital Members: Last Week to View Quality Data Before It Is Published to www.mhmc.info

The Northeast Health Care Quality Foundation has uploaded the most recent hospital 'Appropriate Care Measure' data report via QualityNet and the report is now available for hospitals to review. The data represents the 3rd quarter 2008 through 2nd quarter 2009 reporting period. Next Friday, December 18th, will mark the last day of the agreed upon ten-day period for hospitals to review, comment and ask questions about their data prior to the January 15, 2010 release on the [Maine Health Management Coalition website](http://www.mhmc.info). The representative(s) within your organization who typically access the QualityNet data will be able to access this data as well.

If you have problems locating it or would like to increase the number of people who can access the information, please contact Addie O'Brien at the Northeast Health Care Quality Foundation: aobrien@nhqio.sdps.org or 603-842-8222. If you have questions about the data (assessment methodology, data interpretation, etc.), please contact Dr. Larry Ramunno at lrnunno@nhqio.sdps.org. If you have questions about the process for reporting on the [MHMC website](http://www.mhmc.info), please contact Sue Butts-Dion at sbutts@maine.rr.com or 207-283-1560.

QualityCounts Announces QC7 Conference

The annual Quality Counts, Part 7 (QC7) conference is being held on April 16, 2010 at the Augusta Civic Center. This year's conference is titled "Transforming Health and Health Care in Maine's Communities: What's Your Role?" and is the latest in a series of

dynamic conferences to promote the transformational changes needed to create dramatic and sustainable improvements in health and health care in Maine. QC7 will build off the success of previous QC conferences and will link with the Aligning Forces for Quality (AF4Q) initiative in Maine to explore opportunities for improving health and health care by building effective partnerships in communities across Maine.

This conference will have sessions geared towards health care professionals, employers, payers, consumers, health policy makers, public health workers and anyone interested in being a part of a unified effort to improve the health of Maine's citizens and health care delivery and communication within the health care profession.

Visit www.mainequalitycounts.org for more information. Registration begins on February 1, 2010!

MHMC Quarterly Board Meeting Set for December 17, 2009 from 9-11AM

The Augusta Civic Center will be the setting for the last Coalition Board meeting of 2009. Highlights and achievements from 2009 will be reviewed and the Coalition's 2010 Strategic Plan and budget will be presented for approval. OnPoint Health Data will share their third benefits and utilization summary and St. Mary's Hospital will present a case study in reducing unwarranted variations. We look forward to seeing you there.

Depression Management Study Seeks Participants in Maine

The Colorado Business Group on Health has extended an invitation to MHMC members to participate in a study conducted by Florida State University's Research Team. Eligible participants will be randomized to receive one of two state-of-the-art presentations that encourage employers to improve depression treatment for employees. There is no cost for participating. If you are interested in learning about depression as a cost driver, [contact Nancy Morris](#) at the Coalition's office for more information.

Physician Executive Committee Member Sought

Stephen Sears, M.D. has recently announced that he will become the states epidemiologist. Although the Coalition's membership recognizes the value Stephen Sears, M.D. will bring to the team at the Maine Centers for Disease Control, we will miss his contributions to the Board and to the numerous committees on which he served. His insight and dedication to patient quality and safety will be missed.

Dr. Sears, departure creates an opening on the Coalition's Executive committee for a new provider member.

Please contact Nancy Morris at nmorris@meahmc.org if you are interested in filling the physician Executive Committee slot.

Don't forget to visit the Resource & Document Library to read the latest meeting minutes and other pertinent information.

PTE - Physicians and Cost

Primary Care Based Systems with High Quality and Cost Efficient Care

The PTE Physicians Steering Committee met this week and over forty participants reviewed the transition to national metrics for PCPs, and continued the work of vetting specialty metrics. Ted Rooney and Lisa Letourneau announced a new reporting framework for Primary Care designed to reflect the MHMC Foundation Board's commitment to move towards a high quality and cost efficient primary care based system. The Foundation Board hopes to both recognize and incent patient-centered medical homes/advanced primary care practices working closely with specialty practices and hospitals to deliver high quality, cost efficient, and highly satisfying care.

Elizabeth Mitchell reviewed the MHMC's commitment to cost measurement and payment reform to support this direction, and the attendees were asked for their help. Reporting efforts in 2010 will focus on recognizing patient-centered medical homes and advanced primary medical practice. In addition, the attendees discussed tracking progress towards the IHI's Triple Aim of focusing on high quality care, per capita costs, and patient satisfaction. This Steering Committee endorsed the metrics for Triple Aim several years ago. These metrics will be used to help benchmark progress against national norms and highly rated "best-in-class" practitioners.

Tom Hopkins of the University of Maine System also reviewed the HeART group's Request for Information. As the leading group of non-provider employers and plan sponsors within MHMC, the HeART Group will be working with their health plans and health systems to support the MHMC's overall direction through benefit re-design and reimbursement changes.

Draft minutes from the most recent PTE Physicians meeting will be accessible in the Resource & Document Library at www.mehmc.org shortly.

Contact: [Ted Rooney](#)

Next meeting: February 25, 2010

Location: Maine Medical Association, Manchester

PTE - Hospitals

MHMC Hospital Website Soon to Include Additional Hospital Measures Category

Starting January 15th, 2010, the MHMC 's Hospital website home page will provide "surfers" the opportunity to explore additional information about certain hospital measures beyond what is currently included in the blue ribbon calculation. Measures currently included in the blue ribbon calculation include: a patient's willingness to recommend a hospital to others; a patient's likelihood of ranking a hospital a 9-10 (on a scale of 1-10); scores from local and national safety surveys; and performance in several clinical measures including heart attack, heart failure, pneumonia, and surgical infection prevention. Effective January 15th, 2010, details on some additional hospital measures will be posted including rates on patient falls with injuries, infections that are acquired in the health care setting, and 30-day readmission and mortality rate data for select clinical areas. During the first six months of 2010, the PTE Hospital Steering Committee and Measures Workgroup will configure a plan to incorporate the above measures into the blue ribbon calculation.

Draft minutes from the most recent PTE Hospitals meeting will be accessible in the

Resource & Document Library at www.mehmc.org soon.

Contact: [Sue Butts-Dion](#)

Next meeting: February 25, 2010

Location: Maine Medical Association, Manchester

Employee Activation Users' Group

2010 Activation Plan

The Employee Activation Users' Group held a dynamic meeting on December 10, in which the 2010 activation plan was developed. The plan has 6 key components and is based on the Partnership for Prevention Leading by Example health initiative assessment tool from the Center for Disease Control. The group is looking forward to a new emphasis on collaboration within and beyond its current membership.

Minutes from the most recent User's Group meeting can be found at the Resource and Document Library at www.mehmc.org

Contact: [Nancy Morris](#)

Next meeting: January 14, 2010

Location: Freeport Community Center

Payment Reform/Health Action Collaborative (HAC)

Categorization & Implementation

The HAC hosted its first work group meeting to review and define which clinical services will fall in each service category within the payment reform model HAC is developing. The 'buckets' are based on the Dartmouth Atlas and include: Supply Sensitive, Preference Sensitive and Effective Care. Initial clinical review and discussion resulted in questions regarding classification of only five conditions:

GI obstruction; septicemia; cardiac arrhythmias; fractures; and malignancies.

Many questions were resolved by recognizing that in many instances it will be treatment decisions rather than the conditions that result in the classifications.

In addition to reviewing the service categories, early implementation issues were discussed. The aim continues to be global budgeting around all services with increased reimbursement and utilization of effective care and reduced reimbursement and utilization for supply-sensitive care. Elizabeth Mitchell and David Wennberg, M.D. clarified that while the payment model was developed from the Dartmouth Atlas research model, it is unlikely that payment would be differentiated based on inclusion in the service categories. However, tracking utilization within the categories will be important in managing within a global budget and important for practice change.

Barbara Crowley, M.D. indicated that this would simplify payment arrangements while still providing information and tools for improvement and accountability. Josh Cutler, M.D. emphasized that it is not the aim to eliminate care for conditions and treatments classified as supply-sensitive but reductions of up to thirty-percent may be achieved. A summary of this meeting and the consensus reached will be available on MHMC's website. For those who were unable to participate, there will be other opportunities to provide input into the model.

A written summary of the meeting can be found at the Resource and Document Library at www.mehmc.org. A [presentation](#) from Health Dialogue on reimbursement can also be found at www.mehmc.org.

Contact: [Celine Kuhn](#)

Next meeting: January 28, 2010

Location: Hilton Garden Inn, Freeport

Patient Centered Medical Home (PCMH)

NCQA Updates Standards for PCMH Recognition

NCQA named a 23-member panel to oversee its process for updating the PPC-PCMH standards, which are used to recognize physician practices that are implementing the patient centered medical home. A second NCQA advisory panel is exploring ways to apply the medical home standards and other quality requirements to accountable care organizations. Draft changes are expected in the first quarter of 2010, when public comment will be sought, with final revised standards expected in January 2011.

Contact: [Sue Butts-Dion](#)

Public Policy

The MHMC's Public Policy Committee held a conference call to review the early findings of the Policy Review conducted by Barbara Shaw and Kim Fox of the Muskie School of Public Service as part of the Coalition's payment reform work. The aim of the review was to identify potential policy barriers to payment reform. Early findings did not show immediate barriers, but anticipated that as the model is more fully developed, challenges would become clearer particularly around providers and ACOs accepting financial risk. Antitrust issues are likely to become a consideration as well as current insurance regulations regarding geographic access. However, self-insured employers are unlikely to face barriers in the near term. A white paper will be available in January outlining these issues and comparing Maine's payment reform efforts and regulatory landscape to other leading states. For more information contact [Elizabeth Mitchell](#).

Recent News & Research

Maine Hospitals Nationally Recognized for High Quality and Efficient Care, Two out of Three Top Performers Located in Maine, Says the Leapfrog Group

While Congress debated whether health care reform would control health care costs, in

Washington, D.C. some of the nation's largest employers were acknowledging 45 hospitals from across the U.S. as those leading by example...delivering the best quality care in America while attaining the highest levels of efficiency. Stephens Memorial Hospital in Norway and Waldo County General Hospital in Belfast were among that group, earning two out the three slots devoted to recognizing rural hospitals. Congratulations to the team members at both of those hospitals! MHMC applauds your enormous success and appreciates the work you do to improve quality and reduce costs.

A total of thirty-four urban, eight childrens' and three rural hospitals have been named 2009 Leapfrog Top Hospitals, based on results from The Leapfrog Hospital Survey. The survey (found at www.leapfroggroup.org).

The Maine Health Management Coalition is Maine's Regional Roll Out for Leapfrog, administering and supporting the survey. Frank Johnson also serves on the Leapfrog Board. Maine is frequently recognized as having the highest participation rates in the country of hospitals completing the Leapfrog survey, often attributed to the publication of the results on the MHMC website.

2010 MHMC Leadership

Frank Johnson was unanimously elected by the Foundation Board to be incoming Chair for 2010. Chris McCarthy of BIW will complete his term as Chair of the Executive Committee in December and Christine Burke of the MEA, who currently chairs the Foundation Board will assume the Chair of the Executive Committee. Many thanks to Chris McCarthy for his dedicated and enthusiastic leadership in 2009.

Institute for Health Care Improvement (IHI) National Forum Plenary Hones in on Health Care Costs

In Donald Berwick's plenary at the 21st IHI Forum on December 8th, the issue of needing to control health care costs was front and center. This was the first time IHI had focused on cost containment in healthcare. Portland, Maine was mentioned several times as one of the ten highest performing hospital referral regions relative to both cost and quality, and was identified by the IHI in their "How do the do that?" initiative. Additionally, Berwick presented data to support the proposition that there is a lot more work to be done. You can read more about the "How do they do that?" initiative at the IHI website. The Coalition will inform members when a copy of the plenary speech is publicly available.

Foundation Board Actions

At the December meeting, the Maine Health Management Coalition's Foundation Board reviewed the status of its transparency efforts, in the context of planning for 2010 and given the growing challenges and tension related to public reporting of hospital measures. Historical documents related to the PTE Hospital Committee's purpose and directives, including the 2004 original program description of objectives and principles, were reviewed, as was the 2007 update from the Executive Committee. This review was intended to add any and all nationally endorsed quality measures unless there are 'compelling local reasons not to'. A summary of measures considered since 2007 and measures approved showed that of the 75 publicly available measures considered for inclusion on the MHMC website, only 20 had been approved, but only 14 had been incorporated into ribbons. There was a shared frustration among staff, the Foundation Board and members about the growing inefficiency of the process and perceived

resistance to expand measures despite directives to do so. The Foundation Board agreed that a more efficient and effective way to report was needed. This was especially true given the shift in focus to payment reform and the need for transparent cost and quality information for that work.

The Foundation Board approved the following changes to the PTE process to set clearer timeframes and clarify authority of the Foundation Board in relation to the PTE Steering Committee:

- The MHMCF will post any nationally endorsed hospital quality measure on its website at the time that it becomes available in the format in which it is publicly reported,
- The PTE Hospital Steering Committee will have six months to recommend to the Foundation Board how to integrate the measure into the MHMCF's public reporting format that ensures fairness to consumers as well as providers,
- The beginning of the six month period will also serve as a notice to hospitals that the measure will be incorporated into the MHMCF's public reporting format and added to the MHMC website in six months,
- At the end of the six month review period, the Foundation Board will consider the PTE Hospital Steering Committee's recommendations and will have an affirmative vote prior to posting each new measure,
- Should the PTE Steering Committee fail to reach consensus within 6 months, the Foundation Board will determine if and how to publicly report new measures.

The measure passed with one vote in opposition.

The Foundation Board also agreed to re-appoint chairs of the PTE Hospital Steering Committee in order to improve its functioning. Chris McCarthy will serve initially as the employer chair and the Foundation Board will also appoint a provider co-chair. Finally, the Board agreed to incorporate patient stories into PTE meetings, following the Institute for Healthcare Improvement model of bringing the patient voice to healthcare discussions. These changes went into immediate effect and were discussed at the PTE Hospital Steering Committee on December 10.

Consumer-Driven Health Plan Participants Display Cost-Conscious Behavior, Utilize Wellness Programs

Individuals in consumer-driven health plans (CDHPs) are more likely than those with traditional coverage to exhibit a number of cost-conscious behaviors, to be more engaged in wellness programs, and to be more inclined to think that financial incentives matter in holding down costs, according to survey results released today by the nonpartisan Employee Benefit Research Institute (EBRI).

At the same time, the fifth annual survey found that satisfaction levels for individuals in traditional health plans were higher again this year than for those in consumer-driven plans. As before, the survey found that the health, income, and education profiles of consumer-driven plan participants were different from those of traditional plan enrollees: People who are younger, healthier, higher-income, and better educated are more likely to be in consumer-driven health plans.

The findings are from the 2009 EBRI/MGA Consumer Engagement in Health Care Survey, which provides nationally representative data regarding the growth of CDHPs and high-deductible health plans (HDHPs), and more generally the impact of these plans and consumer engagement has on the behavior and attitudes of adults with private health insurance coverage. Findings from this survey are compared. Go to www.ebri.org for more details.

National Updates

Overview of the 12/4 Commonwealth Fund Report on Health Care Reform

According to a December 4th report by the Commonwealth Fund: Following are the key changes that the House and Senate bills would make to help ensure long-run cost containment and improve the quality of health care.

1. Changing the Insurance Market

Both the House bill and the bill under consideration in the Senate would establish a health insurance exchange, or exchanges, with a choice of plans; rules to shift insurers from competing for healthier enrollees to competing on value; and greater transparency.

2. Offering a Public Plan

The House bill would offer a public health plan in the insurance exchange. The HHS secretary would be charged with negotiating provider payment rates and authorized to use an array of proven value-based purchasing payment methods. Providers participating in Medicare would be assumed to participate in the public health insurance plan unless they opt out.

The Senate bill includes a community health insurance option that is publicly sponsored and negotiates provider payment rates up to the average commercial level. Individual states would be allowed to opt out of offering the option.

3. Instituting Provider Payment Reform

The House and Senate bills would establish a Medicare and Medicaid Payment Innovation Center with broad authority for the HHS secretary to test innovative payment methods for medical homes that provide patient-centered coordinated care, for accountable care organizations that assume responsibility for quality and cost across the continuum of patient care, and for bundled hospital acute and post-acute care. The Senate bill also would implement a national, voluntary shared savings program for accountable care organizations. The secretary would have broad authority to sustain and spread effective payment methods, although participation by providers in new payment methods would be voluntary.

The House bill calls for two studies to be conducted by the Institute of Medicine. The secretary would be authorized to implement the recommendations of one study, on geographic adjustment factors in Medicare payment. The secretary also would be authorized to implement the recommendations of the second study, on geographic variation in health spending and promotion of high-value health care in Medicare, unless Congress votes to disapprove it.

4. Adjusting Payment for Productivity Improvement

The hospital industry agreed to slow increases in Medicare payment rates in recognition

of the increased revenue realized through covering more uninsured Americans and the potential for significant ongoing productivity improvements.

5. Creating an Independent Medicare Advisory Board

The Senate bill would establish an independent Medicare advisory board within the executive branch that has significant authority to identify areas of waste and additional federal budget savings. The board would first review physician and home health services; hospitals would be exempt initially. Congress would be required to make an up-or-down vote on its annual recommendations.

6. Negotiating Pharmaceutical Prices

The House bill calls for negotiating pharmaceutical prices and for increased prescription drug rebates for beneficiaries covered by both Medicare and Medicaid. The Senate bill includes rebates, but not negotiation of pharmaceutical prices-the result of an agreement among the chairman of the Senate Finance Committee, the White House, and the pharmaceutical industry, in which the industry agreed to provide discounts of half the cost of brand-name drugs in the Medicare coverage gap, or "doughnut hole."

7. Primary Care and Prevention Incentives

The House and Senate bills include a number of provisions to increase primary care payment rates under Medicare and Medicaid, cover effective preventive services without patient cost-sharing, and support community and employer prevention and wellness programs.

8. Utilizing Value-Based Benefit Design

Both the House and Senate bills contain provisions that would permit patient cost-sharing and payment rates to be modified to encourage the use of services that promote health and value. The House bill allows value-based benefit design in the public health insurance plan, while insurance plans that reduce or eliminate cost-sharing for clinically beneficial care are exempt from certain requirements under the Senate proposal.

9. Promoting Quality Improvement and Public Reporting

The Senate bill would reduce payment for hospital-acquired conditions, and both the House and Senate bills would enhance public reporting of quality and cost. Under the Senate proposal, hospitals with high rates of hospital-acquired conditions would have their Medicare reimbursement rates cut by 1 percent. The House bill would require all hospitals to publicly report their infection rates.

10. Encouraging Medicare Private Plan Competition

Both the House and Senate bills would level the playing field between Medicare private plans and the traditional Medicare public health insurance plan.

About MHMC

The Maine Health Management Coalition (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. For more information about MHMC, visit www.mehmc.org.

Quick Links

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