Proposed CMMI Rural Shared Savings Demonstration Project: Frontier/Rural Community Care Organizations

Executive Summary

Rural networks across the nation have been working with rural providers to assist them in applying for and participating in the Medicare Shared Savings Programs (MSSP). While these networks were successful in applying for the MSSP for a few physician-only networks and as part of a few Urban/Rural Accountable Care Organizations (ACOs) they were unsuccessful in applying on behalf of the more common rural Physician Hospital Organizations (PHOs). This is not due to a lack of significant interest, but due to beneficiary assignment issues and limitations on the Advanced Payment program. These networks came together to form the Rural Health Innovators Group, which currently engages rural providers in California, Nevada, Washington, Michigan, Louisiana, Texas, Montana, Florida and Oklahoma.

Subsequent to conversations with CMS and CMMI on the issues preventing participation in the MSSP and Advanced Payment Program in Texas, California, Oklahoma and Michigan rural communities, the Rural Health Innovators Group was invited to a CMS/CMMI listening session to discuss the challenges and opportunities surrounding rural health care reform.

The listening session on August 3rd in Washington, DC, was highly attended by senior officials representing CMMI, CMS, ORHP, ONC and HHS. After a lively discussion the Rural Health Innovators Group was invited to submit a proposal for a CMMI demonstration project for consideration by CMMI. The following proposal is not a panacea for all rural providers, but addresses its largest segment – rural hospital anchored healthcare delivery systems which include 1,337[1] hospital service areas and 27% of the 4,985 community hospitals in the United States who are currently unable to participate in the MSSP.[2]

The specific CMMI Demonstration Project proposal is as follows:

1. Assign all Medicare and Medicaid beneficiaries, by zip code, to rural communities that provide a plurality of primary care for their service area zip code(s) to a Community Care Organization (CCO).
2. Provide Advanced Payments to all CCOs to support infrastructure development.
3. Share savings equally between CMS, Beneficiaries, Physicians and Hospitals.

If implemented in 500 rural service areas over five years, this program is projected to save more than $4 billion. Net of the Advanced Payment investment, the Federal government, patients, rural hospitals and physicians can each expect to save $868 million. This will fund the redesign of roughly one third of the rural-hospital anchored healthcare delivery systems to achieve the three part aim of better health, better care and lower costs.

[1] http://www.tricare.mil/hospitalclassification/
[2] http://www.aha.org/research/rc/stat-studies/fast-facts.shtml

Background

The rural healthcare delivery system takes many different forms. Given its diversity, it is difficult to describe a single program that would be applicable to all types of rural providers and systems. While some states have minimal geographic distance and barriers between urban, suburban and rural providers, many states have isolated communities that are served by a single rural hospital and a tightly knit group of primary care providers who typically work in hospital owned rural health clinics. Of the 4,985 acute care hospitals in the United States, 1,987 are rural -- of which 1,331 are Critical Access Hospitals (CAHs).[3] In 2000, almost half of CAHs were public district hospitals, often supported by local taxes.[4] This ratio is expected to be fairly stable as hospital district formation is fairly complex and static.

CAHs must be located in a rural area (or an area treated as rural); be more than 35 miles from another hospital (or 15 miles in areas with mountainous terrain or only secondary roads available) or be certified before January 1, 2006 by the State as being a necessary provider of health care services. CAHs are required to make available 24-hour emergency care services that a State determines are necessary. CAHs may have a maximum of 25 acute care and swing beds, and must maintain an annual average length of stay of 96 hours or less for their acute care patients. CAHs are reimbursed by Medicare on a cost basis (i.e., for the reasonable costs of providing inpatient, outpatient and swing bed services X Medicare Share X 101%).[5]

Rural hospitals are typically tightly integrated with their community physicians, with 20.4% having fewer than 5 admitting providers, 50.4% with 5-10 admitting providers and 29.3% with more than 10 admitting providers.[6] The hospital is often the largest employer in town and a driver of the local economy. Less than 10% are for-profit. The experience of the Rural Health Innovators Group is that mid-levels (Nurse Practitioners and Physicians Assistants) frequently account for 25-75% of primary care provided in each community. Across the US, 73% of CAH inpatient days and 36% of outpatient visits are covered by Medicare. Unlike typical urban hospitals, median outpatient revenue for CAHs is 69% of total revenue.[7]

Rural hospitals are important contributors to local economies and often the community's largest employer. Estimates range from $700,000 to $1,000,000 per year in direct contribution to local economies. When retail sales and tax collections are included estimates increase and range from $18,549 to $54,739 local contribution per bed.[8]

The "rural hospital based community healthcare delivery system" is the subject of this proposed CMMI Demonstration Project. We have identified 1,371 of these types of communities including 1,118 CAHs more than 15 miles away from the nearest hospital[9] and 253 Rural Hospitals that are Sole Community

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[3] http://www.aha.org/research/rc/stat-studies/fast-facts.shtml

[4] Hospitals in Rural America.Ricketts and Heaphy.Western Journal of Medicine.2000. December; 173(6): 418–422.

[5] CAH Financial Indicators Report:Summary of Indicator Mediansby State Flex Monitoring Team Data Summary Report No. 7. August 2010.

[6] Report to the Congress: Medicare and the Health Care Delivery System. June 2012. MEDPAC.Chapter 5.

[7] CAH Financial Indicators Report:Summary of Indicator Mediansby State Flex Monitoring Team Data Summary Report No. 7. August 2010.

[8] The Economic Impact of Hospitals in Rural Communities.Richard E. McDermott, Gary C. Cornia, Robert J. Parsons. The Journal of Rural Health.Volume 7, Issue 2, pages 117–133, March 1991

[9] Report to the Congress: Medicare and the Health Care Delivery System. June 2012. MEDPAC.Chapter 5.

Providers.[10] Rural Medicare beneficiaries represent 23% of all fee-for-service (FFS) beneficiaries and receive roughly 70% of their care from rural providers.[11]

Strengths

A common misperception is that rural care is more expensive than urban care[12,13]. While costs are higher on a unit basis due to lack of economies of scale, in 2010 rural Medicare per beneficiary spending was 3.52% lower than in urban counties. Inpatient spending was 1.87% lower and physician spending was 18.39% lower, offset by 14.07% higher spending in outpatient services.[14]

The natural strengths of these delivery systems are the tight integration between providers and the hospital, whether or not the providers are employed or contracted in hospital-based clinics, and the passion and support from the community for their healthcare institutions. Strong personal relationships exist between providers and patients. Providers operate at the top of their licenses and treat locally wherever possible. Skilled nursing facilities are often part of the system supporting continuity of care. Taxpayer support and cost-based reimbursements provide much needed operating funds.

Weaknesses

Although total per beneficiary spending is lower for rural residents, rural providers have higher unit costs and beneficiaries pay more than twice as much for outpatient services. In 1995, Congress passed a law that protected Medicare Beneficiaries by mandating they only pay 20% of the Medicare allowed charges, not the amount charged by the hospital which is highly variable. This benefit was not passed on to Medicare Beneficiaries seen in CAHs, a program that was started in 1996. As a result, Medicare Beneficiaries getting outpatient services in CAHs pay 47% of costs instead of the 20% paid in all other settings, although many have co-insurance.[15] Medigap insurance covers 28-36% of patients, 19-24% are covered by Medicaid, 31-41% have commercial insurance and 9-16% have no secondary insurance.[16] The experience of the Rural Health Innovators Group is that some commercial plans do not cover more than 20% of the PPS rate, leaving the beneficiary with the balance of the bill, so as many as 50% of patients have a strong financial incentive to get their care elsewhere, or delay care.

Many rural areas have difficulty recruiting physicians and cannot support specialists in rural settings due to volume limitations. Rural providers have limited opportunities to control costs at distant tertiary care centers. Communication between tertiary care and rural providers is poor or non-existent. In a recent survey of 28 California CAH CEOs, not one rural community received communication when a patient was discharged from a tertiary care center. A disproportionate share of patients seek primary care in the emergency department (ED), with 50% primary care in the rural ED vs. 30% in urban.[17] Information technology infrastructure and managed care experience is sparse to non-existent. Transportation is an issue for communities covering a large geographic area or with mountainous terrain.

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[10] http://www.tricare.mil/hospitalclassification/

[11] Report to the Congress: Medicare and the Health Care Delivery System. June 2012. MEDPAC.Chapter 5.

[12]Modernizing Rural Healthcare.Coverage, Quality and Innovation.Working Paper #6. July 2011. United Health Group.

[13]http://www.healthreform.gov/reports/hardtimes/ruralreport.pdf

[14] Rural Relevance Under Healthcare Reform. Version 3.0.June, 2012 I-Vantage Health Analytics.

[15] Report to the Congress: Medicare and the Health Care Delivery System. June 2012. MEDPAC.Chapter 5.

[16]Ibid.

[17]Ibid.

Opportunities

One area offering significant improvement is to reduce utilization of the rural emergency room for primary care. Unlike urban centers that see less than 30% Level 1 visits, rural residents frequently don't have after-hours access to primary care; thus more than 50% of rural ED visits are for primary care.[18]

Lack of communication and coordination of care between tertiary care settings and rural settings plagues the rural safety net. Rural providers typically received no notification or information when patients were returned to the community following tertiary care hospitalizations, and frequently first learned about the hospitalization when the patient presents to the ED. Establishing these linkages should reduce readmissions, ED utilization and ambulatory sensitive admissions.

Similar to urban areas, the greatest potential for improvement in rural health care costs are the 5-10% of the patients who make up 40-60%[19] of the health care budget. By focusing efforts to support these patients, better care, better health and lower costs can be achieved in rural settings. Patient Centered Medical Homes and Community Case Managers are widely recognized to achieve these goals, including reducing the aforementioned high rates of ED use for primary care, but currently no reimbursement systems exist to support those programs. Rural providers do not have the resources to fund these initiatives without assistance.[20]

RECOMMENDATIONS

The strength of rural healthcare delivery systems is the integration of the physician and the hospital providers and the support and engagement of the community. Modeled after the Medicare Shared Savings Program (MSSP), the Community Care Organization (CCO) Demonstration Project would lower the barriers to participation for rural providers and reward patients for better health behaviors. The rules for quality reporting and calculation of shared savings would be identical to the MSSP, while the beneficiary assignment rules and the Advanced Payment program would be modified to fit rural providers:

- Eligibility: Rural communities that contain a rural hospital more than 15 miles from the next nearest hospital would be eligible to apply to become CCO's. CMS would analyze hospital discharge data to determine the 75th percentile service area zip codes. Claims data for these zip codes would be analyzed for primary care services. All RHC, FQHC, and hospital-based clinic claims would be considered primary care unless specified otherwise. Zip codes with a plurality of primary care claims would be assigned to the Community Care Organization (CCO). All community-hospital credentialed providers are allowed to participate in the CCO, but at least 75% of primary care visits delivered in the zip code must be accounted for by the participating providers in order for the community to be eligible. Referring providers and clinics that are not in the primary service area can join the CCO, provided that they provide more than 50% of primary care for the zip code and 75% of all primary care visits are accounted for by these providers. These zip codes would also be assigned to the CCO.
- Eligibility Alternative: In our investigation of this proposal, we found several instances of FQHC/RHC/Independent Physician networks that provide the preponderance of care in rural areas that do not contain a rural hospital. We request that these networks are also able to participate in this program as a standalone CCO if they provide more than 50% of primary care

[18] Rural Relevance Under Healthcare Reform. Version 3.0.June, 2012 I-Vantage Health Analytics.
[19] High Cost Medicare Beneficiaries, May, 2005.Congress of the United States.Congressional Budget Office.
[20] California's Critical Access Hospitals: The Financial Landscape. California Healthcare Foundation. 2010.

for the zip code and 75% of all primary care visits are accounted for by these providers. These zip codes would also be assigned to the CCO. In this case, shared savings would be divided three ways between CMS, the providers and the patients.

- Beneficiary Assignment: 100% of Medicare and Medicaid beneficiaries in eligible zip codes would be assigned to the CCO (with full retention of beneficiary rights to choose care providers). Medicare and Medicaid beneficiaries from non-eligible zip codes would be allowed to elect to join the CCO if desired. In some state Medicaid participation may not be possible.
- The Advanced Payment Program would be applied to support these communities in their transformation except they would not be subject to the income cap. Under the Advance Payment CCO Model, participating CCOs receive three types of payments:
    - An upfront, fixed payment: Each CCO will receive a $250,000 payment in the first month of the Shared Savings Program.
    - An upfront, variable payment: Each CCO will receive a payment in the first month of the Shared Savings Program equivalent to the number of its preliminary, prospectively assigned beneficiaries times $36.
    - A monthly payment of varying amount depending on the size of the CCO: Each CCO will receive a monthly payment equal to the number of its preliminary, prospectively assigned beneficiaries times $8.
    - Advanced payments would be deducted from the entire savings pool prior to calculation of shared savings payments.
- Preference would be given to applicants that join a CCO network of at least 5 CCOs that would provide policies, procedures, training and informatics support. This would lower the cost of the delivery system redesign and improve odds for success. When the CAReHIN Network developed a model for network support for rural ACOs, the analysis indicated that the cost of setting up a separate IT and quality reporting infrastructure for each community was 13-25% of total Medicare spending. By aggregating 10 communities into a support network, the cost of the IT, analytics and quality reporting could be reduced to less than 2% of total spending for each community.[21] In addition, networks can more easily gain participation from commercial payers, while stand alone communities would find it harder to get their attention.
- Payment methodologies and quality reporting would follow the MSSP program. CCOs will not be forced to take risk and will only participate in a one-sided model even after the initial period. CCOs that have less than 5,000 beneficiaries will have to aggregate with other CCOs to meet the 5,000 beneficiary minimum to maintain actuarial integrity.
- The CCO would have the ability to charge members the standard PPS co-pays and deductibles, if desired, instead of the increased cost-sharing required for CAH outpatient services utilization. The CCO would absorb the decline in revenue.
- All beneficiaries will be excluded from other ACOs.
- Shared Savings would be split 25% for CMS, 25% for Beneficiaries, 25% for Physicians and 25% for the Hospital.
    - **Hospitals** as single entities would receive the entire 25% to offset lost revenues.
    - **Physicians** would split shared savings based on performance on the quality metrics and total Medicare and Medicaid visits. Each Physician would receive a total quality score based on individual performance compared to the average for the CCO for a quality performance score. The percentage of visits would be multiplied by the quality performance score for each physician. For example:

[21] CAReHIN MSO Innovation Challenge Grant. Unpublished.

	Number of Visits	% of Visits	Total Quality Score	% Quality	Payment/$100,000 of Shared Savings
Dr. A	2500	20%	20	0.714	$ 14,285.71
Dr. B	3000	24%	34	1.214	$ 29,142.86
Dr. C	4000	32%	25	0.893	$ 28,571.43
Dr. D	1000	8%	30	1.071	$ 8,571.43
Dr. E	2000	16%	30	1.071	$ 17,142.86
Total	12500	100%	139	4.964	$ 97,714.29

- **Patients** who choose a primary care provider and demonstrate optimal health behaviors would be eligible for annual rebates of up to 100% of their co-pays and deductibles paid into the community health system, if the CCO meets cost-saving targets. Compliance with applicable measures would be calculated as a percentage and applied against the patient out of pocket costs. A patient with 100% compliance with the measures would get up to 100% of costs, up to the limit of shared savings available.
  - Preventive Health — Influenza Immunization Up to Date
  - Preventive Health — Pneumococcal Vaccination Up to Date (if applicable)
  - Preventive Health — Normal BMI or enrolled in mitigation program
  - Preventive Health — No Tobacco Use or in Tobacco Cessation Program
  - Preventive Health — No Depression or in treatment
  - Preventive Health — Colorectal Cancer Screening up to date
  - Preventive Health — Mammography Screening up to date
  - Preventive Health — Blood Pressure <140/90 or in mitigation program
  - Preventive Health — Complete Lipid Profile and LDL Control <100 mg/dl
  - Preventive Health — Annual physical
  - Preventive Health — Identify Medical Home
  - Preventive Health — No use of the ER for primary care
  - Preventive Health — Enrolled in Care Management Program after discharge
  - Diabetics — Hgb A1c Control (<8 %) or in mitigation program
  - CHF/COPD/Asthma — Enrollment in Care Management Program

- Quality Measures: All CCOs would report on the 33 MSSP Quality Measures. Physician payments would be divided according to volume and quality measure performance with the ability to get up to 1 point for each quality score except meaningful use, which is two points. Measures 8, 9 and 10, which measure numbers of readmissions and ambulatory sensitive admission per 1,000 beneficiaries would be judged by the percentage of CHF, COPD, Asthma and recently hospitalized patients enrolled in the Community Case Management program due to limitations of analyzing low volume admission data. Payments to the CCOs would not be adjusted based on performance and would be paid for reporting only, however CCOs that perform below the 50th percentile of the national average of the MSSP participants will be required to put in place a corrective action plan in order to remain in the program. For more detail on the quality measures please see Appendix A.
- All CCOs would be exempt from antitrust review. By definition, they are health care monopolies and clinically integrated in their regions. This would apply for commercial insurers as well. All other fraud and abuse waivers of the MSSP would apply.

- Governance: Each CCO would have an advisory board that has equal representation of the Hospital, Physicians and Beneficiaries without a conflict of interest. Non-hospital CCOs would not require a Hospital on the board. Hospitals would act as the fiscal entity to reduce administrative costs and burden, but payments would be prescribed by the program, unless there is no hospital in the CCO.
- Five year term
- Each CCO has the right to request reasonable modifications of this structure in their proposal, at the discretion of CMMI.

Network Support and Data Sharing

Fundamental to the assumptions in this proposal is the existence of networks to support CCOs that have access to Medicare and Medicaid claims data. The Rural Health Innovators group believes the $250,000 provided up front by the Advanced Payment program, in addition to gain sharing arrangements, would be sufficient to support the networks involvement in each community. We also recommend that a National Learning Network is funded so that legal agreements, processes, procedures, success stories and failures can be rapidly shared between the networks to increase efficiency, which would need to be funded separately, and would have a strong advisory role. Finally, we are powerless without data. We request that CMS provide a current de-identified data warehouse of rural claims data to support this effort, which can be accessed by Network Business Associates and mined to identify areas for improvement.

Expected Costs and Impact

On the average, previous demonstration projects have shown a cost reduction of 13% by implementing chronic disease case management and medical homes, prior to accounting for costs.[22] Medicare per beneficiary spending in rural was $7,369 in 2010,[23] which would yield $957,970 in savings per 1,000 beneficiaries before costs. We expect only 50% of that target in the first year due to start up time.

Per 1,000	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Expected Savings	$478,985	$957,970	$957,970	$957,970	$957,970	$ 4,310,865
Advanced Payment	$382,000	$96,000	$96,000	$96,000	$96,000	$766,000
Less Advance	**$96,985**	**$861,970**	**$861,970**	**$861,970**	**$861,970**	**$3,544,865**
To CMS	$24,246	$215,493	$215,493	$215,493	$215,493	$886,216
To Hospital	$24,246	$215,493	$215,493	$215,493	$215,493	$886,216
To Doctors	$24,246	$215,493	$215,493	$215,493	$215,493	$886,216
To Patients	$ 24,246	$215,493	$215,493	$215,493	$215,493	$886,216

Depending on whether communities collaborated with a support network, we estimate that the cost of key interventions can range from 4% to 29%.[24] Assuming network support to minimize costs to 4% of total spend, the average community could expect a shared savings payment of $861,970 per 1,000

[22]Congressional Budget Office Issue Brief. Lessons from Medicare's Demonstration Projects on Disease Management,Care Coordination, and Value-Based Payment. January 2012
[23] Rural Relevance Under Healthcare Reform. Version 3.0.June, 2012 I-Vantage Health Analytics.
[24]CAReHIN MSO Innovation Challenge Grant. Unpublished.

patients. Assuming 10 providers per 1,000 beneficiaries,[25] we would expect annual payments of $215,493 per hospital, $21,549.25 per physician and $215.49 per beneficiary. The primary benefit to the rural community would be seen in the form of increased utilization of services by the community, capturing more of the primary care business that might be going elsewhere, increasing economies of scale and lowering unit costs. They would also benefit from the advanced payment funding, which would partially cover the costs of implementing health care reforms and position them well for future success.

Frontier Communities

We analyzed how this program would fare in a Frontier environment with only 250 Medicare Beneficiaries. Making the same assumptions on per beneficiary savings, with a minimal Advanced Payment from CMMI, Frontier communities would have the incentives to align their efforts toward the triple aim and still expect to see financial benefit for their performance starting in year 2, providing they had network support.

Per 250	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Expected Savings	$ 119,747	$ 239,493	$ 239,493	$ 239,493	$ 239,493	$ 1,077,719
Up Front Payment	$ 250,000					$ 250,000
Up Front $36 PM	$ 9,000					$ 9,000
$8 PMPM	$ 24,000	$ 24,000	$ 24,000	$ 24,000	$ 24,000	$ 120,000
Total Advanced Payment	$ 283,000	$ 24,000	$ 24,000	$ 24,000	$ 24,000	$ 379,000
Less Advance	**$ (163,254)**	**$ 52,240**	**$ 215,493**	**$ 215,493**	**$ 215,493**	**$ 698,716**
To CMS	$ (40,813)	$ 13,060	$ 53,873	$ 53,873	$ 53,873	$ 133,866
To Hospital	$ (40,813)	$ 13,060	$ 53,873	$ 53,873	$ 53,873	$ 133,866
To Doctors	$ (40,813)	$ 13,060	$ 53,873	$ 53,873	$ 53,873	$ 133,866
To Patients	$ (40,813)	$ 13,060	$ 53,873	$ 53,873	$ 53,873	$ 133,866

This proposal could be offered to 500 rural communities through the CMMI Demonstration Project process. Interested communities would apply directly to CMMI. In order to assess the impact of the program in different size rural markets, the Rural Health Innovators Group recommends 100 Frontier CAHs with 250-1,000 beneficiaries (mean = 500), 300 CAHs or FQHC/RHC networks with 1,000-5,000 beneficiaries (mean = 2,000) and 100 rural PPS hospital-based communities with 1,000 -5,000 beneficiaries (mean=3,000). It is important to study the impact of cost-based reimbursement on shared savings in different size facilities. If the majority of savings is from decreased services within a community that receives cost-based reimbursement, unit costs may increase and savings would be

[25] Report to the Congress: Medicare and the Health Care Delivery System. June 2012. MEDPAC.Chapter 5.

negligible. If, however, the expected savings come from reducing unnecessary admissions to tertiary care hospitals, savings will be substantial. This is the expected focus from participating communities.

Based on the assumptions above, the expected cost of Advanced Payments for 500 rural communities is $615 million. If these reforms were successful for 500 rural communities, CMS and CMMI could expect approximately $4 billion in reduced per beneficiary spending over the life of the project. Of this, CMS could expect to save $829 million net of the advanced payment. It would also strengthen the rural safety net, promote jobs and local economies and assist rural providers in achieving the triple aim.

100 Frontier CAHs (mean beneficiaries = 500)	
Total Advanced Payment	$ 50,800,000
Total Savings	$ 215,543,250
Total Net Savings	$ 157,092,500
Net to CMS	$ 39,273,125

300 CAHs (mean beneficiaries = 2000)	
Total Advanced Payment	$ 384,600,000
Total Savings	$ 2,586,519,000
Total Savings net of AP	$ 2,201,919,000
Net to CMS	$ 550,479,750

100 Rural Hospitals (mean beneficiaries = 3000)	
Total Advanced Payment	$ 179,800,000
Total Savings	$ 1,293,259,500
Total Savings net of AP	$ 1,113,459,500
Net to CMS	$ 278,364,875

Acknowledgement

The Rural Health Innovators Group gratefully acknowledges the architects of the MSSP for giving us an excellent starting point for this proposal. We would also like to recognize Terry Hill from the National Rural Health Resource Center for bringing the Innovators together and the Office of Rural Health Policy, the National Rural Health Association, the National Opinion Research Center at the University of Chicago (NORC), I-Vantage, the California Association of Rural Health Clinics, the California Hospital Association and the Association of California Hospital Districts for their input into this proposal.

Appendix A: Quality Measures

Quality Measures	Calculation (percentage score maximum = 1 point)
Measures 1-7: Patient Satisfaction	% of patients giving top box score for each measure
Measure 8: 30 Day Readmission Rates	% of discharged patients enrolled in Community Case Management
Measure 9-10: Ambulatory Sensitive Admissions for CHF/COPD/Asthma	% of CHF/COPD/Asthma patients enrolled in Community Case Management
Measure 11: EHR Incentive Payment	3 points for getting MU payment
Measure 12: Medication Reconciliation within 60 days of discharge	% of patients receiving MR
Measure 13: Patients screened for fall risk	% of patients screened
Measure 14: Patients with flu vaccine	% of patients with flu vaccine
Measure 15: Patients >65 with pneumococcal vaccine	% of patients with pneumococcal vaccine
Measure 16: BMI Screening and Follow up	% of patients within limits or in documented program
Measure 17: Smoking Screening and intervention	% of patients not smoking or in documented program
Measure 18: Patients Screened for Depression w/intervention	% of patients screened and in documented program prn
Measure 19: Colorectal Screening (50-75)	% of patients screened
Measure 20: Mammography	% of patients screened
Measure 21: High Blood Pressure Screening	% of patients screened
Measure 22: Diabetics - HBA1c < 8%	% of Diabetics
Measure 23: Diabetics - LDL-C < 100mg/dl	% of Diabetics
Measure 24: Diabetics - BP < 140/90 mm Hg	% of Diabetics
Measure 25: Diabetics - tobacco non-use	% of Diabetics
Measure 26: Diabetics with IVD - Daily ASA use	% of Diabetics
Measure 27: Diabetics with HbA1c < 9%	% of Diabetics
Measure 28: Hypertensives - BP < 140/90 mm Hg	% of Hypertensive
Measure 29: IVD - Complete lipid profile with LDL-c < 100 mg/dl	% of IVD pts
Measure 30: IVD - Use of ASA or other anti-thrombotic	% of IVD pts
Measure 31: Heart Failure - Beta Blocker for LVSD	% of CHF pts
Measure 32: CAD - LDL-C < 100 mg/dl or plan of care	% of CAD pts
Measure 33: CAD with Diabetes or LVSD - ACE inhibitor or ARB	% of CAD/CHF and CAD/Diabetic pts