ACO #11 — Percent of Primary Care Physicians Who Successfully Meet Meaningful Use Requirements

Measure Information Form (MIF)

Data Source

- ACO Final Participant Lists
- Medicare Part B Carrier Claims
- Medicare Part A Outpatient Claims
- Medicare Provider Enrollment, Chain, and Ownership System (PECOS)
- National Plan and Provider Enumeration System (NPPES)
- National Level Repository (NLR)
- Medicare Advantage Organization Attestation Data

Measure Set ID

- ACO #11

Version Number and Effective Date

- Version 5.0, effective 1/1/2016

CMS Approval Date

- 6/22/2016

NQF ID

- N/A

Date Endorsed

- N/A

Care Setting

- Ambulatory

Unit of Measurement

- Accountable Care Organization (ACO)

Measurement Duration

- Calendar Year

Measurement Period

- Calendar Year

Measure Type

- Process

Measure Scoring

- Percentage

Payer Source

- Medicare Fee for Service (FFS)

Improvement Notation

- Higher percentage indicates better performance

Measure Steward

- Centers for Medicare and Medicaid Services (CMS)

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- N/A

Measure Description

- Percentage of Accountable Care Organization (ACO) primary care physicians (PCPs) who successfully meet Meaningful Use requirements.

Rationale

Health information technology (IT) 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 (Chaundry et al., 2006). 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 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 health IT and utilization of qualified EHRs. The final rule for the electronic health records incentive program serves to establish guidelines and implement the HITECH incentive payments for meaningful use (CMS 2011).

Under the final rule for the electronic health records incentive program, eligibility criteria for the incentive payment differ 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 2011).

Clinical Recommendation Statement

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 criteria. Certification also helps providers and patients be confident that the 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 meaningful use, that health IT should:

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

The ARRA specifies three main components of meaningful use (CMS 2011):

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

The CMS criteria for meaningful use is currently at Modified Stage 2 criteria for all attesters (CMS 2016). Stage 3 will be optional for providers in 2017 and required for all providers in 2018.

References

Blumenthal D, Tavenner M. The "Meaningful Use" Regulation for Electronic Health Records. N Eng J Med 2010;363(6):501.

Chaudhry B, Wang J, Wu S, Maglione M, Mojica W, Roth E, Morton, SC, Shekelle PG. Systematic Review: Impact of Health Information Technology on Quality, Efficiency, and Costs of Medical Care. Ann Intern Med 2006;144:742-752.1c17 Provide references for the guideline used or studies if there is not a guideline.

Centers for Medicare and Medicaid. Medicare and Medicaid Programs; Electronic Health Record Incentive Program: Final Rule. (Last accessed February 11, 2016, from https://www.gpo.gov/fdsys/pkg/FR-2010-07-28/pdf/2010-17207.pdf).

Centers for Medicare and Medicaid. EHR Incentive Programs: EHR Incentive Programs Overview. (Accessed August 26, 2011, from http://www.cms.gov/EHRIncentivePrograms/).

Centers for Medicare and Medicaid. EHR Incentive Programs: 2015 Program Requirements. (Last accessed February 11, 2016, from: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2015ProgramRequirements.html).

Congressional Budget Office. Evidence on the Costs and Benefits of Health Information Technology. 2008 (Last accessed February 11, 2016, from https://www.cbo.gov/publication/41690).

Release Notes / Summary of Changes

- Version 5, will be effective for calendar year 2016.
- Pediatricians are now included in the definition of primary care physicians measure calculation.
- Primary care physicians who bill solely through FQHC or RHCs are included to align with the EHR Incentive Program.
- Three primary care services codes were added to align with the updated Shared Savings Program assignment methodology.
- Medicare Advantage organization EHR attestation data is included, to the extent possible this data is available.

Technical Specifications

- Target Population

  All primary care physicians (PCPs) participating in an Accountable Care Organization (ACO) under the Medicare Shared Savings Program (Shared Savings Program) or the Medicare Pioneer ACO Model.

Denominator

- Denominator Statement

  All PCPs who are participating in an ACO in the reporting year under the Shared Savings Program or the Medicare Pioneer ACO Model.

- Denominator Details

  Codes:

  1. The following Current Procedural Terminology (CPT) codes indicating primary care services:

     Office or Other Outpatient Services
     99201 New Patient, brief
     99202 New Patient, limited
     99203 New Patient, moderate
     99204 New Patient, comprehensive
     99205 New Patient, extensive
     99211 Established Patient, brief
     99212 Established Patient, limited
     99213 Established Patient, moderate
     99214 Established Patient, comprehensive
     99215 Established Patient, extensive

     Initial Nursing Facility Care
     99304 New or Established Patient, brief
     99305 New or Established Patient, moderate
     99306 New or Established Patient, comprehensive

     Subsequent Nursing Facility Care
     99307 New or Established Patient, brief
     99308 New or Established Patient, limited
     99309 New or Established Patient, comprehensive
     99310 New or Established Patient, extensive

     Nursing Facility Discharge Services
     99315 New or Established Patient, brief
     99316 New or Established Patient, comprehensive

     Other Nursing Facility Services
     99318 New or Established Patient

     Domiciliary, Rest Home, or Custodial Care Services
     99324 New Patient, brief
     99325 New Patient, limited
     99326 New Patient, moderate
     99327 New Patient, comprehensive
     99328 New Patient, extensive

99334 Established Patient, brief
99335 Established Patient, moderate
99336 Established Patient, comprehensive
99337 Established Patient, extensive

Domiciliary, Rest Home, or Home Care Plan Oversight Services
99339 Brief
99340 Comprehensive

Home Services
99341 New Patient, brief
99342 New Patient, limited
99343 New Patient, moderate
99344 New Patient, comprehensive
99345 New Patient, extensive
99347 Established Patient, brief
99348 Established Patient, moderate
99349 Established Patient, comprehensive
99350 Established Patient, extensive
99490 Chronic Care Management Service, 20 minutes
99495 Transitional Care Management Services within 14 days of discharge
99496 Transitional Care Management Services within 7 days of discharge

2. The following CMS G-codes indicating primary care services:

Wellness Visits
G0402 Welcome to Medicare visit
G0438 Annual wellness visit
G0439 Annual wellness visit

3. The following Provider Specialty codes in the Medicare Part B claims indicating primary care physicians:

1 General Practice
8 Family Practice
11 Internal Medicine
37 Pediatric Medicine
38 Geriatric Medicine

4. The following specialty codes in PECOS indicating primary care physicians:

01 General Practice
08 Family Medicine
11 Internal Medicine
37 Pediatric Medicine
38 Family Medicine-Geriatric
38 Internal Medicine-Geriatric

5. The following taxonomy codes in NPPES indicating primary care physicians:

208D00000X (01-General Practice)
207Q00000X (08-Family Medicine)
207R00000X (11-Internal Medicine)
208000000X (37-Pediatric Medicine)
207QG0300X (38-Family Medicine-Geriatric)

207RG0300X (38-Internal Medicine-Geriatric)

Details:

1. Identifying individual providers (NPIs):

   a. For ACOs participating in the Shared Savings Program, providers participating in the ACO include individual National Provider Identifiers (NPIs) on:
      i. Medicare Carrier Part B claim lines that include an ACO Participant's Tax Identification Number (TIN), where the TIN listed either does not also have a CMS Certification Number (CCN) in the Final Participant List or is listed alongside a CCN with CCN Identification Code T (Teaching Amendment), or
      ii. The Final Participant List, where an individual NPI is already listed alongside a CCN associated with a critical access hospital (CAH).

   b. For ACOs participating in the Pioneer ACO Model, providers participating in the ACO include those NPIs on:
      i. The Final Participant List, where an NPI is listed alongside a TIN or a Method II CAH CCN.

2. Identifying primary care physicians (PCPs):
   For providers identified in (1) above, PCPs are identified in several ways:

   a. If the NPI was identified with an ACO participating TIN, the provider will be considered a PCP if the NPI has at least one Medicare Physician Part B claim line for a primary care service and a primary care physician specialty.
   b. If the NPI was identified with an ACO participating CCN, the NPI will be considered a PCP if the NPI's record in PECOS has a PCP specialty code as the primary designation. If a PECOS record is not available for the NPI.
   c. If the NPI identified with an ACO participating CCN does not have a PECOS record associated with it, the NPI will be considered a PCP if the NPI's NPPES database record has a PCP specialty code as the primary taxonomy.

- Denominator Exceptions and Exclusions

1. Entities (i.e., identified by TIN or CCN) that are not used for beneficiary assignment.
2. Providers who did not have any primary care services during the reporting year.
3. Hospital-based physicians, as identified by the CMS EHR Incentive Program through Medicare claims (i.e., not self-reported), who are participating in a Shared Savings Program or Pioneer Model ACO during the reporting year.
4. Physicians who are deceased, to the extent this data is available.
5. Physicians who have been approved for a hardship exemption, to the extent this data is available.

- Denominator Exceptions and Exclusions Details

Codes:

1. Primary care services codes are the same as those listed under the denominator codes.
2. The following codes will be considered inpatient place of service (POS) codes:

   21 Inpatient hospital
   23 Emergency room - hospital

Details:

1. All TINs and CCNs from the Final Participant Lists not used for beneficiary assignment will be excluded from the denominator identification.
2. Providers without primary care service codes in the Part B Carrier file in the reporting year will be excluded from provider identification.
3. PCPs that may be practicing solely as hospital-based physicians will be excluded from the denominator. A provider NPI will be considered a hospital-based physician if the ratio of his/her inpatient and ER claims to their total claims is greater than or equal to 0.90.

$$Ratio\ of\ Inpatient\ \&\ ER\ claims = \frac{\#\ of\ encounters\ billed\ with\ inpatient\ or\ ER\ POS}{\#\ of\ total\ encounters}$$

4. Physicians who are deceased according to data available in PECOS.
5. To the extent data is available, physicians who have been approved for a hardship exemption for the program year.

Numerator

- Numerator Statement

  PCPs included in the denominator who successfully qualify to participate in either the Medicare, Medicare Advantage, or a Medicaid EHR Incentive Program in the current (2016) or prior (2015) reporting year.

- Numerator Details

  NPIs will be included in the numerator if the record associated with the NPI in the CMS National Level Repository meets one of the following three criteria:

  1. In the Provider Attestation Report:

     a. "Program Year" field equal to the current or prior reporting year, and
     b. "Program/Provider Type" field equal to "Medicare-Only EP", and
     c. "Attestation Status" field equal to any of the following values:
        i. Accepted
        ii. Locked for Payment
        iii. Payment Issued
        iv. Passed

  OR

  2. In the Payment Detail Report:

     a. "Program Year" field equal to the current or prior reporting year, and
     b. "Program/Provider Type" field equal to "Medicaid-Only EP", and
     c. "Payment Status" field equal to "Paid".

  OR

  3. In the Medicare Advantage Organization EHR Attestation Report:

     a. "Program Year" field equal to the current or prior reporting year.

Stratification or Risk Adjustment

- N/A

Sampling

- N/A

Calculation Algorithm

1. Identify denominator. Identify all primary care physicians in each ACO:

    a. Identify all TINs, CCNs, and combinations of TIN/NPIs and CCN/NPIs from the Shared Savings Program ACO and Pioneer Model ACO Final Participant Lists.
    b. Exclude all TINs and CCNs that are not used for beneficiary assignment (for Shared Savings Program ACOs) or alignment (for Pioneer Model ACOs).
    c. Identify unique NPIs for each SSP ACO:
        i. From Part B Carrier file (primary care service lines only) using TINs and selected CCNs;
        ii. From the Final Participant List if available.
    d. Identify unique NPIs for each Pioneer ACO from the Final Participation List.
    e. Determine if the NPI is a primary care physician (General Practice, Family Practice, Internal Medicine, or Geriatric Medicine):
        i. The provider has a code for PCP in the Part B Carrier claim line's PROVIDER SPECIALTY field; or
        ii. The provider has a code for PCP from the primary specialty field in PECOS; or
        iii. The provider has a code for PCP in the primary taxonomy in NPPES.
    f. Include PCPs in the denominator for each ACO.

2. Denominator Exclusion. Determine if the PCP in the denominator meet the exclusion criteria:

    a. Determine if the PCP in the denominator is a hospital-based physician. If so, exclude the PCP from the denominator.
    b. Determine if the PCP had any Part B primary care services claims. If not, exclude the PCP from the denominator.
    c. Determine if the PCP is deceased according to his or her PECOS records. If so, exclude the PCP from the denominator.
    d. Determine if the PCP's hardship exemption application for the current program year was approved by CMS. IF so, exclude the PCP from the denominator.

3. Identify numerator. Determine if each PCP remaining in the denominator satisfies the numerator criteria:

    a. Search the CMS NLR database to determine if the NPIs remaining in the denominator meet the following criteria as defined by the presence of one of the following in the NLR as of March 31 of the year following the reporting year:
        i. In the Provider Attestation Report:
            1. "Program Year" field equal to the current or prior reporting year, and
            2. "Program/Provider Type" field equal to "Medicare-Only EP", and
            3. "Attestation Status" field equal to any of the following values:
                - Accepted
                - Locked for Payment
                - Payment Issued
                - Passed

    OR

        ii. In the Payment Detail Report:

1. "Program Year" field equal to the current or prior reporting year, and
2. "Program/Provider Type" field equal to "Medicaid-Only EP" and
3. "Payment Status" field equal to "Paid".

OR

iii. In the Medicare Advantage Organization EHR Attestation Report:

1. "Program Year" field equal to the current or prior reporting year.

4. Calculate performance. For each ACO, the measure performance (the percent of the ACO's PCPs who successfully meet meaningful use requirements) is equal to the ACO's numerator population divided by the ACO's denominator population (accounting for exclusions) multiplied by 100%:

$$ACO\ Performance\ (\%) = \left(\frac{\#\ PCPs\ meeting\ Meaningful\ Use\ requirements\ in\ numerator}{\#\ PCPs\ eligible\ for\ denominator}\right) * 100\%$$