



MARTIN'S POINT[®]

HEALTHCARE

**Medicare Advantage in Practice:
Enhanced Care Models for High
Need Patients**

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HEALTHCARE

Who is Martin's Point Health Care?

A not-for-profit health care organization committed to providing the best possible health care experience to its patient and members

Two health plans serving more than 75,000 members

- US Family Health Plan
- Generations Advantage



Seven health care centers serving more than 75,000 patients across Maine and New Hampshire



750+ employees who care for our members and patients each and every day



Approximately 18% of our Health Plan members are also Patients in our Primary Care Delivery System (15% of Medicare Advantage)



Martin's Point Mission & Vision

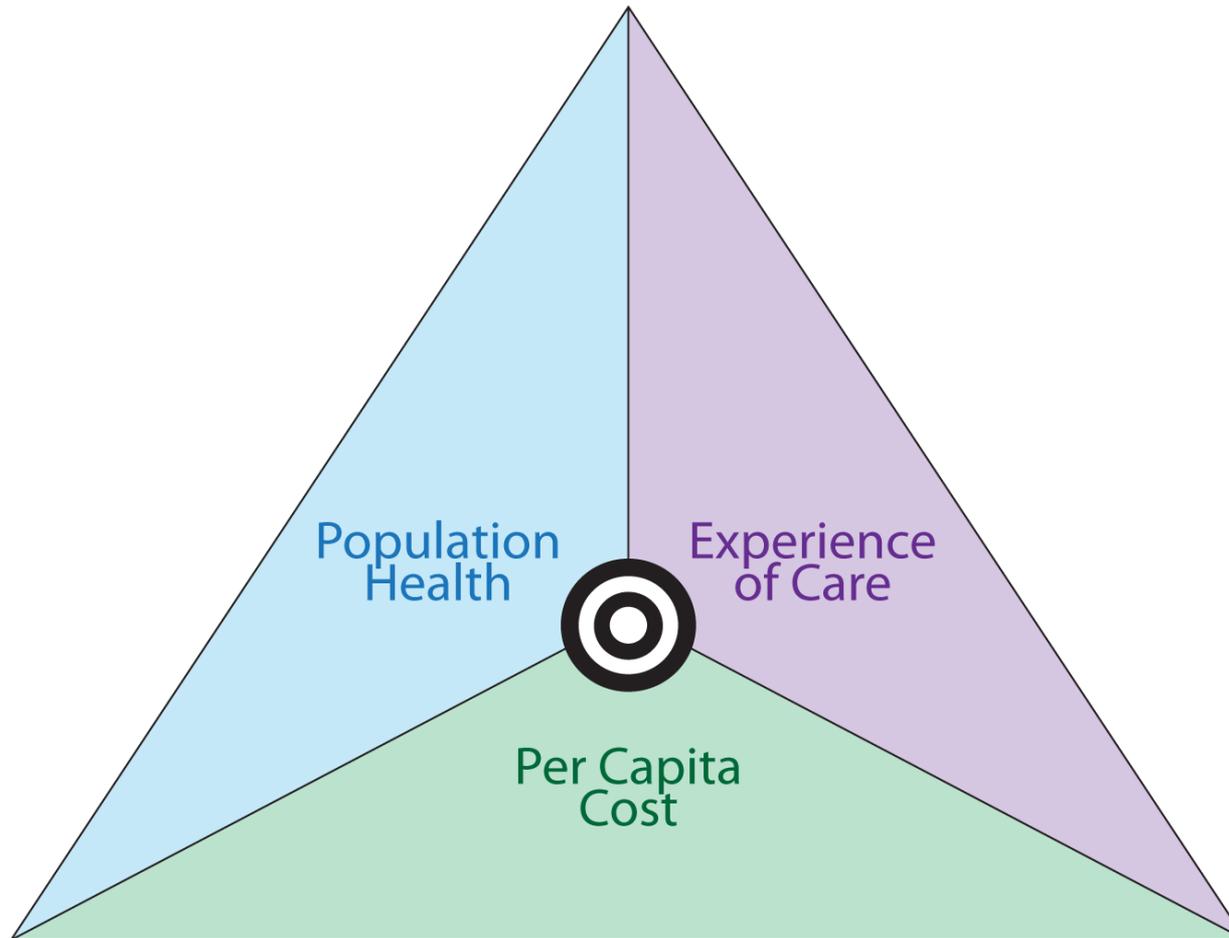
Mission

To create a healthier community through authentic relationships built on trust. "People caring for people."

Vision

Trusted for care. Chosen for service. Uniting the community in affordable health.

Triple Aim: Framework through which we Create Community Value



Overview of Martin's Point Health Plans



Generations Advantage

**Number of Members
(March 2017)**

40,873

Who Do We Serve?

Provides coverage to Medicare Beneficiaries through Medicare Advantage contracts

Service Area

ME & 2 NH Counties
(Strafford & Hillsborough)

Quality Ratings

5 Stars 4 out of last 8 years
& 4.5 stars other 4 years



US Family Health Plan

45,978

Provides TRICARE Prime benefits to military retirees & family members and active duty family members

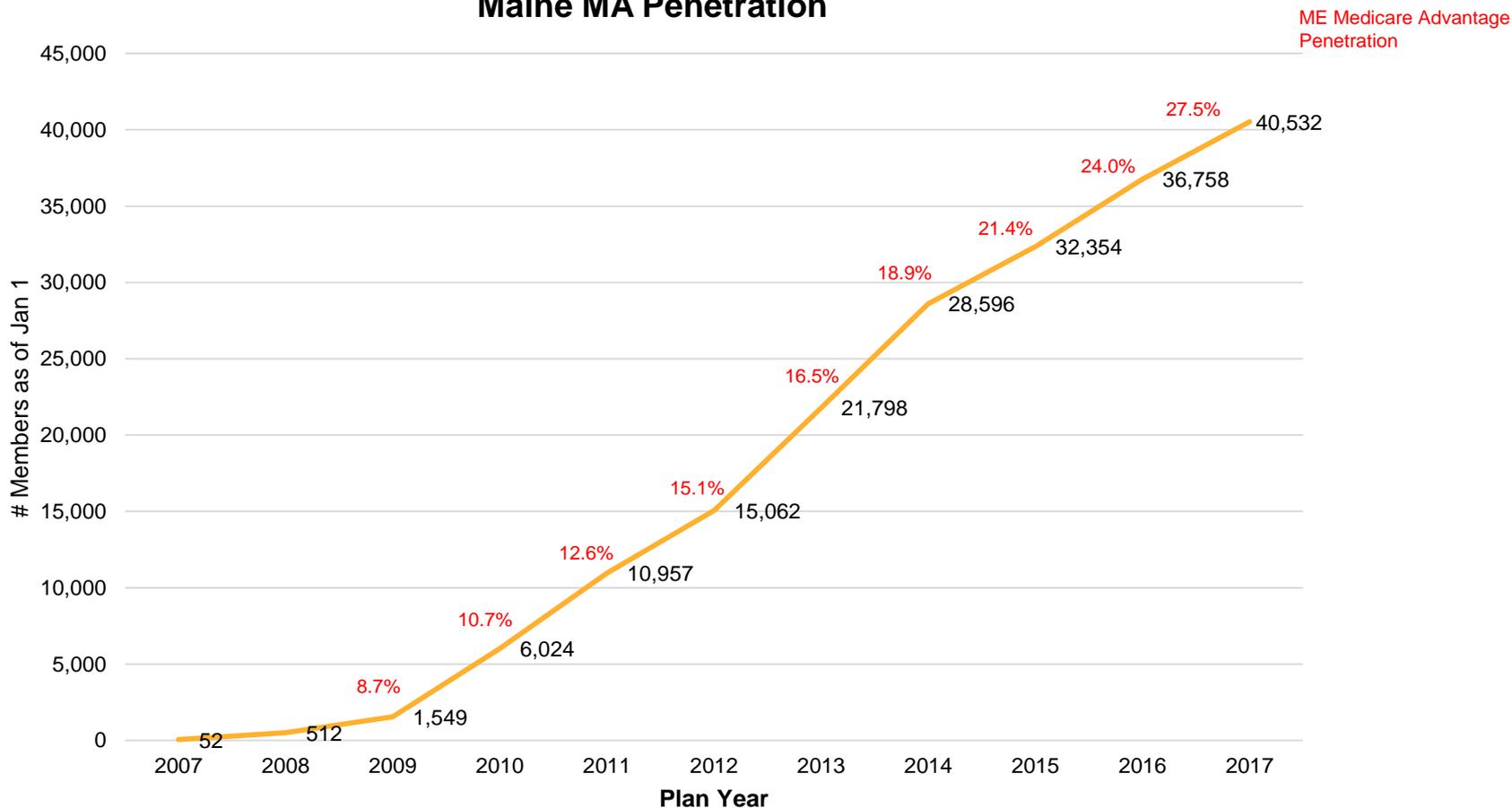
ME, NH, VT, Upstate NY, Northern PA

NCQA: ME (5 Stars, Excellent);
Other States (4.5 Stars, Commendable)



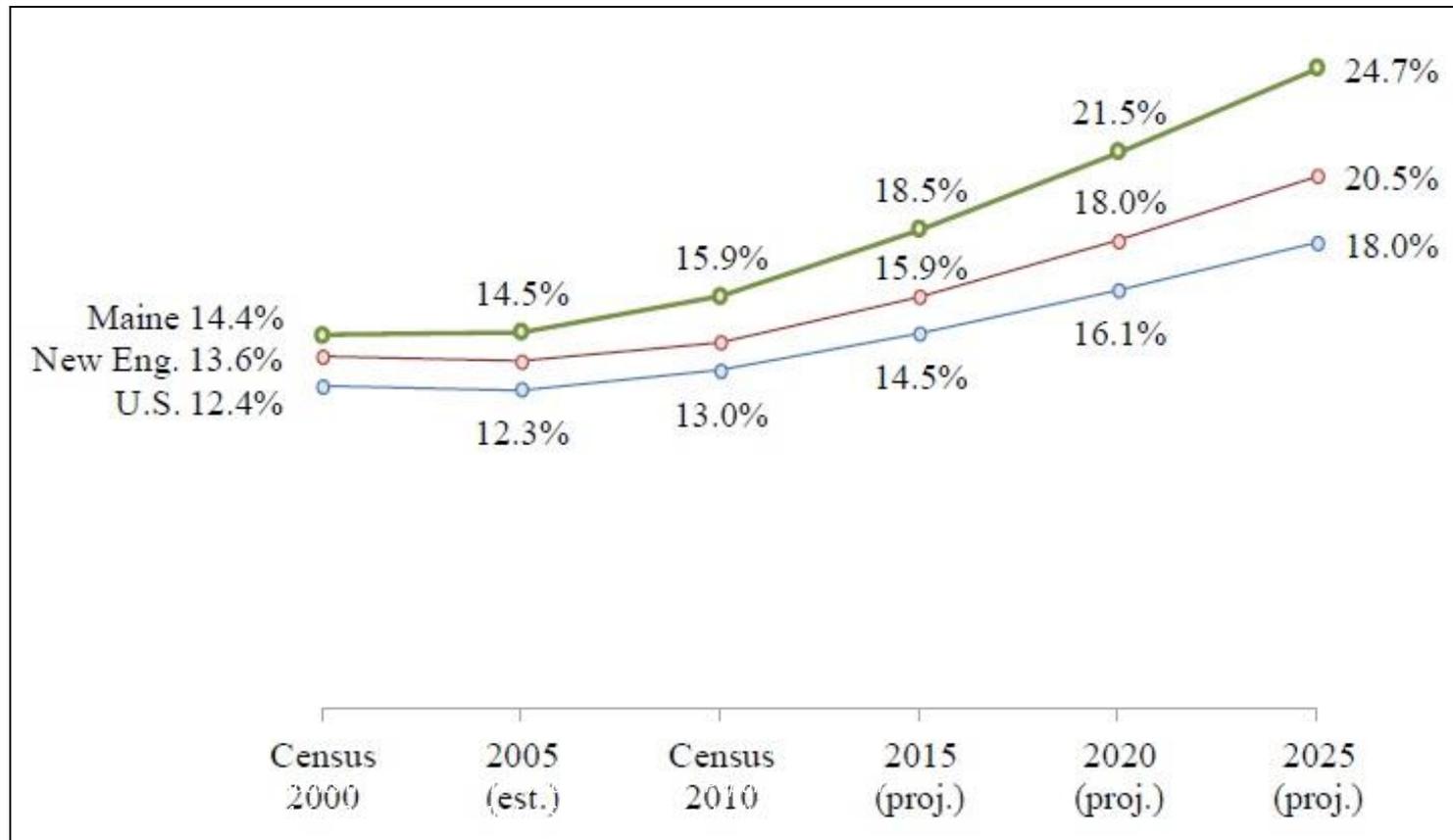
Generations Advantage Growth

Generations Advantage Growth & Maine MA Penetration



Maine - Aging Population Presents Opportunity for Those Serving Senior Market

Percentage of Maine Population Age 65+



Source: *Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine 2012 Edition*, Muskie School of Public Health

Source: 2010 US Census Bureau Florida Quick Facts Sheet
<http://quickfacts.census.gov/qfd/states/23000.html>



Key Challenges Facing Medicare Advantage in Maine

- Access to Care
 - Primary Care; Specialties; Behavioral Health
 - Rural
- Growing competency in diagnosis coding due to relative immaturity of Medicare Advantage
- The hospital market has moved to local monopolies
- Approximately 80% of physicians in Maine are employed by a hospital system
- Year over year intensification of utilization and billing practices



Population Health Continuum

Lower 85% Health Risk

Top 15% Health Risk

Well

Pre-disease or
Early disease or
Cancer Care

Moderate to
severe disease (≥2 of DM2,
ASCVD, CHF, COPD, Morbid
Obesity or
Unstable Mental Illness)

Hospitalized
and Severe Disease

Measurement, Analysis and Reporting

Distributed, coordinated, effective
population health activities

Focused, coordinated, effective care
management activities

- ↑ Predictive and HCC Risk
- ↑ Quality of Care opportunities
- ↑ PMPM Expense
- ↑ Mortality risk
- ↑ Social/Behavioral determinants
- ↑ Risk disengagement
- ↑ discoordination care



Overall Model of Care





Congestive Heart Failure Telemonitoring Program

- Population:
 - “Stage C” of Heart Health Program population
- Monitoring through home-based unit to identify management of CHF on day-to-day basis
- Initial population of approximately 400 members
- Outcomes to this point: (12 months post-initial engagement)
 - Readmission rate dropped to 11.9% vs. 21.7% pre-engagement
 - Discharges per 1000 dropped by 15%





Integrated Care Connection Program

- **Designed** to improve the coordination of care for Martin's Point patients with chronic conditions
- **Initial Population:**
 - Members of our Medicare Advantage Plan who are also Patients in Martin's Point's Primary Care Delivery System
 - COPD, Heart Failure, or Diabetes + Utilization (ER or Inpatient Admission) in past 12 months
 - Exclude ESRD, Hospice, Advanced Stages of Cancer
- **Visit Structure:**
 - Initial intensive visit with Population Health Nurse with Physician/NP joining
 - Referral to other services (e.g. pharmacy, arrangement of social support)
 - Follow-up based on care plan progression



“We see you, we hear you, we care.”



Integrated Care Connection Program (cont.)

- **Evaluation of Outcomes (Triple Aim Framework)**

Experience of Care	Health of Population	Cost of Care
<ul style="list-style-type: none">• Patient “confidence” question• Patient phone survey post program completion• Patient completion of ICC “Table of Contents” & Patient Goals Met	<ul style="list-style-type: none">• Clinical quality measures such as:<ul style="list-style-type: none">• A1c control• Immunizations received• Spirometry testing• Preventive such as:<ul style="list-style-type: none">• AWV or PE scheduled• Advanced Care Directives• Medication Adherence	<ul style="list-style-type: none">• Utilization measures:<ul style="list-style-type: none">• ER• Inpatient• Re-admissions• SNF admissions• PMPM (longer term)

- **Provider and Patient/Member Feedback**



On the Horizon...

- Continued Expansion & Refinement of Current Programs
- Home-Based Care Program
- Partnerships with Area Agencies on Aging
- Working with our local Health System Partners



In Closing...

- The aging of our population only continues
- Challenges with access to care will continue to present themselves
- Continue to focus on improving the health of our populations and bringing community value through the Triple Aim