

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 4.1, effective 1/1/2015

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., 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 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 will be developed in three stages. Stage 1 set the baseline for electronic data capture and information sharing. Stage 2 expanded the baseline and Stage 3 is expected to expand on the baseline established in Stage 1 (CMS 2011).

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. EHR Incentive Programs: EHR Incentive Programs Overview. (Accessed August 26, 2011, from <http://www.cms.gov/EHRIncentivePrograms/>)

Release Notes / Summary of Changes

- ◆ Version 4.1, effective 6/22/2016 will be effective for calendar year 2015.
- ◆ Added “Passed” as additional Attestation Status value from the CMS National Level Repository, which captures providers that have successfully attested to the EHR Incentive Program but are not receiving an incentive payment.
- ◆ Included Medicare Advantage organization attestation data.

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
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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

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 Shared Savings Program, 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 either does not also have a CMS Certification Number (CCN) in the Final Participant List or is listed along a CCN with CCN Identification Code X (Other) or 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), or
 - iii. Medicare Outpatient Part A claim 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 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 (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 an ACO participating 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 an ACO participating 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 who did not have 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 a Shared Savings Program or Pioneer Model ACO during the reporting year.
4. Physicians solely from FQHCs or RHCs, as identified in the participant list.
5. Physicians who are deceased.
6. 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.

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

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").
5. Physicians who are deceased according to data available in PECOS.
6. 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 (2015) or prior (2014) 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 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;
 - ii. From the Final Participant List if available;
 - iii. From Part A Outpatient file using CCNs.

- 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 NPES.
 - 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 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.
 - c. Determine if the PCP had any Part B primary care services claims. If not, exclude the PCP from the denominator.
 - d. Determine if the PCP is deceased according to his or her PECOS records. If so, exclude the PCP from the denominator.
 - e. 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 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 qualify for an EHR Incentive Program incentive payment in the current and prior performance year) is equal to the ACO's numerator population divided by the ACO's denominator population (accounting for exclusions) multiplied by 100%:

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