

 Astrana Health

2026

Provider Manual

for

APA ACO

Participants

 **apaaco**

Part of  Astrana Health

CMS ID #D0215

Version: January 15, 2026



Astrana Health

ACO REACH

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Digital Version

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Section 1

Claims & Payment

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Payment Flowchart (Capitation)

How are my Claims Processed and Capitated in ACO REACH?



1

Beneficiary sees ACO Participant Provider for care



2

ACO Participant Provider bills Medicare for services rendered to the beneficiary



3

The provider's MAC (Medicare Administrative Contractor) receives and adjudicates the claims



4

The Center for Medicare Services (CMS) provides Astrana the adjudicated claims from all providers each week



5

Astrana pays the practice the agreed upon capitation rate (PBPM)



Capitation FAQ



ACO REACH Capitation Payments

- **Payments will be made monthly, typically within 30 days after the ACO receives its payment from Medicare.**
- **While the ACO makes every effort to process capitation accurately, minor errors may occur. Providers have the right to appeal any payment discrepancies, as outlined in the agreement with the ACO.**

Billing Frequently Asked Questions

Q1. What does it mean to receive capitated payments in an ACO?

Capitated payments are fixed, per-member, per-month (PMPM) payments made to providers, in lieu of the Fee-For-Service Medicare payments, to cover specified healthcare services for patients attributed to them. These payments are made regardless of the number or type of services delivered, encouraging cost-effective and efficient care.

Q2. How are capitated payments typically calculated?

Your payments are determined by your contracted PMPM amount and the number of beneficiaries attributed to you within a given month. CMS sends the ACO a set of files with claim information and beneficiary alignment. Payments each month are calculated retrospectively – meaning that the ACO will look back at the previous month's attribution to pay in the current month. This ensures that you receive payments for the most accurate count of beneficiaries.

Q3. Why am I getting paid a different amount each month?

There are three (3) typical reasons why you may see fluctuation in your beneficiary attribution:

- **New Patients:** Patients joining the ACO.
- **Patient Departures:** Patients leaving the ACO due to changes in insurance, eligibility, or provider choice.
- **Re-attribution:** Patients switching primary care providers within or outside the ACO, which affects who receives capitation payments for their care.

Your monthly EOBs will show you a list of all your beneficiaries, their effective and term dates, and termination reason (if applicable).

Q4. Who do I call for questions related to payment disputes?

The ACO does not deny payments. All payment denials are handled by CMS and the MAC and questions about denials should be addressed to the MAC. All other payment disputes or questions are handled by the ACO. Payment disputes are handled by the ACO. Please call the Astrana Provider phone line at:

Toll Free: (877) 476-7066, Option 1

Continued on following page

Q5. Can I receive direct deposits for my claims?

Yes, all providers are expected to enroll with direct deposit for 2026. Please complete the ACH Enrollment Form found in this section of the manual and email the completed form to the ACO at ProviderRelations@Astranahealth.com.

Q6. Can I receive my EOBs as Electronic Remittance Advice (ERA)?

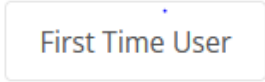
Yes, please complete the ERA Enrollment Form found in this section of the manual and email the completed form to ProviderRelations@Astranahealth.com.

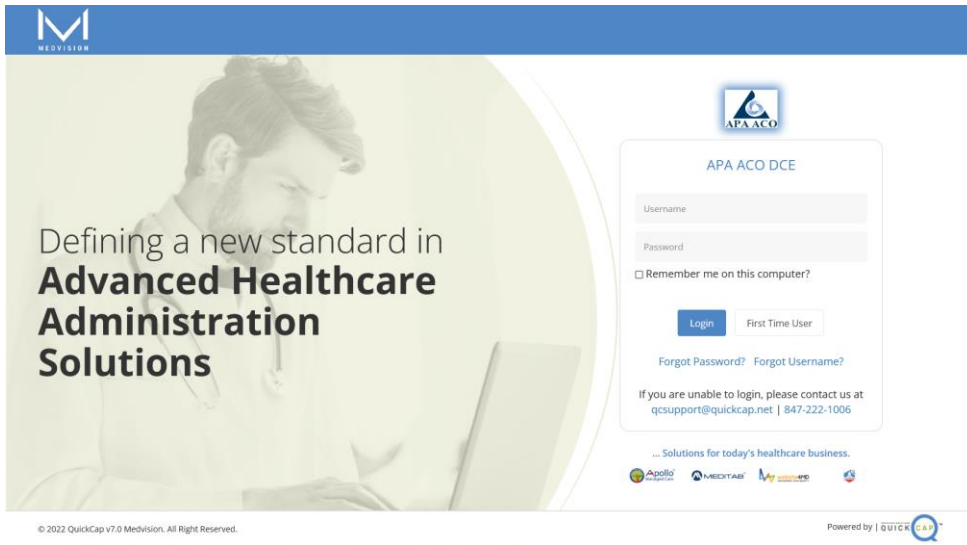


QuickCap Registration


How to Request a QuickCap Account

Register for a Login


- Open your web browser and visit <https://apollomed.quickcap.net> to be taken to the Web Portal. You will be taken to the page below.
- Click on  and you will be taken to the next page.



Request to Login Form

- Once you've arrived at the page below, fill out the following information on the form and click  once finished.
- You may also provide access to other members in your organization or third parties by attaching a formal letter requesting authorization for the person(s) involved.
- Note: All fields marked with an **asterisk*** must be completed.

Request To Login
Close



- **If you wish for your Organization information to be accessible to third parties (like a billing company), you will be able to create username/passwords for them like described in the tutorial found above. Optionally, you can attach a formal letter below listing the persons you authorize to request this access.**
- **If you are requesting a username/password for a billing company or similar third party, please request username/passwords from your Organization or make sure they provide us with an authorization letter for you to use their Organization id.**

*First Name:

*Last Name:

*Title:

*Organization Tax ID:

*Name of the Organization:

*Office Phone:

Cell No:

Date of Birth:

Fax:

*Email:

*Address:
(Please provide the address of the Primary Organization)

*City:

*State:

*Zip:

Upload optional authorization letter: No file chosen
[Max file size 256M]

Notes:



QuickCap User Guide (Capitation)

How to View Claims



Defining a new standard in
**Advanced Healthcare
Administration
Solutions**



APA ACO DCE

Username

Password

Remember me on this computer?

Login

First Time User

[Forgot Password?](#) [Forgot Username?](#)

If you are unable to login, please contact us at
ProviderRelations@apolloed.net |
877-476-7066

... Solutions for today's healthcare business.



- Claims**
- Dashboard
- EDI Services
- Eligibility
- PDR
- Payment Processing
- Reports

Claims Search Hide Search Options [Back](#)

Search Claim #

Claim # From: To: Authorization #: Provider Claim/Patient Account #:

Search Member

Member ID: Company:

Optional Additional Details

Provider ID: Organization ID: Diag Code:

Service Code: Check #: Billed Amount: <=

Date of Service From: To: Date Paid:

Date Received: Show Claims: Paid Pending Both Group By:

Outcome:

Claim Details Notes:** All blue text is clickable, N/A = Not Applicable.

Health Plan Details History

Click here to view search results!

Search claims by clicking the Claims tab on the left sidebar and selecting Claims Search/Status. Use the empty form fields to search for claims. By default, you will be in the Claims Search view seen above.

- Claims
- Claims Search/Status
- Dashboard
- EDI Services
- Eligibility
- PDR
- Payment Processing
- Reports

Claims Search

Hide Search Options Back











Search Claim

Claim # From: To: Authorization #: Provider Claim/Patient Account #:

Search Member

Member ID:   Company:

Optional Additional Details

Provider ID:  Organization ID:  Diag Code: 
 Service Code:  Check #: Billed Amount: <=
 Date of Service From:   To:  Date Paid: 
 Date Received:  Show Claims: Paid Pending Both Group By:
 Outcome: = (Equal To) ALL 1 - HOME AC - ACO PAID 

Claim Search Clear

Show Document Requested Claims

Claim Details



Notes:** All blue text is clickable, N/A = Not Applicable.

Health Plan Details

Member Search — Mozilla Firefox

https://apollomed.quickcap.net/DotNet/SearchAuthMember.aspx?enc=D4VBg+bvvdzwt3PmP0OMFOr92rFHuBYwkRfx4 110%

Member Search Close

Member ID/Other ID: Last Name: First Name:
 HP: DOB:  Gender:
 Employer Group Code:  Company: Site Number:
Search Clear

You can also click on any of the search icons or calendar icons to search using specific criteria. Another window will pop up with different form fields to fill in.

Member Search — Mozilla Firefox

https://apolloed.quickcap.net/DotNet/SearchAuthMember.aspx?enc=D4VBg+bvwdzwt3PmP0OMFOr92rFHuBYwkRfx4n7qQu3Q3NA+/lVnjB2wx9Sm6U80EfyHNE4mNp3fmuzcHHMp 110%

Member Search Close

Member ID/Other ID:

HP:

Employer Group Code:

Last Name:

DOB:

Company:

First Name:

Gender:

Site Number:

[1 to 1 of 1] 1 Page(s): 1

Details	Member ID	Name	Gender	Date Of Birth	Age	HP Code	Emp Grp	PCP Name	PCP Effective Date	HP Effective From	HP Effective To	Phone	Member SSN	Subscriber ID	Company	Secondary ID	Other ID	Site Info
		BARRETT	F			ACR			01-01-2023	01-01-2023					AMED			

[1 to 1 of 1] 1 Page(s): 1

Once you've added your search terms, click the search button and the results will show up below. Click the **identifier** to pre-fill one of the form fields on the main search page. It will appear as below.

Identifier

Claims Search Hide Search Options Back

Search Claim #

Claim # From: To:

Authorization #:

Provider Claim/Patient Account #:

Search Member

Member ID:

Company:

Optional Additional Details

Provider ID:

Organization ID:

Diag Code:

Service Code:

Check #:

Billed Amount: <=

Date of Service From:

To:

Date Paid:

Date Received:

Show Claims: Paid Pending Both

Group By:

Outcome: ALL
1 - HOME
AC - ACC PAID

Show Document Requested Claims

Claim Details Notes:** All blue text is clickable, N/A = Not Applicable.

Health Plan Details PCP History

From here, you can continue to add more search terms such as service code, date of service, provider name, etc. Once you are satisfied, click Claim Search to pull the results.

Based on the criteria, the search results will display as such.

10-21-2023		10-11-2023	11 OFFICE	BARRETT	Organization	\$225.00	\$140.90	127.04	AMED	ACO REACH PAID							
Service Date	ServiceCode	Modifier(s)	Diag. Code	Financial Resp.	Adjust Descr.	Paid Date	Check #	Qty	Billed	Contract	CoPay	Coinsurance	Deductible	Adjust	Net	Admin. Fee/Withhold	Status
F: 10-11-2023 T: 10-11-2023	99214 OFFICE O/P EST MOD 30-39 MIN		I10	ACR	Prearranged demonstration project adjustment, Sequestration Adjustment, PQEM Adjustment	10-25-2023		1.00	225.00	140.90	0.00	28.18	0.00	-14.32	127.04	0.00	PROCESSED
Notes																	
10242023 claims to be paid																	
P.D0215.TPARC.RP.D231021.T2221007.txt																	
Claims Priced by SYSTEM at Oct 23 2023 8:47AM																	

Check Total Amount : \$698.28

Show EOB Print CMS 1500

How to Verify Eligibility

- Claims
- Dashboard
- EDI Services
- Eligibility**
- Member Verification
- PDR
- Payment Processing
- Reports

Eligibility - Member Verification

* Member ID:

(OR)

* Last Name:

* First Name:

SSN:

Gender:

Health Plan:

* Date of Birth:

Service Date:

Search Eligibility by clicking the Eligibility tab on the left sidebar and selecting Member Verification. Use the empty form fields to search for a patient. Only fields marked with a red asterisk are required. Note: the Service date will be pre-filled to the current date.

- Claims
- Dashboard
- EDI Services
- Eligibility
- Member Verification
- PDR
- Payment Processing
- Reports

Eligibility - Member Verification

* Member ID:

(OR)

* Last Name: Health Plan:

* First Name: * Date of Birth:

SSN: Service Date: 05-10-2024

Gender:

Verify Eligibility Clear

[1 to 1 of 1] 1 Page(s): 1

Details	Member ID	Name	Gender	Date of Birth	Member SSN	Health Plan	Provider ID	Name	Other Coverage?	Resp. Code	Policy #	HP Status	PCP Status
	[Redacted]	[Redacted]	F	[Redacted]		ACR	[Redacted]	[Redacted]	No			Active	Active

[1 to 1 of 1] 1 Page(s): 1

This will say "Active" if the patient is eligible, and "Inactive" if they are not

Once you have entered the information, click **Verify Eligibility** and the results will pop out below.
Section 1: Claims & Payment

How to Download EOBs (CAP)

Capitation - Explanation of Benefits

*Organization Name:

Check No: Retrieve Checks *If you do not know the check number please press Retrieve Checks.

*Paid Date:

Summary EOB Reconciliation EOB

Search EOBs by clicking the Capitation tab on the left sidebar and selecting Capitation EOB. You will be brought to the Capitation - Explanation of Benefits screen. *Note:* the Organization Name field will be pre-populated.

Enter the check number that the EOB was paid with. If you do not know the check number, you can search for the check by clicking the Retrieve Checks button.

Check No Search

Check No:

From Date: 01-30-2015 To Date: 05-25-2015 Search Clear All

Prefix	Check No	Paid Date	Amount
0	1	05-19-2015	\$0.00
2323	65473	02-03-2015	\$10.00
455	1	02-03-2015	\$10.00
1	948207	01-30-2015	\$400.00

The Check No Search screen will display. Search the payment by entering either the check number or by entering date ranges. To search for all payments, leave the fields blank and click the Search button.

Select the check by clicking on the Check No to the left.

Capitation - Explanation of Benefits

*Organization Name: ABC Health

Check No: 65473 Retrieve Checks *If you do not know the check number please press Retrieve Checks.

*Paid Date: 02-03-2015

Summary EOB Reconciliation EOB

By entering the check number, the Paid Date field will be populated with the relevant date automatically. Click the Summary EOB or Reconciliation EOB button and the EOBs will be generated.

How to Download Electronic Remittance Advice (835)

Click Search to display results.

	ERA ID	Trading Partner	Billing/Org. Prov. Name	Check Prefix	Check #	Check Date	ERA Date	Total Claims	Total Billed Amount(\$)	Check Amount(\$)	EOB	Created Date	Download ERA
<input type="checkbox"/>	[REDACTED]	[REDACTED]	[REDACTED]	2	[REDACTED]	10-08-2025	10-08-2025	47	\$1 [REDACTED]	\$ [REDACTED]		10-08-2025	Download

Select EDI Services on the left sidebar and select 835 Download. You will be brought to the Electronic Remittance Advice(835) Download screen.

Note: ERAs will default to only show files generated in the last 10 days. If you wish to go further back, select the drop-down button above to change your selection. You can also view specific timeframes by clicking Custom.

Click Download to download a copy of the ERA.

Search Files

Billing/Org. Prov. Name:

ERA ID:

Trading Partner Name:

Check #:

Created Date: -

	ERA ID	Trading Partner	Billing/Org. Prov. Name	Check Prefix	Check #	Check Date	ERA Date	Total Claims	Total Billed Amount(\$)	Check Amount(\$)	EOB	Created Date	Download ERA
<input type="checkbox"/>	2218	VALLEY OAKS MEDICAL GROUP	VALLEY OAKS MEDICAL GROUP	2	33417	10-08-2025	10-08-2025	47	\$12,206.77	\$5,656.89		10-08-2025	Download

If you need to search for a specific check #, first locate the organization name using the search button above, then select the check search button to find the specific check.



EOB Sample (Capitation)

AMED
PCP CAPITATION RECONCILIATION REPORT BY ORGANIZATION, PROVIDER
CAPITATION EOB FOR DECEMBER, 2024

PROVIDER: D0052 - ACO REACH CAP [REDACTED]

Provider Number: [REDACTED]

VENDOR: [REDACTED] M.D., INC. - [REDACTED]

PAGE: 1

MEMBER NAME	INSURED ID#	DOB	SEX	EFFECTIVE DATE	TERM DATE	CAP PERIOD	GROSS \$	PREVIOUS CAP\$	ADJUST CAP\$	CURRENT CAP \$
CARRIER: 0052										
C [REDACTED]	5 [REDACTED]	[REDACTED]	[REDACTED]			12/1/24	\$51.50	\$0.00	\$0.00	\$51.50
C [REDACTED]	5 [REDACTED]	[REDACTED]	[REDACTED]			12/1/24	\$51.50	\$0.00	\$0.00	\$51.50
E [REDACTED]	8 [REDACTED]	[REDACTED]	[REDACTED]			12/1/24	\$51.50	\$0.00	\$0.00	\$51.50
R [REDACTED]	5 [REDACTED]	[REDACTED]	[REDACTED]			12/1/24	\$51.50	\$0.00	\$0.00	\$51.50
T [REDACTED]	8 [REDACTED]	[REDACTED]	[REDACTED]			12/1/24	\$51.50	\$0.00	\$0.00	\$51.50

Total Current Member Months for 0052	5	Total Current Capitation for 0052	\$257.50
Total Positive Retro Member Months for 0052	0	Total Positive Retro Capitation for 0052	\$0.00
Total Negative Retro Member Months for 0052	0	Total Negative Retro Capitation for 0052	\$0.00
Total Member Months for 0052	5	Total Capitation Amount for 0052	\$257.50



ACO Direct Deposit Enrollment Form



Astrana Health, Inc. – ACO

Payment Direct Deposit Authorization Form

I. PAYEE INFORMATION

Name: _____

Vendor Name: _____

Tax ID: _____

II. BANK ACCOUNT INFORMATION

Bank Name: _____

Bank Routing Number: _____

Account Number: _____

Business Checking Business Savings Personal Checking Personal Savings

Select ACO Entity: D0215 - APA ACO A1596 - Accountable Care Coalition of Georgia
 A3319 - Mid-Atlantic Collaborative Care A5450 - Astrana Care Partners

*****Please provide a copy of a voided check*****

I hereby authorize Astrana Health, Inc. to initiate credit entries to the account listed on this form. This authority will remain in effect until Astrana Health has received written notification from me of its termination in such time and in such manner as to afford Astrana Health and financial institution a reasonable opportunity to act on it.

Signature _____ Date _____

Contact Person _____ Phone _____

E-Mail Address _____

PLEASE COMPLETE AND E-MAIL THIS FORM TO:

ProviderRelations@Astranahealth.com

SHOULD YOU HAVE ANY QUESTIONS, PLEASE CONTACT

Provider Relations Department at (877) 476-7066
Section 1: Claims & Payment



Electronic Remittance Advice (ERA) Enrollment Form



Part of .i. Astrana Health

ERA Enrollment Form

Electronic Remittance Advice (ERA/835)

CLEARING HOUSE

PROVIDER IDENTIFIERS INFORMATION

Provider Federal Tax Identification Number (or)
Employer Identification Number (EIN):

Vendor Name / Organization Name

Organization NPI

Print Name

Title

Signature

Date

Email

Phone

Submit form to ProviderRelations@Astranahealth.com, subject line- ERA Registration.



Payment Calendar (Capitation)

REACH Capitation Payment Calendar

Week of Payment	Description
2/16/2026	Cap Payment for January
3/16/2026	Cap Payment for February
4/20/2026	Cap Payment for March
5/18/2026	Cap Payment for April
6/15/2026	Cap Payment for May
7/20/2026	Cap Payment for June
8/17/2026	Cap Payment for July
9/21/2026	Cap Payment for August
10/19/2026	Cap Payment for September
11/16/2026	Cap Payment for October
12/21/2026	Cap Payment for November
1/20/2027	Cap Payment for December

Disclaimer: The dates listed above are based on the release dates of the Claim and Claim Line Feed (CCLF) files from CMS, from which a provider's alignment is calculated, and upon which capitation payments are subsequently based. The release dates for CCLFs have been published by CMS and are subject to any changes based on future communications from CMS.



Section 2

Quality

Contents

ACO REACH Quality Overview

Annual Wellness Visit (AWV) and Quality Measure Requirements

AWV Progress Note Template

Health Risk Assessment (HRA) Patient Questionnaire

AWV FAQs

Advance Care Planning Codes

Advance Care Planning Template

Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey



ACO REACH Quality Overview

REACH Quality Performance Metrics

Quality performance is a key component of REACH participation and directly impacts Shared Savings

Quality performance is based on 4 evenly weighted metrics:

3 Claims-Based Measures

Patient Experience

Patient Experience Survey:

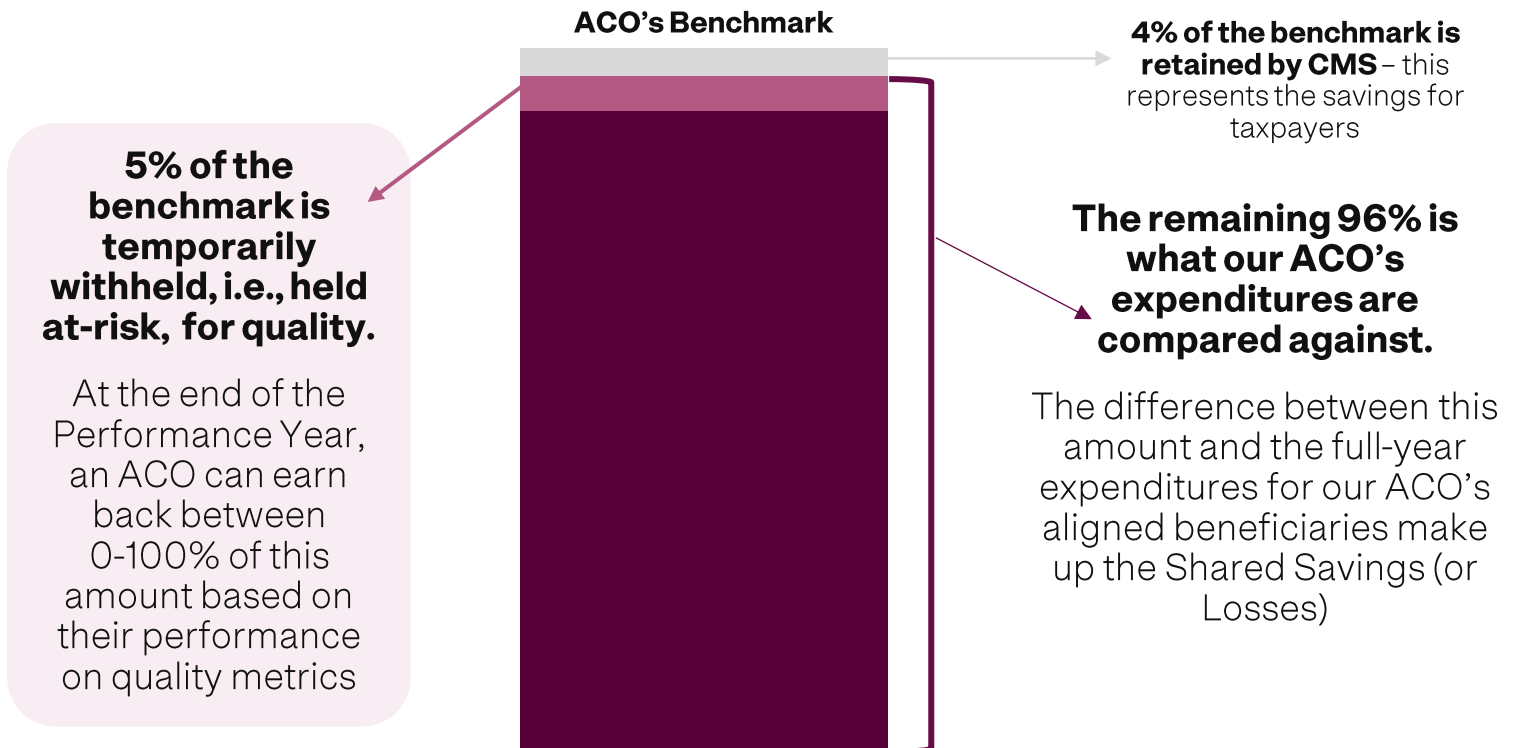
Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey administered by the ACO with an approved vendor

Claims-Based Measures:

Measure Name	Description
Risk-Standardized All Condition Readmission (ACR)	<p>Risk-adjusted percentage of hospitalizations of REACH ACO-assigned beneficiaries that result in an unplanned readmission to a hospital within 30 days following discharge from the hospital admission.</p> <p>Planned readmissions are excluded. Other exclusions include: admissions for patients with medical treatment of cancer, for primary psychiatric disease, for rehabilitation care, and for patients discharged against medical advice</p>
All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (UAMCC)	<p>Rate of risk-standardized, acute, unplanned hospital admissions per 100 person-years among beneficiaries who are 66 years or older at the start of the measurement period, have multiple chronic conditions, and are aligned to the REACH ACO</p> <p>To meet the criteria of having multiple chronic conditions for this measure, a beneficiary must have a diagnosis within two or more of the following chronic disease groups: (1) acute myocardial infarction, (2) Alzheimer’s disease and related disorders of senile dementia, (3) atrial fibrillation, (4) chronic kidney disease, (5) COPD and asthma, (6) depression, (7) heart failure, (8) stroke and transient ischemic attack, and (9) diabetes</p>
Timely-Follow-Up After Acute Exacerbations of Chronic Conditions (TFU)	<p>Rate of follow-up for patients with chronic conditions who have experienced an acute exacerbation for one of six conditions of interest, which can be attributed to providers participating in the model.</p> <p>The conditions of interest are: CAD, high-acuity diabetes, HF, asthma, high-acuity hypertension, medium-acuity hypertension, COPD, and low-acuity CAD</p>

REACH Quality Performance Metrics

How does Quality performance affect Shared Savings?



The 'Quality Withhold' represents a significant opportunity; failure to earn back the Quality Withhold represents revenue that the ACO could have attained through improved quality performance

ACOs are also eligible to share in a High Performers Pool

- CMS evaluates ACOs using a set of **“Continuous Improvement/Sustained Exceptional Performance” (CI/SEP) criteria**
 - ❖ These criteria assess whether ACOs (1) continue to improve their performance in these metrics year over year, or (2) maintains a certain level of performance if already achieving excellent outcomes
- **If an ACO meets this CI/SEP criteria, and averages 70th percentile rank or greater across all claims-based measures, they are eligible for additional quality dollars to be added to their Shared Savings total**



Astrana's REACH ACOs have a proven track record of achieving the High Performers Pool



Annual Wellness Visit (AWV) and Quality Measure Requirements

Annual Wellness Visit and Quality Measure Requirements Reference Guide for Medicare Fee for Service (ACO)

Measure and Requirement	CPT / CPT II codes	ICD-10-CM codes
Annual Wellness Visit (AWV) (For Telehealth with (Audio/Video) , use appropriate POS: 10 or 02)	G0438 (AWV includes PPPS, Initial visit) G0439 (AWV includes PPPs, subsequent visit) G0402 (IPPE) (“Welcome to Medicare” for new beneficiary during first 12 months of Medicare enrollment- only in person, no telehealth acceptable)	For AWV - Any acceptable ICD-10 code Link to any applicable diagnosis code from the assessment and treatment plan
AWV components include the following – must be documented in medical record		
<input type="checkbox"/> Health risk assessment (HRA) <input type="checkbox"/> Medication Review <input type="checkbox"/> Medical/Surgical history/Family History <input type="checkbox"/> Cognitive Assessment <input type="checkbox"/> Depression Risk Factors Screening <input type="checkbox"/> Functional Ability & Level of Safety Assessment	<input type="checkbox"/> Health Risks Factors (Education/Preventive Counseling) – Fall Risk, Nutrition, Physical Activity, Smoking cessation <input type="checkbox"/> Pain Assessment <input type="checkbox"/> Advance Care Planning <input type="checkbox"/> Best practice – Preventive Health Screenings	
BMI (For telehealth – Member can self-report HT, WT and BMI). Make sure it is documented in Progress Note.	BMI (requiring height and weight) requires an associated weight-related diagnosis (such as morbid obesity, overweight, underweight) per ICD-10-CM guideline.	Z68.____
Depression Screening and follow up plan PHQ9 score _____ (Age 12y and older)	G0444: Annual depression screening, 5 to 15 minutes G8510: Screen negative, no follow-up plan required G8431: Screen positive, follow-up plan documented G8433: Screen not completed, patient or medical reasons documented G8511: Screen positive, follow-up plan not documented, reason not given G8432: Screen not documented; reason not given	(- depression) Z13.31 (Encounter for screening for depression) <u>Or</u> (+ depression – link to type of depression dx code) F3____
HbA1c Control for Patients with Diabetes (Age 18-75y) Most recent glycemc assessment	M1371: HbA1c <7.0% M1372: HbA1c ≥7.0% & <8.0% M1373: HbA1c ≥8.0% & ≤9.0% M1211: HbA1c >9% M1212: HbA1c missing or not performed	Link to applicable Diabetes diagnosis For Example: E11.9 (type 2 DM w/o complications) E11.22 +N18.__(type 2 DM w/CKD)
Hypertension: Controlling Blood Pressure (Age 18-85y) Most recent BP	G8752: Systolic BP <140mmHg G8753: Systolic BP ≥140mmHg G8754: Diastolic BP <90mmHg G8755: Diastolic BP ≥90mmHg G8756: No BP documented; reason not given	Link to applicable Hypertension diagnosis
Breast Cancer Screening (MMG q2y, up to age 74)	G9899: Screening mammography results documented and reviewed. G9900: Screening mammography results were not documented and reviewed; reason not otherwise specified.	Z12.31 (Encounter for mammogram screening)
Colorectal Cancer Screening (Colonoscopy within 10yrs or FOBT annually, up to age 75)	3017F: Colorectal cancer screening results documented and reviewed. 3017F with 8P: Colorectal cancer screening results not documented and reviewed, reason not otherwise specified.	Z12.11 (Encounter for colorectal screening)

All the Annual Wellness Visit elements must be completed to bill an AWV G code. If all are not provided, bill the most appropriate E/M code.

*CMS guidelines for Telehealth change periodically. It is recommended to look out for any updates.

This guidance is to be used for easy reference; however, the current ICD-10-CM code classification and the Official Guidelines for Coding and Reporting are the authoritative references for accurate and complete coding. The information presented herein is for general informational purposes only. Neither APA ACO nor its affiliates warrant or represent that the information contained herein is complete, accurate or free from defects.

The following are helpful tips regarding claim submission when reporting an AWV:

- **For Providers:**
 - Recommend assessing and reporting all active/new chronic conditions. All conditions affecting the care, treatment or management of the patient should be documented with their status and treatment and coded to the highest level of specificity. Make sure to address/assess and document all the Annual Wellness components in your progress notes.

- **Billers/Coders:**
 - Only report conditions and services assessed/completed during the visit and there is supporting documentation in the progress note. Make sure to report all appropriate ICD-10-CM codes (up to 12 ICD-10-CM codes per claim)
 - Necessary Evaluation and Management (E/M) services can be billed for at the same visit as the AWV when clinically appropriate. Modifier 25 must be added to the E/M to show it is a significant, separately identifiable service from the AWV. Report the additional CPT code (99202–99205, 99211–99215) with modifier 25.

 Astrana Health

AWV Progress Note Template

Medicare Fee For Service ACO | Annual Wellness Visit (AWV) – Progress Note

Member's Name: _____ DOB: _____ Date of Service: _____ Sex: M F

Conducted: In-person Telehealth encounter (Audio and Video) with patient consent, HIPAA compliant platform
 Self-reported vitals (Telehealth) BP reading obtained from a digital blood pressure machine Unable to obtain BP reading (Telehealth)

VITAL SIGNS	BP: /	HR:	HT: ft. in.	WT: lbs.	BMI: Z68.____	TEMP:	RR:	PULSE OX:	%
--------------------	--------------	------------	--------------------	-----------------	----------------------	--------------	------------	------------------	----------

REASON FOR VISIT:	PAST MEDICAL/SURGICAL HISTORY:
Annual Wellness Visit	SOCIAL MEDICAL HISTORY: <input type="checkbox"/> Tobacco <input type="checkbox"/> Alcohol <input type="checkbox"/> Substance use or drugs
	FAMILY MEDICAL HISTORY:

HPI:	
-------------	--

CURRENT MEDICATIONS LIST (prescription & non-prescription) All medication Reconciled & Reviewed Patient is not taking any medications

	MEDICATION ALLERGIES:

REVIEW OF SYSTEMS – Review with member

System	Normal	Abnormal findings
HEENT	<input type="checkbox"/>	Eye pain, ear pain, neck pain, visual problems, masses, hoarseness, hearing & speech, other:
Lungs	<input type="checkbox"/>	Cough, wheezing, sputum, hemoptysis, other:
Heart/Circulation	<input type="checkbox"/>	Chest pain, SOB, palpitation, orthopnea, other:
Gastrointestinal	<input type="checkbox"/>	Abdominal pain, nausea, vomiting, diarrhea, other:
Kidneys/Urinary Tract	<input type="checkbox"/>	Difficult or painful urination, nocturia, frequency, hematuria, other:
Musculoskeletal	<input type="checkbox"/>	Joint pain, swelling, other:
Endocrine	<input type="checkbox"/>	Polyuria, heat or cold intolerance, other:
Neurological	<input type="checkbox"/>	Disoriented, paresthesia, weakness, gait, other:
Skin	<input type="checkbox"/>	Skin breakdown, rashes, pruritus, other: <input type="checkbox"/> All other system reviewed and are negative

PHYSICAL EXAM

Area	Normal	Describe findings if abnormal
Constitutional	<input type="checkbox"/>	
HEENT	<input type="checkbox"/>	
Cardiovascular	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	
Gastrointestinal	<input type="checkbox"/>	
Genitourinary	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	
Psychiatric	<input type="checkbox"/>	

ASSESSMENT AND TREATMENT PLAN

ICD-10	Diagnosis Description	Assessment	Treatment Plan
		<input type="checkbox"/> Stable <input type="checkbox"/> Unstable <input type="checkbox"/> Controlled <input type="checkbox"/> Uncontrolled	<input type="checkbox"/> Monitor <input type="checkbox"/> On Meds _____ <input type="checkbox"/> Other plan:
		<input type="checkbox"/> Stable <input type="checkbox"/> Unstable <input type="checkbox"/> Controlled <input type="checkbox"/> Uncontrolled	<input type="checkbox"/> Monitor <input type="checkbox"/> On Meds _____ <input type="checkbox"/> Other plan:
		<input type="checkbox"/> Stable <input type="checkbox"/> Unstable <input type="checkbox"/> Controlled <input type="checkbox"/> Uncontrolled	<input type="checkbox"/> Monitor <input type="checkbox"/> On Meds _____ <input type="checkbox"/> Other plan:
		<input type="checkbox"/> Stable <input type="checkbox"/> Unstable <input type="checkbox"/> Controlled <input type="checkbox"/> Uncontrolled	<input type="checkbox"/> Monitor <input type="checkbox"/> On Meds _____ <input type="checkbox"/> Other plan:
		<input type="checkbox"/> Stable <input type="checkbox"/> Unstable <input type="checkbox"/> Controlled <input type="checkbox"/> Uncontrolled	<input type="checkbox"/> Monitor <input type="checkbox"/> On Meds _____ <input type="checkbox"/> Other plan:
		<input type="checkbox"/> Stable <input type="checkbox"/> Unstable <input type="checkbox"/> Controlled <input type="checkbox"/> Uncontrolled	<input type="checkbox"/> Monitor <input type="checkbox"/> On Meds _____ <input type="checkbox"/> Other plan:
		<input type="checkbox"/> Stable <input type="checkbox"/> Unstable <input type="checkbox"/> Controlled <input type="checkbox"/> Uncontrolled	<input type="checkbox"/> Monitor <input type="checkbox"/> On Meds _____ <input type="checkbox"/> Other plan:
		<input type="checkbox"/> Stable <input type="checkbox"/> Unstable <input type="checkbox"/> Controlled <input type="checkbox"/> Uncontrolled	<input type="checkbox"/> Monitor <input type="checkbox"/> On Meds _____ <input type="checkbox"/> Other plan:
		<input type="checkbox"/> Stable <input type="checkbox"/> Unstable <input type="checkbox"/> Controlled <input type="checkbox"/> Uncontrolled	<input type="checkbox"/> Monitor <input type="checkbox"/> On Meds _____ <input type="checkbox"/> Other plan:
		<input type="checkbox"/> Stable <input type="checkbox"/> Unstable <input type="checkbox"/> Controlled <input type="checkbox"/> Uncontrolled	<input type="checkbox"/> Monitor <input type="checkbox"/> On Meds _____ <input type="checkbox"/> Other plan:

Member's Name: _____ DOB: _____ Date of Service: _____ Sex: M/F

RECOMMENDED VACCINES		OTHER PHYSICIANS CURRENTLY INVOLVED IN PATIENT'S CARE	
Influenza	Date given: ____/____/____	Specialty:	Name:
Shingles	Date given: ____/____/____	Specialty:	Name:
Pneumonia	Date given: ____/____/____	Specialty:	Name:
Tdap or Other	Date given: ____/____/____	Specialty:	Name:

Provider use: check all that apply	
1 Annual Wellness Visit	<input type="checkbox"/> Patient presents for Annual Wellness Visit. The purpose of the visit was explained to the patient <input type="checkbox"/> Health Risk and Preventive Care Assessment (HRA) completed by member <input type="checkbox"/> Reviewed HRA and medications with patient, gave personalized health advice per provided responses, discussed individualized preventative health screening schedule
2 Medication Review	<input type="checkbox"/> Meds & their side effects reviewed w/ patient
3 Cognitive Assessment	<input type="checkbox"/> Mild Impairment <input type="checkbox"/> Moderate Impairment <input type="checkbox"/> Severe Impairment
4 Functional Status Assessment	<input type="checkbox"/> Able <input type="checkbox"/> Unable to perform ADLs Recommend: <input type="checkbox"/> IHSS <input type="checkbox"/> CBAS <input type="checkbox"/> Other: _____
5 Screening for Future Fall Risk	<input type="checkbox"/> Screened or assessed for history of falls <input type="checkbox"/> No falls <input type="checkbox"/> 1+ fall(s) +/- injury (description) _____ <input type="checkbox"/> Plan & treatment (if positive fall screen) _____
6 Pain Assessment Potential risk for substance use disorders (SUDS)	<input type="checkbox"/> Negative pain <input type="checkbox"/> Positive pain <input type="checkbox"/> Pain management plan _____ <input type="checkbox"/> Review any potential opioid use disorder (OUD) risk factors <input type="checkbox"/> Screen for potential substance use disorders (SUDs)
7 Advance Care Planning	<input type="checkbox"/> Discussed advance directive with patient <input type="checkbox"/> Advance directive filed in patient's chart <input type="checkbox"/> Patient refused

Measure	Check all that apply	ICD-10CM	Choose applicable CPT/HCPCS
* Annual Wellness Visit		<i>Link to any applicable diagnosis code from the ASSESSMENT AND TREATMENT PLAN</i>	G0402: Welcome to Medicare (only during first 12 mos. of Medicare enrollment) G0438: Initial AWV (once per lifetime) G0439: Subsequent AWV
1 HbA1c Control for Patients with Diabetes (Age 18-75y)	<input type="checkbox"/> Lab result: _____	E10. _____ E11. _____ E13. _____	M1371: HbA1c <7.0% M1372: HbA1c ≥7.0% & <8.0% M1373: HbA1c ≥8.0% & ≤9.0% M1211: HbA1c >9% M1212: HbA1c missing or not performed
2 Depression Screening & Follow-up Plan (Age 12y and older)	<input type="checkbox"/> PHQ9 score _____ <input type="checkbox"/> Depression screening positive <input type="checkbox"/> If (+) screen, follow-up plan documented <input type="checkbox"/> Depression screening negative	N/A (- Depression) F3 ____ (+ Depression)	G0444: Annual Depression Screening, 5 to 15 minutes G8510: Screen negative, no follow-up plan required G8431: Screen positive, follow-up plan documented G8433: Screen not completed, patient or medical reasons documented G8511: Screen positive, follow-up plan not documented G8432: Screen not documented; reason not given
3 Hypertension: Controlling Blood Pressure (Age 18-85y)	<input type="checkbox"/> Results reviewed with patient <input type="checkbox"/> On medication	I10. _____	G8752: Systolic BP <140mmHg G8753: Systolic BP ≥140mmHg G8754: Diastolic BP <90mmHg G8755: Diastolic BP ≥90mmHg G8756: No BP documented; reason not given
4 Breast Cancer Screen (MMG q2y, up to age 74)	Mammogram (2 years): Normal Abnormal Findings: _____		G9899: Screening mammography results documented and reviewed. G9900: Screening mammography results were not documented and reviewed; reason not otherwise specified.
5 Colorectal Cancer Screen (Colonoscopy within 10y or FOBT annually, up to age 75y)	Colonoscopy (within 10 years): Normal Abnormal Findings: _____ FIT-DNA (3 years): Negative Positive FOBT (Annually): Negative Positive Sigmoidoscopy (within 5 years): Negative Positive		3017F: Colorectal cancer screening results documented and reviewed. 3017F with 8P: Colorectal cancer screening results not documented and reviewed, reason not otherwise specified. Date of screening: _____
6 Health education or preventive counseling	<input type="checkbox"/> Fall prevention <input type="checkbox"/> Physical activity <input type="checkbox"/> Self-health care <input type="checkbox"/> Alcohol <input type="checkbox"/> Weight loss <input type="checkbox"/> Aging process <input type="checkbox"/> Other: _____ <input type="checkbox"/> Nutrition <input type="checkbox"/> Tobacco use cessation <input type="checkbox"/> Sex education		

I certify this is an outpatient record and I have reviewed it with the member during the visit. I hereby verify all the above records are correct.

NP/PA's Name (Print): _____ Credential(s): NP/PA Provider's Signature: _____ Date: _____
 Provider's Name (Print): _____ Credential(s): MD/DO Provider's Signature: _____ Date: _____



Health Risk Assessment (HRA) Patient Questionnaire



Health Risk and Preventive Care Assessment

Patient's Name: _____ DOB: _____ Date of Service _____ Sex: M/F

My overall health condition is	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
---------------------------------------	---	--------------------------------------	--------------------------------------	--------------------------------------

Please answer questions 1-23 below as the preceding statement pertains to you & speak with your doctor if you have any questions

Diet			
1	I eat three balanced meals a day that includes fruits, vegetables, grains, and calcium rich foods.	Yes	No
2	I limit eating fried or fast foods and seldom drink soda, juice drinks, sports, or energy drink.	Yes	No
3	I have gained or lost over 10 lbs. in the last 6 months.	Yes	No
Physical Activity			
4	I exercise.	Yes	No
If you answered "Yes," please answer the following questions a and b:			
a. How many days a week do you exercise? <input type="checkbox"/> 1 to 2 days <input type="checkbox"/> 3 to 4 days <input type="checkbox"/> 5 to 7 days			
b. How long do you exercise? <input type="checkbox"/> <30 mins <input type="checkbox"/> > 30 mins <input type="checkbox"/> 1 hour <input type="checkbox"/> ≥ 1 hr			
Continence			
5	I have problems with urinating.	Yes	No
If you answered "Yes" to question 5, why do you have trouble with urinating?			
<input type="checkbox"/> Leaking <input type="checkbox"/> Frequent trips <input type="checkbox"/> Other			
6	I have frequent urinary tract infections (more than 2 times a year).	Yes	No
7	I have been diagnosed with an enlarged prostate.	Yes	No
Home and Safety			
8	I feel safe where I live.	Yes	No
9	I drive cautiously, always wear a seat belt while sitting in a car and have not had a car accident in the past year.	Yes	No
Fall Risk, Vision, and Hearing Problem			
10	I have fallen in the past 12 months.	Yes	No
If you answered "Yes" to question 10, please answer the following questions a and b:			
a. How many times did you fall? <input type="checkbox"/> 1 time <input type="checkbox"/> 2 or more times			
What caused your fall? _____			
b. Did your fall cause a fracture or serious injury?			
<input type="checkbox"/> Yes. Explain the injury: _____			
<input type="checkbox"/> No			
11	I have safety bars installed in my bathroom.	Yes	No
12	My vision and hearing changed a lot in the past 12 months.	Yes	No
Oral Health and Lifestyle & Staying Healthy			
13	I have problem with my oral health.	Yes	No
14	I can chew and swallow easily.	Yes	No
15	I smoke/chew tobacco. Frequency of Tobacco Use	Yes	No
16	I drink alcohol. If you answered "Yes," How many glasses do you drink a day?	Yes	No
<input type="checkbox"/> < 2 glasses <input type="checkbox"/> ≥ 2 glasses			
17	Have you had the following health vaccinations?		
a. Flu shot in the last year <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know or remember <input type="checkbox"/> Not Applicable			
b. Pneumonia shot in the last 5 years <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know or remember <input type="checkbox"/> Not Applicable			
c. Covid-19 vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know or remember <input type="checkbox"/> Not Applicable			



Health Risk and Preventive Care Assessment

Patient's Name: _____ DOB: _____ Date of Service _____ Sex: M/F

Functional Status Assessment			
18	I can take care of my daily living activities: eating, toileting, bathing, dressing, walking, etc. If you answered "No," please explain:	Yes	No
19	I can handle jobs like doing laundry, cooking, paying bills, using the telephone, driving or taking buses, shopping, etc. If you answered "No," please explain:	Yes	No
20	I have trouble remembering important things such as taking my medications on time.	Yes	No

Pain Scale											Location of Pain: _____	
Circle the number that best describes pain level in the last five days												
21	0	1	2	3	4	5	6	7	8	9	10	
Verbal Scale	No Pain	Mild Pain		Moderate Pain				Severe Pain			Worst Possible	
	0	1	2	3	4	5	6	7	8	9	10	
Activity Scale	No Pain	Can be Ignored		Interferes with Tasks		Interferes with Concentration		Interferes with Basic Needs			Bed Rest Required	

Advance Directive			
22	Have you ever completed an Advance Care Plan?	Yes	No
	If you marked "No," do you want to receive one? *Please ask your PCP for materials	Yes	No
23	Do you have other questions or concerns about your health?	Yes	No
	If Yes, please describe:		

* I understood the above questionnaire and received education and counseling from my Primary Care Physician.

Office Use Only			
Six Item Cognitive Impairment Test (6CIT)			Score
24	What year is this?	<input type="checkbox"/> Correct (0pts) <input type="checkbox"/> Incorrect (4pts)	
25	What month is this?	<input type="checkbox"/> Correct (0pts) <input type="checkbox"/> Incorrect (3pts)	
26	Give the patient an address phrase to remember with 5 components - <i>example</i> : John Doe, 52 Grand St, Arcadia.	Make sure patient can repeat address phrase properly and inform him/her that you will ask to repeat later.	
27	About what time is it (within one hour)?	<input type="checkbox"/> Correct (0pts) <input type="checkbox"/> Incorrect (3pts)	
28	Count backwards from 20-1.	<input type="checkbox"/> Correct (0pts) <input type="checkbox"/> 1 Error (2pts) <input type="checkbox"/> > than 1 Error (4 pts)	
29	Say the months of the year in reverse.	<input type="checkbox"/> Correct (0pts) <input type="checkbox"/> 1 Error (2pts) <input type="checkbox"/> > than 1 Error (4 pts)	
30	Repeat address phrase.	<input type="checkbox"/> Correct (0pts) <input type="checkbox"/> 1 Error (2pts) <input type="checkbox"/> 2 Errors (4pts) <input type="checkbox"/> 3 Errors (6pts) <input type="checkbox"/> 4 Errors (8pts) <input type="checkbox"/> All wrong (10 pts)	
(6CIT score) Add all scores to total =			

0-7 Normal 8-9 Mild Cognitive Impairment (consider referral) 10-28 Significant Cognitive Impairment (referral)



Health Risk and Preventive Care Assessment

Patient's Name: _____ DOB: _____ Date of Service _____ Sex: M/F

Depression Screening (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?		Not at all	Several Days	More Than Half the Days	Nearly Every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed or being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
10	If you circle any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all			<input type="checkbox"/>
		Somewhat difficult			<input type="checkbox"/>
		Very difficult			<input type="checkbox"/>
		Extremely difficult			<input type="checkbox"/>
1-4 Minimal Depression 5-9 Mild Depression 10-14 Moderate Depression 15-19 Moderately Severe Depression 20-27 Severe Depression		TOTAL:			

Provider's Name (Print): _____ Credential(s): M.D. / D.O.

Provider's Signature: _____ Reviewed Date: _____

* I have reviewed this questionnaire with my patient and will schedule a follow up as needed.



AWV FAQs

Frequently Asked Questions

Medicare covers an Annual Wellness Visit (AWV) providing personalized prevention plan services (PPPS) for beneficiaries who have not received an AWV within the past 12 months. As a Primary Care Participant with an Astrana ACO, performing AWV will help capture HCC gaps to improve RAF scores, identify preventive care services for quality reporting and support definitive attribution of the beneficiaries to your practice. The following are some important details from CMS Medicare Learning Network Education Tool on AWV.

Who Is Covered?

All Medicare beneficiaries who are both:

- Not within 12 months after the effective date of their first Medicare Part B coverage period
- Have not received an Initial Preventive Physical Examination (IPPE) or AWV within the past 12 months

CODING:

Use the following HCPCS code when filing claims for AWVs

AWV HCPCS CODES	Frequency	BILLING CODE DESCRIPTION
G0402	Once per lifetime <i>Within 12 months of first Part B coverage period</i>	Welcome to Medicare preventive visit <i>Also known as the Initial Preventative Physical Exam (IPPE)</i>
G0438	Once per lifetime	Annual wellness visit, includes personalized prevention plan of service (PPPS), initial visit
G0439	Once every 12 months <i>All subsequent AWVs after initial AWV</i>	Annual wellness visit, includes personalized prevention plan of service (PPPS), subsequent visit

***Please note the above amounts are only approximate estimates and will vary from provider to provider.**

DIAGNOSIS:

You must report a diagnosis code when submitting a claim for the AWV. Since you are not required to document a **specific** diagnosis code for the AWV, you may choose any diagnosis code consistent with the beneficiary's exam.

BILLING:

Medicare Part B covers AWW if performed by a:

- Physician (a doctor of medicine or osteopathy)
- Qualified non-physician practitioner (a physician assistant, nurse practitioner, or certified clinical nurse specialist)
- Medical professional (including a health educator, registered dietitian, nutrition professional, or other licensed practitioner) or a team of such medical professionals who are directly supervised by a physician (doctor of medicine or osteopathy).

When you furnish a significant, separately identifiable, medically necessary Evaluation and Management (E/M) service along with the AWW, Medicare may pay for the additional service. Report the additional Current Procedural Terminology (CPT) code with modifier -25. That portion of the visit must be medically necessary to treat the beneficiary's illness or injury, or to improve the functioning of a malformed body part.

Is the AWW the same as a beneficiary's yearly physical?

No. The AWW is not a "routine physical checkup" that some seniors may get periodically from their physician or other qualified non-physician practitioner. Medicare does not cover routine physical examinations.

Are clinical laboratory tests part of the AWW?

No. The AWW does not include any clinical laboratory tests, but you may make referrals for such tests as part of the AWW, if appropriate.

Do deductible or coinsurance/copayment apply for the AWW?

No. Medicare waives both the coinsurance or copayment and the Medicare Part B deductible for the AWW.

Can I bill an electrocardiogram (EKG) and the AWW on the same date of service?

Generally, you may provide other medically necessary services on the same date of service as an AWW. The deductible and coinsurance/copayment apply for these other medically necessary services.

How do I know if a beneficiary already got his/her first AWW from another provider and know whether to bill for a subsequent AWW even though this is the first AWW I provided to this beneficiary?

You have different options for accessing AWW eligibility information depending on where you practice. You may access the information through the Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) or through the provider call center Interactive Voice Responses (IVRs). CMS suggests providers check with their Medicare Administrative Contractor (MAC) to see what options are available to verify beneficiary eligibility. Contact your MAC for more information.

Resources: Medicare Preventive Services

<https://www.cms.gov/medicare/prevention/prevntiongeninfo/medicare-preventive-services/mps-quickreferencechart-1.html#AWV>



Advance Care Planning Codes

Astrana Health

Medicare Fee For Service

Advance Care Planning (ACP) as an Optional Element of an AWW

Advance care planning (ACP) is a voluntary, face-to-face discussion between a physician or other qualified health care professional (QHP) and your patient, their family member, caregiver, or surrogate (as appropriate) to discuss the patient's health care wishes if they become unable to make their own medical decisions. You can provide the ACP at the time of the Annual Wellness Visit (AWV), at the beneficiary's discretion. ACP does not replace living will/advance directive.

CODING

Use the following CPT codes to file claims for ACP as an optional element of an AWW:

ACP CPT CODES	BILLING CODE DESCRIPTORS
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes , face-to-face with the patient, family member(s), and/or surrogate.
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)

DIAGNOSIS

You must report a diagnosis code when submitting a claim for ACP as an optional element of an AWW. Since you are not required to document a specific diagnosis code for ACP as an optional element of an AWW, you may choose any diagnosis code consistent with a beneficiary's exam

BILLING

Medicare waives both the coinsurance and the Medicare Part B deductible for ACP when it is:

1. Provided on the same day as the covered AWW (HCPCS codes G0438 or G0439)
2. Furnished by the same provider as the covered AWW
3. Billed with **modifier -33** (Preventive Service)
4. Billed on the same claim as the AWW

ACP Services Are Time Based. You must follow CPT rules about minimum time requirements to report and bill for ACP services. Don't bill any ACP discussion of 15 minutes or less as ACP services. If you meet another service's requirements, bill a different Evaluation and Management (E/M) service, like an office visit.

The deductible and coinsurance for ACP is waived only once per year, when it is billed with the AWW. If the AWW billed with ACP is denied for exceeding the once per year limit, the deductible and coinsurance will be applied to the ACP. There are no limits on the number of times you can report ACP for a certain patient in a certain period. When billing ACP multiple times in a year, document changes in the patient's health status or wishes about their end-of-life care.

NOTE: The deductible and coinsurance apply when ACP is provided outside the covered AWW.

RESOURCES: MLN909289 MARCH 2025 <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/advancecareplanning.pdf>

Revised Jan.2026



Advance Care Planning Template

Astrana Health

Medicare Fee For Service

Patient Name:

Gender:

Date of Service:

DOB:

Age:

Race/Ethnicity:

ADVANCE CARE PLANNING (ACP)

Patient Reported Answers:

Living Will: Yes/No

Durable Power-of Attorney: Yes/No

Patient has consented to Advance Care Planning Discussion

Advance Care Planning Discussion

1. The following topics were discussed with patient:
 - Purpose of Advance Care Planning
 - Practical applications in the future (examples of situations based on beneficiary's current medical conditions)
 - Reversibility of decisions made- responsible party
 - Explanation of Living Will
 - Explanation of Durable Power of Attorney (POA)
 - Do Not Resuscitate (DNR)
 - Organ and Tissue Donation
 - ICDs and pacemakers
2. Who was present for the discussion (patient, family, surrogate, others)?
3. What forms were completed to date (i.e. advance directive/POLST)?
4. New forms provided to the patient, family and/or surrogate (i.e. advance directive/POLST)
5. Comments/Outcome of Discussion:

6. Time spent during this discussion. Initial 30 minutes required for billing. Check additional boxes if applicable.
 - Initial 30 minutes of ACP discussion (CPT Code 99497-33)
 - Additional 30 minutes (add CPT Code 99498-33)

Provider Signature: _____ **Date:** _____
Print Name & Credentials: _____

 Astrana Health

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

Annual CAHPS Survey for MSSP & ACO REACH Providers

What is CAHPS?

The **Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey** is an **annual CMS requirement** for ACOs participating in the Medicare Shared Savings Program (MSSP) and ACO REACH model. The ACO-specific surveys capture beneficiary experience with care and **directly contribute to each ACO's annual quality score and shared savings eligibility.**

Participating practices do not need to administer the survey as this is a service provided by the ACO. The ACO selects a certified vendor, and CMS provides the vendor with a list of aligned beneficiaries. The vendor uses random sampling to choose beneficiaries to include in the survey process.

Why does the CAHPS Survey matter?



CAHPS scores directly impact the ACO's annual quality results



Higher patient-experience performance increases shared savings opportunities



Survey results are included in CMS public reporting

What does the CAHPS survey typically measure?

1. Getting timely care, appointments, and information
2. Provider communication quality
3. Care coordination across the care team
4. Courtesy and helpfulness of office staff
5. Patient's overall rating of the provider
6. Access to specialists
7. Health promotion and education
8. Shared decision making
9. Health status and functional status
10. Stewardship of patient resources

Annual CAHPS Survey for MSSP & ACO REACH Providers

When does CAHPS surveying occur?

Beneficiaries in Medicare ACOs are surveyed annually on a scheduled determined by CMS. In recent years, the survey process began in the 3rd and 4th quarters of the year, while the Medicare Advantage (Part C) CAHPS survey occurs at a different time of year (typically March to June).

Will my patients receive a CAHPS survey?

There is high likelihood that some of your patients will be included in the survey. The survey process includes a random sample; however, the ACO is not informed of which patients receive the survey.

If your patients are included in the process, they will receive a paper survey, and they may receive reminder post cards or telephone calls if they do not respond in a timely manner.

How can I positively influence my ACO's CAHPS survey score?

- ✓ Communicate about the survey clearly using patient-friendly language.
 - ✓ Share survey information close to the survey period.
- ✓ **Communicate about health matters using language patients can easily understand.**
 - ✓ Confirm patient understanding using the 'teach back' method.
- ✓ **Ensure timely access to care** and prompt follow-up on messages.
- ✓ Provide clear next steps, follow-up, and referral coordination.
- ✓ Maintain **courteous, supportive** office staff interactions.
- ✓ Encourage patients to complete the survey if selected (without influencing responses).

How can I receive a copy of the CAHPS survey?

You can ask your Astrana market representative for a copy of the survey.

Remember: Every patient interaction—clinical or administrative—shapes their experience and directly influences CAHPS outcomes



Section 3

Care Management

Contents

ACO Care Management Programming

Care Coordination Responsibilities

Sample Hospital Discharge Notification

About Astrana's Care Management Team



ACO Care Management Programming

Care Management Programming for ACO – Summary

Transition of Care

- ✦ Patients **called within 72 hours of discharge** to facilitate smooth transition*
- ✦ **Automated fax notifications** of patient admissions & discharges to your office
- ✦ **Automated text alerts** for patients discharging from the ER*

High-Intensity Care Management

- ✦ **Dedicated Complex Care Manager** works closely with high-utilization patients
- ✦ Develop comprehensive, **tailored care plans**
- ✦ **Help patients access needed resources**, such as transportation

Disease Management

- ✦ Provides patients with **individualized education & care coordination** on managing CHF, COPD, and ESRD/CKD
- ✦ Frequent **check-ins**
- ✦ Ensure **regular communication** amongst entire care team

* Subject to availability of patient contact information through Admissions, Discharges, and Transfers (ADT) feed networks. Astrana Health is contracted with several ADT vendors that comprise a nationwide network. Coverage may vary by geographic region. We aim to supplement missing information through EHR integration and/or collection of patient information directly from patients or practices.



CARE MANAGEMENT PROGRAMMING FOR ACO PROVIDERS AND PATIENTS

Dear Astrana Health ACO Provider,

We are excited to share with you our dedicated Care Management (CM) Team at Astrana Health, designed to optimize your clinical experience and alleviate challenges associated with complex patient care. Our interdisciplinary CM Team of Doctors, Nurses, Social Workers, & Care Coordinators are committed to providing invaluable support to both your practice and beneficiaries under your care.

Our CM Team strives to offer the following services:

Transition of Care

- Within 72H of discharge, our CM team will call your patient directly to facilitate a smooth transition from hospital/SNF to home – ensuring they understand their discharge instructions, medications, and follow-up appointments.*
- Automated fax notifications of patient admissions and discharges to ensure your office is immediately informed of a patient's hospitalization or discharge.
- Automated text alerts for patients discharging from the ER – offering CM contact info and reminders for follow-up appointments, reinforcing a continuous support system for the patient.*

High-Intensity Care Management

- A dedicated Complex Care Manager that works closely with high-utilization patients to coordinate all aspects of their care to prevent unnecessary ER visits and readmissions.
 - Develop comprehensive, tailored care plans that address the patient's specific medical, social, and behavioral health needs, focusing on stabilization and long-term management.
 - Help patients access needed resources, such as transportation, while advocating for them in the healthcare system to improve engagement and reduce reliance on emergency services.

Disease Management

- Provides patients with individualized education/care coordination on managing **CHF**, **COPD**, and **ESRD/CKD** – focusing on symptom monitoring, medication adherence, and lifestyle modifications like diet and exercise.
- Frequent check-ins to track the patient's well-being, allowing for early identification of exacerbations or deterioration in condition. May include remote patient monitoring (RPM) for eligible patients, enabling daily tracking of key health indicators and early detection of potential complications.
- Ensure regular communication between you, the specialists, and other care team stakeholders

Continued on reverse side

* Subject to availability of patient contact information through Admissions, Discharges, and Transfers (ADT) feed networks. Astrana Health is contracted with several ADT vendors that comprise a nationwide network. Coverage may vary by geographic region. We aim to supplement missing information through EHR integration and/or collection of patient information directly from patients or practices.



Our goal at Astrana Health is to foster mutually beneficial health outcomes through implementing care programs and allocating additional services to help support you and your patients. Our CM Team members may occasionally reach out to your office to help facilitate an optimal level of care for your patient's post-discharge, including assisting in timely appointment scheduling, notifying you when we are unable to connect with your patient, and verifying patient contact information for prompt post-discharge outreach.

We look forward to working with you, our valued Primary Care Participant Provider, towards a common goal of better health outcomes for your patients.

If you have any questions, please feel free to contact us at the number and email listed below.

Sincerely,

Astrana Health – Care Management Team

(T) (626) 876-2191 | **(F)** (626) 226-1620 | **(E)** ACO.IPReferrals@astranahealth.com

** Subject to availability of patient contact information through Admissions, Discharges, and Transfers (ADT) feed networks. Astrana Health is contracted with several ADT vendors that comprise a nationwide network. Coverage may vary by geographic region. We aim to supplement missing information through EHR integration and/or collection of patient information directly from patients or practices.*



Care Coordination Responsibilities

ACOs and Care Coordination Responsibilities

ACOs enable more cohesive care coordination, as CMS provides the ACO with **visibility into nearly ALL Medicare claims* for aligned beneficiaries** throughout the entire healthcare system, which our ACO uses to extract insights and partner with clinicians to better coordinate care.

Key Responsibilities:

(1) Collaboration and Communication

- ◆ Active provider engagement with Care Management programs is essential to achieving ACO quality goals and ensuring comprehensive, patient-centered care.
- ◆ Providers are required to work closely with the ACO and Care Management (CM) teams to facilitate seamless communication and coordinated care. This collaboration includes:
 - **Responding promptly to CM requests and initiatives**, including outreach coordination and follow-up activities.
 - **Proactively collaborating with CM staff** to support high-risk or recently discharged patients.
 - Accommodating expedited or more frequent visits when clinically appropriate.
 - **Ensuring post-discharge visits occur** within Medicare regulatory timeframes to promote safe transitions of care.
 - Partnering with front office staff to **verify and update patient contact information**, ensuring CM teams can reach patients effectively.
 - Sharing patient health information to support care transitions, monitor outcomes, and identify potential care gaps.

(2) Access to Data

- ◆ To enable effective coordination, the ACO may need to request access to relevant patient medical records and supporting documentation.
- ◆ **Providers and their staff are expected to cooperate fully in sharing necessary data with the ACO and CM teams** to support comprehensive care planning, reporting, and quality improvement efforts.

**Exclusions apply for beneficiaries who elect to decline data sharing or for services related to the diagnosis and treatment of substance use disorder (SUD).*



Sample Hospital Discharge Notification



Hospital Discharge Notification

Date: XX/XX/2026

TO: Dr. PCP NAME

RE: PATIENT NAME (DOB: XX/XX/19XX)

PATIENT PHONE: XXX-XXX-XXXX

PATIENT ADDRESS:

Dear Dr. PCP NAME

Your member, PATIENT NAME, was admitted to FACILITY NAME on XX/XX/2026 and discharged on XX/XX/2026. According to the hospital, your member was admitted for DIAGNOSIS.

For continuation of care purposes, member will be instructed to follow up with his/her primary care provider within 2 weeks of discharge.

- **Member Name:** PATIENT NAME
- **Hospital Name:** FACILITY NAME
- **Admit Type:**
- **Admitted Date:** XX/XX/2026
- **Discharge Date:** XX/XX/2026
- **Discharge Disposition:** HOME – ROUTINE DISCHARGE
- **Reason:** DIAGNOSIS

We encourage your office to get in contact with the hospital for a copy of the member's history and physical, discharge summary, and/or specialty test report.

Thank you for your time and attention.

Sincerely,

Astrana Health / ACO Care Management Team

TEL: 626-282-0288

FAX: 626-226-1620

PRIVACY NOTICE:

This message is intended only for use of the individual or entity to which it is addressed and may contain information that is privileged, confidential or exempt from disclosure under applicable Federal or State law. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. If you do not receive all pages in this transmission, please call our office at (877) 476-7066.

 Astrana Health

Astrana's Care Management Team

Meet the Care Management Team at Astrana Health



Dr. George Christides, MD, MBA
Sr. Medical Director, Population Health



Natasha Reyes, LVN
Manager, Care Management



Mitch Agorrilla, RN, MSN, MBA
Sr. Director of Health Services



Jantinee Hicks, RN MSN
Manager, Care Management

In his role as Sr. Medical Director at Astrana Health, **Dr. George Christides** supports high risk-programs, care management and utilization outcomes. He has over 20 years of healthcare leadership experience. Dr. Christides received his medical degree from the Pennsylvania State University College of Medicine and completed his residency in internal medicine at LA County/USC Medical Center. He also holds an MBA from West Texas A & M University.

Mitch Agorrilla has been a dedicated leader at Astrana Health since 2015, bringing extensive experience as a registered nurse working across diverse patient populations. As the Sr. Director of Health Services, he oversees population health care management, ensuring high-quality, patient-centered care for the patients Astrana serves. Mitch obtained his MSN & MBA from Benedictine University and holds a Bachelor's degree from Cal State Fullerton.

Natasha Reyes has been a Licensed Vocational Nurse since 2015 and joined Astrana Health in 2018. She has been a leader for the Ambulatory Care Management team since 2019 and is passionate about improving population health through care coordination and multidisciplinary collaboration.

Jantinee Hicks is an accomplished nursing professional with 15 years of diverse clinical experience spanning intensive care, telemetry, medical-surgical, and pediatric settings. Jantinee holds a BSN from Bowie State University and a Master's in Nursing Education from Grand Canyon University. Over the past 11 years, she has excelled as a case manager, demonstrating a strong ability to coordinate patient care and drive outcomes. Currently serving as Clinical Nurse Manager, she leads and mentors nursing teams, fostering professional growth while ensuring the delivery of high-quality, patient-centered care. She is passionate about advancing nursing practice and empowering her team.

Meet the Care Management Team at Astrana Health



Heather Hartman, RN
Manager, Care Management



Obiageri (Oby) Adejo, RN
Manager, Care Management



Irene Orellana, CMA
Supervisor, Transitions of Care



Plus their teams, composed of dozens of Care Managers, Community Health Workers, Social Workers, and Care Coordinators

Heather Hartman has been a Registered Nurse since 2004, with a diverse background in behavioral health, home health, and skilled nursing. In 2021, she transitioned her focus to population health management and, in 2024, joined the Clinical Management team at Astrana Health. In her current role, Heather oversees a clinical team across the Northeast region, with a focus on complex care management and transitions of care. Her work centers on reducing utilization and optimizing healthy outcomes through proactive, patient-centered care.

Oby Adejo has been a registered nurse for over 18 years. She earned her RN certification at Lakeview College of Nursing. During her career, she has worked in a variety of healthcare settings, including hospitals, long term care, and home health care. She is known for ensuring her patients receive the highest level of care and is passionate about providing quality care while remaining mindful of her patients' individual needs. Over the past 8 years, she has transitioned to a clinical management role. She focuses on creating and improving healthcare systems, policies, and processes and working with a team that puts the patient's needs first and ensures they are receiving the best care possible.

Irene Orellana began her healthcare career as a Certified Medical Assistant and has experience in both front and back-end medical office operations. In 2022, she transitioned to care coordination. Since joining Astrana Health in 2023, she oversees care coordinators who support patients post-discharge and has played a key role in developing processes to enhance patient care and ensure quality outreach efforts.



Section 4

Provider Portal

Contents

Provider Portal Overview

Provider Portal User Guide

Astrana's Provider Portal

The Astrana Health Provider Portal is a platform designed to enable your practice to more easily manage your entire patient panel that is aligned through Astrana products (HMO/Medicare Advantage and ACO).

The Provider Portal will provide your practice with HCC and Quality gaps for your aligned patient panel and make the process of tracking of AWWs more seamless.

The User Guide contained on the following pages will serve as your reference to the features currently available for ACO patient data.

Please note: We regularly enhance the features available in the Provider Portal and will update the User Guide as these features become available.

Astrana Provider Portal Navigation Guide

↕ Astrana Health

The single platform to simplify practice management and care coordination



Practice-Level Dashboards

Provides at-a-glance views of panel health, new/termed members, and key performance indicators for quality and risk.



Centralized Worklists

Unified lists for tracking the status of all prior authorizations and claims, allowing staff to manage workflows efficiently.



Annual Visit & Care Gap Worklists


Smart lists that help staff schedule patients for wellness visits and close care gaps—even when the patient isn't in the office.


Provider Portal

Email

Password [Forgot password?](#)

[Need login assistance?](#)

 [Provider Portal Help Center](#)

 [Check Claim Status](#)

 [Authorization Forms](#)

[Notice of Privacy Practices](#)

[Notice of Non-Discrimination](#)

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Build: 20251001.3

Go to <https://provider-portal.astranahealth.com/login> and log in with your username and password.

AV Chase List Quality Gap Performance

1 Click "Select Providers" to find your practice/group



Find by patient name Line of Business Medicare ACO Provider **Select Providers** Measure Year 2025 PAF submission required

2 Click on your practice's name under "Medical Groups" to view all participating providers under the TIN



Medical Groups

- [Redacted]
- [Redacted]
- [Redacted]
- ✓ ERIC [Redacted]
- [Redacted]
- [Redacted]
- [Redacted]
- [Redacted]

Providers

Search Providers ...

Select All

ERIC [Redacted]

NICHOLAS [Redacted]

MARY [Redacted]

No providers selected Cancel Apply Filter

AV Chase List Quality Gap Performance

Find by patient name Line of Business Medicare ACO Provider 1 provider selected Measure Year 2025 PAF submission required

Medical Groups

- ERIC

Providers

Search Providers ...

Select All

- ✓ ERIC
- NICHOLAS
- MARY

1 provider selected Deselect all Cancel Apply Filter

1 You may select one or more provider names listed to view the beneficiaries aligned under the provider(s)

2 Click "Apply Filter" to view the list of beneficiaries aligned under the provider(s)

Quality & Risk

AV Chase List Quality Gap Performance

1 You can filter the results by current Annual Wellness Visit (AWV) completion statuses with these options. Based on the criteria selected in this section, the search results will display below.

2 Results can be exported to PDF or Excel for easy viewing

3 You can search for a specific patient using the search tool here

Find by patient name Line of Business Medicare ACO Provider 1 provider selected Measure Year 2025 PAF submission required

Viewing 188 patients for provider ERIC X Reset Filters

Export Lists (PDF) Export List (Excel)

All (188) Need Scheduling (171) Scheduled (0) Visit Done (0) Confirmed Complete (17) Cannot Complete (0)

Table with columns: Patient, PCP, AV Due Date, HCCs & Quality Gaps, Print PAF, Mark Visit Scheduled, Mark Visit Done, Submit PAF, Cannot Complete. Contains 7 rows of patient data.

4 Each patient's name, birthdate and gender will be listed here

- Feedback Help Center Contact Us Report Issues

Quality & Risk

AV Chase List Quality Gap Performance

Find by patient name Line of Business Medicare ACO Provider 1 provider selected Measure Year 2025 PAF submission required

Viewing 188 patients for provider ERIC X Reset Filters

Export Lists (PDF) Export List (Excel)

All (188) Need Scheduling (171) Scheduled (0) Visit Done (0) Confirmed Complete (17) Cannot Complete (0)

<input type="checkbox"/>	Patient	PCP	AV Due Date	HCCs & Quality Gaps ● Closed ● Pending ● Open	Print PAF	Mark Visit Scheduled	Mark Visit Done	Submit PAF	Cannot Complete
<input type="checkbox"/>	[Redacted]	Eric [Redacted]	By Dec 1, 2025 6 months since last AV	HCCs ●● Quality Gaps ●●●●●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	
<input type="checkbox"/>	[Redacted] LOB: Medicare ACO	Eric [Redacted]	By Dec 1, 2025 6 months since last AV	HCCs ●● Quality Gaps ●●●●●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	
<input type="checkbox"/>	[Redacted] LOB: Medicare ACO	Eric [Redacted]	By Jan 1, 2025 No previous AVs found	HCCs ● Quality Gaps ●●●●●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	
<input type="checkbox"/>	[Redacted] LOB: Medicare ACO	Eric [Redacted]	By Aug 1, 2025 10 months since last AV	HCCs ●●●●● Quality Gaps ●●●●●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	
<input type="checkbox"/>	[Redacted] LOB: Medicare ACO	Eric [Redacted]	By Nov 1, 2025 7 months since last AV	HCCs ●● Quality Gaps ●●●●●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	
<input type="checkbox"/>	[Redacted] LOB: Medicare ACO	Eric [Redacted]	By Jul 1, 2025 11 months since last AV	No HCCs Quality Gaps ●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	

AWV eligibility date and history of last visit can be found here

of open HCCs and Quality Gaps can be found here

- Feedback
- Help Center
- Contact Us
- Report Issues

Patient	PCP	AV Due Date	HCCs & Quality Gaps	Print PAF	Mark Visit Scheduled	Mark Visit Done	Submit PAF	Cannot Complete
<input type="checkbox"/> [Redacted] LOB: Medicare ACO	Eric [Redacted]	By Dec 1, 2025 6 months since last AV	No HCCs Quality Gaps ●●●●●		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	 Required	<input type="checkbox"/>
Updated by [Redacted] on 06/10/2025								
<input type="checkbox"/> [Redacted] LOB: Medicare ACO	Eric [Redacted]	By Dec 1, 2025 6 months since last AV	HCCs ●●●●● Quality Gaps ●●●●●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	<input type="checkbox"/>
<input type="checkbox"/> [Redacted] LOB: Medicare ACO	Eric [Redacted]	By Jan 1, 2025 No previous AVs found	HCCs ●●●●● Quality Gaps ●●●●●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	<input type="checkbox"/>
<input type="checkbox"/> [Redacted] LOB: Medicare ACO	Eric [Redacted]	By Aug 1, 2025 10 months since last AV	HCCs ●●●●● Quality Gaps ●●●●●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	<input type="checkbox"/>
<input type="checkbox"/> [Redacted] LOB: Medicare ACO	Eric [Redacted]	By Nov 1, 2025 7 months since last AV	HCCs ●●●●● Quality Gaps ●●●●●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	<input type="checkbox"/>
<input type="checkbox"/> [Redacted] LOB: Medicare ACO	Eric [Redacted]	By Jul 1, 2025 11 months since last AV	HCCs ●●●●● Quality Gaps ●●●●●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	<input type="checkbox"/>

For documenting AAVs, you can **use the “Mark Visit Scheduled” or “Mark Visit Done” buttons to indicate whether the visit was scheduled or completed.** The corresponding box will be marked with a green check mark, and a note will show the name of the user and date the update was made.

Once we receive and process the corresponding claim, that will be stated in the note as confirmation.

Visit for [Redacted] marked as Done

A temporary confirmation window will appear here.

Patient	PCP	AV Due Date	HCCs & Quality Gaps	Print PAF	Mark Visit Scheduled	Mark Visit Done	Submit PAF	Cannot Complete
<input type="checkbox"/> [Redacted] LOB: Medicare ACO	Eric [Redacted]	By Dec 1, 2025 6 months since last AV	HCCs ●●●●● Quality Gaps ●●●●●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	<input type="checkbox"/>
<input type="checkbox"/> [Redacted] LOB: Medicare ACO	Eric [Redacted]	By Dec 1, 2025 6 months since last AV	HCCs ●●●●● Quality Gaps ●●●●●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	<input type="checkbox"/>
<input type="checkbox"/> [Redacted] LOB: Medicare ACO	Eric [Redacted]	By Jan 1, 2025 No previous AVs found	HCCs ●●●●● Quality Gaps ●●●●●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	<input type="checkbox"/>
<input type="checkbox"/> [Redacted] LOB: Medicare ACO	Eric [Redacted]	By Aug 1, 2025 10 months since last AV	HCCs ●●●●● Quality Gaps ●●●●●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	<input type="checkbox"/>
<input type="checkbox"/> [Redacted] LOB: Medicare ACO	Eric [Redacted]	By Nov 1, 2025 7 months since last AV	HCCs ●●●●● Quality Gaps ●●●●●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	<input type="checkbox"/>
<input type="checkbox"/> [Redacted] LOB: Medicare ACO	Eric [Redacted]	By Jul 1, 2025 11 months since last AV	No HCCs Quality Gaps ●●●●●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	<input type="checkbox"/>

- Patient refused
- Patient deceased or terminated
- Unable to schedule
- Other

If an AAV cannot be completed, please use the “Cannot Complete” button and select one of the following reasons that apply:

- Patient refused
- Patient deceased or terminated
- Unable to schedule
- Other (with a free-text input option)

<input type="checkbox"/> Patient	PCP	AV Due Date	HCCs & Quality Gaps	Print PAF	Mark Visit Scheduled	Mark Visit Done	Submit PAF	Cannot Complete
<input type="checkbox"/> [Redacted] LOB: Medicare ACO	Eric [Redacted]	By Dec 1, 2025 6 months since last AV	HCCs ●● Quality Gaps ●●●●●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	
<input type="checkbox"/> [Redacted] LOB: Medicare ACO	Eric [Redacted]	By Dec 1, 2025 6 months since last AV	HCCs ●● Quality Gaps ●●●●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	
<input type="checkbox"/> [Redacted] LOB: Medicare ACO	Eric [Redacted]	By Jan 1, 2025 No previous AVs found	HCCs ● Quality Gaps ●●●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	
<input type="checkbox"/> [Redacted] LOB: Medicare ACO	Eric [Redacted]	By Aug 1, 2025 10 months since last AV	HCCs ●●●● Quality Gaps ●●●●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	
<input type="checkbox"/> [Redacted] LOB: Medicare ACO	Eric [Redacted]	By Nov 1, 2025 7 months since last AV	HCCs ●● Quality Gaps ●●●●●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	
<input type="checkbox"/> [Redacted] LOB: Medicare ACO	Eric [Redacted]	By Jul 1, 2025 11 months since last AV	No HCCs Quality Gaps ●	 	<input type="checkbox"/>	<input type="checkbox"/>	 Required	

You can access a beneficiary's Patient Assessment Form (PAF) by clicking on the corresponding "Print PAF" button shown above. A new window will pop up as shown on the next page.



The PAF is an important tool that concisely summarizes open HCC and Quality Gaps in one place, helping ensure closure of all gaps for the patient. Please complete a PAF for all ACO beneficiaries to ensure we are delivering comprehensive preventative care and accurately capture of the patient's risk profile, improving the accuracy of the benchmark set by CMS.

Patient Assessment Forms provide information on a patient's AWW status, historical & suspected health conditions, and quality gaps. You can use the information displayed to address any open items during an Annual Wellness visit or routine office visit throughout the performance year.

Print Preview

Any changes you've made to the digital PAF won't appear on the printed version until we've received and processed a claim for the annual visit.

Patient Assessment Form 1 / 2 100%

Patient Assessment Form – printed on 2025-06-10 Astra Health

(M) ██████████, 5, IPA: D0215, Phone: Unknown, Member ID: 6 ██████████

PCP: ERIC ██████████
Plan: APA ACO Inc.
Address: ██████████

Annual Visit Status: Incomplete
Last Annual Visit: G0439 on 2024-12-19 by ERIC ██████████

Historical & Suspect Conditions
Not yet assessed (7)

Assess the conditions below. If a condition is present, mark it as accepted. Document the condition and include the ICD10 codes on your claim.

Chronic Kidney Disease, Moderate (Stage 3, Except 3B)	Prior Diagnoses N1830 - Chronic kidney disease, stage 3 unspecified 5 supporting claims ERIC ██████████ M.D on 2024-05-07	<input type="checkbox"/> Accept condition <input type="checkbox"/> Condition has resolved <input type="checkbox"/> Condition is incorrect <input type="checkbox"/> Did not assess
Coma, Brain Compression/Anoxic Damage	Prior Diagnoses G935 - Compression of brain 1 supporting claim ERIC ██████████ M.D on 2023-01-03	<input type="checkbox"/> Accept condition <input type="checkbox"/> Condition has resolved <input type="checkbox"/> Condition is incorrect <input type="checkbox"/> Did not assess
Dementia, Mild or Unspecified	Prior Diagnoses G911 - Obstructive hydrocephalus 1 supporting claim ERIC ██████████ M.D on 2023-01-03	<input type="checkbox"/> Accept condition <input type="checkbox"/> Condition has resolved <input type="checkbox"/> Condition is incorrect <input type="checkbox"/> Did not assess
Diabetes with Chronic Complications	Prior Diagnoses E1169 - Type 2 diabetes mellitus with other specified complication 5 supporting claims ERIC ██████████ M.D on 2024-05-07	<input type="checkbox"/> Accept condition <input type="checkbox"/> Condition has resolved <input type="checkbox"/> Condition is incorrect <input type="checkbox"/> Did not assess
Heart Failure, Except End-Stage and Acute	Prior Diagnoses I5022 - Chronic systolic (congestive) heart failure 1 supporting claim ERIC ██████████ M.D on 2024-05-07 I509 - Heart failure, unspecified 1 supporting claim ERIC ██████████ M.D on 2023-09-26	<input type="checkbox"/> Accept condition <input type="checkbox"/> Condition has resolved <input type="checkbox"/> Condition is incorrect <input type="checkbox"/> Did not assess

Print Preview

Any changes you've made to the digital PAF won't appear on the printed version until we've received and processed a claim for the annual visit.

Patient Assessment Form 2 / 2 100%

Quality gaps
Not yet assessed (3)

Address open quality gaps below. If a measure was completed, refer to the instructions for documentation and coding in your visit note.

Measure	Details	Status
Annual Wellness Visit	Patients who had an annual wellness visit during the measurement year. Actions: Complete an AWW and bill G0402, G0438, or G0439	<input type="checkbox"/> Completed <input type="checkbox"/> Scheduled/Referred <input type="checkbox"/> Could not complete <input type="checkbox"/> Patient exclusion
Controlling High Blood Pressure	Patients 18-85 years of age with hypertension whose most recent blood pressure was adequately controlled (<140/90 mmHg). Actions: For Systolic, use G8752 (BP <140 mmHg) or G8753 (BP > or = 140 mmHg) and for Diastolic, use G8754 (BP <90 mmHg) and G8755 (BP > or = 90 mmHg)	<input type="checkbox"/> Completed <input type="checkbox"/> Scheduled/Referred <input type="checkbox"/> Could not complete <input type="checkbox"/> Patient exclusion
Screening for Depression and Follow-Up Plan	Patients aged 12+ screened for depression using an age-appropriate tool with a documented follow-up plan within 2 days if positive. Actions: To report result, use G8510 (Negative screen w/o follow up), G8431 (Positive screen w/ follow up plan), G8433 (Screen not completed), or G8511 (Screen positive w/o follow up)	<input type="checkbox"/> Completed <input type="checkbox"/> Scheduled/Referred <input type="checkbox"/> Could not complete <input type="checkbox"/> Patient exclusion

Completed quality gaps confirmed by claim (0)

<input type="checkbox"/> Patient	PCP	AV Due Date	HCCs & Quality Gaps ● Closed ● Pending ● Open	Print PAF	Mark Visit Scheduled	Mark Visit Done	Submit PAF	Cannot Complete
<input type="checkbox"/> [Redacted] LOB: Medicare ACO	Eric [Redacted]	By Dec 1, 2025 6 months since last AV	HCCs ●● Quality Gaps ●●●●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	
<input type="checkbox"/> [Redacted] LOB: Medicare ACO	Eric [Redacted]	By Dec 1, 2025 6 months since last AV	HCCs ●● Quality Gaps ●●●●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	
<input type="checkbox"/> [Redacted] LOB: Medicare ACO	Eric [Redacted]	By Jan 1, 2025 No previous AVs found	HCCs ● Quality Gaps ●●●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	
<input type="checkbox"/> [Redacted] LOB: Medicare ACO	Eric [Redacted]	By Aug 1, 2025 10 months since last AV	HCCs ●●●● Quality Gaps ●●●●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	
<input type="checkbox"/> [Redacted] LOB: Medicare ACO	Eric [Redacted]	By Nov 1, 2025 7 months since last AV	HCCs ●● Quality Gaps ●●●●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	
<input type="checkbox"/> [Redacted] LOB: Medicare ACO	Eric [Redacted]	By Jul 1, 2025 11 months since last AV	No HCCs Quality Gaps ●		<input type="checkbox"/>	<input type="checkbox"/>	 Required	

You also have the option to submit the Patient Assessment Form digitally, directly in the portal using the “Submit PAF” button above. A separate window will pop up as shown on the next page.



Submitting the PAF digitally along with associated clinical documentation allows Astrana’s Risk Adjustment team to review and identify opportunities for clinical documentation improvement. Your office may hear from a coding specialist throughout the year to discuss chart reviews for your ACO patients.

The form below matches the PAF that was used by the provider during the visit. With the paper form in front of you, copy your provider's selections for each condition and quality gap by selecting the corresponding radio buttons below.

Enter Date of Service (DOS) →

Date of Service *
MM/DD/YYYY

Review historical & suspected conditions →

Historical & Suspect Conditions		
Not yet assessed (7)		
Assess the conditions below. If a condition is present, mark it as accepted. Document the condition and include the ICD10 codes on your claim.		
Chronic Kidney Disease, Moderate (Stage 3, Except 3B)	Prior Diagnoses N1830 - Chronic kidney disease, stage 3 unspecified 5 supporting claims [Redacted] M.D on 2024-05-07	<input type="checkbox"/> Accept condition <input type="checkbox"/> Condition has resolved <input type="checkbox"/> Condition is incorrect <input type="checkbox"/> Did not assess
Coma, Brain Compression/Anoxic Damage	Prior Diagnoses G935 - Compression of brain 1 supporting claim [Redacted] M.D on 2023-01-03	<input type="checkbox"/> Accept condition <input type="checkbox"/> Condition has resolved <input type="checkbox"/> Condition is incorrect <input type="checkbox"/> Did not assess
Dementia, Mild or Unspecified	Prior Diagnoses G911 - Obstructive hydrocephalus 1 supporting claim [Redacted] M.D on 2023-01-03	<input type="checkbox"/> Accept condition <input type="checkbox"/> Condition has resolved <input type="checkbox"/> Condition is incorrect <input type="checkbox"/> Did not assess
Diabetes with Chronic Complications	Prior Diagnoses E1169 - Type 2 diabetes mellitus with other specified complication 5 supporting claims [Redacted] M.D on 2024-05-07	<input type="checkbox"/> Accept condition <input type="checkbox"/> Condition has resolved <input type="checkbox"/> Condition is incorrect <input type="checkbox"/> Did not assess
Heart Failure, Except End-Stage and Acute	Prior Diagnoses I5022 - Chronic systolic (congestive) heart failure 1 supporting claim [Redacted] M.D on 2024-05-07 I509 - Heart failure, unspecified 1 supporting claim	<input type="checkbox"/> Accept condition <input type="checkbox"/> Condition has resolved <input type="checkbox"/> Condition is incorrect <input type="checkbox"/> Did not assess

Close gaps by clicking on the applicable status →

Quality gaps

Not yet assessed (3)

Address open quality gaps below. If a measure was completed, refer to the instructions for documentation and coding in your visit note.

Measure	Details	Status
Annual Wellness Visit	Patients who had an annual wellness visit during the measurement year. Actions: Complete an AWV and bill G0402, G0438, or G0439	<input type="checkbox"/> Completed <input type="checkbox"/> Scheduled/Referred <input type="checkbox"/> Could not complete <input type="checkbox"/> Patient exclusion
Controlling High Blood Pressure	Patients 18-85 years of age with hypertension whose most recent blood pressure was adequately controlled (<140/90 mmHg). Actions: For Systolic, use G8752 (BP <140 mmHg) or G8753 (BP > or = 140 mmHg) and for Diastolic, use G8754 (BP <90 mmHg) and G8755 (BP > or = 90 mmHg)	<input type="checkbox"/> Completed <input type="checkbox"/> Scheduled/Referred <input type="checkbox"/> Could not complete <input type="checkbox"/> Patient exclusion
Screening for Depression and Follow-Up Plan	Patients aged 12+ screened for depression using an age-appropriate tool with a documented follow-up plan within 2 days if positive. Actions: To report result, use G8510 (Negative screen w/o follow up), G8431 (Positive screen w/ follow up plan), G8433 (Screen not completed), or G8511 (Screen positive w/o follow up)	<input type="checkbox"/> Completed <input type="checkbox"/> Scheduled/Referred <input type="checkbox"/> Could not complete <input type="checkbox"/> Patient exclusion

Completed quality gaps confirmed by claim (0)

Notes for Astrana Quality Team

Enter notes...

[Continue to Upload](#) →

Review preventive screenings and open quality gaps

Update gaps by clicking on the applicable status

Additional notes related to the visit can be included here

Before submitting, click here and you'll be prompted to upload the visit documentation on the next screen

(M) [redacted] IPA: ACO, Phone: N/A, Member I [redacted]

1 Complete PAF Form — 2 Upload Visit Note

Close Save Confirm & Submit

Please upload the visit documentation that corresponds to this PAF submission. You can drag and drop files directly or click to browse your computer.

Upload Documentation
Drag and drop files here, or click to select files
Select Files

You can drag and drop files or select them from your computer.

Once uploaded, you'll be able to click "Confirm & Submit" to complete the PAF submission.

If you're not ready to submit, you can click "Save" to store your progress. You can return to the same PAF at any time to complete and submit later.



Our Quality & Risk Adjustment team will review your submission and reach out periodically if they identify clinical documentation improvement opportunities.



Section 5

Compliance

Contents

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REACH CEHRT Requirements

Data Reporting Requirement



REACH Compliance Highlights

ACO REACH COMPLIANCE HIGHLIGHTS

APA ACO, Inc. maintains a comprehensive set of Compliance and Operational Policies & Procedures (P&Ps) designed to ensure adherence to the ACO REACH Model Participation Agreement and protect Medicare beneficiaries. You can access a copy of the Participation Agreement here: [CMS REACH PARTICIPATION AGREEMENT](https://www.wrgtraining.com/anonymous-reporting-tool/). (tinyurl.com/APAACO25PA) **While all providers are required to review and comply with the ACO's P&Ps, this page highlights specific items that may require your direct action.**



**Compliance Officer
Michelle Amador**

Michelle.Amador@astranahealth.com
714-683-2583

COMPLIANCE REPORTING & NON-RETALIATION



- **To make a Compliance Report, visit** <https://www.wrgtraining.com/anonymous-reporting-tool/>
- The Compliance Reporting Tool allows anyone (beneficiaries, staff, providers, etc.) to report issues of non-compliance, complaints, or concerns anonymously.
- **The ACO has a Non-Retaliation Policy** meaning that no individual can be retaliated against when making a report in good faith.

CLINICAL OPERATIONS



- **Notify the Compliance Officer immediately** if a Participant or Preferred Provider is on the OIG/GSA Exclusion List.
- **Complete the required Annual ACO Compliance Training.**
- **Use Certified Electronic Health Record Technology (CEHRT).**
- **Honor CMS Data Protections.** CMS prohibits you from sharing data received, even aggregate data, with anyone outside of the ACO. If you need to share CMS data, contact Compliance so we can obtain appropriate documentation.



- **Participate and cooperate in any evaluation activities** conducted by CMS and/or its designees. **Maintain all books and records for at least 10 years.**
- **Provide a staff roster of all clinical and non-clinical staff.** The roster must include their resident city and state, date of birth and their email addresses. This roster will be used to perform required OIG sanction checks and distribution of compliance training.

BENEFICIARY CARE, ENGAGEMENT, & INCENTIVES



- **Have the ACO Beneficiary Notification Letter available upon request.**
- Beneficiaries may opt-out of data sharing with the ACO (or reverse their decision) by calling 1-800-MEDICARE.
- Beneficiaries may align and designate a primary clinician online at Medicare.gov.



- **Do provide Beneficiaries with access** to their own medical records and maintain those records for at least 10 years.



- **Do not avoid treating at-risk Beneficiaries** or cherry-pick Beneficiaries based on risk or cost to the ACO.
- **Make medically necessary covered services available** to all Beneficiaries.
- **Do not provide anything of value** to Beneficiaries as inducements for care.

ACO REACH COMPLIANCE HIGHLIGHTS

- **Review and follow requirements** of applicable Benefit Enhancements and Beneficiary Engagement Incentives.

COMMUNICATIONS



- **Use CMS-approved and/or templated materials** provided by the ACO when communicating with Beneficiaries about the ACO, ACO initiatives, or Voluntary Alignment.

PUBLIC REPORTING REQUIREMENT FOR REACH ACOS



- **To comply with CMS regulations, APA ACO, Inc. is required to maintain a publicly accessible webpage dedicated to ACO REACH reporting.**
- This page must include specific organizational, financial, and performance information using the CMS Public Reporting Template.
- Updates must be made within 30 calendar days of any organizational changes or the release of CMS performance results.
- Additionally, a current list of ACO Participants and Preferred Providers must be posted and kept up to date at all times.
- APA ACO's public reporting website is available at: <https://www.apaaco.net/>



Beneficiary Notification Overview & Sample

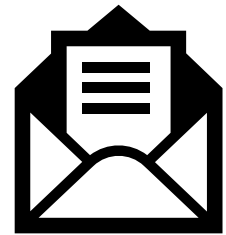
REACH BENEFICIARY NOTIFICATION SAMPLE



To comply with Section 5.05 of the ACO REACH Model Participation Agreement, **all REACH ACOs must distribute a beneficiary notification letter to aligned beneficiaries during each Performance Year (PY).** This requirement ensures beneficiaries are informed about their provider’s participation in the ACO REACH Model and their rights under Medicare.

BENEFICIARY NOTIFICATION REQUIREMENT OVERVIEW

CMS beneficiary notification requirements: As part of the ACO REACH Model requirements, APA ACO, Inc. will be mailing a **CMS-approved Beneficiary Notification Letter** to all Medicare beneficiaries aligned to the ACO during each Performance Year (PY). This letter is a formal communication that explains the ACO REACH Model, outlines beneficiary rights, and highlights the benefits of coordinated care.



What You Need to Know

- **Purpose of the Letter:** The notification informs beneficiaries that their provider is participating in the ACO REACH Model and explains how this may enhance their care experience. It emphasizes that beneficiaries retain full freedom to choose any Medicare provider.
- **Your Role:** While APA ACO will handle the mailing, each Participant Provider will receive a copy of the letter for reference. *You are not responsible for distributing the letter, but you should be familiar with its content in case patients have questions.*
- **Key Messages in the Letter:**
 - Participation in ACO REACH is designed to improve care coordination and patient outcomes.
 - Beneficiaries may receive enhanced services such as telehealth, home visits, and support with co-pays.
 - **Medicare rights remain unchanged—patients can still see any provider that accepts Medicare.**
 - Health information may be shared among care team members to improve safety and efficiency, but patients can opt out of data sharing.
- **Documentation:** APA ACO will retain records of mailing dates and methods to meet CMS compliance standards. No action is required from Participant Providers regarding documentation.

REACH BENEFICIARY NOTIFICATION SAMPLE

SAMPLE INITIAL NOTIFICATION

NOTIFICATION ONLY



-800-288-9931, TTY 711

Your Provider Is Working with APA ACO Inc to Enhance Your Care Through the Accountable Care Organization Realizing Equity, Access and Community Health (ACO REACH) Model

The ACO REACH Model is a pilot program designed to improve your health care experience and better meet your individual health needs. As part of this pilot program, you will receive greater support with your health care to help you better manage your conditions. You may have access to enhanced benefits, such as telehealth visits, home care after leaving the hospital, and help with co-pays. The goal of ACO REACH is for your health care providers—including primary and specialty care doctors, hospitals, and others—to work together to give you high-quality, coordinated care, improve health outcomes, and manage costs. Your Medicare rights are the same. You can continue to go to any provider, practice, or hospital you choose.

As part of APA ACO Inc, your provider may recommend a specialist for your specific health needs. Using a recommended specialist is your choice. You always have the right to go to any provider, practice, or hospital that accepts Medicare.

We're working together to provide coordinated care.

To provide you with better, safer, and more coordinated care, your health data may be shared between members of your health care team.

When everyone on your care team can see the same test results, treatments, and prescriptions, they can work together to support your health. More coordination helps prevent medical errors and drug interactions. You may save time, money, and frustration by avoiding repeated tests and appointments. Medicare protects the privacy of your health information. Your information is kept private by law. If you don't want Medicare to share information with your health care providers for care coordination, call 1-800-MEDICARE (1-800-633-4227). Medicare may still share general information to help evaluate the pilot program. For more information on how Medicare may use and give out your information, visit Medicare.gov and search for "privacy."

Want more information?

If you have questions about this letter or the expanded benefits, call us at 1-800-288-9931, TTY 711. You can also visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

To report a Medicare-related concern or complaint, call 1-800-MEDICARE (1-800-633-4227).

Learn more about Accountable Care Organizations here:



APA ACO Inc

CMS is authorized to collect your information under Section 3021 of the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152). The Privacy Act System of Records Notice associated with this collection is the Master Demonstration, Evaluation, and Research Studies (DERS) for the Office of Research, Development and Information (ORD), CMS System No. 09-70-0591, as amended, 72 Federal Register, 19705, Apr. 19, 2007. This statement provides the notice required by the Privacy Act of 1974 (5 U.S.C. § 552a(e)(3)).



Compliance Training Overview

ACO REACH COMPLIANCE TRAINING HIGHLIGHTS

As part of our commitment to regulatory compliance and high-quality care delivery, **APA ACO distributes annual compliance training for all Participant Providers and their staff engaged in our REACH models. Compliance Training is a CMS requirement and is subject to**

auditing. This training is in alignment with CMS regulations and supports our shared goals of integrity, transparency, and accountability.



ANNUAL COMPLIANCE TRAINING CONTENT AND DELIVERY FOR REACH ACOS

The annual compliance training will include the following core modules:

- ACO-Specific Compliance Overview
- Fraud, Waste, and Abuse (FWA)
- Health Insurance Portability and Accountability Act (HIPAA)



Training will be delivered via Litmos, our learning management system.

- **Credentials:** Learners who have not previously used Litmos will receive credentials and login instructions one week prior to launch.
- **Timeline:** Training will launch in Q1 2026, and learners will have 90 days from their assigned date to complete it.
- **Support:** For login issues (e.g., forgotten username or password), please contact provider.training@astranahealth.com.

COMPLIANCE MONITORING



- **CMS conducts routine audits** to ensure ACOs meet compliance training requirements.
- **Completion of annual training is mandatory and will be tracked.**
- **Non-compliance may result in corrective actions or impact participation status.**

PROVIDER RESPONSIBILITIES

To ensure timely and accurate training distribution, each provider organization must be prepared to:



- Submit a roster of all staff required to complete training to your provider representative.
- Include valid email addresses for each learner to facilitate Litmos credential delivery.
- Coordinate with your ACO provider representative to keep rosters updated and accurate.
- Have all staff complete the required compliance training by the due date.



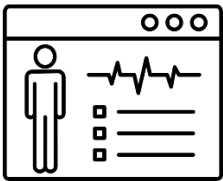
REACH CEHRT Requirements

CERTIFIED ELECTRONIC HEALTH RECORD TECHNOLOGY (CEHRT) REQUIREMENTS FOR ACO REACH PARTICIPANTS

To support care coordination, quality improvement, and data sharing, **the ACO REACH Model requires all participating providers to utilize Certified Electronic Health Record Technology (CEHRT).** This requirement aligns with CMS's broader goals of promoting interoperability and ensuring that providers have the tools necessary to deliver high-quality, patient-centered care.



KEY REQUIREMENTS FOR ACO PARTICIPANTS



- **CEHRT Adoption: All ACO Participants must actively use CEHRT in daily clinical operations** that meets the standards set by the Office of the National Coordinator for Health Information Technology (ONC). This includes technology certified under the ONC Health IT Certification Program.
- **Data Sharing and Interoperability:** CEHRT must support secure, electronic exchange of health information across care settings. ACO Participants are expected to share clinical and administrative data with the ACO and other providers involved in beneficiary care.
- **Compliance Monitoring:** CMS may audit CEHRT usage and data exchange capabilities as part of its oversight of ACO REACH Model participants. ACOs must ensure that all Participant Providers are compliant and capable of supporting model operations.

ACO PARTICIPANT RESPONSIBILITIES

- **Ensure that all providers within your organization are using CEHRT** that is currently certified under ONC standards.
- Maintain documentation of CEHRT capabilities and certification status.
- Cooperate with ACO leadership and CMS in any data validation or audit activities related to CEHRT use.

REQUIRED DOCUMENTATION

To verify CEHRT use, Astrana collects the name, vendor, version, and ONC of your CEHRT during onboarding and annually thereafter. If audited, ACO Participants may be required to submit one of the following to their provider representative:

- A screenshot demonstrating the CEHRT vendor / product / version in use
- ONC Certification ID (Certified Health IT Product List (CHPL) ID)
- Verification of active user status for each Participant Provider

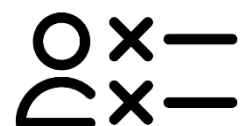


WHY THIS IS REQUIRED

CEHRT verification is a CMS requirement under the ACO REACH Model.

Failure to submit documentation may result in:

- **Removal from ACO participation**
- CMS compliance actions that may impact the ACO's standing and Shared Savings for all Participants



CERTIFIED ELECTRONIC HEALTH RECORD TECHNOLOGY (CEHRT) REQUIREMENTS FOR ACO REACH PARTICIPANTS

SUPPORT



Providers not currently using CEHRT **must disclose this to the ACO**. Astrana can assist with transition planning or access to partner CEHRT options at reduced licensing cost.



REACH Data Reporting Requirements

Data Reporting

Dear Provider,

As part of its mission address disparities in health care access and outcomes, **CMS is requesting that REACH ACOs and their participating providers collect Social Determinants of Health (SDoH) data aligned beneficiaries using one of the 3 approved screening tools listed below.** This will be an ongoing effort throughout the year.

For aligned beneficiaries for whom we have not received SDoH data, our ACO REACH team may email and/or mail the surveys on behalf of your practice later in the year.

The proportion of aligned population with SDoH collected (or attempted and declined) will directly impact the ACO's Quality Score for the Performance Year.

Please see the attached FAQs and feel free to reach out to your ACO representative if you have any questions.

Thank you again for your partnership.



Health Data Reporting Requirement for ACO REACH

There are 2 ways to report this data to the ACO:

1. Ongoing Paper Survey

We can provide you with surveys specifically associated with your clinic (NC tool). Once a beneficiary completes the survey, upload the form to: getmabel.com/uploadHEDR

2. Quarterly EHR Data Export

If your practice already collects this data in your EHR, using one of the 3 approved tools, you can provide us with an export.

CMS-Approved Survey Tools

Please help us complete this request from CMS by collecting SDoH using one of the following tools:

- 1. Standardized Screening for Health-Related Resource Needs in North Carolina.** The North Carolina Department of Health and Human Services (DHHS), in partnership with stakeholders from across NC, developed a standardized set of SDoH screening questions. Please note that at present, the NC screening tool only has associated Logical Observation Identifier Names and Codes (LOINC) for the ValueSet values (for example, “Yes” and “No” responses).
- 2. Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool.** The ACH HRSN screening tool was developed by CMS to use in the AHC Model. AHC provided support to community bridge organizations to test promising service delivery approaches aimed at linking beneficiaries with community services that may address their HRSN.
- 3. National Association of Community Health Centers’ (NACHC’s) Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) Screening Tool.** The PRAPARE tool was created by National Association of Community Health Centers (NACHC) and the Association of Asian Pacific Community Health Organizations (AAPCHO) for use across health care settings. It is a nationally validated assessment tool with the following core domains: personal characteristics, family and home, money and resources, and social and emotional health.

Frequently Asked Questions

What is the purpose of Data Reporting in the REACH model?

The purpose of the Data Reporting requirement is to help identify and address disparities in health outcomes, access to care, and quality of care among different populations. By collecting

and then analyzing data on disparities, healthcare organizations and providers can better understand the needs of the populations they serve and develop targeted interventions to improve health outcomes and reduce disparities.

Is completing the SDoH survey mandatory for patients?

No, patients are not required to complete the survey. If patients choose not to complete the survey, please record that the patient declined and note the date. This will count towards satisfying CMS's requirement to collect SDoH data, and is a meaningful response that should be documented.

What to do if a beneficiary declines to share SDoH responses?

REACH ACOs should not impose on beneficiaries any requirement to report such information. Beneficiaries have the freedom of choice to respond or not. However, REACH ACOs need to disclose if this choice was made. REACH ACOs that document and submit a beneficiary's choice not to disclose such data will receive credit for reporting that data.

If our practice is unable to collect SDoH data, what happens next?

Aligned beneficiaries from whom we do not receive SDoH data will receive a survey by email and/or mail so we can capture their responses and submit to CMS. These will be sent to aligned beneficiaries on behalf of your practice.

Will our practice have access to the survey data collected on our behalf?

Yes, any collected data we receive for patients who are aligned to your practice and complete the survey will be available for your practice to access so you can better manage their care.

What is the relationship between the newer Healthcare Common Procedure Coding System (HCPCS) code, G0136, and the ACO REACH Data Reporting Requirement?

Like other screenings, the goal of using a health-related social needs screening tool with all beneficiaries is to identify needs and have an opportunity to intervene/address those needs.

The goal of the G0136 SDOH Risk Assessment that was introduced in the CY 2024 Medicare Physician Fee Schedule final rule is to identify which HRSNs are posing or may pose issues in diagnosis, treatment, and management of a specific patient's health conditions where there is reason to believe that this may in fact be the case.

The HRSN screening tools that exist in ACO REACH meet the criteria for the SDOH assessment required for G0136, in that they are standardized, evidence-based tools that include questions about housing insecurity, food insecurity, transportation needs, and utility difficulties. It is therefore possible that administration of the screening tool for some beneficiaries could be part of meeting the criteria for billing G0136.

If the tool is administered in connection with a qualifying visit and the provider has reason to believe that an unmet need might interfere with or influence diagnosis, treatment, choice of

treatment, or plan of care for this beneficiary, then the completion of the HRSN screening tool by the beneficiary may satisfy requirements to bill G0136. Note that, except when billed in connection with an AWW, patient cost sharing will apply to G0136.



REACH Sample SDoH Form

Patient Name _____

Today's Date _____

Medicare Number _____

Patient DOB _____

Completing this health screening is voluntary. If you do not wish to participate, please check the box below to opt out.

I choose not to participate.

Scan the QR code to submit your responses online:

yesdoc.us/umy64912



We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all of your needs, but we will try and help as much as we can.

FOOD

YES

NO

1. Within the past 12 months, did you worry that your food would run out before you got money to buy more? YES NO

2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more? YES NO

HOUSING/UTILITIES

3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)? YES NO

4. Are you worried about losing your housing? YES NO

5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed? YES NO

TRANSPORTATION

6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living? YES NO

INTERPERSONAL SAFETY

7. Do you feel physically or emotionally unsafe where you currently live? YES NO

8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone? YES NO

9. Within the past 12 months, have you been humiliated or emotionally abused by anyone? YES NO

Please return this form to our practice or mail to:

