Practice Selection Checklist DVACO MSSP Assessment *(Initial Practice Assessment to determine entrance into the DVACO's MSSP Contract #1-2)	
1	**The practice must be using a 2015 Certified Electronic Health Record for the Merit-Based Incentive Payment System (MIPS) Promoting Interoperability *(Primary Care and Specialty Practices)***
	Practices must document the following information to show full utilization of their EMR: a. Documenting the Encounter Note for each patient visit b. Promoting Interoperability Measures- *See Demonstrate Competence in reporting Promoting Interoperability for requirements* c. Clinical Quality Measures (eCQMs)- Must document eCQMs and provide a report showing eCQMs scores (see attached list of eCQMs) (Primary Care Practices)
2	**Demonstrate Competence in reporting Promoting Interoperability for the Merit-Based Incentive Payment System (MIPS)*(Primary Care and Specialty Practices)***
	Promoting Interoperability (PI) Measures- Practices/TINs must score a minimum of 75 points using 2015 CEHRT. a. 2015 CEHRT: Security Risk Analysis; ePrescribing; Health Information Exchange (HIE) to include Sending Health Information and Receiving and Incorporating Health Information, Patient Electronic Access to their Health Information and Participation in Public Health and/or Clinical Data Exchange (Registries) Practices/TINs must report quarterly Promoting Interoperability measures to the DVACO.
Participation and Reporting Criteria Required for DVACO MSSP Membership **(Practices are Required to Meet #1-6)	
3	**Meet DVACO Care-Model Standards *(Primary Care and Specialty Practices)***
	Primary Care Practices: 1. Demonstrate transformation within 12 months of initial contract year through the completion of one Path and maintain transformation in subsequent participation years by revalidating practice transformation work: a. CPC+ Program (Path 1) b. NCQA's PCMH Recognition/Renewal (Path 2) c. The DVACO's Practice Transformation Criteria (Path 3) 2. Care Coordination Payments a. Tier 1 Care Coordination payments are dependent on demonstrating practice transformation as outlined above b. Tier 2 Care Coordination payments additionally require practice-provided complex care coordination meeting DVACO criteria. **Specialty Practices:** 1. Commit to DVACO Preferred Specialist Criteria
4	**Accurate Provider Enrollment, Chain, and Ownership System (PECOS) *(Primary Care and Specialty Practices)***
	All TINs must have their providers' PECOS accounts updated, including their correct taxonomy, under their organization's/practice's TIN by 12/31/19 in order to give an accurate representation of practicing providers under the TIN/practice. a. Practices must participate in quarterly checks to verify that PECOS is up-to-date. b. A TIN/Practice must provide a screenshot of their roster of providers in PECOS under their organization's/practice's TIN. c. A TIN/Practice must remove a provider from their TIN in PECOS within 90 days of termination to account for trailing claims payments. The TIN/Practice must confirm that they removed the terminated provider(s) from the existing practice's TIN. Once the termination letter from CMS is received, it must be made available to review as evidence that your PECOS account has been updated. d. All Physicians, Physician Assistants (PA), Nurse Practitioners (NP), Clinical Nurse Specialists (CNS), Certified Registered Nurse Anesthetists (CRNA), Physical Therapists (PT), Occupational Therapists (OT), Speech Language Pathologists, Audiologists, Psychologists,

	and Registered Dieticians/Nutrition Professionals need to be credentialed with Medicare for MIPS reporting purposes.
5	**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 Web Interface Reporting and Commercial Quality Reporting (Star Ratings/HEDIS). *(Primary Care and Specialty Practices)* Work as required with Quality and Practice Transformation Staff to achieve and sustain competency in reporting all practice EHR-reportable Clinical Quality Measures (CQMs), by 12/31/2019 (see page 2). *(Primary Care Practices)* Cooperate in outreach activities to close gaps in care *(Primary Care Practices)*
6	**Submit Appropriate Number of ICD-10 Codes for Billing *(Primary Care and Specialty Practices)***
	Practices must be able to submit up to (12) ICD-10 codes on claims. a. Practices must provide evidence ensuring that they are able to do this. b. A hardship may be granted in cases of contractual problems with billing companies.

**Initial Practice Assessment to determine entrance into the DVACO's MSSP Contract.*

***Failure to meet any of these DVACO participation criteria (#1-6), after review by the Membership Subcommittee, may result in the implementation of a DVACO Corrective Action Plan up to 6 months, with suspension or forfeiture of Care Coordination and Shared Savings payments unless requirements are met. Failure to complete the Corrective Action Plan could result in a dismissal from the DVACO contracts.*

DVACO Primary Care Practices must achieve reporting competency in these Eleven Clinical Quality Measures (eCQMs)

MU Domain	NQF #	ACO 2019 # Or Commercial Measure	Measure Title	Description of Measure
Effective Clinical Care	0059	27	**Diabetes: HbA1C Poor Control**	The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if a test was not done during the measurement year.
	0055	HEDIS/Commercial Measure	**Comprehensive Diabetes Care: Eye Exam**	The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had an eye exam (retinal) performed.
	0057	HEDIS/Commercial Measure	**Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing**	The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who received an HbA1c test during the measurement year.
	0062	HEDIS/Commercial Measure	**Comprehensive Diabetes Care: Medical Attention for Nephropathy**	The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who received a nephropathy screening test or had evidence of nephropathy during the measurement year.
	0034	19	**Colorectal Cancer Screening**	The percentage of patients 50–75 years of age who had an appropriate screening for colorectal cancer.
	0018	28	**Controlling High Blood Pressure**	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.
	2372	20	**Breast Cancer Screening**	The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.
	0032	HEDIS/Commercial Measure	**Cervical Cancer Screening**	Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: • Women age 21–64 who had cervical cytology performed every 3 years. • Women age 30–64 who had cervical cytology/ HPV co-testing every 5 years.
Community/Population Health	0028	17	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**	Percentage 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
	0418	18	**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. * The depression screening must be reviewed and addressed in the office of the provider-Interpretation of results must be documented (score alone not sufficient)
Patient Safety	0101	13	**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