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Accountable Care Organization 2014 Program Analysis Quality Performance Standards Narrative Measure Specifications

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SECTION 1 INTRODUCTION

On November 2, 2011, the Centers for Medicare & Medicaid Services (CMS) finalized the Medicare Shared Savings Program (SSP), as authorized by the Patient Protection and Affordable Care Act (Affordable Care Act) to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). ACOs create incentives for health care providers to work together to treat an individual patient across care settings—including doctor’s offices, hospitals, and long-term care facilities.

ACOs are groups of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) that agree to work together to coordinate care for the Medicare Fee-For-Service patients they serve. The goal of an ACO is to deliver seamless, high-quality care for Medicare beneficiaries, instead of the fragmented care that often results from a Fee-For-Service payment system in which different providers receive different, disconnected payments. ACOs will be responsible for maintaining a patient-centered focus and developing processes to promote evidence-based medicine, promote patient engagement, internally and publicly report on quality and cost, and coordinate care.

CMS has two ACO initiatives: the Medicare Shared Savings Program (Shared Savings Program) and Pioneer ACO Model. Specific eligibility and other requirements may vary between the programs. More specific information is available at:

- Pioneer: <http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/>
- Shared Savings Program: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/>

This manual contains specific guidance for the 33 quality measures in the 2014 ACO quality standard. Only those measures defined in this document will be considered as part of the ACO’s quality performance for the 2014 performance year. This manual is being provided to allow ACOs an opportunity better understand each of the 33 quality measures being reported for the 2014 performance year.

1.1 ACO Quality Measures

Before an ACO can share in any savings created, it must demonstrate that it met the quality performance standard for that year. CMS will measure quality of care using 33 nationally recognized measures in four key domains:

- Patient/caregiver experience (7 measures)
- Care coordination/patient safety (6 measures)
- At-risk population (5 measures and 2 composites)
 - Diabetes (1 measure and 1 composite consisting of 5 measures)

- Hypertension (1 measure)
- Ischemic Vascular Disease (2 measures)
- Heart Failure (1 measure)
- Coronary Artery Disease (1 composite consisting of 2 measures)
- Preventive Care (8 measures)

The 33 quality measures will be reported through a combination of CMS claims and administrative data (4 measures), a database designed for practice- or ACO-level clinical quality measure reporting (22 measures), and a patient experience of care survey (7 measures). The database planned for use in the 2014 performance year for the Shared Savings Program is the Web Interface (WI), and for the Pioneer ACO model it is the Quality Measures Assessment Tool (QMAT).

Measures are provided at-a-glance in Table 1. For each measure, the table arranges measures by domain and provides 1) the ACO measure number, 2) the title of the measure, 3) the measure’s National Quality Forum (NQF) number, 4) the measure steward, and 5) the method of data submission. Note that for the diabetes-related measures, five of the six measures are grouped into one “all-or-nothing” composite performance rate. Similarly, the two coronary-artery disease measures are also grouped into one “all-or-nothing” composite rate for reporting purpose.

1.1.1 Patient Experience of Care Measures / Consumer Assessment of Healthcare Providers and Systems (CAHPS) for ACOs Survey

ACOs are responsible for selecting and paying for a CMS-approved vendor to administer the CAHPS for ACOs survey. The CAHPS for ACOs is based on the Clinician and Group (CG) CAHPS. Additional information about the CAHPS for ACOs survey can be found at <http://acocahps.cms.gov/Content/Default.aspx>

1.1.2 Claims-Based/Administrative Data Measures

For the claims-based measures, ACOs do not need to collect or submit data. The CMS ACO Program Analysis Contractor (ACO PAC) will coordinate with CMS to obtain the necessary Medicare claims files. The CMS ACO PAC will then calculate the rates for these measures for each ACO.

For the EHR measure, the CMS ACO PAC will calculate the measure using CMS claims and administrative data extracted from the National Level Repository. Given the potential lag in data (especially from the state Medicaid incentive programs), CMS encourages all eligible providers within the ACOs to successfully attest¹ to the EHR Meaningful Use program as early as possible.

¹ <https://ehrincentives.cms.gov/hitech/>

Table 1
Measures for use in establishing quality performance standards that ACOs must meet for shared savings

ACO #	Measure title	NQF #	Measure steward	Method of data submission
Domain: patient/caregiver experience				
ACO-1	CAHPS: Getting timely care, appointments, and information	0005	AHRQ	Survey
ACO-2	CAHPS: How well your providers communicate	0005	AHRQ	Survey
ACO-3	CAHPS: Patients' rating of provider	0005	AHRQ	Survey
ACO-4	CAHPS: Access to specialists	N/A	CMS	Survey
ACO-5	CAHPS: Health promotion and education	N/A	CMS	Survey
ACO-6	CAHPS: Shared decision making	N/A	CMS	Survey
ACO-7	CAHPS: Health status/functional status	N/A	CMS	Survey
Domain: care coordination/patient safety				
ACO-8	Risk standardized all condition readmission (new version to be released Spring 2014)	1789 (adapted)	CMS	Claims
ACO-9	Ambulatory Sensitive conditions admissions: chronic obstructive pulmonary disease (COPD) or asthma in older adults	0275	AHRQ	Claims
ACO-10	Ambulatory sensitive conditions admissions: heart failure (HF)	0277	AHRQ	Claims
ACO-11	Percent of primary care physicians who successfully qualify for an EHR program incentive payment	NA	CMS	Claims and EHR Incentive Program Reporting
CARE-1 (ACO-12)	Medication reconciliation	0097	AMA-PCPI/NCQA	QMAT/WI
CARE-2 (ACO-13)	Falls: screening for future fall risk	0101	AMA-PCPI/NCQA	QMAT/WI

(continued)

Table 1 (continued)
Measures for use in establishing quality performance standards that ACOs must meet for shared savings

ACO #	Measure title	NQF #	Measure steward	Method of data submission
Domain: preventive health				
PREV-5 (ACO-20)	Breast cancer screening	NA	NCQA	QMAT/WI
PREV-6 (ACO-19)	Colorectal cancer screening	0034	NCQA	QMAT/WI
PREV-7 (ACO-14)	Preventive care and screening: influenza immunization	0041	AMA/PCPI	QMAT/WI
PREV-8 (ACO-15)	Pneumonia vaccination status for older adults	0043	NCQA	QMAT/WI
PREV-9 (ACO-16)	Preventive care and screening: body mass index screening and follow-up	0421	QIP	QMAT/WI
PREV-10 (ACO-17)	Preventive care and screening: tobacco use: screening and cessation Intervention	0028	AMA/PCPI	QMAT/WI
PREV-11 (ACO-21)	Preventive care and screening: screening for high blood pressure and follow-up documented	NA	QIP	QMAT/WI
PREV-12 (ACO-18)	Preventive care and screening: screening for clinical depression and follow-up plan	0418	QIP	QMAT/WI
Domain: at-risk population				
Diabetes				
DM-2 (ACO-27)	Diabetes: hemoglobin A1c poor control	0059	NCQA	QMAT/WI
DM-13 through 17 (ACO-22 through 26)	Diabetes all-or-nothing composite: <ul style="list-style-type: none"> ▪ High blood pressure control ▪ Low density lipoprotein (LDL-C) control ▪ Hemoglobin A1c control (<8%) ▪ Daily aspirin or antiplatelet medication use for patients with diabetes and ischemic vascular disease ▪ Tobacco non-use 	0729	MCM	QMAT/WI
Hypertension				
HTN-2 (ACO-28)	Controlling high blood pressure	0018	NCQA	QMAT/WI

(continued)

Table 1 (continued)
Measures for use in establishing quality performance standards that ACOs must meet for shared savings

ACO #	Measure title	NQF #	Measure steward	Method of data submission
Ischemic vascular disease				
IVD-1 (ACO-29)	Ischemic vascular disease: complete lipid panel and LDL control	0075	NCQA	QMAT/WI
IVD-2 (ACO-30)	Ischemic vascular disease: use of aspirin of another antithrombotic	0068	NCQA	QMAT/WI
Heart failure				
HF-6 (ACO-31)	Heart failure: beta-blocker therapy for left ventricular systolic dysfunction	0083	AMA/PCPI/ ACC/ AHA/AMA	QMAT/WI
Coronary artery disease				
CAD-2 (ACO-32)	Coronary artery disease all-or-nothing composite: Lipid Control	0074	AMA/PCPI/ ACC/ AHA/AMA	QMAT/WI
CAD-7 (ACO-33)	Angiotensin-converting enzyme inhibitor or angiotensin receptor blocker therapy—diabetes of left ventricular systolic dysfunction	0066	AMA/PCPI/ ACC/ AHA/AMA	QMAT/WI

*AHRQ = Agency for Healthcare Research and Quality, ACC = American College of Cardiology, AHA = American Heart Association, AMA = American Medical Association, MCM = Minnesota Community Measurement, NCQA = National Committee on Quality Assurance, PCPI = Physician Consortium for Performance Improvement, QIP = Quality Insights of Pennsylvania.

1.1.3 Practice Reported Clinical Quality Measures

The method of data submission varies by ACO type. Pioneer ACOs will submit data using the Quality Measure Assessment Tool (QMAT), and Shared Savings Program ACO’s will use the Web Interface (WI). Note the QMAT is designed to align with electronic measure submission where possible. Every effort has been made to align both the QMAT and WI data submission tools and although data entry instructions may vary by tool, the clinical measure specifications and intentions are aligned for all 22 practice reported clinical quality measures.

In each method, a database pre-populated with select quality measure information for a sample of the ACO’s beneficiaries will serve as the data collection tool for collecting and submitting data to the CMS. The data collected will be based on services furnished during the January 1, 2014 through December 31, 2014 reporting period. For purposes of the 2014 performance year reporting, patient age is determined during the sampling process, and patients must meet each age criteria for measure by January 1 of the measurement period.

Groups of measures related to a single clinical condition are grouped together as follows: care, coronary artery disease, heart failure, hypertension, ischemic vascular disease, diabetes, and preventive care. Note that five of the six diabetes related measures are grouped into one “all-or-

nothing” composite performance rate. Similarly, the two coronary-artery disease measures are also grouped into one “all-or-nothing” composite performance rate.

Note that practice reported measures in the ACO initiative are aligned with the measure requirements for those practices who select the WI as a group practice reporting option (GPRO) for the Physician Quality Reporting System (PQRS) initiative. For the purposes of program coordination and version control, narrative descriptions for each of the 22 “GPRO WI” measures are not detailed in this document. Rather, a link to the GPRO Web Interface website is provided. Supplementary documents which provide additional guidance relative to the practice reported measures reporting can be found on the CMS 2014 GPRO Web Interface website, under the “2014 GPRO Web Interface Measures List, Narrative Measure Specifications, and Release Notes” link in: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html.

SECTION 2 NARRATIVE MEASURE SPECIFICATIONS

2.1 Domain: Patient/Caregiver Experience

2.1.1 Consumer Assessment of Health Care Providers and Systems for Accountable Care Organizations (CAHPS for ACOs)

Description

CMS finalized the use of the Clinician and Group Consumer Assessment of Health Care Providers and Systems (CG CAHPS) to develop a survey to measure patient experience of care received by ACOs. The CAHPS for ACOs survey includes core questions from version 2.0 CG CAHPS survey and supplemental items from sources including the CAHPS Patient-Centered Medical Home Survey, Core CAHPS Health Plan Survey Version 5.0, existing CAHPS supplemental items, and new content written for the CAHPS for ACOs survey. In addition the survey includes questions that collect information on English proficiency, disability, and self-reported race and ethnicity categories required by section 4302 of the Affordable Care Act.

- ACO-1: CAHPS for ACOs: Getting Timely Care, Appointments, and Information
- ACO-2: CAHPS for ACOs: How Well Your Providers Communicate
- ACO-3: CAHPS for ACOs: Patient Rating of Provider
- ACO-4: CAHPS for ACOs: Access to Specialist
- ACO-5: CAHPS for ACOs: Health Promotion and Education
- ACO-6: CAHPS for ACOs: Shared Decision Making
- ACO-7: CAHPS for ACOs: Health Status/Functional Status

Measure Information

For additional information regarding any of the above CAHPS measures and their use in the ACO program, please refer to the *CAHPS® Survey for Accountable Care Organizations Participating in Medicare Initiatives* website: <http://acocahps.cms.gov/Content/Default.aspx>

Guidance

ACOs are required to contract with a CMS-approved survey vendor to administer the survey.

The survey for the 2014 reporting period will be conducted in late 2014-early 2015. CMS has developed a process to approve independent survey vendors that will be capable of administering the patient experience of care survey in accord with the standardized sampling and survey administration procedures. A list of certified vendors is available on a website dedicated

to the ACO patient experience of care survey. New vendors may be added to the list annually after vendor training. This website also includes application instructions for survey vendors interested in applying for approval to administer the CAHPS for ACOs survey.

2.2 Domain: Care Coordination/Patient Safety

2.2.1 ACO 8: Risk Standardized All Condition Readmission

Description

Risk-adjusted percentage of Accountable Care Organization (ACO) assigned beneficiaries who were hospitalized and who were readmitted to a hospital within 30 days following discharge from the hospital for the index admission.

Initial Patient Population

ACO Assigned or Aligned Beneficiaries

Improvement Notation

Lower readmission rates are better. The measures information form (MIF) is updated annually is available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html.

Denominator

All hospitalizations not related to medical treatment of cancer, primary psychiatric disease, or rehabilitation care, fitting of prostheses, and adjustment devices for ACO assigned beneficiaries at non-Federal, short-stay acute-care or critical access hospitals, where the beneficiary was age 65 or older, was continuously enrolled in fee-for-service Medicare Part A for at least one month after discharge, was not discharged to another acute care hospital, was not discharged against medical advice, and was alive upon discharge and for 30 days post-discharge.

Denominator Exclusions

Excluded from the measure are all admissions for which full data are not available or for which 30-day readmission by itself cannot reasonably be considered a signal of quality of care.

Exclusions:

1. Admissions for patients without 30 days of post-discharge data
2. Admissions for patients lacking a complete enrollment history for the 12 months prior to admission
3. Admissions for patients to a PPS-exempt cancer hospital
4. Admissions for patients with medical treatment of cancer
5. Admissions for primary psychiatric disease

6. Admissions for rehabilitation care
7. Admissions for patients discharged against medical advice

Denominator Exceptions

Not applicable

Numerator

Risk-adjusted readmissions at a non-Federal, short-stay, acute-care or critical access hospital, within 30 days of discharge from the index admission included in the denominator, and excluding planned readmissions.

Numerator Exclusions

Not applicable

Definition(s)

None

Rationale

Readmission following an acute care hospitalization is a costly and often preventable event. During 2003 and 2004, almost one-fifth of Medicare beneficiaries—more than 2.3 million patients—were readmitted within 30 days of discharge (Jencks et al., 2009). A Commonwealth Fund report estimated that if national readmission rates were lowered to the levels achieved by the top performing regions, Medicare would save \$1.9 billion annually.

Hospital readmission is also disruptive to patients and caregivers, and puts patients at additional risk of hospital-acquired infections and complications (Horwitz et al., 2011). Some readmissions are unavoidable, but readmissions may also result from poor quality of care, inadequate coordination of care, or lack of effective discharge planning and transitional care.

Since studies have shown readmissions within 30 days to often be related to quality of care, coordination of care, or other factors within the control of health care providers, interventions have been able to reduce 30-day readmission rates for a variety of medical conditions, and high readmission rates and institutional variations in readmission rates indicate an opportunity for improvement, it is important to consider an all-condition 30-day readmission rate as a quality measure (Horwitz et al., 2011).

This ACO risk standardized all condition readmission quality measure is adapted from a hospital risk standardized all condition readmission quality measure developed for CMS by Yale (Horwitz et al., 2011).

Clinical Recommendation Statements

Randomized controlled trials have shown that improvement in health care can directly reduce readmission rates, including the following interventions: quality of care during the initial admission; improvement in communication with patients, caregivers and clinicians; patient

education; predischARGE assessment; and coordination of care after discharge (Naylor et al., 1994; 1999; Krumholz et al., 2002; van Walraven et al., 2002; Conley et al., 2003; Coleman et al., 2004; Phillips et al., 2004; Jovicic et al., 2006; Garasen et al., 2007; Mistiaen et al., 2007; Courtney et al., 2009; Jack et al., 2009; Koehler et al., 2009; Weiss et al., 2010; Stauffer et al., 2011; Voss et al., 2011). Successful randomized trials have reduced 30-day readmission rates by as much as 20-40% (Horwitz et al., 2011).

Widespread application of these clinical trial interventions to medical practice settings has also been encouraging (Horwitz et al., 2011). Since 2008, 14 Medicare Quality Improvement Organizations (QIOs) have been funded to focus on care transitions, implementing lessons learned from these clinical trials. Several of these interventions have been notably successful in reducing readmissions within 30 days (CFMC, 2010).

ACOs have incentives under the Shared Savings Program and Pioneer Model to manage the range of medical care, coordination of care, and other factors affecting readmission rates for their assigned beneficiaries. By taking responsibility for all aspects of the medical care of their assigned beneficiaries, ACOs will be able to assess the range of possible interventions affecting readmissions and then select the interventions appropriate for each population of patients included in among their assigned beneficiaries.

2.2.2 ACO 9: Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults

Description

All discharges with an ICD-9-CM principal diagnosis code for COPD or Asthma in adults ages 40 years and older, for ACO assigned or aligned Medicare fee-for-service (FFS) beneficiaries with COPD or Asthma, with risk-adjusted comparison of observed discharges to expected discharges for each ACO.² This is a ratio of observed to expected discharges.

Improvement Notation

Lower PQI scores are better. The measures information form (MIF) is updated annually and is available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html.

Initial Patient Population

ACO assigned or aligned Medicare beneficiaries

² For the purposes of the Medicare ACO initiatives, the following modifications were made to the original Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicator (PQI) version 4.4 technical specifications: 1) denominator changed from general population in a geographic area to Medicare FFS beneficiaries assigned or aligned to a Medicare ACO, including part-year beneficiaries; 2) denominator changed from patients of any disease status to beneficiaries with a diagnosis of COPD or Asthma; and 3) added a denominator exclusion for beneficiaries with ESRD. To verify that these modifications were valid, the following analyses were completed: 1) dry run testing; 2) validity testing; 3) reliability testing; 4) variability testing; and 5) exclusion testing.

Denominator

Expected discharges from an acute care hospital with a principal diagnosis of COPD or Asthma, for Medicare FFS beneficiaries assigned or aligned to an ACO, aged 40 years and older, with COPD or Asthma.

Denominator Exclusions

- Admissions that are transfers from a hospital, Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), or another health care facility
- Beneficiaries with a diagnosis of ESRD
- Beneficiaries not eligible for both Medicare Part A and Part B
- Beneficiaries with missing data for gender, age, or principal diagnosis

Denominator Exceptions

Not applicable

Numerator

Observed discharges from an acute care hospital with a principal diagnosis of Chronic Obstructive Pulmonary Disease or Asthma, for Medicare FFS beneficiaries in the denominator population for this measure.

Numerator Exclusions

The discharge is excluded from the numerator if the admission is associated with a diagnosis of Cystic fibrosis or anomalies of the respiratory system

Definition(s)

None

Rationale

Hospital admissions for COPD or asthma are a Prevention Quality Indicator (PQI) of interest to comprehensive health care delivery systems including ACOs. COPD or asthma can often be controlled in an outpatient setting. Evidence suggests that these hospital admissions could have been avoided through high quality outpatient care, or the condition would have been less severe if treated early and appropriately. Proper outpatient treatment and adherence to care may reduce the rate of occurrence for this event, and thus of hospital admissions.

Clinical Recommendation Statements

Bindman et al. (1995) reported that self-reported access to care explained 27 percent of the variation in COPD hospitalization rates at the ZIP code cluster level. Physician adherence to practice guidelines and patient compliance also influence the effectiveness of therapy. Practice guidelines for COPD have been developed and published over the last decade (Hackner, 1999).

With appropriate outpatient treatment and compliance, hospitalizations for the exacerbations of COPD and decline in lung function should be minimized.

Based on empirical results, areas with high rates of COPD admissions also tend to have high rates of other Ambulatory Sensitive Conditions Admissions (ASCAs). The signal ratio (i.e., the proportion of the total variation across areas that is truly related to systematic differences in area performance rather than random variation) is very high, at 93.4 percent, indicating that the differences in age-sex adjusted rates likely represent true differences across areas (AHRQ, 2007). Risk adjustment for age and sex appears to most affect the areas with the highest rates. As a PQI, admissions for COPD or Asthma are not a measure of hospital quality, but rather one measure of outpatient and other health care.

2.2.3 ACO 10: Ambulatory Sensitive Conditions Admissions: Heart Failure (HF)

Description

All discharges with an ICD-9-CM principal diagnosis code for HF in adults ages 18 years and older, for ACO assigned or aligned Medicare fee-for-service (FFS) beneficiaries with HF, with risk-adjusted comparison of observed discharges to expected discharges for each ACO.³ This is a ratio of observed to expected discharges.

Improvement Notation

Lower PQI scores are better. The measures information form (MIF) is updated annually and is available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html

Initial Patient Population

ACO Assigned or Aligned Beneficiaries

Denominator

Expected discharges from an acute care hospital with a principal diagnosis of HF, for Medicare FFS beneficiaries assigned or aligned to an ACO, aged 18 years and older, with HF.

Denominator Exclusions

- Admissions that are transfers from a hospital, Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), or another health care facility

³ For the purposes of the Medicare ACO initiatives, the following modifications were made to the original Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicator (PQI) version 4.4 technical specifications: 1) denominator changed from general population in a geographic area to Medicare FFS beneficiaries assigned or aligned to a Medicare ACO, including part-year beneficiaries; 2) denominator changed from patients of any disease status to beneficiaries with a diagnosis of HF; and 3) added a denominator exclusion for beneficiaries with ESRD. To verify that these modifications were valid, the following analyses were completed: 1) dry run testing; 2) validity testing; 3) reliability testing; 4) variability testing; and 5) exclusion testing.

- Beneficiaries with a diagnosis of ESRD
- Beneficiaries not eligible for both Medicare Part A and Part B
- Beneficiaries with missing data for gender, age, or principal diagnosis

Denominator Exceptions

Not applicable

Numerator

Observed discharges from an acute care hospital with a principal diagnosis of HF, for Medicare FFS beneficiaries in the denominator population for this measure.

Numerator Exclusions

The discharge is excluded from the numerator if a cardiac procedure was performed during the admission

Definition(s)

None

Rationale

Hospital admissions for HF are a Prevention Quality Indicator (PQI) of interest to comprehensive health care delivery systems, including ACOs. HF can often be controlled in an outpatient setting. Evidence suggests that these hospital admissions could have been avoided through high quality outpatient care, or the condition would have been less severe if treated early and appropriately. Proper outpatient treatment and adherence to care may reduce the rate of occurrence for this event, and thus of hospital admissions.

Outpatient interventions such as the use of protocols for ambulatory management of low-severity patients and improvement of access to outpatient care would most likely decrease inpatient admissions for HF. In addition, physician management of patients with HF differs significantly by physician specialty (Edep, 1997; Reis, 1997). Such differences in practice may be reflected in differences in HF admission rates.

Clinical Recommendation Statements

Based on empirical results, areas with high rates of HF admissions also tend to have high rates of other ASCAs. The signal ratio (i.e., the proportion of the total variation across areas that is truly related to systematic differences in area performance rather than random variation) is very high, at 93.0 percent, indicating that the observed differences in age-sex adjusted rates very likely represent true differences across areas (AHRQ, 2007). Risk adjustment for age and sex appears to most affect the areas with the highest rates. As a PQI, admissions for HF are not a measure of hospital quality, but rather one measure of outpatient and other health care.

This indicator was originally developed by Billings et al. in conjunction with the United Hospital Fund of New York. It was subsequently adopted by the Institute of Medicine and has been widely used in a variety of studies of avoidable hospitalizations (Bindman, 1995; Rosenthal, 1997).

2.2.4 ACO 11: Percent of Primary Care Physicians who Successfully Qualify for an EHR Program Incentive Payment

Description

Percentage of Accountable Care Organization (ACO) primary care physicians (PCPs) who successfully qualify for either a Medicare or Medicaid Electronic Health Record (EHR) Program incentive payment.

Improvement Notation

Higher percentage indicates better performance. The measures information form (MIF) is updated annually and is available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html.

Initial Patient Population

PCPs in Shared Savings Program and Pioneer Model ACOs

Denominator

All primary care physicians who are participating in an Accountable Care Organization in the reporting year under the Shared Savings Program or under the Medicare Pioneer ACO Model

Denominator Exclusions

- Entities (i.e., identified by TIN or CCN) that are not used for beneficiary assignment.
- Providers who did not bill any primary care services during the reporting year.
- Hospital-based physicians, as identified by CMS through Medicare claims, who are participating in a Shared Savings Program or Pioneer ACO model during the reporting year.
- Physicians solely from FQHCs or RHCs, as identified in the participant list.

Denominator Exceptions

None

Numerator

PCPs participating in an ACO and identified as included in the denominator for that ACO for this quality measure, who successfully qualify for either a Medicare or the Medicaid EHR Program incentive payment for the reporting period.

Numerator Exclusions

Not Applicable

Rationale

Health information technology has been shown to improve quality of care by increasing adherence to guidelines, supporting disease surveillance and monitoring, and decreasing medication errors through decision support and data aggregation capabilities (Chaudhry et al., 2007). According to a 2008 CBO study, in addition to enabling providers to deliver care more efficiently, there is a potential to gain both internal and external savings from widespread adoption of health IT (CBO, 2008).

The American Recovery and Reinvestment Act of 2009 (ARRA) provides incentive payments for Medicare and Medicaid providers who “adopt, implement, upgrade, or meaningfully use [MU] certified electronic health records (EHR) technology.” These incentives are intended to significantly improve health care processes and outcomes, and are part of the larger Health Information Technology for Economic and Clinical Health (HITECH) Act (Blumenthal and Tavenner, 2010). The goal of the HITECH act is to accelerate the adoption of HIT and utilization of qualified EHRs. The final rule for the electronic health records incentive program serves to establish guidelines for and implement the HITECH incentive payments for meaningful use (CMS, 2010).

Under the final rule for the electronic health records incentive program, eligibility criteria for the payment incentive differ somewhat between the Medicare and Medicaid programs. To qualify for Medicare EHR incentive payments, PCPs must successfully demonstrate meaningful use for each year of participation in the program. To qualify for Medicaid incentive payments, PCPs must adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology in the first year of participation, and successfully demonstrate meaningful use in subsequent participation years (CMS, 2010).

Clinical Recommendation Statements

Electronic data capture and information sharing is critical to good care coordination and high quality patient care. For the purposes of the Medicare and Medicaid EHR Incentive Programs, eligible professionals, eligible hospitals and critical access hospitals (CAHs) must use certified EHR technology. Certified EHR technology gives assurance to purchasers and other users that an EHR system or module offers the necessary technological capability, functionality, and security to help them meet the meaningful use (MU) criteria. Certification also helps providers and patients be confident that the electronic health IT products and systems they use are secure, can maintain data confidentially, and can work with other systems to share information.

The American Health Information Management Associations (AHIMA) states that “the most critical element of meaningful use is widespread adoption of standards-based certified EHRs.” AHIMA identifies 5 key measurements of MU. It states that the use of Health Information Technology (HIT) should:

- Reflect the end goals (AHIMA states the goal of HIT is achieving improvements in quality, cost, and health system performance.)
- Be incremental
- Leverage the standards, certification, and information exchange progress of recent years
- Be auditable
- Be relevant to consumers

The ARRA specifies three main components of MU (CMS, 2010):

- The use of a certified EHR in a meaningful manner, such as e-prescribing.
- The use of certified EHR technology for electronic exchange of health information to improve quality of health care.
- The use of certified EHR technology to submit clinical quality and other measures.

The CMS criteria for MU will be developed in three stages. Stage 1 set the baseline for electronic data capture and information sharing. Stage 2 expands on the baseline established in Stage 1. Stage 3 will be developed through future rule making.

2.2.5 Care Coordination and Patient Safety Practice Reported Measures

The remaining measures within this domain are WI measures. As noted above, for the purposes of program coordination and version control, narrative descriptions for each of the 22 WI measures are not detailed in this document. These measures do not have ACO numbers, and are instead listed with their GPRO WI number. For additional information regarding any of the following measures:

- CARE-1: Medication Reconciliation
- CARE-2: Falls: Screening for Future Fall Risk

Please refer to the following documents, available under the “2014 GPRO Web Interface Measures List, Narrative Measure Specifications, and Release Notes” link at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html:

- The 2014 Group Practice Reporting Option (GPRO) Web Interface Disease Modules, Care Coordination/Patient Safety and Preventive Care Measures List document which consists of the (22) 2014 GPRO Web Interface GPRO reporting method measures.

- The 2014 Group Practice Reporting Option (GPRO) Web Interface Narrative Measure Specifications which provides a description of each of the 22 measures.
- The 2014 GPRO Web Interface Narrative Specification Release Notes which provides a list of changes to existing measures made since the release of the 2013 GPRO Narrative Measure Specifications, Version 4.1.

2.3 Domain: At-Risk Population

All measures within this domain are WI measures. As noted above, for the purposes of program coordination and version control, narrative descriptions for each of the 22 WI measures are not detailed in this document. These measures do not have ACO numbers, and are instead listed with their GPRO WI number. For additional information regarding any of the following coronary artery disease, diabetes, heart failure, hypertension, or ischemic vascular disease measures:

2.3.1 Coronary Artery Disease Measures

- CAD-2: Composite (All or Nothing Scoring): Coronary Artery Disease (CAD): Lipid Control
- CAD-7: Composite (All or Nothing Scoring): Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy—Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)

The CAD Composite measure consists of CAD-2 and CAD-7.

2.3.2 Diabetes Measures

- DM-2 (NQF 0059): Diabetes: Hemoglobin A1c Poor Control
- DM-13: Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: High Blood Pressure Control
- DM-14: Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control
- DM-15: Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Hemoglobin A1c Control (< 8%)
- DM-16: Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Daily Aspirin or Antiplatelet Medication Use for Patients with Diabetes and Ischemic Vascular Disease⁴

⁴ The narrative specification for this measure (in the link above) indicates use of Lovenox (enoxaparin) as an acceptable exception for medical reasons. Note that this is an error: the use of Lovenox (enoxaparin) is **not** an acceptable medical reason to remove a patient from this measure.

- DM-17: Diabetes Composite (All or Nothing Scoring): Diabetes Mellitus: Tobacco Non-Use

The DM Composite measure consists of DM-13, DM-14, DM-15, DM-16, and DM-17.

2.3.3 Heart Failure Measures

- HF-6: Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

2.3.4 Hypertension Measures

- HTN-2: Controlling High Blood Pressure

2.3.5 Ischemic Vascular Disease Measures

- IVD-1: Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
- IVD-2: Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic

Please refer to the following documents, available under the “2014 GPRO Web Interface Measures List, Narrative Measure Specifications, and Release Notes” link at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html:

- The 2014 Group Practice Reporting Option (GPRO) Web Interface Disease Modules, Care Coordination/Patient Safety and Preventive Care Measures List document which consists of the (22) 2014 GPRO Web Interface GPRO reporting method measures.
- The 2014 Group Practice Reporting Option (GPRO) Web Interface Narrative Measure Specifications which provides a description of each of the 22 measures.
- The 2014 GPRO Web Interface Narrative Specification Release Notes which provides a list of changes to existing measures made since the release of the 2013 GPRO Narrative Measure Specifications, Version 4.1.

2.4 Domain: Preventive Care

All measures within this domain are WI measures. As noted above, for the purposes of program coordination and version control, narrative descriptions for each of the 22 WI measures are not detailed in this document. These measures do not have ACO numbers, and are instead listed with their GPRO WI number. For additional information regarding any of the following preventive care measures:

2.4.1 Preventive Care Measures

- PREV-5: Breast Cancer Screening

- PREV-6: Colorectal Cancer Screening
- PREV-7: Preventive Care and Screening: Influenza Immunization
- PREV-8: Pneumonia Vaccination Status for Older Adults
- PREV-9: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
- PREV-10: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- PREV-11: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
- PREV-12 (NQF 0418): Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

Please refer to the following documents, available under the “2014 GPRO Web Interface Measures List, Narrative Measure Specifications, and Release Notes” link at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html:

- The 2014 Group Practice Reporting Option (GPRO) Web Interface Disease Modules, Care Coordination/Patient Safety and Preventive Care Measures List document which consists of the (22) 2014 GPRO Web Interface GPRO reporting method measures.
- The 2014 Group Practice Reporting Option (GPRO) Web Interface Narrative Measure Specifications which provides a description of each of the 22 measures.
- The 2014 GPRO Web Interface Narrative Specification Release Notes which provides a list of changes to existing measures made since the release of the 2013 GPRO Narrative Measure Specifications, Version 4.1.

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