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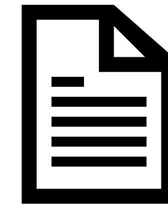
MEDICARE ACO
PATHWAYS TO SUCCESS FINAL RULE

Agenda
--start 10:05 am Central

- NOIA and Application Timeline
- Pathways to Success - Overview
- Sectary Azar and Seema Verma
  - Choose your risk or we will choose for you
- In-addition or Alternatives to ACOs
  - CIN, MIPS, Virtual Group, Alternative Payer, Self-Insured Employer, CCH
- How to achieve shared savings
  - Bring initiatives to provider team
- ACO Strategy Meetings
  - Consumer-Centered Health (CCH) Program



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Notice of Intent to Apply (NOIA)

- July, 2019 Period
  - Opens January 2, 2019
  - Closes January 18, 2019

- May submit ACO Participant and SNF Affiliate sample agreements and draft repayment mechanism documentation with NOIA.

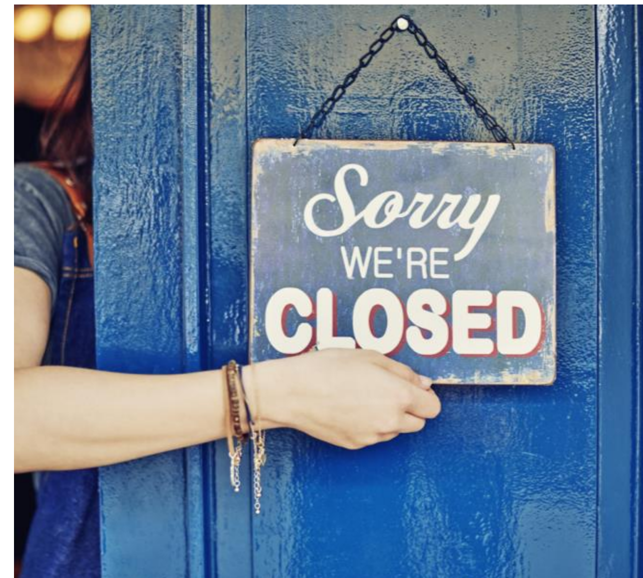
Application Timeline

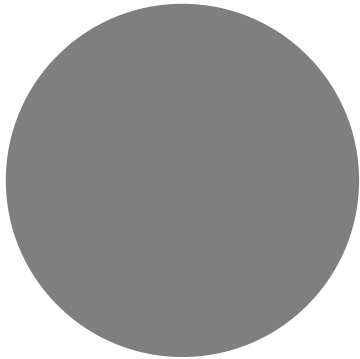
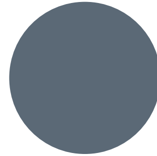
- Special one-time July 1, 2019 agreement start date for those seeking to apply to pathways early or as a new ACO.
- First step is submission of NOIA.
- ACO participation agreements, SNF affiliate agreements, governing body and organizational chart updates
- 90% of ACOs extended participation for agreement periods ending December 31, 2018 to June 30, 2019.

MSSP Tracks

Discontinued for New and Re-applicants

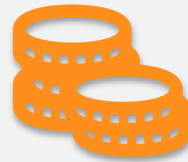
- Tracks 1, 1+, 2, and 3 have been discontinued.
  - ACOs currently participating would not have the option to re-apply.
  - New applicants and renewal applicants must apply under the proposed BASIC and ENHANCED tracks.



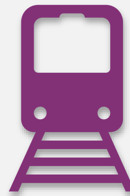



Glide Path to Enhanced

National Average



34% earn shared savings



60% save within corridor of MSR/MLR

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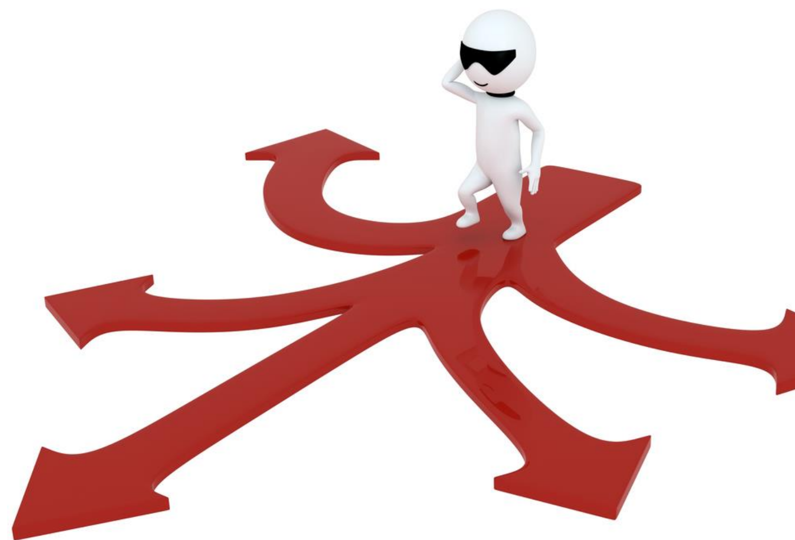
Path Overview

- Basic Glide Path Offers 5 levels with incremental approach to transition eligible ACOs to higher levels of risk and reward.
- Basic Glide Path to automatically advance at start of each performance year with ability to elect higher levels of risk.
- Enhanced Path is highest level of risk and reward.



Savings and Losses	Shared Savings (once MSR met or exceeded)	Shared Losses (once MLR met or exceeded)	Advanced APM 5% or MIPS Upward Adjustment Part B
Level A & B	1st dollar savings at a rate up to 40% based on quality performance; not to exceed 10% of updated benchmark	N/A	MIPS Upward Adjustment
Level C	1st dollar savings at a rate of up to 50% based on quality performance, not to exceed 10% of updated benchmark	1st dollar losses at a rate of 30%, not to exceed 2% of ACO participant revenue capped at 1% of updated benchmark	MIPS Upward Adjustment
Level D	1st dollar savings at a rate of up to 50% based on quality performance, not to exceed 10% of updated benchmark	1st dollar losses at a rate of 30%, not to exceed 4% of ACO participant revenue capped at 2% of updated benchmark	MIPS Upward Adjustment
Level E	1st dollar savings at a rate of up to 50% based on quality performance, not to exceed 10% of updated benchmark	1st dollar losses at a rate of 30%, not to exceed the percentage of revenue specified in the revenue-based nominal amount standard under the Quality Payment Program (for example, 8% of ACO participant revenue in 2019 – 2020), capped at a percentage of updated benchmark that is 1 percentage point higher than the expenditure-based nominal amount standard (for example, 4% of updated benchmark).	Advanced APM 5%
ENHANCED	No change. 1st dollar savings at a rate of up to 75% based on quality performance, not to exceed 20% of updated benchmark	No change. 1st dollar losses at a rate of 1 minus final sharing rate, with minimum shared loss rate of 40% and maximum of 75%, not to exceed 15% of updated benchmark	Advanced APM 5%

ACO Paths

High/Low Revenue Calculation	35%	Part A + Part B Expenditures (All Spend)	ACO Revenue for Participants	35%
High Revenue	If the ACO's assigned beneficiary Part A + Part B for ACO Participants revenue is greater than 35% of the expenditures, the ACO would be considered "High Revenue".	$93,411,313	$34,562,186	$32,693,960
Low Revenue	If the ACO's assigned beneficiary Part A + Part B revenue is less than 35% of the expenditures, the ACO would be considered "Low Revenue".	$93,411,313	$13,630,983	$32,693,960

High/Low Revenue

MSR/MLR (One-Sided)

(b) Minimum savings or loss rate. (1) For ACOs under a one-sided model of the BASIC track's glide path, as specified under paragraphs (d)(1)(i) and (ii) of this section, CMS uses a sliding scale, based on the number of beneficiaries assigned to the ACO under subpart E of this part, to establish the MSR for the ACO as follows:

Number of Beneficiaries	MSR (low end of assigned beneficiaries) (percent)	MSR (high end of assigned beneficiaries) (percent)
1 – 499	≥12.2	
500 – 999	12.2	8.7
1,000 – 2,999	8.7	5.0
3,000 – 4,999	5.0	3.9
5,000 – 5,999	3.9	3.6
6,000 – 6,999	3.6	3.4
7,000 – 7,999	3.4	3.2
8,000 – 8,999	3.2	3.1
9,000 – 9,999	3.1	3.0
10,000 – 14,999	3.0	2.7
15,000 – 19,999	2.7	2.5
20,000 – 49,999	2.5	2.2
50,000 – 59,999	2.2	2.0
60,000 +	2.0	2.0

MSR/MLR (Two-Sided)

- Zero Percent
- Symmetrical in a 0.5 percent increment between 0.5 and 2.0 percent.
- Symmetrical that varies based on the number of assigned beneficiaries (see one-sided model)

Financial Example

ACO Track	Part A + Part B Benchmark Expenditures	ACO Revenue (Parts A and B)	% of ACO Revenue at Risk	Risk Revenue %	CAP - % of Updated Benchmark Expenditures	CAP - Updated Benchmark Expenditure %
Basic C	$93,411,313	$13,630,983	$272,620	2%	$934,113.13	1%
Basic D	$93,411,313	$13,630,983	$545,239	4%	$1,868,226	2%
Basic E	$93,411,313	$13,630,983	$1,090,479	8%	$3,736,453	4%
Enhanced	$93,411,313	$13,630,983	N/A	N/A	$14,011,697	15%

ACO Year of Application Impact

ACO Type	Experienced with Risk	High/Low Revenue ACO	Start/Renewal Date	Option to Renew Early under Pathways	Basic Track	Basic E Track	Enhanced Track	Option to Advance to Higher Level
New ACO*	No	High	7/1/2019 and after	N/A	Yes (A-E)	Yes	Yes	Yes
		Low	7/1/2019 and after	N/A	Yes (A-E) - Can elect for 3rd year under Basic B, but would require automatic advancement to Basic E in Year 4 and 5.	Yes	Yes	Yes
New Legal Entity ACO (40% of composition with ACO participants with prior risk experience)*	Yes	High	7/1/2019 and after	N/A	No	No	Yes	No
		Low	7/1/2019 and after	N/A	No	Yes	Yes	No
Track 1 Existing Renewal (2013 New/2016 New/Renewal)(that have extended for 6 months 1/1/2019 to 6/1/30)*	No	High	7/1/2019	N/A	Yes (Max of 1.5 Years under Basic B and Min of 2 years under Basic E)	Yes	Yes	Yes
		Low	7/1/2019	N/A	Yes (Max of 1.5 Years under Basic B and Min of 2 years under Basic E)	Yes	Yes	Yes
Track 1 Existing Renewal (2014 New/2017 New/Renewal)	No	High	1/1/2020	Yes	Yes (Max of 1 Year under Basic B and Min of 2 years under Basic E)	Yes	Yes	Yes
		Low	1/1/2020	Yes	Yes (Max of 1 Year under Basic B and Min of 2 years under Basic E)	Yes	Yes	Yes
Track 1 Existing Renewal (2015 New/2018 New/Renewal)	No	High	1/1/2021	Yes	Yes (Max of 1 Year under Basic B and Min of 2 years under Basic E)	Yes	Yes	Yes
		Low	1/1/2021	Yes	Yes (Max of 1 Year under Basic B and Min of 2 years under Basic E)	Yes	Yes	Yes
Track 1+ Existing Renewal (2018 New)	Yes	High	1/1/2021 Must start a Enhanced Pathways Track	Yes	No	Yes - If ACO is to renew under Pathways 2020 or before.	Yes	No
		Low	1/1/2021 Must start Enhanced Pathways Track	Yes	No	Yes - If ACO is to renew under Pathways 2020 or before.	Yes	No
Track 2 Existing Renewal (ALL)	Yes	High	All Renewal Dates	Yes	No	No	Yes	No
		Low	All Renewal Dates	Yes	No	Yes	Yes	No
Track 3 Exisiting Renewal (ALL)	Yes	High	All Renewal Dates	Yes	No	No	Yes	No
		Low	All Renewal Dates	Yes	No	Yes	Yes	No
NextGEN	NextGEN ACO Model expected to continue until 2020 and will release and updated model soon based on future options. No changes to model at this time.							

**Renewal ACOs starting on 7-1-19 would have a 1 time agreement period of 5 Years and 6 mo. The first 6 month period would be under the Basic B model and the new ACO would be allowed a maximum of 1.5-3.5 years with no risk.*

**ACOs starting on 7-1-19 would have a 1 time agreement period of 5 Years and 6 mo. The first 6 month period would be under the Basic A model and the new ACO would be allowed a maximum of 2.5-3.5 years with no risk depending on revenue model*

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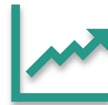
Benchmarking



CMS finalized proposal to use a blend of regional and national growth rates based on Medicare FFS expenditures with increasing weight placed on the national component of the blend as the ACO's penetration in its regional service area increases.

This approach is expected to result in more favorable trend factors for ACOs with high penetration in a regional service area with lower spending growth compared to the nation and less favorable trend factors for ACOs with high penetration in a regional service area with higher spending growth compared to the nation.

This approach is expected to have little impact on ACOs with low to medium penetration in their regional service area.

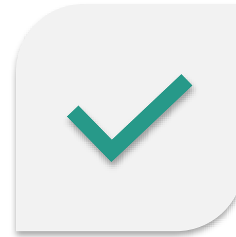
Program Flexibility

Program Flexibility					
	Choice of Beneficiary Assignment?	Annual election to enter higher risk?	Beneficiary Incentive Program	Expanded Telehealth Services	3-Day SNF Rule Waiver
Level A & B	Yes	Yes	No	No	No
Level C	Yes	Yes	Yes, ACOs may establish an approved program starting July 1, 2019, or in subsequent years	Yes, in 2020 for ACOs electing prospective assignment	Yes, ACOs may apply to start on July 1, 2019, and in subsequent years
Level D	Yes	No; ACO will automatically transition to Level E at the start of the next performance year.	Yes, ACOs may establish an approved program starting July 1, 2019, or in subsequent years	Yes, in 2020 for ACOs electing prospective assignment	Yes, ACOs may apply to start on July 1, 2019, and in subsequent years
Level E	Yes	No; maximum level of risk/reward under the BASIC track	Yes, ACOs may establish an approved program starting July 1, 2019, or in subsequent years	Yes, in 2020 for ACOs electing prospective assignment	Yes, ACOs may apply to start on July 1, 2019, and in subsequent years
ENHANCED	Yes	No; maximum level of risk/reward	Yes, ACOs may establish an approved program starting July 1, 2019, or in subsequent years	Yes, in 2020 for ACOs electing prospective assignment	Yes, ACOs may apply to start on July 1, 2019, and in subsequent years

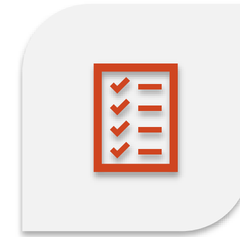
Beneficiary Incentive Program

An ACO approved to operate a beneficiary incentive program will provide an incentive of up to $20 to an assigned beneficiary for each qualifying primary care service that the beneficiary receives from certain ACO professionals, FQHC or RHC.

Beneficiary Notices



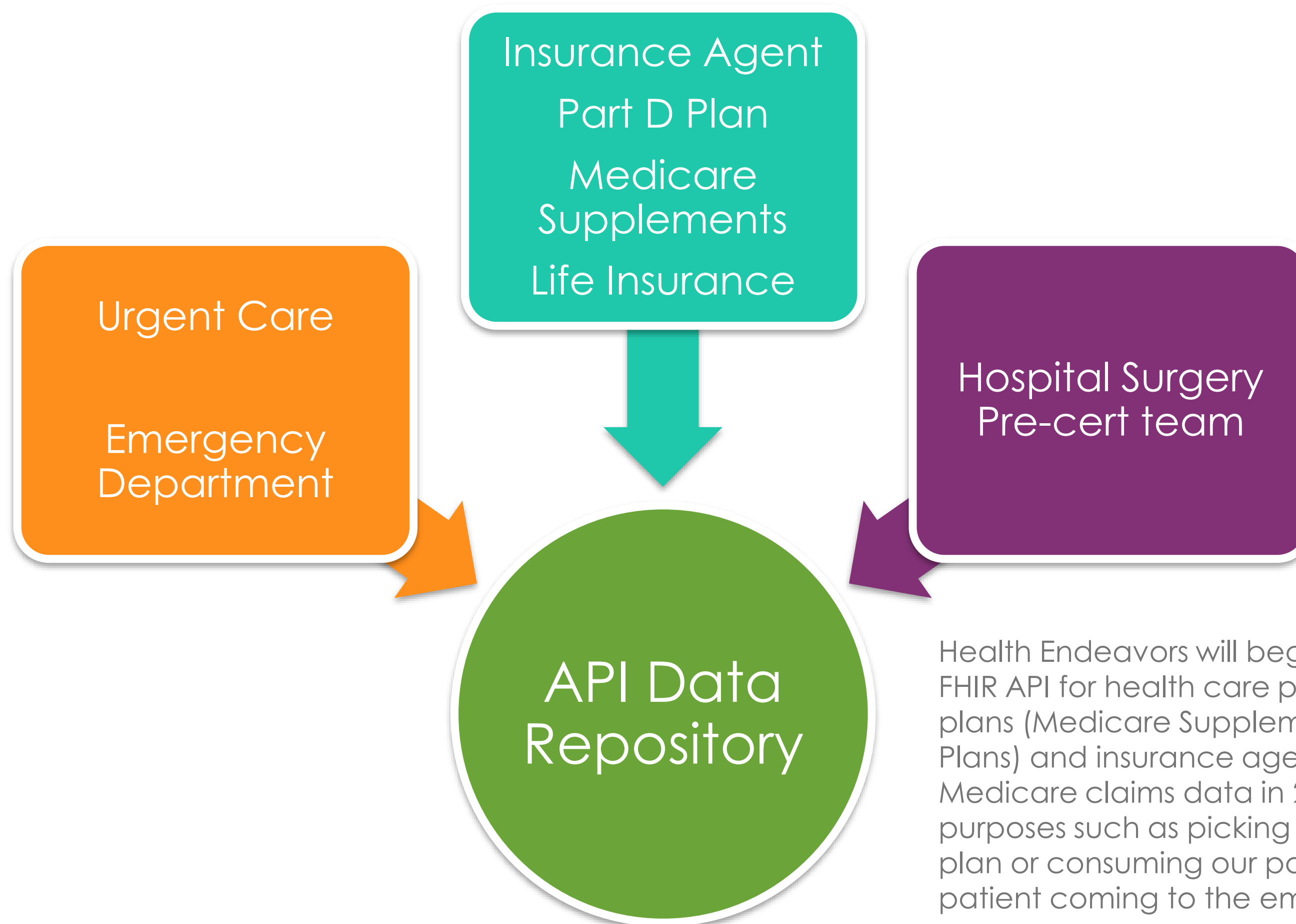
AN ACO MUST ENSURE THAT MEDICARE FFS BENEFICIARIES ARE NOTIFIED ABOUT ALL OF THE FOLLOWING: (1) ITS ACO PROVIDERS/SUPPLIERS ARE PARTICIPATING IN THE SHARED SAVINGS PROGRAM; (2) THE BENEFICIARY'S OPPORTUNITY TO DECLINE CLAIMS DATA SHARING; AND (3) THE BENEFICIARY'S ABILITY TO, AND THE PROCESS BY WHICH, HE OR SHE MAY IDENTIFY OR CHANGE IDENTIFICATION OF THE INDIVIDUAL HE OR SHE DESIGNATED AS THEIR PRIMARY CLINICIAN FOR PURPOSES OF VOLUNTARY ALIGNMENT.



IN ADDITION, AN ACO THAT OPERATES A BENEFICIARY INCENTIVE PROGRAM MUST ENSURE THAT ITS ASSIGNED FFS BENEFICIARIES ARE NOTIFIED OF THE AVAILABILITY OF THE BENEFICIARY INCENTIVE PROGRAM. ACOS OR THEIR ACO PARTICIPANTS MUST PROVIDE SUCH NOTIFICATIONS PRIOR TO OR AT A BENEFICIARY'S FIRST PRIMARY CARE SERVICE VISIT OF EACH PERFORMANCE YEAR. TO MITIGATE THE BURDEN OF THESE ADDITIONAL NOTIFICATIONS, WE ARE DEVELOPING TEMPLATE NOTICES FOR ACOS AND ACO PARTICIPANTS TO USE.

Lastly, in the final rule we discuss comments received in response to our request for input on how Medicare ACOs and the sponsors of stand-alone Part D prescription drug plans (Part D sponsors) could be encouraged to collaborate so as to improve the coordination of pharmacy care for Medicare FFS beneficiaries.

Application Program Interface (API) Vendors Approved by Consumer



Health Endeavors will begin offering a FHIR API for health care providers, health plans (Medicare Supplements and Part D Plans) and insurance agents to access the Medicare claims data in 2019 for various purposes such as picking a Part D drug plan or consuming our patient history for a patient coming to the emergency room or to your facility for surgery.

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Choose your path or have it chosen for you

Value-Based may be mandatory

The Center for Medicare and Medicaid Innovation will soon launch "new, bold" models for value-based care — and they might be mandatory, according HHS Secretary Alex Azar's remarks at a Sept. 6 meeting in Washington, D.C., for the Physician-Focused Payment Model Technical Advisory Committee.

Leaving the ACO program solves nothing for providers

- Still have
  - Quality reporting requirements
    - Currently getting MIPS upward adjustments
  - Possibility of forced risk
  - Market Share Concerns
    - Consumer alignment
    - Provider engagement
    - Out-of-Network
    - New ventures coming into market – CVS Health, Amazon, etc.
  - Data-Sharing/Interoperability Issues

Options?

- Stay in your current agreement period until the end of its term.
  - Exit the ACO program upon termination of your agreement period.
  - Apply for No Risk to Risk path with 5% APM at end of your current term.
- Apply and/or Renew under Medicare ACO - Pathways to Success July 2, 2019.
  - 5 years and 6 months initial period starting July 1, 2019

Options?

- Implement Revenue Models
  - CCM 99490
  - Virtual Check-in
  - Remote Evaluation
  - Redirect Out-of-Network (consumer alignment)
  - IPA Association (GPRO and HEDIS Quality Reporting)

- Form organizational alternatives to ACO program (in addition to or in place of)
  - Clinically integrated network (CIN)
  - Virtual Group under MIPS
  - MIPS Qualified Registry (IPA/Medical Staff)
    - MIPS Upward Adjustment
  - All Payer Advanced Alternative – 5% APM
  - Consumer Centered Health (CCH) Program
    - Self-Insured Employer
    - Medicare
    - Medicare Advantage
    - Commercial
    - Medicaid

Why form an "Alternative Model"?

ACHIEVE 5% APM QUICKER

MORE FLEXIBILITY

ALL PAYER

RISK READINESS

CREATE REVENUE MODELS

CONSUMER ALIGNMENT

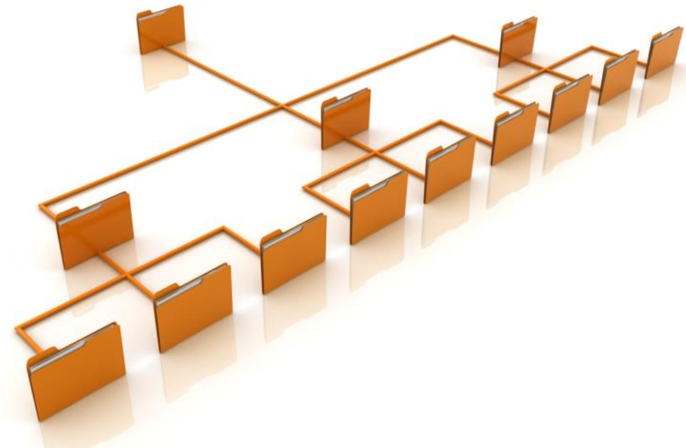
PROVIDER ENGAGEMENT

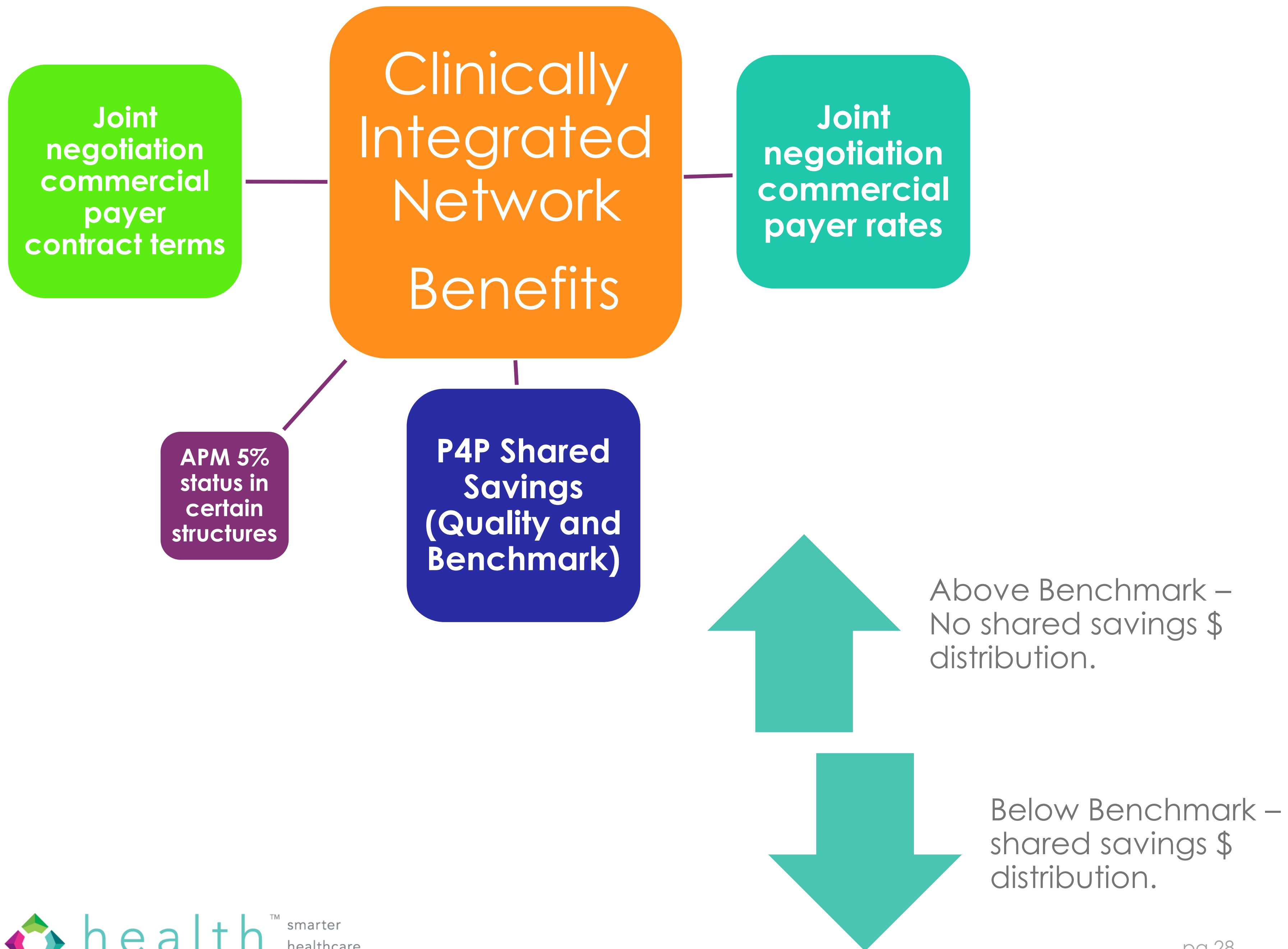
BRANDING AND MARKETING

Clinically Integrated Network (CIN)
ACO is a CIN

How to achieve CIN?

- Use of common information technology to ensure exchange of all relevant patient data;
- Development and adoption of clinical protocols;
- Review of care based upon implementation of clinical protocols; and
- Mechanisms to ensure adherence to protocols.




Clinically Integrated Network Benefits
Joint negotiation commercial payer contract terms
Joint negotiation commercial payer rates
APM 5% status in certain structures
P4P Shared Savings (Quality and Benchmark)
Above Benchmark – No shared savings $ distribution.
Below Benchmark – shared savings $ distribution.
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Moving Forward Options

Accountable Care Organization (ACO)

Is a CIN

Clinically Integrated Network (CIN)

Specific Targeted Collaborations

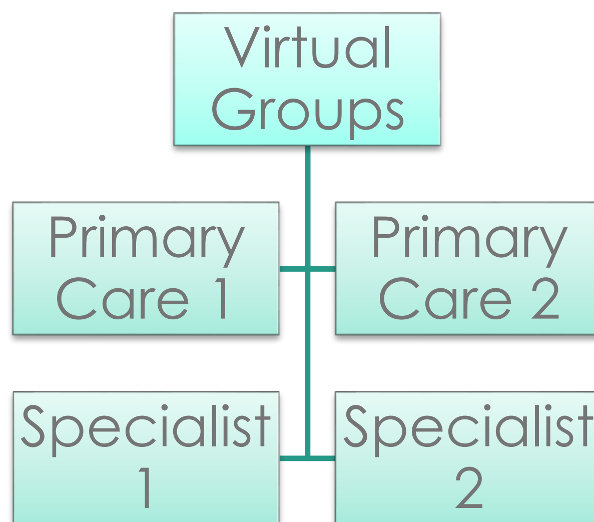
Move to CIN or ACO after establishing a more comprehensive initial quality reporting and data-sharing platform that include revenue models.

	Pros	Cons/Concerns
Accountable Care Organization (ACO) Medicare ACO Claims Data	CIN designation Negotiate payer price terms, payment terms and medical staff credentialing with payers (joint negotiator) Shared Savings Collective network quality platform established Advanced APM 5% in certain cases	**Quality scored as one organization** **Base number of lives is 5,000** Effort of collaboration may not be conducive to the resources available.
Clinically Integrated Network (CIN) Commercial Claims Data Medicare Blue Button Claims Data	Negotiate payer price terms, payment terms and medical staff credentialing with payers (joint negotiator) P4P shared savings program Collective network quality platform established Advanced APM 5% in certain cases	Effort of collaboration may not be conducive to the resources available.

What is a Virtual Group

A virtual group is defined as a combination of two or more TINs assigned to one or more solo practitioners, or to one or more groups consisting of 10 or fewer clinicians (including at least 1 MIPS eligible clinician), or both, that elect to form a virtual group for a performance period for a year.

Specialty, Geographic, Revenue Size



Why "Virtual Group"?

The formation of virtual groups provides for a comprehensive measurement of performance, shared responsibility, and an opportunity to effectively and efficiently coordinate resources to achieve requirements under each performance category much like an ACO.

How to form a "Virtual Group"?

- A virtual group must have a formal written agreement with each entity that composes the virtual group that outlines requirements/expectations under MIPS.
- Name an official representative to be responsible for submitting on behalf of the group.
- The representative must submit a virtual group election on behalf of the group via email to MIPS_VirtualGroups@cms.hhs.gov
- The Virtual Groups Toolkit can be found at: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html

All-Payer Advanced Alternative Payment Model

- All-Payer Advanced Alternative Payment Models (APMs) Option
- Starting in the 2019 QP Performance Period, eligible clinicians will be able to become Qualifying Alternative Payment Model Participant (QPs) through the All-Payer Option.
- This Option is attainable through participation in a combination of Advanced APMs with Medicare and Other-Payer Advanced APMs.

How to Achieve Shared Savings

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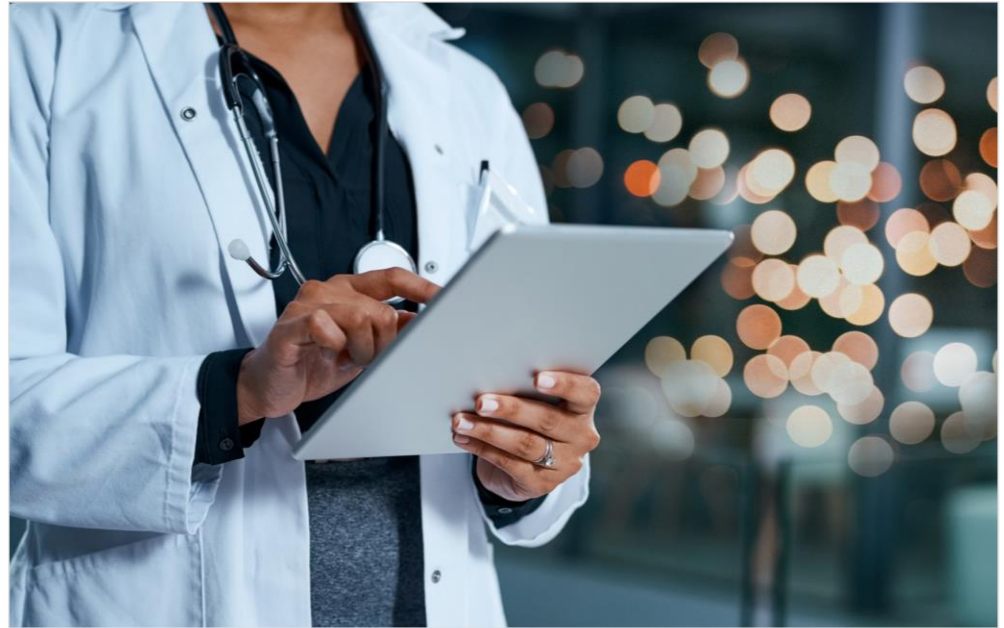
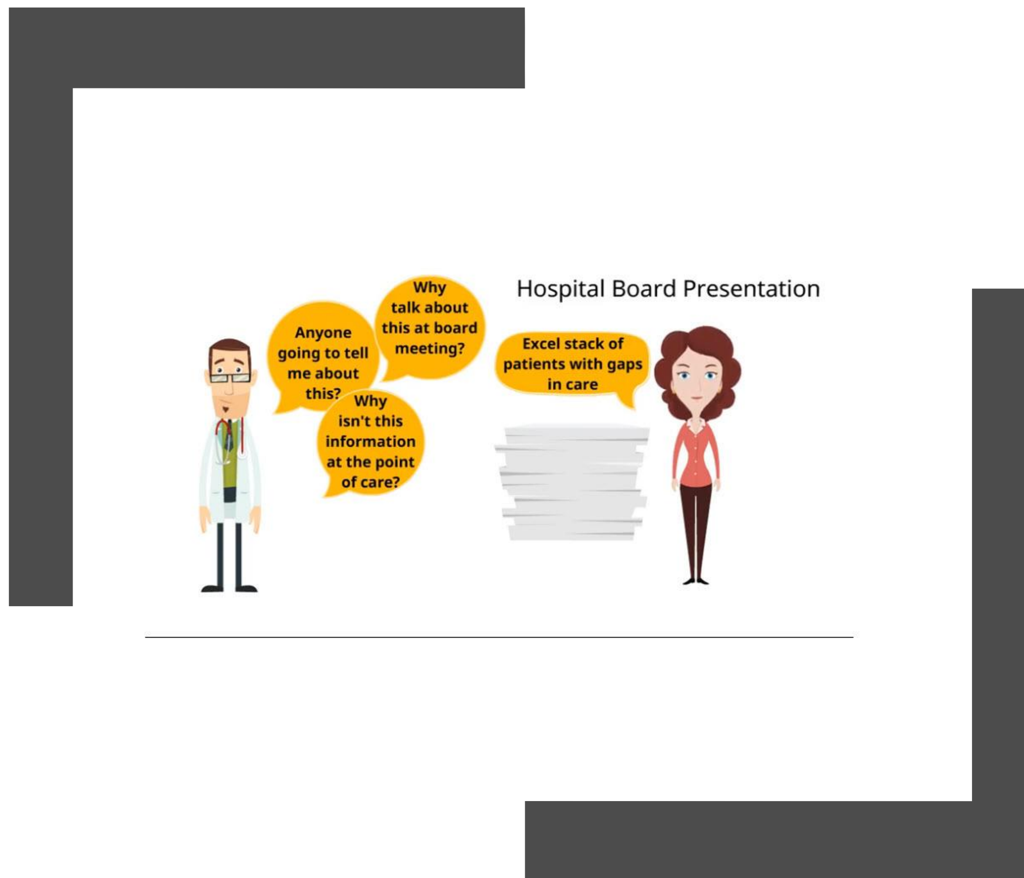
The problem:

Lots of data for ACOs, CINs and Payers but very little actionable data put in front of the provider team and the consumer which results in lack of engagement and goal achievement.



- Provider Team Buy-in of Initiatives
  - Awareness of Initiatives
  - Engagement with Initiatives
- Consumer
  - Network Alignment
  - Care Engagement

Need to put the initiatives in front of provider team at point of care



- Benchmark/Spend
- Risk Score
- Cost & Utilization
- Quality
- Care Gaps
- HCC Coding
- Out-of-Network
- Provider Performance
- Enroll Text Alerts – Care Gaps

EHR Connector

Patient Requires Attention (Spend is Greater Than Expected)

Michelle TestPatient878F8

Export / Print Quick Profile PDF

Export / Print Patient History PDF

HICN: 900478330X

MBI:

DOB: 09-25-1927

Gender: F

HCC Risk Score: 2.195

Primary Assigned Practice: Demo Hospital

Primary Assigned Provider: None Assigned

Population: ACO

Text Alert Enrolled: No

Status: Attributed

CCM Eligible: Yes

Potentially Costly: Yes

Quick Profile | Patient History | Patient Contact Details

2018 vs 2017 HCC DX
Chronic Kidney Disease (Stage 5)
Chronic Kidney Disease, Severe (Stage 4)
~~Diabetes without Complication~~
Other Significant Endocrine and Metabolic Disorders
Protein-Calorie Malnutrition
Specified Heart Arrhythmias
Vascular Disease

2018 vs 2017 Medications
Calcitriol
Clopidogrel
Fludrocortisone Acetate
Lovastatin
Metoprolol tartrate
Midodrine Hydrochloride
~~Nitrofurantoin (monohydrate/macrocrystals)~~
Synthroid
Tobramycin

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Patient Requires Attention (Spend is Greater Than Expected)

Quick Profile | Patient History | Patient Contact Details

2018 vs 2017 HCC DX

- Acute Renal Failure
- Cardio-Respiratory Failure and Shock
- Chronic Ulcer of Skin, Except Pressure
- ~~**Congestive Heart Failure**~~
- Diabetes with Chronic Complications
- Diabetes without Complication
- ~~**Disorders of Immunity**~~
- Hemiplegia/Hemiparesis
- Hip Fracture/Dislocation
- Ischemic or Unspecified Stroke
- Major Depressive, Bipolar, and Paranoid Disorders

2018 vs 2017 Medications

- Alprazolam
- Aptiom
- ATORVASTATIN CALCIUM
- Azithromycin
- celecoxib
- Cephalexin
- ~~**Clonazepam**~~
- COLLAGENASE SANTYL
- Divalproex Sodium
- Ezetimibe
- Gabapentin

Quality

Care-1 Medication Reconciliation	**Action Required**
Care-2 Falls: Screening for Future Fall Risk	Not Applicable
PREV-5 Breast Cancer Screening	Not Applicable
PREV-6 Colorectal Cancer Screening	Not Applicable
PREV-7 Influenza Immunization	Done
PREV-8 Pneumococcal Vaccination	Not Applicable
PREV-9 Body Mass Index (BMI) Screening and Follow-up	Done
PREV-10 Tobacco Use: Screening and Cessation Intervention	Done
PREV-12 Screening for Depression and Follow-up Plan	Done
PREV-13 Statin Therapy	**Action Required**
DM-2 Composite/DM with HbA1c > 9 percent (poor control)	Done

Cost and Utilization

2018 YTD Spend	$100232.15
2018 HCC Benchmark	$48761.40
2018 HCC Benchmark vs 2018 YTD Spend	**206.00%**
Out of Network Spend*	$70101.87
Office Visits*	01-10-2018;04-02-2018;06-01-2018
Most Visited Provider*	1033290549 LANORA RILEY
Last Wellness Visit*	**N/A**
Admits*	**1**
Readmissions*	0
ED Visits*	**10**
ED Visits that led to Hospitalizations*	**1**

Gaps In Care

Wellness Visit Done Last 12 Mo	**No**

Gaps In Care at Risk

Diagnosed with Diabetes	Yes
Blood Pressure Last 12 Mo	**No**
Foot Exam Last 12 Mo	**No - 08/10/2016**
HbA1C Last 12 Mo	Yes - 09/19/2018
LDL-C Last 12 Mo	Yes - 09/19/2018
Retinal Exam Last 12 Mo	Yes - 04/10/2018
Tobacco Use Last 12 Mo	**No - 06/23/2015 - 3-Not a tobacco user**
Diagnosed with Hypertension	Yes
Blood Pressure Last 12 Mo	**No**

Benchmarks - Spend

Patient Requires Attention (Spend is Greater Than Expected)

Provider team instantly knows if patient is above their risk-stratified benchmark thus causing the ACO to exceed its benchmark.

Risk Score

Patient Requires Attention (Spend is Greater Than Expected)

Martin TestPatient0173C

Export / Print Quick Profile PDF

Export / Print Patient History PDF

HICN: 106727479X	**HCC Risk Score:** .386	**Text Alert Enrolled:** Yes
MBI:	**Primary Assigned Practice:** Demo Hospital	**Status:** Attributed
DOB: 06-23-1976	**Primary Assigned Provider:** None Assigned	**CCM Eligible:** Yes
Gender: M	**Population:** ACO/Medicare	**Potentially Costly:** No

Quick Profile | Patient History | Patient Contact Details

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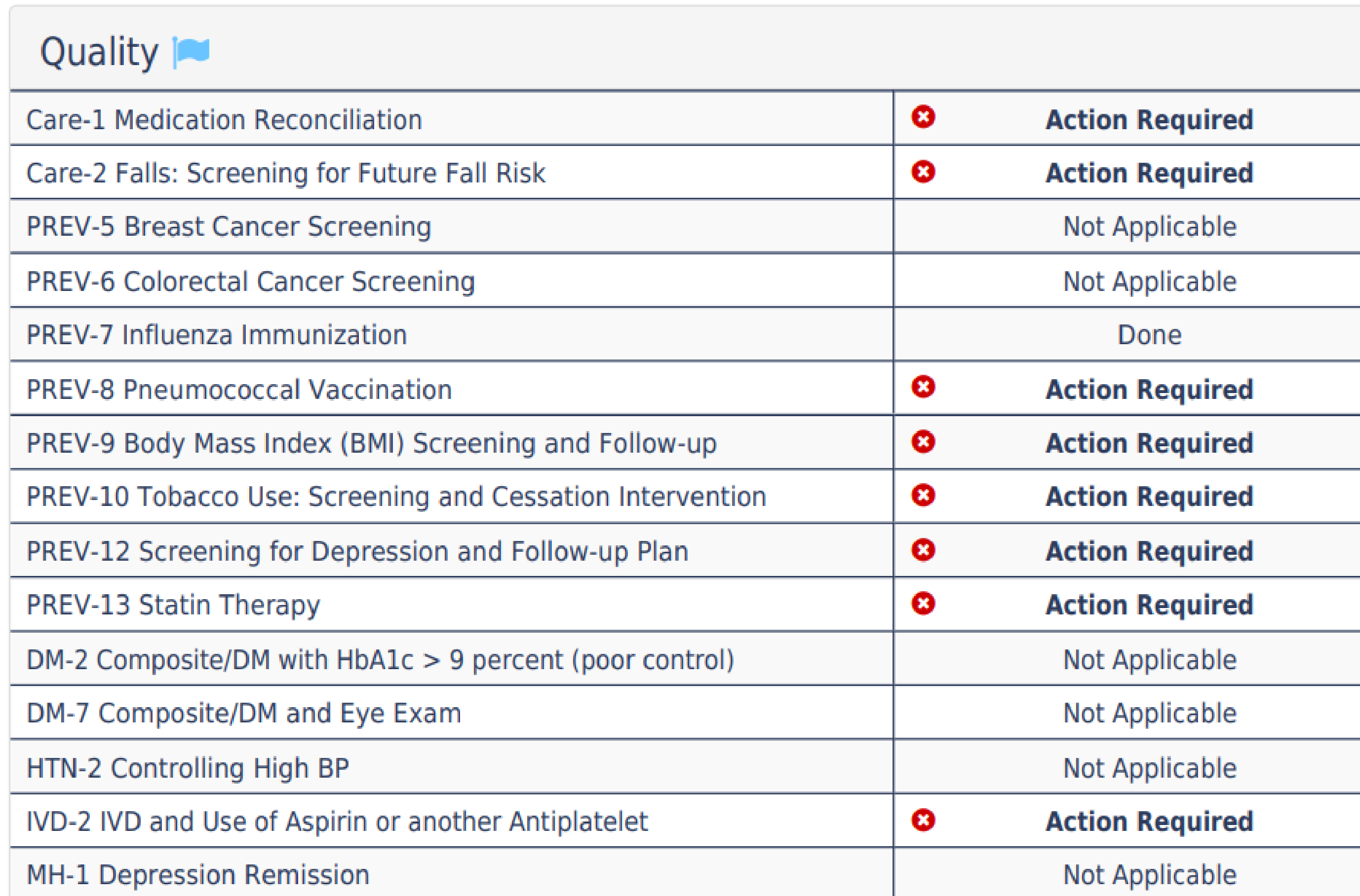
Cost & Utilization

Patient Requires Attention (Spend is Greater Than Expected)

Cost and Utilization

2018 YTD Spend		$20037.49
2018 HCC Benchmark		$19864.75
2018 HCC Benchmark vs 2018 YTD Spend	⊗	**101.00%**
Out of Network Spend*		$18634.66
Office Visits*		06-26-2018;06-26-2018;06-27-2018
Most Visited Provider*		1003177767 DONALD TOBIAS M.D.
Last Wellness Visit*	⊗	**N/A**
Admits*	⊗	**1**
Readmissions*		0
ED Visits*	⊗	**1**
ED Visits that led to Hospitalizations*	⊗	**1**
CT Scans*	⊗	**2**
MRI Events*		0

Quality Metrics
Action Required Alerts Provider Team to Care Caps



Quality

Measure	Status
Care-1 Medication Reconciliation	**Action Required**
Care-2 Falls: Screening for Future Fall Risk	**Action Required**
PREV-5 Breast Cancer Screening	Not Applicable
PREV-6 Colorectal Cancer Screening	Not Applicable
PREV-7 Influenza Immunization	Done
PREV-8 Pneumococcal Vaccination	**Action Required**
PREV-9 Body Mass Index (BMI) Screening and Follow-up	**Action Required**
PREV-10 Tobacco Use: Screening and Cessation Intervention	**Action Required**
PREV-12 Screening for Depression and Follow-up Plan	**Action Required**
PREV-13 Statin Therapy	**Action Required**
DM-2 Composite/DM with HbA1c > 9 percent (poor control)	Not Applicable
DM-7 Composite/DM and Eye Exam	Not Applicable
HTN-2 Controlling High BP	Not Applicable
IVD-2 IVD and Use of Aspirin or another Antiplatelet	**Action Required**
MH-1 Depression Remission	Not Applicable

Gaps In Care	
Wellness Visit Done Last 12 Mo	No - 09/15/2017 - Complete

Gaps In Care at Risk	
Diagnosed with Hypertension	Yes
Blood Pressure Last 12 Mo	**No - 06/17/2016 - IN RANGE**
Tobacco Use Last 12 Mo	**No - 06/17/2016 - 3-Not a tobacco user**

Gaps In Care at Risk	
Diagnosed with Diabetes	Yes
Blood Pressure Last 12 Mo	**No**
Foot Exam Last 12 Mo	**No**
HbA1C Last 12 Mo	Yes - 05/29/2018
LDL-C Last 12 Mo	**No - 03/30/2016**
Retinal Exam Last 12 Mo	**No - 02/22/2016**
Tobacco Use Last 12 Mo	**No**
Diagnosed with Hypertension	Yes
Blood Pressure Last 12 Mo	**No**
LDL-C Last 12 Mo	**No - 03/30/2016**

Care Gaps

HCC at Point of Care: Re-code removed diagnoses at the clinic encounter

CPOE Viet, Two - 00011850 Opened by Test DR, Hospitalist

Task Edit View Patient Chart Links Notifications Navigation Help

Home Message Centre Patient List Physician Handoff Dynamic Worklist eHealth Viewer PharmaNet Viewer PowerChart Web Manual VIHA Clinical Resources DynaMed UpToDate

Tear Off Exit Calculator AdHoc PM Conversation Communicate Patient Education Add Explorer Menu Endorse Results [5] Docum.: 2 Order.: 58 Resul.: 93

CPOE Viet, Two
DOB:10-Oct-1954 61 years Male
PHN:5122-376-438 MRN:00011850
Enc:103592
Inpatient Acute; Reg Date: 25-Aug-2015 13:14
Disch DT:
Loc:4-NRG; 4026; 1
MRP:Test DR, Hospitalist
PCP:Test, Ambulatory: Urgent Care Physician
Alerts:Falls Risk,Elopement
Precautions:Droplet
Meas. Wt:75.2 kg
MOST:M3 – treatment including transfer care
Allergies: Grass, ampicillin, Apple Juice, Calcium

Menu: Provider View, Results Review, Historical View, Clinical Notes, Allergies (Add), Diagnosis & Problems, Documentation (Add), eHealth Viewer, Form Browser, Growth Chart, Health Maintenance, Histories, Immunization Schedule, Interactive View and I&O, MAR Summary, Medication List (Add), Orders (Add), Patient Information, Sepsis Antibiotic Advisor, Transfusion Medicine Summary

Provider View — Full screen · Print · 1 minutes ago

Patient Requires Attention (Spend is Greater Than Expected)

Michelle TestPatient878F8

Export / Print Quick Profile PDF · Export / Print Patient History PDF

HICN: 900478330X
MBI:
DOB: 09-25-1927
Gender: F

HCC Risk Score: 2.195
Primary Assigned Practice: Demo Hospital
Primary Assigned Provider: None Assigned
Population: ACO

Text Alert Enrolled: No
Status: Attributed
CCM Eligible: Yes
Potentially Costly: Yes

Quick Profile · Patient History · Patient Contact Details

2018 vs 2017 HCC DX
Chronic Kidney Disease (Stage 5)
Chronic Kidney Disease, Severe (Stage 4)
~~Diabetes without Complication~~
Other Significant Endocrine and Metabolic Disorders
Protein-Calorie Malnutrition
Specified Heart Arrhythmias
Vascular Disease

2018 vs 2017 Medications
Calcitriol
Clopidogrel
Fludrocortisone Acetate
Lovastatin
Metoprolol tartrate
Midodrine Hydrochloride
~~Nitrofurantoin (monohydrate/macrocrystals)~~
Synthroid
Tobramycin

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Out-of-Network

Eligibility

Dual Eligible: Non-Medicaid

Medicare Status Code: Aged without ESRD

HCC Trend

2017 Your Risk Score: 1.826

2016 Your Risk Score: 2.676

2015 Your Risk Score: .817

2014 Your Risk Score: .265

Part A In Network | Part A Out Of Network | Part B In Network | Part B Out Of Network

2018

January

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

February

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28			

March

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Patient First Name | Patient Last Name | Admin | Logout

Cost and Utilization

2018 YTD Spend		$39189.40
2018 HCC Benchmark		$11864.55
2018 HCC Benchmark vs 2018 YTD Spend	✖	**330.00%**

Quality

Care-1 Medication Reconciliation	✖	**Action Required**
Care-2 Falls: Screening for Future Fall Risk	✖	**Action Required**
PREV-9 Body Mass Index (BMI) Screening and Follow-up	✖	**Action Required**
PREV-10 Tobacco Use: Screening and Cessation Intervention		Done
Wellness Visit Done Last 12 Mo	✖	**No**

Alternative to EHR Connector - Patient Search

Enroll Consumer Medical Text Alerts

An example Medical Text Alert is when a diabetic patient gets a text alert about their labs, exams and other tests being due to complete.

Or a medication alert about an unfilled prescription prescribed to managed a condition.

Or if engaging in remote monitoring of blood pressure, an alert your blood pressure has been in an unhealthy range for an extended period.

Home Things to Complete

Activity	Status	
Wellness Visit	Complete	Change Status
HbA1C	Action Required	Change Status
Foot Exam	Action Required	Change Status
Blood Pressure	Action Required	Change Status
Tobacco Use	Action Required	Change Status
LDL-C	Action Required	Change Status

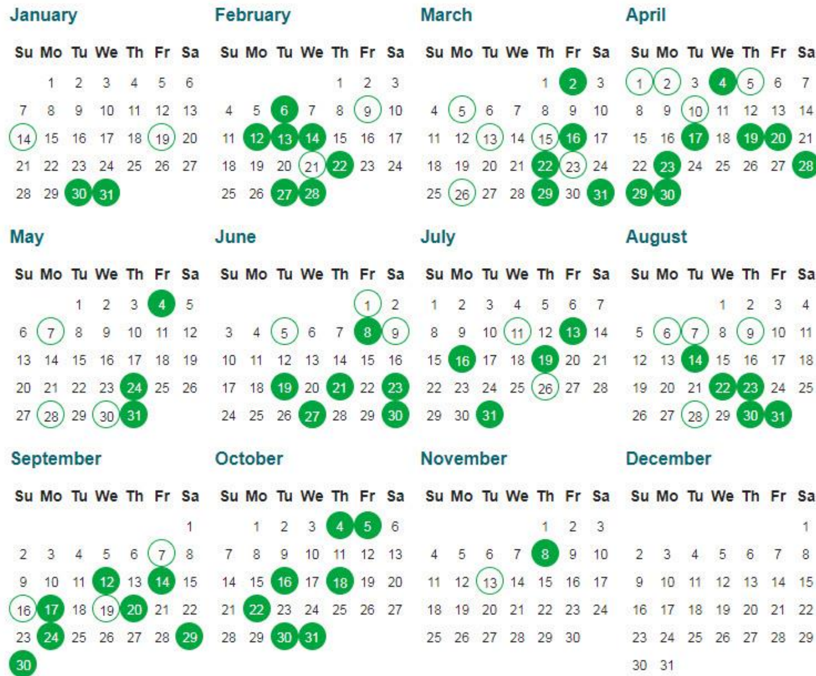
Save Activity Statuses

Patient's contact information

Enter the patients phone or email address so we can send an enrollment link

Enter Cell Phone Number or Email

Cancel OK



Current Diagnosis List (ICD-10)

- R9439 Abnormal result of other cardiovascular function study
- D631 Anemia in chronic kidney disease
- I770 Arteriovenous fistula, acquired
- I2510 Athscl heart disease of native coronary artery w/o ang pctrs
- N261 Atrophy of kidney (terminal)
- Z6825 Body mass index (BMI) 25.0-25.9, adult
- I429 Cardiomyopathy, unspecified

Current Medication List

- Breo Ellipta
- Calcium Acetate
- Furosemide
- Hydrocodone Bitartrate and Acetaminophen
- Lantus Solostar
- Levemir
- Metoclopramide Hydrochloride

Part A Data *(2018)* +

Part B Data *(2018)* +

Part D Data *(2018)* -

11/13/2018 $3.35

Drug Name	Qty / Days
Sertraline	180.0 / 90

Package Description
90 Tablet, Film Coated In 1 Bottle (68180-352-09)

Form	Route
Tablet, Film Coated	Oral

Labeler Name	Pharmaceutical Class
Lupin Pharmaceuticals, Inc.	Serotonin Reuptake Inhibitor

Active Ingredients

Name	Strength Unit
SERTRALINE HYDROCHLORIDE	50 mg/1

Show Provider Details

11/13/2018 $8.35

Drug Name	Qty / Days
NOVOLOG / insulin aspart	45.0 / 90

Package Description
5 Syringe, Plastic In 1 Carton (0169-6339-10) > 3 Ml In 1 Syringe, Plastic

Form	Route
Injection, Solution	Intravenous, Subcutaneous

Labeler Name	Pharmaceutical Class
Novo Nordisk	Insulin Analog

Active Ingredients

Name	Strength Unit
INSULIN ASPART	100 [iU]/mL

Show Provider Details

Consumer syncs Medicare Blue Button Data

Home Things to Complete

Wellness Visit Complete	Change Status
HbA1C Action Required	Change Status
Foot Exam Action Required	Change Status
Blood Pressure Action Required	Change Status
Tobacco Use Action Required	Change Status
LDL-C Action Required	Change Status

Save Activity Statuses

7:28

My Account

Home

Health Score
4.344
Poor
Health Spend
Above Expected

Things To Complete (7)

My Journal

Health Records

8:12

My Account

Home

Health Score
0.624
Excellent
Health Spend
Below Expected

Things To Complete (0)

My Journal

Health Records

12:03

Claims History

View Your Doctor Visits

Select a date to view more details

2017

January

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

February

Su	Mo	Tu	We	Th	Fr	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25

App generates Health History, Care Gap Text Alerts, Health Score, Expected Spend

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Medical Text Alerts
Medicare Approved App

95% of text messages opened in minutes

MyMedicare Secure Sign In

Enter your User name and Password and sign in to MyMedicare.gov to continue.

User name

Password

By accessing this system, you agree to our Terms and Conditions. Read more +

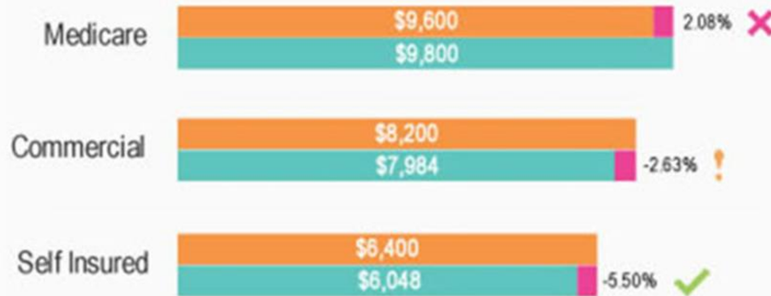
Sign In

Consumer Addresses

- New 2019 CCLF file updates include addresses.
- Direct Mailer to consumers (assigned) to enroll in app for benchmarking, spend, health score text alerts.

Provider Performance

YTD Spend



2018 PMPY YTD Spend
2018 PMPY Benchmark
% Difference From

2018 Health Endeavors *Data Through:* 12/28/2017

Quality Measures Detail Performance

Medicare | Commercial | Self Insured

Measure	*Medicare Target*		*Medicare Actual*
	Care Coordination		
Medication Reconciliation Post Discharge	90	!	86
Fall Screening	90	✗	78
Annual Monitoring for Patients on Persistent Medications	90	✓	98
	Preventive Care		
Breast Cancer Screening	90	✓	76

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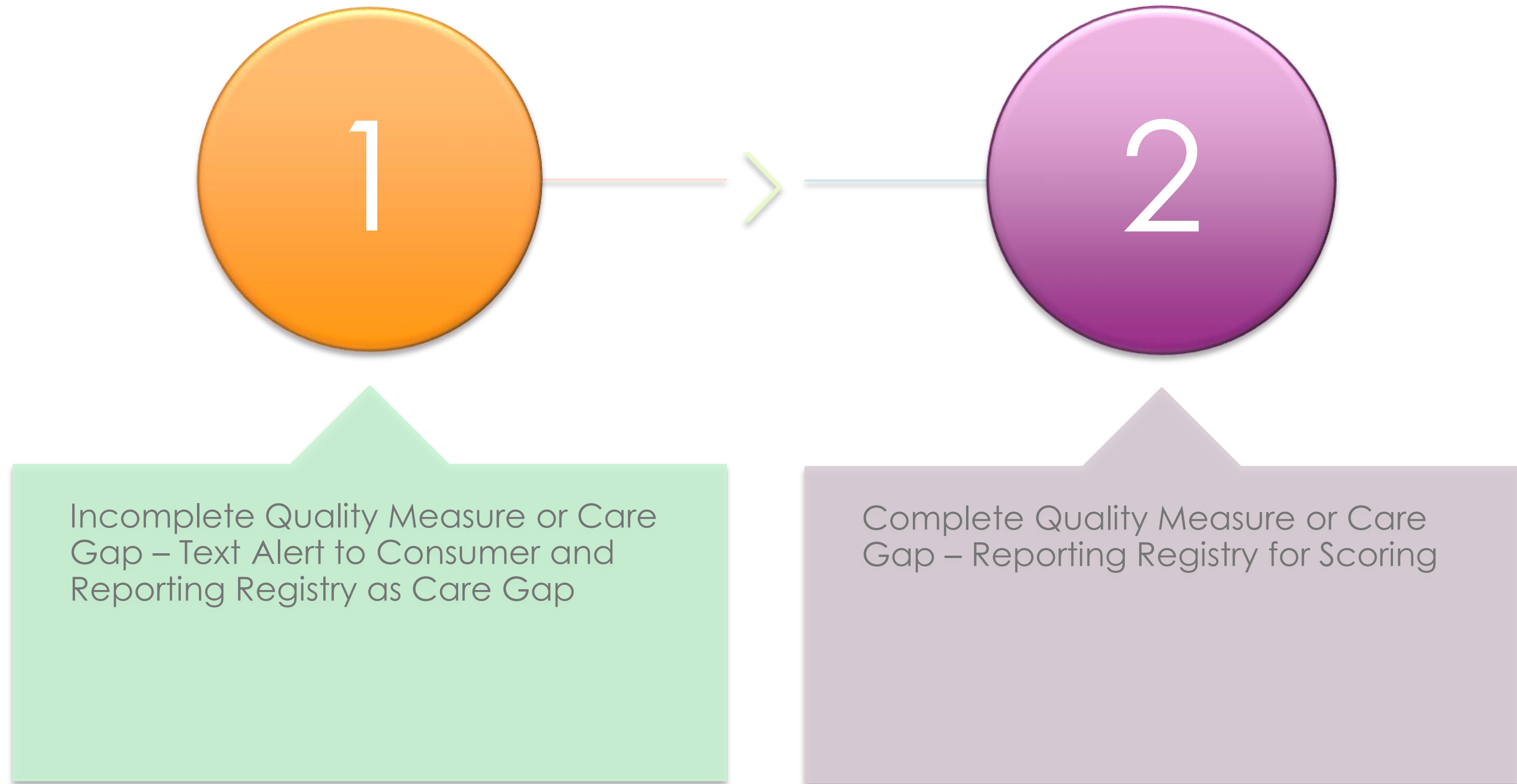
Data in 2 Buckets



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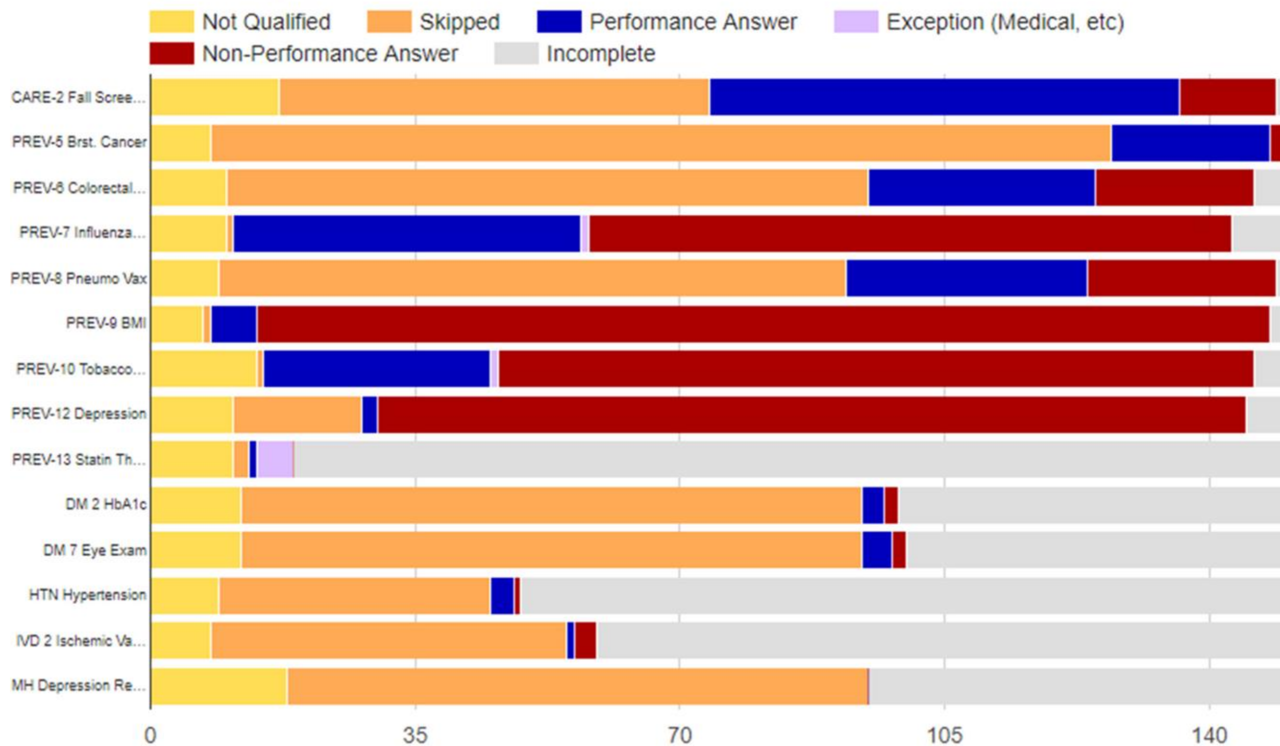
Medicare ACO
GPRO Quality Metrics

Collection, Reporting, Performance,



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Optimal Gaps
When your team clicks final submit in GPRO
They will know it will achieve the best score

Select Report Options: GPRO ▾ 2017 ▾

Default View: ◉ Percentage ○ Points/Score ○ Numerator/Denominator

Based on: ○ Full sample ◉ Required sample (248 + skips) ○ Consecutively answered patients.

Completed/All: Score completed measures only ▾

Select Division: Select a Division

Select Practice Name: Select a Practice

Each patient must be assigned to one facility (TIN) for primary responsibility of quality measure and financial performance for this report to be accurate.

Select Sub-TIN: Select a Sub-Tin

Select NPI: Select a NPI

Calculate

SETUP STRATEGY MEETING

Contact

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