

NWX-HHS-AOA-1 (US)

**Moderator: Lauren Solkowski
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1:00 pm CT**

Coordinator: Welcome and thank you for standing by. All participants will be on a listen-only mode for the duration of today's conference until the end of the presentation when we will be conducting a question and answer session.

Today's call is being recorded. If anyone has any objections you may disconnect at this time.

I would now like to turn the conference over to Lauren Solkowski. Thank you. You may begin.

Lauren Solkowski: Great thank you. And good afternoon and thank you everyone for joining us today for the Administration for Community Living's Business Acumen Webinar entitled Community Based Organization Impact on Health System Quality and Performance Measures.

Today's Webinar is the third of three part series focusing on health system quality measures. And the Webinar for today will focus on ACO or Accountable Care Organization quality measures.

This is Lauren Solkowski with ACL and I will be facilitating our Webinar.

So for today we have invited Tim McNeil and he's going to be presenting on the ACO quality measures.

Before we start with this presentation I have a few housekeeping announcements. So the first is if you have not done so please use the link that was included in the calendar appointment to get onto WebEx so that you can follow along with the slides but also since you can ask your questions when you have them through chat.

If you don't have access to the link that was emailed you can also go to www.webex.com, click on the Attend a Meeting button that's at the top of the page and then enter the meeting number.

Today's meeting number is 669853365. Again that meeting number is 669853365. If you have problems getting onto WebEx please call technical support number. That phone number is 1-866-229-3239. Again it's 1-866-229-3239.

As our operator has mentioned all of our participants are in a listen-only mode however we do welcome your questions throughout the course of the Webinar.

There are two ways that you can ask your questions. The first is through the Web using the chat function in WebEx. So you can enter your questions and we will sort through them and answer them once Tim has completed his presentation.

In addition to asking your questions through the chat function again after Tim wraps up we will - you'll have a chance to ask your question through the phone line.

So when that time comes the operator will give us instructions as to how to queue up to ask your question.

If there are any questions that we aren't able to answer during the webinar we will be sure to follow up with you to get them answered.

If you think of any questions after the Webinar please feel free to email them to me at lauren.solkowsk@acl.hhs.gov. I have entered my email address in the chat box on the Webinar on the right-hand side of the screen.

Also as the operator had mentioned we are recording the Webinar. We will be posting the recording the slides and a transcript of the Webinar online for your reference.

Okay so with that I would like to introduce and welcome our speaker for today Tim McNeil. Tim is an independent healthcare consultant specializing in health program development and sustainability.

Tim thank you again for being with us today and I will turn the call over to you.

Tim McNeill: Great. Thank you so much. So Lauren are the slides up because I don't have the slides on my screen?

Lauren Solkowski: Okay. I see the slides you don't see. Let's see at the top there's like three tabs. It says Quickstart Event and so and then a tab for your slides?

Oh someone else just said that they don't - not seen the slides. Okay, my apologies. Let me try this one more time. I'm going to close this out and reload them, just give - everyone give me one second.

Okay they should - can you see them now?

Tim McNeill: I see them now. I sure do.

Lauren Solkowski: Perfect great. Okay you're welcome to begin.

Tim McNeill: Great.

Lauren Solkowski: Sorry about that.

Tim McNeill: Okay thank you. So this is the third part in the Quality Series. Today we'll take a deep dive into the accountable care organizations.

Next slide, so we're going to have a little conversation about macro and its impact on ACOs and what I foresee what will likely cause a growth in ACO activity in your local markets.

As - then we will look at the ACO quality measures. I will highlight some particular points of pain as it relates to ACOs and potential next steps.

Next slide, so the - as was kind of been the underlying theme throughout all of these quality presentations there is robust changes in the healthcare landscape. And a lot of that was spurred by the Affordable Care Act.

And what's really moving things now is MACRA which is the Medicare Access and CHIP Reauthorization Act where there's increased emphasis on position participation and what is termed alternative payment models.

There are a couple types of alternative payment models that are specifically spelled out in the MACRA legislation. And one is ACOs or Accountable Care Organizations and bundled payment.

Next slide, so as there was a significant push for greater adoption in physician and hospital participation in APMs or Alternative Payment Models.

And that was really kicked off by an event that occurred on January 26 in 2015 where HHS Secretary Sylvia Burwell announced measurable goals and a timeline to move the Medicare program towards paying for quality rather than paying for quantity.

So essentially we're moving the entire health care system to one where we pay for outcomes instead of just paying for units of service.

And those goals outlined in this press release where the link that is below if you'd like to read the actual transcript of the press release is that 30% of all fee for service Medicare payments will be through an alternative payment model and 50% of those payments will be through these models by 2018. The 30% was by 2016.

And so CMS or excuse me, HHS set a specific target where we would move to the payment system going to these alternative payment models and ACO's is definitely one of those models that meets the mark.

Next slide, so the - one of the early impacts of MACRA or the Doc Fix bill which many refer to is it repeals the SGR methodology which was the sustainable growth rate formula which essentially reset the payment system to adjust all Medicare payments down to save costs or save expenditures and to preserve the Medicare Trust Fund.

The macro legislation essentially sunsets the - this current physician payment adjustments which included PQRS or the Physician Quality Reporting System the value-based payment modifier for physicians and the EHR Incentive program.

And so providers that scored poorly on those markers have the potential of losing accumulative amount of 8% of their Medicare payments by 2018.

And it - the macro legislation replaces all of those things with what's called a Merit-based Incentive Payment System or MIPS by 2019.

So we will continue down the path of maintaining these existing physician payment adjustments based on quality and meeting specific requirements and begin ramping up to a merit based incentive payment model by 2018.

And I want to emphasize that just like with the hospital readmission program a facility or physician is assessed based on their level of meeting certain quality benchmarks during a particular calendar year.

And then any potential penalty or increases in revenue based on worst or improved performance is applied to the following year.

So when we talk about maximum penalties of 8% by 2018 that means that they're going to be assessed in 2017 which means they need to get things in

place by 2016 to meet the markers by 2017 and then they will - that penalty or lack thereof will be assessed by 2018.

And then the merit-based payment incentive payment system also will be assessing physician quality in 2017 and 2018 to apply the incentive model by 2019.

So I wanted - the reason I highlight that is you may look at those and say well the, you know, 2018, 2019 those are eons away and no one's really paying attention to that now.

Or I rest assured that all of these physician advocacy groups are having continued presentations and Webinars to help provider begin getting prepared for these models now. Because as I said they're going to rate them in advance of the implementation and then their score is what the score is and the penalty or lack thereof will be assessed going forward.

Next slide, an additional impact of macro is that eligible providers will be subject to an initial 4% payment adjustment. And this is again is in 2019 which grows to 9% by 2022 and then continues it plateaus at potential 9%.

So this merit-based incentive payment system is completely based on provider quality. So you see we are getting very serious about adjusting provider payments based on quality and outcomes.

And we're really highlighting providers because it's not just physicians. The eligible providers includes nurse practitioners, physicians assistants so all of these providers in group practices and all the providers in those group practices are going to be impacted by these payment adjustments that are well underway.

Now eligible providers -- and this is a key point -- eligible providers that meet the alternative payment methodology threshold are exempt and receive a lump sum incentive payment instead of being subject to a potential MIPS penalty.

So if we - if I am a group practice, I'm a hospital and the majority of the providers in my group are participating in ACOs and bundled payment then we are exempt from this potential 4% to 9% adjustment up or down in our Medicare payment and actually we get a lump sum incentive payment at the beginning of the year and we're not subject to the potential penalty all by being a participant in Alternative Payment Models like ACOs and bundle payment.

Next slide, so what is that lump sum? So these eligible providers that meet the minimal threshold will receive a 5% lump sum incentive payment based on the estimated aggregate of Part B covered professional services for the preceding year. So let's look at 2019.

So in 2019 an eligible provider, a multi-specialty group practice, if they have 25% of their payments through alternative payment models like ACOs and bundle payment then at the beginning of 2019 they're going to get a 5% lump sum incentive payment that is estimated based on the aggregate of all of their services for the year in one big check at the beginning of the year as incentive for them to continue to be in these alternative payment models.

So you see that there's a big carrot at the end of the rainbow there for a provider to be in these models. And it, you know, it equates to real cash in real-time.

By 2021, 2022 eligible providers must have 50% of their payments through alternative payment models in order to get the 5% lump sum incentive payment at the beginning of the year.

So if you're in a market where there was little activity of ACOs and a few participants in bundled payment just wait until these things begin to take hold.

And this type of hard cash incentive on the front end in addition to being exempt from potential penalties on the back end all will - are seen as a way to incentivize providers to robustly participate in alternative payment models. And the two that are most quoted includes ACOs and bundled payments.

Next slide, so the alternative payment model of accountable care organizations what are those?

So CMS defines accountable care organizations as groups of doctors, hospitals and other healthcare providers who come together voluntarily to give coordinated care to Medicare beneficiaries.

So I want to highlight that the target population for ACO participation are Medicare eligible beneficiaries that are in original Medicare fee for service Medicare.

If a consumer elects to be in Medicare Advantage then they are opting out of participation in an accountable care organization because Medicare Advantage participation is it excludes a person from being in an ACO. It is only for original Medicare.

So that fee for service population includes traditional original Medicare. It includes dual eligibles that have Medicare as their primary payer all that as

well as end-stage renal disease consumers that have Medicare as their primary insurer. All of those consumers would be part of an accountable care organization based on an attribution methodology that I will explain next.

Next slide, so the ACO goal is to provide coordinated care to the attributed set of Medicare fee for service beneficiaries.

They really strive to improve health outcomes and reduce healthcare expenditures. And by if they are able to successfully improve outcomes and reduce expenditures then they are eligible for a share in the savings that they create.

Next slide, so when the ACO succeeds in improving these health outcomes they get a share in the savings. Prior to ACOs or accountable care organizations there was not a mechanism to for CMS to share savings with providers.

So if I was a provider at one hospital I had excellent outcomes and I significantly because of the excellent outcomes there was reduced cost to the taxpayer, reduced expenditures of Medicare I got the exact same payment amount as the provider across town that had horrible outcomes and had tremendously high expenditures with lots of complications.

Actually it was almost a reverse incentive model. The provider that had lots of complications did more and more procedures to correct those complications. And they actually got more in the way of financial compensation purely on the fact that it was a - we were - are in a traditional fee for service model so the more services you provide the more fees you pay.

And so the ACO provides a mechanism for providers that have excellent outcomes and reduced cost of care and reduced Medicare expenditures to receive a percentage of the savings they create.

Next slide, so the - there three types of Medicare ACO programs currently. One is the Medicare Shared Savings program. This is by far the most common. There's hundreds and hundreds of participants in the Medicare Shared Savings program across the country.

There's the Pioneer ACO model. There are only 19 remaining participants in the Pioneer ACO model. And at this time CMS has stated they don't foresee having another round of Pioneer applicants.

And most recently there's been an open application for the next generation ACO models. Those will be awarded. They're expected to begin January 1 of 2016. And the next generation ACOs are almost a full risk model ACO.

So we're waiting to see which sites are selected to be part of the next generation ACOs.

I will - just one point of clarification a site that was currently operating as a Medicare Shared Savings program ACO or a Pioneer ACO was eligible to apply to transition over to next generation ACO status this round. So we may see some movement where there were existing Pioneers or existing Medicare Shared Savings programs ACO' that applied and may be selected to be a next generation ACO. We'll find out when the awardees are noticed - are publicly notified and submitted on the CMS Web site.

Next slide, so the attribution process so what happens when a group of providers decide to go into the ACO program?

The MSSP or the Medicare Shared Savings Program ACO applications the application window opens each July. In - and that process entails all of the providers that are wishing to be part of that ACO will submit their tax ID number two as part of the group to CMS or the tent.

And then there's a three year look back of all beneficiaries that were served by the primary care providers that were linked to those tax ID numbers prior to their request to start in the ACO program.

Consumers are then attributed to a provider based on which provider paid, received the majority of paid primary care services during that three year look back period and so and it is essentially a one to one count of paid claims.

So if a consumer a good example are the snowbirds. So a snowbird lives in New York for part of the year and then lives in Florida for a part of the year they may have a doctor in Florida and a doctor in New York.

If either one of those doctors chooses to participate in the ACO program CMS would look at the tax ID numbers of both of those providers and then they would do a count to see which provider had the preponderance of Medicare paid claims for that consumer and which - and there's a one to one count which everyone had the majority of paid claims that consumer will be attributed to that provider.

And so then that consumer is attributed to the ACO for which the provider had the most paid claims during the three year look back period.

Next slide, so hospitals and specialists. Since the ACO attribution process is tied to the primary care provider consumers are attributed linked to where they got the most primary care services.

And so therefore primary care providers can only participate in one ACO. They can change ACO so they have the option to leave one ACO and join another but they can only - the primary care provider can only participate in one ACO at a time.

Specialists generally do not attribute beneficiaries unless a beneficiary had no primary care claims during the three year look back period prior to the ACO start.

Hospitals also don't attribute beneficiaries because they don't - hospitals don't provide primary care. The caveat is when a hospital owns a primary care practice generally that primary care practice operates under a different tax ID number than the hospital and it's the primary care practice that goes into the - that attributes consumers or beneficiaries to the ACO. The hospital tax ID number generally doesn't attribute consumers to the ACO.

Now one thing that is also important to note just like the primary care provider can only participate in one a specialist can participate in multiple ACOs and hospitals can participate in multiple ACOs.

One thing that also a requirement when ACOs apply to be part of the ACO program they have to submit to CMS information about how they plan to self-regulate good participants in the ACO to assure that all providers within the ACO are meeting the standards for quality and costs that are set forth by the program.

And the ACO has to provide to CMS a method by which they allow new providers to come into their ACO. They also have to provide information about how they remove providers from the ACO that do not meet benchmark qualities for standards.

So many of you as you think about how you're establishing your networks -- and that's one thing that we've talked about multiple times -- is setting performance and quality standards.

The ACOs all had to do that as well. In addition to that they had to provide information to CMS about how they will remove a provider that does not meet the minimum metrics for quality standards that the ACO sets and they have to have a process by which they remove providers.

Next slide, so MSSP or Medicare shared saving program ACOs can earn up to 60% of the savings they create depending on how they perform on 33 quality measures. We're going to go in-depth on these 32 quality measures.

For the initial three to five year period MMS ACO MSSP ACOs are not required to take risks but then after that they have to begin taking risks to stay into the program.

Pioneer ACOs can earn up to 75% of the savings they create so you see they are able to earn a considerable more of the savings that they're able to create. But Pioneer ACOs almost take risks for the losses that are also incurred.

So the next generation ACOs they have to take risks as soon as they begin the program. The Pioneer ACOs are all at a period, a phase where they have to take this now. And MSSP ACOs if they request the maximum percentage of savings at 60% they have to take some risks to get that level.

If they choose a no risk one-sided upside only model then they can only earn up to 50% of the savings they create.

Next slide, so what makes up the cost analysis? When we talk about the savings that are created as I said there's a three year look back period to identify which consumers are attributed to the ACO. And then they start in the ACO program January of the - of that preceding year, the following year.

So that three-year look back period looks at all the costs that those consumers had to establish a baseline. And it's a three year weighted average to establish what the baseline costs are.

And so the ACO knows January when they start the benchmark cost for their population and what's included in those costs are only Part A and Part B expenditures.

What's excluded from those benchmark costs as well as the reconciliation or comparison of their participants to looking for potential savings what's excluded are all Part B costs. So that's the prescription costs. Medicaid costs are not included because it's only Medicare Part A and Part B Medicaid long term service support, Medicaid home community-based services.

None of these things are included in either the benchmark costs nor are they included in the savings calculations for shared savings program ACOs. Only - ACOs only assess Part A and Part B expenditures. And that's important and I'll go into that here soon.

Next slide, so Part A benefits just as a recap Part A benefits cover inpatient hospital care, skilled nursing care, home health and hospice.

And the two biggest cost drivers of Part A obviously is inpatient hospital care and skilled nursing facility care.

And there's a particular emphasis on as you can imagine readmissions, what's called ambulatory sensitive admissions or unnecessary admissions, skilled nursing facility, primary admissions and readmissions. Because those are so expensive so there's a great emphasis on those.

Next slide, Part B benefits cover outpatient services, preventative health, doctor visits and so forth. So generally Part B services are much less costly and the preventive health services hopefully will drive down the utilization of the Part A services which should only occur when there's a complication.

Next slide, so Medicaid, the reason I highlight Medicaid is because when you have a dual and a dual has primary payer be a Medicare with Medicaid be a secondary payer those tools would be attributed to an ACO when the ACO providers provided the primary - the bulk of the primary care for those duals that remain in original Medicare as a start.

So when CMS gives the benchmark data to ACOs they generally give them their benchmark data in three categories.

They give them their total benchmark cost and quality for the non-dual eligible population.

Then they give them the second report that singles out the dual eligibles. Then they give them a third statement that singles out the end-stage renal disease.

And the reason that the duals and the end state renal disease populations are highlighted because for the vast majority of ACOs the two groups that have the greatest per capita expenditures of Part A and Part B services are duals and end-stage renal disease.

And so that - there's a lot of emphasis placed on those two population groups because from a shared savings perspective if you're looking to bring down costs and improve quality you likely look at the groups that have the highest per capita cost.

And it's - for most ACOs it is the duals and end stage renal disease population. And CMS give those reports separately so their groups can very quickly begin stratifying their population health methodology to address the needs of those groups. Because the biggest pot of money for potential savings are held in those groups.

Next slide, so duals, 20% of Medicare beneficiaries are dual eligibles. Duals have as I said, significantly higher per capita expense. So a MedPAC report June of 2013 on Page 153 if you just Google MedPAC Report to Congress June 2013 you'll pull up this report.

And on Page 153 they specifically outlined dual eligibles and fee for service. Their per capita spending was \$15,743 compared to 8081 for non-duals.

So as you see the per capita spending difference is tremendous. And if I am - if I'm running an ACO and I have limited resources because I can't have a private duty case manager for every consumer if you look at an ACO like BJC Healthcare in St. Louis that's working with one of the business acumen partners part of the St. Louis collaborative, they have 50,000 beneficiaries in

their ACO. They could not possibly have a private duty case manager for 50,000 consumers.

But if so if knowing that they have limited resources if they were going to target their care management services to the group that potentially give them the greatest earnings in a shared savings model it would be the dual eligibles because the per capita spending is so tremendously higher.

And if there's any ACO or if you're working with any hospital ACO they had if they question that or if they felt as though that was not true then, you know, definitely provide them this information with the MedPAC report. But most of them are keenly aware of that issue.

Next slide, so duals and shared savings. So the potential increases in utilization and cost for duals directly impact the success or failures of ACOs.

And many ACOs have a specific strategy just in targeting duals. And now there's a whole new business model for population health where I see and see many for-profit entities running into space. And guess what their mantra is?

I can help you with the duals and we can help you realize there's a huge potential in earnings and shared savings that rest in these nuggets of duals that are embedded in your ACO.

And so they have all kind of market material about how they identify the needs, and stratify it. And it really all boils down to what, providing those high risk consumers with services to support them in the community to reduce the risk of institutionalization which is what the Age and Disability Network has always done.

Now for-profit entities are running in and saying ACOs bundled payment we can help you with your point of pain by coordinating community services to drive down the cost of care and reduce institutionalization for the duals.

One of the other things that was highlighted in the MedPAC report is - and this again is very intuitive for most of the people on the phone is that Medicaid home and community-based services that are targeted to reduce the use of institutionalization drives down the cost of Medicaid, drives down Medicare Part A and Part B expenditures because now we are supporting the person in the least restrictive environment as possible.

And by the way that's the whole goal of the 1915 C waivers are to reduce institutionalization for Medicaid and the dual eligibles that are high risk for institutionalization.

Next slide, so shared savings and quality, each year ACOs must submit their quality data to CMS. And so they literally every year between January and March they are given a list of consumers that they have to report their measures on.

And there's a portal that opens up and it opens up around January and then closes sometime in March. And they have to get all of their data in.

What's important with these 33 quality measures a lot of them are all or nothing. So if you don't have the data then it's assumed that you failed on that measure.

And if you are asked to report on multiple consumers and you don't have data on those consumers then you will fail.

And if you don't meet a minimum threshold in reporting data on consumers then the ACO will first get a request for a corrective action plan.

And then if they repeatedly fail then they will be terminated from participation in the ACO program.

Next slide, so there are four quality measure domains. One is the patient caregiver experience. And the patient caregiver experience, a lot of that is done by cap surveys. The other one is care coordination and patient safety, preventive health, and then at risk population health management.

And that - this was the ACOs have to report specific measures on diabetes, hypertension, ischemic, cardiovascular disease and coronary artery disease.

Next slide, so the ACO quality measures for the patient caregiver experience as you see these are very subjective measures and they're done by an independent survey where a representative of a sample of beneficiaries in the ACO are randomly contacted by a third party entity.

CMS has a list of approved entities to do these surveys. And then the ACOs consumers and beneficiaries are asked these questions.

And then there's a score and then that is provided at a later time to the ACO. So it's very - it's not for the patient caregiver experience domain. There's very little that the ACO can actively do at the time of reporting to impact these measures.

Next slide, the care coordination patient safety domain is a little different. This is where you see this, the first one on the list and show this for anyone

that's participated in CCTP and other care transition activity you see that the all cause readmissions is the number one thing on the list.

And so ACOs are rated and scored based on all cause readmissions for the population of Medicare beneficiaries that they're serving.

This again includes non-dual eligibles, dual eligibles, end-stage renal disease so this is all cause readmissions.

Next are ambulatory sensitive admissions. And you may not have heard that term before, ambulatory sensitive admissions.

And what - essentially what an ambulatory sensitive admission is, it is when a consumer is admitted to the hospital and the cause of the factor that made that consumer have that admission was something that could have been easily addressed in an outpatient setting or an ambulatory environment.

So an ambulatory sensitive admission for something like asthma or COPD I lost my inhaler I couldn't get a refill I forgot to call in I ran out - I'm in the donut hole so I couldn't afford my inhaler so I didn't take it and now I'm short of breath and have to get admitted.

All of those are ambulatory sensitive. And so that person, that admission could have been averted if there was some targeted interventions done in an outpatient basis so that person should not have been admitted.

So ACOs are rated and scored based on the percentage of their beneficiaries that have ambulatory sensitive admissions. Next are ambulatory sensitive admissions for congestive heart failure.

The percent of PCPs that meet minimal meaningful use standards, medication reconciliation after discharge and lastly screening for fall risk.

And so that screening for fall risk is again the percentage of ACO participants that are in an ACO that are screened for their risk of falls and once they - and if they screen positive the ACO is to refer them to a fall risk reduction program and so they're rated and scored based on the ability to achieve high ratings in these specific measures.

Next slide, preventive health, this includes things like influenza, pneumococcal vaccination. A big one that many ACOs struggle with is depression screening.

So the number of ACO beneficiaries non-duals, duals, end-stage renal disease, what is the percentage that were screened for depression? And if they're screened positive obviously did they get some treatment?

So remember the attribution process where it is a total count that wherever who had the preponderance of primary care claims for that beneficiary the assignment is made.

And so I've had the opportunity to see ACOs, to listen to providers when at the moment in time when they get their attribution list. And many of them are absolutely shocked because they see people on the list one that they never heard of.

Or they see people on the list that they may have seen one time in the past three years. Well guess what, they didn't get any primary care from anybody else so tag you're it. It's now your beneficiary.

A good one that I've seen multiple times or physicians say, "Well that person has a balance in my practice and so I banned them from coming to my practice so they can't come until they pay that balance that they owe me."

Guess what that's - its population health buddy. So you have to manage that person's health. And so you can't talk about they didn't pay me and so I'm not going to serve their needs. Don't service their needs you're going to be subject to meeting poor quality measures for that beneficiary.

Another one that I often see is well these people live in assisted living and every time I try to schedule them to come in its always something happens. They don't get transportation, they don't come. By the time they get to my practice they miss their appointment time so we have to cancel. I hardly ever see them so how can I be held accountable?

Again its population health. You are responsible for the whole population including snowbirds and so forth.

Another good one that I often hear is well I've only given that person, they only come to my practice for the flu shot. And then they get all of their other care from a specialist. Well the attribution it spurs to the primary care provider.

And then if they have no primary care claims then the specialist. So you'd be surprised how many primary care providers see in there attribution cancer patients, orthopedic patients, chronic back pain patients that they've never see unless it's a sick visit.

And if it's a sick visit are they're doing a hemoglobin A1C? Are they doing all of the preventive health measures? They're likely not. And so then again

they're at risk for meeting all of these quality measures because it's for the preponderance of the entire population that's attributed to them.

And again if they can't - if they don't have the data so I don't know if that person got a flu shot or not I fail that measure. It doesn't count that I couldn't reach them or they got the influenza shot at a health fair or the senior center was given free influenza shots so they didn't want to come to my practice and get their influenza shot and I can't prove they got it at the senior center I still fail.

So if I don't have proof that occurred and I'm the provider then I fail that measure for that consumer.

Next slide, so next are the at risk population. So I highlighted diabetes. Many of you are providing things like patient activation diabetes self-management training and so forth.

Well there's a specific carve out looking at just diabetes so the diabetes composite looking at the number of beneficiaries that have A1C that is control which is considered at less than eight and you see at the bottom the number of consumers that are - have poor control is greater than nine.

And once again if there is no A1C on file for that year then I feel that measure. I did not - I could not report.

It doesn't matter that the person couldn't get in, didn't have transportation, came after hours, didn't pay the lab bill -- none of that matters for the ACO.

They're in the ACO. You have to report. If you have to report on that consumer you don't have the data then you fail that measure for that consumer.

Next slide, at risk population again, hypertension ischemic vascular disease and coronary artery disease. So many of these measures are looking at medication adherence and so are they on the appropriate medication? Are they actually taking that medication?

And again if they're in the donut hole and so they weren't compliant with their medication or didn't have the means or they made a decision for whatever reason not to take it I still fail the measure because it's about the overall population health for the consumers that are attributed to the ACO.

Next slide, so in the overall scoring each of these domains has a particular weight and there's four domains and each domain has a 25% weight.

So if I have excellent caregiver experience and I fail on preventive health, I fail on readmissions and I fail to manage the diabetes then I'm going to fail the program.

And so the cumulative weight of each of the 25 person supply is attributed to each domain. The cumulative total is 100%.

Next slide, so there is a sliding scale measure scoring approach. So points are earned based on the comparison of individual ACO stores. And the total points are earned for each domain is summed up and then the ACO is given a final overall quality score.

Next slide, so the analysis of that score for most measures the higher the level of performance then the higher the number of points.

For some the - a lower score is better and those that you would guess. Obviously that we don't want more readmission, we want lower readmission so we want low as score as possible there.

We don't want ambulatory sensitive admissions. We want the least amount of ambulatory sense of admission so we want a lower score there.

We want diabetes A1Cs. We want the least number of people to be listed as in poor control.

Next slide, so it's a sliding scale measures scoring approach. And so now all of the ACOs are rated based on quality and then based if there in the 90th to 30th percentile there's points attributed.

If you fall below the 30 percentile then there are no points. And then that gives you an overall total score. If you are an ACO and you want to be in the 80th percentile or greater for as many measures as possible.

Now the way the shared savings is earned remember the slide where I talked about in ACO can earn anywhere between 50% to 75% of the savings that they create and it's up to because they have to improve quality and reduce cost.

So an example if I'm a Medicare shared (unintelligible) program ACO so I'm - this is a - I'm a group of provider in Tim's ACO. And we have 10,000 Medicare beneficiaries and we work really hard to bring down total cost of care.

And we saved the Medicare Shared Savings program \$20 million over the course of the year through intensive care coordination. We partnered with the AAA. We flooded all of our high risk dual eligibles with home and community-based services.

We averted all of those nursing home admissions and we really brought down the cost of care for that population.

However I wasn't able to capture all of the data on my beneficiary so I failed in quite a few of the measures.

And now I come in at the 60th percentile for all of my quality measures. But I saved the program \$20 million. There's a complicated formula on the backend but in a nutshell just to give you a broad understanding of the way this is applied.

Because I only scored 60th percentile on my quality measures that - as an ACO I earned \$20 million. I'm eligible for up to 50% of that which would be \$10 million. But because I only scored in the 60th percentile I'm only eligible for 60% of the \$10 million.

So I can get 60% of 50% that I actually earned because I did not score well enough on my quality measures.

Next slide, so I'd pull the 2014, 2014 mean ACO performance rating for all ACOs. So this is the average mean ACO scores. This is live data for all of the ACOs across the country for 2014. And this is how they scored.

So for fall screening risks 46%, 46.71% actually screened of the population was screened for fall risk and placed into a program.

Now remember I wanted to be in what, 80th percentile and I'm saying that on average most ACOs scored around 46% so tremendous room for improvement is clearly there.

Influenza, 58%, pneumococcal 56%, depression screening 40%, so and when I talk to ACOs that is exactly what they said especially since they have to screen as many consumers as possible, screening them for depression getting them into a program. And then addressing that depression score is a huge problem.

So I'm a community-based organization and I have a PEARLS program. I have or - or I have another - I forget the other evidence-based program for screening for depression. And I marry that with an ACO and I know that on average ACO is only scoring about 40% and they need to get to 80% or better so they can make sure they get the maximum amount of savings they earn.

It would be a shame for them to do all that work, earn savings and not get the maximum amount of money that's eligible to them only because they could not screen enough of their high risk beneficiaries for depression.

Health promotion and education 58%, all condition readmissions lower is better 15% on average. And medication reconciliation that was actually pretty high at 82%.

Next slide, and so I brought back up these percentile numbers just to highlight potential points of pain. So if you see 40th percentile or 40% is way down on

the list. And they only get a 1.25 points out of two quality points if they wind up in the 40th percentile.

So an ACO really needs to get 80% or more. And so if I identify that the mean score is at a certain level and I have a program that can help that ACO improve that level that's where a point of pain meets my strength. I have a program for that and we can match that to help them improve that score.

Next slide, some additional mean ACO performance ratings and again this is live data. So the diabetes composite score rating around 26% so tremendous room for improvement.

A1C poor control 19% so lower is better. I want that number to be as low as possible.

Proportion of adults who had blood pressure screened in the past two years 60%. I was shocked at that. This is the Medicare beneficiary population.

I mean what's the first thing that happens when you go to the doctor is somebody checks the blood pressure. So if only 60% are actually even having their blood pressure checked that's telling me they're not even getting in for primary care.

They feel it's not even touching 40% of the population if they're only able to just document that they have a blood pressure rating of 60%. So where is that - where is the rest of that population that's attributed to them?

Well what the ACOs are saying is it's those duals. It's those people and skilled nursing facility. It's those people in assisted living. It's those people

that are “noncompliant.” They don’t come in and I need help with those.
Clearly they do.

Next slide, again looking again at the sliding scale approach and then looking at just on blood pressure check in the past few years we’re at 60% is the mean score. There is tremendous room for improvement.

And so ACOs that are coming in at the mean average are still, you know, they’re only getting 1.55. That’s something that on the surface should be an easy measure to knock out of the park.

Next slide, so the alternative payment model, so to highlight the points of pain I have lots of - I have had tremendous opportunities, it’s been great fun talking and meeting with groups working with ACOs and hospitals.

And oftentimes we from the ACO director or from the readmission coordinator that oh, we have it all wrapped up.

We don’t need any help. We know we have this thing locked up. We had the best technology. We’re risk stratifying. We’re analyzing. MedPAC says something totally different.

They’re saying that there is concern from hospitals, especially hospitals and ACOs that large numbers of hospitals that serve the poor tend to have higher readmission rates.

And if they’re having higher readmission rates what’s the quality measure for the ACO? Quality measure for the ACOs is all college readmissions, ambulatory sensitive admissions and hospitals based on a MedPAC report. June 2013 on Pages 106 and 107 that - where its they specifically have

documented that hospitals with higher share of poor patients that's indicated by Medicare beneficiaries on SSI tend to have high readmission rates, have higher penalties as it relates to readmissions and higher per capita cost.

So that means from a shared savings perspective a point of pain for those hospitals would be consumers that are poor and who in the Medicare program categorically would meet that requirement.

Your SSI population would also be your dual eligibles. Those are consumers that get low income subsidies. Those consumers that are 1915 C waiver eligible because they have - they are Medicaid eligible. That is the same group that the MedPAC Report has proven have the most readmissions and hospitals have the least ability to address readmissions and, i.e., cost for that population.

Next slide, so because of that MedPAC report there is actually were two bills that were introduced. So Senate Bill 2501 the sponsor was Senator Joe Manchin, a Democrat from West Virginia. That - the status of that bill has been referred to committee on finance. And it - the cuts of this bill is that it provides a mandate for CMS to develop a special risk adjustment to account for patient socio-economic status.

And all of the major hospital groups, physician groups had great fanfare in support and rah-rah around this bill. And so they all submitted letters of support.

You should Google those. Some of the sites that have requested that information for me I will provide, those that information to you where you can see where organizations like the American Hospital Association, the American Association of academic Medical Centers, the Association of

essential hospital which are the safety net hospitals all have come out in categorical full-fledged support.

And they all have said that consumers that have low social economic status have - have higher costs, have more readmissions. And they want a special provision to adjust for social economic status because it's too hard to address the needs of that population base.

So again if I'm a community-based organization and I have a long history of working with high risk vulnerable populations in my community that may be of lower social economic status, i.e., eligible, dual eligibles, those that are waiver eligible.

And I have older American Act Services, I have this engine to deliver services to that population. And I have every major hospital association group in full support saying that we need help as it relates to those population of beneficiaries that have low social economic status there is an opportunity.

The opportunity is created because there's a point of pain. They're saying they cannot address that point of pain. If I have a solution for that point of pain now let's talk about a contract model.

Next slide, so there's a house. There's a separate House bill, HR 1343. And it's establishing the beneficiary equity in the Hospital Readmission Program Act of 2015.

This bill is - now it would be a committee on Ways and Means. And this - the essence of this bill it requires the HHS Secretary to make a risk adjustment based on the proportion of inpatients who are full benefit dual eligible.

So again we are stating the hospitals again they are all in full support of this bill as well were they said that they need a risk adjustment based on the proportion of dual eligibles that we see.

And they wanted a second adjustment to take into account the social economical status of the entire population in their catchment area because they said even if I have a non-dual the fact that I'm serving consumers that are originating from an area that has low social economical status well guess what?

Those same consumers are faced with food deserts, lack of access or transportation, lack of access to primary care, lack of access to pharmacy and other things.

And the hospitals feel as though they need a special exemption to adjust to mitigate the risk that they will face a penalties for readmission for that population.

Well I'm sure nine times out of ten any community that I'm in there's probably a network of community-based organizations that are already working with that same population that these hospitals said that they have the most points of pain with. And they're doing as part of their mission driven focus to serve the needs of those consumers.

They don't realize always that that's a point of pain for a hospital that's now in a risk-based model. And so there's a potential for contract. And even if we could maximize if I was a community-based organization and I had a contract for home and community-based services where I could be reimbursed whether that to be managed long term service support or directly for Medicaid.

And if I'm partnering with a hospital that says that this is their largest point of pain it becomes a tremendous upside opportunity to me to be the exclusive provider for home and community-based services targeting those high risk beneficiaries that are at risk for institutionalization that are in that institution involved in the bundle payment, involved in the ACO.

And not only can I help them but I want to participate in the game sharing, the shared savings on the back end by my work in the community to drive down the cost of care and let's stratify out the group that you already said is your biggest point of pain. And that's dual eligibles and consumers in lower social economic status.

And by the way 20% of the Medicare population are dual eligibles. So if you look at - if you were in an area - I was looking at an area one of the biz acumen group where they have about 150,000 Medicare beneficiaries in their market.

So now we're talking about 20% of 150,000 consumers. That's a sizable market share.

And now if I'm partnering with this same facility I'm addressing their point of pain then I would work with them to go to the Medicare Advantage plans in the same market and say collectively I want you to be - I'm helping you on one side and I want you to help me advocate and negotiate with his Medicare Advantage plan for a carved out rate for my home and community-based services or my care transition program for the Medicare Advantage population as well.

And now I'm - I have a multitude of revenue streams throughout the marketplace for my services. I have multiple payers buying my services and I

do not have an increase in instrumental cost to serve those additional contracts.

Because if I have one care coordinator at one hospital, they could serve a Medicare dual eligible in Bed A. They can serve a Medicare Advantaged person in Bed B. They can serve a dual SNP plan in Bed C.

And I would not have to hire additional care management to serve the needs of those three contracts but I'd be paid by three resources. And I'd get my foot in the door by negotiation to flood the home community based services for that group of high risk beneficiaries, at risk for institutionalization that the facility has already said is their highest point of pain.

And as I said for all of these bills there's letters of support, there's high praise and acclimation from all of the major groups such as the American Hospital Association, the Association of Academic Medical Centers, the Association of Essential Hospitals, just your safety net hospitals all are in full support of getting a special provision to adjust penalties based on the percentage of dual eligibles and the percentage of low income consumers that they serve.

Next slide, so the Medicare Advantage plans -- and I know this isn't the Medicare Advantage Quality Report but this is the third fourth in the series -- I also thought this is also interesting.

So last time I talked about CMS did a study of social economic factor and its impact on Star ratings. So that was released in September 8 of 2015. And again I will make this - the slides that CMS presented the results of this data available to all the groups.

But beneficiaries with low social economic status was assessed by CMS based on those Medicare eligible beneficiaries that elected a Medicare Advantage plan or dual SNP plan that also received a low income subsidy or LIS and/or were dual eligible.

And the study found that 12 out of 16 Star measures had a statistically significant negative association with low income subsidy or dual eligible status.

That means the 12 out of the 16 measures there was a direct very strong correlation between being in low income subsidy or dual eligible, i.e., being in a low social economic status with a poor Star rating as it relates to all cause admissions, medication adherence and diabetes and heart disease measures.

And one thing that was important about all cause remissions CMS's own report said that for all cause admissions if any of you are familiar with something called P values which is a statistical - it's a measure of statistical significance.

And so there's a P value for not to get too technical but 95% confidence interval essentially is strong evidence. And usually a standard P value is a .05.

For all cause readmissions the strength in the correlation between low income subsidy and dual eligible status was almost was 10 times statistical significance showing that there's a tremendous correlation between all cause readmissions and dual eligible status and so that's within CMS's own report.

So it very much correlates see everyone's speaking in concert in tune. You have MedPAC saying there's - that there's a correlation. You have Congress, you have the Senate, you have the House all saying that there is a correlation.

And now CMS is saying this is a statistically significant very significant based on their own data showing that there is a correlation.

So now if I am, again if I am a community-based organization and I have a intervention that can serve that population by the way is at least 20% of the population in any given market. I've now carved out a niche.

And I can go to a facility and I can show them that their own trade associations are saying that they can't handle that group. So why can't we work out a happy medium where I could be the preferred provider of home and community-based services to drive down institutionalization to improve the outcomes for this group?

Next slide, so see you the opportunity. I really believe that if you could stratify the population. So if you go into a facility especially a facility that's invested heavily in their care management resources in their data systems - and believe me they are spending goo goo gobs of money on data systems and population health analysts systems.

So if you go in there and say well I mean I really want a contract and I want a contract to provide X service they're going to say I've already spent a ton of money. I know I can do this. I don't need a lot of help.

But when you begin to sing a tune where I know you have a great program, I know you have a great care management model, I know you have case managers, I know you have strong systems but if we can stratify a subset of the population where your providers, physicians, hospitals, hospitalists are having challenges with and I have a target based intervention for that group then that becomes to set the stage for an opportunity to move from just a mere discussion about an opportunity to somewhat targeted focus time on a subset

of the population that pretty much everyone has said they can't handle if you were to go about it that way.

Next slide, so it's important to in all of these contract models understand what the consumer needs versus what the customer needs. And the consumer obviously is the person you're serving.

Next slide, so the customer, the customer needs is data, data and more data. And the reason data is important remember I gave the example of if an ACO can't find the person, can't get them in so and then they have to report on a measure if they can't report on the measure they fail.

So I'll give you an example of I have a strong fall prevention program and I partner with an ACO. And that ACO wants me to provide services to those beneficiaries.

I screen them for fall risk. I do a time them up and go. I do a Tinetti. I document their attendance. I do a knock out the park homerun in serving that population.

I have 100% attendance at every program. Consumers are finishing my fall prevention and staying for my enhanced fitness program and they want more strength and then balance. They can't get enough of my work.

But I can't document it. And I can't document it in a way that the ACO can take credit for it, i.e., make its way into their EHR. Then it's just like I didn't do anything. I wasn't a benefit to the ACO.

Because if they can't report it, if they can't pull it out of their DHR and prove that that beneficiary was screened for fall risk, they had a time them up and

go, they had a Tinetti, and then they had an intervention then I failed the measure. So data, data, data's king.

And if I was a community-based organization and I'm - if I decide or I'm working with this great hospital and I have this program again fall prevention and I fax over the Tinetti scores, I fax over the tie them up and go, I fax over the attendance record and then say they take this extra step of they scan in that information into their EHR, remember when I said the reporting period for the ACO? The ACO is given a list of all of all the beneficiaries they have to report on and which specific measures they have to report on because they don't know before that time. They're not presenting. They're not submitting on 100%.

So they're given a random sampling of beneficiaries and specific measures they have to report on those beneficiaries. They're given that in January. They have till March to report that.

Again I give the example of BJC Healthcare in St. Louis. They have 50,000 lives. So now they're given - they have to report on say 30,000 of those beneficiaries for fall risk.

They are not going to have the time to go through and say oh yes Tim's CBO sent us a bunch of scanned records or scanned handwritten documents. And now somebody needs to sit and manually go one by one through all those scanned images and read through my broken handwriting to see if that person was actually screened for fall risk. They're not going to do it. They're just going to move on.

And unfortunately what I'm seeing more and more there's four competencies that are coming in and saying I have a program and I'm going to document

and I'm going to send the data back to you. And it'll come back electronically so it can be incorporated into your EHR. And then you'll have a check in the box for all of your measures.

So data, data more data, data's king for ACOs data's king for Medicare Advantage so we've got to get them over. We can provide data.

And so that's how we can contribute to improve on quality and reducing financial risk.

Next slide, so the next steps know your market, know your competition. Competition is heating up.

To fall there's a lot of big changes that are really heating things up. One, I tell you about the alternative payment models, macro legislation for Medicare Advantage plans.

The last Webinar I talked about how beginning in 2016 which is a few months from now and we're then we're going to be in 2016.

So Medicare Advantage plans that continue to score a three or worse after 2016 will no longer be in the Medicare Advantage program. And we've already proven it's based on CMS's data that 12 out of the 16 Star measures ACOs are directly impacted based on the percentage of dual eligibles or consumers with low income subsidy that are in their plan.

So those plans do they have a point of pain, absolutely. Are they at risk? Beginning 2016 if they don't fix the vast majority of their population to get them to the 80th percentile and they continue to score at a three star or worse they will no longer be a Medicare Advantage plan. So it is do or die time.

And so they are looking for solutions. If I have a solution that's targeted to their point of pain there's obviously opportunity for contract.

Next slide, so that's the end and I'd love to field any questions there may be.

Lauren Solkowski: Great thank you Tim. So operator if you could now provide instructions for asking a question through the phone that would be great.

Coordinator: Thank you. At this time if you'd like to ask a question please press Star then 1 on your phone and record your first and last name clearly when prompted.

Again if you would like to ask a question at this time over the phone please press Star then 1 and record your first and last name clearly when prompted.

One moment for your first question.

Lauren Solkowski: Thank you. Let's see so we did have a question come in on the chat. It says if there - if okay sorry.

Is there a minimum number of customers to qualify as an ACO? If so what - are the rural areas going to become ACO approved?

Tim McNeill: That's an excellent question. And I thought I had that slide in there but you just reminded me that I must have - when I organize my slides I must have muted that one.

So the Medicare Shared Savings programs ACO must have a minimum of 5000 beneficiaries. A Pioneer ACO although there's no more Pioneers or no new Pioneers but they have to have a minimum of 15,000.

So they have to have that minimum number to start and then they have to maintain that minimum throughout the duration of their participation in the ACO.

So if - and so if people die, they leave the ACO, if they start getting more of their primary care from a non-ACO provider, they leave the ACO, if they elect that's open enrollment period right?

So now if they elect Medicare Advantage once that consumer elects to go into a Medicare Advantage plan they come out of the ACO.

So an ACO is always at risk of going - if they're right at 5000 they're always at risk of going below 5000. If they go below 5000 they get a nasty gram from CMS and they better do something about it.

And they better do something quick. If they don't and if they fail to do something pretty quickly then they will be asked to leave the program because you've got to have met the minimum threshold.

So how does an ACO add lives, add beneficiaries? They have to recruit more doctors.

So if I - and so in the rural areas a phenomenon that we're seeing is - let me take it back. So many ACOs have begun to see just like with the Medicare Advantage plans there's strength in numbers.

The more the larger the population the less a bad score or a bad or a bad mix of consumers will impact your quality ratings.

The larger of the population the more it washes out. It's a law of averages. The bads outweigh, excuse me, the goods outweigh the bad the larger the population is.

But if I have so if I only have 5000 lives if I'm right at the minimum and I have say one bad physician that has 1000 lives that doesn't participate or has very poor quality I'm failing. I'm already failing because one out of five are already scoring badly. So they want to get as large as possible.

So in the rural areas and in well many areas you have consolidation of ACOs just like you have consolidation of Medicare Advantage plans where they're consolidating to get larger and larger.

And in the rural areas you have ACOs that are operating in multiple states. And so one of the largest ones serving rural areas is an ACO called rural ACO.

And they serve multiple states and they specifically target physicians in rural areas and they ban them all together to get the numbers they need.

So now the rural ACO has, you know, 10,000, 20,000 lives and those 20,000 lives are made up of hundreds of small rural providers. And some of those rural physicians may only bring in 100 - excuse me, 100 beneficiaries.

I was at a presentation in DC and there was a group of minority physicians in DC and they all had very small numbers of Medicare. They served a lot of Medicaid. And each of them only had 100 Medicare lives in their panel.

And so in order to get to the 5000 number they had to get a whole lot of doctors that had 100 to get to 5000. That particular group never, they were never able to get to 5000 so they didn't even get in but that's an example.

Next slide.

Lauren Solkowski: Thank you Tim.

Tim McNeill: Oh I'm sorry not next slide, other questions? I'm sorry.

Lauren Solkowski: It's okay. Operator have we had any questions come in on the phone?

Coordinator: There are no questions over the phone lines.

Lauren Solkowski: Okay. I'm not showing other questions on the chat. We'll give it another minute or so just in case anything else comes in.

In the meantime I just wanted to remind everyone that since we have our next in person meeting with our learning collaborative members coming up the first week in November. We will not be hosting a topical Webinar in November.

So we're looking to schedule the next Webinar for December 2015. So there will be more to come on that. Okay let me just check back.

Okay there is a question, one second. Okay the next question says how and when do beneficiaries who are recently enrolled in Medicare become involved with an ACO?

Tim McNeill: So generally a beneficiary has to have a - has to have data in the ACO excuse me, been in the Medicare program for a year to count.

And so during that - so if they enroll they just become Medicare eligible this year say they just turned 65 or they were eligible based on a disability beginning this year over the course of the next 12 months if that consumer gets the bulk of their primary care from a physician or practice as part of the ACO then the next cycle that consumer will be attributed to that ACO.

And actually every quarter the ACO - the ACOs get an update of their attributions and so they get updated the number of beneficiaries that have been added or deleted during the quarter.

And so and consumers can be deleted based on joining Medicare Advantage and they can be added based on joining the Medicare program.

Lauren Solkowski: Great. Okay there is another question that has come in. Let's see are their existing data systems that work well with ACOs that would work for Older American Act programs?

Tim McNeill: So the office of the National Coordinator and it's an odd name but - or I believe it's an odd name. But the office of the National Coordinator is part a Department at HHS and they govern health IT policies. And they have established something called meaningful use standards.

And all hospital systems, all providers systems that receive a EHR, Electronic Health Record incentive payment has to be made those meaningful use standards.

And any system that meets meaningful use standards automatically by definition can communicate and share data with any hospital and any physician that's also held to the same meaningful use standards.

And so if you are operating or choose a platform that meets meaningful use standards you automatically can communicate with everybody in the market that's also meeting meaningful use standards.

And right about now any major player hospital or physician is either meeting meaningful use or aggressively working towards meaningful use.

And the rules for meaningful use require that any meaningful use certified product has to be able to exchange information and receive information with another meaningful use certified product.

So as long as you have a meaningful use certified product you are going to meet the requirement.

And there's a long list of meaningful use certified products out there. The Office of National Coordinator publishes a list of those products that meet meaningful use standards. And so getting a system that is on that list is important.

Another thing that I just - that I also think is important is that with - many of you have heard about the new chronic care management billing codes for providers of Medicare's reimbursing for non-face-to-face care coordination for beneficiaries with two or more chronic conditions.

And then there's all - there's been the code is chronic care management or CCM is collectively referred to as CCM. And it pays a per person per month

rate for care coordination services for a beneficiary with two or more chronic conditions.

And then there's the TCM or Transitional Care Management codes which pays for care transition services for Medicare beneficiaries.

So what's important is that CMS in the final rule for CCM services or chronic care management services for one of the first times in memory they came out. They CMS specifically outlined that in order to bill for those services a provider and/or the network of people doing care coordination supporting those beneficiaries have to do it in a meaningful use certified product or else you cannot bill.

And so that I believe is almost like a line in the sand that we all have to - and whether you're doing care management, care coordination, transitional care management, direct services we are all having to move to a platform the meets meaningful use standards in order to survive long term.

And what I am seeing in the for profit space is those groups that are able to negotiate contracts for care transitions and other services they're all using the meaningful use certified product. They're exporting that data back to the ACOs and hospitals. It's being absorbed automatically absorbed right into their EHR.

So now when the next time that provider opens up their system they're seeing what that for-profit entity did. It's already incorporated part and parcel with their EHR because they're both on a meaningful use certified platform.

Lauren Solkowski: Okay operator I will check back with you to see if you've had questions come in?

Coordinator: There are no questions on the phone lines.

Lauren Solkowski: Okay thanks. We have another question in the Webinar. It says what type medication reconciliation model do you think is most effective in the EH CBS setting as delivered by a CBO? How “clinical” does it need to be?

Tim McNeill: So that the medication reconciliation requirement is based on the rules for medication reconciliation or the guidelines that are set forth by NCQA.

And so they have very explicit instructions on medication reconciliation in order to meet the requirement to qualify.

And it requires a final review of the medication of all of that consumers prescribed medications, over the counters, herbals, and anything else that consumer’s taking in the way of medication or not taking. It has to be collected, has to be reviewed and then there has to be a direct encounter with that consumer and a pharmacist in order to meet the requirements for NCQA.

And so if that pharmacist, the pharmacist can absolutely work with a community based program and a home community-based environment where community program is capturing that information, documenting it, sharing it with the pharmacist.

But the pharmacist has to have a direct encounter with that consumer and it can be via Telehealth. So that pharmacist can have a secure Skype encounter with the consumer, a telephone encounter with the consumer.

And during that time that pharmacist must review all of their prescribed medication, their over the counters and their herbals and make recommendations.

If I was a community-based program and I'm working with a pharmacist and they're checking for only medication that may cause a problem or they're only looking at their prescribed medications, they're not looking at over-the-counter and herbals it doesn't meet the requirement.

I mean it's very explicit what the requirement has to be it has that community based organization can assist with capturing the data, educating the consumer, linking them with the pharmacist. But then the pharmacist has to review all aspects of that medication regime with that consumer in order to meet the requirement.

And this is a new requirement for Medicare Advantage plans again this year. It is - you see is something that all the ACOs have to adhere to. And guess what at the last Medicare Star conference Medicare Advantage Star conference I was at I saw three new startup venture capital funded entities.

And the only thing they're doing is marketing to Medicare Advantage plans to help them meet the measure for medication reconciliation where they were - these programs they were sending a community health worker in the home to capture the information to document it and then with an iPad link that person back to a pharmacist at a call center that then has a face to face interaction with that consumer and reviews all aspects of their medication regime and then documents it to meet that requirement.

So it's created a new opportunity. And it I - if we can have a model that supports them in meeting that requirement that's something we can take to

market and take the market quickly. But it has to meet all of those requirements and those requirements are set forth by NCQA.

Lauren Solkowski: Okay. Let's see I - we are just about over. I will check back one more time with the operator for an audio question?

Coordinator: There are no questions at this time.

Lauren Solkowski: Okay and Tim we had another question coming but since we are at the end of the time I will send this to you in an email to be...

Tim McNeill: Okay.

Lauren Solkowski: So I will do that and so just wanted to thank you again for presenting on the series.

Our - we've heard from several of our learning collaborative members they found it extremely helpful so thank you again.

If you are - would like to access the previous Webinars from the series they are on the MLTSS Web site. So you can find them there.

If you have any trouble finding them please let me know and I can help direct you to them.

So thank you again to everyone for joining us today and enjoy the rest of your afternoon.

Coordinator: Thank you. This concludes today's conference. You may all disconnect.

END