

## CASE STUDY

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# Serious Illness Approaches by ACOs: MaineHealth Accountable Care Organization (MHACO)

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## Summary

### Background

MaineHealth ACO (MHACO) spans 10 regions across Maine and northern New Hampshire, many of which are rural regions. MHACO includes 10 hospitals, more than 1,600 providers, more than 400 practice locations, and over 240,000 patients. In 2012, MaineHealth joined the Medicare Shared Savings Program (MSSP), and it has private ACO contracts with 11 different payers. Participating ACO providers include large hospitals, rural hospitals, specialists, and primary care physicians. The ACO itself directly employs approximately 90 people, 40 of whom are members of the complex care team and 50 of whom serve administrative and executive functions of the ACO.

### Approach

MHACO has several approaches to caring for patients with serious illness. First, MHACO has a complex care management program designed for patients who are high cost and high need, defined as patients with multiple chronic conditions or who have polypharmacy plus inpatient or emergency department (ED) utilization in the past 6 months. Given the criteria for qualifying for the care management program, many patients who are eligible for the program are seriously ill. Once identified, the complex care management intervention typically involves components of the Care Transitions Intervention™ developed by Dr. Eric Coleman to help the patient better understand their conditions, medications, symptoms related to their illness, and physician follow-up. Home visits are key, and the team consists of nurses, social workers, and health guides. The care team also helps the patient better understand and navigate the health system, access community resources, and engage in their care.

Second, MHACO has developed care protocols for heart failure, urinary tract infections, and chronic obstructive pulmonary disease. For heart failure, there is one protocol for skilled nursing facilities (SNF) and one for home health.

### Key Learnings

**Effective communication and organization can promote collaboration in a geographically large ACO.** MHACO has been able to overcome many of the challenges introduced by being an ACO with a diverse group of participating providers and an ACO operating in a state with many rural regions by emphasizing communication and organization. A Value Oversight Committee, established in late 2012, includes representatives from MHACO's 10 regions and is responsible for establishing MHACO's priorities and overseeing performance and accountability to achieve the goals set forth. An Improvement Team then helps implement the Value Oversight Committee's priorities across all 10 regions.

**Flexibility within the complex care management program can improve outcomes.** On average, patients are enrolled in the complex care management for one to six months. Typically, an initial home visit is preceded by a series of telephone calls and/or touchpoints during office visits. However, MHACO allows enough flexibility within its program to meet the needs of individual patients. For example, if a patient is engaged with their care but would benefit from more home visits or a longer stay in the program, then the program flexes to meet the patient's needs.

**Building the competencies for value-based care takes time.** MaineHealth has been engaged in using data and care management to improve care quality since the 1990s and hired its first care managers in 2004. This foundation of care management helped facilitate the system's transition to an ACO when it joined the MSSP. Providers who are newer to the ACO movement may take more time to build the competencies needed for accountable care.

The protocols are intended to better monitor and manage a patient's condition and prevent unnecessary ED visits and hospitalizations. The protocols include Physician Order for Life-Sustaining Treatment (POLST) documentation and advance directives. Also in development by the MaineHealth system are protocols for pneumonia and hip fractures.

## Results to Date

MHACO's MSSP expenditure per beneficiary are 8% lower than national fee-for-service Medicare. Quality scores improved from 91% to 97.3% from 2014–2016. Preliminary results of the SNF heart failure protocol show a readmission rate of 10% for patients on the protocol vs. a baseline rate of 20.1% prior to protocol implementation.

## Tools & Vendor Partners

For its complex care management program, MHACO follows components of the model of coaching from the Care Transitions Intervention™ developed by Dr. Eric Coleman. The program begins with a home visit within 24–48 hours of referral to the program. During this home visit, the care manager performs a medication reconciliation, reinforces the patient's knowledge of red flags, ensures the patient understands and has no barriers to their follow-up appointments with primary care physicians and specialists, and educates the patient on the use of a personal health record. The care team also helps the patient better understand and navigate the health system, access community resources and engage with their care. Follow-up telephone calls occur at weeks 1, 2, and 4. After the week 4 phone call, there is a decision to graduate the patient, or continue with complex care management for up to six months.

Health Information Technology infrastructure also enables MHACO to identify and track patients for the complex care management program and disease protocols. Most providers in the MHACO network use Epic as their electronic health record (EHR), although more than 40 different EHRs exist throughout MHACO. MHACO is in the final stages of creating a population health management tool called Arcadia, which will aggregate claims and clinical data from Epic and other EHRs. MHACO also intends to use John's Hopkins ACG system's predictive capabilities. Arcadia and the John's Hopkins ACG system will allow MHACO to identify patients using a configuration of risk scores, including predictive risk, to identify patients at risk and offer care management sooner.

## Challenges with Implementation

MHACO describes itself as a “kitchen sink ACO” because it includes providers from across the care continuum and all types of facilities, from large hospitals and multispecialty clinics in the urban Portland area to critical access hospitals and primary care physicians in the state's rural areas. The variety of participating providers means incentives do not always align. For example, as MHACO considers how to address utilization and reduce ED visits and hospitalizations to manage total cost of care, it must balance that objective with the reality that hospitals in MHACO still rely on patient volume to meet their budgets.

### MHACO Details

Maine Health ACO is primarily owned by MaineHealth, the largest health care organization in Maine. MHACO participates in the Medicare Shared Savings Program (Track 1) and has several ACO contracts with commercial payers. MHACO includes 10 hospitals, more than 1,600 physicians, and more than 240,000 patients.

**Location:** Headquartered in Portland, ME and includes 10 regions in Maine and northern New Hampshire

**Website:** <https://mainehealth.org/mainehealth-accountable-care-organization>

# Detailed Case Study:

## MaineHealth Accountable Care Organization (MHACO)

### Overview

MaineHealth Accountable Care Organization (MHACO) spans 10 regions across Maine and northern New Hampshire, many of which are rural regions. MHACO includes 10 hospitals, more than 1,600 providers, more than 400 practice locations, and over 240,000 patients. In 2012, MaineHealth joined the Medicare Shared Savings Program (MSSP) and also has private ACO contracts with 11 different payers. The ACO itself directly employs approximately 90 people, 40 of whom are members of the complex care team and 50 of whom serve administrative and executive functions of the ACO.

Central to MHACO's care for patients with serious illness is the complex care management program. The goal of MHACO is to provide "coordinated care to ensure that patients, especially the chronically ill, get the right care at the right time while avoiding duplication of services and preventing medical errors."<sup>1</sup> MHACO's complex care team, which consists of nurse care managers, social workers, and health guides, provide in-home and telephonic care management services to patients in the complex care program. The care team does not provide clinical services, but instead helps to educate the patient and their care team on the patient's conditions and how to appropriately manage their medications and health needs.

MHACO describes itself as "kitchen sink" ACO that is simultaneously both ahead and behind the health care transformation from volume to value. The diversity of participating providers—from rural hospitals to specialty physicians—contributes to the kitchen sink moniker. This variety introduces challenges because each type of provider often has its own financial priorities and incentives that may not align with other provider types. MHACO is both a leader and a slow adopter in the transition to value because although it has participated in care management and quality focused efforts since the managed care era of the 1990s, it is only just beginning to examine and act on the cost component of accountable care by focusing on utilization. However, MHACO's challenges are shared by many health care systems and, therefore, its successes can be practically applied to other systems participating in accountable care.

MHACO attributes much of its success to the culture and population of Maine. A small state with only 1.3 million people, Maine ranks 42nd in population among states in the United States. Fewer residents have enabled MHACO to implement more creative and innovative solutions. Moreover, MHACO's leaders observe that many people live in Maine because they love the state. Maine does not offer the highest paying jobs and does not have highly sought-after cities such as Manhattan or San Francisco, so its residents often choose the state because they grew up there; have family there; and, consequently, are invested in improving their community, city, and state. MHACO's leaders also believe many people's choice to live in Maine also contributes to the collaborative nature of the state, which has enabled multiple partnerships between the state's providers and payers in accountable care. This collaborative orientation may be what has influenced MHACO's leaders to pursue value-based care not because the return on investment is inevitable, but because care management for complex and seriously ill patients is the best way to care for their patients and community.

### Key Components of Care Model

#### Complex Care Management Program

The MHACO care management program targets patients who are at risk for high utilization or who are high cost. These patients are often seriously ill. Patients are eligible for the program if they have multiple chronic conditions or have poly-pharmacy plus have had inpatient or ED utilization in the past 6 months. A central navigation department applies these criteria to several different MaineHealth reports to identify patient populations, including high-risk, panel, payer, inpatient and ED, and population health. Patients who meet the criteria for the care management program are referred to each region's care managers. Physician referrals and payer data are also sources of patient identification.

The complex care team consists of nurse care managers, social workers, and health guides. Forty nurses, social workers, and health guides serve as the complex care management team supporting MHACO's 10 regions. Care managers hold BSNs and have two or more years of experience with care management. Each nurse care manager is partnered with a health guide, each of whom has a high school diploma and several years of health care experience or a social worker who is licensed by the state of Maine.

## Short Overview of MHACO

### Organizational Description

MHACO joined the MSSP in 2012, continues to participate in the MSSP, and has contracts with 11 different private payers. MHACO is primarily owned by MaineHealth, the largest health care organization in Maine. MHACO includes 10 hospitals, more than 1,600 physicians, and more than 240,000 patients.

### People in the Model

About 90 individuals work for MHACO itself, with approximately half of those serving on care teams as care managers, health guides, and social workers, and the other half serving executive and administrative functions (contracting, data analysis and operations, and improvement resources). MHACO focuses on patients with complex care needs, many of whom are seriously ill. Patients are referred for complex care management if they have multiple chronic conditions or have polypharmacy plus have had inpatient or emergency department (ED) utilization in the past 6 months.

### Key Programs and Care Innovations

MHACO includes two primary types of interventions for patients with serious illness. The first is a complex care management program that involves the care team—nurse care managers, social workers, and health guides—visiting the patient in their home and helping the patient learn how to manage their conditions. The second is a series of clinical protocols designed for different conditions including urinary tract infections (UTIs), chronic obstructive pulmonary disease (COPD), and heart failure. Protocols are designed for use within different settings.

### Local Market and Context

MHACO operates in 10 regions across Maine and northern New Hampshire, and many of MHACO's regions are rural. Significant variation in resources and health information technology infrastructure exists between the greater Portland-based providers and many of MHACO's rural providers.

### Evolution and Buy-In

MHACO evolved from a physician hospital organization (PHO) that began in the managed care era during the 1990s. Although MHACO joined the MSSP in 2012, it hired its first care managers in 2004 when the PHO focused on disease management. Physician engagement and buy-in is obtained through several committees that connect participating practices to MHACO's leadership, including a Value Oversight Committee that includes CMOs from each region and a Physician Engagement and Accountability Committee where physicians provide advice and consultation to MHACO's board of directors.

### Financing & Infrastructure

MHACO is primarily funded through its parent organization, MaineHealth. Participating hospitals receive 40% of shared savings, and physicians receive 60%, which is then split 50/50 between primary care physicians and specialists. Grant funding also supports some elements of the care model.

### Implementation Challenges

With significant diversity among provider types across the continuum of care, the business models of each can clash with MHACO's priorities. For example, while MHACO wants to focus on total cost of care by reducing hospital utilization, MHACO's hospitals still rely on patient volume to meet their budgets and operating costs. The care management program has yet to demonstrate its desired return on investment.

### Results and Key Outcomes

MSSP expenditures per beneficiary are 8% lower than national fee-for-service Medicare. Quality scores improved from 91% to 97.3% from 2014–2016. Preliminary results of the skilled nursing facility (SNF) heart failure protocol show a readmission rate of 10% for patients on the protocol vs. a baseline rate of 20.1% prior to protocol implementation.



Once identified, prompt communication with patients is a central component of the complex care management program. Nurse care managers contact patients 24-48 hours after a utilization, such as an admission to the hospital, an ED visit, or a hospital discharge.

After initial communication, the first step in the care management program is a home visit by a member of the care team, which can last as long as one hour or more. A home visit allows the care team to better understand the environment in which the patient lives and meet with the patient in a more comfortable and familiar setting. During the home visit, care managers follow the Care Transitions Intervention™ developed by Eric Coleman, MD, MPH. The four pillars are to:

- Perform a medication reconciliation and develop a plan for consistently taking each medication.
- Reinforce the patient's knowledge of red flags and who to call when concerned about symptoms.
- Ensure the patient understands and has no barriers to their follow-up appointments with primary care and specialists.
- Educate the patient on the use of a dynamic patient-centered personal health record that includes the patient's care goals. Patients are encouraged to take the care plan with them to their appointments to share and discuss with their providers.

**To train for the complex care management program, staff attend a four-day training course that covers common conditions for patients in the program, including congestive heart failure, diabetes, and COPD, a two-day course on motivational interviewing to help develop the rapport with patients and encourage engagement and adherence to the program, and a 3 month on-boarding process which includes education, job shadowing, and demonstration of core competencies.**

The care team also helps the patient better understand and navigate the health system, access community resources, and engage with their care. In some cases, care managers will attend a follow-up appointment with the patient to serve as an advocate for the patient. In addition to better understanding the health care system, care managers encourage and empower patients to be active participants in their interactions with physicians.

The goal of the complex care management program is to help patients better manage their conditions and reduce preventable ED visits and hospitalizations. Engaging patients in their care, educating them on their conditions, and ensuring patients are receiving the proper follow-up appointments are central components of the home program. Home visits do not involve any hands-on clinical care, but instead focus on building a rapport with the patient and educating the patient on their health conditions, medications, and physician visits. Care managers maintain regular phone contact with patients and return for additional home visits as necessary.

On average, patients are enrolled in the program for one to six months, at which time they “graduate” from the intensive complex care management program. If appropriate, patients may graduate early or may remain in the program past six months if they are sufficiently engaged in their care. If a patient is not adequately engaged in their care, then they may cycle off the program and be re-engaged on a later date.

### **Social Determinants of Health**

Social workers and health guides are members of the care management team and help address patients' social determinants of health. MHACO predominately connects patients to community resources, but is piloting different ways MHACO itself can help patients overcome social barriers. For example, MHACO has a yearlong grant to experiment with additional ways to address patients' social determinants. One patient struggled with transportation challenges and was unable to reliably make the two-hour bus ride to her appointments. Through the grant, MHACO was able to provide this patient with vouchers for cab rides, which enabled her to get to her appointments. Grant funding helps to experiment with some innovative approaches to integrating social determinants of health assistance into the complex care management program; however, the finite funding from grant arrangements challenges the sustainability of these types of efforts.

### **Rural Challenges**

Maine's rural regions introduce several challenges as well. Social determinants of health issues can be more of a factor in rural areas, but the same resources of a city or larger community often do not exist. However, rural areas also introduce opportunities for creative solutions. For example, rural ambulance drivers often have more knowledge of the high-risk patients in their community and at times conduct home visits or transport patients to more routine (non-emergency) appointments.

### **Protocols for Nursing Facilities and Home-based Care**

In addition to the complex care management home program, MaineHealth and the ACO have developed several care protocols for chronic conditions for use in both the home and SNF. In 2014, the home health heart failure protocol was implemented.

Two years later, the SNF heart failure protocol was implemented. The SNF and home health heart failure protocols include instructions to assess patients' wishes for end of life care. MaineHealth/Maine Medical Partners and MHACO also have a protocol for UTIs and guidelines for inhaler use in COPD patients. MHACO has been invited to the table by Maine Medical Partners as they develop protocols for pneumonia and hip fractures.

MHACO has implemented the heart failure protocol in 25 nursing homes across its 10 regions and is training providers on the protocol in another 19 SNFs. The protocol is designed to help providers identify early symptoms of heart failure and prevent an ED visit or a hospitalization. The protocol is initiated by obtaining a target weight, the weight at which a patient is considered euvolemic. Patients are weighed daily and fluctuations from target weight trigger adjustments in diuretics. End-of-life preferences and goals of care are also part of the heart failure protocol.

The SNF heart failure protocol is showing signs of meeting its goals. Before the implementation of the protocol, facilities had a baseline hospital readmission rate of 20%. Since the protocol has been implemented, the hospital readmission rate has dropped to 10%. MHACO has seen similar results for ED visits. Before the implementation of the protocol, facilities had a 14% ED visit rate, a percentage which shrunk to 8% after implementation of the protocol. Communication is an important feature of the protocol's success. Medical directors of each SNF regularly meet with MaineHealth geriatricians to discuss the protocol and coordinate efforts.

### Scaling the Intervention

MHACO has several strategies for scaling its intervention for patients with serious illness. To identify patients in the "rising risk" category who could benefit from complex care management, MHACO plans to leverage the predictive capabilities of the John's Hopkins ACG system and its own Arcadia population health tool.<sup>2</sup> Identifying rising risk patients (i.e., patients at risk for high utilization) will both help to scale the program and potentially reduce costs by intervening in a patient's care trajectory with care management before preventable high utilization occurs. Moreover, MHACO is expanding its disease protocols with the development of the hip fracture and pneumonia care protocols.

## Implementing Care Models Inside an ACO

MHACO has an administrative office with 90 employees. MHACO does not directly employ any practicing physicians, but some of its leadership are physicians.

Approximately half of MHACO's employees are members of the care team who implement the complex care management program. The other half of MHACO employees serve in executive or administrative roles, which include contracting, data analysis and operations, and improvement resources.

MHACO itself is jointly owned. MaineHealth is the parent organization that financed the creation of MHACO. MaineHealth owns 90% of MHACO; the other 10% is owned by a private, for-profit specialty physician group. MaineHealth is a not-for-profit integrated delivery network and is the largest health care organization in the state.<sup>1</sup> There are approximately 1600 physicians who participate in the ACO across 10 hospitals and physician groups. For participating physicians, MHACO negotiates contracts, except with hospitals.

MHACO shares savings across the participating practices and retains some savings for infrastructure investments, such as the new population health tool called Arcadia, and distributes the rest of the savings to practices. Physicians receive 60% of the savings, and hospitals receive 40%. The 60% to physicians is split 50/50 between primary care and specialty care physicians.

## Organizational Factors Necessary for Success

### Foundation

MHACO had a foundation in managed care beginning in the mid-1990s that it was able to leverage for the formation of the ACO. During the managed care era of the 1990s, Maine Medical Center organized a physician hospital organization (PHO). When quality reporting became a major focus of the 2000s, the PHO was well positioned to capture quality data and developed an internal data warehouse. In 2004, the PHO hired its first care managers and created a disease management program. At the time, MaineHealth was a joint venture program with Blue Cross and Blue Shield in a commercial health plan Maine Partners Health. The passage of the Affordable Care Act and the creation of the MSSP ushered in the next phase of what is now MHACO when MaineHealth joined the MSSP in 2012. As an ACO, MaineHealth transitioned away from disease management to complex care management. The organization also shifted away from a pay for performance framework toward thinking in terms of total cost of care.

The relationship of physicians to MaineHealth also evolved over this period. When the PHO existed, affiliated physicians were mostly private practitioners. Today, the majority of MHACO's physicians are employed by MaineHealth. Moreover, on January 1, 2019, MaineHealth changed from a federation of hospitals to a unified system, with MaineHealth serving as the parent organization of MHACO.

## ACO Communication and Physician Engagement

The breadth and diversity of regions and providers within MHACO introduce some inherent challenges around coordination and organization. To address these complications, MHACO has developed ways to foster and institutionalize effective communication and collaboration. Finally, an improvement team consisting of clinicians and personnel skilled in improvement science work with physician practices in each of MHACO's regions to implement the priorities established by the Value Oversight Committee.

**MHACO created two committees—the Value Oversight Committee and the Physician Engagement and Alignment Committee—that facilitate collaboration and engage physicians in the efforts of MHACO.**

The Value Oversight Committee consists of C-suite leaders, including chief medical officers, chief financial officers, medical directors, and chief operating officers from the different regions. During two-hour monthly meetings, the Value Oversight Committee establishes and monitors priorities for MHACO, including quality and financial targets. Each region's Value Oversight Committee representative then works to translate and implement the committee's priorities in their local region. In addition to the Value Oversight Committee, the MHACO leadership has quarterly meetings with the CEOs of each MaineHealth hospital and physician group.

An improvement team takes the priorities determined by the Value Oversight Committee and helps to implement them across MHACO's ten regions. The improvement team consists of a director of practice improvement and four people with either clinical and/or improvement science backgrounds who are assigned to specific MHACO regions. Improvement advisors have extensive experience in the primary care setting and have effective leadership skills. The improvement team disseminates and helps implement the ACO-wide priorities established by the Value Oversight Committee to the physician practices in their regions. These teams use data from the local practices to identify areas where the practices can improve to achieve the Value Oversight Committee's goals. The improvement team shares challenges and best practices across the system.

To enhance physician engagement, MHACO hired four physician liaisons to work closely with the improvement team. According to MHACO, most physicians are receptive to the role of the improvement teams because of the physician's familiarity with the patient-centered medical home structure and the use of data to evaluate and improve their practices.

Nevertheless, building strong relationships between physicians and the improvement advisors remains a focus of MHACO. A Physician Engagement and Alignment Committee helps promote physician engagement. Primary and specialty physicians who participate in MHACO serve on the committee.

## Population Health Management Tool

MHACO is in the final stages of working with a vendor to create a population health management tool called Arcadia. Arcadia will aggregate both clinical and claims data, identify patients for the complex care management program, improve tracking of patients, and streamline quality reporting. Additionally, MHACO is planning to use the John's Hopkins ACG system to identify patients who are in the "rising risk" category for high utilization using a configuration of risk scores, including predictive risk, to identify patients. MHACO intends data collection from these different systems to help the Value Oversight Committee establish and monitor priorities.

## Implementation Challenges and Implications for Spread

### Diversity of Participating Providers

A primary challenge MHACO faces is the variety of physicians the organization includes. Although MaineHealth has become increasingly unified since its managed care days in the 1990s, MHACO describes itself as the "kitchen sink ACO."

**MHACO today includes large hospitals, critical access hospitals, rural hospitals, employed physicians, private practice physicians, and primary care and specialty physicians. MHACO constantly must consider how to engage and excite physicians in the mission of MHACO.**

A challenge related to the "kitchen sink" nature of MHACO is the wide spectrum of practice's infrastructure capabilities and preparedness for value-based care. Many practices in rural regions, for example, struggle with sufficient resources and even types of practices. On the other hand, the Portland-based Maine Medical Partners that participates in MHACO has a much more robust health information technology infrastructure. Maine Medical Partners also has their own care managers, which introduces the need to distinguish between the roles and responsibilities of Maine Medical Partners' and MHACO's care managers, although only MHACO care managers provide home visits.

# Specific Organizational Competencies and Example Actions Used to Implement Serious Illness Care Model

## Specific Competency\*

## Example Actions

### Care Delivery

Design care teams

Complex care teams consist of nurse care managers, social workers, and health guides. The care team helps the patient understand their condition, their medications, and how to identify red flags. Social workers and health guides connect patients to community resources to address patients' social determinants of health needs.

Establish and maintain use of care guidelines

MHACO has established protocols for certain conditions for use in both SNFs and in the home. Currently, protocols exist for UTIs, COPD, and heart failure. Protocols are in development for hip fractures and pneumonia.

### Governance

Commit to pursue value-based care

MaineHealth began focusing on quality in the 1990s, hired its first care managers in 2004, and remains committed to value-based care because it is what is best for patients. MHACO faces challenges with Centers for Medicare & Medicaid's current emphasis on transitioning MHACOs to downside risk, but leadership remains committed to accountable care.

Establish quality and leadership teams

MHACO has a quality work group that each year identifies 10 quality measures (from a list of 57) upon which MHACO will focus. The work group provides all participating physicians a quality heat map for each measure that demonstrates where the physicians are succeeding and where improvement is needed.

### Finance

Align incentives with value-based objectives

The Value Oversight Committee develops system-wide priorities for MHACO, which are then implemented at the practice level with support from the Improvement Team. Equipped with practice-specific data, the improvement team helps practices understand areas for improvement and assists in how to accomplish this. MHACO distributes shared savings to both hospitals and physicians. Participating hospitals receive 40% of shared savings, and physicians receive 60%, which is then split 50/50 between primary care physicians and specialists.

### Health IT

Develop platforms to house and analyze data

Developing a population health management tool called Arcadia, which will allow for the analysis of both clinical and claims data and will offer more predictive analytic capabilities.

\* Competencies drawn from the *Accountable Care Atlas* published by the Accountable Care Learning Collaborative.



Demonstrating ROI

Another challenge to scaling MHACO and the care model for patients with serious illness is that the return on investment of the care management program remains elusive. The ability to effectively measure the outcomes of the care management program has limited its spread. To calculate the ROI, MHACO explained how it would need a comparable group of patients who did not receive the care management intervention. The challenges around evaluation and understanding which efforts are leading to the desired outcomes combined with the nation-wide questions that remain on whether accountable care can meaningfully reduce costs while improving quality contribute to MaineHealth's leadership hedging their bets on the accountable care movement. Although committed to improving care, MaineHealth's leaders examine the speed and the seriousness of the ACO movement.

Without a clear ROI, MHACO's primary business case is that care management is the best thing to do for patients and the community. Providing high-quality patient care is the main driver of MaineHealth's business case.

Quality and Utilization Data

For deciding which quality metrics MHACO focuses on, there is a quality workgroup and a utilization workgroup. A challenge MHACO faces with quality capture is that between the MSSP, Medicare Advantage Star ratings, and commercial contracts, there are 57 quality measures on which to report. Many times these quality measures are not well aligned. Each year, MHACO selects 10 measures on which to focus. Medicare Advantage quality measures are becoming a big priority. For all 10 measures, MHACO makes a quality heat map that is shown monthly to the practices.

Measuring, reporting on, and creating goals around utilization introduces more challenges because there is a tension between the needs of MHACO (to lower utilization) and the needs of the hospitals to meet their budgets through the necessary volume. So long as accountable care models continue to exist on a fee-for-service chassis, this tension will exist. While MHACO wants to focus on managing total cost of care, the hospitals still rely on volume to meet their budgets. To navigate these competing priorities, MHACO is careful to message its efforts around utilization as reducing "avoidable" ED visits and hospitalizations.

Rural Challenges

Finally, the rural environment of many of MHACO's regions present challenges. Like rural settings across America, Maine's rural regions have fewer resources, including community resources to help with patients' social determinants of health and staffing resources. Moreover, reducing ED visits in a rural area is not always an option. With insufficient primary care practices, for some rural Maine residents the ED is their only option.

Contextual Factors Affecting the Ability to Spread the Model

Contextual Factors      Description

Institutional	MHACO is still trying to demonstrate the return on investment of the complex care management program, which hampers its ability to scale the program. The diversity of groups within MHACO, including hospitals, clinical groups, and both rural and urban providers, creates challenges within MHACO.
Local Market	The diverse local market context of MHACO, which includes relatively resource-rich facilities in the Portland area and more resource-strapped facilities in the rural regions challenges MHACO's ability to spread its care interventions across the entire ACO.
Regulatory	The Centers for Medicare & Medicaid Service's emphasis on ACOs transitioning to downside risk is a concern for MHACO as it is just now beginning to examine utilization in addition to quality.

## Challenges with Downside Risk

The most significant policy challenge for MHACO is the Centers for Medicare & Medicaid's effort to hasten ACOs' participation in downside risk with the changes to the MSSP in the Pathways to Success program. Even though MHACO recognizes downside risk is the way to advance the accountable care movement, the transition away from shared savings only poses challenges and concerns. The current priority clash between MHACO seeking to manage total cost of care by keeping people out of the hospital and the hospitals' need for patient volume to meet their revenue targets hampers MHACO's ability to succeed in a two-sided risk arrangement. In a downside risk arrangement, MHACO would have to focus even more on complex patients attributed to the ACO, an approach which is contrary to physician's desire to care for all patients equally. Downside risk would also bring a much sharper focus on cost and utilization, which runs the risk of sharpening existing tensions between MHACO's and the hospitals' priorities and incentives.

## Summary

MHACO includes a wide variety of providers, from southern Maine-based large hospitals and multispecialty clinics, to critical access hospitals and small primary care clinics in the state's rural regions. This diversity of providers has pushed MHACO to create several committees that help set MHACO's priorities, engage physicians in MHACO's efforts, and unify MHACO's 10 regions around a set of quality metrics and utilization goals. A complex care management program and disease-specific protocols help patients with serious illness receive more coordinated care.

## References

- <sup>1</sup> MaineHealth. About Maine Health. <https://mainehealth.org/about>. Published 2019. Accessed May 31, 2019.
- <sup>2</sup> The Johns Hopkins ACG System models and predicts an individual's health over time using existing data from medical claims, electronic medical records, and demographics like age and gender. <https://www.hopkinsacg.org/>

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