Items Requiring Practice Reporting						
1)	Submission of Reports: Practices must report A,B, and C to UMACO					
Α.	Thirty-four ACO Quality Measures					
	-See Appendix A					
В.	Average Same-Day-Appointment Report including the 3 rd next available appointment					
C.	Meaningful Use Status					
	-Will be reported once a year					
2)	Patient Experience Surveys					
Α.	Independent practices must cooperate with UMACO (or vendor) facilitate patient					
	experience surveys as necessary					
В.	Employed practices will meet this requirement through their organization sharing patient					
	experience data with UMACO					
**Plea	**Please direct any questions you have about reports to the CIO, John Donnelly at					
jdonnelly@umusa.net or 302-266-9166 x651						
PCMH Requirements: Practices will be required to become a Patient Centered Medical Home (PCMH)						
in order to remain a member of UMACO. Practices that are NOT PCMH Recognized must do the						
following:						
3a)	Submit to an Initial Gap Analysis and Action Plan for achieving NCQA PCMH Must-Pass					
	Elements by 12/31/2016					
	-UMACO will provide a Gap Analysis Tool and will assist practices at a cost to be determined. If					
	the practice is signed up for a Summer or Fall learning collaborative then the gap analysis does					
	not need to be completed					

3b) Submit for NCQA Recognition (level 1, 2, or 3) by 12/31/2016

**Please direct any questions you may have regarding PCMH Transformation to the Practice Administrator, Hazel Dimat at <u>hazel@umusa.net</u> or 302-266-9166 x633

Items Monitored by UMACO but do NOT require practice reporting:				
4)	Percentage of Annual Wellness Visits performed on MSSP patients annually			
	Source: Internal UMACO Tracking			
5)	Percentage of Patients with a PCP Visit within 30 days of a Hospital Stay			
	Source: Internal UMACO Tracking			
6)	Diagnosis Coding: addressing and assessing the risk profile of the practice's patient population			
	through the appropriate use of ICD-9/10 HCC coding			
	Source: Internal UMACO Tracking			
7)	Care Coordination: must positively collaborate with care coordinators and demonstrate referrals			
	of complex cases			
	Source: Internal UMACO Tracking			
8)	ACO Quality Metric Data Collection: must cooperate with the timely record review and retrieval			
	requirements to meet contractual obligations related to CMS Quality Reporting (GPRO)			
	-See Appendix A			
9)	Participation in meetings: Monthly provider meetings; on-site practice meetings with			
	UMACO population health management team, in-person learning session and/or			
	webinars			
10)	UMACO Provider Portal and Reports: practice must access provider profile			
	reports Source: Internal UMACO Tracking			
*Ploas	reports Source: Internal UMACO Tracking e direct any questions you may have regarding these to the Director of Clinical Integration. Donn			

**Please direct any questions you may have regarding these to the Director of Clinical Integration, Donna Gunkel at <u>dgunkel@umusa.net</u> or 302-266-9166 x640; and Anthony Onugu at <u>aonugu@umusa.net</u> or 302-266-9166 x619

Appendix A: ACO Quality Measures

ACO Quality Measures

Domain	Measure number	Description
Patient/Caregiver Experience	ACO #1	CAHPS: Getting Timely Care, Appointments, and Information
Patient/Caregiver Experience	ACO #2	CAHPS: How Well Your Doctors Communicate
Patient/Caregiver Experience	ACO #3	CAHPS: Patients' Rating of Doctor
Patient/Caregiver Experience	ACO #4	CAHPS: Access to Specialists
Patient/Caregiver Experience	ACO #5	CAHPS: Health Promotion and Education
Patient/Caregiver Experience	ACO #6	CAHPS: Shared Decision Making
Patient/Caregiver Experience	ACO #7	CAHPS: Health Status/Functional Status
Patient/Caregiver Experience	ACO #34	CAHPS: Stewardship of Patient Resources*
Care Coordination/Patient Safety	ACO #8	Risk-Standardized, All Condition Readmission
Care Coordination/Patient Safety	ACO #35	Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)*
Care Coordination/Patient Safety	ACO #36	All-Cause Unplanned Admissions for Patients with Diabetes*
Care Coordination/Patient Safety	ACO #37	All-Cause Unplanned Admissions for Patients with Heart Failure*
Care Coordination/Patient Safety	ACO #38	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions*
Care Coordination/Patient Safety	ACO #9	ASC Admissions: COPD or Asthma in Older Adults
Care Coordination/Patient Safety	ACO #10	ASC Admissions: Heart Failure
Care Coordination/Patient Safety	ACO #11	Percent of PCPs who Successfully Meet Meaningful Use Requirements
Care Coordination/Patient Safety	ACO #39	Documentation of Current Medications in the Medical Record*
Care Coordination/Patient Safety	ACO #13	Falls: Screening for Future Fall Risk
Preventive Health	ACO #14	Preventive Care and Screening: Influenza Immunization
Preventive Health	ACO #15	Pneumonia Vaccination Status for Older Adults
Preventive Health	ACO #16	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up
Preventive Health	ACO #17	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Preventive Health	ACO #18	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan
Preventive Health	ACO #19	Colorectal Cancer Screening
Preventive Health	ACO #20	Breast Cancer Screening
Preventive Health	ACO #21	Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Documented
Preventive Health At-Risk Population Depression	ACO #42 ACO #40	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease Depression Remission at Twelve Months
At-Risk Population (Diabetes Composite)	ACO #27 & 41	ACO -27: Hemoglobin A1c Poor Control (>9%) ACO -41: Diabetes—Eye Exam*
At-Risk Population Hypertension	ACO #28	Percent of beneficiaries with hypertension whose BP <140/90
At-Risk Population IVD	ACO #30	Percent of beneficiaries with IVD who use Aspirin or other antithrombotic
At-Risk Population HF	ACO #31	Beta-Blocker Therapy for LVSD
At-Risk Population CAD Composite	ACO #33	ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD

*New measures that will phase into pay-for-performance for the 2017 reporting year and benchmarks will be released prior to the start of the 2017 reporting year.

ACO Quality Measures		
Domain	Measure number	Description
Patient/Caregiver Experience	ACO #1	CAHPS: Getting Timely Care, Appointments, and Information
Patient/Caregiver Experience	ACO #2	CAHPS: How Well Your Doctors Communicate
Patient/Caregiver Experience	ACO #3	CAHPS: Patients' Rating of Doctor
Patient/Caregiver Experience	ACO #4	CAHPS: Access to Specialists
Patient/Caregiver Experience	ACO #5	CAHPS: Health Promotion and Education
Patient/Caregiver Experience	ACO #6	CAHPS: Shared Decision Making
Patient/Caregiver Experience	ACO #7	CAHPS: Health Status/Functional Status
Patient/Caregiver Experience	ACO #34	CAHPS: Stewardship of Patient Resources*
Care Coordination/Patient Safety	ACO #8	Risk-Standardized, All Condition Readmission Skilled Nursing Facility 30-Day All-Cause
Care Coordination/Patient Safety	ACO #35	Readmission Measure (SNFRM)*
Care Coordination/Patient Safety	ACO #36	All-Cause Unplanned Admissions for Patients with Diabetes*
Care Coordination/Patient Safety	ACO #37	All-Cause Unplanned Admissions for Patients with Heart Failure*
Care Coordination/Patient Safety	ACO #38	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions*
Care Coordination/Patient Safety	ACO #9	ASC Admissions: COPD or Asthma in Older Adults
Care Coordination/Patient Safety	ACO #10	ASC Admissions: Heart Failure
Care Coordination/Patient Safety	ACO #11	Percent of PCPs who Successfully Meet Meaningful Use Requirements
Care Coordination/Patient Safety	ACO #39	Documentation of Current Medications in the Medical Record*
Care Coordination/Patient Safety	ACO #13	Falls: Screening for Future Fall Risk Preventive Care and Screening: Influenza
Preventive Health	ACO #14	Immunization
Preventive Health	ACO #15	Pneumonia Vaccination Status for Older Adults
Preventive Health	ACO #16	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up
Preventive Health	ACO #17	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
Preventive Health	ACO #18	Preventive Care and Screening: Screening for Clinica Depression and Follow-up Plan
Preventive Health	ACO #19	Colorectal Cancer Screening
Preventive Health	ACO #20	Breast Cancer Screening
Preventive Health	ACO #21	Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Documented
Preventive Health	ACO #43	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
		Cardiovascular Disease Depression Remission at Twelve Months
At-Risk Population (Diabetes Composite)	ACO #27	ACO -27: Hemoglobin A1c Poor Control (>9%) ACO -41: Diabetes—Eye Exam*
At-Risk Population Hypertension	ACO #28	Percent of beneficiaries with hypertension whose
	ACO #00	Percent of beneficiaries with IVD who use Aspirin or
At-Risk Population IVD		other antithrombotic Beta-Blocker Therapy for LVSD
At-Risk Population HF		

Appendix B: 2015 CMS Quality Reporting Measures

*New measures finalized in the 2015 PFS Final Rule

Reporting quality metrics under Group Reporting (through the UMACO) will satisfy an individual practice's PQRS reporting requirements, as well as, the Clinical Quality Measures (CQMs) that must be submitted for Meaningful Use. Therefore, practices participating in the ACO will not have to report PQRS or CQM metrics to CMS. Practices will still be responsible for reporting individually on their Core and Menu measures (required under Meaningful Use) to CMS.