This document provides an overview of the Kansas City Metropolitan Physicians Association (KCMPA) Accountable Care Organization (ACO) and its participation in the Medicare Shared Savings Program (MSSP) under the Advance Payment Model. The organizational goals; general scope of activities; assignment of patients; and overall structure are presented as a reference for participants in the ACO.

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The Basics

Physicians Working Together

The Kansas City Metropolitan Physician Association, LLC (KCMPA) is a physician led organization working to make healthcare work better for everyone.

Our participating physicians deliver high quality, evidence-based healthcare at a reasonable cost while working to enhance the patient experience.

Building a Health System that Works

KCMPA physicians empower their patients to be as healthy as possible and try to ensure that when patients need care, it comes at the right time and in the right setting.

We are excited that Medicare has accepted a subset of the KCMPA to participate in the Medicare Shared Savings Program (MSSP): Accountable Care Organization (ACO). The primary care practices participating in the KCMPA-ACO will seek to facilitate a high level of cooperation and coordination with our patient’s health and care partners across the entire healthcare system. The goals are to improve the quality of care, increase patient satisfaction, and improve the health of our Medicare Fee-for-Service patients while decreasing the rate of medical errors, eliminating the use of unnecessary or duplicate services, and decreasing the overall cost of care. This ACO designation is an important step for all of the practices in the KCMPA as we seek to provide coordinated, affordable, more effective care for our patients and help make the medical system work better for everyone.

Beginning in January 2013, 54 physicians and 19 mid-level providers across the KCMPA practices are responsible for the health of more than 11,000 Medicare Fee-For-Service beneficiaries throughout the greater Kansas City area. We will succeed by employing robust care coordination and state-of-the-art technology to improve on our already outstanding patient care. In making these great strides, we hope to set an example for other independent physician groups across our region.

What is an ACO?

Accountable Care Organizations (ACOs)*1 are groups of doctors, hospitals and other health providers who come together voluntarily to give coordinated high quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

When an ACO succeeds in both delivering high-quality care and spending healthcare dollars more wisely, it will share in the savings it achieves for the Medicare program. Medicare offers several ACO programs including the Medicare Shared Savings Program (MSSP), Advance Payment and Pioneer Models.
What is the Medicare Shared Savings Program?
On Nov. 2, 2011, the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), published a final rule in the Federal Register implementing an Affordable Care Act provision to help doctors, hospitals, and other healthcare providers better coordinate care for Medicare patients through ACOs. ACOs create incentives for healthcare providers to work together to treat an individual patient across care settings – including doctor’s offices, hospitals, and long-term care facilities.

The Medicare Shared Savings Program will reward ACOs that lower their growth in healthcare costs while meeting performance standards on quality of care by sharing a portion of these savings with the providers. Provider participation in an ACO is purely voluntary, and Medicare beneficiaries retain their current ability to seek treatment from any provider they wish.  

Our Model
KCMPA chose to become an ACO within our organizational structure in order to realize our goals and remain as independent practitioners when many practices are being acquired by hospital systems. Under the Center for Medicare & Medicaid Innovation Center (CMMI), the opportunity provided as participants of the MSSP Advance Payment Model allows KCMPA to develop our ACO and prove that our delivery model meets high quality standards and can reduce costs.

In order to establish the ACO, we have established the KCMPA-ACO limited liability company. We established a leadership team and applied for and were accepted to participate in the Advance Payment Model. The Advance Payment Model is designed for physicians like us; those who practice high quality care and are not employed by a hospital system. Through the Advance Payment ACO Model, we are receiving payments from CMMI and we will use them to enhance our practices’ ability to provide care coordination.

Through mid-2014 we will focus on the development of programs to enhance patient experience through engagement and communication; coordinate and generate smooth transitions of care; meet the CMS quality standards and establish cost efficient and effective practices that comply with our program requirements. Our ultimate goal will be to provide our patients with care that they believe is the best in the Kansas City area.

ACO Structure
Accountable Care Organizations are regulated by the Federal government which sees itself in a protective role toward people with Medicare benefits. In light of this stance, The Centers for Medicare & Medicaid Services (CMS) requires all ACOs to have a governing board and active oversight committees to monitor and ensure completion of the activities of the ACO. Control and voting power of the ACO is mandated to include ACO participants (the practices), and Medicare beneficiaries. In addition, the governance of the ACO includes the Board of Directors and a number of required committees.
Our Leadership
We have a strong leadership team from the practices that make up KCMPA-ACO. In order to develop the ACO, a Board of Directors and Executive Team was established and initiated the application to become an ACO. Since acceptance of the ACO application by CMS, the Executive Team developed the company and hired positions approved in the CMS spend plan. Additionally, several committees are used to create functional process and work toward the ACO goals. The leadership team is posted and updated on the KCMPA website: http://kcmetrophysicians.com/ACO.

Our Committees
The ACO established several committees to develop and innovate processes that will help meet the mission and goals. While there is an ACO Executive Team to provide daily operational functions, provider and staff involvement on the committees is integral to the success of the ACO. The following committees report to the Board of Directors:

✓ Executive Committee
✓ Compliance Committee
✓ Finance Committee
✓ Information Technology Committee
✓ Quality Improvement & Care Coordination Committee
✓ Specialty/Hospital Committee (not required by CMS)

As the ACO develops, providers and staff will be more involved in ACO decision-making through committee participation.

What are the CMS Three Part Aim Objectives
CMS created the MSSP to achieve the “Triple Aim” Objectives*. They are:

✓ Better overall care in a safe environment, equitable to all who seek it, and always available when needed.
✓ Improved health accomplished through the practice of proactive, preventative medicine and chronic care coordination.
✓ Lower per capita cost aimed at reducing the trending of medical costs associated with the Original Medicare (commonly referred to as Medicare Fee for Service) population.

To ensure that savings are accompanied by improved care, CMS will track patient data through reports submitted by our ACO and from other sources. All information will remain HIPAA compliant.

Our Participants
The ACO is comprised of independent medical practices that are part of the KCMPA. The practices maintain their current corporate structure as independent practices while they participate in the ACO yet they will receive the benefits of the ACO such as care coordination, data reporting and quality improvement initiatives. The following provider group applications were submitted to CMS to be participants in the accountable care organization:

✓ Barry Pointe Family Care
✓ Blue River Medical Group
✓ Blue Springs Family Care
✓ Clay Platte Family Medicine Clinic
✓ Cobblestone Family Health
✓ Landmark Medical Center
✓ Midtown Family Medicine
✓ Northland Family Care
✓ Spring Hill Family Medicine
✓ Stephanie Revels, MD Family Practice
✓ Summit Family and Sports Medicine
✓ Sunflower Medical Group
✓ United Medical Group

The list is subject to change. See the website for a current list, http://kcmetrophysicians.com/ACO

Our Patients
CMS assigns Medicare Fee for Service beneficiaries to the ACO based on prior utilization. If patients are already seeing one of our participants, they probably are assigned to the ACO. In addition, Medicare may choose to assign patients to our ACO if they have not recently received primary care services and believe they could benefit from seeing one of our ACO providers.

An ACO agrees to coordinate the healthcare needs of 5,000 or more patients with Original Medicare (not Medicare Advantage) for at least three years. KCMPA-ACO has been assigned more than 11,000 patients and can receive up to 15,000 assigned beneficiaries.

CMS will share claims history and share data on the patients assigned to the ACO. Patients can decline to share their data with our ACO (see Patient Notification training) and may require explanation as to the benefits of sharing their data prior to making a final decision.
Our Scope

ACOs must also demonstrate to CMS that they have the infrastructure and ability to:

1. Promote patient-centeredness and ongoing commitment to quality improvement by:
   - Ensuring patient involvement in ACO governance;
   - Implementing standards for patient access and communication including access to medical records;
   - Communicating understandable clinical knowledge and evidence-based medicine to patients and engaging them in shared decision-making;
   - Utilizing systems and processes to assess patient health needs and health literacy including consideration of diversity, and developing individualized care plans;
   - Conducting patient experience surveys and creating improvement.
2. Provide data and tracking information to CMS.
3. Determine potential payments for shared savings.
4. Implement processes to promote:
   - Evidence-based medicine;
   - Reporting of quality and costs;
   - Effective and efficient coordination of care;
   - Patient engagement.

Patient Engagement

Engaging Our Patients

There are many ways to engage patients within your practice. KCMPA-ACO recognizes the importance of relationships between engaged patients, their caregivers and you as providers of care. Engagement is critical to patient safety and quality. Building relationships creates mutual responsibilities and accountabilities among the patient, family and provider that make care effective. Mutuality includes the sharing of information, creation of consensus and shared decision making to round out a positive patient experience. Together, the patient and provider experience includes opportunities to participate in treatment programs and improve the patient’s health.

Patient Engagement leads to a positive experience and overall satisfaction for both patients and their providers. The first step in launching our ACO is a centralized effort to communicate with patients and engage them in understanding the benefits and objectives of the ACO through our patient notification process.

Initial Patient Notifications

CMS has provided notification documents and procedures for the ACO to give to assigned beneficiaries. Each attributed patient receives a packet that includes:

- A Welcome & Introduction to our ACO with basic information regarding the MSSP.
- A form for patients to decline to share their medical information their claims data.

Upon a patient’s first visit to a provider, ACO participants must determine if the patient received the notification packet by mail; assess whether the patient has questions and be prepared to answer them; and provide and accept decline to share form if the patient declines to share their claims data. Patients who do not receive the packet by mail, are given the packet at their provider’s office.

Some patients may elect to decline to share their personal health information. However, patients may reverse their decision and choose to begin sharing their information at any time.

“Original Medicare” (Medicare FFS) patients who are not attributed to the ACO and see a provider who is in the ACO, should be offered the Patient Notification letter at the point of care and a request made to CMS to add the patient to the ACO attributed patient roster of the participant group.

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Practices keep track of the unattributed patients they have notified. Practices routinely provide a list of notified patients to KCMPA-ACO in order for the ACO to request claims data from CMS. Providers do not request data directly from CMS.

### Our Patient Experience Strategies

The KCMPA-ACO views the strategies for beneficiary engagement, education, and outreach along with community integration as complimentary and interdependent. The ACO implements a relationship-based culturally diverse approach centered on integration of resources combining beneficiaries, medical providers, advocacy and community groups as well as community stakeholders. The patient “experience” as a positive outcome often depends upon engagement strategies. Our ongoing engagement processes will include various methods to increase our success.

### Patient-Centered Care

- KCMPA-ACO sees and treats each patient as a unique person.
- We respect the individual needs of our patients.
- Our participants provide care that does not vary in quality based on personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
- Surveys will be used by CMS (for 2013) or the ACO (for 2014 & 2015) to assess the patient experience and strategies implemented to assess the outcomes.

#### Standards for Patient Access & Communication

We embrace the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home standards as a model for patient access and communication to include:

- The ACO encourages a uniform/advanced access scheduling policy to promote continuity of care.
- Same day appointments with an available clinician are available for patients who need to be seen.
- The ACO promotes timely beneficiary communication through phone, email, interactive website and secure internet connections with their primary care team.
- Interpretation services are available and determined by each practice when needed.

### What is Patient-Centered Care?

“Patient-centered” means considering patients’ cultural traditions, personal preferences and values, family situations, social circumstances and lifestyles.²

### What is Evidence-Based Medicine?

“The use of mathematical estimates of the risk of benefit and harm, derived from high-quality research on population samples, to inform clinical decision-making in the diagnosis, investigation or management of individual patients.”³

### Communication of Clinical Knowledge

- The ACO encourages evidence-based medicine designed order sets and care plans.
- Each patient is encouraged to complete a personal health assessment and then set a plan of action.
- We work to ensure patients receive appropriate care.
- Providers and care coordinators track patient progress and include the patient in the decision-making process.
- Ongoing dialogue between providers and patients contributes to the refinement of patient health status and care plans.
- Continued follow-up and interaction occurs through office visits and ACO mailings, telephone outreach and, when possible, electronic communications (such as emails or via online patient portals).
- Use of team based care models.

### Beneficiary-Driven Health Records & Devices

- KCMPA-ACO beneficiaries have the opportunity to claim an online personal health record based on physician practice.
- Patients may enter data in their health record such as biometrics, exercise and weight.
- The online health record may leverage biometric devices individualized to the patients in order to share data with their providers.
- Beneficiaries have the right to access their medical records per protocols developed by the ACO.

### Shared Decision-Making

The ACO uses a care delivery model that implements a comprehensive health management plan. The plan incorporates:

- Care coordination;
- Risk analysis;
- Social assessment and needs;
- Level of understanding and educational needs;
- Medical services required.

The optimal benefit of our ACO is to improve quality and create cost efficiency. Research shows that primary care practices can accomplish this through:

- Increasing accessibility and communications;
- Promoting prevention;
- Proactively supporting patients;
- Engagement in self-management and decision-making.

### What is Health?

From a population health perspective, health has been defined not simply as a state free from disease but as “the capacity of people to adapt to, respond to, or control life’s challenges and changes.”³⁷

### How does the Patient Experience measure up?

During 2012, CMS developed standardized sampling and survey administration procedures for the patient experience of care survey. CMS will administer the patient experience of care survey using these procedures in 2014 to assess performance for 2013. CMS will analyze the survey results and refine sampling & procedures. For 2014 and beyond, ACOs participating in the Shared Savings Program will be required to contract with a CMS-certified survey vendor to administer the survey.⁹

The patient experience measures relate to the aim of better care for individuals and are as follows:

ACO 1: Getting Timely Care, Appointments, and Information

ACO 2: How Well Your Doctors Communicate

ACO 3: Patient Rating of Doctor

ACO 4: Access to Specialist

ACO 5: Health Promotion and Education

ACO 6: Shared Decision Making

ACO 7: Health Status/Functional Status

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² Patient-Centered Care: A national initiative to ensure that people receive the care that is right for them based on their individual needs.

³ Evidence-Based Medicine: A method of medical practice that integrates the best available research with clinical expertise and patient values.

⁷ National Committee for Quality Assurance: A non-profit organization that promotes patient-centered medical homes.

⁹ CMS-Certified Survey Vendor: An organization accredited by CMS to administer the patient experience of care survey.
Our Population Communication Focus

Assess the Needs of the Population

- Analyze historic Medicare claims data and assess patients to identify:
  - ✓ Basic demographics (e.g. age, gender, location, etc.).
  - ✓ Preferred language and communication methods.
  - ✓ Historic care needs and utilization of services.
  - ✓ High-risk populations, chronic and other conditions that are likely to require coordinated care.

Meet the Needs of the Population

- ✓ Anticipate cultural and social diversity needs.
- ✓ Partner with community stakeholders to refine practices using evidence-based medicine.
- ✓ Use government and community data analysis to assess risky behaviors and costly diagnoses and educate to change behaviors.
- ✓ Work with local agencies to help diminish or eradicate unsafe practices by patients.
- ✓ Provide an annual community health analysis and develop engagement opportunities to improve health.

Methods of Communication

- ✓ Provide outreach to patient families, informal caregivers and community resources to help patients understand and act on their treatment plans.
- ✓ Create online newsletters and educational materials to teach different patients about health, wellness, chronic care and disease management and medication education.
- ✓ Provide interpretation or bilingual services to meet the language needs of all populations served by our ACO.
- ✓ Utilize Care Coordinators, who are social workers and nurses, as a team to assess chronic conditions, barriers to health, caregiver involvement and participate in development of individualized care treatment programs.

What is Population Health?

Population health has been defined as “the health outcomes of a group of individuals, including the distribution of such outcomes within the group.” This is an approach to health that aims to improve the health of an entire population. One major step in achieving this aim is to reduce health inequities among population groups. Population health seeks to step beyond the individual-level focus of mainstream medicine and public health by addressing a broad range of factors that impact health on a population-level, such as environment, social structure, resource distribution, etc. An important theme in population health is importance of social determinants of health and the relatively minor impact that medicine and healthcare have on improving health overall.

Patient-Clinician Communication

Basic Principles ¹³

1. Mutual respect
2. Harmonized goals
3. A supportive environment
4. Appropriate decision partners
5. The right information
6. Transparency and full disclosure
7. Continuous learning

Provider Involvement

The Goals

Patient engagement is essential to the success of KCMPA-ACO. Our initial administrative goal is to make sure you and your staff are prepared to help patients understand:

- ✓ How an integrated healthcare delivery system can enhance their patient experience; and
- ✓ How the ACO will work for them to improve the way they receive care and the quality of care they receive.

The second goal of our provider involvement plan is to educate you about the ACO including:

- ✓ How the ACO can assist you in caring for your patients
- ✓ Provide you with the framework to create an action plan to engage in care coordination with your patient population.

As the key stakeholder of our ACO program, you will play a critical role in:

- ✓ Assessing a patient’s overall health status;
- ✓ Preparing Individualized Care Plans;
- ✓ Activating our ACO’s care coordination resources; and
- ✓ Engaging in quality improvement initiatives

You and your team also educates and engages ACO patients and encourages them to be more involved in decisions that impact their health.

Scope of Activities

Educate Your Patients on the “ACO Basics”

ACOs are a new concept for your Medicare fee for service patients, and there is no enrollment process or opportunity for face-to-face patient education prior to auto-assignment. Therefore you and your staff have an important role to educate your attributed ACO patients on what your clinic’s involvement in the ACO means, assure them of the program’s benefits, and address any questions or concerns they express.

The ACO Patient Notifications policy and the Frequently Asked Questions (FAQs) are useful resources in responding to questions or requests for more information. The ACO Poster provided by Medicare also may be helpful to you and includes:

Improving Care for Patients

Any patient who has multiple doctors probably understands the frustration of fragmented and disconnected care: lost or unavailable medical charts, duplicated medical procedures, or having to share the same information over and over with different doctors. Accountable Care Organizations are designed to lift this burden from patients, while improving the partnership between patients and doctors in making healthcare decisions. ¹⁴

*10: The Centers for Medicare and Medicaid Innovation

*11: The Centers for Medicare and Medicaid Innovation

*14: The Centers for Medicare and Medicaid Innovation
Basic information about our ACO, its goals and benefits;
CMS website links for more information on ACOs and the MSSP; and
Contact information for your office.
The ACO Executive Team met with you and your staff to provide education on the notification process and is available to you to ensure that you understand the ACO notification process defined by CMS.

Receive Provider Education
Without a clear understanding of the ACO, confusion or concerns can arise among providers and their team members.
To prepare you and your team, the ACO offers education and training opportunities. These include:
Individual office meetings;
Online webinars and a web-based training program; and
Educational materials via mail and/or Internet.
In addition to these education and training events, the ACO has staff committed to assisting you in understanding the ACO and its goals. As ACO patients raise questions or concerns, you and your staff should be prepared to respond with simple, straight-forward answers that will provide reassurance and clarity.

Beneficiary Access to Medical Records
Patients have the right to their medical records. We work to ensure our processes allow them to access their records without delay or complication.

Patient Annual Wellness Examinations
Regular interactions with ACO patients are important. We recommend utilizing Annual Wellness Visits (AWV) to reinforce the critical doctor-patient relationship, to help document existing patient conditions and identify any new or previously unrecognized conditions and to ensure preventive and chronic disease quality measures are met. These exams establish patient baselines and provide new opportunities for meeting patient needs. CMS has special billing codes for these visits which may be helpful in identification of patients who may benefit from care coordination. Where needed, our ACO can offer additional care coordination services based on your examination.

In our first year, KCMPA-ACO will focus on the identification of patient status in relation to the 33 quality measures identified for tracking by CMS. Some of these measures require provider support to clearly identify the patients for safety, depression and at risk diagnoses. (See Appendix II)

Assimilate Your Care Coordinator
KCMPA-ACO understands practices are strapped for resources to provide new care coordination services for your patients. The biggest part of the advanced payment funds are used to hire and train care coordinators who are embedded in each ACO participant clinic. Your clinic’s care coordinator is assigned to work in your clinic full or part time based on the number of ACO patients attributed to your clinic.
Treat your care coordinator like a member of your staff.
Identify a work space.
Include her as part of your care team.
Understand the skills & talents of your care coordinator and the additional resources she can access on your behalf like dietitians, diabetes education and pharmacist consultation.
Identify a process for patients who are medically or socially complex, high risk or recently discharged from inpatient care to meet with your care coordinator.

Care Coordination Identification
Care coordination is an additional resource that KCMPA-ACO offers participants. Typically, 10% of patients will require care coordination and may be identified in several ways:
Assessment of population demographics, diagnoses and potential resource requirements
Analysis of the patient’s Medicare claims history and utilization;
Annual Wellness Visits; and
Health Risk Assessments (HRA) outreach
**Care Coordination**

**Our Philosophy**

The value of patient engagement, care coordination and provider involvement have been proven to improve patient health outcomes. Our ACO philosophy is to provide an integrated care coordination model across the full continuum of care. We believe that by doing so, we can accomplish the following:

- ✓ reduce the fragmentation of care;
- ✓ diminish duplication of services;
- ✓ prevent inadvertent omission of care and services;
- ✓ reduce avoidable admissions/readmissions;
- ✓ avoid improper usage of emergency room services; and
- ✓ improve patient experiences.

By focusing on these achievements we will improve our outcomes and health for patients while lowering costs. In the end, it will enable us to share savings under the MSSP.

**Key Characteristics**

Our care coordination model will include:

- ✓ identification of our population within the ACO;
- ✓ identification of those beneficiaries within the highest “at risk” strata;
- ✓ a defined package of comprehensive health and social care services;
- ✓ a broad range of patient-centered medical home providers, specialists and ancillary providers to meet the needs of the beneficiaries.

KCMPA-ACO believes the primary care physician in a patient-centered medical home is the key coordinator-partnering with the patient as they navigate the complexities of the healthcare system in wellness and in illness. This is the approach most likely to result in a successful ACO.

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**Care Coordination Interaction**

The KCMPA-ACO was organized to assist physicians and other providers in helping patients be healthy and remain active. For those patients who are unhealthy, have chronic conditions, experience injury or have other healthcare needs, the ACO pays for care coordinators and other resources to allow participant providers to enhance their services. These resources also lead patients to engage in healthy behaviors. We believe successful patient interaction is best achieved through care coordination, patient communication and sensitivity to cultural needs of patients.

Successful care coordination requires ongoing communication between you and the Care Coordination Team. This communication keeps the patient and all of the people associated with the care of the patient up-to-date regarding the patients status and helps in the development of treatment plans. The patient experience improves when the healthcare team provides consistent care and smooth transitions between healthcare settings.

Healthcare events trigger communication opportunities between you and the Care Coordination Team. For instance, you may be contacted directly by the Care Coordination Team when ACO patients:

- ✓ Require transitions in care (e.g., admissions, transitions between facilities, discharge plans);
- ✓ Would benefit from active outpatient care coordination (e.g., home assessments, treatment plans, community resource utilization);
- ✓ Are referred to care coordination by other providers; and
- ✓ Are identified as care coordination candidates through the analysis of data by the ACO.

In addition, you may want your Care Coordinator to assist in patient education in your office on a regular basis post-procedure or hospital admission to ensure patient engagement and prevent further health concerns.

**In Summary**

Providers ARE key to the success of the ACO. The KCMPA-ACO support teams are here to help you to deliver the best possible care. Contact us with ideas, needs or solutions for OUR healthcare system. Get involved and together we can succeed!
Our Patient Health Strategy

KCMPA-ACO wants patients to be healthy. The initial strategy includes efforts to ensure that all beneficiaries are assigned to a primary care physician (PCP). The physician is responsible for the coordination of care and services, working to develop a patient-centered relationship that includes the family and/or caregivers along with the care team.

The participant groups in the ACO use a Patient-Centered Medical Home (PCMH) model as a foundation. KCMPA-ACO supports an integrated care coordination model using trained nurses and social workers as Care Coordinators (CCs) located in the practices. Physicians along with their nurses and medical assistants will track patients’ progress along the prescribed pathway throughout the beneficiary care plan. Physicians can utilize CCs to act upon variances in quality care and eliminate barriers to patient success.

Interdisciplinary Care Team

KCMPA-ACO believes that comprehensive care should encompass the biopsychosocial entirety of the beneficiary including health, medical conditions, psychological status and social setting. The KCMPA-ACO deploys a multi-prong approach to the development of the care coordination model by encompassing the following stakeholders to form the Interdisciplinary Care Team (ICT) and development of a Care Plan with the beneficiary as the center:

✓ Beneficiary
✓ Family and/or Caregiver
✓ Provider (PCP in PCMH)
✓ Specialists
✓ Behavioral Health Providers including Social Workers
✓ Care Coordinators (Social Workers, Nurses)
✓ Pharmacist
✓ Community Agencies
✓ Home Care, PT, OT, RT and OT
✓ Dieticians
✓ Transportation Vendors

Services provided within an integrated care model require communication among ICT members.

Information about our team and vendors may be found at KCMPA website: http://kcmetrophysicians.com/.

Care Coordination Program

One focal point for a successful integrated care coordination model includes a navigator of care called a Care Coordinator who assists the beneficiary in maintaining premium levels of health for prevention and chronic care, arranging appointments with providers and other healthcare professionals as needed, and removing any barriers to attaining appropriate levels of care.

Care Coordinators are trained to work in ways that are consistent with the culture of the practices they support. Care Coordinators will offer and suggest ways they can help but their involvement with patients is directed by the physician.

The functions of the Care Coordinator include but are not limited to:

✓ Adherence to evidence based protocols;
✓ Performance of health risk assessment;
✓ Stratification of high risk members and those with chronic conditions;
✓ Development of a Care Plan with the ICT to assist the beneficiary in meeting their goals;
✓ Educate, assess, plan and monitor the beneficiary care needs;
✓ Bridge the cultural divide between social and health services;
✓ Collaborate with all stakeholders involved in the beneficiary’s care;
✓ Facilitate the social integration of beneficiary and flexible community services; and
✓ Care for beneficiary to meet cultural, linguistic and ethnic needs.

Care Coordination Team Leadership

Chief Medical Officer

The Chief Medical Officer (CMO) is responsible for direct oversight of medical management and quality improvement activities. ACO providers and medical management staff can consult the CMO on decisions requiring physician input. The CMO is available to interact directly with ACO participants, the care coordinators or the ICT as needed.

Clinical Manager

In conjunction with the CMO, the Clinical Manager is responsible for supporting and developing the Care Coordination Program. The Clinical Manager captures and reports data to the CMO, the Quality Improvement Committee of the ACO and also is available to ACO providers and care coordination staff to help supervise day-to-day activities.
Care Coordination Scope of Activities

Care coordinators are directed by the primary care physician responsible for the patient’s care. The following explains ways care coordinators can assist.

Health Risk Assessments (HRAs)
Care Coordinators work with physicians to obtain HRAs as part of the Annual Wellness Visit or when patients with complex conditions visit your practice.

Patient Outreach
Care Coordinators reach out to patients based on health risk assessment results and establish patient-centered care plans in consult with the physician. The provider care team may also determine that pre-visit planning is required to best create a successful patient experience and enhanced quality of care. Working with the primary care physician and ICT, the CC will address medical conditions and needs of the patients using education, care coordination and evidence-based medicine protocols.

Inpatient Care Coordination
Admission to a healthcare facility can be stressful for patients whether a hospital, skilled nursing facility or rehabilitation. In addition, practitioners are often unaware of the admission and subsequent care required, leading to gaps in coordination or even readmission to a facility.

By facilitating collaboration between our ACO physicians, facilities serving ACO patients, and patients and their families, the Interdisciplinary Care Team (ICT) works to prevent this type of situation, focusing on in-patient care and having a coordinated post-discharge plan.

Our ACO’s Care Coordination Team includes professional care coordinators who serve as an additional resource and will assist in:

- Notifying PCPs of patient admissions.
- Coordinating with hospital care teams to create smooth transitions of care;
- Developing individualized care plans with the ICT and community physicians seen by the patient;
- Providing information on patient progress and treatment plans to HIPAA approved care team members;
- Engaging patients and families using education and discharge planning to create smooth transitions between home and other settings; and
- Moving patients toward their healthcare goals.

Transitions of Care
Care Coordinators work with patients, their physicians and healthcare facilities to ensure transitions between care settings. The Care Coordinator is be able to work with the health facility and ICT to:

- Make sure patients receive appropriate discharge instructions and understand them;
- Ensure that any required medications are obtained or delivered and attempt to ensure patient compliance through assessment and education;
- Check in with patients to see that they are safe and secure in their new setting whether at home or in an extended care health facility; or
- Assist the patient in making follow up appointments with the PCP and any specialists based on their treatment plan.

In-Office Care Coordination
The Care Coordinators are based in physician practices that participate in the KCMPA-ACO. The Care Coordinator will work with a wide variety of interdisciplinary health team members to meet patient clinical and social needs. Their goal is to remove barriers that keep patients from completing their care plan. Activities that physicians may request the Care Coordinator to assist with may include:

- Education of patients on a wide variety of health, disease, and conditions along with tracking and follow up of patient compliance;
- Assess medication regime, reconcile medication profiles and monitor compliance; (including accessing services from KCMPA - ACO - contracted pharmacist.)
- Tracking and follow up of patient treatments and completion of care plan actions;
- Identifying barriers to health improvement such as social, cultural, linguistics, or financial needs that may require assistance from social workers or other community resources;
✓ Identify DME or Home Health needs and coordinate delivery or referrals; or
✓ Schedule follow up appointments and coordinate transportation when necessary.

Track, Measure and Care
Care Coordinators use all available data sources such as HRAs, medical and prescription claims, and EMR records to establish risk levels of the patient population in the ACO. Ongoing data assessments and reports will be used to find opportunities to reduce population risk levels and measure changes in outcomes.

In keeping with our philosophy, the emphasis is on reducing care fragmentation; diminishing duplication of services; preventing inadvertent omissions of care and services; reducing avoidable admissions/readmissions; and avoiding improper usage of emergency room services. CCs will focus patient-centeredness and improving health while considering cost effective process.

Your Care Coordination Requests
When you have a patient who requires assistance from the Care Coordination Team, please complete the Care Coordination Request process defined by your practice. You may have a place in your EMR or use a form to request CC assistance for your patients.

Pay for Performance
CMS will be phasing in pay for performance over the ACO’s first agreement period as follows:

✓ Year 1: Pay for reporting applies to all 33 measures.
✓ Year 2: Pay for performance applies to 25 measures. Pay for reporting applies to eight measures.
✓ Year 3: Pay for performance applies to 32 measures. Pay for reporting applies to one measure that is a survey measure of functional status. CMS will keep the measure in pay for reporting status for the entire agreement period. This will allow ACOs to gain experience with the measure and will provide important information to them on improving the outcomes of their patient populations. *15

Quality Improvement
Our Quality Improvement Committee (QIC) establishes the quality performance and improvement goals for the KCMPA-ACO and presents the annual Quality Improvement Program (QIP) to the Participants, the Board of Directors and other required by the CMS, state agencies and other regulatory agencies. CMS has made continuous quality improvement a focus of the MSSP.

The basis for health information in the ACO is the Electronic Medical Record (EMR). Each practice utilizes its own EMR. KCMPA has partnered with Cerner to connect all of the participating practices into our own Health Data Network. Our data network will eventually enable us to collect, analyze and report data on all 33 CMS quality measures. In addition, our data network will connect to the regional Lewis and Clark Information Exchange (LACIE) where participants can assess clinical information from outside our ACO on our patient population. Our connection to LACIE helps practices achieve Meaningful Use Stage II criteria.

In the interim, the KCMPA-ACO contracts with Health Metric Systems to collect clinical data from each ACO Participant’s EHR system to report quality data.

Scope of Activities

Patient Experience Survey
To better understand how KCMPA-ACO patients view their primary doctors and their associated office staff members, an annual patient experience survey must be conducted on behalf of the ACO. In year one, the survey will be conducted by CMS. In the following years the ACO must hire an approved CMS vendor to conduct the survey.

ACO Benchmarks
The benchmark for the ACO is calculated based on the per capita Medicare costs of beneficiaries that would have been assigned to ACO participants in each of the three years before the start of the agreement. For example, for ACOs starting in 2012, benchmarking years will be 2009, 2010, and 2011. The assignment algorithm described in the final rule will be applied to each of these years. The ACO’s benchmark is not set for individual ACO participants, rather, the benchmark is set for the ACO as a whole based on the per capita Part A and B expenditures for all beneficiaries who would have been assigned to the ACO in any of the 3 most recent years prior to the start of the agreement period. The benchmark is trended using national Medicare expenditure growth factors and risk adjusted to reflect the most recent benchmark year, which is also weighted the most in establishing the 3 year historical benchmark. The benchmark is updated annually by the projected absolute amount of growth in national Part A and B fee-for-service expenditures *16.
CMS has chosen to direct the attention of the survey to the patient “experience” of care rather than on the historical satisfaction model and will:

✓ Measure the level of satisfaction with the experience of care received;
✓ Identify and classify areas of high and low patient care experiences;
✓ Provide data and opportunities for quality improvement;
✓ Determine key drivers of patient experience outcomes; and
✓ Compare KCMPA-ACO results to the National Benchmarking Database.

An executive summary of the Patient Experience Survey results will be made available to the leadership of the ACO and to all its participants/providers/suppliers.

Evidence-Based Guidelines

To ensure a consistent approach to Care Coordination, KCMPA-ACO adopts evidence-based clinical guidelines. Guidelines are recommended by the CMO, QI Committee and clinical staff using literature and research from nationally recognized associations, along with input from appropriate local physicians and providers.

As part of the QI plan, the ACO reviews the guidelines annually or more frequently if changes occur in medical research to ensure their efficacy for the population we are serving. When guidelines are finalized, our KCMPA-ACO Board of Directors approves and distributes them to participating providers. Adopted guidelines can be found on the website at kcmetrophysicians.com.

Quality Measures within the Shared Savings Program

As required by the Affordable Care Act, before an ACO can share in any savings created, it must demonstrate that it met the quality performance standard for that year. CMS will measure quality of care using nationally recognized measures in four key domains:

✓ Patient/caregiver experience (7 measures)
✓ Care coordination/patient safety (6 measures)
✓ Preventive health (8 measures)
✓ At-risk population:
  ■ Diabetes (6 measures)
  ■ Hypertension (1 measure)
  ■ Ischemic Vascular Disease (2 measures)
  ■ Heart Failure (1 measure)
  ■ Coronary Artery Disease (2 measures)

KCMPA-ACO quality measures support those used in other CMS quality programs, such as the Physician Quality Reporting System and the Electronic Health Record Incentive Programs. They also align with the federal Department of Health & Human Services (HHS) National Quality Strategy and other priorities such as the Million Hearts Initiative.

KCMPA-ACO must report these measures to CMS through a web interface designed for clinical quality measure reporting and through the results of care surveys that capture ACO patient experience. In addition, CMS directly calculates claims and compiles administrative data through its own measures in order to reduce our administrative burden (See Appendix II for complete list of measures).

Each MSSP ACO must demonstrate that it meets the quality performance standards for each year. In the first performance year, the quality performance standard requires our ACO to provide complete and accurate reporting for all quality measures. In the second and subsequent performance years, our ACO must continue to report all measures but we will eventually be assessed on phased-in performance standards. (See ACO Benchmarks on Page 25). ACO Participants will not report PQRS measures independently. The ACO quality reporting also will suffice for PQRS reporting.

In addition to standards related to quality performance, CMS will use certain measures to ensure that ACOs are not avoiding at-risk patients or engaging in overuse, underuse or misuse of healthcare services. KCMPA-ACO’s IT and QI committees guide the projects to report on behalf of our practices.

Our Focus

DATA COLLECTION

✓ Use clinical care teams that coordinate care across the medical and social settings of the beneficiary and collect patient data.
✓ Monitor patient experience and ideas to improve our systems.
✓ Identify known, suspected, or potential quality or safety problems in patient care delivery, the physical environment of the organization, or other aspects of patient or customer service.

ANALYSIS & EVALUATION

✓ Support the use of scientific performance improvement methodologies and tools.

Encourage the process of participating in comparative databases in order to identify and benchmark against best practices.

**REPORTING**

- Identify opportunities for further clinical and service improvement by acting upon trends identified in analysis of aggregate data and generated reports.
- Establish accountability for improvement activities through organized reporting.
- Provide physicians and mid-level providers with a scorecard style report that allows them to focus on areas to improve and drives quality patient care.

**ACCOUNTABILITY**

- Facilitate desired changes through education, system adjustments, and policy/procedure development.
- Stimulate the adoption of best practices across the KCMPA-ACO organization.
- Support the use of multidisciplinary performance improvement teams to design new processes or services or to address specific improvement opportunities.

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**Physician Collaboration + Evidence Based Medicine = Quality**

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**Reporting & Analytics**

**Patient Needs and Reports on Care**

Your Accountable Care Organization (ACO), KCMPA-ACO, is working in partnership with Cerner Corporation to collect data from practice Electronic Health Records and CMS to provide custom reports to:

- Establish patient needs or trends and identify areas to improve;
- Help you and your team to understand the unique needs and medical risks of the Medicare patients you serve;
- Track and measure key ACO quality measures such as the 33 quality measures from Medicare along with key operating metrics such as patient utilization, administrative processes and financial projections.

**Scope of Activities**

You will receive reports at regular intervals to help you ensure that your Medicare patients get the right care at the right time; develop care plans and address needs of the chronically ill; and monitor for duplication of services.

As a provider of care, your review of reports and involvement in monitoring trends or individual patient care needs will benefit your practice and your ACO. In addition, use of scorecard style reports will allow individual providers to address areas where standards of care can be accelerated and care coordination beneficial to patients under their care.
Reports that the ACO plan to provide include:
(NOTE: spend = amount Medicare spent on the ACO attributed patients)

<table>
<thead>
<tr>
<th>Reports by ACO</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top Conditions by Occurrence</td>
<td>This will show the highest occurrence conditions</td>
</tr>
<tr>
<td>Top Procedures by Occurrence</td>
<td>This report shows the most common procedures sorted by occurrence</td>
</tr>
<tr>
<td>Top Conditions by Spend</td>
<td>This report is the conditions sorted by the spend</td>
</tr>
<tr>
<td>Top Procedures by Spend</td>
<td>This report is the procedures sorted by the spend</td>
</tr>
<tr>
<td>Frequent ED Visits</td>
<td>This report shows the highest Emergency Department utilization of patients attributed to the ACO</td>
</tr>
<tr>
<td>Top Rx Spend</td>
<td>This report shows the highest pharmacy utilization based on Medicare part D across the ACO</td>
</tr>
<tr>
<td>Highest Spend Patient List</td>
<td>This is a list of patients with the highest spend across the ACO</td>
</tr>
<tr>
<td>Spend by Practice</td>
<td>List of average patient spend by practice</td>
</tr>
<tr>
<td>Spend by Physician</td>
<td>List of average patient spend by physician</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reports by Practice</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top Conditions by Occurrence</td>
<td>This will show the highest occurrence conditions at the practice level</td>
</tr>
<tr>
<td>Top Procedures by Occurrence</td>
<td>This report shows the most common procedures sorted by occurrence at the practice level</td>
</tr>
<tr>
<td>Top Conditions by Spend</td>
<td>This report is the conditions sorted by the spend at the practice level</td>
</tr>
<tr>
<td>Top Procedures by Spend</td>
<td>This report is the procedures sorted by the spend at the practice level</td>
</tr>
<tr>
<td>Frequent ED Visits</td>
<td>This report shows the highest ED utilization of patients attributed to the ACO at the practice level</td>
</tr>
<tr>
<td>Top Rx Spend</td>
<td>This report shows the highest pharmacy utilization based on Medicare part D across the ACO at the practice level</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reports by Physician</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top Conditions by Occurrence</td>
<td>This will show the highest occurrence conditions for each physician</td>
</tr>
<tr>
<td>Top Procedures by Occurrence</td>
<td>This report shows the most common procedures sorted by occurrence for each physician</td>
</tr>
<tr>
<td>Top Conditions by Spend</td>
<td>This report is the conditions sorted by the spend at the physician level</td>
</tr>
<tr>
<td>Top Procedures by Spend</td>
<td>This report is the procedures sorted by the spend at the physician level</td>
</tr>
<tr>
<td>Frequent ED Visits</td>
<td>This report shows the highest ED utilization of patients attributed to the ACO at the physician level</td>
</tr>
<tr>
<td>Top Rx Spend</td>
<td>This report shows the highest pharmacy utilization based on Medicare part D across the ACO at the physician level</td>
</tr>
<tr>
<td>Highest Spend Patient List with Diagnosis</td>
<td>This is a list of patients with the highest spend across the ACO at the physician level</td>
</tr>
</tbody>
</table>

Data Files & Analysis

Through our partnership with Cerner Corporation, our ACO has access to a data warehouse which incorporates data from various sources including:

✓ Claims files from Medicare.
✓ Patient files (Patient demographics, Risk scores, PCP affiliation);
✓ Provider files (Provider demographics, Group affiliations, Network affiliations);
✓ The data is turned into actionable information, enabling users to quickly identify opportunities for improvement in the efficiency and quality of care delivery. The Cerner tools allow users to:
✓ Compare performance among providers against key efficiency measures including, but not limited to, emergency room utilization, inpatient efficiency and prescription efficiency.
✓ Develop detailed compliance information regarding quality measures at the patient, physician and ACO level.
✓ Access pharmaceutical information such as contra-indications and/or generic equivalents.
✓ Mine claims data for trends and develop customized reports.

Our eventual goal will be to provide you access to compare your ongoing performance against efficiency measures, you can access the system via the Internet, using a secure log-in.

Health Information Exchange (HIE)

KCMPA-ACO is fortunate to be included in an enterprise health information exchange among independent physicians and the regional HIE exchange with the Lewis And Clark Information Exchange (LACIE) that includes healthcare providers and hospitals around Kansas City. Over time, this system will be established for our ACO practices. Patients will be able to access their medical information and providers will be able to obtain records from any facility or participating provider in the exchanges. The enterprise HIE will allow for any patient referred within KCMPA to have information about their visit pushed from PCP to specialist and vice versa. Through the LACIE connection a healthcare provider will be able to pull information from KCMPA practices as well as participating hospitals.

Provider Involvement

New reports can be created based on input from the leadership team and participants in the ACO. We anticipate that as the data reports become more robust, providers may want information in a variety of sorts and formats. The ACO will work to involve providers in the process, especially through our QI Committee in order to maximize the efficiency and effectiveness of the reporting tools.
Compliance

Ensuring Compliance

The KCMPA-ACO’s Board of Directors has established a Compliance Plan to ensure the organization operates in a manner consistent with all applicable legal and ethical standards. The ACO’s Compliance Officer reports directly to the Board of Directors. The Compliance Officer, with the support of the Compliance Committee, is responsible for the compliance plan’s operations. The Compliance Officer does not provide legal counsel for the ACO, although he works closely with the ACO’s attorneys.

Scope of Activities

The scope of KCMPA-ACO’s Compliance Plan includes:

✓ Mechanisms for identifying and addressing compliance problems related to the ACO’s operations and performance
✓ A well-publicized method for any person or organization associated with the ACO to anonymously report suspected problems related to the ACO’s operations to the Compliance Officer
✓ Ongoing compliance training for ACO staff, participants, and suppliers/providers
✓ A requirement to report any probable violation of law to the appropriate law enforcement agency
✓ A process for evaluating the Compliance Plan’s performance and making periodic updates to enhance its operations and reflect changes in laws and regulations
✓ Support for ACO participants’ compliance efforts within their individual practices

Questions regarding the ACO’s compliance plan or concerns regarding the ACO’s compliance with legal and ethical standards should be directed to:

Matt Condon, JD/MBA
Compliance Officer
mcondon@arcpt.com
(913) 831-2721

Stephanie Revels, MD
Compliance Committee Chair
smrev59@aol.com
(913) 451-9889

Appendix I – Reference List

The following list refers to references and website links used throughout the Reference Guide for the KCMPA-ACO.

15. How is a Benchmark determined for the ACO? http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/MSSP-FAQs.pdf

General References


All reports will be treated as confidential to the fullest extent possible, and no form of retaliation against a person who makes a report will be tolerated. If you wish to remain anonymous, however, please submit a written report to the following address:

Compliance Officer
KCMPA-ACO, LLC
435 Nichols Road, Suite 200
Kansas City, MO 64112

Reference Guide
## Appendix II – Quality Measures

### Accountable Care Organizations (ACOs)

The Centers for Medicare & Medicaid Services (CMS)

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure Title</th>
<th>NQF Measure#/ Measure Steward</th>
<th>Method of Data Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aim: Better Care for Individuals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Patient/ Caregiver Experience</td>
<td>CAHPS: Getting Timely Care, Appointments, and Information</td>
<td>NQF #5, AHRQ</td>
<td>Survey</td>
</tr>
<tr>
<td>2 Patient/ Caregiver Experience</td>
<td>CAHPS: How Well Your Doctors Communicate</td>
<td>NQF #5, AHRQ</td>
<td>Survey</td>
</tr>
<tr>
<td>3 Patient/ Caregiver Experience</td>
<td>CAHPS: Patients’ Rating of Doctor</td>
<td>NQF #5, AHRQ</td>
<td>Survey</td>
</tr>
<tr>
<td>4 Patient/ Caregiver Experience</td>
<td>CAHPS: Access to Specialists</td>
<td>NQF #5, AHRQ</td>
<td>Survey</td>
</tr>
<tr>
<td>5 Patient/ Caregiver Experience</td>
<td>CAHPS: Health Promotion and Education</td>
<td>NQF #5, AHRQ</td>
<td>Survey</td>
</tr>
<tr>
<td>6 Patient/ Caregiver Experience</td>
<td>CAHPS: Shared Decision Making</td>
<td>NQF #5, AHRQ</td>
<td>Survey</td>
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<tr>
<td>7 Patient/ Caregiver Experience</td>
<td>CAHPS: Health Status/ Functional Status</td>
<td>NQF #6, AHRQ</td>
<td>Survey</td>
</tr>
<tr>
<td>8 Care Coordination/ Patient Safety</td>
<td>Risk Standardized, All Condition Readmission*</td>
<td>CMS</td>
<td>Claims</td>
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<tr>
<td>9 Care Coordination/ Patient Safety</td>
<td>Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease (AHQ Prevention Quality Indicator (PQI) #5)</td>
<td>NQF #275 AHRQ</td>
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<tr>
<td>10 Care Coordination/ Patient Safety</td>
<td>Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure (AHQ Prevention Quality Indicator (PQI) #8)</td>
<td>NQF #277 AHRQ</td>
<td>Claims</td>
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<tr>
<td>11 Care Coordination/ Patient Safety</td>
<td>Percent of PCPs who Successfully Qualify for an EHR Incentive Program Payment</td>
<td>CMS</td>
<td>EHR Incentive Program Reporting</td>
</tr>
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### Aim: Better Health for Populations

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure Title</th>
<th>NQF Measure#/ Measure Steward</th>
<th>Method of Data Submission</th>
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</thead>
<tbody>
<tr>
<td>12 Care Coordination/ Patient Safety</td>
<td>Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility</td>
<td>NQF #97 AMA-PCPI/NCQA</td>
<td>GPRO Web Interface</td>
</tr>
<tr>
<td>13 Care Coordination/ Patient Safety</td>
<td>Falls: Screening for Fall Risk</td>
<td>NQF #101 NCQA</td>
<td>GPRO Web Interface</td>
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<tr>
<td>14 Preventive Health</td>
<td>Influenza Immunization</td>
<td>NQF #41 AMA-PCPI</td>
<td>GPRO Web Interface</td>
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<tr>
<td>15 Preventive Health</td>
<td>Pneumococcal Vaccination</td>
<td>NQF #43 NCQA</td>
<td>GPRO Web Interface</td>
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<tr>
<td>16 Preventive Health</td>
<td>Adult Weight Screening and Follow-up</td>
<td>NQF #421 CMS</td>
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<td>17 Preventive Health</td>
<td>Tobacco Use Assessment and Tobacco Cessation Intervention</td>
<td>NQF #28 AMA-PCPI</td>
<td>GPRO Web Interface</td>
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<td>18 Preventive Health</td>
<td>Depression Screening</td>
<td>NQF #418 CMS</td>
<td>GPRO Web Interface</td>
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<tr>
<td>19 Preventive Health</td>
<td>Colorectal Cancer Screening</td>
<td>NQF #34 NCQA</td>
<td>GPRO Web Interface</td>
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<tr>
<td>20 Preventive Health</td>
<td>Mammography Screening</td>
<td>NQF #31 NCQA</td>
<td>GPRO Web Interface</td>
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<tr>
<td>21 Preventive Health</td>
<td>Proportion of Adults 18+ who had their Blood Pressure Measured within the preceding 2 years</td>
<td>CMS</td>
<td>GPRO Web Interface</td>
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<tr>
<td>22 At Risk Population – Diabetes</td>
<td>Diabetes Composite (All or Nothing Scoring): Hemoglobin A1c Control (&lt;8 percent)</td>
<td>NQF #0729 MN Community Measurement</td>
<td>GPRO Web Interface</td>
</tr>
<tr>
<td>23 At Risk Population – Diabetes</td>
<td>Diabetes Composite (All or Nothing Scoring): Low Density Lipoprotein (&lt;100)</td>
<td>NQF #0729 MN Community Measurement</td>
<td>GPRO Web Interface</td>
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<tr>
<td>24 At Risk Population – Diabetes</td>
<td>Diabetes Composite (All or Nothing Scoring): Blood Pressure &lt;140/90</td>
<td>NQF #0729 MN Community Measurement</td>
<td>GPRO Web Interface</td>
</tr>
<tr>
<td>Domain</td>
<td>Measure Title</td>
<td>NQF Measure#/ Measure Steward</td>
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</tr>
<tr>
<td>26 At Risk Population — Diabetes</td>
<td>Diabetes Composite (All or Nothing Scoring): Tobacco Non Use</td>
<td>NQF #0729 MN Community Measurement</td>
<td>GPRO Web Interface</td>
</tr>
<tr>
<td>26 At Risk Population — Diabetes</td>
<td>Diabetes Composite (All or Nothing Scoring): Aspirin Use</td>
<td>NQF #0729 MN Community Measurement</td>
<td>GPRO Web Interface</td>
</tr>
<tr>
<td>27 At Risk Population — Diabetes</td>
<td>Diabetes Mellitus: Hemoglobin A1c Poor Control (&gt;9 percent)</td>
<td>NQF #59 NCQA</td>
<td>GPRO Web Interface</td>
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<tr>
<td>28 At Risk Population — Hypertension</td>
<td>Hypertension (HTN): Blood Pressure Control</td>
<td>NQF #18 NCQA</td>
<td>GPRO Web Interface</td>
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<tr>
<td>29 At Risk Population — Ischemic Vascular Disease</td>
<td>Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL Control &lt;100 mg/dl</td>
<td>NQF #75 NCQA</td>
<td>GPRO Web Interface</td>
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<tr>
<td>30 At Risk Population — Ischemic Vascular Disease</td>
<td>Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic</td>
<td>NQF #68 NCQA</td>
<td>GPRO Web Interface</td>
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<tr>
<td>31 At Risk Population — Heart Failure</td>
<td>Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
<td>NQF #83 AMAPCI</td>
<td>GPRO Web Interface</td>
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<tr>
<td>32 At Risk Population — Coronary Artery Disease</td>
<td>Coronary Artery Disease (CAD) Composite: All or Nothing Scoring: Drug Therapy for Lowering LDL-Cholesterol</td>
<td>NQF #74 CMS (composite)/ AMAPCI (individual component)</td>
<td>GPRO Web Interface</td>
</tr>
<tr>
<td>33 At Risk Population — Coronary Artery Disease</td>
<td>Coronary Artery Disease (CAD) Composite: All or Nothing Scoring: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)</td>
<td>NQF #66 CMS (composite)/ AMAPCI (individual component)</td>
<td>GPRO Web Interface</td>
</tr>
</tbody>
</table>

For more specific information on the ACO Quality data measures and the details of the performance standards, see the following document: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_QualityMeasures.pdf.
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Title</th>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GPCI</td>
<td>Geographic Practice Cost Index</td>
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<td>GPRO</td>
<td>Group Practice Reporting Option</td>
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<td>HAC</td>
<td>Hospital Acquired Conditions</td>
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<td>HCAHPS</td>
<td>Hospital Consumer Assessment of Health care Provider and Systems</td>
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<tr>
<td>HCC</td>
<td>Hierarchal Condition Category</td>
</tr>
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<td>HCCS</td>
<td>Healthcare Common Procedure Coding System</td>
</tr>
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<td>HHAs</td>
<td>Home Health Agencies</td>
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<tr>
<td>HICN</td>
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<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act of 1996</td>
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<tr>
<td>HIE</td>
<td>Health Information Exchange</td>
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<tr>
<td>HIT</td>
<td>Health Information Technology</td>
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<tr>
<td>HITECH</td>
<td>Health Information Technology for Economic and Clinical Health</td>
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<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
</tr>
<tr>
<td>HRSA</td>
<td>Health Resources and Services Administration</td>
</tr>
<tr>
<td>HVBP</td>
<td>Hospital Value Based Purchasing</td>
</tr>
<tr>
<td>ICD-10</td>
<td>International Statistical Classification of Diseases and Related Health Problems, 10th Revision</td>
</tr>
<tr>
<td>IME</td>
<td>Indirect Medical Education</td>
</tr>
<tr>
<td>IOM</td>
<td>Institute of Medicine</td>
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<tr>
<td>IPPS</td>
<td>Inpatient Prospective Payment System</td>
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<tr>
<td>IQR</td>
<td>Inpatient Quality Reporting</td>
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<tr>
<td>IRS</td>
<td>Internal Revenue Service</td>
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<tr>
<td>LITChs</td>
<td>Long-Term Acute Care Hospitals</td>
</tr>
<tr>
<td>LOA</td>
<td>Letter of Authorization</td>
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<tr>
<td>LOB</td>
<td>Lines of Business</td>
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<tr>
<td>MA</td>
<td>Medicare Advantage</td>
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<tr>
<td>MAPCP</td>
<td>Multipayer Advanced Primary Care Practice</td>
</tr>
<tr>
<td>MedPAC</td>
<td>Medicare Payment Advisory Commission</td>
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<tr>
<td>MHCQ</td>
<td>Medicare Health Care Quality</td>
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<tr>
<td>MMA</td>
<td>Medicare Prescription Drug, Improvement, and Modernization Act</td>
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<tr>
<td>MS-DRGs</td>
<td>Medicare Severity-Adjusted Diagnosis Related Groups</td>
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<tr>
<td>MSP</td>
<td>Minimum Savings Percentage</td>
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<tr>
<td>MSR</td>
<td>Minimum Savings Rate</td>
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<tr>
<td>NA</td>
<td>Network Analyst</td>
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<tr>
<td>NCQA</td>
<td>National Committee for Quality Assurance</td>
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<tr>
<td>NCCCN</td>
<td>North Carolina Community Care Network</td>
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<tr>
<td>NOI</td>
<td>Net Operating Income</td>
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<tr>
<td>NP</td>
<td>Nurse Practitioner</td>
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<td>NPI</td>
<td>National Provider Identifier</td>
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<td>NQF</td>
<td>National Quality Forum</td>
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<td>OIG</td>
<td>Office of Inspector General</td>
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<td>OMB</td>
<td>Office of Management and Budget</td>
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<tr>
<td>PA</td>
<td>Physician Assistant</td>
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<tr>
<td>PACE</td>
<td>Program of All Inclusive Care for the Elderly</td>
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<tr>
<td>PACFs</td>
<td>Post-Acute Care Facilities</td>
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<td>PCMH</td>
<td>Patient Centered Medical Home</td>
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<td>Primary Care Physician</td>
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<tr>
<td>PECOS</td>
<td>Provider Enrollment, Chain, and Ownership System</td>
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<td>PFS</td>
<td>Physician Fee Schedule</td>
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<td>PGP</td>
<td>Physician Group Practice</td>
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<td>PHI</td>
<td>Protected Health Information</td>
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<td>Point of Service</td>
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<td>PPACA</td>
<td>Patient Protection and Accountable Care Act (2010)</td>
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<td>PPO</td>
<td>Preferred Provider Organization</td>
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<td>PPS</td>
<td>Prospective Payment System</td>
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<td>PQRI</td>
<td>Physician Quality Reporting Initiative</td>
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<tr>
<td>PQRS</td>
<td>Physician Quality Reporting System</td>
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<td>PRA</td>
<td>Paperwork Reduction Act</td>
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<td>PSA</td>
<td>Primary Service Areas</td>
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<td>PSN</td>
<td>Provider Sponsored Network</td>
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<td>RFI</td>
<td>Request for Information</td>
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<td>RHCs</td>
<td>Rural Health Clinics</td>
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<td>RIA</td>
<td>Regulatory Impact Analysis</td>
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<td>SNFs</td>
<td>Skilled Nursing Facilities</td>
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<td>SNOMED</td>
<td>Systematized Nomenclature of Medicine -- Clinical Terms</td>
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<td>Social Security Administration</td>
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<td>Social Security Number</td>
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<tr>
<td>TACHC</td>
<td>Texas Association of Community Health Centers</td>
</tr>
<tr>
<td>TIN</td>
<td>Taxpayer Identification Number</td>
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<tr>
<td>UM</td>
<td>Utilization Management</td>
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**KCMPA-ACO Acronym Title**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Title</th>
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<tbody>
<tr>
<td>CC</td>
<td>Care Coordinator</td>
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<tr>
<td>BOD</td>
<td>Board of Directors</td>
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<tr>
<td>HRA</td>
<td>Health Risk Assessment</td>
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<tr>
<td>ICT</td>
<td>Interdisciplinary Care Team</td>
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<tr>
<td>POA</td>
<td>Power of Attorney</td>
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<tr>
<td>QIC</td>
<td>Quality Improvement Committee</td>
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</table>
**CMS Definitions**

**Accountable Care Organization** (ACO) means a legal entity that is recognized and authorized under applicable State, Federal, or Tribal law, is identified by a Taxpayer Identification Number (TIN), and is formed by one or more ACO participants that is (are) defined at §425.102(a) and may also include any other ACO participants described at §425.102(b).

**ACO Compliance Officer** is the person responsible for implementation and oversight of the Compliance Program and adherence with Medicare Shared Savings Program requirements.

**Advance Payment ACO Model** is an initiative developed by the Innovation Center designed for organizations participating as ACOs in the Shared Savings Program. Through the Advance Payment ACO Model, selected participants in the Shared Savings Program will receive advance payments that will be repaid from the future shared savings they earn. CMS will recoup these advance payments from an ACO’s shared savings as further described below.

The Advance Payment ACO Model will test:

- Whether providing an advance (in the form of up-front and monthly payments to be repaid in the future) will increase participation in the Shared Savings Program, and
- Whether advance payments will allow ACOs to improve care for beneficiaries and generate Medicare savings more quickly, and increase the amount of Medicare savings.

The Advance Payment ACO Model is meant to help entities such as smaller practices and rural providers with less access to capital participate in the Shared Savings Program. The Advance Payment Model was initially only made available to ACOs who began participation in the Medicare Shared Savings Program on April 1, 2012 or July 1, 2012. On June 12, 2012, CMS announced that it will also accept applications from ACOs that are applying for participation in the Shared Savings Program with a start date of January 1, 2013.

**ACO Participant** means an individual or group of ACO provider(s)/supplier(s), that is identified by a Medicare-enrolled TIN, that alone or together with one or more other ACO participants comprise(s) an ACO, and that is included on the list of ACO participants that is required under §425.204(c)(5).

**ACO Professional** means an ACO provider/supplier who is either of the following:

1. A physician legally authorized to practice medicine and surgery by the State in which he performs such function or action.
2. A practitioner who is one of the following:
   (i) A physician assistant (as defined at §410.74(a)(2) of this chapter)
   (ii) A nurse practitioner (as defined at §410.75(b) of this chapter)
   (iii) A clinical nurse specialist (as defined at §410.76(b) of this chapter)

**ACO Provider/Supplier** means an individual or entity that —

1. Is a provider (as defined at §400.202 of this chapter) or a supplier (as defined at §400.202 of this chapter);
2. Is enrolled in Medicare;
3. Bills for items and services it furnishes to Medicare fee-for-service beneficiaries under a Medicare billing number assigned to the TIN of an ACO participant in accordance with CMS-1345-F 628 applicable Medicare regulations; and
4. Is included on the list of ACO providers/suppliers that is required under §425.204(c)(5).

**Agreement Period** means the term of the participation agreement which begins at the start of the first performance year and concludes at the end of the final performance year.

**Antitrust Agency** means the Department of Justice or Federal Trade Commission.

**Assignment** means the operational process by which CMS determines whether a beneficiary has chosen to receive a sufficient level of the requisite primary care services from a physician who is an ACO provider/supplier so that the ACO may be appropriately designated as exercising basic responsibility for that beneficiary’s care.

**At-Risk Beneficiary/Patient** is defined in the Proposed Rule, CMS offered a definition of “patients at-risk” to mean patients “who have a high risk score on the CMS–HCC risk adjustment model, are considered high cost due to having two or more hospitalizations or emergency room visits each year, are dually eligible for Medicare and Medicaid, have a high utilization pattern, those who have one or more chronic conditions… or beneficiaries who have a recent diagnosis … that is expected to result in an increased cost.” 76 Fed. Reg. at 19625. Additionally rule §425.20 of the ACO regulations further defines a list of at-risk beneficiaries in the final rule:

**At-Risk Beneficiary** means, but is not limited to, a beneficiary who —

1. Has a high risk score on the CMS-HCC risk adjustment model;
2. Is considered high cost due to having two or more hospitalizations or emergency room visits each year;
3. Is dually eligible for Medicare and Medicaid;
4. Has a high utilization pattern;
5. Has one or more chronic conditions.
6. Has had a recent diagnosis that is expected to result in increased cost.
7. Is entitled to Medicaid because of disability; or
8. Is diagnosed with a mental health or substance abuse disorder.

**Continuously Assigned Beneficiary** means a beneficiary assigned to the ACO in the current performance year who was either assigned to or received a primary care service from any of the ACO’s participant during the most recent prior calendar year. CMS-1345-F 629

**Covered Professional Services** has the same meaning given these terms under section 1848(k)(3)(A) of the Act.

**Critical Access Hospital** (CAH) has the same meaning given this term under §400.202 of this chapter.

**Eligible Professional** has the meanings given this term under section 1848(k)(3)(B) of the Act.

**Federally Qualified Health Center** (FQHC) has the same meaning given to this term under §405.2401(b) of this chapter.

**Hierarchical Condition Category** (HCC) codes are used in the CMS payment model implemented in 2004 to adjust Medicare capitation payments to private healthcare plans for the health expenditure risk of their enrollees.

**Hospital** means a hospital subject to the prospective payment system specified in §412.1(a)(1) of this chapter.
Marketing Materials and Activities include, but are not limited to, general audience materials such as brochures, advertisements, outreach events, letters to beneficiaries, web pages, data sharing Decline to Share letters, mailings, social media, or other activities conducted by or on behalf of the ACO, or by ACO participants, or ACO providers/suppliers participating in the ACO, when used to educate, solicit, notify, or contact Medicare beneficiaries or providers and suppliers regarding the Shared Savings Program. The following beneficiary communications are not marketing materials and activities: certain informational materials customized or limited to a subset of beneficiaries; materials that do not include information about the ACO, its ACO participants, or its ACO providers/suppliers; materials that cover beneficiary-specific billing and claims issues or other specific individual health related issues; educational information on specific medical conditions (for example, flu shot reminders), written referrals for health care items and services, and materials or activities that do not constitute “marketing” under 45 CFR 164.501 and 164.508(a)(3)(i). CMS-1345-F 630

Medicare Fee-For-Service Beneficiary means an individual who is —

1. Enrolled in the original Medicare fee-for-service program under both parts A and B; and

2. Not enrolled in any of the following:
   (i) A MA plan under part C.
   (ii) An eligible organization under section 1876 of the Act.
   (iii) A PACE program under section 1894 of the Act.

Medicare Shared Savings Program (Shared Savings Program) means the program, established under section 1899 of the Act and implemented in this part.

Newly Assigned Beneficiary means a beneficiary that is assigned in the current performance year who was neither assigned to nor receives a primary care service from any of the ACO’s participants during the most recent prior calendar year.

Performance Year means the 12-month period beginning on January 1 of each year during the agreement period, unless otherwise noted in the ACO’s agreement. For an ACO with a start date of April 1, 2012 or July 1, 2012, the ACO’s first performance year is defined as 21 months and 18 months, respectively.

Physician means a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act).

Physician Quality Reporting System (PQRS) means the quality reporting system established under section 1848(k) of the Act. CMS-1345-F 631

Primary Care Physician means a physician who has a primary specialty designation of internal medicine, general practice, family practice, or geriatric medicine, or, for services furnished in an FQHC or RHC, a physician included in an attestation by the ACO as provided under §425.404.

Primary Care Services mean the set of services identified by the following HCPCS codes:

1. 99201 through 99215.
2. 99304 through 99340, and 99341 through 99350, G0402 (the code for the Welcome to Medicare visit), G0438 and G0439 (codes for the annual wellness visits);
3. Revenue center codes 0521, 0522, 0524, 0525 submitted by FQHCs (for services furnished prior to January 1, 2011), or by RHCs.

Quality Measures means the measures defined by the Secretary, under section 1899 of the Act, to assess the quality of care furnished by an ACO, such as measures of clinical processes and outcomes, patient and, where practicable, caregiver experience of care and utilization.

Reporting Period means the calendar year from January 1 to December 31.

Rural Health Center (RHC) has the same meaning given to this term under §405.2401(b).

Shared Losses means a portion of the ACO’s performance year Medicare fee-for-service Parts A and B expenditures, above the applicable benchmark, it must repay to CMS. An ACO’s eligibility for shared losses will be determined for each performance year. For an ACO requesting interim payment, shared losses may result from the interim payment calculation.

Shared Savings means a portion of the ACO’s performance year Medicare fee-for-service Parts A and B expenditures, above the applicable benchmark, it is eligible to receive payment for from CMS. An ACO’s eligibility for shared savings will be determined for each performance CMS-1345-F 632 year. For an ACO requesting interim payment, shared savings may result from the interim payment system calculation.

Taxpayer Identification Number (TIN) means a Federal taxpayer identification number or employer identification number as defined by the IRS in 26 CFR 301.6109-1.

KCMPA-ACO Definitions

Advance Directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

After Hours will mean a system used by a provider to respond to a patient’s urgent needs when the office is closed.

Availability will mean the ease with which a patient may obtain the following within established time frames:

1. An appointment with a practitioner
2. Access to emergency care
3. Access to after-hours care
4. A response from the Patient Services department

Authorized Representative is an individual appointed by an enrollee or other party, or authorized under State or other applicable law, to act on behalf of an enrollee or other party involved in an appeal or grievance. Unless otherwise stated, the representative will have all of the rights and responsibilities of an enrollee or party in obtaining an organization determination, filing a grievance, or in dealing with any of the levels of the appeals process, subject to the applicable rules described at 42 CFR Part 405. A member has the right to designate an authorized legal representative to act on his/her behalf at any time during the grievance process. The designated representative can be anyone to whom the member designates the authority to speak for him or her and may include a health care provider or attorney. If someone other than the member calls in to file a complaint, staff will ask for an Appointment of Representative (AOR) Form in order to be able to accept the grievance.
Care Coordination is a collaborative process that promotes quality care and cost-effective outcomes that enhance the physical, psychosocial, and emotional health of individuals. Care coordination is designed to be a collaborative effort that engages patients, participants, and community resources with the care coordination staff to address the needs of the population served by the ACO.

Compliance Program is the organizational, value-based and actionable system that identifies, prevents, detects, corrects and reports, suspected non-compliance with state and federal regulatory requirements.

Complaint means any expression of dissatisfaction to the medical practice, provider, facility or ACO Committee made by a member orally or in writing. This can include concerns about the operations of providers, insurers, or the Plan such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to members, the claims regarding the right of the member to receive services or receive payment for services previously rendered. It also includes the organization’s refusal to provide services to which the member believes he or she is entitled. Every complaint must be handled under the appropriate complaint process.

Emergency Care will mean health care services provided in response to a recent onset illness that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his/her condition, sickness or injury is such a nature that failure to get immediate medical care could result in placing the patient’s health in serious jeopardy; serious impairment to bodily functions; serious dysfunction of any bodily organ; serious disfigurement; or in the care of pregnant woman, serious jeopardy to the health of the fetus. Examples: Chest Pain; Possible fractured limb; Fever of 102 degrees in a child under two months of age; or, no fetal movement in 24 hours.

Evidence Based Medicine (EBM) is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.

Health Maintenance/Preventive Care will mean medical care including, but not limited to, services provide for periodic health assessment, routine physical examinations as medical recommended based on the patient’s age and sex, immunizations and inoculations (including injectable) in accordance with accepted medical practice, vision and hearing screening as ordinary preformed, routine hearing examinations and annual well woman examinations.

Health Insurance Portability and Accountability Act (HIPAA) is the Privacy Rule establishes national standards to protect individuals’ medical records and other personal health information and applies to health plans, health care clearingshouses, and those health care providers that conduct certain health care transactions electronically.

HRA is the Health Risk Assessment (HRA) screening tool that facilitates identification of patient healthcare needs.

In-Kind Services includes preventative care items or services that advance one or more of the following clinical goals:
- Adherence to a treatment regimen;
- Adherence to a drug regimen;
- Adherence to a follow-up care plan; or,
- Management of a chronic disease or condition.

Kickback means to knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce business reimbursed under the Medicare or Medicaid programs.

Notifications - a communication mailed to the beneficiary by the ACO and/or discussed during the first office visit. The notifications provide beneficiaries with information regarding the ACO and related processes for data sharing.

Organization means anyone or any entity that falls within the regulatory compliance of the ACO.

Patient is a Medicare beneficiary who has been assigned by CMS to KCMPA-ACO.

Protected Health Information (PHI) – information that relates to the: (i) physical or mental health or condition of an individual; (ii) provision of health care to the individual; or (iii) future payment for the provision of health care to an individual and that (x) identifies the individual or (y) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Quality of Care Issue is a complaint filed regarding the quality of services (including both inpatient and outpatient) received. Services must meet the professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in an appropriate setting. A quality of care issue may be filed through the plan or the Quality Improvement Committee (QIC) applicable to the service area in which the member resides. All QIC complaints must be responded to in writing whether filed orally or via hard copy. There is no time limit for a member to file a QOC complaint with the ACO.

Request means a notification from a participant and/or provider requesting care coordination assistance for inpatient or outpatient follow-up, social needs, patient education, or other activities that can help meet patient needs.

Referral means a direct communication between a physician and a specialist or specialty company to provide specific care or service to a patient to meet their needs.

Unknown patients – patients listed on CMS roster that are not recognized or claimed by a participating provider.

Urgent Care will mean medical services provided in response to a medical condition that does not present emergent/urgent symptoms and does not need the immediate attention of a provider unless conditions persist or worsen. Provider may discuss the condition telephonically and schedule an appointment if the symptoms persist.