INDEPENDENT PHYSICIANS NETWORK

IPN-UHC VBP UPDATE

August 1, 2018

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Meeting Overview

- **UHC Presentation**
  - **Michelle Graham, M.D., Market Medical Director**
  - **Kelly Wiza, Director Network Programs**
- **New UHC Medicaid CIS Program**
- **UHC Accountable Care Registry**
- **UHC Medicare Update**
- **IPN VBP Measures and Reporting**

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New UHC Medicaid CIS Program Overview

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IPN-UHC T19 Contract Model

- IPN UHC Medicaid Membership – over 25,000
- Intent is to Move to ACO Model 1/1/2019
- New Interim CIP Model Effective 8/1/2019
- 3 Target Areas
  - Inpatient Care Transitions
  - ER Visit Transitions
  - High Risk Cohort Patients

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IPN-UHC T19 Contract Model, cont.

- CIP Precursor to Full ACO Model
- Full Membership Roster Available in Mid-August
- High Risk Members Already Identified
- Will Start Receiving Admission Notifications
  - IPN will receive all and send out to offices per current process
  - Offices can be trained on UHC system and pick up
- UHC's Accountable Care Population Health Registry is Available to All IPN PCPs to Get Information/Log Information Directly

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Potential Medicaid Accountable Care Shared Savings (ACSS) Model

ACCOUNTABLE CARE SHARED SAVINGS MODEL

Providers receive fee-for-service reimbursement

Shared Savings opportunities are based on savings accrued by lowered Total Cost of Care

The number of quality targets met determines the amount of shared savings

UHC Clinical Transformation FTE Support & Access to Population Management Reports/Tools

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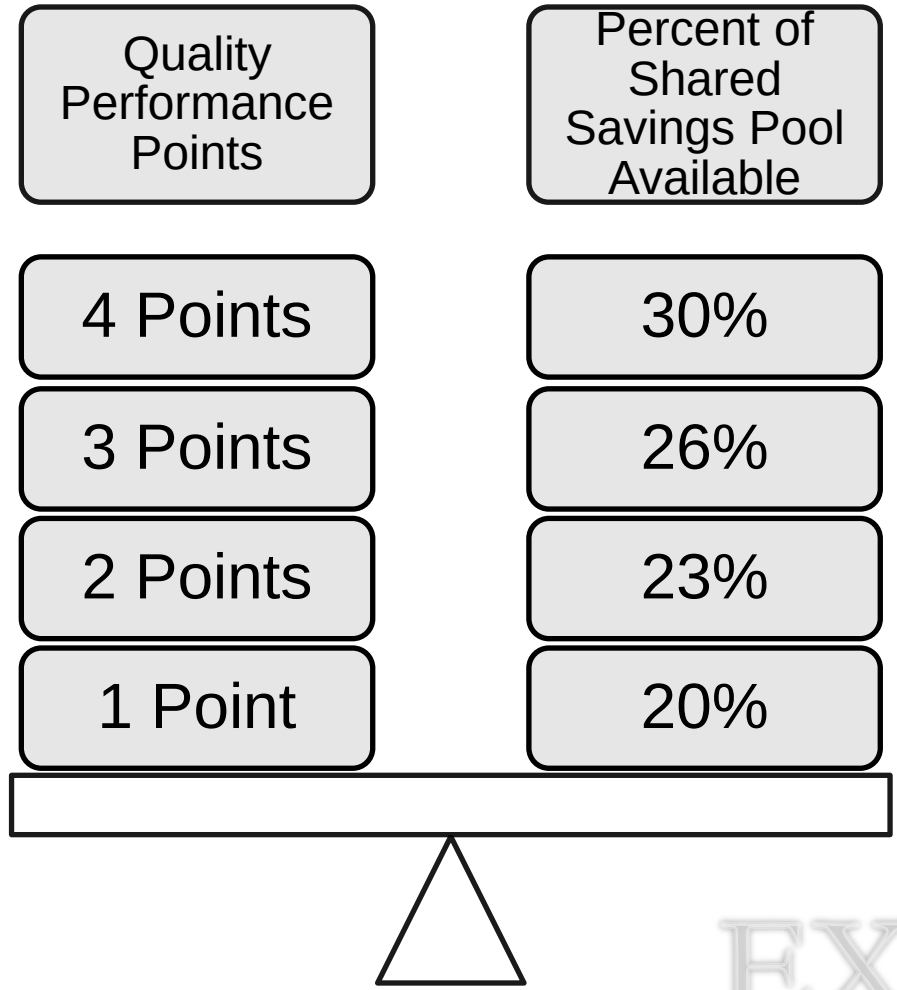
ACSS Shared Savings Pool Availability



EXAMPLE

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DHS Medicaid Quality Metrics – BC+

BC+ MY2018 P4P Targets													
P4P Measure	**MY2018 baseline WI Avg**	**NCQA percentiles (CY2016, aka HEDIS 2017)**						**Level Target**			**RIE Target**		
		25th	*33rd*	*50th*	*67th*	*75th*	*90th*	*High*	*Med*	*Low*	*High*	*Med*	*Low*
AMB - ED Visits	**59.5 visits**	52.3	**55.6**	62.7	69	72.6	86.4	<=55.6	55.7–62.7	>=62.8	>= 5% of base	2%-4.9%	<=1.9%
AMM (continuation) - Depression Rx	**45.9%**	32.5	33.9	36.2	39.3	**41.1**	49.2	>=41.1%	39.3%-41.0%	<=39.2%	>=5%	2%-4.9%	<=1.9%
Breast Cancer Screen (BCS)	**67.3%**	52.7	54.8	59	63	**65.5**	70.3	>=65.5%	63%-65.4%	<=62.9%	>=10%	5%-9.9%	<=4.9%
CDC-HbA1c Test (Diabetes)	**91.4%**	84.3	85.4	87.1	88.9	**90.1**	92.8	>=90.1%	88.9%-90%	<=88.8%	>=10%	5%-9.9%	<=4.9%
CDC – HbA1c Control < 8	**51.5%**	41.9	45	48.9	51.8	**53.7**	59.1	>=53.7%	48.9%-53.6%	<=48.8%	>=10%	5%-9.9%	<=4.9%
Controlling BP (CBP)	**58.8%**	47.7	51.3	56.9	**63.1**	64.8	71.7	>=63.1%	56.9%-63%	<=56.8%	>=10%	5%-9.9%	<=4.9%
CIS - Childhood Immunization (Combo 3)	**74.4%**	65.3	67.8	71.6	74.4	**75.9**	79.3	>=75.9%	71.6%-75.8%	<=71.5%	>=10%	5%-9.9%	<=4.9%
FUH-30	**71.9%**	55.9	60.3	65.4	72	**74.1**	80.1	>=74.1%	65.4%-74%	<=65.3%	>=10%	5%-9.9%	<=4.9%
IET Engagement - AODA	**14.4%**	7.9	9.6	12.3	14.7	**16.1**	20.8	>=16.1%	12.3%-16%	<=12.2%	>= 5%	2%-4.9%	<=1.9%
PPC – Prenatal care	**83.5%**	77.7	79.9	83.6	86.8	**88.6**	91.7	>=88.6%	79.9%-88.5%	<=79.8%	>=10%	5%-9.9%	<=4.9%
PPC - Post-partum care	**66.1%**	59.6	61.1	64.4	67.8	**69.4**	73.7	>=69.4%	64.4%-69.3%	<=64.3%	>=10%	5%-9.9%	<=4.9%
Tobacco (Counseling)	**65.3%**	N/A	N/A	N/A	N/A	N/A	N/A	>=68.8%	63.6%-68.7%	<=63.5%	>=10%	5%-9.9%	<=4.9%
Dental – Children	**54.9%**	46.3	48.9	**54.9**	60.5	62.5	66.9	>= 54.9%	48.9%-54.8%	<=48.8%	>=7%	4%-6.9%	<=3.9%
Dental - Adults	**34.1%**	N/A	N/A	N/A	N/A	N/A	N/A	>=36.7%	31.5%-36.6%	<=31.4%	>=7%	4%-6.9%	<=3.9%

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DHS Medicaid Quality Metrics - SSI

SSI MY2018 P4P Targets													
P4P Measure	**MY2018 baseline WI Avg**	**NCQA percentiles (CY2016, aka HEDIS 2017)**						**Level Target**			**RIE Target**		
		25th	*33rd*	*50th*	*67th*	*75th*	*90th*	*High*	*Med*	*Low*	*High*	*Med*	*Low*
AMB - ED Visits	**114 visits**	N/A	N/A	N/A	N/A	N/A	N/A	<=108.3	108.4–119.7	>=119.8	>= 5% of base	2%-4.9%	<=1.9%
AMM (continuation) - Depression Rx	**45.4%**	32.5	33.9	36.2	39.3	**41.1**	49.2	>=41.1%	39.3%-41.0%	<=39.2%	>=5%	2%-4.9%	<=1.9%
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CDC – HbA1c Control < 8	**49%**	41.9	45	48.9	51.8	**53.7**	59.1	>=53.7%	48.9%-53.6%	<=48.8%	>=10%	5%-9.9%	<=4.9%
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FUH-30	**69.1%**	55.9	60.3	65.4	72	**74.1**	80.1	>=72%	65.4%-71.9%	<=65.3%	>=10%	5%-9.9%	<=4.9%
IET Engagement – AODA	**8.3%**	7.9	9.6	12.3	14.7	**16.1**	20.8	>=14.7%	9.6%-14.6%	<=9.5%	>= 5%	2%-4.9%	<=1.9%
Tobacco (Counseling)	**67.1%**	N/A	N/A	N/A	N/A	N/A	N/A	>=70.4%	65.5%-70.3%	<=65.4%	>=10%	5%-9.9%	<=4.9%

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UHC Accountable Care Population Registry

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UHC Accountable Care Population Registry

- Proprietary UHC system available for ACO providers
- Each clinic will have access to their information only
  - IPN will have access to all IPN clinic information
- Population View
  - Hospital and ER Discharges
  - High Risk Patients
  - Preventive Care Gaps
- Patient View
  - Provides patient history on individual level

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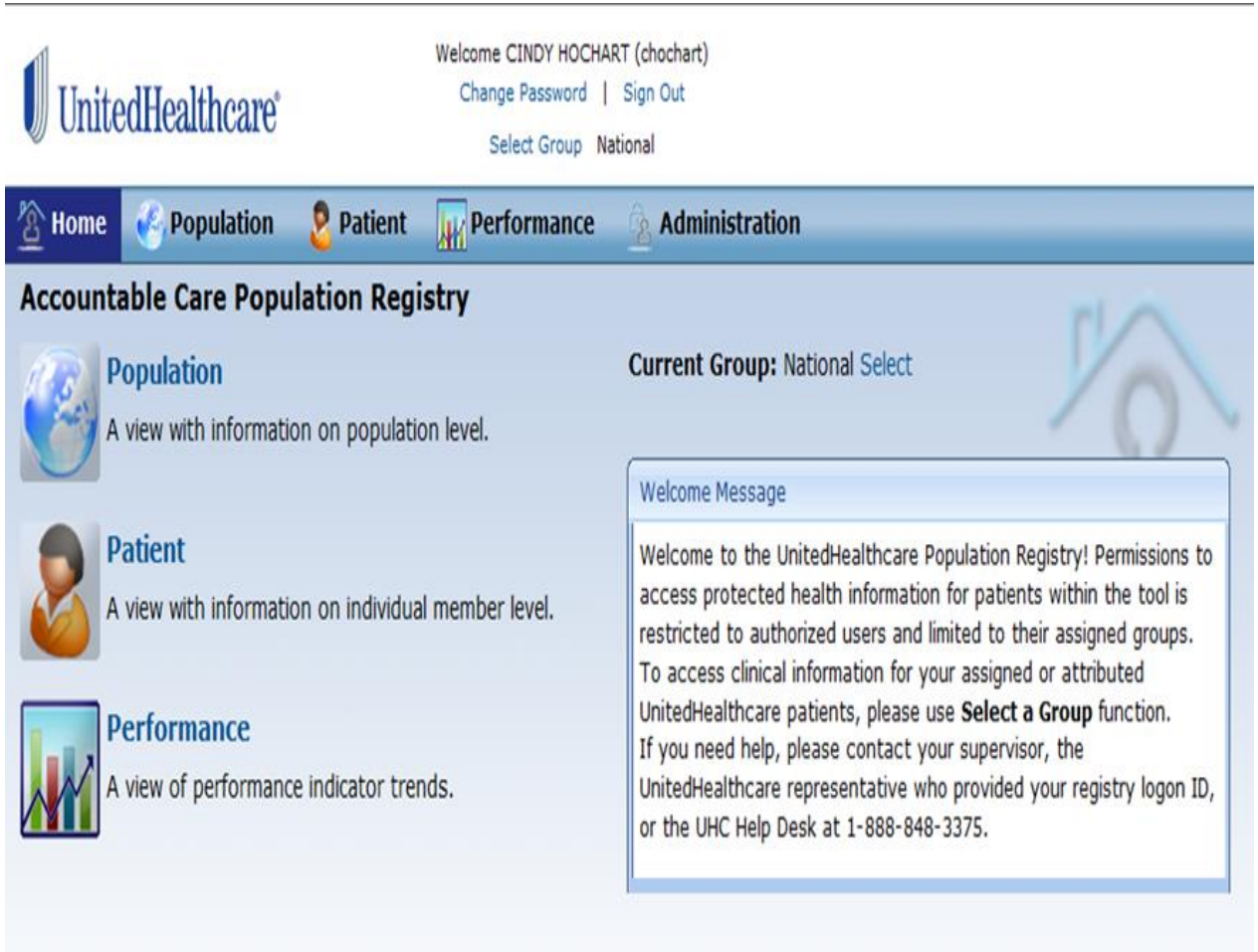
UHC Accountable Care Population Registry



- **Population View**
  - provides access to lists of priority patients in the population who need specific follow up action
- **Patient View**
  - provides access to three years of clinical history for every patient in the assigned population, one patient at a time
  - refreshed twice monthly
- **Performance View**
  - not enabled

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UHC MEDICARE ACO UPDATE

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UHC Medicare ACO Update

- Just completed our 5th year
- Highly Successful in the Shared Savings Program
- Membership Continues to Grow
  - 2013: 1,170
  - 2018 (May): 4,370
- Have consistently hit the Mandatory Quality Measures for Shared Savings
  - HbA1c testing – 80%
  - Nephropathy Screening – 85%
  - Metabolic Lab – BMP, CMP or Renal Panel – 65%
  - PCP Visit – 75%

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UHC Medicare QM Performance

IPN 2017 Performance
Dates of Service January - December 2017
Paid through May 2018

Comprehensive Diabetes Care (n=787)	# of mbrs	% of mbrs	Year-to-Date Target				2018 Target
			Q1	Q2	Q3	Q4	
HbA1c Determination	702	89.2%	10.0%	30.0%	60.0%	65.0%	80.0%
Nephropathy Screening	658	83.6%	10.0%	30.0%	60.0%	65.0%	85.0%

Metabolic Lab (n=397)	# of mbrs	% of mbrs	Year-to-Date Target				2018 Target
			Q1	Q2	Q3	Q4	
BMP,CMP,or Renal Panel	384	96.7%	10.0%	25.0%	40.0%	55.0%	65.0%

Annual PCP Visit (n=3084)	# of mbrs	% of mbrs	Year-to-Date Target				2018 Target
			Q1	Q2	Q3	Q4	
PCP Visit	2448	79.4%	10.0%	30.0%	60.0%	65.0%	75.0%

IPN 2018 Performance YTD
Dates of Service January - May 2018
Paid through May 2018

Comprehensive Diabetes Care (n=1196)	# of mbrs	% of mbrs	Year-to-Date Target				2018 Target
			Q1	Q2	Q3	Q4	
HbA1c Determination	811	67.8%	10.0%	30.0%	60.0%	65.0%	80.0%
Nephropathy Screening	738	61.7%	10.0%	30.0%	60.0%	65.0%	85.0%

Metabolic Lab (n=661)	# of mbrs	% of mbrs	Year-to-Date Target				2018 Target
			Q1	Q2	Q3	Q4	
BMP,CMP,or Renal Panel	512	77.5%	10.0%	25.0%	40.0%	55.0%	65.0%

Annual PCP Visit (n=4686)	# of mbrs	% of mbrs	Year-to-Date Target				2018 Target
			Q1	Q2	Q3	Q4	
PCP Visit	2381	50.8%	10.0%	30.0%	60.0%	65.0%	75.0%

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UHC Medicare P4P Initiatives

- **UHC Medicare – Clinical Opportunity Initiative (PCOR report)**
  - **Based on CMS Star Rating Scores**
  - **Additional payment made if IPN able to establish a meaningful use data exchange using a population health platform**
  - **Need minimum average star rating of 3.76 to qualify**
- **Medical Condition Assessment Incentive Program (MCAIP)**
  - **Focus on Closing Suspect Medical Condition Coding Gaps**
    - **Identifying Condition is Present**
    - **Identifying that patient's diagnosis does not support Suspect Medical Condition**
    - **Need minimum average star rating of 3.76 to qualify**

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UHC PCOR Performance – YTD 2018

Quality Measure	Eligible Mbrs	Compliant Mbrs	Non Compliant Mbrs	Current Rate	4 STAR Threshold % Target	# of Mbrs to Achieve 4 STAR Threshld	5 STAR Threshold % Target	# of Mbrs to Achieve 5 STAR Threshld	Quality Rating	CMS Weight	CMS Weighted Quality Rating
C01-Breast Cancer Screening	1057	701	356	66%	≥78.0%	127	≥84.0%	191	**2**	1	2
C02-Colorectal Cancer Screening	2345	1553	792	66%	≥72.0%	141	≥80.0%	329	**3**	1	3
C07-Adult BMI Assessment	2365	1776	589	75%	≥94.0%	450	≥98.0%	544	**2**	1	2
C13-Diabetes Care - Eye Exam	918	364	554	40%	≥72.0%	294	≥81.0%	377	**1**	1	1
C14-Diabetes Care - Kidney Disease Monitoring	918	791	127	86%	≥96.0%	92	≥98.0%	111	**1**	1	1
C15-Diabetes Care - Blood Sugar Controlled	918	236	682	26%	≥73.0%	432	≥80.0%	496	**1**	3	3
D11-Medication Adherence for Diabetes Medications	352	318	34	90%	≥94.0%	15	≥96.0%	22	**3**	3	9
D12-Medication Adherence for Hypertension (RAS antagonists)	964	883	81	92%	≥94.0%	20	≥96.0%	39	**3**	3	9
D13-Medication Adherence for Cholesterol (Statins)	896	815	81	91%	≥93.0%	18	≥95.0%	36	**3**	3	9

Quality Measure	Observed Eligible Admits	Expected Admits (Rounded)	National Ave	Current Rate	4 STAR Threshld % Target	# of Admits Before Dropping Below 4 STAR	5 STAR Threshld % Target	# of Admits Before Dropping Below 5 STAR	Quality Rating	CMS Weight	CMS Weighted Quality Rating
DMC16-Hospitalizations for Potentially Preventable Complications	39	81	3.4%	17	≤ 50	2	≤ 35	14	**5**	3	15
C21-Plan All-Cause Readmissions	24	49	12.3%	6%	≤9%	21	≤6%	23	**5**	3	15
									Total	**23**	**69**
										Average Star Rating	**3**

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MCAIP YTD 2018

2018 INDEPENDENT PHYS NTWK - WI (G_124153) MCAIP Summary Report

The following shows information for potential conditions that United believes a MCAIP Customer may have but that have not been reported during the current year on a claim or encounter.
Information includes Medicare members specific to INDEPENDENT PHYS NTWK - WI

UnitedHealthcare Medicare Solutions

MCAIP Summary				
Total Suspect Medical Conditions	**Not Assessed**	**Assessed and Diagnosed**	**Assessed and unable to diagnose at this time**	**Percentage Assessed (Assessed and Diagnosed + Assessed and unable to diagnose at this time)**
1664	1177	487	0	29%

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IPN VBP Reporting

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IPN QUALITY MEASURE CHEATSHEET - 8/1/2018

Quality Measure	Category	UHC Medicare	iCare Medicare	ACO	Anthem Comm	UHC Comm	UHC Medicaid	Other Medicaid	
								BC+	SSI
Breast Cancer Screening	Preventive	x	x	x	x		x	x	x
Cervical Cancer Screening	Preventive				x				
Colorectal Cancer Screening	Preventive	x	x	x					
Adult BMI Assessment	Preventive	x	x	x			x	x	x
Fall Risk Screening	Preventive			x					
Blood Lead Screening	Preventive						x	x	
Annual Wellcheck - Children/Adolescents	Preventive				x		x	x	
Annual PCP Visit	Preventive	x							
Prenatal and Postpartum Care	Preventive						x	x	
Frequency of Prenatal Care	Preventive						x	x	
Childhood Immunizations	Preventive				x		x	x	
Influenza Immunization	Preventive			x					
Pneumonia Vaccination Status for Older Adults	Preventive			x					
Initial Evaluation of New Medicare Members	Preventive	x							
Osteoporosis Management for Women with a Fracture	At Risk	x	x						
Diabetes Care - Eye Exam	At Risk	x	x	x	x				
Diabetes Care - Kidney Disease Monitoring	At Risk	x		x					
Diabetes Care - Blood Sugar Controlled	At Risk	x	x	x			x	x	x
Diabetes Care - HbA1c Testing	At Risk	x	x	x	x		x	x	x
Diabetes Care - Nephropathy Screening	At Risk	x	x	x	x				
Metabolic Lab - BMP, CMP or Renal Panel	At Risk	x							
Hypertension Controlling Blood Pressure	At Risk		x	x	x		x	x	x
CMARD Drug Therapy	At Risk		x		x				
Chlamydia Screening	At Risk				x				
Brand Formulary Compliance	Pharmacy				x				
Generic Pharmacy Prescription Rate	Pharmacy					x			
Medication Reconciliation - Post Discharge	Pharmacy		x	x					
Medication Adherence for Diabetes Medications	Pharmacy	x			x				
Medication Adherence for Hypertension (RAS antagonists)	Pharmacy	x			x				
Medication Adherence for Cholesterol (Statins)	Pharmacy	x			x				
Appropriate Antibiotic Treatment for Adults with Bronchitis	Pharmacy				x				
Annual Monitoring for Patients on Persistent Medications - ACE/ARB	Pharmacy			x	x				
Annual Monitoring for Patients on Persistent Medications - Diuretics	Pharmacy				x				
Statin Therapy for Prevention and Treatment of CVD	Pharmacy			x					
Appropriate Testing for Children with Pharyngitis	Pharmacy				x				
Appropriate Treatment for Children with Upper Respiratory Infection	Pharmacy				x				
Medication Management for People with Asthma	Pharmacy				x				
IVD: Use of Aspirin or Another Antithrombotic	Pharmacy			x					
Depression Screening	MH/SA			x					
Depression Medication (AMM Continuation)	MH/SA						x	x	x
Depression Remission at 12 months	MH/SA			x					
IET Engagement - AODA	MH/SA						x	x	x
Follow Up after MH inpatient discharge	MH/SA						x	x	x
Tobacco Counseling	MH/SA			x			x	x	x
Mental Health Utilization	MH/SA						x	x	x
New Episode of Depression: Effective Acute Phase Treatment	MH/SA				x				
New Episode of Depression: Effective Continuation Phase Treatment	MH/SA				x				
Emergency Department Visit Rate	Utilization						x	x	x
Potentially Avoidable ER Visits	Utilization				x				
Ambulatory Care Sensitive Admissions	Utilization	x		x	x				
Pediatric Ambulatory Care Sensitive Admissions	Utilization				x				
All Cause Hospital Readmission Rate (30 days)	Utilization	x	x	x		x			
SNF All Cause Readmission Rate (30 days)	Utilization			x					
All Cause Unplanned Admissions for Diabetes	Utilization			x					
All Cause Unplanned Admissions for Heart Failure	Utilization			x					
All Cause Unplanned Admissions with Multiple Chronic Conditions	Utilization	x		x					
Inpatient Admission Average Length of Stay	Utilization					x			
Hospitalization for Potentially Preventable Complications	Utilization	x							
Use of Imaging for Low Back Pain	Utilization			x	x				
Post Inpatient Discharge Follow Up within 7 days	Utilization	x					x		
ER Follow Up Appointment within 7 days	Utilization	x					x		
High Risk Patient follow up - seen every 90 days	Utilization						x		
Adult Access to Ambulatory Care	Access						x	x	x
Children and Adolescents access to Primary Care	Access						x	x	
Non-par Lab Utilization	Administrative					x			
Physician Documentation Training	Administrative	x							
Getting Timely Care, Appointments and Information	CAHPS			x					
How Well Your Doctors Communicate	CAHPS			x					
Patient's Rating of Doctor	CAHPS			x					
Access to Specialists	CAHPS			x					
Health Promotion and Education	CAHPS			x					
Shared Decision Making	CAHPS			x					
Health Status/Functional Status	CAHPS			x					
Stewardship of Patient Resources	CAHPS			x					

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Methods to Get/Report Data

- IPN Website
  - Membership Lists/Care Gap Reports (Monthly/Quarterly)
  - Care Coordination Request Form
- Payer Applications
  - Availity (Anthem Commercial)
  - Accountable Care Population Registry – UHC Medicaid
- Fax/Secure emails (need contact person from every office)
  - Hospital/ER Census reports (Daily)
  - HEDIS/Quality Care Gap record requests/responses to IPN
- External Access to EMR for IPN/Payers
- Direct Data exchange
  - UHC (see form in packet)
- Manual Chart Pulls

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Accountable Care Coalition of Southeast Wisconsin
Established by Independent Physicians Network, Inc.

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- ACO ER Reports
- ACO Opiod Use
- ACO Roster Reports
- Health Payment Systems Client List
- iCare Reports
- Trilogy Eligibility
- UHC AARP
- UHC Community Plan Eligibility
- UHC P4P Summary Report
- UHC PCOR Report
- UHC Quality Measures Summary 2018

Accountable Care Coalition of Southeast Wisconsin
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Click the image above for the ACO Website.

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Keys to Succeeding in Risk Agreements

- Know and Retain Your Patients – Work the lists
  - IPN Website – ACO, UHC Medicare/Medicaid, iCare, Trilogy, NHP
  - Availity – Anthem
- Practice Transformation from "sick care" to population management
- Get Staff Involved – Assign lists to them
  - Wellness exams/Physicals
  - Chronic Problems - See Chronic Patients Quarterly
- Utilize Data
  - Close gaps in Care
  - Identify High Risk/Chronic Patients – see them every 90 days
  - Identify High Quality, Cost Effective Providers
  - Improve Accuracy and Specificity of Coding
  - Set up Alerts in your EMR

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Keys to Succeeding in Risk Agreements, cont.

- Care Coordination
  - Preventive/Quality Focus
  - Engage and Manage High Risk/Chronic Patients
  - Improve Transitions of Care at All Levels
- Keep Patients out of the Hospital
- Refer to other IPN Physicians
- Utilize Cost Effective Diagnostic/Outpatient Facilities

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Questions?

Thank You for Your Continued Support and Dedication to IPN!

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