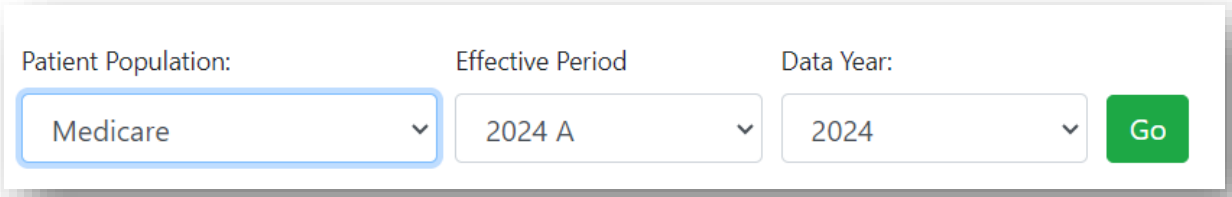
Analytics Dashboard Details ALERT

The analytics dashboard is designed to closely model Medicare projections from quarterly or annual reports. However, variances may occur due to several factors, such as patients opting out or CMS administratively removing physicians. While CCLF data files do not include any claims that identify alcohol and substance abuse treatment information (SUD codes) to protect patient privacy, the costs are included in the quarterly reports. Medicare uses an estimated run-out rate of 7.2% in their 4th quarter report. Your ACO may experience a different run-out rate, which could be lower or higher.



Patient Population Dropdown: Select the patient payer population you want to view, e.g., Medicare, Medicare Advantage, Self-Insured Employer, Commercial or Medicaid. You may only select one population at a time.

Effective Period Dropdown: Select the period for the patients you want to view, e.g., the active / attributed patients during that period. Effective periods apply to Accountable Care Organizations (ACOs), Primary Care First (PCF), and Direct Contracting Entity (DCE) but not commercial populations as it shows only the most recent imported membership list. Effective Period is intended to display patients for the time period selected and the current year of data unless the **Data Year** is changed to a different year.

Definitions below are for ACOs

- **QASSGN** - A quarterly assignment file supplied from CMS. Note this naming convention was used for Q4 2018 or prior.
- **QALR** – A quarterly assignment file supplied from CMS. Note this naming convention started in Q1 2019 and after
- **HALR** – An annual assignment file supplied from CMS. Note this naming convention started in 2019 and after.

Definitions below are for REACH ACOs

- Year MMonth example is 2021 M12 for December 2021

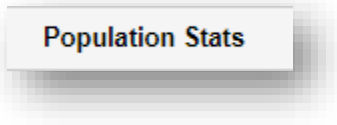
Definitions below are for PCFs

- Q1, Q2, Q3, and Q4

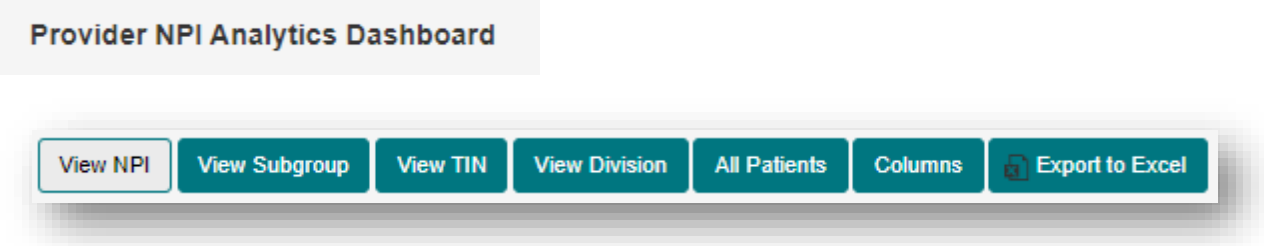
Data Year Dropdown: Select the year of claims data you want to view, e.g., selecting 2024 will show claims from calendar year 2024. Data year is intended to display the data for the year selected. To select patients, use the **Effective Period** dropdown.

Aggregate Expenditure & Utilization: This button allows the user to drilldown to the Interactive Aggregate Expenditure & Utilization tool.

PAC Dashboard: This button allows the user to drilldown to the PAC and SNF Dashboards.



The Population stats display aggregated data at the access level. For example, a Master ACO user will see the bar for all ACO participants combined or a commercial Master user will see data for all commercial participants combined. A clinic or facility user will only see aggregated data for their assigned patients.



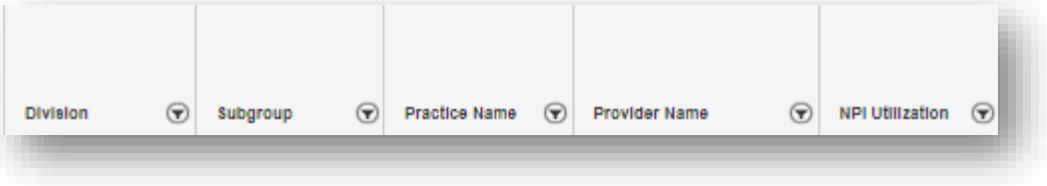
Provider NPI Analytics Buttons: Displays aggregated data at the National Provider Identifier (NPI)/Individual Provider level, SubGroup/location level, Tax Identification (TIN)/facility level, or Division level.

- **View NPI** – View individual providers within the organization. The provider/NPI is the specific provider billing under the given National Provider Identifier.
- **View TIN** – View individual facilities designed by Tax Identification Number (TIN). The TIN is a single TIN with access to all provider data under the TIN.
- **View Subgroup** – View groups of NPIs setup in a group, created in Network Manager.
- **View Division** – View groups of facilities setup in a group, created in Network Manager.

All Patients – This button will bring users to the Patient Master Dashboard showing all patients that make up data in the Analytics Dashboard.

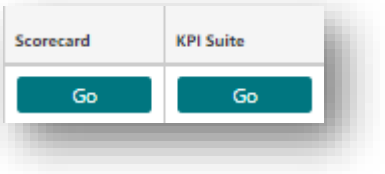
Columns – The columns button allows the end user to define which columns to view.

Export to Excel – Export to Excel to view the filtered information.



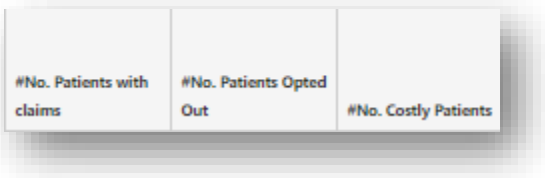
Division, Facility/TIN, Subgroup and Provider/NPI networks are configured by your organization to better organize and group many practices and providers within it.

- **Division** – a division is a group of facilities. This column has a "contains" filter. Type in a portion of the division name and the solution will filter and display.
- **Subgroup** – (Facility Locations) – E.g., a TIN may have 2000 patients and 5 locations. This column has a 'contains' filter. Type in a portion of the subgroup name and the solution will filter and display.
- **Practice Name** – Name of the practice for the NPI shown.
- **Provider /NPI** – A provider or NPI is the specific provider that is billing under the given National Provider Identifier.
- **NPI Utilization** - Clicking on the NPI number allows a drill down to the aggregate expenditure and utilization benchmarks for the NPI.



Scorecard – Click scorecard to view the scorecard for the Organization, NPI, Subgroup or TIN shown. The scorecard shows financial and quality performance for the hierarchy selected.

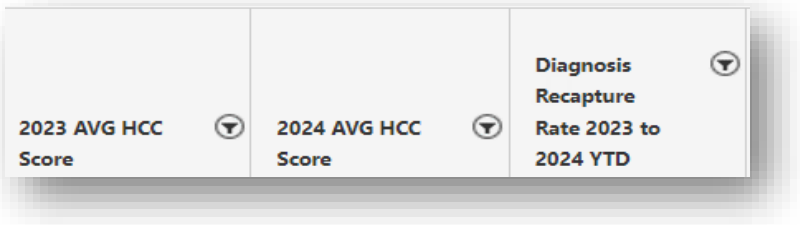
KPI Suite – Click KPI Suite 'Go' button to view the KPI Suite for the Organization, NPI, Subgroup or TIN shown. The scorecard shows financial performance and identifies targets for health outcome improvement, cost reductions and more.



#No. Patients with Claims – Shows the number of patients that are active/attributed and have claims data. Patients with no encounters or that have opted out of data sharing will not display in the number. Click #No. Patients with Claims to view the Patient Master Dashboard with those specific patients shown.

#No. Patients Opted Out – Shows the number of patients that have opted out of data sharing or have been removed due to Administrative Suppression by CMS if a physician is removed from the ACO. Click #No. Patients Opted Out to view the Patient Master Dashboard with the specific patient detail.

#No. Costly Patients – Shows costly patients today or trending to be costly in the future. HCC in the Top 30th Percentile in this year or previous year (AND) 1 or More Hospitalizations in Last 12 Months or 3 or more ED Visits in Last 24 Months (AND) 3 or More Chronic Conditions. Click No. Costly Patients to view the Patient Master Dashboard for those specific patients.

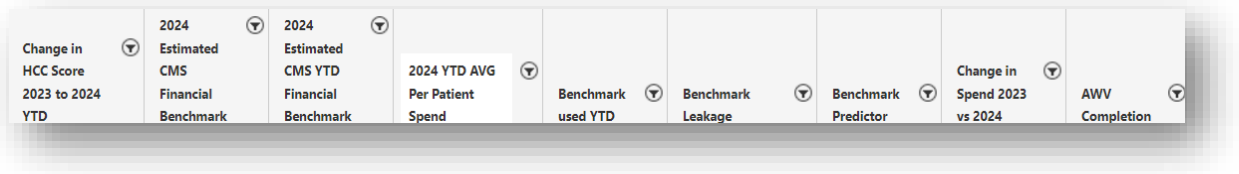


Hierarchical Condition Category (HCC) scores are used by the Centers for Medicare & Medicaid Services (CMS) to estimate the future healthcare costs of beneficiaries based on their demographic characteristics and health status. The HCC model categorizes patients into different risk groups based on the presence of specific diagnoses. Each diagnosis is assigned a HCC, and each HCC has an associated risk factor. These risk factors are additive, meaning that a beneficiary with multiple diagnoses will have a higher overall risk score. The model accounts for several factors including **Demographic Factors**: Age, gender, Medicaid status, and other characteristics as well as **Health Status**: Diagnoses from the previous year, identified through International Classification of Diseases (ICD-10) codes.

Average Hierarchical Condition Categories (HCC Risk Score) – The average HCC risk score for the assigned patients calculated for TIN, Subgroup or NPI. The risk scores are calculated using the diagnoses for the year displayed. The higher the score, the greater the expected healthcare needs and costs for that patient. Patients that are healthier than average will have an HCC score below 1.000 and those that are less healthy than average would have a score above 1.000

Current Year HCC Risk Score – The average HCC risk score for the assigned patients calculated for TIN, Subgroup or NPI. The risk scores are calculated using the diagnoses for the year displayed. The higher the score, the greater the expected healthcare needs and costs for that patient. This score is used to adjust provider payments to match the health status and predicted costs for beneficiaries.

HCC Diagnosis Recapture Rate – A comparison of the current year to past year recaptured HCC diagnoses codes. This column displays the total percentage of HCC diagnoses (recurring chronic condition codes) that have been recaptured in the current year. Clicking on the button here will drill down to the HCC Coding Impact quick report for additional review.



HCC Risk Score Change – Selected year risk score compared to the prior year.

2024 Estimated CMS Financial Benchmark-The Estimated Annual CMS Financial Benchmark updates the CMS benchmark provided on quarterly basis using the trending information for both regional and national expenditures and weights found in the quarterly expenditure and benchmark reports. Once the settlement files are received the calculation will be replaced with the benchmark from the settlement file. The benchmark is normalized. The benchmark refers to the financial target set by CMS for Accountable Care Organizations (ACOs). This benchmark is used to measure financial performance and is a factor in determining cost savings. It is based on several factors including Risk Adjustment (HCC scores), trend factors at national and regional levels, and demographic characteristics.

2024 Estimated CMS YTD Financial Benchmark- This field aligns the year-to-date (YTD) expenditures to the **CMS Estimated Financial Benchmark** to illustrate a prorated share that matches the current expenditures.

Year to Date average per patient spend – Average year to date per patient spend for Part A and Part B (including DME) but not including Part D for assigned patients to a TIN, Subgroup or NPI.

Percent of Benchmark used YTD. Percentage of financial spend benchmark used year to date. What has been spent vs the total HCC benchmark.

Benchmark Leakage – Identifies the approximate (not exact) dollar value to the benchmark of non-acute diagnosis codes that were reported in previous years but have not yet been recaptured in the current year, and thereby represent potential for erosion of the benchmark.

Benchmark Predictor- A warning symbol indicates our algorithm is predicting the actual spend will exceed the financial benchmark before the end of the current year.

Change in Spend (per patient) – The per patient spend for the selected year as compared to the prior year.

AWV Completion – The percentage of Annual Wellness Visits (AWV) completed during a rolling 12 months from claims through date. The % includes all attributed population (including deceased). You may click on the button to drill to the incomplete patients.

Switch Companies – Sometimes an organization has subsidiaries, sister companies or companies they may merge with in the future for ACO and commercial lines. When they want the company accounts separate, this option allows the assignment of company access.