McLaren High Performance Network
New Participant Onboarding

Kim Hamm, VP Clinical Operations
Dawn Smith, Program Manager

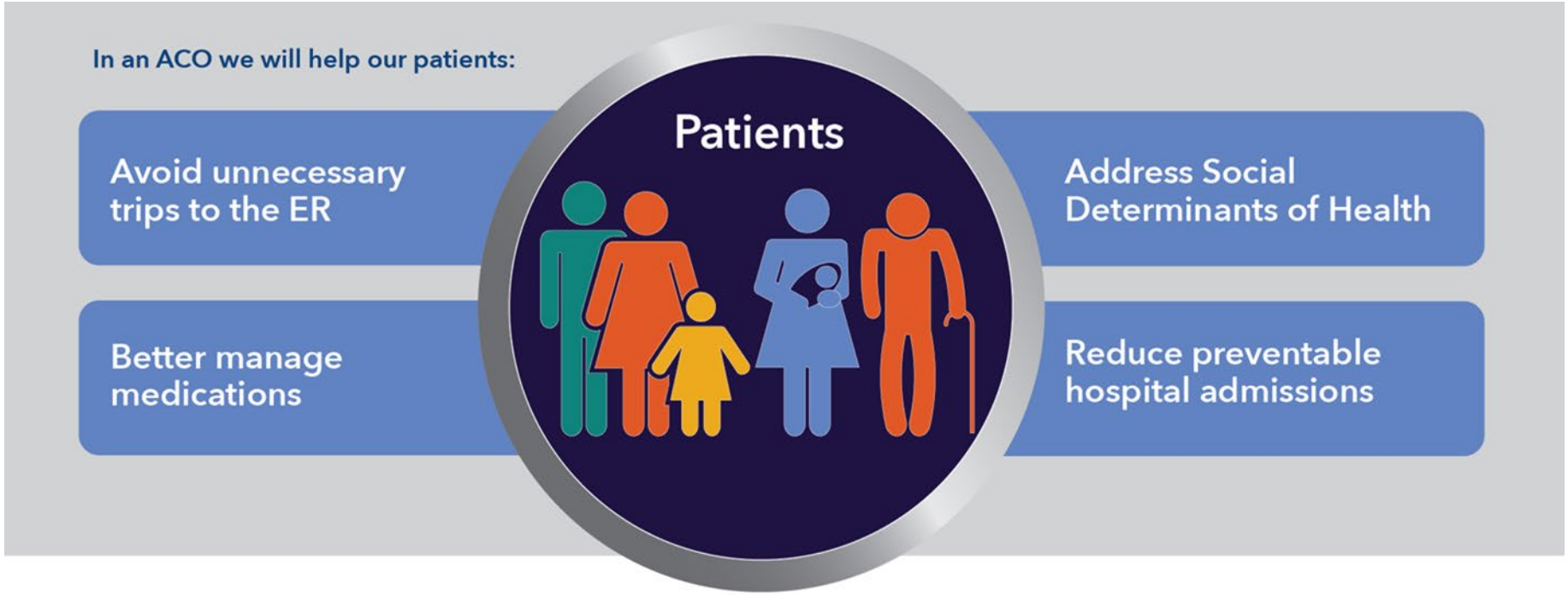
McLaren

Accountable Care Organization

McLaren High Performance Network, LLC

What is an ACO?

Accountable Care Organizations, (ACOs) are groups of hospitals, providers and community partners who come together to improve patient outcomes and reduce health care costs by delivering highly coordinated care.



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Definitions

- Participant – participates at the Tax ID (TIN) level
- Provider/Supplier – may be physicians, APPs, and other provider types
- Beneficiary – this program includes Traditional Medicare Fee for Service patients only, not Medicare Advantage
- Attributed Beneficiary – assigned to the provider based on the plurality of primary care services rendered to a beneficiary.

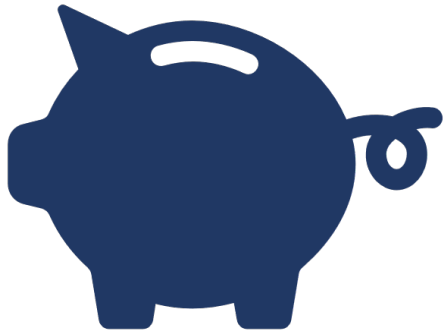
Keys to Success in Value-Based Care

Quality Improvement

Better outcomes and improved patient satisfaction drive stronger patient engagement and cost-efficient outcomes

Care Coordination

Coordinating care to manage chronic disease in populations and improve health outcomes



Cost and Utilization

Eliminating unnecessary care and reducing total costs results in shared savings for patients, employers, health plans, and providers

Coding

Coding to the highest specificity provides accurate reflection of the complexity of a patient's health conditions, allowing for appropriate allocation of healthcare resources and ensuring fair reimbursement for providers treating patients with complex medical needs

Quality Metrics

ACOs are scored on the following quality metrics on an annual basis:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience survey
- Hospital-Wide, 30-day, All-cause Unplanned Readmission Rate
- Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions
- Hemoglobin A1c (HbA1c) control
- Preventive Care and Screening: Screening for Depression and Follow-up Plan
- Controlling High Blood Pressure
- Falls: Screening for Future Fall Risk
- Preventive Care and Screening: Influenza Immunization
- Preventive Care and Screening: Tobacco Use: Screening and Cessation
- Colorectal Cancer Screening
- Breast Cancer Screening
- Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
- Depression Remission at Twelve Months

Optimizing Quality Performance

- Utilize MPP Top Ten Quality Metric Resource Guide
  - Provided to you
- CPTII Coding, where applicable
  - Quick Orders in Cerner, website resources
- Integration of your EMR with Persivia, Population Health Tool
  - Provides gaps in care

Risk Optimization

Optimal reflection of a population's care needs by capturing more complete diagnosis, resulting in higher and more appropriate reimbursement and improved care delivery for complex patients

- Use Medicare Annual Wellness Visits (AWV) to close quality and risk gaps
  - Patient lists provided to you quarterly
- HCC Coding to highest specificity (Average HCC target is 1.0 or higher)
  - HCC coding references by specialty available on MPP Website – Physician Resources
- Review the number of codes able to be billed in your EHR on a single encounter. Will want to allow at least 12 codes per claim.
  - Some EHRs limit the number of codes that can be included on a claim

Managing Costs

- McLaren Network Utilization
  - Use of in-network providers and facilities
- Access to Clinical Decision Maker 24/7
  - After hours contact for patients to reduce visits to Urgent Care/ED
- High Value Care
  - Non-duplication of services
  - Right place, right time, right service

Downside Risk is here to stay

- Medicare, Medicaid and Commercial Payors (Employers) are requiring (Value-Based) Upside and Downside Gain sharing contracts where providers are at risk for the cost and quality of care provided to patients.
- CMS – 100% of those with Original Medicare will be in a care relationship with accountability for quality and total cost of care by 2030.

Downside Risk

- Downside risk is the financial risk associated with losses.
  - In a downside risk model, providers must refund the payer for the incurred losses if they exceed financial benchmarks.
- What does it mean for providers?
  - Low performers placed on improvement plans
  - Potential removal from contract
- McLaren is at risk for financial performance of all providers as a **group**
  - Providers are not at individual financial risk at this time

Downside Risk- What do I need to do?

Physicians are required to participate in:

- MPP Care Coordination programs including managing patient transitions among care settings to home
- Utilization of evidence-based guidelines to deliver the most effective care in the most appropriate setting

Downside Risk – Best Practices

- Physician Engagement/Education
  - Watch videos on website
- Optimize Coding
  - HCC
  - CPT II Codes
- Persivia Physician Access
- Utilize in-network providers and facilities

How Care Coordination Impacts Quality & Cost

Chronic Care Management (CCM) - encompasses a variety of services to support disease management and improve outcomes while reducing avoidable cost; while patients are enrolled in CCM, our team focuses on:

Screening Compliance

Colorectal

Mammogram

Fall Risk

Depression

Immunizations (Flu/Pneumonia)

Diabetic Management Measures

HgbA1C testing

Eye Exams

Reduce Utilization

ED Visits

Hospitalization/Readmissions

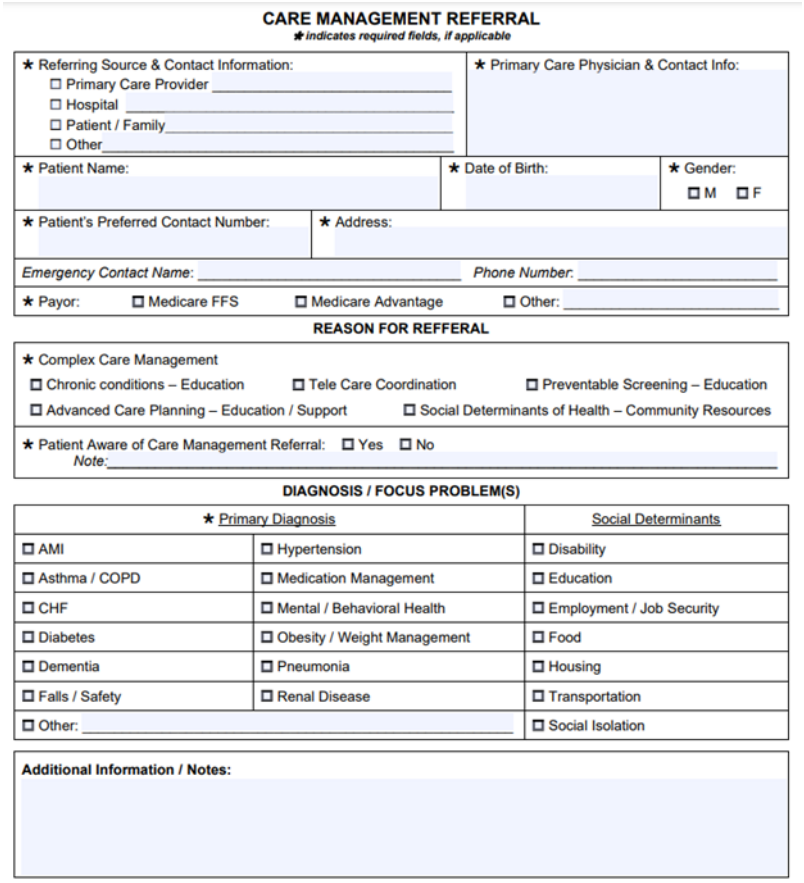
Care Coordination Referrals

McLaren Physician Partners Accepts Referrals from our Members

Ideal referrals include:

- Patients with educational needs
- Patients newly diagnosed with a chronic condition
- Patients who would benefit from Disease Management
- Patients needing assistance with Coordinating Care
- Patients in need of Community Resources/Social Determinant Concerns

To refer, add an electronic referral in Cerner or go to: https://www.mclaren.org/mclaren-physician-partners/care-management-referrals



CARE MANAGEMENT REFERRAL

★ *indicates required fields, if applicable*

★ Referring Source & Contact Information:
☐ Primary Care Provider _____
☐ Hospital _____
☐ Patient / Family _____
☐ Other _____

★ Primary Care Physician & Contact Info:

★ Patient Name:

★ Date of Birth:

★ Gender: ☐ M ☐ F

★ Patient's Preferred Contact Number:

★ Address:

Emergency Contact Name: _____ *Phone Number:* _____

★ Payor: ☐ Medicare FFS ☐ Medicare Advantage ☐ Other: _____

REASON FOR REFFERAL

★ Complex Care Management
☐ Chronic conditions – Education ☐ Tele Care Coordination ☐ Preventable Screening – Education
☐ Advanced Care Planning – Education / Support ☐ Social Determinants of Health – Community Resources

★ Patient Aware of Care Management Referral: ☐ Yes ☐ No
Note: _____

DIAGNOSIS / FOCUS PROBLEM(S)

★ Primary Diagnosis		Social Determinants
☐ AMI	☐ Hypertension	☐ Disability
☐ Asthma / COPD	☐ Medication Management	☐ Education
☐ CHF	☐ Mental / Behavioral Health	☐ Employment / Job Security
☐ Diabetes	☐ Obesity / Weight Management	☐ Food
☐ Dementia	☐ Pneumonia	☐ Housing
☐ Falls / Safety	☐ Renal Disease	☐ Transportation
☐ Other: _____		☐ Social Isolation

Additional Information / Notes:

Reports

- Below is an example of a report you will receive monthly from the Quality department

Physician Performance Analysis

Physician Comparison | November-22 thru October-23

Region 3 - Flint

Physician Name	Specialty	PCP Emp/Ind Indicator	Total Beneficiaries	Avg. HCC Score	PBPY (Risk Adjusted)	ED Visits / 1k (Risk Adjusted)	CT Scan Events per 1,000 (Risk Adjusted)	Leakage	AWV	TOC
	INTERNAL MEDICINE	Independent	255	1.08	$9,301	441	522	62.5%	69.8%	58.6%
	INTERNAL MEDICINE	Employed	241	0.93	$12,081	660	768	35.8%	27.8%	72.7%
	FAMILY MEDICINE	Employed	192	0.88	$11,606	652	743	49.0%	32.8%	69.2%
	FAMILY MEDICINE	Employed	182	0.87	$11,237	475	526	32.9%	37.4%	60.0%
	INTERNAL MEDICINE	Employed	173	1.00	$11,724	572	659	43.0%	41.0%	48.6%

- Beneficiaries – Medicare Fee for Service (non-Medicare Advantage) beneficiaries attributed based on plurality of care
- HCC Score – Hierarchical Condition Category – sum of the score or weight attributed to each of the demographic factors and HCCs within the model, normalized to 1.0
- PBPY – Average Cost Per Beneficiary Per Year
- Leakage – Claims processed for services outside of the McLaren Network
- AWV- Completion rate of eligible Annual Wellness Visits
- TOC – Patients seen by PCP within 7-14 days of an inpatient stay

Questions?

Please contact:

Dawn Smith

Program Manager

Compliance Officer

dawn.smith@mclaren.org

248-484-4942