

# Beaumont ACO

A Physician/Health System Partnership

## Medicare Shared Savings Care Coordination Program

### Medicare Shared Savings Program (MSSP) Overview

The Shared Savings Program is a volunteer (opt-in) program which is focused on Medicare parts A and B fee-for-service

### You as a Participant (Primary Care Provider, PCP)

As a participant in the Beaumont ACO's MSSP, your Medicare beneficiaries (patients) who are attributed to you are eligible for assistance within the MSSP-Advanced Illness Management (AIM) program. MSSP-AIM is a concept of beneficiary/family centered care delivered by our multidisciplinary team of health professionals adhering to evidenced-based best practice guidelines.

### Targeted Population

Beneficiaries who need guidance and support for complex medical issues that may be compounded by social, economic, environmental and behavioral factors are the targeted population. Examples include but not limited to beneficiaries with changes in functional status and/or progression of conditions such as:

- Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- End Stage Renal Disease
- Multiple co-morbidities

### How Beneficiaries are identified for MSSP-AIM

- Direct referrals from healthcare team members, such as PCPs
- CMS utilization data and reports from EPIC EMR
- ADT (admission, discharge, transfer reports)

### The MSSP -AIM includes

- Transition of Care telephonic follow-up by a RN care coordinator within a few days of discharge from a hospitalization, emergency department visit or skilled nursing facility.
- Skilled Nursing Liaison- RN Care Coordinator focusing on care in the SNF and transition post SNF
- Advanced Illness Management is face to face NP/RN care coordination visits, focusing on beneficiary/family centered care, PCP engagement and collaboration with other healthcare team members.

### The Process

- Identify individuals with more complex health issues
- Seek approval of the beneficiary to participate in MSSP-AIM
- Conduct a person/family-centered assessment
- Collaborate with the PCP and health care team to develop a plan of care
- Execute and monitor the care coordination plan and beneficiary's self-directed care

## Role of the PCP

Physician engagement is the key to success. The PCP remains the leader in treatment decisions. The team will support the goals of care as established by the beneficiary and his/her PCP.

For this program, we are asking that you take the lead in inviting your beneficiary to participate in care coordination. The biggest influence in their active participation is your support. The PCP's support includes:

- Schedule beneficiary (include family as appropriate) for office visit with you and a care coordinator
- Encourage the beneficiary's participation in MSSP-AIM
- Collaborate with the care manager in your plan of care

**There is *no charge or copay* to the beneficiary or PCP for MSSP- AIM program participation.**

## Contact Us

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*Anyone on the team can receive your referral by either telephone or email.*

## Our Goal

To assist the beneficiary/family to effectively manage health conditions, improve overall health status, and decrease unnecessary costs through care coordination.