

2023 Conditions of Participation for Practices

1. Access

- a. Documented plan for non-traditional office hours (outside 8:00 a.m.- 5:00 p.m.)
- b. Provides 24/7 phone access for patients and other clinical providers (e.g.- Relay Service or direct contact to the clinician(s))
- c. Provides same-day appointments
- d. Ensures annual visit with patient's Primary Care Provider (PCP)

2. Quality

- a. Clinicians use evidence-based medicine to drive best practice
- b. Clinicians comply with all required/requested quality and care coordination data collection
- c. Designated staff of providers with attribution carry out regular patient outreach to close gaps in care utilizing EMR or external reports
- d. Providers with attribution and/or designated staff engage with DVACO Quality Improvement and with QI Staff/Practice Transformation (PT) Coaches for contracted Quality Improvement activities at least monthly or more dependent upon the amount of support necessary
- e. Identify measure(s) and/or payer of focus
- f. Implement improvement plan for measures that are below payor targets as defined in Quality Dashboard. Collaborate on specific plans to meet goals for improvement (phone calls, mail outreach, implementation of new tools as they become available, etc.)
- g. Collaborate with PT Coach or QI staff to review outcomes each quarter
- h. Providers with attribution are expected to close their projected gaps to meet or exceed targets for all core measures across all non-MSSP payors in which they participate. Projected gaps are located on the Performance Glide Path/Quality Improvement – Core Measures Performance (Glide Path) by TIN section of the QI Dashboard.
 - i. Practices that are below target and have flat/declining trends for 2 consecutive quarters in 5 or more Core Measures will be referred to Membership Committee to discuss a corrective action plan
 - ii. 2022 Core Measures confirmed (CY2023 confirmation TBD):
 1. Breast Cancer Screening (BCS)
 2. Cervical Cancer Screening (CCS) '22
 - a. Anticipate Controlling High Blood Pressure (CBP) in '23
 3. Colorectal Cancer Screening (COL)
 4. Diabetes HbA1c Control - Poor Control (>9.0%)/Good Control (≤9.0%) (HBD)
 5. Diabetes Eye exam (EED)
 6. Diabetes: Medical Attention for Nephropathy (CDC: Nephropathy) '22
 - a. Anticipate Kidney Health Evaluation for Patients with Diabetes (KED) in '23
 7. Statin Therapy Treatment of Cardiovascular disease (SPC) (Dispensed)
 8. Statin Therapy Treatment of Diabetes (SUPD) (Dispensed)
 - iii. Providers with attribution are exempt from the above requirement for the first year of any new DVACO contract.
- i. Agrees to data transparency throughout DVACO enterprise

- j. Providers with attribution will provide designated DVACO staff with remote access to the EMR for quality review and Payer reporting (e.g.- submission of screenshots).
- k. Collaborate with PT Coach or QI staff to document process for identifying patients who have not had a visit in the past year and AWWs as appropriate.
- l. Clinicians review and adhere to DVACO toolkits, workflows, and user guides.

3. Resource Stewardship

- a. Commitment to optimizing total cost of care outcomes for attributed population as evidenced by reviewing performance of such compared to targets and implementing improvement activities for KPIs that are below payor targets.
 - i. Practices are required to maintain performance in MSSP Total Cost of Care (TCOC) no worse than an outlier threshold specific to their panel size, as determined by DVACO and its actuarial consulting firm.
 - 1. The thresholds represent the estimated 99.9th percentile performance vs MSSP benchmark when compared with all nationwide TINs based on an analysis of all Medicare Fee-For-Service claims.
 - 2. The threshold starts at 9.3% above benchmark and increases as practice panel size decreases below 5,000 members to account for random variation that disproportionately impacts smaller practices.

TIN Size		TCOC Threshold
5,000	+	9.3%
2,000	5,000	12.4%
1,000	2,000	15.5%
900	1,000	21.6%
800	900	24.7%
700	800	27.8%
600	700	30.9%
500	600	34.0%
400	500	37.1%
300	400	40.2%
200	300	43.3%

- 3. Practices (TINs) below 200 lives will not be held to a quantitative performance threshold.
 - ii. Practices with 200 or more attributed lives whose MSSP Total Cost of Care (TCOC) is, at the time of any quarterly performance update, worse than the 99.9th percentile threshold calculated above will go on a Corrective Action Plan (CAP) informing them that they are at risk for exclusion from the MSSP contract in the following Performance Year (PY).
 - iii. The Membership Subcommittee will evaluate practices for removal from the MSSP contract practices if these practices have 200 or more attributed lives and their MSSP TCOC remains worse than their assigned threshold for 2 of the 4 most recent quarters, as evaluated 6 weeks prior to CMS' deadline for removal (typically August/September).

- iv. After reviewing both qualitative and quantitative performance, if the Membership Subcommittee votes to remove a practice, that practice will be given notice that it will not be included in the MSSP contract for the following Performance Year (PY).
- b. Appropriate specialist utilization across continuum
 - i. All patients are referred to a PCP when they do not have one
 - ii. Specialists refer non-specialist problems back to PCP
 - iii. Specialists co-manage care in acute/complex cases with the focus on PCP care delivery
- c. Steers toward high value specialist clinicians/organizations where identified
- d. Office has implemented a process for daily team communication (e.g.- huddles, emails to team members about daily schedule, etc.)
- e. Uses preferred provider home health, SNF, hospice, and in-home rehabilitation services network
- f. Utilize lower cost generic drugs where feasible

4. Citizenship

- a. Defined mechanism to identify DVACO attributed lives in EMR or alternative system that has the capacity to be updated monthly to align with payor roster updates. Demonstrated evidence of applying population health workflows/strategies specifically to the DVACO attributed population.
- b. All PCPs actively participate in at least one in-office visit/Zoom or WebEx meeting with CIN/DVACO leadership in the calendar year
- c. Appropriate members of the office staff participate in at least one educational program on various topics of value-based care at least twice a year (e.g.- HCCs webinars, MIPS webinars, etc.)
- d. Practices, providers, and appropriate practice staff agree to collaborate with and engage with DVACO resources including but not limited to care coordination, quality improvement, practice transformation, leadership, and administration.
 - i. The DVACO will provide all DVACO Independent Practices with “Clinical Support” which includes practice transformation, quality improvement, and care coordination services. The practice transformation support will be focused strictly on adherence to DVACO’s program of clinical integration and care coordination, with auditing and coaching focused solely on DVACO participation and care coordination with DVACO assigned beneficiaries. As HCC coding is at the foundation of the change to value-based care, DVACO is providing quality improvement support to DVACO practices to continue the transition to population-based payment models. The HCC quality improvement support will be limited to patients assigned to DVACO and for practices that do not demonstrate progress on HCC coding accuracy, including both overcoding and undercoding, will be subject to DVACO’s corrective action process.
 - ii. DVACO Independent Practices agree to cooperate, engage, and liaison with their DVACO assigned clinical support team on at least a monthly basis.
 - iii. Referrals for complex patients directly from the practice or providers to care coordination are highly encouraged.

5. Regulatory Reporting

- a. 2015 Cures Edition CEHRT EMR usage with a minimum score of 89.
 - i. Complies with EMR requirements as outlined by CMS.
 - ii. Documents encounter note for each patient visit in the EMR.

- iii. Documents Promoting Interoperability (PI) Measures.
- iv. Documents in a manner that will successfully result in quarterly Clinical Quality Measures (“eCQMs”) report submission required by DVACO.
- b. Complies with Merit-Based Incentive Payment Systems (MIPS)/ Advanced Alternative Payment Model Program (AAPM) requirements where applicable.
- c. Complies with quarterly PECOS compliance review.
- d. Complies with annual compliance requirements (e.g.- Clinician compliance education, beneficiary notification, audit, etc.).
- e. Alternative Payment Model (APM) Performance Pathway- Quality Preparatory Requirements for the MSSP and MIPS Program.
 - i. EMR must be able to successfully support eCQM measures.
 - ii. Documents workflows for eCQMs as appropriate.

6. Risk Capture

- a. Provides evidence ensuring the practice can submit up to (12) ICD-10 codes on claims.
- b. Complies with coding accuracy and specificity audit.
- c. All clinicians with attribution complete annual 1:1 education to improve accuracy for risk score coding and revise HCC workflows as needed.

Attestation- All Practices Must Complete

Practices that are participating with DVACO will receive per member per month (PMPM) up-front prepayments of shared savings (i.e.- Care Coordination Fees) monies for all attributed lives. Practices must meet the DVACO’s required Conditions of Participation Criteria and be in good standing to receive the PMPM payment. Eligibility will be determined on a quarterly basis; and payments will be made quarterly.

[Click or tap here to enter text.](#)

I have read and understand the DVACO Conditions of Participation and Corrective Action Plan Policy.

Practice Name: [Click or tap here to enter text.](#)

Printed Name: [Click or tap here to enter text.](#)

Signature: [Click or tap here to enter text.](#)

Date: [Click or tap to enter a date.](#)

*Additional specialty-specific Conditions of Participation may be required.