

As Maine Goes, So Does the Conversation On How to Form an ACO

The letters “ACO” still make up an acronym foreign to most of the country.

But in Maine, health leaders are beginning to unscramble the letters so medical providers and those picking up the tab for medical costs can navigate the still new accountable care organization (ACO) model.

An ACO is an umbrella entity that links doctors, hospitals and other medical care providers to improve quality and rein in costs, contracting with a health insurer, employer or government payer like Medicare to take care of a population of patients. The ACO concept can be daunting because it’s still a phenomenon with a track record of generally less than three years.

So the [Maine Health Management Coalition](#) has developed a new role to help the insurer or employer on one side, and the providers of medical care on the other, agree on cost, quality, and transparency metrics, and to track the results.

“We are playing the adjudicator role,” said Andrew Webber, president and chief executive officer of the Maine Health Management Coalition, which includes some of the state’s largest employers like Bath Iron Works; hospitals and physician practices like those that are part of Eastern Maine Healthcare System; and payers like Aetna, Cigna and Anthem Blue Cross and Blue Shield. “We can be built into the negotiations if the contracting entities are interested in an objective third party.”

To make an ACO work, the Maine Health Management Coalition said providers and purchasers want a trusted source to track the performance measures and quality metrics to be achieved as part of the ACO contract. Over its two-decade history, the Maine Health Management Coalition has developed provider performance reports using cost and quality information primarily gleaned from insurance claims data.

“If you are going to be held accountable, then you better understand and have the capacity to influence the cost and quality performance metrics established in ACO contracts,” Webber says. “By combining cost and quality we can start to have a whole new conversation about total value.”

The Maine Health Management Coalition is now working to assist employers, commercial insurers, and others achieve similar successes with their ACOs, including strategic approaches to ACO contracting.



Andrew Webber, CEO



“Ultimately providers are being asked to take on more financial risk but, in the beginning, you may want to put more of the risk on the purchaser to allow providers to invest in the needed infrastructure for population health management,” Webber said.

To be sure, providers in the ACO may need additional capital to hire care coordinators like nurses or social workers to do more outreach to patients, making sure they are on their medications, getting to their doctor’s appointments or seeing a social worker to assist in the management of chronic conditions. “It’s going to take some time to move the battleship,” Webber said. “Building the capacity to effectively manage defined populations to total cost and population health improvement goals will take time and requires incremental steps, particularly if your legacy has been as a hospital-based system. But I believe in the long-term there is going to be a payoff and employers and other payers need to understand it’s worth investing in but it’s not going to happen over night.”

Early adopters of ACOs in Maine are seeing benefits that should benefit purchasers in the long run. Webber agreed that it’s clear that the ACO as an entity to improve quality and reduce costs is no passing fad. The U.S. Department of Health and Human Services said in January of 2015 it will shift 50 percent of Medicare payments to value-based models such as bundled payments, patient-centered-medical homes and ACOs by 2018. And since ACOs tend to need 5,000 or more patients to achieve their goals, most industry analysts see such organizations as being linked to the most patients across the country.

Commercial health plans are also escalating their contracts with ACOs. UnitedHealthcare, the nation’s largest private insurer, said in February of 2015 that it would increase by 50 percent its contracts with ACOs.

“It’s going to be the future, at least here in Maine,” Webber said of ACOs and the move to value-based care.

How’d They Begin the Conversation in Maine?

The cooperation among doctors, hospitals and insurance companies through the Maine Health Management Coalition is unique when compared to other health collaborative organizations in that it is led by purchasers of health care services including employers, unions and government agencies. Other areas of the country include more dominant roles by doctors, hospitals and large provider-led health care systems in their health collaboratives.

“We are different,” says Webber, who was president and CEO of the National Business Coalition on Health, a large employer coalition before heading up Maine Health Management Coalition two years ago. “We are more on the demand side of reform attempting to measure, report, and reward value in health care.”

In large part because of a state law requiring health insurance companies to contribute insurance claims information through an all payer claims database (APCD), Maine Health Management Coalition has data from all payers including Medicare, Medicaid and commercial insurers such as Anthem Blue Cross, Aetna and Cigna.

At Maine Health Management Coalition, the claims data is used to measure quality and cost information tied to medical care providers. Physician practices know what the total cost of care is on an annualized basis for their attributed patient populations.

A practice will not only know what their average costs are for primary patient care but the data also looks at the downstream costs and resources all providers are using, so practices can work together to provide health care more efficiently. A group of diabetic patients in a practice might experience more hospitalizations, for example, suggesting more medical attention could be needed in an ambulatory setting.

“The measure used attributes a certain population to a doctor’s practice,” Webber said. “We can then tease out whether the total costs are driven more by unit pricing or by resource use. We can track total cost and resource use and then permit individual practices and practice groups to benchmark their performance against other providers in the state.”

Why It Works in Maine and What Are the Hurdles To Doing More

Tying costs and utilization of patient health care services to doctor practices isn’t a perfect science in Maine to achieve all of their goals.

Because most of the data in Maine Health Management Coalition’s practice reports come from claims data, some doctors and hospitals are concerned about disclosing cost information without better clinically based quality metrics as a needed complement.

“Quality metrics are still evolving,” Webber said.

Webber acknowledges that clinical data from the providers and more outcomes based information like patient experience surveys represent a long-term challenge because of the combination of political sensitivities and cost barriers.

Patient experience surveys can involve expensive ongoing market research, polling and questioning of patients through a lengthy list of questions. It also takes time to survey the patients and get a meaningful participation rate.

“Patient experience surveys are great but they present an ongoing issue for regional collaboratives like ours,” Webber says. “How can they be sustainable? Are all of the providers and payers willing to chip in? And consumers assume such patient experience data will be free, which presents a problem.

“Getting to more clinically and outcome based quality metrics is a big issue in terms of the future of transparency,” Webber says. “As long as we have scientifically valid performance measures understood by, and shared first with the provider community before going public, I think we are fine. Within this multi-stakeholder process, we will always look for ways to make provider performance metrics better, more transparent, and for the active use by providers, purchasers, and consumers in improving and choosing care.”