

CBE ID

3612

Title

Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System

Endorsement Status

Endorsed

Is Under Review

No

Next Maintenance Cycle

Spring 2027

Previous Endorsement Cycle

Spring 2021

Initial Endorsement

Tue, 11/30/2021 - 10:48

Steward

Centers for Medicare & Medicaid Services

1.0 New or Maintenance

Maintenance

1.1 Measure Structure

Single Measure

1.3 Electronic Clinical Quality Measure (eCQM)

No

1.6 Measure Description

Risk-standardized rate of acute, unplanned cardiovascular-related hospital admissions among Medicare Fee-for-Service (FFS) patients aged 65 years and older with heart failure (HF) or cardiomyopathy.

1.7 Measure Type

Outcome

1.8 Level of Analysis

Clinician: Group/Practice, Clinician: Individual

1.13 Data Dictionary

Not attached. I attest that all information will be provided where codes and/or value sets are needed (1.14a - 1.15c).

1.14 Numerator

The outcome for this measure is the number of acute cardiovascular-related admissions per 100 person-years at risk for admission during the measurement year.

1.15 Denominator

This measure assesses the care provided to patients with heart failure by primary care providers and cardiologists. Patients included in the measure (target patient population) The target patient population for the outcome includes Medicare FFS patients aged 65 years and older with heart failure or cardiomyopathy. Provider types included for measurement

- Primary care providers (PCPs): CMS designates PCPs as physicians who practice internal medicine, family medicine, general medicine, or geriatric medicine, and non-physician providers, including nurse practitioners, certified clinical nurse specialists, and physician assistants.
- Cardiologists: Cardiologists are covered by the measure because they provide overall coordination of care for patients with HF and manage the conditions that put HF patients at risk for admission due to acute cardiovascular-related conditions.

Outcome attribution The measure begins by assigning each patient to the clinician most responsible for the patient's care, based on the pattern of outpatient visits with PCPs and relevant specialists. The patient can be assigned to a PCP, a cardiologist, or can be left unassigned. Patients who have had no Evaluation and Management (E&M) visits with a MIPS eligible clinician are excluded.

Step 1: A patient who is eligible for attribution is assigned to a cardiologist only if the cardiologist has been identified as "dominant." A cardiologist is considered "dominant" if they have two or more visits with the patient, regardless of how many visits that patient has with a PCP.

- There are two scenarios where a patient can be assigned to a PCP. First, if the patient has seen the PCP at least once but has no visits with a cardiologist, the patient is assigned to the PCP. The patient will then be assigned to the PCP with the highest number of visits as long as there are no relevant specialists who are considered "dominant."
- Second, if the patient has seen the PCP more than two or more times and has only one visit with a cardiologist, the patient is assigned to the PCP.
- If the patient has one visit each with a cardiologist and a PCP, the patient is assigned to the cardiologist.
- If the patient has one visit with a cardiologist and no visit with a PCP, the patient is assigned to the cardiologist.
- Finally, the patient will be unassigned if they only saw non-relevant specialists, if the patient has not seen a PCP and no "dominant" specialist can be identified, or if the patient has not had more than one visit with any individual PCP.

Step 2: Patients are then assigned at the Taxpayer Identification Number (TIN) level, which includes solo clinicians and groups of clinicians who have chosen to report their quality under a common TIN. At the TIN level, patients are first assigned to the clinician (NPI/TIN) most responsible for their care (using the algorithm for individual clinician-level attribution above). Then, patients "follow" their attributed clinician to the TIN of that clinician. Patients unassigned at the individual clinician level continue to be unassigned at the TIN level.

1.20 Types of Data Sources

Claims Data, Other

6.1.2 Current or Planned Use(s)

Public Reporting, Payment Program

6.1.3 Current Use(s)

Public Reporting, Payment Program, Not in use

Developer POC email

ccsq-op-measures@acumenllc.com

Exclusions

The measure excludes:

1. Patients without continuous enrollment in Medicare Part A and B for the duration of the measurement period.
2. Patients in hospice during the year prior to the measurement year or in hospice at the start of the measurement year.
3. Patients who have had a heart transplant, been on home inotropic therapy, or who have had a left ventricular assist device (LVAD) placed.
4. Patients with end stage renal disease (ESRD), defined as chronic kidney disease stage 5 or on dialysis.
5. Patients who had no E&M visits with MIPS eligible clinician.

Measure Disclaimer

N/A

Planned Use

Payment Program, Public Reporting

Risk Adjustment

Statistical risk model

The measure developer is different from the measure steward

Yes

Steward Organization

Centers for Medicare & Medicaid Services

Steward POC email

Janis.Grady@cms.hhs.gov