Measure Information Form Timely Follow-Up After Acute Exacerbations of Chronic Conditions

Project Title: Timely Follow-Up After Acute Exacerbations of Chronic Conditions

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Project Overview:

The Centers for Medicare & Medicaid Services (CMS) contracted with Yale New Haven Health Services Corporation–Center for Outcomes Research & Evaluation (CORE) to respecify the Timely Follow-Up After Acute Exacerbations of Chronic Conditions measure, which can be attributed to providers participating in the Centers for Medicare and Medicaid Innovation Center (Innovation Center) Accountable Care Organization (ACO) REACH model. The contract name is Quality Measure Development and Analytic Support, Option Year 4. The contract number is HHSM-75FCMC18D0042, Task Order HHSM-75FCMC19F0003.

1. Measure Name/Title (CMS Consensus-Based Entity [CBE] Measure Submission Form, Measure Specifications sp.01)

Timely Follow-Up After Acute Exacerbations of Chronic Conditions

2. Descriptive Information

2.1 Measure Type

Process

2.2 Brief Description of Measure (CMS CBE Measure Submission Form Measure Specifications sp.02 and sp.06)

This is a measure of follow-up for patients with chronic conditions who have experienced an acute exacerbation of one of six conditions of interest (coronary artery disease [CAD], hypertension, heart failure [HF], diabetes, asthma, and chronic obstructive pulmonary disease [COPD]) which can be attributed to providers participating in the Innovation Center ACO REACH model. Results of the measure are aggregated on an ACO level for Standard and New Entrant ACOs. CORE has respecified the Timely Follow-Up After Acute Exacerbations of Chronic Conditions Measure, which was originally specified by IMPAQ, CBE #3455.

Measurement duration: Calendar year

Rationale:

Patients hospitalized or evaluated in the emergency department (ED) for exacerbations of chronic conditions are at high risk of readmission with poorly coordinated follow-up care. These readmissions, in turn, may increase health care spending, worsen clinical outcomes, and result in poor quality of life.

The intent of the Timely Follow-Up Measure is to encourage appropriate follow-up care and improve care coordination at discharge. Better coordination of care and time spent with providers can lead to improved quality of care, improved quality of life, and reduced health care costs.

The Timely Follow-Up measure is part of the pay-for-performance quality measures for the ACO REACH model, which aims to reduce administrative burden by simplifying billing code practices—freeing time and resources to focus on advanced primary care and care coordination for patients with complex, chronic conditions. The measure is claims-based and low-burden to align with this intent of the ACO REACH model. We anticipate the Timely Follow-Up measure will encourage model participants to improve care coordination and produce long-term savings for a given health care system.

Clinical Recommendation Statement:

Outpatient follow-up rates can differ substantially among patients, suggesting there is potential for improving care. Although it remains uncertain whether specific health outcomes can be consistently attributed to rapid follow-up,[1] data from 27 countries in the European Union demonstrates that patients with more than two chronic conditions benefit the most from strong primary care systems that allow for adequate outpatient follow-up.[2] Moreover, while relatively healthy patients may not demonstrate significant benefit from rapid follow-up after an acute care visit, a study conducted on a sample of nearly 45,000 Medicaid recipients demonstrated a 19.1% reduction in readmission among the highest risk patients who had follow up within 14 days after discharge.

Additionally, the benefit of early outpatient follow-up after hospital discharge may vary according to a patient's specific disease process. For example, follow-up consistently increased patient self-efficacy while decreasing health care utilization over a 3-month period among individuals with COPD.[4] HF patients appear to derive significant benefit from rapid follow-up after receiving acute care for an exacerbation. Among hospitals with higher rates of early follow-up, the risk of 30-day readmission was lower for patients initially admitted for HF.[5] Another study found that the composite outcome of death or ED visit or hospitalization within 30 days of first discharge from a hospital or ED during which HF was thought to be the primary diagnosis has been shown to be statistically significantly better among patient who have outpatient follow-up within 14 days of discharge.[6] Finally, for both non-ST-elevation myocardial infarction (NSTEMI) and HF, an outpatient visit with a physician within 7 days of discharge has been associated with a lower risk of 30-day readmission.[5]

Although some variation in follow-up may be due to condition or disease severity, there is evidence that some variation may also be due to quality of care for patients, rather than patient-level differences. For example, researchers have found that decreased health-related quality of life (as assessed by the Assessment of Quality of Life [AQoL] instrument) was predictive of ED visits over a 3-year period.[7] Although the long-term outcomes, which can be attributed to timely follow-up as a stand-alone intervention remain unclear, a systematic review has demonstrated that, when coupled with other types of discharge support, timely follow-up does positively contribute to health outcomes and is a key component of high-quality health care.[1]

2.3 If Paired or Grouped N/A

3. Measure Specifications

3.1 Measure-Specific Webpage (CMS CBE Measure Submission Form, Measure Specifications sp.09)

Measure Information Forms and Value Sets for ACO REACH quality measures are available on the 4i Knowledge Library.

3.2 If this is an electronic clinical quality measure (eCQM) (CMS CBE Measure Submission Form, Measure Specifications sp.10)

N/A

3.3 Data Dictionary, Code Table, or Value Sets (CMS CBE Measure Submission Form, Measure Specifications sp.11)

The value set (ACOREACH_PY2025_TFU_ValueSet) is used to determine which codes qualify for each condition and which codes qualify as a follow-up visit.

3.4 For an instrument-based measure (CMS CBE Measure Submission Form, Measure Specifications sp.23 and sp.24)

N/A

3.5 Update since last submission (CMS CBE Measure Submission Form, Specifications: Maintenance Update spma.01 and spma.02)

Updates from the last submission include the addition of telehealth codes and clarifying the cohort includes patients 18 years and older.

3.6 Numerator Statement (CMS CBE Measure Submission Form, Measure Specifications sp.12)

The numerator is the sum of the ACO-level* denominator events (ED visits, observation hospital stays, or inpatient hospital stays) for patients ages 18 years and older for acute exacerbations of hypertension, asthma, HF, CAD, COPD, or diabetes where follow-up was received within the time frame recommended by clinical practice guidelines, as detailed below:

- Hypertension: Follow-up within 14 days of the date of discharge for high-acuity patients or within 30 days for medium-acuity patients
- Asthma: Follow up-within 14 days of the date of discharge
- HF: Follow-up within 14 days of the date of discharge
- CAD: Follow-up within 7 days of the date of discharge for high-acuity patients or within 6 weeks for low-acuity patients
- COPD: Follow-up within 30 days of the date of discharge
- Diabetes: Follow-up within 14 days of the date of discharge for high-acuity patients

* Accountable Care Organization (ACO): An organization/entity participating in the ACO REACH model

3.7 Numerator Details (CMS CBE Measure Submission Form, Measure Specifications sp.13)

This measure is defined at the ACO level, meaning that results are aggregated for each participating entity in the ACO REACH model. Timely follow-up is defined as a claim for the same patient after the discharge

date of the acute event that is a non-emergency outpatient visit and has a Common Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code indicating a visit that constitutes appropriate follow-up, as defined by clinical guidelines and clinical coding experts. The follow-up visit may be a general office visit or telehealth visit and can also take place in certain chronic care or transitional care management settings. For a list of the appropriate codes for timely follow-up, please refer to the "Follow-Up" tab in the Value Set.

The follow-up visit must occur within the condition-specific timeframe to be considered timely and for the conditions of the numerator/measure to be met. For a list of individual codes for timely follow-up, please refer to the "Final Condition Codes" tab in the Value Set and their rules as described in the Denominator Details section of this document.

For two conditions, CAD and hypertension, the cohort is subdivided based on the acuity of the exacerbation, and the code set for each portion of the cohort has its own follow-up window. The follow-up visit timeframes are based on the most-recent evidence-based clinical guidelines.

3.8 Denominator Statement (CMS CBE Measure Submission Form, Measure Specifications sp.14)

The denominator is the count of the ACO-level acute exacerbations that require either an ED visit, observation stay, or inpatient stay (i.e., acute events) for any of the conditions listed above (hypertension, asthma, HF, CAD, COPD, or diabetes).

3.9 Denominator Details (CMS CBE Measure Submission Form, Measure Specifications sp.15)

As noted in Section 3.8, the denominator is the count of exacerbations attributed to a provider group (i.e., ACO) that leads to an acute care visit (i.e., ED visit, observation stay, or inpatient hospitalization) for any of the following eight condition cohorts: high-acuity CAD, high-acuity hypertension, asthma, HF, high-acuity diabetes, COPD, medium-acuity hypertension, and low-acuity CAD. The cohorts for hypertension, CAD, and diabetes were divided by acuity of condition because clinical guidelines reflected heterogeneity in follow-up timeline recommendations for exacerbations of different acuities; therefore, because CAD and HTN were subdivided into higher- and lower-acuity categories, the measure structure reflects eight condition cohorts for the six conditions of interest. Only high-acuity diabetes exacerbations were included in this measure.

Please refer to the codes in the "Inpat, Obs, ED, Discharge" tab of the Value Set for codes related to these acute care visits. The Inpatient codes should be used for inpatient claims. The Emergency Department and Observation Stay codes should be used for outpatient and carrier claims. Outpatient claims should also be limited to those with the appropriate type of bill code or claim type included on the "TOB-Outpatient" tab of the Value Set.

The value set contains both sufficient codes, which are unambiguously linked to the associated condition, and related codes, which are codes that often occur in conjunction with the condition.

Distinctions are also made between principal and secondary diagnoses when assigning a visit to a specific clinical condition cohort. The first diagnosis code in the header for each claim is used as the principal diagnosis code. All other diagnosis codes in the header are referred to as secondary diagnosis codes. Using the sufficient and related International Classification of Diseases (ICD) codes listed on the "Final Condition Code" tab in the Value Set, claims are assigned to one of the eight condition cohorts.

For all six conditions, an acute encounter is assigned to [condition] if the principal diagnosis is a sufficient code for [condition]

OR

If the principal diagnosis is a related code for [condition] AND at least one additional diagnosis is a sufficient code for [condition].

For conditions with different levels of acuity (e.g., high-acuity hypertension and medium-acuity CAD), the encounter is then assigned to the highest-acuity condition for which a code is present. The Value Set includes codes for low-acuity hypertension and diabetes conditions to appropriately classify events for the high- and medium-acuity cohorts; however, low-acuity hypertension and diabetes cohorts are not included in this measure, given that these conditions do not generally require outpatient follow-up as urgently as the other chronic conditions of interest.

In cases where the encounter has a related code applicable to two or more conditions that qualifies as principal diagnoses and two or more sufficient codes in a secondary diagnosis position, the encounter is assigned to the condition with a higher follow-up priority in the following order: high-acuity CAD, high-acuity diabetes, HF, asthma, high-acuity hypertension, medium-acuity hypertension, COPD, and low-acuity CAD.

The following explains how the rules about sufficient and related codes and principal and secondary diagnoses can be applied.

Asthma, COPD, and HF do not have acuity levels. For these conditions, the following must be present:

(1) a sufficient code as a principal diagnosis **or** (2) a related code as a principal diagnosis and a sufficient code as a secondary diagnosis.

CAD, diabetes, and hypertension all have low to high acuity levels.

For the CAD condition, the following must be satisfied: (1) a high- or low-acuity sufficient code as a principal diagnosis **or** (2) a high- or low-acuity related code as a principal diagnosis **and** a high- or low- acuity sufficient code as a secondary diagnosis.

- High acuity can only be satisfied with (1) a high-acuity sufficient code as a principal diagnosis **or** (2) a high- or low-acuity related code as a principal diagnosis **and** a high-acuity sufficient code as a secondary diagnosis **or** (3) a high-acuity related code as a principal diagnosis **and** a high- or low-acuity sufficient code as a secondary diagnosis.
- If criteria for a high-acuity CAD condition is not satisfied, then the low acuity criterion is met.

For the diabetes condition, the following must be satisfied: (1) a high-, medium-, or low-acuity sufficient code as a principal diagnosis **or** (2) a high- or medium-acuity related code as a principal diagnosis **and** a high-, medium-, or low-acuity sufficient code as a secondary diagnosis.

- High acuity can only be satisfied with (1) a high-acuity sufficient code as a principal diagnosis **or** (2) a high- or medium-acuity related code as a principal diagnosis **and** a high-acuity sufficient code as a secondary diagnosis **or** (3) a high-acuity related code as a principal diagnosis **and** a high-, medium-, or low-acuity sufficient code as a secondary diagnosis.
- Note that only high-acuity diabetes conditions are eligible for this measure. The diabetes cohort was narrowed to reflect the heterogeneity of conditions originally included and a lack of evidence-based follow-up timeline recommendations for less acute exacerbations.

For the hypertension condition, the following must be satisfied: (1) a high-acuity or low-acuity sufficient code as a principal diagnosis **or** (2) a high-, medium-, or low-acuity related code as a principal diagnosis **and** a high- or low-acuity sufficient code as a secondary diagnosis.

- High acuity can only be satisfied with (1) a high-acuity sufficient code as a principal diagnosis **or** (2) a high-, medium-, or low-acuity related code as a principal diagnosis **and** a high-acuity sufficient code as a secondary diagnosis **or** (3) a high-acuity related code as a principal diagnosis **and** a high- or low-acuity sufficient code as a secondary diagnosis.
- If the criteria for the high-acuity condition are not satisfied, then the medium-acuity condition is satisfied with the following: a medium-acuity related code as a principal diagnosis **and** a high- or low-acuity sufficient code as a secondary diagnosis.
- Note that only high- and medium-acuity hypertension conditions are eligible for this measure.

Each unique claim—based upon the from and through dates as well as the claim type (i.e., inpatient, outpatient, carrier)—is assigned to a condition cohort. If a beneficiary has a unique claim that begins on the same or the following day of another unique claim, the claims are considered part of one continuous acute event. In this case, the discharge date of the last claim is the beginning of the follow-up interval. And, if the unique claims that make up an acute event are assigned to different condition cohort, the acute event is assigned to the condition cohort that occurs last chronologically. Following this methodology, only one condition is recorded in the denominator per acute encounter.

The final claim of the acute event must be a discharge to community. Please refer to the Discharge to Community codes on the "Inpat, Obs, ED, Discharge" tab in the Value Set.

For measure development and testing, we have respecified the measure to include Medicare Fee-for-Service (FFS) ACOs.

3.10 Denominator Exclusions (CMS CBE Includes "Exception" in the "Exclusion" Field) (CMS CBE Measure Submission Form, Measure Specifications sp.16)

The measure excludes events with the following:

1. Subsequent acute events that occur 2 or more days after the prior discharge but still during the follow-up interval of the prior event for the same condition cohort. Note, if the encounters are for different conditions, none are excluded.
2. Acute events after which the patient does not have continuous enrollment for 2 months for all the condition groups, except the low-acuity CAD group, which requires continuous enrollment of 3 months.
3. Acute events where the discharge status of the last claim is not "to community" (e.g., "left against medical advice" is not a discharge to community). For a list of the appropriate codes, please refer to the Discharge to Community codes on the "Inpat, Obs, ED, Discharge" tab in the Value Set.
4. Acute events for which the calendar year ends before the follow-up window ends (e.g., acute asthma events occurring fewer than 14 days before December 31 will not be included.).
5. Acute events where the patient enters a skilled nursing facility (SNF), non-acute care, or hospice care within the follow-up interval. For a list of the appropriate codes to identify non-acute care, please refer to the "Non-acute" tab in the Value Set.

ACO REACH Model–Specific Timely Follow-Up Exclusions:

6. Acute events for non-claims-based-aligned patients who were voluntarily aligned after January 1, 2025. This ensures that a REACH ACO is not responsible for quality of care that occurred prior to beneficiaries becoming officially aligned to that REACH ACO.

7. Acute events for patients who are participating in the Guiding an Improved Dementia Experience (GUIDE) Model.

3.11 Denominator Exclusion Details (CMS CBE Includes "Exception" in the "Exclusion" Field) (CMS CBE Measure Submission Form, Measure Specifications sp.17)

N/A

3.12 Stratification Details/Variables (CMS CBE Measure Submission Form, Measure Specifications sp.18)

Because the TFU measure's results are aggregated at the ACO level and it is a process measure, stratification and risk adjustment are not applied. Consequently, the stratification described in the CBE form, which is not relevant to payment in this program, is not included in this section.

3.13 Risk Adjustment Type (CMS CBE Measure Submission Form, Measure Specifications sp.19)

- ☐ no risk adjustment or risk stratification
- ☒ stratification by risk category/subgroup
- ☐ statistical risk model
- ☐ other

3.14 Type of Score (CMS CBE Measure Submission Form, Measure Specifications sp.20)

- ☐ count
- ☒ rate/proportion
- ☐ ratio
- ☐ categorical (e.g., yes or no)
- ☐ continuous variable (CV) (e.g., an average)
- ☐ composite/scale
- ☐ other (specify)

3.15 Interpretation of Score (CMS CBE Measure Submission Form, Measure Specifications sp.21)

The final score (that is, the ACO-Level Timely Follow-up Rate) is the total number of qualifying follow-up visits after an acute exacerbation over the total sum of all qualifying acute exacerbations of any of the six conditions (hypertension, asthma, HF, COPD, CAD, and diabetes), aggregated on an ACO level. The score is expressed as a percentage.

3.16 Calculation Algorithm/Measure Logic (CMS CBE Measure Submission Form, Measure Specifications sp.22)

8. Denominator events are identified by hospitalization, observation, and ED events with appropriate codes (i.e., codes identifying an acute exacerbation of 1 of the 6 included chronic conditions).

9. Exclusions are applied to the population from Step 1 to produce the eligible patient population for the measure (i.e., the count of all qualifying events).

10. For each qualifying event, it is determined whether or not claims included a subsequent code that satisfies the follow-up requirement for that particular qualifying event (e.g., a diabetes acute event receiving follow-up care within the appropriate time frame for diabetes from a provider). Each event for which the follow-up requirement was satisfied is counted as 1 in the numerator. Each event for which the follow-up requirement was not satisfied is counted as a 0 in the numerator.
11. The percentage score is calculated as the numerator divided by the denominator multiplied by 100.

3.17 Sampling (CMS CBE Measure Submission Form, Measure Specifications sp.25 and sp.26)

N/A

3.18 Survey/Patient-Reported Data (CMS CBE Measure Submission Form, Measure Specifications sp.25 and sp.26)

N/A

3.19 Data Source (CMS CBE Measure Submission Form, Measure Specifications sp.28)

- ☐ administrative data
- ☒ claims data
- ☐ paper patient medical records
- ☐ electronic patient medical records
- ☐ electronic clinical data
- ☐ registries
- ☐ standardized patient assessments
- ☐ patient-reported data and surveys
- ☐ non-medical data
- ☐ other—describe in 3.20 (CMS CBE Measure Submission Form, Measure Specifications sp.29)

3.20 Data Source or Collection Instrument (CMS CBE Measure Submission Form, Measure Specifications sp.29)

The data sources for these analyses are Medicare FFS administrative claims data (Parts A and B) and Medicare beneficiary summary file (MBSF) data, which include beneficiary enrollment information. The original measure used both Medicare Advantage encounter data and administrative claims data submitted by private qualified health plans. Patients included in CORE's respecification are beneficiaries who can be attributed to providers participating in the ACO REACH model.

The datasets for measure development utilized Calendar Year (CY) 2018 claims and 2018 MBSF data to define the cohort (denominator) and outcome (numerator). We used this 2018 data to attribute beneficiaries to ACOs, but subsequent testing can utilize ACOs participating in the ACO REACH model and their patients.

3.21 Data Source or Collection Instrument (Reference) (CMS CBE Measure Submission Form, Measure Specifications sp.30)

N/A

3.22 Level of Analysis (CMS CBE Measure Submission Form, Measure Specifications sp.07) Accountable Care Organization

3.23 Care Setting (CMS CBE Measure Submission Form, Measure Specifications sp.08)

- ☐ ambulatory surgery center
- ☒ clinician office/clinic
- ☐ outpatient rehabilitation
- ☐ urgent care – ambulatory
- ☐ behavioral health: inpatient
- ☐ behavioral health: outpatient
- ☐ dialysis facility
- ☐ emergency medical services/ambulance
- ☒ emergency department
- ☒ home health
- ☐ hospice
- ☒ hospital
- ☒ hospital: critical care
- ☒ hospital: acute care facility
- ☐ imaging facility
- ☐ laboratory
- ☐ pharmacy
- ☐ nursing home/skilled nursing facility (SNF)
- ☐ inpatient rehabilitation facility (IRF)
- ☐ long-term acute care
- ☐ birthing center
- ☐ no applicable care setting
- ☒ other (specify)
  Hospital Outpatient, Rural Emergency Hospital

3.24 Measure (CMS CBE Composite Measure Submission Form, Measure Specifications sp.30)

N/A

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