**2017 DVACO Participation Criteria and Reporting Requirements**
**February 2017**

| **Participation Criteria required for ACO Membership*** ***Practice reporting required*** | |
|---|---|
| **1)** | **Demonstrate Competence in reporting Advancing Care Information (ACI) for the Merit-Based Incentive Payment System (MIPS*) (Primary Care and Specialty Practices)*** |
| | Quarterly reporting until projected ACI Score of 70 points achieved (minimum score of 50 required for 2017 performance year). |
| **2)** | **Use ACI-certified EHR *(Primary Care and Specialty Practices)*** |
| | Report annually. |
| **3)** | **Meet DVACO Care-Model standards** |
| A. | *(Primary Care)* Demonstrate transformation through achievement and maintenance of DVACO patient-centered medical home principles within 12 months of initial contract year as demonstrated by ongoing NCQA PCMH recognition status, or providing copy of CPC+ reporting, or meeting transformation competency goals established by the DVACO Transformation team.<br>-Tier 1 Care Coordination payments require this patient-centered medical home competency<br>-Tier 2 Care Coordination payments additionally require practice-provided complex care coordination meeting DVACO criteria |
| B. | *(Specialty Practices)* Commit to DVACO Preferred Specialist Criteria |
| **4)** | **Report ACO Quality Metric Data** |
| | *(Primary Care and Specialty Practices):* Cooperate with the timely record review and retrieval requirements to meet annual contractual obligations related to CMS Quality Reporting (GPRO) ,and Commercial Quality Reporting (STAR/HEDIS)<br>*(Primary Care Practices):* Demonstrate achieving and sustaining competency in reporting at least 90% of Clinical Quality Measures (CQMs), by 12/31/2017 (see page 2). Work as required with Quality and Transformation Staff to achieve this competency. |

**Failure to meet any of these participation criteria, after review by the Membership Committee, may result in the implementation of a DVACO up to 6 month corrective action plan, with suspension of Care Coordination and Shared Savings payments unless requirements met.*

**DVACO primary care practices must achieve reporting competency in these Ten Clinical Quality Measures (CQMs)**

The measures are expected to be reportable through your EHR.

| MU Domain | ACO # | NQF # | Measure Title | Description of Measure |
|---|---|---|---|---|
| Clinical Process/Effectiveness | 27 | 0059 | Diabetes: HbA1C Poor Control | % of patients 18-75 years of age with diabetes who had HbA1C > 9.0% during the measurement period |
| | 19 | 0034 | Colorectal Cancer Screening | % of adults 50-75 years of age who had appropriate screening for colorectal cancer |
| | 28 | 0018 | Controlling High Blood Pressure | % of patients 18-85 years of age with a diagnosis of HTN and whose BP was adequately controlled (<140/90) during the measurement period |
| | 15 | 0043 | Pneumonia Vaccination Status for older adults | % of patients 65 years of age or older who have ever received a pneumococcal vaccine |
| | 20 | N/A | Breast Cancer Screening | Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer |
| Population/Public Health | 16 | 0421 | Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan | % of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter<br>Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2 |
| | 17 | 0028 | Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention | % of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user |
| | 14 | 0041 | Preventive Care and Screening: Influenza Immunization | % of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization |
| | 18 | 0418 | Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan | % of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen. |
| Patient Safety | 13 | 0101 | Falls: Screening for Future Fall Risk | % of patients 65 years of age and older who were screened for future fall risk during the measurement period |