2018 DVACO Participation Criteria and Reporting Requirements

Participation and Reporting Criteria Required for ACO Membership*	
1.	**Demonstrate Competence in reporting Advancing Care Information (ACI) for the Merit-Based Incentive Payment System (MIPS)*(Primary Care and Specialty Practices)***
	ACI Base Measures (50 points) are required from each Practice/TIN. Practices/TINs must report quarterly ACI measures to the DVACO.
2.	**Use ACI Certified EHR *(Primary Care and Specialty Practices)***
	Must have an ACI certified EHR.
3.	**Meet DVACO Care-Model Standards**
A.	Demonstrate transformation through achievement and maintenance of DVACO patient-centered medical home principles within 12 months of initial contract year as demonstrated by participating in at least one path: CPC+ Program (Path 1); NCQA's PCMH Recognition/Renewal process (Path 2); or the DVACO's Practice Transformation Criteria (Path 3). *(Primary Care Practices)* -Tier 1 Care Coordination payments require this patient-centered medical home principles competency. -Tier 2 Care Coordination payments additionally require practice-provided complex care coordination meeting DVACO criteria.
B.	Commit to DVACO Preferred Specialist Criteria *(Specialty Practices)*
4.	**Report ACO Quality Metric Data**
	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/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 12/31/2018 (see page 2). *(Primary Care Practices)* Cooperate in outreach activities to close gaps in care (Primary Care Practices).

**Failure to meet any of these participation criteria, 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.*

DVACO Primary Care Practices must achieve reporting competency in these Ten Clinical Quality Measures (CQMs)

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	2372	**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 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