

Mission Health Care Network

April 2017



WHAT IS MISSION HEALTH CARE NETWORK?

Mission Health Care Network is a Clinically Integrated Network including groups of doctors, the hospital and other health care providers that have agreed to work together to treat an individual patient across care settings – including doctor's offices, hospitals, and long-term care facilities.

The goal of **Mission Health Care Network** is to help patients live their best life - through education and collaboration between the patient and their health care team. Accountable Care Organizations such as Mission Health Care Network promotes seamless, coordinated care that:

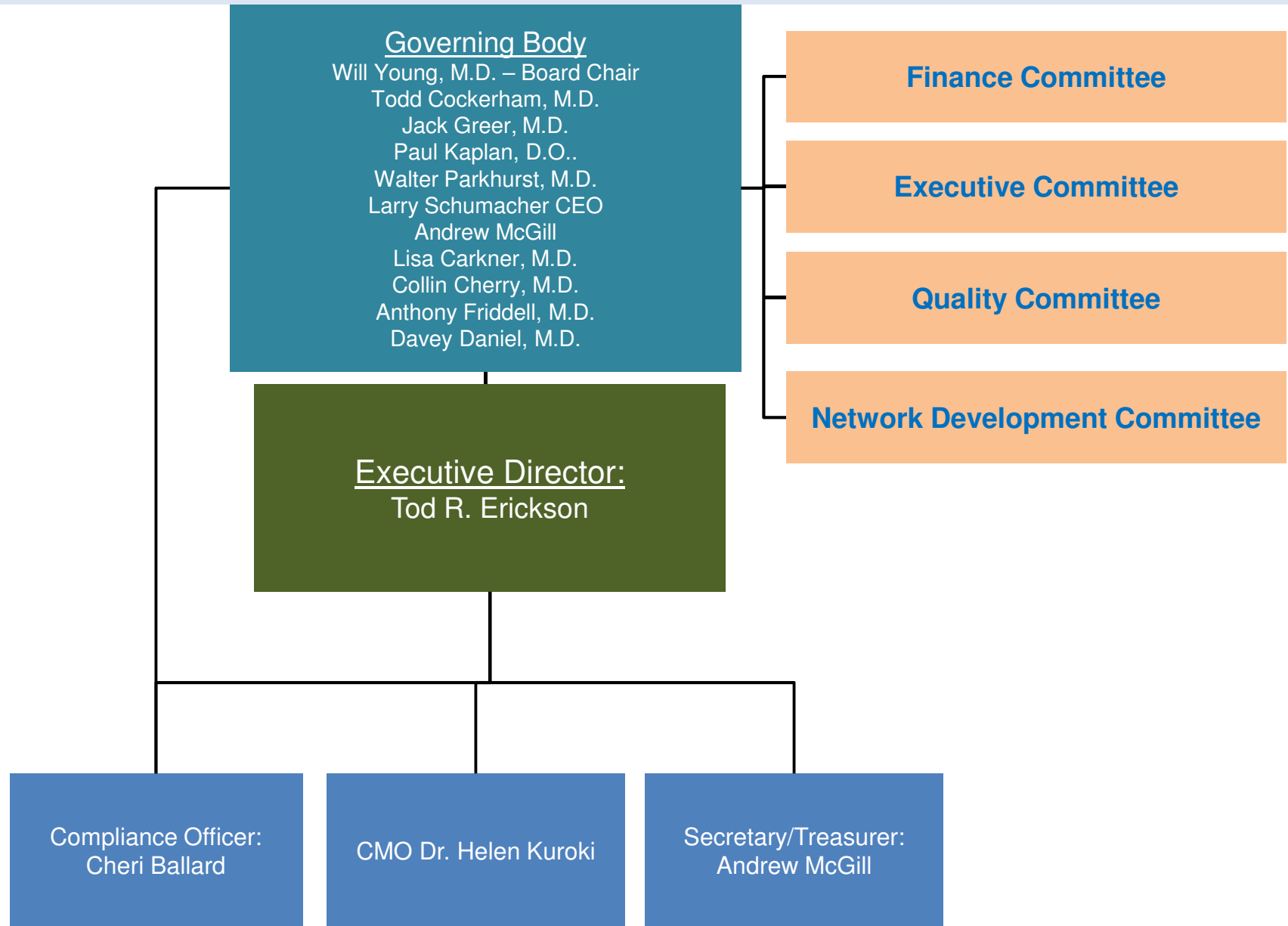
- Puts the **patient and family at the center** of all its activities
- **Remembers patients** over time and place
- Attends carefully to **care transitions**
- **Manages resources** carefully and respectfully
- **Proactively reaches out to patients** with reminders and advice
- **Evaluates data** to improve care and patient outcomes
- Innovates around **better health, better care** and lower growth in expenditures through improvement
- Invests in **team-based care** and workforce

Accountable Care Organizations that lower growth in health care costs while meeting performance standards on quality of care and putting patients first are being rewarded for doing so by Medicare and other health plans.

**CLINICALLY INTEGRATED NETWORK:
*MISSION HEALTH CARE NETWORK***



MHCN Organizational Chart



MHCN Leadership Team

Executive Director

Tod Erickson



Data/Quality Metrics

Carol Newton

Dan Whitlock

Integrated Care Director

Lisa Ellis, RN MSN

Outpatient Care Manager

Sandy Loveless ,RN BSN

INITIAL POPULATIONS



MHCN POPULATIONS

- Initial populations for Mission Health Care Network (beginning January 1, 2015):
 - Memorial Associates and Dependents
 - MSSP
- Other populations could be added at a later date as those conversations progress

Population	Attribution	Start Date	Clinically Integrated Network ("CIN") Revenue
Memorial Associates and Dependents	6,633	January 1, 2015	Incentive Payments
Medicare Shared Savings Program ("MSSP")	28,650	January 1, 2015	Shared Savings




THE LANDSCAPE FOR THE CHATTANOOGA MSA – MEDICARE BENEFICIARIES



74,145 - Total Medicare beneficiaries in Chattanooga metropolitan service area ¹

23,686 - Enrolled in a Medicare Advantage Program (31.9 percent total Medicare)

50,459 - Traditional Medicare fee-for-service (“FFS”), non-MHCN (68.1 percent total Medicare)

 = 5,000 Medicare Beneficiaries


¹ Chattanooga MSA is comprised of the following counties: TN – Hamilton, Marion, Sequatchie, Bradley; GA – Catoosa, Dade and Walker

MISSION HEALTH CARE NETWORK – MEDICARE BENEFICIARIES



28,000 - Traditional Medicare **FFS, Mission Health Care Network (“MHCN”)** (55.5 percent traditional FFS)

22,459 - Traditional Medicare **FFS, non-MHCN** (44.5 percent traditional FFS)

 = 5,000 Medicare Beneficiaries

¹ Chattanooga MSA is comprised of the following counties: TN – Hamilton, Marion, Sequatchie, Bradley; GA – Catoosa, Dade and Walker

MEDICARE SHARED SAVINGS:

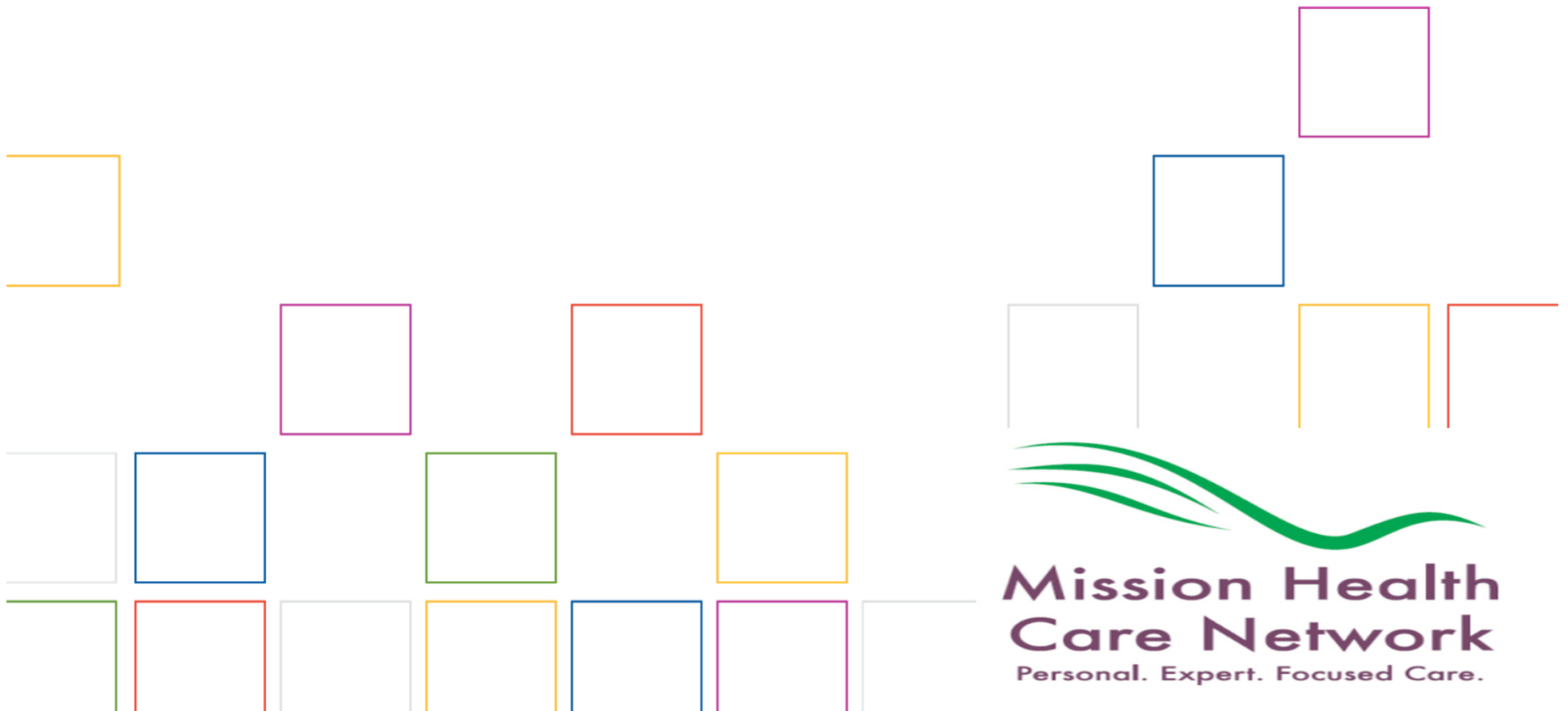
MSSP **is**:

- A popular program for a shared savings arrangement with Medicare Fee-for-service beneficiaries
- Shown to be beneficial for patients by focusing on clinical quality improvement and care coordination
- A "no-risk" opportunity to perform under a shared savings arrangement for an existing population

MSSP **is NOT**:

- A new insurance product
- A method for CMS to reduce or alter FFS arrangements with providers
- Forcing physicians to accept Medicare patients, even if they have a signed participant agreement with a CIN participating in the program

Mission Health Care Network: *Care Management*



CARE MANAGEMENT TEAM

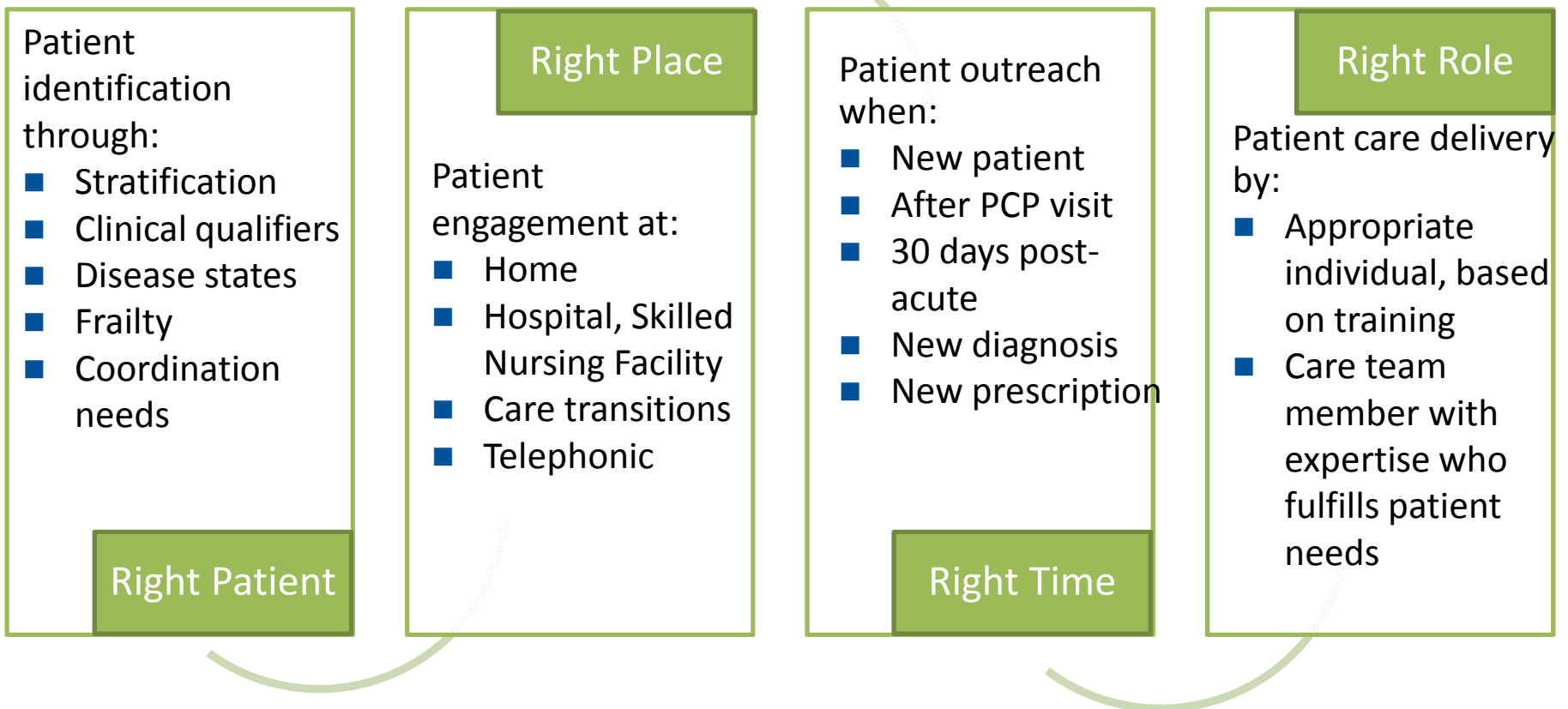
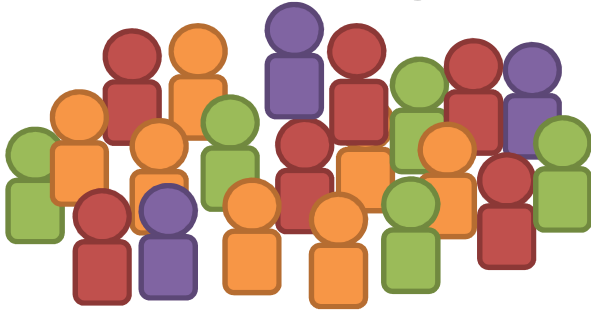
Team Composition:

- Ambulatory care management team develops personal relationships with enrolled patients and work closely with physicians to help identify gaps in patient care, coordinate providers and services, facilitate communication especially during transitions, and help educate patients and providers.
 - *RN Population Health Coach (1: 5,000)*
 - *Population Care Coordinator (1: 3,000)*
 - *Care Management Associate*
- RN Population Health Coach follow up through telephone calls and in-person interactions during physician office visits. They communicate with existing transition of care programs where available .

COMPREHENSIVE CARE COORDINATION GUIDING PRINCIPLES

- The Care Coordination Model encompasses a number of programs that address both episodic and longitudinal care management needs, and all programs adhere to a set of guiding principles.
- Uses a collaborative, interdisciplinary **team** approach.
- Address needs across the entire continuum of care with **special attention to coordination between episodic and longitudinal programs** and providers as well as to the **transitions** between care settings, providers, and care or case managers.
- Utilize evidence-based **Health Risk Assessment Tools and Risk Stratification** models to identify people who will benefit from care coordination and to allocate staff and other resources. While care management services will be available to all patients or members, individuals and populations will be prioritized based on risk assessment.
- Prioritize **patient empowerment** and support for self-care.

HOW WE WILL BE SUCCESSFUL: CARE MANAGEMENT AT MHCN

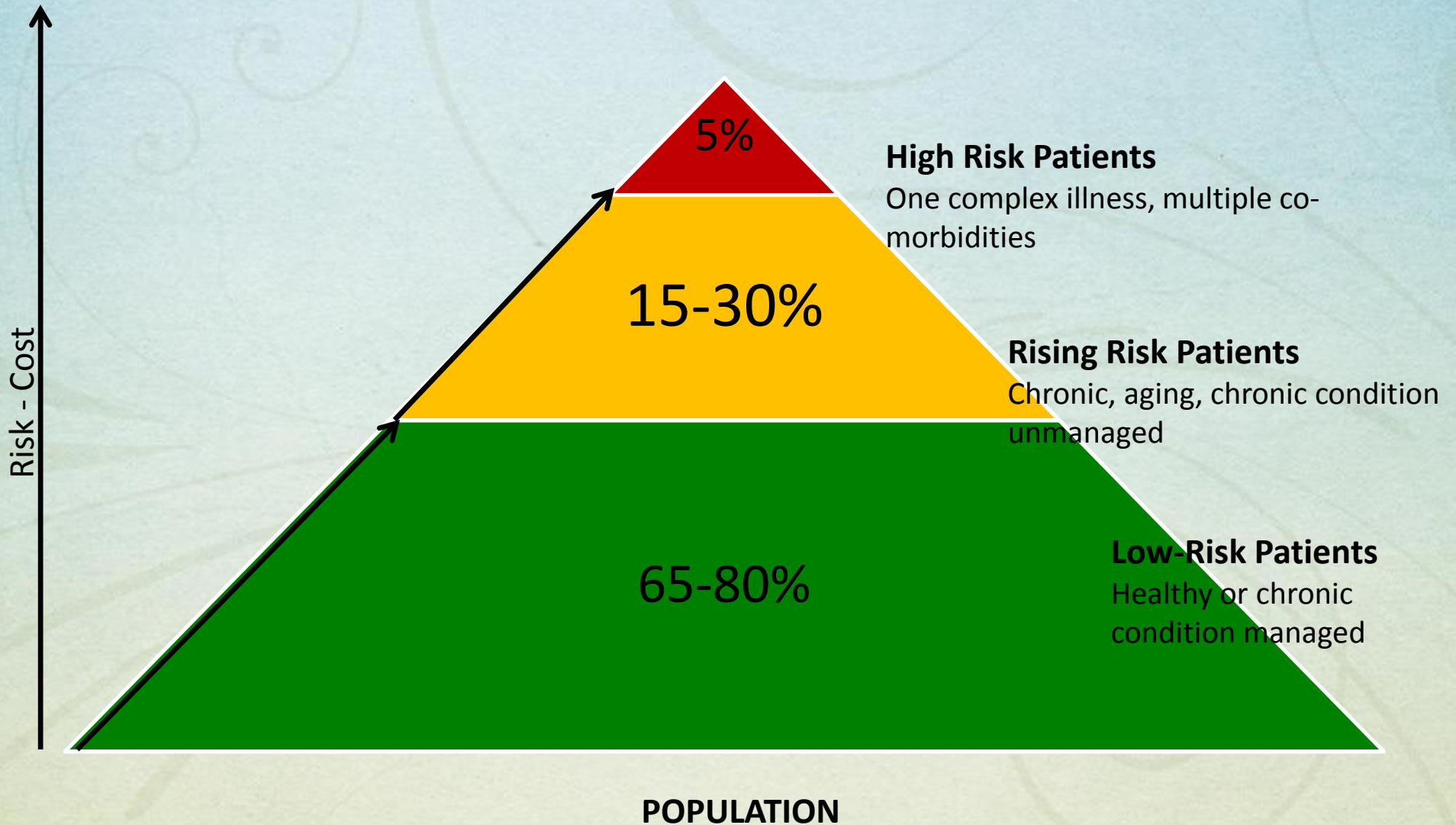


PATIENT IDENTIFICATION

Members prioritized based on risk and opportunity for care management:

- Predictive modeling, which identifies opportunities through monitoring of claims and involves analysis of numerous factors (McKesson Risk Manager).
- Multiple admissions, readmissions, and emergency department visits
- Identification and referral by physician

POPULATION MANAGEMENT: RISK CATEGORIZATION



PARTICIPATING PRACTICES

- CHI Memorial Practices: (24) Embedded and Onsite
- Chattanooga Family Practice: Onsite but telephonic
- Beacon: (telephonic)
- Galen:(telephonic)
- Specialist may give referrals
- Corporate Health

REMOVE SILOS OF CARE

- Integrated Care Management Focus
- Collaboration with inpatient (LACE)
- Manage Transitions of Care
- Strong hand off communication with other navigation programs(HF bundle)
- Streamline inpatient and outpatient educational tools
- Analytic tools for claims data review

TWO KEY ELEMENTS

- RN and MSW coach all patients with motivational interviewing style to improve patient engagement and self empowerment.
- RN and MSW huddle with clinical staff with issues that need provider input.

Medicare Shared Savings Program: *Quality Reporting*



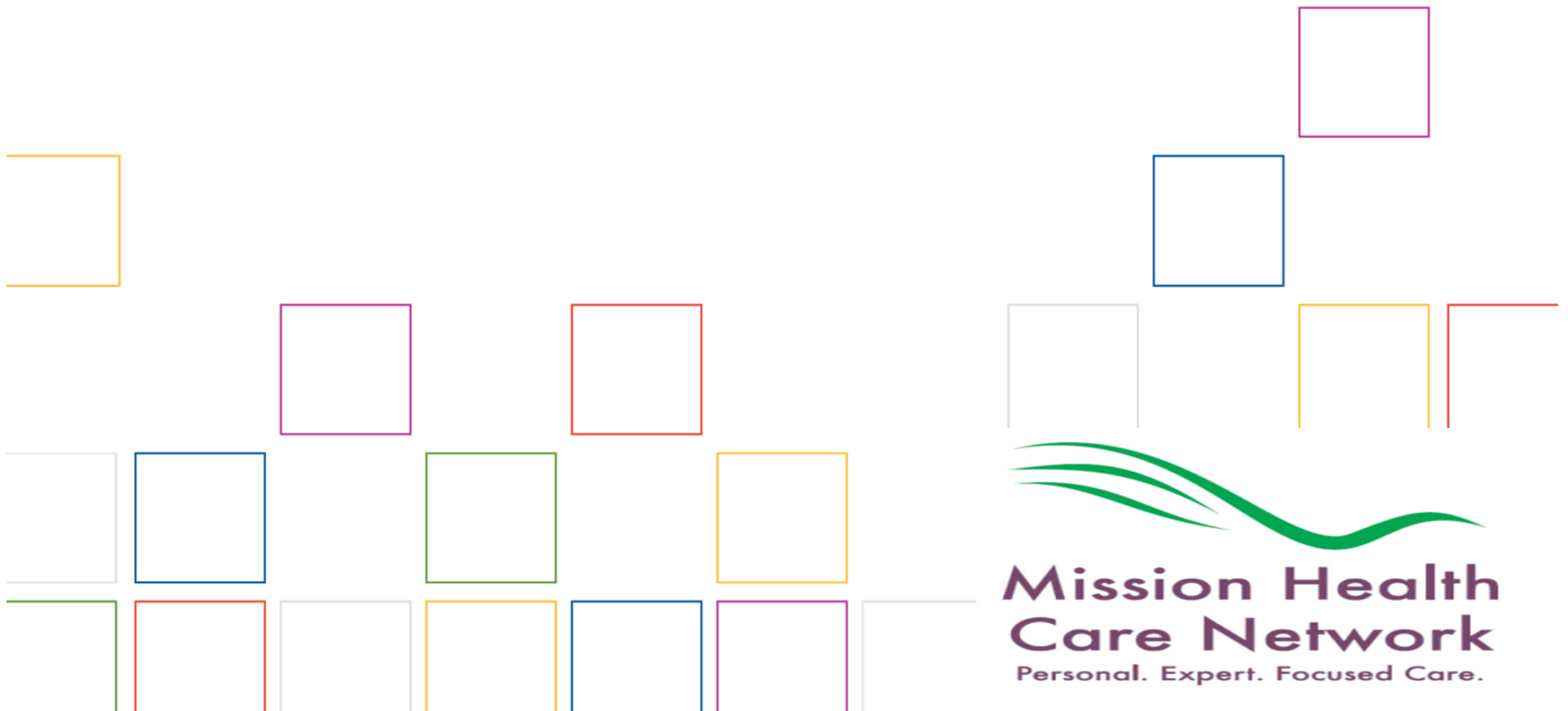
QUALITY PERFORMANCE SCORING

- First performance year: ACO eligible for maximum sharing rate if ACO generates sufficient savings and successfully reports the required quality measures
- Subsequent years: ACO must successfully report quality measures and will be assessed on performance
- **Pay-for-Performance (“P4P”) phasing:**
 - **Year 1: Pay-for-reporting applies to all 33 measures (2015)**
 - **Year 2: P4P applies to 25 measures. Pay-for-reporting applies to 8 measures(2016)**
 - **Year 3: P4P applies to 32 measures. Pay-for-reporting applies to one measure that is a survey measure of functional status (2017)**
- CMS will establish and release national benchmarks for ACO quality measures at the start of the second performance year
- For P4P measures, the minimum attainment level will be set at a national 30 percent of the performance benchmark
 - Performance equal to or greater than the minimum attainment level for a measure will receive points on a sliding scale
 - Performance at or above 90 percent of the performance benchmark will earn the maximum points available for the measure
- CMS will add the points within domains and divide by the total points available for each of the four domains
- Domains will be weighted equally and scores averaged to determine the ACO’s overall quality performance score and sharing rate

QUALITY MEASURES

- Prior to participation in shared savings, an ACO must demonstrate that it met the quality performance standards for that year
- 33 total quality measures in 4 domains:
 - Patient/Caregiver experience (8 measures)
 - Care coordination/Patient safety (10 measures)
 - Preventive health (8 measures)
 - At-risk population:
 - Diabetes (2 measures)
 - Hypertension (1 measure)
 - Ischemic Vascular Disease (1 measure)
 - Heart Failure (1 measure)
 - Coronary Artery Disease (1 measure)
 - Depression (1 measure)
- Quality measures align with PQRS and EHR incentive programs

Medicare Shared Savings Program: *Information Management*



INFORMATION MANAGEMENT

- One of the benefits to MHCN of participating in MSSP is the opportunity to receive and learn from patient data received by CMS to assist us in providing services consistent with the goals of improved individual health, improved population health and lower costs.
 - **CMS will provide aggregated data on beneficiary use** of health care within our defined population at the start of the agreement period, quarterly and yearly
 - **CMS will also provide MHCN with a list of beneficiary names**, DOB, sex and HICN derived from the beneficiaries whose data was used to generate the preliminary prospective aggregate reports and in conjunction with each quarter aggregate report.
 - **MHCN will be able to formally request beneficiary identifiable claims data** on a monthly basis from those beneficiaries:
 - **Who received a primary care service from a primary care physician participating in MHCN and**
 - **Who have had the opportunity to decline such data sharing**
- MHCN has also invested in population health management tools to assist in developing data to assist us in our care management and reporting. **MCHN providers will be expected to assist in developing population health data by:**
 - **Providing patient demographic information for assigned beneficiaries** to assist MHCN in the beneficiary notification process
 - **Providing clinical data** for population health management tools through interface of EHR or other methods.

DATA SHARING - BENEFICIARY NOTIFICATION

- **MHCN Providers are required to notify the beneficiary** that they are participating in the Medicare Shared Savings Program and provide information about the program such as:
 - We are participating in MHCN to **better coordinate health care**
 - By **helping our doctors communicate more closely with other providers**, MHCN can deliver high-quality, more coordinated care that meets the patients needs and preferences
 - The **patients Medicare benefits do not change** (ACO's are not a Medicare Advantage Plan, HMO plan or insurance plan of any kind).
 - To help us give the right care, in the right place, at the right time, **Medicare plans to start sharing information with us about the patients care** – such as dates and times the patient visited a doctor or hospital, the patients medical conditions, and a list of past and current prescriptions.



DATA SHARING - BENEFICIARY NOTIFICATION

- MHCN will provide the notification to beneficiaries in **three** ways:
 - All MHCN participants will display a poster in their office
 - Beginning January 1, 2015
 - All M HCN participants must make available the Notice to Patients letter and the Decline to Share Personal Health Information form in practices in which Medicare Fee-for-Service beneficiaries receive primary care services.
 - Provided to Medicare Fee-For-Service patients beginning January 1, 2015
 - MHCN will mail the Notice to Patients letter and Decline to Share Personal Health Information form
 - Early/mid January 2015
 - Not required effective Jan 2016



DATA SHARING – OPTING OUT

- Beneficiaries will be given the opportunity to decline data sharing as part of the notification requirements
 - The patient can ask Medicare not to share their medical information with MHCN for care coordination and quality improvement by:
 - Calling 1-800-MEDICARE
 - Completing and signing the “Declining to Share Personal Health Information” form in the doctors office
 - Completing, signing and returning the “Declining to Share Personal Health Information” form that is mailed to them by MHCN.
- The options for patients to opt-out of having claims information shared, does not affect their participation in the ACO or CMS’ use of the patients data to assess quality or cost measure





***HOW TO GET STARTED WITH
CARE MANAGEMENT?***