ACO #11 -- Percent of Primary Care Physicians Who Successfully Qualify for an EHR Program Incentive Payment

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)

Measure Set ID
- ACO #11

Version Number and effective date
- Version 2.0, effective 1/1/13

CMS approval date
- 10/24/13

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
Measure Development

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 qualify for either a Medicare or Medicaid Electronic Health Record (EHR) Incentive Program incentive payment.

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 (Chaundry 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 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 (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 HIT should:
Measure Development

1. Reflect the end goals (AHIMA states the goal of HIT 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 MU (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 MU will be developed in three stages. Stage 1 sets the baseline for electronic data capture and information sharing. Stage 2 and Stage 3 will expand on the baseline established in Stage 1, and will be developed through future rule making (CMS 2010).

References


Release Notes / Summary of Changes
- The following inclusion criteria has been deleted and will no longer be used to identify providers participating in the Pioneer ACO model:
  - NPIs on Medicare Outpatient Part A claims submitted by an FQHC, RHC or Method II CAH that includes an ACO Participant’s CCN from the Final Participant List, where the CCN listed in the Participant List does not have any NPIs listed.
- The numerator statement has been updated to include the Payment Detail Report as a possible source for identifying providers who have successfully qualified for the Medicaid EHR Incentive Program incentive payment.

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

Denominator
- Denominator Statement
  All primary care physicians (PCPs) who are participating in an Accountable Care Organization (ACOs) in the reporting year under the Medicare Shared Savings Program (MSSP) or under 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
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
   - 38 Geriatric Medicine

4. The following specialty codes in PECOS indicating primary care physicians:
   - 01 General Practice
   - 08 Family Medicine
   - 11 Internal 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)
   - 207QG0300X (38-Family Medicine-Geriatric)
   - 207RG0300X (38-Internal Medicine-Geriatric)

Details:

1. Identifying individual providers (NPIs):
   a. For ACOs participating in the MSSP, providers participating in the ACO include those 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 does not also have a CMS Certification Number (CCN) in the Final Participant List, or
      ii. The Final Participant List, where an individual NPI is already listed alongside a CCN associated with a critical access hospital (CAH), or
iii. Medicare Outpatient Part A claim submitted by an FQHC, RHC or Method II CAH that includes an ACO Participant’s CCN from the Final Participant List, where the CCN listed in the List does not have any NPIs listed.

b. For ACOs participating in the Pioneer ACO Model, providers participating in the ACO include those NPIs on:
   i. The Final Participant List, where a TIN/NPI combination is already provided, and where the TIN listed does not also have a CCN listed, or
   ii. The Final Participant List, where an NPI is listed alongside a 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 a TIN (i.e., Steps 1.a.i and Step 1.b.i.), 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 a CCN (i.e., Steps 1.a.ii, 1.a.iii, and 1.b.ii), the NPI will be considered a PCP if the NPI’s record in PECOS has a PCP specialty code as the primary designation.
   c. If the NPI identified with a CCN (i.e., Steps 1.a.ii, 1.a.iii, and 1.b.ii) 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 from the Part B Carrier file who did not bill any primary care services during the reporting year.
3. Hospital-based physicians, as identified by CMS through Medicare claims (i.e., not self-reported), who are participating in an MSSP or Pioneer Model ACO during the reporting year.
4. Physicians solely from FQHCs or RHCs, as identified in the participant list.

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. Medicare Part B Carrier claim lines without primary care service codes 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.

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\text{Ratio of Inpatient & ER claims} = \frac{\# \text{ of encounters billed with inpatient or ER POS}}{\# \text{ of total encounters}}
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4. Physicians practicing solely at FQHCs or RHCs will be excluded. This is defined as all NPIs that are only listed in the participant list from an FQHC or RHC (as identified with a CCN identification code of “F” or “R”).
Numerator

- Numerator Statement
  
  PCPs included in the denominator who successfully qualify for either a Medicare or a Medicaid EHR Incentive Program incentive payment in the reporting year.

- Numerator Details
  
  NPIs will be included in the numerator if the record associated with the Payee NPI in the CMS National Level Repository has meets one of the following two criteria:

  1. In the Provider Attestation Report:
     a. “Program Year” field equal to the 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

     OR

  2. In the Payment Detail Report:
     a. “Program Year” field equal to the reporting year, and
     b. “Program/Provider Type” field equal to “Medicaid-Only EP”
     c. “Payment Status” field equal to “Paid”.

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 MSSP ACO and Pioneer Model ACO Final Participant Lists.
   b. Exclude all TINs and CCNs that are not used for beneficiary assignment (for MSSP ACOs) or alignment (for Pioneer Model ACOs).
   c. Identify unique NPIs for each ACO:
      i. From Part B Carrier file (primary care service lines only) using TINs;
      ii. From the Final Participant List if available;
      iii. From Part A Outpatient file using CCNs for FQHCs, RHCs and CAHs.
   d. 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.
   e. 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 has an NPI only identified from the FQHC/RHC participant list (NPI listed with a CCN identification code “F” or “R”). 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 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
      OR
      ii. In the Payment Detail Report:
         1. “Program Year” field equal to the reporting year, and
         2. “Program/Provider Type” field equal to “Medicaid-Only EP” and
         3. “Payment Status” field equal to “Paid”.

4. **Calculate performance.** For each ACO, the measure performance (the percent of the ACO’s PCPs who successfully qualify for an EHR Incentive Program incentive payment in the performance year) is equal to the ACO’s numerator population divided by the ACO’s denominator population (accounting for exclusions) multiplied by 100%:

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   ACO\ Performance\ (\%) = \left(\frac{\#\ PCPs\ qualified\ for\ EHR\ incentive\ in\ numerator}{\#\ PCPs\ in\ denominator - \#\ hospitalists\ excluded\ from\ denominator}\right) \times 100\%
   \]