

Community Care Partnership of Maine

Accountable Care Organization

Bangor, Maine



Eleven health care organizations across the state of Maine have partnered to form the Community Care Partnership of Maine - an Accountable Care Organization (CCPM ACO). Under an effort spearheaded by Saint Joseph Healthcare, Bangor and Penobscot Community Health Care, Bangor, the CCPM ACO has emerged as a community-focused, mission-based health care organization committed to improving the health of the communities they serve.

Other ACO models in Maine are focused around major hospital systems or major health services corporations. The CCPM ACO model was developed to pilot a very different model based on robust joint ownership and control among community hospitals and community health centers. All these organizations, while working collaboratively with major health care systems, are committed to remain highly independent and focused on the needs of their particular communities – many of them rural.

The ACO community hospital partners include:

- Saint Joseph Healthcare, Bangor
- Cary Medical Center, Caribou
- Millinocket Regional Hospital, Millinocket

The ACO Federally Qualified Health Center partners include:

- DFD Russell Medical Centers, Turner (Androscoggin and Kennebec Counties)
- Katahdin Valley Health Center, Millinocket (Aroostook and Penobscot Counties)
- Nasson Health Care, Springvale (York County)
- Penobscot Community Health Care, Bangor (Penobscot, Waldo, and Somerset Counties)
- Pines Health Services, Presque Isle (Aroostook County)
- Portland Community Health Center, Portland (Cumberland County)
- Seabasticook Family Doctors, Pittsfield (Penobscot, Piscataquis, and Somerset Counties)
- Fish River Rural Health (Aroostook County)

All are participating in a MaineCare Accountable Community initiative – which started August 1, 2015. CCPM ACO also became a Medicare Shared Savings Program ACO in January 2016. In addition, CCPM ACO is involved with shared savings ACO plans with three commercial payers in Maine. Altogether, CCPM ACO has over 60,000 covered patient lives in ACO-model shared savings plans; more are expected in next few years.

Principles and Benefits

By working together, CCPM ACO member organizations will enhance the delivery of healthcare through meaningful shared learning on how to help deliver the most effective health care for its patients. They work together toward the Triple Aim - improve access to care, improve clinical outcomes, reduce costs, and improve patient experience of care.

The underlying philosophy of CCPM ACO is:

- Full collaboration and joint and equal ownership of the ACO among all its members.
- Commitment through finances and the extensive time of clinical and administrative leaders.
- Common cultures as community rooted organizations and as non-profit and mission-based organizations.
- Access to quality and effective health care for the most vulnerable residents
- Independence, but collaborating with larger hospital systems and many other groups.
- Nationally certified Patient Centered Medical Homes staffed with local care managers who serve patients with higher levels of chronic disease and high rates of ED or hospital readmissions.
- Full utilization of the Maine Health Information Exchange - HealthInfoNet.
- Distribution of shared savings to member organizations based on the number of their patients in the ACO program.

All partners have committed to membership criteria that includes without limitation:

1. Being a not-for-profit legal entity,
2. Maintaining or achieving NCQA medical home recognition or its equivalent or, at a minimum, being in the process of submitting for NCQA or equivalent recognition within a reasonable period of time from the date of admission to the ACO,
3. Utilizing a meaningful use-certified electronic medical record in a manner that allows participation in population health management,
4. Providing effective practice-based care management, and
5. Having the capacity to generate and utilize population health data.

Governance and Leadership Structure

By working together, CCPM ACO strives to transform the delivery of health care through meaningful sharing and accountability for the health of their patients by sharing information openly to achieve constant improvement in patient care, patient satisfaction and efficient healthcare delivery. CCPM ACO shares decision-making equally among members, and establishes a governance structure that ensures full participation of all members in the decisions affecting them with one vote per member organization on all matters.

CCPM ACO has three major and very active committees: Quality & Clinical Integration, Finance & Operations Committee, and Compliance. The Quality & Clinical Integration Committee is supported by four subcommittees: Data and Information Technology; Care Management; Medication Use; and Quality & Process Improvement.

In addition, St. Joseph's Healthcare (SJH) and Penobscot Community Health Care (PCHC) have collaborated to consolidate quality departments and share resources to improve primary care and to achieve efficiencies across CCPM. As the two largest member organizations and both based in Bangor, SJH and PCHC are piloting some initiatives like predictive analytics tools, and clinical pharmacy supported through PCHC's pharmacy residency program. After piloting, these and other strategies can be brought forward to other interested CCPM members.

Patient Centered Medical Home

The patient-centered medical home (PCMH) is a way of organizing primary care emphasizing care coordination and communication to transform the way this service is delivered. A beneficiary is

assigned to an ACO if the beneficiary receives at least one primary care service by a provider affiliated with that ACO.

All physicians included in an FQHC attestation are considered primary care physicians. For FQHCs that are ACO participants, CMS considers a reported service to be primary care if the associated Healthcare Common Procedure Coding System (HCPCS) or revenue center code meets the definition of a primary care service and if a primary care physician is the attending provider is reported on the claim.

Medical homes can lead to higher quality and lower costs, and can improve patients' and providers' experience of care. NCQA Patient-Centered Medical Home Recognition is the most widely-used way to transform primary care practices into medical homes. Although not a requirement of PCMH, most CCPM ACO members have integrated mental health services, and many of the community health centers have integrated dental services.

Managing Population Health



A health information exchange (HIE) is a secure, standardized electronic system where health care providers can share important patient information, giving them the tools they need to make more informed, data-driven treatment decisions. [HealthInfoNet](#) is the state's HIE. It was incorporated in 2006 and is governed by a board of directors and several committees run by Maine people serving on behalf of doctors, hospitals, public health, patients, and groups representing various consumer interests.

In 2013, the State of Maine was awarded one of six [State Innovation Model](#) (SIM) Testing Grants sponsored by the Centers of Medicare and Medicaid Services (CMS). The three-year grant with total funding of just over \$33 million is used to help improve care and reduce health costs in Maine. Specific areas of focus include supporting current payment and delivery reform efforts and using health information technology to better understand cost and quality to further health reform efforts across Maine. HealthInfoNet is one of three sub-contractors to this grant. HealthInfoNet provides leadership support for the Maine SIM Data Infrastructure Subcommittee, which advises on activities related to the health information technology improvements.

CCPM ACO providers gather and report data from across the care continuum to help providers drive quality and cost improvements. As part of the SIM evaluation, a dashboard has been created that shows progress on core metrics. The data are further segmented by MaineCare, Medicare, and commercial patients and includes metrics on things like non-emergent emergency department use, use of imaging studies for low back pain treatment, and developmental screenings for children in the first three years of life. Each metric shows whether the measure has made progress towards its goal.

The HIE analytics service then uses real-time clinical data to help providers drive quality and cost improvements, manage risk and population health, and inform operational decision making. For example, a patient records an abnormal A1C risk score which is relayed to a care manager who can then engage the patient within 24 hours after testing. Scoring guides are used to detect patients at highest risk for complications and are helpful for predicting readmissions. This level of analysis coordinates care management and risk to achieve savings and quality care.



HealthInfoNet has been selected by DASH -- [Data Across Sectors for Health](#) -- as one of ten grantees to implement projects that improve health through multi-sector data sharing collaborations. DASH is a national program of the Robert Wood Johnson Foundation that identifies and tests innovative practices that foster collaboration, engages across sectors and builds robust data and information systems to increase capacity of organizations to improve health in their communities.

HealthInfoNet plans to incorporate electronic health record (EHR) data from members of the CCPM ACO utilizing the HIE's real-time predictive analytics system. The integrated predictive analytics will allow the practice sites to identify patients needing care management and community support and bring significantly greater collaboration among health care and social service agencies. Another innovation involves two community action programs (CAP) that will start loading their social determinant data into the HIE record.

Accountable Care

The [MaineCare Accountable Community](#) (AC) initiative program is Medicaid's version of Accountable Care Organizations (ACOs) in Maine. The AC must include providers that directly deliver primary care services, as primary care practices are the main basis for assigning MaineCare members to the AC. Like the Medicare Shared Savings Program, groups of providers can share in savings for an assigned population, with the savings payments directly tied to the ACs score on a range of quality measures.

Under the program, the Maine Department of Health and Human Services (DHHS) enters a three-year AC contract with the AC "Lead Entity." The Lead Entity, CCPM ACO in this case, represents the providers that comprise the AC. The program offers broad flexibility of provider types allowed to be part of the AC and the AC operational structure. CCPM ACO currently provides ACO shared savings support for about 60,000 patient lives – and since member organizations provide similar care management and other support services to all patients regardless of pay class, the number of covered lives is actually much higher.

Summary

The eleven partners of CCPM ACO have created a model of delivery and coverage that is unique in its combination of provider types and principles. Collaboration between community hospitals and FQHCs has extended coverage across the state providing access to primary care through the CCPM ACO. Safeguarding independence with joint and equal ownership assures accountability to the group and ultimately to the member subscribers, as well as vests each organization in the ACO's outcomes. Emphasis on PCMH and care management underscores the importance of standardization and quality across all eleven partners. The ACO has great potential to improve population health through the HIE and CCPM ACO has gathered experience through participation in MaineCare, Medicare and a number of commercial payers.

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