Tapping Into New Payment and Delivery Models:
An Innovative AAA-ACO Partnership to Improve Care and Reduce Costs

Elizabeth H. Johnson, MD, MS
President and CEO MaineHealth Accountable Care Organization
EHJohnson@mmc.org

Larry Gross, MPA
Executive Director Southern Maine Agency on Aging
lgross@smaaa.org

Part of the Aging and Disability Business Institute Series – a collaboration of n4a and ASA.
The “Business Institute”

The mission of the Aging and Disability Business Institute (Business Institute) is to successfully build and strengthen partnerships between community-based organizations (CBOs) and the health care system so older adults and people with disabilities will have access to services and supports that will enable them to live with dignity and independence in their homes and communities as long as possible.

www.n4a.org/businessinstitute
Partners and Funders

Partners:
- National Association of Area Agencies on Aging
- Independent Living Research Utilization/National Center for Aging and Disability
- American Society on Aging
- Partners in Care Foundation
- Elder Services of the Merrimack Valley/Healthy Living Center of Excellence

Funders:
- Administration for Community Living
- The John A. Hartford Foundation
- The SCAN Foundation
- The Gary and Mary West Foundation
- The Colorado Health Foundation
- The Marin Community Foundation
Overview of Our ACO Journey

- Movement from Volume to Value
- What is an ACO?
  - Who We Are
  - What We Do
  - How We Work
Call To Action: To Move...

FROM

PROVIDER centered system

VOLUME-based reimbursement

PRICE focus

TO

PATIENT centered system

VALUE-based reimbursement

TOTAL Medical expense

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Slide used with permission from Dr. Gene Lindsey
Our Next Challenge is TRUE Population Health Management

Requires a collaborative strategy between leaders in healthcare, politics, charity, education, and business

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What is an Accountable Care Organization (ACO)?

High Quality Care

- More than 400 ACOs participate in the Medicare Shared Savings Program (MSSP)
- Roughly 7.7 million beneficiaries are cared for by ACOs nationally in 49 states (plus Washington DC)

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MaineHealth ACO: Vision & Mission

Our Vision
To be the leader in supporting value-based integrated health care

Our Mission
To support ACO physicians and hospital(s) in the delivery of value-based, integrated health care that is patient centered through application of systems and programs that support improved clinical processes and outcomes, efficiency, better practice management and appropriate recognition and reimbursement.
MaineHealth ACO: Who We Are:

• Independent LLC providing ACO services to an integrated and collaborative network of over 1400 providers and 10 hospitals in the MaineHealth system (11 Maine counties and one New Hampshire county) as well as private, independent provider groups.

• Committed to supporting healthy individuals and healthy communities.

• Nearly 90 employees.

• Contracts cover more than 178,000 Medicare and commercial lives.

• Dedicated to improving health care in Maine and Carroll County, New Hampshire by advancing the work of the Triple Aim with a focus on Physician and Staff engagement.

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Who We Are: Our ACO Network

- **1,427 TOTAL PROVIDERS**
  - 390 PCPs
    - 256 Employed (66%)
    - 134 Other (34%)
  - 1,034 Specialists
    - 664 Employed
    - 370 Independent
- **10 HOSPITALS**
  - 4 Critical Access
  - 1 630-BED Teaching Tertiary
- **378 PRACTICE SITES**
  - 6 Rural Health Care Centers
  - 4 Federally Qualified Health Centers
- **35 UNIQUE HEALTH RECORD SYSTEMS**
  - 68% Physicians using Electronic Records
  - 46% Using EPIC
  - 32% Still on Paper

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What We Do: Our ACO Services

Network Management/Provider Relations/Value-Based Contracting
- Payer Issue Resolution & Payment Verification
- Contracting
- Network Management
- Quality Measure Selection & Reporting
- Communication, Education & Training

Care Coordination/Clinical Initiatives
- Care Management & Care Transition Interventions
- Care Coordination
- End-of-Life and Palliative Care Training & Resources
- Community Resource Education & Connection
- Care Management Training

Quality and Performance Improvement
- Data Interpretation & Improvement Identification
- Clinical Care & Process Improvement
- Patient Centered Medical Home (PCMH) Coaching
- Clinical Guidelines Access & Support

Data Operations and Analysis
- Clinical Improvement Registry (CIR) Training & Analysis
- Quality, Cost & Utilization Reporting
- Clinical Application Helpdesk
- Customized Claims-Based Reporting

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**What We Do:**
Our ACO Value-based Agreements

<table>
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<th>GOVERNMENT CONTRACTS</th>
<th>MEDIA 178,000 TOTAL COVERED LIVES</th>
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<tr>
<td>65,000 lives</td>
<td>Medicaid Shared Savings Program</td>
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<td>MaineCare Accountable Communities Program</td>
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<td>Maine Community Health Options</td>
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<td>Harvard Pilgrim</td>
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<td></td>
<td>Aetna</td>
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<td>MaineHealth Self Insured</td>
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**BEHAVIORAL HEALTH**

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<th>190,000 LIVES</th>
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<tr>
<td>6 AGREEMENTS</td>
</tr>
<tr>
<td>5 STATES</td>
</tr>
<tr>
<td>125 FACILITIES</td>
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<tr>
<td>6,000 TOTAL CLINICIANS</td>
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How Our ACO Works:

MAINEHEALTH ACO
BOARD OF DIRECTORS

Payers

Quality Committee
Contracting Committee
Quality Huddles
Contract Huddles

Leadership Huddles

Business Intelligence:
- Community dashboards
- Practice dashboards
- Contract performance dashboards

Dashboards = cost/quality utilization

Participants

VOC
PI Leadership
Local VOCs

Payers

Value Improvement
Complex Case Management
Care Transitions

Participants

Structure
Collect
Analyze
Educate
Transform

Payers

Financial & Quality Targets

Data Collection:
Claims | Clinical

Data Aggregation & Integration

Quality Committee
Contracting Committee
Quality Huddles
Contract Huddles

Leadership Huddles

Value Improvement
Complex Case Management
Care Transitions

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How our ACO Partners with the Southern Maine Agency on Aging (SMAA):

• Established a Close collaboration between the ACO and SMAA through CMS’s CCTP (Community-Based Care Transitions Program) program:
  – Over 6,739 patients touched by the Maine CTTP program design
  – Over 331,759 patients touched by all CCTP sites to date
  – Achieved 16.2% readmit rate for 4 Maine hospitals with a 19.6% readmit rate for all CCTPs

• Built Strong infrastructure:
  – Inclusive of central navigation, hospital liaison/schedulers at two major hospitals, rehab liaison, supporting data systems
  – Deep integration with hospital sites and patient primary care

• Have modeled an unmatched partnership
  – Continued SMAA & ACO collaboration ensures patients truly receive the care they need at the time they need it most
The Population Health Pyramid
Specialized care models for population segments with distinct needs

- Dedicated psychiatric NPs/MDs
- Bio-monitoring of Rx adherence
- Dedicated social worker and PCP
- Case worker embedded in care team
- Dedicated coach focused on nutritional and mental health needs
- Affordable acute care options
- Rewards and incentives
- Social/mobile health tracking tools

END OF LIFE
- Palliative care experts
- Support for caregivers
- Hospice centers
- Legal/financial advisers for family

SEVERE BEHAVIORAL
- Dedicated health coach focused on fitness, nutrition
- Attention to behavioral health
- Rewards for meeting health goals

POLY-CHRONIC/COMPLEX
- Dedicated "Extensivists"
- Remote monitoring
- Specialty clinics
- Integrated behavioral health

CHRONIC WITH SOCIAL NEEDS

EARLY CHRONIC/AT-RISK

GENERALLY HEALTHY

Source: Oliver Wyman analysis

http://owy.mn/1MjxsKA

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How did we go about identifying patients at risk?

Risk Segmentation Construct

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How we “Share in Savings with our CBOs: Our novel Financial Distribution Model

• Distribution to Participants and Partners

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<tr>
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<th>Savings</th>
<th>Losses</th>
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<tr>
<td>PCPs</td>
<td>27.5%</td>
<td>27.5%</td>
</tr>
<tr>
<td>Specialists</td>
<td>27.5%</td>
<td>27.5%</td>
</tr>
<tr>
<td>Hospitals</td>
<td>40%</td>
<td>45%</td>
</tr>
<tr>
<td>Partnering providers (eg SMAA)</td>
<td>5%</td>
<td>0%</td>
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• This model recognizes the contributions of other providers and community partners to the overall success of the ACO
  – In 2015, over $360,000 was distributed to community partners and partners

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More Examples of the MaineHealthACO – SMAA Partnership

• Financial
  – Shared Savings through the financial distribution model
  – Yearly Grants from the Value Oversight Committee (VOC)

• Executive / Advisory Committees: shared leadership, joint membership with ACO, SMAA
  – Care Coordination Advisory Committee
  – Elder Care Services Leadership Team
  – Post Acute Care Steering Committee

• Joint Training
  – Care Transitions Intervention
  – Matter of Balance program
  – Gunderson’s First Steps (Advance Care Planning)

• Direct Patient Care
  – Community Links
  – CCTP Medicare Demonstration Program
  – Evidence-based Programs (Chronic Disease Self Management, Matter of Balance)
  – Advance Care Planning

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Details of ACO - SMAA Innovation

- **CCTP**
  - Shared Coaching staff between the ACO and SMAA
  - Rehab/SNF liaison funded by SMAA, on-site at ACO
  - Simply Delivered Meals

- **Value Oversight Committee (VOC) Grants**
  - Enhanced CCTP (Spectrum Generations)
  - Dementia Intervention Project
  - Simply Delivered
  - Respecting Choices First Steps

- **Community Links on Desktop/Closed-Loop referral process**

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MHACO Post-Acute Care Care Program

- Engage post-acute care (PAC) facilities and community based organizations, such as the Southern Maine Agency on Aging (SMAA) to improve quality and contain costs

- Convene MH Senior Living Collaborative
  - 40 PAC organizations
  - 15/40 MH owned, affiliated, or with MMP Medical Directorship

- Share data to drive quality improvement
  - Cost per visit
  - Length of stay
  - Readmissions
  - Potentially avoidable ED transfers

- Support specialized competencies
  - INTERACT tool to reduce readmissions
  - HF & COPD pathways to reduce variations in cross continuum care & improve outcomes

- Provide education on CMS rules and regulations that affect payment structure and quality reporting
  - i.e. IMPACT Act

- Identify high performing PAC organizations within each MH region
  - Goal: Invite high performers to partner in cost/risk sharing

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Advance Care Planning Partnership

• MH/MHACO Palliative & End of Life Programs collaborated with the Southern Maine Agency on Aging (SMAA) to train 30+ volunteers in the First Steps Advance Care Planning Program

• Volunteers guide individuals by:
  – Facilitating family discussions
  – Assisting with selection of a healthcare decision maker
  – Completing a basic written advance directive

• SMAA subsequently partnered with Southern Maine Healthcare to create a referral program for assisting patients with the completion of advance directives

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Who We Are
What We Do
&
How We Developed Our ACO Partnership

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Who We Are

Non-Profit (501(c)(3)) – Designated Area Agency on Aging (AAA)/ Aging & Disability Resource Center (ADRC).

Primarily supported by Older American’s Act with broad mix of other state, federal, local, contractual and philanthropic funding.
Services We Offer Directly
Social Services Programs

• Home Delivered Meals
• Community Cafés (congregate dining)
• Medicare Counseling (SHIP, SMP, MIPPA)
• Family Caregiver Support Program
• Community Resource Specialists
• Retired & Senior Volunteer Program
• Adult Day Services
• Maine Senior Games

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Services We Offer Directly
Evidenced Based Programs

• Matter of Balance (MOB)
• Chronic Disease Self-Management Program (CDSMP)
• Tai Chi for Better Balance
• Savvy Caregiver
• Gunderson’s First Steps/Respecting Choices (Advanced Care Planning)
• Care Transitions Intervention (CTI)

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Why We Reached Out to Hospitals, Physician’s Practices and Health Plans

- SMAA’s Strategic Plan to address burgeoning need for our services.
- Resolved to diversify away from stagnant “discretionary” funding to dynamic “entitlement” and contractual funding sources.
- Agency vision to integrate social service model of AAA services with the medical model of health care. (to address social determinants).
How We Built Bridges to the Health Care Sector

Over nearly a decade, we:

• Sought Executive and Governance Level Champions.
• Conducted joint program development and research through grants and pilots.
• Embedded staffing models (often grant funded).
• Conducted Joint Training.
How We Built Bridges to the Health Care Sector

Executive and Governance Level Champions

- Invited healthcare stakeholders to join SMAA’s Advisory Council
- 1998 - 2011 AAA CEO serves on several local healthcare nonprofit Boards of Directors (Community Health Service, Maine Behavioral Health, Hospice of Southern Maine)
- 2000 – SMAA joined with MaineHealth to form Partnership for Healthy Aging
- 2006 – Recently retired CEO of MaineHealth invited to join SMAA’s Board of Directors

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How We Built Bridges to the Health Care Sector

- 2008 - Long standing CEO of well-regarded regional hospital joins SMAA Board of Directors
- 2010 - Director of Case Management of 2nd regional hospital invited to join SMAA Board of Directors
- 2011-2015 AAA CEO invited to join multiple ACO planning and leadership committees on elder care
- 2014 - Chief Medical Officer of major insurance company and Chief Medical Officer at PHO both agree to join SMAA Board of Directors

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Conducted Joint Programs Development, Training and Research through Grants and Pilots

- Translation of Matter of Balance
- Chronic Disease Self Management Program to Maine
- Simply Delivered Meals
- Alzheimer’s Disease Initiative
- ACL Matter of Balance
- Aetna Tai Chi statewide pilot

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Embedded Staffing and Referral Tool Innovations

• Community Links: HIPPA-compliant desktop referral tool created for ED and physician practices

• Joint Staffing with ACO: Community-Based Care Transitions Program (CCTP)

• Embedded Staffing agreements for Community Resource Specialists:
  • Maine Medical Center Geriatric Center
  • InterMed Physician Practice
  • Webhannet Internal Medicine and Kittery Family Practice
  • York Hospital

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The Triple Aim as Integrating Paradigm

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Recognize role of social determinants and physical environment to improve clinical quality indicators

Re-examine funding incentives and restrictions

Commit to greater patient engagement, self-management and caregiver satisfaction
Shared Opportunities for ACO’s and CBO’s

- Sustained need to minimize readmission costs as well as penalties
- Reduce unnecessary resource utilization and increase published quality star ratings
- Entry into bundled payments requires pre and post discharge interventions as part of solution
- Facilitate access to community based resources
- Foster information exchange
Risk Segmentation Construct: AAA contribution

- **Self-Managing**
  - Pre-Condition Risk
    - Family Caregiver Program
    - Chronic Disease Self-Management
    - Advanced Care Planning
    - Care Transitions Initiative
  
  - “Healthy”
    - Family Caregiver Program
    - Chronic Disease Self-Management
    - Advanced Care Planning
    - Matter of Balance
    - Advanced Care Planning
    - Community Resource Specialist
    - Welcome to Medicare

- **Capacity Risk**
  - Significant/Critical Clinical Risk
    - Family Caregiver Program
    - Chronic Disease Self-Management
    - Care Transitions Initiative
  
  - Long-term Condition(s)
    - Family Caregiver Program
    - Chronic Disease Self-Management
    - Advanced Care Planning
    - Care Transitions Initiative

- **Compromised Capacity**
  - End of Life
    - Family Caregiver Program
    - Chronic Disease Self-Management
    - Community Resource Specialist
    - Care Transitions Initiative
  
  - Family Caregiver Program
    - Meals on Wheels
  
  - Advanced Care Planning
    - Community Resource Specialist
    - Advanced Care Planning
    - Money Minders
    - Matter of Balance
    - Advanced Care Planning
    - Community Resource Specialist
    - Welcome to Medicare

- **Capacity to Manage Burden**
  - Clinical/Condition Burden
We have a good start and are building capacity to respond as the health care system transitions to a population health approach that integrates health and social care services into coordinated networks of care.
Questions & Answers:
Please Submit Using the “Questions” Box
Please join us for future webinars in the Aging and Disability Business Institute Series

Questions about the Aging and Disability Business Institute?

Email us: 

BusinessInstitute@n4a.org