Building a Statewide ACO and Structure for Population Health

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Outline

• Mercy ACO background
• Organizational Structure and Governance
• Management Structure
• Population health services
• IT & Data Strategy
• Physician engagement
• Rural healthcare and Mercy ACO
• View from the Chapter
• Contracting
Mercy ACO Background
• Founded in 2012 by CHI-Iowa Corp.

• History of Population Health Success

• Independent & Specialty Groups
  – 130+ Participant Organizations
  – 1,700+ Providers Value Based

• Contracts
  – 133,000+ Covered Lives
  – 23,500+ Rural Lives

• Mercy Health Network Foundation
  – 5 ACO Chapters
  – 54 of 99 Iowa Counties

Medicare Shared Savings Program
Commercial Shared Savings
Direct to Employer
Medicaid
Medicare Advantage

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Mercy Health Network – Created by CHI and Trinity in 1998

- Joint Operating Agreement
- Stated Purpose: Strengthen Catholic Health Care in Iowa
- 13 owned hospitals:
  - 7 urban; 6 rural
- 26 affiliated hospitals
- 181 physician clinics
- 793 employed physicians
- $2+ billion in total annual operating revenues
- 14,500 employees

Des Moines Market (4)  Sioux City Market (4)  North Iowa Market (2)  Clinton Market (1)  Dubuque Market (2)
Catholic Health Initiatives

- Headquarters in Englewood, Colo.
- Catholic Not-for-Profit
- Ministries in 19 states
- 102 hospitals, including 4 academic health centers and major teaching hospitals; 30 CAHs
- Annual revenue, FY 15: $15.2 billion
- Approximately 95,000 employees

Source: CHI Communications 11-3-15
Trinity Health

- Geographic Reach: 88 hospitals in 21 States
- Continuum of Care Services:
  - 126 continuing care locations — including home care, hospice, PACE and senior living facilities — that provide nearly 2.5 million visits
- Revenue: $15.8 billion
- Community Benefit Ministry: Almost $1 billion
- Discharges: 511,000
- Full-Time Employees: 95,000

Source: Trinity Health Communications 11-3-15
Where we are... “The Mercy ACO Network”

- MHN Urban Hospital
- Owned CAH Hospital
- Managed CAH Hospital
- Managed Rural Hospital
- Primary Care Clinic

AMGA 2016 Annual Conference
# Mercy ACO Provider Network

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Total</th>
<th>Employed</th>
<th>Independent</th>
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<tbody>
<tr>
<td>Central Iowa</td>
<td>984</td>
<td>527</td>
<td>457</td>
</tr>
<tr>
<td>Clinton</td>
<td>63</td>
<td>63</td>
<td>63</td>
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<tr>
<td>Dubuque</td>
<td>222</td>
<td>222</td>
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<tr>
<td>North Iowa</td>
<td>335</td>
<td>188</td>
<td>147</td>
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<tr>
<td>Sioux City</td>
<td>159</td>
<td>61</td>
<td>98</td>
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<tr>
<td>Total</td>
<td>1763</td>
<td>776</td>
<td>987</td>
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## Mercy ACO Covered Lives
### As of Dec. 2015

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<tr>
<th>Mercy ACO</th>
<th>ACO</th>
<th>Central Iowa</th>
<th>North Iowa</th>
<th>Siouxland</th>
<th>Dubuque</th>
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<td>75,000</td>
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<td>Wellmark Shared Savings</td>
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<td>Trinity Colleagues (starting Jan 2016)</td>
<td>10,879</td>
<td>NA</td>
<td>4,678</td>
<td>2,742</td>
<td>2,340</td>
<td>1,119</td>
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<td>CHI Employees</td>
<td>10,216</td>
<td>10,216</td>
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<td>NA</td>
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<td>NA</td>
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<td>Aetna - Exchange Product</td>
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<tr>
<td>(starting Jan 2016)</td>
<td></td>
<td></td>
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<tr>
<td>Coventry MA</td>
<td>543</td>
<td>543</td>
<td>NA</td>
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<td>Harvest Plains MA (starting Jan 2016)</td>
<td>TBD</td>
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<td>NA</td>
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<td>Humana MA</td>
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<td>Iowa Medicaid (IHWP)</td>
<td>6,867</td>
<td>4,665</td>
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<td>323</td>
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<tr>
<td>Medicaid Managed Care (starting Jan 2016)</td>
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<td>TBD</td>
<td>TBD</td>
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<td><strong>TOTAL</strong></td>
<td><strong>140,034</strong></td>
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<td><strong>7,449</strong></td>
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<td>--------</td>
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<td>2012</td>
<td>▼ 2.9%</td>
<td>$2,545,114</td>
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<td>2013</td>
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<td>2014</td>
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<tr>
<td>2012/13</td>
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<tr>
<td>2014</td>
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<td>$7,560,515</td>
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<td>2013</td>
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<td>$330,647</td>
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<tr>
<td>2014</td>
<td>▼ 7.2%</td>
<td>$303,461</td>
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<td>2013[1]</td>
<td>▼ 1.9%</td>
<td>$708,214</td>
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<td>2014[1]</td>
<td>◀▶ 0.5%</td>
<td>($191,258)</td>
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</table>

[1] From 2012 Actual PMPM

*Reduced Healthcare Expense for Iowans*
Organizational Structures & Governance
Mercy ACO - Statewide Clinically Integrated Network

Organization of Health systems, employed physicians, and independent physicians with key functions of:

• **Network membership / credentialing**
  – Participants commit to common triple aim goals

• **Population health infrastructure**
  - Data Warehouse
  - Care models and protocols
  - Care Management

• **Joint contracting**
  – Interface with insurers and employers to Capture the value for improved performance

• **Governance model**
  – Coordinate and standardize activities
  – Hold each other accountable for agreed upon goals
Why a Statewide MHN CIN?

- **Scale**
  - Share infrastructure Expenses: IT, management, consulting
  - Increased size decreases actuarial downside risk
  - MSSP lower minimum savings rate
- **Optimization within the legal and regulatory environment**
  - legal waiver availability through MSSP
- **Clinical Improvement through sharing of best practices**
- **Brand identity** - important for contracting
- **Geographic coverage for contracting**
- **Network Strength & Performance** to compete with insurance company networks and competitor CINs
Mercy ACO Committee Structure

Clinical Integration Workgroup
- Includes of Chairs of the local chapter Gov. Committee
- Standardize clinical care & care management across Mercy ACO
Mercy ACO is Organized Into Clinically Integrated Network (CIN) Chapters

- The Clinically Integrated Network (CIN)
  - Is not a health care provider. The hospital and participating physicians are the health care providers.
  - The CIN provides the infrastructure to share information and promote adoption of best practices for achieving the triple aim.
- Mercy ACO Is a CIN structured to be a statewide integrator
- Chapter CINs are structured to be the local market integrators.
- Both the ACO and Chapters need a governance structure to manage themselves
CIN Chapters as Sub-Committees of Mercy ACO

MHN Payer Contract Strategies Group

Delegation of Authority to CIN Chapters thru Mercy ACO Operating Agreement

Participation Agreements with Chapter Entities

- NI Chapter
  - NI Hospital
  - Employed Doctors
  - Independent Groups
  - CAH

- DQ Chapter
  - DQ Hospital
  - Independent Groups
  - CAH

- CL Chapter
  - CL Hospital
  - Independent Groups
  - CAH

- SC Chapter
  - SC Hospital
  - Employed Doctors
  - Independent Groups
  - CAH

- DSM Chapter
  - DSM Hospital
  - Employed Doctors
  - Independent Group
  - CAH
  - Rural Hosp

Participation Agreements with Chapter Entities
Principles for the development of Chapters

• Chapters will be governed by a Chapter Governance Committee which will be a sub-committee of Mercy ACO
  – The Mercy ACO will delegate authority to the Chapter Governance Committee to govern the functions of the Local CIN though the Mercy ACO operating agreement
  – Membership of local Chapter Governance Committee will be determined by the chapter participants
  – Mercy ACO will have an ex officio (non-voting) seat on each Chapter Governance Committee

• Chapters will function like a franchise like model where the ACO sets the standards and the chapter implements the standards

• Chapters will have representation on the committees which create the standards
Principles for the development of Chapters

• Chapters have a local committee and workgroups to support CIN work

• Chapters need FTE resources to carry out their functions
  – Administrator for business ops, data, communications, compliance
  – Care Management Director
  – Health Coaches and navigators
  – Medical Director

• The local Chapters must have a sponsor, usually a regional health system, which will be financially responsible for chapter expenses

• Functions, expenses, and revenues will be pushed to the Chapter level as much as possible while maintaining efficiency and regulatory requirements
Local CIN is responsible for local CI work:
- Quality across the continuum of the local market
- Care Management in the local market
- Local Network development and maintenance
- PI to help providers meet goals

MHN CIN is responsible for:
- Statewide guidelines and care models
- Coach Training and standards
- Data management
- Performance monitoring
- Setting metrics and goals
- Contracting
Chapter Charter:

1. Defines Governance Committee members
2. Assigns financial responsibility
3. Delegates authority

1. **PURPOSE.** The [insert local market name] Chapter Committee (“Committee”) shall be a standing committee of Mercy ACO, LLC (the “ACO”). As part of the ACO, the Committee shall oversee clinical integration efforts in the service area of [insert local market name] The Committee shall have and exercise the delegated authority and shared governance roles as outlined in Section 4 below.

2. **STRUCTURE AND OPERATIONS.**

   A. **Composition and Qualifications.** The Committee shall be comprised of an equal number of members chosen by participating physicians and the [insert local market name] Health System. The Committee will also include one (1) representative appointed by the ACO (the “ACO Appointee”). The Committee Chair will be elected by majority vote of the members of the Committee. (Note – this section may need to be modified to fit local market dynamics).

   The Committee shall be composed of individuals who are committed to ensuring that the goals of the ACO and Committee are met, and who have education and/or experience in areas which may enable a considered review of the matters which are brought before the Committee. Any individual appointed to serve on the Committee may be removed by a majority vote of the Committee, with or without cause, and in its sole discretion.

   B. **Terms of Appointment.** Except as noted below, the term of each Committee member shall be for three (3) years from the date of his or her appointment. The terms of the members shall be staggered in such a manner as to assure that the term of each of the three groups will expire every third (3rd) year with one-third (1/3) of the Committee members being appointed each year. The terms of the initial members may be more or less than three (3) years each to accomplish this objective. In the event a member resigns or is removed prior to the expiration of such member’s term, the person or persons who appointed such member shall appoint a replacement to serve through his or her term.

   C. **Financial Responsibility.** [insert local market name] shall be responsible for the expenses of the Committee and clinical integration (“CI”) activities in the Service Area. All such expenses must be approved by the CEO of [insert local market name] or his/her designee prior to being incurred. As appropriate, [insert local market name] may be reimbursed from any future earnings from value based contracts that are earned as a result of CI activities attributable to the [insert local market name] Chapter and in accordance with the ACO’s policies and procedures. Any resources provided to a [insert local market name] Chapter participant for CI activities, including health coaches, shall be used solely for those activities and not for the benefit of the participant’s private practice.

3. **MEETINGS.**

   A. **Regular Meetings.** The Committee shall schedule its regular meetings so as to reasonably conduct its business (expected to be at least six (6) meetings a year).
Chapter Details

• Governance Committee Membership
  – Equal votes for physicians and hospital sponsor
  – Mercy ACO has one voting seat in each chapter

• Financial Responsibility
  – Market health system is responsible for and must approve all chapter expenses
  – Chapters can provide health coaches and IT systems to independent physician practices
    • Protected by ACO MSSP waivers
The statewide CIN (Mercy ACO) governs the following functions:

1. Relationship with payers and contracting
2. IT systems & sharing of information among participants
3. Development of performance strategies
4. Development of patient care protocols and standards
5. Development of Clinical Performance measures for the network & chapters
6. Monitoring of performance
7. Define ACO and CIN participation criteria
8. Compliance with ACO programs
9. Financial reconciliation and distribution of incentives to chapters
10. Relationships with state and national entities in respect to ACO activities
The Local CIN (Chapter) Governs the Following Functions:

1. Work with the care providers in the local market to share information and improve performance
2. Maintaining local provider relations, communication and education
3. Identify and enroll Chapter participants
4. Implement and monitor performance initiatives and strategies
5. Hold local participants accountable (i.e. clinical quality, cost, service, regulatory)
6. Allocate resources for care management and coordination to follow ACO care management protocols and meet standards
7. Convening a local committees and workgroups to support ACO work
8. Provide members for statewide committees such as: CI-Workgroup, ACO care management, Data, Contracting
9. Management of ACO incentive payments to Chapter participants
ACO Funds Distribution

• All ACO Funds are allocated to the Chapters based on the number of covered lives in the contracts for which the funds were received

• When are IT systems are capable we will add
  – Financial performance metrics
  – Quality metrics

• All ACO Expenses are allocated to the chapters
  • No revenue is retained in the ACO
Chapter Funds Distribution

• Model 1
  – Distributes 25% to physicians and uses remaining 75% to cover expenses.
  – When expenses are covered then 50% paid to physicians and 50% paid to financial sponsor

• Model 2
  – All expenses are covered before any distribution
  – When expenses are covered then 50% paid to physicians and 50% paid to financial sponsor

• Funds distributed to Tax IDs based on attributed lives until we have the capability to add quality and financial metrics
Management and Staffing
<table>
<thead>
<tr>
<th>Position</th>
<th>Centrally based</th>
<th>Chapter Based</th>
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</thead>
<tbody>
<tr>
<td>President</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Medical Director</td>
<td>0.1</td>
<td>2.0</td>
</tr>
<tr>
<td>Executive Director/COO</td>
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<tr>
<td>Population Health Care Management Lead</td>
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<td>5.0</td>
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<td>Additional Care Managers/Assistants</td>
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<td>80.0</td>
</tr>
<tr>
<td>Director Performance Improvement</td>
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<td>Clinical Information Specialist</td>
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<td>Data Analyst</td>
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<tr>
<td>Contracting/Finance Manager</td>
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<td>HR Manager</td>
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<td>Communication Manager</td>
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<td>Clerical/Admin</td>
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<tr>
<td>Community Health Worker/Care Coord. Asst.</td>
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<td>Other FTEs (Grants Management)</td>
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<tr>
<td>Total FTEs</td>
<td>17.1</td>
<td>94.0</td>
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# Mercy ACO Ambulatory Care Management Staffing Standards

Approved by Mercy ACO Board Nov. 2015

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<thead>
<tr>
<th>Urban Care Management Staffing - Projected Need</th>
<th>Des Moines</th>
<th>Mason City</th>
<th>Clinton</th>
<th>Sioux City</th>
<th>Dubuque</th>
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<tbody>
<tr>
<td>Commercial</td>
<td>5000</td>
<td>94,700</td>
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<td>19,655</td>
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<td>* Medicaid may require higher ratios when the Medicaid MCO are active</td>
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* Medicaid may require higher ratios when the Medicaid MCO are active

**Rural staffing is funded through the CMMI grant and the CAHs it is not included in the above numbers**
Mercy ACO
IT & Data Strategy
Data Warehouse Challenges

1. Corporate intermediary between Mercy ACO and Vendor
   – Business needs not understood
2. Data aggregation too slow, too costly, and ineffective
   – Participant data - 140 tax IDs each with 4 data sources
   – More than 1 year to bring in new commercial claims data
3. Data not all in one platform
   – Adjudicated claims in one product
   – Pre-adjudicated claims and EMR data in separate product
4. Limited access and security options
   – Lack of role based security
   – Inability to provide chapter level access at the ‘backend’ without exposing other chapter’s data (regulatory barrier)
5. Off the shelf solution with little flexibility
   – Changes take more than a year to make
6. Did not notice when data flow changed
Solution – home grown data warehouse

• Started with a company hired to aggregate and normalize data
• In 3 months they brought in data from 34 sites and aggregated it in a database hosted on our server
• Successfully transferred the data to our analytics vendor
• Built analytics capability onto the database to allow us to query it directly
Solution Highlights

1. Data Aggregation and normalization into one platform
   – Automated monitoring of data flow
2. Point and click data filtering to seamlessly filter data based on conditions and comparators across any dimension of the data
3. Measures Builder to effortlessly create complex measure calculations across any dimension from the data
   – Change measures in minutes
4. Dashboard Builder using a simple point-n-click interface
5. Work-queue generation for Health coaches
6. User Access and Security so worksets can be shared with other users of the platform with granular options for exactly the data that needs to be shared
7. Will give us maximum flexibility
Population Health Services
Population Health Services

- Care Management Program
- Health Coaches in physician offices
- High risk & transition coaching
- Post Acute Networks
- Care coordination councils
- TAV – Care management software
- Care Models
- PCMH
- IT
- Grants & Research
Mercy ACO Care Management Program

- Patient Centered Medical Home
  - 30+ sites NCQA certified
- Discharge transition program
- Health Coaching for high risk patients
  - Hospital discharge, 3 or more ED visits, 2 or more chronic illnesses, Dx of HF or COPD
- BP and HgA1c improvement projects
- Track quality metrics and develop programs to fill care gaps and improve performance
- TAV care management software
- Care Coordination Councils
- Post Acute Networks
- CMS annual wellness visits
Health Coaches

All Coaches Go through Mercy ACO Training Program

- Self-Management Support
  - Health Behavior change and Motivational interviewing
  - Connection to community resources
- Coordination of care
  - Closing the loop on referrals and transitions
- Review population data for opportunities
  - Gaps in Care
- Shared decision making
  - Distribution of decision aids and f/U
- Quality Improvement
  - Point person for introduction of new care processes
- High Risk Patient case manager
  - Proactive follow up
  - Care access point – direct phone & e-mail
Transition and High Risk Coaching

- **ACO patients identified while in the hospital**
  - Risk Assessed by LACE scores
    - LOS, Admit through ED, Co-Morbidities, ED visits in last 6 months
  - Transition back to the medical home is facilitated
    - Appointment for joint F/U with doctor and health coach
    - Patient is encouraged to bring all meds to the office visit
    - Discharge info Communicated to the medical home Health Coach

- **Patient is tracked by the Coach until seen back in the medical home**

- **High Risk Coaching initiated with the office visit**
  - Teach warning symptoms and what to do if they occur
  - Assesses medication issues
  - Goal setting and motivational interviewing
  - Office coach makes weekly calls for 4 - 6 weeks
Post Acute Network

- SNFs and Home care sign ACO Participation agreements
  - Must be 3 star SNF
  - Urban & rural divisions
- Share data un-blinded
  - ED use, 30 day Re-admits, LOS, UTI, Pressure Ulcer
- Meet monthly for QI planning
- Follow protocols
  - Fever, SOB, Knee & Hip replacement
MHN Care Coordination Councils

• Established in each ACO Chapter with leaders from:
  – Ambulatory Care, Acute Care, Home care, Palliative care, Post-acute care, Specialty Care, ED, senior market executive

• Accountable for all care coordination activities across the continuum
  – Be a link between acute and ambulatory care
  – Plan patient pathways & workflows through the continuum

• Pathway to have all care management in a market report up to a single executive
TAV Care Management Software Implemented in all Chapters

• Used to track care management across the continuum
  – Acute care and ambulatory on the same platform
  – Communication across the continuum
• Created in partnership with TAV Health
• TAV is built on a CRM platform allowing us to track patient preferences and resources used
• Coach interventions are standardized and documented in TAV templates
• Community resources are cataloged and rated
• TAV tracks coaching interventions so Mercy ACO can report on the number and types of interventions provided to patients
Over 50 million Americans have hypertension. It is the most commonly used diagnosis in Family Medicine. Multiple studies have shown a strong, continuous, graded increase in cardiovascular events with increased blood pressure and that the association for Systolic BP is stronger than for Diastolic BP. Mercy ACO endorses the following recommendations:

1. **Disease Registry.** All hypertension patients should be followed in a disease registry.

2. **Office Visits.** For patients with HTN the recommended visit interval is:
   - Every 6 months - for patients with stable HTN
   - Every 1 month - for patients whose BP is above goal

3. **Set a clear BP Goal of therapy for each patient.** Control blood pressure to:
   - Below 150/90 for uncomplicated hypertension age 60 years or older
   - Below 140/90 for Age 59 and younger
   - Below 140/90 for patients with diabetes or chronic kidney disease
   - Patients not meeting goals should be systematically followed up as described in the BP Control **Process Map** (see back of guideline)

4. **Quality Measures.** GPRO HTN metrics include:
   - BP done within year and < 140/90 (most recent result)

5. **Self-Management-Support** …
Population Based Care
Blood Pressure Control
Process Map

Standard Process
• Tells the system what to do, not doctors
• Requires physician support, but not change in physician / patient encounter

HTN Registry
• Tracks 55,000 patient with HTN
  • All patients in practice, not just value based contracts
• 75% are currently controlled
• 2016 goal is 80% controlled
Results: Better Health (Quality)

[ YTD 2015 Medicare - Compared to Benchmark ]

Key Quality Indicators

- CHF Admits: ▼ 14%
- COPD Admits: ▼ 23%
- Bacterial Pneumonia Admits: ▼ 12%

Utilization

- Readmits/1000: ▼ 6.0% 4,261
- Admits/1000: ▼ 17.3% 12,285
- CT Events/1000: ▼ 7.7% 5,468
- MRI Events/1000: ▼ 0.8% 568
- Primary Care Visits: ▲ 1.7% 1,207
Physician Engagement
Source of Information for:
• Provider Directories
• Communications
• Care Models
• Dashboards
  • Chapter, Clinic, and Provider measures
• List of patients behind each measure

Supported platforms
• Web
• Apple iOS
  • iPhone / iPad
• Android App
Dashboards: Provider Level

PROVIDER DASHBOARD -- REPORT PERIOD ENDING 11/30/2015

Provider Name: MD
Provider NPI: 123456789
Chapter: Central Iowa

Your Risk Adjusted PMPM: $465.32 (1)
October ACO Average: $347.74

HYPERTENSION - BP < 140/90 (4)
74.8% of 139 Eligible

CLINIC VISITS (7) - AVG VISIT: $503
355 Total Visits

DIABETES - HbA1c < 8.0 (10)
56.4% of 39 Eligible

CLINIC LIKELIHOOD OF HOSPITALIZATION
>= 70% (2)

DIABETES - HbA1c > 9.0 (5)
36.5% of 39 Eligible

Clinic Re-Admissions (8)

Relative Value Unit (RVU) (11)
COMING SOON
COMING SOON

IMMUNIZATIONS (6) 7 Eligible

CMS WELLNESS VISIT (9)
3.0% of 33 Eligible

Additional Chapter Specific Data (Pending/TBD)
COMING SOON

PCP Quality Scores and Opportunities for Hypertension BP < 140/90, Diabetes HbA1c > 9, Diabetes HbA1c < 8 and MMR/VZV Immunizations have been filtered to include only those Population Manager Attributed Patients known to have had at least 2 Office Visits with the Assigned Provider. There is no filtering for CMS or Wellmark Attributed Patients.
### Provider Level Patient List

#### Hypertension Patients - BP > 140/90 at Last Visit

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<thead>
<tr>
<th>Name</th>
<th>EOB</th>
<th>Health Plan ID</th>
<th>Health Plan Name</th>
<th>Latest Event Date</th>
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<td>138/90</td>
</tr>
</tbody>
</table>
Physician Collaboration approach that Encompasses Both Independent and Employment Models

1. Hold monthly CIN chapter meetings at all sites with employed and independent physicians.
2. Both employed and independent physicians together develop common goals, metrics, guidelines and protocols.
3. Data sharing between all physicians: employed and independent.
4. Offer a non-exclusive contract to independent physicians who are unable to commit.
Physician Compact

Mercy ACO Providers Commit to:

1. **Share data** including clinical data from your EHR and billing data from the claims you submit. The data will be used to create performance measures which will be shared transparently.

2. Provide timely and **effective communication** with clinical and administrative colleagues within the Clinically Integrated Network.

3. **Support** physician colleague leaders in their efforts and support the development of future physician leaders.

4. **Recognize the authority** of the CIN physician committees to set common goals for quality, utilization, and patient satisfaction.

5. Work with the CIN staff and programs to review and use data to achieve the **triple aim** of improved health, improved care and, lower costs for the communities we serve.

6. Improve **access** for patients in need of services.
Physician Compact

Mercy ACO Commits to:

1. Employ fair process and transparency when making decisions that impact patients, physicians, and practices.

2. Provide feedback on practice utilization patterns based on reliable data, and ensure that performance-based metrics are aligned with stated goals.

3. Create an environment to improve patient outcomes by providing IT systems, health coaches, care models, education, scorecards, and process improvement.

4. Develop appropriate financial recognition for those who engage in CIN activities.

5. Collaborate with physicians to achieve the ACO Mission: to improve health, improve care, and lower costs for the communities we serve.
Mercy ACO Physician Integration Issues

- Independent providers unwilling to pick a side
  - UnityPoint v. Mercy
- Specialists see this a primary care power grab
  - Don’t see what’s in it for them
- Historically difficult relationship between health systems and some independent groups
  - Lack of trust
- Large groups do not want to cede autonomy
- Complex agreements and terminology required by regulators
  - MSSP, HIPAA
- Difficult to understand the financial incentives for the critical access hospitals
Rural Healthcare
Mercy ACO Rural Strategy

- Iowa Accountable care must embrace Rural providers
- All rural sites participate in to MSSP
- Rural sites are affiliates of urban chapters
  - No Rural only chapter
  - Improve coordination between urban & rural
- Grant funding obtained to support development of rural pop health infrastructure
  - CMMI & HRSA
Purpose is to implement population health infrastructure in rural Iowa sites

- Health Coaches
- Physician Champions
- IT – Data Warehouse and TAV care management
- Performance improvement - PCMH
- Inclusion in a Clinically Integrated Network (CIN)

25 Rural Hospitals
- 73 Clinic sites
- 165 physicians, 58 ARNPs, 35 PAs
- 164,199 patients impacted

$10,171,000 over three years

Goal is to make this financially self-sufficient
- Value Based contracts
- Increased primary care and ancillary revenue
Rural Health Challenges

How does a cost based system work in a value based world

- **MSSP performance** deteriorated as we added CAH
  - Contracts without CAHs are still performing
- **Difficult to understand CAH reimbursement system**
  - Cost plus CMS payment with reconciliation reports
  - Impact on shared savings and bundled payments is unclear
- **Reimbursement is much higher in a CAH setting than in a rural setting**
  - Swing beds
  - CAH fear that ACO will shift use from rural sites
- **Low inpatient census**
- **Measuring Quality with small numbers**
- **Attribution** is lower than in urban sites (as a % of CMS patients in the county)
- **Physician shortages** – access issues
- **Data** from many disparate sources – hard to integrate
- **Distance to facilities**
  - Video conferences were not effective in building new relationships
Rural Plan

• CMS Claims data obtained for research
  – Partner with U of Iowa to analyze

• Make pop health infrastructure permanent
  – Sustainability focus shifting to increased primary care and ancillary services
  – Include coaches in cost reports

• Physician leadership development

• Rural post acute network

• PCMH development – QI

• Clinical data acquisition
View from the Chapter - MNI
North Iowa Chapter

- Mercy North Iowa
- 14 county service area
- 8 Critical Access Hospitals
- 40 Primary Care Clinics
  - Each clinic with Health Coach and navigators
- 150 employed providers
- Alignment of independent Specialty group

AMGA 2016 Annual Conference
Chapter Org Structure

• Governance- divided into 10 regions- each with representative to Governance Council.
• GC meets monthly- serves as quality committee for ACO.
• GC representative meets quarterly with all providers in region.

Mercy ACO Clinical Integration Workgroup
North Iowa Chapter Steering Team
Quality Committee (Governance Council)
Regional Provider meetings

AMGA 2016 Annual Conference
Community Care Coordination Program

• Grant funded initiative between Mercy, Public Health, Community Action, Mental Health Center and Prairie Ridge Addiction Center.

• Community based health coaching and resources for social determinants for high risk patients.

• TAV made available to participants for improved communication and coordination.

• Multiple community partners have joined as affiliates.
Referral Authorization

• Referrals tracked at multiple levels:
• CAHs report transfers from ED daily- Problem solving to any not transferred to Mercy.
• Frequent causes “Established elsewhere” or “Patient request”
• Each clinic tracks referrals to outside specialists and asked to document reason why they went out-of-network.
• Frequent education to Providers and staff regarding importance of in-network referral.
ACO vs Chapter Conflicts

- Standardization vs Autonomy
  - Data access
  - Standard processes
  - Choosing & managing vendors – TAV, Virtual visits
  - Limiting autonomy
  - Communication
Contracting
MHN Contracting Principles
Capturing the value we create

- Fee for service contracts
  - MHN assets function as a single signature entity
  - Other ACO participants execute their own FFS contracts
- Mercy ACO Contracts for the value based components of the FFS contracts
- Mercy ACO will evolve into a single signature entity (FFS and Value based) for all its participating providers
  - Need to meet FTC Clinical or financial integration rules to avoid antitrust claims
- Payor Contracting and Finance Committee oversees contract analytics and negotiations
  - Trinity Health, CHI, and Mercy ACO representation
- Evaluate Iowa Market segments and plan a go to market strategy for each segment
# Commercializing Value-based Care Delivery

<table>
<thead>
<tr>
<th>Market Segment Products</th>
<th>Description</th>
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<tr>
<td><strong>Medicare</strong></td>
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<tr>
<td>MA Product</td>
<td>Narrow network products to capture MA market share launched in 2016</td>
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<tr>
<td>Medicare Shared Savings Program</td>
<td>Participation in CMS’ Medicare Shared Savings Program to manage an attributed FFS population</td>
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<td>Contracts for MA Risk</td>
<td>Contracts with private payers for population risk on MA members</td>
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<tr>
<td><strong>Commercial</strong></td>
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<tr>
<td>Individual Product</td>
<td>Narrow network products primarily offered on public exchanges</td>
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<tr>
<td>Small Group Product</td>
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<tr>
<td>Large Group - Contract for Commercial Risk</td>
<td>Contracts with private payers for population risk on Commercial members</td>
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<tr>
<td><strong>Medicaid</strong></td>
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<tr>
<td>Medicaid Product</td>
<td>Narrow network product that captures 10% of the Managed Medicaid market by 2018</td>
</tr>
<tr>
<td>Contracts for Managed Medicaid Risk</td>
<td>Contracts with private payers for population risk on Managed Medicaid members starting in 2016</td>
</tr>
</tbody>
</table>
MHN started BPCI program in April 2015
   – Now participate in 30 different bundles across 5 sites
• Too early to tell financial results
• Much variability across chapters
   – SNF Discharges for lower extremity joint replacement vary from 90% to 23%
• Impact on CAH needs to be determined
   – Will decreasing the use of Swing beds damage the relationship
   – How does cost plus reimbursement impact the reconciliation calculation
• No Physician incentive programs are in place
• The role of Mercy ACO and the hospitals needs to be determined
   – BPCI is a hospital not ACO contract
   – How do we standardize best practices & metrics
Summary & Conclusions

• Physician engagement in governance and clinical oversight is key
  – Requires regular meetings and communication channels

• CAH financial relationships are difficult to understand
  – May not work for value based care

• IT and staffing infrastructure cost are high
  – Des Moines is the only chapter able to re-coup costs
  – Grant funding was required for rural infrastructure

• Shared savings is not the end game
  – Stepping stone to assuming risk

• ACOs align the reimbursement system with our mission and values
  – Better Health instead of more services