2016 Quality Measures Validation Audit Overview

For Participating Accountable Care Organizations

January 9, 2017

Center for Medicare, Performance-Based Payment Policy Group

Center for Medicare & Medicaid Innovation, Seamless Care Models Group

Medicare Shared Savings Program
Pioneer Model
Next Generation Model

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Accessing Slides

- Shared Savings Program ACOs:
  - Please login to the ACO Portal (https://portal.cms.gov) and click on today's event.
    - ACO contacts maintained in the Health Plan Management System (HPMS) have access to the SSP Portal and receive the ACO Spotlight newsletter.
    - If you do not have access to the Portal, please work with your ACO to obtain the quality webinar slides and the ACO Spotlight newsletter for quality updates and webinar announcements.
- Pioneer and Next Generation ACOs:
  - Slides are on the Pioneer and Next Generation Connect sites
    - Pioneer Connect site https://app.innovation.cms.gov/PioneerConnect
    - Next Generation Connect site: https://app.innovation.cms.gov/NGACOConnect

Agenda

- Audit Overview
- Audit Submission Requirements
- Audit Measures
- Documentation Requirements
- Timeline
- Resources

Audit Overview

Audit Overview

- The Quality Measures Validation Audit
  - Provides an opportunity to identify areas that need education and outreach.
  - Ensures ACOs are fulfilling their obligation to completely and accurately report clinical quality information.

- CMS Regulatory Authority
  - In the November 2011 final rule, the Shared Savings Program finalized a proposal to retain the right to validate the data ACOs enter into the Web Interface (76 FR 67893 through 67894).
  - In the 2017 Physician Fee Schedule final rule, the Shared Savings Program finalized improvements to this audit process (81 FR 80488 through 80492).

Audit Overview

- Each ACO will be audited on 4 measures, determined by CMS.
- For Shared Savings Program and Next Generation ACOs
  - CMS will provide a sample of 200 beneficiaries
  - 50 beneficiaries per measure
- For Pioneer Model ACOs the methodology will be consistent with prior years
  - CMS will provide a sample of 120 beneficiaries
  - 30 beneficiaries per measure

Audit Overview

- If your ACO is selected to participate in the audit you will be asked to provide:
  - Medical record documentation that corresponds with the data you entered into the Web Interface; and, if applicable,
  - A written explanation of any anomalous data entry patterns identified by CMS.

Note that all Pioneer and Next Generation ACOs will be audited

Audit Overview

- CMS will calculate a “match rate” for each Shared Savings Program and Next Generation ACO.
- A “match” is when the medical record documentation adequately supports the Web Interface data

$$Match\ Rate = 100 * \frac{Number\ of\ Matches}{Number\ of\ Audited\ Records}$$

  - Match Rate ≥ 90% = Audit Pass
  - Match Rate < 90% = Audit Fail
- Pioneer ACOs will receive per measure match rates, and will pass/fail the audit at the individual measure level, consistent with prior year audits.

Audit Submission Requirements

- Medical Record Documentation
- Written Explanation of Data Anomalies

Medical Record Documentation

- Documentation provided for the audit should be consistent with the documentation used to support the GPRO Web Interface data submission on each measure selected for audit.
- Documentation should substantiate the following for each record, as applicable:
  - Denominator criteria, including confirmation of a diagnosis, where applicable;
  - Exclusions;
  - Numerator criteria (i.e., that the beneficiary met the measure); and
  - Exceptions (i.e., medical, patient or system reasons for removing the beneficiary from the denominator).

Written Explanation of Data Anomalies

- What is a data anomaly?
  - Data anomalies are patterns of data entry exhibited by an ACO that are considered outliers from the patterns we see across all ACOs.
  - For example, an ACO is selecting “Medical Record Not Found” at a rate that is significantly higher than the rate of that selection across all ACOs.
- If CMS identifies anomalous data entry patterns, overall or for specific measures, your ACO will be required to submit a written explanation.
- A written explanation helps CMS (1) understand the unique circumstances of your ACO, and (2) identify opportunities for CMS to provide additional education and support.

Audit Measures

Audit Measures

Measures Subject to Audit		
ACO-13	CARE-2	Falls: Screening for Future Fall Risk
ACO-27	DM-2	Diabetes Mellitus: Hemoglobin A1c Poor Control
ACO-41	DM-7	Diabetes: Eye Exam
ACO-28	HTN-2	Controlling High Blood Pressure
ACO-19	PREV-6	Colorectal Cancer Screening
ACO-15	PREV-8	Pneumonia Vaccination Status for Older Adults
ACO-16	PREV-9	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
ACO-17	PREV-10	Preventive Care and Screening: Tobacco Use: Screening Cessation Intervention
ACO-18	PREV-12	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

Documentation Requirements

- General Documentation Requirements
- Measure-specific Documentation Requirements
- Helpful Hints

General Documentation Requirements

- The following documentation requirements are generally applicable:

Documentation Requirements Applicable to All Measures	
Not Qualified for Sample	Specific reason a patient is not eligible for the sample (i.e., death, hospice, non-US resident, or HMO enrollment) in the medical record.
Other CMS Approved Reason	The QualityNet Help Desk ticket number with response

Measure-specific Documentation Requirements

Falls: Screening for Future Fall Risk (CARE-2)		
Denominator	No documentation required	Not Applicable
Numerator	Completion of patient screening for a history of falls or any fall with injury. Documentation of “no falls” is sufficient.	January 1, 2016 – December 31, 2016
Exception	Medical reason for not screening the patient for future fall risk (e.g., non-ambulatory at most recent encounter)	Most recent visit occurring between January 1, 2016 – December 31, 2016

Measure-specific Documentation Requirements

Diabetes Mellitus: Hemoglobin A1c Poor Control (DM-2)		
Denominator	History of or active diagnosis of diabetes	January 1, 2015 – December 31, 2016
Numerator	Date and value of the most recent HbA1c	January 1, 2016 – December 31, 2016

Diabetes Mellitus: Eye Exam (DM-7)		
Denominator	Active diagnosis of diabetes	January 1, 2015 – December 31, 2016
Numerator	The date and result of the most recent retinal or dilated eye exam and result of an eye exam	January 1, 2015 – December 31, 2016

- For eye exams performed between January 1, 2016 – December 31, 2016, the date of the dilated or retinal exam without the results will be sufficient.

Measure-specific Documentation Requirements

Controlling High Blood Pressure (HTN-2)		
Denominator	Active diagnosis of essential hypertension	Must begin prior to June 31, 2016 and must not end prior to January, 2016
Numerator	Date and value of most recent systolic and diastolic blood pressure readings	January 1, 2016 – December 31, 2016
Exclusion	Pregnancy, ESRD, or Stage 5 CKD	Must not end prior to January 1, 2016
	Dialysis or history of renal transplant	May begin prior to and must not end prior to January1, 2016

- If there are multiple readings on the same date of service, use the lowest systolic and lowest diastolic on that date.

Measure-specific Documentation Requirements

Colorectal Cancer Screening (PREV-6)		
Denominator	No documentation required	Not Applicable
Numerator	Completion of an appropriate screening, including the date performed and result of screening	Screening must be within the timeframe specified for the screening test performed. Result must be on or after the date of the screening.
Exclusion	Diagnosis or history of total colectomy or colorectal cancer	Documented on or before December 31, 2016

- Documentation of “abnormal” or “normal” result is acceptable for this measure.

Measure-specific Documentation Requirements

Pneumonia Vaccination Status for Older Adults (PREV-8)		
Denominator	No documentation required	Not Applicable
Numerator	Year and type (PPSV23 or PCV13) of vaccination	Documented on or before December 31, 2016

- For patient reported vaccinations occurring prior to January 1, 2015, documentation indicating receipt of pneumonia vaccination is sufficient.

Measure-specific Documentation Requirements

Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (PREV-9)		
Denominator	Age of patient at time of screening	Date of the BMI screening
Numerator	BMI screening date and result	During the most recent visit or six months prior to the most recent visit
Numerator follow-up	A follow-up plan, specified as an abnormal BMI intervention, was discussed with the beneficiary	During the most recent visit or six months prior to the most recent visit
Exclusion	Pregnancy	Must not end prior to January 1, 2016
	Medical or patient reason for not screening beneficiary for an abnormal BMI	January 1, 2016 – December 1, 2016

Measure-specific Documentation Requirements

Preventive Care and Screening: Tobacco Use: Screening Cessation Intervention (PREV-10)		
Denominator	No documentation required	Not Applicable
Numerator	Date and result of query of patient's tobacco use	January 1, 2015 – December 31, 2016
Numerator follow-up	Cessation intervention	January 1, 2015 – December 31, 2016
Exception	Medical reason the patient was not screened for tobacco use	January 1, 2015 – December 31, 2016

Measure-specific Documentation Requirements

Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan (PREV-12)		
Denominator	Age of patient at time of screening	Date of depression screening result
Numerator	Date and result of an age appropriate screening tool. Must indicate the specific screening tool used.	On date of the encounter, which must be between January 1, 2016 – December 31, 2016
Numerator follow-up	A follow-up plan, specified as a depression intervention, was discussed with the beneficiary	The follow-up plan must be documented on the date of the positive screen.
Exclusion	Active diagnosis of depression or bipolar disorder	Prior to January 1, 2016
Exceptions	Medical or patient reason for not screening the beneficiary for clinical depression	January 1, 2016 – December 31, 2016

Helpful Hints

- ACOs do not need to submit a beneficiary's medical record in its entirety. Only the documentation supporting the answer provided in the GPRO Web Interface is needed.
- Any documentation submitted must be legible and should reflect the beneficiary's name and the date of service.
- Screen shots from Electronic Health Records are acceptable.
- Claims data is not sufficient for any of the audited measures.
- If you determine that an answer you provided in the GPRO Web Interface for a measure is incorrect, please note this on the audit documentation that you submit.

Helpful Hints

- Common reasons for mismatch between reported data:
  - Test/procedure results not being captured in discrete fields, making them not easily abstracted (e.g., echocardiogram results showing ejection fraction)
  - Misinterpretation of and/or lack of follow-up plan documentation
  - Age appropriate depression screening tools not being universally used
  - Failure to submit documentation
    - Any documentation
    - Documentation to support diagnosis for denominator inclusion (claims data is not appropriate for diagnosis confirmation)
    - Documentation of a query for history of falls.

Timeline

Timeline

- Web Interface submission closes: **March 17, 2017**
- Audit selections made and ACOs notified: **Early April**
- Beneficiary samples to selected ACOs: **Mid April**
- **ACOs will have approximately 15 business days to submit their medical record data**
- Quality Performance and Audit Reports Delivered: **Late summer 2017**

Resources

- Guides and Specifications
- Newsletters
- Websites and Portals
- Mailboxes and Help Desks

Guides and Specifications

- **2016 Quality Measures Validation Audit Guide**
  - Available on the Shared Savings Program ACO Portal, Next Generation ACO Connect site, and Pioneer ACO Connect Site
- **2016 Web Interface Quick Reference Guides**
  - Available under ACO Portal Program announcement 2016 Quality Measurement, Reporting, and Scoring Quick Reference Guides
  - Also available on the Next Generation ACO Connect site and Pioneer ACO Connect site
- **2016 Web Interface measure specifications and supporting information**
  - Available on the PQRS GPRO Web Interface web page

Newsletters

- Include announcements for:
  - Important program information
  - Upcoming deadlines
  - Upcoming webinars
- Shared Savings Program ACOs
  - Spotlight Newsletter
  - Sent to contacts listed in HPMS
  - Published weekly
- Pioneer ACOs
  - Pioneer Briefing
  - Sent to ACO Executives, Primary Contacts, and any other ACO-designated Newsletter/Briefing contacts
  - Published monthly
- Next Generation ACOs
  - Next Generation Newsletter
  - Sent to ACO Executives, Primary Contacts, and any other ACO-designated Newsletter/Briefing contacts
  - Published weekly

Websites and Portals

- **PQRS Group Practice Reporting Option (GPRO) Web Interface webpage**
  - http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html
  - Web Interface measure specifications and supporting information
  - Educational demonstrations on a variety of Web Interface reporting topics

- **Shared Savings Program website**
  - http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html
- **Shared Savings Program ACO Portal**
  - https://portal.cms.gov
  - Quality webinars (all are recorded and posted on the Shared Savings Program ACO Portal)

Websites and Portals

- **Pioneer ACO Model Website**
  - https://innovation.cms.gov/initiatives/Pioneer-ACO-Model/index.html
- **Pioneer ACO Connect Site**
  - https://app.innovation.cms.gov/PioneerConnect

- **Next Generation ACO Model Website**
  - https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/
- **Next Generation ACO Connect Site**
  - https://app.innovation.cms.gov/NGACOConnect

Mailboxes and Help Desks

- **For questions related to the GPRO Web Interface, EIDM, quality measures, or PQRS payment adjustment**

  Contact the QualityNet Help Desk and identify yourself as a representative from an ACO

  E-mail: qnetsupport@hcqis.org

  Phone: (866) 288-8912 | TTY: (877) 715-6222 | Fax: (888) 329-7377

  Monday – Friday 7 a.m. - 7 p.m. CT

- **Medicare Shared Savings Program**
  - E-mail: SharedSavingsProgram@cms.hhs.gov
- **Pioneer Model**
  - Email: PioneerQuestions@cms.hhs.gov
- **Next Generation Model**
  - Email: NextGenerationACOModel@cms.hhs.gov
- **VM Help Desk**
  - Phone: (888) 734-6433 Option 3 or pvhelpdesk@cms.hhs.gov
- **EHR Incentive Program Information Center**
  - Phone: (888) 734-6433 (TTY 888-734-6563)

Question & Answer Session