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**An Alternative ACO Model for Independent,
Community-Focused, Health Care Organizations**

Kenneth Schmidt, MPA, CEO & Chair of CCPM and President & CEO of PCHC

Bob Peterson, MBA, FACHE, Chief Executive Officer, Millinocket Regional Hospital

Audie Horn, Jr., PA-C, DFAAPA, Clinical Practice Director, Katahdin Valley Health Center



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Rationale, Development and Structure of CCPM

Kenneth Schmidt, MPA, CEO & Chair of CCPM and President & CEO of PCHC

The Future of Health Care Reimbursement – Value-Based



- CMS rapid to Value Based Payment
 - Pay for Performance
 - Triple Aim
 - Less Cost Taxpayers, Employers, Employees
- MaineCare – implementing similar
 - Accountable Communities
 - Health Homes
 - Behavioral Health Homes



- Commercial Payers
 - Quality Counts PCMH Pilot Over End of Year
 - Adopting Variations of Shared Savings
- All are pilots
 - No clear, future reimbursement structure
 - But will be based on Value, Outcomes
 - Essential pilots are ACO/shared savings plans

Maine ACO Models/Pilots



- Different models good
 - And appropriate in different circumstances
- Hospital Systems, Affiliates, Related
 - Beacon, Maine General, Maine Health, etc.
- Maine Primary Care Association
 - FQHCs and Universal American
- CCPM
 - Independent FQHCs and community hospitals

Why the CCPM ACO Model?



- Five CCPM members left other models – not a “fit”, didn’t feel “at home”
- For *independent*, non-profit, *values-based*, *community-focused* organizations
- For CHCs wanting to work closely with community hospitals, CAPs, others
- Not “top down” - equal votes/influence each member organization



- Not “top heavy”
 - Costs affordable – generally \$4pmpy
 - 100% shared savings go to members
 - Shared savings same per member – just based on attributed lives
 - All ships lift together, regardless of quality outcomes
 - Builds partnership & investment



- “Skin in” – real involvement, participation, sharing
 - Bi-monthly CEO meetings
 - Monthly various clinical leader meetings
- Choice - don't have to join every program

Membership of CCPM: *Community Health Centers*



- DFD Russell Medical Center 
- Fish River Rural Health 
- Greater Portland Health 
- Hometown Health Center 
- Katahdin Valley Health Center 
- Nasson Health Center 
- Penobscot Community Health Center 
- Pines Health Services 

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Membership of CCPM: *Community Hospitals*



- Cary Medical Center



- Millinocket Regional Hospital



- St. Joseph Health Care

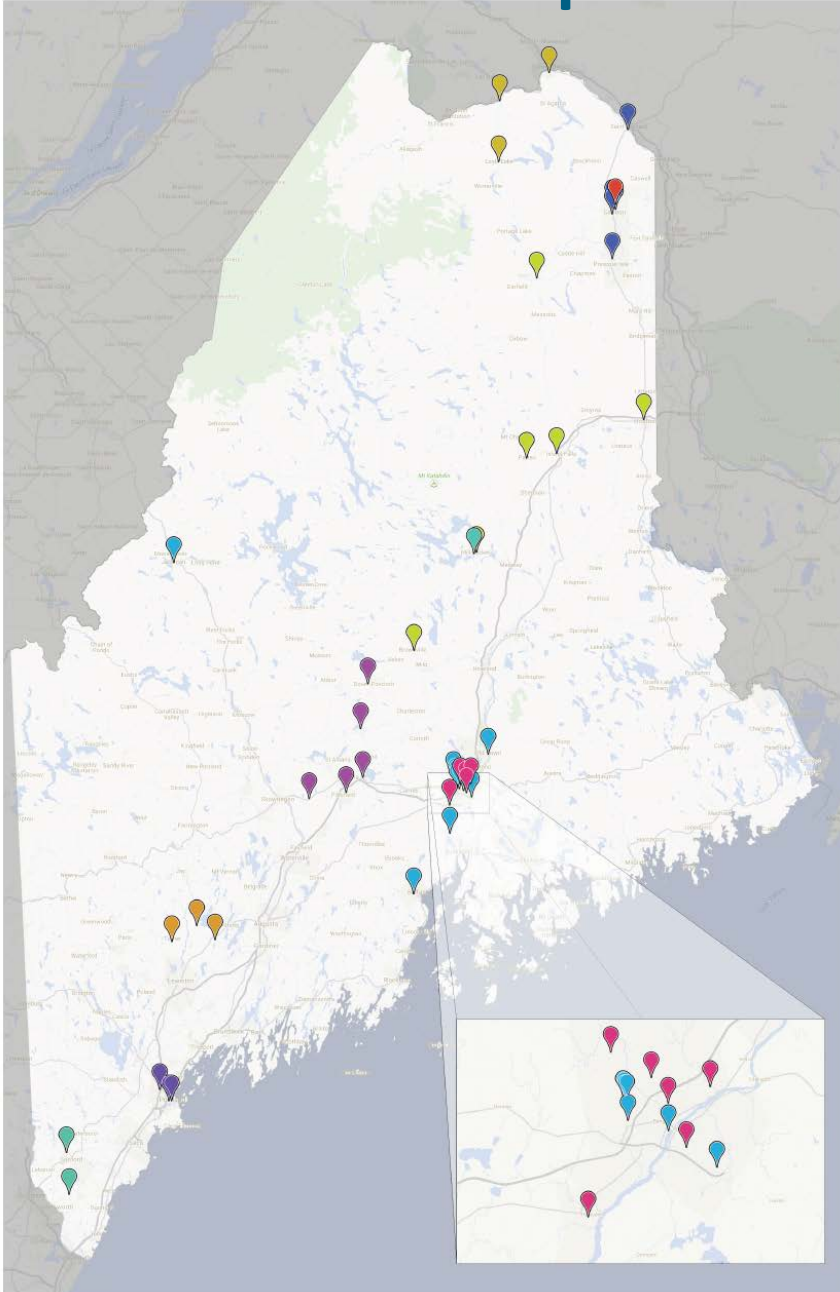


St. Joseph healthcare
St. Joseph Hospital
In the Spirit of Healing

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Membership of CCPM



- Cary Medical Center**
Caribou
- DFD Russel Medical Center**
Turner • Leeds • Monmouth
- Fish River Rural Health**
Eagle Lake • Fort Kent • Madawaska
- Greater Portland Health**
Portland • South Portland
- Hometown Health Center**
Newport • Canaan • Dexter
Dover-Foxcroft • Pittsfield
- Katahdin Valley Health Center**
Millinocket • Ashland • Houlton
Island Falls • Patten • Brownville
- Millinocket Regional Hospital**
Millinocket
- Nasson Health Care**
Springvale • North Berwick
- PCHC**
Bangor • Brewer • Old Town
Belfast • Winterport • Jackman
- Pines Health Services**
Caribou • Presque Isle • Van Buren
- St. Joseph Healthcare**
Bangor • Brewer • Hampden

Some Principles of CCPM

- Member orgs need to be ready
 - EMR, care management, PCMH, HIN
- Transparency of data, results
- Share best practices
- No risks right now – but coming, and want to be ready
- Want best health care for our patients
 - Including the most vulnerable



Current CCPM Shared Savings Plans



- **MaineCare** Accountable Coms. – 2nd year - all
- **Medicare** Shared Savings – 1st year, most
- **Cigna** Shared Savings -1st year, most of group
- **Aetna** – start early 2017 – all group
- **Harvard Pilgrim** – start early 2017 – all group
- **Medicare Advantage** – likely early 2017
- **Anthem** – 2017 first year larger group bundle

- **Total attributed lives** in 2017 – about 70,000

Corporate Structure

- LLC
- Each org, one vote
- Elected Officers:
 - Chair (Ken - PCHC)
 - Treasurer (Jim - Pines)
- CCPM Staff Officers
 - CEO – Ken
 - CMO – Dr. Negin; 2017 Dr. Kaufman (SJH) likely
 - CQO – Theresa Knowles, FNP-C (PCHC)
 - Chief Compliance Officer – Lori Dwyer, Esq. (PCHC)





- Other CCPM staff
 - HRSA 3 year grant \$200,000/year
 - 2 Performance Coaches
 - Data Analyst/Infomatics
 - Quality Staff (PCHC)
 - Risk Manager (volunteer) – Beth Dodge, SJH
 - Accounting, grants. admin support at PCHC
 - HIN grant from RWJF supports HIN staff to
 - Bring all onto bi-directional HIN
 - And HIN analytics tool
 - Bring 2 CAPs social determinants data on HIN
 - Looking for other grants to bring on more CAPs

Committee Structure

- Finance & Operations
- Quality & Clinical Integration
- Care Management
- Medication Use
- Data/IT
- Compliance



Budget

- About half million/year, including \$200,000 HRSA grant
- Contributions by member orgs
 - About \$4 per attributed life, per year
 - So if org has 3,000 patients in various shared savings programs
 - They contribute \$12,000/year



Returns on Member Contributions



- Most programs provide a PMPM (per member per month) payment
- Helps replace Maine PCMH Pilot PMPM
- Opportunities for shared savings
 - Distributed based on attributions



Questions/Comments

Kenneth Schmidt, MPA
ceo@pchc.com

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Critical Access Hospitals & the ACO Decision

Bob Peterson, MBA, FACHE, Chief Executive Officer
Millinocket Regional Hospital



The Future of Critical Access Hospitals Under the ACA

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Initial Goals of CCPM



- Cervical Cancer Screenings 70%
- Breast Cancer Screenings 80%
- Diabetes: Annual Nephropathy Screening 90%
- Diabetes: HgbA1C <9% 88%
- Diabetes: Annual Eye Exam 90%
- Persistent Asthma with Controller Med 90%
- Use of Aspirin/Antithrombotic in IVD 90%

The “Four Paths”

- Closure
- Severe Downsizing and Cost Shedding
- Merger
- Growth



Our Choice?

- GROWTH!
- “Tarnish” vs. “Burnish”
- “Green and Growing”
- “Ripe and Rotting”
- I was not hired to cut healthcare services in my community – Were You?
- Be Ready to Fight, But Be Ready to Collaborate



Critical Access Hospitals are and Always will be “Critical”

- Timely Emergency Care
- Local, Accessible Primary and Preventative Care
- Specific “Population Care”
- Economic Impact
 - As an Employer
 - As a Purchaser of Goods and Services
 - As an Indicator of Community Strength



Two-Tiered System of Healthcare



- Rural Citizens vs. Urban Citizens
- Timely Access to Critical Services
- Access to Family Support and Advocacy
- State and Federal Income Tax Rate
- Maine Hospital CEO: “Well they choose to live in the sticks.”

ACA Triple Aim

- Better Health for Populations
- Better Care for Individuals
- Lower Per Capita Costs
- More Healthy,
- For a Longer Period of Time,
- and Independent in Your Own Home.
- All Good!
- Genetics, Habits, End of Life – Still There!



The ACO Decision

- How are we going to optimize our care and pursue the Triple Aim?
- What do we have to learn?
- How are we going to learn it?
- Striking the Balance Between Proactive Care and Sick Care
- How will we be paid?



ACA Payment Changes

- The Big Payment Shift - Volume to Value
- Current Competency in New Payment Models – Zero
- Facing Decreased Payments for “Sick Care”
- Hospital Operating Margins in Maine
- Rut – Ro



Freshman Year at ACO University!

- Paradigm Shift to Value
- Use of Analytics
- Proactive Care vs. Reactive Care
- Prediction and Prevention
- Best Practice



Why Community Care Partnership of Maine?



- Partnership with FQHC's
- Primary Care Volume = Leverage with Payers
- The Opportunity to Learn and Practice
- Forced Engagement of Providers and Staff
- The Risk of Not Pursuing Learning
- Shared Savings Model vs. Risk Model

Let's Talk Risk Shall We?



- High Cost Business with Variable Volume
- High Risk Product with Variable Outcomes
- Litigious Environment
- No Movement on Tort Reform (537)
- Reimbursements that Don't Cover Costs
- Insurance Industry Controls the Data
- All Risk-Based Contracts Favor the Payer
- Repeat - All Risk-Based Contracts Favor the Payer
- All Together – All Risk-Based Contracts Favor the Payer
- Sure, Let's Take on Some More Risk!

Report Card on CCPM



- Our Partners? A+
- Our Progression Toward Better Patient Management? A
- Our Progress in the Use of Analytics? B+
- Identification of Best Practices? A
- Standardization to Best Practice? B+
- Leverage with Payers? B
- Decision to Join CCPM? A+!!



Questions and Comments?

Bob Peterson, MBA, FACHE
rbpeterson@mrhme.org

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Benefits of Membership for Rural Health Centers

Audie Horn, Jr., PA-C, DFAAPA, Clinical Practice Director
Katahdin Valley Health Center

KVHC Service Area



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- Support
- Networking

Support

Having the expertise of multiple individuals and organizations at your fingertips. This means that you do not have to constantly “reinvent the wheel.” Rather we can draw from each other and things which have been developed by other organizations.



Networking

One of the biggest problems we face in rural health is the tendency to become insular. Having the ability to interact with peers from a number of organizations keeps us fresh and thinking about how we do things.



How has this influenced Katahdin Valley Health Center



We are now tracking, and reporting, on a number of goals. This forces us, as an organization to take a hard look at where we are versus where we want to be. The result of this is clear focus on areas that can improve our patient care and consequently improve the lives of our patients.

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Supplemental Goals of CCPM



- ER Utilization <165/1000
- BP Control >80%
- Increased Patient Access >80%

How Has KVHC been Impacted by CCPM Involvement



- Our providers, and administration, have become more focused on the measures that we are tracking.
- Consequently we have seen significant improvement in those areas.
- This has resulted in KVHC receiving a recent grant. KVHC exceeded the State in all sixteen quality measures and exceeded Federal levels on 15 of 16 measures.

Summary

- Membership in an ACO, such as CCPM, holds a number of benefits to a rural organization such as KVHC.
- The ability to work with, and learn from, our partners is invaluable.
- The focus on important health care measures results in improved care and quality of life for our patients as well as improved job satisfaction for our providers.





Questions/Comments

Audie Horn, Jr., PA-C, DFAAPA
audie.horn@kvhc.org

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