Maine Quality Counts and the Maine Health Management Coalition present…

QC Brown Bag Forum
Accountable Care Organization (ACO) Series

Maine Community ACO & Central Maine Healthcare ACO

March 26, 2013 (12N - 1PM)

** Don’t forget to dial in to hear the audio! **
Dial: 866.740.1260, Access Code: 6223374
Who We Are

Maine Quality Counts (QC) is a regional health improvement collaborative that brings together people who give care, get care and pay for care to improve health care quality throughout Maine.
Our Mission

QC is transforming health and health care in Maine by leading, collaborating and aligning improvement efforts.

- Maine Patient Centered Medical Home Pilot
- Community Care Teams
- Aligning Forces for Quality (AF4Q)
- Behavioral Health Integration
- Quality Counts for Kids / First STEPS Initiative
www.mainequalitycounts.org
QC Learning Community Webinars

• Monthly webinars:
  – Provider Lunch & Learn: 1st Tues/mo – 12N
  – QC 2013 Triple Aim Series: 3rd Thurs/mo – 12N
  – QC Brown Bag Forum: 4th Tues/mo – 12N

• Next ACO Series Webinar:
  – Tues, April 23 at 12N
    • MaineCare Accountable Communities Initiative & MaineGeneral / State Employee Health Commission ACO
QC 2013
Aligning Maine’s Forces to Become the First State to Reach the *Triple Aim*

**population health** • **cost reduction** • **care experience**

**Wednesday, April 3, 2013** 8am-4pm
Augusta Civic Center, Augusta, Maine

A Maine Quality Counts conference held in partnership with Maine Public Health Association—Maine Primary Care Association

**Keynote Speakers:**

Dr. Donald Berwick  
Rosemary Gibson

Register online at [www.mainequalitycounts.org](http://www.mainequalitycounts.org)

Registration extended to Tuesday, April 2 at 12N
The MHMC is a 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 MHMC-F 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.
Bill Wypyski is the CEO of Harrington Family Health Center, in Harrington, Maine. He is also the Chairperson of the Management Committee of the Maine Community Accountable Care Organization. Bill has served as the CEO at Harrington for over 2 ½ years, has worked at Penobscot Community Health Center in Bangor, and worked as a Senior Administrator at The Acadia Hospital, in Bangor, for 17 years. His education includes healthcare and public administration, and he is a Licensed Clinical Social Worker. Bill is a Fellow of the American College of Healthcare Executives.

Edmund (Ned) Claxton, Jr., MD, works as a part-time faculty member and as the Physician Advisor for Clinical Redesign for the Central Maine Medical Group - the employed providers working at Central Maine Healthcare. For the past year, he has also been the Medical Director of the CMH ACO and the CMH Chief Medical Information Officer. After medical school at the University of Cincinnati (1975) and Family Medicine training at the University of Minnesota (1978), Dr. Claxton started and practiced in a private medical practice in Auburn for 23 years. From 2001 - 2009, he was the program director of the Central Maine Medical Center (CMMC) Family Medicine Residency. During that time, he completed the National Institute for Program Director Development course and was a Hanley Fellow with The Daniel Hanley Center for Health Leadership.
Quality Counts – ACO Update
March 26, 2013
What is an ACO?

- A group of doctors, hospitals, or other healthcare providers who come together voluntarily to coordinate care for individuals with Original Medicare (often referred to as “Medicare” or “Medicare Fee-for-Service”).

- An ACO provides care to Medicare Fee-For-Service beneficiaries (beneficiaries) with Original Medicare who are assigned by CMS. There is a three-year commitment with annual reporting requirements.

- If a beneficiary traditionally utilizes a physician participating in an ACO for primary care services, the beneficiary is assigned to that ACO.

- ACOs were designed with the stated objective of achieving the three-part aim:
  1. **Improved Care** – in a safe environment, equitable to all who seek it and available when needed.
  2. **Improved Health** – accomplished through prevention and chronic care coordination.
  3. **Lower Per Capita Costs** – intended to reduce the trend of cost increases associated with the Medicare Fee-for-Service population.
What an ACO is **NOT**

- An ACO is not a Medicare Advantage plan or a Health Maintenance Organization (HMO) plan.
- No limits on provider choice; Medicare Fee-For-Service beneficiaries may continue to see any doctor who treats individuals with Original Medicare, regardless of whether or not their doctor is part of an ACO.
- No changes to benefits and coverage, including coverage through a Medicare Supplement.
ACO Basics

- Medicare Fee-For-Service beneficiaries (beneficiaries) are assigned to the ACO based upon their pattern of utilization (2 step process)
- No election or lock-in period
- Minimum 3 year agreement; followed by annual renewals at the discretion of CMS and ACO
- Required to have structure to receive and distribute payments for shared savings
- Enough Primary Care Physicians (PCPs) and other providers to care for beneficiaries assigned to the ACO (minimum 5,000)
- Participation is voluntary for providers
- PCPs can only participate in one ACO
- Providers enter into direct agreements with the ACO
- Providers continue to be paid Fee-for-Service payments by CMS
- Shared savings payments distribution made by ACO (participating provider)
Required Infrastructure

• **Sufficient information systems to:**
  • Support Medicare Fee-For-Service beneficiary (beneficiary) attribution including beneficiary preference process
  • Determine payments for shared savings

• **Processes to promote:**
  • Evidence-based medicine
  • Report data on quality and costs
  • Coordinated care

• **Ability to meet patient-centeredness criteria**
Maine Community ACO - Participants

- Eastport Health Center – 2 Locations
- Harrington Family Health Center
- HealthReach Community Health Centers – 11 Locations
- Regional Medical Center Lubec – 2 Locations
- Islands Community Medical Services
- Pines Health Services – 3 Locations
- Portland Community Health Center
- Sacopee Valley Health Center
- Your County Community Health Center
MCACO Overview

- Host Organizations
  - Collaborative Health Systems
  - Maine Primary Care Association
- Start Date: July 1, 2012
- Covered Lives: 9,222
- Staffing
  - Executive Director
  - Provider Relations Representative
  - Clinical Manager
    - 3 Care Coordination Nurses
- Highlights of Care Model
  - Patient Engagement
  - Provider Engagement
  - Adaptive Technologies
  - Expert Consultation
Medicare Fee-for-Service Beneficiaries

• The Provider is participating in the ACO, not the Medicare Fee-For-Service beneficiary.
  – Their beneficiaries have NOT joined or been enrolled in the ACO.
  – Beneficiaries are not “members” of the ACO.

• There IS NO CHANGE to customer service for beneficiaries.
  – Medicare still handles service-related calls.

• There IS NO CHANGE to claims payment processes for beneficiaries.
  – Providers still submit claims directly to Medicare.
The ACO Vision

- An ACO promotes seamless coordinated care
  - Puts the Medicare Fee-For-Service beneficiary and family at the center of care
  - Attends carefully to care transitions
  - Proactively coordinates the beneficiary’s care
  - Evaluates data to improve care and beneficiary outcomes
  - Invests in team-based care and workforce
Infrastructure

- IT Structure & Technology Interface; EMR access
- Care Coordination System
- Analytics & Reporting
  - > 33 required Quality Measures
  - > Utilization metrics, Financial & Actuarial
- Best practices, P & Ps, ACO Governance Training
- Disease & Case Coordination Programs
- Quality Improvement Program
Disease and Care Coordination

- Processes to identify and track the progress of Medicare Fee-For-Service beneficiaries in certain disease categories
  - These processes are both retrospective (reporting) and concurrent (point of service)
- Reporting is a compilation of various data sources (claims, referral/authorization, revenue) to profile the beneficiary base as accurately and timely as possible
  - These reports are distributed to the primary care providers to ensure ownership of and continued outreach to the patient population
- In conjunction with reporting, a key element of success will be utilization of the EMR/HIE to push data directly into practices for identification and intervention at the point of service
  - Historical diagnoses as well as required testing/preventive measures will be presented to the provider for necessary documentation and/or intervention in order to maximize compliance with the quality elements outlined in the Shared Savings Program
Care Coordination Team Goals

- Working with the provider and his or her staff to:
  - Facilitate care coordination through timely exchange of Medicare Fee-For-Service beneficiary (beneficiary) activity and information
    - Ensure beneficiaries are getting annual physicals
  - Provide additional resources, through care coordination professionals, to:
    - Develop Personal Health Assessments and individualized care coordination plans where needed
    - Coordinate with inpatient discharge planning staff
    - Identify and monitor beneficiaries with ongoing chronic and/or complex healthcare needs.
    - Help to avoid hospital re-admissions and emergency room visits
QUESTIONS
Central Maine ACO

- **Host Organization:**
  - Central Maine Healthcare (CMH)

- **CMS Program:**
  - Shared Savings ACO

- **Population of Focus:**
  - Medicare beneficiaries

- **Population Size:**
  - 16,000 CMS
  - 22,000 commercial insurance

- **Timeline:**
  - June ‘10 - employees
  - 7/1/12 CMS
  - 1/1/12 – 7/1/13 commercial insurance ACO contracts

**Highlights of Care Model and/or Primary Intervention Strategies:**

- PCMH for PCP offices
- Population management
- Analytics capacity
  - *Internal and Partnerships*
- Risk stratification
- Focused interventions
  - *Care managers/health coaches*
- Sustainability
- Team-based care
- Behavioral/mental health
- Community partnerships
- Enhanced access in PCP offices
ACO Assets

- PCMH
  - Multi-payor Pilot
  - Steering committee
  - Care mgrs/Health coach
  - LCSW
- HIT
  - Outpatient EMR – 1999
  - CQIC Protocols
  - Meridios ‘buckets’
  - Better Integration – 2013
- Care coordination with Community partners
  - VNA - AHCH
  - SNF
  - CCT
- Aligned providers
  - Mostly employed
  - QI incentives – 3rd year
ACO Foundational Work

- **Business development**
  - *Employee health plan – “ACO-like”*
    - Risk assessment, employee benefits structure, health coach
  - “ACO” regularly in discussions – March 2011
  - *Existing payers increasingly migrating to ACO efforts*
  - *CMS/ACA*

- **Readiness assessment**
  - *Premier Consulting – June 2011*
ACO Foundational Work (2)

- **PCMH commitment**
  - ME PCMH multi-payer pilot (3) + 10 MECare Health Homes

- **Provider quality incentives:** + 3%; +/- 3%; - 6%

- **Population management – Saving Lives Initiative**
  (Mining 13 years of Centricity history)
  - AAA 58% Critical 3 Surgery 70
  - Breast Cancer 90% Cat 4 145 Cancer 25
  - Colon Cancer 75% Pre-cancer 645 Cancer 15

- **Medical staff bylaws revisions - 2010**
ACO Status Update

- Employees – 3000
  - Expenses decreased 10% YTD
- Private insurers
- CMS MSSP ~ 16,000 (July 1, 2012 start)
  - Successes: Readmission rates, advanced imaging, LOS
  - Challenges: ED visits, Amb Care Sensitive conditions
- Resources
  - Registries – Centricity (Meridios)
  - Case (Care) Managers
  - Health coaches, LCSW’s
Who is doing the work?

- **ACO Board** (quarterly)
  - President CMH, CFO, PR, Contracting, COO
  - Strategic review & Accountability

- **ACO Steering Committee** (monthly)
  - Pres CMH & CMMG, CFO, PR, Contracting, COO, Board
  - Coordinating operational support across silos
  - Monthly meetings

- **ACO Operations** (weekly)
  - COO, Nurse leadership (Quality & CM), IT, Accounting, Medical Director
  - Coordinating efforts with other initiatives
Who is really doing the work?

- **Nursing** – 1 FT + 6 PT
  - Care management
  - Case management
  - Gap report review
- **IT & Accounting** – 6 PT
  - Optimize value of reports coming in
  - Coordinate data extraction for reporting out
- **COO & Medical Director** - PT
OPPORTUNITIES FOR HEALTHCARE COST REDUCTION

- Improved Inpatient Care Efficiency
- Use of Lower-Cost Treatments
- Reduction in Adverse Events
- Reduction in Preventable Readmissions
- Improved Management of Complex Patients
- Use of Lower-Cost Settings & Providers
- All Providers
- Lower Total Healthcare Cost

- Improved Prevention & Early Diagnosis
- Improved Practice Efficiency
- Reduction in Unnecessary Testing & Referrals
- Reduction in Preventable ER Visits & Admissions
Lessons Being Learned

• Patients
  • Earlier and greater involvement (Board, Steering, Ops)
  • Communication - Social media?
  • Mental Health integration a huge challenge

• Providers and Administration
  • Communication
  • Champions
  • Cultural sensitivity and change management
  • Transparent and shared decision-making
  • PCP burden
  • Aligned incentives
  • How to use all of the data to create information